Australia Indonesia Health Systems Strengthening Program 2011 - 2016

Program Design Document June 2011

Contents

Executive Summary 2
1. Analysis and Strategic Context 4
1.1 Country and Health Sector Issues 4
1.2 Poor people and health care in Indonesia 5
1.3 Lessons Learned 6
1.4 Consistency with Existing AusAID and other donor/multilateral Programs 7
1.5 Rationale for AusAID involvement 7
2. Program Description 8
2.1 Impact and Outcome 8
2.2 Indicative Interventions to achieve program outputs 10
District Selection 10
2.3 Forms of Aid Proposed 11
2.4 Estimated Program Budget and Timing 12
3. Implementation Arrangements 12
3.1 Management and Governance Arrangements and Structure 12
3.2 Implementation Plan 14
3.3 Monitoring and Evaluation Plan 14
3.4 Procurement Arrangements 14
3.5 Sustainability Issues 15
3.6 Overarching policy issues (gender, anti-corruption, and the environment) 15
3.7 Compliance with the Financial Management and Accountability Act 16
3.8 Business Case regarding Imprest account 16
3.9 Critical Risks and Risk Management Strategies 16
Acronyms & Glossary 19
5. ANNEXES

Executive Summary

1. This program will support the Government of Indonesia's plan to strengthen health systems and achieve the health Millennium Development Goals, in particular the seriously off track maternal mortality MDG. The Ministry of Health of Indonesia engaged strongly in the design of the program and views it as an important part of its own plans. The program aligns with the Ministry of Health Strategic Plan (2010-2014) and has targets and indicators linked to the Plan's attached Performance Matrix. It also aligns with the Government's 'Roadmap to Accelerate Achievement of the MDGs in Indonesia' which includes an explicit commitment to achieve the maternal mortality MDG. The design process has resulted in a high level of Ministry of Health ownership and leadership of the program, its intended deliverables and implementation modality.

2. The program impact (goal) is improved health status of poor people. It will be measured beyond the life of the project by improved maternal mortality rate and improved under 5 mortality rate. The outcome (purpose) will be improved utilisation of quality primary health care and appropriate referral by the poor and near poor to achieve the health MDGs (in 20 districts in 5 provinces). The program impact, outcome and outputs have been negotiated with strong Ministry of Health ownership and leadership. The program will specifically target increased utilisation of primary health care by the poor and near poor. Program monitoring will include collection and analysis of data by socio-economic status to track the benefits the lowest quintiles gain from program.

3. The program is designed on the basis of a problem analysis that suggested that improving health outcomes of poor people requires interventions and capacity development at the service delivery level of puskesmas, the management and supervision level of districts and provinces and the policy and stewardship level of national government.

4. AusAID support will be partially harmonised with Global Fund HSS support to strengthen primary health care services for poor people. AusAID support will improve the efficiency of health financing and increase the number, quality, distribution and effectiveness of primary health care workers. The AusAID investment will be up to $50 million in five years from 2011 to June 2016. The Global Fund investment will be US$37 million in five years. The Australia Indonesia Health Systems Strengthening Program will deliver its own benefits in support of the national health plan. By linking with the Global Fund HSS program it provides an opportunity for AusAID to engage government in policy dialogue to maximise the benefits of Australia's investments through the Global Fund through both core contributions and the Debt2Health agreement in Indonesia.

5. The program will contribute to achieving this outcome through addressing key supply side obstacles to improving primary health care. Access to primary health care, particularly for poor women, is limited by problems of affordability, distance to the nearest health worker or facility, and socio-cultural factors. The program aims to reduce the barrier of affordability to increase demand for primary health care but will rely on other interventions and programs to address other supply side factors (for which there are other AusAID programs). Quality of primary health care includes the quality and safety of the services delivered and also considerations of infrastructure, medical supplies and equipment. Health financing and health workforce quality,

supply and distribution are the focus of the program because of their centrality to primary health care access and quality.

6. AusAID support will result in achieving five outputs (end of project outcomes):

Output 1: Ministry of Health using evidence-based data and up to date information for the national level policies' decision making on health financing and health human resources to improve access and quality of primary health care for the poor and the near poor.

Output 2: Twenty districts/city health offices in five provinces implement health financing and human health resources' policies and programs more effectively and efficiently to improve access and quality to primary health care for the poor and the near poor.

Output 3: Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in twenty districts/cities in five provinces having (empowered) qualified health workers and have sufficient resources to deliver quality and free primary health care services and referral for the poor and the near poor (Puskesmas achieve Poned status, i.e. management of basic emergency obstetric neonatal care to Poned).

Output 4: Centre for Health Workforce Education and Training (Pusdiklatnakes) ensures selected government health polytechnics (Poltekkes) run accredited nursing and midwifery study programs (Prodi) to produce qualified nurses and midwives for the selected primary health care and village health posts.

Output 5: Universities, research institutes, civil society organizations are able to deliver evidence-based data and advocate the central and local policy-makers on health financing and health workforce and provide TA and training to districts and Puskesmas to increase health access for the poor and the near poor people.

7. The AIHSS program will be implemented by a Program Management Office in the Bureau of Planning and Budgeting in the Ministry of Health for implementation of national, provincial and district activities. In addition AusAID will contract an Implementing Services Provider (ISP) to provide technical assistance, recruit an M&E adviser, and manage a Health Policy Network and a Civil Society Challenge Fund.

8. The program design process emphasized strong government ownership and leadership, and a government led implementation modality. This was done with a longer term vision of creating the opportunity for future Phase II funding to the program after 2016 to support further scale up of the interventions. The joint nature of Global Fund and AusAID support also demonstrates the opportunity for other interested donors to bring additional support.

1. Analysis and Strategic Context

1.1 Country and Health Sector Issues

Indonesia is the largest national economy in Southeast Asia. It has recorded sustained economic growth since 1997/98. GDP is expected to increase by 6% in 2011.[1] The population is over 230 million, of whom 31 million live below the poverty line, and a further 70 million are "near poor" with consumption levels below US$2 per day.[2] Total expenditure on health per capita increased from US$19.8 in 2002 to US$55.4 in 2009.[3] Government expenditure on health is relatively low as a proportion of total government expenditure, 6.2% in 2007, but has been increasing, from 4.5% in 2000.[4] However government expenditure on health has also increased significantly from 42% of total health expenditure in 1996 to 50% in 2006.

Health outcomes have not kept pace with this economic growth and increased investment in health. Maternal mortality is particularly bad for a middle income country: 228 per 100,000[5] is very similar to Burma (219 per 100,000) and much worse than Vietnam (64 per 100,000).[6] Philippines and Indonesia have similar GNI per capita (PPP) ($3,900 to $3830) but incomparable maternal mortality (84 compared with 228 per 100,000). While Infant mortality and under 5 mortality are also lower than other comparable countries, and immunisation coverage is low (77%) (Cambodia and Vietnam are both above 90%). Non-communicable diseases are also on the rise resulting in an increasing double burden of disease, teamed with increasing life expectancy to increase pressure on the health system.

The Government of Indonesia is committed to achieving universal coverage of health insurance and has put the legislative framework in place. The Ministry of Health Strategic Plan (2010-2014) includes targets to strengthen primary health care and improve maternal mortality, and the Government's 'Roadmap to Accelerate Achievement of the MDGs in Indonesia' plan has an explicit commitment to reduce maternal mortality to achieve the MDG. These policy commitments are backed up by increasing government funding for health. Health insurance coverage was an estimated 85.9 million people in 2005, approximately 41% of the population (this assumed full coverage of the poor through Jamkesmas – targeted funding for poor people – which was not the case).[7] Almost 60% of the population therefore does not have health insurance and is at risk of the catastrophic cost of health care. The Government has a number of increasing funding schemes for priority health issues including BOK (operating costs for PHC), *Jamkesmas* (targeted funding for poor people) and *Jampersal* (for free maternity care). But evidence suggests that these funding channels may not be reaching front line primary care services for the poor.

---

[1] http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/EASTASIAPACIFICEXT/INDONESIAEXTN/0,,menuPK:287081~pagePK:141132~piPK:141107~theSitePK:226309,00.html

[2] Jakarta Globe reference from original project document.

[3] Indonesia - National Health Accounts 2005-2009: Public Sector, January 2011.

[4] WHO, World Health Statistics 2010.

[5] BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.

[6] Chongsuvivatwong, J et al. The Lancet Series Health in Southeast Asia 1: Health and health-care systems in southeast Asia: diversity and transitions. Vol 377 January 29, 2011.

[7] World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

The last 10 to 12 years have seen a shift in the responsibility for financing, planning and delivering health care from the national level to the district level, as part of broader national decentralisation programs. This rapid decentralisation however has not been accompanied by sufficient development in the capacity of district level health officials to fulfil their new responsibilities. This weak capacity causes major bottlenecks in the use of national and district finances to deliver health care. The cumbersome planning process requiring district plans to develop up to provincial and then national plans for approval can lead to up to 6 months delay in disbursement of the annual health budget. This is further compounded by insufficient communication between MoH and Ministry of Finance and a lack of willingness of MoF to allocate sufficient budget to comply with the Health Law (see Annex 1).

1.2 Poor people and health care in Indonesia

Poor people are not proportionately benefiting from publically funded health care and make greater use of under-funded primary health care. The majority of government health expenditure is on secondary care, and poor people have very little access to public hospitals. One consequence of this is that the poorest quintile benefits the least from public funding to hospitals, only 13%.[8] In 2006 the poorest two quintiles constituted over 40% of the utilisation of primary health care but only 20% of the utilisation of hospitals. There are vast geographic inequities in district and central government health spending by province. Typically poorer regions including the two initial program provinces, NTT and East Java, have much lower levels of health expenditure.[9]

Poor people are greater users of primary health care, but often have to rely on low quality primary health care. Primary health care financing is relatively low, but is further complicated by the fragmented health funding streams from national level to districts and to Puskesmas. This reduces the efficiency of primary health care budget allocations, many of which are underspent at the end of the year. In addition there is a mal-distribution of health workers, with critical vacancies in many *Puskesmas*, in particular in remote and poor areas. The skills mix can be inappropriate, and the level of staff training and experience insufficient for the health issues and complications that they face. Restrictive national regulations on appointing health workers (as civil servants) limit the possibilities for districts to innovate and find local solutions to their shortage of health workers.

Many poor people who are entitled to free care under the Jamkesmas scheme are not currently participating.[10] Estimates of the proportion of total health expenditure for health that is spent by people out of pocket vary from 30% (according to WHO data) to 48% (World Bank). For the large number of poor or near poor this is a substantial risk to the catastrophic cost of health care. In 2006 1.2% of households suffered catastrophic health expenditure (a reduction from 1.5% in 2005).[11] Impoverishment as a result of health care costs also decreased slightly from 1.2% to 0.9% of households between 2005 and 2006. This is still a significant number of Indonesia's 230 million population. The cost of health care is not the only factor.

[8] World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008
[9] Ibid
[10] World Bank: Indonesia Health Sector Review: Does Jamkesmas Protect the Population from Health Expenditure Shocks?
[11] World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

Geographical access and proximity to health care is a problem in many remote parts and smaller islands in Indonesia. Many of the interventions required to improve child and maternal health require effective primary health care for immunisation, ante-natal care leading to safe delivery and for integrated child health. However utilisation of primary health care is low because of perceptions of high cost and low quality. Many *Puskesmas* do not have the staff they need (doctors, nurses or midwives). Health workers in primary health care facilities (*Puskesmas*) often do not have the needed skills, or do not see sufficient number of cases to maintain a high level of skill and experience in managing complications. The lack of application of nursing and midwifery standards in some districts can be a contributory factor. Crucially for maternal health, there are unclear or inefficient referral pathways from primary care, resulting in unnecessary deaths during obstetric complications.

Finally national health policies are sometimes made without due process to gather and analyse the appropriate evidence to inform policy options and choices. There is insufficient data generated and analysed on whether and why poor people are benefiting from public health expenditure.

There are of course multiple other determinants of health, including in particular poor access to safe water and sanitation, and education in Indonesia.

In summary, the evidence suggests that poor people are disproportionately not benefiting from public expenditure on health care. Poor people use primary health care more than secondary care, although utilisation is below expectations. Primary health care is underfunded and understaffed, and funding is inefficient. The situation is worse in poorer, remote and rural districts. Many of the key interventions that would help Indonesia achieve the maternal health MDG should be delivered by Puskesmas with efficient referral pathways for emergency obstetric care.

1.3 Lessons Learned

There are important lessons from AusAID support for Maternal and Neonatal Health (AIPMNH) because it addresses similar health systems constraints. A key lesson from this partnership are that weak capacity at district and puskesmas level can be addressed using donor funding and technical assistance to improve health care delivery. A second lesson is that it is difficult to develop full national and local ownership and leadership of the program when funding and decision making responsibility and accountability lies with an externally contracted implementer.

There are many potential lessons from international health systems strengthening programs. Firstly, primary health care is an appropriate focus for a health systems program which aims to benefit the health of the poor. Quality, accessible primary health care is cost-effective and vital to any health systems aspiring, as in Indonesia, for universal coverage.[12] Secondly in a large country with a highly decentralised fiscal and political system health system strengthening requires both national (policy) and district (delivery) level interventions. Finally, in a middle income country the challenge for a donor is not “what its project can do” but “how can the donor funding leverage increased efficiency and effectiveness from the considerably larger scale of national health funding”. This can only be achieved by working within national

[12] World Health Organisation: World Health Report 2006

programs. A program modality that links national policy work to district implementation is essential.

1.4 Consistency with Existing AusAID and other donor/multilateral Programs

Pillar 2 in the Australia Indonesia Partnership Country Strategy 2008-2013 is "Investing in People" and states that Australia will work with Indonesia to deliver better health access and systems. This program is consistent with that objective and will underpin the existing AusAID support to Indonesia for Maternal and Neonatal Health, HIV/AIDS and Emerging Infectious Diseases. Health systems, and by extension this program, contribute to the achievement of these other projects because strong health systems are needed to deliver emergency obstetric care, to provide AIDS treatment, and to respond to emerging infectious diseases.

The program will also align geographically with the Australia Indonesia Partnership for Decentralisation (AIPD) and, with its specific health focus, leverage from AIPD's broader supply and demand side activities to achieve improved resource allocation at the sub-national level.

This program is designed to be partially harmonised with the Global Fund HSS program which will provide $37 million between 2012 and 2016 to focus on strengthening health information systems and procurement and supply chain management. This is the largest other donor supporting health systems. These are two areas that are complementary to and mutually reinforcing with AusAID's focus on health financing and human resources for health.

There are few donors funding health systems strengthening in Indonesia. Indonesia has a $24 million GAVI grant for HSS approved in 2008 for 5 years to 2013. It has suffered slow implementation and has to date disbursed only $3m however it is to be reprogrammed and will coordinate with GF and AusAID HSS investments. The Government of Indonesia is unlikely to take further loans from the World Bank or ADB for health systems because of its relatively strong health infrastructure, and higher loan repayments as a MIC. The World Bank produces high quality health financing and systems analysis which the program could link with in the future. USAID, the other large bilateral donor to health in Indonesia is not investing in health systems strengthening, and GTZ is exiting health in Indonesia at the end of 2011 The World Health Organisation is not strongly active in health systems strengthening.

1.5 Rationale for AusAID involvement

AusAID is increasing its investment in the health of poor people globally. Australia's largest development partnership is with Indonesia, and there are over 100 million poor or near poor in Indonesia. Many of them are not accessing quality primary health care, or are vulnerable to the shock of catastrophic cost of health care. Indonesia is a middle income country with a policy of universal coverage, increasing government expenditure on health, and the fiscal space to continue increasing. The rationale for AusAID involvement on health systems with Indonesia to work with government is to help increasing government funding for health benefit the poorest. The analysis of primary health care delivery (outlined in Annex 1) suggests that key issues to be addressed include (i) increasing the efficiency of existing health resources for primary health care and (ii) increasing the quality, number and distribution of primary health care workers, in particular nurses and midwives. In addition analysis of the political economy of the health sector suggests that a critical

obstacle to increasing the effectiveness and efficiency of health spending is the limited capacity at the district level, which has the prime responsibility for funding, planning and delivering health care in highly decentralised Indonesia. AusAID has an important role to bring funding, technical assistance and international best practice and innovation to help government ensure that poor people really do benefit from public funding for health.

There is also a rationale for AusAID to invest in health systems in Indonesia to maximise the benefits of its existing programs. Firstly there is a global recognition that vertical health programs (such as maternal and child health, HIV/AIDS, and immunisation) are unsustainable and do not deliver full potential if not complemented by system strengthening. This program therefore provides a vital underpinning to assist Indonesia achieve its health MDG targets and is complementary to AusAID's existing portfolio of development support in Indonesia. Secondly under AusAID's Debt2Health Swap arrangement with the Global Fund and Government of Indonesia, Australia foregoes the repayment of debt owed in return for investment in Global Fund approved tuberculosis programs in Indonesia. AusAID support for health systems in Indonesia, harmonised with the Global Fund, will underpin higher performance of these other programs. Finally AusAID support will focus on public, not private, funded health care and seek to influence the efficiency of this increasing public health care expenditure.

2. Program Description

The program has been designed with a process of extensive consultation and joint working with the Ministry of Health. The impact, outcome, outputs, indicators and modalities have been negotiated and agreed in joint workshops with strong Ministry of Health leadership. It will support the Government of Indonesia's plan to strengthen health systems and achieve the health Millennium Development Goals. The program aligns with the Ministry of Health Strategic Plan (2010-2014) and has targets and indicators linked to the Plan's attached Performance Matrix. It also aligns with the Government's 'Roadmap to Accelerate Achievement of the MDGs in Indonesia' which includes an explicit commitment to achieve the maternal mortality MDG. The design process has resulted in a high level of Ministry of Health ownership and leadership of the program, its intended deliverables and implementation modality. The program is designed on the basis of a problem analysis that suggested that improving health outcomes of poor people requires activities and capacity development at the implementation level of puskesmas, the management and supervision level of districts and provinces and the policy and stewardship level of national government. Annex 9 sets out the problem analysis and program theory of change. There are on-going discussions with Ministry of Finance, BAPPENAS and the Provincial Governments to broaden government ownership. This is critical for successful program implementation.

2.1 Impact and Outcome

The goal of the program is improved health status of poor people. This can be measured beyond the life of this program with indicators on maternal mortality and under 5 mortality . The program outcome is improved utilisation of quality primary health care and appropriate referral by the poor and near poor to achieve the health MDGs (in 20 districts in 5 provinces). The focus of the program will be to increase the utilisation of primary health care by poor and near poor. This will be tracked by

collecting and analysing data that will be disaggregated by socio-economic status (income quintiles). The program will contribute to achieving this outcome through addressing key supply side obstacles to improving primary health care and by improving the poverty focus and effectiveness of national and local policy, planning and budgeting for service delivery. It will also address the major demand side barrier of the high cost to poor people of primary health care. The programme will improve access to better primary health care services where poor people are the major users. It will strengthen national, provincial and district systems for monitoring health service delivery, health seeking behaviour, and health care utilisation by poor people.

Access to primary health care, particularly for poor women, is limited by problems of affordability, distance to the nearest health worker or facility, and socio-cultural factors. Quality of primary health care includes the quality and safety of the services delivered and also considerations of infrastructure, medical supplies and equipment. Health financing and health workforce quality, supply and distribution are the focus of the program because of their centrality to primary health care access and quality. Australia's contribution to efforts to achieve these goals is to support activities to contribute to five program outputs:

Output 1: Ministry of Health using evidence-based data and up to date information for the national level policies' decision making on health financing and health human resources to improve access and quality of primary health care for the poor and the near poor.

Output 2: Twenty districts/city health offices in five provinces implement health financing and human health resources' policies and programs more effectively and efficiently to improve access and quality to primary health care for the poor and the near poor.

Output 3: Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in twenty districts/cities in five provinces having (empowered) qualified health workers and have sufficient resources to deliver quality and free primary health care services and referral for the poor and the near poor (Puskesmas to Poned).

Output 4: Centre for Health Workforce Education and Training (Pusdiklatnakes) ensures selected government health polytechnics (Poltekkes) run accredited nursing and midwifery study programs (Prodi) to produce qualified nurses and midwives for the selected primary health care and village health posts.

Output 5: Universities, research institutes, civil society organizations are able to deliver evidence-based data and advocate the central and local policy-makers on health financing and health workforce and provide TA and training to districts and Puskesmas to increase health access for the poor and the near poor people.

Outputs 2 and 3 are the most critical for achieving the program outcome. Output 4 is an investment in future staffing for primary health care. Output 1 and 5 ensure a linkage between national policy development and district implementation, and provides an in-built mechanism for lessons from this program to be rolled out to other provinces and districts in future. Output 5 engages with civil society and academia outside of the health bureaucracy to (i) advocate for increased government expenditure on health, (ii) advocate for improved district and facility level

accountability for health expenditure and (iii) conduct research on poor people's health care, for evidence based policy and transparency of implementation.

The program does not have a strong focus on addressing individual and social barriers to health seeking behaviour other than reducing the major barrier of affordability. This is because the international evidence suggests that major increases in utilisation can be achieved by addressing supply side constraints and removing the financial barriers to health care. There are other programs, including AusAID's AIPD, which include some demand side interventions. There is scope for future phases of programming to include interventions to increase demand for health care, but it was viewed appropriate (and more ethical) to improve quality and affordability of primary health care first.

2.2 Indicative Interventions to achieve program outputs

An indicative set of interventions and activities essential for achieving program outputs has been developed and agreed with the Ministry of Health. These are outlined in Annex 6. Examples include:

Output 1: technical assistance to Ministry of Health to improve human resource information systems, funding to support research on poverty, equity and health, support for policy studies and innovation to improve health financing mechanisms.

Output 2 and 3: technical assistance to provincial health offices to increase leadership and supervision of district health offices. Technical assistance to district health offices to build capacity to improve planning and disbursement of health financing and distribution of human resources. Training and capacity building for Puskesmas to better utilise health financing and increase staff skills to deliver primary health care that meets national standards. This will include funding for research, technical assistance and training for institutional and individual capacity.

Output 4: Funding and technical assistance to Ministry of Health to support Poltekes to improve training standards for midwifery and nursing to meet new accreditation standards. Includes support to Poltekes to meet the new standards.

Output 5: Funding and technical assistance to support a Health Policy Network of universities and research institutes to conduct research and generate data on health poverty and equity including capacity to make research more accessible to policy makers. Funding for a Civil Society Challenge Fund to enable civil society to advocate for more funding for primary health care, and for poor people to utilise primary health care.

District Selection

Criteria for selection for districts and provinces are: districts to be ranked poor; low performance on key health indicators; preference to districts where program can capitalise on existing AusAID support (esp. NTT – AIPMNH and AIPD); district leadership demonstrates political will to improve health systems (measured by $ allocated to health, history of strengthening system); aligned to districts for Global Fund HSS program and other donor support; and provide examples for scaling up. Two of the five targeted provinces have been agreed: East Java and NTT, with district selection underway. Selection of subsequent provinces and districts will be endorsed by the Program Steering Committee.

A new Presidential decree PP10/2011 on the management of loans and grants states that local government should provide assistance to grants in the form of

staffing and that a letter of support must be supplied by the District Head and Head of the local Parliament.

Interventions at the sub-national level afford the opportunity for the program to work collaboratively with the Global Fund HSS investment and also GAVI HSS, USAID maternal and neonatal health programs and UNICEF child health projects.

2.3 Forms of Aid Proposed

The modalities for delivering the HSS program were selected to meet criteria agreed with the Ministry of Health. These are: (i) most likely to support achievement of project outcomes, (ii) most likely to support national ownership and leadership, (iii) robust financial risk management – protecting AusAID $ from misuse or leakage, (iv) maximises AusAID - MOH policy dialogue, (v) minimises transaction costs for AusAID and MOH, (vi) flexible to allow scale up with additional resources in the future, (vii) possibility to extend beyond immediate 5 year programme, (viii) capacity to accommodate other potentially interested donors, (ix) based on international best practice and (x) feasibility to start quickly (early 2012).

The program design best fitting these criteria is a government led program with grant funding to be managed by a Project Management Office in the Ministry of Health for implementation of national, provincial and district activities. This will be supplemented by an Implementing Service Provider (ISP) to provide technical assistance, manage the Health Policy Network and a Civil Society Challenge Fund.

Other forms of aid considered include partnering with a development Bank, UN agency, sector budget support or contracting a private sector managing contractor. The strongest alternative option would have been a World Bank Trust Fund. This was discounted because of the low interest on the part of the Ministry of Health in taking out additional World Bank loans for the health sector, and the risk of reducing national ownership and of limiting AusAID policy dialogue with Ministry of Health. It would also have required a much longer design process. However the program should keep open the option of linking with the World Bank on future analytical work as long as this work is conducted in a way that ensure government ownership of the results and findings. There are no UN agencies with a track record or expertise in strengthening health systems in Indonesia to consider for this type of program. The option of engaging a private sector managing contractor was also considered but is unlikely to achieve the high level of partner government ownership and leadership required. Sector budget support was discounted for two main reasons: firstly it does not score well against the financial risk management criteria, and secondly there is the risk that AusAID funding, by being relatively small compared to government funding, would not leverage sufficient additional results and could suffer the same inefficiencies that affect disbursement and use of the government budget.

The design proposes partial harmonisation with the Global Fund HSS program (the details are outlined below under Implementation Arrangements). The principle benefits of this approach are: (i) use of the existing and proven Global Fund aid management model which is country led but with strong fiduciary risk management, (ii) potential synergies to the Government of Indonesia of bringing two HSS funding streams in alignment with national priorities; (iii) complementarity of AusAID support for human resources and health financing, with Global Fund support for health information systems and pharmaceutical supply chain management and (iv) the potential for AusAID to influence implementation of Global Fund support and leverage greater outcomes – particularly important because of AusAID's support to

the Global Fund globally as well as in Indonesia through the Debt2Health program. The key risks of this harmonisation are seen to be: (i) Global Fund's slow grant disbursement record limiting impact of its funding, (ii) global perceptions of misuse of Global Fund grants being applied to Indonesia (real or perceived); (iii) increased transaction costs for AusAID staff in policy dialogue and managing key national level relationships – aid coordination always takes more time than envisaged. On balance AusAID, the Ministry of Health and the Global Fund agreed that the partial harmonisation approach should bring benefits and can minimise the risks.

2.4 Estimated Program Budget and Timing

This table provides an estimate of budget breakdown by the five outputs.

	FY					Total	%
	2011-12	2012-13	2013-14	2014-15	2015-16		
Output 1	$500,000	$1,000,000	$1,000,000	$1,000,000	$800,000	$4,300,000	9%
Output 2 and 3	$500,000	$3,000,000	$8,000,000	$10,000,000	$8,400,000	$29,900,000	61%
Output 4	$100,000	$500,000	$500,000	$500,000	$400,000	$2,000,000	4%
Output 5	$200,000	$500,000	$500,000	$500,000	$400,000	$2,100,000	4%
M and E	$500,000	$500,000	$600,000	$600,000	$600,000	$2,800,000	6%
Sub Total Outputs and M&E	$1,800,000	$5,500,000	$10,600,000	$12,600,000	$10,600,000	$41,100,000	84%
Management (national, provincial, district)	$90,000	$275,000	$530,000	$630,000	$530,000	$2,055,000	4%
ISP TA and Management	$500,000	$1,000,000	$1,000,000	$1,000,000	$800,000	$4,300,000	9%
Program Technical Adviser	$300,000	$300,000	$300,000	$300,000	$300,000	$1,500,000	3%
LFA Costs	$100,000	$80,000	$80,000	$100,000	$100,000	$460,000	1%
Sub Total TA and Management	$990,000	$1,655,000	$1,910,000	$2,030,000	$1,730,000	$8,315,000	17% [13]
Grand Total	$2,790,000	$7,155,000	$12,510,000	$14,630,000	$12,330,000	$49,415,000	100
	6%	14%	25%	30%	25%	100%	

It is expected that $40.05m will be managed through national PMO, up to $7.4 through the ISP, and the remainder covering the costs of the Program Technical Adviser and the LFA.

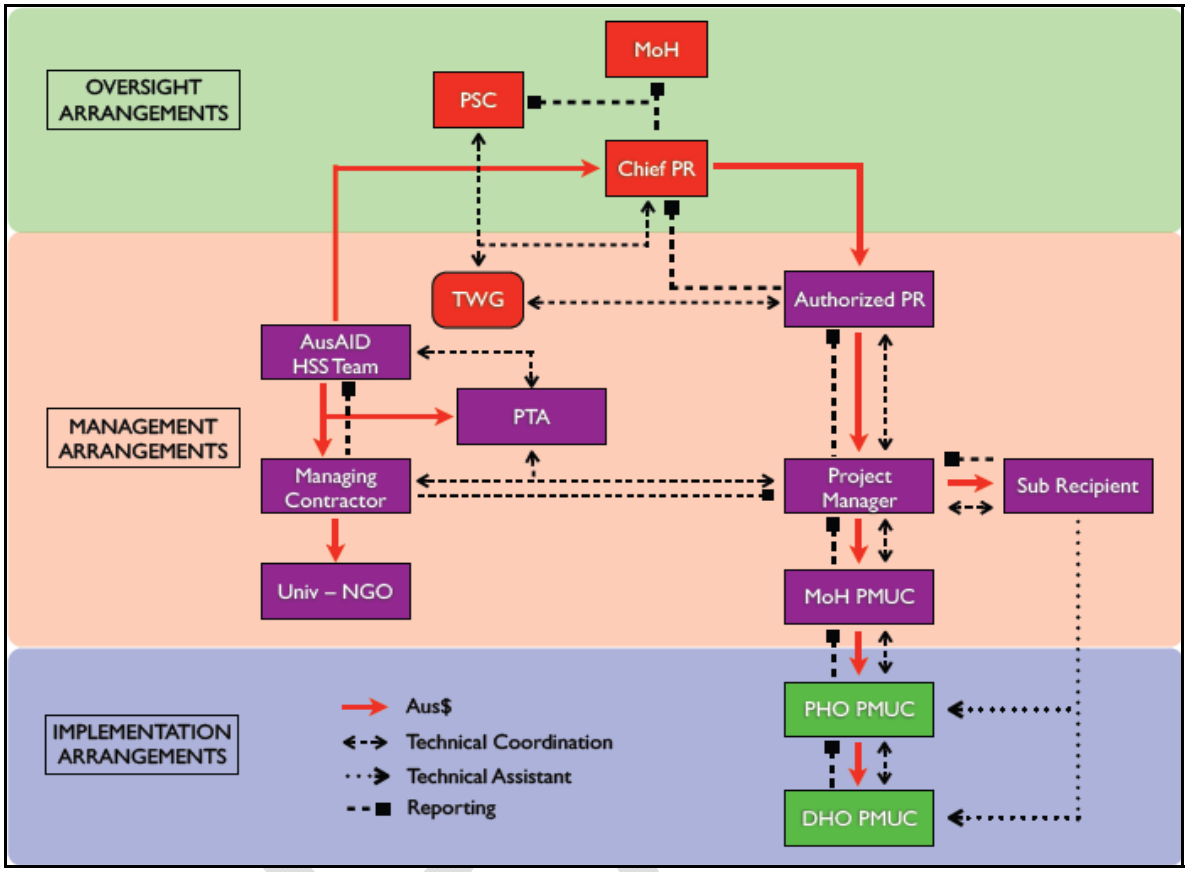
3. Implementation Arrangements

3.1 Management and Governance Arrangements and Structure

The AIHSSP will be partially harmonised with the Global Fund HSS grant. This will support the Ministry of Health to achieve better outcomes more efficiently through both programs working together. Strengths and risks of this approach are set out in

[13] Note that % do not add up to 100 because of rounding.

Annex 7. They will share governance arrangements, have separate management arrangements, but share implementation arrangements. The AusAID program will be delivered by a Program Management Office (PMO) within the Ministry of Health, with support from an AusAID contracted Implementing Service Provider and a Program Technical Adviser.



The governance and management arrangements have been designed to ensure joint accountability between the Government of Indonesia and AusAID, but to ensure lead accountability for managing and implementing the project lies with the PMO in the Ministry of Health.

AusAID and the Global Fund will share two oversight mechanisms. Firstly, the *Chief Principal Recipient* will be the same for both donor funds, with responsibility to report directly to the Minister of Health. Secondly, there will be a joint *AusAID-Global Fund HSS Technical Working Group* (TWG) to provide technical oversight on both programs. In addition there will be a *Program Steering Committee* (PSC) with AusAID, MOH, and other Ministries (BAPPNEAS, Ministry of Finance, Ministry of Home Affairs, provincial and district level representation). It will have responsibility for setting the program's strategic direction and monitoring progress. It should ensure that the HSS program is contributing to improving the effectiveness of national programs. It is anticipated that it will meet twice a year, possibly more in the first year.

In the Ministry of Health there will be separate management arrangements for the AusAID and Global Fund programs because of the separate technical issues. The *Authorised Principal Recipient* and *Program Management Office* for the AIHSSP will be within the Bureau of Planning and Budgeting. The PMO will be responsible for developing; managing, implementing and reporting on annual work plans, convening

TWG, overseeing HPN and ISP and putting in place a clear M&E plan (see Annex 7 for full responsibilities). AusAID will provide funds for staff in the PMO. There will be very close cooperation between the PMO for AusAID and Global Fund grants, and potentially co-location of offices. There will be separate bank accounts. The PMO will be led by a national program manager who reports to the PSC. AusAID will contract a Program Technical Adviser to work in PMO as a senior adviser to the program manager. Her/his role will be to provide high level technical advice on health systems and health policy, and to assist the program manager in overall program coordination. AusAID will also contract the Global Fund Local Fund Agent to perform the same level of programmatic and financial oversight as it undertakes for Global Fund Grants in Indonesia.

AusAID will contract an Implementing Service Provider to provide TA, training and capacity building. It will also be responsible for managing and contracting the Health Policy Network and the Civil Society Challenge Fund. The ISP manager will report to the PMO, AusAID and the HSS Program Steering Committee. The ISP will develop annual work plans with the PMO so that they are demand led and respond to program needs. It will submit annual workplans and annual reports to the PMO for sign off and to PSC (including AusAID) for formal approval.

It is expected that the PMO manager will convene a monthly meeting with the Program Technical Adviser, the ISP manager and the M&E adviser to ensure coordination between their activities.

3.2 Implementation Plan

Program implementation will begin in 2011 and continue until June 2016. There will be an inception period from program approval until early 2012 until the PMO and ISP are operational. The outline implementation plan is at Annex 10. The inception period will include critical activities to get the project operational as soon as possible, and to maintain the positive momentum of MoH-AusAID program design discussions. These will include any additional fiduciary risk assessment, establishing PMO (including with first districts and provinces) and recruiting staff, contracting ISP, agreeing indicators, baselines, milestones and targets for the logical framework and collection of necessary baseline data.

3.3 Monitoring and Evaluation Plan

The PMO will develop a Monitoring and Evaluation Plan during its first six months. This will be based on the Logical Framework, and an evaluability assessment. The inception phase will include activities to finalise the Logical Framework including agreement on the indicators, targets, baselines and milestones. The M&E Plan will also assess the available data sources and develop a plan of activities to build capacity to strengthen national routine health information systems or surveys. AusAID will recruit an M&E adviser to support the Ministry with inception activities and work in the PMO. The adviser will be novated into the ISP contract once this is established.

3.4 Procurement Arrangements

Program design does not envisage large MoH led procurement processes. Procurement will mostly be of services including technical advice and research. This will adhere to standard GoI procurement process. The fiduciary risk assessment of the PMO (Bureau of Planning and Budgeting) will include assessment of contracting and tendering systems and capacity.

3.5 Sustainability Issues

There are three key elements to the sustainability of this program: (i) sustained funding of health service delivery from national and district budgets, (ii) sustaining improved planning by districts and service delivery by Puskesmas and (iii) sustaining and the demand for, generation of, and use of evidence for making pro-poor health policies.

The sustainability of funding of health services should be possible because AusAID funding for actual health service delivery will be almost zero (maybe a few small grants to encourage innovation) and will be minimal compared with existing government funding for health services for poor people. There is the fiscal space for government to continue to increase health service funding, and there appears to be the political will to sustain this.

Sustaining improved health planning by districts and health service delivery is a key challenge that program activities will need to address and plan for from the outset. In particular the practice of 'mutasi' is a particular risk to future sustainability. The program will need a strong focus on institutional capacity building which involves considerations beyond knowledge and skills. Districts will be selected carefully to identify those where there is strong political will to improve health care for poor people, and to strengthen the capacity of the district level health office.

The third element to sustainability is the use of evidence for making health policies that benefit the poor. A key strategy for the program is to create demand through by funding, TA and ownership to the Ministry of Health and District Health Offices to commission research and use the results. The program will also invest in building capacity by researchers to provide relevant evidence in accessible formats to policy makers.

The program will also influence policy through the improvement of administrative datasets and systems, including those that involve transfer of information from the districts to the central level. It will support both the technical aspects (i.e. good quality data) and the `softer' processes (i.e. advocacy, leadership and maybe even new mechanisms to incorporate evidence into policy) related to evidence based policy, planning and budget decision making.

3.6 Overarching policy issues (gender, anti-corruption, and the environment)

Gender

There are significant gender related issues to achievement of the program outcome. Firstly quality gender disaggregated data on health status and health care utilisation is essential for program, as well as health system, planning. Secondly there are considerable differences in the health issues faced by women and men which require different planning at district and primary health care level. In particular is the focus of this health systems program on supporting improved maternal health outcomes. Surveys have demonstrated gender related concerns for women accessing health services and women working in the health system face gender related barriers to safe employment and promotion. The program will develop a gender action plan in its first six months to identify, prioritise and implement activities to addresses these identified gender issues. A gender assessment was conducted to inform the design of this program and a summary of this and other data is at Annex 4.

Anti-corruption

Corruption is recognised as a risk by GoI. The three main risks are: (i) collusion and kickbacks in procurement processes; (ii) collusion in recruitment of staff and (iii) misuse of funds for inappropriate activities, activities not undertaken or false accounting. The program modality includes clear arrangements for managing fiduciary risk and ensuring sound financial management (see Annex 5 and Annex 7). The program modality has been selected and designed specifically to minimise fiduciary risk while also maximising national leadership and ownership. PWC, the Global Fund's Local Fund Agent, will be contracted to provide fiduciary oversight over the program. AusAID will work with MoH to identify a mechanism to deal with allegations of funds misuse with the MOH, should such allegations arise.

Environment

The main environmental risk is unsafe disposal of contaminated medical waste at health facilities. The program will ensure that Ministry of Health standards for safe disposal of medical waste are adhered to in all program supported facilities. The program complies with the Environment Protection and Biodiversity Conservation Act.

3.7 Compliance with the Financial Management and Accountability Act

The AIHSS program will comply with the Financial Management and Accountability Act.

3.8 Business Case regarding Imprest account

There will not be an Imprest Account.

3.9 Critical Risks and Risk Management Strategies

The overall risk rating is medium. The table below outlines the 7 "high" probability or impact risks and some of the risk management strategies. A detailed outline of risks and risk management measures is at Annex 12.

Risk	**Probability**	**Impact**	**Risk Management Strategies**
General risks			
There are reports of misuse or wastage of Ministry of Health funds.	High	High	• Ring-fencing of AusAID funds • Identification of a mechanism to deal with allegations of funds misuse with the MOH
Project specific risks			
Mutasi at district level (in particular) limits the potential for technical assistance and training to lead to sustainable improvements in health planning, budgeting and service	High	High	• Capacity building develops systems in offices and in individuals. • Program identifies options for managing the risk of *mutasi* and advocating for policy changes. • Letter of commitment from

Risk	Probability	Impact	Risk Management Strategies
delivery.			participating district heads and parliament agrees to no/managed rotation of staff.
There are reports of misuse or wastage of AusAID or Global Fund HSS funds in Indonesia.	Med	High	• Comprehensive fiduciary risk assessment. • Clear agreement on financial management rules and controls • Contingency plan to freeze and recover assets if required. • Annual audit
Capacity in district health offices remains weak	Medium	High	• Program framework for assessing capacity of district health offices. • PMO monitors capacity development and raise alarm if insufficient.
The absorptive capacity of the PMO and sub-national Health Offices is limited	Medium	High	• Technical oversight on quality of PMO provided by Program Technical Advisor
The establishment of the PMO encounters delays that impact on implementation	Med	High	• Clarity between AusAID and MOH on roles, responsibilities and timelines on recruitment of PMO staff.
Ineffective use of resources due to a lack of cooperation between MOH, other relevant ministries and subnational government partners.	Med	High	• Steering committee provides clear direction to all levels of government on program implementation • Technical Working Group ensures consistency between AusAID and GF HSS programs and ensure alignment with MoH priorities
Changes in the political economy across the sector (across all levels of govt and legislature)	Low-Med	High	• Stronger links between MOH and AusAID delivered through the program enable changes to be anticipated and the program to adapt accordingly

Risk	Probability	Impact	Risk Management Strategies
			• At subnational level alignment with AIPD provinces and districts gives additional leverage • Presidential decree that requires all districts to give written undertakings prior to receiving program grants.
Improvements in PHC services are not recognised by poor people and there is no change to demand	Low	Low	• The HSS program will work in the same five provinces and 20 districts as the AIPD which has a strong focus on generating demand for health services. • Work in VPs office to better target health insurance for the poor (Jamkesmas) to lower two income quintiles • PNPM Generasi CCTs scaled up significantly from 2012.

4. Acronyms & Glossary

ADB	Asian Development Bank
AIHSSP	Australia Indonesia Health System Strengthening Program
AIP	Australia-Indonesia Partnership
AIPD	Australia-Indonesia Partnership for Decentralisation
AIPEID	Australia-Indonesia Partnership for Emerging Infectious Diseases
AIPH	Australia-Indonesia Partnership for HIV
AIPMNH	Australia-Indonesia Partnership for Maternal and Neonatal Health
APBD	District government consolidated budget
APBN	National government consolidated budget
ASKESKIN	Basic Health Insurance for the Poor Program (operated by PT ASKES)
AUSAID	Australian Agency for International Development
AUD	Australian Dollar
BANSOS	Bantuan Sosial (social assistance)
BAPPENAS	Badan Perancanaan Pembangunan Nasional (National Development Planning Agency)
BBPSDMK	Badan Pengembangan dan Pemberdayaan Sumber Daya Manusia Kesehatan (National Institute for Development and Empowerment of Health Human Resources, Ministry of Health)
BIRO PERENCANAAN DAN ANGGARAN	Bureau of Planning and Budget
BOK	Bantuan Operasional Kesehatan (Block Grant Program)
BPS	Central Bureau of Statistics
CCT	Conditional Cash Transfers
DAU	Dana Alokasi Umum (General Allocation Fund/GAF: government funds provided from MOF to district governments to fund public services: mainly operational costs covered)
DAK	Dana Alokasi Khusus (Special Allocation Fund/SAF: government funds provided from line ministries to district governments to primarily fund public infrastructure/equipment – requires 10% local counterpart funding, generally from DAU support)
Debt2Health Swap	Australia foregoes repayment of debt owed in return for investment in Global Fund approved tuberculosis programs in Indonesia
Dekon	Dana Dekonsentrasi (Deconcentration Fund: government funds provided via line ministries to provincial government specifically for the funding of national priorities)

DfID	Department for International Development (United Kingdom)
DHA	District Health Accounts
DHE	Directorate of High Education, MONE
DHO	District Health Office
DINKES	Dinas Kesehatan (Provincial/District Health Office)
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestoc Product
GF	Global Fund to Fight AIDS, TB and Malaria
GF HSS	Global Fund grant for Health System Strengthening
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Association for International Cooperation)
GNI	Gross National Income
GOI	Government of Indonesia
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPN	Health Policy Network
HSS	Health System Strengthening
IFLS	Indonesian Family Life Survey
ISP	Implementing Service Provider
JAMKESMAS	Jaminan Kesehatan Masyarakat (Basic Health Insurance for the Poor Program (operated by MOH)
JAMKESDA	Jaminan Kesehatan Daerah (Basic Health Insurance for the Poor Program operated by district governments/DHO)
JAMPERSAL	Jaminan Persalinan (Targeted Funding for Free Maternity Care operated by MoH)
LFA	Local Funds Agent
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MENKO KESRA	Menteri Koordinator Kesejahteraan Rakyat (the Coordinating Ministry for People's Welfare)
MIC	Middle Income Country
MNH	Maternal and Neo-Natal Health
MOF	Ministry of Finance
MOH	Ministry of Health (Kementerian Kesehatan/Kemkes)
MONE	Ministry of National Education
MTDP	Mid-Term National Development Plan (Rencana Pembangunan Jangka Menengah/RPJM)
NGO	Non Government Organisation
NHA	National Health Accounts
NTT	Nusa Tenggara Timur (East Nusa Tenggara) Province
PHC	Primary Health Care
PHA	Provincial Health Account

PMO	Program Management Office
POLTEKKES	Health Polytechnics
POSKESDES	MCH Post (at the village level)
PONED	Pelayanan Obstertri Neonatal Dasar (Essential Neonatal Obstetric Care)
PPP	Purchasing Power Parity
PNPM-GENERASI	Program Nasional Pemberdayaan Masyarakat Generasi Sehat dan Cerdas (National Program for Community Empowerement-Healthy and Smart Generations)
PRODI	Nursing and Midwifery study programs
PSC	Program Steering Committee
PTA	Program Technical Adviser
PUSDIKLATNAKES	Pusat Pendidikan dan Latihan Tenaga Kesehatan (Center for Health Workforce Education and Training, MOH)
PUSLITBANGKES	Pusat Kajian dan Pengembangun Kebijakan Kesehatan (Centre for Health Policy Development, MOH)
PUSKESMAS	Pusat Kesehatan Masyarakat (PHC Community Health Centre at the sub-district level)
PUSRENGUN	Pusat Perencanaan dan Pendayagunaan Tenaga Kesehatan (Center for Planning and Utilization of Health Human Resources)
PWC	PriceWaterhouseCoopers
PUSTU	Puskesmas Pembantu (Auxiliary PHC Centre at the village level)
RENSTRA	Rencana Strategis (Strategic Plan)
RPJM	Rencana Pembangunan Jangka Menengah (Mid-Term Development Plan)
SUSENAS	Social and Economic Household Survey (a survey conducted periodically by BPS in every province and district of Indonesia)
TA	Technical Assistance
TP	Dana Tugas Pembantuan (Co-administration Fund for district governments to carry out additional tasks assigned by the central government)
TOR	Terms of Reference
TWG	AusAID-Global Fund HSS Technical Working Group
UGM	Universitas Gadjah Mada (Gadjah Mada University)
UI	Universitas Indonesia
UN	United Nations
UNICEF	United Nations Children’s Fund
USAID	United States Development Aid Agency
WHO	World Health Organisation