

**Independent Progress Review (Mid-Term Review)
of the
Australia Indonesia Partnership for Maternal and Neonatal Health
(AIPMNH)**



December 2010

Aid Activity Summary

Aid Activity Name	Australia and Indonesia Partnership for Maternal and Neonatal Health (AIPMNH)		
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Total other \$	\$0		
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Implementing Partner(s)	Ministry of Health, Bappenas, NTT Bappeda, NTT Provincial Health Office, Bappeda in 14 districts, DHO in 14 districts, Family Planning, Community Empowerment, Women's Empowerment at NTT province and 14 districts		
Country/Region	Indonesia		
Primary Sector	Health		

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The views expressed in this report are those of the authors and do not necessarily represent the views of the Government of Australia or the Government of Indonesia

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Note: The review team thanks the implementing team for the photo used on the front page of this report. They advised that permission was given for its use.

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Acronyms and glossary

AIPD	Australia-Indonesia partnership for Decentralisation
AIPMNH	Australia and Indonesia partnership for maternal and neonatal health
AusAID	Australian Agency for International Development
Bappeda	Badan Perencanaan Pembangunan Daerah (Regional Development Planning Agency -at provincial and district level)
Bappenas	Badan Perencanaan Pembangunan Nasional (National Development Planning Agency)
BKKB	Badan Koordinasi Keluarga Berencana (Family Planning Agency)
BKKBN	Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Board/Office)
BOK	Bantuan Operasional Kesehatan (Puskesmas Operational Fund)
BPMD	Local Government Community Development Bureau
BPP	Local Government Women's Empowerment Bureau
Bupati	Elected Head of District Government
DCC	District Coordinating Committee
Desa Siaga	National Health Aware and Alert Villages program
DHA	District Health Accounts
Dinkes	Dinas Kesehatan (Health Office at District and Province level)
DPC	District Program Coordinator
DTPS	District Team for Problem Solving
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German Technical Cooperation)
HSS	Health Systems Strengthening program (funded by AusAID)
Jamkesmas	Jaminan Kesehatan Masyarakat (Social Health Insurance for the poor)
Kemkes	Kementrian Kesehatan (Kemkes)
KIBBLA	Kesehatan Ibu dan Bayi Baru LAhir (maternal and neonatal health)
MoHA	Ministry of Home Affairs
NTB	Nusa Tenggara Barat
NTT	Nusa Tenggara Timur – the province in which AIPMNH operates
PCC	Provincial Coordinating Committee
PEACH	Public Expenditure Analysis and Capacity Enhancement
PMI	Palang Merah Indonesia (Indonesian Red Cross)
PNPM	Program Nasional Pemberdayaan Masyarakat (National Community Empowerment Program)
Polindes	Pondok bersalin desa (Village Birthing Hut)

Independent Progress Review:
Australia and Indonesia Partnership for Maternal and Neonatal Health

PONED	Pelayanan Obstetri dan Neonatal Emergensi Dasar (Basic Emergency Obstetric and Neonatal Care = BEONC)
PONEK	Pelayanan Obstetri dan Neonatal Emergensi Komprehensif (Comprehensive Emergency obstetric and neonatal care = CEONC)
Posyandu	Pos Pelayanan Terpadu (Integrated Health Service Post)
PRC	Performance Review Committee
Pra-musrenbang	Pra – Musyawarah Perencanaan Pembangunan (community meeting to start discussing their priorities for development plan)
Puskesmas	Pusat Kesehatan Masyarakat (Community / Primary Health Centre)
Reformasi Puskesmas	Puskesmas reform
Revolusia KIA	Maternal and Child Health Revolution
Rumah Tunggu	Waiting house
SKPD	Satuan Kerja Perangkat Daerah (Local Government Agency or Department)
ToR	Terms of Reference
UNFPA	United Nations Population Fund
Yanmedik	Medical Services Unit

Executive summary

AIPMNH is a partnership between the Australian and Indonesian governments to help address maternal and neonatal health issues. The Program began in 2008 and currently operates in 14 of the 21 districts in Nusa Tenggara Timur (NTT). The Program provides technical assistance and additional funds to provincial and district level governments with the aim of their effectively managing a range of resources to progressively meet Millennium Development Goal targets for maternal and child health. The Program works through the government's own planning and budgeting processes. An independent progress review was undertaken in October and part of November 2010.

Strengthening capacity of government staff and systems is a major component of the Program. The review found evidence of some immediate outcomes in terms of changes in skills, knowledge and practices. Where training has occurred or technical assistance provided, it is apparent that: health staff more confidently manage a range of complications that they were not able to do previously; referral processes are being put in place at the local level; clinical standards are being implemented; more coordinated planning is occurring between agencies; and maternal and neonatal health activities are progressively being aligned to local need.

It also appears that the Program is contributing to improvements in maternal and neonatal health status through actively supporting provincial and local governments to move from home-based to facility-based delivery, where improved care is more likely. Whilst government data systems are not yet robust enough to reliably report trend data, it appears that combined actions within districts could be having a positive effect on both the number of facility-based deliveries (as a means of achieving safer deliveries) and the number of maternal and neonatal deaths.

The review sought to assess the added value of the Program through applying a framework of additionality. A small number of examples were identified where the Program has directly added value:

- In one district, a significantly increased budget bid for maternal and child health was supported by all agencies, with parliamentarians and key leaders systematically lobbied;
- The introduction of the sister hospital program has helped address an immediate need for specialist health services, as well as putting in place strategies for addressing this need over the longer-term;
- Being able to manage complications locally through the sister hospital program has resulted in significant financial savings for the local government, the district hospital and the community;
- A prototype design for a PONEP Puskesmas and a waiting house have been developed that have now been used more widely in Indonesia, including after the Padang earthquake; and
- Through the partnership, all agencies have come to realise and accept a joint responsibility for addressing maternal and neonatal health issues, where previously it was seen only as the responsibility of the provincial or district health offices.

An important contributing factor to the successes in relation to capacity strengthening has been the use of contemporary good practice by the implementing team. Specifically, they have: been diligent in facilitating government ownership; worked at a pace that meets the local need; used local resources wherever possible; attended to strengthening the capacity of individuals, organisations and systems iteratively and over the long-term; and been focused on development outcomes. The one area of contemporary good practice in which the implementing team has been less successful is in knowing if a difference is being made.

The review found a need for more robust monitoring and evaluation. The current strategy is not meeting the needs of the partners, especially in relation to what works, where, and why. The strategy is over reliant on government processes and systems that are poorly developed and in need of strengthening over the longer-term. The Program has a mandate to help strengthen the monitoring and evaluation capacity of government agencies but has not yet been able to provide the necessary supports. It is anticipated that this support is soon to be put in place and it will be important that it become a priority of the Program. Likewise, it is critical that the implementing team begins to focus on developing its own monitoring and evaluation capacity because it needs to fill the shortfalls whilst government capacity is being strengthened.

The review highlighted two major challenges to capacity strengthening. The first relates to the low number of births that midwives deliver, which makes it difficult for them to gain the experience needed to manage complications and recognise the need for referral. There are some government policies that could be inadvertently having an adverse impact on any solutions to increase the number of deliveries with which any midwife assists. Therefore, there is a need for AusAID to undertake policy discussions with government about these implications.

The second challenge is the poor state of many facilities, particularly in relation to inadequate water supplies to delivery rooms, limited or no power, a shortage of drugs and equipment, and a generally poor level of maintenance of facilities. There is a need to help resolve these issues through improved planning and budgeting.

The use of a partnership is a new delivery mode for AusAID in the health sector in Indonesia. A framework that incorporates assessing partnership prerequisites, structure, processes and outcomes was used for this review. The review found that the necessary prerequisites such as supportive political attitudes, organisational priorities and commitment, various drivers and expectations, and shared objectives are in place. The partnership has appropriate formal structures. However, there is inconsistent involvement of the most senior Government of Indonesia officials. Contributing factors appear to be a combination of other workload demands, a lack of clarity and focus of the Performance Review Committee, and the relative importance of the Program. It might be more useful for Australia to integrate its partnership governance arrangements in the health sector at the national level rather than at an individual program level. A more strategic dialogue could help command more senior attention and overcome the former project relationship, of which some remnants are still evident.

A critical issue is the absence of AusAID from the partnerships at sub-national level. These have been formed between the various government agencies only, with the implementing team acting as a service provider to the local partners. This means that it is not possible for mutuality to develop between AusAID and the local governments, diminishing AusAID's influence over its investment and increasing its risk. It is also making it difficult to achieve the necessary level of policy dialogues, including well structured joint allocation and expenditure analyses, which are an essential element of partnerships.

To ensure that objectives of the AIPMNH are achieved, it will be important for AusAID to play an active part in the sub-national partnerships, possibly through a combination of modifying the role of the implementing team and a greater hands-on involvement by selected AusAID staff. Furthermore, there is a need for the local government partners, along with AusAID, to begin to plan and implement a graduated, staged transition to independence from the Program. It is suggested that the Program assists local governments to do this through facilitating the development of rolling five-year plans and through targeted short-term technical assistance that will help to progress such plans in a timely way.

A positive outcome of the work of the Program has been the way in which the local government agencies have been developing a collaborative approach. There is a growing sense of jointly planning and implementing activities to address maternal and neonatal health issues. However, there have been times when the benefits of focusing on a collaborative approach have led to costly delays in implementing needed aspects of the Program, most notably, monitoring and evaluation and community engagement. This has impacted on the Program's capacity to deliver what is required by the national partners and highlights a need for a balanced view and approach.

Partner agencies at the sub-national level have in place various arrangements that help them understand the needs of beneficiaries so that they can be more responsive. A more inclusive membership of the National Technical Team with agencies or teams that have a more direct role with beneficiaries could assist the national partners to improve their responsiveness.

The Program has also been establishing important linkages with other programs, both AusAID and government programs. However, there is a need for AusAID to better coordinate its work within the province, because some of the activities being undertaken by AIPMNH are better suited to the Australia Indonesia Partnership for Decentralisation (AIPD).

The issues identified with the partnership as part of this review highlight the importance of periodic assessments of the health of the partnership. By building this into the monitoring and evaluation strategy, it would help determine if the partnership is moving in the desired direction at an acceptable level of cost and benefit, and indicate if any changes need to occur.

The review has found that the relevance of the Program is strong. It is strongly aligned to the policies and priorities of both the Government of Indonesia and the Government of Australia. The Program's components and activities are similar to those promoted in the literature as being effective in helping to impact positively on maternal and neonatal health. A program logic diagram developed as part of this review indicates that the Program's pathways could lead to the desired outcomes and that there is a plausible link with the higher level outcomes. Notwithstanding this, the review has highlighted a number of areas that require further attention. The first is a possible need to scale up sexual reproductive health activity because of the current limited focus. Any such scale up in a later stage of this Program would need to be informed by further study. The second is a need for further study to determine if there is a need to scale up activities to reduce neonatal deaths, which remain high in NTT. Two studies that focus on understanding the effectiveness of training and community education are suggested. The third relates to the need to ensure that gender equity work remains focused on maternal and neonatal health outcomes and does not become too generic in nature.

The final area for further attention relates to the use and strengthening of government systems. The Program has used a Good Governance Action Plan as its basis for diagnosis of system issues and the adoption of solutions. However, this has not been a good tool and it has inadvertently led to the Program taking on activities that cannot be achieved without widespread public financial management reform, and hence, not within the mandate of AIPMNH. There is a need for the Program to focus its efforts on areas in which it can have a direct influence. It is suggested that AIPMNH and AIPD jointly review these activities and clarify the role of diagnostic assessments. To assist the AIPMNH and AIPD target system strengthening more effectively, a number of guiding principles have been outlined in the body of the report.

A key aspect of systems strengthening is effective expenditure analysis. Whilst support to partner agencies in the preparation of District Health Accounts is a useful stepping stone, there is a need for the Program to undertake its own analyses of budgeting and spending, including understanding the impact of these accounts on resource allocation decisions.

Similarly, there is a need to monitor the financing of government maternal and neonatal programs more closely in order to gauge the extent to which any funding for recurrent operations is sustainable, and to establish a principle that the Program will not artificially inflate local capacities.

The final finding of note is that there is a need for the Program to consolidate efforts, rather than expand in the immediate future. It is suggested that the current contract be extended to 2013 and that this time be used to: consolidate in the current 14 districts; implement the recommendations of this review; and design the Program for the next phase.

Recommendations in order of priority

In the body of the report the recommendations are listed in context. Here, they have been prioritised according to a priority setting matrix as outlined in Annex 6.¹ For prioritising, they have been collated into three sets of recommendations:

- i. Those that relate to the implementing team
- ii. Those that relate to AusAID and the national partnership
- iii. Those that relate to partner governments.

Note: AusAID has advised that before the implementing team can respond to, and follow-up, the recommendations suggested for their implementation, that approval must be gained from AusAID.

For the implementing team

A group of recommendations relating to monitoring and evaluation have been collated as the first priority for the implementing team. The current monitoring and evaluation processes do not provide sufficient information about the effect of the Program. There has been an over reliance on using government processes and systems which are poorly developed. There is a need for alternative processes to be put in place whilst government systems are being strengthened.

Implementing team recommendation 1: That Program performance management of AIPMNH be improved through ensuring that a more robust and appropriate Monitoring and Evaluation Strategy that addresses the issues identified in this report is developed and implemented as a matter of urgency:

- That the Program theory of AIPMNH be more clearly articulated to:
 - incorporate the key practices approaches – partnerships; capacity strengthening; and technical assistance;
 - show more accurately the logical links between and within components, including how immediate and intermediate outcomes are necessary and sufficient to reach the end-of-program outcomes; and
 - ensure end-of-program outcomes are expressed as performance outcomes.
- That an improved level of understanding of which mix, degree and level of activities best result in the desired outcomes is sought by incorporating into the revised Monitoring and Evaluation Framework ways to monitor and evaluate how, where and why different approaches work or not.
- That, as part of a revised AIPMNH Monitoring and Evaluation Strategy the partnership aspect of the AIPMNH be regularly monitored and periodically evaluated using indicators and processes jointly developed by the partners, and for the partnership to be adapted as needed.

¹ AusAID requested that the recommendations be prioritised in the report. It is the usual practice of this particular Team Leader to establish such priorities in conjunction with the partners. However, because this request came as the review team was leaving Indonesia there was no opportunity to do so. Therefore, the priority was established by the Team Leader based on the information about the Program, its governance and implementation gained during the review. The Team Leader acknowledges that this priority might need to be adapted by the partners.

- That a Monitoring and Evaluation Team consisting of a highly experienced full time Advisor and a full time Data Manager be recruited to the implementing team to:
 - develop and implement a robust monitoring and evaluation framework that enables the work undertaken by the implementing team to be measured, including developing a revised program logic with a more appropriate results framework;
 - build monitoring and evaluation capacity within the implementing team; and
 - gather and report on data that will supplement the government systems while these are being strengthened, ensuring that this part of the role is coordinated with the work undertaken by the Monitoring and Evaluation Coordinator who is shortly to be engaged by the partners.
- That the Monitoring and Evaluation Team and the Gender Team jointly review the program logic, outcomes and measures for the Gender Strategy to ensure that gender equity work remains focused on maternal and neonatal health outcomes that are achievable within the life of the Program, and that this be included in a revised Monitoring and Evaluation Strategy.
- That the role of AIPMNH staff in implementing the Gender Strategy be clarified (especially the role of District Program Coordinators and the Community Engagement Team) and that these staff receive capacity-building that enables them to take on the agreed role.
- That the Monitoring and Evaluation Coordinator who is to help strengthen the capacity of government agencies be professionally supported by a mentor with particular expertise in developing contemporary monitoring and evaluation systems and in strengthening capacity within government agencies.

Some AIPMNH strengthening activities to date have been focused on Government of Indonesia systems with very indirect impact on maternal and neonatal outcomes. In some cases these systems require engagement of multiple local government partners well beyond the reach of the program's engagement.

Implementing team recommendation 2: That AIPMNH focuses its support for system strengthening where it can be most effective and where it can have greatest impact on the key impediments to adequate allocation and efficient management of resources for maternal and neonatal health and the operation of health facilities.

There are concerns that if maternal and neonatal activities are predominately supported by donors this will compromise the long-term sustainability when donors exit.

Implementing team recommendation 3: That the sustainability risk be reduced through:

- AIPMNH monitoring the overall context of financing for maternal and neonatal programs more closely, in order to gauge the extent to which funding levels supporting ongoing recurrent operations are sustainable; and
- Partnership agreements including a principle that partnership supports for ongoing recurrent costs will not be at a level that exceeds the sustainable fiscal capacity of local governments.

District Health Accounts provide useful information for decision-makers in local government, through a picture of the whole resourcing environment for health. However, the Partnership needs more detailed information on how local governments are budgeting and spending in order to assess whether the Program is influencing better allocation of health resources, and to determine whether the Program's contribution to funding maternal and neonatal health activities is likely to adversely impact on sustainability in the long term.

Implementing team recommendation 4: That until the Health Systems Strengthening program is operating, AIPMNH should continue to support preparation of District Health Accounts, but the Program should also:

- undertake its own analysis of budgeting and spending, in order to better interpret the significance of budgetary and spending decisions that affect resourcing of health and maternal and neonatal health programs;
- seek input and advice from AusAID's public financial management team in designing the templates for collecting expenditure information to ensure these address AusAID's needs; and
- develop the skills of District Program Coordinators to be actively involved in the collection, analysis and interpretation of budget and expenditure data, so that they are able to use the information to engage in first-level policy dialogue, even if they do not actually undertake the analysis themselves.

The design for AIPMNH aims to increase the extent to which the Program works through government systems, but a subsequent fiduciary risk assessment indicates risks are still high, and the local governments' commitment to reform is unclear. Partial use of government systems can be even less desirable than full donor execution, and the benefits of this approach should be clear, whether in terms of capacity development, better alignment of how aid is used, or impact on the effectiveness of the government's own systems.

Implementing team recommendation 5: That AIPMNH and AIPD approaches to working through government systems be reviewed, focusing in particular on:

- developing a strategy for stimulating and supporting government-led programs of public financial management reform;
- clarifying and focusing on the role of diagnostic assessments, in particular their relationship to stimulating government-led financial management reform, and harmonising the use of different diagnostic instruments; and
- balancing the system strengthening benefits and program effectiveness drawbacks of partial use of government systems through partner-government execution of parallel systems.

The number of deliveries which midwives attend is probably too low for them to maintain their skills or provide them with sufficient experience to manage complications and recognise when to refer.

Implementing team recommendation 6: That AIPMNH supports sub-national partners to help maintain midwives' skills, by identifying practical local solutions for midwives to increase the number of deliveries they attend.

The literature notes that effective sexual reproductive health education can impact positively on the health status of women. The current Program design has a limited focus in this area, which might indicate a need to scale up activities.

Implementing team recommendation 7: That the need to scale up sexual reproductive health activities be explored more fully by AIPMNH in collaboration with BKKBN and UNFPA and for the findings to inform the next AIPMNH design stage.

Neonatal deaths remain high in NTT and the current Program's efforts are focused on effective training of midwives and education of mothers in newborn care. In the absence of good monitoring and evaluation data it is not possible to determine if this approach is sufficient.

Implementing team recommendation 8: That two studies be undertaken to help inform the effectiveness of AIPMNH supported activities that specifically focus on improvements in neonatal health: i) Review the skills of health workers in performing newborn care and newborn resuscitation; and ii) Evaluate the extent to which women are learning and applying appropriate newborn care practices.

For partner governments

Whilst local partnerships are maturing well, there is currently little or no attention paid to how to progress towards a time when AIPMNH will cease to exist. To achieve the Program's objectives, there is a need for progressive levels of independence of local governments from the Program.

Partner government recommendation 1: That each partnership, with the assistance of the implementing team, develops and implements five-year rolling plans that enable a graduated, staged transition to independence from AIPMNH that:

- articulate partnership development goals and the steps and resources needed to achieve these; and
- are operationalised annually, based on a review process.

As one means of assisting partner governments achieve this independence, short-term technical assistance could be used to progress plans and reduce current bottlenecks.

Partner government recommendation 2: That district partnerships, in cooperation with the technical advisors from the implementing team, identify where additional technical assistance could help them progress their plans more quickly, cost such assistance, and recruit to such short-term positions quickly and efficiently.

The only existing source of financing ongoing, routine facility maintenance is through local government budgets, which have very little discretionary capacity.

Partner government recommendation 3: That partners address the critical and urgent facility issues that are likely to adversely impact on maternal and neonatal outcomes, in particular:

- District Health Office and health facilities should find ways to budget adequately for facility operation costs, including ongoing repairs and maintenance;
- District Health Office should ensure adequate availability of drugs and equipment by implementing recently revised logistics management systems; and
- District Health Office to make the critical whole-of-government links required to address the issue of poor supply of water and power to health facilities.

For the national partnership

An important partnership outcome is being able to be responsive to the needs of beneficiaries. Given that the national partnership does not have a direct interface with beneficiaries, this responsiveness needs to occur through well-informed third parties. It would help if such third-parties were included in the National Technical Team.

National partnership recommendation 1: That the national partnership strengthens its third-party knowledge of beneficiary needs by including on the National Technical Team representatives from the Community Engagement Team, BPP (Women's Empowerment Bureau), BKKB (Family Planning), and BPMD (Local Government Community Development Bureau).

For AusAID

Generally, the Program is focused on the right things and progressing well but it has faced several implementation difficulties. Partnership approaches need time to be successful but the implementing team has established the necessary relationships and processes with the partners. There is significant work still to achieve. In such a context, it would be prudent for the Program to consolidate rather than expand in the immediate future, and for AusAID to retain the current implementing partners.

AusAID recommendation 1: That the current contract be extended to June 2013 and that this time be used to: i) consolidate AIPMNH in the current districts in NTT; ii) implement the program improvement recommendations contained in this report and the associated public financial management report; and iii) design the program for the next contract phase 2013-2018.

It would be more strategic for AusAID to take a health sector approach to the national partnership by integrating its health Programs at this governance level. This would elevate the importance of the partnership and be more likely to command involvement by appropriately senior government officials.

AusAID recommendation 2: That a single national level governance arrangement (Performance Review Committee) between AusAID and the Government of Indonesia be established for all health partnership work in order to facilitate the efficient involvement of the most relevant senior government officials, with each individual program having its own technical working group that provides the partners with a forum to discuss and resolve specific program matters.

A key aspect of partnerships is about engaging with partner government systems as a basis for advocating reforms and undertaking policy dialogue. Currently, there is little or no policy dialogue by AusAID, making it extremely difficult for there to be any systematic improvement to government systems. To be effective, such dialogue needs to be based on solid information about the effectiveness and impact of the Program, and the allocation and management of resources.

AusAID recommendation 3: That AusAID targets its investment better by picking up an active partnership role at the sub-national level through:

- delegation of the partner role to appropriate positions either within AusAID and/or the implementing team;
- regular structured engagement with the partner governments (predominately at the district level) on issues of resource allocation, expenditure and management; and
- using analyses of budget and spending undertaken by AIPMNH to inform a more focused policy dialogue.

It is apparent that the respective work of AIPMNH and AIPD will sometimes overlap. Whilst coordinative processes have been put in place, it would be beneficial for an ongoing process that promotes identification of the strategic inter-sectoral opportunities between the programs in a more structured way.

AusAID recommendation 4: That the coordination of AusAID programs in NTT be strengthened by:

- AIPMNH and AIPD jointly identifying current AIPMNH activities that are better suited to be led by AIPD, agreeing upon a process and timeline for transfer of responsibility; and
- the newly established Coordinator NTT and NTB establishing a regular, formal mechanism of supervision with the AIPMNH Program Director that allows potential program overlaps to be identified and addressed on an ongoing basis.

The Government of Indonesia's policies in relation to the location and remuneration of midwives are possibly adversely impacting on the ability of midwives to deliver sufficient numbers of births to gain and maintain their skills. If midwives do not assist sufficient numbers of deliveries they might not gain the needed experience to manage complications or recognise when to refer.

AusAID recommendation 5: That AusAID should policy dialogue with the Government of Indonesia in relation to the policy implications of, and possible solutions for, a 'one village one midwife' policy and salary supplementation for deliveries.

1. Introduction

The Australia and Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) program is a partnership between Australia and Indonesia to improve the health of pregnant women and neonatal babies. In recent years the Indonesian Government has undertaken a series of important initiatives as part of its commitment to improved health status such as: an increase in the national health budget; the introduction of a national health insurance for the poor; and the Making Pregnancy Safer initiative. AIPMNH is working with provincial and district governments in Nusa Tenggara Timur (NTT) to implement *Revolusi KIA* (Maternal and Child Health Revolution strategy) – that province’s response to the Making Pregnancy Safer initiative.

AIPMNH is built on the experience of previous activities with which AusAID has been involved, particularly in NTT. It is trying to achieve improved outcomes by: addressing system constraints; improving system governance; and introducing a performance focus.

The long term objective is for provincial and district governments to effectively manage national, local and donor resources to progressively achieve Millennium Development Goal targets for maternal and child health. The short-term objective is for selected provincial and district governments to have the necessary mechanisms in place to achieve the longer-term objective.

The partnership works with and through Government of Indonesia systems. Working through the governments’ own planning processes, the implementing service provider and local governments together select the activities and performance targets.

AIPMNH commenced in 2008 with interim activities in three districts. By the end of 2009 AIPMNH covered a total of nine districts and in 2010 an additional five districts were selected. These 14 districts represent two-thirds of the total districts in NTT. The partnership has a total value of \$32 million over 2.5 years.²

This independent progress review³ was commissioned by AusAID to answer the following key questions:

- i. To what extent have program objectives and outcomes been achieved?
- ii. How effectively is the partnership model working?
- iii. How relevant is the program model in the context of the likely future needs of Government of Indonesia and Government of Australia’s policy?
- iv. How might this program be improved to meet the future needs of Government of Indonesia and Government of Australia policy?

An initial scoping and planning phase for the review was conducted in July 2010, with the on-ground activities of the review occurring over a four-week period in October and early November. An evaluation plan⁴ was developed to guide the review. A mixed-methods approach was used that, generally, involved the various techniques outlined in the plan.⁵ In summary:

² More details about the program can be found in Annex 8, Terms of Reference

³ More details about the review can be found in Annex 8, Terms of Reference

⁴ Available as Annex 9

⁵ For the changes, limitations and constraints refer to Annex 10

- The review was undertaken at both national and sub-national levels and involved a diverse range of respondents, including: partners; implementing team; heads of government; health workers; beneficiaries; representatives from relevant other Programs funded or operated by both donor partner and county partner; relevant non-government organisations
- It included visits to the province and three of the districts in which the Program operates. These three districts represented each of the three stages of the Program's life cycle and were used as illustrative case examples, not as comparative examples.
- The review team visited a sample of health facilities at province, district and village level.
- Data were gathered through a mix of: semi-structured interviews; workshops with partners; document review; observational visits; informal discussions with health workers and beneficiaries; and group discussions (facilitated by a local interpreter) with villagers in one of the villages.

This report addresses the first three key evaluation questions in chapters two, three and four. The fourth key evaluation question is addressed through the recommendations that occur throughout the report. AusAID requested a 35-page report (excluding executive summary and annexes). The team leader of the review has taken this as indicative rather than prescriptive, given that page numbers can be as much about formatting as content.

2. To what extent have program objectives and outcomes been achieved?

2.1. What are the objectives and end-of-program outcomes?

The short term objective of the Program is:

Selected provincial and district governments have mechanisms in place to manage national, local and donor resources to achieve national target levels for the priority 'Making Pregnancy Safer' indicators.

This objective is being operationalised through three interrelated components: service delivery; system management; and system performance. A review of program documentation indicates that the initial end-of-program outcomes for each of these components were recently altered in the most recent progress report, as follows:

Table 1: End-of-program outcomes as expressed in the Program Design Document, Monitoring and Evaluation Strategy and September 2010 Progress Report

	End-of-program outcomes as expressed in PDD and M&E Strategy	End-of-program outcomes as expressed in Sep 2010 progress report
Component 1	National MPS target percentages of pregnant women attend ANC, receive assistance at delivery, and receive care post partum; 75% of the estimated number of women and newborns with complications receive referral level care	Increased coverage (access to and utilisation) of key maternal and neonatal health service interventions
Component 2	Service providers and communities have the resources, skills, technical support and infrastructure needed to improve service delivery and utilization	Improved management of health system resources and health service interventions
Component 3	Explicit linking of resource allocations (budgets) to performance targets in annual work plans; reliable and open reporting of achievements and use of resources against performance targets to communities, parliament and partner donors; partner donor readiness to harmonize resource support through Gol systems	Improved productivity of public workforce, and improved identification of and achievement of performance targets for health service interventions

It is not unusual for program outcomes to be adapted during implementation. Generally, adaptations are based on ongoing review and reflection, and seek to make improvements to the Program based on the findings of such review and reflection. The progress report for September 2010 does not indicate why the end-of-program outcomes were changed, nor on what evidence. A discussion of the objective and the end-of-program outcomes is provided in 2.3 of this chapter.

For this review, the terms of reference questions relating to progress against the log frame and the end-of-program outcomes were answered directly by the implementing team in its September progress report and an accompanying outcomes report. Therefore, this review report will not repeat that information because those reports are readily available.

For this chapter, of greater interest is whether the many Program activities are resulting in change and what value is being added by the Program. Such interests are, generally, not the subject of the progress reports.

2.2. Capacity is being strengthened

This sub-section begins with illustrations of the changes being made by the Program. These are drawn from the observations and interviews conducted as part of this review. The illustrations focus on:

- examples of where capacity (changes in skills, knowledge, practice, processes and systems) has been strengthened as a result of AIPMNH – these are the ‘immediate’ outcomes and, generally, can be attributed to the Program; and
- examples of where AIPMNH has contributed to the improved health status of pregnant women and newborns – these results cannot be directly attributed to the Program because of other factors that also contribute.⁶

The sub-section then addresses the issue of added value. It concludes with a short summary of progress to date towards the end-of-program outcomes.

Some immediate outcomes are evident

Changes in clinical knowledge and skills: Health workers at the facilities visited were all able to discuss the new knowledge, skills and confidence they have gained as a result of one or more training sessions supported by AIPMNH. Workers in PONE⁷-rated facilities reported feeling more confident to manage complications. In one facility, staff reported that since the training they are now able to manage asphyxia cases. In another facility, as well as asphyxia, the midwife reported now being able to handle complications such as: pre-eclampsia, placenta extraction, vacuum extraction, and resuscitation of babies. In brief, staff at the PONE Health Centres declared that they are now able to manage all obstetric and neonate complications that are expected to be managed in a PONE facility.

Even in facilities that are not yet rated as PONE positive changes were found. For example, in a puskesmas⁸, a midwife reported feeling more confident to manage complications such as haemorrhaging now that she has worked alongside a more experienced health worker as part of the training follow-up and assisted in saving a woman from haemorrhage. This same midwife also reported being more skilled in stitching to repair any perineal tear that might occur during delivery. Her coordinator reported that the improved stitching has reduced the risk of infection and increased the rate of healing.

Changes in planning and budgeting knowledge and skills: At each of the partnership workshops, stories of changes in planning and budgeting knowledge and skills were reported, such as:⁹

Before AIPMNH partners were not yet able to make ToR.¹⁰ Year by year they just copy and paste. This did not create lessons-learned in conducting activities. This is the same for budgeting. Partners create budget and only aimed at how to spend the whole budget. Partners used to have project mindset instead of concentrating on the results of the activities. After AIPMNH people can now make ToR and budget. With this capacity, we can see if activities and budget are duplicated so it can be avoided.

⁶ Given that this review did not gather data from all districts, the examples provided are indicative of the Program, not definitive

⁷ PONE – BEONC: basic emergency obstetric and neonatal care

⁸ Puskesmas – Community Health Centre at the sub-district level

⁹ Example provided in Bahasa Indonesian and later translated to English. Retaining the respondent's original style as closely as possible has resulted in somewhat stilted English.

¹⁰ Terms of Reference

A Bappeda¹¹ representative in one of the districts advised that, as a result of the attention to District Health Accounts, the government is now aware that there is sufficient money for health for that district but that it is not being spent well. He reported that agencies have begun thinking differently about how to allocate, although they have not yet had a budget cycle to put this into action.

Changes in clinical practice: Changes to how wards are configured, as a result of training, were observed in two health facilities visited: a hospital and a puskesmas. In each, different rooms are now allocated to first stage and second stage labour, and a lactation room has been set up, as required by the standards. In another health centre, the doctor reported having begun early initiation of breastfeeding since learning of its importance through the AIPMNH supported training. In each of the facilities visited, staff were implementing the 'pocket charts'¹² to track pregnant women. The records appeared to be up to date and midwives were able to discuss how the chart was used and its benefits.

Similarly, training has resulted in a doctor at one of the puskesmas changing his practice relating to the management of medicines. After learning about the importance of having a range of medicines for birth available and ready in case of emergency, he set up a pocket of labelled medicines on the wall near the birthing table, as illustrated in the photo to the right.



Positive changes to the practice of cadres were highlighted by respondents in a district in which Posyandu Revitalisation¹³ has been supported by AIPMNH. As part of this initiative, 500 cadres have been trained and key changes in practices include: more regular opening of each posyandu; the provision of a more comprehensive range of services; and a team approach by kaders (village level volunteers).

Changes in planning and implementation of activities: At each of the partnership workshops, stories of changes in planning and implementation of activities were reported, for instance: *Before AIPMNH activities were running separately. Each SKPD¹⁴ had high ego and was not open to collaboration...Activities were used for merely political consumption. The aim was "as long as the boss happy". Now there is coordination. There is not overlapping in programs and activities... Also there is a change in SKPD work pattern, for example: in sending proposal for an activity: it must be submitted in a ToR...and funding which is not absorbed, it has to be returned. Before AIPMNH there's a tendency that if some funding still remains, it will not be returned.*

Referral processes: Despite a delay in developing referral guidelines by the Provincial Health Office (as reported by stakeholders), referral processes in the field are progressing well, as the following examples indicate:

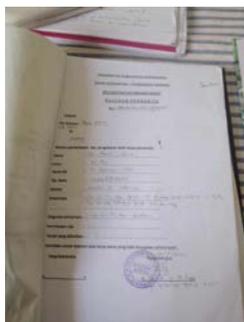
¹¹ Bappededa – Regional Development Planning Agency at provincial and district levels

¹² A practical and easy to use method of tracking pregnant women on a monthly basis using a chart with pockets for each month – women's details are placed on a card and inserted into the relevant monthly pocket. It is a method being promoted through the training and the partners.

¹³ Posyandu Revitalisation – National program to revitalise posyandu (Integrated Health Service Post) at community level

¹⁴ SKPD – Local Government Agency or Department

Improved referral processes were evident in each of the districts visited. Agreements, such as that pictured at the right, have been reached between midwives and traditional birth attendants¹⁵ that promote referral of pregnant women to the facility by the birth attendant. These agreements have, mostly, been developed through the active cooperation of village and church leaders and accompanied by some sort of socialisation program.



Referral books, such as that in the photograph to the left, appeared to be up to date and midwives were able to explain the processes to the review team. Staff from one of the health centres reported that as a result of post-training evaluation, they have developed a relationship with the specialist from the district hospital who conducted that evaluation. This unexpected outcome is reported to have improved referral communications between the health centre and the hospital staff.

Contribution to improvements in maternal and neonatal health status

Increase in the number of deliveries at facilities: Facility-based delivery can improve the outcomes for pregnant women because it allows midwives to provide better monitoring of women during labour and the critical 24 hours post partum (Chowdhury et al, 2006; and Graham and Hussein, 2006). Such monitoring enables early detection and basic management of problems, and more timely referral to hospital for emergency care, where needed.

The majority of the health facilities visited reported an increase in the number of deliveries at their respective centres. For example, one midwife coordinator reported that there are now between one to four deliveries in the facility every month, whereas it used to be only one every three to four months. Staff from another puskesmas reported that so far in 2010 there had been 180 deliveries in the facility, with an expected 200+ by the end of the year; up from 150 in 2009.

A range of factors are reported as influencing this change towards facility-based delivery including:

- the Provincial Government decree and an agreement by local authorities to implement this;
- introduction of regulations at village level requiring women to use the facilities;
- agreements between midwives and traditional birth attendants that promote referral of the pregnant women to the facility by the birth attendant;
- greater uptake of Jamkesmas¹⁶, thereby reducing families' costs of delivery care;
- socialisation activities;
- improved skill level of midwives; and
- renovations of facilities.

How a combination of these factors has contributed to changes is illustrated in the following example, provided by one of the District Program Coordinators:

¹⁵ Unqualified village women who have traditionally delivered babies

¹⁶ Jameskmas - National Social Insurance for the poor

In 2009, with support from AIPMNH, the polindes¹⁷ midwife implemented community engagement activities at the village level, including: a partnership between midwife and traditional birth attendant; community meetings on birth planning; local problem solving; and social audits of maternal perinatal. Together, these have increased community awareness and support for facility-based delivery. Traditional birth attendants understand their tasks. Village leaders allocated financial support from PNPM¹⁸ funds. Medicines and equipment are available at the polindes. In 2009, there were no deliveries at the polindes: 43 deliveries occurred at home and 5 deliveries at hospital due to complications. Up to August 2010, 36 out of 43 deliveries have occurred at the polindes, 7 delivered at home and 3 referred to hospital. Mothers said they felt more secure in delivery at the polindes.

Similarly, data from another district shows a significant increase in facility-based deliveries following a combination of: renovations of the puskesmas; conduct of PONEC training; agreement between midwives and traditional birth attendants; Posyandu Revitalisation; and Desa Siaga¹⁹, as shown in the following table.

Table 1: Change in deliveries in two AIPMNH-supported puskesmas in one district following a range of Revolusi KIA activities

Puskesmas	Year of renovation by AIPMNH	Year 2008		Year 2009		Year 2010 (Up to May)	
		Delivery in puskesmas delivery room	% deliveries in puskesmas delivery room	Deliveries in puskesmas delivery room	% deliveries in puskesmas delivery room	Deliveries in puskesmas delivery room	% deliveries in puskesmas delivery room
A	2008	27	5.84%	96	20.92%	85	39.17%
B	2008	15	5.14%	50	14.62%	25	21.55%

Despite these reported upwards trends, respondents in each district gave examples of the local context inhibiting further uptake of facility-based delivery. Such things as cultural beliefs and the remoteness of some villages with poor accessibility to facilities were often cited. Most districts have begun trying to address these issues through activities such as socialisation programs and the building of 'waiting' houses, so that families have accommodation closer to the facility that they can go to when labour is imminent.

Such situational differences highlight the importance of tailoring the mix of activities to the local context, as promoted in the literature (Annex 1). This requires active participation in planning and decision-making by local communities, which is receiving attention from the partners.

Now that the Community Engagement Team has started, the scaling up of local participatory processes is anticipated. To be effective in the longer-term, these local solutions to addressing maternal and neonatal health issues need to be sustainable. The Community Engagement Team is using a number of approaches that are likely to achieve this sustainability of effort. For example, they have created a provincial team of resource people who will continue community engagement activities post AIPMNH. In addition, they are facilitating the integration of the many community-level government initiatives to help streamline efforts and make them more sustainable.

¹⁷ Polindes – village level maternity clinic or village birthing centre

¹⁸ PNPM – National Community Empowerment Program

¹⁹ National Health Aware and Alert Villages program

It was too soon for this review to pick up any evidence of the sustainability of the community engagement efforts and solutions, but the Community Engagement Team reported that it is conducting brief evaluations of its work to assess effectiveness and to adapt activities according to any lessons. This is a positive step. An appraisal of the Community Engagement Strategy is provided in Annex 2.

Reductions in number of deaths: Along with the reported increases in facility-based births are reports of reductions in the number of maternal and neonatal deaths. For example, respondents in one district reported that up until the end of September 2010, there had been seven maternal deaths. Although it was too early to yet be certain that the number would remain less than the 15 deaths in 2009, respondents advised that all seven deaths had occurred at home and that the deliveries had been assisted by traditional birth attendants, not midwives. Although we cannot be certain that the number of reported deaths is completely accurate (because of limitations with the government reporting systems) it does nonetheless suggest that the combined actions within the district could be having some level of positive effect.

Adding value

Notwithstanding these examples of achievements, we are left with the difficult question of whether AIPMNH has made any actual difference. Has it added any value or has it simply achieved what might have been achieved anyway? Data presented in progress reports do not indicate a clear difference between AIPMNH supported and non-AIPMNH supported districts. There are many possible explanations. It might be too early for any difference to have been detected. Data collection might not be good enough.

Non-AIPMNH supported districts are not remaining static. They are receiving a range of government maternal and neonatal health programs, which are also building capacity and are trying to reduce maternal and neonatal deaths. Indeed, one of the villages visited had not yet received support from AIPMNH but the review team observed a fully functioning posyandu being used by a large number of families; a team of cadres who were confident in the tasks they were performing and who were supported by a team of local midwives; a strong advocate for maternal and neonatal health services in the village head; and village regulations that included a set of incentives and obligations to encourage families to use maternal and neonatal health services.

To assist with determining whether AIPMNH is adding value, the review used a framework called *additionality*.²⁰ This framework seeks to look beyond the achievement to assess the degree to which these have been influenced by the Program. By doing this, we hope to determine the additional value brought by AIPMNH. Three factors are considered:

- *Input additionality:* which seeks to assess whether the input resources by those other than AusAID, as the funding source for AIPMNH, are additional to what would be invested by the collaborator and not merely replace resources.
- *Output and outcome additionality:* which seeks to assess the proportion of outputs and outcomes that would not have been achieved without public sector support; this category includes unintended effects and spill-overs.
- *Behavioural additionality:* which seeks to assess scale, scope and acceleration; plus long-term changes in behaviour at the strategic level or in competencies gained.

The review team has not attempted to identify all examples of additionality, rather the following is a selection of key examples to show whether AIPMNH is adding value.

²⁰ Developed by Buisseret et al (cited in Georghiou, 2002) and later refined by Georghiou et al (2006), and later adapted by Hind (2010).

Input additionality

District Teams for Problem Solving (DTPS) is a process promoted by government to analyse Puskesmas and district data, identify problems, and prioritise solutions for inclusion in the annual plan. This process is one way of encouraging inter-sectoral collaboration, thus helping to strengthen the system. It is useful if it leads to improved application of resources, as well as improved allocation. AIPMNH has supported these processes in some locations, where this has been agreed.

In one particular district, the process has resulted in a heightened awareness by agencies of the need for an increased maternal and neonatal budget. The partner agencies subsequently agreed to bid for an increased budget (from Rp 13 million in 2010, to Rp 2.6 billion for 2011). An Advocacy Team, established as part of the DTPS, has undertaken a systematic lobbying of parliamentarians and key leaders in the community. Whilst parliament had yet to meet to consider the proposed budget at the time of the review, key respondents, including the Bupati, reported confidence in this level of budget being passed. Respondents reported that the DTPS process was not likely to have been implemented in that district without the support of AIPMNH. It was through the Program that awareness of its potential was raised and processes to establish it were facilitated. Given this, should even a proportion of this proposed increase be achieved, it is a positive example of input additionality.

Output and outcome additionality

A creative solution to local difficulties has been the development of the Sister Hospital initiative. With only 16 public hospitals across the 21 districts in NTT and a shortage of specialists, the province's capacity to manage complications is low. In March 2010, AIPMNH supported the Provincial Health Office to present and discuss the dilemma with Gadjah Mada University (UGM). It was agreed that extraordinary measures were needed to address the lack of services and the outsourcing of emergency obstetric and neonatal services was explored. Gadjah Mada University had experience in outsourcing staff for one district hospital in post-tsunami Aceh but outsourcing of this kind or scale had not been tested previously in Indonesia. Nonetheless, the partners were willing to trial this. Hospitals from six NTT districts were selected and matched with either a public or private hospital from which an obstetric and neonatal emergency team is contracted. Each team consists of an obstetrician, a paediatrician, an anaesthetic technician, a neonatal intensive care nurse, and a laboratory technician.

Each of these districts now reports improved capacity to manage complications. In one district, data showed that in the months from January to June 2010 (prior to the Sister Hospital program) an average of 19 complications cases were referred each month to the provincial hospital. Since the initiative, only one case has needed to be referred, and only because of the severity of complication. Being able to manage these complications locally has meant that the risk to women and their unborn babies is reduced because they can receive the needed medical care earlier than if forced to travel the long distance to the provincial hospital.

This change in capacity has also resulted in some unintended consequences. For example, Bappeda and the District Hospital Director reported that since its inception in July 2010 the initiative had resulted in economic benefits for the government, the hospital and the community. The district government was reported to have saved an estimated Rp40,500,000 in fuel and staff allowances by not having to send patients to the provincial hospital. The local hospital was reported as having gained an additional Rp200 million in income from non-Jamkesmas patients who did not need to be referred. The community was reported as having saved Rp24.3 million in living costs in not having to accompany their family member to the provincial hospital.

The reductions in risk to mothers and babies and the economic benefits are important outcomes that, according to respondents would not have eventuated without AIPMNH.

A second unintended consequence has been the significant rise in workload for the district hospital and the subsequent impact on its budget. Initially, the hospital had only two nurses in the operating theatre but the increase in the number of surgeries resulted in the need to add four more people. The hospital found it also had to provide incentives for the staff. The director advocated strongly to the parliament and Bupati²¹ with the result that the hospital obtained an additional nine staff from puskesmas. Through the district's consolidated budget, the government has also provided a budget for incentives to those hospital staff who now have an increased direct interface with the clients (pharmacist, sanitarian, and radiologist). The director is now working on a further incentive budget for the operating theatre staff (in the form of transport costs) as they are often called upon outside working hours.

An additional potential outcome from this initiative is the sustainability of capacity post the sister hospital program. Representatives from district Dinkes (Health Office) and Bappeda reported that they had been trying for 10 years to find ways of attracting specialists to their district hospital but had never been successful. They claim that it was only through the expertise and networks of the AIPMNH that a solution was found. As part of the sister hospital program the district is now implementing a five-year sponsorship scheme in which doctors are being given the opportunity to retrain as specialists. Such scholarships are conditional, bonding doctors to the district hospital for a period of time. Respondents advised that with AIPMNH support they will achieve their required level of specialists within five years, whereas without AIPMNH it would take upwards of 20 years. AIPMNH is, therefore, helping to accelerate this strategy by some 15 years (a behavioural additionality).

Spill-over as an added benefit

As part of the AIPMNH work a prototype design for a PONEP puskesmas and a rumah tunggu (waiting house) were developed. These designs were highly regarded and subsequently used in developing basic designs for reconstruction of health facilities following the Padang earthquake in 2009. Respondents were confident that it would have been highly unlikely that this design would have been developed (and available for a broader benefit) but for AIPMNH.

Behavioural additionality

In each of the districts the acceptance of a joint responsibility for maternal and neonatal health, and the subsequent participation in activities by all partner agencies, is clearly a value-add of the AIPMNH. Respondents from the majority of partner agencies were adamant that it has been the involvement in AIPMNH that has brought about this change in behaviour. In two of the visited districts, collaboration is a direct result of the work of the AIPMNH (as reported through interviews and partnership workshops). In the third district, the partnership had been long established, but until AIPMNH, had not accepted any need or responsibility for a collaborative effort for maternal and neonatal health (as reported by all partners at the partnership workshop).

This shared responsibility in the third district has resulted in changes at the village level. For example, respondents advised that AIPMNH's involvement has resulted in maternal and neonatal health issues being brought into the planning process for the first time, a point illustrated by this comment:

I have followed the musrenbang²² for seven years and there has been no KIBBLA²³ [in all that time]; now it is included [because of AIPMNH].

²¹ Bupati – the elected Head of Local Government

²² Musrenbang – Community Development Planning Meeting

Progress towards end-of-program outcomes

In the next sub-section of this report, limitations of the end-of-program outcomes are discussed. Notwithstanding such issues, a summary of progress is provided in Table 2.

Table 2: Summary of progress towards end-of-program outcomes

End-of-program outcomes as expressed in PDD and M&E Strategy ²⁴	Summary of progress ²⁵
<p>Component 1</p> <p>National MPS target percentages of pregnant women attend ANC, receive assistance at delivery, and receive care post partum; 75% of the estimated number of women and newborns with complications receive referral level care</p>	<p><i>ANC and post partum care</i></p> <ul style="list-style-type: none"> • September outcomes report concluded: for the 2008 cohort of districts it is not possible to identify trends on the key ANC indicators due to variation and small proportion of pregnancies; for the 2009 cohort data indicate steady or slightly increasing; for the 2010 cohort a slight fall is indicated. Variation amongst districts re: MPS coverage indicators with some districts meeting it and others not • District and local health workers and village elders in each of the 3 districts visited reported increasing numbers of women attending ANC and PNC. However, review of data at individual health facilities and district health could not verify this because data not in readily available form <p><i>Assisted deliveries</i></p> <ul style="list-style-type: none"> • September progress report data indicates varying rates of facility-based births amongst AIPMNH assisted districts, with some quite high and others extremely low – no clear reasons as to why variation • The September outcomes report found an increasing trend of facility-based births for both 2008 and 2009 cohorts, with a large rise in the 2010 cohort. Variation amongst districts re: MPS coverage indicators with some districts meeting it and others not • Individual health facilities in all districts visited reported increasing numbers of facility-based deliveries and/or births attended by midwife. However, review of data at individual health facilities and district health could not verify this because data not in readily available form <p><i>Referral level care</i></p> <ul style="list-style-type: none"> • Sister Hospital initiative is showing good results in relation to women and neonates receiving timely and appropriate level of care for complications. Examples from visited services showed reduction in deaths, though too soon into life of initiative for trends • September outcomes report indicates an increase in numbers of obstetric complications identified and managed <p><i>Activities contributing to the outcomes</i></p> <ul style="list-style-type: none"> • Progress reports indicate increasing numbers of midwives receiving targeted MNH training but do not indicate if making difference to practice • Individual midwives from visited facilities reported improved confidence, skill and competence but this is unknown across districts or province • Progress reports indicate facilities are being upgraded but too few to make a significant difference to overall province data yet • Difficulties re: workforce stability • Supervision processes lagging • Little or no data re: change in women's and families' knowledge • Increasing focus on demand-end activities but little or no data beyond simple process/output data to indicate if having effect

²³ KIBBLA – maternal and neonatal health

²⁴ The outcomes as stated in PDD and M&E Strategy are used because the most recently stated outcomes are less specific (refer to discussion in next sub-section)

²⁵ As per September report, September outcomes report, interviews and data provided by district and local health facilities

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Australia and Indonesia Partnership for Maternal and Neonatal Health

End-of-program outcomes as expressed in PDD and M&E Strategy ²⁴	Summary of progress ²⁵
	<p><i>Overall comment</i> The general 'feel' is that this outcome is progressing well but data are unreliable or too small to indicate real trends or to provide definitive evidence. It is likely that a few individual sub-districts might meet the targets by end of Program but not whole districts or province.</p>
<p>Component 2 Service providers and communities have the resources, skills, technical support and infrastructure needed to improve service delivery and utilization</p>	<ul style="list-style-type: none"> • September outcomes report indicates that facilities capable of PONEC care lack required staff, equipment or medicines – this was confirmed via review visits • Sister Hospital initiative is improving local capacity in those particular districts • Progress reports indicate training undertaken for staff re: finance, planning, and reporting but review found no generalised outcomes to date re: monitoring and reporting systems for finance and activities - however some individual improvements reported • Progress reports and village heads report increasing numbers of local laws and regulations, with individual villages indicating some effect of these – no formalised data to indicate effect across districts or province • September outcomes report indicates lack of specialist doctors impacting on capacity of PONEK facilities • Formalised activities for management up-skilling not yet in place but in design phase • Progress reports indicate increasing levels of coordination between agencies and with NGOs – this was confirmed during review visits with some districts having well established processes • Community Engagement work lagging, but picking up now that team is operating across range of activities at village level <p><i>Overall comment</i> The end-of-program outcome is too broad and the data too focused on activity outputs (such as numbers trained; numbers of workshops) to enable a judgement to be made as to whether this outcome will be met. There is a need for greater specificity of outcome and for data to include effect of the various activities so that progress can be measured.</p>
<p>Component 3 Explicit linking of resource allocations (budgets) to performance targets in annual work plans; reliable and open reporting of achievements and use of resources against performance targets to communities, parliament and partner donors; partner donor readiness to harmonize resource support through Gol systems</p>	<p><i>Effective budgeting and reporting</i></p> <ul style="list-style-type: none"> • September outcomes report indicates some progress of performance framework but still in early stages • Some good examples of focus on the right sort of supports, e.g., BOK and Jamkesmas training – this is where there is scope to target budget • Limited attention on budget expenditure analysis • Attention Good Governance Action Plan misplaced and will not lead to desired results <p><i>Harmonization</i></p> <ul style="list-style-type: none"> • Good links being made with partner donors <p><i>Overall comment</i> The end-of-program outcome is too broad and the data too focused on activity outputs (such as number of assessments; numbers trained) to enable a judgement to be made as to whether this outcome will be met. There is a need for greater specificity of outcome and for data to include effect of the various activities so that progress can be measured.</p>

2.3. Need for more robust monitoring and evaluation to measure performance, progress, and inform decision making

Governments are under increasing pressure from internal and external stakeholders to be more transparent and accountable for performance. There is a growing expectation for information about the difference that investments make. Monitoring and evaluation are important management tools in helping to answer the 'so what' questions (Gorgens and Kusek, 2009). So what that 150 midwives were trained? So what that 25 health facilities were renovated? So what that local government agencies are planning collaboratively?

Monitoring and evaluation have been built into the AIPMNH through the Monitoring and Evaluation Strategy, which incorporates:

- ways to measure Program activities undertaken by the partners, drawing on regular Government of Indonesia processes and systems;
- activities to strengthen those government systems and processes; and
- ways to measure the performance of the partnership, the capacity strengthening, and technical assistance.²⁶

Activity data (such as the number of people trained) have been regularly compiled and the implementing team has provided regular reports to the partners using this data, and data drawn from the government systems. It is apparent from the various progress reports that, as well as regular monitoring and reporting, the implementing team has undertaken some ad hoc reviews to assess the effectiveness of particular approaches. The findings from these have been used to adapt activities and approaches. In addition, one of the consortium team members has been providing periodic advice and undertaking occasional reviews.²⁷

To date, AIPMNH has relied mainly on the Government of Indonesia's own monitoring and evaluation data and processes. This approach was chosen because the Program Design Document promoted working in and with partner government systems, and not setting up parallel systems. Unfortunately, the government's monitoring and evaluation systems are, generally, functioning poorly.²⁸ For example, the government system does not have adequate processes for monitoring and supervision in place, so it is unable to measure and report on such things as:

- the impact that renovations of facilities is having on usage;
- whether the knowledge and skills learned from training sessions is maintained and applied in the workplace; and
- what contextual and situational factors are impacting on the capacity to implement changes.

Even where data are being collected that could help the partners make a judgement as to whether the Program is contributing to improvements (such as the patterns of antenatal care attendance), data collection and collation are often not reliable or are collated in such complicated ways that health workers cannot readily retrieve this information.²⁹

Consequently, the degree to which the government systems have been able to provide robust information has been limited.³⁰ In any case, government monitoring systems rarely provide the sort of information that is needed to make a judgement about whether aid activities are having an *impact* on a development outcome.

²⁶ Monitoring and Evaluation Strategy

²⁷ Examples of advice and assistance include: participation in the process for design and recruitment for monitoring and evaluation technical assistance to strengthen GoI systems; assistance in trialling new report format; conduct of outcomes review to accompany September 2010 progress report

²⁸ Program Design Document and advice from a variety of respondents

²⁹ From interviews, observation and reports

³⁰ Indicative from the progress report and as advised by a variety of respondents

A key role of the implementing team is to help strengthen the government's monitoring and evaluation systems and its capacity to use these effectively. However, significant attention has not been possible because of a long delay in the process of recruiting appropriate personnel. In part, this delay has been due to the partnership approach. Adhering strictly to the partnership principle has meant that it has taken an extraordinary amount of time to agree upon the roles of the monitoring and evaluation positions, scope the services, and proceed through the recruitment phase. The time taken was further protracted because of the decision to procure this technical assistance through the Procurement Panel³¹, as one of the opportunities to provide this panel with more real-life experience in procurement. Yet further delays eventuated when the partners were not successful in finding a company to take on all the complicated roles and tasks identified in the scope of services.

The review team acknowledges the importance of ownership of, and participation in, these processes to long-term sustainability. However, monitoring and evaluation capacity is fundamental to effective implementation of the Program and performance management. Not having this technical assistance from the outset of the Program has been costly in terms of not being able to facilitate development of needed data systems and processes that could improve accountability, assist in telling a performance story, and making an immediate start in strengthening government capacity. This is a case example of when the costs associated with not having the technical assistance outweigh the benefits of adhering strictly to the partnership and capacity strengthening approaches. For further discussion on this refer to the next chapter.

Notwithstanding these issues, it is important to note that even though there are not yet any dedicated monitoring and evaluation positions to assist the partnerships, it is apparent from interviews and documentation that efforts are being made to improve capacity. For example:

- the implementing team has been working with the partner agencies to develop and work with performance indicators;
- Dinkes in each of the three visited districts now receive regular reports from health facilities on maternal and neonatal health usage, and generally, they are actively monitoring this data for such things as: how sub-districts are meeting targets; the management of puskesmas; the condition of posyandu; and uptake of P4K³²; and
- the Bappeda in one of the visited districts has put in place an annual review of the projects and programs facilitated by donors and non-government agencies.

On a further positive note, the implementing team advised that the Monitoring and Evaluation Coordinator, who will help to strengthen government systems, has recently been appointed by the partners and will take up the position shortly. Among other duties, this person will coordinate the work of yet to be contracted technical assistants with expertise in particular components of monitoring and evaluation systems. The task ahead of this Coordinator is great. The review team is not aware of the level of experience of the soon to be appointed Coordinator, however, as a professional field, 'monitoring and evaluation' is comparatively new, and so are the professionals (Gorgens and Kusek, 2009). It is likely, therefore, that this person could benefit from professional support, especially given the enormity of the task. Some support and advice is anticipated to come from within the consortium of the managing contractor. Notwithstanding this, the Coordinator might also benefit from being linked to a mentor who has particular expertise in developing contemporary monitoring and evaluation systems and in strengthening capacity within government agencies.

³¹ Procurement Panel has been established as part of AIPMNH to skill up Government staff in regular government procurement processes

³² Birth preparedness program

Recommendation: *That the Monitoring and Evaluation Coordinator who is to help strengthen the capacity of government agencies be professionally supported by a mentor with particular expertise in developing contemporary monitoring and evaluation systems and in strengthening capacity within government agencies.*³³

The difficulties associated with the Program's monitoring and evaluation are broader than the limited capacity of the government systems and the delay in setting in place the necessary capacity strengthening. An appraisal of the Monitoring and Evaluation Strategy is contained in Annex 3 but an overview is provided below.

Despite the Monitoring and Evaluation Strategy being broader in intent, monitoring and evaluation of the Program has been focused mainly on whether the log-frame is being implemented and if the money is being spent on the activities that contribute to the design.³⁴ This approach is typical of traditional monitoring and evaluation, which focuses on measuring inputs, activities and outputs. To meet the demands of performance-based management, monitoring and evaluation strategies must combine the traditional approach with assessment of results (Kusek and Rist, 2001).

For AIPMNH a robust Monitoring and Evaluation Strategy should help in determining such things as:

- whether capacity is being strengthened and sustained;
- whether partnerships are maturing and helping to make a difference to the beneficiaries;
- if the mix of activities is making a difference to the health status of pregnant women and newborns;
- if outcomes are being achieved in the most efficient way;
- how contextual differences impact on the Program's capacity to achieve the desired outcomes;
- whether the Program assumptions continue to hold over time; and
- what adaptations to the Program need to occur.

The current Monitoring and Evaluation Strategy has little or no focus on these important areas, apart from the ad hoc evaluation activities that have occurred.

A significant issue with the current Strategy is the limitation of the existing log-frame to adequately guide the Program. The logical links between aspects of the Program are not always clear. For example, despite the detail in the log-frame, the Program's theory of change is not explicit. It does not provide the immediate or intermediate outcomes or changes that are expected and whilst it includes assumptions, these are, often, not about the process through which change is expected to occur. In addition, the logical links within and between the three components are not explicit. It is fair to accept that components two and three are necessary to achieve the service delivery outcomes, however, the log-frame does not articulate the degree of 'necessary' and 'sufficient' of each of the outputs in meeting the end-of-program outcomes. Without this being made clear there is a danger of efforts being placed on seemingly worthwhile activities that are not necessary or sufficient to reach the desired results.

³³ It is estimated that this recommendation will cost \$20,000 (one-third pro rata of the \$60,000 discussed as part of the previous recommendation)

³⁴ As was reported by a representative of the implementing team and noted from progress reports

A particular impediment is that the long-term and short-term objectives are expressed broadly and are unlikely to be achieved within the timeframe. Furthermore, the link between these and the goal is tenuous. The end-of-program outcomes are not expressed in terms of performance outcomes; they do not articulate the changes that are expected to the relevant processes, systems, and people. End-of-program outcomes need to be clear as to what will be different by the end of the Program.

A further impediment of the log-frame is its silence on the critical underlying theories of the Program around the three key practice approaches: partnerships, capacity strengthening and technical assistance.³⁵ Yes, the Monitoring and Evaluation Strategy incorporates measurement of these through its performance management component. However, this separates these key functions from the core of the Program, whereas they are central. Furthermore, they have received little attention to date. Given the implementing team's critical role in the provision of technical advice, facilitation of partnership processes and in helping to strengthen capacity, it is important that this work is captured in the Program's theory. There is a need for the Program's theory to be more clearly articulated and used to revise the Monitoring and Evaluation Strategy.

Recommendation: *That the Program theory of AIPMNH be more clearly articulated to:*

- *incorporate the key practices approaches – partnerships; capacity strengthening; and technical assistance;*
- *show more accurately the logical links between and within components, including how immediate and intermediate outcomes are necessary and sufficient to reach the end-of-program outcomes; and*
- *ensure end-of-program outcomes are expressed as performance outcomes.*³⁶

A further limitation of the existing monitoring and evaluation processes is that they do not incorporate any alternate, short-term monitoring and evaluation activities to provide necessary data whilst the government systems are being strengthened. Whilst the Program Design Document made it clear that parallel systems should not be put in place, this should not preclude ensuring relevant performance data is gathered in the meantime. It is appropriate for the implementing team, in conjunction with the partners, to identify the data gaps and to put in place temporary monitoring and evaluation activities. Naturally, these temporary activities should not place undue burden on the government processes and systems so are, therefore, likely to fall to the implementing team.

Given the current gaps in data, it is difficult for the implementing team to provide AusAID with the type of performance information it requires. In response to concerns from AusAID about the limitations of current progress reports, the implementing team has decided to recruit two dedicated monitoring and evaluation positions to its team. This is a positive step. However, a review of the draft terms of reference indicated a need for these to be refined because of a lack of clarity of roles.

Furthermore, this documentation is still not capturing the critical nature of the roles in terms of the discussion outlined in this report. To achieve the significant amount of performance management work that is required, including strengthening the capacity of the implementing team, it is suggested that the implementing team's proposed position of Monitoring and Evaluation Advisor might need to be a highly experienced specialist and appointed full time.

³⁵ Refer to a program logic diagram on page 39 that was developed as part of the analysis to see diagrammatically how these approaches underpin the Program

³⁶ It is anticipated that this recommendation could be implemented within existing budget

If it is not possible to recruit a highly experienced person to this position, there would be benefits in this position being linked to a very experienced monitoring and evaluation specialist who could act as a mentor (for similar reasons as outlined for the Monitoring and Evaluation Coordinator).

Recommendation: *That a Monitoring and Evaluation team consisting of a highly experienced full time Advisor and a full time Data Manager be recruited to the implementing team to:*

- *develop and implement a robust monitoring and evaluation framework that enables the work undertaken by the implementing team to be measured, including developing a revised program logic with a more appropriate results framework;*
- *build monitoring and evaluation capacity within the implementing team; and*
- *gather and report on data that will supplement the government systems while these are being strengthened, ensuring that this part of the role is coordinated with the work undertaken by the Monitoring and Evaluation Coordinator who is shortly to be engaged by the partners.³⁷*

Considering the shortfalls of the Strategy identified in the appraisal, it is timely for the Strategy to be revised. There are a number of recommendations in this report that are focused on improvements to monitoring and evaluation. These should be incorporated in the revision.

Recommendation: *That Program performance management of AIPMNH be improved through ensuring a more robust and appropriate Monitoring and Evaluation Strategy that addresses the issues identified in this report is developed and implemented as a matter of urgency³⁸*

2.4. AIPMNH is using contemporary good practice

Strengthening capacity of the systems, organisations and people is a fundamental approach of AIPMNH. The approach is inherent in the three components of the Program. Although strengthening capacity has been a key, and often central, concept in international development for many years, a major challenge remains in how to bring about sustainable

³⁷ Prior to the review the implementing team had developed terms of reference for these two positions for approval by AusAID. It is understood that this recommendation will, therefore, be met within the existing Program budget. If it is not possible to recruit a highly experienced monitoring and evaluation specialist to the position of Advisor, it is further recommended that this team be professionally supported by a mentor with particular expertise in developing monitoring and evaluation systems and in strengthening performance management capacity. Should this be required, it is suggested that the mentoring support be shared with the Monitoring and Evaluation Coordinator position (to work with the partners – refer to next recommendation). Were this to happen, the implementing team's cost is estimated at \$40,000 (two-thirds pro rata of \$60,000, as based on the following assumptions)

	A\$	Day	Unit	Total
Consultant Cost				
Professional Fees	1,500	30	1	45,000
International Airfares	4,000	1	2	8,000
Domestic Airfares	1,000	1	2	2,000
TA	95	7	2	1,330
Accommodation	186	7	2	2,604
Visa, etc	1,000	1	1	1,000
				59,934
			approx	60,000

³⁸ It is anticipated that this recommendation can be implemented within the existing Program budget given that monitoring and evaluation is an expected activity

change (UNFPA, 2003; OECD, 2006). Therefore, an assessment of the capacity strengthening approach used by the implementing team and whether this would lead to sustainable change was considered an essential element of the review. From the literature, seven indicators were identified as being relevant against which to measure.

Ownership and at the partner's pace: A demand-driven process has been promoted as being better than processes that are imposed (UNFPA, 2003) with ownership being a key objective (Hunt, 2005; Nagao, 2006). As part of the partnership approach, the implementing team has established a strong principle of a demand-driven approach. Work plans are, generally, developed in direct response to the objectives of the partners and have taken up a pace and a level of challenge that the partners have determined. However, ownership can be inhibited by low local capacity (OECD, 2006). The team has facilitated processes that promote general problem-solving capacity at an institutional and whole-of-government level, an approach that can help address low capacity of ownership (Nagao, 2006).

Later in this report, the issue of the need to help build local strategies for a gradual transition towards a time when AIPMNH will not be working with partners is discussed. Such a transition will require more complex forms of ownership by the government agencies than is demonstrated now. It will also require them to be bolder in terms of the pace and the level of challenge they take up. To assist them achieve this, APMNH could look for more opportunities for general problem-solving at the institutional and whole-of-government level.

Use of local resources: Hunt (2005) notes the importance of endogenous processes to promote sustainability. The implementing team has been diligent in doing this. For example, the majority of the implementing team positions have been filled by skilled local people, many of whom demonstrated having an excellent network of organisations and local resources. In setting up the Technical Assistance Panel and those teams engaged by the partners, they have also recruited locally, wherever possible. These are good examples of AIPMNH taking up the important principle of building on already existing local capacity (Blagescu, 2006). The community engagement and gender activities have emphasised the importance of using existing networks and processes, and on building the skills of people within the government agencies. Professional and partnership links have been established with local institutions such as Gadjadara University and public and private hospitals elsewhere in Indonesia. Using such resources enables ongoing partnerships between agencies and institutions post AIPMNH.

Attention to the capacity of individuals, organisations and systems: A comprehensive systems perspective appears to be crucial to successfully achieving capacity and requires attention to all three levels of individuals, organisation, system (UNFPA, 2003; Hunt, 2005). The program design of AIPMNH addresses the capacity at each of these three levels and the implementing team has actively pursued progress in each. Without exception, team members could outline and discuss the important interdependency of the three components. Progress reports and work plans indicate a balance of attention to all three. Baser and Morgan (2010) note the importance of both 'soft skills' as well as 'hard skills' to aid system development. Through the partnership work, AIPMNH has ensured attention to important soft skills such as the crafting of relationships, trust and legitimacy as important foundations to the development of sustainable processes and systems.

Iterative and long-term: Effective capacity building takes time and should not be piecemeal (Smillie, 2001; Blagescu, 2006). It is best developed during the course of an iterative and long-term process of learning and adaptation, in the process of 'doing' (UNFPA, 2003). The implementing team has acknowledged the importance of iteration over the long-term. For example, promotion of post training evaluation and follow-up helps to ensure that training is

not a once-off activity but that participants receive some opportunity to cement the learning. The importance of quick wins in the short-term to sustain capacity development efforts over the long haul (ECPDM, 2003; Baser and Morgan, 2010) has also been acknowledged in the way the implementing team has been operating. For example, the quick wins have been achieved through training of current midwives in key knowledge and skill areas to provide the system with sufficient development while waiting for the longer-term capacity that will come about from efforts with the Midwifery Academy to improve midwifery pre-service training.

A focus on development outcomes: Given that capacity development should occur within a process of 'doing' (UNFPA, 2003), it is important that efforts are focused on activities that are most likely to meet the desired development outcomes – in this instance, improved maternal and neonatal health outcomes. Whether the Program is focused on the desired development outcomes is discussed in chapter 4 of this report. Generally speaking, it finds that the Program is focused on the desired development outcomes but raises some points where this might be an issue.

Knowing if a difference is being made: Given that a key emphasis of capacity development is on achieving sustaining outcomes, it is critical to know what difference (if any) is being made and if the desired outcomes are being achieved. Because capacity development is often embedded in other Programs (as is the case for AIPMNH) it can be difficult to separate out so that it can be monitored and evaluated specifically (Jones, 2007; Baser and Morgan, 2010). This is further compounded by the long-term nature of capacity development (Jones, 2007) and the little guidance people have because there are so few examples of evaluations of capacity development (Watson, 2006; Baser and Morgan, 2010). Nonetheless evaluation remains important.

As noted previously, AIPMNH has not been very successful in monitoring and evaluating its capacity strengthening approach and a number of recommendations have been made in the previous sub-section to help address this.

2.5. Several challenges to building capacity

The review has also found a number of challenges that threaten capacity development. Most of these have been raised by the implementing team in various progress reports. This report raises two challenges that were thought to be the most pressing.

Personnel challenges

Not enough cases to maintain skills: The government has a policy of 'one midwife in every village'. This is to help raise awareness and enable the provision of maternal and neonatal health services as locally as possible. In each district visited, partners reported a shortage, based on this policy, with one reporting as few as half of the required number. Whilst this policy is likely to help the socialisation process and help the uptake of deliveries with a skilled birth attendant and facility-based deliveries, it has an implication in terms of maintaining skills.

A study by Makowiecka et al (2005) found that midwives in Indonesia attend a median of 40 births per year. A review of data in one visited district confirmed a similar figure, with some of the midwives in the smaller villages attending even fewer.

Whilst there is no internationally agreed minimum of deliveries that a midwife should perform to maintain her skills, Scotland and Bullough (2004) recommend an optimal annual workload for obstetricians of between 100 and 125 normal deliveries. If the same recommendation were to be applied to Indonesian midwives, delivery volumes would fall significantly below these optimal levels. This suggests that the capacity to manage complications and recognise

the need for referral might be compromised because midwives experience situations so infrequently.

Facility-based care, if midwives were to work in teams, could help to increase the number of deliveries a midwife attends. Some facilities reported having put a team approach in place as a way of skilling up workers who had not yet undertaken the upgraded training. This is a positive step and should be promoted as a standard operating practice across all facilities. Unfortunately, this alone will not address the issue. Currently, midwives receive a supplementary payment when they deliver a patient who is eligible for Jamkesmas. This is a way of offsetting a relatively low salary base. This arrangement is likely to act as a disincentive to midwives to co-deliver with a colleague because it could result in a lower supplementary payment if payment is shared. As part of its mandate to help partners find systemic solutions, AIPMNH should help partners look for ways to increase the volume of deliveries that each midwife attends. In addition, AusAID should undertake policy dialogue with the government about the implications of its policies.

Recommendation: *That AusAID holds policy dialogue with the Government of Indonesia in relation to the policy implications of, and possible solutions for, 'one village one midwife' policy and salary supplementation for deliveries.*³⁹

Recommendation: *That AIPMNH supports sub-national partners to help maintain midwives' skills by identifying practical local solutions for midwives to increase the number of deliveries they attend.*⁴⁰

Facility challenges

Poor state of facilities: Health facility operations are particularly crucial to effective delivery of maternal and neonatal health services. Facilities provide a base from which to conduct effective outreach proximate to communities, and functioning infrastructure is necessary to ensure as many women as possible deliver in a safe environment. The review team found that many facilities were in a poor state of repair and lacked access to routine maintenance funding for buildings and repairs. This issue of poor state of facilities has been highlighted by the implementing team in various reports to the partners. Present funding for these costs can only come from discretionary local government budget funding, which is limited. As part of its work in component two, AIPMNH should encourage local governments to make facility operation costs a priority.

Water supply to delivery rooms for drinking and hygiene is an essential requirement for safe management of births, particularly if there are complications⁴¹. Likewise, power is an important amenity, particularly for the operation of equipment. A number of facilities visited during the review lacked a regular supply of running water to the delivery room and had poor levels of, or no power. Again, these issues are not newly presented. The implementing team has raised them in progress reports. At present, provision of water and power supply to health facilities is outside the scope of AIPMNH because it is not the responsibility of the District Health Office. This highlights that solutions for improved maternal and neonatal health are matters for whole-of-government. Partners have a responsibility to work with other government agencies to address these issues.

Availability of drugs and equipment is also essential to safe delivery practices. In each of the three PONE health centres visited as part of this review, staff reported issues of availability of drugs and equipment, particularly antibiotics and infusion sets, which are required when managing infection and haemorrhage. Such issues have also been raised by the implementing team in various reports, including the recent outcomes report. Drugs and

³⁹ It is anticipated that this recommendation could be implemented within existing financial capacity

⁴⁰ It is anticipated that this recommendation could be implemented within existing financial capacity

⁴¹ White Ribbon Alliance, *Safe Motherhood Fact Sheet*

equipment supply is not the business of AIPMNH but it raises a potential planning, budgeting and logistics issue with which AIPMNH might be able to support District Health Office to overcome. Part of the solution might be to assist partners to improve the logistics management system that has recently been revised under UNICEF support.

Recommendation: *That partners address the critical and urgent facility issues that are likely to adversely impact on maternal and neonatal outcomes, in particular:*

- *District Health Office and health facilities to find ways to budget adequately for facility operation costs, including ongoing repairs and maintenance;*
- *District Health Office to ensure adequate availability of drugs and equipment by implementing recently revised logistics management systems; and*
- *District Health Office make the critical whole-of-government links required to address the issue of poor supply of water and power to health facilities.*

3. How effectively is the partnership working?

The partnership model is increasingly being used in international development as a means of moving towards greater country ownership (Jobin, 2008), particularly in response to the significant paradigm shifts brought about by the Millennium Declaration in 2000 and subsequent international agreements (Picciotto, 2007). Whilst proclaiming a commitment to partnerships, many donor partners are still caught in relationships and processes that more closely reflect traditional project-based style approaches (Picciotto, 2007). This makes evaluation of partnerships important. Despite the increasing use of this mode there have been few studies to assess the performance of partnerships and no single or favoured tool to evaluate them (Brinkerhoff, 2002; Serafin, 2008).

Drawing on the literature a framework for conceptualising partnerships was developed for this evaluation, as outlined in Annex 4. The framework consists of four partnership aspects components: *prerequisites; structure; process; and outcomes*. Each of these has two or three dimensions, which in turn are comprised of sub-dimensions. It is against this framework that the AIPMNH partnership was evaluated.

The following sub-sections directly relate to the four partnership aspects and the discussion in each draws on the particular dimensions and sub-dimensions.

3.1. The necessary prerequisites are in place

AIPMNH operates at both a national and sub-national level, with a strong enabling environment at both. National and sub-national policies support the work of the partnership.⁴² The Australian Government's commitment to neonatal and maternal health has recently been confirmed in the newly developed Country Strategy. The political will by Indonesia is evident. All levels of government are required to develop their own Millennium Development plans. Revolusi KIA is the commitment made by the NTT Government. At the district level, the two Bupati who participated in interviews discussed the work of the AIPMNH with a depth of knowledge that indicated they were very familiar with, and supportive of, the Program. In addition, stakeholders in each of the three visited districts advised that the local government has, or is currently preparing, relevant local regulations.

This high level of political and administrative commitment is providing a degree of assurance and stability for the partnership as well as strong incentives and obligations. For example, one senior official from Bappeda advised that he had been assigned by the Governor to coordinate the needed change, including establishing the necessary processes and communication channels, and is required to keep the Governor abreast of progress. Similar drivers were evident in the responses at the partnership workshops. With few exceptions, respondents reported that their senior managers supported the partnership and allocated time for partnership work to be undertaken. Likewise, from the enthusiastic way in which many respondents spoke about how they view the work of the AIPMNH, it is evident that there are many who are acting as champions of the partnership. These champions advocate for the partnership and its work both within their own organisation and to other stakeholders.

The partnerships are supported by written agreements and governance structures. They have agreed shared goals, which are articulated in program documentation. It was evident during the partnership workshops that these shared goals are well understood and accepted.

⁴² AIPMNH Program Design Document, July 2008

3.2. An incomplete partnership structure is impacting on practice and performance

Formal dimensions of the partnership are evident. AIPMNH is officially structured at the national level through a Subsidiary Agreement between AusAID and the Kemkes (Ministry of Health).⁴³ A Performance Review Committee (PRC), with representatives from the partners plus Bappenas (National Development Planning Agency), is the means through which the partnership governance occurs, including the setting of direction, monitoring of progress, and accountability for results. The roles and responsibilities of the Performance Review Committee are articulated in program documents.⁴⁴ The governing body is supported in its work by a National Technical Team, which provides technical guidance on the implementation of the program. It is comprised of representatives from the partners and the implementing team. Its roles and responsibilities are also articulated in program documents.⁴⁵

The work of the partnership is implemented at the sub-national level to which each partner is contributing. At this sub-national level – both provincial and district – the work of the AIPMNH is implemented through a local partnership comprised of five SKPD: Bappeda; Dinkes; BPP (Women’s Empowerment Bureau); BKBK (Family Planning); and BPMD (Local Government Community Development Bureau). In some locations, the partnership also includes other relevant provincial or district agencies or organisations. These sub-national partnerships are formalised through Memorandums of Understanding. Local implementation decisions are made within the direction set at the national partnership level. There is a Provincial Coordinating Committee (PCC) and District Coordinating Committees (DCC), each of which is supported by a local Technical Team. Roles and responsibilities are documented.⁴⁶

Whilst the AIPMNH partnership is relatively new, the relationship between the partners, at both national and sub-national levels, is long-established.⁴⁷ From how respondents discussed their partners, it was clear that mutual trust and respect has developed over the decade in which they have been involved with each other. This social capital is illustrated thus:

AusAID brings a comparative advantage...they are not like the World Bank; they offer technical support that will help them [province and districts] become independent (Bappenas representative).

This is the best cooperation and partnership that has ever worked to support local government. AIPMNH wants to support government’s ideas [whereas] others [other donors] see it as gambling – they [other donors] are only concerned about their own name (senior manager, Dinkes).

Despite these positive aspects, the review highlighted a concern in relation to the partnership’s structure, which in turn, impacts on partner practice and performance. This concern plays out in three ways, which are discussed below.

⁴³ Partnership information obtained from interviews and review of documents

⁴⁴ AIPMNH First Annual Plan 2009

⁴⁵ Ibid

⁴⁶ Ibid

⁴⁷ AIMPNH Program Design Document

Inconsistent involvement of the most senior officials

The first concern relates to the difficulties that both Bappenas and Kemkes have experienced in achieving consistent involvement in the partnership by their most senior managers.⁴⁸ Workload and other pressing demands were the most often mentioned reasons. However, a lack of clarity and focus of the Performance Review Committee could also be contributing, with reports that the meetings are not well focussed and minutes confirming a lack of strategic discussion. Respondents commented that the purpose is not sufficiently agreed, with some questioning its value now that the Program is being implemented. This highlights a misunderstanding of the ongoing role of the committee in relation to monitoring, accountability and periodic adaptation of the partnership and could help explain some of the difficulty in involving the most senior managers.

A further complicating factor appears to be the relative importance of AIPMNH to the various partners. For AusAID it represents a large investment and a major focus of its Country Strategy. However, for Bappenas and Kemkes, AIPMNH is only one of many donor programs and, therefore, does not demand the same degree of urgency, notwithstanding their support for the Program. If the staff representing Bappenas and Kemkes on the Performance Review Committee had sufficient decision-making power it might not matter that they are not the most senior. However, this does not appear to be the case, as illustrated in the following comment:

I'm committed but my power is little [so] I cannot have the right level of influence [at the Performance Review Committee]

Unless the most appropriate senior officials are consistently involved in the Performance Review Committee it will be difficult to achieve the needed policy dialogue or to make the necessary decisions about the Program's direction.

To attract a more senior level of involvement from Bappenas and Kemkes in the ongoing high level governance of AIPMNH it might help to integrate AIPMNH with other health partnership programs. An obvious integration would be with the soon-to-be established Health Systems Strengthening (HSS)⁴⁹ program. Rather than having separate governance arrangements for each of AIPMNH and the HSS it could be more advantageous to have a single governance structure (that is a single Performance Review Committee) at the national level for all of AusAID's health partnership work with the Government of Indonesia. This could elevate the importance of the dialogue to a level that commands more senior attention as well as minimise the demands on senior managers from both governments. In addition, it could help ensure that systems issues that emerge from the AIPMNH are linked with the HSS immediately, with alternative solutions discussed by the partners if the HSS is not the most appropriate avenue for resolution of such issues. Under a single governance arrangement, separate technical teams could operate for each program, providing the structure for specific program matters to be discussed and endorsed. A further advantage of a single governance arrangement would emphasise the partnership nature of the health work and assist in moving from the former project relationship AusAID had with the Government of Indonesia.

⁴⁸ Information obtained from interviews and PRC minutes

⁴⁹ Expected to commence in 2011, the program will focus on a better resourcing of primary health care by having central level policy intervention. The program will tackle two main health system issues: Financing and Health Workforce. The program will have sentinel sites which can be used to inform policy development, such as in NTT

Recommendation: *That a single national level governance arrangement (Performance Review Committee) between AusAID and the Government of Indonesia be established for all health partnership work in order to facilitate the efficient involvement of the most relevant senior government officials, with each individual program having its own technical working group that provides the partners with a forum to discuss and resolve specific program matters.*⁵⁰

AusAID's absence from the partnership at the sub-national level

The second concern relates to the absence of AusAID from the partnership at the sub-national level. AusAID delegates its sub-national partnership role to the implementing team (through the managing contractor). The implementing team is, therefore, the operational mechanism for fulfilling AusAID's partnership commitment. However, it is apparent from how each of the implementing team described the local situations that they have not interpreted their role as one of the partners (in lieu of AusAID direct). Rather, the sub-national partnerships are between the relevant Government of Indonesia agencies only, with the implementing team members providing a service to partners. For example, members of the implementing team referred to themselves as the partners' 'contractor' and during a group interview, the implementing team described the partnership thus:

The partners are Bappeda, Dinkes, BPMD, BPP and BKKBN. We facilitate the group.

With the implementing team acting as a service provider, rather than as a partner, AusAID has not been able to achieve mutuality, a critical partnership practice measurement as identified from the literature.⁵¹ Mutuality requires equitable decision-making, equitable exchanges of resources, reciprocal accountability and a sharing of risks and benefits. However, almost all of those interviewed at sub-national level described processes that indicated that whilst the implementing team might provide advice, decisions about Program activities are made jointly by participating local government agencies. Indeed, work plans of District Program Coordinators are driven by such decisions, with Coordinators reporting a reactive rather than a proactive role. Mutuality does imply that each partner will contribute at the same level as each other. Rather, it is about the partners accepting their fair and just share of responsibility.

Similarly, processes described by most respondents at the sub-national level indicated a high level of one-sided exchanges of resources. In many instances, AusAID resources are being provided with little expectation of mutual contribution and are often used in ways that resemble a traditional project approach or the more ad hoc approach associated with facilities. This tendency of many of the partner agencies to perceive AIPMNH as a project was confirmed by the implementing team, almost all of whom reported being frustrated by it. In the absence of mutuality AusAID's risk is elevated. The structures and processes are not in place for it to have a fair share of influence over its investment. It will be important to rectify this situation. Options for this are discussed in the next topic area.

On a positive note, there were examples of attention being given to the principle of mutual contribution such as joint funding for training, with resources from local government agencies being combined with funds from AusAID. In addition, there were some notable examples of where the funding of activities is being staged so that over time the percentage of AusAID funds decreases and agency funds increase.

⁵⁰ It is anticipated that this recommendation could be implemented within existing budgets

⁵¹ One of the key measurements of partnerships as identified in the literature. Indicators of mutuality include equality in decision-making, resource exchange, reciprocal accountability and even benefits (mutual benefit and risk sharing)

However, from how the decision-making processes were described it appears that, mostly, mutual contribution is taken up as a result of advocacy by individual members of the implementing team rather than as an institutionalised practice. In talking about how they work, it seems that some of the implementing team are strongly committed to the principle of mutual contribution and therefore it is integral to how they go about their work with the partner agencies. The importance of this principle needs to be incorporated in all AIPMNH work.

Need to engage in policy dialogue

At present, the governance arrangements are placing a heavy emphasis on receiving update reports from the Program Director, much of which are operational rather than strategic in nature.⁵² By the implementing team not being active partners in lieu of AusAID at the sub national level, the opportunities for policy dialogue are further diminished. From a review of minutes and interviews with AusAID managers and implementing team staff, it is apparent that AusAID has taken a 'back seat' during this first phase of the Program. A number of things have contributed to this situation. Firstly, AusAID's capacity to have much of an actual presence on-ground is limited because of a lack of staff resources.⁵³ Secondly, the Program design had assumed that the Health Advisor would provide strategic guidance and oversight. This has not been possible due to competing priorities.⁵⁴ Thirdly, AusAID has not been explicit about what it seeks from the partnership. Picciotto (2007) has noted the difficulties many donor partners have had in grappling with the relatively new concept of partnership, so AusAID is not alone.

There is a need for AusAID to help drive reform and not simply follow because in trying to strengthen government systems, it is important for AusAID to help diagnose system weaknesses and solutions. To be effective this dialogue also needs to be informed by much more robust information about how systems are performing; precisely that information which is needed to monitor whether the Program is having any impact. This issue of more robust monitoring and evaluation has been noted previously in this report.

Regular policy dialogue should be an important aspect of the governance arrangements at each level. Program-based approaches like sector-wide approaches (SWAPs) often incorporate formal processes of regular sector review that engage both partners (government and donors) in a joint process of information gathering and analysis to facilitate this sort of dialogue. At the national level it is suggested that the Performance Review Committee agenda be re-structured to focus more on strategic and policy issues and that the sub-national committees feed up critical national-level policy issues to the national partnership.

At the sub-national level, given that the aim of AIPMNH is to improve the allocation and management of resources for MNH programs, there should be specific mechanisms through which AusAID, as the donor partner, can engage in dialogue with district governments about how they are allocating and spending resources. Dialogue of this kind provides an opportunity to advocate around the priorities that are reflected in the budget and to jointly identify system weaknesses and activities the Program can fund to address these. Negotiation of agreements between Bupati and AIPMNH are a good basis for engaging partner governments at the political level. In future, it would be useful to increase the specificity in these agreements to reflect the issues discussed between the partners about resource allocation and management.

⁵² PRC minutes and interviews with those involved with PRC

⁵³ As advised by AusAID

⁵⁴ As advised by AusAID

Well-structured expenditure analysis will be essential to support dialogue with local governments. The District Health Accounts address some of this need for data on expenditure but they are not sufficient on their own. PEACH⁵⁵ reports do not provide any information about sub-sector allocations. Until such time as the government generates its own information in a sufficiently timely and detailed way, the Program will need to generate that data itself with support of the Australia-Indonesia Partnership for Decentralisation (AIPD).⁵⁶ Doing so can be as valuable a development activity as the activity seed-funding which the Program is currently providing.

Engaging in dialogue with 14 district governments will not be easy. The Program will need to develop a strategy for engaging at a number of levels: through its district coordinators; provincially-based staff; the Program Director; and through regular visits by AusAID staff. One option could be to ensure that the AIPMNH Program Director takes up responsibility for the partner role at the provincial level and the District Program Coordinators do likewise at the local level. Taking on these roles would not mean that the implementing team would no longer provide technical assistance. They would simply do this as their partnership contribution rather than as a service provider external to the partnership. Whilst this solution has some practical benefits it has the disadvantage that none of these positions are held by AusAID staff. Therefore, AusAID would need to provide a more active role in liaising with and guiding the implementing team.

A second option could be to delegate this partnership role to the newly established AusAID position of Coordinator for NTT and Nusa Tenggara Barat (NTB). This would have the advantage of not requiring a scaled-up involvement of AusAID's Health Unit Manager or the AIPMNH Program Manager. However, the downside would be the capacity for this position to fulfil the role across the province and the districts, given that this role is not a dedicated one.⁵⁷ Given the autonomous nature of district agencies, it would be important that the partnership role is not neglected at this level and it might be difficult for the Coordinator for NTT to manage this alone. Therefore, it is possible that the solution might be found in some combination of these two choices.

At least one senior manager in AusAID suggested that scaling up involvement in this way would increase AusAID's transaction costs. Jobin (2008) notes that transaction costs relating to partnerships are broader than simply the costs associated with the monitoring of implementation. He suggests that transaction costs are impacted by such things as: the level of trust and social capital; the specificity of the assets exchanged; the degree of uncertainty in the environment; how frequently transactions occur; the degree to which coordination is required; and the measurability of partner contributions. A more active partner role is likely to increase the frequency of transactions and the level of coordination, and hence increase the costs.

On the other hand, this review has found that some of these measures (trust, social capital, and the certainty of the environment) are decreasing transaction costs. Together, this might result in a reasonable balance of transaction costs. Regardless, choosing not to scale up involvement could increase the risk that the investment will not be well targeted over the longer-term.

⁵⁵ Public Expenditure Analysis and Capacity enHancement

⁵⁶ The suggested working relationship between AIPMNH and AIPD is discussed later in this report

⁵⁷ This role is not dedicated – the person to hold this position is also the Deputy Manager AIPD

Recommendation: *That AusAID targets its investment better by picking up an active partnership role at the sub-national level through:*

- *delegation of the partner role to appropriate positions either within AusAID and/or the implementing team;*
- *regular structured engagement with the partner governments (predominately at the district level) around issues of resource allocation, expenditure and management; and*
- *using analyses of budget and spending undertaken by AIPMNH to inform a more focused policy dialogue.⁵⁸*

3.3. Partnerships are maturing at the sub-national level

As noted in the preceding topic area, inconsistent involvement by the most senior officials from the Government of Indonesia is having a negative impact on partnership practice and performance. Likewise, the absence of AusAID from the sub-national level means that the local partnerships are limited in what they can do. However, putting these two issues aside, the review found that partnerships between the local government agencies at both provincial and district level are maturing well. This was evidenced in a number of ways. Firstly, the survey conducted at the each of the partnership workshops indicated that the nature of the interaction between partners is positive, aided by robust relationships. The majority of respondents agreed that partners compromise and negotiate fairly, that they recognise and value the contribution made by each other, and use the particular skills of each partner well. People also reported a high level of trust.

It was evident by the way in which partners interacted on the day that people knew each other and are used to working together. Most were knowledgeable about each other's work. People spoke to each other with an air of familiarity. They were willing to discuss their thoughts about the partnership with each other. Notwithstanding these positive aspects, it is important to note that data from each of the partnership workshops show that there is at least one and sometimes two agencies that are not feeling as included in the partnership as others. In addition, data from one of the districts indicate that one of the agencies continues to favour implementation of activities on its own rather than in collaboration with others. Whilst these relationship issues involve only a small minority it is nonetheless important to address issues of inclusion and cooperation if ongoing collaboration between the agencies is to be sustained post AIPMNH.

Despite the issues of mutuality for AusAID, as discussed in the previous topic areas, it is not an issue amongst the local government agencies partners. The majority of local partners were in general agreement about the goals and reported a shared ownership, including contributing a fair share of resources. Almost all reported that the benefits of the partnership outweighed the costs. A notable example of the mutuality between local government partners is the extent to which a shared sense of responsibility for improved maternal and neonatal health outcomes is developing. The majority of sub-national respondents reported that whereas once Dinkes was seen as the only agency responsible for maternal and neonatal issues, other agencies are now accepting that they, too, have a responsibility. By and large, this has been an important process outcome of the AIMPNH and is illustrated in the following quote, expressed by a Bappeda representative at one of the district workshops:

We have been a partnership for many years but only this year, since AIPMNH, has everyone seen that it [maternal and neonatal health] is responsibility of all of us.

⁵⁸ It is anticipated that this recommendation could be implemented through existing budgets

From observations and interviews it was apparent that whilst each of the sub-national partnerships that participated in this review is developing in terms of capacity, they are doing so at varying rates. In each, Bappeda has taken up the responsibility for coordinating the partnership. However, it is evident from how respondents described processes that the level of confidence in doing this varies. Some rely on direct support from the implementing team to undertake this task whilst others do this independently. Some expressed concern about any prospect of a reduction in support from the implementing team yet others expressed confidence in taking on greater local responsibility for such things as oversight and approval of activities funded through AIPMNH. Some take active steps in encouraging all relevant agencies to be active partners yet others do not see that this is their role.

The degree to which the local partnerships have developed is not related to the length of time AIPMNH has been supporting them. Of the four that participated, two have been supported by AIPMNH since 2008; one came in to the program in 2009 during the second phase; and one has been supported since March 2010. Generally, the partnerships were established as part of the AIPMNH so they have been developing for one or two years. One partnership, however, preceded the introduction of AIPMNH, having been established with support from GTZ⁵⁹ five years ago. This particular partnership demonstrated the most maturity. Here, Bappeda coordinates the various SKPD and participating non-government agencies independently of direct AIPMNH assistance. It expressed a desire and capacity to take on additional responsibility for oversight and approval of AIPMNH funded activities. It has already begun building in graduated phasing out of AIPMNH funds and technical assistance for many of its activities. The length of the partnership might not be the only factor contributing to its level of maturity. Other factors might include such things as the commitment of individuals or the particular environment in which the partnership is operating. Nonetheless, this experience is an important reminder of how long it takes for partnerships to develop to a level that is more sustainable.

Need to develop partnerships with an end point in mind

In addition, the variation between partnerships is an important reminder that they mature not only at different rates but also in different aspects at different times. When a partnership will be ready to be more independent of AIPMNH will vary, as will in what areas of the work in which they will be ready. Now that the Program is at its mid-point, it is timely for the implementing team to begin to work with each partnership to identify in which areas there is capacity for greater levels of independence. This is an important next step because the AIPMNH is not intended to strengthen capacity amongst partners indefinitely. It is a time limited Program, notwithstanding that AusAID might have an ongoing involvement in Indonesia.

It is therefore important that each partnership begins to plan and implement a graduated, staged transition to independence from the Program. Transition need not, and should not, wait until a partnership has strengthened its capacity across all components and activities. Rather, a partnership will make the transition in one area whilst still developing its capacity in another. These plans will be tailored to each situation but are likely to involve a range of strategies such as:

- determining when and how responsibility for overseeing and approving terms of reference for activities will be transferred to a partnership;
- the steps required for Bappeda to coordinate independently of the implementing team;
- setting criteria for what is an acceptable level of capacity for the given situation in various activities and components that will enable efforts to be sustained;

⁵⁹ GTZ – German Government international development agency

- which aspects of the program might be accelerated and move more quickly towards independence;
- what additional short-term technical assistance might assist acceleration of independence;
- how any technical assistance and funds provided through AIPMNH will be gradually phased out; and
- how ongoing maintenance of efforts will be funded and supported from within partners' resource base (once the intensive once-off investment is used to strengthen capacity).

To encourage a strategic focus, partnerships are encouraged to develop rolling five-year⁶⁰ plans, which are operationalised annually, based on a review of progress.

Recommendation: *That each partnership, with the assistance of the implementing team, develops and implements five-year rolling plans that enable a graduated, staged transition to independence from AIPMNH that:*

- *articulate partnership development goals and the steps and resources needed to achieve these; and*
- *are operationalised annually, based on a review process*⁶¹

Now that district partnerships have shown that they are maturing, it is timely for an assessment to be made of where additional short-term technical advice might be beneficial. To help progress the recommendation for sub national partnerships to move towards greater levels of independence from AIPMNH, it could be particularly beneficial to focus such short-term assistance on this task. This might mean that it is better for such assistance to be placed at the district level, following a joint assessment of needs.

Recommendation: *That district partnerships, in cooperation with the technical advisors from the implementing team, identify where additional technical assistance could help them progress their plans more quickly, cost such assistance, and recruit to such short-term positions quickly and efficiently.*⁶²

Need to periodically assess the 'health' of the partnership

The use of a partnership approach is central to this program. It was chosen as the delivery mode in the hope that it would better address issues of sustainability and government capacity, neither of which was addressed well in the former project-based mode.⁶³ However, despite its importance, there has been little focus on the practice or performance of partnership in any of the program design, the monitoring and evaluation system, or the governance arrangements. The exception to this has been the tracking of the longer-term program outcomes desired by the partnership and a recent brief assessment of the effectiveness of the partnership as part of the implementing team's preparation for this mid-term review.

⁶⁰ The review team considered that a three-year rolling cycle would be more suitable. However, a five-year cycle has been recommended because current government plans are on a five-year cycle – the intention is to integrate these plans into the existing planning formats

⁶¹ It is anticipated that this recommendation could be implemented within existing Program budget

⁶² It is anticipated that the assessment part of this recommendation could be implemented within existing Program budget. Likewise, it is anticipated that the short-term technical assistance would be funded as a district activity through the Imprest Account. Estimations of cost for technical assistance is not possible as part of this report because each district's needs will vary.

⁶³ AIPMNH Program Design Document, July 2008

From the literature (Brinkerhoff, 2002) we learn that focusing only on the longer-term results of partnerships is not an effective management approach. Outcomes cannot assist with tactical decision-making or help in understanding how a partnership is performing over the shorter-term.

In addition, the dynamic nature of partnerships means that they are likely to yield different costs and benefits at different stages (Brinkerhoff, 2002). Given that a partnership approach is relatively new for the Australian and Indonesian Governments, gaining a better understanding of how the partnership is progressing and the relative costs and benefits is important to decide if this mode of delivery will bring about the desired sustainable capacity.

Hence, it is important that the partnership aspect of AIPMNH, at each of the levels, is monitored on a regular basis and periodically evaluated. This will help determine if it is moving in the desired direction at an acceptable level of cost and benefit, and indicate if any changes need to occur.

The framework developed for this review could provide a basis for this monitoring and evaluation work (Annex 4). Alternatively, the partnership might wish to use or adapt an existing tool such as the Partnership Assessment Tool.⁶⁴

Recommendation: *That, as part of a revised AIPMNH Monitoring and Evaluation Strategy, the partnership aspect of the AIPMNH be regularly monitored and periodically evaluated using indicators and processes jointly developed by the partners, and for the partnership to be adapted, as needed.*⁶⁵

3.5. Partnerships are achieving early results and adding value but face some efficiency issues

Effectiveness is evidenced through the influence the various partnerships are having on administrative and service delivery capacity of partners, as well as on the capacity of communities with which they are working. These achievements have been discussed in the second chapter of this report so are not replicated here. A further sub-dimension of effectiveness is responsiveness, which is addressed below.

Early signs of responsiveness

Maintaining links with the beneficiaries of the services and products of the partnership and other important external entities is an important measure of responsiveness, an indicator of effectiveness (Caplan et al, 2007).

Responsiveness to beneficiaries

To varying degrees, partners have in place processes to help them work with and be responsive to beneficiaries. For example, one Bappeda has established a schedule of annual visits to communities in which the program operates. These are used to review the program effectiveness and determine the level of community satisfaction. Following the visits, Bappeda representatives will review the findings with the District Program Coordinator and other partner agencies. In another district, Reformasi Puskesmas⁶⁶ began with a community survey to obtain feedback on communities' views. The findings from this survey have informed the strategies that have since been developed.

⁶⁴ *Partnership Assessment Tool* developed by the Nuffield Institute for Health – based on six partnership principles, it is designed as a rapid appraisal of the health of partnerships for the purposes of continual improvement

⁶⁵ It is anticipated that this recommendation could be met within the existing Program budget

⁶⁶ National program to reform puskesmas

In each of the districts, the direct community work being undertaken by BPP (Women's Empowerment Bureau), BKKB (Family Planning), and BPMD (Local Government Community Development Bureau) provides partners with opportunities to engage directly with beneficiaries.

How much these opportunities are used to better understand the need of beneficiaries is not clear. However, it is anticipated that, through the Community Engagement Team, strategies will be put in place that will assist partners be more responsive, though it is currently too early for such results to have been achieved.

Because the provincial and national partners do not engage directly with beneficiaries they are reliant on third-party information to help them be responsive. It is therefore important that this information be well-informed. The Community Engagement Team's intention to establish a team of resource people at provincial level⁶⁷ will hopefully put in place a strategy that will provide a conduit to beneficiaries for provincial partners. This conduit does not need to be direct with beneficiaries. Rather, these resource people, through their direct support to those working at the community level, should be in a position to obtain more informed third-party information that will assist provincial partners to be responsive.

For the national partners, if the Community Engagement Team were to have representation on the National Technical Team, they, too, could have an improved third-party conduit to the needs of beneficiaries as well. Likewise, if BPP, BKKB, and BPMD were also represented on the National Technical Team, the national partners are likely to build up a much improved level of information about beneficiary needs.⁶⁸

Recommendation: *That the national partnership strengthens its third-party knowledge of beneficiary needs by including on the National Technical Team representatives from the Community Engagement Team, BPP (Women's Empowerment Bureau), BKKB (Family Planning), and BPMD (Local Government Community Development Bureau).*⁶⁹

Responsiveness through linkages with other donors and NGOs

Responsiveness through productive linkages with other programs, donors and NGOs is an important indicator of partnership outcomes. In the province and two of the visited districts AIPMNH coordination with other donors is occurring through a secretariat arrangement that is overseen by Bappeda. At the provincial level, Bappeda advised that it facilitates discussions between the various external agencies. In the two districts, the AIPMNH office at Bappeda is co-located with other non-government agencies and relevant agencies, and these secretariats are actively involved in the district partnership. They participated in the partnership workshop, describing AIPMNH activities in which they are involved and discussing plans for future work with AIPMNH. One such example was the involvement in one of these districts of PMI or Indonesia Red Cross. As part of the local partnership, PMI will work jointly with AIPMNH in 2011 to implement a program that aims to identify blood type for up to 45,000 people in seven sub-districts as a critical step to building up local blood banks.

⁶⁷ *Community Engagement Team Inception Report, Sep 2010*

⁶⁸ The review team was asked why it had recommended inclusion of the Community Engagement Team but not the Gender Team. This is because the former has a direct involvement with beneficiaries whereas the Gender Team's work is with agencies and organisations. Improved third-party would, in this instance, come from BPP

⁶⁹ It is anticipated that this recommendation could be implemented within existing Program budget

Links have also been established with other relevant programs operated by AusAID and the Government of Indonesia. At the province level, managers of AIPMNH and AIPD reported that regular discussions are held to update each other on progress and explore matters that are of joint interest. It is timely that these discussions become more formalised because AIPMNH has begun trying to address broad public financial management systems, some of which are beyond AIPMNH's mandate.

This is outlined in more detail later in this report, but in summary includes activities such as the introduction of e-finance at provincial and district offices, and implementation of accrual accounting. It will be very difficult for AIPMNH to have any impact on strengthening broader public financial management systems, given that it is a sub-sectoral Program that is engaged with a handful of districts in one province. Financial management arrangements at district level in Indonesia are highly circumscribed by Ministry of Home Affairs (MoHA) regulations, and some of the most problematic weaknesses appear to be deeply structural in nature. It is not easy to identify a local-level agency with a clear leadership role in relation to public financial management. Given this, it is likely that high level political commitment to public financial management reform will be needed before any progress can be achieved. AIPD is much better placed to support improvement of these systems through its engagement both at a whole-of-local government level and with its counterpart central government agency, the Ministry of Home Affairs.

A more formalised approach to the relationship between AIPMNH and AIPD is also timely given the additional NTT coordination role AusAID has recently given to the AIPD Deputy Program Director position.

Recommendation: *That the coordination of AusAID programs in NTT be strengthened by:*

- *AIPMNH and AIPD jointly identifying current AIPMNH activities that are better suited to be led by AIPD, agreeing upon a process and timeline for transfer of responsibility; and*
- *the newly established Coordinator NTT and NTB establishing a regular, formal mechanism of supervision with the AIPMNH Program Director that allows potential program overlaps to be identified and addressed on an ongoing basis.*⁷⁰

Responsiveness through linkages with other government and AusAID programs

Responsiveness through productive linkages with other government and AusAID programs is another important indicator of partnership outcomes. At district level, respondents from both the implementing team and agencies reported that there are efforts to achieve a collaborative approach between government programs such as Desa Siaga and PNPM⁷¹ with AIPMNH activities. From descriptions provided by respondents, it appears that these links are often focused at the level of cooperation rather than collaboration.⁷²

⁷⁰ It is anticipated that this recommendation could be implemented within existing Program budget, given that coordination between Programs is an expected component of both AIPMNH and AIPD

⁷¹ PNPM is the National Community Empowerment Program

⁷² *Cooperative arrangements:* partners help each other meet respective organisational goals without making substantial changes in services or regulations; no common goals. *Collaboration:* used when intent is to change fundamentally the way services and programs are designed and delivered: mutual goals; joint problem sharing; pooling resources; sharing responsibility for the outcomes (Kimmich)

With the introduction of the Community Engagement Team these links are likely to be strengthened further as the team begins to implement its program. The team advised that all of its community-based activities are focused on helping communities engage better with existing government programs such as Desa Siaga, Reformasi Puskesmas, PNPM, and pramusrenbang.⁷³ They expressed an intention not to replicate any of the processes for these programs but rather to work collaboratively. It is too soon since the team's inception for there to have been much in the way of results in terms of achieving collaboration, although recent training of local facilitators conducted by the Community Engagement Team that involved PNPM facilitators is an example of cooperation.

Whilst each district has been establishing links, developing these into robust collaborations will take some time. It will be important for AIPMNH to strengthen these links, promoting ways in which they can mature from cooperative to collaborative relationships through such things as looking for opportunities to develop mutual goals, undertake joint problem solving, pool resources, and share responsibility for the outcomes of activities.

Efficiency issues

The findings in relation to efficiencies are more mixed. Without exception, the sub-national partners were of the view that the benefits of being involved in the partnership outweighed the costs involved.⁷⁴ On the other hand, it has already been noted that the absence of AusAID from the sub-national partnerships diminishes the benefits for AusAID by making it more difficult for it to have a direct influence on its investment. In addition, there is the issue of opportunity costs for AusAID given that many of the partners have difficulties in expending the funds provided. This issue relates to two main matters. The first is the absorptive capacity of partner agencies. This issue is picked up in next chapter under the topic area of 'sustainability'.

The second issue concerns bottlenecks that are occurring because of the limited capacity of the implementing team to meet the level of demand. For example, each of the districts reported not being able to progress some key activities as quickly as they would like because of the need for input from the implementing team's technical advisors, each of whom is experiencing heavy work demands. From descriptions of, and the reasons for, the various activity approval processes, it is clear that the implementing team has focused on quality assurance as well as being concerned not to waste public funds. It has not sought to expand its own team of technical advisors as a means of lessening the load because of a concern to ensure the bulk of funds can be used for activity implementation. Furthermore, some processes have been slowed because the team has been concerned to build capacity of partner agencies at every possible opportunity. Key examples of this are the time it took to recruit the Community Engagement Team and the Gender Team (six months after the Performance Review Committee approved it)⁷⁵, and the delays in putting in place needed monitoring and evaluation technical assistance.

Building capacity is important, especially to help ensure sustainability. However, there are times when the opportunity costs to AusAID and the program overall outweigh the costs associated with expanding the number of technical advisors or the benefits of building capacity of partners. The delay in appointing the Community Engagement Team and the monitoring and evaluation technical assistance has resulted in a high opportunity cost to the program. Both of these teams play a crucial role in key activities and the program would have benefited more if they had have been in place much sooner.

⁷³ Initial planning stages for musrenbang – community development planning meeting

⁷⁴ Survey data from the four partnership workshops

⁷⁵ As advised by the implementing team

Although some community engagement activities were implemented prior to the Community Engagement Team being appointed, the much needed activities to increase service demand have lagged significantly. Given the interdependence between the supply and demand activities in the quest for improvements in maternal and neonatal health,⁷⁶ such delays are likely to have had a negative impact on the effectiveness of the supply activities.

As discussed earlier in this report, the delay in appointing monitoring and evaluation technical assistance has resulted in the absence of much needed work on developing ways for the Program to measure its effectiveness, given the limited capacity of the government systems to do this. This has meant that the program has lacked critical guidance that a more robust monitoring and evaluation system can provide.

For the remainder of the Program, it will be important for the Program Director and partners to assess the relative costs and benefits of the often competing aims of capacity development and faster program implementation. At times, they will need to prepare to forgo the capacity building for the greater good of the Program.

⁷⁶ Refer to the section on relevance for further information about this interdependence

4. How relevant is the program model?

The question of relevance has been considered in the following ways:

- Whether the rationale for the program is still valid, including if it is aligned to the policy needs of both the Indonesian and Australian Governments
- The plausibility and appropriateness of the program, particularly in relation to helping reduce maternal and neonatal deaths
- The sustainability of program achievements
- The appropriateness of the implementation model

4.1. Program rationale is still valid and aligned to policy and priorities

Recent official data confirms that maternal and neonatal mortality rates in NTT are still higher than the national average.⁷⁷ Despite district respondents reporting decreases in the numbers of deaths of pregnant women and neonates,⁷⁸ they also advised that a continued sustained effort is still required. When the official rates for 2010 are released, it is unlikely that they will be close enough to the national Millennium Development Goal maternal mortality target of 102: 100,000 to warrant any reduction in effort.⁷⁹

It is evident that AIPMNH aligns with Indonesian Government policy and priorities. The Health Ministry reported earlier this year that reducing the maternal mortality rate is now the first priority in the Indonesian health care system.⁸⁰ Representatives from Bappeda and Dinkes described Revolusi KIA as '*a mandatory commitment*'. However, the vast geographical and context variation between provinces means that additional support from donors and others is required to ensure a sustained effort.⁸¹ Bappeda at the provincial level advised that the National Government is now insisting on an integrated approach to maternal and neonatal health as part of its push to meeting the Millennium Development Goals. The integrated approach will require input from all relevant sectors, with Bappeda having responsibility to lead the coordination, including facilitating the setting and monitoring of targets for each SKPD. This is a new role for Bappeda, but one that is already being supported by AIPMNH in NTT at both provincial and district level.

Without exception, government officials at all levels reported that AIPMNH is very compatible with their policy needs. AIPMNH activities coincide with their listed priorities, including: improving the musrenbang process; strengthening Desa Siaga; renovating puskesmas; improving skills of midwives; promoting facility-based delivery; and building planning and budgeting capacity.

AIPMNH also aligns with Australian Government policy and priorities. Australia has an interest in ensuring its region is '...peaceful, stable and prosperous'⁸² and as part of this interest supports large scale development programs in Indonesia. Health is one of these key program areas and over the next five years AusAID Jakarta anticipates a continuing emphasis on maternal and neonatal health.⁸³ Furthermore, the partnership is aligned to AusAID's commitment to the Paris declaration and ACCRA, not only in principle but in practice, as illustrated in this statement made by a Dinkes representative:

⁷⁷ Indonesia MDG Report 2010

⁷⁸ Interviews with Bappenas and Dinkes in each of the visited districts

⁷⁹ In 2007 MMR in NTT was 306:100,00 compared with national of 228:100,000

⁸⁰ A matter of life and death, Rita A. Widiadana, The Jakarta Post, Wed, 01/13/2010, <http://www.thejakartapost.com/news/2010/01/13/a-matter-life-and-death.html>

⁸¹ Advice from Bappenas, Kemkes, Bappeda and Dinkes

⁸² Australia-Indonesia Partnership Country Strategy 2008-13, pg. 1.

⁸³ AusAID Jakarta Draft Health Delivery Strategy and advice from senior managers

'... [AIPMNH] supports government's ideas...It is democratic. We discuss ideas together and if we don't agree then we say so then work together to meet the requirements of both [Government and AusAID]'.

This approach is important to AusAID for other reasons as well. After working in NTT for 10 years, AusAID saw AIPMNH as the opportunity to achieve a level of sustainable change that it had not achieved through traditional projects. The Program is taking partnership and capacity strengthening approaches, both of which are designed to achieve this desired sustainable change. As noted in an earlier section of this report, the partnership approach is, generally, maturing well but not without some issues that need to be addressed. The effectiveness of the capacity strengthening approach was outlined in the second chapter.

One alignment concern relates to AusAID's desire to impact on the maternal and neonatal mortality rates. AIPMNH can only influence rates in NTT, which are unlikely to shift the national rates significantly even if they are reduced in that province. Even then, these rates are likely to reduce over time rather than within the contract life of this program. What is expected of the program is, therefore, an important consideration for the next contract phase.

4.2. The components of the program are supported by the literature

Generally speaking, the components and activities on which AIPMNH is focused are similar to those promoted in the literature as being effective and helping to impact positively on maternal and neonatal health. As noted previously, a literature review can be found in Annex 1, but in summary highlights:

- A mix of components such as training, education, provision of supplies, and upgrading of equipment, transport and infrastructure in one program (Ross et al, 2005);
- The inclusion of community engagement that seeks to facilitate linkages between communities and available health services (Haws et al, 2007; De Brouwere et al, 2010; McCoy et al, 2010; McPherson et al 2010);
- Increasing the number of births assisted by a skilled birth attendant (McPake and Koblinsky 2009);
- Promotion of facility-based delivery (Chowdhury et al, 2006; Graham and Hussein, 2006; McPake and Koblinsky, 2009);
- Planning processes that seek localised short-term solutions to low blood donation issues whilst full-scale blood-banks are being developed (McPake and Koblinsky, 2009);
- Programs that seek to change household practices regarding delivery and newborn care. (John Hopkins School of Public Health, 2007);
- Activities to promote family planning (Collumbien et al cited in McCoy et al, 2010);
- An integrated approach to perinatal health, with activities to address newborn health as part of efforts to address maternal health (De Bouwere et al);
- Attention to gender (Gill et al (2007);
- Strengthening health systems to improve health delivery, infrastructure development, program sustainability and enhanced problem solving (Hawe et al cited in NSW Health Department, 2001);
- Attention to planning and the management capacity of health ministries and personnel (McCoy et al, 2010); and
- Strengthening capacity through a partnership approach (Harris et al cited in NSW Health Department, 2001).

Notwithstanding that the components of AIPMNH reflect what is deemed important in the literature it is not possible to be definitive about whether the level, degree, or mix of activities will result in the desired outcomes. The literature reminds us that there is no single recipe for success (McPake and Koblinsky, 2009; De Brouwere et al, 2010; McCoy et al, 2010). Context is nominated as a critical factor (De Brouwere et al, 2010; McCoy et al, 2010) and, therefore, the correct mix, level and degree of components and activities will differ in different contexts and situations.

Given this, AIPMNH cannot simply assume that, because it is incorporating the range of activities promoted in the literature that it is effective in the given context and situation. Routine monitoring and evaluation is critical to understanding if programs that seek to address maternal and neonatal health issues are effective (McPake and Koblinsky, 2009). Evaluation techniques that take account of the importance of context and both the complexity and the social nature of health systems are advocated (McCoy et al, 2010). Were such techniques to be used, this would assist in gathering evidence needed to understand better how, where and why different approaches work, or not. This requires the development of more context-specific monitoring and evaluation systems. McPake and Koblinsky (2009) argue also for the use of techniques that dig much deeper into the processes that lead up to maternal deaths and other bad outcomes. They call for routine monitoring and exploration of the gaps in basic infrastructure as a means of understanding why gaps are emerging. This needs to be incorporated in the new monitoring and evaluation framework that is established.

Recommendation: *That an improved level of understanding is sought of which mix, degree and level of activities results best in the desired outcomes by incorporating into the revised Monitoring and Evaluation Strategy ways to monitor and evaluate how, where and why different approaches work or not.*⁸⁴

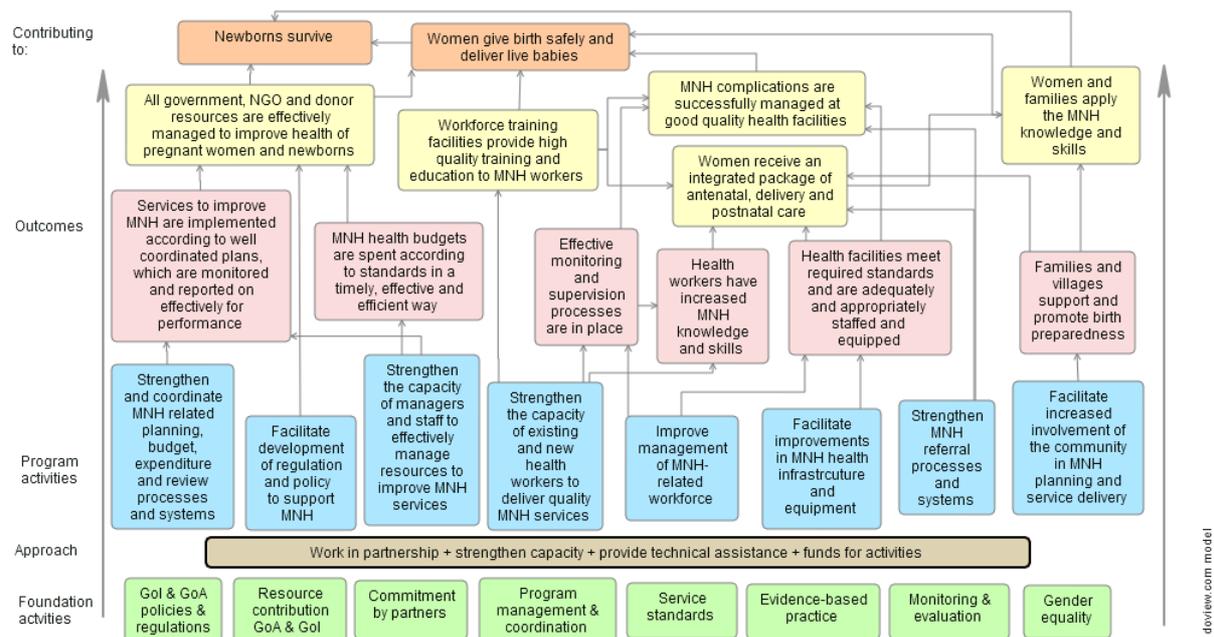
4.3. A high degree of plausibility and appropriateness

In considering the plausibility and appropriateness of the AIPMNH, the program was mapped into a program logic diagram. This was done as one way of tracking the pathways of the three components of the program to test the links between the components, the activities and outcomes. It provides a visual perspective of those pathways. It was decided to re-map the program logic because of perceived limitations of the log-frame (refer to Annex 3). The following diagram⁸⁵ is indicative and is presented not as the definitive diagrammatic summary, but rather as a working summary for the purposes of this report. It notes a number of 'foundation activities'. These are the aspects that guide the program and which, generally, need to be in place for the program to be implemented. It also includes the program approaches because they underpin all program activities. The program's major activities have been coloured in blue. First and second level outcomes are coloured in pink and yellow, respectively. Higher level outcomes to which the Program contributes are shown in tan. The arrows indicate what is necessary and sufficient for the next level of outcomes. The diagram confirms that the Program's pathways could lead to the desired outcomes and that there is a plausible link with the higher level outcomes to which the program wishes to contribute.

⁸⁴ It is anticipated that this recommendation could be implemented within existing Program budget

⁸⁵ An early version was discussed with the implementing team. Such diagrams can be the beginning of a process to develop a M&E framework: various tasks that lead from the activities to the outcomes would be plotted on supporting documentation, along with indicators, measures, and assumptions. This was not the purpose of the diagram for this report so these supporting documents have not been developed. However, it would be timely to use this draft program logic diagram (or some other) as a beginning point for the revision the monitoring and evaluation framework.

Diagram 1: Program logic diagram of AIMPNH



A possible need to scale up sexual reproductive health activity

However, the diagram also highlights an important issue related to sexual reproductive health. As indicated previously, the literature notes that effective sexual reproductive health education can impact positively on the health status of women. From the program logic diagram we can see that attention to sexual reproductive health is through an integrated approach to antenatal, delivery and post natal care. Midwives advised that this means that matters of family planning are included during antenatal and post natal visits. However, whilst respondents advised that numbers of women attending antenatal and post natal care are increasing, the percentage is still under target levels.⁸⁶ Hence, too few women will be targeted in this way.

In addition, by containing sexual health matters to antenatal and post natal care, the program cannot reach young women who have not yet had children and who, because of their age, are in a high risk category. Health workers who participated in this review noted the importance of reaching teenage girls as a way of decreasing the incidence of teenage and high risk pregnancies. Their concern is echoed by McCoy et al (2010) and Haws et al (2007) who highlight the importance of including the pre conceptual stage in the service continuum, including a focus on reducing teenage pregnancies. AusAID, too, has indicated an interest in scaling up efforts in sexual reproductive health.⁸⁷

How any additional activity should be implemented, were it to be included in any future design, needs to be considered more fully than has been possible in this review. However, three suggestions that arose as part of the review were:

- Provincial health staff advised that counselling and information for adolescents already exists at the sub-district level but needs to be extended to village level. Perhaps AIMPNH, through its community engagement work, could promote local ways of doing this.

⁸⁶ AIMPNH Progress Reports

⁸⁷ From interviews with key AusAID health staff

- Health staff in one of the puskesmas reported that adolescents tend not to use health centre services and advised that sexual reproductive health promotion work that occurs directly in schools could be more effective. However, health staff reported that they have limited budgets for outreach work. Whilst providing such funds is not the mandate of AIPMNH, there could be a role in supporting health facilities in improved budgeting and planning so that such funds might be identified and set aside.
- One district outlined its use of a mobile sterilisation van. They reported that the combination of an education component and having the van go to villages has successfully increased the number of men who have taken up this method. It was suggested that this might be one possible service that AIPMNH could support through planning processes in other districts.

Any scale up of effort by AIPMNH would need to occur in collaboration with BKKBN and other organisations, such as UNFPA, that have a significant role in sexual reproductive health. To help inform the next design stage, it would be beneficial for the AIPMNH to collaborate with BKKBN and UNFPA to identify the need more fully. Given the discussion in relation to the need to consolidate efforts, as outlined in the next topic area of this report, it is suggested that additional short-term technical assistance be recruited to undertake this piece of work.

Recommendation: *That the need to scale up sexual reproductive health activities be explored more fully by AIPMNH in collaboration with BKKBN and UNFPA and for the findings to inform the next AIPMNH design stage.*⁸⁸

Further study to determine if there is a need to scale up activities to reduce neonatal deaths

From the logic diagram we can see that newborn survival depends on improvements in health care and mothers and families applying the knowledge they obtain through their antenatal visits. From what midwives describe, newborn care information is provided to mothers in a general way. In the absence of follow up data it is not known how well mothers understand newborn care or the degree to which they apply the knowledge. In addition, the program has not captured data of the effectiveness of the training unit on newborn care or the quality of antenatal and delivery care. In the absence of reliable post training and supervision data it is not known how well midwives are applying the appropriate practices.

As noted previously, the rate of neonatal deaths is still very high in NTT. Of particular concern is the continuing high rate of deaths of newborns in the first week of their life. This concern is reflected in the literature, which notes that there has been relatively little decrease in the neonatal period (Lawn et al), with the majority of infant deaths in Indonesia now occurring during the first month of life (Statistics Indonesia and Macro International, 2008). Dinkes is currently auditing all deaths to see if lessons can be learned as to the particular contributing factors. This will provide important information that can help inform changes to activities or practice.

However, it is possible that health workers view this current audit as a process to attribute blame. Should this be the case, it is unlikely that health workers will be open about the

⁸⁸ It is anticipated that this work could cost \$179,500, based on the assumption of two consultants (1 national, 1 international) and about 100 days per year, as follows:

Consultant Costs	A\$	Day/Freq	Unit/Pax	Total
Professional Fees	750	100	2	150,000
Airfares	500	4	2	4,000
Travel Allowance	75	75	2	11,250
Accommodation	95	75	2	14,250
Visa				
				179,500

causes of neonatal death. There could be a role for AIPMMNH in working with Dinkes to improve the current perinatal death audit so that its emphasis is clearly on learning, not blame.

In addition, there is a need for two pieces of study. The first in reviewing the skills of health workers in performing newborn care and newborn resuscitation; the second in finding out the level of transfer of knowledge to mothers and the degree to which they are practising good newborn care. Both of these studies could be done through a brief case study method. It could be beneficial to conduct these using a 'success case' method because it can provide valid results in a practical and quick way.

Recommendation: *That two studies be undertaken to help inform the effectiveness of AIPMMNH supported activities that specifically focus on improvements in neonatal health: i) Review the skills of health workers in performing newborn care and newborn resuscitation; and ii) Evaluate the extent to which women are learning and applying appropriate newborn care practices.⁸⁹*

Ensure gender equity work remains focused on maternal and neonatal health outcomes

The Gender Team is taking a broad, systemic, human rights-based and long-term approach to gender which works on both the supply and demand sides. On the supply side, the Gender Team has spent considerable time checking each district's terms of reference for consideration of gender issues. Its main supply-side approach, however, is to mainstream gender into the work of SKPDs through participatory gender audits. Through conducting these gender audits with key SKPD⁹⁰ partners at the province and district level, the Gender Team aims to achieve broad institutional change.⁹¹ Each SKPD is then expected to use the gender audit as a baseline to develop and monitor its own gender strategy and action plan.

The idea of working with government partners to help them identify their own priorities in gender mainstreaming helps build organisational ownership for gender equality initiatives and aligns with AIPMMNH's partnership approach. Although the Gender Team is currently facilitating the gender audits, they are also building up a technical assistance pool consisting of universities and non-government organisations that can conduct these gender audits in the future. The Gender Team is also building the capacity of the provincial and district BPP to play a significant role in facilitating and providing technical assistance to implement gender mainstreaming in SKPD. It will be important that expectations for BPP's role match its capacity, given that all of the BPPs interviewed face challenges in finding adequate funding and human resources. While the approach of working through SKPDs can enhance sustainability, it also requires a longer timeframe to implement than is currently available to the Gender Team.

Rather than focusing specifically on supporting SKPDs to integrate gender into their existing maternal and neonatal health activities, the gender audits look at gender mainstreaming more broadly. They involve a broad organisational assessment which includes looking at issues such as how gender is mainstreamed throughout the SKPD, organisational culture in regards to gender, staff capacity in gender, perceptions of gender, information and knowledge management, and products and public image.

Although the unit of study for these gender audits is meant to be maternal and neonatal health, the question guides for the gender audits largely focus on gender mainstreaming

⁸⁹ It is anticipated that these brief reviews could be part of the role of the Monitoring and Evaluation Team so could be implemented within existing budget

⁹⁰ BPP, Bappeda, Dinkes, BPMD, Family Planning and Social Welfare

⁹¹ Gender Inception Report

more broadly and not on maternal and neonatal issues specifically.⁹² While the gender audits may achieve changes in institutional behaviour, the broad nature of these audits means they are unlikely to contribute to improvements in maternal and neonatal health even within the extended period of AIPMNH (that is, by June 2013).

Work on the demand side does not appear to have been prioritised as strongly as the supply side work, with few activities commenced in this area. On the demand side, the Gender Team intends to conduct women's empowerment activities (yet to be determined); work with the Community Engagement Team to integrate gender into the tools and guidelines of community engagement activities; and support SKPDs to promote stronger partnerships with non-government organisations, universities, research centres, members of parliament, community leaders, religious leaders and media. The Gender Team is also considering establishing a gender hub within the provincial BPP to harmonise gender efforts by AusAID programs⁹³ in NTT. If AIPMNH aims to impact more directly on maternal and neonatal health outcomes within the program time-frame, it will need to place a greater priority on working on these demand-side activities and ensure the range of activities are achievable within the program time-frame.

The review team is concerned that there is a real risk that the work of the Gender Team will be diverted from direct maternal and neonatal health outcomes unless dedicated efforts are made to ensure it remains focused. Having clear outcomes and a well articulated logic can help to focus the work. Unfortunately, the expected gender outcomes for AIPMNH are unclear. There are different gender outcomes articulated in the Gender Strategy Phase 1 and the Gender Inception Report and it is unclear how these two sets of outcomes relate to each other. It is unclear whether the outcomes are limited to maternal and neonatal health programs only, or all partner programs.

It is also unclear what gender outcomes AIPMNH hopes to achieve through integrating gender equality into partner programs and how this will contribute to achieving improved maternal and neonatal health. For example, is gender equality being integrated into partner programs in order to improve women's power to make decisions to be able to access maternal and neonatal health services, including giving birth in facilities; or to improve women's participation in community planning processes in order to ensure their maternal and neonatal health needs are met; or to ensure maternal and neonatal health clinical services are delivered in a gender-sensitive way? This needs to be clarified, so that the way in which gender equality is integrated into partner programs is likely to lead to these most appropriate gender outcomes.

A further concern is that there are no mechanisms in place to measure progress towards gender outcomes. None of the gender outcomes articulated in the Gender Strategy Phase 1 or the Gender Inception Report are included in the AIPMNH Monitoring and Evaluation Strategy and the only gender indicator included in that Strategy does not relate to these outcomes.⁹⁴ The intention has been to focus on monitoring Government of Indonesia outcomes and indicators rather than monitoring the AIPMNH Program's contribution, including on gender. As a result, AIPMNH's gender outcomes are not being measured or reported. Previously, there were very few gender activities to report on, so this was not a significant problem. But now that the Gender Team has started, its work needs to be guided by clear outcomes which are measured and reported. Given the lack of clarity of AIPMNH's expected end-of-program outcomes and gender outcomes, it is difficult to judge whether the stated approach and related interventions are

⁹² See 'critical area 3'.

⁹³ AusAID programs would include AIPMNH, ACCESS, AIPD, AVA and Oxfam/Aus.

⁹⁴ The gender indicator included in the M&E Strategy is to measure changes in gender inequalities in health status and access to services.

appropriate. However, the breadth of work being planned by the Gender Team seems ambitious given the timeframe for the program, even if it is extended until June 2013.

Recommendation: *That the Monitoring and Evaluation Team and the Gender Team jointly review the program logic, outcomes and measures for the Gender Strategy to ensure that gender equity work remains focused on maternal and neonatal health outcomes that are achievable within the life of the Program, and that this be included in a revised Monitoring and Evaluation Strategy.*⁹⁵

In the Gender Strategy Phase 1⁹⁶, it was envisaged that the Gender Team would provide gender training, mentoring and support to the AIPMNH team, especially the District Program Coordinators. Both the Gender Strategy Phase 1 and the Inception Report acknowledge that Coordinator capacity on gender issues needs to be strengthened. The Community Engagement Team also needs support to ensure that it is able to effectively integrate gender into its activities. However, the Gender Team prefers not to provide targeted training to AIPMNH staff. Instead, its approach is to include Coordinators in the gender audit workshops and to hold weekly discussion groups on gender sessions for AIPMNH staff. These efforts alone are unlikely to sufficiently build the gender capacity of AIPMNH staff. The Gender Team needs to clarify the role of various AIPMNH staff in implementing the Gender Strategy and provide capacity-building support appropriate to these roles.

Recommendation: *That the role of AIPMNH staff in implementing the Gender Strategy be clarified (especially the role of District Program Coordinators and the Community Engagement Team) and that these staff receive capacity-building that enables them to take on the agreed role.*⁹⁷

Need for a more targeted approach to using and strengthening government systems

At the heart of the aid effectiveness agenda is the recognition that improving service delivery depends on the effective functioning of systems that operate across the whole of government (for example, financial and personnel management systems). Strengthening these systems in a sustainable way takes a long time, usually beyond the horizon of any individual aid activity. Country leadership is an essential element of successful system strengthening activities. In the AIPMNH design this is given a formal focus through the concept of partnership.

Working through program approaches to influence the way government funds are spent requires donors to work in quite different ways. The whole thrust of a program approach is that donors get behind a government-led program of activities. Strengthening public financial management systems is an integral part of any program approach, and having a government-led program of reform is even more essential for sustainability where these systems are concerned. The approach necessarily relies on partner government officials identifying system weaknesses and correctly diagnosing solutions. This can be difficult to achieve in a weak capacity environment. This tension between government leadership and government capacity presents the greatest challenge to successful system strengthening. It is for this reason that most donor guidance premises decisions about the use of partner systems on the presence of a credible, government-owned program of reform.

As noted above, the extent of government ownership and commitment to improving maternal and neonatal health is one of the strengths of AIPMNH. It is quite likely that many years of

⁹⁵ It is anticipated that this recommendation can be implemented within existing Program budget

⁹⁶ See pages 15 and 26 of the Gender Strategy Phase 1

⁹⁷ It is anticipated that this recommendation can be implemented within existing Program budget

dialogue and support contributed to the presence of a strong, government-led maternal and neonatal program, and a logical next step is for much stronger government leadership in how donor resources will be used to support it. Unfortunately the same is not true of the broader system strengthening agenda. There is very little evidence of a government-owned program of reform for public financial management systems more generally, either at national or at district level. The design for AIPMNH sought to address this gap through the preparation of a Good Governance Action Plan.

Good Governance Action Plan: The program design intended that the Good Governance Action Plan would be the mechanism for diagnosis and the adoption of appropriate solutions, in the absence of any government-led, government-owned program of financial management system strengthening. It is not quite clear from the design how the Good Governance Action Plan would generate government ownership of the reform plan it included. The Program Design did not fully take account of two important factors bearing on the question of government ownership. First, for the Plan to be owned by the governments that would be required to implement system reform, it really needed to be 14 plans, not one. A single plan framed at the provincial level was unlikely to serve as the blueprint for reform of the financial management systems of 14 local governments. Second, a major focus of the Good Governance Action Plan was the development of a process to manage fiduciary risk. Managing fiduciary risk is really an issue for AusAID. It is not really appropriate to attempt to deal with this question in a plan the main purpose of which is to generate government ownership for addressing fiduciary risks. In short, the main problem was with the conception of the Good Governance Action Plan more than with its execution.

There is evidence that partnership leaders are selecting some of the right sorts of support for strengthening resource management systems directly connected with delivery of maternal and neonatal health programs, for example: supporting the effective implementation of District Teams for Problem Solving; and the BOK⁹⁸ and Jamkesmas training. However, the evidence is less clear in relation to the strengthening of broader public financial management systems. These problems are partly because of technical weaknesses in the Good Governance Action Plan (as documented in Annex 5) and partly because of a more fundamental problem: the lack of any clear government commitment to broader public financial management reform.

In the absence of real leadership from agencies that would be expected to demonstrate it,⁹⁹ AIPMNH has relied on engagement with BPKP, the national government internal audit agency. Since decentralisation, BPKP's workload has shrunk because it no longer has a formal role in relation to provincial or local governments, which have taken over the bulk of government operations outside Jakarta. The agency has sought to justify its broad presence across Indonesia's regions by marketing its considerable expertise to regional governments, specifically to help them address problems revealed in reports by the external audit agency, BPK. While BPKP may be a useful partner to help implement some system strengthening activities at this level, it is inappropriate (and unsustainable) to encourage it to lead the public financial management reform agenda. It does not have a mandate to lead a sub-national reform process, and (as is evident in the Good Governance Action Plan) it has a natural auditor's focus on control elements of public financial management systems. A program for reforming public financial management systems needs to be developed from a broader perspective.

Developing government commitment to broader public financial management reform will not be easy, because of the high degree of centralised control of regional (provincial and local)

⁹⁸ BOK – Operational assistance for health

⁹⁹ Broad public financial management reform would normally be led from within a finance agency.

financial management through the Ministry of Home Affairs. AIPD is much better positioned to support development of this commitment than is AIPMNH.

To assist partners identify the system weaknesses and decide on where to place its efforts, there is a need for a more nuanced and carefully constructed approach to diagnosis and solution setting than is provided by the Good Governance Action Plan.

Recommendation: That AIPMNH and AIPD approaches to working through government systems be reviewed, focusing in particular on:

- *developing a strategy for stimulating and supporting government-led programs of public financial management reform;*
- *clarifying and focusing the role of diagnostic assessments, in particular their relationship to stimulating government-led financial management reform, and harmonising the use of diagnostic instruments; and*
- *balancing the system strengthening benefits and program effectiveness drawbacks of partial use of government systems through partner-government execution of parallel systems.*¹⁰⁰

Principles for targeting system strengthening: It is important to keep in mind that system strengthening is not an end in itself, but a means to increase the effective use of government resources to achieve results. Some systems have a greater potential than others to impact on service delivery outcomes. The Program should focus its activities on systems that are most likely to have a direct impact on service delivery. In the absence of a broader, government-owned program of public financial management reform, AIPMNH is more likely to have a meaningful impact on systems close to the points with which it engages with government—those systems that are under the control of health facility and maternal and neonatal health program staff. Direct central government financing for health facilities through BOK and Jamkesmas is the largest source of funding for maternal and neonatal activities at this level, and these funds are most proximate to the activities that really matter; those carried out by puskesmas staff. Therefore, AIPMNH supported activities that assist puskesmas plan, but more importantly expend, these funds should be promoted.

A number of principles are proposed to inform the future direction of system strengthening efforts through AIPMNH. These are outlined in the following table.

¹⁰⁰ It is anticipated that this recommendation could be implemented within existing budgets

Table 3: Principles for targeting system strengthening

Principle	Comments
<p>Principle 1: Focus where AIPMNH sphere of influence is effective</p>	<p>AIPMNH operates at the level of a sub-sectoral program.¹⁰¹ Although it has successfully engaged at senior levels of District Health and Bappeda, it is apparent that the sphere of influence of the Program is not as broad as it would be if it were a sector-wide program. It is important to be realistic about the kind of influence that the Program can have on improving systems, especially those that are the bailiwick of agencies (like Finance SKPD) that are not represented on partnership governance bodies. Broader system strengthening activities fit better with the mandate of AIPD and the impending HSS program. These programs are better placed to support these activities in future.</p>
<p>Principle 2: Focus on the systems with the most direct impact on health services</p>	<p>AIPMNH has continued to support District Team for Problem-Solving (DTPS), a methodology developed internationally to support improved problem-responsive planning around maternal and child health service delivery. In addition to continuing the focus at this level, it is proposed that there should also be increased focus on facility-level financing (Principle 5) and on funding the costs of running health facilities (Principle 6). This is where system strengthening efforts are likely to have the most direct impact on health service delivery</p>
<p>Principle 3: Increase the focus on spending and review</p>	<p>Much of the focus of the Program until now has been on supporting better planning and budgeting. Yet there is considerable evidence that by far the greater dysfunctions in the system are downstream (spending). Emphasising planning and budgeting without considering how plans are implemented contributes to the common problem that staff see the two as completely unconnected activities. A greater focus on how funds are spent will provide a much sounder basis for connecting planning to results.</p>
<p>Principle 4: Use problem-centred approaches to tackle system weaknesses</p>	<p>The landscape of poorly functioning government systems in developing countries is vast, and it is possible to spend a long time working on strengthening systems without having much impact on government performance. This happens for many reasons: because systems are only as strong as their weakest link; because sequencing is poorly thought through; or because diagnosis of weaknesses has not been robust. Some recent work by the World Bank (Fritz et al, 2009) suggests that a less systemic, more problem-centred approach to analysing and addressing the obstacles to development may provide a more practical way to generate impact from system strengthening efforts. Within the context of the AIPMNH Program this might take the form of addressing a problem like 'low spending rates of district health budgets' rather than 'strengthening budget management'. This approach also consciously focuses on the political economy dimensions that underpin many systemic problems.</p>
<p>Principle 5: Make better use of evidence and analysis to stimulate and support reform</p>	<p>Carefully structured and rigorous (but practical) research can often be the most powerful way to stimulate recognition of a system problem that needs fixing. AIPMNH should make more use of targeted action research in order to support local and provincial (and central) governments in better understanding why they are not achieving results.</p>
<p>Principle 6: Continue the focus on facility level financing</p>	<p>Health services are delivered through health facilities, but donor engagement around financing often takes place with health administrators who are actually the <i>purchasers</i> of health service delivery. Funding to resource their activities can often take priority over funding for the activities of <i>providers</i>—the facilities that actually deliver the services. The recent support to help health facility staff manage their financing (BOK and Jamkesmas) should be extended and expanded.</p>
<p>Principle 7 Encourage adequate spending on health system costs (including water supply) as well as MNH programs</p>	<p>For many years, donors in the health sector have placed undue emphasis on vertical health programs at the expense of the broader health systems that provide the institutional foundation for effective delivery of public health programs (Atun et al, 2008). There is now a growing agenda to refocus on strengthening health systems, because vertical programs cannot be implemented effectively without a functioning health system. Health facility operations are particularly crucial to effective delivery of maternal and neonatal health services. Facilities provide a base from which to conduct effective outreach proximate to communities, and functioning infrastructure is necessary to ensure as many women as possible deliver in a safe environment.</p>

¹⁰¹ Health is a sector. Sub-sectoral health programs include maternal and neonatal health, communicable diseases (TB, malaria, leprosy), non-communicable diseases (cardiac disorders and cancers), environmental health, nutrition and so on.

Principle	Comments
	Health financing analysis undertaken as part of this review found that, at present, funding for these costs can only come from discretionary local government budget funding, which is limited. AIPMNH should expand its focus on spending to include resourcing of health facility operations, and should encourage local governments with limited funding to make facility operation costs a priority.
Principle 8: Engage in national-level and local-level dialogue around reducing or managing the complexity of facility financing	The multiplicity of funding sources at Puskesmas level is a major impediment to effective service delivery because it diverts an already limited pool of health workers away from their primary role. Some health workers reported spending more than 10 hours per week engaged on administrative duties related to applying for and acquitting funding. To a large extent, this complexity can only be addressed by changes to national-level policy concerning the management of BOK and Jamkesmas.

Recommendation: *That AIPMNH focus its support for system strengthening where it can be most effective, and where it can have greatest direct impact on the key impediments to adequate allocation and efficient management of resources for maternal and neonatal health, and operation of health facilities.*¹⁰²

Expenditure analysis: Expenditure analysis is a critical input for program-based approaches that seek to maximise the use of government resources to achieve development outcomes. Expenditure analysis helps donors and government to understand:

- what impact system strengthening activities are having (in terms of effectiveness, and efficiency in the use of government funds);
- how government health resources are currently being prioritised, and how they can be prioritised better; and
- whether donor funds are displacing government funds.

At present, the only source of expenditure information comes from District Health Accounts. While these accounts are an important, structured way of introducing government officials to the preparation of expenditure analysis, they do not provide information on all the dimensions of budgeting and spending that are needed to inform robust resource allocation and management dialogue between the partners. For example, they do not provide information on:

- budget execution – spending compared with original budget; or
- functional spending by *source* of funding (how much local governments are contributing to maternal and neonatal health costs compared with donors and national government funding).

It makes sense to continue to support preparation of District Health Accounts by local government health officials as a stepping stone towards more detailed expenditure analysis. If these accounts are not yet embedded it is unlikely that a more sophisticated analysis will take root. However, it is apparent that more proactive support (probably over several years) will be needed to entrench District Health Account preparation in districts. The review team has been advised that, whilst AIPMNH supported the preparation of these accounts, this activity is not a formal part of the Program, belonging more appropriately to the Health Systems Strengthening program. Given that that program is not due to begin until 2012, there is merit in AIPMNH having a continued role in the meantime. AIPMNH should monitor the *impact* of these accounts in terms of their influence on resource allocation decisions, to ensure that they do develop into a useful policy tool.

¹⁰² It is anticipated that this recommendation can be implemented within existing Program budget

Recommendation: *That until the Health Systems Strengthening program is operating, AIPMNH should continue to support preparation of District Health Accounts, but the Program should also:*

- *undertake its own analysis of budgeting and spending, in order to better interpret the significance of budgetary and spending decisions that affect resourcing of health and maternal and neonatal health programs;*
- *seek input and advice from AusAID's public financial management team in designing the templates for collecting expenditure information to ensure these address AusAID's needs; and*
- *develop the skills of District Program Coordinators to be actively involved in the collection, analysis and interpretation of budget and expenditure data, so that they are able to use the information to engage in first-level policy dialogue, even if they do not actually undertake the analysis themselves.*¹⁰³

4.4. An appropriate focus on sustainability

From the findings in relation to strengthening capacity (second chapter of this report) and partnership (third chapter), it is evident that the Program is taking needed steps to achieve sustainability. However, one caution needs to be raised. Given both the absorptive and fiscal capacities of districts, there are likely to be some very real sustainability concerns around the level of financing of maternal and neonatal activities.¹⁰⁴ If Program financing for district office-level maternal and neonatal activities is substantially greater than that of government financing for the same activities, there is a risk of artificially inflating expectations of stakeholders about what they need, and can expect to receive, to run such activities on a long-term basis.

Both when activities are planned and approved, and later when they are monitored, it would be useful to distinguish between activities of an ongoing, operational nature and those that are better characterised as investments. These latter activities pose a lower sustainability risk. From the described processes, it is apparent that the implementing team does try to make this distinction. However, it appears that this is often reliant on the diligence of an individual rather than something that has been institutionalised within the partnership agreements. There is a need, therefore, to formalise the principle that the Program will not artificially inflate local capacities. Further, there is a need to monitor the financing of government maternal and neonatal programs more closely in order to gauge the extent to which any funding for recurrent operations is sustainable.

Recommendation: *That the sustainability risk be reduced through:*

- *AIPMNH monitoring the overall context of financing for maternal and neonatal programs more closely, in order to gauge the extent to which funding levels supporting ongoing recurrent operations are sustainable; and*
- *Partnership agreements including a principle that the partnership supports for ongoing recurrent costs will not be at a level that exceeds the sustainable fiscal capacity of local governments.*¹⁰⁵

¹⁰³ It is anticipated that this recommendation can be implemented within existing Program budget

¹⁰⁴ Figures provided to the evaluation team indicate that in Manggarai a total of Rp1.5 billion in Program funding has been allocated to be managed by the District Health Office in 2010. The Manggarai district budget provides a total of Rp560 million for MNH programs, including food supplements for pregnant women and infants, and counterpart funding for AIPMNH programs. This might suggest that a substantial proportion of MNH activities are being supported by the Program in this district. However, further analysis would be needed to separate out capital and community activities since these are not classified as MNH activities in the district budget.

¹⁰⁵ It is anticipated that this recommendation can be implemented within existing Program budget

4.5. A need to consolidate efforts

As noted previously, the workload for the core implementing team has been too great. None of the stakeholders was critical of the quality of work from the core implementing team; indeed the contrary. The concern people raised related to the amount of work with which they were attempting to deal. Contributing factors appear to be the disparity between the rate of Program roll-out and the level of resources. When the implementing team took over responsibility, the Program was already operating in three districts and a further six were coming on stream. Within a year, a further five districts were incorporated into the Program. This meant that the new team found itself not only supporting an existing Program but scaling up at significant rate. Deliberate decisions were taken by the managing contractor not to expand its core team even during this hectic development stage.

From how the core implementing team described the Program and their roles in it, it is apparent that they have thrived on this work and are passionate about what they do. However, this level of work is neither sustainable nor healthy. Only recently, since technical assistance to partners has been expanded by way of the Community Engagement Team and the Gender Team, has some of the pressure on the core implementing team decreased. Prior to the recruitment of these new teams by the partners, members of the core implementing team were trying to ensure some aspects of community engagement and gender work were nonetheless incorporated in the program.¹⁰⁶ When the Monitoring and Evaluation Team is recruited, this will decrease workload pressure further. Workload issues could also be reduced through the recruitment of short-term technical assistance at district level (as part of district work plans) to help progress key activities and reduce bottlenecks. A recommendation for this was included in the partnership section of this report.

This review has found that the approach being undertaken by AIPMNH is, generally, the correct one. The Program is, largely, progressing well, although there is a need to revise the Program theory and set more realistic end-of-program outcomes. Sustainable change takes time, especially when delivered through a partnership mode, which requires more commitment in terms of both time and resources than does the traditional project-based approach. However, it is likely to lead to more enduring change.

It is important for the success of the partnership approach that the current implementing partners not be replaced. They have built the necessary relationships with the country partners that are required for the partnerships at the sub-national level to flourish. The implementing team is very ably led by the current Program Director, whose commitment and approach to strengthening capacity, working in partnership, and using resources effectively and efficiency clearly reflects contemporary good practice.¹⁰⁷

Because of the overwhelming need, there can often be a temptation to expand development programs too quickly. In this instance, it is clear that the Program has a need to consolidate rather than expand. It will require this consolidation period not only to complete its current work but also to address the important issues identified in this report.

¹⁰⁶ From interviews and program documentation

¹⁰⁷ When assessed against the literature

Recommendation: *That the current contract be extended to June 2013 and that this time be used to: i) consolidate AIPMNH in the current districts in NTT; ii) implement the program improvement recommendations contained in this report and the associated public financial management report; and iii) design the Program for the next contract phase 2013-2018.*¹⁰⁸

Any future expansion to another district should be the subject of: the national partners determining what outcomes are wanted; an assessment of need in terms of which province; and a further program design stage. Future design should be built on a robust program theory that clearly articulates both the theory of change and the theory of action.

¹⁰⁸ It is anticipated that the additional funds to implement recommendations identified in this report will be incorporated in any new agreement for the period up to 2013. On advice from AusAID, it is anticipated that the design for the next phase will cost between \$200,00 - \$500,000 depending on duration and people involved

Annex 1: Alignment of program with literature

A similar mix of service delivery and community engagement activities as suggested in the literature

Generally speaking, the components and activities on which AIPMNH is focused are similar to those promoted in the literature. Literature related to maternal and neonatal health in developing countries has concluded that combining different components such as training, education, provision of supplies, and upgrading of equipment, transport and infrastructure in one program, may help to reduce maternal mortality (Ross et al, 2005). AIPMNH includes all such components.

Furthermore, the inclusion of community engagement that seeks to facilitate linkages between communities and available health services has also been found to be effective (Haws et al, 2007). This helps ensure a balance between supply and demand, both of which need to be strengthened (De Brouwere et al, 2010; McCoy et al, 2010). AIPMNH is supporting the Government's efforts to strengthen both supply and demand. McPherson et al (2010) found that community mobilisation approaches that target influential women in the community have been effective in Nepal. Whilst McPake and Koblinsky (2009) caution against taking an overly deterministic view of what can be transferred from one place to another, there could be some merit in AIPMNH considering whether specifically targeting influential women, as one aspect of their community engagement work, might help progress their efforts.

AIPMNH is supporting the Government of Indonesia in its work to increase the number of births assisted by a skilled birth attendant. Indonesia, as part of Members of Partners in Population and Development (PPD) recently agreed to alleviating the two main causes of high maternal mortality rates by training skilled birth attendants and improving access to emergency obstetric care.¹⁰⁹ Both of these are activities within the AIPMNH program. In NTT, the program is going beyond a simple focus on training midwives. It includes attention to improving the quality of care through helping to improve supervision and monitoring. This aligns with studies undertaken by McPake and Koblinsky (2009). Their findings highlighted that increased use of skilled birth attendants alone might not impact on mortality rates and that there is a need to assure the quality of the care.

The program is also supporting the Provincial Government's policy of promoting facility-based delivery. This, too, has been found to be an effective approach (Chowdhury et al, 2006; Graham and Hussein, 2006). Midwives, working in teams, can provide ready monitoring of women during labour and the critical 24 hours post partum. This enables early detection and basic management of problems, and more timely referral to hospital for emergency care, where needed. A concern raised in the literature is that the often basic conditions in women's homes make it more difficult for midwives to cope with emergencies.

McPake and Koblinsky (2009) state that the leading causes of maternal mortality in Asia are haemorrhage (30.8% of all deaths) and anaemia (12.8%). This highlights the importance of training health workers in emergency procedures and promoting facility-based care where emergency assistance is more likely to be available. AIPMNH has such activities. These causes of death also highlight the importance of the availability of blood. However, availability is affected by: inadequate funds and government commitment to safe blood services, a shortage of donors, particular issues of access in rural areas, problems with quality control, lack of appropriate linkages between blood-banks and health service providers, and problems with rational use of blood.

¹⁰⁹ Ary Hermawan, The Jakarta Post, Yogyakarta | Fri, 10/29/2010
<http://www.thejakartapost.com/news/2010/10/29/24-countries-vow-cut-maternal-mortality-rates.html>

The Government's Desa Siaga program ensures that attention to blood donation is included in local planning, and this program is being actively supported by the AIPMNH. These planning processes are seeking localised short-term solutions whilst full-scale blood-banks are being developed, an approach that has been found to work in India (McPake and Koblinsky, 2009).

Government programs that AIPMNH is supporting include efforts to change household practices regarding delivery and newborn care. A program in Nepal has shown that many maternal and newborn deaths can be averted through such changes (John Hopkins School of Public Health, 2007), and can be assisted through two important community-level *platforms* or *vehicles* through which key services can be delivered: antenatal contacts and early post natal home visits. Both of these are regular provincial and district activities that are supported by AIPMNH.

A further activity supported by AIPMNH is Local Government's work in relation to family planning. The link between maternal health and greater access to, and use of, family planning is noted in the literature. Some have estimated that it is possible to avert 20% of obstetric related mortality and morbidity by the use of effective contraception (Collumbien et al cited in McCoy et al, 2010).

AIPMNH supported activities are taking an integrated approach to perinatal health, with activities to address newborn health as part of efforts to address maternal health. De Bouwere et al (2010, p. 907) emphasise the intimate link between newborn health and maternal health, and advise an approach for 'mother and child', not for just one of them. Likewise, Haws et al (2007) suggest that as a newborn infant's health is intrinsically linked with its mother's, incorporating newborn care into existing safe motherhood as well as child survival programmes can be a cost-effective way to bundle interventions to simultaneously improve neonatal, maternal and child health outcomes.

McCoy et al (2010) also mention the interconnectedness, particularly noting: a) that maternal health is a significant determinant of child health; and b) that improvements in child survival contribute to lower fertility rates, which has a positive impact on maternal mortality rates. These particular authors go so far as to say that the health of one is so interlinked with the health of the other that it is misleading to make separate calculations of their needs.

The attention to gender is the final point in the discussion. Factors contributing to maternal mortality rates are many; not only health-related. Gill et al (2007) cite a variety of studies that show that among the critical factors are education and employment. They note that studies have found that women's education: increases the use of maternal health services, including the likelihood of using antenatal care; is positively associated with safe delivery; and positively affects the mother's own health care and that of her daughters. In relation to poverty they cite studies that show that employment is associated with reductions in maternal mortality rates and increases in the use of maternal health services.

Decision-making has been found to be one of the important measures of a woman's ability to make critical choices such as whether to use health services, take up family planning, and put in place child rearing practices that positively impact on health (Gill et al, 2007). The AIPMNH partners have recently recruited a Gender Team for the purposes of supporting partners integrate gender equality into existing programs and systems.

Attention is being given to strengthening the system

Components two and three of AIPMNH deal with systems issues. The types of activities on which AIPMNH is focusing are promoted in the literature. For example, in strengthening health systems to improve health delivery, infrastructure development, program sustainability and enhanced problem solving have been identified as important (Hawe et al cited in NSW Health Department, 2001). AIPMNH is assisting with renovations of health facilities, supporting local governments to develop and maintain processes for problem solving, and uses practices that seek to ensure sustainability of effort.

Attention to planning and the management capacity of health ministries and personnel are also highlighted as important, as is the need for effective and integrated referral system (McCoy et al, 2010). AIPMNH attends to all of these. Likewise, strengthening capacity through a partnership approach is core to the AIPMNH program and is promoted in the literature (Harris et al cited in NSW Health Department, 2001).

Annex 2: Appraisal of Community Engagement Strategy¹¹⁰

Indicator	Rationale	Comments
<p>The strategy has a clearly articulated practice framework</p>	<p>Whilst there is no single definition of, or set of processes, for engagement, several authors promote the need to articulate these (Cass, 2000; Cavaye, 2004; Hartz-Karp, 2005; Cass, 2006; Videira et al, 2006; Tindana, 2007). The strategy should show evidence of:</p> <ul style="list-style-type: none"> • a definition • a purpose • the theoretical underpinning • the level(s) of engagement being sought • the key mechanisms that will be used 	<p><i>Definition</i> The document describes both the ‘who’ and levels of engagement (p.16).</p> <p><i>Purpose</i> Implied in the description of community engagement in this context (p.16) and further articulated in the objective (p.18) indicative outcomes. The purpose is directly related to increasing the number of safe, facility-based births through: increasing people’s awareness and acceptance of facility-based births; and facilitating communities to take active role in helping ensure safe births.</p> <p><i>Theoretical underpinning</i> Not articulated. Underlying assumption that community engagement will lead to the community itself planning and implementing supports. There is also an implied assumption that it is best to build on existing strategies and activities. However, there is nothing to indicate whether those existing activities are, themselves, based on a theoretical underpinning or in line with contemporary good practice.</p> <p><i>Levels of engagement</i> The document defines levels of engagement as (in summary): to be informed and empowered to mobilise resources to respond to local needs in supporting pregnant women; the empowerment of people to engage in decision-making processes at a local (community) level. The strategy highlights the importance of broad participation of stakeholders and for this to occur as an ongoing process. Numerous authors (Karl 2000; Carson and Twyford 2005; Cavaye 2005; Videria et al 2006; Carson 2009) have conceptualised a spectrum of engagement. This Strategy incorporates the two ends of such a spectrum (inform being at the least engaging end and empower at the most). Because no theory has been articulated it is difficult to ascertain if the focus on the two extremes is deliberate. For example: are other points in the spectrum not considered important? Have other points simply not been considered? Why have the two ends of the spectrum been chosen versus only empowerment versus all parts of the spectrum?</p>

¹¹⁰ In the absence of a standard set of criteria against which to assess the Community Engagement Strategy, indicators were selected from a review of the relevant literature.

Indicator	Rationale	Comments
		<p><i>Key mechanisms</i></p> <p>Community Engagement Strategy is pulling together a number of mechanisms already in place with an intention to ensure that the "...positive aspects of existing community engagement activities will act as a foundation for strengthening and re-orienting weaker aspects..."(p. 19). However, strengths and weaknesses of various strategies have not been identified due to time limitations. This is a serious shortfall of the Strategy because it means that support is to be given to programs and activities based on their existence rather than on their merit or evidence of efficacy. Nor does the Inception Report (Sep, 2010), which outlines the newly-established team's response to the Strategy, identify the importance of reviewing the efficacy of the various existing programs and activities. The Inception Report, like the Strategy, links monitoring and evaluation of community engagement to AIPMNH's Monitoring and Evaluation Strategy, which does not adequately address assessment of community engagement. Consequently, the Community Engagement Team risks focusing on programs that might not deliver the desired outcomes.</p> <p><i>Summary comment for this indicator:</i></p> <p>Community engagement, as it applies to the AIPMNH, is made clear. The Strategy highlights the importance of broad participation and the long-term nature of engagement. This approach and the intent to build it into existing regular activities reflect the good practice as outlined in the literature (Cavaye, 2004). The Strategy could be strengthened by basing it on a clearly articulated theory of community engagement. This would provide a strong basis for activities. In addition, it would be helpful if the quality and theory of existing strategies and activities were also critiqued. Whilst it is appropriate to build on what exists, the reader is not able to determine if those activities are, themselves, based on contemporary good practice and a sound theory. Therefore it is not possible to determine if this strategy is further strengthening sound practice or inadvertently reinforcing poor practice. If the recommended review stage is done well then there is an opportunity to ensure the Strategy works towards contemporary good practice – but to achieve this, the underlying theory base needs to be articulated.</p>

Indicator	Rationale	Comments
<p>The strategy is framed within the principles of good practice</p>	<p>Whilst there is no one best practice model of engagement, several authors identify a range of good practice principles (Cavaye , 2004; Carson and Twyford, 2005; and Hartz-Karp, 2007). Drawing on these, there should be evidence of:</p> <ul style="list-style-type: none"> • Sincere motivation (rationale, purpose and mechanisms suggest genuine desire to engage; expectations and limits have been negotiated) • Reciprocal relationships (all parties contribute; processes promote consistency and are context specific; communication mechanisms are transparent) • Collaborative leadership (shared responsibility for outcomes; leadership is recognised at all levels and across all spheres) • Inclusive decision-making (a plurality of viewpoints; mechanisms and processes promote equality; information is shared and transparent) • Clear structures and procedures • Accountability (mutual obligation is made clear; mechanisms encourage two-way interaction and feedback) • Sustainable (strategies in place for ongoing engagement) 	<p><u>Sincere motivation:</u> This is apparent in a number of areas, for example:</p> <ul style="list-style-type: none"> • The definition clearly states the importance of community engagement (p.16). • There is an underlying assumption that a better health service will prevail as a result of community engagement (objectives and expected outcomes, p.18). • The capacity for the Strategy to be definitive is acknowledged, noting its suggestions are indicative only (p.34). <p><u>Reciprocal relationships:</u> Examples include:</p> <ul style="list-style-type: none"> • The definition indicates a ‘two-way’ process in which all community members are committed to solving common problems • Activities are based on local context, need, priorities and resources • Communication mechanisms are implied through the structures and procedures <p><u>Collaborative leadership:</u> Intended collaborative leadership is apparent, for example:</p> <ul style="list-style-type: none"> • The definition indicates that processes will help to empower community members. It also indicates that the community will play an active role in the provision and support of MNH services including, the identification of needs, participating in finding solutions to issues, and helping monitor whether these solutions work. • Activities are to be carried out jointly by partners and stakeholders <p><u>Inclusive decision-making:</u> Within the definition it is clear that there is an intention to engage those most directly concerned with maternal and neonatal health as well as community members more broadly. For example, it notes that ‘community’ includes all people living in a village. It also makes note of the particular importance of pregnant women, their families, those who might influence the behaviour of pregnant women, the traditional birth attendant, the kepala desa and relevant kader. In addition, it incorporates both religious and cultural leaders. Activities are to be decided upon in a collaborative way.</p>

Indicator	Rationale	Comments
		<p><u>Clear structures and procedures:</u> It states the various organisations to be involved in decision-making and, broadly, their responsibilities, e.g., District Bappeda to cost and budget activities; DPCs and District Health Department responsible for orientation of government, non-government and stakeholders. The kecamatan has been chosen as the focus with the program to be facilitated by an NGO. All four community engagement programs have been combined to allow for a coordinated approach. Recommended activities for implementing the kecamatan program are provided.</p> <p><u>Accountability:</u> Mutual obligation is implied in the collaborative approach and responsibilities are outlined. It is assumed that feedback and other accountability measures will be achieved through supervision and regular monitoring. Roles and responsibilities are outlined in some detail (pp.35-36).</p> <p><u>Sustainability:</u> By building on existing activities and structures it is more likely that ongoing community engagement might occur. Activities include training and capacity building that are to help facilitate ongoing community engagement post the strategy. The Inception Report outlines the intention to skill up local resource people. Not only should this help sustain effort post the Engagement Team's input, the use of local government staff should help embed community engagement in everyday practice.</p> <p><i>Summary comment for this indicator</i> This strategy is framed within the principles of good practice as outlined in the literature</p>
<p>The strategy includes a plan to monitor and evaluate the engagement strategy</p>	<p>Although the theory and practice of monitoring and evaluating engagement is in its infancy, Karl (2000), Carson and Twyford (2005) and Cass (2006) highlight their importance.</p>	<p>A monitoring and evaluation framework had not been developed at the time the Strategy was developed (July 2009). There is an expectation that one will be developed and this will be aligned with the overall Monitoring and Evaluation Framework for the program. The AIMPNH, in partnership with health departments, is charged with the responsibility (p.35). The Strategy, largely, assumes this will be done through short-term technical assistance.</p>

Indicator	Rationale	Comments
	<p>The strategy should show evidence of how engagement processes and outcomes will be monitored and evaluated for purposes of accountability and continuous improvement.</p>	<p>There is a table identifying indicators against strategic objectives and strategic outcomes. These nominate indicators that could be expected if the community has been successfully engaged e.g.</p> <ul style="list-style-type: none"> • “Increased participation of communities in decisions (number of decisions involving community input) taken regarding services at posyandu, puskesmas, and the Desa Siaga safety nets.” (p.37) • “Increased utilisation of human, material and financial resources from within the community to identify, support and facilitate a woman to deliver in a facility.” (p.38) • “A decrease in the % of women who say they could not access delivery services because no one could care for children at home.” (p.38) <p>For each indicator, a means of verification is provided (where to find the data). Some indicators have specific targets whilst some are in terms of “increase” or “decrease” because there is as yet no baseline data. Districts are to incorporate indicators into their monitoring frameworks during the beginning of the second phase. (p.34) Examples of checklist tools are provided for use at programmatic level for supervisors to ensure engagement is monitored.</p> <p>However, the review of AIPMNH has confirmed that Government monitoring and evaluation systems, including supervision processes, are not yet well developed. They are unlikely to provide the necessary information.</p> <p>Since the Community Engagement Team has been established, the intention to monitor and evaluate community engagement as part of the Monitoring and Evaluation Framework for the entire AIPMNH has been re-confirmed (Inception Report). Unfortunately, that framework has several shortfalls (refer to separate appraisal) and, as a consequence, important aspects of community engagement are at risk of not be adequately monitored and evaluated. If it is to be part of the overall Framework, there is a need for an urgent review of that Framework to ensure it incorporates appropriate aspects of community engagement. As well as processes and outcomes, the literature highlights the importance of monitoring and evaluating things such as:</p> <ul style="list-style-type: none"> • Contextual factors that facilitate or constrict participation (Hughes, 2002); • Relationships (Kingma and Beynon, 2000);

Indicator	Rationale	Comments
		<ul style="list-style-type: none"> • Degree of partnership, for example: mutual respect, power-sharing, equity, working towards mutual benefit (Tindana 2007); and local ownership of development process (Hall and Howell, 2010); • Attitude, behaviour, perception and change in the community (Jayakaran, 2008); • Intermediate outcomes (Gaventa and Barrett, 2009). <p>The reader is concerned that the monitoring and evaluation design has been left to a later stage (during implementation). It is best to develop monitoring and evaluation at the outset because these should occur throughout the Strategy's implementation. If left till the second phase and the final three months (as suggested in the Strategy) this risks:</p> <ul style="list-style-type: none"> • not picking up and addressing any process issues along the way; • not having in place the needed data processes for measuring outcomes; and • partners (at all levels) not taking the monitoring and evaluation of the Strategy seriously. <p>Developing the monitoring and evaluation plan with the partners at the beginning could have helped strengthen the capacity of partners.</p> <p>The Community Engagement Strategy lacks a program theory so it is difficult to determine if the outcomes are plausible in the time frame and if the activities are both necessary and sufficient to achieve these. Therefore, it is difficult to determine if the suggested indicators are appropriate. Likewise there is no clear planned set of steps against which achievement and progress can be reviewed.</p> <p><i>Overall comment for this indicator</i></p> <p>It is positive that the Strategy both recognises the importance of monitoring and evaluation and makes suggestions as to how this might occur. However, it assumes that nominated processes (the Monitoring and Evaluation Framework and the Government's supervision) will provide a good basis for monitoring and evaluation. These processes are not yet adequate enough. The lack of a monitoring and evaluation plan significantly weakens the Strategy as does the absence of a program theory.</p>

Indicator	Rationale	Comments
<p>The strategy is focused on progressing aid effectiveness</p>	<p>The strategy should show evidence of:</p> <ul style="list-style-type: none"> • Mutual ownership and responsibility (collaborative design and implementation; meets partner government needs; mutual satisfaction) • Alignment with government systems and processes (partner government systems and processes are incorporated; designed and implemented within existing partner government capacity; further strengthens partner government capacity) • Coordination with others who are engaging these communities • Being readily understood and easy to use 	<p>Mutual ownership is highlighted. The strategy notes that there was insufficient time in the design stage to achieve this at but outlines activities to rectify this during implementation. The activities are to be based on local needs, priorities and capacities. There is an expectation that mutual satisfaction will be monitored. It is curious why this Strategy was developed as a separate process from the establishment of a Community Engagement Team. The reader believes that recruitment of the Team, based on a brief scope of services document, with the Team then developing the Strategy as part of its initial inception work would likely have resulted in: a) mutual ownership being embedded in the Strategy from the outset; and b) more efficient use of resources.</p> <p>The intention is to coordinate the four government community engagement programs and to use existing activities. There is an underlying assumption that these programs are designed to achieve successful community engagement. This strategy could be strengthened by the addition of a program theory to succinctly show underlying theories and how change is expected. As noted, some critique of existing programs would be helpful so that it is clear whether this strategy is upholding good practice and sound theories.</p> <p>Decision-making and activities are to be carried out collaboratively. DPCs and NGO staff facilitating the strategy are expected to strengthen the capacity of government personnel. Activities are included that will assist to strengthen the supply side as well as the demand side of services. These focus on improving the ongoing capacities of people and the system.</p> <p>The least strong aspect of this strategy is its ease to be readily understood and used. It uses sophisticated language rather than plain English, with many long and complex sentences. It is very lengthy and the structure is not simple, and required several readings before all the intent was obvious to the reviewer. It is difficult to see how the document could, therefore, be readily understood by those with minimal understanding of community engagement and whose first language is not English.</p> <p>The complex language and structure of the Strategy would likely complicate translation of concepts and intentions into Bahasa Indonesian.</p>

Independent Progress Review:
Australia and Indonesia Partnership for Maternal and Neonatal Health

Indicator	Rationale	Comments
		<p><i>Overall comment for this indicator</i></p> <p>The Strategy and the subsequent Inception Report are clearly focused on progressing aid effectiveness. Its convoluted construction, however, reduces its usefulness. The reader is uncertain of the benefit of developing a Strategy as a separate process. A more efficient and effective process is likely to have resulted if the Community Engagement Team developed the Strategy as part of its inception work.</p>
Evidence of strategy being applied	The strategy should be a living document	Interviews with the Community Engagement Team and the AIPMNH implementing team confirmed that this document is being actively used. Likewise, suggested modifications in the Inception Report (Sep 2010) indicate that it is being used dynamically.

Annex 3: Appraisal of monitoring and evaluation strategy¹¹¹

Indicator	Rationale	Comments
Utility	<p>This is one of the four standards that have been adopted by the evaluation¹¹² profession (Patton, 2002; Owen, 2006; Yarborough et al, 2011). It is concerned with whether evaluation provides practical and useful information. The strategy should include evidence of:</p> <ul style="list-style-type: none"> • Identification of, and attention to, stakeholders (also highlighted in AusAID Guidelines 6.5; AusAID Guidance on M&E for Civil Society Programs; UNDP Handbook on Planning, Monitoring and Evaluating for Development Results; Evaluation standard – Utility) • Evaluator credibility • Clarity of purpose • A breadth of information to ensure responsiveness to stakeholder needs and interests • Meaningful processes and products • Bases for judgement • Reporting clarity • Timeliness • Appropriate dissemination of findings • Promoting follow-through of findings • Being able to be readily understood 	<p><i>Stakeholders</i> are identified by implication through noting reporting to AusAID and the Government of Indonesia. Government of Indonesia partners were involved in the development of, and commenting on, the Strategy. It appears that AusAID had little, if any, involvement. This could help explain why AusAID representatives reported during the review that their monitoring and evaluation needs are not being met by the current Strategy. There is little emphasis on the needs of communities and beneficiaries, who are critical stakeholders for this Program. This is an important oversight given that the Community Engagement Team is relying on their work to be evaluated as part of the general Strategy. It also means that, although communities are being encouraged through AIPMNH to increase their demand for services, they are not part to any processes that will help them assess the effectiveness of their efforts. Likewise, the Gender Team is relying on the general Strategy yet the document notes the inherent difficulties in obtaining the necessary data and does not incorporate alternative means.</p> <p><i>Evaluator credibility</i> – The Strategy is to be implemented through AIPMNH planning and budgeting processes at the provincial and district levels. It notes that implementation will be reliant on the willingness of provincial and district health offices. It also notes the limited capacity of the Offices to undertake this work. Whilst it incorporates an intention to strengthen capacity it does not put in place alternative means to implement the Strategy in the meantime. Furthermore, it does not outline who will undertake the strengthening of capacity nor the type of skills and experience that will be required. The implementing team advised the Review Team that the partners intend to recruit a Monitoring and Evaluation Coordinator to undertake this work. Terms of Reference were not available to help assess credibility. For the monitoring and evaluation of development assistance and partnership, the Strategy provides limited guidance in relation to required skills and experience.</p>

¹¹¹ Indicators against which to assess the Monitoring and Evaluation Strategy were drawn from a combination of: leading authors; standards set by the Australasian Evaluation Society (AES); Yarborough et al, *Program Evaluation Standards* set by the Joint Committee on Standards for Education Evaluation; relevant AusAID Guidelines and Good Practice Checklists; and Paris Declaration and Accra Agenda.

¹¹² Within the evaluation profession, evaluation refers to all forms and approaches of evaluation, one of which is monitoring (Owen, 2006). This appraisal uses the term evaluation as a generic term for all forms of monitoring and evaluation.

Indicator	Rationale	Comments
		<p><i>Clarity of purpose</i> The purpose of the Strategy is described and in summary is: describing the planned outcomes, indicators and processes for measurement; and providing a reference document and framework for partners. It sets out two aspects. The first relates to the program log-frame and uses information and reporting associated with the Government of Indonesia systems. The second is about specific reporting by the contractor on the effectiveness of the partnership and development assistance. Within the work-plan section of the Strategy, more specific aims and objectives are outlined in further detail. These are focused on practical usage of data for decision-making. Although ongoing improvement of the Program is not made explicit, it is implicit in the intention to monitor the performance of AIPMNH</p> <p><i>Breadth of information</i> Data tools and guides indicate a comprehensive range of information will be collected and analysed. However, the Strategy's major focus is on information for use by the Government partners for accountability and decision-making. As noted above, the Strategy does not provide a strong base of information for use by AusAID, the Community Engagement Team, Gender Team, or communities.</p> <p><i>Meaningful processes and products</i> The Strategy, wherever possible, favours the use of existing data collection processes and products. Where additional information is sought, the Strategy proposes processes that suggest minimal additional requirements. This is a positive approach so that additional burden is not placed on systems and staff with limited capacity. This should also assist in encouraging people to be involved and therefore to use the data. Unfortunately, the products will have limited use for stakeholders because of the current limited capacity of the Government systems and the absence of any short-term alternative data collection by the implementing team to supplement the system shortfalls.</p> <p><i>Bases for judgement</i> It is difficult to see how the Strategy provides a strong base for judgement because of the over reliance on existing systems that are very limited in capacity. There is little or no attention given to the immediate effects of the Program. For example, whilst data is gathered in relation to the number of people trained, no data is gathered in relation to how effective that training is or if the new knowledge is leading to changes in practice.</p>

Indicator	Rationale	Comments
		<p>Each of the progress reports has continued to highlight the shortfalls in data and the constraints and limitations. The Strategy should have incorporated short-term alternative data collection by the implementing team as a way of filling the gap in existing systems while capacity is strengthened. In addition, monitoring and evaluation activities associated with communities are, largely, restricted to household surveys undertaken by parties not connected to the Program. If these surveys are not undertaken for any reason, or do not include aspects of importance to AIPMNH, the Program risks not getting information it needs.</p> <p><i>Reporting clarity</i> The document outlines the reporting requirements to AusAID and the partners.</p> <p><i>Timeliness</i> The timing of reports is outlined and appears to be frequent enough to meet the needs of AusAID and partners. However, some data is not available within these timeframes. For example, the community surveys are not frequent and as a consequence, stakeholders must wait some time before any data becomes available.</p> <p><i>Appropriate dissemination of findings</i> Strategies for dissemination adapted to various groups are discussed and importance of providing findings to different levels of stakeholders is emphasised.</p> <p><i>Promoting follow-through of findings</i> Not evident</p> <p><i>Being able to be readily understood</i> The reviewer found that the structure of the report and the language used made it difficult to gain an overall view of the Strategy without several readings of the document. It is also difficult to picture how each of the two components of the Strategy (log-frame and development assistance) complement each other.</p> <p><i>Summary comment for this indicator</i> The over reliance on government systems that are limited in capacity and the absence of alternative processes to fill the gaps in the short term mean that this Strategy will have difficulties in ensuring timely, reliable and useful data.</p>

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Indicator	Rationale	Comments
Feasibility	<p>This is one of the four standards that have been adopted by the evaluation profession (Patton, 2002; Owen, 2006; Yarborough et al, 2011). It calls for evaluations to be realistic, diplomatic and financially well managed. The strategy should evidence of:</p> <ul style="list-style-type: none"> • Practical procedures • Appropriate and sensitive management of various interests • Cost effectiveness 	<p>As noted above, the Strategy has attempted to use practical procedures by using existing systems and processes wherever possible. There is an intention not to place undue burden on people or systems. Costs are provided in annex 5. However, the limited capacity of the current systems means that it is not feasible to gather much of the data that is proposed.</p>
Propriety	<p>This is one of the four standards that have been adopted by the evaluation profession (Patton, 2002; Owen, 2006; Yarborough et al, 2011). It takes account of the legal and ethical issues. Professional bodies such as the Australasian Evaluation Society (AES) highlight the importance of evaluation being guided by ethical practice. An ethical framework should not only point us to the right conduct it should also foster continuing improvement in the theory, practice and use of evaluation. The strategy should show evidence of relevant legal and ethical issues and how these will be addressed.</p>	<p>Whilst there is no specific mention of ethical and legal issues some implicit attention to this can be found within the document, for example:</p> <ul style="list-style-type: none"> • Issues for data collection identified and discussed, and strategies and activities to address these included in Strategy • Training planned for those who are to record data • Design appears to be rigorous
Accuracy	<p>This is one of the four standards that have been adopted by the evaluation profession (Patton, 2002; Owen, 2006; Yarborough et al. 2011). It is concerned with the production of valid and reliable information. AusAID Guidelines 6.5 and AusAID's Good Practice Checklist highlight the importance of clearly articulating the data requirements The strategy should evidence of:</p> <ul style="list-style-type: none"> • Clearly identifying the program and context • The purpose of the strategy • Defensible, reliable and valid information • Systematic review of information • Methods of data analysis 	<p>A clear overview of the Program and its context is provided. The purpose of the Strategy is described and in summary is: describing the planned outcomes, indicators and processes for measurement; and providing a reference document and framework for partners. It sets out two aspects. The first relates to the program log-frame and uses information and reporting associated with the Government of Indonesia systems. The second is about specific reporting by the contractor on the effectiveness of the partnership and development assistance.</p> <p>In the annexes, the Strategy sets out indicators, measures and data sources. However, these do not always appropriately match the desired output or outcome. For example:</p> <ul style="list-style-type: none"> • 1.3 refers to women and families having knowledge, yet the indicators relate to behaviour change.

Indicator	Rationale	Comments
		<ul style="list-style-type: none"> • 1.1 and 1.2 refer to availability of services yet the indicators seek to measure only presence, ignoring the issue of quality and effectiveness. • Output 2.1 refers to improved monitoring and reporting systems yet the indicators relate to punctuality and completion of reports only as the measures of 'improved', with no indicators relating to the difference these reports are making. <p>The document notes problems with baseline data due to poor recording and reporting of data and other systems issues. It is important to outline such constraints. Whilst there are strategies in place to strengthen capacity of sources to record and provide data, there is a heavily reliance on using government systems that are known will not deliver the information that is required. There is a need for the Strategy to use alternate means of data collection whilst the government systems are being strengthened. The Strategy should include this in the monitoring and evaluation tasks of the implementing team.</p> <p>A positive aspect of the Strategy is the inclusion of effectiveness of development assistance and the partnership. However, there is an over reliance on process measures and too little emphasis on the difference that the development assistance and partnerships are making. For example, whilst there is an intention to measure achievements of the development assistance it is limited to achievements in terms of proposed aims of district and provincial activities. There is an assumption that these will lead to the desired outcomes. Unfortunately, the Strategy does not test these logical links (refer to the discussion on outcomes later in this appraisal for further discussion). Likewise, whilst the partnership assessment include some key indicators highlighted in the literature it does not include outcomes of the partnership (refer to annex 1).</p> <p>Analysis, compilation and validation are to occur at district and provincial level, with training, mentoring and the provision of IT capability to support this. Whilst this is positive in terms of local ownership, it is unlikely to result in the needed information for useful and reliable monitoring and evaluation, because of the noted limited capacity. As previously noted, there is a need for the implementing team to undertake this in alternative ways whilst simultaneously strengthening local capacity.</p>

Indicator	Rationale	Comments
		<p>There is a heavy emphasis on monitoring – collection and analysis of quantitative data, although workshops and discussion provide opportunity for qualitative evaluative input. The Strategy would be strengthened if a greater emphasis on evaluation were included. This could be through such things as identifying particular program aspects or themes to be periodically evaluated or testing out specific logical links.</p>
<p>A focus on outcomes or results</p>	<p>The Paris Declaration and Accra Agenda require: a focus on outcomes rather than outputs; and donor countries working with partner governments in ways that promote a mutual accountability for results. The strategy should articulate:</p> <ul style="list-style-type: none"> • the underlying program theory (including theory of change and theory of action); and • the relevant program logic model, log frame or other means of articulating the indicators, measures, assumptions and risks. 	<p>The document provides a simple diagram of the program logic, which has been developed from the program log-frame in the Program Design Document. The simplicity of this logic model is not, in itself, an issue. Program logic models can vary, depending on purpose; there is no single correct model (Cooksey et al, 2001). Nonetheless, for purposes of setting out a monitoring and evaluation strategy, program logic models (however simple) should be supported by: some testing of the logic; the underlying hypotheses of the program theory (theories of change and theories of action); and program assumptions and risks (Weiss, 1997; Davidson, 2000; Funnell, 2000; Rogers, 2000; Rogers, 2007). This particular Strategy includes a risk assessment and the assumptions can be found in the original log-frame in the Program Design Document. However, these assumptions mostly relate to process assumptions such as ‘adequate staff and resources’ rather than program theory assumptions.</p> <p>The log-frame outlines the desired outputs and outcomes. However, the logical links between these are uncertain as the Strategy does not articulate the program theory nor test the hypotheses underlying the program. It does not appear that any assessment of ‘necessary’ and ‘sufficient’ is made of activities, outputs or outcomes. For example, the logical link is not made to show that if governments satisfactorily manage resources they will achieve MPS target indicators. The end-of-program outcomes appear to be very nebulous, providing little guidance as to what is expected. Furthermore, short term and medium term outcomes are expressed solely in terms of change to government practices. There are no outcomes relating to the changes to other aspects of the system or in the status of beneficiaries. The absence of these outcomes contributes to the difficulties in ascertaining the logical links between activities, outputs and outcomes.</p>

Indicator	Rationale	Comments
		<p>Likewise, many of the desired outputs do not provide sufficient guidance as to the change that is being sought. For example, 1.4. refers to communities being involved in provision and support of MNH services instead of stating the change or result that is sought. This is more a process statement than a statement of change or result.</p> <p>Indicators and measures have been developed for each of the outputs and outcomes articulated in the log-frame. However, most are focused on output measures, for example, the number of districts where DHA is conducted, the percentage of puskesmas submitting reports. The focus on outputs is compounded by the use of outputs and outcomes (in the log-frame) rather than the use of an outcomes hierarchy. If the latter were chosen then the Strategy could measure the immediate and intermediate outcomes, both of which should be achieved, or show trends, within the time of the Program. This would help the Program begin to focus on outcomes.</p> <p><i>Summary comment for this indicator</i></p> <p>Whilst the Strategy has a program log-frame, it does not clearly articulate or test the program theory. This is a significant shortfall of the Strategy. Without a deliberate means to articulate and test the program theory, there is no way to clearly determine if the Program is focused on the right set of activities. The Strategy could have been strengthened if a more comprehensive review of the initial log-frame had been undertaken to include articulating the program theory. Had this occurred, the important links between the activities associated the partnerships and development assistance would have been clarified and tested and incorporated in the overall program theory.</p>
Strengthening the counterpart's capacity	The Paris Declaration and the Accra Agenda require governments, donors and implementing agencies to work with partner governments and other donors and implementers to ensure alignment with partner government systems. This principle is also highlighted in AusAID Guidelines 6.5 and M&E Good Practice Checklist. The monitoring and evaluation strategy should clearly articulate a capacity strengthening design that takes account of current capacity and seeks to further strengthen partner government systems, processes and personnel.	This is a particular strength of the Strategy. There is a significant emphasis on training, mentoring, technical support. Specific strategies have been outlined.

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Indicator	Rationale	Comments
<p>A focus on accountability and continuous learning</p>	<p>The importance of this dual focus is highlighted in a number of key documents: AusAID Guidelines 6.5; AusAID Guidance on M&E for Civil Society Programs; and UNDP Handbook on Planning UNDP Handbook on Planning, Monitoring and Evaluating for Development Results.</p> <p>The monitoring and evaluation strategy should include:</p> <ul style="list-style-type: none"> • Feedback mechanisms and processes • Processes that enable the program to be refined along the way in response to lessons learned 	<p>There appears to be little in the way of activities and processes for reflection and continuous learning other than the proposed annual workshops.</p>

Annex 4: The framework used to assess the partnership

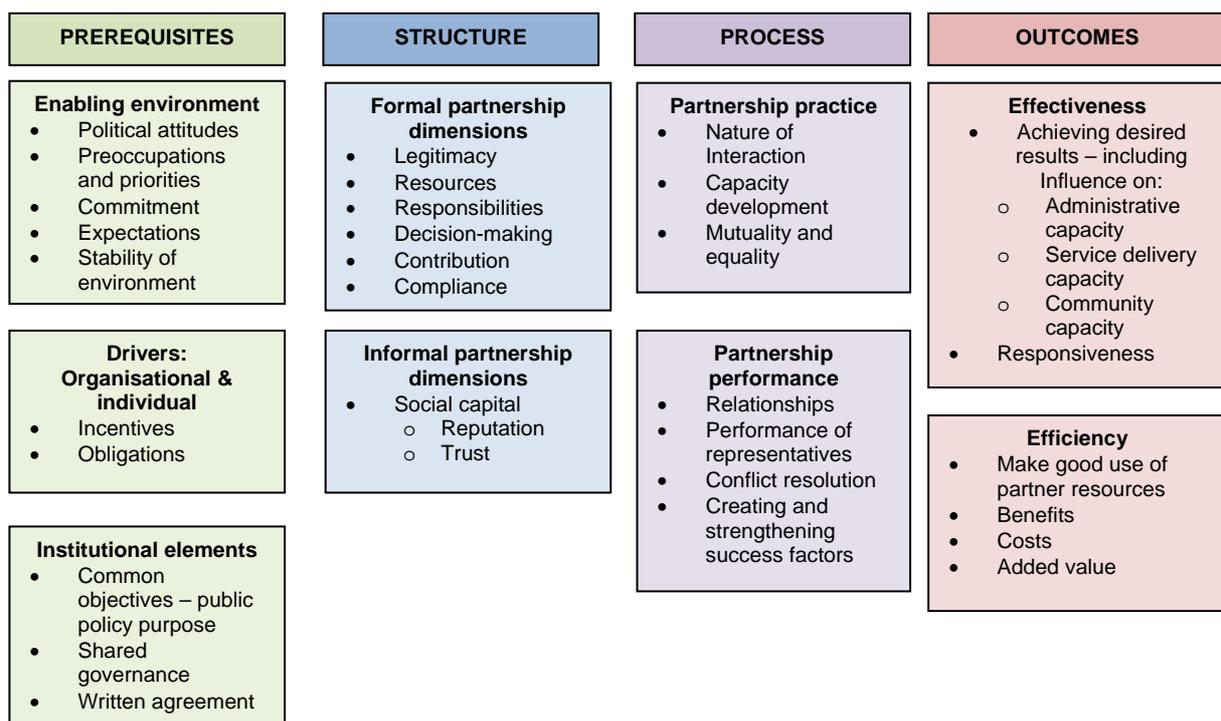
The partnership model is increasingly being used in international development as a means of moving towards greater country ownership (Jobin, 2008). Despite this increasing use there have been few studies to assess their performance and no single or favoured tool to evaluate them (Brinkerhoff, 2002; Serafin, 2008). In the absence of a commonly agreed tool or framework, there is a need for evaluators to adjust their regular evaluative methods (Conlin and Stirrat, 2008; Jobin, 2008).

Often, evaluations concentrate on particular partnership elements. Serafin (2008) advocates a combination of: the way in which partnerships are organised; impact towards outcomes; added value; and benefits. Stern (2004) highlights the importance of trust. Consideration of both process and results is recommended by Jorgensen (2006). Caplan et al (2007) advocate assessing the drivers of partnerships. Among other things, Klitgaard (2004) highlights the importance of the enabling environment. Transaction costs are raised by Jobin (2008) and Brinkerhoff (2007) emphasises governance.

During the evaluation scoping and negotiation phase I was able to discuss with various partners (individually) the partnership aspects that they thought most important to include in the evaluation. There was consistent interest in incorporating partnership process and outcome. In addition, some respondents highlighted other partnership conditions that were neither process nor outcomes related, for example, the context, the environment and supporting structures. Taking these preliminary ideas the review team leader then drew heavily on the frameworks of Brinkerhoff (2002), Caplan et al (2007) and Jobin (2008), and to a lesser degree Atkinson (2005). The ideas from the partners were incorporated with the most salient and most commonly used features described in the body of literature in an effort to develop a simple yet comprehensive framework for evaluating partnerships.

The framework is outlined in Diagram1, with the sub-dimensions in Table 1.

Diagram 1: Framework used for evaluating the AIPMNH partnership – the four partnership aspects and their dimensions



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Table 1: The specifics of the framework's dimensions

Aspect	Dimension	Key areas of assessment
Prerequisites	Enabling environment	Extent to which: <ul style="list-style-type: none"> partnership is supported politically; has the backing of key stakeholders; there are real opportunities for collaboration; partners tolerate and encourage power-sharing partnership meets current priorities partners are able to focus on the partnership given other work/priorities/demands partners provide leadership; there are champions; partners are willing to adapt; partners are future oriented there are clear and reasonable expectations; expectations are similar between partners environment is stable and conducive to collaborative working; key individuals are in place to facilitate partnership; external context is understood
	Drivers: organisational and individual	Extent to which: <ul style="list-style-type: none"> purpose, mandate, vision of partner organisations supports/facilitates partnership partners have inbuilt organisational culture, processes, systems, demands to facilitate partnership partners have legal and/or organisational requirements to partner decision making processes are clear and sufficient to facilitate partnership partners have processes in place to address lapses in commitment
	Institutional elements	Extent to which: <ul style="list-style-type: none"> there are common, shared goals linked to relevant public policies; partners articulate what they want to achieve from the partnership formal and informal governance structures are in place and work; processes and structures have been developed collaboratively the partnership is articulated in writing yet flexible to adapt as required
Structure	Formal partnership dimensions	The extent to which: <ul style="list-style-type: none"> the partnership structures and processes enable effective decision making; partnership is recognised and accepted by stakeholders partners contribute and allocate a fair share of resources (financial and non-financial) roles and responsibilities are clear, agreed, and documented decision-making processes are transparent, understood, agreed, appropriate, facilitate the work of the partnership partners deliver on their commitments,
	Informal partnership dimensions	The extent to which: <ul style="list-style-type: none"> partners trust and respect each other to commit and deliver on commitments partners have a reputation that promotes confidence in other partners decision making and accountability processes promote trust and respect
Process	Partnership practice	The extent to which: <ul style="list-style-type: none"> interactions between partners are positive, appropriate, as agreed, subject to review there are processes for review and evaluation of the partnership and the partners there is an ethos of collaboration, communication and learning there is mutual benefit; each partner's capacity is acknowledge, respected and strengthened further; partnership practices are subject to continuous improvement there is equality in decision making, resource exchange, partner representation and participation partners perceive even benefits there is reciprocal accountability there is shared risk; level of risk appropriate to situation
	Partnership performance	The extent to which: <ul style="list-style-type: none"> positive partner relationships are forming and being maintained partnership effectiveness is being reviewed and practices adapted as required partners address issues effectively, efficiently and ways that are supportive of ongoing partnership effort partners are aware of what makes for good practice and performance and work to creating and strengthening these
Outcomes	Effectiveness	The extent to which: <ul style="list-style-type: none"> agreed objectives and outcomes are being met the partnership is having a positive influence on relevant administrative, service delivery and community capacity partners understand the needs of beneficiaries and work toward responding to these effectiveness of processes of engagement with stakeholders and beneficiaries
	Efficiency	The extent to which: <ul style="list-style-type: none"> partners use all available resources efficiently for the correct purposes partners perceive mutual benefits; the extra benefits outweigh the costs of the partnership; partners are satisfied with the partnership and what it is achieving; obligations and drivers are being met; reputation is enhanced the partnership costs are appropriate to the level of outcomes and other benefits gains in social capital forms of transaction costs outweigh administrative transaction costs the partnership achieves things that would not otherwise be achieved ; there are multiplier effects

This framework was used to guide the evaluation of the partnership. A mix of evaluative techniques was chosen rather than a single one. This enabled the various partnership elements to be explored in ways best suited to the particular element and context. Furthermore, it allowed more robust triangulation of the data.

Annex 5: Appraisal of Good Governance Action Plan

The design for AIPMNH provided for the preparation of a Good Governance Action Plan to guide the implementation of component 3 activities. The Plan was intended to serve a number of purposes:

- respond to joint assessments of fiduciary risk undertaken with local government, by providing action plans to 'review and strengthen procedures, and / or provide training and guidance to address identified weaknesses' (page 25, description of Program Components);
- identify outcomes and indicators for component three (page 45);
- provide a process to manage fiduciary risk (page 42);
- identify potential avenues of corruption, and how these will be addressed (page 49) and monitored (page 50);
- provide information to monitor whether resources available are sufficient to cover the estimated costs of service provision at required standards (Indicator for component three, Program log frame, page 63); and
- provide a framework for progressively bringing funding on budget (draft GGAP, page 79).

Responsibility for developing the GGAP was given to the Managing Contractor to develop a plan in accordance with an outline provided in an annex to the PD (page 42).

Annex 5 of the PD provided a draft of a GGAP with five sections covering:

- Commitment and leadership from government (funding and service agreements);
- Budget transparency (including progressively greater use of government systems);
- Control of expenditure (three activities all focused on control of expenditure of program funds, in line with the staged transition to use of government systems);
- Public oversight and complaints; and
- Monitoring and sanctions (random audits and fiduciary risk assessments).

Appraisal criteria

There are no obvious appraisal criteria to be used for appraising a document of this kind. Since it effectively constitutes an extension of the design process for the Program, current Quality at Entry (QAE) criteria were used, appropriately adapted to an appraisal conducted at the level of a Program component:

- **Relevance** (is the activity relevant to the context-specific analysis and issues);
- **Effectiveness** (is the theory of change clear, are objectives clear, measurable and achievable, and are key partnerships and risks identified);
- **Efficiency** (are proposed technical solutions and implementation arrangements high quality, appropriate to context and good value for money);
- **Monitoring and evaluation** (to support management, accountability and lessons-learning needs);
- **Analysis and learning** (takes into account relevant political, economic, institutional and other issues); and
- **Sustainability** (are constraints to sustainability addressed, are benefits in terms of outcomes and processes clear);

Relevance—Rationale and purposes of the Plan

It is appropriate for the PD not to have designed the activities that support system strengthening in detail. A key plank of the new approach to strengthening government systems is that this is unlikely to be successful, or sustainable, unless partner governments take the lead. One of the reasons for this is that PFM systems are among the most difficult parts of government to reform. Since these systems are diffused across many actors in government, they are among the least amenable to change through external intervention (Fukuyama 2004). The approach most commonly adopted by donors seeking to strengthen government systems is to support a process of diagnosing system weaknesses and developing a government-owned reform plan to address them, which donors can then support.

However, a document like the GGAP cannot substitute for a government-owned reform plan. First, ownership of the plan is clearly tied to the managing contractor. Second, a single plan for a collection of district governments is not likely to be ‘owned’ by each of them individually, unless considerable effort is put into building ownership of the diagnostic processes around each of the individual district-level fiduciary risk assessments.

It is understandable why the Program designers adopted this approach. Getting a government-owned program of PFM reform in the Indonesian sub-national context is complicated by the highly prescriptive nature of the regulatory framework set by the Ministry of Home Affairs. This means that the changes any individual local government can put in place are limited. There are also real logistic complications from a Program management perspective in trying to support 14 local governments each individual pursuing PFM reforms. A more realistic approach might have been a provincial government-led program focusing on some weaknesses that are common to a number of local governments. However, the supervisory role of provincial governments, particularly in relation to local government PFM, is not clear or well established.

These problems undermine the potential for GGAP activities to contribute to the broader system strengthening objectives it is intended to serve. It should be stressed that these are problems with the *concept* of the GGAP as much as they are with its execution.

Managing fiduciary risk

The concept of fiduciary risk assessments was not well thought through in the original PD. It is recognised that a fiduciary risk assessment will be required in order to move towards greater use of government systems for funding, and the assumption seems to have been that the Partners themselves will be required to undertake this risk assessment.

The conduct of a fiduciary risk assessment to satisfy internal donor requirements is an entirely separate exercise from that which a partner government might undertake to inform a reform program. The way in which the fiduciary risk assessments have been approached has confused the two. A recent OECD publication on managing aid through partner government systems (OECD 2009) stresses that PEFA is a high level framework for diagnosis, not a substitute for a fiduciary risk assessment.

AusAID’s internal guideline on the use of partner systems (Guideline 126, which is currently under revision) requires that an independent FRA be conducted before a decision is taken to put funds through government PFM systems.

The existence of *diagnostic* assessments like PEFA can inform this assessment but is unlikely to be sufficient to replace it. A particular weakness in PEFA assessments is that the indicator measuring procurement systems is extremely high level and gives only a broad indication of where problems might lie. Most donors now use the OECD Methodology for Assessing Procurement Systems (MAPS) framework to diagnose problems in procurement systems. Other instruments like the World Bank's Country Procurement Assessment and Review (CPAR) serve a similar purpose.

The existence of these separate instruments for procurement is a response to the fact that procurement systems are a particularly complex and important element of PFM systems. Given that much of the funding AIPMNH might put through partner systems would be used in ways that trigger the use of procurement systems, this is a fundamental gap in the diagnostic framework.

Approaching the application of PEFA as a fiduciary risk instrument (something done to government by a donor) may well have undermined its capacity to stimulate the sort of government-owned commitment to reform that is an essential foundation of sustainable system improvement.

Effectiveness—Financial management strategy

There are two effectiveness issues with the GGAP that relate to the likelihood that the bundle of activities laid out will result in any measurable improvement in the systems to which they are addressed. The first is the decision to engage with BPKP¹¹³ as the key interlocutors for PFM reform on the Gol side, and the second is the choice of activities that resulted largely from that engagement.

As noted above, the evaluation team could find no evidence of any active PFM reform on the part of either provincial or district-level government agencies. Members of the implementing team with long and senior experience in provincial and district-level government were unable to agree on which agency in local government would be considered the lead agency on PFM reform. Clearly there is not only no active reform program, but not even a clear assignment of responsibility for this function. This presents a real challenge to a Program that is attempting to strengthen government systems around broad parameters like as resource allocation. In hindsight, the Program design should have been much less ambitious in what it sought to achieve from a change perspective.

Notwithstanding the absence of any clear point of entry at local government level, the implementing team found a responsive engagement with local representatives of BPKP. Prior to decentralisation, BPKP had a large presence across Indonesia as a centralized internal audit body for the national government. The agency's role was substantially diminished when many of the functions it had previously interacted with were transferred to provincial and local governments. In the last decade it has carved out a role for itself as a service provide to provincial and local governments.

While it is part of the Government of Indonesia, it is the wrong part to lead PFM reforms. BPKP has no formal role at the sub-national level. BPKP is potentially a good body to contract to implement specific PFM strengthening activities, but it cannot be the primary point of engagement with government around sub-national PFM reform.

¹¹³ Badan Pengawasan Keuangan dan Pembangunan, State Development Audit Agency

The choice of BPKP as a key partner in the Program's approach to PFM reform has led to some activities being chosen that are poorly connected to the system improvement outcomes on which the Partnership is focused. The Financial Management Strategy (FMS) that forms part of the GGAP has three sub-strategies:

- (1) Support development of the COSO internal control framework specifically for the hospital system and pilot in at least one hospital;
- (2) Fund capacity building in accrual accounting; and
- (3) Fund capacity building of staff to become certified procurement officers.

The first two choices in particular appear to have been informed by the particular perspective of BPKP, which is an audit agency and therefore focused on quite specific dimensions of PFM—in particular those where they have the capacity to offer training and other capacity development services.

Sub-strategy 1: Internal control framework. Indonesia has recently adopted a financial management regulation requiring the implementation of the COSO internal control framework in all government agencies. Adoption of this framework is one the conditions that an entity must meet in order to qualify for BLU status. BLU status allows government entities (like hospitals) to operate on a semi-autonomous basis, giving them greater control over staffing and revenues.

The argument for helping one hospital to achieve BLU status is that it may lead to more efficient and effective operations, leading in turn to better services provided to pregnant women. From a theory of change perspective, this is quite a long bow to draw, and its effects will not be evident for a long time. There is also the risk that becoming independent will lead the hospital to semi-privatise, becoming even less accessible to poor women, as has happened in other parts of Indonesia.

Continuing to support the hospital to achieve BLU status might reap large rewards in terms of improved services, but the number of women who will benefit from improved services in one hospital in one district will necessarily be limited. Before expanding this activity to other hospital sites, the Partnership should carefully monitor the extent to which:

- (a) implementation of the internal control framework is actually getting the hospital closer to achieving BLU status; and
- (b) how BLU status actually affects the quality of service the hospital offers to pregnant women, and pregnant women who are poor in particular.

Sub-strategy 2: Capacity building in accrual accounting. Accrual accounting is an approach to accounting that treats expenditure and revenue when they are incurred, rather than when cash is exchanged. This has most impact on the way that assets are treated in balance sheets. Recent reforms in public sector financial management have embraced a variety of forms of accrual accounting, accrual reporting and accrual budgeting, involving different ways of treating revenues, expenses, liabilities and assets (Marti 2006). Accrual accounting is generally applied as part of an overall reform approach to make debt and the depreciation of assets more transparent. This should encourage a longer-term perspective on investment in assets, and a more prudent approach to debt and deficit financing.

The national government of Indonesia formally adopted modified accrual reporting in 2004, but the framework for accrual accounting was not incorporated into the new integrated financial management framework (IFMIS) that was subsequently developed. The effect of this is that agencies still do not record transactions on an accrual basis. Law 17 of 2003 imposes an accrual framework on local governments as well as central government, but it is not clear whether this was meant to apply to financial statements or to the budget. At this stage the process of implementing accrual accounting at the national level has slowed owing to a range of problems, and in 2009 the then Minister for Finance approached Parliament and sought a deferral of the deadline for implementing accrual accounting at the national level to 2015.¹¹⁴

While the requirement for accrual accounting to be applied at local level may still be on the Indonesian statute books, supporting this should be a very low priority for AIPMNH, for a range of reasons:

- accrual accounting is a sophisticated and late-stage reform that should not be attempted until basics are in place;
- it should be introduced on a government-wide basis—there is very little to be gained by implementing it in Dinkes alone. The local government finance agency should lead this change; and
- cash management is a fundamental subset of accrual accounting, and based on the FRAs it seems likely there are very substantial cash management problems at the local level.

Sub-strategy 3: Capacity building for staff to become certified procurement officers. This is one of the areas of AIPMNH support where there is evidence of improved capacity to operate systems. How this is translating into practice in terms of system outcomes needs to be more closely monitored. International experience suggests that even where staff of government agencies implement improved procurement practices in project management units (PMUs), these skills often fail to translate into improved practices in government procurement.

The theory of change justifying investment in procurement training and certification (and the use of government staff to undertake program procurement) is that it will result in improved performance of government procurement systems. Ideally, this would be tested through regular measurement against some selected indicators from the OECD-MAPS framework. This may not be feasible initially, but it is something that AIPD could work towards. In the meantime less rigorous monitoring techniques could be used to assess the extent to which staff who have been certified are applying those skills in their management of government funds.

Efficiency—Application of PEFA indicators

In the context of an aid activity, the efficiency criteria address the technical and resourcing characteristics of the way in which it has been designed.

The key efficiency issues with the GGAP are around the way the PEFA (Public Expenditure Framework for Accountability) framework has been applied and the way it has been ‘converted’ into a fiduciary risk assessment (FRA). These raise questions about the validity and usefulness of the end product. The following observations are not intended to be exhaustive:

¹¹⁴ Based on information was provided by an Australian adviser working with MoF and BPK.

- Some key indicators have been omitted, for reasons that are not explained in the narrative. For example, PI-2, which measures the composition of expenditure out-turn¹¹⁵ compared with the original approved budget, has not been ranked. This indicator is highly relevant in the poor budget execution context of Indonesia.
- Other omitted indicators are PI-5, which measures classification of the budget, PI-6, measuring comprehensiveness of information provided in the budget, PI-8 on transparency of inter-governmental relations, PI-12 on multi-year perspective in planning and budgeting, PI-15 on effectiveness of tax collection, PI-17 on recording of cash balances, debt and guarantees.
- These indicators may have been omitted out of a perception that they were not applicable at the sub-national level. Guidelines on the application of PEFA at sub-national level are available on the PEFA website (www.pefa.org) that show how to adapt the indicators in this context.
- For the purpose of the FRA, rankings on PEFA indicators have been provided as “substantial, moderate or low”, as a way of somehow aggregating the scores across the three sites where PEFA was applied. This is an unusual conflation of different scoring methodologies. PEFA itself uses quite a technical approach to scoring ranked A, B, C or D with very precise definitions given for the score on each indicator.
- Some comments suggest a poor understanding of the public sector accounting context, or what the PEFA indicators actually mean. For example:
 - PI-4 measures the stock and monitoring of expenditure payment arrears. The FRA notes that arrears are not recorded because NTT does not use accrual accounting. In fact, most governments across the world do not use accrual accounting, but they still keep track of arrears. This is done using commitment systems that allow funds to be set aside when a financial commitment is made.
 - The absence of accrual accounting was also provided as the explanation for the low ranking on PI-22, which measures the quality and timeliness of in-year budget reports. In year budget reports are provided by to managers so that they know what they have spent funds on and how much budget they have left. Whether accrual accounting is used or not is not relevant.

While the FRA includes some very useful and relevant observations and information, neither it nor the underlying three PEFA assessments should be used as the basis for much-needed baselines against which to measure local government PFM performance improvement.

Three observations are offered to assist in the forward planning by AIPD and AIPMNH in the arena of PFM system strengthening:

- Attention to the institutional and developmental context in which PEFA or other diagnostic tools are used will be needed in order to generate genuine ownership, understanding of the need for reform and commitment.

¹¹⁵ PI-1 (which was scored) measures aggregate out-turn compared with budget, or the extent to which total spending was more or less than total budget. PI-2 measures the extent to which there was variance in spending on individual budget lines. This is a very important measure of the credibility of the budget as a plan for spending, and serves to highlight key weaknesses in the management of budget execution.

- Assistance from AusAID's PFM section in Jakarta should be sought in developing ToRs for PFM activities, as well as in selecting consultants to carry them out.
- Careful consideration should be given to which tool is most likely to be useful in establishing a diagnostic baseline and encouraging governments to develop a reform agenda. PEFA is internationally accepted, but the government of Indonesia has also developed a PFM performance measurement framework that is equally comprehensive, and against which a number of local governments have already been assessed. The following table provides a comparison of the indicators in the two frameworks which might help assess the relative strengths of the two.

Comparing PEFA and Indonesian PFM Measurement Framework

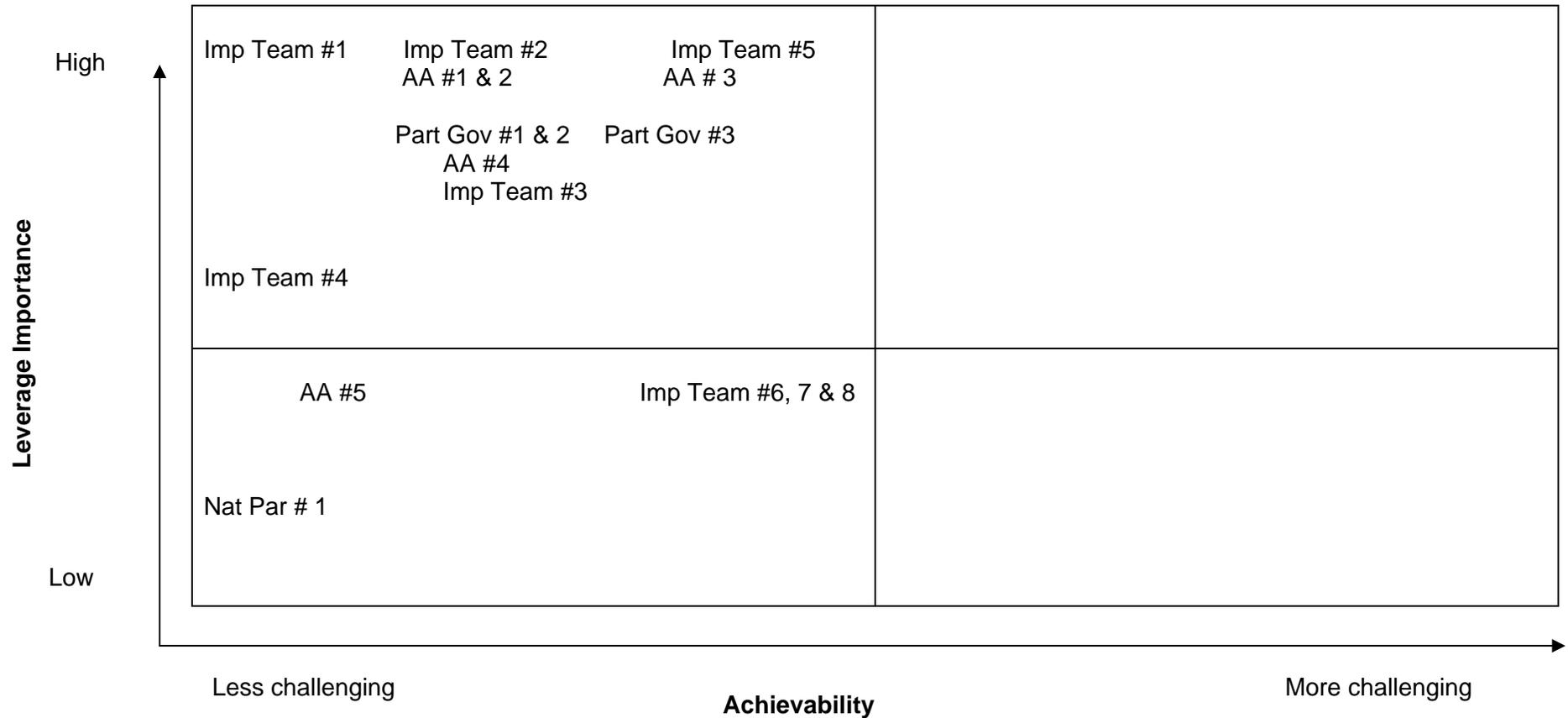
PEFA		LOCAL GOVERNMENT PFM MEASUREMENT	
		LOCAL REGULATORY FRAMEWORK	
		1.	A comprehensive local regulatory framework for PFM as required by national legislation exists
		2.	The local regulatory framework provides for effective law enforcement and organisational structure
		3.	Local regulatory framework includes measures to increase transparency and public participation
BUDGET CREDIBILITY			
PI-1	Aggregate expenditure out-turn compared with budget	6.	Budget out-turns are reasonable and indicate realistic budget-making processes
PI-2	Composition of expenditure out-turn compared with budget		
PI-3	Aggregate revenue out-turn compared with budget		
PI-4	Stock and monitoring of arrears		
COMPREHENSIVENESS AND TRANSPARENCY			
PI-5	Classification of the budget		
PI-6	Comprehensiveness of information included in budget documentation		
PI-7	Extent of unreported government operations		
PI-8	Transparency of inter-governmental fiscal relations		
PI-9	Oversight of aggregate fiscal risk from other public sector entities	22.	Procedures and mechanisms for effective governance of local enterprises
PI-10	Public access to key fiscal information	8.	Comprehensive participatory monitoring and evaluation system for planning and budgeting process is established
POLICY-BASED BUDGETING			
PI-11	Orderliness and participation in the annual budget process		
		4.	Consistent link between bottom-up planning processes, local development plans, sector plans and budget exists

PI-12	Multi-year perspective in planning and budgeting	5.	Budgets are based on a medium-term horizon
		7.	Budget is pro-poor
PREDICTABILITY AND CONTROL IN BUDGET EXECUTION			
PI-13	Transparency of taxpayer obligations and liabilities		
PI-14	Effectiveness of measures for taxpayer registration and tax assessment		
PI-15	Effectiveness in collection of tax payments	11.	Efficient system for billing and collecting local revenues is established
PI-16	Predictability in availability of funds for commitment of expenditures		
PI-17	Recording and management of cash balances, debt and guarantees	9.	Policies, procedures and controls to promote efficient cash management are in place
		10.	Cash receipts, cash payments and temporary cash surpluses are managed and controlled efficiently
		21.	Risk-based policies, procedures and controls for management of borrowings and investments
		22.	Procedures and mechanisms for effective governance of local enterprises
PI-18	Effectiveness of payroll controls		
PI-19	Competition, value for money and controls in procurement	12.	Policies, procedures and controls to promote efficient and competitive procurement of goods and services are established and implemented
		13.	A complaint-handling system is operating
PI-20	Effectiveness of internal controls for non-salary expenditure	23.	Policies, procedures and controls for acquisition of new assets and effective management of physical assets
		24.	Supporting asset management information base is established and maintained
		25.	Asset management linked to plans and budgets
PI-21	Effectiveness of internal audit	18.	Internal audit agency is organized and empowered to work effectively
		19.	Internal audit standards and procedures are acceptable
		20.	Internal audit findings are followed up adequately
ACCOUNTING, RECORDING AND REPORTING			
		14.	Adequate human and institutional capacity for accounting and finance
		15.	Accounting and management functions are integrated
PI-22	Timeliness and regularity of accounts reconciliation	16.	Local government financial transactions and balances are recorded promptly and accurately
PI-23	Availability of information on resource received by service delivery units		
PI-24	Quality and timeliness of in-year budget reports	17.	Reliable financial management and information reports are produced

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PI-25	Quality and timeliness of annual financial statements		
EXTERNAL SCRUTINY AND AUDIT			
PI-26	Scope, nature and follow-up of external audit	26	External audits provide effective accountability of local government
PI-27	Legislative scrutiny of annual budget law		
PI-28	Legislative scrutiny of external audit reports		
		27.	Effective independent oversight of local government financial management exists

Annex 6: Priority setting matrix



Annex 7: Terms of reference for review

1 Background

1.1 Context

Indonesia's economic development has improved the health outcomes of much of the population. However, recent gains at the national level mask disparities in the poorest provinces and regions. Under decentralisation, local governments struggle to find, fund and successfully manage the human resources required to implement their mandate. Public awareness and participation in health issues remains poor and public demand for health sector improvements remains weak.

While Indonesia is making progress towards achieving Millennium Development Goal 4 (reducing child mortality), it is unlikely to achieve MDG 5 (reducing maternal mortality) by 2015, without additional resources.

The Government of Indonesia's (GoI) National Making Pregnancy Safer (MPS) Strategy (2001-2010) provides the framework for efforts to reduce maternal and neonatal mortality in Indonesia. The strategy integrates supply and demand side interventions, with a focus on addressing health system constraints to service delivery, and sets targets for coverage with key MPS interventions.

The Australian Government launched the Australia Indonesian Partnership Country Strategy in 2008 which aims to support the Government of Indonesia to achieve sustainable poverty alleviation by delivering the development outcomes outlined in Indonesia's Medium Term Development Plan. One component of the Strategy focuses on the Australian and Indonesian Governments working together to improve access to and quality of health care. The health of mothers and babies in Indonesia is a key focus of both the Government of Australia and Government Indonesia in achieving the Millennium Development Goals.

1.2 Program Description

Through the Australia-Indonesia Partnership for Maternal and Neonatal Health (AIPMNH), the Governments of Australia and Indonesia work together to achieve jointly agreed aims in implementing the National Making Pregnancy Safer Strategies in selected provinces and districts and improving public administration in the health sector. It built on the experience of previous activities, and on the ongoing reform and decentralisation of GoI By addressing system constraints, improving system governance, and introducing a performance focus through the provision of appropriate additional resources, the Partnership contributes to significant improvements in outcomes at the district and provincial levels. The Partnership works with and through GoI systems, including working to GoI planning and budgeting cycles and timelines, in a phased approach which seeks to match progressive improvements in GoI system functioning with performance incentives and increased disbursement. The program is considered to be a long term Partnership between Australia and Indonesia with the long term objective that Provincial and district governments can effectively manage national, local and donor resources to progressively achieve MDG targets for maternal and child health.

The end-of-program objective (end of June 2011) is that selected provincial and district governments have mechanisms in place to manage national, local and donor resources to achieve national target levels for the priority Making Pregnancy Safer indicators.

At present the Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) is working with Provincial and District Governments in NTT to implement *Revolusi KIA* or Maternal and Child Health Revolution strategy to reduce Maternal and Neonatal mortality. The program commenced in 2008 with interim activities in three districts in East Nusa Tenggara (NTT) province, followed by a full implementation from February 2009 to June 2011, managed by an Implementation Service Provider (Coffey ID), with a total value of \$32 million over 2.5 years.

Activities selected under the program includes providing support to local governments and other agencies to improve health service delivery; bottom-up consultative planning; budget processes involving beneficiaries; and enhancing public awareness of the health system. It is implemented in a partnership approach where activities are decided jointly by the Implementation Service Provider and the Local Governments and based on the governments' own planning processes. In the partnership approach the partner government has a substantial role in deciding the performance targets and types of activities that they would like to do. The role of the implementing team is to assist the partner government in making sure their plans / programs are relevant to the objectives that they would like to achieve.

By the end of 2009 AIPMNH covered a total of nine districts and in 2010 an additional five districts were selected so that AIPMNH currently works in a total of 14 districts (2/3 of total districts in NTT).

1.3 Key Issues

1.3.1 Partnership Approach and Pace of Implementation

The progress reports indicated that implementation of the Partnership model requires a substantial amount of time and effort to develop a mutual understanding between the implementing team and the partner governments at the provincial and district levels. Previous government and donor programs in Maternal and Child Health projects in NTT in the past years have been taking a "project" approach where activities are decided by the funder of the program be it the National level government agencies or donor and therefore partners are familiar with 'project-types' activities. However the program's partnership approach requires a different way of working and interacting, as the partner government is much more in the driver's seat.

At the current pace of implementation, it is not clear whether the program will be able to achieve its objective at the end of June 2011 and whether the activities that are supported by the partnership are contributing to achievement of the end-of-program objectives. The new partnership approach also requires certain skills and resources and it is important to also look at whether the implementing service provider (Coffey International Development) is appropriately and adequately resourced to support the program.

1.3.2 Relevance of the program

The program is working within the context of decentralisation and is recognising the differences in district capacity to plan and implement MCH programs. A recent study identified that decision making for prioritising effective interventions and investment for Maternal and Child Health should be initiated at the district level.

At the moment, the program is spending a reasonable amount of time providing support to the provincial partners than to the districts. However, districts definitely receive the benefit of a much larger proportion of the financial resources.

It is therefore necessary to look at the how the partnership should prioritise its resources and whether more emphasis should be directed towards working with the districts to strengthen their local government development plan process. However, it is also important to note that the roles of province and district continue to evolve and the Gol is currently reviewing the legal framework which may provide provinces with more authorities.

1.3.3 Recommendation for the extension period

The Subsidiary Arrangement between the Government of Australia and Government of Indonesia expires at the end of June 2011 and the current contract between AusAID and the implementation service provider is finishing in June 2011 with an option to extend for up to two years.

The independent review process will inform both governments in considering and making decision for the extension of the Subsidiary Arrangement and the contract with the implementation service provider.

2 Objective

The objective of the Independent Progress Review of AIPMNH is to assess how the program is progressing in achieving its objectives; the relevance of the program; how the partnership model is working in NTT and how it could be improved; and to inform the Government of Indonesia and AusAID recommendation for the future direction of the program including the potential for scaling up in this sector and links with other programs.

This Independent Progress Review is being used as a case study by the Performance and Quality Unit of AusAID Jakarta, with the aim of producing a good practice example of an evaluation and to study what is required to achieve this.

The primary audience of the Independent Progress Report (IPR) is the Ministry of Health of Indonesia (Kemkes); the Indonesia National Planning Agency (Bappenas), and AusAID. In particular: AusAID Senior management; AusAID Health Unit; and the relevant directorates of Kemkes and Bappenas.

3 Scope

The Independent Progress Review will assess and rate the program's performance against AusAID's evaluation criterion of relevance, efficiency, effectiveness, sustainability, monitoring and evaluation, gender equality and analysis and learning¹¹⁶, by giving priority to examining the following key questions:

To what extent have the program objectives been achieved?

- How effectively is the partnership model working?
- How relevant is the program model in the context of the likely future needs of Government of Indonesia and Government of Australia's policy?
- How might this program be improved to meet the future needs of Government of Indonesia and Government of Australia's policy

The list below outlines the aspects the evaluation should consider in the development of the evaluation questions.

3.1 Relevance:

3.1.1 Is there a reasonable link between the end-of-program outcome and reduction in maternal and neonatal deaths?

¹¹⁶ The review will not address impact (or potential impact) as the program has only been implemented for about 18 months and therefore it is too early to assess impact.

- 3.1.2 Are the activities reflecting the priority needs of the districts and province and supporting national targets / policies? Are they likely to contribute to achievement of objectives?
- 3.1.3 Is there a sufficient attention on Sexual and Reproductive Health? What capacities/opportunities exist to strengthen the Sexual and Reproductive Health?
- 3.1.4 Will the changes in the context influence how the partnership is implemented or its priorities? In particular, consider:
 - 3.1.4.1 Decentralisation issue (currently the program works at both provincial and district levels. Should greater emphasis be directed to supporting districts?)
 - 3.1.4.2 Budget substitution issue (districts' tendency to reduce their health budget in proportion to total district budget).
 - 3.1.4.3 Any other important changes in the context?

3.2 Outcomes (& Sustainability)

- 3.2.1 How is the partnership progressing towards achieving the end of program outcome (2.5 years?) as outlined in the program logframe?
- 3.2.2 Are there any early outcomes in terms of improved capacity, quality and accessibility of the health services at puskesmas level? (in both clinical and non-clinical aspects)
- 3.2.3 Are the end-of-program outcomes achievable within the timeframe?
 - 3.2.3.1 Do we need a re-articulation of the end-of-program outcomes?
- 3.2.4 What works well and what doesn't work well? Why?
- 3.2.5 How does the partnership define sustainability? What are the factors that will influence sustainability? Are these being addressed?
- 3.2.6 Are we achieving Gender outcomes? Why?/Why not?
- 3.2.7 Have there been any unintended outcomes from the program?

3.3 Quality of Deliverables

- 3.3.1 Appraise the quality including appropriateness and usability of the Monitoring and Evaluation Strategy and the Community Engagement Strategy in relation to partners' needs and their current capacity.
- 3.3.2 Appraise the quality and appropriateness of the Good Governance Action Plan (including the Fiduciary Risk Analysis and Financial Management System)

3.4 Quality of Management Systems

- 3.4.1 What is the partnership approach? What is it resulting in? What are the challenges? What are the criteria / prerequisites required to using this model?
- 3.4.2 What are the expected outcomes of the partnership from AusAID and partners? How has this progressed?
- 3.4.3 How well is the partnership approach implemented in a low capacity environment like NTT?
- 3.4.4 Is the contractor appropriately and adequately resourced to implement this partnership approach? Would they have the capacity to manage an expansion?
- 3.4.5 What is the perceived and actual quality of the technical assistance? (i.e. are they adopting appropriate capacity building techniques?)

3.4.6 What is the Quality of the Monitoring and Evaluation System? Is it giving us the information we need? How can it be improved?

3.5 Links with Government of Indonesia's and other AusAID programs

3.5.1 Have there been links? How are they working?

3.5.2 Is there a future for further linkages? If so, what would be the area of focus? For example:

3.5.3 In the area of health financing systems, how should the program be working with the Australia Indonesia Partnership for Decentralisation on Public Finance Management and Governance Issues and the district health accounts supported through health systems strengthening?

3.5.4 In the area of community support, how should the program be working with the national program for community empowerment (PNPM) Generasi conditional cash transfer program? What impact would this have on current work with the Desa Siaga approach?

3.5.5 What are the health systems issues in the area of health financing and health workforce in the primary care setting that require attention at the national level and could be taken forward by the proposed health system strengthening program currently in development?

3.5.6 Is there potential for trialling innovative approaches to strengthen primary care at the district level, leveraging relationships and systems development undertaken in the AIPMNH?

The structure of the report will be informed by the Independent Progress Report template. Ratings will use the standard AusAID six-point scale outlined in the IPR template (see Appendix 1).

4 Required Expertise

The Independent Progress Review will have three members:

4.1. Team leader – an Evaluation Specialist. The Team Leader should have the following skills:

- Demonstrated practical experience and skills in research or evaluation methodology, conduct, and management, including articulation of evaluation questions, development of sound methods and tools, conduct of data collection activities, analysis of data (or supervision of such), interpretation and dissemination of results and report preparation;
- Demonstrated ability to breakdown and communicate complex concepts simply with a range of stakeholders including in multi-cultural settings;
- Have previous experience in evaluation the impact of international development programs, preferably in health;
- A high standard of report writing and oral communication skills;
- Strong leadership and facilitation skills.
- The role of the Team Leader
- Primarily to apply their skills and experience in evaluation design, methodology, conduct and management in order to ensure a good quality evaluation;
- Lead the evaluation team;
- Coordinate and liaise with the other team members on the allocations of assignment and reporting arrangements;
- Participate in a telecom briefing with AusAID and other team members;
- Participate in a briefing meeting in country in July;
- Develop the draft evaluation plan in consultation with the Public Sector Specialist and Health Sector Specialist;

- Finalise the draft evaluation plan upon receiving feedback from AusAID;
- Lead the in-country fieldwork in October 2010 or another mutually agreed time and ensure the team fulfils the evaluation plan;
- Build the capacity of the Performance and Quality Unit (PQU) Senior Program Manager in performing an evaluation task during the in-country mission;
- Participate in the initial briefing in Jakarta and lead sessions to present preliminary findings in the field and in Jakarta;
- Be responsible for the writing of the draft and final review report, with input from other team members.

4.2. Team Member – Public Financial Management Specialist

- Demonstrate experience in public sector reform in developing countries across a range of policy areas including health;
- Demonstrate understanding of national and sub-national public financial management issues in low-capacity environment.

The role of the Public Financial Management Specialist

- Participate in a telecom briefing with AusAID and other team members
- Provide comments to the team leader on evaluation plan; especially on the key evaluation questions that are relevant to public sector /financial management issues;
- Undertake in-country field work in October 2010 or another mutually agreed time;
- Provide inputs to the following areas of review (but not limited to):
- Assess the effectiveness of program's contribution to improved management of financial and human resources;
- Assess and advise on links between AIPMNH and other tools and methodologies that are being implemented to assist with health sector financing particularly those promoted by other AusAID programs (District Health Accounts and Public Expenditure Analysis).
- Participate at the initial briefing in Jakarta and present preliminary findings at sessions in the field and in Jakarta;
- Contribute to the preparation of the draft and final review report under the Team Leader's coordination.

4.3. Team Member – Indonesia Health Specialist

- Technical expertise in Sexual Reproductive Health including Maternal Health issues in Indonesia
- Understanding of health system in Indonesia's decentralisation context

The role of the Indonesia Health Specialist

- Participate in a telecom briefing with AusAID and other team members;
- Provide comments to the team leader on the evaluation plan especially on the key evaluation questions that are relevant to Indonesia health issues;
- Undertake in-country fieldwork in October 2010 or another mutually agreed time;
- Provide inputs the following areas of review (but not limited to):
- The relevance between end-of-program outcomes and reduction in maternal and neonatal deaths?
- Is achievement of objectives of the program constrained by insufficient focus of Sexual Reproductive Health?
- Participate at the initial briefing in Jakarta and present preliminary findings at sessions in the field and in Jakarta
- Contribute to the preparation of the draft and final review report under the Team Leader's coordination

Apart from the independent consultants, staff from AusAID and the Government of Indonesia will also participate in the review:

AusAID Program Manager for Maternal and Neonatal Health / Evaluation Manager.

The role of the program manager in this review will be to:

- Liaise and coordinate with the Review Team, Implementation service provider and AusAID management on both technical and administrative aspects of the review
- Participate in parts of the field work, in order to manage the evaluation process, ensure the evaluation is of high quality and fulfils the evaluation plan and to learn more about the program and issues facing implementation.
- Ensuring administrative and logistical support for the review process
- Manage comments from internal and external stakeholders on the draft report.
- Prepare the management response and learning and dissemination plan for the evaluation.

AusAID Senior Program Manager for Performance and Quality. The role of the PQU SPM in this review will be to:

- Provide advice, support and mentoring to the Evaluation Manager throughout the process to ensure a high quality evaluation report is produced, which can be used as a good practice example for future evaluations.
- Participate in the in-country mission, to mentor the evaluation manager in how to manage an evaluation process and ensure the evaluation plan is carried out.
- Undertake a research task as part of the evaluation, as a capacity-building opportunity in evaluation methodology and implementation.
- At the end of the evaluation process, support the evaluation manager in preparing the management response and learning and dissemination plan.
- Representative from the Government of Indonesia may also participate. The role of the Government of Indonesia Representative will be to:
 - Provide insights on the national policies in relation to Maternal and Neonatal Health
 - Comments on the partnership model

5 Evaluation Process

The review process will be undertaken from July to November 2010. The in-country mission will take around 3.5 weeks and is planned for 11 October to 3 November 2010. The exact date and timeline of the review is to be confirmed based on the evaluation plan (including methodology) that will be developed by the evaluation specialist.

In undertaking the review, the team will:

- Participate in a verbal briefing with AusAID at the outset of the evaluation process, to discuss background, issues and priorities for the evaluation and AusAID's expectations for development of the evaluation plan (up to 0.5 day)
- The briefing process above may involve an in-country visit by some or all of the team members (up to 7 days)
- Familiarise themselves with all relevant partnership and activity documentation provided by AusAID and advise AusAID of any additional documents or information required prior to the in-country-visit (these documents are listed below). (up to 3 days)
- Develop an evaluation plan, which includes: (up to 3 days for team leader, 1 day each for team members)
 - outlining the evaluation approach
 - providing more detailed evaluation questions based on this terms of reference
 - describing the methods that will be employed to gather information to answer each evaluation question, including identifying key respondents to be consulted

- providing guidance on scheduling to enable AusAID to develop the itinerary, and
- clearly allocating responsibilities between team members.
- Appraise the M&E strategy and Community Engagement Strategy (up to 3 days)
- Participate in an AusAID briefing session at the start of the in-country field visit (up to 0.5 day)
- Conduct meetings in Jakarta and field visits to MNH activity sites in NTT, as required, including undertaking debriefing sessions with visited district and provincial government (up to 28 days)
- Present the initial findings of the Independent Progress Review to AusAID Jakarta, the activity implementation team and partnership agencies in separate sessions and locations. (up to 1 day)
- Process evaluation data (3 – 4 days)
- Prepare draft Independent Progress Review report (up to 7 days for the team leader, up to 4 days each for team members)
- Prepare final Independent Progress Review report, incorporating comments from AusAID and other key stakeholders (where the team deems appropriate) (up to 3 days for the team leader, up to 1 day each for team members)

Total estimated consultant input is: TL up to 60 days; Members up to 40 days.

6 Reporting Requirements

The review team will submit to AusAID the following:

- Evaluation plan (including methodology) – to be submitted in August 2010.
- Draft Independent Progress Review report – to be submitted within two weeks of completing the in-country field visit.
- Final Independent Progress Review report – to be submitted within one week of receipt of AusAID’s comments on the draft report.
- Both the draft and final reports should be no more than 30 pages of text excluding appendices. The Executive Summary, with a summary list of recommendations, should be no more than 2-3 pages. Where possible, recommendations should be costed.

AusAID will seek comments from internal and external stakeholders on the draft report. The draft report will also be reviewed by a member of the AusAID M&E Panel and a health sector specialist. AusAID will provide consolidated comments to the Evaluation Team within three weeks of receipt of the draft report from the Team Leader. AusAID will also arrange for translation of the final report into Bahasa Indonesia.

7 TIMEFRAME & KEY MILESTONES

No	Stages	Timing
1.	IPR TOR developed	May – June 2010
2.	Contracting of Review team	July 2010
3.	Review design and methodology approved by AusAID	July – August 2010
4.	Review team conduct fieldwork in Jakarta and NTT	11 Oct – 3 Nov 2010
6.	Draft Report submitted to AusAID	30 Nov 2010

7.	Final Report submitted to AusAID	30 Dec 2010
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8 REFERENCES

Key documents include:

1. AIPMNH Design Document, 1st and 2nd Annual Workplan, 1st and 2nd Progress Report
2. AusAID's guidelines on conducting an Independent Progress Review (IPR)
3. AusAID – UNICEF Joint Review of Maternal and Child Health Activities in Indonesia, January 2005
4. ICR of Women's Health and Family Welfare Program
5. AIPMNH QAIs
6. AIPMNH Strategy Documents: Gender, Community Engagement, Technical Assistance, Monitoring and Evaluation
7. AIPMNH Good Governance Action Plan including FRA and FMS.
8. Indonesia Country Program Strategy: AusAID
9. National Strategic Plan on Making Pregnancy Safer (MPS) in Indonesia 2001 – 2010, 2001
10. Ministry of Health RI, Strategic Plan, 2010 – 2014
11. Revolusi KIA, NTT Governor Regulation No. 42 Year 2009
12. PNPM Program Brief
13. AIPD Program Brief

Annex 8: Evaluation plan

1. What is this document?

This document outlines the evaluation plan for the independent progress review of the Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH). It has been guided by the review's terms of reference and informed by discussions held with a range of key stakeholders during an orientation visit in July 2010.

An evaluation plan is an important first milestone that determines the direction and design of an evaluation (Weiss, 1972 cited in Shadish et al, 1995; Owen, 2006). Therefore, this document is to assist further discussions and negotiation about the review with the AIPMNH partners and the evaluation team, in particular: its focus; how information will be collected; how information will be used; and the management of the evaluation (Taylor-Powell et al, 1996). It is anticipated that agreement will be reached about how the review is to proceed and what can reasonably be achieved.

It is a flexible document that will be reviewed regularly by the AIPMNH partners and the review team throughout the review. This will enable appropriate adaptations to be made should circumstances change (Owen, 2006; Day, 2008).

2. What is being evaluated?

The review will be conducted on the AIPMNH program, which is a partnership between Australia and Indonesia that seeks to improve the health of pregnant women and neonatal babies.

Indonesia's economic development has improved the health outcomes of much of the population. However, recent gains at the national level mask disparities in the poorest provinces and regions. Under decentralisation, local governments struggle to find, fund and successfully manage the human resources required to implement their mandate. Public awareness and participation in health issues remains poor and public demand for health sector improvements remains weak.

While Indonesia is making progress towards achieving Millennium Development Goal 4 (reducing child mortality), it is unlikely to achieve Millennium Development Goal 5 (reducing maternal mortality) by 2015, without additional resources.

The Government of Indonesia's National Making Pregnancy Safer Strategy (2001-2010) provides the framework for efforts to reduce maternal and neonatal mortality in Indonesia. The strategy integrates supply and demand side interventions, with a focus on addressing health system constraints to service delivery. It also sets targets for key interventions.

The Australian Government launched the Australia Indonesian Partnership Country Strategy in 2008. This aims to support the Government of Indonesia to achieve sustainable poverty alleviation by delivering the development outcomes outlined in Indonesia's Medium Term Development Plan. One component of the Strategy focuses on the Australian and Indonesian Governments working together to improve access to and quality of health care. The health of mothers and babies in Indonesia is a key focus of both the Government of Australia and Government of Indonesia in achieving the Millennium Development Goals. Through the AIPMNH, the Governments of Australia and Indonesia work together to achieve jointly agreed aims in implementing the National Making Pregnancy Safer Strategies in selected provinces and districts.

At present the AIPMNH is working with Provincial and District Governments in Nusa Tenggara Timur (NTT) to implement *Revolusi KIA* (Maternal and Child Health Revolution strategy) which aims to reduce maternal and neonatal mortality.

AIPMNH is built on the experience of previous activities, and on the ongoing reform and decentralisation of the Government of Indonesia. The partnership seeks to contribute to improvements in outcomes at the district and provincial levels by:

- addressing system constraints;
- improving system governance; and
- introducing a performance focus.

The partnership works with and through Government of Indonesia systems, including working to the Government's planning and budgeting cycles and timelines. A phased approach is used that matches progressive improvements in function of Government of Indonesia systems with performance incentives and increased disbursement of funds.

The long term objective of the partnership is for provincial and district governments to effectively manage national, local and donor resources to progressively achieve Millennium Development Goal targets for maternal and child health. The short-term objective for the first phase of the partnership, which is due for completion at the end of June 2011, is that selected provincial and district governments have the necessary mechanisms in place to achieve the longer-term objective. Mechanisms have been translated broadly to embrace a range of things that are required to help bring about the desired outcomes. They include:

- improving the accessibility and quality of service delivery;
- engaging the community in the provision and support of MNH services;
- improving health systems;
- strengthening the capacity of the workforce; and
- improving performance and accountability.

Activities selected under the program are decided jointly by the implementing service provider and the Local Governments. The activities are based on the Governments' own planning processes. In the partnership approach the partner government has a substantial role in deciding the performance targets and types of activities. The role of the implementing team is to assist the partner government in making sure their plans and activities are relevant to the objectives that they want to achieve. To date, activities have included such things as: providing support to local governments and other agencies to improve health service delivery; bottom-up consultative planning; budget processes involving beneficiaries; and enhancing public awareness of the health system.

AIPMNH commenced in 2008 with interim activities in three districts in East Nusa Tenggara province. This was followed by a full implementation from February 2009, managed by an implementation service provider, Coffey International Development. By the end of 2009 AIPMNH covered a total of nine districts and in 2010 an additional five districts were selected. AIPMNH currently works in a total of 14 districts (2/3 of total districts in NTT). The partnership has a total value of \$32 million over 2.5 years.

3. What is the purpose of the evaluation?

According to Owen (2006) there are five different forms of evaluation, each with its own purpose. From the terms of reference for the review of AIPMNH it is apparent that this review falls within two of these forms: impact evaluation and clarificative evaluation.

- i. Impact evaluation – the partners wish to assess the effects of the AIPMNH at the 'mid-point' of the first agreed phase, with a view to how it should be refined in its next phase. This aspect of the review is to:

- assess progress of the AIPMNH against its stated objectives;
- assess how well the AIPMNH is meeting the needs of the Australian and Indonesian Governments;
- identify outcomes, both intended and unintended (negative and positive); and
- assess whether the implementation strategy will lead to intended longer-term outcomes.

In relation to the implementation strategy, the partners have a particular interest in the effectiveness and efficiency of the partnership approach. This is a new delivery mode for the Australian and Indonesian Governments and the partners seek advice in relation to:

- the relevance of the program in the given context;
 - the success (or otherwise) of the capacity strengthening approach used to implement the partnership objectives, including whether and how the assistance will help the partners in evaluating and refining its policy strategy; and
 - the relative advantages and disadvantages of the partnership approach.
- ii. Clarificative – the partners wish to make explicit the underlying theory and logic of the AIPMNH, which to date has not been clear. Clarification of this will inform questions of relevance as well as any design changes to the next phase of the AIPMNH. This aspect of the review will:
- involve working with the partners and the implementing service provider to agree upon and describe the program theory;
 - examine the current linkages and networks with other relevant AusAID and Government of Indonesia programs, and how these can be strengthened in the future; and
 - examine the opportunities to strengthen sexual and reproductive health.

It is also an expectation that this review will assist in strengthening the capacity of two AusAID Jakarta staff: the Performance and Quality Unit Senior Manager and the Program Manager for Maternal and Neonatal Health. Specifically, the capacity relates to the management and conduct of an evaluation. These two staff will participate in the evaluation tasks as negotiated with the team leader. This aspect of the evaluation will be subject to separate, individual plans with the two staff.

4. What is the focus of the review?

It is important to understand where an evaluation is to focus because this will have a bearing on the scope and design. The AIPMNH is what Owen (2006) terms a 'macro' program. It is concerned with the specific intervention of a policy at a provincial level, with implementation at multiple sites. Whilst progress against the stated objectives and the program's progress against the AusAID evaluation criteria are important elements of this review, the major emphases are to be placed on:

- Identifying the outcomes that have been achieved;
- The effectiveness and efficiency of the partnership;
- The relevance of the program in the given context; and
- Future direction of the AIPMNH, including clarifying the theories of change and action.

5. Who is the audience?

The primary audience for this review is the partnership, namely: the Ministry of Health of Indonesia (Kemkes), the Indonesian National Planning Agency (Bappenas), and AusAID.

Specifically, this means: the relevant directorates of Kemkes and Bappenas; AusAID Jakarta senior management and the AusAID Jakarta Health Unit; and the implementing team (because the partnership is being implemented on behalf of AusAID by this team). The primary audience can be further delineated as the partnership at the national level and the partnership at provincial and district level.

The national level partnership will use the findings to help decide the future direction of the program.

The provincial and district level partnerships will use the findings to inform operational changes to the program.

In addition, there are two secondary audiences, as follows:

- The Performance and Quality Unit of AusAID Jakarta – this independent progress review is being used as a case study by this Unit, with the aim of producing a good practice example of an evaluation.
- AusAID Governance and Services Delivery Branch (Health) – this section is interested in the clarificative aspect of this review and how AIPMNH will align with overall AusAID health policy and direction.

6. What resources are available?

The review will be undertaken by a team of three external evaluators – a team leader who is an evaluation specialist; a public financial management specialist; and an Indonesian health specialist. The AusAID Jakarta office has negotiated the roles of these team members with each of the individuals. These roles have been articulated in the terms of reference. The total estimated consultant input for this review is as follows: Team leader – 60 days; public finance management specialist – 40 days; Indonesian health specialist – 40 days. These days cover all phases of the review, including the scoping and preparation phases. A budget for disbursements has been individually negotiated by AusAID with each of these external team members.

In addition, two AusAID Jakarta staff will join the team – the Program Manager for Maternal and Neonatal Health and the Senior Program Manager, Performance and Quality Unit. AusAID Jakarta has negotiated dedicated time with each of these staff members. The roles of these staff have been articulated in the terms of reference. A budget for disbursements has been set aside by AusAID to support these staff during all phases of the review process.

To ensure the partnership is represented by each partner, a representative from the Government of Indonesia will join the review team. The role of this person has been also been articulated in the terms of reference. The Government of Indonesia will provide the necessary resources to support the input of this person.

As well as these dedicated resources for the review team, AusAID, the Government of Indonesia and the implementing service provider will input resources through the participation of their staff as key informants.

7. What are the key evaluation questions?

Four key evaluation questions have been outlined in the terms of reference, as follows:

- i. To what extent have program objectives and outcomes been achieved?
- ii. How effectively is the partnership model working?

- iii. How relevant is the program model in the context of the likely future needs of Government of Indonesia and Government of Australia's policy?
- iv. How might this program be improved to meet the future needs of Government of Indonesia and Government of Australia policy?

From the scope outlined in the terms of reference and discussions held with the various stakeholders, these questions have been further elaborated. The following table outlines these more specific questions.

Key evaluation question	What do we want to know?
To what extent have program objectives and outcomes been achieved?	<p>What progress is being made against the program logframe? What works well and what are the challenges? Why?</p> <p>What outcomes have been achieved in relation to improved capacity, quality and accessibility of relevant health services (clinical and non-clinical)?</p> <p>What effects (positive and negative) is the program having on how the province and districts undertake planning, budgeting and human resource management?</p> <p>What are the unintended outcomes (positive and negative)? Have there been any unanticipated outcomes? What are the implications?</p> <p>How and why is the AIPMNH contributing to these various outcomes?</p> <p>How aligned are the program activities to the priorities of the province and districts? How aligned are they to the national targets and policies?</p> <p>Are the stated longer-term outcomes achievable in the timeframe? If not, why and what changes should be made?</p> <p>To what extent is the program achieving Gender Outcomes? Why or why not?</p> <p>What is the quality and degree of appropriateness of:</p> <ul style="list-style-type: none"> • The monitoring and evaluation strategy? • The community engagement strategy? • The good governance action plan?
How effectively is the partnership model working?	<p>How does the partnership model operate? What are the underlying assumptions of the model?</p> <p>What are the expected outcomes of the partnership? To what extent are these outcomes being achieved? Why? Why not?</p> <p>What are the strengths and challenges of the partnership approach? Does this partnership have the necessary prerequisites for success?</p> <p>What is being achieved through the partnership that could not be achieved by other means? How could the partnership approach be improved?</p> <p>How effective is the capacity strengthening model in helping to achieve the partnership outcomes and build needed capacity? What are its strengths and challenges? How could it be improved?</p>

Key evaluation question	What do we want to know?
	<p>What networks and linkages (relevant AusAID and Gol programs) are important to the program and why? To what extent are effective networks and linkages being made? How could these be improved?</p> <p>How effective is the monitoring and evaluation system and how could it be improved?</p>
<p>How relevant is the program model in the context of the likely future needs of Government of Indonesia and Government of Australia's policy?</p>	<p>What are the current and future needs of the Government of Indonesia (at all levels) in relation to assistance in implementing the Making Pregnancy Safer Strategy? How well aligned to these needs is the current program?</p> <p>Should any changes be made to the program in the context of decentralisation? Is the balance between supporting provincial and district governments right or should there be greater emphasis at the district level?</p> <p>What is the current policy of the Government of Australia in relation to its assistance to the Government of Indonesia? How well aligned to this policy is the current program?</p> <p>How does the partnership define sustainability? Is it likely to be successful? Why? Why not?</p> <p>How relevant is the structure of the implementing service provider to the meeting of these needs? How well aligned is the capacity of the implementing service provider to meet these needs?</p>
<p>How might this program be improved to meet the future needs of Government of Indonesia and Government of Australia policy?</p>	<p>What is the underlying rationale for the program?</p> <p>What is the program theory? Can a plausible link to the reduction in maternal and neonatal deaths be demonstrated?</p> <p>What program elements need to be modified to improve the likelihood that the desired outcomes hierarchy will be achieved?</p> <p>What innovations might be considered to strengthen primary care at the district level?</p> <p>What opportunities exist to strengthen sexual and reproductive health?</p>

8. What general approach will be taken?

Participatory

To increase the likelihood of the review findings being used (Patton, 2008; Owen, 2006), a participatory approach is proposed. Both the primary and secondary audiences participated in the development of the review's terms of reference, the scoping phase of the review, and in making comment on this evaluation plan. Key activities to promote participation during the review itself include:

- Inclusion of representatives from the partners on the review team;
- Regular updates to the primary audiences through processes that will be agreed jointly at the outset of review;
- Inclusion of all key stakeholder groups to ensure the various perspectives are heard;
- Tailoring evaluative techniques to the different stakeholder groups;

- Promoting the participation of representatives from both primary and secondary audiences in the workshop to present the findings, discuss the implications, and explore possible future directions; and
- Encouraging the participation of representatives from the primary audience (national level) in the workshop to clarify the program theory and determining the future direction of the program.

Emphasis on the most important components using a mixed-methods approach

As noted previously (focus section), the major emphases are to be placed on:

- Identifying the outcomes that have been achieved;
- The effectiveness and efficiency of the partnership;
- The relevance of the program in the given context; and
- Future direction of the AIPMNH, including clarifying the theories of change and action.

Therefore, methods to assess the progress against the stated objectives and the program's progress against the AusAID evaluation criteria will be subject to more cursory evaluative methods that are succinct in time and human resources. This will allow the review team to direct resources to the most important questions.

The review will adopt a mixed-methods approach (refer to data section for detail). In essence, this will involve the use of available quantitative data for the entire program and the gathering of qualitative data in a sample of districts where the program operates. Qualitative methods will be tailored to the particular evaluation questions.

9. What are the limitations and constraints?

A number of limitations and constraints are noted:

- For quantitative data, the review team will rely on available data from relevant Government of Indonesia systems and the implementing service provider. The extent and quality of this data will not be fully understood by the review team until the review begins. However, it is important to use the available data for the following reasons:
 - It will prevent placing undue pressure on the partners to gather new data solely for this review.
 - It respects the partnership decision to operate, wherever possible, with Government systems.
 - With limited in-field time it is more effective for the review team to place its efforts on data techniques that will provide added richness, breadth and depth.
- Time and resource constraints mean that it is not possible to visit all locations where the program operates. Therefore, it will be necessary to gather qualitative data from a sample of locations (refer to data section of this plan for further information). This sample has been chosen to reflect, as much as possible, the many variables that exist within the program. In addition, time and resource constraints mean that not all data methods will be applied in all sample locations. Therefore, careful attention has been paid to the triangulation of data.
- The methodology includes a comparative district (refer to data section of this plan). A limited number of in-field activities will occur in that district because it will be important to not raise expectations about future expansion of the program to that particular location.

- Two of the three independent reviewers do not speak Bahasa Indonesia so will need to rely on interpreters. Although the team will be supported by highly skilled interpreters, possible implications include:
 - a risk that the nuances of reviewers' questions and people's responses might not be fully captured. This will mean that the reviewers and interpreters will need to be very diligent in clarifying the meaning of what people say through the use of process feedback during interviews, discussions and workshops; and
 - evidence in the form of quotes is likely to be indicative of people's comments rather than precise word-for-word quotes.
- Although attention will be paid to maximising time for in-field activities, it is important to note that travel to, and within NTT, will have an impact on available time. This plus necessary out-of-field activities (pre field preparation; data analysis; and preparation and facilitation of final workshops) mean that the time available for in-field activities will be approximately 2.5 weeks (of a total possible four). Furthermore, working through interpreters adds to the time it takes to conduct interviews and other qualitative sessions, which, in turn, impacts on the total time available.
- There are potential political sensitivities around the future direction of the program, particularly how and where it might be scaled up. It will be important for the review to obtain perspectives about future direction from a wide range of stakeholders. However, it will be important that these stakeholders are made aware that their perspectives will help inform future direction but that the decision rests with the national partners.

10. What data methods will be used?

Data methods

Data management choices for this evaluation have been selected on the basis of what will best answer the evaluation questions (Burke-Johnson and Onwuegbuzie, 2004; Owen, 2006). A mixed-methods approach has been determined as best suiting that purpose. The use of mixed methods will assist with triangulation of data, thus strengthening the review study (Patton, 2002). The triangulation methods that will be applied match the four basic types of triangulation identified by Denzin (cited in Patton, 2002):

- Data triangulation – the use of a variety of data sources;
- Investigator triangulation – the use of different evaluators;
- Theory triangulation – the use of multiple perspectives to interpret the data; and
- Methodological triangulation – the use of multiple methods and samples.

Using mixed methods enables the inclusion of: induction (discovery of patterns), deduction (testing of theories), and abduction (uncovering explanations) forms of inquiry (Burke-Johnson and Onwuegbuzie, 2004). This mix will enable the team to test for consistency of findings. Consistencies and any inconsistencies will provide deeper insights into the program.

Desk-based document analyses

These will include:

- documents that will provide an overview of the program, its operation and its achievements, for example:
 - policy statements;
 - program design documents;

- work plans;
- documents that will provide more in-depth information about how AIPMNH is being applied, for example:
 - a sample of minutes or other formal notes of partner meetings;
 - a sample of relevant financial and budget records from the selected locations;
- documents that will provide information about achievements, for example:
 - the implementing service provider will be invited to prepare a self-assessment written report against the logframe;
 - current and past presentations of progress prepared by district coordinating committees;
 - progress reports that have been provided to AusAID
- documents that will provide comparative information, for example:
 - service delivery targets from all districts

The analyses will be used to:

- learn directly about the program;
- inform the review team of paths of inquiry during observation; and
- make linkages with data sourced by other means.

The desk-based document analysis will be undertaken both prior to, and as part of, the in-field activities. It will seek evidence in relation to key evaluation questions one, two, and three.

Case study sample

A small sample of locations has been chosen in consultation with the implementing service provider using a mixed purposeful sample (refer appendix 1).

In three locations – Sumba Timur; Manggarai; and Timor Tengah Selatan (TTS) – a wide range of activities will be conducted, including:

- Semi-structured individual or group interviews with representatives from district government agencies:
 - Bappeda (Regional Planning and Development Bureau);
 - Dinkes (District Health Department);
 - Biro Pemberdayaan Masyarakat Daerah (Community Empowerment Bureau);
 - Biro Pemberdayaan Perempuan (Women's Empowerment Bureau); and
 - Badan Koordinasi Keluarga Berencana "Daerah" (Regional Family Planning and Coordination Bureau)

These interviews are anticipated to take up to 1.5 hours and will focus on key evaluation questions one, two and three.

- Semi-structured interviews with District Program Coordinators. These interviews are anticipated to take about 1.5 to 2 hours and will focus on key evaluation questions one, two and three.
- Facilitated survey workshop with district level partnership group to undertake joint self-assessment of the partnership. These workshops will take 2-3 hours and focus on key evaluation question two.
- Observational visits to a sample of health facilities – hospitals, puskesmas, posyandus – (refer to appendix 1 for sample selection). These visits will be used to:
 - observe the usage of renovations purchased as part of the program;
 - hold opportunistic informal discussions with staff and service users; and
 - undertake analysis of relevant service-held documents and charts.

These visits will take 2-3 hours and the activities will focus on key evaluation question one.

- Semi-structured interviews with relevant health service deliverers. These interviews will take about 1.5 hours each and will focus on key evaluation question one, two and four.
- Analyses of a sample of planning, financial, human resources and clinic records – at both district level and health facility. Up to half a day should be allocated for these analyses. They will focus on key evaluation questions one and two.
- Confirmatory research of selected aspects of logframe. The sample of aspects will be determined purposefully by the three independent team members, based on particular areas of review and hypotheses. This research will be incorporated in the other activities at the sample locations. They will focus on key evaluation question one.
- Analysis of Visitasi Assessment of Clinical Standards for PONEK and PONEK (Sumba Timur). This analysis will focus on key question one.
- Analysis of clinical referral processes and clinical innovations (Sumba Timur). This activity will take around 1.5 hours and will focus on key evaluation question one.
- Conduct consultation with a sample of communities (refer to appendix 1 for sample selection) using participatory methods such as ‘pocket charts’ and ‘ten seeds’ (Jayakaran, 2002) techniques (refer to appendix 2 for a brief outline of these techniques). The sample of communities will be drawn from those in which the program has been implementing community engagement activities. The review activities will take about 2 hours with each local group and will focus on key evaluation questions one and four.

As well as the three locations for the broad range of activities, Kupang has been chosen for specific consideration: analysis of

- Fiduciary risk
- Internal control training

About 2 hours will be needed at this location. The activity will focus on key evaluation question one and will include:

- semi-structured interviews with relevant representatives from health facilities, Bappeda and Dinkes; and
- analyses of a sample of planning and financial records.

Comparative sample

One non-program location has been included for comparative purposes. Each of the partners was keen for some comparative analysis to be undertaken. For this location, a limited number of in-field activities will occur because it will be important to not raise expectations in that location about future expansion of the program. Therefore, activities will be restricted to a one-day visit and will involve semi-structured interviews with representatives of the district government. In addition, comparative service delivery targets will be analysed, along with those of other districts.

Other comparative methods

To help in understanding the added benefit of the AIPMNH (or estimating the counterfactual), other comparative methods have been included in the methodology (refer to appendix 2 for a brief outline of these methods):

- Shadow controls (Vedung, 2004) – estimates of the net impact will be sought from a selection of people with insight to the program (those with particular expertise in the field; program administrators; and ‘participants’); and
- Additionality – a mixed-methods framework developed by Buisseret et al (1995 cited in Georghiou, 2002), as a means of evaluative comparison of the counterfactual.

These two methods are lens through which questions are designed and analyses occur. No separate time is required for these as they are built into other activities.

Interviews

Semi-structured individual or group interviews will be conducted with representatives from:

- National level of Government of Indonesia:
 - Bappenas (National Planning and Development Bureau)
 - Kemkes (Ministry of Health)
- Provincial level of government:
 1. Bappeda (Regional Planning and Development Bureau)
 2. Dinkes (Provincial Health Department)
 3. Biro Pemberdayaan Masyarakat Daerah (Community Empowerment Bureau)
 4. Biro Pemberdayaan Perempuan (Women’s Empowerment Bureau)
 5. Badan Koordinasi Keluarga Berencana “nasional” (National Family Planning and Coordination Bureau)
- AusAID
 - Senior management
 - Health Unit
 - Relevant program and project areas such as AIPD, HSS
- Implementing service provider

These interviews will go for about 1-1.5 hours each and will focus on key evaluation questions one, three and four.

Facilitated survey workshops

Facilitated survey workshops will be conducted with national and provincial partnership groups to undertake joint self-assessment of the partnership. These workshops last for 2-3 hours and will focus on key evaluation question two.

Network analysis workshop

A workshop will be facilitated with the implementing team to identify and analyse the depth and breadth of linkages and networks with relevant AusAID and GoI programs. This workshop will last for 2-3 hours and will focus on key evaluation question two.

Feedback workshop

A half-day workshop with representatives from all partners at each level (this could include representatives from the districts that are not part of the case study sample) to feedback findings and discuss implications.

Future direction workshop

A half-day workshop with partners at the national level to: present findings, clarify the program theory and discuss future direction (key evaluation question four).

Literature review

Brief literature reviews will help inform contemporary good practice in relation to components such as: partnership approaches; strengthening capacity; contemporary primary care

11. How will data be collected?

Gaining access to data

Because the implementing service provider has the relationship with all the key stakeholders it is proposed to negotiate access to stakeholders and data through them.

Data measures

The following measures will be used:

- The program logframe for assessing progress against the stated objectives
- Agreed criteria for specific elements of the program such as:
 - The partnership
 - Contemporary good practice in relation to strengthening capacity
 - Capacity, quality and accessibility of health services
 - Monitoring and evaluation practices
 - Community engagement
 - Good governance

These criteria will be drawn from a mix of relevant literature and professional judgement then agreed upon between the review team and the partners. Refer to appendix 3 for these criteria.

Data tools

The evaluation team will agree upon the various data tools to be used for the review. Where the tools are specific to the expertise of a review team member, for example tools to analyse financial records, that team member will be responsible for obtaining or developing the tool. Where the tool is more generic, for example, a semi-structured interview schedule, the team leader will coordinate a process through which all team members can input to the development of the tool.

A consistent approach to how common process methods are undertaken will be developed. For example, how team members introduce the review to stakeholders; how information from documents is recorded; what types of observations should be noted; what should be included in field notes; how information will be shared amongst team members. The team leader will coordinate a process through which all team members can input to the development of such processes and templates.

Time will be set aside at the start of the in-field work for the team to meet together to: a) become familiar with any common tools; and b) work through process methods.

Working in small numbers

It is proposed that team members work in pairs or threes rather than in a larger group. It is anticipated that this approach will assist review team members in building the necessary short-term professional relationship with stakeholders and help maximise active participation by stakeholders.

Use of Bahasa Indonesia and other relevant languages

To maximise participation of stakeholders, the majority of interviews and workshops will need to be conducted in Bahasa Indonesia or, in the case of communities, in the local language. Interpreters will work alongside review team members who are not proficient in Bahasa Indonesia. They will provide simultaneous translation and interpretation services.

For the conduct of the 'pocket chart' and 'ten seed' techniques' with communities, local interpreters will be engaged to work with the review team. These techniques work best where the discussion can occur unhindered by simultaneous translation. Therefore, it is proposed that a number of local people participate in training to learn how to conduct these techniques, specifically for this review. These people would then facilitate the techniques with the communities and record responses. Responses would then be translated into Bahasa Indonesia and English. Review team members would be observers to the process.

12. How will data be analysed?

Analysis of the data will occur on an ongoing, iterative basis during the in-field activities. Team members will record and track analytical insights during the data collection phase. Wherever possible, time at the end of each day will be set aside for team members who have been working together to briefly discuss their major observations, impressions and emergent sense-making of the data.

Once during the in-field phase (twice if time permits), the whole team will come together for one day to undertake joint iterative data analysis. This process will:

- Help successfully manage the large quantities of data;
- Identify emerging patterns, themes and hypotheses;
- Make links between the quantitative and qualitative data;
- Help point to areas where further data needs to be gathered;
- Help in disconfirming and confirming earlier patterns, themes and hypotheses.

The team leader will develop a system of manual coding and matrices for use by the review team during these sessions. Time will be set aside at the beginning of the in-field activities to discuss how this system will be used.

Towards the end of the in-field phase, the team will convene together twice more. First to jointly draw conclusions, make judgements and consider preliminary recommendations. This analysis will inform the future direction workshop. The second will occur after the future direction workshop to consider the impact of the information from that workshop on the preliminary conclusions, judgements and recommendations. It is noted that whilst the review team will make professional judgements and recommendations based on the evidence, the final decisions about the future direction of the program rest with the partners.

As part of these two latter analysis sessions, the team leader will facilitate a session with the review team to consider all data against the AusAID evaluation criteria. The group will jointly identify the supporting evidence and come to a consensus about the ratings for each.

Independent Progress Review:
Australia and Indonesia Partnership for Maternal and Neonatal Health

Key evaluation question	What do we want to know?	Data collection methods
To what extent have the program objectives been achieved?	What progress is being made against the program logframe? What works well and what are the challenges? Why?	<ul style="list-style-type: none"> • Written self-assessment of progress from implementing service provider • Written self-assessments by District Coordinating Committees • Confirmatory research of selected aspects of the logframe • Analysis of program documentation • Interviews with key informants – three levels of Government of Indonesia; implementing service provider; community
	What outcomes have been achieved in relation to program governance?	<ul style="list-style-type: none"> • Data methods, as above PLUS • Application of comparative methods, as listed • Partnership survey workshop
	What outcomes have been achieved in relation to improved capacity, quality and accessibility of relevant health services (clinical and non-clinical)? <i>For criteria to be used to determine capacity, quality and accessibility refer to Appendix 3</i>	<ul style="list-style-type: none"> • Data methods, as above PLUS • Application of comparative methods, as listed
	What effects (positive and negative) is the program having on how the province and districts undertake their planning, budgeting and management of human resources? <i>For potential effects refer to Appendix 3</i>	<ul style="list-style-type: none"> • Interviews with three levels of Government of Indonesia • Analyses of a sample of planning, financial and human resources records – at both district level and health facility
	What are the unintended outcomes (positive and negative)? Have there been any unanticipated outcomes? What are the implications?	<ul style="list-style-type: none"> • Program documentation analysis • Observational visits • Interviews with key informants – three levels of Government of Indonesia; implementing service provider; community
	How and why is the AIPMNH contributing to these various outcomes?	<ul style="list-style-type: none"> • Interviews with key informants – three levels of Government of Indonesia; implementing service provider; community
	How aligned are the program activities to the priorities of the province and districts? How aligned are they to the national targets and policies?	<ul style="list-style-type: none"> • Analysis of Government of Indonesia policy • Interviews with three levels of Government of Indonesia and Government policy • Analysis of planning documents
	Are the stated longer-term outcomes achievable in the timeframe? If not, why and what changes should be made?	<ul style="list-style-type: none"> • Interviews with key informants – three levels of Government of Indonesia; implementing service provider; community
	To what extent are the AusAID evaluation criteria being met? Why or why not? <ul style="list-style-type: none"> • Relevance • Efficiency • Effectiveness • Sustainability • Monitoring and evaluation • Gender equality • Analysis and learning 	<ul style="list-style-type: none"> • Document analysis • Interviews (individual and group) with key informants, drawn from all three levels of Government of Indonesia; AusAID; implementing service provider • Written self-assessment of progress from implementing service provider • Written self-assessments by District Coordinating Committees • Confirmatory research of selected aspects of the logframe – using a purposeful sample • Analyses of a sample of planning, financial and human resources records – at both district level and health facility • Observational visits
	What is the quality and degree of appropriateness of: <ul style="list-style-type: none"> • The monitoring and evaluation strategy? • The community engagement strategy? • The good governance action plan? 	<ul style="list-style-type: none"> • Desk-based peer appraisal based on criteria agreed with AusAID • Interview with Program Director • Comparison of application with intention

Independent Progress Review:
Australia and Indonesia Partnership for Maternal and Neonatal Health

Key evaluation question	What do we want to know?	Data collection methods
	<i>For criteria for each of these refer t Appendix 3</i>	
How effectively is the partnership model working?	How does the partnership model operate? What are the underlying assumptions of the model?	<ul style="list-style-type: none"> • Analysis of program documentation • Partnership survey workshops with each of the levels of partners: national; province and the case sample districts
	What are the expected outcomes of the partnership? To what extent are these outcomes being achieved? Why? Why not?	<ul style="list-style-type: none"> • Analysis of program documentation • Partnership survey workshops with each of the levels of partners: national; province and the case sample districts • Key stakeholder interviews
	What are the strengths and challenges of the partnership approach? Does this partnership have the necessary prerequisites for success?	<ul style="list-style-type: none"> • Partnership survey workshops with each of the levels of partners: national; province and the case sample districts • Determination of prerequisites for successful partnership – drawn from combination of literature and partners
	What is being achieved through the partnership that could not be achieved by other means?	<ul style="list-style-type: none"> • Partnership survey workshops with each of the levels of partners: national; province and the case sample districts • Application of 'additionality' as a lens to questions and analysis • 'Shadow' controls to estimate net impacts of partnership
	How could the partnership approach be improved? <i>For partnership criteria refer to Appendix 3</i>	<ul style="list-style-type: none"> • Partnership survey workshops with each of the levels of partners: national; province and the case sample districts • Assessment against partnership literature
	How effective is the capacity strengthening model in helping to achieve the partnership outcomes and build needed capacity? What are its strengths and challenges? How could it be improved?	<ul style="list-style-type: none"> • Interviews with key informants drawn from all three levels of Government of Indonesia; health service managers; community • Analyses of a sample of planning, financial and human resources records – at both district level and health facility • Assessment against strengthening capacity literature
	How effective is the monitoring and evaluation system and how could it be improved?	<ul style="list-style-type: none"> • Observation of demonstration of the system as part of observational visits • Interviews with key informants drawn from all three levels of Government of Indonesia; health service managers; AusAID; and the implementing service provider • Analysis of progress report
What networks and linkages (relevant AusAID and Gol programs) are important to the program and why? To what extent are effective networks and linkages being made? How could these be improved?	<ul style="list-style-type: none"> • Network analysis through interactive, illustrative methods at workshop with the implementing team • Interviews with key informants drawn from all three levels of Government of Indonesia; health service managers; AusAID; and the implementing service provider 	
How relevant is the program model in the context of the likely future needs of Government of Indonesia and Government of Australia's policy?	What are the current and future needs of the Government of Indonesia (at all levels) in relation to assistance in implementing the Making Pregnancy Safer Strategy? How well aligned to these needs is the current program?	<ul style="list-style-type: none"> • Interviews with representatives from all three levels of Government of Indonesia • Analysis of Government policy statements
	Should any changes be made to the program in the context of decentralisation? Is the balance between supporting provincial and district governments right or should there be greater emphasis at the district level?	<ul style="list-style-type: none"> • Statement of policy provided by Government of Indonesia • Interviews with key informants drawn from all three levels of Government of Indonesia; health service managers; and the implementing service provider
	What is the current policy of the Government of Australia in relation to its assistance to the Government of Indonesia? How well aligned to this	<ul style="list-style-type: none"> • Statement of policy provided by AusAID • Interviews with key informants drawn from AusAID and the implementing service provider

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Key evaluation question	What do we want to know?	Data collection methods
	<p>policy is the current program?</p> <p>How does the partnership define sustainability? Is it likely to be successful? Why? Why not?</p> <p>How relevant is the structure of the implementing service provider to the meeting of these needs? How well aligned is the capacity of the implementing service provider to meet these needs?</p>	<ul style="list-style-type: none"> • Partnership survey workshops with each level of partners (national; province; case sample districts) • Interviews with implementing team; representatives of the three levels of Government of Indonesia
<p>How might this program be improved to meet the future needs of Government of Indonesia and Government of Australia policy?</p>	<p>What is the underlying rationale for the program?</p> <p>What is the program theory? Can a plausible link to the reduction in maternal and neonatal deaths be demonstrated? Are the stated outcomes achievable in the timeframe?</p> <p>What program elements need to be modified to improve the likelihood that the desired outcomes hierarchy will be achieved?</p>	<ul style="list-style-type: none"> • Document analysis • Interviews with key informants with relevant expertise – drawn from Government of Indonesia; AusAID; University of Indonesia; implementing service provider • Workshop in partners at national level to: <ul style="list-style-type: none"> ○ Clarify program theory ○ Develop program logic ○ Test plausibility of outcomes ○ Explore program modifications and innovations ○ Discuss implications
	<p>What innovations might be considered to strengthen primary care at the district level?</p> <p>What opportunities exist to strengthen sexual and reproductive health?</p>	<ul style="list-style-type: none"> • Interviews with key informants with relevant expertise – drawn from Government of Indonesia; AusAID; University of Indonesia; implementing service provider • Analysis of relevant literature re contemporary good practice

13. What is the schedule of review activities?

Whilst the review will be conducted between the 18 July and 30 December 2010, the bulk of the in-field activities will occur between 14 October and 9 November 2010. One of the team members (the public sector financial management expert) will begin up to a week in advance of this period. Some desk-based activities will be undertaken both prior to and following the in-field activities. A draft report is due for comment by the partners by 30 November and the final report by 30 December.

The following table provides a brief overview of the in-field schedule:

Review activity	Timeframe	Team member
Jakarta-based activities: planning and budgeting; Document analyses; Confirmatory activities against logframe; Interviews with Gol (national)	Negotiated times in period 6-13 October	PFM specialist
Interviews with national level Gol	½ day each 14, 15 Oct	All 3 specialists
Interviews with AusAID Jakarta	½ day 14 Oct	All 3 specialists
Workshop with partners at national level	½ day: 15 October	Team Leader, PFM specialist
Team orientation activities	Two days, 16 and 18 Oct	All team members
Kupang-based activities:	Period 19-21 Oct	Allocated between team members
Whole of team meeting for feedback and preliminary analysis	21 October (while Kathy still there if possible)	All team members
Activities in 3 selected districts	22 – 30 October	Allocated team members
Activities in Sumba Tengah	29 October	Team Leader
Whole of team meeting for: analysis of data; preparation of workshop	2-4 November	All team members
Workshop in Kupang to present findings and discuss implications for future	5 November	All team members
Whole of team meeting for preparation of workshop	6 November	All team members
Future direction workshop in Jakarta	8 November	All team members
Whole of team meeting for : final analysis ; planning of report	9 November	All team members

Note: Team members representing AusAID and the Government of Indonesia will take part in the activities at provincial and district level. The exact location and the nature of their input is subject to negotiation.

14. How will findings be disseminated?

The findings will be disseminated in the following ways:

- At the conclusion of group sessions with local communities, a summary of the information will be shared with the participants.
- The partnership and network analysis workshops are designed to be interactive. Hence, information will be shared through plenary-type activities with the group.
- At the conclusion of the in-field phase, all those who have been involved on the review team (not only the independent team members) will jointly prepare and present:
 - a workshop with representatives from Government of Indonesia (from all three levels); AusAID Jakarta; and implementing service provider. This workshop will present key findings and provide opportunities for feedback and discussion about implications; and
 - a future directions workshop with the partners at a national level.
- All team members will input to an Independent Progress Review report for consideration by the AIPMNH partners. The drafting will be overseen by the team leader. This report will not be structured according to AusAID's evaluation criteria. Rather, its structure will align (but not necessarily follow exactly) the key evaluation questions. Evidence and ratings for each of AusAID's evaluation criteria will be provided as an appendix.
- All team members will input to the development of a poster that summarises the findings of the review. This poster will be used to share review findings with a broad range of stakeholders in a concise way.

15. What codes of behaviour will be put in place?

The work will be conducted in accordance with the Code of Ethics of the Australasian Evaluation Society. The team leader will provide a copy to each of the team members (independent and internal).

Key practices will include:

- Ensuring all those who participate in the review as informants are provided with clear information about the review and what will happen to the information
- Confidentiality will be assured
- Data will be displayed in ways that do not permit identification of the informant
- People will be asked for permission before photos are taken and advised about how these will be used. Copies of photos will be sent to the relevant facility, department, and village
- Where negative findings emerge, these will be discussed with the relevant partners (as a courtesy) prior to the workshop to present the findings
- When visiting health facilities the dignity and privacy of mothers will be respected. For example, team members will not enter any room where a woman is birthing, permission will be sought from women to enter their rooms, and so forth.

References

- Day, N. (2008). Benefits of planning. In Shrimpton, B., St. Leger, P., Campbell, L., Hurworth, R., Owen, J., & Day, N. *Evaluation Practice* (CD). Melbourne, Vic: The University of Melbourne.
- Owen, J. M. (2006). *Program Evaluation: Forms and Approaches* (3rd Edn.). Crows Nest, NSW: Allen and Unwin.
- Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods* (3rd Edn). Thousand Oaks, CA: Sage Publications.
- Patton, M.Q. (2008). *Utilization-Focused Evaluation* (4th Edn.). Thousand Oaks, CA: Sage Publications.
- Shadish, W.R., Cook, T.D., & Leviton, L.C. (1995). *Foundations of Program Evaluation: Theories of Practice*. Thousand Oaks, CA. Sage publications.
- Taylor-Powell, E., Steele, S., & Douglass, M. (1996). *Planning a Program Evaluation*. Madison: University of Wisconsin-Extension.
- Weiss, C. H. (1972). *Evaluation research: Methods for assessing program effectiveness*. Englewood Cliffs, NJ: Prentice-Hall. Cited in Shadish, W.R. Jnr., Cook, T.D., & Leviton, L.C. (1995). Thousand Oaks, CA: Sage Publications.

Annex 9: Methodological changes, limitations and constraints

A mixed-methods approach was used and involved the various techniques outlined in Annex 8, except for the following changes:

- The intended visit to a comparative district did not eventuate because of time constraints. It was hoped that sufficient comparison could be made using available health data. However, data proved to be not sufficiently reliable or up-to-date to enable this to occur.
- The use of other comparative methods was limited to use by the Team Leader because time constraints meant that there was insufficient time for other team members to learn how to use these.
- The network analysis workshop was not conducted because of confusion as to who would be the best respondents for this activity. Once it had been determined that it should be District Program Coordinators, there was not sufficient time to arrange time release nor the travel and accommodation needed by most of these people.
- The proposed number of community engagement activities did not eventuate. The Team Leader was advised that the sessions needed to occur in the local language and not Bahasa. Local facilitators who had some experience of using the proposed “Ten Seeds” approach were engaged. Time to train these people in what was required was extremely limited and further complicated by the need to do this via an interpreter. One community session was held in one location. Whilst this provided some excellent contextual data it did not yield useful informative data for three main reasons. Firstly, despite the session being open to all comers, village leaders had pre-picked participants. Secondly, despite having a script with which to work, the facilitators were confused about the purpose. They normally facilitate the delivery of health information and during this session often veered from the script to information giving. Thirdly, the facilitators are used to using the “Ten Seeds” technique in a different way than was asked for this session and found it difficult to use it in the new way.
- A proposed second community engagement session to be conducted in Bahasa using the Team Leader as the facilitator and an interpreter was not conducted because of a last minute requirement for the Team Leader to visit a different location. Because of the geographic distances, this meant that there was no longer time for her to visit the proposed second community location.
- Data measures were not developed for ‘Capacity, quality and accessibility of health services’ nor ‘good governance’ because of time constraints.
- Generally, data analysis occurred as an ongoing activity, as outlined in Annex 11. However, for much of the time in the field, the review team was not in the same location. This meant that the anticipated daily sessions together did not occur.
- Once the preliminary data analysis was completed, a series of four interactive presentations were held to feedback findings and discuss implications with various stakeholder groups.
- The planned future direction workshop to explore the program theory did not occur. Instead, a half-day session was held with the implementing team to discuss the findings further and explore the program logic, in general terms.
- The proposed session to consider data against the AusAID evaluation criteria was not held. Instead, the Team Leader and Program Manager held discussions once the review had been completed.

Time was a significant constraint. A period of a few days at the beginning of the in-country phase had initially been set aside to allow the team to do such things as: agree upon success criteria; develop interview guides; and determine how to write up notes and analyse them. However, most of this time was lost due to constant pressures to fit more into, and rearrange the schedule because of changing work commitments of various respondents. As a consequence, most of the important planning work was done 'on the run'. This had little impact on the quality of the tools used by the Team Leader because of her evaluation experience or those conducted by the financial management specialist because of her level of expertise in reviewing similar programs and activities. However, it meant that other team members, who did not have much evaluation experience, were constantly struggling to keep abreast of their workload and were often less sure of the comprehensiveness of their data.

As often as work schedules permitted, the Team Leader provided guidance and held discussions with team members either individually or collectively. Because deliberate attention had been paid to different ways to triangulate data¹¹⁷, the Team Leader was confident that sufficient quality data was available to the review team from across all the sources.

¹¹⁷ Four methods of data triangulation were used: i) Data triangulation – the use of a variety of data sources; ii) Investigator triangulation – the use of different evaluators; iii) Theory triangulation – the use of multiple perspectives to interpret the data; and iv) Methodological triangulation – the use of multiple methods and samples.

Annex 10: References

- Atkinson, M. (2005). The Development of a Evaluation Framework for Partnership Working. *The Electronic Journal of Business Research Methodology*. Vol. 3, issue 1, pp. 1-10.
www.ejbrm.com
- Bjurulf, S, and Vedung, E. (2009), *Do public interventions for innovation hit their targets? Evaluating cluster organisations in Northern Central Sweden*
www.ec.europa.eu/regional_policy/conferences/evaluation2009/.../bjurulf.doc
- Blagescu, M.m and Young, J. (2006). *Capacity Development for Policy Advocacy: Current thinking and approaches among agencies that support Civil Society Organisations*. ODI Working Paper 260. London.
- Brinkerhoff, J.M. (2002). Assessing and improving partnership relationships and outcomes: a proposed framework. *Evaluation and Program Planning*, 25, pp. 215-231.
- Buisseret et al cited in Georghiou, L. (2002). *Impact and Additionality of Innovation Policy*. Paper presented to Six Countries Programme on Innovation, Brussels. Spring Conference, 28 February – 1 March.
- Caplan, K., Gomme, J., Mugabi, J., and Stott, L. (2007). *Assessing Partnership Performance: Understanding the Drivers for Success*. Building Partnerships for Development. UK.
- Carson, L. & Twyford, V. (2005) *Improving Accountability for Participatory Processes through Effective Evaluation*, at <http://www.engagingcommunities2005.org/abstracts/Twyford-Vivienfinal.pdf>
- Carson, L. (2009) "Deliberative Public Participation and Hexachlorobenzene Stockpiles," *Journal of Environmental Management*, 90, pp. 1636-1643.
- Cass, N. (2006) *Participatory-Deliberative Engagement: a literature review*, published by the School of Environment and Development, Manchester University, Manchester M13 9PL, UK, at http://www..manchester.ac.uk/sed/research/beyond_nimbyism
- Cavaye, J. (2004) "Governance and Community Engagement: The Australian experience" in Lovan, W.R., Murray, M., and Shaffer, R. (Eds.) *Participatory Governance: Planning, conflict mediation and public decision-making in civil society*. pp. 85-102.
- Cavaye, J. (2005). *Community Engagement – New Insights and Learnings from Practice*, at <http://www.engagingcommunities2005.org/abstracts/Cavaye-Jim-final.pdf>
- Chowdhury, M.E., Ronsmans, C., Killewo, J., Anwar, I., Gausia, K., Das-Gupta, S., Blum, L.S., Dieltiens, G., Marshall, T., Saha, S., and Borghi, J. (2006). Equity in use of home-based or facility-based skilled obstetric care in rural Bangladesh: an observational study, *The Lancet*, 368: pp. 1377-1386.
- Conlin, S., and Stirrat, R.L. (2008). Current Challenges in Development Evaluation. *Evaluation*. Vol 14 (2), pp. 1930208.

De Brouwere, V., Richards, F., and Witter, S. (2010). Access to maternal and perinatal health services: lessons from successful and less successful examples of improving access to safe delivery and care of the newborn. *Tropical Medicine and International Health*, Vol. 15, No. 8, pp. 901-909.

Fritz, Kaiser and Levy, (2009). *Problem-Driven Governance and Political Economy Analysis: Good Practice Framework*. PREM Network, World Bank, Washington DC. Downloadable at <http://vle.worldbank.org/bnpp/en/publications/governance/problem-driven-governance-and-political-economy-analysis>

Gaventa, J., and Barrett, G. (2009). *Citizenship, Participation and Accountability: Mapping the Outcomes of Citizen Engagement*. Development Research Centre, DFID, UK.

Georghiou, L., and Clarysse, B. (2006). Introduction and Synthesis, In OECD [Eds], *Government R&D Funding and Company Behaviour: Measuring Behavioural Additionality*. Paris, Fr: OECD Publishing.

Gill, K., Pande, R., and Malhotra, A. (2007). Women deliver for development. *Lancet*, Vol. 370, pp. 1347-57.

Gorgens, M. and Kusek, J.Z. (2009). *Making Monitoring and Evaluation Systems Work: A Capacity Development Toolkit*. World Bank, Washington, DC.

Graham, W., and Hussein, J. (2006). *Strategies to Reduce Maternal Mortality: No One Size Fits All*. Paper presented at XVIII FIGO World Congress: President's session, Kuala Lumpur, 7 November, 2006.

Hall, J., and Howell, J. (2010). *Working Paper: Good Practice Engagement with Civil Society*. AusAID, Canberra.

Hartz-Karp, J. (2005) "A Case Study in Deliberative Democracy: Dialogue with the city," *Journal of Public Deliberation*: Vol. 1, No. 1, Article 6.

Haws, R.A., Thomas, A.L., Bhutta, Z.A., and Darmstadt, G.L. (2007). Impact of packaged interventions on neonatal health: a review of the evidence. *Health Policy and Planning*. 22:193–215.

Hind, J. (2010). Additionality: a useful way to construct the counterfactual qualitatively? *Australasian Journal of Evaluation*. Vol. 10. No. 1. Pp. 28-35.

Hughes, A. (2002). *Lessons Learnt on Civil Society Engagement in PRSP Processes in Bolivia, Kenya and Uganda*. Brighton, UK.

Hunt, J. (2005). *Capacity Development in the International Development Context: Implications for Indigenous Australians*. Discussion Paper No. 278/2005. ANU. Canberra.

Jayakaran, R. (2008). New Participatory Tools for Measuring Attitude, Behaviour, Perception and Change. in *ROSA Evaluation Journal, Evaluation South Asia*. UNICEF.

Jobin, D. (2008). A Transaction Cost-Based Approach to Partnership Performance Evaluation, *Evaluation*, 14: pp. 437 – 465.

John Hopkins School of Public Health. (2007). *Community-Based Maternal and Neonatal Care Program (CB-MNC): Summative Report on Program Activities and Results in Banke, Jhapa and Kanchanpur districts from September 2005 – September 2007*.

Jørgensen, M. (2006). *Evaluating cross-sector partnership*. Working paper presented at the conference 'Public-private partnerships in the post WSSD context', Copenhagen Business School, August 14, 2006.

Karl, M. (2000) *Monitoring and Evaluating Stakeholder Participation in Agriculture and Rural Development Projects*, at <http://www.fao.org/sd/PPdirect/PPre0074.htm>

Kimmich, Madeleine, (1994). "Collaboration in Action" in Bradley, Valerie J., Ashbaugh, J., and Blaney, B. C. (Eds). *Creating Individual Supports for People with Developmental Disabilities – A Mandate for Change at Many Levels*. Paul Brookes Publishing Co.

Kingma, O. & Beynon, N. (2000). *It Can't Work Without People: Conceptual frameworks for analysing effective relationships between players in natural resource management*, prepared for Land & Water Australia.

Kitgaard, R. (2001). Evaluation of, for and through Partnerships. World Bank conference on *Evaluation and Development: the Partnership Dimension*, Washington, 2001.

Kusek, J.Z. and Rist, R.C. (2001). Building a performance-based monitoring and evaluation system. *Evaluation Journal of Australasia*. Vol. 1 (new series), no. 2, pp. 14-23.

Lawn, J., Zupan, J., Begkoyian, G., and Knippenberg, R. (-). Newborn Survival in Diseases Control Priorities in Developing Countries. <http://files.dcp2.org/pdf/DCP/DCP27.pdf> accessed 18 Nov, 2010.

Lawn, J.E., Cousens, S.N., and Zupan, J. (2005). Four Million Neonatal Deaths: When? Where? Why? Neonatal Series Paper 1. *Lancet*. 365 (9462): 891-900.

McCoy, D., Storeng, K., Filippi, V., Ronsmans, C., Osrin, D., Matthias, B., Campbell O.M., Wolfe, R., Prost, A., Hill, Z., Costello, A., Azad, K., Mwansambo, C., and Manandhar, D.S. (2010). Maternal, neonatal and child health interventions and services: moving from knowledge of what works to systems that deliver. *International Health*. 2: pp. 87-98.

McPake. B., and Koblinsky, M. (2009). Improving Maternal Survival in South Asia—What Can We Learn from Case Studies? *Journal of Health Population and Nutrition*. April, 27(2):93-107.

McPherson, R.A., Tamang, J., Hodgins, S., Pathak, L.R., Silwal, R.C., Baqui, A.H, and Winch, P.J. (2010). Process evaluation of community-based intervention promoting multiple maternal and neonatal practices in rural Nepal. *BMC Pregnancy and Childbirth*, 10:31. <http://www.biomedcentral.com/1471-2393/10/31>.

Makowieccka, K., Achadi, E., Izati, Y., and Ronsmans, C. (2007). Midwifery provision in two districts in Indonesia: how well are rural services served? *Health Policy and Planning*. Pp. 1-9.

Nagao, M. (2006). Challenging times for evaluation of international development assistance. *Evaluation Journal of Australasia*. Vol. 6, No. 2, pp. 28-36.

- NSW Health Department. (2001). *A Framework for Building Capacity to Improve Health*. NSW Health Department Better Health Centre.
- OECD. (2006). *The Challenge of Capacity Development: Working Towards Good Practice*. France.
- Owen, J. (2006). *Program Evaluation: Forms and Approaches [3rd edn]*. Allen & Unwin, Crows Nest.
- Patton, M. Q., (2002). *Qualitative Research & Evaluation Methods [3rd ed]*, Sage, Thousand Oaks.
- Picciotto, R. (2007). The New Environment for Development Evaluation. *American Journal of Evaluation*. Vol. 28, No. 4, Dec, pp. 509-521.
- Ross, L., Simkhada, P., and Smith, W.C.S. (2005). Evaluating effectiveness of complex interventions aimed at reducing maternal mortality in developing countries. *Journal of Public Health*. Vol. 27. No. 4. Pp. 331-337.
- Scotland, G.S., and Bullough, C.H.W. (2004). What do doctors think their caseloads should be to maintain their skill for delivery care? *International Journal of Gynaecology and Obstetrics*. 87. Pp. 301-307.
- Serafin, R., Stibbe, D., Bustamante, C., and Schramm, C. (2008). *Current practice in the evaluation of cross-sector partnerships for sustainable development*. TPI Working Paper No. 1/2008, The Partnering Initiative.
- Statistics Indonesia and Macro International. (2008). *Indonesia Demographic and Health Survey, 2007*. Calverton, Maryland. USA. BPS and Macro International.
- Stern, E. (2004). Evaluating Partnerships, in Liebenthal, A., Feinstein, O., and Ingram, G. (eds) *Evaluation and Development: The Partnership Dimension*, pp. 29-42. New Brunswick.
- Tindana, P., et al. (2007). Grand Challenges in Global Health: Community Engagement in Research in Developing Countries. *PLoS Medicine*. 4 (9).
- UNFPA. (2003). *Evaluation Report #20*. UNFPA's Support to National Capacity Development Achievements and Challenges. Office of Oversight and Evaluation. UNFPA, NY.
- Videria, N., Antunes, P., Santos, R. Lobo, G. (2006) "Public and Stakeholder Participation in European Water Policy: A critical review of project evaluation processes," *European Environment*, 16, pp. 19-31.
- Yarbrough, D.B., Shulha, L.M., Hopson, R.K., and Caruthers, F.A. (2011). *The Program Evaluation Standards: A Guide for Evaluators and Evaluation Users [3rd Edn]*. Thousand Oaks, CA. Sage Publications.