AUSTRALIA – INDONESIA PARTNERSHIP FOR MATERNAL AND NEONATAL HEALTH

Program Design

JULY 2008

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Executive Summary

This document sets out the strategic context, provides an analysis of the problems, and describes the proposed Australia-Indonesia Partnership for Maternal and Neonatal Health (including the management and implementation arrangements). The program of assistance will initially target the province of Nusa Tenggara Timur (NTT) with a possible extension to Nusa Tenggara Barat (NTB) and other provinces. It is based on the Design Framework for a Program of Assistance in Maternal and Neonatal Health (MNH) which was approved by peer review in June 2006, subject to further development of implementation and management mechanisms. A second peer review of the Partnership Design Document was held on 3 April 2008.

A. Context and Analysis

While Indonesia is making progress towards achieving Millennium Development Goal 4 (reducing child mortality), it is currently struggling with the achievement of MDG 5 (reducing maternal mortality) and is unlikely to achieve the target by 2015, without additional resources. The Government of Indonesia (GoI) has nominated reducing child and maternal mortality as priorities in their medium term development plan and the National Making Pregnancy Safer (MPS) Strategy (2001-2010) provides the framework for efforts to reduce maternal and neonatal mortality. 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 provinces of NTT and NTB are generally further behind on achievement of the MPS indicator targets than the rest of Indonesia and have lower government revenues, higher rates of poverty, and poorer health indicators. They also face a number of health system constraints including: dysfunctional referral systems, poor quality and low numbers of key health workforce, poor systems of pharmaceuticals and supply distribution, weak management, and a complex financing system that results in late budget disbursement, lack of operational funds, and frequent inability to expend all the budget allocation. This is exacerbated by poor governance of the system, with weak accountability to clients and communities, pervasive financial irregularities, and lack of a performance focus.

This proposed Partnership will:

- support the Strategic Framework for the Australia-Indonesia Partnership (2008-2013) which aims to ‘strengthen health systems to enable Indonesia to reach the MDG targets for maternal and child health, HIV/AIDS and other major diseases in targeted populations and better manage avian influenza in targeted areas’;
- address a priority need for the GoI, in an area with a high rate of poverty, and poor health indicators;
- build on the experience of previous projects, and on the ongoing program of reform and decentralization of GoI. The Partnership will contribute to significant improvements in health and system outcomes by addressing system constraints, improving system governance, and introducing a performance focus through the provision of appropriate additional resources;

- support and directly address aspects of the broader 'good governance' and anti-corruption focus of Australian assistance' in line with GoI's identification of strengthened governance at district government level as being critical to achieving the MDG's; and
- increase civic demand for improved health outcomes.

B. Partnership Description

This document focuses on the initial 3 years of what is conceived as a longer term Partnership. As a result, both short term (3 year) and longer term (10 year) objectives are identified.

The short term (3 year) objective is that:

Selected provincial and district governments have mechanisms in place to manage national, local and donor resources to achieve national target levels for priority MPS indicators.

The longer term (10 year) objective is that:

Selected provincial and district governments can effectively manage national, local and donor resources to progressively achieve MDG targets for maternal and child health.

Outcomes will occur at different levels:

a) Higher level outcomes: The program will contribute to improvements in maternal and neonatal health shown by reduced maternal and neonatal mortality rates at provincial levels, by improvements in those provinces currently with poorest health.
b) Service delivery outcomes: Increased coverage (access to and utilisation by target population groups) of key maternal and neonatal health service interventions, with a focus on increased outcomes in those districts and sub districts currently with lowest coverage levels; increased understanding of and adoption of healthy behaviours by communities.
c) System management outcomes: Improved management of health system resources, including increased allocation and expenditure of government budgets, improved reporting on service outcomes, improved availability of skilled workforce, improved availability of supplies and equipment.
d) System performance outcomes: Improved productivity of public workforce, and improved identification of and achievement of performance targets.

The partnership will have three components**:**

Component 1: Service Delivery and Community Engagement

Objective: Provincial and district governments develop and implement MNH programs based on the national MPS strategy and address supply and demand aspects to achieve

annual performance targets using an integrated reproductive health approach considering gender equity and equality.

Outcome: National MPS target percentages of women attending antenatal care, receive assistance at delivery, and receive care post partum; 75% of the estimated number of women and newborns with complications receive referral level care and contraceptive prevalence rate (70%).

Component 2: Health Systems Support

Objective: Provincial and district government agencies and communities access and manage the technical, human and financial resources needed to achieve improvements in MNH.

Outcome: Service providers and communities have the resources, skills, technical support and infrastructure needed to improve service delivery and utilisation.

Component 3: System Reforms in Performance and Accountability

Objective: Provincial and district governments manage GoI and donor resources to improve accountability, performance, accessibility and sustainability of public health services.

Outcomes: a) Explicit linking of resource allocations (budgets) to performance targets in annual work plans; b) reliable and transparent reporting of achievements and use of resources against performance targets to communities, parliament and partner donors; c) partner donor readiness to harmonize resource support through GoI systems.

The Partnership will provide funding for provincial and district government work plans for activities designed to reach MNH program targets. For NTT, under component one, indicative amounts of an additional 5% of the district government budget (APBD) allocation to health (up to a maximum of $1 AUD per capita) will be provided for activities in the health work plan and budget. Funds equal to GoI allocations (national, provincial or local) up to a maximum of $0.25 AUD per capita will also be provided for activities supporting community engagement in MNH in work plans and budgets prepared by other (non-health) government agencies. Funds will also be provided under component two for provincial and district government agencies and non government organizations to address health system constraints, improve system financial controls, and improve management and delivery of health system supports.

The Partnership has commenced preparatory activities in 10 districts of the province of NTT with most of its activities covering all subdistricts. Further expansion to other districts will be determined in collaboration with GoI.

C. Implementation and Management Arrangements

The arrangements proposed for the province of NTT are described in detail in this document. It is likely that similar arrangements will apply to NTB and other provinces should the Partnership expand, however the details will need to be based on an assessment of needs and capacities of each province.

Organisational structure and roles

AusAID will independently contract a Maternal and Neonatal Sub national Health Systems Specialist to be located in the AusAID Jakarta office, with frequent travel to NTT. The Specialist will assist AusAID and GoI to address the underlying health system constraints to effective reform of those systems in NTT and potentially NTB.

AusAID will contract a Managing Contractor (MC) who will have responsibility for the implementation of the Partnership at the provincial and district levels with oversight from AusAID and GOI. The MC will source, contract and manage technical and administrative support which will be located within provincial and district governments as much as possible. District Program Coordinators will be placed within government health offices at the district level.

A Performance Review Committee (PRC) will be established at the national level which will be co-chaired by GoI and GoA. The PRC will meet 6 monthly and will provide overall strategic direction to the Partnership. The PRC will make decisions on the continuation of funding to district and provincial governments based on their performance against agreed targets. The MC will provide the secretariat to the PRC. The PRC will include a National Technical Team (NTT) from MoH and AusAID. The National Technical Team will provide technical guidance to the PRC and assist the PRC in monitoring the implementation of the Partnership.

At provincial and district level, the development planning board (Bappeda) and the provincial (PHO) or district (DHO) health office will be the main agencies involved. Bappeda will act as coordinator and manage the planning, funding, implementation and reporting of programs among health and other involved agencies. As the Partnership moves to funding through regular GoI mechanisms the provincial and district government secretariat (Sekda) will become involved.

A Provincial Coordinating Committee (PCC) will coordinate the Partnership at the provincial level, confirm the selection of districts participating in the Partnership, review and agree on the performance outcomes expected for districts and Identify any issues related to coordination with other donor or GoI Programs; or with national level policy, and recommendations on dealing with these issues.

A District Coordinating Committee (DCC) will be set up in each district where the Partnership operates. The DCC will provide oversight to Partnership activities within the districts and address any issues as they arise. The DCC will also act as a forum for the sharing of information and will take primary responsibility in ensuring that coordination and harmonization with other donor programs takes place.

Implementation Process

Support for component one will be based on the district government annual work plans and budgets. The MC will provide technical assistance, guidelines and support in the development of these work plans, and ensure that the planned activities are appropriate and support improvements in MNH service delivery. The funding support will be provided on the basis of provincial and district government agreement to achieve specified levels of target MPS indicators, with further annual funding dependent on satisfactory performance on the previous year's indicators as agreed by the PRC.

The MC will establish an imprest account with signatories from the local government (Bappeda) and the Partnership. Bappeda will transfer funds on an activity or activity package basis to the local implementing agency, with further funds provided on receipt of satisfactory acquittals of expenditure. Following the development of a medium term MNH action plan and finance estimates, and assessment and capacity building of the GoI funding process, the Partnership may move to providing funding as a supplementation to the APBD budget for the MNH annual work plan, paid in quarterly tranches, through the local government finance managers (Sekda and government treasurer). The timing of a move to the use of local government finance systems by the Partnership will be agreed by GoI and GoA.

Support for component two will initially be directly managed by the MC. This will include the recruitment and provision of technical advisors, and the implementation of training and capacity building activities. This may include activities with PHO and DHO, as well as with other agencies and organizations involved in supporting MNH, such as other government institutions, training institutions, and professional and community organizations. Initially, the MC in conjunction with the provincial Bappeda and PHO will undertake an assessment of the health system constraints to MNH service provision, and facilitate the preparation of a province level medium term MNH action plan and finance framework. Further support will be based on the priorities identified in the action plan, and will progressively shift towards inclusion of activities in the relevant local government agency work plan, and funding through the government systems. The funding mechanism for component three will be designed in collaboration with GoI.

Monitoring and Evaluation

Consistent with the agreement between donors and the provincial government in NTT for a harmonized and unified approach to M&E, the Partnership will seek to harmonize with current GoI data collection systems, and coordinate with and use M&E processes developed by other donors. Reporting on most of the MPS indicators is already included in the national health information system. Periodic national level household surveys supplement this information with community level measurements, including estimates of maternal and childhood mortality, and community reports of service use. However, the current monitoring and reporting systems of the GoI are functioning poorly in the selected provinces. Regular monthly reporting from Puskesmas to DHO, and then from DHO to Province has largely broken down; with only incomplete and partial data received. The accuracy and reliability of the data is low, and it uses estimates for denominator populations that can differ significantly from reality.

Additional surveys and audits will be undertaken to complement and provide an independent data source. These will include collaboration with GTZ and other donors on household surveys (an initial survey already undertaken by GTZ in NTB and NTT), as well as third party or peer audits of service standards.

Risks and Risk Management

The Partnership faces significant risks, which the design endeavours to minimize. The major risks include:

- Commitment of local governments to performance improvement and reform. Agreements will be signed with each local government prior to commencement of activities to clarify this commitment. The use of performance indicators and annual assessment of performance and financial controls will enable the Partnership to monitor and respond to government commitment.
- Availability and capacity of key Bappeda and PHO/DHO managers to engage with the Partnership. As the Partnership is essentially the local government's Partnership, it will only proceed at the pace that local government managers can accommodate.
- Poor choice of activities which do not result in achievement of desired outcomes. The Partnership TA will work together with local government staff in developing and reviewing plans of activities to ensure the choice of effective strategies.
- Corruption and misuse of funds. While this is a significant risk, fiduciary risk assessments, regular audits, and the progressive approach to funding support, enable the Partnership to monitor and address these risks.
- Community reluctance to change practices or use services. The integrated supply and demand approach, and the ability to build on other demand incentives such as the CCT Partnership, will focus on changing community attitudes and practices.

D. Next Steps

The Partnership design is now being finalised and will be used as the basis for preparing tender documents for a managing contractor expected to mobilize in late 2008.

Acronyms and Glossary

ADB	Asian Development Bank
ANC	Antenatal Care
ANTARA	Australia-Nusa Tenggara Assistance For Regional Autonomy (funded by AusAID)
APBD	District government consolidated budget
APBN	National government consolidated budget
ASKESKIN	Basic Health Insurance for the Poor Program (operated by PT ASKES)
AusAID	Australian Agency for International Development
BAPPENAS	Badan Perancanaan Pembangunan Nasional (National Development Planning Agency)
BAPPEDA	Regional Development Planning Agency (at provincial and district levels)
BEONC	Basic Emergency Obstetric and Neonatal Care (=PONED)
BKB	District level family planning agency
BKKBN	National Family Planning Board
BLU	Self managing service unit (Badan layanan umum)
BPK	National government audit board
BPMD	Local government community development support agency
BPS	Central Bureau of Statistics
Bupati	Administrative Head of a District
Camat	Head of kecamatan (subdistrict)
CCT	Conditional Cash Transfer (=PNPM Programs)
CDC	Communicable Disease Control
CEONC	Comprehensive Emergency Obstetric and Neonatal Care (=PONEK)
CSO	Civil Society Organisation
DAU	Dana Alokasi Umum (government funds provided from MOF to district governments to fund public services: mainly operational costs covered)
DAK	Dana Alokasi Khusus (government funds provided from line ministries to district governments to primarily fund public infrastructure/equipment – requires 10% local counterpart funding, generally from DAU support)
Dekon	Dana Dekonsentrasi (government funds provided via line ministries to provincial government specifically for the funding of national priorities)
DepKes	Departmen Kesehatan (Ministry of Health)
Desa siaga	Health aware and alert villages
Dewan kesehatan	Health council
DFID	Department for International Development (United Kingdom)
DHA	District Health Accounts
DHO	District Health Office
DHS	Decentralized Health Services Project (ADB)
DHS	Demographic and Health Survey
DinKes	Dinas Kesehatan (Provincial/District Health Office)
DPRD	Dewan Perwakilan Rakyat Daerah (Provincial/District Level Parliament)
Dukun	Traditional birth attendant
GoA	Government of Australia
GoI	Government of Indonesia

GTZ	Deutsche Gesellschaft fur Technische Zusammerarbeir (German Technical Development Assistance Agency)
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRD	Human Resource Development
HSS	Health System Strengthening
IMHEI	Improving Maternal Health in Eastern Indonesia (UNICEF)
IMR	Infant Mortality Rate
Kabupaten	District; headed by bupati
Kader	Village level volunteers
Kecamatan	Subdistrict level of administration; headed by camat
LBW	Low birth weight
M&E	Monitoring and Evaluation
MC	Managing Contractor
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MNCH	Maternal and Neo-Natal Child Health
MNH	Maternal and Neo-Natal Health
MoF	Ministry of Finance
MoH	DepKes (Ministry of Health)
MOU	Memorandum of Understanding
Musrembang	Community development planning meeting
MPS	Making Pregnancy Safer
NHA	National Health Accounts
NTB	Nusa Tenggara Barat Province
NTT	Nusa Tenggara Timur Province
PEACH	Public Expenditure Analysis and Capacity Enhancement (AusAID)
PHC	Primary Health Care
PHO	Provincial Health Office
PKH	Program keluarga harapan - Household Grants Program
PMU	Performance Monitoring Unit
PNPM Generasi	Program nasional pemberdayaan masyarakat – Community Grants Program
Polindes	Village Birthing Centre
PONED	Basic Emergency Obstetric and Neonatal Care (=BEONC)
PONEK	Comprehensive Emergency Obstetric and Neonatal Care (=CEONC)
Posyandu	Integrated Health Post
PP	PerDa or Peraturan Daerah (local regulation)
PRC	Performance Review Committee
PRMAP	
Puskesmas	Community Health Centre (at the sub-district level)
Pustu	Sub-Health Centre
RPJM	Medium Term Development Strategy
Sekda	Local government executive secretariat
SHI	Social Health Insurance
SISKES	Improvement in District Health Systems in NTT/NTB (GTZ)
SKPD	Local government agency or department

SPJ	Expenditure acquittal report for an activity
SPM	Minimum Service Standards
SUSENAS	Social and Economic Household Survey (a survey conducted periodically by BPS in every province and district of Indonesia)
Swadana	Self managing government unit
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHFW	Women's Health and Family Welfare
WHO	World Health Organization

1. Introduction and Background

This document sets out the design for the Australia – Indonesia Partnership for Maternal and Neonatal Health (Partnership). The main text contains the context analysis, recommended approach, and a description of the Partnership design and Partnership components. The annexes contain more specific analysis of the situation in the province of Nusa Tenggara Timur (NTT) where the Partnership has commenced preparatory implementation. It is anticipated that similar analysis will be prepared for NTB and other provinces should the Partnership extend beyond NTT.

AusAID has been supporting the Government of Indonesia (GoI) in the area of maternal and child health (MCH) since 1995, through a series of projects in the provinces of NTB, NTT, South-east Sulawesi, Maluku and Papua. These projects have now largely concluded, with the Women's Health and Family Welfare (WHFW) project in the provinces of NTB and NTT finishing in mid 2006. A design mission in March 2006 reviewed the situation in NTT, and recommended the need for a program of further assistance in maternal and neonatal health (MNH) to the greatest areas of need with a particular focus on the province of NTT[1]. The design concept prepared by this mission was approved at peer review, subject to clarification of implementation and management arrangements.

Preparatory steps for the Partnership commenced under direct AusAID management in early 2007 which included the appointment of a Regional Health Coordinator (RHC) and the subsequent establishment of an administrative support team, the selection of three districts (Sikka, Ende and Sumba Timur) by the provincial government for initial implementation, and planning missions in the areas of midwifery and district level planning and budgeting. In November 2007, AusAID contracted a design team for the national health system strengthening (HSS) program and asked this team to review and finalize the design document for the MNH Partnership with a view to identifying potential linkages with the HSS Program. A follow up mission was undertaken in January 2008 to consult with NTT counterparts on the proposed design framework and to finalise the design document.

2. Analysis and Strategic Context

2.1 Country and Sector Issues

Indonesia has passed through dramatic changes over the last ten years, including the economic recession of 1997, the downfall of Suharto and replacement with a democratically elected government, and the progressive implementation of significant decentralization of government since 2000.

The latest national medium term development plan (RPJM 2004 – 2009) situates health as part of one of the three key strategies, to provide for the welfare of its citizens. Maternal and child health remain central to the health sector strategy, with reduction in infant mortality

[1] Design framework report for a program of Assistance In Maternal and Neonatal Health in Nusa Tenggara Timur. June 2006.

(IMR), maternal mortality (MMR) and childhood malnutrition as key health targets of the plan.

However, as the National Planning Board (Bappenas) noted in recent presentations on the health sector[2], progress is uneven, and there are still significant health system challenges. While the IMR has fallen from 52/1000 in 1997 to 35/1000 in 2002-03 and appears on target for the RPJM target of 25/1000 in 2009, progress on MMR and childhood malnutrition appears to have stalled. The latest MMR estimate of 307/100,000 for 2002/03, based on the sisterhood method, has been recently revised to 420/100,000 by WHO[3] and does not demonstrate statistically significant change since the figure of 334/100,000 in 1997. This is supported by little change in the key service indicator of the proportion of deliveries assisted by a trained attendant, which has only increased from 67% in 2000 to 72% in 2006.

The key challenges facing the health sector are essentially those set out in the RPJM and include:

- Inequalities in health status, with significantly worse health status for the poor, populations in the more rural and remote areas, and in Eastern Indonesia;
- The double disease burden, of increasing non communicable disease, with persistent communicable disease and maternal-perinatal health problems;
- Poor performance of public health services in delivery of services;
- Poor health status and access to services for the poor;
- Community attitudes and behaviours which do not support healthy lifestyles and practices;
- Poor environmental health;
- Inequalities in quality and access to health services; and in distribution of health workforce across Indonesia;
- Relatively low allocation of public finance to health.

In addressing these challenges, the GoI has undertaken a series of significant interventions. The Ministry of Health (Depkes) released a strategy for Healthy Indonesia 2010 in 1999, which focused on achieving health benefits from development, particularly for the health of infants, children and mothers. Strategies included focusing public health services on 'public goods' services, while entrusting individual care more to the private sector; improving the performance of the health workforce; and the establishment of health insurance to improve equity in access within affordable costs as a means to improve community contribution to health finances; progressive development of health facilities as self-managed facilities (swadana); improvement in health services management, including re-aligning health organizations with their functions, and delegation of authority to regions in line with decentralization.[4]

The GoI has also progressively increased the national budget allocation for health, both through allocation to Depkes, and more recently through the social health insurance

[2] Experience of 7 years of decentralization in health: what direction for the future. Presentation by dr Arum Atmawikarta, Director Health and Community Nutrition, Bappenas. Decentralisation in Health Forum, Bali, August 2007.
[3] Maternal Mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and World Bank. (2007) www.who.int/reproductive-health/publications/maternal_mortality_2005/index.html
[4] Healthy Indonesia 2010 at www.depkes.go.id

program. The total central health allocation has increased five fold between 2001 and 2008, and the amounts provided to provincial and district health services through deconcentration funds (dana dekon) and special allocation funds (DAK) have doubled. Local government allocations to health also appear to have increased; with a doubling of the allocation in four provinces where the amounts were calculated (which includes NTT).However expenditure of these increased funds has emerged as a problem, with only 50 to 70% of central allocations actually expended in 2005 and 2006.

The GoI has also been progressively developing the administrative and regulatory framework for decentralization, which provides a basis for improving performance of public health systems. Key elements of the 'grand strategy' for decentralization and regional autonomy being progressed by the government[5] include:

- clarification of the functions of government at central, province and district level as central functions; concurrent (shared functions); and decentralized functions. Health is a concurrent function, and the contributions of different levels of government have been set out in regulation PP 38/2007;
- clarifying the appropriate sizes and types of government institutions at regional government levels, set out in regulation PP 41/2007;
- reorganization of the public services, with a policy of minus growth, and emphasis on competency standards and career development;
- improving provision of public services, through the establishment and use of minimal service standards (SPM) as a basis for planning and budgeting through PP 65/2005;
- national plan of action of fiscal decentralization (RANDF) which aims to provide a framework to improve the efficiency and equity of fund flows from centre to regions;
- collaboration among regional governments as an innovation in addressing resource constraints to provide services.

Of particular relevance to this Partnership is the increasing emphasis on SPM as the basis for planning and budgeting, with the preparation of instruments and guidelines for planning and budgeting, training and monitoring of implementation of the SPM. The health SPM are currently under revision, but it is understood that the key indicators for services to infants and mothers such as antenatal care and assisted delivery coverage, are likely to be retained in the revised version.

Health Insurance for the poor

The GoI is also progressively developing a national health insurance scheme, based on the national social insurance law 40/2004. Social safety net support for the poor to access health services has been expanded via the national social health 'insurance' for the poor (Jamkesmas), now administered by the Ministry of Health (MOH). The previous scheme (Askeskin), was administered by PT Askes, and provided payment for health services used by the poor enrolled in the program.

In 2007, the number of poor enrolled in the Askeskin program increased to 76.4 million, nearly one third of the total population. While there are still problems with identifying and enrolling the poor, with some poor excluded and non-poor included, the scheme provides significant support for the poor to access health services, as well as additional resources to

[5]Handbook of the Administration of Government and Regional Development. Government of Indonesia (2007).

health care providers who provide services to the poor. The poor are currently identified based on information collected by the Bureau of Statistics (BPS). The scheme covers hospital inpatient and ambulatory primary health care services for members; and inpatient primary health care services (including delivery care), plus a capitation payment for public health services provided by Puskesmas. Hospital providers were reimbursed directly by PT Askes on the basis of claims submitted; funding for Puskesmas was transferred through Depkes in 2007.

In 2008, the Jamkesmas program pays providers (mainly publicly owned and operated) directly after a review of the individual claims by either ASKES claims processors or independent processors hired directly by the Ministry of Health at the sub-national level. This change was thought to improve efficiency and the timeliness of payment relative to the Askeskin approach.

Conditional Cash Transfer (CCT) program

The GoI commenced a pilot of CCT programs in seven provinces, including NTT, in 2007. The program has two approaches:

- CCT – Households (program keluarga harapan – PKH)
- CCT- Communities (program nasional pemberdayaan masyarakat – PNPM Generasi)

Under these programs, payments are made to poor families or to poor communities that fulfil various health and education conditions. The health conditions are closely aligned with MNH services. For example, for PKH, pregnant women must attend antenatal care according to the MoH protocol; and children under 6 must attend health clinics and utilize health services as advised by MoH. For PNPM Generasi grants are provided to communities (average annual grant USD 8,400, although USD 2000 in NTT) on the basis pregnant women must make 4 ANC visits, receive iron tablets, be delivered by a trained attendant, and receive two post natal visits; infants must record monthly weight increases, and children under three must be weighed monthly and receive 2 vitamin A capsules per year.

Villages are assisted to plan use of the grant, which could include MNH supporting activities, such as transportation subsidies for midwives; subsidies for mothers using health services; and infrastructure and tools for posyandu.

Targeted provinces

Initially the target province is East Nusa Tenggara (NTT) with the possibility of extension to West Nusa Tenggara (NTB) and other provinces based on need. NTT and NTB contain some of the poorest districts in Indonesia, with the poorest health status. The proportion defined as poor is above 25% in NTT and NTB and these provinces have relatively weak economies and low capacity to raise their own resources, with GDP per capita levels below 30% of national levels in NTT (See Data Table at Annex 1).

The latest infant mortality estimates (from the DHS 2002) are well above the national average of 35/1000, with NTB nearly double at 74/1000. The latest MMR estimates by province which apply to 1997, indicate that the MMR in NTT (554/100,000 live births) and in NTB (390/100,000 births) were above the national average at that time of 334/100,000.

Maternal care coverage indicators are also below national averages, particularly for 4 ANC visits (70.3% compared to 77.1%) and delivery assisted by trained attendant (63.9% compared to national average of 72.4%). NTT performs poorly in trained deliveries (See Data Table at Annex 1).

2.2 Problem Analysis

The overall framework for addressing MNH challenges and services is provided by the National Strategic Plan on Making Pregnancy Safer (MPS) Indonesia 2001 – 2010. This framework sets out outputs and activities for national, province and district levels, and remains the basic planning framework for MNH in provinces and districts.

The plan identifies gaps in MNH service provision, in MNH service utilization, financing of MNH services, and gaps in political and policy commitment, and provides a list of effective interventions from which individual districts can select those most appropriate to their situations. The MPS strategy builds on the earlier Safe Motherhood Initiative, but is a health sector strategy 'which focuses on a systematic and integrated planning approach to address the key clinical and health systems interventions necessary to reduce MNH morbidity and mortality'.

The mission of the National MPS strategy is 'to reduce MNH morbidity and mortality in Indonesia by strengthening the health system to ensure the access to and provision of quality cost-effective evidence based interventions; empowering women, families and communities, and promoting MNH as a priority in the national development programs'.

The four main strategies are to:

1. Improve access to and coverage of quality care that is cost-effective and evidence based;
2. Build effective partnerships through intra sectoral, inter sectoral and other partner collaborations to advocate for and to maximize available resources and strengthen coordination of plans and activities in MPS;
3. Encourage women and family empowerment through improving their knowledge to ensure appropriate practices and utilization of MNH services;
4. Encourage community involvement in ensuring the provision and utilization of MNH services.

The key evidence based interventions nominated are:

- The availability of trained health providers to assist deliveries;
- Basic and comprehensive essential obstetric and neonatal care; and
- Prevention and management of unwanted pregnancy and unsafe abortion.

The plan provides targets for key health outcomes (maternal and neonatal mortality) and for key health services (antenatal care, assisted deliveries, basic and comprehensive obstetric and neonatal care – BEONC, CEONC).

Indonesia is unlikely to achieve the MPS targets as set out in the MPS strategy by 2010. Reporting on other key aspects of the MPS program is incomplete or unknown, due to the non - availability of data on facilities providing BEONC and CEONC, budget allocated to

MNH, and social and community actions. Definitions and data collection / reporting systems have not yet been established for these aspects.

The main problems and issues facing the health system and health service delivery in Eastern Indonesia include:

a) Health Services

- Coverage of the initial visit for antenatal care (ANC) is generally good, and up to target, although many initial visits occur late in pregnancy and strictly should not be included in the initial visit indicator. However, coverage of the recommended four ANC visits is lower and below targets and recent surveys in NTT and NTB[6] have indicated low levels of coverage of the 5 key ANC interventions, such as tetanus immunization, and provision of iron tablets, raising questions about the quality of the services provided.
- Coverage of assisted deliveries is generally fair, but these are mainly home deliveries, with low rates of facility deliveries.
- Low rates of referral of women with complications of pregnancy or child birth.
- Not all Puskesmas with beds or district hospitals are capable of providing the required levels of BEONC / CEONC; or providing management of complications of unsafe abortion
- Low rates of coverage with modern contraceptives, particularly in NTT.

b) Community

- The populations tend to have high rates of pre disposing risk factors, such as early age of first pregnancy and high parity pregnancies, and poor underlying nutrition, with high rates of maternal anaemia and malnutrition. As a result, rates of low birth weight (LBW) infants are also relatively high.
- Fertility rates tend to be higher than in the rest of Indonesia, and rates of unwanted pregnancy were also high in the recent survey. This raises the possibility of induced abortions, although data on this issue is scarce.
- Cultural beliefs strongly favour the use of traditional birth attendants, and home delivery, and lead to reluctance to accept referral to hospital.
- Women face significant constraints in participating in decision making, or in accessing services, due to gender based inequalities in power and access to resources.
- Significant geographic and cost barriers to access referral services were noted in the original design concept.

c) Health System

1) Poor functioning of the referral system, which provides the continuum of care from the primarily level (village) to Puskesmas and to District Hospitals. The issues of community reluctance to be referred, transportation and geographic obstacles, low capacity of services to manage maternal and neonatal complications, are compounded by the separation of hospital and community health service management. Hospitals are not under the authority of the head of the district health office (DHO) and report directly to the head of the district government (Bupati). They have thus little incentive to consider their role in the referral system, or to provide

[6] *Maternal and child health practices and care seeking behaviour in NTT and NTB*, Centre for Health Research, University of Indonesia, funded by GTZ, 2007.

support and supervision to community level staff. The recent moves to become self managing units (BLU) may further reduce their interest in supporting community level services. The new government regulations (PP38/2007 and PP 41/2007) provide a framework for clarifying the relationship between DHO and district hospitals, but this will require the preparation and enactment of local supportive regulations.

2) Health workforce weaknesses. Eastern Indonesia suffers from difficulty in attracting particularly medical and specialist medical workforce in rural areas. While this is less of a problem for nurses and midwives, new graduates from training institutions tend to have poor skills, and need in-service training. The capacity and quality of pre-service and in-service training facilities is low, and many staff rarely receive skills upgrades. The system lacks incentives for good performance or sanctions for poor performance, and a supervisory and performance management capacity.

3) Some support components of the health system function poorly, particularly in the areas of the supply of medicines and equipment and the maintenance of infrastructure and facilities. Many facilities lack key amenities such as water and toilets, and are frequently short of essential medicines and supplies. In particular, distribution of contraceptives has been hampered by the decentralization of the previously centralized family planning service (BKKBN), and the uncertainty about its institutional presence at district level.

4) Weakness in management at the levels of Puskesmas, District Health Office, and District hospitals, and poor function of key management support systems. The collection and reporting of health data through health information systems does not function well despite significant time spent by staff in completion of reporting forms. The complex and protracted annual planning and budgeting process still does not result in well developed plans or budgets linked to performance indicators. Plans tend to be incremental on previous years, and activity based, rather than linked to achievement of the SPM; and subject to sometimes arbitrary deletions in the final stages by district planning bodies (Bappeda) and parliaments. There is a lack of a well developed medium term strategic plan, accompanied with reliable estimates of budget needs and expenditure frameworks, as a basis for the annual work plans.

5) Resource constraints. Finally, the complexity of the funding mechanisms for public service provision, from central, provincial and district levels, leads to funding constraints, despite increasing allocations. This is despite the paradoxical under-spending of allocated funds, particular of funds from central level. However, the lack of reliable reporting of fund allocations and expenditure does make it difficult to provide accurate figures.

As an example, the following table sets out estimates of the funds available in the Province of NTT for health in 2006. It is based on reports in the Provincial Health Profile, as well as National level reports, but as the notes to the table indicate, inconsistencies and gaps in the reports have required assumptions in order to prepare estimates. These amounts are budgeted amounts, and expenditure is probably below this. For example, expenditure of Dekon funds was reported as 70% and of DAK, 48%.

Table 1 Estimates of levels of funding for health programs in NTT 2006

Source of Funds	Rp '000	Rp per capita	AUD per capita
APBD (District Government)[7]	375,535,331	86,228	11.50
APBD (Provincial Government) [8]	86,688,019	19,905	2.70
APBN (Central Govt – Dekon) [9]	87,741,318	20,146	2.70
APBN (Central Govt – DAK) [9]	105,600,000	24,247	3.20
Askeskin [10]	31,828,104	12,000	1.60
Total	687,392,772	157,836	21.00

d) Public Administration

The resource shortfalls and under-expenditure noted in the health sector are the result of constraints in the system of public administration, which affects all sectors.

Factors contributing to the insufficient allocation of budget to health, and the under-expenditure of the allocated funds, include:

- Delays in the disbursement of funds, due to late receipt of centrally allocated funds, delays in finalization of district level budgets, and slow disbursement at district level due to lack of administrative staff or lack of capacity. [11] These delays contribute to difficulties in expending the funds, which need to be expended within the financial year of disbursement.
- Conditions on the use of funds: DAK funds may only be used for infrastructure, and require a 10% counterpart contribution from local government; Dekon funds may only be used for service development of 'devolved' functions, such as meetings, seminars etc
- Local government funds (APBD) are mainly allocated to the costs of wages and salaries (80%), which together with the counterpart requirement for DAK, means that there is little funds available for recurrent operational expenses.
- Askeskin reimbursements generally provide salary enhancements for staff, and are not often used to address operational service needs.

The health sector is also impacted by broader weaknesses in public administration, these include:

- Weaknesses in budget preparation and parliamentary approval. As indicated in the earlier design framework, there is no agreed formula for the allocation of funds according to needs or to relate future funding to performance. Allocations are frequently altered by national or local parliaments in response to local political agendas. This may result in deletion of activities which need to be implemented in order for subsequent

[7] Based on extrapolation of average rates from Health Profile reports 2006 (Sikka, Ende, Sumba Timur) – probably excludes hospital budgets which could add an extra 20 – 25%. Note differs significantly from estimates in design concept paper. (Average Rp per capita Rp 125,000)
[8] Based on presentation on APBD funding by PHO July 2007- includes provincial hospital (74%)
[9] Based on NTT Health Profile 2006
[10] Based on minimum allocation of Rp 12,000 per eligible poor person reported by Ende 2006
[11] Report on health planning in Sikka, Sumba Timur and Ende, NTT, October, 2007.

funded activities to be implemented. As a result the subsequent activities cannot be implemented, contributing to under-expenditure.

- Financial irregularities and weaknesses in financial controls. Challenges exist around financial controls. Improved financial systems and controls will minimize irregularities in spending and provide for a more transparent system including decisions on contracting and procurement.

- Performance, and accountability for services or use of funds. Budget allocation to government agencies is maintained irrespective of performance, and permanent public servants rarely face sanctions for poor performance. There is little provision or capacity for civil society oversight of government agency performance, or accountability of service providers to clients or the community served.

The **National Making Pregnancy Safer Strategy** provides a framework for an 'integrated and systemic' approach to achieving improvements in MNH, which addresses both community and health service aspects, and provides a 'continuum of care' from home to referral hospital. It is consistent with best practice and international evidence, and commences to address some of the underlying health system issues.

However, the strategy does not appear to be significantly used in guiding MNH program development at province and district levels. Constraints to the use of the strategy include:

(1) The lack of guidance for prioritizing and systematically implementing the strategy. The strategy resembles a 'menu' of interventions, and does not provide a structure for selection of interventions, or for developing a medium term investment plan for progressive implementation over a series of annual work plans;
(2) The lack of attention to the resources required for its implementation. The strategies are uncosted, and there is no expenditure framework to estimate resources available to guide the development of a medium term investment plan. Allocation of resources is not matched to need, nor linked to performance;
(3) Despite the acknowledgement of the need to address underlying health system constraints, the MPS strategy only proposes outputs and activities around planning, and human resource issues. Health system capacity constraints continue to hamper implementation.

Thus the requirements to implement the MPS agenda at province and district level include:

- Improvements in planning and financing, particularly support to managers in preparation of plans and budgets, including adequate information on current needs, the development of a costed medium term investment plan, estimates of financial requirements, and finances available;
- Improvements in other components of health systems, including human resources, supplies of medicines and equipment, revision to policies and regulations, and coordination among the components of the health system;
- Adequate resources, both financial and technical. Technical assistance is needed for managers in planning and financing implementation, and in addressing the other health system constraints. Additional finance, particularly to address operational expenditure, and to better link needs and performance to funding;

- Improvements in public administration, in particular in budget preparation and approval, financial controls, and performance oversight and accountability.

2.3 Government of Indonesia and Donor Programs

Government of Indonesia Programs

Since 2005, the Ministry of Health has focused its efforts on four priorities ('the four pillars'):

(1) Motivate and empower communities to live healthily; every village becomes a *desa siaga* (alert village) as a step towards a healthy village;
(2) Improve access to quality health services; every poor person receives a quality health service; all villages have adequate health staff and supplies;
(3) Improve monitoring, surveillance and health information systems; reporting of outbreaks, response to outbreaks; food and environment safety; and
(4) Increase funding for health; APBN and APBD 15% to health; social insurance.

While the focus on primary level services and access to the poor is welcome, concerns have been raised about the appropriateness of the desa siaga model to all regions of Indonesia, and the efforts to re-assert central control over budget allocations through increased national budget allocations. In addressing some of these issues Dr Sri Hermiyanti, the Director of Maternal emphasized (in 2007), the need for:

- Delivery in health facilities, particularly those with capacity to assist delivery, such as Polindes and Puskesmas with Basic Obstetric and Neonatal Emergency Care (PONED) capacity, as appropriate to each region's conditions;
- Providing more authority to health care providers at the Primary Health Care (PHC) level to undertake necessary measures to save lives of mothers and newborn;
- Ensuring a functioning referral system from Puskesmas PONED to District Hospitals with Comprehensive Obstetric and Neonatal Emergency Care (PONEK) ;
- Allocation of funds to enable operational activities to support MNH services, integrated with other Partnerships;
- Cultural and gender analysis to develop appropriate Partnerships for specific areas.

Further information on Indonesian Government programs in NTT is at Annex 4.

Donor Programs

AusAID

Women's Health and Family Welfare Project

The Women's Health and Family Welfare Project (WHFWP) finished in 2006, having operated in 6 districts in NTT. The project built relationships and infrastructure (in particular in-service training centres) which can be used by the Partnership (five of these districts have been selected to continue work in).

Health System Strengthening Program

This Partnership addresses health system constraints and health systems strengthening by working with provincial and district governments with a focus on achieving MNH service outcomes. The HSS Program proposes to adopt a more generic and 'systems' approach to identifying and addressing health system constraints. The HSS Program will have an initial focus on health financing and proposes to support the development and conduct of District Health Accounts in selected districts throughout Indonesia, including within the province of NTT. This would support Partnership activities to improve financial accountability, planning and budgeting, and to develop estimates of future finance requirements. The HSS Program clearly provides a potential area of collaboration. Further areas of collaboration will be identified as the HSS Program design progresses.

Australia Nusa Tenggara Assistance for Regional Autonomy

Australia Nusa Tenggara Assistance for Regional Autonomy (ANTARA) works in 7 districts in NTT – Sumba Barat, Manggarai Barat, Flores Timur, City of Kupang, TTS, TTU and Belu and focuses on 3 main areas: provincial and district governance, peri-urban and rural incomes; and access and quality of basic services (specifically health and education). Several of the outputs for the Assistance interrelate closely to AIPMNH including; improving provincial and district capacities in planning and financial management and financing and, monitoring and delivering basic health services at district level.

AusAID supports the World Bank's Public Expenditure Analysis and Capacity Enhancement (PEACH) program. PEACH is a participatory Regional Public Expenditure Analysis that is followed by a set of capacity building activities. The emphasis of PEACH is on its participatory nature, which is aimed at increasing local ownership and building local capacity. The PEACH teams have recently undertaken public expenditure reviews in 7 districts in NTT and is being managed and supported by ANTARA. A mechanism will be developed to ensure PEACH is rolled out in the same districts as the Partnership so that the public expenditure analysis and capacity building activities dovetail with planning and budgeting activities of this program.

Delivery Improvement and Local Governance Project (DIALOG)

The goal of DIALOG is to improve the quality of public service delivery and public financial management in participating regions. It will operationalise a local government (LG) monitoring and evaluation system with central and provincial governments and pilot a system providing incentives to LGs based on improvement in performance. The project will focus on supporting reforms in public financial management, budget transparency and the budget preparation process as well as public service delivery (PSD). In PSD, the Project will provide support to enable improved medium term planning and resource allocation in health and education sectors with a view to improve access and quality of these services. Component Three of the Partnership which will include the designing of a system of incentives for funding will collaborate closely with Dialog as it is being implemented.

Linking with other donors

There are increasing efforts from all donors to support the government efforts at all levels to improve donor coordination, harmonization and alignment in maternal and neonatal health. The Health Partners in NTT and NTB Expression of Intent signed between GoI and all major donors (including AusAID) aims to:

- Make the Provincial Health Master Plans the guiding document for joint provincial health planning, implementation, monitoring and evaluation;
- Ensure partner's inputs are designed in a manner that supports the outputs of this plan and are harmonized and aligned with existing support to the health sector;
- Coordinate research, undertake joint progress reviews, planning, monitoring and, evaluation on the basis of agreed indicators.

The Master Plan is still being developed by GoI and donors. It is envisaged that a single monitoring and evaluation framework will also be developed. AusAID is encouraging and supporting the provincial government to further strengthen coordination among donors and harmonization of programs. The Provincial Coordination Committee meetings are a good start and it is hoped that these can be mirrored at the district level.

The Partnership is already collaborating closely with other donors including GTZ, UNICEF and ADB at the national level (especially required for more strategic engagement) and there continues to be joint implementation of activities, monitoring and evaluation and the sharing of lessons learnt at the provincial and district level.

GTZ

GTZ's Improvement of the District Health System in NTT and NTB with a focus on Maternal and Neonatal health (SISKES PLUS) has the objective that the population in the provinces of NTT and NTB, especially the poor, women and children, use quality health services. GTZ's programs include:

(i) SISKES: integrated health planning support in all NTT districts (funded by Germany and DfiD);
(ii) SISKES: health centre and hospital management support – selected Puskesmas in districts including Sumba Timur (funded by Germany and DfiD)
(iii) SISKES: MPS services, desa siaga – all districts of West Timor and Rote (funded by DfiD).
(iv) HRD: human resource development, support for training institutions – all districts + Province. (funded by dfiD).

GTZ provides human resource development in MNH in the districts which AusAID is not providing support to the health sector. This includes training in clinical areas, clinical quality improvement programs, and management improvement in Puskesmas and district hospitals.

AusAID will continue to coordinate closely with the GTZ in all areas including planning, budgeting and referral activities (which are broader than MNH). GTZ will phase out assistance in the health sector in Indonesia at the end of 2009 and AusAID is in discussion

with them on reducing the impact of this withdrawal. GTZ have expressed interest in working towards a sector wide program and AusAID are keen to partner with them on this.

KfW

KfW will provide furnishing and equipment for Puskesmas and Pustu in many districts in NTT and NTB in 2008. GTZ and KfW have also provided hospital equipment and have trained equipment maintenance teams in the district hospitals, who could supervise, maintain and repair the new equipment.

UNICEF

UNICEF's Improving Maternal Health in Eastern Indonesia (IMHEI) Program (funded by AusAID) has been operating in 4 districts of NTT (and five districts of Papua) since mid 2004. The Program aims to strengthen health systems, ensure quality maternal and neonatal health service delivery and create an environment in which government, civil society and communities work in partnership to improve pregnancy and birth outcomes. It has been using district level memoranda of understanding (MoU) and service agreements with Puskesmas in an effort to better align with GoI Programs. UNICEF focuses on making pregnancy safer interventions, as well as a district team problem solving approach to planning, and adolescent reproductive health. UNICEF is also developing a program which will address malaria in pregnancies and will commence in all districts in 2008. While AusAID has not been working in the same districts as UNICEF, this will change in the future and both organisations have agreed to coordinate activities and a joint approach to working within GoI systems.

UNFPA

UNFPA will be a key collaborating partner with AusAID in NTT where they have a reproductive health program in 5 districts.

ADB

ADB's Second Decentralized Health Services Project (DHS2) will strengthen local capacity to deliver quality health and family planning services. The loan is aimed at all districts in NTT and NTB and aims to create a structure to ensure better equity, quality and financial sustainability of decentralized health care, and help the Ministry of Health (MoH) and the National Family Planning Coordinating Board (BKKBN) support regional governments in delivering quality health services to the poor.

GoI and World Bank

The Conditional Cash Transfer / PNPM Program will be expanded to all districts in 2008. This Program provides a significant potential vehicle to increase demand for health services.

2.5 Rationale for the Partnership

The rationale for AusAID assistance to maternal and neonatal health includes:

- a clear need to improve service delivery and health outcomes, which is consistent with priorities in the Australian government assistance program, and with priorities in the development program of the Government of Indonesia;
- A clear need for assistance to Indonesia to achieve MDG 4 in relation to maternal mortality and this is consistent with the Australia-Indonesia Partnership goal of supporting achievement of the MDGs;
- There is significant potential to improve system functions, service delivery and community utilisation, and to contribute to improvements in health outcomes, and the social and economic conditions of poor communities.

The basic elements and framework for supporting GoI MNH activities have been established. The National MPS strategy which was developed by GoI in collaboration with donors and the UN provides a program for service improvements. The strategy is consistent with international best practice and recommendations of the UN Millennium Taskforce on achieving maternal and child health MDG's. The activities set out in the strategy have been the basis for district level planning and donor support throughout Indonesia, and the indicators and targets of the strategy have been incorporated into the National Minimum Service standards.

GoA assistance could assist the GoI in implementation of the National MPS strategy in the following ways:
(a) Judicious additional funding for provincial and district governments to accelerate implementation of MNH programs, address current gaps in funding (particularly operational funding) and assist in the better use of government and other donor funding;
(b) Technical support and capacity building to assist the GoI in addressing health system constraints and weaknesses, particularly in areas of planning, budgeting, monitoring and reporting, health workforce training and management, and logistics;
(c) Technical support and resources to enable improvements in performance accountability of provincial and district administrations particularly through reforms in financial accountability, and performance based funding;
(d) Technical support and advocacy with other donors and multilaterals to enable local government to better coordinate donor supports, and to move towards harmonized sectoral support in the health sector.

Issues considered:

(a) AusAID has been involved for over a decade in assistance projects in the area of women and children's health. However, while there were significant gains during this time, the Government has not made sustainable improvements in service delivery or health outcomes. Despite developing some useful approaches, including the 'birth planning program' / midwife – dukun partnerships, community based desa siaga, and contraceptive supply improvements of the WHFW project, these approaches have not been adopted more broadly, and facilities targeted in earlier projects have not always maintained improvements, as staff are transferred, and insufficient operation and maintenance resources allocated.

It is considered that these failures are the result of insufficient government allocation of resources (both funds and workforce), underlying system constraints and weaknesses, particularly a lack of focus on performance improvement, and a implementation approach that was parallel to but outside government systems and which did not improve system performance. The Partnership approach with a focus on systems, coupled with GoI investments in improving systems and increasing resources, should overcome these issues.

(b) While there are other donors, particularly in NTT, providing assistance in the area of maternal and child health, assistance is provided on a per district basis, and there remain districts where no donors are providing assistance. The programs of other donors still tend to focus on developing new models and interventions and there is the opportunity for this Partnership to support GoI in adopting and implementing more broadly these models and interventions.

(c) The issue of low capacity of local governments to absorb and use additional resources. Reports that the provincial and district health offices have been unable to fully expend additional funds provided by the central government (Dekon and DAK funds) raise concerns that additional donor funds may also not be expended. Management and administrative staff and capacities are limited in a number of the provinces, particularly NTT, and this may prevent managers from developing the plans, budgets, and achieving the performance improvements required for effective use of donor funds.

This remains a significant risk for the provision of assistance. However, by linking assistance to a judicious percentage increase on government funding, and to performance on use of funds; and by providing managerial, technical and administrative support to address system and planning constraints, it is considered that the capacity constraints can be overcome.

(d) Weaknesses in public administration and financial control systems are also issues to be addressed. These weaknesses not only result in wastage and inefficiency in use of resources, but undermine public confidence in government provided services, and create barriers to service access, particularly by the poor. The GoI acknowledge these issues, and have established the policy framework to address them. The Partnership design seeks to support the GoI in the implementation of public administration reforms, while establishing the appropriate safeguards and oversight to ensure that GoA funds are properly used, and do not contribute to undermining GoI public administration systems.

3. Partnership Description

3.1 Partnership Objectives

This document focuses on the initial 3 years of what is conceived as a longer term Partnership. As a result, both short term (3 year) and longer term (10 year objectives) are identified.

The short term (3 year) objective is that:

> ***Selected provincial and district governments have mechanisms in place to manage national, local and donor resources to achieve national target levels for priority MPS indicators***.

The target indicators are those identified in the National MPS strategy as the key outcomes needed to achieve improvements in maternal and neonatal health, and include:

- Delivery assisted by a trained attendant (85%)
- Attendance at four antenatal examinations (90%)
- Appropriate care for obstetric and neonatal complications (80%)
- Post natal visits
- Family planning acceptance.

While the National MPS strategy proposes that these targets be achieved by 2010, the current situation in regards to achievement against target levels varies considerably among the provinces of focus. The program will determine the timeframe for the achievement of the targets for each province (and district), wherever possible, within the target timeframe of the national strategy.

The longer term (10 year) objective is that:

> ***Selected provincial and district governments can effectively manage national, local and donor resources to progressively achieve MDG targets for maternal and child health.***

The three key elements of the Partnership are:

(a) The delivery of services and the engagement of communities in access to and utilisation of these services through public health services provided by district governments;

(b) The management of the resources provided by the health system at provincial and district level, which comprises government functions of planning, budgeting, reporting, workforce management, the provision of supplies and equipment; and support provided by a range of supporting organizations and institutions, including training academies, research and technical organizations, non-health government agencies, and community organizations;

(c) The accountability of public administrations, particularly health administrations, for the management and use of public finance, and in achieving performance expectations.

The design recognizes that the level of readiness and the support needs of these elements vary, and this is reflected in the component structure of the Partnership. However, the elements are inter-connected, and progress on each element will require progress on the other elements, while, at the same time, contributing to progress on the other elements. This will require a phased approach, with some elements ready for implementation, while others will require further design and development work.

The initial focus will be on implementation of the national MPS strategy and achieving the MPS indicator targets. With satisfactory progress on these targets, support will be extended

to other related areas, such as adolescent reproductive health, malaria, HIV-AIDs and other sexually transmitted infections, nutrition etc based on assessment of needs. The longer term objective envisages support being extended on a sectoral basis, across the health program, without limitation to particular target groups.

3.2 Expected Outcomes

Outcomes will occur at different levels:

I. Higher level outcomes: The program will contribute to improvements in maternal and neonatal health shown by reduced maternal and neonatal mortality rates at provincial levels, by improvements in those provinces currently with poorest health.
II. Service delivery outcomes: Increased coverage (access to and utilisation by target population groups) of key maternal and neonatal health service interventions, with a focus on increased outcomes in those districts and subdistricts currently with lowest coverage levels; increased understanding of and adoption of healthy behaviours by communities.
III. System management outcomes: Improved management of health system resources, including increased allocation and expenditure of government budgets, improved reporting on service outcomes, improved availability of skilled workforce, improved availability of supplies and equipment.
IV. System performance outcomes: Improved productivity of public workforce, and improved identification of and achievement of performance targets.

The outcomes are described in more detail with indicators in the log frame (Annex 2).

It is anticipated that these outcomes will be achieved progressively, with districts participating in the Partnership initially achieving improvements in service delivery, followed by improvements in system management, and then in system performance, which in turn contribute to further improvements in service delivery.

3.3 Form of Aid proposed

The Partnership proposes to adopt a program based approach as the form of aid, with a progressive move to increasing use of GoI systems as capacity is built in those systems. However even from the commencement, the program will use GoI systems rather than set up parallel project systems.

This form of aid and approach was selected based on the lessons learnt and experience in previous assistance, which has been delivered more in the project form. The project approach recognizes the weaknesses of GoI systems, and the lack of capacity of program managers, and enables more effective management of support, and flexibility in response. However previous projects have not resulted in significant sustained improvements; lessons from previous projects suggest that the project mode of delivery is seen as outside the government system, and thus does not contribute to improvements in the system.

The program mode of delivery uses government systems, and has the potential to achieve sustainable improvements in those systems. This approach is also consistent with the

decentralization of GoI and with AusAID policy and the Paris Declaration on harmonization among donors. But the program mode does require[12]:

(a) a government program strategy which identifies priorities;
(b) a medium term expenditure framework which identifies resource needs;
(c) coordination arrangements led by government;
(d) government capacity to implement, monitor and report on performance.

These requirements are not all fully in place in NTT and NTB. The National MPS strategy provides a program framework for identifying priorities, and arrangements for GoI coordination and leadership of donor assistance are developing, such as the master plan in NTT. However, in most cases expenditure frameworks have not been developed, and capacity to implement, monitor and report on performance is weak.

Thus the program approach will require progressive capacity building of GoI systems, and operational support to provide this capacity building. The operational support will need to manage the interface between GoA funded resources and technical assistance, and GoI systems.

Three options for provision of this support were considered:

(1) Co-financing of an existing donor
(2) Partnership with a multilateral agency (UN agency)
(3) Contracting a provider

The main existing donor in the province of NTT is GTZ. The option of co-financing was discussed with GTZ, but as noted, GTZ are moving away from direct involvement in the health sector, and were not interested in a co-financing arrangement.

Currently two UN agencies are operating in NTT, UNFPA and UNICEF. UNICEF is already receiving funding from AusAID and DFID to implement MCH programs in NTT and other provinces of Indonesia. The UNFPA program is quite small and focused on reproductive health. While UNICEF was considered as an option, it was felt that their specific focus on MCH rather than broad system wide performance was not consistent with the approach of this Partnership.

It is proposed to contract an organization to manage the provision of the technical and other support to be provided to local counterparts and not establish parallel 'project' systems. This will be achieved by placing all technical advisors within GoI agencies; use of GoI systems for planning, reporting, budgeting from the start; and progressive use GoI systems for funding and procurement.

3.4 Partnership Program Components

The program consists of three components, each of which will contribute to the achievement of one level of the three levels of outcomes.

[12] AusGuideline 3.1 Principles of Activity Design – Forms of Aid

It must also be noted that each component is at a different level of 'readiness' for implementation in terms of GoI system capacity, and an agreed program of work. Components which are 'ready' for implementation can commence immediately (indeed some activities have already begun in component one); while other components will require further preparatory work in assessment, consultation, design and planning.

The three components are linked, in that achievement of the outputs of one component will support and be supported by achievement of the outputs in the other components.

Table 2 Component Structure

Component title	Outcomes	Readiness and Capacity	Links with other components
Component 1: Service delivery and community engagement	Service delivery outcomes: increased coverage of key MNH interventions	District health agencies are capable and ready to implement	This component is the performance outcome of the whole Partnership; components 2 and 3 will support component one
Component 2: Management of health system resources	System management outcomes: improved planning, budgeting, availability of resources	Some areas ready, but others will require further assessment. TA will be needed to build capacity.	This component will increase district capacities to implement component 1 and enable the system to adopt the outputs of component 3
Component 3: System reforms in performance and accountability	System performance outcomes: efficient use of resources and performance focus	Needs considerable further work in assessment, consultation and design with GoI. Will need TA and system capacity	This component will support both components 1 and 2, improving both system management and delivery outcomes, while achievement of component 2 outputs will be requirements for additional performance funding under this component

Component description

Components one and two incorporate the strategies and activities of the National MPS Strategy, while component 3 supports GoI initiatives in performance budgeting and decentralization.

The component description will specify the outputs, indicators and targets to be achieved, while provincial and district governments will identify and select the activities to achieve the outputs. This may include activities nominated in the National MPS Strategy, as well as activities which have been developed subsequent to the Strategy or address particular

needs (e.g. adolescent reproductive health services). The log frame (annex 2) sets out in detail the outputs for each component and the relationship with MPS strategies and outputs.

Component 1: Service Delivery and Community Engagement

***Objective**: Provincial and district governments develop and implement MNH programs based on the national MPS strategy and address supply and demand aspects to achieve annual performance targets using an integrated reproductive health approach considering gender equity and equality*.

***Outcome**: National MPS target percentages of women attending Antenatal care, receive assistance at delivery, and receive care post partum; 75% of the estimated number of women and newborns with complications receive referral level care and contraceptive prevalence rate (70%).*

This component includes those activities in the MPS program which are direct service delivery and operational, and generally will involve recurrent funding. These activities will be planned and implemented by district level agencies (District Health Office, and Planning Office – Bappeda). Planning and implementation has already commenced in the initial three districts and demonstrates that district agencies have the capacity to identify additional appropriate activities for implementation with supplementary resources from the partnership program. However, the linkage of plans and outcomes is often not clear, integration between 'supply' and 'demand' side interventions is poor, and the quality of implementation is low.

The component structure encourages an integrated approach between 'supply side' strategies (MPS strategy 1) and 'demand side' (MPS strategies 3 and 4) with an emphasis on community empowerment, addressing underlying gender discrimination, and building links between service providers and the community they serve.

Output 1.1: *Basic MNH care and first aid provided at all health facilities*
Care includes Antenatal care, care for pregnancy and complications, care of normal newborn and family planning information. This encompasses the activities of MPS Strategy 1, Output 1a. Care in pregnancy should also address health problems related to pregnancy, including malaria, nutritional status, and where appropriate other infectious diseases such as HIV.

***Output 1.2:** Services for the management of MNH complications are available at Puskesmas and district hospital*
Services include post-abortion care, care of LBW neonate, care of obstetric complications, family planning; and infection control. This encompasses the activities of MPS Strategy 1, Outputs 1b and 1c, and associated training activities in Output 2.

***Output 1.3:** Women and families have knowledge of appropriate practices and MNH services*
This includes the outputs 1 and 2 of MPS Strategy 3: Encourage women and family empowerment through improving their knowledge to ensure appropriate practices and

utilisation of maternal and neonatal health services. This output will particularly address the gender discrimination that constrains women's involvement in decision making and use of health services, while encouraging men to accept greater responsibility and involvement.

Output 1.4: *Communities are involved in the provision and support of MNH services*
This includes outputs 1, 2 and 3 of MPS Strategy 4: Encourage community involvement in ensuring the provision and utilisation of MNH services

Component 2: Health Systems Support

Objective: *Provincial and district government agencies and communities access and manage the technical, human and financial resources needed to achieve improvements in MNH.*

Outcome*: Service providers and communities have the resources, skills, technical support and infrastructure needed to improve service delivery and utilisation.*

This component includes those aspects of the MPS strategies that require development of systems and structures, and which support the implementation of the activities in component 1. It includes the outputs of National MPS Strategy 2, as well as some system issues from Strategy 1, and additional outputs addressing aspects of the health system not included in the MPS Strategies. These will address the underlying system constraints of poor financial management and controls, and poor planning and budgeting, which are also the basic requirements for effective assistance using a program support modality, and linking performance to resourcing.

The level of 'readiness' for outputs in component two varies. Some work has already been undertaken around outputs 2.1, 2.2 and 2.3, but assessment and development of activities will be needed for the remaining outputs. It is anticipated that the initial development of the activities will require technical assistance, and be primarily managed at a provincial level. However system management capacity will be progressively built at both provincial and district levels, and the support from provincial level will be primarily directed at improving district level capacity.

Output 2.1: *Improved monitoring and reporting systems for finance and activities.*

Currently monitoring and reporting between sub district, district and province functions poorly. Reports are often incomplete and inaccurate. Improvement in planning and linking performance with resources will require improved data and reporting. Indicative activities include:

- Assessment of expenditure and implementation reports provided by district agencies on initial activities;
- Assessment of activity reports provided by Puskesmas, hospitals in terms of completeness, timeliness and accuracy;
- Identification of constraints and weaknesses in the collection, recording and reporting of data;
- Provision of guidelines, training, and supervisory support to improve recording and reporting.

- Consideration of adoption of computerized systems being trialled by GTZ and UNICEF
- Encouraging more complete reporting by linking further funding to receipt and acceptance of reports on previous activities.

Output 2.2: *Province and district governments develop and report on medium term and annual plans and budgets with MNH performance targets.*
This includes the activities noted in the National MPS Strategy 1 addressing improvements to planning and information systems. As the preparation of plans and budgets are the basis for ongoing program funding, this output is also a core output. Indicative activities include:

- Develop guidelines for planning for annual work plan and budget preparation and provide training in use of guidelines;
- Provide technical support to the provincial and district government agencies (Bappeda, PHO / DHO) in the development of annual work plans and budgets;
- Develop guidelines and assist in measurements of the costs of providing services, potentially in collaboration with District Health Account estimates;
- Develop guidelines for planning and expenditure estimates for medium term MPS action plans;
- Provide technical support, including data collection and analysis if required, to Bappeda, PHO / DHO in the development of medium term MPS action plans;
- Provide technical support, including data collection and analysis, to enable Bappeda, PHO and DHO to develop medium term expenditure frameworks.

While annual planning systems and capacity is well established, these plans are not well linked to longer term plans, such as five year strategic plans. This limits the ability to plan progressive improvements over the medium term. Medium term MPS action plans, based on an assessment of the system support needs at district and provincial level, would provide the framework for a multi-sectoral phased investment in improving MNH services and community engagement. They would become the basis for subsequent selection of activities and investments in annual work plans, for support through the GoA, other donors, and GoI funding. However further assessment and consultation is required with the GoI to determine the appropriate format and process for medium term planning, and linking this with the current GoI system of five year strategic plans (Renstra).

Output 2.3: *Health workforce is distributed more equitably, performance is monitored, and refresher training provided more frequently.*
This includes the activities in output 2 of the National MPS Strategy 1 addressing improving human resources and supervision, as well as activities to improve the quality of the training and pre-service education provided by training facilities and pre-service education institutions. Indicative Activities:

- Provide technical support to the assessment of midwife workforce time allocations and review of job descriptions. This activity has already commenced during the preparatory phase of the program;
- Conduct needs assessment of training institutions: Poltekkes and provincial and district clinical training centres (P2KS, P2KP) and assist in developing facility improvement plans.

Output 2.4: *Local laws, policies & regulations which support MNH developed and approved.*
This includes the outputs in output 3 of the National MPS Strategy 1: Revised laws, polices and regulations. Indicative Activities:

- Review of regulations governing authority of midwives
- Development of regulations to support midwife – dukun partnerships

Output 2.5: *Facilities have appropriate infrastructure equipment and supplies to support service delivery.*
This output will support the provision of services under component 1 by addressing deficiencies in systems of renovation and maintenance of facilities; as well as the procurement, distribution and use of medicines and equipment. Indicative Activities:

- Assessment of infrastructure needs in selected Puskesmas: contract for renovation of Puskesmas, provision of water supply, creation of delivery rooms and provision of equipment.

Assessments of infrastructure needs in Puskesmas in the initial districts have been undertaken during the preparatory phase of the program.

Output 2.6: *Managers of services have skills and resources to provide good management.*
This is an additional output that supports both health system improvements and service delivery. Indicative Activities:

- Assessment of management needs of Puskesmas and DHO program managers; identify options to address including short course training, distance courses, mentoring and support, placement of short term facilitators;
- Assess needs for administration support at Puskesmas especially data analysis, financial management and identify options to address.

Output 2.7: *Government and Non- government organizations / groups with roles related to MNH provide effective support.*
This output encompasses the various outputs in MPS Strategy 2 in regard to collaboration with other Government Institutions, Dukun Bayi, Private sector and NGOs, Professional and Academic groups, and the Red Cross.
This output will also include activities from MPS Strategy 2, Output 1: Support establishment of appropriate coordination structures and processes between GoI and donors for MPS programs at national, provincial and district levels. Indicative Activities:

- Identify appropriate indicators for family planning support under the program e.g. levels of unmet need.
- Support review of roles and functions on the basis of new organizational arrangements at province and district level.
- Midwives association: Support for role in professional development and licensing of midwives.

Output 2.8: *Communities and civil society have the resources, capacities and supportive environment to actively engage in planning and delivery of services.*

Indicative Activities under this output will include:

- Activities to address gender discrimination and inequalities, consistent with the National MPS strategies on women on family empowerment, including an

assessment of gender based constraints and identification of strategies to address them;
- IEC campaign to improve general community understanding and awareness of MNH, using appropriate media;
- facilitation and advocacy for the inclusion of activities addressing MNH in the development plans prepared by communities for use of PNPM Generasi funds and ADD funds;
- Village level: support for village government to understand and take actions on MNH issues; training for kader (village volunteers) on community rights to services and on advocacy; how to input into Musrenbang desa on MNH issues; develop accountability mechanism for village midwives to village government;
- Kecamatan level: develop role of kecamatan government in support for MNH – provide training and materials to camat, and facilitate liaison and engagement between kecamatan and Puskesmas; provide training and support to Puskesmas staff in 'customer oriented' service delivery, measurement of client satisfaction, encourage client focused interventions;

Component 3: System Reforms in Performance and Accountability

***Objective**: Provincial and district governments manage GoI and donor resources to improve accountability, performance, accessibility and sustainability of public health services.*

***Outcomes**: Explicit linking of resource allocations (budgets) to performance targets in annual workplans; reliable and transparent reporting of achievements and use of resources against performance targets to communities, parliament and partner donors; partner donor readiness to harmonize resource support through GoI systems.*

This component moves beyond the system strengthening and management capacity building of component two, to address the fundamental drivers of the system which can impact on performance. This will include accountability for the use of resources to communities, local parliament and donor partners; and also the explicit linking of use of resources with achievement of performance targets. This will require assessment and improvements in financial accountability systems, strengthening of oversight structures and systems, and linking of future funding support to performance.

Under this component, incentives will be developed and provided to encourage district government agencies to adopt a performance focused approach, and to progressively improve their performance. Provision of incentives will be conditional on achieving satisfactory standards of financial accountability and performance reporting (output 2.1), medium term MNH action plans and associated expenditure frameworks (output 2.2), and progressive increases in local government allocation to health, and will be linked to achieving improvements in performance against agreed targets.

While this approach is consistent with and support national policy for performance based budgeting, it does involve addressing areas of some sensitivity within local government systems. It will need to be approached sensitively, and on the basis of strong relationships of trust and mutual commitment between the partners in the Partnership. Thus it will build

on the engagement and relationships developed through the implementation of components one and two, and the progressive improvements in capacity developed through this implementation. It is anticipated that a period of assessment, consultation and design will be needed to further develop this component, and to build commitment to the proposed activities, so that implementation will be progressively phased in.

Output 3.1: *Management of funds and resources satisfies good governance standards.*
This output will involve the joint assessment of finance management systems and procedures, with a view to identifying potential weaknesses, and developing action plans to address these. Indicative activities include:
- Review of fiduciary risk assessments undertaken by PEACH and other public sector expenditure reviews;
- Consultation with local government and development of a joint assessment process, which will address fiduciary risks associated with resource management including budgeting, expenditure, procurement, and asset management.
- Development of action plans to review and strengthen procedures, and / or provide training and guidance to address identified weaknesses;
- Regular review of systems and procedures to monitor potential risks.

Output 3.2: *Provincial and district government agencies monitor and report on performance to communities, government representatives and donors*

This output will develop systems, procedures and commitment in district and provincial government health agencies and facilities to monitor and report on performance, and account for performance to local stakeholders, including communities, government and donors. While these systems and procedures need to be developed, indicative activities include:

- District level: advocacy and information for DPRD members; engagement with district health council and support for its members (dewan kesehatan kabupaten); improve capacity of local NGOs and civil society organizations to engage with the health sector.
- Subdistrict level: Support and capacity building to communities to enable monitoring of Puskesmas and village level health worker performance and accountability for that performance;
- Strengthening of the capacity of district health agencies to measure and monitor performance, and determine appropriate performance targets linked to resource availability.

In the development of performance monitoring systems and procedures, the focus will be on strengthening the role, capacities and functions of the relevant GoI agencies and institutions, rather than establishing structures outside current GoI systems. This will include agencies such as the BPKP, and appropriate commissions of the local parliament.

Output 3.3: *Performance based funding support provided to agencies and organizations which satisfy governance and accountability conditions.*

For district governments, and health agencies which satisfy the fiduciary risk and performance monitoring conditions developed through outputs 3.1 and 3.2, additional funding and resources will be made available based on agreements to achieve progressive performance improvements against agreed performance targets. These additional resources will be channelled through appropriate GoI systems, and will be used to provide the resources needed to achieve the performance improvements. The nature and size of the performance incentives are still to be developed, but resource investment will need to be matched with sustainable local government capacity, and will be of the same order as the additional funding provided under component one arrangements. The mechanisms and procedures for the provision of resources and the link with performance targets will also need to be developed in close consultation with GoI. Implementation will not then occur until later in the program, by which time capacities will have been build through components one and two, as well as relationships and commitment among the partners.

Output 3.4: *Donors and regional governments agree to harmonize and develop a sectoral approach to assistance in the health sector.*

This output will build on the donor-GoI agreement for harmonized monitoring and evaluation in NTT, to progressively develop the pre-conditions and commitment for a sectoral approach to assistance in the health sector, commencing in NTT. This will involve building the capacity of regional governments to lead and coordinate donor assistance; building the systems to manage and report on that assistance to the satisfaction of donors; and building consensus and commitment among donors to adopt a harmonized approach to supporting a jointly agreed GoI program of work. It is anticipated that this will be a progressive process over time, and will take some years to achieve the long term outcomes.

3.5 Assistance inputs

The Partnership will provide additional resources in the form of funding for activities (operational and capacity building / investment), and technical advice to assist in the planning and implementation. The amounts and mechanisms for provision of funding are different at province and district levels, although are based on the following district level model.

Funding at District level

Additional funding will be provided by the Partnership to complement the resources being provided by the GoI and by other donors. Given the constraints on absorption and utilisation of current funding, it is important to ensure that the funding allocation remains within the capacity of the relevant agencies to utilize the funds effectively, and does not distort the balance of funding across the health system (i.e. between other programs, such as communicable disease control, environmental health, nutrition etc). Partnership resources are designed to be used to address priority interventions which will achieve improvements in performance, not to cover all possible needs; and to encourage ongoing and increasing local government allocation to health, not to displace government budgets.

In the absence of the medium term expenditure framework or estimates of costs of provision of services to guide funding requirements, it is proposed to allocate an additional

budget based on a proportion of the previous year's APBD (local government) budget allocation to health per capita. This will encourage local government to continue to allocate budget to health, while respecting the government's authority to decide its own priorities within the health sector. As the local government budget's funding source is the general allocation from the central budget (DAU) in most poor districts, the linkage with the health budget allocation will not disadvantage poorer districts, which receive the same or larger central allocations.

Indicative allocation amounts are set out below:
(1) Component 1: Allocation for MNH activities in the annual district health work plan = 5% of the previous year's district government budget (APBD) allocation to health, up to a maximum of AUD $1 per capita. The 5% proportion is equivalent to about Rp 5,000 (or AUD 70c) per capita based on current health allocations in the province of NTT. This proportion can be reviewed following preparation of the province and district medium term MNH action plans, which should contain estimates of future funding needs. This amount is allocated annually for the duration of Partnership activities in the district.
(2) Component 1: Allocation for activities which support MNH outputs at community level through annual work plans of other government agencies (kecamatan, village, BPMD, BKB) = an amount matching the allocation from GoI (from any level, national, provincial or district) up to a maximum of AUD 25 cents per capita. This amount is allocated annually in the same way as the amount above.

Planning and Budgeting: The Partnership will use the GoI Planning and Budgeting systems as the basis for its plans and budgets. This is illustrated at Table 3 below. The annual planning cycle commences in January and finishes in December of each year. During this cycle annual work plans and budgets are prepared for the following calendar year (which is also the Indonesian financial year).

The planning system uses a combination of 'bottom up' annual participative planning, and annual sectoral plans based on sectoral and whole of government medium term strategic plans (Renstra). The planning cycle commences with community participative planning and sectoral planning occurring independently (January-March period). During this period AIPMNH TA will provide advice, support and guidelines for the selection, planning and costing of activities, and the development of performance targets to be achieved. Activities for possible AIPMNH funding are included in the drafts submitted to Bappeda.

The district / provincial planning agency (Bappeda) then combines these two streams into a single planning framework, and uses this as the basis for determining local government budget priorities and sectoral allocations (budget ceilings) during the months April – July. This includes activities for potential Partnership funding. AIPMNH will provide estimates to Bappeda and DHO on the amount of funding available based on the previous year's APBD budget allocation to health.

Sectoral agencies then use the budget ceilings as the basis for preparing more detailed work plans and agency annual budgets (RKA-SKPD) (July-August). Budget ceilings will clarify which activities require AIPMNH funding, and whether the performance targets are realistic. The resulting plans and budgets are reviewed by Bappeda, and are then submitted to the executive and parliament for approval (Sept – November).

Table 3 Annual Government Planning and Budgeting Process

Timeline	Stage in Process	Documents	Stakeholders	Process	AIPMNH links
Jan – March	Sectoral planning Participatory Planning	Renja – SKPD (Annual sectoral Partnership plan) Kecamatan reports District reports	Government agencies Communities Village heads Camat Bappeda	Sectoral plan is based on strategic plan, Bupati's priorities and District Musrenbang Village, kecamatan and district meetings to identify community priorities	TA and technical guidelines to provide a menu of additional activities to be included in Renja. Performance targets agreed.
March-April	Drafting district development plan	RKPD (Annual district development plan)	Bappeda	Bappeda compiles the agency work plans and Musrenbang proposals	Bappeda compiles community & agency proposals
April-May	Draft general budget policy	Draft APBD general directions (RAKU-APBD)	Secretariat under Bupati	Based on Bupati's priorities and RKPD	AIPMNH provides estimates of funds available based on previous years APBD health budget
May-July	Determine sectoral policies and budget ceilings	APBD priorities and Ceilings (Plafon)	DPRD Bupati	DPRD and Bupati deliberate to determine budget sectoral allocations and ceilings	Activities not able to be funded under APBD identified
July-August	Draft sectoral budgets	RKA – SKPD	Government agencies	Agencies prepare detailed annual budget and work plans (RKA-SKPD)	Activities for AIPMNH funding identified & included in RKA-SKPD. TA review & advise
August	Drafting APBD	Draft local govt regulation on APBD	PPKD and budget team under Bupati	Based on RKA-SKPD, draft APBD prepared for submission to DPRD	
Sept-Nov	DPRD deliberation & approval of budget	Joint decree on APBD regulation	DPRD, Bupati, Government agencies	DPRD reviews and revises draft APBD in consultation with government	
Dec	Evaluation by provincial governor	Local govt regulation on APBD	Governor, DPRD, Bupati	Governor reviews draft APBD from DPRD & Bupati	Confirmation of APBD allocation to health & activities for AIPMNH funding
Jan – June	Auditing	Accountability report	Bupati BPK	Bupati prepares accountability report on previous year's APBD. BPK conducts audit of report	Report includes activities funded by AIPMNH

Funding mechanism: Initially, the Partnership will use an imprest account jointly managed by the district Bappeda and the MC to provide funds to Bappeda / the implementing agency (DHO) for activity implementation. Funds will be released on request of the implementing

agency for each activity or group of related activities. Release of funds for further activities will be conditional on submission of a full acquittal of the expenditure of the initial funds, checked and accepted by the MC.

This mechanism is that recommended by the GoI in NTT, and is the mechanism used by UNICEF to provide funds for its activities. This is not the mechanism used by the GoI for national and district government funds, which are managed by the local government secretariat (Sekda), but use the same activity acquittal process. That is, the relevant agency submits an acquittal for the activity on completion, in the form of a list of expenditure and receipts (SPJ), as well as monthly, three monthly and semester financial reports (balance sheets). Further funds will not be released to the SKPD until acquittals for funds already released have been received and accepted. However Sekda currently does not have the capacity to manage additional donor funds. AusAID and GoI will jointly decide when a local government's system is ready to manage MNH Partnership funds through the Sekda.

If performance is satisfactory on the management of funding by activity, and the conditions below are satisfied, further funding may be transferred as quarterly or half yearly tranches to supplement the APBD allocation to health. Under this basis, the supplementary funds provided by the GoA will be applied to the APBD budget allocation for the district RKA-SKPD MCH program, without requiring nomination of specific activities for AIPMNH funding. Reporting will then cover the performance of the MNH program as a whole rather than just activities funded by AIPMNH.

Conditions for movement to funding by tranches will include:
(a) Preparation of medium term MNH action plan outlining phased development of services and an associated expenditure and finance framework;
(b) Adequate performance of activities funded under the initial phase in terms of expenditure, reporting, and achievement; and
(c) Fiduciary risk assessment of the GoI funding system and capacity building as necessary to ensure the system satisfies AusAID and GoI requirements.

Funding at Provincial level

Activities to be funded at provincial level will primarily be those included in component 2, as the role of the province is the provision of technical support and supervision, and the monitoring and evaluation of activities implemented at district level. For activities in component 2, budget from AIPMNH has been divided among the outputs to provide indicative allocations. These allocations are based on the province providing support to the number of districts implementing activities under component one.

Provincial level Bappeda, PHO and Technical advisors will develop an annual work plan for the activities under component two, as part of the annual work plan and budgeting process at provincial level. As part of this process, activities and the associated funds which will be directly managed by provincial Bappeda or the PHO will be agreed, based on the assessed capacity of the provincial agency to manage the funds and implementation. These activities and the funds requested from AIPMNH will be included in the provincial RKA-SKPD in the same way as the activities at district level.

Funding mechanism: Funds will be transferred to the implementing SKPD (mainly the PHO) from an imprest account jointly managed by provincial Bappeda and the MC in the same way as at district level. That is funds will be released on an activity basis, with funding for further activities released only on submission and acceptance of an acquittal of the funding for the initial activities.

Progressively more of the annual work plan activities and funding under component two will be transferred to direct management by the provincial agencies, or district agencies, where appropriate, and included in the relevant RKA-SKPD as capacity of provincial and district agencies is assessed and built, and as the conditions for funding by tranches are fulfilled. These are the same as those at district level:
(a) Preparation of medium term MNH action plan outlining phased development of services over 3 – 4 year period, and an associated expenditure and finance framework;
(b) Adequate performance of activities funded under the initial phase in terms of expenditure, reporting, and achievement; and
(c) Fiduciary risk assessment of the GoI funding system and capacity building as necessary to ensure the system satisfies AusAID and GoI requirements.

Technical Assistance (TA)

Given the current capacity constraints on government agencies in the selected provinces, technical assistance will be required to enable the agencies to manage the additional resources provided by the program, and to build capacity in the agencies.

The main TA needs will be in the areas of:
(a) Operational support. TA to assist the GoI agencies (notably Bappeda and the PHO / DHO) to plan, budget, manage and report on funding, and report on activity implementation. This TA will need to work within GoI systems, and build capacity in planning, budget, management of resources, and in reporting. While it is likely that this TA will need to be provided over medium to long term, in order to build the understanding and relationships needed to facilitate appropriate changes in the way GoI systems operate, it is expected to decrease as government systems strengthen. An important role of this TA will be to identify other technical support needs, and to act as intermediaries in the briefing and orientation of additional TA, and to follow up on the adoption and application of other TA inputs.

(b) Technical support. There will also be a need for a range of TA in specific technical areas, to undertake tasks such as specific assessments and recommendations, development of new procedures and guidelines, provision of specific technical expertise in areas such as costing of service provision, or development of IEC materials, and provision of training in both clinical and non-clinical areas. While much of this technical expertise is available in Indonesia, it is often not available in the provinces selected for the Partnership program. Again the level of TA is expected to decrease over time.

TA mechanism

The managing contractor (MC) will be required to develop a mechanism for identifying and responding to TA needs, which is flexible, effective, and simultaneously builds capacity in the identified technical gap area, but also builds local capacity in the selected provinces to source and provide required TA.

In considering sources of TA, a range of options are possible: consultants (national or international); volunteers; contracting of organizations (national or international); twinning arrangements with organizations; a combination of local and national / international TA in mentoring arrangements.

The MC will develop a Technical Assistance Strategy in collaboration with provincial and district government agencies for the identification of TA needs, sourcing of appropriate TA, and the management of TA in the field. The Strategy is expected to include a component which articulates the processes of reducing and existing from the need to provide TA.

Indicative key principles which should guide the TA Strategy include:

- TA provision should be in response to needs identified by partner government agencies or non-government organizations, and be led by the partner governments, rather than by the MC;

- Partner government agencies, particularly the agency requesting the TA, should be involved in the decision on the appropriate type of TA, and in the selection and recruitment of the TA;

- Once mobilized / contracted, the partner government agency / organization should be responsible for the management of the technical inputs to be provided; while the MC manages administrative supports;

- The specific capacity building outputs expected from the provision of TA will be explicitly identified, and the provider of TA in conjunction with the partner organization will develop a process for building that capacity, with measurable outcomes;

- Following provision of short term inputs, or regularly (at least annually) for long term inputs, the outcomes and function of the TA will be assessed and reviewed, to identify the effectiveness of the TA, and whether further TA is required;

- Technical advisors provided under the Partnership must demonstrate:

    - a receptiveness and respect to local players and a willingness to listen rather than to dictate;
    - Commitment to the task and working with the local team to achieve the job required;
    - Professionalism and level of expertise
    - High level of responsiveness and preparedness to adapt to the context and situation of the partner agency
    - Commitment to build capacity in the partner agency while providing the technical inputs

In addition the MC will seek to build capacity in the relevant technical area in the provinces and districts of Partnership operation through the process of providing technical assistance. Thus the MC will:

- use local sources / suppliers of technical assistance or services wherever possible;
- if it is considered that local sources do not have the required expertise, seek to involve local suppliers / organizations in the provision of technical support in conjunction with a national or international supplier, in such a way as to build their capacity;
- where possible, seek to contract with local or national organizations to provide the technical assistance / support, rather than subcontract individuals, as this will support capacity building within these organizations;
- consider the capacity and where appropriate support national Partnership staff from Depkes to provide required technical support.

3.6 Program Phasing and Budget

Phasing

Phasing in the Partnership will occur at two levels:
(a) Phasing within individual districts of operation: progressive development of capacity and performance, and matching of provision of assistance with that capacity in individual districts, and at provincial level;
(b) Phased geographic expansion to other provinces and districts: progressive expansion of the program from an initial 3 districts in one province, to two provinces with up to 14 districts over the 3 year implementation period.

Phasing within individual districts

A progressive development of capacity, strengthening of assistance, and move towards greater use of GoI systems and introduction of performance, accountability and governance reforms will take place over a 3 – 5 year period. This will result in progressive achievement of the outcomes for components one, two and three.
The initial operations can be regarded as Phase 1, which through development and support will progressively move to the operations of Phase 2, as set out in the following table:

Table 4 Phases of operation within individual districts (3 – 5 year time period)

Phases	PHASE 1	Development and Support	PHASE 2
Component 1	Funds provided from Imprest accounts jointly managed by Bappeda / MC on activity basis; transfers and expenditure reported to local and central GoI as required by GoI	Activities included in annual workplans and budgets Performance indicators and targets agreed and monitored	Activities included in annual workplans and budgets Performance indicators and targets agreed and monitored Funds transferred to Sekda / Bappeda as tranches Additional funding available to address system issues from component 2 budget
Outputs 1.1	DHO plan activities as	Improved plans and budgets for	Increased integration: single

and 1.2 Service improvements	additions to annual govt work plan to achieve specified increases in coverage indicators MC transfers funds from imprest account managed by Bappeda up to 5% APBD allocation to health for implementation DHO / Puskesmas implement and provide acquittals and reports on implementation by activity DHO reports on coverage achieved	MNH activities based on guidelines and training provided in phase 1 Inclusion of program funded activities in annual workplans Funds transfer as in phase 1 Improved use of performance indicators and targets & reporting on performance and service standards by MNH program	multi-sectoral program, including both supply and demand aspects, with annual program reporting
Outputs 1.3 and1.4 Community engagement	Bappeda identifies activities to support community engagement through inter-sectoral planning MC transfers funds from imprest account to Bappeda for implementation by other agencies up to difference between 5% APBD allocation to health and AUD $1 per capita Bappeda provides acquittals and reports on implementation by activity	Improved plans and budgets for MNH activities based on guidelines and training provided in phase 1 Inclusion of program funded activities in annual workplans Funds transfer as in phase 1 Improved linkage with DHO / Puskesmas activities & inclusion in reports	
Component 2			
	PHO and MC develop annual work plan for component 2 activities setting out TA and activity funding requirements. Funded through Provincial Imprest account PHO & MC develop joint management of TA based in PHO technical support office	Joint MC / PHO planning as in phase 1, with progressive shift of activities to be included in PHO annual work plan and budgets. Progressive increase in management of funds by PHO	Increasing inclusion of activities and budget in provincial Bappeda / PHO annual workplans and budgets. Increasing use of Bappeda / PHO to directly manage procurement and contracting including of TA
2.1 Monitoring and reporting	MC assesses acquittal reports from DHO / Bappeda MC arranges audits Assessment of data collection and reporting Trial of service audits as a measure of performance Costing of service provision (link with DHA)	Training / guidelines to improve monitoring and reporting of services; costing of activities. Use of service and financial audits	Decreasing
2.2 Planning and budgets	PHO / Bappeda Provincial / MC develop planning & cost guidelines for annual plans; provide training to district DHO & Bappeda	Support provided for system assessments and development of medium term plans and expenditure frameworks	Planning and budgets based on medium term plans & expenditure frameworks
2.3 Health workforce	PHO / MC undertake assessments of workforce skills and training institutions;	Implementation of plans to improve training institutions / centres; training planning &	Decreasing

	develop plans to improve training capacity	evaluation	
2.4 Regulations &and policies	PHO / MC identify regulation / policy needs	Review and ongoing	Decreasing
2.4 Infra-structure & equipment	PHO / MC contract for infrastructure / equipment needs assessment & procurement of priority items for province & district facilities	Assessment of maintenance / operation and asset controls – training / guidelines as required	Decreasing
2.6 Manager skills & resources	PHO / DHO /MC contract for assessment of Puskesmas management needs and develop plan to strengthen	Further training/ support as required	Decreasing
2.7 System support organisations	PHO / MC request proposals for support from BBKBN, professional & academic groups. MC provide TA to assist proposal development Proposals assessed and funded directly (contract / agreement with PHO)	Ongoing	Decreasing
2.8 Community groups	PHO / MC request proposals from community groups, NGOs, IEC providers MC provide TA to assist proposal development if needed Proposals assessed and funded directly (contract / agreement with PHO)	Ongoing	Decreasing
Component 3			
	MC provides TA to develop design – process and structures for GGAP	Agreements with selected districts & provincial governments to implement GGAP	Based on satisfactory progress on GGAP, agree to move to phase 2 funding
	Revised design for component 3 becomes GGAP Review & consultation on draft GGAP with central agencies and other donors	GGAP support team established at provincial level (identify appropriate counterpart agency? BPKP)	GGAP support team continue
3.1 Fiduciary management	Review of PEACH and other fiduciary risk assessments. Consultation with local government & development of assessment process (may be contracted out)	Conduct of agreed assessments; consultation on results and follow up actions. Provide training / support for follow up actions	Assessments to be integrated into GoI system
3.2 Oversight and accountability	Review of performance measurement and oversight bodies Consultation with local government and agreement on oversight process	Support for oversight by communities / health councils – training, operational funding – as required	Increase involvement in GGAP
3.3 Incentives	Review of experience with CCT / Askeskin Consultation with local	Planning and implementation of pilots	Evaluation and expansion of pilots in collaboration with other donors

	government and agreement on incentive pilots		

Phasing of Geographic Expansion - The Partnership has commenced initial activities in three selected districts in the province of NTT, and proposes to expand to a further 7 in mid 2008. Selection of districts will be in accordance with selection criteria as outlined below and agreed to by both GoA and GoI.

It is clear that the provincial government in NTT is keen that donors support 'scaling up' of programs, rather than 'pilots' in only a few areas. Bearing this in mind, the design envisages the possible expansion to further districts in 2010. Expansion to further districts in NTT or to NTB will be based on the response and progress in 2008 and 2009, and will be decided jointly by the GoI and GoA. Expansion is also based on the assumption that the Partnership will be extended beyond its current 4 years, as it will need 4 – 5 years in each district to achieve significant improvement.

Criteria for selection of provinces or districts, which will be undertaken in conjunction with GoI will include:

- Performance on key MPS service indicators; especially where there is considerable variation in performance and the potential to achieve improvements in low performing areas;
- Poverty: proportion of households / population categorized as poor;
- Need for donor support: activities of other donors; evidence of a resource short fall ;
- Local government commitment: proportion of APBD allocated to health; willingness to participate in the proposed Partnership; and interest in allocating resources based on need and performance; political and security situation;
- Consideration of links with other AusAID programs in the same province.

Prior to commencement of activities, a Subsidiary Arrangement between the GoI and GoA will be needed, followed by exchange of letters between AusAID and relevant district government, specifying the purpose and outcomes expected of the assistance programs, the conditions, and the monitoring and review structures and process. The conditions will include the preparation of a medium term MNH action plan and associated finance estimates; satisfactory fiduciary assessment; ongoing commitment and allocation of funds from the local government; and satisfactory achievement of the agreed performance targets.

Budget

Given the progressive and flexible nature of this program, it is difficult to provide fixed estimates of the budget required. The following table is based upon estimates of budget requirements for two provinces, starting in NTT with 10 districts, and then potentially moving to an additional 4 districts in 2010. The province of NTB has been used to provide an indication of population for the 4 additional districts and thus budget requirements.

Estimates used in the budget calculations are based on the following assumptions:

(1) Component 1:

(a) Allocation for MNH activities in the annual district health work plan = 5% of the previous year's district government budget (APBD) allocation to health, up to a maximum of AUD $1. This amount is allocated annually for the duration of Partnership activities in the district, 2 – 3 years on the current four year Partnership, but will probably be needed for 4 – 5 years.

(b) Allocation for activities which support MNH outputs at community level through annual work plans of other government agencies (kecamatan, village, BPMD, BKB) = an amount matching the allocation from GoI (from any level, national, provincial or district) up to a maximum of AUD 25 cents per capita. This amount is allocated annually in the same way as the amount above.

(2) Component 2: An allocation has been calculated for capacity building activities under the outputs of component two, divided into four categories:
- allocations for outputs 2.1 (monitoring & reporting) and 2.2 (planning and budgeting)
- system support allocation for outputs 2.3 (health workforce), 2.4 (laws & regulations), 2.6 (management) and 2.7 (other organizations). Funds are to be allocated among the outputs based on priorities and needs identified through the provincial MNH action plan;
- infrastructure support allocation, for output 2.5 (renovation and equipment)
- community accountability allocation for output 2.8 (community accountability)

(3) Component 3: An allocation based on the same amount as for component 1, but commencing for half of the districts in year 3.

(4) Technical assistance and management. An allocation to cover the costs of technical support, management, and Partnership monitoring and evaluation. This assumes operational support of provincial and district coordinators, and initial TA in the areas of planning and budgeting, monitoring and reporting, and governance (financial systems and accountability). Further TA will be determined based on needs and program development.

Actual budget allocations will depend on the population in the districts selected for support. A detailed breakdown of estimated costs is provided at section 4.6.

4. Implementation Arrangements

4.1 Management and Governance

Management structure and roles
These are the structures and arrangements proposed for NTT based on AusAID's experience in the province. While it is likely that these are the basis of the management structures for other provinces, the arrangements in other provinces will be based on assessment of their needs for support.

(a) Central level

Ministry of Health (MoH)
The Directorate of Maternal Health and Directorate of Child Health at the MoH will provide technical oversight and technical supervision and support. These two Directorates as the

members of the National Technical Team will support Provincial Coordinating Committee in the development of the technical guidelines. The bureau of Planning and Budgeting directorate will provide oversight and technical guidance for the planning and budgeting process.

Ministry of Finance (MoF)
As required by Indonesian regulations, funds provided and expended will be reported to the Ministry of Finance at central level.

National Planning and Development Agency
The National Planning and Development Agency will also be involved in the provision of oversight and technical guidance, particularly in relation to the performance incentives proposed under component three.

Performance Review Committee
A Performance Review Committee (PRC) will be established at the national level which will be co-chaired by GoI and GoA. The PRC will meet 6 monthly and will provide overall strategic direction to the Partnership. The PRC will make decisions on the continuation of funding to district and provincial governments based on their performance against agreed targets. The MC will provide the secretariat to the PRC. The PRC will include a National Technical Team (NTT) from MoH and AusAID. The National Technical Team will provide technical guidance to the PRC and assist the PRC in monitoring the implementation of the Partnership.

When the Partnership expands to more than one province, the PRC could also be attended by representatives of the provinces involved. This meeting would be an opportunity to invite representatives of other relevant programs particularly the National HSS program. The MC will provide the secretariat for the PRC.

AusAID Jakarta
The AusAID Jakarta office will be responsible for overall administration and management of the Partnership and will lead high level engagement with GoI and other donors working in the sector. AusAID will be responsible for liaison with other relevant programs including the HSS program and other AusAID and donor funded health programs.

Maternal and Neonatal Sub national Health Systems Specialist
An AusAID Maternal and Neonatal Sub national Health Systems Specialist will be contracted directly by AusAID and will be located in the AusAID Jakarta office, with frequent travel to NTT and other provinces as required. The Specialist will assist AusAID and GoI in addressing the underlying health system constraints to the effective reform of those systems in selected provinces and districts. Critical local level policy areas to be addressed include sustainable health financing; health sector planning; health information systems; strengthening infrastructure and maintenance; and enhancing transparency and accountability of health procurement systems. Draft Terms of Reference for the Specialist are at Annex 6.

(b) Provincial level

Provincial Coordination Committee
In each province, commencing in NTT, a Provincial Coordination Committee will be established (or an existing committee used such the Extending the life span, and protecting mothers and children Committee in NTT). Membership will include representatives of the PHO and Provincial government; and the DHO and district government in the districts of the Partnership; AusAID; representatives of other provincial or district agencies as decided by the committee e.g. BKKBN, BPMD.

The Chair will be from the provincial government. The Provincial Coordination Committee will meet approximately every 6 months. Its role and responsibilities will include:

- Confirmation of selected districts;
- Review and agree on the performance outcomes expected;
- Review progress on achievement of the performance outcomes and recommendations on any steps necessary to achieve those outcomes; and
- Identify any issues related to coordination with other donor or GoI Partnerships; or with national level policy, and recommendations on dealing with these issues.

AusAID NTT
An AusAID Officer is based in Kupang, NTT to progress broader strategic engagement around development, and in particular decentralisation, with key stakeholders and promote effective coordination of all AusAID and other donor investments in NTT. In relation to the Partnership this officer will:

- Lead on high level engagement with GOI at district and provincial levels;
- Promote effective coordination between health and other related AusAID and other donor programs in NTT (and NTB if required) in consultation with AusAID Jakarta;
- Assist AusAID Jakarta in monitoring and evaluation of the Partnership;
- Other duties as tasked by AusAID Jakarta including support to progress the development of new initiatives.

Provincial government and agencies
The Governor / DPRD will be the key counterpart agencies. They will be asked to agree to participate in the Partnership and commit to:

- achieve performance standards
- allocate ongoing funds to health sector
- address fiduciary risks and system constraints identified by program
- support performance agreements with implementing units within the Provincial Government

The Sekber will assist in coordination and communication and the Bappeda will:

- coordinate planning with PHO and relevant units
- compile Renja SKPD and RKA and submit to DPRD
- Be a joint signatory to the imprest account

- Manage receipt of provincial support funds, transfer to relevant SKPD and receive and submit reports and SPJ
- Develop guidelines and provide support to district Bappeda in planning and budgeting
- Coordinate development of provincial medium term MNH action plan and expenditure framework (EF)
- lead provincial coordination

The Provincial Health Office will:

- Develop Dinkes provincial Renja and RKA SKPD and submit to Bappeda
- Include supervision, monitoring and support for district DHOs
- Establish and coordinate technical support through MPS technical team

Maternal and neonatal technical teams will be formed at province level and in each district to provide technical oversight and assist decision making on Partnership implementation. The technical teams will consist of representatives from the relevant PHO or DHO, other local technical experts (e.g. Obstetrics, gynaecology specialist, professional group representative), TA provided by the Partnership, and the provincial or district coordinator. The role of the technical team will be to review allocations of funds and performance outcomes; review priorities for implementation; review of TA requirements and needs for health system reform.

(c) District level

District Coordinating Committee (DCC)

A District Coordinating Committee (DCC) will be set up in each district where the Partnership operates. Membership of DCC will be consisting of district health office, Bappeda, DPRD and other relevant stakeholders. The DCC will provide oversight to Partnership activities within the districts and address any issues as they arise. The DCC will also act as a forum for the sharing of information and will take primary responsibility in ensuring that coordination and harmonization with other donor programs takes place.

District government and agencies

The Bupati and representatives of the DPRD, as well as other relevant local government representatives will be informed of the Partnership's aims, its partnership approach and arrangements, and the expectations and requirements of participation. If the Bupati and DPRD representatives agree to commit to the Partnership, and to the conditions and requirements, a formal agreement will be signed.

The agreement will emphasize the partnership nature of the collaboration, and set out the overall aims, both in terms of working towards achieving MPS and MDG targets, and improvements in performance and accountability of public service provision; the assistance to be provided; and the links between the assistance and achievement of performance and fiscal accountability targets. The Bupati will be requested to:

- agree to participate in program and commit to achieve performance standards
- Allocate ongoing funds to health sector

- Address fiduciary risks and system constraints identified by program
- Support performance agreements with implementing units within district government

The Bappeda will:

- coordinate planning with DHO and relevant units
- compile Renja SKPD and RKA and submit to DPRD
- be joint signatory to imprest account
- manage receipt of district support funds, transfer to relevant SKPD, receive and submit reports and SPJ
- coordinate development of district medium term MNH action plan and expenditure framework
- lead district coordination

The District Health Office will be requested to:

- develop Dinkes district Renja and RKA SKPD and submit to Bappeda
- compile plans from Puskesmas & prioritize support
- include supervision, monitoring and support for Puskesmas
- provide inputs into development of medium term MNH action plan & EF
- Provide technical support to Puskesmas

The District Program Coordinators will work within district governments participating in the Partnership, with a focus on support provided to the DHO. The District Program Coordinators will report to the Provincial Coordinator in collaboration with the DHO. District Program Coordinators may work with more than one district government.

Managing Contractor (MC)

AusAID will contract a Managing Contractor (MC) who will have responsibility for the implementation of the Partnership including providing technical and financial support to the provincial and district level governments and other partners. The MC will be over sighted by GoI and AusAID and will:

1. For continuity, especially with GoI agencies and to meet budgeting timeframes, continue implement existing activities already commenced in NTT including novating existing personnel as requested by AusAID.
2. Establish an imprest account and manage funds transfer.
3. Contract a Partnership Director to manage the Partnership. An Operations Manager, Health Systems Coordinator, MNH Advisor and Provincial Coordinator are also to be contracted.
4. The Provincial Coordinator will manage and supervise the District Coordinators and coordinate overall Partnership support and communication with district governments participating in the Partnership. The Provincial Coordinator will report to the Operations Manager and will work closely with the provincial government, District Coordinators and district governments.
5. Contract Districts Coordinators (DC) who will be located in participating District Health Offices to assist with planning, budgeting, community engagement and overall coordination of activities. The MC will undertake a needs assessment of staff numbers required at the district level (DCs could cover one or more districts). District

Coordinators will report directly to the Provincial Coordinator in collaboration with the DHOs. The MC will also assess whether there is a need for administrative support at this level while government systems are being strengthened.

6. Establish a Program Support Unit managed by the Operations Manager which will contain administrative support staff including in administration, finance, human resources, procurement and contracts. The Unit will provide the management support required by the whole Partnership, including the provincial and district local governments, in the administration and operation of the Partnership. This includes but is not limited to:
    - Communication, documentation, report and information management
    - Recruitment, selection, placement, management and support of technical inputs and Partnership funded personnel (long and short term technical advisors in areas such as health systems, reproductive health, health planning, budgeting and financing; community engagement, gender, communications, procurement and probity and M&E. Technical support will be based on requests from the GoI and will be integrated into Indonesian Government agencies as much as possible.
    - administrative and logistical support arrangements (travel, accommodation).
    - procurement of general and technical items.
    - contracting for the provision of services with other organizations / institutions.

    facilitation and coordination support at district level for district governments and agencies.
7. In collaboration with GoI, develop a Partnership Planning, Budgeting and Implementation manual to guide GoI agency participation in the Partnership. This Manual is to be updated as the Partnership progresses.
8. Develop a Technical Assistance Strategy in collaboration with the Provincial Government within three months of commencement. The MC will recruit TA based on strict principles of engagement with the province and districts as set out in Section 3.4

    The TA Strategy should include the mechanisms of delivery. In addition to the TA already identified, additional TA may be required either in the form of subcontracts to organizations or institutions, or individuals to provide technical advice or support services. This will be funded by the allocation of short term / additional TA in the Partnership budget. The TA requirements and potential sources of TA (particularly options to develop local capacity through mentoring or joint arrangements with local organizations) will be included in the annual work plan prepared by the MC. In selecting and contracting TA, the MC will comply with Commonwealth Procurement Guidelines.

9. Implement the Monitoring and Evaluation Framework which will be developed prior to commencement of the contract (see Section 4.2 for details).
10. Establish an implementation approach that supports the progressive capacity development and progression through the phases of the Partnership including:
    - that all Partnership technical staff work within government systems as much as possible and that technical support is integrated within GoI and its agencies

- a process to develop GoI ownership of further design and implementation processes including undertaking a joint needs analysis to decide the feasibility of moving to further districts in NTT or districts in NTB (and if so which districts are to be included in the Partnership).
- incentives for districts to move to a full program approach (funding based on costs + bonus)
- process of annual review to gauge progress towards moving to a program approach (e.g. improvements in financial management and performance accountability capacity)
- process to measure increasing integration of TA and institutional support structures into local government systems and structures (this includes key management positions (Partnership Director and Provincial and District Coordinators)
- ensure performance assessment is streamlined with minimal extra data collection
- develop a process for GoI and GoA to diagnose and assess the capacity of GoI systems, structures and personnel to decide they are ready to move to Phase Two and what will be the trigger for this (eg satisfactory independent Fiduciary Risk Assessment/ Financial Management Assessment of the district government, strength of direct management, agreed costed inter-sectoral plan and which includes targets, satisfactory M&E and support needs identified).

11. Develop a Good Governance Action Plan in collaboration with GoI which includes a process to manage fiduciary risk (a draft Plan is at Annex 5).
12. Manage receipt and review of performance and expenditure reports.

4.2 Monitoring and Evaluation

Monitoring and Evaluation of Partnership Achievement

The Managing Contractor will be required to implement a comprehensive M&E Framework which will be based on the following information.

Consistent with the agreement between donors and the provincial government in NTT for a harmonized and unified approach to M&E, the Partnership will seek to harmonize with current GoI data collection systems, and coordinate with and use M&E processes developed by other donors. Accordingly, current data collection and reporting activities which will be included in the M&E framework will include:

- GTZ funded community household survey undertaken in all districts of NTB (9) and NTT (16) in January 2007 by the Centre for Health Research, University of Indonesia. This survey covered 8,153 households with pregnant women and / or children under age 5 years, a minimum sample 195 per district. It provides a combination of quantitative data on community attitudes and practices, as well as qualitative data from 142 in-depth interviews plus 44 focus group discussions with officials.

- The outputs/outcomes and lessons learnt from the Independent Monitoring and Evaluation Team (IMET) which reviews MNH projects funded by AusAID and DIFD, including the IMHEI project in NTB. IMET uses a participatory process as well as

providing external review. The current AusAID contract will finish in mid 2009, and will focus on the GTZ Partnership in NTT and UNICEF program in Papua in 2008. Whether the Partnership will use the IMET model will be addressed as part of the independent assessments requirements for the M&E Framework.

- National community level surveys conducted by the Bureau of Statistics (BPS) with samples in all provinces provide independent community level measurements of service utilisation and enable comparison with health service reports. Health related surveys include: Susenas (every 3 years, social and economic focus, but includes household expenditure on health); DHS (Demographic and Health surveys, every 5 years, last in 2002-03); and SKRT (specific health surveys, conducted every 5 years, last in 2007, results not yet available).

- National health information system (SIMPUS) which includes a MCH component. Puskesmas report monthly to the District Health Office, which collates the reports and sends on to Province and National levels. Monthly reports are compiled into an annual profile at district, province and national level. Profiles for 2006 for some districts, the province of NTT, and national level are available. As these reports are dependent on data collection and reporting from Puskesmas staff, there are issues with the accuracy and completeness of these reports. For example, immunization data reported by health services has been found to overestimate rates when compared with household surveys. It is possible to compare health service reports with DHS and SKRT data, but the data use different periods and questions and are not directly comparable.

However, the current monitoring and reporting systems of the GoI are functioning poorly in the selected provinces. Regular monthly reporting from Puskesmas to DHO, and then from DHO to Province has largely broken down; with only incomplete and partial data received. The accuracy and reliability of the data is low, and it uses estimates for denominator populations that can differ significantly from reality. Despite this, reporting is already a significant burden for service providers, requiring as much as 1 week of each 4 weeks work for Puskesmas staff.

Attempts have been made by GTZ and UNICEF in NTT to introduce computerized systems in an effort to reduce the workload. IMET commented that UNICEF MCH-LAM method showed promise and could be further extended. However significant ongoing technical support would be needed to maintain operation.

The Partnership will focus on strengthening GoI systems of data collection and reporting, both through technical capacity building, but also by providing an incentive to report, as performance reports will be required for receipt of further funding, and to move towards performance incentives.

There will also be a need to develop additional indicators and methods of measurement for the standard of service provision (current indicators only measure coverage); and for system improvements under component two. Any new methods of measurement will use GoI systems as much as possible, and demonstrate clearly the value of collecting and reporting additional data, in terms of planning, budgeting, and management of resources.

Indicators and Methods of Measurement

These are set out in the Log frame (Annex 2) including methods of measurement. The key M&E methods are as follows:

1. Objectives and higher outcomes: most of the indicators are taken from the national MPS strategy and are routinely collected:

- Maternal, infant and neonatal mortality – national survey estimates from DHS and SKRT;
- Health service coverage indicators – SIMPUS reports in annual profiles;
- Local Government budget allocations to health – included in PHO / DHO annual reports;
- Community level practices / knowledge – DHS, SKRT and GTZ community survey;
- Disaggregated by location as a proxy for SES to ensure improvements in access for the poor and geographically isolated.

Data not routinely collected at the moment will include:

- Fiduciary risk assessments (component three)
- Annual performance reports (these are already prepared by provincial and district agencies, but will need to better focus on achievement of annual performance targets)

2. Component One: service standards and availability. These indicators include: villages with access to basic MNH service; pregnant women who receive all aspects of ANC; Puskesmas that provide BEONC; villages with functioning desa siaga or dukun-midwife collaborations. Availability and access will need to include consideration of the gender constraints, and the degree to which men and women are both involved in decisions on service use. These indicators are not routinely reported, and, in many cases, there are no agreed definitions of standards for access. It is recommended that a periodic (annual) service audit process be undertaken to measure these indicators. (see below)

3. Component 2: Indicators for the system components function are not routinely collected. Assessments will be undertaken by the PHO / TA jointly, using the frameworks already developed by WHO and USAID[13]. The service audits referred to above will provide significant data for M&E in this component.

Specific indicators and methods of measurement for each output are set out in the log frame, including:

Output 2.1 (Monitoring and reporting). Indicator: quality of financial acquittal and activity implementation reports; development of a mechanism and process of service audits

Output 2.2 (Planning and Budgeting) Indicator: quality of partner government agencies' medium term and annual plans; performance reporting against plans:

[13] USAID, February 2007. Health Systems Assessment Approach: A How-To Manual. http://healthsystems2020.org

Output 2.3 (Human resources) Indicator: quality of health workforce. Service audits. Training / competency gains

Output 2.4 (Supportive policy & regulations): Indicator: changes to policies and issue of new regulations.

Output 2.5 (Infrastructure & equipment): Indicator: facilities and equipment satisfy standards. Measurement: service audits

Output 2.6 (Facility management): Indicator: manager training; BLU status achieved. Measurement: service audits

Output 2.7: (Supporting organizations): Indicator: achievement of performance outcomes in agreements. Measurement: organization reports, audits

Output 2.8: (Community accountability): Indicator: Community role in oversight of service provision. Measurement: service audits.

Service audits will be a key method of monitoring and measurement of changes in service provision, access and utilisation, as well as availability and competency of staff; management changes; availability of equipment and appropriate facility; achievement of performance targets.

Options for the audit process will be explored by the MC, and could include:

(i) joint audit by PHO/DHO and TA (appropriate where partner organization reports on performance to PHO / DHO;
(ii) contracted out to external third party;
(iii) peer review by peer organizations from a different location (e.g. DHO from another district).

4. Component Three

The GoI system does not yet measure or report on the aspects of accountability and performance to be developed under component three. Thus additional indicators and methods of measurement will be required. These will be further developed in component three, with the aim of being adopted by the GoI.

Outcomes: The revised Good Governance Action Plan will provide a framework for identification of outcomes and indicators for component three. The GGAP will be developed in collaboration by the MC and the relevant provincial / district government.
Annual performance reports will provide another source of data.

Output 3.1 (Financial accountability). Assessment and measurement of financial accountability will be undertaken by fiduciary risk assessments. The process and mechanism for these assessments will be developed as part of component three, and will involve use of existing GoI authorities or agencies where possible.

Output 3.2 (Governance and oversight). Annual performance reports; and reports from communities which undertake oversight of local providers.

Output 3.3 (Performance based funding support). Achievement against targets and funding provided will be reported in annual performance reports.

Output 3.4 (Donor harmonisation). Agreements with other donors; minutes of donor coordination meetings.

Monitoring of Effectiveness of Development Assistance

While some of the indicators used to monitor program achievement will also measure aspects of effectiveness, additional indicators and measurement will need to be developed. These will be included in the MEP to be developed by the MC during the initial six months.

Indicative indicators for measurement of effectiveness include:

(1) Effective utilisation of additional funding:
- Improvements in performance achieved (annual performance reports);
- Increases in funding from national and local government sources (annual government reports)
- Improvements in governance and accountability (results of fiduciary risk assessments; transparency in performance reporting)

(2) Effective utilisation of TA

The MC will develop appropriate indicators and measure and report on performance in regard to management and provision of TA.
Indicators will measure:
- Integration with the work of the GoI or other recipient organization.
- Appropriateness of skills / approach taken by TA or technical support organization;
- Impacts in terms of capacity built or performance achieved
- Satisfaction expressed by recipient organization / counterpart
- Likely sustainability when the TA is withdrawn

(3) Progress on movement towards a harmonized sectoral approach
- GoI capacity and willingness to lead coordination
- Donor interest and commitment to harmonization

These are more qualitative aspects and will need to be reported by the MC and the AusAID MNH Technical Advisor.

In addition to regular reporting from the MC and the AusAID MNH Sub-national Technical Advisor, external review will also be required. This review will need to confirm reported program achievements, and measure effectiveness of assistance.

Other aspects the external review could consider include:

- the extent to which the approach and model is effective in achieving improvement in performance of government agencies, and in supporting improved governance;
- the performance of the managing contractor, and the contribution of the MC to the broader strategies;
- -the linkage between this Partnership and other AusAID health Partnerships, notably the HSS, and the extent to which the two Partnerships act in synergy to achieve broader strategic aims.

It is proposed that a review be undertaken about 6 months prior to the conclusion of the current 3 year funding arrangement, with a view to informing decisions to extend. Possibly the existing IMET team or a harmonized arrangement with other donors could be utilized.

4.3 Sustainability

By adopting a Partnership approach and working through government systems, the Partnership has built sustainability into its design. However, even within government systems, there are a number of elements which can impact on sustainability. These elements, and possible strategies to address this, are described below:

(i) Workforce

Re-assignment of workforce occurs frequently within the government health service, resulting from allocation to new positions, promotion, retirement, and (occasionally) transfer to the private sector. This requires ongoing training of replacement new workforce; ongoing in-service training; and ongoing professional development.

Strategies: support to improve the capacity and quality of pre-service and in-service training; support for professional representative organizations to play a role in supporting professional development.

(ii) Recurrent costs

Typically, government budgets do not allocate sufficient funds for recurrent costs, particularly maintenance and operation of equipment / facilities; and regular replacement of equipment which has worn out.

Strategies: support to improve the procurement, logistics and infrastructure systems; and to develop expenditure estimates which include costs of M&E, and equipment replacement.

(iii) Technical support

Government budgets rarely allocate funding for technical advisors needed for ongoing higher level analysis or policy development; and there are few sources of this advice available in the provinces and districts of Eastern Indonesia.

Strategies: ensure that provision of technical advice involves and builds the capacity of relevant local technical organizations; and use of local sources of technical advice where possible, if necessary with mentoring and support from international / national sources.

(iv) Political support

Ongoing funding allocation for health and MNH from local government budgets is dependent on political support by local government executives and parliament for MNH

Partnerships against many competing interests and needs. Elections may result in a new executive and parliament with different priorities. Equally, even where there is political support, there may be resistance or lack of commitment from within the bureaucracy and from Partnership managers.

Strategies: support for the ongoing development of the GoI planning and finance system to ensure focus on national priorities through addressing minimum service standards; and support for civil society groups (community / NGO and academic) to oversight and advocate for government funding for MNH needs.

(v) Community accountability

The effective use of resources and ensuring services address community needs will require ongoing community scrutiny and demand for accountability to local government and service providers.

Strategies: support for civil society organizations (community, NGO, professional) to develop capacities in advocacy and in engaging with government and service providers.

4.4 Overarching Policy Issues

(1) Gender

Inequalities in access to resources and decisions, male attitudes about the role of women and unequal power in male-female relationships are underlying issues in poorer health for women and children in Eastern Indonesia.

The GoI has committed to addressing gender inequalities through the establishment of a Ministry of Women's Empowerment and the promulgation of related policies. Gender related targets in the National Medium Term Development Plan include revision of the legal framework to provide justice for women; improvement in the Gender related development index and Gender Empowerment measure; and reduction of violence against women. Strategies include institutionalization of gender mainstreaming, and development of capacity of provincial and district governments to address gender related development through establishment of women's empowerment units in local government.

Strategy: The MNH Partnership will model the mainstreaming of gender through all policies and plans, and will particularly support the gender focused aspects of the National MPS Strategy, notably Strategy 3 on women and family empowerment. Monitoring and evaluation will also focus particularly on progress on gender related issues, and will be able to monitor this through the gender related indicator data collected through the regular national community surveys (DHS, SKRT). These include questions on women's involvement in household decisions, and attitudes towards wife beating and refusal to have sex.

(2) Anti-corruption

Corruption is recognized as significant issue by the GoI, and there a significant efforts to educate the community and officials as to what constitutes corruption, and to develop the legal and regulatory framework to control it. However donor funded Partnerships may be seen as opportunity for corrupt use of funds, particularly where donor funds are being managed through government systems.

Potential opportunities for corrupt use of funds, and strategies to address these include:
(a) Procurement and contracting: reports of collusion and kickbacks in procurement and other contracts are widespread.
Strategy: direct management of procurement and contracting by the MC, until satisfied that the relevant GoI agency has adequate procedures and capacity to implement.
MC to provide appropriately qualified technical oversight and monitoring of procurement and contracting.

(b) Workforce: recruitment and placement of staff reported to be influenced by collusion and kickbacks, particularly appointments to permanent civil service. People with inappropriate qualifications or non performers / absent staff may be appointed.
Strategy: recruitment and placement of civil service employees is under control of local government, and the Partnership has limited ability to influence this. However where staff in positions related to the Partnership are clearly incompetent or not qualified, the Partnership will report this to local government, and can require change in the appointment as a condition for ongoing support.

(c) Use of funds: common methods of misuse of funds include payments for activities not conducted, or not fully conducted; payment for travel not undertaken or not undertaken using the method specified; false receipts for purchase of incidentals; collection of portion of per diem from participants in activities and payment to activity organizers.
Strategy: payments will be made initially by activity, from an imprest account with joint signatories, followed by audit of activity performance and use of funds; ongoing audits of performance and use of funds will continue for Partnership funding.

(d) Incentives to staff: payment of incentives to staff to undertake work related to the Partnership; refusal of staff to undertake work without these incentives.
Strategy: this is a well established practice and difficult to combat. Payments should only be made for work that is outside normal duties, and is linked to production of outcomes.

The Partnership will develop in close collaboration with the GoI a 'Good Governance' Plan which will identify potential avenues of corruption, and how these will be addressed. An initial framework and indicative measures is included as Annex 5.

(3) Environment
The main environmental risks are related to infection control, and the disposal of bio-contaminated waste at health facilities.
Strategies: infection control and waste disposal will be included in the standards for facilities providing services, and will be subject to audit. Where required, support will be provided such as appropriate equipment or training to improve infection control practices.

(4) Performance Orientation
The Partnership design recognizes that the lack of a performance orientation is a significant constraint on improving health system function and service delivery. The provision of the supplementary funding under component one will be linked to explicit and agreed performance targets, and subsequently funding will depend on achievement of those targets. The Partnership will also encourage better collection of data and reporting as

evidence of achievement of performance; and the development of annual and medium term plans that are based on the results of monitoring and evaluation.

(5) Partnerships
The Partnership will be delivered in partnerships with all three levels of government in Indonesia, and encourage the national and provincial levels to undertake their roles in the setting of standards, providing technical and resource support, and monitoring and evaluation of implementation by the district level. The system wide focus of component two will be based on improving the capacity and information available to government to better manage the health system, and improve its performance. By using an approach that supports government planning and implementation procedures, the Partnership will support stronger partnerships with government.

(6) Poverty reduction
The Partnership has selected some of the poorest regions of Indonesia in which to operate, and selection of districts within these provinces will focus on those that are poorer. Improvements in the delivery and access to services will reduce the financial burden of illness on the poor, and improve their livelihoods. The Partnership will include measurements of the access of the poor and those in remote communities to ensure that they benefit from improvements in service delivery.

Although the additional funding provided by the Partnership is linked to a proportion of the local government's budget allocation of health, this should not disadvantage poorer districts, as each district receives a similar block grant (DAU) from the central government to allocate. However, the Partnership allocation of support may be increased if the medium term MNH plan indicates that increased resources are required.

4.5 Risks and Risk Management

An assessment of the risks to the Partnership and possible strategies to address these risks have been identified and are displayed in the risk matrix at Annex 3. A summary of the main risks can be found below:

- Commitment of local governments to performance improvement and reform. Agreements will be signed with each local government prior to commencement of activities to clarify this commitment. The use of performance indicators and annual assessment of performance and financial controls will enable the Partnership to monitor and respond to government commitment.
- Availability and capacity of key Bappeda and PHO/DHO managers to engage with the Partnership. As the Partnership is essentially the local government's Partnership, it will only proceed at the pace that local government managers can accommodate.
- Poor choice of activities which do not result in achievement of desired outcomes. The Partnership TA will work together with local government staff in developing and reviewing plans of activities to ensure the choice of effective strategies.
- Corruption and misuse of funds. While this is a significant risk based on history in several targeted provinces, fiduciary risk assessments and regular audits, the

progressive approach to funding support, and the 'good governance plan' enable the Partnership to monitor and address these risks.

- Community reluctance to change practices or use services. The integrated supply and demand approach, and the ability to build on other demand incentives such as the CCT Partnership, will focus on changing community attitudes and practices.
- Meeting budget expenditure targets could be effected by delays in the designing and contracting processes. Putting all efforts into finalizing these processes as fast as possible will mitigate against under expenditure.

The level of risk is however, considered to be manageable, particularly if local champions can be identified to lead Partnership implementation, and in particular, provide an environment which is conducive to change/reform, in line with an objective to improve health system performance and maternal and neonatal health outcomes.

AusAID presence in Kupang will also strengthen the capacity to monitor the Program.

4.6 Partnership Costs

Budget: Two provinces														
'000 AUD			2008			2009			2010			2011		Total
Component	Cost / month /pp	Months	No.	Total	Months	No.	Total	Months	No.	Total	Months	No.	Total	'000 AUD
Component 1		6			12			12			6			
NTT														
Districts				3			10			10			10	
Population: additional				730945			1678436							
Population: cumulative							2409381			2409381			2409381	
Allocation SKPD health $1AUD pc				731			2,409			2,409			1,205	6,754
Allocation other SKPD $0.25 pc				183			602			602			301	1,689
Total Component 1				914			3,012			3,012			1,506	8,443
Component 2	district p.a	yrs		3			10			10			10	
District level														
2.1 Financial accountability	20	3		60			200			200			200	660
2.2. Planning & budgeting support	20	3		60			200			200			200	660
2.3 System support allocation	30	3					300			300			150	750
2.6 System support allocation														
2.5 Infrastructure allocation	50	3					500			500			250	1250
2.8 Community accountability	20	3		60			200			200			100	560
Province level	province p.a.													
2.1/2 Province level	50	4		25			50			50			25	150
2.3/6 System support allocation	50	3					50			50			25	125
2.4/7 System support allocation	50	3					50			50			25	125
2.5 Infrastructure allocation	50	3					50			50			25	125
2.8 Community accountability	100	3					100			100			50	250
M&E surveys / audits				50			50			50			50	200
Research				50			50			50			50	200
National level														
PCC				20			50			50			25	145
Financial audit	10			40			110			110			110	370
														0
Total Component 2				365			1960			1960			1285	5570
Component 3														
3.1 Fiduciary risk	20 initial; 10 f/up			80			180			110			110	480
3.2 Performance accountability				25			50			50			25	150
3.3 Performance incentives										1205			602	1807
3.4 Donor harmonisation							20			20			20	60
Total Component 3				105			250			1385			757	2497
Management & Admin														
1. Provincial Support Office														
Office manager	2	6	1	12	12	1	24	12	1	24	6	1	12	72
4 x admin /logistics	1	6	4	24	12	4	48	12	4	48	6	4	24	144
vehicles x 2 (lease)	1.33	6	2	15.96	12	2	31.92	12	2	31.92	6	2	15.96	95.76
utilities + penjaga	1.33	6	1	7.98	12	1	15.96	12	1	15.96	6	1	7.98	47.88
rental	0.8	6	1	4.8	12	1	9.6	12	1	9.6	6	1	4.8	28.8
stationery	0.67	6	1	4.02	12	1	8.04	12	1	8.04	6	1	4.02	24.12
communication - phones 20 HP	3	6	1	18	12	1	36	12	1	36	6	1	18	108
set up: computers, internet (10 laptop, 10 PC, server, internet)	22.67	1	1	22.67		1	0		1	0		1	0	
Subtotal				109.43			173.52			173.52			86.76	543.23
District & Regional offices														
admin x 1	1	6	3	18	12	8	96	12	8	96	6	8	48	258
vehicle x 1	1.33	6	3	23.94	12	8	127.68	12	8	127.68	6	8	63.84	343.14
utilities + stationery	0.5	6	3	9	12	8	48	12	8	48	6	8	24	129
communication	0.3	6	3	5.4	12	8	28.8	12	8	28.8	6	8	14.4	77.4
start up laptop/PC/internet(4)	3	1	3	9	1	5	15	1	0	0	1	0	0	24
Regional office: 2														
admin x 1	1	6	0	0	12	2	24	12	2	24	6	2	12	60
vehicle x 2	2.66	6	0	0	12	2	63.84	12	2	63.84	6	2	31.92	159.6
rental	4	6	0	0	12	2	96	12	2	96	6	2	48	240
utilities + stationery	1	6	0	0	12	2	24	12	2	24	6	2	12	60
communication	0.5	6	0	0	12	2	12	12	2	12	6	2	6	30
start up laptop/PC/internet(4)	3	1	0	0	1	2	6	1	0	0	1	0	0	6
Subtotal				65.34			541.32			520.32			260.16	1387.14
Coordination meetings														
Meetings Prov : prov pp	0.05	6	20	6	12	20	12	12	20	12	6	20	6	36
Meetings Prov: dist pp	0.5	6	10	30	12	30	180	12	30	180	6	30	90	480
Meetings District	0.1	3	90	27	6	300	180	6	300	180	3	300	90	477

Personnel														
Core team : nominated														
Avergage cost @ 5 persons	22	6	5	660	12	5	1320	12	5	1320	6	5	660	3960
Subtotal nominated personnel				660			1320			1320			660	3960
Non-nominated personnel														
Averaged costs for add TA and staff	6	6	18	648	12	18	1296	12	18	1296	6	18	648	3888
Subtotal: non nominated				648			1296			1296			648	3888
Personnel : travel														
Local travel - prov based LT	2.5	6	8	120	12	8	240	12	8	240	6	8	120	720
Local travel - prov based ST	2.5	1	5	12.5	1	10	25	1	10	25	1	6	15	77.5
Local travel - dist based	2	6	6	72	12	20	480	12	20	480	6	20	240	1272
Subtotal: travel				204.5			745			745			375	2069.5
Personnel + travel				1512.5			3361			3361			1683	9917.5
Profit = 30% personnel	30%			392.4			784.8			784.8			392.4	2354.4
TOTAL				3,441			10,244			10,223			5,419	29328.3
'000 AUD			2008			2009			2010			2011		Total
Component	Cost / month /pp	Months	No.	Total	Months	No.	Total	Months	No.	Total	Months	No.	Total	'000 AUD
Component 1		6			12			12			6			
Province #2 (NTB)														
Districts				0			0			4			4	
Population: additional										2000000				
Population: cumulative							0			2000000			2000000	
Allocation SKPD health $1AUD pc				0			0			2,000			1,000	3,000
Allocation other SKPD $0.25 pc				0			0			500			250	750
Total Component 1				0			0			2,500			1,250	3,750
Component 2														
District level	district p.a.													
2.1 Financial accountability	20									80			80	160
2.2. Planning & budgeting support	20									80			80	160
2.3 System support allocation	30									100			100	200
2.6 System support allocation														
2.5 Infrastructure allocation	50									400			200	600
2.8 Community accountability	20									200			100	300
Province level	province p.a.													
2.1/2 Province level	50									50			25	75
2.3/6 System support allocation	50									50			25	75
2.4/7 System support allocation	50									50			25	75
2.5 Infrastructure allocation	50									50			25	75
2.8 Community accountability	100									100			50	150
M&E surveys / audits										50			50	100
Research										50			50	100
Financial audit	10									50			50	100
														0
Total Component 2				0			0			1310			860	2170
Component 3														
3.1 Fiduciary risk	20 initial; 10 f/up												60	60
3.2 Performance accountability										50			25	75
3.3 Performance incentives													500	500
3.4 Donor harmonisation													20	20
Total Component 3				0			0			50			605	655
Management & Admin														
1. Provincial Support Office														
Office manager	2	6	0	0	12	0	0	12	1	24	6	1	12	36
4 x admin /logistics	1	6	0	0	12	0	0	12	4	48	6	4	24	72
vehicles x 2 (lease)	1.33	6	0	0	12	0	0	12	2	31.92	6	2	15.96	47.88
utilities + penjaga	1.33	6	0	0	12	0	0	12	1	15.96	6	1	7.98	23.94
rental	0.8	6	0	0	12	0	0	12	1	9.6	6	1	4.8	14.4
stationery	0.67	6	0	0	12	0	0	12	1	8.04	6	1	4.02	12.06
communication - phones 20 HP	3	6	0	0	12	0	0	12	1	36	6	1	18	54
set up: computers, internet (10 laptop, 10 PC, server, internet)	22.67	1	0	0		0	0	1	1	22.67		1	0	
Subtotal				0			0			196.19			86.76	282.95

District & Regional offices														
admin x 1	1	6	0	0	12	0	0	12	4	48	6	4	24	72
vehicle x 1	1.33	6	0	0	12	0	0	12	4	63.84	6	4	31.92	95.76
utilities + stationery	0.5	6	0	0	12	0	0	12	4	24	6	4	12	36
communication	0.3	6	0	0	12	0	0	12	4	14.4	6	4	7.2	21.6
start up laptop/PC/internet(4)	3	1	0	0	1	0	0	1	4	12	1	0	0	12
Subtotal				0			0			162.24			75.12	237.36
Coordination meetings														
Meetings Prov : prov pp	0.05	6	0	0	12	0	0	12	20	12	6	20	6	18
Meetings Prov: dist pp	0.5	6	0	0	12	0	0	12	30	180	6	30	90	270
Meetings District	0.1	3	0	0	6	0	0	6	120	72	3	120	36	108
Meetings national	20	1	0	0	2	0	0	2	1	40	1	1	20	60
Subtotal				0			0			304			152	456
Total Management				0			0			662.43			313.88	976.31
Subtotal nominated personnel														
Non-nominated personnel														
Average cost	7	6	6	252	12	6	504	12	6	504	6	4	168	1428
ST's														0
Int - Gender, IEC, M&E, Health tech, Planning & budget, info spec, health systems	50	1	0	0	1	0	0	1	12	600	1	6	300	900
Unspecified national ST / contracts national orgs	10	1	0	0	1	0	0	1	25	250	1	12	120	370
Subtotal: non nominated				252			504			1354			588	2698
Personnel : travel														
Local travel - prov based LT	2.5	6	0	0	12	0	0	12	3	90	6	3	45	135
Local travel - prov based ST	2.5	1	0	0	1	0	0	1	10	25	1	6	15	40
Local travel - dist based	2	6	0	0	12	0	0	12	8	192	6	8	96	288
Subtotal: travel				0			0			307			156	463
Personnel + travel				252			504			1661			744	3161
Profit = 30% personnel	30%			75.6			151.2			406.2			176.4	809.4
TOTAL				328			655			6,540			3,344	10866.7
TOTAL 2 PROVINCES				3,769			10,900			16,763			8,763	40,195
				3000.0			9000.0			20000.0			14000.0	46000.0

Annexes

Annex 1: Data Tables: National level Indicators by Province

Table 1: Key economic and general health indicators

Province	Population 2005	% below pov line (2004)	% avg GDP pc (2005)	IMR (2003)	TFR (2003)	% U5 malnourished (2005)	Malaria / 10,000 (2005)	Women UAC<23.5 (2005)
Aceh	4,031,589	28.5	101.8%				7.1	12.7
North Sumatera	12,450,911	14.9	88.3%	42	3.0	28.7	7.2	15.2
West Sumatera	4,566,126	10.5	78.6%	48	3.2	30.4	0.7	12.6
Riau	4,579,219	13.1	243.8%	43	3.2	25.8	4	13.1
Jambi	2,635,968	12.5	68.5%	41	2.7	24.3	13.6	17.8
South Sumatra	6,782,339	20.9	96.6%	30	2.3	26.1	6	17.1
Bengkulu	1,549,273	22.4	51.9%	53	3.0	26.6	0	14.9
Lampung	7,116,177	22.2	45.0%	55	2.7	24	5.7	15.6
Bangka Belitung islands	1,043,456	9.1	103.0%	43	2.4	25.7	11.2	12.3
Riau Islands	1,274,848		258.2%			27.5	-	12.1
DKI Jakarta	8,860,381	3.2	395.4%	35	2.2	22.3	-	14
West Java	38,965,440	12.1	79.8%	44	2.8	22	1	17.1
Central Java	31,977,968	21.1	58.9%	36	2.1	24	0.1	17.8
DI Yogyakarta	3,343,651	19.1	60.6%	20	1.9	15	0.1	15.6
East Java	36,294,280	20.1	89.3%	43	2.1	23.8	0.5	16.8
Banten	9,028,816	8.6	75.3%	38	2.6	26.2	0	11.7
Bali	3,383,572	6.9	80.6%	14	2.1	20.5	0	15
West Kalimantan	4,052,345	13.9	66.9%	47	2.9	32.7	0	16.6
Central Kalimantan	1,914,900	10.4	88.2%	40	3.2	27.4	11.9	17.5
South Kalimantan	3,281,993	7.2	71.2%	45	3.0	35.8	2.1	10.9
East Kalimantan	2,848,798	11.6	493.2%	42	2.8	25.9	1.1	9.8
North Sulawesi	2,128,780	8.9	67.2%	25	2.6	23.1	11.5	12.7
Total Rest of Indonesia	192,110,830	15.8%	102.9%					
West Nusa Tenggara	4,184,411	25.4	49.4%	74	2.4	33.4	20.5	22
East Nusa Tenggara	4,260,294	27.9	27.5%	59	4.1	41.1	100.5	40.4
Central Sulawesi	2,294,841	21.7	59.8%	52	3.2	31.3	23.1	15.8
South	8,479,133	14.9	55.7%	47	2.6	30.2	0.5	16.5

Sulawesi								
South East Sulawesi	1,963,025	21.9	53.1%	67	3.6	29.4	6.9	16.2
Gorontalo	922,176	29.0	38.7%	77	2.8	41.5	11.9	13.8
Maluku	1,251,539	32.1	29.3%			33.7	66.2	15.5
North Maluku	884,142	12.4	23.4%			27.3	67.2	17.5
Papua	2,518,400	38.7	186.9%			31.2	208.8	24.7
Total Eastern Indonesia	26,757,961	23.2%	59.8%					
Total Indonesia	218,868,791	16.7	AUD $1680 Rp 12,450,737	35	2.6	28.1	8.4	16.2
Eastern Indonesia %	12.2%							

Sources:
Population 2005: Health Profile 2005, MOH (2007)
Percentage population below the poverty line (2004): Selected Socio-Economic Indicators of Indonesia, National Statistics Board (March 2007)
Percentage average GDP per capita (2005): % of national average GDP per capita in each province. Selected Socio-Economic Indicators of Indonesia, National Statistics Board (March 2007)
IMR: Infant Mortality Rate per 1000 live births (2003): Demographic and Health Survey (note: did not include provinces of Aceh, Maluku and Papua)
TFR: Total Fertility Rate per woman during her lifetime: (2003) Demographic and Health Survey
% U5 Malnourished: Percentage of children under 5 reported as severely malnourished or malnourished (weight for age). Health Profile 2005 MOH (2007).
Malaria / 10,000: Number of cases reported by health centres per 10,000 population. Health Profile 2005 MOH (2007).
Women UAC,23.5: Percentage of women aged 15-49 years with mid upper-arm circumference less than 23.5 cm (a measure of general malnutrition): Health Profile 2005 MOH (2007).

Table 2: MNH related Indicators

Province	Population 2005	Dr /10,000	Midwife / 10,000	Village Midwife /village	1ANC visit (2005)	4+ ANC visits (2005)	Assisted delivery	% couples use FP
Aceh	4,031,589	0.6	9.9	0.5	84.3	73	62.2	40.4
North Sumatera	12,450,911	0.6	4.5	0.6	84.1	78.4	74	42.5
West Sumatera	4,566,126	0.5	2.8	0.6	91.2	79.8	80.2	47.6
Riau	4,579,219	0.4	1.8	0.3	87.7	83.5	71.6	49.8
Jambi	2,635,968	0.7	3.9	0.6	91.3	78.5	82.1	62.9
South Sumatra	6,782,339	0.5	3.6	0.5	92.1	86.2	81.1	59.4
Bengkulu	1,549,273	1.1	7.4	0.7	80	73.9	69.7	66.4
Lampung	7,116,177	0.5	2.5	0.5	90.6	83.2	75.2	66
Bangka Belitung islands	1,043,456	0.7	2.9	0.7	96	91.1	87.1	63.7
Riau Islands	1,274,848	0.8	2.4	0.8	93	78.9	82.1	49.5
DKI Jakarta	8,860,381	0.3	0.9		90.1	74.6	70	54.1
West Java	38,965,440	0.3	1.5	0.6	86	76.3	65.8	62.9
Central Java	31,977,968	0.5	2.3	0.6	89.1	79.2	73.2	61.3
DI Yogyakarta	3,343,651	0.7	1.6	0.4	98.2	81.7	82.6	62.1
East Java	36,294,280	0.4	2.2	0.7	89.6	79.5	86.1	59.7
Banten	9,028,816	0.4	1.3	0.4	89.8	72.1	62.7	58.6
Bali	3,383,572	0.6	2.7	0.7	108.6	86.7	89.5	68.2
West Kalimantan	4,052,345	0.5	3.0	0.5	89.5	65.7	68.4	61.3
Central Kalimantan	1,914,900	1.2	4.6	0.5	90.2	77.5	74.9	67.1
South Kalimantan	3,281,993	0.8	4.7	0.6	91	80.4	73.3	64.9
East Kalimantan	2,848,798	1.1	3.0	0.2	90.9	74.6	80.9	54.5
North Sulawesi	2,128,780	0.9	3.4	0.4	93.9	80.6	66.8	70
Total Rest of Indonesia	192,110,830	0.5	2.5	0.5	88.8			
West Nusa Tenggara	4,184,411	0.4	2.1	0.7	88.6	80	74.2	55.7
East Nusa Tenggara	4,260,294	0.4	4.0	0.5	91.9	65.9	59.3	33.8
Central Sulawesi	2,294,841	0.7	6.3	0.7	85.4	75.5	62.7	55
South Sulawesi	8,479,133	0.2	1.0	0.2	89.4	70.1	68.6	41.9
South East Sulawesi	1,963,025	1.9	8.6	0.7	81.5	69.8	66.9	47.4
Gorontalo	922,176	0.8	2.7	0.6	91	79.3	70.2	59.9
Maluku	1,251,539	0.4	3.1	0.2	98.7	79.2	58.8	28.1
North Maluku	884,142	0.5	3.3	0.3	86.4	71.5	60.2	44.5
Papua	2,518,400	0.5	5.3	0.2	62.2	44.9	33.5	32.8
Total Eastern	26,757,961	0.5	3.3	0.4	87.0	70.3	63.9	

Indonesia								
Total Indonesia	218,868,791	0.5	2.6	0.5	88.6	77.1	72.4	57.9

Source: All data from Health Profile 2005 MOH (2007)

Dr/10,000: General Doctors in government service per 10,000 population
Midwife/ 10,000: Midwives in government service per 10,000 population
Midwife/ village: Village midwives per village (rural areas only)
1 ANC visit: Percentage of pregnant women who made at least one ANC visit during pregnancy
4+ ANC visit: Percentage of pregnant women who made at least four ANC visits during pregnancy
Assisted delivery: Percentage of birth attended by trained health care provider
% couples use FP: Percentage of couples of reproductive age that are current users of a modern method of contraception

Annex 2: Partnership Log Frame

Narrative summary	Indicators	Means of verification	Assumptions
Higher order outcome (goal) Improved maternal and neonatal health (MNH) in selected Provinces and Districts of Indonesia	Maternal mortality Infant mortality Neonatal mortality In selected provinces / districts	National surveys – SKRT (5 yearly, next due 2007)	Improvements in selected provinces will contribute to improvements in national indicators
Long term objective (10 years) Provincial and district governments in Eastern Indonesia can effectively manage national, local and donor resources to progressively achieve MDG targets through a harmonized sector wide approach.	Progressive increase in local government budget allocation to health towards estimated finance requirements. Satisfactory performance on fiduciary risk assessments Achieve 90% of agreed annual performance indicators	APBD budget allocations to health in local government annual reports Annual district performance reports	Other donors support harmonized sector wide approach Regional GoI has capacity and interest in leading donor coordination
Short term Objective (3 years) Provincial and selected district governments in two provinces of Indonesia satisfactorily manage national, local and donor resources to achieve national target levels for priority MPS indicators.	Coverage levels of MPS indicators for ANC, assisted delivery, post natal care and family planning at national target levels in selected districts No subdistrict is below 75% of the average indicator level for the district Satisfactory performance on fiduciary risk assessments	Health information system – annual profile DHS surveys – 3 years Reports of fiduciary risk assessments and follow up of actions taken Annual district performance reports	Provincial and district governments have the capacity and willingness to lead reform of health systems to achieve improved performance.
Component 1			
Provincial and district governments develop and implement MNH programs based on the national MPS strategy and addressing supply and demand aspects to achieve annual performance targets.	Appropriateness of mix of activities selected in annual workplans for achieving MPS targets. % achievement of performance targets % change over 3 year period	Annual reports of DHO and PHO	National MPS strategies provide an appropriate framework for programs at provincial and district level.

Narrative summary	Indicators	Means of verification	Assumptions
Component 1 outcomes 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	District / subdistrict coverage levels for MPS indicators of ANC, delivery care, PNC, FP and neonatal care. % community who know danger signs of pregnancy / newborn and what to do	Annual reports of DHO & PHO Community surveys (DHS)	In achieving the targets, programs will address the needs of poor and marginalized communities.
Outputs			
1.1Basic MNH care and first aid provided at all health facilities Care includes ANC, care for pregnancy & complications, care of normal newborn, family planning information	% villages with access to basic MNH care and first aid % estimated pregnant women who receive all aspects ANC (TT, Fe, BP, weight, abdom palpation) % estimated women giving birth / newborns who receive all aspects of PNC	Service audits Community survey (GTZ)	Adequate staff and resources available to provide services
1.2 Services for the management of MNH complications are available at Puskesmas and district hospital Services include post-abortion care, care of LBW neonate, care of obstetric complications, family planning; infection control.	% Puskesmas that provide BEONC % District hospitals that provide CEONC C-section rate (minimum 5% deliveries)	Service audits	Adequate staff and resources available to provide services
1.3 Women and families have knowledge of appropriate practices and MNH services	Progressive improvements in: % estimated women with newborns who exclusively breast feed % pregnant women attending ANC with anaemia % pregnant women attending ANC in high risk groups (age, parity) % pregnant women attending	Annual reports DHO Community surveys (DHS)	Women and families have resources and capacity to implement improved health practices & improve nutrition Community cultural and social traditions do not impede adoption of practices;

Narrative summary	Indicators	Means of verification	Assumptions
	ANC with malnutrition		
1.4 Communities are involved in the provision and support of MNH services	Progressive improvements in: % villages which function as desa siaga % villages where dukun bayi and midwives collaborate % maternal-perinatal deaths where audit conducted & community involved in audit	Annual reports DHO Service audits	Communities perceive MNH as significant issue and accept some responsibility for addressing it. Community have resources and capacity to engage in MNH issues
Component 2			
Provincial and district agencies and communities access and manage the technical, human and financial resources needed to achieve improvements in MNH	Progressive annual increase in: GoI budget allocations to health and MNH District health MNH staff who have completed refresher training in previous 3 years	Annual report DHO / PHO Service audit (to be developed)	Organisations (eg training centres, hospitals) involved in other elements of the health system willing to commit to support MNH targets.
Component 2 Outcomes Service providers and communities have the resources, skills, technical support and infrastructure needed to improve service delivery and utilization.	District health facilities where infrastructure, staffing and operational funds satisfy requirements.	Service audits (to be developed)	
2.1. Improved monitoring and reporting systems for finance and activities	Satisfactory acquittals of expenditure; Satisfactory audits of expenditure Regular monthly reporting from all district health facilities Annual reports on performance provided Mechanism & procedures for conduct of service audits developed & implemented	Audit reports DHO performance reports	Prov / district agencies commit to and implement improved reporting
2.2. Province and district governments develop and report on medium term and annual plans and budgets with MNH	Submission of satisfactory: Annual workplans and budgets Medium term strategic plans Medium term expenditure	Appraisal of plans and reports (joint TA-PHO)	

Narrative summary	Indicators	Means of verification	Assumptions
performance targets	framework		
2.3. Health workforce is distributed more equitably, performance is monitored, and refresher training provided more frequently.	Availability of skilled staff in facilities especially in remote areas Performance of health workforce measured	Service reports Service audits	Health workforce agree to be placed in remote locations & undertake training.
-Workforce training facilities provide high quality training & education to MNH providers	Quality of graduates of training facilities and training courses	Post training assessment reports	Training institutions have staff, resources & willingness to improve performance
2.4. Local laws, policies & regulations which support MNH developed and approved.	Changes to policies & regulations Guidelines for dukun bayi-midwife agreements	Program reports	Local government supports and enacts changes
2.5. Service delivery facilities have appropriate infrastructure, equipment and supplies to deliver quality services.	Service points which satisfy standards for equipment, supplies and facilities.	Service Audits	Quality contractors and suppliers available
2.6. Managers of services have skills and resources to provide good management	Facilities where managers have received training in management Facilities with adequate skilled administrative support staff Facilities achieve BLU status	Service reports Service Audit	Adequate management staff available and willing to be trained
2.7. Government and non government organizations and donors with interests or roles related to MNH provide effective support.	FP trained staff and supplies available at health facilities Agreements for collaboration with NGOs, professional groups and academic groups, and with Red Cross Indonesia	Audits Copies of agreements	Organisations are willing and have capacity to support MNH
2.8. Communities and civil society have the resources, capacities and	Development plans at community level address MNH	Community plans and reports which address	Technical support available; govt agencies

Narrative summary	Indicators	Means of verification	Assumptions
supportive environment to actively engage in planning and delivery of services.	needs; annual reports of progress in implementation.	MNH	willing to participate
Component 3			
Provincial and district governments manage GoI and donor resources to improve accountability, performance, accessibility and sustainability of public health services.	Resources available sufficient to cover estimated costs of service provision at required standards; Governments report progressive improvements in performance achievement	Good Governance Action Plans	Provincial & district governments agree and commit to improvements in these areas
Component 3 outcomes Explicit linking of resource allocations (budgets) to performance targets in annual workplans; 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 GoI systems	Workplans include performance targets and are based on realistic estimates of costs of achieving targets; Annual reporting of performance to communities, parliaments and donors satisfies reporting standards Donors agree to harmonize assistance	Annual reports of PHO / DHO Donor coordination meeting minutes	Government agencies prepared to provide full and unbiased reports
Outputs			
3.1 Management of funds and resources satisfies good governance standards	Conduct of fiduciary risk assessments Follow up actions undertaken Satisfactory assessments	Reports of fiduciary risk assessments	GoI financial procedures consistent with FRA standards
3.2 Provincial and district government agencies monitor and report on performance to communities, government representatives and donors	Performance reports provided by agencies to parliament Community monitoring reports of service providers	Annual reports of PHO/ DHO Community oversight reports	Community groups have capacity and interest in oversight role
3.3 Performance based funding support provided to agencies and organizations which satisfy	Mechanisms and procedures developed for provision of funds & monitoring of performance	Annual reports of PHO / DHO	GoI systems able to manage and respond to performance based

Narrative summary	Indicators	Means of verification	Assumptions
governance and accountability conditions.	Reports of achievement against performance targets		funding. GoI agencies able to satisfy governance & accountability conditions
3.4 Donors and regional governments agree to harmonize and develop a sectoral approach to assistance in the health sector.	Agreements between regional GoI and donors for assistance in the health sector	Agreements	Donors interested and willing to harmonize activities

Annex 3: Risk Matrix

The Risk Management Matrix contains an assessment of risk based on the following criteria:

L = Likelihood of occurrence (1=Rare, 2=Unlikely, 3=Possible, 4=Likely, 5=Almost certain)
C = Consequence of occurring (1=Negligible, 2=Minor, 3=Moderate, 4=Major, 5=Severe)
R = Risk level - a combination of the above two assessments (E=Extreme, H=High, M=Medium, L=Low)

Further details relating to the likelihood and consequence scores, and resulting assessment of risk level, are provided in AusGUIDElines (refer www.ausaid.gov.au/publications - Ausguide)

Function / Level	Risk	Issue	L	C	R	Risk Mitigation
Partnership with provincial and local government	Commitment of provincial and district government to the MNH Partnership and associated reforms in public administration	A critical factor in the success of assistance provided through the Partnership modality is shared commitment to the same goals and objectives. There is a risk that partner local governments might adopt new areas of focus in health, or reduce their commitment to public administrative reforms when difficult decisions are needed. Changes in government or in key government officials with elections could result in changes in priorities and commitments.	3	4	H	There will be an exchange of letters with each local government (provincial or district) which the Partnership supports, and conditions for ongoing support will be negotiated annually. This will provide an opportunity to review levels of commitment should there be a change in policy focus or in government.
Provincial and district government agencies (Bappeda, PHO / DHO) managers	Availability and capacity of GoI agency resources to implement the Partnership, in particular the time and capacity of Bappeda and PHO / DHO managers and key staff	GoI agency managers face competing demands from national agency level, from the local government executive and parliament, and from other donors and Partnerships. Their availability and capacity to manage the planning, implementation and reporting processes of the Partnership is limited, and this may impact on the speed and quality of implementation. Use of GoI systems means use of a bureaucratic and rather inflexible	2	4	H	Implementation needs to proceed at the pace and capacity of GoI managers and AusAID and Partnership staff need to be sensitive to that pace. However, as the Partnership is essentially that of the government, there should only be limited additional planning, implementation or reporting demands. By retaining some flexibility and direct management of component two activities, there is the potential to progress implementation of system supports which could assist GoI managers even if progress on implementation of component one is slow.

		processes, which may take significant time and resources to manage.				
	Lack of capacity or willingness to address corruption or improve administrative systems to reduce corrupt use of funds or assets	Despite a strong administrative and legal policy and regulation framework, managers lack the time, understanding and support from superiors to address poor performance and corruption.	2	4	H	The main strategies are outlined in section 4d. The Performance Monitoring Unit and the District Coordinators will have the main responsibilities for monitoring and combating corruption. The significant audit process, including the fiduciary risk assessment, and the conditionality of funding on satisfactory financial performance, will contribute to raising awareness of corruption, and how to combat it. An anti corruption action plan has been developed and can be found at annex 5.
	Planning processes do not result in the selection of appropriate or effective activities and as a result implementation is not effective in achieving MNH outcomes	As the Partnership specifies outputs and outcomes, but maintains flexibility in choice of activities, the activities selected may not be the most effective or efficient in achieving MNH outcomes, may not address the key constraints; or may be implemented in a poor quality way which reduces effectiveness.	2	4	H	The Partnership will provide significant resources to assist data analysis, prioritization, and preparation of medium term strategic and investment plans as a basis for annual work plans and selection of activities. Work plans will also be subject to appraisal. This should improve the selection of activities. The role of the health technical advisors will be particularly to ensure that effective activities are selected for implementation. The identification of performance outcomes, reporting on these outcomes, audit of these reports and conditionality for further funding on performance will contribute to improving the quality of implementation
Technical and training support for improvements in system function and service delivery	Difficulty in identifying or engaging providers of technical advice, researchers and trainers / capacity builders to support the improvement in MNH services and health systems.	At national level in Indonesia there are relatively few good providers of technical advice or training in the health sector. Locally in Eastern Indonesia and NTT there are even fewer providers, and they will need support to build their skills and capacities. International expertise may not have the understanding to effectively engage; and does not result in sustainability	3	4	H	The MC will seek innovative ways of engaging national and particularly local technical expertise to support the Partnership, and will also encourage mentoring and twinning between more experienced and local providers in order to build local capacity. The Partnership will also assess and provide support to local training providers and system support organizations, including NGOs, to improve their capacity to engage with and support the health sector and MNH in

						particular.
Health Care providers in Puskesmas and villages	Health care providers particularly in rural areas lack the time, willingness / motivation, or capacity to improve their practices and service delivery.	Eastern Indonesia and NTT in particular has difficulty in sourcing and retaining appropriately trained health care providers in rural areas. Those that work in these areas often lack motivation or interest in improving their skills or practices to improve service delivery.	3	4	H	The Partnership will address this issue at several levels, through working to improve health human resource planning and management, strengthening manager skills and resources, providing training for health workers, and providing additional funding for activities as an incentive for health workers to achieve service delivery targets.
	Health care workers may neglect the hard to reach and poor	In efforts to achieve outcome targets, it may be more efficient and easier to improve services to the already served, and difficult to improve services to those who are geographically isolated or lack resources to access services.	2	4	H	Monitoring of outcomes will include disaggregating by location and where possible socio-economic status (SES) (or use of location as a proxy for SES) to ensure improvements in access for the hard to reach. Appraisal of plans and performance reports will also need to consider the extent to which the poor have benefited.
Community, families and women	Community reluctance or inability to use services provided.	Interventions to improve service availability and quality are easier to implement and may be more attractive to managers, than interventions to improve community awareness, willingness and capacity to use services. Community engagement with services will also be limited by the context of community – government agency interaction, the weakness of community organizations, and general lack of a strong community development approach, and the community's own attitudes of disengagement from government Partnerships.	3	4	H	Community directed outputs have been included in component one, based on the national MPS strategies, to encourage health agencies and staff to develop their role in engaging with communities, rather than consider this the role of other agencies. Outputs in component two seek to increase the capacity of organizations which can support communities in improving their awareness and engaging with health care providers. This aspect will need attention from the TA in ensuring that plans adequately reflect an integrated approach.
	Community reluctance or inability to change practices or behaviours	Communities, and particularly families and women, have tended to maintain traditional beliefs and practices, and have been reluctant to accept the advice of health care workers, particularly in regard to	3	4	H	The Partnership will provide information and education to communities in general, and to families and couples in particular on health issues. The Partnership will also develop the skills and capacity of health workers, community organizations, and other

		nutrition practices, and referral of high risk patients to hospital.				government agencies, to encourage healthy behaviours and practices.
External Environment	Changes in the political, social or economic situation or natural disasters may divert attention or resources away from MNH, and reduce community capacity to engage.	NTT and NTB are prone to natural disasters; social or political disturbances are frequent; and there is a medium to high risk of further economic downturns. All of these would create a more difficult context for the Partnership.	3	4	H	While these events are outside the control of the Partnership, it will work closely with provincial and district governments to assist in addressing any changes which might occur in the political, social or economic context.
	Meeting budget expenditure targets could be effected by delays in the designing and contracting processes.		3	4	H	Putting all efforts into finalizing these processes as fast as possible will mitigate against under expenditure.

Annex 4: Nusa Tenggara Timur (NTT)

1. Introduction and Background

Preparatory activities in the province of NTT commenced in March 2007, with PHO recommendations on the selection of the initial three districts (April 2007), appointment of regional health advisor (RHA) in June 2007, and establishment of office, appointment of district coordinators in the three districts, and initial inputs by short term advisors (Aug – November 2007).

The design was prepared based on inputs and consultations undertaken during the preparatory period by the RHA and short term advisors, followed by more intensive consultation on the draft MNH in Eastern Indonesia design. This took the form of a design mission to NTT in January 2008, with a team consisting of members from AusAID Indonesia office, the AusAID NTT MNH team, DPAG section of AusAID, and consultants. During the mission, the design team met initially with the head of the PHO, and then facilitated a one day workshop with key provincial stakeholders (Bappeda, PHO and other government institutions) and representatives from the three initial districts (Bappeda, DHO and District coordinators). At the workshop the design team presented the design outline, sought feedback on this, and then discussed in detail with each district and the province team the budget allocations and work plans.

2. Sectoral Analysis

The province of NTT is among the poorest both economically and in terms of health status in Indonesia. More than one quarter (28%) of the population is below the Indonesian Bureau of Statistics poverty line (Indonesia average 17%), while the resources available to government are low with GDP per capita only 27% of the national province average (AUD $4.50). The Infant Mortality Rate (IMR) in 2003 of 59/1000 live births is well above the Indonesian average of 35/1000, and the Total Fertility Rate (TFR) of 4.1 births per woman during her reproductive lifetime is the highest found in the 2003 survey (national average TFR 2.6). The rate of malnutrition among children under 5 of 41% is second highest in Indonesia, and well above the national average of 28%. The proportion of women suffering malnutrition is also the highest with 40% of women aged 15 – 44 having a mid upper arm circumference below 23.5 cm. Primary educational levels are relatively high, with only 28.5% of women not completing primary school; but relatively few go on to high school (DHS 2003)

The province now has 19 districts (kabupaten) and one municipality (Kupang) following the recent division of districts to form 4 new kabupatens. However the following analysis is based on the previous 16 kabupaten and municipality, as data is not yet available on the basis of the new 20 districts. (See Tables Annex 1)

Examination of indicators by district indicates considerable variation in levels of poverty and health. This is confirmed by the range of variation of different indicators of poverty, although the indicators do not agree on the poorest districts. The proportion of households with

monthly expenditure <Rp 80,000 ranges from 1% in the city of Kupang and in Flores Timor, to 46% in TTS, and 30% in Alor, Manggarai and Rote Ndao. (Susenas 2005). The NTT Health Profile of 2006 reports that 39% of families are poor, with highest proportions in Sumba Barat (82.5%), Ende (81.9%), Sumba Timur (73.1%) and Sikka (72%). The GTZ household survey found that 84% of households had expenditures of < US $1 per day (Rp 270,000 per month), with highest proportions in Manggarai barat, Lembata, Flores Timur, Sikka and Sumba Barat (> 95%).

Health indicators also vary considerably among the districts. The NTT Health Profile of 2006 reports an average of 37% of children under 5 are malnourished, with highest proportions in TTU, Alor and Sumba Barat (all above 45%).

A. MNH Services

In regard to MNH, the coverage of key service interventions varies considerably:

Antenatal care: While the coverage of at least one ANC visit is relatively high (92%, above national average), the coverage of the minimum of four 4+ visits is significantly lower (66% in National profile 2005, the lowest province except for Papua).

This is confirmed by NTT Health Profile for 2006, which reports an average coverage for 4 ANC visits of 63%, ranging from 51 – 53% in Sumba, to 80% in Ende and Belu. This is little changed from the figure of 64.7% in 2005, although improved on the figure of 43.9% in 2004.

The GTZ household survey reports similar figures, with 70% levels in districts on Flores, but lower levels of 50% in Sumba and Alor. The GTZ survey also measured the proportion of women receiving all 5 ANC interventions (TT vaccination, blood pressure measurement, iron tablets, weight, and abdominal palpation). Only 50% received all 5 interventions in Flores and West Timor, and only 20% in Sumba and Alor.

Deliveries assisted by a trained health worker: The proportion of deliveries assisted by trained health staff reported in 2006 was 77% which is a slight increase on 75% in 2005, but a considerable improvement on 48% reported in 2004. Some of this improvement could be due to improved reporting rather than just performance. The proportion varies among districts from 42% (Alor) to 89% (Belu). Sikka and Ende report fairly high rates (82% and 77%) while the rate in Sumba Timur is 59%. (NTT Health Profile)

The GTZ household survey found that 56% of mothers reported delivery by a trained health attendant for their last birth, with lowest rates in Manggarai, Rote Ndao and Kupang district (below 40%) and highest rates in Sikka (over 90%). These rates are not directly comparable with the Health Profile which reports on deliveries in the previous year. The GTZ survey found that 38% of mothers in NTT reported being assisted by a traditional birth attendant (dukun) in their last delivery, and that the vast majority (65%) of deliveries, assisted or otherwise, take place at home.

Family planning: The high TFR noted above is paralleled by the NTT Health Profile report of low proportions of contraceptive users - 38.5% well below the national average 60.3%. This is confirmed by the GTZ household survey, which found that only 44% of surveyed

households were current contraceptive users, with lowest proportions on West Sumba, Lembata and Ende.

The Susenas of 2005 reported a rate of 67% of married couples using contraceptives, with lowest proportions in Sumba and Belu. (Note that the GTZ survey found high rates in Belu). The most common reasons reported for not using contraceptives were side effects (16%), lack of knowledge (8%) and husband didn't permit (6%) according to GTZ.

The levels of unmet need (married women who do not desire any more children, or wish to space birth, but not using contraception) is estimated to be high at 39%, with highest levels in Sumba and Alor (nearly 50%). (GTZ) DHS 2002 reported 16.7%, the highest level from the provinces surveyed. Around 10% of GTZ respondents reported a history of abortion, with highest levels in Ende (26%), Alor (18%) and Sumba Barat (15%)

In terms of facilities and staff for MNH services, there is less variation among districts, and generally levels are near national averages.

The NTT Health Profile reported 264 Puskesmas in NTT, which is an average of one per16, 500 population, better than the national standard. Higher populations per Puskesmas are found in the District of Kupang, Sumba Barat, Belu and Manggarai (above 20,000).

The ratios of doctors per 10,000 population (0.4), midwives (4) and midwives per village (0.5) are at the level of, or better than national averages (National Health Profile 2005). The NTT Health Profile reports a general doctor per 10,000 population ratio of 1.0, with lowest rates in Flotim, Manggarai and Kupang district (0.5); and a midwife to 10,000 population ratio of 5.1, with lowest rates in Sumba Barat (1.3), Sumba Timur (3.1) and TTS (3.4).

However utilisation of public community services remains low, with an average of only 1 visit per person to Puskesmas per year. Ngada, Sumba Barat, TTS and Flotim had lower rates (below 0.6).

B. Finance for Health Services

Gani and Chamberlain in the initial concept design framework, analysed budget allocations to health from five districts in NTT. They found an average budget allocation from local government (APBD) to health in 2006 of Rp 125,000 per capita (AUD $16.70).

The three districts selected for initial activities reported APBD allocations to health in 2007 of between Rp 85,000 for Sikka and Ende, to Rp 124,000 for Flotim. This includes the allocation for the district hospital, but does not include the allocation for salaries. The comparable allocation at provincial level was only Rp 2,600 per capita. Most of the provincial government allocation (APBD) goes to the Provincial hospital.

Districts also receive allocations from the central government as Dana Allokasi Khusus (DAK) and Dana Dekonsentrasi (Dekon- which is distributed through the province). The average per capita allocations in 2006 were Rp 24,250 for DAK and Rp 20,150 for Dekon. Based on the data from Sikka and Ende, local government allocations from general funds contribute around 80% of the district health budget, with the remainder from central government earmarked funds. Unfortunately it is difficult to get complete data on finances.

Table 1: Districts + Province budget allocation to health (Rp)

Source of funds	Sikka	Ende	Sumba Timur	Total
Population	290547	257258	214422	762,227
2007				
APBD (2007)	24,486,280,988	22,046,122,100	26,545,040,420	73,077,443,508
APBD per capita	84,276	85,69	123,798	95,874
2006				
APBD (2006)	21,270,845,936	18,107,567,000	23,649,841,050	
DAK (2006)		7,470,567,000		
Dekon (2006)	1,336,312,500	1,304,969,500		
Other (Askeskin)	1,404,004,000	1,767,744,000		
Total	24,011,162,436	28,650,847,500	23,649,841,050	76,311,850,986
Total per capita	87,017	120,607	108,758	104,402

Source: Health Profile for Sikka and Ende; Workshop on 30 Jan 2008

There are currently no adequate estimates of the costs of provision of health services at district level, let alone costs for MNH services. The authors of the MNH in NTT design concept, Gani and Chamberlain, used some estimates from UNDP which suggest around USD 10 per capita is needed for basic health services. On this basis they calculated that two districts had allocated surplus to requirements, and three were below requirements.

C. Expenditure

Expenditure of local government budget allocations for health reported from the three initial districts ranged from 85% (Sumba Timur), 90% (Ende) and 100% (Sikka) with an average of around 90%.

The main reasons for inability to expend the budget in full reported by the DHO were:

- Delays in the finalization and disbursement of the local government budget, which resulted in delays and insufficient time for tendering for some activities;
- Lack of sufficient staff to manage finances and disbursement within the local government, resulting in delays in disbursement;
- Errors in the work plans prepared by DHO and PHO, particularly duplication of funding from centre or province levels, or in supplies of medicines provided from the centre, resulting in no need to spend local government funds;
- Failure to progress in donor projects and consequently failure to use allocated counterpart funds;
- Some activities unable to progress due to lack of suitable candidates (eg training Partnerships).

Expenditure at province level seems to be lower, with only 70% of local government allocation for community health expended in 2006, 70% of central government Dekon funds, and 48% of central government DAK funds. The PHO reported a variety of reasons including:

- local government alterations to work plans and budgets, particularly the deletion of essential component activities, which prevent full implementation and utilisation of funds;

- delays in the allocation of funds from central government, resulting in insufficient time to expend the funds;
- changes in the allocation during the year, with the withdrawal of some centrally allocated funds to fill over expenditure on Askeskin.

D. Health Systems and Public Administration

Constraints and issues in relation to the health system in NTT that have been identified in the initial consultations and consultant reports include:

Human Resources issues:

- Difficulty in recruiting and retaining specialist doctors (such as obs-gyn specialists) at the district hospital. This constrains the capacity of the district hospital to provide caesarean sections, an essential part of comprehensive MNH emergency care. General doctors at the hospitals are receiving training to enable them to take on this role
- Puskesmas doctors particularly those on contract rotate frequently and many do not have adequate skills in management of MNH emergencies. It is suggested that newly appointed Puskesmas doctors undertake a period of supervised on the job training at the district hospital before commencing their placement at the Puskesmas
- Rates of delivery for some midwives are very low, below what is needed to maintain skills.
- Midwife registration. Few midwives have completed the 3 year diploma now required for licensing, and most who do, do not return to the village to work. The implications of the 3 year diploma requirement for midwife licensing needs to be considered.

Puskesmas Management:

- Some Puskesmas do not have adequate basic facilities to provide MNH emergency care, such as a suitable room, equipment, water and electricity.
- Puskesmas generally lack trained managers or administrative staff to provide management support, particularly in regard to finances.
- Absenteeism and limited hours of operation remain a significant problem particularly at Puskesmas level. Managers do not appear to have authority to take sanctions against staff who are absent without due reason.
- Current Askeskin reimbursement arrangements for delivery are individual provider based, and do not encourage team delivery at the Puskesmas. Increasing Puskesmas and facility deliveries will reduce the income of village midwives and act as a disincentive to referral.
- Lack of Puskesmas engagement with sub-district (kecamatan) level of government, and participation in sub-district planning (musrembang kecamatan).

Status of BKKBN (Family Planning Agency). The provincial government is currently making a decision on the future of the provincial office. At district level, BKKBN offices now operate as Family Planning units within the district Department of Population, Civil Registration and Family Planning, but implications for role and function are not clear. The PHO has recently established a Family Planning section, and the respective roles of BKKBN and health service in family planning services is not clear. The allocation of contraceptive supplies from the central office BKKBN to districts and provinces is no longer

reliable, and it is reported that there is no allocation for 2008. Interruption to contraceptive supplies creates a significant problem for continuity of services.

Health training academies. The provincial national health training academy (Poltekkes) provides a 3 year diploma for midwives. However the quality of new graduates is generally regarded as poor, and most require in-service training to provide them with the basic skills needed to undertake their functions. The Poltekkes reports a lack of suitably qualified lecturers, large class sizes, lack of practical sites, and poor teaching methods. Potential for twinning with Indonesian / Australian institutions; or placement of volunteer midwife teacher

MNH In-service training centres have been developed at province and district hospitals with the assistance of the WHFW project. Two centres have been established in Flores, one in Sumba and one at Province level. However, following the cessation of the WHFW project, the centres have not been maintained, and only a small proportion of midwives have had refresher in-service training.

Professional organizations: IBI: Midwives association in NTT.

- 2,780 midwives are registered with IBI, but most have only one year diploma qualifications.
- IBI has a role in providing a supporting letter for applications for license to practice, but procedures have yet to be clarified.

E. Public administration

Elections for Bupati should be completed in all districts in NTT by 2008, while the election of governor is scheduled for mid - late in 2008. The elections have led to several districts introducing popular Partnerships such as free health care and schooling, although the capacity of districts to continue to fund these Partnerships, and the impact on staff performance, results in questionable benefit to the population.

The quality of public administration varies significantly among districts, and depends to a great extent on the quality of the bupati and local parliament. Newly elected administrations frequently change the appointments of heads of agencies, which creates significant risks of change in Partnership direction and administrative capacity. However, the changes to public administration required by government regulations PP41 and PP 38 are progressively being implemented, with the PHO indicating that the PHO structure is being revised in line with the new regulations.

The Public Expenditure Analysis and Capacity Enhancement (PEACH) Partnership has commenced analysis of financial management in two districts (Flotim and Sumba Timur) and plans to undertaken analysis in a total of 7 districts.

- While the reports have yet to be released, the main issues identified include:
- inability to disburse funds allocated, rather than shortage of budget;
- fragmentation of budgets and work plans;
- ‘unspecified expenditure’ remains a significant problem
- high expenditure on travel (up to 50%)

- high cost administration in relation to service delivery[14]

4. Problem Analysis

The key problems which need to be addressed in the management and implementation of the MNH Partnership in NTT are:

(1) Public administration

Public administration in NTT has demonstrated weakness in planning and budgeting, and in financial management and control. The province has a poor record on expenditure of government funds and on corruption control. This is compounded by increasing politicization of public administration, and the influence of elected bupati and parliaments.

The Partnership support will need to provide adequate oversight and controls over expenditure of funds, and an assessment of planning and finance systems to identify and address weaknesses in these areas. There is the potential of collaborating with ANTARA and PEACH to achieve improvements in public administration and governance.

(2) Experience with donor funding

There are a significant number of donors operating in the health sector in NTT, and despite agreements to 'harmonize' and use joint monitoring and a joint 'master plan', the coordinating structures between donors and government remain weak. Multiple donors in the same district are a significant burden to the district administration; Sumba Timur complain they are overwhelmed with three donor Partnerships.

In addition, significant delays in disbursement of donor funds through government Partnerships have been reported eg delays with UNICEF funds reported by Pak Thoby. There is also previous experience that local parliaments may reduce budget allocation to particular sectors in view of donor support, rather than maintain or increase.

Implications

The Partnership will encourage and support the provincial government of NTT in developing cooperation among donors and harmonization, including the establishment of coordination structures and joint planning and M&E. Decisions on expansion to districts of NTT where other donors are operating will be undertaken in consultation with the provincial government and other donors. Linkage of funding support to local government budget allocation and to performance will be important to avoid problems of lack of disbursement or reduction in government allocations.

(3) Health sector reform

While there are significant health system issues which impact on the performance of MNH services, the plans developed by PHO and DHO have tended to focus on more technical issues, and not address broader system reform. Partly this is because broader reform requires the commitment and leadership of the local government as a whole, not just the health sector. However, in the absence of this leadership and with relatively weak civil society demand or accountability mechanisms, there is a risk that reform will be overlooked.

Implications

[14] Conversation with PEACH director, Kupang, 31/1/08

The Partnership will need to provide significant support to get health system components functioning while building the information base and support for reform
There are potential opportunities with the PNPM pilot, HSS Partnership and ANTARA to identify and advocate for system reforms.

Data Tables for NTT

District	Population 2005	% poor	% h-holds < Rp 80,000 expend per month	% U5 malnourished (2005)	Pop per Puskesmas	GP Dr /10,000	Midwife/10,000
Sumba Barat	409,851	82.5%	29.5%	46.4	24,109	0.8	1.3
Sumba Timur	217,454	73.1%	19.2%	33.3	12,791	1.3	3.1
Kab Kupang	362,790	15.5%	28.1%	40.4	13,437	0.9	4.9
TTS	412,353	18.9%	45.8%	45	17,181	1.0	3.4
TTU	209,037	60.2%	22.3%	50.3	13,936	0.8	8.9
Belu	394,810	14.5%	28.0%	31.6	21,934	1.1	5.3
Alor	177,009	15.8%	30.2%	45.8	9,834	0.7	4.2
Lembata	102,344	16.5%	18.7%	27.6	12,793	1.9	9.9
Flotim	225,268	62.5%	7.0%	38.8	15,018	0.5	8.5
Sikka	275,936	72.1%	19.3%	37.4	16,232	1.5	9.1
Ende	237,555	81.9%	16.7%	34.3	11,878	1.9	6.7
Ngada	250,305	57.3%	20.7%	22.9	17,879	0.8	7.2
Manggarai	495,136	10.7%	30.3%	36.2	21,528	0.5	3.5
Rote Ndao	110,617	15.5%	30.2%	38.3	9,218	2.5	5.3
Kota Kupang	279,124	11.5%	2.5%	30.8	39,875	0.5	3.9
Manggarai Barat	195,532	27.0%	21.6%	35.8	16,294	1.3	4.2
Total	4,355,121	38.8%	24.7%	36.8	16,497	1.0	5.1

District	Pregnancies 2006	4 + ANC visits 2006 %	Assisted delivery last year 2006 %	Referred for management complications (2006) %	Married couples current FP user (2006) %	Married couples current FP user (Susenas 2005) %
Sumba Barat	15030	51	50.9	6	58.1	50.8
Sumba Timur	5782	53.5	58.7	25	38	60.3
Kab. Kupang	9223	72.8	70	100	70.1	67.6
TTS	11082	56.4	72.3	78.2	11.6	67
TTU	6801	68.7	81.3	0.7	28.1	67.2
Belu	9727	79.8	88.9	14.2	33.3	60.3
Alor	4588	69.3	41.9	15.9	81.5	77.4
Lembata	2670	77.7	73.6	17.2	57.1	68.9
Flotim	5846	66.2	71	17.5	42.5	62.4
Sikka	7713	58.3	81.8	37.7	41.8	73.6
Ende	6347	80.1	77.3	12.3	51.6	64.7
Ngada	6473	61.9	71.3	85.1	32.1	65.3
Manggarai	13638	62.7	66.5	65.6	100	77.9
Rote Ndao	2918	62.3	70.9	100	51.4	63.6
Kota Kupang	8360	55.3	66.7	37.7		67.6
Manggarai Barat	6220	59.1	61.3	38.9	40	64.7
Total	122418	63.3	68.8	36.3	50	67.4

Source: NTT Health Profile, 2006; Susenas NTT 2005

Annex 5: DRAFT Australia-Indonesia Partnership Maternal and Neonatal Health Good Governance Action Plan

Measure	Summary	Responsibility
A. Commitment and leadership from government		
Exchange of Letters with provincial and district governments to participate in the Partnership	• Prior to commencing the Partnership, **AusAID** will meet with provincial and district government representatives and seek their interest and commitment to work in partnership on the program, including improving the governance and accountability of public service provision in the health sector. • The Partnership will seek local government's support to address financial management targets such as (a) transparency in budget allocations; (b) use of budget and Partnership funds in accordance with agreed annual plans; (c) full reporting of expenditure against budget allocation as well as amounts received; (d) Bappeda to maintain an imprest account with joint signatories which include a representative from the MC; (e) annual audits by an independent body (could be the government audit agency – BPK); (f) participation in fiduciary risk assessment and implementation of any remedial actions recommended; (g) prompt action in accordance with law to address any malfeance reported or identified; (h) similar conditions on any government or non government agency / organisations to which funds are transferred. • Only where government leaders agree to work in partnership on all aspects of the program, will the Partnership agree to provide support funds. • Partnership funding will be suspended if irregularities are identified, pending appropriate action by the provincial / district government; • If any provincial or district government does not address irregularities or financial management weaknesses identified, advice will be sought from the national agencies on the Performance Review Committee as to appropriate action. • Following elections or change of government leadership, the commitment of the new government will be sought, and where given, the agreement will be renewed.	MC
Commitment from government and non	• Government agencies or institutions (PHO/DHO, hospitals, Puskesmas, health worker training academies) or non government organisations which receive	Provincial or district Bappeda

Measure	Summary	Responsibility
government agencies receiving Partnership support	Partnership support will be required to sign a service agreement with the relevant provincial or district government which will include the anti-corruption requirements.	
B. Budget transparency		
Clear linkage of budget to work plans and performance targets	The Partnership will provide technical support and oversight of the preparation of work plans and budgets. The Partnership will assist in costing of activities and where appropriate provide agreed costs Work plans will specify the performance targets expected. These measures are in line with GoI planning and budgetary procedures	Provincial and district agencies, Bappeda Technical support and oversight by MC
Partnership funding support will progressively be provided on budget	Partnership funding support under component one will be included in the annual local government agency work plans and budgets The amount of Partnership funding support will be based on a proportion of the previous year's local government budget allocation to health. Funding under component two will be managed by a combination of direct management by the MC, and funding to provincial agencies for activities in their annual work plans and budgets. Initially the Partnership will use an activity based funding mechanism managed jointly by Bappeda and the Partnership, while providing support to provincial and district governments to improve the official government funding system. When this system is functioning effectively, and with the agreement of AusAID and the relevant local government, funding will be provided through the official mechanism	Provincial and district agencies, Bappeda Technical support and oversight by MC
Reporting of actual amounts of allocated budget received	Annual expenditure reports from government agencies will include the actual amount of the allocated budget received	Provincial and district agencies, Bappeda Technical support and oversight by MC
C. Control of expenditure		
Funding provided on an activity basis, following acceptance of	Initial funding will be provided on an activity / activity cluster basis with funding for subsequent activities dependent on submission and acceptance of satisfactory acquittal of expenditure, through a joint account managed by the MC and Bappeda.	Provincial and district agencies, Bappeda Technical support and

Measure	Summary	Responsibility
expenditure acquittals		oversight by MC
Funding on a Partnership / tranche basis dependent on satisfactory performance and fiduciary risk assessment	Funding will be provided on a Partnership / tranche basis only when the recipient agency / organisation demonstrates satisfactory performance and expenditure acquittal on an activity basis; where activity implementation is satisfactory; where a medium term strategy plan has been developed as a basis of funded activities; and where a fiduciary risk assessment has been undertaken and satisfies AusAID requirements	Provincial and district agencies, Bappeda Technical support and oversight by MC
Procurement managed by MC until satisfactory procedures demonstrated.	Procurement will be directly managed by the MC in accordance with relevant Indonesian law and Commonwealth procurement guidelines. Only where procurement processes have been reviewed as part of the fiduciary risk assessment and are considered satisfactory will procurement be undertaken by local government or its agencies The Partnership will engage a procurement and probity officer to oversee all procurement and contracting, and to assist local government agencies in improving procurement processes.	MC
D. Public oversight and complaints		
Community oversight of health facilities will be encouraged and supported	The Partnership will provide support for community representatives to participate in facility management groups for hospitals and Puskesmas. The facility management groups will review budget allocations, budget receipts, income receipt and expenditure; staff absences and staff performance	Provincial and district agencies, Bappeda Technical support and oversight by MC
Community complaints will be investigated and responded to by local government	The Partnership will provide support and encourage communities to express and report complaints about services The Partnership will assist services and facilities to respond to complaints and report back to communities on actions taken	Provincial and district agencies, Bappeda Technical support and oversight by MC
Facilities to provide information to consumers on fees, services and complaint procedures	The Partnership will assist facilities to develop service charters, and to provide information to consumers on service availability, fees and charges, and how to make complaints	Provincial and district agencies, Bappeda Technical support and oversight by MC

Measure	Summary	Responsibility
E. Monitoring and sanctions		
Annual and random audits of local government agencies / non government recipients of Partnership funds	Annual audits and periodic random audits will be undertaken and results reported to the relevant provincial / district government and to the PRC. Where irregularities are found Partnership funding will be suspended pending appropriate action from the provincial / district government	PD
Fiduciary risk assessments will be undertaken	Fiduciary risk assessments will be undertaken in provincial / district governments that participate in the Partnership The assessments will examine the health sector and any relevant related aspects of the community sector and will include an assessment of at least the (a) budget preparation process (b) income and expenditure controls; (c) procurement; (d) expenditure reporting; (e) independent scrutiny. The results of fiduciary risk assessments will be reported to provincial and district governments and the PRC together with any recommendations for remedial action.	PD
Partnership funding to be ceased where local government fails to act on reported irregularities, or results of fiduciary risk assessment	Provincial and district governments will be required to respond to any reported irregularities in audits, or recommendations from fiduciary risk assessments. Responses will be monitored and reported to the PRC for consideration of resumption or cessation of Partnership funding	PD, PRC

Annex 6: Selected Terms of Reference and Indicative Organisational Structure

Position to be directly recruited by AusAID:

Maternal and Neonatal Sub national Health Systems Coordinator

Positions to be nominated by MC:

1: Partnership Director
2: Operations Manager
3. Maternal and Neonatal Health Advisor
4. Health Systems Coordinator
5. Provincial Coordinator

AusAID Maternal and Neonatal Sub-national Health Systems Coordinator

Background

AusAID advises the Government on international development policy and manages Australia's overseas aid program including contributing to a global commitment to achieve the Millennium Development Goals (MDGs). Indonesia is faltering in progress on achieving several of these goals. While it appears likely that Indonesia will achieve the MDG #4 target on infant mortality, it is unlikely to achieve the MDG #5 target on maternal mortality. During the period 1992 to 2002, the proportion of births assisted by skilled health personnel (an important MDG 5 intermediate indicator) has increased from 40.7% to 72%, but is still far from the Government of Indonesia's (GoI) target of 90% by 2010. Sharp economic differences remain, with only 48% of poor women delivering with a trained provider, compared with 90% of wealthy women. Regional disparities are also marked, with just 35% of women delivering with a trained provider in NTT, compared with 96% in Jakarta.

Australia-Indonesia Partnership for Maternal and Neonatal Health (AIPMNH)

The AIPMNH will work with the national, provincial and district governments to enable the health system in selected provinces and districts to effectively deliver MNH programs. It aims to address the main supply and demand side constraints to improving maternal and neonatal health including an increase in skilled deliveries and institutional deliveries, an increased use of modern contraceptive methods, and a reduction in maternal malaria and anaemia. The program will be implemented through District government systems, with a strong emphasis on health systems strengthening. The emphasis is on supporting Districts' own planning and initiatives.

AusAID will provide technical and financial support to Districts to implement the MNH activities. Assistance will be responsive and flexible, and may include work in areas such as midwifery, reproductive health, family planning, malaria, micronutrients, social insurance, gender, and communication, depending on Districts' needs. The program has started in ten

districts in Nusa Tenggara Timur (NTT) province with the intention of replication in other districts and provinces in future years. AusAID's support will be closely coordinated with the activities of other donors working in the program area, including most notably GTZ and UNICEF.

AusAID requires a Maternal and Neonatal Health Systems Coordinator to engage with the GoI in addressing the underlying health system constraints and reforming health systems in selected provinces and districts to achieve improvements in MNH health service delivery.

Critical local level policy areas to be addressed include sustainable health financing; health sector planning; health information systems; strengthening infrastructure and maintenance; and enhancing transparency and accountability of health procurement systems.

Job Description for the Maternal and Neonatal Sub-national Health Systems Coordinator

The successful applicant will be expected to:

Provide sectoral analysis and advice

1. Analyse the maternal and neonatal health policies of the Government of Indonesia particularly as it pertains to effective district level delivery of health services. This includes identifying generic system weaknesses, appropriate interventions to strengthen programs
2. Build relationships with provincial and district governments in targeted provinces and districts, donor agencies and non-government agencies which enable discussion of public administration weaknesses and constraints and identification of reforms needed for improvements in MNH health service delivery.
3. Facilitate dialogue and exchange of views among AusAID supported health and relevant other sectoral programs with the MNH program, in particular the Health System Strengthening program, and the ANTARA program in NTT, to maximise coordination and effective collaboration.
4. Liaise with academic, civil society and professional organisations in Indonesia that contribute technical support to the Indonesian government MNH program, and encourage effective involvement of these organisations in the GoA support programs, and capacity building of these organisations through GoA programs particularly at the local level
5. Acting as a high level technical advisor, Advise AusAID on the feasibility and appropriateness of moving towards a health sectoral (SWAp) approach and facilitate development of donor consensus if this agreed.
6. Assist in the preparation, implementation, monitoring and evaluation of AIPMNH at the provincial and district level including advising how best to use GoA funded resources to engage with GoI to achieve system reforms, gender equality considerations, work plans of AusAID appointed contractors and the future pace and extent of expansion of the Partnership to other provinces and districts.
7. Contribute to the Canberra based AusAID Health advisor's broader AusAID health strategy development in the region and globally.

Contribute to improved effectiveness

8. Advise on measures to ensure the coherence and effectiveness of AusAID's maternal and neonatal health programs.

9. Monitor the sector to assist AusAID to direct resources towards those areas where maximum impact can be achieved.

Contribute to improved donor coordination

10. Support GoI leadership in and contribute to the development of improved donor coordination and harmonization and more effective aid for maternal and neonatal health at the local level.

Build technical capacity of AusAID Indonesia health program staff

11. Play a key role in building the technical capacity of AusAID Indonesia program health staff (Canberra and Jakarta) though mentoring.

The duties may be subject to change.

Selection Criteria

The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Sound technical knowledge of the district level service delivery in the health sector in Indonesia including an understanding of the main challenges for district level service delivery systems and service improvement in a decentralised environment.
- Proven ability to provide effective, high quality, strategic policy and technical advice to Government of Indonesia agencies at all levels, donor agencies, non-government organisations and other stakeholder's agencies.
- Ability to develop effective means of securing support and technical advice for the design, implementation and monitoring of AusAID activities including Sector Wide and other programmatic approaches at the provincial and district level.
- Strong communication and interpersonal skills, including a demonstrated ability to build and maintain networks, provide advice and communicate effectively (both in writing and verbally) on sensitive issues with both a culturally and professionally diverse range of stakeholders.
- The ability to work effectively as part of an organisation and as part of a team.

(B) Desirable:

- Experience in maternal and neonatal health programs.
- Successful relevant work experience in managing or guiding public health systems development in one or more developing countries, preferably in the Asia Pacific region.
- An understanding of AusAID policies and cross-cutting issues.

Duration and Location

AusAID will directly appoint the Maternal and Neonatal Health Technical Coordinator for an initial period of 12 months commencing in mid 2008, with an option to extend the appointment for another 12 months. There will be an initial probation period of 6 months.

The Coordinator will be based in AusAID's Jakarta office. International and domestic travel (in particular to NTT) is anticipated.

Performance Management

In line with AusAID's Guidelines for Overseas Based Staff, the Performance Payment and Assessment Process will apply.

MC Nominated Positions

Partnership Director

Location: Kupang, NTT

Duration: Full Time, 3 years

Responsibility: The Partnership Director will be responsible for strategic oversight of the Partnership including responsibility for overall planning, coordination and management of technical support provided to provincial and district governments for Partnership activities; including the conduct of fiduciary and risk assessments. The PD will also be responsible for developing and maintaining good working relationships with provincial and district governments in relation to the management and coordination of the Partnership. The PD will need to ensure that all Partnership reporting is of a high standard and general communication and coordination with GoI, AusAID and other donors and partners is well managed.

Relationships:

The Partnership Director will have overall responsibility for delivery of the Partnership. The PD will provide strategic direction at the provincial and district levels with oversight from GoI and AusAID. The PD will work closely with AusAID Kupang particularly on GoI and Donor engagement and coordination. The PD will work with AusAID Maternal and Neonatal Sub national Health System Specialist on technical elements of the Partnership and with AusAID Activity Manager on the contractual relationship and on program management related issues. .

Tasks:

1. In collaboration with AusAID Kupang engage with government at provincial and district level by providing information, and discussion of tactics, opportunities;
2. Lead the negotiation of partnership agreements with provincial and district governments, and annual funding agreements
3. Manage long term technical advisors including selection, briefing, orientation and performance;
4. Manage and coordinate communication between the contractor, national, provincial and district governments and AusAID
5. Manage coordination with other donors and other AusAID funded activities, and seek to build harmonization
6. Ensure that capacity building strengthens GoI systems at all levels of government, and that the program progressively moves to implementation through GoI systems, consistent with management of levels of fiduciary risk.
7. Ensure Partnership Performance standards are met;

8. Ensure all reporting is in accordance with AusAID standards and procedures;
9. Ensure local resources are utilized wherever possible, particularly the use of local organizations and expertise;
10. Ensure cross-cutting issues are continuously addressed; such as gender and anti-corruption throughout the Partnership;
11. Ensure efficient use of AusAID resources in achieving Partnership objectives.

The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Graduate or post-graduate qualifications in international development studies, management or related areas;
- Substantial experience managing and/or leading development Partnerships in countries of the Asia- Pacific region, specifically in the establishment and management of a Partnership, and administrative and reporting arrangements to satisfy donor requirements;
- Substantial experience in the management and delivery of technical assistance to strengthen public sector service delivery at sub-national level (province / district) in the Asia-Pacific context;
- Strong leadership, communication and interpersonal skills;
- Substantial experience working in the field of international development; and
- Demonstrated ability to engage with and build relationships with government agency managers and government representatives;

(B) Preferable:

- Indonesian Language
- Understanding and experience of working with GoI systems and procedures
- An understanding of AusAID policies and cross-cutting issues.
- Experience in the health sector, particularly reproductive health

Operations Manager

Location: Kupang, NTT

Duration: Full Time 3 years

Responsibility: The Operations Manager will be responsible for the coordination and management of the administrative and financial aspects of the Partnership as well as human resource and general activity management.

Relationships:

The Operations Manager will report directly to the Partnership Director and supervise the Partnership Support Unit and Oversight the Provincial and District Coordinators

Tasks:

The Operations Manager shall:

1. Ensure application of standards of financial control in provision of funds and procurement;
2. Provide administrative support and supervision to provincial and district coordinators
3. Manage and supervise the Partnership Support Unit
4. Together with relevant technical inputs, establish and manage administrative systems in areas of finance, human resources, procurement, and asset control
5. Together with the PD establish and manage systems for the identification, recruitment, placement and support of TA
6. Establish and manage systems for subcontracting / procurement and management of subcontracts;
7. Ensure all reporting is in accordance with AusAID standards and procedures
8. Ensure local resources are utilized wherever possible, particularly the use of local organizations and expertise
9. Ensure cross-cutting issues are continuously addressed; such as gender and anti-corruption throughout the Partnership
10. Ensure efficient use of AusAID resources in achieving Partnership objectives

Experience required:

The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Graduate or post-graduate qualifications in a international development, Management or relevant field;
- Substantial experience managing and/or leading development Partnerships in Indonesia, specifically in the establishment and management of systems and procedures, and administrative and reporting arrangements to satisfy donor requirements;
- Strong leadership, communication and interpersonal skills;
- Strong financial and administrative skills;
- Experience managing a team.
- Demonstrated ability to engage with and build relationships with government agency managers and government representatives;
- Fluency in Indonesian language and English for speaking and writing
-

(B) Preferable:

- Experience and understanding of GoI systems and procedures
- An understanding of AusAID policies and cross-cutting issues.

Maternal and Neonatal Health Advisor

Location: Kupang, NTT

Duration: Full Time 3 Years

Responsibility: Provide technical advice and support to AusAID and provincial and district governments on maternal and neonatal health interventions and outcomes.

Relationships: The Maternal and Neonatal Health Advisor will be located within the technical support team at the Provincial Health Office (PHO), and will liaise closely with the Head of the PHO in terms of task allocation. The Advisor will report to the Partnership Director in terms of performance management, and receive administrative support from the Partnership Support Unit.

Tasks:

The Maternal and Neonatal Health Advisor shall:

1. Working with PHO / DHO advise on the most appropriate maternal and neonatal health interventions for each area.
2. Provide advice on how proposed MNH interventions might impact on meeting the MNH targets and on determining appropriate performance targets for annual agreements;
3. Work with provincial and district governments on options to improve MNH organisational structures;
4. Assess and identify appropriate interventions to improve the distribution and performance of MNH service providers / workforce;
5. Identify and ensure appropriate support provided to demand side interventions to strengthen community participation in MNH services;
6. Provide training, guidelines and mentoring support to provincial and district MNH technical teams;
7. Contribute to the medium term MNH action plans and expenditure frameworks;
8. Communicate with relevant provincial and district level policy makers and senior officials about MNH programs and related sector reform policy issues, as well as participate in program coordination meetings with government and other donors at the local level
9. Participate in donor harmonization dialogue as required;
10. Liaise and coordinate with other technical advisors on all levels of planning and implementation.

Experience required:

The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Post-graduate qualifications in maternal and neonatal health or public health;
- Substantial experience in maternal and neonatal health, particularly in areas of policy, management and organizational structure;
- Experience in providing technical assistance to health service managers in a developing country context;
- Strong communication and interpersonal skills; and

(B) Preferable:

-

- Indonesian language
- Previous experience working in Indonesia in government health services ;
- An understanding of AusAID policies and cross-cutting issues.

Health Systems Advisor

Location: Kupang, NTT

Duration: Full Time 3 Years

Responsibility: Provide technical advice and support to provincial and district governments on health system functions, constraints and potential interventions.

Relationships: The Health Systems Advisor will be r located within the technical support team at the Provincial Health Office (PHO), and will liaise closely with the Head of the PHO in terms of task allocation. The Advisor will report to the Partnership Director in terms of performance management, and receive administrative support from the Partnership Support Unit.

Tasks:

The Health Systems Advisor shall:

1. In conjunction with PHO / DHO, undertake mapping and assessment exercises of the provincial and district health systems, using the WHO systems framework or similar framework;
2. Provide advice on system constraints and options for achieving service performance improvement and how proposed service interventions might impact on the system ;
3. Liaise with the national HSS Partnership on system issues as appropriate;
4. Work with provincial and district governments on options to improve health systems organizational structures consistent with PP 38/2007;
5. Identify and ensure appropriate support is provided to interventions to improve the accountability of health systems to their communities and parliamentary representatives;
6. Provide training, guidelines and mentoring support to provincial and district technical teams on health systems issues;
7. Contribute to the medium term MNH action plans and expenditure frameworks;
8. Assist in identifying any further required TA inputs to the Partnership and manage / coordinate these inputs;
9. Provide briefing / orientation and support to short term TA on systems perspective
10. Provide advice and supervision on research related to system performance

Experience required:

The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Post-graduate qualifications in public health or health service management;
- Substantial experience in public health service management, particularly in areas of policy, management and organizational structure;

- Experience in providing technical assistance to health service managers in a developing country context;
- Strong communication and interpersonal skills; and
- Experience in the management of project teams
- Good understanding of health systems strengthening approaches

(B) Preferable:

- Indonesian language
- Previous experience working in Indonesia in government health services ;
- An understanding of AusAID policies and cross-cutting issues.

Procurement and Probity Advisor

Location: Kupang, NTT

Duration: 3 Years

Responsibility: The Procurement and Probity Advisor will be responsible for the establishment and oversight of procurement and contracting undertaken directly by the MC; as well as assessment, capacity building, and technical support to procurement and contracting undertaken by partner provincial and district government agencies.

Relationships: The Procurement and Probity Advisor will be located within an appropriate provincial government agency (Sekber / Bappeda) and will liaise closely with the Sekber / Head of Bappeda. The Advisor will report to the Partnership Director in terms of performance management, and receive administrative support from the Partnership Support Unit.

Tasks:

The Procurement and Probity Officer shall:

1. Assist in the establishment and management of administrative systems in areas of procurement and asset control
2. In conjunction with provincial and district agencies, review and assess systems of procurement, contracting and control of use of procured items, assets and supplies, and provide recommendations on improvements;
3. Provide technical advice and capacity building support to provincial and district agencies in implementing the recommendations and improving procurement and equipment / supplies and asset controls;
4. Provide advice and recommendations to the Operations Manager and PD on the potential for use of local government agency systems for procurement and contracting with program funds

5. Where AusAID and provincial and district governments agree to use local government systems, provide oversight, monitoring and review of the systems and their function.

Experience required:

The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Graduate or post-graduate qualifications in business management, accounting or a relevant field;
- Substantial experience in procurement, contracting and management of assets and equipment / supplies in the Indonesian context;
- Strong administration skills and experience in the establishment of administrative systems for procurement and management of assets;
- Good communication and interpersonal skills; and
- Familiarity with Indonesian government regulations and systems

(B) Preferable:

- Previous experience working in the Indonesian government health sector;
- An understanding of AusAID policies particularly in relation to procurement and anti-corruption.

Provincial Coordinator

Location: Kupang, NTT

Duration: 3 Years

Responsibility: The Provincial Coordinator will manage and supervise the District Coordinators and coordinate overall Partnership support and communication with district governments participating in the Partnership.

Relationships: The Provincial Coordinator will report to the Operations Manager and will work closely with the provincial government, District Coordinators and district governments.

Tasks: The Provincial Coordinator shall:

1. Oversight, supervision and provision of support to district teams in the districts of the region, facilitating communication between district teams and provincial teams;
2. Performance management of district team staff ;
3. Establish and manage district and/ or regional offices, and the provision of administrative support to technical specialists stationed at regional offices (if required);
4. Facilitate communication, support and exchanges among the districts and district teams of the province;

5. Oversight and monitor the provision of Partnership financial support through the imprest account with Bappeda at the district level, and the role of district coordinators in the management of these funds.

Experience required:
The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Graduate qualifications in field relevant to administration / management;
- Experience in the management of small teams and implementation of projects;
- Experience in engagement with and collaboration with local government agencies in Indonesia;
- Excellent communication and report writing skills.

(B) Preferable:

- Experience in the health sector;
- Experience in the establishment of administrative / management systems.

Indicative ToR District Program Coordinator (Generic – non nominated)

Location: Each district or two districts of operation, indicatively within the District Health Office or Bappeda office

Duration: Dependent on commencement of operations in the district: 2 – 3 years

Responsibility: The District Program Coordinators will coordinate Partnership support and communication with district governments participating in the Partnership, with a focus on support provided to the DHO; acts as leader of the district Partnership team.

Relationships: The District Program Coordinators will work closely with the district health office and district Bappeda office and report to the Provincial Coordinator.

Tasks: The District Coordinator shall:

1. Liaise with district government in relation to the Partnership as a whole, including facilitating communication and understanding of the Partnership approach and the steps in the performance monitoring process.
2. Facilitate dissemination of documents and guidelines from the Partnership; and the transmission of reports and requests from the district government and its agencies
3. Facilitate and coordinate visits from technical specialists / provincial MPS support team and associated meetings / training activities
4. Facilitate support to DHO in the preparation of medium term MNH action plans and annual work plans, and liaison with and review by the technical specialists and provincial MPS team.
5. Support the district government in addressing cross cutting issues such as gender and anti-corruption in the planning and implementation of Partnership activities

6. Facilitate the provision of Partnership financial support through the imprest account with Bappeda; act as co-signatory to the account and assist Bappeda in the distribution of the funds to the DHO, and in the collection and submission of expenditure reports.

Experience required:
The position requires a competent and experienced person with the following attributes:

(A) Essential:

- Graduate qualifications in field relevant to administration / management
- Experience in the implementation of donor assistance projects
- Experience in engagement with and collaboration with local government agencies in Indonesia;
- Excellent communication and report writing skills

(B) Preferable:

- Experience in the health sector

Annex 7: Indicative Organisation Structure