



### **Australia-Indonesia Maternal & Newborn Health & Nutrition Program – Cover Note**

The Australia-Indonesia Maternal & Newborn Health & Nutrition Program concept note has passed internal AusAID peer review.

The concept note outlines a new AUD200 million program of support for maternal and newborn health in Indonesia over eight (8) years. The overarching program goal is to assist the Government of Indonesia to close the socio-economic and geographical equity gap in reducing maternal and neonatal deaths and childhood stunting in Indonesia. AusAID support will contribute to the following end-of-program outcomes in selected provinces and districts:

- Reduced number of maternal deaths, particularly among poor and near poor women.
- Reduced number of neonatal deaths, particularly among poor and near poor populations.
- Reduced prevalence of stunting, particularly among poor and near poor children under five.

The concept note for Australia-Indonesia Maternal & Newborn Health & Nutrition is provided for the information of individuals/organisations.

Based on the Concept Note, and in a collaborative effort to ensure the quality of the investment, individuals/organisations are encouraged to submit views and/or issues that they would like to see further considered/clarified during the design process. All submissions submitted, and received by AusAID, are done so with the individual's/organisation's understanding of the *Submission Conditions* detailed below. Submissions should be sent to [mnch@ausaid.gov.au](mailto:mnch@ausaid.gov.au).

Submissions are welcomed before 30 June 2013. AusAID cannot guarantee that submissions received after this date will be considered by the design team.

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- AusAID and the design team will not respond directly to any issues or views raised by individuals/organisations.

Individual submissions will not be referenced/identified in the design document but may be referred to generically as representing a market opinion.



# **Australia-Indonesia Maternal and Newborn Health and Nutrition Program**

## **Draft concept note**

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## Acronyms

AIPD	Australia-Indonesia Partnership for Decentralisation
AIPHSS	Australia-Indonesia Partnership for Health Systems Strengthening
AIPMNH	Australia-Indonesia Partnership for Maternal and Neonatal Health
ANC	Ante-natal care
AusAID	Australian Agency for International Development
Bappenas	Indonesian National Development Planning Agency
Bappeda	Development Planning Agencies at Province and District levels
BEmONC	Basic emergency obstetric and neonatal care
<i>Bidan di desa</i>	Village-based midwife
BKKBN	National family planning agency
BPS	Central Statistics Bureau ( <i>Badan Pusat Statistik</i> )
<i>Bupati</i>	Elected Head of District
CEmONC	Comprehensive emergency obstetric and neonatal care
CPR	Contraceptive prevalence rate
<i>Desa Siaga</i>	Village Alert program to support pregnant women to have safe deliveries
DTPK	Less-Developed, Remote, Border and Island areas
EMAS	Expanding Maternal and Neonatal Survival
EmONC	Emergency obstetric and neonatal care
GIZ	German International Development Agency
GoA	Government of Australia
Gol	Government of Indonesia
HSS	Health systems strengthening
IDHS	Indonesia Demographic and Health Survey
IMCI	Integrated management of childhood illness
IMET	Independent Monitoring and Evaluation Team
IUD	Intrauterine device
<i>Jamkesmas</i>	National health insurance for the poor
<i>Jampersal</i>	National maternal health coverage for all
LAPM	Long-acting and permanent methods of contraception
M&E	Monitoring and evaluation
MAMPU	Empowering Indonesian Women for Poverty Reduction ( <i>Maju perempuan Indonesia untuk mengatasi kemiskinan</i> )

MCC	Millennium Challenge Corporation
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MNCH	Maternal, newborn and child health
MoF	Ministry of Finance
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
NGO	Non-Government Organisation
NICE	Nutrition Improvement through Community Empowerment
NTB	Nusa Tenggara Barat
NTT	Nusa Tenggara Timur
PFM	Public financial management
PNC	Post-natal care
PNPM	National Program for Community Empowerment ( <i>Program Nasional Pemberdayaan Masyarakat</i> )
PONED	Basic emergency obstetric and neonatal care
PONEK	Comprehensive emergency obstetric and neonatal care
<i>Posyandu</i>	Integrated health post at village level
<i>Promkes</i>	National and sub-national units for health promotion messaging
<i>Puskesmas</i>	Community health centre
<i>Risfaskes</i>	Health facility research
<i>Riskesdas</i>	Basic health research
SBA	Skilled birth attendance
<i>Stikkes</i>	Private sector training institutes
SUN	Scaling Up Nutrition
TBA	Traditional birth attendant
UGM	Universitas Gajah Mada
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## Executive summary

This note outlines a concept for a further eight years of AusAID support for maternal and newborn health in Indonesia to assist the Government of Indonesia (GoI) to improve health and nutrition outcomes for women and children. Support will build on the Australia-Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) in Nusa Tenggara Timur (NTT), include additional family planning and nutrition interventions and expand to additional provinces. The duration reflects the long-term commitment that will be required to make a meaningful difference to the health and nutrition of poor women and children in Indonesia.

**Health and nutrition status:** Indonesia has made considerable progress in improving the health of its population over the last 20 years but compares poorly with other countries in the region on key health and nutrition indicators. Maternal mortality remains high and there has been limited progress in reducing neonatal mortality. Maternal and young child under-nutrition is a serious problem and a major factor in maternal, newborn and child mortality. More than one-third of children under five are stunted. The equity gap in health and nutrition outcomes is significant and widening. Rates of maternal and neonatal death and stunting are higher in the poorest provinces and among the poorest women and children.

**Evidence base:** There is a strong evidence base for proven interventions that can prevent maternal and neonatal death, a clear case for investing in family planning to reduce mortality in women and young children and global consensus on cost-effective health sector interventions to tackle maternal and young child under-nutrition.

**Challenges to be addressed:** Lessons learned from GoI programs and previous AusAID support show what can be achieved as well as what still needs to be done. Indonesia needs to address a number of challenges in order to improve health and nutrition outcomes. In maternal and neonatal health, these include improving service coverage, in particular delivery care and basic and comprehensive emergency obstetric and neonatal care (EmONC), tackling inequalities between provinces and between the rich and the poor in access to health care, improving referral systems and addressing poor quality of care. Family planning challenges include unmet need, over-reliance on short-term methods and the predominance of private sector provision, which excludes the poorest from accessing services. Coverage of proven nutrition interventions that can be delivered by health services is low. Community awareness of maternal health, family planning and maternal and child nutrition issues is limited. Low demand for maternal health services is a key challenge in reducing maternal and neonatal mortality. Furthermore, deeply entrenched cultural norms concerning the role of women and traditional 'health' and birthing practices need to change, and this change process is complex and time consuming.

**Government of Indonesia priorities:** The GoI gives high priority to accelerating progress towards achievement of MDGs 4 and 5. Government commitment to reducing maternal mortality is reflected in a range of strategies and plans, including the National Action Plan for Maternal Mortality Reduction 2012-2015, which aims to increase the coverage and quality of maternal health services, strengthen the role of local government and the private sector and empower families and communities. The GoI has funded a number of programs, including: large-scale training of village midwives; education for pregnant women at *Puskesmas*; and social health insurance targeting the poor and near poor through the *Jamkesmas* and the *Jampersal*, which are intended to contribute to improved maternal health. The Ministry of Health (MoH) recognises that neonatal death is the most significant contributor to child mortality. The GoI is showing renewed interest in family planning, including a commitment to increased financing and

inclusion of family planning within universal health care coverage. The Gol is also strongly committed to tackling stunting and has signed up to the Scaling Up Nutrition (SUN) framework<sup>1</sup>.

**Other donor support:** Donor assistance represents only 1.7% of total expenditure on health in Indonesia. Donor presence has reduced as the country has achieved middle-income status. AusAID is the largest donor in the health sector. USAID is the other main bilateral donor for maternal and neonatal health. Current USAID support is through the Expanding Maternal and Neonatal Survival (EMAS) program. Donor investment in family planning has declined and no bilateral donors support family planning at present. There is increasing donor interest in nutrition. UN agencies are providing technical assistance to the Gol and the Millennium Challenge Corporation (MCC) program aims to reduce stunting by integrating maternal and child health, nutrition, water and sanitation through the Gol *Program Nasional Pemberdayaan Masyarakat program (PNPM Rural)* program, but there is no donor support for delivery of nutrition interventions through the health sector.

**Rationale for AusAID investment:** Continued AusAID support for maternal and neonatal health in Indonesia and expansion of this support to encompass family planning and nutrition aligns with Australian Government priorities, particularly the strategic goal of saving lives, and the priorities of the Government of Indonesia (see above). It helps to fulfil a key priority of the new draft Indonesia Country Strategy 2013-2018, which is to help Indonesia address the off-track MDGs, among which maternal and neonatal mortality and under-nutrition are prominent. These areas receive similar emphasis in AusAID Indonesia's draft Health Sector Delivery Strategy. A further phase of AusAID investment provides an opportunity to strengthen the bilateral relationship between Australia and Indonesia, which welcomes our support in this subsector, and to build on AusAID's comparative advantage based on its lessons learned, existing achievements and experience in Indonesia. AusAID can add value by assisting the Gol to increase the efficiency and effectiveness of investment, ensure equitable coverage, improve the quality of service delivery and build national capacity. Specifically, AusAID can play an important role in enhancing policy, standards and training, bringing international and regional experience, introducing innovative approaches and alternative models of service delivery and generating evidence to demonstrate that such approaches can be adopted at scale by the Gol. There is also considerable potential for geographical and programming synergies with other AusAID programs in health, governance, social protection, community development and women's empowerment.

**Program goal and outcomes:** The overarching program goal is to assist the Government of Indonesia to close the socio-economic and geographical equity gap in reducing maternal and neonatal deaths and childhood stunting in Indonesia. AusAID support will contribute to the following end-of-program outcomes in selected provinces and districts:

- Reduced number of maternal deaths, particularly among poor and near poor women.
- Reduced number of neonatal deaths, particularly among poor and near poor populations.
- Reduced prevalence of stunting, particularly among poor and near poor children under five.

Achieving these will hinge on ensuring intermediate outcomes of:

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<sup>1</sup> The SUN framework proposes two complementary approaches: specific nutrition interventions during pregnancy and the first 2 years of life; and a multi-sector approach.



- Increased access by communities to family planning, maternal and neonatal health and nutrition services and increased accountability among providers of these services to meet community needs.
- Improved quality of key family planning, maternal and neonatal health and nutrition service delivery at primary and referral level health facilities, particularly in geographically remote and poor areas.
- Increased utilisation of health services by communities in target provinces and districts.
- Greater informed demand and changed individual, household and community knowledge and behaviour related to family planning, maternal and neonatal health and nutrition.

**Geographical coverage:** The scope of the program will include both provinces and districts with the worst health and nutrition indicators and the highest proportion of people living in poverty, and provinces and districts with the largest numbers of poor people. With respect to the former, it will concentrate on Eastern Indonesia, which accounts for 70% of poorly performing districts and where more intensive support will be required. With respect to the latter, AusAID will also extend support to a selection of provinces and districts with high numbers of poor women and children. The majority of Indonesia's poor live in the more densely populated provinces. In comparison with other middle-income countries almost all of Indonesia's provinces perform poorly in terms of health and nutrition indicators. In these provinces, significant gains could be made with relatively limited investment per capita compared to poorer provinces if AusAID support focuses on leveraging Gol and private resources and improving the efficiency and effectiveness of Gol investment. Engagement in provinces such as Java will also give AusAID a higher political profile and, hence, a greater opportunity to influence national policy.

**Beneficiaries:** The main beneficiaries will be mothers and women of reproductive age, newborns and children under five in provinces and districts covered by the program. The final selection of target provinces and districts will be determined during the design phase, but preliminary analysis suggests that approximately 9.3 million women aged 15-49 years, almost five million pregnant women, more than four million children aged below five years and 2.2 million potentially stunted children under five could benefit directly from program interventions.

**Timeframe, budget and modalities:** The design is expected to be approved in September 2013 with the next phase of AusAID support commencing in mid-2014, following a 9-month preparation and tender phase. The first year will be an inception phase to allow sufficient time to establish governance structures, partnerships, funding modalities, baseline data and M&E systems prior to starting significant implementation of activities. In addition, during the first year, support will be maintained for key interventions in NTT that are currently funded through the AIPMNH, which will end in June 2014. The eight-year timeframe will be divided into two four-year phases. The proposed funding allocation is AUD\$200 million, with AUD\$80 million allocated for the first four-year phase and AUD\$120 million allocated for the second four-year phase. The program will be subject to a full independent review after the first four-year phase, which will provide an opportunity to adjust the design to reflect changes in the policy and operating environment, implementation progress and challenges and emerging needs. AusAID expects to use a combination of modalities to deliver the program, including: channelling funds through Gol systems; implementation through a managing contractor and sub-contractors; implementation through multilateral and bilateral partners; and flexible funds. The independent review will also assess the effectiveness of implementation and funding modalities.

**Next steps and design process:** If this concept note is approved, a five-page summary will be prepared using AusAID's Investment Concept Template and submitted to the Strategic Program Committee (SPC). If this is approved, AusAID Indonesia will proceed to the design stage, which

will run until September 2013, when the design peer review will be held. Key steps will include: more in-depth stakeholder analysis; further consultation and dialogue with key GoI, AusAID and other stakeholders; additional analysis, including political economy and institutional analyses and a more detailed assessment of potential funding modalities and fiduciary risk; and detailed consideration of the program fit within the AusAID Indonesia portfolio and management and operational arrangements.

# 1. Introduction

Saving the lives of poor women and children through greater access to quality maternal and child health services is one of the five strategic goals of Australia's aid program, as outlined in both Australia's Comprehensive Aid Policy Framework and AusAID's Health Sector policy "*Saving lives: improving the health of the world's poor.*" Similarly, a key priority of the new draft Indonesia Country Strategy 2013-2018 is to help Indonesia address the off-track MDGs, among which maternal and neonatal mortality and under-nutrition are prominent. The Country Situation Analysis of the country strategy (approved by the Development Effectiveness Steering Committee in September 2012) reaffirmed our commitment to maintain a focus on maternal and child health and strengthen our attention on nutrition. These areas also receive similar emphasis in AusAID Indonesia's draft Health Sector Delivery Strategy.

In line with the above strategies, this concept note outlines a further eight years of AusAID support for mother and newborn health in Indonesia, in order to assist the Government of Indonesia (GoI) to improve health and nutrition outcomes for women and children. This support will build on the existing Australia-Indonesia Partnership for Maternal and Neonatal Health (AIPMNH), which is currently being implemented in 14 of the 21 districts in Nusa Tenggara Timur (NTT). It will include additional family planning and nutrition interventions and expand geographical coverage to additional provinces in Indonesia. The program will focus on ensuring that the poorest have access to comprehensive, quality maternal and neonatal care, family planning services and a package of proven nutrition interventions. It will also focus on changing behaviours at the individual, household and community levels, since improving service delivery alone will not deliver better health and nutrition outcomes for women and children. The proposed timeframe reflects recognition that improving health and nutrition outcomes, through supply- and demand-side interventions and changing individual and community behaviours will require long-term commitment.

The concept note has been developed by AusAID Indonesia, based on dialogue with the GoI, other donors, UN agencies and Australian Government partners, analysis of the international and Indonesian literature and evidence for effective interventions and AusAID Indonesia program experience.

# 2. Situation analysis

## 2.1. Maternal and neonatal health and nutrition in Indonesia

Indonesia has made considerable progress in improving the health of its population over the last 20 years. Life expectancy has increased from 60 to 67 years. Infant and child mortality<sup>2</sup> fell from 68 to 32 per 1,000 live births and from 97 to 40 per 1,000 live births respectively between 1991 and 2012 (IDHS, 2012). However, despite the GoI's efforts, health outcomes have not kept pace with the country's economic growth and increased investment in health. Indonesia compares poorly with other countries in the region on a number of health and nutrition indicators (see Table 1). Though achieving the MDGs has been and continues to be a priority for the GoI, progress towards reducing neonatal mortality under MDG 4 (to reduce the under-five mortality

<sup>2</sup> Neonatal mortality is the probability of death in the first month (0-28 days old); Infant mortality is the probability of death before the first birthday (0 – 11 months); Child mortality is the probability of death between the first and fifth birthday (1-4 years); Under-five mortality is the probability of death before the fifth birthday (0-4 years).

rate by two-thirds by 2015) has been slower than expected and mortality is increasing in some provinces. MDG 5 (to reduce the maternal mortality ratio by three-quarters by 2015) will not be met. This is due in large part to a variety of cultural and systemic issues outlined in more detail in the Problem Analysis.

**Table 1: Comparison of key health and nutrition indicators**

Country	GNI per capita (int PPP \$)	Maternal mortality ratio (per 100,000 live births)	Neonatal mortality rate (per 1,000 live births)	Stunting (% of children under five)
Indonesia	3,600	228	19	37%
Philippines	3,900	94	14	32%
Malaysia	13,740	31	3	17%
Vietnam	2,900	56	12	31%
Thailand	7,770	48	8	16%

**Rates of maternal death remain high** Although the maternal mortality ratio declined from 450/100,000 to 228/100,000 between 1987 and 2007 (IDHS, 2007), maternal mortality remains high, particularly given Indonesia's middle-income country status and considerable government and donor investment in maternal health programs<sup>3</sup>. There is little prospect of meeting the MDG target of 102/100,000 by 2015. Women in Indonesia face a lifetime risk of maternal death of 1 in 210 compared with 1 in 870 in Vietnam and 1 in 1400 in Thailand<sup>4</sup>. The population size – over 237 million according to the 2010 Population Census – also means that Indonesia has the highest number of maternal deaths in the region. Recent estimates show that about 10,000 women die of maternal causes each year.<sup>5</sup>

**Neonatal mortality has fallen more slowly than child and infant mortality** There has been less progress in reducing the neonatal mortality rate (see Figure 1), which declined from 32 to 19 per 1,000 live births between 1991 and 2007 (IDHS, 2007). In Indonesia, neonatal deaths are projected to comprise more than 50% of under-five deaths (compared to a global average of 40%<sup>6</sup>) and almost 75% of infant deaths (compared to a developing country average of 40-60%<sup>7</sup>) by 2015.

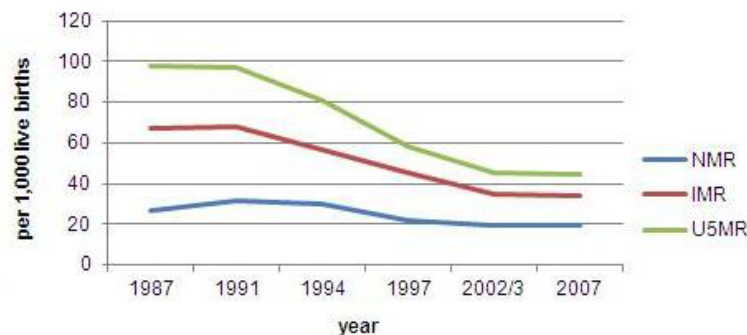
<sup>3</sup> The GoI is currently in the process of estimating MMR, comparing estimates from different data sources including the IDHS and the Census. Indications are that this will show that MMR is not declining as expected and may, in some areas, be increasing.

<sup>4</sup> WHO. (2012) "Trends in Maternal Mortality: 1990 to 2010 – WHO, UNICEF, UNFPA and The World Bank estimates."

<sup>5</sup> Ibid.

<sup>6</sup> [www.who.int/bulletin/volumes/87/2/08-050963/en/index.html](http://www.who.int/bulletin/volumes/87/2/08-050963/en/index.html)

<sup>7</sup> Norton, M (2005). "New evidence on birth spacing: promising findings for improving newborn, infant, child, and maternal health". International Journal of Gynaecology & Obstetrics 89: S1-S6

**Figure 1: Trends in neonatal, infant and under-five mortality in Indonesia**

**Weaknesses in family planning contribute to maternal and neonatal mortality** Indonesia has high rates of unintended pregnancy and the second highest abortion rate in the region at 37 abortions for every 1,000 women of reproductive age<sup>8</sup>. Available evidence suggests that abortion is often unsafe; poor women who cannot afford the services of a trained provider are disproportionately affected. An estimated 14-16% of maternal deaths in South-east Asia are linked to unsafe abortion<sup>9</sup>. Analysis of IDHS 2007 data shows that neonatal mortality rates are nearly three times higher in babies born to older and younger mothers, born as a fourth and fifth child and born less than 24 months after the previous child (Odds Ratio 2.82 – Titaley et al, 2008). Increased use of family planning could therefore play a significant role in reducing neonatal mortality.

**Maternal and young child under-nutrition is a serious problem**<sup>10</sup> More than one in 10 Indonesian babies are born underweight. Contrary to some cultural beliefs in Indonesia of small baby size being good for ease of birth, the same analysis of neonatal death in Indonesia showed a nearly three-times higher probability of death in small neonates (Odds Ratio 2.80 – Titaley et al, 2008). Micronutrient deficiencies are common. Many pregnant women are vitamin A deficient. Rates of iron-deficiency and other forms of anaemia in young children, adolescent girls and women of reproductive age are high. Poor nutritional status in children also reflects low rates of exclusive breastfeeding – at 35% compared with the Ministry of Health (MoH) target of 80% – and poor complementary feeding practices. Under-nutrition is a significant factor in both maternal and child mortality. Globally, around 14% of maternal deaths are attributed to anaemia. Low birth weight affects neonatal and child survival, increases the risk of stunting and is associated with higher risk of non-communicable diseases in adulthood.

**Stunting affects more than one-third of young children** Indonesia has around 7.6 million stunted children, the fifth highest number in the world (UNICEF, 2010) and an estimated 37% of children under five are stunted<sup>11</sup>. Stunting increases the risk of illness; undermines cognitive development, affecting school attendance and academic performance; and reduces long-term health, development and productivity<sup>12</sup>. Poor nutrition is estimated to reduce GDP in Indonesia

<sup>8</sup> In a 2008 report, the Guttmacher Institute estimated that there are 2 million abortions a year in Indonesia. Sedgh G and Ball H, 2008. Abortion in Indonesia. *In Brief*, New York: Guttmacher Institute, No. 2.

<sup>9</sup> Sedgh G and Ball H, 2008. Abortion in Indonesia. *In Brief*, New York: Guttmacher Institute, No. 2.

<sup>10</sup> Dickey V et al. USAID Indonesia nutrition assessment for 2010 new project design. March 2010.

<sup>11</sup> Shorter than the standard height for their age, reflecting chronic under-nutrition.

<sup>12</sup> UNICEF brief on maternal and child nutrition 2012.

by 3-4% a year<sup>13</sup>. Maternal health and nutrition is a key determinant of stunting in children. Approximately 60% of future stunting occurs *in utero* and 40% in the first two years of life (SCN, 2010). Around 23% of women aged 15 years and over are underweight and 40% of pregnant women receive insufficient dietary intake of energy and protein. Stunting also has an inter-generational impact. Women who were stunted as children are more likely to have low birth weight babies.

**The equity gap in health and nutrition outcomes is significant and widening** Rates of maternal and neonatal death and of stunting are higher in the poorest provinces and among the poorest women and children. For example, the overall maternal mortality rate of 340/100,000 in NTT is three times the overall rate of 105/100,000 in East Java. The neonatal mortality rate is also higher in NTT, at 31/1,000, than in East Java where it is 21/1,000. The prevalence of stunting is 58% in NTT compared with 35% in East Java. The highest rates of low birth weight are found in Eastern Indonesia, for example in Papua (27%), Papua Barat (23.8%) and NTT (20.3%). Nationwide there is a significant gap in neonatal death rates between the poorest and the wealthiest quintiles, at 27/1,000 and 17/1,000 respectively. The gap between the richest and poorest quintiles in rates of stunting increased from 10 percentage points to 19 percentage points between 2007 and 2010. During this period, the prevalence of stunting among children in the richest quintile fell from 30% to 24%, but among children in the poorest quintile it increased from 40% to 43% (*Riskesdas*, 2007 and 2010).

## 2.2. Problem analysis

Indonesia needs to address the following challenges if the country is to deliver services that meet the needs of the poor and to improve health and nutrition outcomes.

**Low coverage of maternal and newborn health services** Reducing maternal mortality requires women to have timely access to maternal health services. Neonatal mortality is also associated with lack of access to antenatal, skilled delivery and immediate post-natal care. Despite significant GoI and donor investment in improving service delivery capacity, there is still a need to scale up interventions and expand coverage. Many *Puskesmas* are understaffed and have an insufficient number of doctors and, in remote rural areas, midwives. Dual practice is also a serious problem. As many as 65% of publicly-employed health staff have second jobs, often in private practice, and absenteeism is as high as 40% at the primary care level<sup>14</sup>. Until recently, GoI efforts have focused on increasing the number of midwives at community level, with limited attention paid to capacity to provide emergency obstetric and neonatal care (EmONC) at *Puskesmas* and hospital levels. The GoI National Action Plan for Maternal Mortality Reduction 2012-2015 identifies inadequate service coverage, in particular the lack of availability of 24/7 delivery care and basic emergency obstetric and neonatal care (BEmONC) at *Puskesmas* and of 24/7 comprehensive emergency obstetric and neonatal care (CEmONC) at district hospitals, as a fundamental challenge.

**Sub-optimal referral systems** Providing a continuum of care requires effective referral systems that include both public and private facilities. However, referral pathways are complex, often inappropriate and unclear to women and their families. Referrals are made to the wrong level of care, midwives are not reimbursed for care prior to referral and referrals are made but

<sup>13</sup> UNICEF, Indonesia sets targets to improve child nutrition, [http://www.unicef.org/indonesia/media\\_12591.html](http://www.unicef.org/indonesia/media_12591.html).

<sup>14</sup> World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.



women are denied services for financial or bureaucratic reasons. The MoH is developing referral guidance; ensuring that this is implemented will be critical.

**Poor quality of care** The 2012 Maternal Health Services Quality Assessment, conducted in district hospitals, health centres and midwifery clinics in 20 districts confirmed the need for major efforts to improve the quality of care in order to reduce maternal and neonatal mortality. Specific weaknesses identified included inadequate counselling during antenatal and post-natal care, lack of knowledge and skills to manage normal deliveries, recognise obstetric and neonatal complications and perform life-saving procedures and shortages of equipment and supplies. Inadequate training and implementation of care standards are key factors in poor quality of care.

**Inadequate training** The overall quality of health workers' education is low. World Bank analysis of data from the Indonesia Family Lifestyle Survey as a proxy for quality of health care provision and health workers<sup>15</sup> indicated that the quality of services has improved, but only marginally, and that overall quality is low. This includes the ability of health workers to correctly diagnose and treat key maternal and child health problems. It also concluded that the quality of health professional education, particularly for midwives and nurses, is insufficient. Other evidence suggests that training for midwives, including that provided by the many private training schools, is often sub-standard, producing midwives without the skills and competencies to manage normal deliveries or obstetric emergencies. Many midwives lack experience in supervising deliveries prior to deployment and are therefore ill-equipped to recognise, manage and refer maternal and neonatal complications. Training for specialists is also inadequate. The Investment Case<sup>16</sup> found that in one district of NTT only 66% of specialist staff at basic and comprehensive EmONC-designated facilities were adequately trained to deal with complications in delivery, particularly complications with newborns. There are also concerns about quality of training in family planning and the extent to which health workers are sufficiently well informed about contraceptive methods. There is limited national capacity in nutrition although there are plans to establish a National Institute of Nutrition<sup>17</sup>. Primary care doctors, midwives and nurses receive little or no pre-service or in-service training in nutrition or nutrition counselling (USAID, 2010), although UNICEF has recently developed in-service training modules that have been adopted by the GoI.

**Inadequate implementation of standards** Many *Puskesmas* and hospitals are not implementing standards of care that would ensure effective management of obstetric and neonatal complications. Greater efforts are needed to standardise quality of care throughout the system, improve supervision and monitoring and strengthen accreditation and regulation of public and private providers.

**Significant inequities in access to care** Inequitable access reflects geographical, financial and gender barriers. Facility coverage is limited in many of the poorest and most remote districts. This is exacerbated by unequal distribution of obstetricians and midwives, which limits access to skilled delivery care and EmONC. For example, caesarean sections can only be performed by an obstetrician or gynaecologist, but there are fewer than 2,000 of these in

<sup>15</sup> World Bank, New Insights into the Provision of Health Services in Indonesia: A Health Workforce Study, 2010.

<sup>16</sup> Laksono T et al. Indonesia: Developing an investment case for financing equitable progress towards MDGs 4 and 5 in the Asia Pacific region. Scale-up report. December 2011.

<sup>17</sup> The WHO-led Landscape Analysis Country Assessments in low and middle income countries highlighted limited capacity in nutrition at national and district levels and the need to create nutritional specialists and improve nutrition in-service training for health professionals.

Indonesia and most are based in Java. The Gol social insurance scheme, the *Jamkesmas*, aims to improve access to health services for the poor and near poor. However, not all those eligible for assistance are covered. The same applies to the *Jampersal*, a scheme specifically intended to cover the cost of delivery care. Some facilities are unwilling to accept clients covered by these schemes and demand payment prior to service. Transport is a key barrier for women in areas that are far from health facilities or who are poor. Insurance schemes do not cover transport costs, although other Gol initiatives such as the *PNPM Generasi* and the *Desa Siaga* (Alert Village) program can be used to address this to some extent. Inequities in access to care contribute to low uptake of maternal health services in the poorest provinces and by the poorest women.

**Low utilisation of services in the poorest provinces and by the poorest women** Continued use of traditional birth attendants (TBAs) and home deliveries are key factors in maternal mortality<sup>18</sup>. Nationally, rates of facility-based delivery range from 17% to 98%<sup>19</sup>. Uptake of antenatal care, facility-based delivery and post-natal care is lower in Less-Developed, Remote, Border and Island areas (*DTPK*) and among the poorest women. Although the overall proportion of women delivered by a skilled birth attendant<sup>20</sup> increased to 83% in 2012, 25% of rural women and 48% of the poorest women are still delivered by a TBA (IDHS, 2012 and 2007). With the exception of North Sulawesi, facility-based delivery rates in all provinces in Eastern Indonesia are lower than the national average of 55%; in a third of these the rate is below 20% (*Riskesdas*, 2010; IDHS, 2007). In Java, nearly 70% of women in the richest quintile are delivered by a health professional, compared with 10% in the poorest quintile. Nationally, rates of post-natal care completion increased in the wealthiest quintile from 41% to 53% between 2007 and 2010 but remained at 28% in the poorest quintile.

**Low use of family planning** The Contraceptive Prevalence Rate in Indonesia has stagnated at 62% and is below 45% in eight provinces. Unmet need for family planning among married women has increased from 9.1% (IDHS, 2007) to 11.4% (IDHS, 2012), and in absolute terms the number of women with unmet need has also increased. The 2015 target of 4.5% is unlikely to be met. The BKKBN<sup>21</sup> Action Plan 2012 identifies reasons for persisting unmet need as: lack of policy and regulations to support family planning; lack of access to family planning services and lack of choice; gaps in provider knowledge about some methods of contraception; and financial and socio-cultural barriers. Indonesia is considered to have made the transition to private sector delivery of family planning, but financial barriers limit access by the poor. Since decentralisation, family planning has become an *ad hoc* program in the public sector, most often used by the poorest, resulting in limited access to services in districts where local governments do not give family planning high priority. Unmarried women do not have legal access to contraception, although the 2000 Population Census found that one-third of women of reproductive age are unmarried and an increasing proportion of these are sexually active.

**Inappropriate family planning method mix** There is an over-reliance on short-term methods, notably pills and injectables. Private sector providers have a bias towards short-term methods in order to generate regular income. However, rates of discontinuation of use of short-term methods are high. In addition, short-term methods are appropriate for spacing but not for limiting

<sup>18</sup> "...and then she died" Indonesia Maternal Health Assessment. World Bank February 2010.

<sup>19</sup> IDHS 2012 Preliminary Report

<sup>20</sup> Not all those defined as skilled birth attendants may meet internationally accepted standards or provide adequate quality of care.

<sup>21</sup> National family planning agency.



births. Many women who have completed their family are not being provided with long-acting and permanent methods (LAPMs) more suited to their needs. Long-term methods are more effective than short-term methods during a year of typical use and there are equity issues too, with use of LAPMs among women who want no more children far lower in the poorest than in the wealthiest quintiles in Indonesia<sup>22</sup>. The GoI recently rescinded regulations that prohibited midwives in the public sector from providing IUDs and implants and BKKBN has started a training program for midwives in IUD and implant insertions and for doctors in male and female sterilisation. This will not, however, be sufficient to increase the uptake of LAPMs unless districts allocate funds for services, women are aware of the range of methods available and can exercise choice and private providers change their practices.

**Limited provision of nutrition interventions by the public health sector** Coverage with proven interventions is low and inadequate attention is given to nutrition at facility and community level. Nutritionists are poorly used and spend much of their time managing the logistics of supplementary feeding rather than on promoting good nutrition. Antenatal visits include weighing and provision of iron supplements but do not address other aspects of maternal and child nutrition. Compliance with iron supplementation is low. Health worker awareness of the importance of preventing low birth weight and stunting is limited. *Posyandu* services include nutrition elements but are provided by volunteers who have little training and tend to focus only on weighing children, so stunting is not identified. The first two weeks of life is a critical time to monitor the health of babies and support the establishment of breastfeeding, but only 50% of newborns receive a health check in the first seven days and only 33% are seen by a medical professional in the second week of life. Widespread promotion of infant formula, including within the public health sector, undermines exclusive breastfeeding.

**Low community awareness and demand** The National Action Plan for Maternal Mortality Reduction identifies low community awareness of maternal health issues and low demand for services as a key challenge, in particular to increasing facility-based delivery. The Investment Case<sup>23</sup> also highlights low demand due to lack of knowledge about services, concerns about quality of care and cultural beliefs about pregnancy and childbirth. The 2007 IDHS found that there had been a decline in public knowledge about family planning since 2002 and limited awareness of LAPMs is an issue. There is also a need to improve community awareness of maternal and child nutrition including understanding of stunting and its causes, the importance of an adequate diet for pregnant and lactating women and of breastfeeding for the health of mothers and babies and the need for appropriate complementary feeding. Further analysis of this issue will be undertaken during project design and implementation, but the limited evidence currently available suggests that inappropriate dietary preferences and practices is a more significant issue than food security.

**Gender discrimination** Women and girls in Indonesia face significant gender inequality. In 2010, Indonesia ranked 108 of 166 countries on the UNDP Gender Inequality Index. Maternal and child health indicators show that women and girls of reproductive age and young children are the most adversely affected by the lack of affordable, quality health services in Indonesia. Women have specific health needs, but often have fewer options to protect their health or to seek care. For example, women's lack of access to health services in general and to emergency

<sup>22</sup> IDHS 2007 data analysed in JHU proposal Improving contraceptive method mix 9ICCM) in NTB and East Java, October 2011.

<sup>23</sup> Laksono T et al. Indonesia: Developing an investment case for financing equitable progress towards MDGs 4 and 5 in the Asia Pacific region. Scale-up report. December 2011.

obstetric care in particular is often the result of unequal access to financial resources within the household, as well as factors such as lack of awareness of services, the need to obtain permission to go to a health facility, being unable to travel alone and concerns about availability of female health workers. Similarly, inter-generational chronic malnutrition is partly due to girls and women being discriminated against in intra-household food allocation. The Gender Analysis of the Health Sector for Indonesia, conducted in June 2010, also highlighted the issue of the lack of gender-specific data on women's utilisation of health care and primary health care services.

### 3. Government of Indonesia priorities and plans

The GoI gives high priority to accelerating progress towards achievement of MDGs 4 and 5. The GoI is also committed to achieving universal coverage of health insurance and has put in place the legislative framework for this. Proposed AusAID support is aligned with GoI priorities and plans, which provide a supportive policy context for implementation.

**Reducing maternal mortality is a GoI priority** This commitment is reflected in a range of national policies, strategies and plans. The Roadmap to Accelerate Achievement of the MDGs in Indonesia (close to being finalised) has an explicit commitment to reduce maternal mortality. Reducing maternal mortality is a core target in the MoH Strategic Plan 2010-2014, which also includes a specific focus on addressing inequities in health and access to health services, particularly in *DTPK* areas. Recently GoI has prioritised 16 provinces for special attention with respect to achieving MDG 5 based on the estimated number of maternal deaths in the province, using nationally compiled routine data for 2011 (see section 7.5 on Beneficiaries below).

The National Action Plan for Maternal Mortality Reduction 2012-2015 aims to reduce the maternal mortality ratio from 228/100,000 to 102/100,000 by 2015. This ambitious target is to be achieved through increasing the coverage and quality of maternal health services; strengthening the role of local government and the private sector; and family and community empowerment. The Plan highlights the need for cost-effective, evidence-informed and standards-based services and referral in both the public and private sectors. Specific interventions include improving the competencies of midwives, ensuring the availability of 24/7 delivery care and BEmONC at *Puskemas* and of 24/7 CEmONC at district hospitals, ensuring effective referral for complications and increasing community awareness, for example of birth preparedness and complications, including through reinvigorating the *Desa Siaga* program. The *Desa Siaga*, linked to Making Pregnancy Safer, aims to revitalise *Posyandu*, assist women to prepare for delivery and address barriers to accessing maternal care. The GoI has funded a number of programs, including large-scale training of village midwives, the *Bidan di Desa*, and a program to implement education for pregnant women at *Puskesmas*. Social health insurance targeting the poor and near poor, in particular the *Jamkesmas* and the *Jampersal*, are also intended to contribute to improved maternal health.

**The GOI will increase its focus on neonatal mortality** The MoH has recognised that neonatal death is the most significant contributor to child mortality and plans to focus on areas of the country where there has been the least progress. Complementing efforts to improve service coverage and quality and to empower families and communities under the National Action Plan for Maternal Mortality Reduction, the emphasis will be on a Child Survival

Acceleration Package of cost-effective interventions, to be prioritised and scaled up according to the local context.

**The GoI is showing renewed interest in family planning** Family planning is an essential component in the Making Pregnancy Safer strategy. Ensuring family planning services are available to all married couples who need them is a GoI policy objective. In 2011, BKKBN received an increase in its budget of 85% to AUD\$251 million. At the Family Planning Summit in London in July 2012, the Minister for Social Welfare announced that family planning will be included within the universal health care coverage scheme, as well as a commitment to maintain increased financing for family planning and to increase method choice, especially LAPMs, including through training for doctors and midwives. Indonesia is represented at the Family Planning 2020 reference group launched to advance family planning commitments made at the London summit.

**The GoI is strongly committed to tackling stunting** The GoI has signed up to the Scaling Up Nutrition (SUN) framework<sup>24</sup> and there is high-level political support to take this forward. Government ministries, including Bappenas and the MoH, are developing a multi-sector approach to reduce stunting. The National Medium Term Development Plan (*RPJMN*) 2010-2014 includes a target of reducing stunting nationally from 37% to 32%. The National Plan of Action for Food and Nutrition (*RANPG*) 2011-2015, coordinated by Bappenas, aims to improve the nutritional status of pre-pregnant and pregnant women and children up to the age of two, including through health service nutrition interventions. The MoH strategy to improve nutrition status includes community nutrition education (*Gerakan Nasional Sadar Gizi*) with an emphasis on reducing low birth weight and stunting. GoI plans also include targeted supplemental feeding for underweight pregnant women and children with wasting and revitalising the *Posyandu* to detect and refer malnutrition early and to improve community awareness of nutrition issues. Considerable efforts have also been made to promote breastfeeding, in particular through training for health staff. Complementary feeding promotion is through the GoI *KADARZI* program, currently limited to communications efforts, although the GoI plans to deploy nutrition staff to activate this and strengthen nutrition surveillance in selected villages. Other efforts to improve nutrition and address micronutrient deficiencies encompass poverty reduction, food security, food fortification and micronutrient supplementation programs.

Table 2 below outlines the GoI's policies and targets that AusAID is proposing to address in the next program.

**Table 2: Key relevant Government of Indonesia Policy and targets**

Policy	Indicator	Targets
RPJMN 2010 – 2014	Reduction of maternal mortality ratio	From 228 (2007) to 118 per 100,000 live births (2014)
	Reduction of infant mortality rate	From 34 (2007) to 24 per 1,000 live births (2014)
Ministry of Health Strategic Plan 2010 – 2014	Percentage of deliveries assisted by skilled attendants	From 84 (2010) to 90 (2014)

<sup>24</sup> The SUN framework proposes two complementary approaches: specific nutrition interventions during pregnancy and the first two years of life; and a multi-sector approach.

Policy	Indicator	Targets
	Percentage of health facilities providing family planning services according to standards	From 10 (2010) to 100 (2014)
	Coverage of first neonatal visit	From 84 (2010) to 90 (2014)
	Coverage of complete neonatal visits	80 (2010) to 88 (2014)
	Coverage of neonatal complications managed	60 (2010) to 80 (2014)
	Percentage of post natal care	84 (2010) to 90 (2014)
	Contraceptive prevalence rate	61 (2010) to 65 (2014)
	Percentage of puskesmas able to provide BEmONC	67 (2010) to 100 (2014)
	Percentage of pregnant mothers receive iron tablets (90 tablets)	From 74 to 85 by 2015
	Percentage of CED (chronic energy deficient) pregnant mothers receive supplementary feeding packages	From 120 thousand to 126 thousand in 2015
	Percentage of infants aged 6 – 12 months and children aged 1-5 years receive vitamin A capsules	From 78 to 85 in 2015
	Percentage of pregnant mothers with the 4 <sup>th</sup> ANC visit	From 61.4 to 95 in 2015
	Percentage of the first neonatal visit (KN1)	From 61.3 to 90 in 2015
	Percentage of infants aged 0-6 months exclusively breastfed	From 61.3 to 90 in 2015
	Percentage of children aged 6-59 months receiving Vitamin A Capsules	From 75 to 85 in 2015
	Percentage of under five children weighed at integrated health service posts (D/S)	From 65 to 85 by 2015

Policy	Indicator	Targets
	Percentage of health centres with trained personnel for growth monitoring	From 60 to 100 by 2015
	Percentage of cadres training at the integrated health service posts (Posyandu)	From 35 to 100 by 2015
	Percentage of health centres with lactation counsellors	From 20 to 100 by 2015

As can be seen above, many known effective interventions to address maternal and newborn mortality and under nutrition are included in MoH policies and strategies. However implementation at a sub-national level is a challenge and coverage of some key interventions remains low<sup>25</sup>. For example, MoH estimates on coverage of all post-natal neonate visits suggest nationally less than three-quarters (71.5%) of infants had all neonatal visits. This, however, ranged from 25% in South Sulawesi to 98% in Bali and 95% in East Java. However, the national health survey 2010 (*Riskesdas*) suggested only 32% of under-fives had completed all neonatal visits. Only 27% of infants were exclusively breastfed to six months (IDHS 2012). MoH statistics suggest that around 71% of pregnant women received iron supplementation (ranging from 22% in Papua to 91% in Riau and 90% in Bali) and 60% received tetanus vaccination (IDHS 2012) (ranging from 27% in East Java to over 100% in Bali)<sup>26</sup>.

## 4. Other donor support

Donor assistance represents only 1.7% of total expenditure on health in Indonesia and the donor presence has reduced in recent years. The Global Fund has been the main source of funding for the health sector over the last 10 years, but future funding is uncertain. However, Indonesia's plans to introduce universal health care coverage have resulted in renewed interest in the health sector among multilateral donors in particular. The following provides a brief overview of current donor support for maternal and neonatal health, family planning and nutrition. Some of the programs listed below are too early in their implementation to identify successes and lessons learnt. Quality evaluations of other programs are limited. AusAID will conduct stakeholder consultations during the design process to ensure the next program draws on the relevant experiences of other donor programs.

**USAID is the other main bilateral donor for maternal and neonatal health.** Current USAID support is through the five-year (2011-2016) Expanding Maternal and Neonatal Survival (EMAS) program. This has an ambitious target of reducing the number of maternal and neonatal deaths by 25% nationally through improving the quality of EmONC services and increasing the

<sup>25</sup> Note that all following statistics are taken from the Ministry of Health's, Indonesia Health Profile 2010 – though they have differing original data sources as outlined in that report.

<sup>26</sup> Note that because calculations are done based on number of pregnancies and then numbers of vaccinations or supplementation provided, estimates are questionable as evidenced by the over 100% achievement in Bali on TT vaccination in pregnancy.

efficiency and effectiveness of referral systems in 128 districts in six provinces<sup>27</sup>. The program works with government at national, provincial and district levels, civil society organisations, public and private health facilities, professional associations and the private sector. Improving the quality of EmONC services in hospitals and *Puskesmas*, equitable access for the poor, accountability, community understanding of social insurance and innovative use of technology are key strategies as well as GoI priorities. AusAID will work closely with EMAS to ensure that future efforts are well coordinated and activities and geographical focus are complementary as well as to share experience and lessons learned.

**Lessons can be learnt from DFID's maternal health program.** DFID's Health System Strengthening for Maternal Health Initiative (2009-2011) was implemented by the World Bank, the University of Indonesia, UGM and three districts in West Java. It had two main components: (1) the Health Sector Assessment (implemented by the World Bank), which included the production of some key studies and some actuarial costings of how health insurance would pay for an essential package of maternal health activities; and (2) maternal health pilots implemented in Bandung, Bogor and Cianjur districts. Lessons from the pilots include the:

- Need to pay attention to communications between *puskesmas* and district hospital to achieve faster referrals
- Need to form midwives into teams, with more experienced ones mentoring and managing less experienced ones
- Need to ensure adequate financial compensation for TBAs if they are going to refer patients to health facilities
- Need to ensure adequate provision of specialist obs/gyn and anesthesiologists at district hospitals 24/7 to cope with increased demand
- Need to work with Ministry of Education on midwifery training standards and accreditation of training institutions
- Need to train generalist doctors and nurses at *puskesmas* level in BEmONC

**Donor investment in family planning has declined.** USAID phased out population assistance to Indonesia in 2006 and there are no other bilateral donors supporting family planning. UNFPA has programmed AUD\$28 million for 2011-2015 to increase access to reproductive health services, address unmet need for family planning, and improve adolescent sexual and reproductive health. AusAID, together with USAID and the Bill and Melinda Gates Foundation, is supporting the Advance Family Planning Operational Research for Improving Contraceptive Method Mix (ICMM) project, which is being implemented by the University of Indonesia and Johns Hopkins University. The project aims to support the GoI to reinvigorate the country's family planning program through knowledge exchange, capacity building for advocacy and research. More specifically it aims to increase the use of LAPMs in six districts of NTB and East Java, develop an evidence-based advocacy training and support package for use in other districts and present evidence-based advocacy plans to government and NGO leaders to encourage them to give higher priority to family planning at district level. Marie Stopes International recently started activities in Jakarta to increase the use of LAPMs.

**There is increasing donor interest in nutrition.** Until recently, the main source of donor support for nutrition was the US\$50 million ADB-funded Nutrition Improvement through Community Empowerment (NICE) project, which aims to reduce the prevalence of underweight

<sup>27</sup> East, Central and West Java, Banten, North Sumatra and South Sulawesi.



in children under five and pregnant and lactating women through strengthening the capacity of central and local government to improve the management of nutrition services. Strengthening community-based services for women and children, social mobilisation for improved nutrition and hygiene and training health and nutrition workers to manage severe malnutrition are core strategies. The project is expected to cover 4,000 villages in 18 districts in six provinces<sup>28</sup>, selected on the basis of prevalence of malnutrition, poverty incidence and local government commitment to contribute counterpart funding. It is also providing technical assistance, including for the establishment of a National Institute for Nutrition.

The US\$131.5 million Millennium Challenge Corporation (MCC) program started in 2012 and aims to reduce stunting by integrating maternal and child health, nutrition, water and sanitation through the GoI *PNPM Rural* program. It will work at national level and in six provinces<sup>29</sup> where rates of stunting and low birth weight are higher than average and plans to target 7,000 villages. AusAID will ensure that its support is coordinated with the MCC program and that program health sector interventions complement community interventions implemented through the *PNPM Rural*. UNICEF is providing technical assistance for policy and planning on stunting and training health workers in breastfeeding, complementary feeding and maternal nutrition counselling. The World Bank is assisting the GoI with plans to reduce stunting. Nutrition, including stunting, is also a priority for the World Food Programme, which is working with the private sector to increase the nutritional content of commercial products and implementing activities in NTT. UN agencies and NGOs are implementing small-scale complementary feeding activities in Central and West Java and NTT.

## 5. Rationale for AusAID investment

There is a clear need for intervention and continued AusAID support. The health and nutrition MDGs in Indonesia are off track and large numbers of poor people are affected. The rationale for AusAID to invest is as follows:

**Alignment with Australia's aid priorities** The program aligns with Australian Government aid priorities in health. It will contribute to saving the lives of poor women and children, one of the strategic goals outlined in Australia's Comprehensive Aid Policy Framework and AusAID's Health Sector policy "*Saving lives: improving the health of the world's poor.*" Investing in health is critical to achieving this goal. AusAID is increasing its investment in the health of poor people globally and Indonesia has persistent poor health outcomes and growing health inequalities relative to other countries in the region. Support for family planning is consistent with AusAID's principle of ensuring that women and men should have access to the widest possible range of safe and effective family planning methods and should participate fully in defining the family planning services they need.

**Delivering AusAID Indonesia results** AusAID's draft Indonesia Country Strategy 2013-2018 emphasises supporting GoI priorities and reaching the poorest people in the poorest places. The Country Situation Analysis of the country strategy (approved by the Development Effectiveness Steering Committee in September 2012) reaffirmed our commitment to maintain a focus on maternal and child health and strengthen our attention on nutrition. This program will also help to deliver the objectives of AusAID Indonesia's draft Health Sector Delivery Strategy, which aims to save and improve the quality of the lives of poor and vulnerable Indonesians

<sup>28</sup> West Kalimantan, South Sulawesi, North Sumatra, South Sumatra, East Nusa Tenggara, West Nusa Tenggara.

<sup>29</sup> West Java, East Java, NTB, NTT, Gorontalo and West Sulawesi.

including women and children. Specifically, it will support the GoI to deliver more and better quality health services, reduce the equity gap in maternal and neonatal health, improve maternal and young child nutrition to prevent stunting and support greater access to family planning. In 2012-2013, health and water and sanitation represent around 15% of AusAID Indonesia funding. It is anticipated that this program will account for around 5% of total AusAID annual funding to Indonesia. The program will be designed in accordance with the ongoing development of the above draft country and health sector strategies.

**Strengthening the bilateral relationship between Australia and Indonesia** As a close neighbour, Australia has a strong interest in a stable and prosperous Indonesia that plays a constructive role in the region and beyond. Australia is currently the largest bilateral donor to Indonesia and has well-established partnerships with a number of ministries. Australia and Indonesia have had a partnership in the health sector over two decades. The GoI has asked AusAID to remain engaged in the sector and AusAID is continuing to strengthen its relationship with the MoH.

**Reinforcing AusAID's position as the lead donor in the health sector** Australia is the lead donor for health in Indonesia and investing in this program will reinforce this position as well as enable AusAID to address gaps in donor support for family planning and nutrition. Currently, USAID is the only other significant donor for maternal and neonatal health. There are no major bilateral donors providing support for family planning or for delivery of nutrition interventions by the health sector.

**Opportunities to scale up support for health** Strategic investment is required to address gaps in GoI funding for health care and to support the piloting and implementation at scale of proven, cost-effective interventions. AusAID is working with the GoI on its plans to establish a universal health care coverage scheme, including defining the package of care to be supported. Roll out of the scheme from 2014 will provide opportunities to support increased supply of services through this program, complemented by other AusAID programs that can influence the demand for health care. The development of the National Reproductive and Maternal Health Strategy 2015-2020 also provides an opportunity to influence future policy and programs and ensure that services meet the needs of the poor.

**Building on experience and success** This program will build on the knowledge, lessons learned and achievements of previous AusAID support through the Women's Health and Family Welfare, Healthy Mothers Healthy Babies and Improving Maternal Health in Eastern Indonesia programs and, most recently, the AIPMNH. It will build on the track record and relationships that AusAID has established, in particular in Eastern Indonesia.

**Adding value and capitalising on Australia's and AusAID's comparative advantage** Australia's funding is small relative to GoI expenditure in the health sector. Policy challenges, institutional and systems bottlenecks and inefficient use of resources rather than lack of government resources are the main constraints to improving maternal, neonatal and child health and nutrition in Indonesia. AusAID can use its financial and technical capacity to assist the GoI to increase the efficiency and effectiveness of its investment, ensure equitable coverage, improve the quality of service delivery and build national capacity. AusAID can play an important role in advocating for and supporting quality services at the primary care level, which are more often used by the poor and in supporting provinces where performance is less good and which may receive less priority from the GoI. AusAID can also add value by drawing on Australian expertise to enhance policy, standards and training (in nutrition and midwifery training, for



example); bring international and regional experience; introduce and test innovative approaches and alternative models of service delivery; and generate evidence to demonstrate that such approaches can be adopted at scale by the GoI. There is also considerable potential for geographical and programming synergies with existing AusAID programs, in particular in health, governance, social protection, community development and women's empowerment.

**Consistency with GoI priorities** The program is consistent with national policies and priorities and has been developed in consultation with GoI stakeholders, in particular Bappenas and the MoH. GoI is supportive of expanded AusAID support for maternal and neonatal health, family planning and nutrition. The GoI has acknowledged the need to revitalise family planning and there is high-level political commitment to tackling stunting. Key GoI stakeholders have indicated that AusAID can make an important contribution with respect to introducing new approaches and strengthening evidence-informed policy and programming. Specific examples of areas where the GoI sees AusAID as adding value include nutrition-related capacity building, improving the quality of midwifery training, including through re-establishing partnerships with training institutions in Australia, developing and implementing standards, addressing high drop-out rates from family planning and increasing uptake of LAPMs. AusAID will continue to work to ensure ownership by GoI of the program at the national and subnational levels during the design process.

## 6. Evidence and lessons learned

### 6.1. Global evidence

There is a strong evidence base for effective interventions to address maternal and neonatal health and nutrition challenges in Indonesia and a clear case for investment in family planning<sup>30</sup>.

**Proven interventions can prevent maternal and neonatal deaths.** These interventions include access to quality antenatal care, skilled delivery and newborn care and post-natal care, EmONC, family planning and safe abortion and eliminating financial and geographical barriers to accessing services. Reducing maternal and newborn deaths depends in particular on timely and effective action if there is an obstetric or neonatal emergency. Available evidence suggests that 80% of such emergencies can be managed at first level facilities and do not need to be referred to a hospital. Skilled birth attendance could prevent up to 50% of maternal and newborn deaths<sup>31</sup>. Improved management of newborns could reduce deaths associated with low birth weight and sepsis by over 60%<sup>32</sup>. Post-natal care can reduce both maternal and neonatal deaths as most post-partum haemorrhage occurs within 48 hours of birth and up to 30% of neonatal deaths occur within the first 24 hours of life. Interventions provided by community-based health workers can also have a significant impact on neonatal mortality<sup>33</sup>. Available

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<sup>30</sup> This is taken from The Partnership for Maternal, Newborn and Child Health (2011) A global review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH). Geneva Switzerland. The full report is available at [http://www.who.int/pmnch/topics/part\\_publications/201112\\_essential\\_interventions/en/index.html](http://www.who.int/pmnch/topics/part_publications/201112_essential_interventions/en/index.html)

<sup>31</sup> Countdown to 2015 decade report: Taking stock of maternal, newborn and child survival. Lancet 2010, 375: 2031-2044.

<sup>32</sup> Duke T et al, 2000. The effect of introduction of minimal standards of neonatal care on in-hospital neonatal mortality. PNG Med J, 43:127-136.

<sup>33</sup> Cochrane Review. Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes.

evidence highlights the need for interventions to improve maternal, newborn and child health to be provided through a continuum of care<sup>34</sup>. Other countries in the region have used these interventions to reduce maternal mortality. Thailand and Sri Lanka invested in midwifery training, improved referral to EmONC, free care at point of use and better supervision. Bangladesh reduced maternal death rates from abortion through higher contraceptive use. Nepal increased skilled birth attendance and contraceptive use, improved referral and made abortion legal.

**There is global consensus on cost-effective health sector interventions to address maternal and young child under-nutrition<sup>35</sup>.** These include nutrition interventions during pregnancy, exclusive breastfeeding, appropriate complementary feeding, iron, vitamin A, iodine and zinc supplementation, and de-worming. Universal coverage with a package of proven interventions could prevent 25% of deaths in children under three and reduce the prevalence of stunting at three years by 33%<sup>36</sup>. Interventions during pregnancy cannot, however, reverse the effects of maternal under-nutrition that is the result of poor nutrition earlier in life and there is also a need to improve the nutrition of girls, especially during adolescence. The Scaling up Nutrition (SUN) framework outlines the benefits to scaling up coverage of these known effective interventions<sup>37</sup>.

**Interventions to reduce stunting need to focus on pregnancy and the first two years of life.** Stunting is practically irreversible after the age of two, hence the focus of an international partnership on “the first 1,000 days” from conception to two years<sup>38</sup>. Maternal nutrition interventions, such as improved energy and protein intake and iron folate, micronutrient and calcium supplementation, are key. Available evidence suggests that these interventions can improve maternal health and birth outcomes, although they have not been assessed at scale. Breastfeeding counselling and improvements in complementary feeding are also key interventions to reduce stunting. Earlier research published in the Lancet in 2005 concluded that improving nutrition education delivered through health services can decrease the prevalence of stunting in children in areas where access to food is not a problem. This was based on two controlled trials which showed that community-based culturally appropriate nutrition education can improve infant feeding practices, dietary intake and growth. However, few other trials have measured the effect of child nutrition education interventions implemented by health services.

**Family planning reduces maternal and child mortality.** An estimated 32% of maternal deaths could be prevented by use of contraception by women wishing to delay or cease childbearing<sup>39</sup>. Family planning reduces the lifetime risk of maternal death and the highest risk births, in younger and older women. It is also one of the most cost-effective ways to reduce maternal mortality, at a cost per DALY<sup>40</sup> saved of US\$30-49. The Indonesia Investment Case<sup>41</sup>

<sup>34</sup> Partnership for Maternal, Newborn and Child Health, 2011. Essential interventions, commodities and guidelines for reproductive, maternal, newborn and child health. A global review of key interventions.

<sup>35</sup> See Black et al, 2008, Lancet Nutrition Series.

<sup>36</sup> Bhutta et al, 2008.

<sup>37</sup> Scaling up Nutrition: A Framework for Action. Policy Brief. September 2010 available many websites including [http://www.unscn.org/files/Announcements/Scaling\\_Up\\_Nutrition-A\\_Framework\\_for\\_Action.pdf](http://www.unscn.org/files/Announcements/Scaling_Up_Nutrition-A_Framework_for_Action.pdf)

<sup>38</sup> See [www.thousanddays.org](http://www.thousanddays.org)

<sup>39</sup> Cleland J et al, 2006. Family planning: The unfinished agenda. *Lancet* 368(9549): 1810-27.

<sup>40</sup> The cost effectiveness of averting a disability-adjusted life year (DALY) is an approach used to assess impact of a health program. One DALY can be thought to represent one lost year of healthy life due to disease or injury; averting a DALY is preventing the loss of a year of healthy life.

notes that family planning is a cost-effective intervention with low coverage that could improve health across the country. By helping women to space births, family planning also has a positive impact on infant and child mortality<sup>42,43</sup>. Analyses of birth-to-pregnancy intervals have shown the risks of adverse outcomes when these intervals are less than 24 months.<sup>44</sup> Short intervals are associated with increased risk of miscarriage, low birth weight, preterm birth, maternal death and child malnutrition. Young children without a mother are more likely to die.

**Family planning contributes to reducing health service costs, poverty and gender inequality.** Each dollar invested in family planning saves US\$1.30 in the cost of maternal and newborn care<sup>45</sup>. Reducing unintended pregnancies also reduces health service costs associated with post-abortion care and complications. Broadening method choice, improving the responsiveness of providers, decreasing distance to services, increasing community-based distribution of contraceptives and reshaping abortion policies all contribute to fertility declines.<sup>46</sup> A decline in fertility in Eastern Indonesia could make a significant contribution to reducing poverty. Enabling women to determine the number, timing and spacing of children is central to empowerment and gender equality.<sup>47</sup>

## 6.2. Lessons from Gol programs

The strategies set out in the National Action Plan for Maternal Mortality Reduction reflect lessons learned from Gol programs. Key lessons include:

**The limitations of a focus on skilled birth attendants** The *Bidan di Desa*, the national village-based midwifery program launched by Gol in 1990, aimed to provide access to maternal and neonatal health services, especially during delivery, at community level by ensuring that there was a trained midwife in every village. Although the program has increased antenatal care, skilled birth attendance and post-natal care rates, two factors have limited its impact on maternal mortality. Firstly, midwives are not present in all villages. Routine data collected by MoH in 2011 data showed that only 82% of village midwives are in the community. Secondly, not all of these midwives have adequate competencies and skills, due to the poor quality of pre-service midwifery training.

**... and hence the need to increase facility-based delivery** Consequently, the Gol is now emphasising facility-based delivery at the *Puskesmas* level. This approach has a number of advantages: midwives can work in shifts, ensuring that delivery care is available 24/7; health workers provide services as a team, which is important when dealing with complications; drugs and equipment are more likely to be available; and *Puskesmas* are usually located in places where it is easier to transport women to a hospital, which enables more timely referral if this is required.

<sup>41</sup> Laksono T et al. Indonesia: Developing an investment case for financing equitable progress towards MDGs 4 and 5 in the Asia Pacific region. Scale-up report. December 2011.

<sup>42</sup> Smith R. et al, 2009. Family planning saves lives. Population Reference Bureau.

<sup>43</sup> Macro International Inc. Demographic and Health Surveys.

<sup>44</sup> Conde-Agudelo A. 2006. Birth spacing and the risk of adverse outcomes: A meta-analysis. *Journal of the American Medical Association*, 29.

<sup>45</sup> Guttmacher Institute. Adding it Up, The Costs and Benefits of investing in Family Planning and Maternal and Newborn Health. 2009

<sup>46</sup> World Bank, 2009. Literature review on determinants of high fertility 1994-2008. Population and reproductive health.

<sup>47</sup> Guttmacher Institute and UNFPA, 2009. Adding it up: The costs and benefits of investing in family planning and maternal and newborn health.

**The need for better compliance with standards** The 2012 Maternal Health Services Quality Assessment found that compliance of health workers with standards was low. For example, standard procedures such as conducting a physical examination and use of a partograph, which can prevent complications during delivery if used correctly, were not always followed.

**The need to increase access to basic EmONC** The GoI recommends that every district should have four *Puskesmas* with the capacity to provide BEmONC. However, the 2011 Health Facility Review showed that 60% of districts in Indonesia do not have the required number of BEmONC *Puskesmas*. Lack of key drugs and supplies is also a factor. For example, despite the fact that haemorrhage and eclampsia are two of the main causes of maternal death, only 70% of *Puskesmas* had a Haemoglobin test kit available and only 43% had magnesium sulphate (MgSO<sub>4</sub>) to manage pre-eclampsia. Almost 25% of in-patient *Puskesmas*, including BEmONC *Puskesmas*, had no transport. Increasing the number of *Puskesmas* capable of providing BEmONC and improving management of obstetric and neonatal emergencies is critical to preventing maternal and newborn deaths.

**The need to increase access to comprehensive EmONC** Around 20% of emergencies involve complications that require hospital management, for example, caesarean section and blood transfusion. However, the 2011 *Risfaskes* shows that only 7.6% of District Hospitals meet the 17 criteria for provision of CEmONC 24/7. Lack of obstetricians and equipment are key factors.

**The need to improve community and family knowledge** Reducing maternal and newborn death also requires families and communities to be able to recognise complications during pregnancy and delivery and to know what to do. The 2010 *Risfaskes* found that only 45% of families had received information about danger signs in pregnancy, and the 2012 Maternal Health Services Quality Assessment found that only 24% of hospitals and 45% of *Puskesmas* provide counselling in antenatal care in accordance with standards.

There are also lessons from social protection programs. In 2007, the GoI launched two large pilot programs in six provinces to accelerate achievement of the health and education MDGs, the Hopeful Family Program (*Program Keluarga Harapan* or *PKH*), which provides conditional cash transfers to households, and the National Community Empowerment Program – Healthy and Smart Generation (*Program Nasional Pemberdayaan Masyarakat – Generasi Sehat dan Cerdas* or *PNPM Generasi*), which provides community block grants. The *PKH* has focused mainly on urban areas and in Java, while the *PNPM Generasi* has operated in rural areas. Both support communities to reach 12 health and education targets. To incentivise communities to focus on the most effective actions, the size of the *Generasi* block grant for the subsequent year is based partly on the village's performance on each of the targets.

An evaluation of the *PNPM Generasi* conducted during 2007-2009 found that it had contributed to improvements in children's nutritional status, especially in areas with higher than average baseline rates of underweight and stunting; increased the number of local health workers; increased delivery of maternal and child health services through *Posyandu*; and increased community participation in health education activities and as *Posyandu* volunteers. However, there was less evidence of impact on long-term outcomes such as malnutrition and infant mortality. Phase 2 (2013-2017) will take account of two other key findings: the program was more effective in areas with the least resources, capacity and infrastructure; and grants that were conditional on community performance with respect to target indicators were more likely to

result in improved health outcomes. AusAID will review the scope for geographical complementarity with the *PNPM Generasi* during the design phase.

**Other lessons for further consideration in a political economy analysis** In addition to the technical evidence and lessons listed above, a political economy analysis during the design process will further inform program design by drawing out implementation lessons from the experiences of previous programs and of relevant programs in other sectors, including such things as how to strengthen the partnership between AusAID and Indonesian counterparts, incentives for local government to allocate the right resources to the priority areas outlined above, how to facilitate better working across multiple government agencies and the effects of high staff turnover on program effectiveness and sustainability.

### 6.3. AusAID experience and lessons learned

AusAID has had a significant involvement in maternal and child health, principally in Eastern Indonesia. This includes support for the Women's Health and Family Welfare (WHFW) project in NTT and NTB (1995-2006), the Improving Maternal Health in Eastern Indonesia (IMHEI) project in NTT and Papua (2004-2006)<sup>48</sup>, the Healthy Mothers Healthy Babies (HMHB) project (1998-2002) in South-East Sulawesi, the Women and Child Health in Papua program (WCHP) (2006-2010) in Papua and West Papua and the AIPMNH (2009-2014). In brief:

The Healthy Mothers Healthy Babies project resulted in improvements in staff skills, service coverage and community participation which, in turn, resulted in a modest improvement in utilisation of health services by mothers. Competency-based training of maternal and child health staff was the major success of the project, although this was qualified with reference to its high cost and limited sustainability. Aspects of the project were replicated elsewhere in Indonesia. However, a drawback was that the project did not integrate family planning, post-abortion care and STI/HIV prevention and care with maternal and child health care.

The Improving Maternal Health in Eastern Indonesia project supported the Gol's Making Pregnancy Safer strategy, which aimed to provide skilled attendance at all births, provide skilled care to women with complicated pregnancies and provide the means to prevent unintended pregnancy. Key successes included strengthening district planning, capacity building for midwives and for health centre teams in emergency obstetric care through the establishment of two clinical training centres, and increased use of health facilities as a result of social mobilisation. Less progress was made in improving referral systems, the supervision of midwives and the management of medicines and supplies at village and health centre levels. Evaluation identified the need to improve clinical training capacity, restore a functional referral system, and strengthen community involvement.

The Women's Health and Family Welfare project improved the relationship between midwives and pregnant women, leading to increases in antenatal and post-natal visits, supervised births and use of family planning services. Health centre capacity to deliver basic and emergency obstetric and neonatal care and family planning counselling was expanded to meet increased demand. The project also improved Gol capacity to plan, deliver and monitor Making Pregnancy Safer programs. Evaluation recommendations focused on the need to improve the quality of, and men's involvement in, family planning services and ongoing support for community involvement through the *Desa Siaga*.

<sup>48</sup> In June 2006 the project was absorbed into the AusAID-funded Women and Children Health in Papua program and the DFID-funded Improving Maternal Health in Indonesia program.



All three projects, however, failed to integrate key elements of GoI policy on maternal care and minimum service standards. One outcome of this was a focus on antenatal and post-natal care, but not on family planning, nutrition and other issues.

The current AusAID maternal and neonatal health program, the AUD\$65 million Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH), has built on lessons from earlier programs. AIPMNH started in 2009 and will be completed in June 2013, with a transition phase from July 2013 to June 2014 to maintain key activities until the continuation program commences. The AIPMNH is implemented in 14 of NTT's 21 districts in partnership with provincial and district government health, planning, community and women's empowerment agencies, BKKBN, professional associations and NGOs. It has three components which aim to: improve service delivery and community involvement; strengthen the health system; and improve the accountability and performance of the health system.

Component 1 supports local government to implement NTT's Mother and Child Health Revolution (*Revolusi KIA*), specifically to improve the delivery of basic maternal and neonatal services at community level and the capacity of health workers to manage complications and emergencies in health centres and hospitals, and to increase community awareness of and demand for services. Component 2 provides support to local government to improve the regulatory environment and local government planning, budgeting and financial reporting and the skills and performance of the health workforce, in order to improve maternal and neonatal health. Component 3 aims to improve the performance, accountability, accessibility and sustainability of public health services.

The AIPMNH has focused on evidence-based interventions<sup>49</sup> adapted to the local context in NTT and on addressing the factors that contribute to high rates of maternal and neonatal mortality. The 2010 Independent Progress Review and the 2012 Strategic Review highlighted approaches that have increased facility-based delivery, increased referral of obstetric cases with complications and improved management of obstetric and neonatal emergencies. A table summarising results and lessons learnt from AIPMNH is at Annex 2. Promising approaches that could be adapted and incorporated within the next phase of support include:

**Training midwives to improve delivery and newborn care, improving supervision and introducing Standard Operating Procedures (SOPs) for post-natal care** These have improved the quality of integrated antenatal care and the competency of midwives to manage normal delivery and to provide quality post-natal care for mothers and babies, including family planning counselling.

**Addressing shortages of specialists through the Sister Hospital approach and CEmONC training for local doctors** The Sister Hospital program links district hospitals in NTT with teaching hospitals in other parts of Indonesia. Specialists from the latter have provided CEmONC and mentored staff in managing maternal and neonatal complications. This has helped to reduce the number of maternal and neonatal deaths in district hospitals in NTT<sup>50</sup>. However, ensuring that health facilities have adequate blood supply remains a challenge.

**Engaging communities through Desa Siaga and Puskesmas reform (Reformasi Puskesmas)** *Desa Siaga* involves establishing a community network to support pregnant women to have safe deliveries and to deliver at health facilities including making sure blood

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<sup>49</sup> <http://www.who.int/pmnh/en/>

<sup>50</sup> An independent review of this initiative will be conducted in early 2013.

donors are available. It indirectly addresses gender issues by involving men and boys in the *Desa Siaga* network. *Puskesmas* reform involves establishing a community board (BPP), which coordinates community engagement with health centre management. Communities have taken on more responsibility for their health facilities and in some cases have built or renovated a *Rumah Tunggu* (see below) at the health centre. *Puskesmas* that have invested in reform, which includes implementing norms and standards to improve service quality, report increased community utilisation of services and reduced impact of staff changes on quality of care.

**Improving the management of complications at Puskesmas through training in BEmONC (PONED) for staff and provision of equipment** Anecdotal evidence suggests that post-partum haemorrhage is no longer the leading cause of maternal death because of better management. *Puskesmas* that have embraced reform have visible evidence of better management and those that are also PONED trained are experiencing more facility births.

**Promoting the use of waiting houses (Rumah Tunggu) for women about to give birth** District health departments in NTT are working with local governments and communities to promote this concept<sup>51</sup>. Districts have taken different approaches, including constructing *Rumah Tunggu* using local health budgets, local government (*Pemda*) funds or PNPM funds. Some communities have used village funds to build *Rumah Tunggu*. However, there is a need to improve management, maintenance and operational funding for these.

**Piloting new ways of working at local levels needs to be combined with policy engagement at national level** Previous AusAID-supported maternal and child health programs had somewhat limited impact in this area. However, the current AIPMNH program in NTT has achieved a somewhat higher profile at national level, with calls for some aspects of the program (e.g. the Sister Hospitals program) to be replicated nationwide. Coupled with the fact that a lot of health sector funding is allocated at the national level, this policy influence has to be achieved through proactive and opportunistic engagement with senior GoI officials as well as through the active involvement of prominent academic institutions and national experts in the program.

The AIPMNH has increased facility deliveries and referrals of obstetric cases with complications, contributing to a reduction in maternal deaths. Facility-based deliveries increased from 40% of births in 2008 to 66% of births in 2011 in districts receiving AIPMNH support; in other districts the proportion of facility-based deliveries declined from 54% to 41% during the same period. Between 2010 and 2011, the number of recorded maternal deaths in NTT fell by 51% in the six AIPMNH districts with a comprehensive program that includes all interventions from *Desa Siaga* to Sister Hospital, compared with a decline of 28% in non-AIPMNH districts that only have the *Revolusi KIA* program. However, the AIPMNH has been less successful in reducing neonatal mortality. The two most common causes of neonatal death in NTT are asphyxia and low birth weight. Reducing neonatal mortality will require improvements in the competencies of health workers to manage asphyxia and an increased focus on maternal nutrition.

Between 2006 and 2010 AusAID also managed an Independent Monitoring and Evaluation Team, which was jointly funded by AusAID and DFID. This carried out eight reviews of four maternal and neonatal health projects in Indonesia implemented by UNICEF and GTZ (including

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<sup>51</sup> Waiting houses are places where pregnant women can come and stay close to the expected time of delivery. The aim is to ensure that women are close to or at a health facility so that distance and lack of transport do not prevent access to facility-based delivery, in particular if there is an obstetric emergency.

the IMHEI and the WCHP). Lessons from AusAID experience and the Independent Monitoring and Evaluation Team (IMET) findings that will inform the design of the new program include:

**Long-term commitment is required to reduce maternal and neonatal mortality.** The underlying causes and health service problems that contribute to maternal and neonatal deaths do not lend themselves to quick fixes. Short program timeframes mean a focus on short-term results and interventions that are less sustainable, such as in-service training rather than addressing the need to improve the quality of pre-service training for midwives. In addition, achievement of results depends on changing behaviours at a number of levels, and this takes time, particularly where it requires changing cultural and social norms. The IMET recommended that the timeframe for a maternal and neonatal health program should be at least 5 years to allow time for changes in institutional practices and community norms.

**Partnerships with non-health agencies and local government commitment are critical.** Much of the success of WHFW and AIPMNH has been due to the involvement of non-health agencies at national and local level including Bappenas and Bappeda, BKKBN and Women's Empowerment. The commitment of Bupati and Local Parliaments to budget allocation for replication of program interventions has been crucial; AIPMNH data suggests that there is a positive correlation between financial commitment and maternal mortality reduction. The NTT government's commitment to *Revolusi KIA* has also fostered a supportive environment for AIPMNH activities.

**Provincial government also needs to be involved.** Decentralisation has promoted a greater role for the district level, and this level has been the focus of AusAID programs to date. However, the sustainability of services also depends on the commitment of relevant provincial agencies and officials and the next phase of support will need to engage with provincial as well as district agencies and officials.

**Engagement with the private sector and other sector ministries is important.** In the five years prior to the 2007 IDHS, the private sector, including private midwifery clinics, accounted for 80% of the increase in facility-based delivery, although the majority of complicated deliveries are still managed by public sector facilities. 67% of family planning is provided through the private sector. As noted earlier, dual practice, where public sector health workers also have their own private practice, is common. The private sector also runs the majority of health worker training institutions, particularly for nurses and midwives, under the supervision of the Ministry of National Education. A clear strategy is therefore needed for engaging with the Ministry of National Education and the private sector providers on training and with the private sector specifically on issues such as referral and use of public sector facilities in cases of obstetric emergency and family planning. This will be developed during the design stage.

**An integrated approach can increase the number of women delivering in facilities.** The AIPMNH has increased the proportion of facility-based births through training and equipping *Puskesmas* and using the *Desa Siaga* to increase community awareness, register pregnant women and coordinate transport to facilities.

**Competency-based training is effective in improving technical skills, but implementation of new skills requires a supportive institutional environment.** Team approaches to training appear to deliver more positive results than individual training. Adequate attention must also be paid to post-training evaluation and supportive supervision, which shows more positive results in terms of improving quality of care than a single training intervention.



**Implementation approaches and interventions should be tailored to local conditions.** This includes taking account of the institutional environment, geographical factors and community culture. For example, the most remote communities incur the highest costs when accessing services and specific strategies need to be developed to ensure that these communities have access to services.

**Strategies are needed to address staff turnover (Mutasi).** Staff turnover in management and clinical positions has been a major problem with earlier programs and continues to be so.

**User satisfaction is an important determinant of care-seeking behaviour and indicator of quality service provision.** User and non-user feedback should inform future program design. Programs also need to pay attention to people's entitlements to quality health services.

**Community engagement needs to be properly resourced.** Initiatives such as the *Desa Siaga* require intensive facilitation and must therefore be supported by an adequate budget.

**Data collection remains challenging.** Despite improvements in *Puskesmas* reporting and recording systems, information systems are often insufficiently robust to provide comprehensive, accurate data on trends in facility-based delivery and maternal and neonatal deaths, and insufficient data is available to assess impact on the poorest. There is also a need to strengthen skills in data analysis and use.

## 7. Program description

### 7.1 Goal and outcomes

The overarching goal of the program is to assist the Government of Indonesia to close the socio-economic and geographical equity gap in reducing maternal and neonatal deaths and childhood stunting in Indonesia.

#### End of program outcomes

It is expected that over eight years, the program will contribute to a:

- Reduced number of maternal deaths, particularly among poor and near poor women in selected provinces and districts.
- Reduced number of neonatal deaths, particularly among poor and near poor populations in selected provinces and districts.
- Reduced prevalence of stunting, particularly among poor and near poor children under 5 in selected provinces and districts.

The program's success in achieving the above outcomes will hinge on its ability to ensure:

- Increased access by communities to family planning, maternal and neonatal health and nutrition services and increased accountability among providers of these services to meet community needs.
- Improved quality of key family planning, maternal and neonatal health and nutrition service delivery at primary and referral level health facilities, particularly in geographically remote and poor areas.
- Increased utilisation of health services by communities in target provinces and districts.

- Greater informed demand and changed individual, household and community knowledge and behaviour related to family planning, maternal and neonatal health and nutrition.

## Outcomes

Specifically, the program will result in the following in targeted communities over the course of the partnership:

- Increased coverage of proven maternal nutrition interventions.
- Increased coverage and quality of post natal care home visits.
- Higher rates of exclusive breastfeeding to six months and improved infant and child feeding practices.
- Greater use of long-term and permanent family planning methods resulting in fewer women having more than three children and birth intervals of fewer than 24 months.
- Increased number of women giving birth in facilities.
- Increased quality antenatal, delivery and post-natal care provided by *Puskesmas*.
- Increased maternal and neonatal complications managed at district hospital and *Puskesmas* as appropriate.
- Increased number of appropriate referrals of maternal and neonatal complications.

These outcomes will be valued most highly for poor and near poor women, children and communities and will therefore be disaggregated by socio-economic status where possible.

## 7.2. Areas of activity

This concept note does not describe activities in detail. However, indicative examples of possible areas of intervention that would be supported by Australia's investment are described below.

### Maternal and neonatal health service delivery

Increasing access and utilisation:

- Increasing coverage of post-natal home visits by midwives through incentives and community education and information campaigns, in response to international and Indonesian evidence that post-natal care home visits have high returns in reducing maternal deaths and neonatal deaths in particular.
- Supporting the implementation by *Posyandu* of a package of proven maternal and neonatal health and nutrition interventions.
- Supporting *Puskesmas* to provide 24/7 delivery care and a *Puskesmas*-centred approach to management of basic complications.
- Improving the functioning of referral networks from community to *Puskesmas* to hospital levels.
- Replicating the Sister Hospital approach where appropriate to build the capacity of district hospitals to provide CEmONC.
- Supporting local government to attract and retain experienced health workers in rural, remote and poor areas in collaboration with the AusAID-funded HSS program.

Improving quality:

- Improving the competencies of health workers in maternal and neonatal health and nutrition through enhanced and standardised pre-service training, competency assessment, targeted in-service training, enhance supervision, and exchange programs.
- Supporting implementation of standards of care, including referral for complications.
- Providing performance-based funding through government systems for *Puskesmas*.
- Supporting improvements in infrastructure and the availability of equipment and supplies.
- Strengthening the use of data, in particular maternal and neonatal death audit data.

Increasing community demand and utilisation:

- Increased knowledge and awareness of maternal and neonatal health, including the importance of facility delivery and recognition of danger signs, through community education and support for the *Desa Siaga* program.

### **An increased investment in family planning**

Although some training of midwives and family planning fieldworkers is included in the current AIPMNH program, family planning is not a core focus of the program. This new Australia Indonesia partnership proposes to include a significant focus on family planning, particularly on shifting the method mix to use of LAPM by women who want to cease or space having children.

Example activities in the new program, based on analysis of binding constraints and consultation with key stakeholders in Indonesia, include:

- Supporting incentives for greater private provision of LAPM
- Working with BKKBN on efficient family planning commodity distribution systems
- Increased knowledge and skills of family planning providers
- Community education, particularly of family members and religious leaders
- Social marketing approaches through private not-for-profit providers (in recognition that such organisations (often co-financed by donors) are at the forefront of family planning efforts in many countries)

The program will also work closely with other AusAID programs, particularly the MAMPU program, which also has a reproductive health focus, and work with key faith-based groups in Indonesia. The baseline assessment and ongoing results of a four-year study on advocacy effectiveness in shifting family planning method mix (Johns Hopkins, University of Indonesia and Advance Family Planning collaboration) co-funded by AusAID and USAID will feed into the program to ensure maximum impact.

Calculations using the FamPlan model and AusAID Jakarta Health Team's own calculations suggest that a family planning focus, whilst adding just under 20% to our program costs, could decrease maternal death by an additional 18% (range 6% – 28%) and neonatal death by around 8 % (range 4% – 18%).

### **A new focus on maternal and infant nutrition**

We propose to add a focus on maternal and under-two nutrition to prevent stunting and maternal and neonatal death. This will include:

- Assisting GoI to get greater coverage of known effective maternal and under-two nutrition interventions
- Individual and community information education and communication
- Improving nutrition skills of key health workers through pre- and in-service training.

The Lancet series on maternal nutrition suggests that implementation of a comprehensive package of known effective nutrition interventions can reduce stunting by up to 36% (Bhutta et al 2008). Calculations in the LiST model and AusAID Jakarta Health team's own spreadsheet model estimate that effective implementation of a package of maternal and infant nutrition interventions (excluding pre and in-service training) could reduce maternal death by around 7%, neonatal death by up to 15% and stunting by up to 36%. Costs will vary significantly depending on the gaps in implementation of nutrition interventions in each program area. A very rough estimate is that nutrition may take up around 12 – 20% of overall program costs of a \$200 million program over eight years.

### 7.3. Program delivery components

Different modes of delivering the program are needed to effect this range of desired improvements in coverage and quality of maternal and neonatal health and nutrition services, utilisation of and engagement with these services and changed individual and community behaviours.

One of the important areas of program focus will be to support the development of national policies and strategies. The Australia Indonesia Partnership for Health System Strengthening (AIPHSS) is already engaging on issues related to the universal coverage agenda in Indonesia, and on broader issues of health financing and human resources for health. These are closely related to improved maternal and neonatal health among the poor and near-poor. This program will bring additional inputs specific to maternal and child health. AusAID can play a role in supporting an appropriate evidence base for these key policies, an area of cooperation already appreciated by Government of Indonesia counterparts. In order to facilitate this, the program will engage with prominent universities and national experts who are influential in guiding national policy development.

In many areas of program focus, such as maternal and infant nutrition, appropriate policies are in place at national level but it is their implementation at subnational level that is the main challenge. This can be due to varying implementation capacities in the districts and provinces, the need for adaptation of national guidance to local context, lack of resources to implement policies and challenging implementation environments. A combination of technical assistance, strategic engagement with local leaders, provision of flexible financing and piloting of implementation approaches is more appropriate to address these issues.

1. Considering these challenges and requests from GoI on specific areas for AusAID involvement, there are likely to be five types of delivery component for this partnership:
2. District level performance based financing to increase primary care quality and coverage of known effective interventions
3. Improving implementation through piloting innovative financing and implementation models for potential GoI scale up
4. Enhancing quality through investment in pre-service education and competencies

5. Contributing to evidence-informed quality national and sub-national policy in maternal and child health and nutrition
6. Promoting individual and community behaviour and social change and engagement

### **Performance-based financing through Ministry of Finance to District channels to increase primary care quality and coverage**

Whilst there are many financing sources for health at a district level, they are all earmarked for specific purposes and have burdensome reporting requirements. Districts and primary care facilities often do not have flexible funds to allocate to what they know are important needs or appropriate delivery models to increase quality and coverage of primary maternal and child health and nutrition services. In addition, existing financing channels are rarely linked to health service delivery and outcome performance.

This partnership will consider provision of flexible and increasingly performance-based financing through existing GoI channels to districts, coupled with district level technical assistance / facilitators. Funding would likely support district innovation to increase coverage of known effective interventions and fill gaps in GoI available financing for primary care resources that support quality delivery such as equipment maintenance. Performance outcomes for payment triggering would include coverage of post natal home visits and other known effective maternal and neonatal health and nutrition interventions where coverage is low such as tetanus vaccination, iron supplementation etc.

Such a model would support innovative context-specific district service delivery and maximise opportunities to leverage other government of Indonesia financing. Fiduciary and other risks and transactions costs associated with this approach will be further explored during the design stage to assess its suitability and likelihood of achieving program goals.

### **Piloting innovative financing and implementation models**

As outlined in the problem analysis, several key interventions to reduce maternal and neonatal deaths are constrained by potential income losses for private providers. These are often the most easily accessible providers to communities. Such crucial interventions include the provision of LAPM family planning methods, delivery care (a key role of traditional birth attendants) and post natal home visits. Other constraints include the uneven deployment of skilled human resources and the lack of affordable transport. These issues may be addressed through a range of innovations, including public-private partnerships, sub-contracted distribution of key family planning commodities, information and communications technology based approaches or innovative ways to redeploy key health workers (e.g. through AIPMNH's Sister Hospital program).

This program component would focus on conducting and evaluating a range of pilots of innovative financing and implementation models at sufficient scale across multiple program areas for consideration for further government scale up. This would be restricted to approaches in which it is not yet known for certain whether they will remove the constraints and improve service delivery, or whether they can be implemented in a cost-effective way on a significant scale. The interventions will be appropriately designed and evaluated so as to provide this evidence. A number of possibilities have already been identified to be further explored at design stage, including further scale-up of successful models already being piloted in NTT under AIPMNH. It is likely that others will arise through the course of the eight-year program.

## Investment in pre-service education and competencies

The lack of sustainability and high cost associated with extensive short-term in-service training has been noted in other donor programs and in AusAID's previous experience (see lessons learned section above). Turnover of health workers (*Mutasi*), particularly in primary care facilities and rural and remote areas, is high in Indonesia, reducing the sustainability of benefit to particular areas or facilities from in-service training. In addition it is often newly graduated health workers with limited skills who are placed in remote rural and poorer areas, exacerbating inequities in the quality of maternal and child health care provided.

AIPHSS has some focus on public sector training institution curricula and accreditation. However, this does not address some of the key areas for maternal and child health, including the main challenge of private sector training institutes (*Stikkes*) having very different accountabilities and standards compared to the public sector. The majority of midwives are now being trained in the former, mostly to an inadequate standard. Another major challenge is the quality of nutritionists' curricula and appropriate inclusion of nutrition in other health professionals' curricula. The Ministry of Health has specifically asked AusAID for collaboration on pre-service training quality, particularly in the nutrition field. Reasons for this include a previous valued partnership that the Government of Indonesia had with the Menzies School of Public Health in Darwin on this.

Investment in pre-service education would expand AusAID's group of main stakeholders for this program, including engagement with the Ministry of Education. This potentially increases the program management demands. Investment in pre-service education is therefore still included as a potential option (see strategic options and economic appraisal below) and areas for specific engagement, if at all, will be further explored during the design stage. This will include consideration of whether the area can be addressed adequately under AIPHSS and discussions with the Ministry of Education and Culture and the World Bank on areas already covered under the World Bank – Ministry of Education Health Professionals Education Quality (HPEQ) partnership. The main inputs in this area are likely to be through technical assistance partnerships at the national level, both through local academic institutions already working in this area (such as UGM) and through international links including potential partnerships with Australian institutions and professional councils.

## Evidence informed policy engagement

Policy engagement with MoH, BKKBN, Bappenas and a range of other key stakeholders has strengthened in the health sector over the past few years. Access to a range of experts to conduct policy applied research and analysis in maternal and infant health and nutrition is highly valued by Government of Indonesia colleagues. Channels for this will include working with the health policy network supported under the AIPHSS and partnership with international institutions, particularly in Australia. There will also be joint work with AusAID Indonesia's knowledge sector program, with health knowledge hubs (particularly on women and children) supported by AusAID Canberra and with other AusAID supported research centres and grants mechanisms.

## Supporting IEC and community engagement

Many of the issues and activities discussed above involve the effective development and use of communication for behaviour and social change. All over the world, government bodies are often weak in this area, with non-governmental organisations often playing an important role. In



Indonesia the national and sub-national units for health promotion messaging (*Promkes*) have quite limited capacity.

AusAID will support effective information and education campaign processes, including through support to key non-government organisations with strengths in this area and where appropriate and for sustainability purposes working with *Promkes*. Cooperation with other AusAID supported programs working on community education, communication and engagement in health and health services such as PNPM, Access and MAMPU will be central to the approach.

#### 7.4. Program strategies

To achieve the expected outcomes the next phase of AusAID support will build on the promising approaches and lessons learned described in Section 6. Additionally, it will:

**Target the sub-national level** In Indonesia's decentralised system the sub-national level is critical to improving service delivery, including through effective implementation of existing policies and standards. Support will therefore be targeted mainly at the provincial and district levels. However, support will also be provided as appropriate at national level, for example, on issues such as policies, norms and standards, task shifting and private sector regulation. Strategic engagement with GoI partners at national level will be required to address other issues that influence service delivery at sub-national level, such as pre-service training for health workers.

**Strengthen the continuum of care** The program will support a continuum of care approach, with an emphasis on improving the quality of care at community, primary and referral levels. There will be a particular focus on building capacity at *Puskesmas* level, reflecting what should be the central role of *Puskesmas* in providing maternal, neonatal, family planning and nutrition services close to the community and oversight of community-level interventions to improve maternal and child health and nutrition. *Puskesmas* also play a key role in dealing with basic complications as well as in providing appropriate and timely referral for those in need of more comprehensive emergency obstetric and neonatal care, and strengthening this role will be given particular emphasis. This will complement the current focus of the MoH on hospital care to address high maternal and neonatal mortality. However, it will be crucial to also work with district hospitals, which play a key role in saving the lives of mothers and newborns, to ensure that they have the capacity to deliver CEmONC, and to support the implementation of appropriate and effective referral between community, primary care and hospital levels.

**Tailor support to local needs** The Indonesia Investment Case<sup>52</sup> shows that in more remote and rural districts, access to health services is the main challenge, because of geographical, transport, financial and other barriers, whereas in more developed and urban districts, the main challenges relate to management, systems and the role of the private sector. Support for service delivery will be required in districts where access to services is the main challenge. Technical assistance and support for addressing bottlenecks and improving quality will be needed in better resourced districts.

**Engage with NGOs and the private sector** The program will primarily work with public sector health services, but will engage with the private sector to tackle specific challenges. Given the private sector's role in provision of delivery care and family planning and in health worker

<sup>52</sup> Laksono T et al. Indonesia: Developing an investment case for financing equitable progress towards MDGs 4 and 5 in the Asia-Pacific region. Scale-up report. December 2011.

training, this engagement is expected to focus initially on improving the quality of training provided by private midwifery training institutions and on strategies, for example, financial incentives, to encourage private providers of family planning service to offer LAPMs. There will also be closer engagement with NGOs, including faith-based organisations, particularly in the area of community engagement and increasing awareness and demand for services.

**Seek to achieve short-term gains and longer-term change** The program will include a combination of activities that will generate more immediate results, for example, nutrition interventions, provision of equipment and supplies and expansion of the Sister Hospital initiative, and activities that will take longer to demonstrate results, for example, private sector regulation, pre-service training and improvements in implementation of care standards.

**Leverage rather than displace GoI resources** Additionality will be a key principle. AusAID funding should not result in reduced expenditure on health by provincial or district governments. Targeted provinces and districts will be expected to demonstrate commitment to financing services both during program implementation and when AusAID funding ends.

**Promote gender equality and women's empowerment** (See under Problem Analysis in 2.2 above.) Any program that aims to tackle maternal mortality needs to address underlying gender inequalities. This program will, in addition to targeting health services that will primarily benefit women and children, ensure that all activities are informed by the principles of gender equality and women's empowerment and build on the gender mainstreaming activities of the AIPMNH. Gender will be incorporated into the program design, following a more in-depth gender assessment and consultation with the MoH's gender working group, Ministry for Women's Empowerment, women's organisations and civil society groups. *Puskesmas* will be central to ensuring a focus on gender in the program, both as service providers, advocates and sources of sex-disaggregated data. Specifically, the program will ensure that gender is addressed in efforts to improve access to and quality of services and within demand-side and community education interventions, and include gender indicators in its M&E framework.

**Ensure social inclusion is central** In addition to gender inequalities, poverty and social exclusion are at the root of high rates of maternal and neonatal mortality in Indonesia. Socio-economic inequalities are increasing within as well as between provinces, and in particular in the more densely populated areas of the country. Growing inequalities are likely to result in worsening health outcomes, given the link between inequality and poor health, including in more developed countries. The program goal is to close the socio-economic and geographical equity gap in reducing maternal and neonatal deaths and childhood stunting in Indonesia, and interventions will therefore target the poorest and most vulnerable women and children. The program's approach to integration of social inclusion will be developed further during the design phase.

**Emphasise sustainability** The program aims to contribute to sustained improvements in health and nutrition outcomes through sustainable provision of quality maternal and neonatal health and maternal and child nutrition services and sustained community demand for services. Strategies to ensure the sustainability of service delivery will include training for health workers and support for implementation of standards and effective referral, as well as ensuring that facilities have the requisite equipment and supplies. The emphasis will be on strengthening existing systems rather than creating parallel systems. The AusAID-funded AIPHSS will also play a critical role in strengthening health systems to be able to deliver effective and responsive services.



Sustained GoI commitment to financing health service delivery and community programs from national and district budgets and to scale up of promising interventions will also be critical. The GoI has the fiscal space to continue to increase health service funding, and appears to have the political will to do so. Building commitment at district level will be important, both through this program and through other AusAID-funded programs such as the Australia Indonesia Partnership for Decentralisation (AIPD). Political engagement at all levels will be important to ensure that those who make decisions about resource allocation understand the value of improving health services. The program will also provide support to enhance strategic information including improving the availability and quality of health data and the use of maternal and neonatal death audits, in order to inform planning and implementation.

## 7.5. Program beneficiaries

The primary beneficiaries will be mothers and women of reproductive age, newborns and children under five (when stunting is measured). These will mainly be in provinces and districts covered by the program and these are included in the calculations below. Though the combination of program target provinces and districts and roll out plans will be decided jointly with the Government of Indonesia during the design stage, initial estimates based on 55 districts across eight provinces suggest that over an eight year program life around 4.9 million pregnant women / new mothers and the same number of newborns may benefit directly from this support, up to 9.3 million women in reproductive age (15-49 years) and around 2.2 million children under five that may otherwise be stunted. In addition, however, work on national policy and pre-service education may contribute to improvements reaching beneficiaries across Indonesia beyond the sub-national areas of specific focus. Secondary beneficiaries including health workers, in particular midwives, nurses and village health cadres, will also benefit, for example from training and improved working conditions. As well as these primary and secondary beneficiaries of the program, the program will also work with religious and traditional leaders, husbands, mothers in law, health cadres and other key members of communities who influence maternal and child health and nutrition.

Reflecting AusAID Indonesia's country strategy and GoI priorities<sup>53</sup> the program will focus on the poorest provinces *and* the poorest women and children. The highest proportions of poor people live in remote but less populous provinces such as West Papua (31.9%), Maluku (23%), Gorontalo (18.7%), NTT (21%), NTB (19.7%) and Aceh (19.6%). However, more than half of all poor people in Indonesia live in Java, because of its population size, even though the proportion of poor people is lower at 15%. Consequently, there is a need for interventions both to target the poorest provinces *and* to reach the poor across the country. The geographical coverage of the program will, therefore, include provinces and districts with the worst health and nutrition indicators and the highest proportion of people living in poverty, *and* provinces and districts with significant numbers of poor people. With respect to the former, the program will concentrate on Eastern Indonesia, which accounts for 70% of poorly performing districts and where more intensive support will be required. This will enable the program to build on AusAID's investment, experience and established relationships in Eastern Indonesia, to benefit from synergies with other AusAID programs that are operating in the same geographical areas, and to complement other donors, which are working elsewhere.

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<sup>53</sup> GoI priority provinces are Aceh, North Sumatera, West Sumatera, Lampung, Banten, DKI Jakarta, West Java, Central Java, Yogyakarta, East Java, NTB, NTT, South Kalimantan and South Sulawesi. This is based on the estimated number of maternal deaths in the province, using nationally compiled routine data for 2011.

The partnership will also extend support to provinces and districts with high numbers of poor women and children. Though many of these are wealthier and with better health outcomes overall, significant inequities still exist between the wealthier and poorer in these areas, and these inequities are tending to increase. The numbers of women and births in these areas are also significantly higher, hence greater numbers of deaths may be prevented resulting in bigger impacts on national maternal and neonatal health statistics, a priority for the Government of Indonesia. This, though, is dependent on these provinces' capacity to benefit from additional investment where maternal mortality ratios are already somewhat lower and declines in maternal mortality have stagnated. It could also be argued that the remaining causes of death are more entrenched and therefore each death prevented may require more investment than in poorer remote provinces where, although the overall number of deaths is lower, the high rates of maternal and neonatal death and continuing declines may mean easier gains can be made from further investment. Operating in a range of provinces with different contexts and populations also provides a greater opportunity to influence national policy.

Provinces under consideration for targeting through this partnership and their beneficiary numbers are provided in Annex 3. An initial analysis showing how the mix of potential provinces where AusAID support might be targeted impacts the number of potential beneficiaries and outcomes is provided in Table 3 below. Variable costs of implementation generally relate to the number of districts, not the number of provinces. In order to ensure a sufficient scale of intervention in each province it is reckoned that coverage should comprise between five and 10 districts depending on the size of each province.

**Table 3: Possible scenarios of primary beneficiaries by province and district selection**

	All worst health indicators and highest proportion poor – 8 provinces – 50 districts <sup>54</sup>	5 representative provinces with higher population and numbers of poor – 45 districts <sup>55</sup>	Combination scenario 8 provinces – 55 districts <sup>56</sup>
Average population per district	185,200	971,870	681,150
% below national poverty line	23%	14%	18%
Total number poor across districts	2.1 million	5.3 million	6.7 million
Number women in reproductive age	2.8 million	13.0 million	9.3 million

<sup>54</sup> Eight provinces considered here are NTT, NTB, Central Sulawesi, South East Sulawesi, West Sulawesi, Gorontalo, Maluku and Papua

<sup>55</sup> Five provinces are East Java, Central Java, West Java, Banten and North Sumatra. With around 30 districts per province greater numbers of districts eg 10 would be targeted per province

<sup>56</sup> Provinces are East Java, Banten, Central Java, NTT, NTB, Central Sulawesi, West Sulawesi, Maluku

Estimated number of births (2012 only)	216,490	877,730	624,790
Potential maternal deaths (2012 only)	81	223	137
Neonatal mortality rate	28 / 1000	21 / 1000	28 / 1000
% births in facilities	24%	59%	41%
% children under 5 stunted	41%	36%	41%

## 7.6. Strategic options and economic appraisal

The Country Situational Analysis of the AusAID Indonesia draft Country Strategy 2013 – 2018 outlines that health will be an ongoing and potentially increased area of Australia-Indonesia partnership. In addition the AusAID Indonesia draft Health Sector Delivery Strategy outlines the case for continued investment in maternal and child health including Indonesia's poor performance on key maternal and child health and nutrition outcomes (and related MDGs), the Gol's priorities and AusAID Indonesia's past investment and experience in this area<sup>57</sup>.

Whilst continued investment in maternal and child health is therefore a priority, this proposed program would be larger than the current AIPMNH both in content and geographic scope and so signifies a scaled up investment in maternal and child health and nutrition.

Three options on content existed to the team, ranging in the degree of comprehensiveness and responsiveness to the Gol's requests for AusAID assistance (see Table 4). These reflect two decisions that needed to be considered:

- 1) Whether to extend the program focus to include family planning and nutrition components;
- 2) Whether to include a focus on the quality of pre-service education for key health personnel (doctors, midwives, nurses, nutritionists) and the resulting assessment of competency.

These represent different scope of activities to reach the same goal of reducing maternal and neonatal death numbers and inequities in Indonesia. They are areas that the current program does not focus on and so represent additional investment for AusAID in terms of dollars, numbers of stakeholders to engage with (and therefore AusAID human resource time) and expertise required. They also, however, add to the returns to reduction in maternal and neonatal death and childhood stunting that the program aims to achieve<sup>58</sup>.

<sup>57</sup> Note that both the Indonesia country strategy and the health delivery strategy are currently in draft

<sup>58</sup> The last (reduction of childhood stunting) is completely reliant on including a maternal and infant nutrition component

**Table 4: Program inclusion options and potential costs and outcomes related to these choices**

1: Least comprehensive – current program scaled to other provinces		2. Include family planning and nutrition focus		3. Additionally include pre-service training focus	
Intervention areas	% cost	Intervention areas	% cost	Intervention areas	% cost
<b>Maternal and neonatal health</b>	100%	<b>Maternal and neonatal health</b>	60%	<b>Maternal and neonatal health</b>	55%
Enhancing availability and quality of 24 hour provision of comprehensive emergency obstetric care at district hospital (Sister Hospitals)		Enhancing availability and quality of 24 hour provision of comprehensive emergency obstetric care at district hospital (Sister Hospitals)		Enhancing availability and quality of 24 hour provision of comprehensive emergency obstetric care at district hospital (Sister Hospitals)	
Improving quality of basic emergency and general obstetric care at Primary Health Centres (Puskesmas)		Improving quality of basic emergency and general obstetric care at Primary Health Centres (Puskesmas)		Improving quality of basic emergency and general obstetric care at Primary Health Centres (Puskesmas)	
Improving timely access to facility based birth from communities (Desa Siaga)		Improving timely access to facility based birth from communities (Desa Siaga)		Improving timely access to facility based birth from communities (Desa Siaga)	
Community information, education and communication		Community information, education and communication		Community information, education and communication	
Health systems for maternal and neonatal health improvement		Health systems for maternal and neonatal health improvement		Health systems for maternal and neonatal health improvement	
		<b>Family Planning</b>	20%	<b>Family Planning</b>	20%
		Expanding use of long term acting and permanent methods		Expanding use of long term acting and permanent methods	
		<b>Nutrition</b>	20%	<b>Nutrition</b>	20%
		Improving exclusive breast feeding and complementary feeding practices		Improving exclusive breast feeding and complementary feeding practices	
		Increasing coverage of key maternal nutrition interventions		Increasing coverage of key maternal nutrition interventions	

				<b>Pre service education</b>	5%
<b>TOTAL COST (8 years) (\$ mill)</b>	\$140		\$230 <sup>59</sup>		\$240 <sup>60</sup>
<b>EST. MATERNAL DEATHS AVOIDED</b>	234 (21%)		525 (48%)		560 (51%)
<b>EST. NEONATAL DEATHS AVOIDED</b>	2361 (16%)		3800 (26%)		4000 (28%)
<b>EST. STUNTING CASES PREVENTED</b>	0		426000 (18%)		490000 (21%)

These costs and benefits are based on estimated fixed and variable costs of implementing an indicative set of interventions possible under this program (outlined in the activity areas). These are necessarily rough guides and will vary depending on numbers and types of provinces and districts targeted by the program partnership. In fact, the selection on number and type of provinces will affect both costs and potential outcomes from the program (see beneficiaries section also). Though numbers of births (and therefore maternal and neonatal deaths potentially avoided) may be higher in high population areas, often rates of death are lower and not declining in these areas. Poorer more remote provinces such as in Eastern Indonesia, on the other hand, have fewer births and deaths but the maternal mortality ratio is far higher and still declining.

The level of the health system where support is concentrated (which will to some degree necessarily depend on areas selected also) also changes the outcomes achieved for the cost. International evidence suggests that investment in basic emergency obstetric and neonatal care at intermediate levels of the health system (in Indonesia's case the *Puskesmas*), rather than in comprehensive emergency obstetric and neonatal care, can support greater reductions in maternal and newborn death.<sup>61</sup> In this program we propose to have a focus on investment at the *Puskesmas* level (including referral) whilst not neglecting hospital level comprehensive care. This focus is likely to add further reductions in maternal death of 9 – 15% in rural remote provinces and 5 – 11% in more populated better off provinces. However, in the current package of interventions this focus does add an additional 7% or more to costs, due to the larger number of *Puskesmas* than hospitals in each district and also greater gaps in equipment availability for quality service provision at *Puskesmas* compared to hospitals.

<sup>59</sup> This is an indicative costing. We will revise down the total to meet our proposed budget of \$200 million in the design process.

<sup>60</sup> This is an indicative costing. We will revise down the total to meet our proposed budget of \$200 million in the design process.

<sup>61</sup> Darmstadt et al (2008) Saving newborn lives in Asia and Africa: cost and impact of phased scale up of interventions within the continuum of care. Health Policy and Planning. Vol 23 pp 101-117.

## 7.7. Links with other AusAID programs

AusAID Indonesia has a comprehensive program portfolio across a range of sectors. Some of these programs include elements that contribute or could contribute to improving maternal, neonatal and child health, family planning and nutrition. This program will explore opportunities for maximising health and nutrition outcomes for poor women and children through a cross-sectoral approach. It will work closely with AusAID programs that are being implemented in the same geographical areas and ensure that activities are complementary. Program areas that offer the most promising opportunities for links are:

**Health** Strengthening the health system is essential to delivering sustainable improvements in maternal and neonatal health outcomes. The program will therefore work closely with the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS), which aims to tackle underlying health system constraints in order to achieve the MDGs, in particular the off-track maternal mortality MDG. The program design emphasises GoI leadership and ownership and a government-led implementation modality. It aims to improve primary health care access and quality for the poor and tackle supply-side obstacles, supporting interventions and capacity development at national, provincial, district and service delivery levels. AIPHSS outputs relate to strengthening generation and use of evidence for national policy and decision-making, district financing and human resources policies, and training for health workers. The program design phase will explore opportunities for working in the same provinces and districts as the AIPHSS as well as ensuring that activities are mutually reinforcing. The program will also explore opportunities for links and lesson learning with the AusAID-funded Advance Family Planning ICMM project described earlier.

**HIV** The Australia Indonesia Partnership for HIV (AIPH) includes support for several programs which are implementing a comprehensive range of HIV interventions. A key area where linkages will be important is prevention of mother-to-child transmission (PMTCT) of HIV. MoH antenatal care guidelines include HIV testing and PMTCT interventions, and the Minister of Health has in January 2013 issued a new decree that requires all ANC and MCH services to implement PMTCT. This program will work with the HIV program to support implementation of these requirements and guidelines in provinces and districts where the prevalence of HIV is high and to promote integration of HIV care within MCH services.

**Governance** On the supply side, the program will also need to work closely with the Australia Indonesia Partnership for Decentralisation (AIPD), which aims to strengthen decentralised government, public sector service delivery and public financial management, in order to improve the provision of essential services, including health, by district governments. The AIPMNH works closely with AIPD in NTT and collaboration will continue during the next phase of support.

**Social protection** There are close links between social protection and the health of the poorest women and children. The program design will explore opportunities to work with AusAID-supported social protection efforts including the PNPM Generasi to increase demand for, and community engagement with, health services. The health team is exploring possible collaboration, including where the two programs will be working in the same districts, with the *PNPM* support facility team.

**Community capacity** There may be opportunities to engage with communities to increase awareness of maternal and neonatal health, family planning and nutrition issues through the next phase of the ACCESS program, which works with village volunteers. The program could learn from the approach taken by the ACCESS and LOGICA programs to building community



capacity and facilitating linkages between communities and local governments. Working in the same locations may provide an opportunity to capitalise on these linkages and to work with more engaged communities. The Decentralisation Unit is currently developing the concept for the next iteration of the ACCESS program.

**Women's empowerment** The program could also collaborate with the AusAID Empowering Indonesian Women for Poverty Reduction (MAMPU) program, which aims to improve the lives of poor women in Indonesia. In particular there is potential to leverage increased demand for health services through two of MAMPU's thematic areas, namely improving women's access to government social protection programs and strengthening women's leadership for better maternal and reproductive health.

**Skills development and expertise** The program will work with the Australian Development Scholarships program to identify opportunities that could help build the capacity of Indonesians. The use of Australian Volunteers (AVI) to address shortages of skills in specific geographical areas will also be explored.

Improving maternal and neonatal health and women's and children's nutrition, in particular reducing stunting, requires cross-sectoral action in addition to health sector-specific interventions. Potential synergies will therefore also be explored with:

**Water and sanitation** Inadequate water supply and sanitation and poor hygiene are key impediments to reducing maternal, neonatal and under-five mortality. Diarrhoeal disease, for example, is associated with poor sanitation and hygiene and contributes to poor nutritional outcomes, including stunting. Programs to improve water and sanitation and hygiene behaviour play a critical role in improving health and nutrition outcomes. Australia is providing support to improve poor people's access to water and sanitation through policy change and funding for local government to improve water and sanitation infrastructure. This program will build on existing cross-sector work between AusAID's health and WASH programs including joint planning, stakeholder engagement and results frameworks, as well as exploring the potential to improve water and sanitation infrastructure at health facilities.

**Education** There is a strong association between maternal education and maternal, neonatal and child health outcomes. Better educated women are typically more likely to use health services and family planning; estimates suggest that an extra year of education can prevent two maternal deaths per 100,000 live births<sup>62</sup>. Female education is also closely related to under-five mortality, which is highest in households where mothers have no schooling. Children born to more educated mothers are more likely to have higher birth weights and less likely to die in infancy. Each additional year of maternal education reduces under-five mortality rates by 5-10%. As noted previously, maternal malnutrition is a leading cause of maternal and neonatal mortality and of childhood stunting, but by the time a woman becomes pregnant it is usually too late to reverse the effects of chronic malnutrition. It is important therefore to improve the nutritional status of girls, especially adolescents, and an effective way to reach many girls is through schools. Conversely, improved nutrition will also improve children's cognitive development and learning outcomes. Australia's Education Partnership is helping to increase access to secondary education in poor and remote areas and to improve the quality of education. During the design stage, the health team will work with the education team to explore ways in which health and nutrition issues could be integrated into basic and secondary education as well as strategies to improve access and retention of girls in secondary school.

<sup>62</sup> UNICEF (2008) Progress for Children: A Report Card on Maternal Mortality

**Infrastructure** Australia is providing significant support in the form of loans and grants to improve infrastructure in Eastern Indonesia. For example, the Eastern Indonesia National Roads Improvement Project (EINRIP) is supporting major road and bridge improvements to promote economic and social development in nine provinces. There may be opportunities to ensure that these improvements help to remove geographical barriers that prevent women from accessing health facilities.

Linkages with other AusAID programs, including mapping potential geographical overlap, will be explored in more detail during the design phase. This will include consideration of the practical implications of links for coordination, implementation and M&E.

### 7.8. What AusAID will not fund

AusAID Indonesia has identified specific areas that this program will not fund, either because they are of lower priority, are already well supported by the GoI, other donors or other AusAID programs, or are politically sensitive. These areas include: food security and food supplementation; wider health systems strengthening; broader child health programs such as IMCI; and abortion services.

## 8. Timeframe, budget and modalities

### 8.1. Timeframe

The design is expected to be approved in September 2013. The next phase of AusAID support is planned to commence in mid-2014, following a 12-month preparation and tender phase. The timeframe is eight years, divided into two four-year phases. The duration reflects the long-term commitment required to make a meaningful difference to the health and nutrition of the poorest women and children in Indonesia, given the time needed to effect changes in factors that influence the supply of and demand for health and nutrition services and in related behaviours. This longer timeframe will also give a clear message to the Government of Indonesia that Australia is serious about our commitment to the partnership in health.

Based on lessons learned from the AIPHSS program, the first year will be an inception phase to allow sufficient time to establish governance structures, partnerships, funding modalities, baseline data and M&E systems prior to starting significant implementation of activities. In addition, during the first year, support will be maintained for key interventions in NTT that are currently funded through the AIPMNH, which will end in June 2014.

The program will be subject to a full independent review after the first four-year phase, which will provide an opportunity to adjust the design to reflect changes in the policy and operating environment and implementation progress and challenges. This will also include a review of the effectiveness of implementation and funding modalities and of contracts. All agreements and contracts with implementing partners will include a break clause giving AusAID the option to extend or end the contract after four years.

### 8.2. Budget

The proposed funding allocation is AUD\$200 million, with AUD\$80 million allocated for the first four-year phase and AUD\$120 million allocated for the second four-year phase. This is subject

to annual budget processes and other considerations outlined in the CAPF. This split reflects the anticipated time needed to establish funding modalities including through the GoI. The budget for the first phase (July 2014 – June 2018) will be prepared during the design process. The total funding envelope has been estimated using preliminary costing estimates for the proposed set of interventions across a large enough geographical area (about 50 districts in seven or eight provinces) to make a significant impact on Indonesia's achievement of these off-track MDG targets.

### 8.3. Governance and implementing partners

Governance arrangements will be developed during the design phase following further consultation with GoI. At national level, it is anticipated that a Steering Committee comprising key AusAID, GoI and other stakeholders will be established to provide overall strategic direction to the program and to complement sub-national partnerships. AIPMNH experience also suggests that Technical Working Groups at national level may not be the most effective way to provide implementation guidance to provincial and district partners. Other options will be explored including more targeted and time-limited involvement of specific MoH and other ministry directorates in providing guidance and support to specific activities. This more targeted approach has worked well with respect to MoH involvement in the AIPMNH Sister Hospital component.

Government agencies at national, provincial and district levels will be key implementing partners. Policy engagement with national level GoI will be crucial. The key technical partner for the program at the national level will be the MoH, in particular the Directorates responsible for maternal and child health and nutrition (DG MCH&N) and for medical services. BKKBN will also be a key partner. The Ministry of Finance (MoF) and Bappenas will be involved in setting the broad strategic direction of the program, as well as issues related to management and disbursement of funds through government channels and coordination of planning and budgeting at sub-national level. Ministries of Home Affairs and of Education and Culture are also key stakeholders to be engaged at the national level. At provincial and district levels, the main partners will be Provincial and District Health Offices, Bappedas, Local Parliaments and the Heads of Provinces and Districts. Other sector agencies, for example, family planning and community empowerment, will also be important partners. Other implementing partners will include professional associations, the private sector, academic institutions, civil society and community organisations. A strategy for coordinating partners will be developed during the design phase.

### 8.4. Modalities

Modalities used will relate to program delivery components described above. A mixed modality approach will be needed given the range of issues and outcomes to be addressed by the program. More detailed assessment of potential modalities will be considered during the design phase, but are likely to include:

#### **Flexible and increasingly performance-based financing through GoI channels to districts**

AusAID will, as far as possible, align all of its support with government planning, budgeting and reporting processes to avoid creating a parallel system and an extra management and administrative burden. As noted above, a performance-based fund through existing MoF to district channels is proposed as part of this partnership. This will give flexibility for districts to address maternal and newborn health and nutrition service coverage in ways most suited to

their contexts, promote cross-sector working on these issues at a sub-national level and maximise potential to leverage Gol's own financing. Funding through Gol systems will present challenges and risks, in particular with respect to absorptive capacity, fiduciary risk and mechanisms through which to implement the performance basis for the financing. AusAID has initiated dialogue with the Gol to explore options for management and disbursement of these funds. Specific approaches will be explored further with the Gol, in particular Bappenas, the MoF and the MoH and their provincial and district counterparts, during the design phase.

**Implementation through a managing contractor and sub-contractors** in order to procure goods and services, particularly technical assistance where Gol current systems are cumbersome, and to support contracting of a range of potential partners. It is likely that a managing contractor will be used for program delivery components other than the Gol channelled financing. Experience has shown that in Indonesia models where Government has oversight and decision making responsibilities over managing contractor activities, can promote rather than hinder ownership as burdens and risks of financial and administrative management responsibilities are removed from them. It is likely that a managing contractor would be used to manage pilot development and implementation, contracts with non-government partners and technical assistance procurement. A managing contractor or contractors would be selected following a competitive tender process. Funding for specific activities would be sub-contracted through the managing contractor or contractors or direct sub-contracts managed by AusAID. To increase the likelihood of sustainability and to enhance the potential for informing Gol policy, any managing contractor would be required to partner with appropriate Indonesian institutions.

We envisage that a proportion of the program budget will be flexible funds, to be managed by a managing contractor. This is intended to provide the scope to fund interventions that might not be financed by government or are not feasible within existing district budget allocations, including testing and scaling up innovative approaches, as well as to be able to respond to emerging needs. Criteria for the use of flexible funds will be developed during the design process.

**Implementation through multilateral and bilateral partners** It is likely that at least one funding partnership with another development partner will be part of this program. Potential partnership with UNICEF particularly on areas pertaining to nutrition is being explored. Work with the World Bank on pre service training and USAID on scaling up aspects of their EMAS maternal health program could also be possibilities. Any work with the World Bank would be organised within AusAID Indonesia's framework for this engagement. Partnership with UNICEF would be in line with new AusAID requirements. AusAID experience suggests that joint funding can work well on a small scale when it is focused on specific activities and there are common objectives between two or more donors.

## 8.5. AusAID resource implications

AusAID Jakarta will be responsible for policy dialogue, maintaining Gol partnerships, strategic planning and decision-making. The health team will manage the program, including oversight of organisations contracted to provide technical assistance and implementation and administrative support. The current staffing of the team (Unit Manager, Senior Program Manager, Program Manager and a part-time Program Officer) may need to be reviewed depending on the implications of chosen program modalities for staff workload.

## 9. Performance management, monitoring and evaluation

This will be a large and complex program, so it is essential that it has a robust monitoring and evaluation framework which is used to keep track of the performance of each part of the program, enabling continuous improvement and, if necessary, corrective action to be taken in a timely manner. Furthermore, since the program is intended to pilot new approaches and improved ways of working in about 55 of Indonesia's approximately 500 districts, it is important to record baselines and progress in a systematic way so that the Government of Indonesia can replicate successes in other parts of the country. The monitoring and evaluation framework will be developed in detail during the design phase.

The core set of outcome indicators to be used for monitoring and evaluation will be derived from the Theory of Change. Over an eight-year program it will be possible to measure change in the key end-of-program outcome indicators, namely reductions in maternal mortality, neonatal mortality and childhood stunting. These cannot be measured annually, so progress against other outcome and intermediate outcome indicators will be measured at an annual or two-yearly frequency, depending on the specific indicator. Examples of these include case fatality rates, referrals, births in facilities, ante-natal and post-natal attendance rates, uptake rates of other key services (including in family planning and nutrition), coverage of various interventions, etc. Numerical milestones and targets will be set for each indicator during the design phase. Whenever applicable and feasible, all indicators will be disaggregated by gender, by socio-economic status and by any other useful distinguishing features that are politically, socially and ethically acceptable (e.g. age, ethnicity, educational attainment, disability).

As far as possible, data will be collected using Gol's own reporting systems, and where these are weak or inappropriately designed the program will work with MOH, local governments and other programs (e.g. AIPHSS) to strengthen the Gol's information systems. The program will not seek to set up parallel systems, bypassing the government, but it will be necessary to add supplementary reporting requirements, as the Gol system does not currently collect all the information that will be needed to monitor and manage the performance of this program.

A critical success factor that is a prerequisite to achieving the end-of-program outcome indicators is the changed knowledge, attitudes and practices of individuals, families and communities. Issues around gender and social inclusion are absolutely crucial to the program's success and will be addressed continuously at every level. While some practices, such as utilisation of health, family planning and nutrition services, are fairly easy to measure, many aspects of knowledge, attitudes and practices can only be measured through periodic surveys and through qualitative research. The program will factor in such surveys and research. Surveys will be conducted during the process of establishing baseline data (during the inception phase), at the four-year program mid-point and at the end-of-project evaluation. Leading academic institutions in both Australia and Indonesia will be involved throughout the project and will guide and/or conduct action research into key behavioural issues and the factors affecting them.

The monitoring and evaluation framework will also include some process indicators to ensure that the program is being managed and delivered in an efficient way that achieves value for money. These can include for example measures of financial and procurement efficiency, best management practices and pro-active engagement with various groups of stakeholders, including other related programs and initiatives.



The reporting requirements of different parts of the program may be somewhat different. Reporting of performance-linked grants to districts will be aligned as far as possible with the GoI's own reporting requirements, although some program-specific indicators will undoubtedly need to be added. It is anticipated that progress reporting by implementing partners will normally be six-monthly. AusAID will ensure that independent annual reviews are conducted. There will be a thorough evaluation of progress at the four-year mid-point conducted jointly by AusAID, GoI and independent experts, and a fully independent impact evaluation will be commissioned at the end of the project. Details of these arrangements will be developed during the design phase.

This program will contribute significantly to AusAID's achievement of the CAPF target for skilled birth attendance. However, although this can and will be measured for corporate reporting purposes, it is not a useful indicator in the Indonesian context. There are three reasons for this: (1) Indonesia has adopted birth in a facility as its national policy, as distinct from skilled birth attendance; (2) "skilled" birth attendance reporting uses the level of qualification of the attending health staff, but in Indonesia, as in many other developing countries, having a qualification does not necessarily mean that the person has adequate skills; and (3) skilled birth attendants cannot save mothers' and new-borns' lives in a range of common obstetric emergency situations that can only be handled effectively at a properly equipped facility. Program performance will therefore be measured using the proportion of births in an appropriate facility as one of its key indicators.

Performance management, monitoring and evaluation need adequate resourcing. The design team will need to ensure that this is factored in. It is envisaged that management contractor(s) engaged in program implementation will be required to provide full-time expertise in health data systems, monitoring and evaluation.

## 10. Risks and risk management

This section provides an overview of key risks and risk management strategies, based on the Investment Concept Risk and Value Assessment Guideline of the Strategic Programming Committee. A more detailed assessment of risks and management of risks will be considered in the design phase but, based on current assessments, we have given the proposed program an indicative overall risk rating of 'Low Risk'. Key risks include:

**Operating environment** The risk rating for the impact of the operating environment on the achievement of intended results is *moderate*. Political change potentially represents a risk. Indonesia will hold presidential elections in 2014. A change of president will result in a change of ministers, and with new ministers come new directions and potential resistance to foreign donors. Experience with other programs suggests that it will be critical to secure institutional commitment to the program rather than relying on the support of one or two individuals and to ensure that program governance arrangements maintain high-level commitment. Insecurity may be a risk in some provinces where the program may operate. For example, there are ethnic and religious tensions in Central Sulawesi, which can impact on access. Before decentralisation, 75% of the district health budget was funded from the centre, 5% from the provincial budget, and around 20% from the district budget. Program priorities and budget allocation were also determined by the central level. Districts now receive funding from a more diverse range of sources and this has made budgeting and financial management more complex and some districts still experience health financing challenges. Provincial and district governments in some *DTPK* have limited capacity for planning and budgeting. This causes



major bottlenecks in the use of national and district finances to deliver health care. The cumbersome planning process, which requires district plans to be developed that flow up to provincial and then national plans for approval, can lead to delays of up to six months in disbursement of the annual health budget. Limited capacity also means that districts do not secure central funding to which they are entitled. For example, financing mechanisms introduced by central government such as the *Jampersal* and *Jamkesmas* to assist local government to tackle maternal, neonatal and child health, are more likely to be taken up by provinces with greater capacity to develop plans and budgets and to absorb and use these resources, thus exacerbating the gap between provinces. Assistance is needed to ensure that financing mechanisms benefit all and in particular the poorest provinces and districts. *Puskesmas* in some districts also lack the capacity to manage funds from different sources, in some cases more than ten different sources, all of which require separate claims and reporting. Delays in financing and receipt of less funding than requested is common. These issues clearly have the potential to affect the new program. In some provinces, they will be addressed by AIPHSS.

Limited technical capacity is also a challenge, and the impact of this on districts' ability to define priority strategies and interventions was highlighted by the Investment Case. The Investment Case report suggested that districts often only implement the easiest interventions or those that are familiar rather than interventions that are likely to be most effective in the local context. A related risk is that districts will not prioritise funding for health, family planning or nutrition interventions that are based on evidence or need, or that AusAID support will displace core health funding.

Lack of essential infrastructure, in particular of health facilities in poorer and more remote areas, also poses a risk to achievement of program outcomes. The program will work with the MoH and local government, as well as with AusAID infrastructure programs to address this.

**Results and Safeguards** The risk of negative unintended consequences or that this investment will cause harm relative to issues such as child protection, displacement and resettlement, environment or disability is low. This is because all the proposed interventions will serve to strengthen the health system in one form or another, the issue being to what extent. Based on assessment of the operating environment above and other factors below, the risk that the investment will fail to achieve the intended results is *moderate*. Success will depend on factors beyond the program, including the political environment and corruption in the allocation and use of Indonesia's own resources, which would limit our investment's ability to leverage Indonesia's resources.

**Fiduciary** The risk of fraud or mismanagement of funds is *moderate*. Corruption and mismanagement of funds channelled via government systems is a risk in Indonesia. AusAID will commission a fiduciary risk assessment of GoI systems, including of on-treasury support. There may be similar issues with some NGO partners. The risk of corruption and misuse of funds will be a key factor in decisions about program aid modalities and funds flow. The fiduciary risk associated with channelling funds via multilateral or bilateral partners or a managing contractor is considered to be low. Fiduciary safeguards and independent audit will be built into the program design.

**Reputation and Partner Relations** The risk that this investment will damage the reputation of AusAID or the Australian Government or our relationship with key partners is *low*. The potentially sensitive family planning aspects of our program are aligned with the GoI's priorities

and existing programs and Gol has requested our assistance in this area. Sensitivities on moral grounds within program provinces to any family planning work may be mitigated by working with the private sector, which in many ways is freer to progress this agenda than Gol. AusAID will ensure it works closely with all partners in the design and during implementation to ensure program relevance and effectiveness.

**Sustainability** Given both the limited absorptive and fiscal capacities of districts, there are likely to be some very real sustainability risks around the level of financing of maternal and neonatal health activities. If program financing for district-level maternal and neonatal activities is substantially greater than that of government financing for the same activities, there is a risk of artificially inflating expectations of stakeholders about what they need and can expect to receive to run such activities on a long-term basis. Both when activities are planned and approved, it would be useful to distinguish between activities of an ongoing, operational nature and those that are better characterised as investments<sup>63</sup>. Over the life of the program, we will work towards the Gol transitioning to take on responsibility for funding our interventions. A strategy for how to achieve this will be developed during the design phase.

**Other** The risk of other factors affecting the achievement of objectives is *moderate*. Institutional challenges represent a risk to successful program implementation. Program success will depend on effective working relationships between different parts of government, (and beyond) for example MoH and MoE with respect to public and private sector training institutions, government agencies at different levels, MoH and BKKBN, as well as within the MoH. In addition, staff turnover (*mutasi*) at all levels of government and in health facilities is endemic. Experience suggests that this will be challenging and not something that it is within AusAID's control, though we will continue to work with the Gol to address this through the AIPHSS. Some of the proposed areas of intervention may also have an adverse effect on the 'interests' of key stakeholders, for example, on income generated from private practice by public sector health workers, and on income generated by private providers of family planning services. Securing support from national and local politicians and professional associations, as well as working closely with the MoH, will be crucial. Opposition from vested interests and key opinion leaders is also to be expected in areas such as promotion of breastfeeding and family planning. There will also be risks associated with program efforts to introduce innovative approaches, but this can be mitigated through effective engagement with policy-makers, planners and implementers.

Changing individual, household and community behaviour is complex and takes time, especially in the areas of maternal health and gender. Communities, and particularly families and women, have strong traditional beliefs and practices. We have seen in the AIPMNH program that there has been reluctance toward health seeking behaviour and advice of health care workers, particularly with regard to birthing practices and referral of high risk patients to hospital. The proposed eight-year program time frame is in recognition of the length of time it takes to effect change. We know from our experience in AIPMNH that behaviour change is possible, but how much change we can effect in the next program and how quickly remains to be seen. Successful management of such a diverse and complex program with potentially wide geographical scope will also rely on effective coordination with other AusAID programs (for example, AIPHSS, ACCESS and MAMPU) at the local level.

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<sup>63</sup> AIPMNH Independent Progress Review 2010, p48

## 11. Next steps and design process

If this concept note is approved, a five-page summary will be prepared using AusAID's Investment Concept Template and submitted to the Strategic Program Committee (SPC). If this is approved, AusAID Indonesia will proceed to the design stage. The design process will run until September 2013, when the design peer review will be held.

Key steps for the program design process include:

- **Stakeholder mapping and engagement** A preliminary analysis has been done to identify stakeholders that will be critical to program success and the extent to which AusAID Indonesia has established a working relationship with these stakeholders. More detailed institutional and stakeholder analysis is required, in particular of government stakeholders at different levels. The health team has also conducted a preliminary mapping of the activities of other donors and technical agencies. The stakeholder analysis and mapping will be further elaborated at the start of the design process to provide the basis for developing a strategy for engagement with key stakeholders and to determine the program's geographical focus and opportunities for collaboration.
- **Consultation and dialogue** Further consultation with GoI and other key stakeholders identified during the mapping process will be required to develop the design in detail and ensure ownership of the program. Key stakeholders for dialogue will include GoI (e.g. Bappenas, MoH, MoE, BKKBN, MoF, MoHA and sub-national counterparts); other donors and technical agencies (e.g. USAID, WHO, UNICEF and UNFPA); and national research institutions and NGOs. Consultation with AusAID stakeholders (e.g. AusAID Indonesia sector programs, Policy Advisory and Design Units, AusAID Canberra Indonesia Desk, Health Advisors and Thematic Group, and Economics Advisory Group) and whole-of-government (e.g. DFAT) will also be an essential element of the design process.
- **Research and analysis** AusAID Indonesia has identified the need for more in-depth political economy and institutional analyses and more detailed assessment of potential funding modalities, including a fiduciary risk assessment. These will be commissioned at the beginning of the design process, in order to inform the program design. Analysis of the findings of surveys and studies that are currently being implemented, for example the IDHS 2012 and AusAID-supported research on health seeking behaviour, will also be conducted to inform program design. Additional research and analysis will include a review of private sector incentives for provision of LAPMs and of service standards.
- **Fit with AusAID Indonesia program portfolio** A key step will be consideration of how the new program will complement and collaborate with existing AusAID programs, including the scope for common management and operational arrangements and results frameworks. More detailed consideration will also need to be given to management of the transition from the AIPMNH program, including identifying successful interventions and areas of activity to be maintained by the new program.
- **Planning, budgeting and M&E** The design process will need to develop detailed costings, criteria for use of flexible funds, an inception phase plan and an M&E framework, as well as terms of reference for implementing partners.

The proposed process, inputs and timing for program design and preparation are as follows:

<b>Timing</b>	<b>Action</b>
<b>January 2013</b>	25 January: Final concept note approved by Senior Management for submission to peer reviewers.  Coordination with EAG: Draft investment concept.
<b>February 2013</b>	1 February: Concept note peer review. Approval from Senior Management to go to SPC.  5 Feb: Finalise and submit five-page Investment Concept for SPC  19 February: SPC review  Agree on design approach: In the Commissioning Minute it was proposed that the facilitated in-house design approach be trialled for the development of this program. During the concept phase it has become clear that significant staff resources would be required to deliver a full in-house design, which is not feasible. Therefore, once the concept note is finalised, planning for the design phase will involve a combination of in-house and contracted resources, but maintaining the main objectives and features of the in-house design approach, in particular AusAID leadership and ownership.  Develop Terms of References for additional expertise, research and analysis required
<b>March – July 2013</b>	Source and contract design consultants  Commission Research and analysis: These will include: <ul style="list-style-type: none"> <li>- political economy analysis (including of pre-service training);</li> <li>- private sector incentives for provision of LAPMs;</li> <li>- review of service standards;</li> <li>- in-depth consultation with Gol and other stakeholders: As described earlier, extensive consultation in Indonesia and Australia has already taken place. Over the next few months, further dialogue will be undertaken with Gol (Bappenas, MoH, BKKBN, Gol at provincial level), professional organisations (doctors, paediatricians, obstetricians, midwives and nurses), AusAID sector programs (in particular social protection, decentralisation and education as well as follow up with tertiary education and knowledge sector programs).</li> </ul>
<b>July – August 2013</b>	Draft program design document
<b>September 2013</b>	Peer review and finalise design document for RFT: it is envisaged that a similar peer review team will be engaged for the final design document as for the concept note.
<b>October</b>	RFT or other preparatory stage depending on agreed modalities.

<b>2013 – June 2014</b>	TAP and selection of managing contractor(s). Contract negotiations and finalise contract.
<b>July 2014</b>	Mobilise managing contractor(s). Implementation by other partners commences.

## Annex 1: Results and lessons from the AIPMNH

One of the strengths of the AIPMNH is that it provides a **comprehensive package of support** that addresses supply and demand side challenges together with systems strengthening and reform, tackles immediate problems at the same time as promoting longer-term solutions, and strengthens existing national and local government programs and initiatives.

**The AIPMNH has contributed significantly to reduction of maternal mortality in NTT.** The maternal mortality ratio has decreased, between 2010 and 2011, by 51 per cent in the six districts with the comprehensive program (Desa Siaga to Sister Hospital); 26 per cent in the eight districts where AIPMNH intervenes but does not have the Sister Hospital program; and 28 per cent in the remaining NTT districts where there is only the *Revolusi Kesehatan Ibu dan Anak*.

**The current strategy has not reduced neonatal mortality as successfully.** The two most common causes of death are asphyxia and low birth weight. Asphyxia has a very small window for treatment and management and the geographic isolation of NTT complicates this, as does the skill set of the first responders. Training in management of newborns has been inadequate.

**The integrated approach has created synergies that result in greater numbers of women delivering babies in better equipped facilities.** The NTT government commitment to “*Revolusi KIA*” has contributed to this by fostering an overall supportive environment for program activities.

**While the integrated approach is working, program efforts are too wide.** Time is spent on activities that have limited impact on overall program objectives. Much time is also spent on negotiation and managing relationships with key stakeholders.

**The partnership modality works well at district level.** However, the Independent Progress Review recommended a **shift from program-specific to strategic sector engagement at national level and increased AusAID engagement with government at sub-national in order to enhance policy dialogue**

**Data collection remains challenging despite improvements in the Puskesmas reporting and recording system.** Fundamental issues include limited data collection from the private sector and inadequate competency in data analysis and use. Government information systems in NTT are insufficiently robust to provide comprehensive and accurate data on trends in facility-based delivery and maternal and neonatal deaths, and **insufficient data is available to assess impact on the poorest.**

Contextual challenges include **weak district capacity**, including in management of financing mechanisms, frequent **movement of staff**, the **low number of deliveries conducted by midwives**, **continued high rates of home delivery**, the **poor state of the health infrastructure**, **low coverage with social health insurance** and **demand for payment by facilities.**

It is difficult to develop full national and local ownership and leadership of an externally funded program when responsibility and accountability for funding and decision making lie with an externally contracted implementer. There is also a **need to build in mutual accountability at the outset**, including establishing clear expectations about AusAID commitment and phase out of support. A related issue is **ensuring that local government can sustain activities** with existing fiscal and human resources.



## Annex 2: table of potential AusAID – GoI partnership provinces and beneficiaries

Province	Total districts	Average no. women 15-49 yrs /district	Average no. under-fives/district	Average expected births/district	Number districts that would be selected
North Sumatra	33	111,088	32,978	8,484	10
East Java	38	275,284	80,031	14,428	10
Banten	8	390,400	147,507	30,003	5
Central Java	35	258,389	72,750	17,097	10
West Java	26	462,154	137,863	32,763	10
Aceh	23	50,396	17,947	4,249	10
NTB	10	136,650	50,769	9,943	5
NTT	21	58,152	24,782	4,853	10
Sulawesi Tengah	11	68,209	28,766	4,924	5
Sulawesi Selatan	24	104,458	31,496	6,701	10
Sulawesi Tenggara	12	53,108	23,247	3,578	5
Gorontalo	6	42,917	21,089	3,465	5
Sulawesi Barat	5	49,760	24,750	4,040	5
Maluku	11	34,427	17,942	3,293	5
Maluku Utara	9	30,133	13,600	2,810	5
Papua Barat	11	14,382	7,533	1,722	5
Papua	29	27,879	8,189	2,174	10
<b>Base no. of beneficiaries</b>		<b>12,712,715</b>	<b>4,472,977</b>	<b>885,804</b>	