Annex – 2 PERMATA Results Framework (final version)

	Indicators	Measurement	Comments
Development Goals: impact level (beyond the program) Reduction in maternal and newborn mortality and stunting, and improved performance of the primary health care system in Indonesia			
Reduction in maternal mortality	• Maternal mortality ratio	Evaluation at Year 8 (2022) Year 11 (2025) (3 years post program end) • Indonesia Demographic and Health Surveys • Census • Susenas • Riskesdas • National TB prevalence surveys	• It is an explicit objective of PERMATA's approach that effective models and interventions are able, in combination with effective policy dialogue, to leverage GoI resources for replication beyond the program areas and impact on national levels of maternal and neonatal mortality and stunting, and strengthening of the primary health care system.
Reduction in neonatal mortality	• Neonatal mortality rate		
Reduction in childhood stunting	• % Children under 5 stunted		
Improved primary health care system	• Reduction in prevalence of raised blood pressure among persons aged 18+ years • Reduction in TB prevalence		
End of program outcomes *Assist the governments and people of three Indonesian provinces to reduce significantly the rates of maternal and newborn deaths and stunting and to improve the detection and management of chronic diseases, through a strengthened primary health care system (including emergency obstetric and newborn referral and care) and improved health-seeking behaviours, particularly in poor and disadvantaged populations, in a way that is both sustainable and replicable beyond the supported districts and provinces. (all indicators below refer only to selected provinces and districts unless stated)*			
Reduced number of maternal deaths particularly in poor and disadvantaged populations in selected provinces and districts.	• Absolute number of maternal deaths by cause disaggregated by socio-economic status, age and remoteness and evaluated against crude birth rates	Baseline Yr 1, evaluation at Year 4 (for progress only) and Year 8 using: • Household survey (baseline and end line) possibly through oversampling of GoI's regular survey (such as Riskesdas, Susenas, SUPAS) in selected provinces and districts, where appropriate • Indonesia Demographic and Health Surveys 2012, 2017 and 2022 (for province-level and support for oversampling could be explored for validity at district level)	• The program will undertake a baseline and end line survey in program districts. • The program will review GOI's current remoteness index (such as DTPK) and agree on a remoteness index in consultation with focal district and provincial governments. • It is expected that districts will continue to count the absolute number of maternal deaths and use that as a basis of planning but
Reduced number of neonatal deaths particularly in poor and disadvantaged populations in selected provinces and districts.	• Neonatal mortality rate disaggregated by sex, socio-economic status and remoteness • Number of neonatal deaths by cause • Still birth rate and early neonatal mortality rate		
Reduced stunting in children under five particularly in poor and disadvantaged populations in selected provinces and districts.	• % of children under 5 stunted disaggregated by sex, socio-economic status and remoteness.		

	Indicators	Measurement	Comments
Improved detection and management of chronic disease by the PHC system in selected provinces and districts resulting from PHC system strengthening	• High blood pressure: case detection rates and treatment success rates by the PHC system disaggregated by sex, socio-economic status and remoteness • TB: case detection rates and treatment success rates by the PHC system disaggregated by sex, socio-economic status and remoteness	• Health information system – annual profile • Specific evaluation of maternal and newborn death audits where available • Service audits to supplement Riskesdas as necessary for high blood pressure measurement	verification and quality improvement processes will need to be supported particularly given the large under reporting at the moment (particularly of newborn deaths). • Hypertension and tuberculosis will be used as tracer conditions for chronic disease as they represent the highest burden non communicable and communicable diseases that need active ongoing management at primary care level. • DFAT and USAID will work together to try and ensure that IDHSs are carried out in 2017 and 2022. In practice the intervals between successive IDHSs have varied from 3 to 6 years.
Effective models and implementation approaches are scaled up and influence policy beyond PERMATA areas.	• Proportion of proven demonstration models and district innovations implemented and resourced by GoI in non-program provinces and districts and time to take up. • GoI policy development informed by PERMATA learning	• Ongoing systematic and adaptive evaluation system for this will be developed and consolidated at year 4 and 8 using: o ongoing influence and impact logs and mapping o GoI national health policies and plans o Provincial and district government workplans and budget allocations o GoI Annual Reports o Health information system – annual profile • Independent evaluation of this area will also be undertaken at years 4 and 8	

	Indicators	Measurement	Comments
Intermediate outcomes *(all indicators below refer only to selected provinces and districts)*			
Outcome 1: To reduce maternal and newborn death and child stunting through empowering of women and families in making healthier choices on number and timing of pregnancies, particularly among poor and disadvantaged populations			
Reduction in unintended and high risk pregnancies – birth age 15-19 and over 35; birth intervals < 2 years apart and 4th or more child.	• Number of unintended and high risk pregnancies prevented (modelled from other indicators) • Modern contraceptive prevalence rate disaggregated by age, socioeconomic status and number of existing children • Proportion of women using LARC (particularly for limiting) disaggregated by age, socioeconomic status and number of existing children • Age range specific fertility rates • Proportion of births less than 2 years apart disaggregated by age of mother and her socio-economic status • Number and proportion of births 4th child or above disaggregated by socio-economic status	Baseline, year 4 and year 8 evaluation using • IDHS 2012, 2017, 2022 • Riskesdas	Need to consider what indicators for district level information and what provincial. All of these indicators available in DHS but currently only valid at province. If support oversampling in PERMATA districts in DHS and add indicators to more regular module approach to Riskesdas (or Susenas expanded health module) this avoids need for project specific household survey.
Outcome 2: To reduce the risk of maternal and newborn death and child stunting through comorbidities and particularly through under-nutrition related risk factors in selected provinces and districts, particularly among poor and disadvantaged populations			
Reduced proportion of preterm and low birth weight newborns	• % Low birth weight singleton live births (< 2500 g) disaggregated by maternal age and socioeconomic status of household • % Pre term births disaggregated by maternal age and socioeconomic status of household	Baseline, year 4 and year 8 evaluation using • IDHS 2012, 2017, 2022 • Riskesdas	• These indicators can normally be disaggregated to the provincial level. Scope to increase the sample size in selected provinces to enable disaggregation to the district level to be explored. • As many births are home deliveries in some districts and provinces, especially NTT, health provider records will not be available and reports need to be collected from the mother or the KMS card on whether newborns were "very small" or "smaller than average" as per IDHS.

	Indicators	Measurement	Comments
Reduced rates of anaemia in women of reproductive age and pregnant women at term	• Numbers of deaths due to post-partum haemorrhage and other causes related to anaemia • Proportion of pregnant women identified with IDA or at high risk of IDA during pregnancy and proportion appropriately treated (e.g. targeted for intensified iron supplementation and follow up or referred if very low Hb and near birth) • Proportion of women of reproductive age with Hb measured in past 12 months • Proportion of women of reproductive age that have measured Hb and are in range of moderate or severe iron deficiency	Baseline, 4 year and 8 year evaluation (plus activity specific linked impact evaluation) including use of • PERMATA baseline, 4 year, and end line surveys • Health service records (including support for implementation of improved Hb / anaemia recording) • Riskesdas / Susenas Health Survey	• Currently there is little specific recording, monitoring or follow up of women with or at high risk of iron deficiency anaemia. This would be both supported and used as a result indicator as part of the partnership. • Need to discuss with Ministry of Health nationally and locally about benefits of improved IDA monitoring and treatment and conducting baseline and follow up along with integration into their systems
Improved diagnosis, monitoring and treatment of hypertension in pregnancy	• Proportion of maternal deaths with cause recorded and proportion of these with hypertension related disorder of pregnancy (particularly eclampsia/pre-eclampsia) recorded as cause • Proportion of pregnant women assessed for risk of pre-eclampsia/eclampsia • Of those women who are assessed as being at risk of pre-eclampsia/eclampsia, the proportion which is followed up appropriately	Baseline, 4 year and 8 year evaluation (plus activity specific linked impact evaluation) including use of • Riskesdas • Assessment of maternal death audits and other health facility records	• There is currently poor recording of diagnosis of maternal death and even poorer for complications that do not result in death. Use of BP and screening tools for high risk hypertension low. Both of these are areas for partnership work so will be supported as well as used in M & E. • Currently Riskesdas does not separate out HBP by pregnancy status but it would have the underlying data to do so – some of these useful indicators for M&E of MNH is an area for national policy dialogue

	Indicators	Measurement	Comments
Reduced rates of malaria among pregnant women in malaria prone areas (NTT)	• Percentage of Low-Birth-Weight singleton live births (< 2500 g), by parity • Percentage of screened pregnant women with severe anaemia (haemoglobin < 7g/dl) in third trimester, by gravidity. • Percentage of pregnant women receiving appropriate Intermittent Preventive Treatment (IPT) for malaria as part of ANC (NTT only).	• Baseline, 4 year and 8 year evaluation • Riskesdas • Malaria indicator surveys (if necessary)	• IPT is not currently national policy, although a clinical trial, comparing its efficacy with the current policy of Intermittent Screening and Treatment (IST), is under way in Sumba Barat Daya. WHO recommends IPT in malarial areas.
Reduced rates of protein-energy malnutrition in women of reproductive age and pregnant women	• Proportion of non-pregnant women of reproductive age having mild, moderate or severe chronic energy deficiency as measured by their BMI and MUAC (mid upper arm circumference) • Proportion of pregnant women having mild, moderate or severe chronic energy deficiency as measured by their MUAC	Baseline, year 4 and year 8 evaluation using • Riskesdas • IDHS 2017, 2022	• The IDHS does not currently collect information on adult malnutrition, but this could potentially be included at minimal additional cost.
Outcome 3: To reduce the risk of maternal and newborn death and child stunting through improved coverage and quality of obstetric and neonatal care in selected provinces and districts and particularly for poor and disadvantaged populations			
Increased coverage of quality ANC as per GoI policies.	• % of pregnant women who received 4 or more ANC contacts performed according to standard disaggregated by socio-economic status and remoteness.	Baseline, 4 year and 8 year evaluation including use of • Household survey (baseline and end line) • IDHS 2012, 2017 and 2022 (for province-level) • Quality of care assessment (baseline and end line) • Health facility records	• A quality of care assessment will measure adherence to quality standards in selected sites.
Increased coverage and quality of institutional deliveries at an appropriate level of service.	• % of births attended by skilled health professional disaggregated by socioeconomic status, remoteness and type of health professional • % of births in a health facility disaggregated by socio-economic status; and level of facility including PONED (BEmONC) designated. • % of deliveries having correctly received prophylactic oxytocin	Baseline, two year follow ups and end evaluation including use of • IDHS 2012, 2017, 2022 (for province-level) • District routine data • Risfaskes • Introduced facility audit of basic skills and commodities for safe delivery and basic complication care • Service delivery audit	• The facility audit is an intervention PERMATA will both support introduction of as well as use in M & E • Improved quality and verification of district routine data is also an area of activity in PERMATA

	Indicators	Measurement	Comments
Increased coverage of quality post-natal care for the mother and baby at an appropriate level of service.	• % Mothers who complete three post-natal visits in the recommended time disaggregated by socio-economic status, remoteness and level of facility. • % of births covered by at least one post natal visit within 2 days after birth • % of post natal care visits that meet quality of care standards	Baseline, two year follow ups and end evaluation including use of • Household survey • IDHS 2012, 2017, 2022 (for province-level) • Riskesdas • KMS card of women • Routine district data from the Kartini HMIS • Quality of care assessment (baseline and end line)	• Improved quality and verification of district routine data is also an area of activity in PERMATA • Ensuring validity of regular routine survey data at district level for PERMATA areas will be explored including possibilities for Riskesdas and/or oversampling in DHS • A quality of care assessment will measure adherence to quality standards in selected sites.
Increased access to timely and culturally acceptable referral to and delivery of quality, CEmONC services	• Proportion of births with complications in CEmONC facilities • Case fatality rates from complications in CEmONC facilities • Referral numbers and case mix figures • Caesarean section rates • Proportion of maternal deaths associated with delayed referral	• Hospital and other unit referral records • Hospital operative delivery records • Maternal death audits • Newborn death audits • Near miss audits • Qualitative research	• Referral needs to link with community based approaches to addressing emergency conditions such as Desa Siaga. • There is a need to specify precisely which complications ought to be referred for CEmONC and which can be handled at BEmONC facilities and provide very precise definitions of these complications and monitor how they are being applied. Otherwise the clinical diagnosis can vary tremendously from facility to facility and from practitioner to practitioner, as seen in AIPMNH.
Outcome 4: To strengthen the effectiveness, efficiency and quality of primary health care service delivery particularly to poor and disadvantaged populations in selected provinces and districts			
Reduced per capita out of pocket expenditure for health.	• Annual out of pocket spending on outpatient, delivery, and inpatient care disaggregated by sex, age and socio-economic status and type of provider.	• Susenas	

	Indicators	Measurement	Comments
Increased capacity and capability of puskesmas facilities to deliver essential primary health care services	• Readiness score of puskesmas facilities and networks to deliver essential primary health services	• Baseline assessment then 2 year follow up through program including use of Risfaskes • Basic facility audit (PERMATA supported introduction and use) • Program facility survey	• This will be too complicated if the SARA analysis and MoH's own index are used, and very hard to ensure consistency of standards being applied. There will be a need to prepare a simpler version during the baseline and continue to support this under PERMATA
Increased availability (attraction, retention and reduced absence) of key health personnel in rural remote Puskesmas	• Health workers (by type) by density adjusted 10,000 population • Average time in position in rural remote Puskesmas by cadre of staff • Proportion of household reporting not receiving services due to absence of health worker	• Baseline assessment then year 4 and year 8 follow up through household level program survey • Basic facility audit (PERMATA supported introduction and use)	
Immediate Outcomes (all indicators below refer only to selected provinces and districts) NB. All immediate outcomes below are indicative at this stage and will need further discussion with the managing contractor before finalising. Achievement of immediate outcomes will involve coordination with other Australian supported Frontline programs (indicative primary and secondary responsibility across DFAT supported Frontline programs is shown)			
Immediate Outcomes 1: Women, families and communities empowered to and make healthier choices especially among poor and disadvantaged populations			
Women and their families empowered and make healthier choices on how many and when to have their children (primary responsibility PERMATA and MAMPU, secondary responsibility PNPM)	• Women's and men's perceived risks on number and timing of children • Accurate knowledge of women and men of reproductive age on contraceptive options, benefits, risks, availability and access • Increased proportion of women with two or more children wanting / intending to limit births • Increased proportion of women and men wanting / intending to space births • Increased social and cultural support for small and healthy family size	At least baseline, year 4 and year 8 (timing to be adjusted in line with SBCC efforts) • Baseline formative and follow up evaluative survey • IDHS 2012, IDHS 2017, IDHS 2022 • Periodic qualitative research to measure changes in social and cultural support for family planning	• Area for joint work with MAMPU

	Indicators	Measurement	Comments
Improved family care of the pregnant woman and newborn (primary responsibility PEMATA and MAMPU)	Family care index to include the following list of indicators disaggregated by socio-economic status: • % Pregnant women that report unhealthy food restrictions during pregnancy. • % Pregnant women that report reduction in heavy workload during pregnancy. • % Pregnant women and newborns sleeping under ITNs in malaria prone areas. • % Mothers report isolation of themselves and their baby post-partum (eg "smoking huts" in NTT).	• Household survey (baseline and endline) • Qualitative research • Program monitoring survey	• Family care index to be developed to capture key dimensions of care and well-being (eg diet, workload, rest). • Indicators will need to be developed that capture changes in harmful traditional practices prevalent in specific geographical areas, eg "smoking huts" in NTT.
Women, their families and communities understand benefits of key nutrition practices and supplementation during pregnancy (primary responsibility PERMATA and PNPM, secondary responsibility MAMPU)	• Perceived risk and accurate knowledge of benefits and risks of different nutrition practices among women, men, and male and female community leaders • Access to key supplementation during pregnancy (eg iron, calcium etc) • Women's participation in nutrition counselling sessions (joint PNPM indicator)	At least Baseline, 4 year and end program using: • PERMATA specific survey • Joint evaluation with PNPM in relevant areas	• Composite measure to be developed to assess access to supplementation during pregnancy
Increase in % of newborns breastfed within 1 hour of delivery. (primary responsibility PERMATA and PNPM)	• % Newborns breastfed within 1 hour of delivery disaggregated by socio-economic status. • Increased family and cultural support for early breastfeeding	• Household survey • IDHS 2012, 2017, 2022 (for province-level) • Qualitative research in selected areas where there is low acceptance of early breastfeeding	

	Indicators	Measurement	Comments
Immediate Outcomes 2: Increased access to primary health care services including maternal, newborn and nutrition services in selected provinces and districts and particularly for poor and disadvantaged populations			
Equal availability and affordability of all methods of modern contraception as close to the community as possible (primary responsibility PERMATA)	• Stock availability of all appropriate methods of contraception including LARCs at local level midwife practices and health facilities at first visit • Average payments made for family planning by clients & % reduction in payment differential between long term acting and short methods of contraception to clients and providers • Number and proportion of family planning services offering services for unmarried women and young people • Proportion of family planning services offering all methods on demand (not restricted to specific days / times etc) • Proportion of women reporting obtaining method of first choice (and reasons why not)	At minimum evaluated every two years including baseline 4 year and end of program survey plus use of: • Facility/provider audits for key commodities • Potential PMA information (in partnership with Gates and BKKBN) • IDHS 2012; 2017; 2022	• Note facility/provider audits for essential primary care commodities will be both supported and used as M & E in the partnership • The legality of providing family planning services for unmarried young people is currently being debated and the normal practice in GoI health services is to deny access. PERMATA will work with key national stakeholders and other international agencies to advocate for a policy and regulatory clarification that enables these services to be provided. It is a clear recommendation in the 2015-2019 RPJMN.
Improvement in the availability and affordability of transport for poor and disadvantaged women and newborns to reach puskesmas and district hospital. (primary responsibility PERMATA and secondary responsibility PNPM, PKH, roads program)	• % Women reporting distance and cost of getting to a health facility a problem when they are sick disaggregated by socio-economic status and remoteness. • Cost and time taken for poor and disadvantaged women and newborns to arrange transport and reach the district hospital and BEmONC at Puskesmas in case of a complications disaggregated by district, wealth, remoteness and female education.	• Household survey (baseline and endline) • Program monitoring survey	
Reduction in the % of women that report a barrier in accessing health care for themselves disaggregated by socio-economic status and remoteness. (primary responsibility PERMATA, MAMPU, PNPM and secondary responsibility roads program, PKH)	• As per IDHS indicator	• Program monitoring survey	

	Indicators	Measurement	Comments
Increased community mobilisation and male involvement in maternal and newborn health and nutrition. (primary responsibility PERMATA and MAMPU)	Progressive improvements in: • % Communities which function as Desa Siaga. • Number and % of villages allocating village development funds for maternal and newborn health measures. • % Husbands that report attending ANC visits with their wives. • % Husbands that report reduction in women's workload during pregnancy. (NB same question asked to pregnant women is included above)	• Program monitoring survey • District reports • Household survey (baseline and endline) • Bapedda reports	
Immediate Outcomes 3: Improved quality of primary health care services including maternal, newborn and nutrition services in selected provinces and districts and especially for poor and disadvantaged populations			
Improved counselling and information exchange in family planning services (primary responsibility PERMATA)	• Proportion of women reporting receiving counselling and key information across family planning methods including in consultations (benefits, risks, side effects, what to do if they occur, supportive tools and information) • Client approval of services received (eg whether would return or refer to provider) • Discontinuation rates by family planning method	• At least at Baseline, 4 years and 8 years with other evaluation timed with activities • IDHS	
Increased quality of antenatal care. (primary responsibility PERMATA)	• % pregnant women reporting receiving nutrition counselling and assessment • % Mothers receiving two or more tetanus toxoid injections during last pregnancy disaggregated by socio-economic status and remoteness. • % Mothers reporting >90 days consumption of iron folate use during last pregnancy disaggregated by socio-economic status and remoteness. • % Mothers receiving calcium as per GoI standards during last pregnancy disaggregated by socio-economic status and remoteness. • % Mothers reporting at least 3 haemoglobin tests during their last pregnancy disaggregated by socio-economic status and remoteness. • % of pregnant women tested for malaria in accordance with national guidelines • % of pregnant women with malaria who receive treatment in accordance with national guidelines	• Service audits • District and program monitoring reports • Household survey (baseline and endline)	
Increase in the provision of 24hr quality normal delivery and BEmONC at Puskesmas level. (primary responsibility PERMATA)	• Number and % of Puskesmas providing all GoI signal functions for BEmONC services disaggregated by remoteness. • Number and % of Puskesmas providing all GoI signal functions for 24 hour normal delivery services disaggregated by remoteness. • Number of PONED designated services (per 500,000 population or per district, depending on the province) • Percentage of complications handled at the Puskesmas level.	• Annual reports of DHO and PHO • Program monitoring reports	

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Increased provision of quality post natal care, particularly home visits. (primary responsibility PERMATA)	• % Babies in-roomed (particularly in facility births) • % Women reporting babies dried and placed skin to skin immediately after and for the majority of the first hour after birth • Proportion of women reporting receiving home pack with formula or formula use supporting commodities (and amount paid where relevant) • % Mothers report that health workers encouraged them to breastfeed their newborn within an hour of delivery.	• Service audits • District and program monitoring reports • Household survey (baseline and endline)	
Increased numbers of public and private primary care providers able to provide all appropriate forms of family planning services. (primary responsibility PERMATA)	• Disruption rates in supply chain of long-acting reversible and permanent methods, trocars (surgical instrument) or other supplies necessary for family planning service provision. • % Midwives skilled to provide at least two long acting reversible family planning methods.	• Annual reports of DHO and PHO • Program monitoring reports • Qualitative research	
Referral system improved to provide appropriate and timely referrals from Puskesmas to district hospital. (primary responsibility PERMATA)	• Time taken to transfer a MNH patient once stabilised disaggregated by remoteness.	• Service audits • DHO and program monitoring reports • Research studies	
Improved availability of 24 hour quality CEmONC services at district hospital (primary responsibility PERMATA)	• Proportion of months when 24 hour CEmONC services are available per district hospital per year. • C-section rate (minimum 5% deliveries) with procedures done in a timely manner and with appropriate clinical quality hallmarks.	• DHO reports • Program monitoring survey	
Immediate Outcomes 4: Improved functioning of the primary health care system in selected provinces and districts particularly for poor and disadvantaged populations			
Increased availability of key equipment, drugs and medical supplies for the provision of quality primary health care at Puskesmas level (primary responsibility PERMATA)	• Stock out rate of essential medicines and supplies at Puskesmas level according to GoI guidelines. • % Availability of functional essential equipment at Puskesmas level according to GoI guidelines.	• Health facility survey	
Increased availability of health personnel per 10,000 population (primary responsibility PERMATA and secondary responsibility AIPHSS and AIPD)	• Health staff deployment per 10,000 population disaggregated by staff position and remoteness. • % Health workers on duty when they should be disaggregated by travel time to District Headquarters and staff position	• Health facility survey • Staff attendance survey	

Strengthened supervision and monitoring of Puskesmas (primary responsibility PERMATA and secondary responsibility AIPHSS)	• % Puskesmas that received a quarterly clinical and managerial supervision visit, and of those:
	  o % of Puskesmas receiving feedback
	  o Proportion of recommendations enacted
		• Service audits
		• Supervisor reports	

Improved financial management of primary health care services in districts and facilities receiving performance based financing (primary responsibility PERMATA and secondary responsibility AIPD)	• Disbursement of performance based grants by budget line and timing in the financial year analysed at district and Puskesmas level within districts implementing performance based financing demonstration.	• District and program monitoring reports • Performance based financing demonstration monitoring and evaluation reports	
Improved district and Puskesmas annual planning and management (primary responsibility PERMATA, secondary responsibility AIPD)	• % of annual budget unspent at District and Puskesmas level	• District financial reports	

	Indicators	Measurement	Comments
More regular and better quality district government consultations with the public on primary health care (primary responsibility PERMATA, secondary responsibility AIPD)	• Index to be developed	• Program monitoring reports	• Index to be developed to measure extent and quality of public consultations on health
Systematic dissemination of learning from PERMATA innovations and implementation approaches (primary responsibility PERMATA, secondary responsibility AIPHSS)	• Learning platform activities influence GoI policy and planning	• Ongoing influence and impact logs and mapping • Provincial and district government workplans and budget allocations	