

ANNEX 03 - PERFORMANCE-BASED FINANCING TO IMPROVE COVERAGE AND QUALITY OF ESSENTIAL MATERNAL AND NEWBORN HEALTH AND NUTRITION INTERVENTIONS

BACKGROUND

There is global consensus on interventions proven to reduce maternal and newborn death and improve nutrition outcomes in a range of settings. Many of these are already included in Indonesia national policy within antenatal, post natal and child care packages. Indonesia faces challenges, however, with implementing these at sufficient scale (and sometimes quality) to substantially impact on relevant health outcomes. Coverage across different provinces and districts in Indonesia varies and in some cases has been decreasing over recent years and maternal and newborn death nationally is not declining. Ensuring greater coverage of known effective interventions in maternal and child health and nutrition is a high priority of GoI currently and an area where they have emphasised a need for support from development partners.

Gaining greater effective coverage of key services requires both improved demand for and supply of these interventions. Indonesia has a number of strategies and policies increasing demand for health services. Both PKH and PNPM use conditions on use of key maternal and child health services for payment of benefits and grants. The national health insurance scheme will increase demand further. However, as in many countries, there is a widely held view that Indonesia's greatest challenge in improving health outcomes from these initiatives will be supplying these services in sufficient quantity and quality to effectively meet demand. Poor trust in and perception of low quality of care in public primary health service delivery is suggested to account for over half of the underutilisation of health care in Indonesia (Rikesdas 2007).

Constraints to greater coverage and quality of services impacting maternal and newborn health outcomes will vary between contexts and districts. The power to address many of these constraints can also lie outside of the direct control of the health sector. Transport and roads for example may limit access to and outreach of services and lack of water connections may limit health centres' ability to provide clean delivery. Currently, there are few incentives for cross sector work at a district level to improve service delivery or outcomes that are seen as belonging to one sector. Overall resourcing to address health service constraints is also low in Indonesia relative to regional averages as well as those for other lower middle income countries. Financial resourcing that does exist is distributed through multiple channels each highly earmarked with its own guidelines on use and reporting. This lack of flexibility together with complicated guidance and fear of accusation of mismanagement constrains district management and local health facility ability to develop and implement innovative solutions that can address their context specific constraints to quality service delivery in timely ways. Further, resource allocations to date are not linked to any evidence on health service delivery performance or outcomes and therefore there is little financial incentive to invest in strategies that have the biggest impact.

Performance-based financing (also called results, outcomes or output based financing depending on type of design and funder) has been used effectively in a number of countries to promote increased attention and resource availability to support coverage and quality with which key focus health services are supplied. Such performance-based financing can impact health service delivery in two ways: first by placing additional financial resources into the health system and secondly through the incentive effect to allocate resources to particular activities.

Performance-based financing is generally a useful approach where there are large information gaps between payers (e.g. central government or development partner) and providers (in this case public primary health care centres or local district governments) which often occur in highly decentralised health systems. In these cases it can be more effective to incentivise local level units to use their contextual knowledge to design service approaches that might best extend quantity and quality of services in their setting. They are also effective in circumstances where health worker motivation is a challenge and where allocation of resources is not as effective as it could be.

As part of the new maternal and newborn health and nutrition partnership therefore, DFAT has been exploring the potential use of performance-based grant financing through Government of Indonesia systems with the Ministries of Health, Finance and Bappenas.

USE OF PERFORMANCE-BASED FINANCING FOR IMPROVING HEALTH SERVICE DELIVERY AND OUTCOMES

Maternal and child health is the most frequent focus of performance-based financing schemes internationally to date. Performance-based financing has been successful in improving coverage of such services as skilled attendance at birth, facility delivery, antenatal care and post natal care in a large number of countries including Cambodia, Philippines, Zambia and Tanzania. Examples of other maternal and child health related incentives have included provision of tetanus vaccine in pregnancy in Rwanda (Basinga et al., 2010), reductions in unnecessary caesarians in Korea and coverage of PMTCT in Sub Saharan Africa countries and nutritional outcomes in children in Philippines (Peabody et al., 2010). In addition other outcomes outside of maternal and newborn health that have showed marked changes in more targeted performance based financing schemes include TB case finding and treatment completion rates (Beith et al., 2007), reductions in overprescribing of antibiotics in China (Yip et al., 2013) and overall primary health service quality in Rwanda and Philippines (Basinga et al., 2010; Peabody et al., 2010). Recently the potential for use of performance-based financing to address growing non-communicable diseases in lower and middle income countries has also been explored (Beane et al., 2013).

Along with positive health outcome and health service coverage results performance-based financing schemes have resulted in increased expenditure by governments on maternal and newborn health (Kinota). Equity in health has also been supported as changes in outcomes resulting from performance-based finance have generally been higher in poorer groups where the wealthier self-select out of public services more frequently. To date such schemes are generally implemented on a small scale as a pilot, however, with only a small number of schemes adopted and adjusted to a national scale. Rwanda has expanded what were early pilots to a national pay for performance scheme that provides supplementary performance-based bonuses on top of standard input-based funding to primary health care centres. Fourteen maternal and child healthcare indicators are used to measure performance including coverage and quality antenatal care coverage, provision of tetanus vaccine during pregnancy and facility-based delivery (Basinga et al., 2010) with additional weightings across all outcomes for improvements in overall quality of care in primary health centres.

Performance-based financing can be particularly useful where provider payment schemes have a lesser focus on quality and a greater focus on efficiency. Such payment systems are being introduced in Indonesia as part of the new national health scheme from 2014 (case-based payment for hospitals and capitation payment for primary care) and discussions on how to incentivise quality through additional financing or other mechanisms are already being discussed in the Ministry of Health.

In most of the schemes described above the performance grants are provided to health facilities. Autonomous financial management of these is an important precondition for success in this case (Soeters et al., 2006). In fewer cases performance grants were allocated to district health offices (Zambia, Rwanda, Tanzania) where these controlled finances for the delivery of primary health care (Witter et al., 2012).

INDONESIAN EXPERIENCE WITH PERFORMANCE-BASED FINANCING FOR HEALTH

In Indonesia performance-based incentives on the demand side for health have been longstanding. The PKH conditional cash transfer includes completion of prenatal and post natal care, iron supplementation, tetanus vaccination in pregnancy and complete immunisation of the child as conditions on receiving grants. PNPM Generasi uses performance on similar key maternal and child health indicators in consideration of each round of community grants. There is evidence that this has increased demand for key maternal and child health services. However, many women may not

receive these services due to limitations in their coverage and quality on the supply side. Few performance incentives for greater coverage and quality in the supply of health services exist in Indonesia. Indeed in some cases funding channels and mechanisms such as in the current DAK, disincentivise good performance, as funding can be reduced once target coverage and service indicators have been attained. Internationally it has widely been shown that a combination of provider and user targeted incentives gives the greatest chance for improvement in health outcomes from financial incentives.

Cordaid supported performance-based financing of Puskesmas in Ngada and Nagekeo districts of Flores Island, NTT, from 2009 to 2010 to increase the quantity and quality of a range of services. This intervention showed some positive impacts including increases in primary care outpatient visits, complete immunisation, TB case finding and cure rates, tetanus vaccination coverage in antenatal care and facility-based delivery. No impact or even declines on other service indicators, though, were seen. Due to discontinued funding this initiative was evaluated at too early a stage to show greater or longer-term impacts. In addition a large number of performance indicators were used contradicting evidence that fewer numbers of key indicators may be linked to greater performance improvements. When discussed with Ngada health officials, including the Head of the District Health Office, who were involved in this pilot, all commented on the positive results they saw from this initiative and their eagerness to see and willingness to participate in something similar through DFAT support.

In 2011, DFAT supported, through the Logica program in Aceh, a small pilot of performance-based incentives for Puskesmas to meet Government of Indonesia minimum service standards. Here incentive payments were primarily provided to CSOs that worked with Puskesmas and held them accountable to service delivery improvements. Though some process evaluation of this initiative has been completed outcomes are still being explored. One risk in design, however, was that incentives were paid to the same group who were responsible for monitoring and verification of results, creating conflict of interest. The use of CSOs for independent verification, however, plus the important role of technical assistance within the initiative (termed “innovation facilitators” in the Logica program), are approaches that would also be used in the PERMATA performance-based financing component.

KEY LESSONS FOR DESIGN OF PERFORMANCE-BASED FINANCING APPROACHES

Careful design of the performance-based scheme is essential for effectiveness. This includes the services that will be incentivised, levels of or changes in performance targets, verification approaches for performance, how the incentives are applied and who is paid and how. Lessons from other performance-based financing schemes show higher impact of performance-based financing with higher payments, for services more under the control of the provider rather than patient decision, and for services in which there remained significant room for improvement.

Where outcomes are more related to patient decisions these should be targeted to the patient (e.g. through conditional cash transfers) and therefore performance-based financing can have greater impact if demand for services is incentivised to households and supply of services is incentivised to health care providers. Services incentivised should not be of many different types so that the problem-solving focus is too divided, diluting the effectiveness of the performance-based incentives. Though concrete evidence on the ideal range of maximum number of indicators is lacking evaluations suggest that more than 14 are likely to be too many to be effective and less than 10 is preferable. Payment amounts for outcomes should be associated with the degree of provider effort needed to change them and include a focus on the content of services (quality) provided rather than just the quantity (Basinga et al., 2010).

Performance should be easily measured and independent development of baselines and targets as well as ongoing verification is important. Levels of performance targets may be too low if set only by the health service to ensure achievement. Alternatively setting them too high may result in districts or health centres being unwilling to put effort into reaching what they view as unattainable targets. Incentivising changes rather than levels of targets together with the creation of positive competition through benchmarking can increase effectiveness of performance-based financing.

Where few incentives or processes for local innovation and performance monitoring have existed through current planning, budgeting and evaluation systems the coupling of performance-based financing with local level technical assistance is important.

OBJECTIVES AND OUTCOMES

OVERALL AIM

To reduce maternal and newborn death by increasing coverage and quality of known effective primary care services and institutions in selected provinces and districts of Indonesia

OBJECTIVES

1. To motivate greater cross sector discussion by senior district decision makers on constraints to maternal and newborn health and nutrition improvement and possible effective initiatives within and beyond the health sector that could impact this.
2. To promote innovation in development of context specific maternal and newborn health interventions at a district level.
3. To encourage evidence informed planning particularly between health and planning offices at a district level around funding for more effective initiatives for maternal and newborn health and nutrition.
4. To influence the more substantial Government of Indonesia funding toward greater performance orientation in allocation decisions.
5. To support dialogue and impact other GoI funding to become more flexible in its support to primary care centres to relieve key constraints to delivery of higher quality maternal and newborn health and nutrition services.
6. To explore the relative effectiveness, advantages and disadvantages of performance-based financing to districts (for greater cross sector problem solving) versus direct to Puskesmas in achieving improvements in key primary care and maternal and newborn health outcomes.

EXPECTED OUTCOMES

- **Long term impact** – greater reductions in maternal and newborn death in selected districts
- **End of initiative outcome** – increases in coverage and quality of known effective interventions in primary care service delivery for maternal and neonatal health in selected districts¹
- **End of initiative outcome** – greater use of performance-based flexible financing in other Government of Indonesia funding channels for primary care

Success on these outcomes will be evaluated through a robust impact evaluation design using matched intervention (performance-based financing) and comparison (other aspects of the PERMATA partnership but no performance-based financing) district approach comparing performance grants to just district level, just Puskesmas or a combination of both.

¹ The particular interventions and therefore performance indicators to be discussed with Government of Indonesia over the course of the design and likely beyond.

APPROACH

SCOPE AND TIMING OF THE PERFORMANCE-BASED FINANCING COMPONENT

Based on discussion with AIPD the amount estimated for a district grant to incentivise participation and performance whilst not risking displacement of the district's own funding is \$250,000 per district per year.

Performance grants are proposed to be trialled in up to 8 districts with some to be provided directly to selected Puskesmas, others to district and in some districts both in order to see the approaches that might be most effective. Providing grants to districts has the advantage that cross sector solutions can be explored, while directing funds straight to Puskesmas means they can respond more directly to financial incentives for the services they provide. The performance grants together with associated implementation costs, including TA and verification contracts with local NGOs and/or research organisations (but excluding the impact evaluation), amount to approximately \$13 million dollars or \$16 million with evaluation. This represents around 10% of the current proposed budget envelope for PERMATA but has large potential for impact (see investment case).

The design and guidelines for the performance-based grant pilot would be developed in collaboration with the Ministry of Health, Ministry of Finance, Ministry of Home Affairs, Bappenas and districts during the implementation of the PERMATA program with an aim to begin this pilot in 2017. A program-wide review at year 4 of PERMATA will provide scope for a follow up of the schemes with the impact evaluation results expected in year 6.

PAIRING WITH LOCAL LEVEL TECHNICAL ASSISTANCE

As performance-based financing has been little used in Indonesia for health, and decentralisation with local level decision making is relatively new, it is expected that districts may require technical assistance to innovate context specific solutions to constraints to quality and coverage in maternal and newborn health and nutrition service delivery. District facilitators/program coordinators to be recruited by the maternal and newborn health and nutrition partnership will play this role as well as a data verification role in the reporting against performance requirements for the grants.

POTENTIAL FINANCING CHANNELS

DFAT has had a number of discussions with Ministry of Finance and their DG Fiscal Balance and areas responsible for sub-national grants are extremely supportive of an outcomes based performance-based granting mechanism to promote improved maternal and newborn health and nutrition outcomes.

In order to provide maximum leverage potential of Government of Indonesia finances, DFAT's preference is to put this performance-based financing component through an existing GoI funding route for primary care. Ministry of Finance has advised that existing channels of financing from Ministry of Finance to districts (Special Allocation Grant - DAK and General Allocation Grant – DAU, together making up APBD) would not allow specification of districts for receipt of grants by DFAT nor allocation for health outcomes specifically. They (and Bappenas also) advised two potential routes through which these could be delivered

- 1) Direct grants – where funds flow from Ministry of Finance to line Ministries at a national level (in our case Ministry of Health) who then distribute funds to their relevant sub national units (e.g. District Health Offices – Dinas Kesehatan)
- 2) Regional grants (Hibah Daerah) – Which can be specifically designed for any donor or other development partner government including which districts are eligible, criteria for receipt of grants, guidelines on use of grants. These grants that flow directly from Ministry of Finance to districts can be allocated across sectors through discussion in local parliaments or allocated to a specific sector as desired. Relevant Line Ministries at a national level (in this case Ministry of Health) can be involved in the setting of guidelines and conditions for the

grants and in their monitoring in terms of performance on outcomes and conditions for receiving future grants but are not intermediaries through which the actual funds flow. The ability for these grants to directly fund Puskesmas needs to be further explored.

DFAT, Ministry of Finance and Ministry of Health's preference is currently the second route through regional grants. This is for a number of reasons:

- 1) Potential for greater effectiveness and leverage across sectors – Rather than going straight to the District Health Office a requirement for use of this funding can be discussion at local parliament level (DPRD) or through a selected cross sector grouping of Government Offices. Using this channel will therefore promote greater cross section discussion on interventions that may impact maternal and newborn health outcomes. Knowing that in many circumstances most effective approaches are not limited to the health sector (e.g. road access, other transportation, water and sanitation) this is very important.
- 2) Ministry of Finance would prefer this route as it strengthens what they believe should be the core role of Line Ministries in contributing their technical expertise rather than being an additional administrative channel of finance.
- 3) Ministry of Health would prefer this route as it means accountability for expenditure lies with the district rather than at national levels of Ministry of Health (therefore their risk exposure is diminished). Using a channel of funding through Ministry of Health has caused significant delays in our existing Australia Indonesia Partnership for Health Systems Strengthening due to concerns over risk and accountability in MoH national offices.
- 4) Existing funding going from Ministry of Finance to Ministry of Health and then to districts experiences greater delays in distribution than direct funding from Finance to districts hence using this latter channel will be more efficient for districts.
- 5) A number of existing donor programs use the regional grant approach including for output-based grants (though to date not in the health sector and more focussed on outputs rather than outcomes).

The Regional Grant approach will still include confirmation from the involved line Ministry (Ministry of Health) to Ministry of Finance regarding their desired involvement and approval of terms of reference for this financing mechanism. DFAT, however, would need to make only one agreement with Ministry of Finance who would then contract with each of the districts receiving the performance-based regional grant. DFAT would develop a technical agreement with Ministry of Health regarding their approval of this mechanism and their role in the development of relevant guidelines for the grants and monitoring of the outcomes required for their payment.

GUIDELINES ON PAYMENT AND USE OF PERFORMANCE-BASED GRANTS

Grants can be used to relieve any constraint to achieving the coverage or quality improvement indicators defined by the performance grants (such as the above). This may be local public private partnerships/contracting, financial incentives, procurement of key supplies and equipment.

A multi-year agreement (3 years in the first instance) would be made with selected districts including agreed annual targets for outcome based performance indicators. Grants would be allocated annually based on annual evaluation against these targets with additional six monthly interim reports required to measure progress and verify data, taking corrective action where necessary to ensure valid data for performance evaluation.

Guidelines on the payment and use of the performance-based grants will be developed during the implementation of the PERMATA partnership jointly by DFAT (health, economic governance and decentralisation programs), Ministries of Health, Finance and Home Affairs and Bappenas. This will include consideration of

- Whether DFAT performance grants would be through advance payment, on a reimbursement basis or a combination of the two.

- The percentage of the grant that would be directly linked to performance and how this may change over time.
- Timing of any requirements for matched funding from the district.
- Any restrictions on use of the funds such as caps for certain types of expenditure (though such requirements should wherever possible be kept at a minimum for performance-based financing to have greatest impact).

PERFORMANCE CRITERIA

No more than eight performance criteria will be applied to grant monitoring and distribution against results. This will ensure that districts are not overburdened by data administration and will ensure that they can focus on a few things therefore increasing the effectiveness of the performance basis to actually influence allocation of resources toward achievement of the performance criteria goals in the district.

Whilst the actual criteria will be worked out during the design, based on performance on important interventions in our focus districts and an analysis of constraints to this, some examples may be:

- Coverage of iron supplementation and tetanus toxoid vaccination in antenatal care
- Coverage of post natal care visits
- Increase in proportion of births delivered in health facilities
- Rate of in-rooming of newborns with mothers in Puskesmas after delivery
- Increase in use of long term acting and permanent methods of contraception as a proportion of total use
- Availability of essential resources (human, equipment etc.) for provision of quality delivery, post natal and newborn care at health centres (using a structural quality multiplication indicator)

It is likely that performance indicators will be different between East Java and NTT. Increasing facility-based deliveries (which PBF is evidenced to have influenced elsewhere – Basinga et al., 2011) is important in NTT, but coverage of some basic antenatal care components such as iron supplementation and TT vaccination may be more important in East Java. In both the use of a facility audit for availability of key BEmONC essential resources will be key.

GOVERNANCE ARRANGEMENTS

A performance grant development, implementation and monitoring and evaluation steering committee will be established with representatives of Ministry of Health, Ministry of Finance, Ministry of Home Affairs and Bappenas, from province and national levels as well as DFAT (across health, decentralisation and economic governance programs). This group will initially be responsible for the detailed design of the grants including required guidelines and will then oversee the implementation and monitoring and evaluation of these grants.

For performance-based financing direct to health facilities autonomous financial management of those facilities is needed. Indonesian law is in the process of allowing Puskesmas to receive finances directly under the new national health scheme (Jaminan Kesehatan Nasional – JKN) paid directly from the health scheme's payer, BPJS 1, rather than channelling through districts and district revenue pooling.

Whether direct grants to Puskesmas under Hibah Daerah would now be possible needs to be explored. Direct performance grants to Puskesmas versus through the district have both drawbacks and benefits and the most valuable policy information is likely to come from a comparison of both approaches. This will also fulfil interests of Ministry of Finance on the potential for performance-based financing to the district going forward under DAK and other funding channels in Indonesia as well as Ministry of Health's interest in what the potential benefit might be from having a performance component included in capitation funding to Puskesmas through BPJS.

USE OF THE PBF PILOT TO SUPPORT CURRENT INDONESIAN HEALTH SERVICE AND FINANCING REFORMS

ROLE OF PROVINCE IN MONITORING AND COORDINATION

The province will coordinate the monitoring of performance on key indicators for the grants including ensuring a unified and strengthened approach to data collection and recording, providing commitment and support to the independent verification process and coordinating cross district meetings and comparisons to incentivise positive competition and performance on these grants. This is supportive of the strengthened role of the province in coordination and monitoring and evaluation of districts under new regulations rather than for the receipt and channelling of finances or service delivery themselves.

INCLUSION OF PERFORMANCE BASIS IN CAPITATION PAYMENTS FOR PRIMARY CARE UNDER JKN

The payment for primary care services on a per head registered at primary care facility – capitation – basis is an efficient means of payment for primary care used throughout the world. However, there is little incentive for quality of care under this payment approach, particularly if facilities can retain any revenue unused, leading to incentives to under provide services. Primary care services will be paid by capitation under the new national health scheme Jaminan Kesehatan Nasional (JKN) from 2014. The Ministry of Health is currently considering potential mechanisms to ensure incentives exist for quality of care also and the introduction of various forms of performance-based financing in later refinements to the capitation approach is being discussed as one of these. The PERMATA pilot of performance-based financing could therefore potentially provide useful evidence for the Ministry of Health for revisions of capitation payment approaches under JKN in the future.

ADDITIONAL BENEFITS

In addition to expectations for improved coverage and quality of service provision incentivised under the grants, other benefits have been shown to return from performance financing. These include improvement in information systems and exchange from the need to have accurate verified information and greater clarity in goals and priorities between levels of government and different stakeholders through negotiation of guidelines and payments.

SUPPORTING A FRONTLINE SERVICES AND INTEGRATED PROGRAMMING APPROACH

CROSS SECTOR PROBLEM SOLVING FOR HEALTH SERVICE DELIVERY

Performance-based financing at a district level across sectors as well as to Puskesmas provides financial incentives for local level problem solving including across sectors (particularly for the district model) to improve service delivery. In this way performance-based grants are a funding model that can be very supportive of the goals of the frontline services approach.

BENEFITS OF JOINING PERFORMANCE-BASED FINANCING FOR HEALTH ON DEMAND AND SUPPLY SIDES

Where DFAT already supports programs that employ performance incentives for the demand for health services (through PNPM and PKH), matching these with performance-based financing incentives for improved supply of health services could be expected to produce greater impacts on health outcomes. This joining together of demand, supply

and accountability (key for performance-based financing) for basic services is also central to the frontline services approach.

JOINT PILOT WITH EDUCATION SECTOR

As the concept for performance-based grants has developed the DFAT education team has expressed interest in exploring a similar mechanism as part of the new education innovation facility and support program. Given that demand-side performance financing occurs across education and health through PNPB and PKH this would be a logical and potentially valuable approach to jointly pilot supply-side performance financing to both health and education sectors. The DFAT health and education teams continue to discuss this possibility and have had a number of meetings jointly both internally and with external stakeholders.

LIMITATIONS, ASSUMPTIONS AND RISKS

It is likely that the flexibility of the financing rather than simply additional resources, will induce participation in the performance grants requirements and mechanism as in many places it is not the lack of funding that is the largest constraint to improved service delivery. The bulk of the districts' funding will not be under a performance basis and so some questions arise as to whether they will bother with the effort required to focus efforts according to the outcome criteria for what will be a small proportion of their overall funding. Evidence does suggest however that even a small proportion of overall funding being performance based can change health service delivery and that it can actually be preferable to have a mix of funding that is and isn't performance based (Savedoff, 2010).

Where there is mixed financing from a range of sources received by health centres the incentives from any one source can be weakened (Savedoff, 2010). This is a risk in the Indonesian setting where health facilities have access to a range of finances with different guidelines on use and reporting requirements and therefore may be unwilling to put additional effort into changing activities to better reach targets through the performance based scheme. The number of financing routes does mean that the risk of PBF incentivising activities to the cost of other services is mitigated. Moreover, by highlighting overarching quality improvements as well as maternal and newborn health specific services and outcomes, PBF will also have health systems benefits.

One drawback of either of the best available approaches is that it adds another channel of finance to districts including accounting and reporting requirements. In future if it were possible it would be preferable to add DFAT funds into an existing Government of Indonesia financing channel. Proposed changes by Ministry of Finance in regulations governing the existing Government of Indonesia Special Allocation Grant, DAK (Dana Alokasi Khusus), are currently sitting with the President's Office. These would increase the scope of expenditure allowable under DAK (currently limited to investment expenditure such as buildings and equipment) and allow the collapsing of a number of other channels of financing currently requiring separate reporting into the DAK. This could still take up to two years for approval but if these changes occur opportunities for adding DFAT funds into DAK but with outcomes-based monitoring and granting requirements can be explored.

NEXT STEPS

Significant attention will be placed on the performance-based grants pilot in the inception and implementation phases of PERMATA. Some meetings have already occurred with Bappenas, Ministry of Finance and Ministry of Health representatives and will continue as PERMATA moves into inception.

A "Working in Partner Systems" (WIPS) assessment for the performance-based grants has been undertaken. A political economy analysis and further scoping and feasibility work will be undertaken during the implementation period to inform the design of the PBF grants.

A steering group will be formed that will include health, frontline, AIPD, AIPEG and education teams within DFAT together with Ministry of Health and Ministry of Finance from Government of Indonesia (with consultation with Bappenas, Ministry of Home Affairs and other relevant government and NGO partners as required). This will oversee and review the continued detailed design of the performance-based grants including ongoing iterations of guidelines developed jointly by Ministry of Health, Ministry of Finance and DFAT.