# UNICEF Women's and Child Health Program in Papua

## Mid Term Review

## Final Report

**February 2009**

# Program Data Sheet

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| **Program Name:** | Indonesia: UNICEF Women's and Child Health Program in Papua |
| **Location:** | Papua Province (2 districts); West Papua Province (2 districts) |
| **Duration:** | Commenced June 2006. Duration three years; ends June 2009. |
| **Funding:** | Total Funding: AUD6.25m – AusAID. |
| **Lead implementing agencies:** | UNICEF, implementing through Provincial and District Health agencies of the GOI, local governments. |
| **Target Groups:** | Pregnant women, infants and children under 5; Communities and families; poor households; Health centre and sub-health centre service providers; Local governments, political and religious authorities; District health authorities, decision-makers, religious leaders, local & international NGOs and local media; Province health authorities, Technical Advisory Group, Bappeda, NGOs, nursing and midwifery schools and media; National level: MOH, AusAID, bilateral and multilateral agencies. |
| **Problems Addressed:** | • High rates of maternal, infant and child mortality<br>• Poor quality and coverage of maternal and child health services<br>• Limited capacity of communities to take self-help action to reduce maternal, infant and child mortality and morbidity<br>• Limited capacity and commitment of district and local governments to MNCH programming. |
| **Project Goal:** | Women of reproductive age and children under five in program areas of Papua and West Papua have improved health and nutrition status resulting from healthier lives. |
| **Project Components** | **Component 1**: Increased community awareness of and initiative in adopting good heath practices;<br>**Component 2:** Decentralised health systems strengthening to improve access to and quality of health services at district and sub-district levels;<br>**Component 3:** Human capacity for health systems management and delivery strengthened to provide women's and child health services at district and sub-district levels;<br>**Component 4:** Supportive management contributing to sustainable and effective program outcomes. |
| **Key Outcome Indicators** | Reduction in: IMR and child mortality rates; children with low birthweight; live births that weigh <2500gm; increased utilisation of health services by women of reproductive age (WRA) and their children; reduction in rates of anaemia among WRA. |
| **Key Process indicators:** | Increased: deliveries by skilled birth attendant (PN); antenatal (ANC) visits with trained provider (K1); four ANC visits (K4); delivery complications referred appropriately; increased postnatal care visits (KN1); KN2 by 28 days; increase in health facilities equipped to provide BEONC and CEONC; increased exclusive breastfeeding; child health services via IMCI standards; increased child immunisation (DTP3, BCG, measles). |

# Acronyms and Abbreviations

| | |
|---|---|
| AIPMNH | Australia Indonesia Partnership for Maternal and Neonatal Health |
| APBD | District Operational Budget |
| APN | Normal Delivery Care |
| AMP | Audit Maternal Perinatal |
| ANC | Antenatal Care |
| ART | Ante-retroviral Therapy |
| AusAID | Australian Agency for International Development |
| BDD | Village Midwife |
| BEONC | Basic Emergency Obstetric Neonatal Care |
| BKKBN | National Family Planning Coordinating Board |
| CEONC | Comprehensive Emergency Obstetric and Neonatal Care |
| CHOICE | Child Health Opportunities Integrated with Community Empowerment |
| DHO | District Health Office |
| DTPS | District Team Problem Solving |
| EPI | Expanded Program of Immunisation |
| FHI | Family Health International |
| FP | Family Planning |
| GOI | Government of Indonesia |
| GSI | Mother Friendly Movement |
| GTZ | German Technical Cooperation |
| HCPI | HIV Cooperation Program for Indonesia |
| HC | Health Centre |
| HIV/AIDS | Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome |
| HR | Human Resources |
| HSP | Health Strengthening Program |
| IEC | Information Education Communication |
| ILO | International Labour Organisation |
| IMCI | Integrated Management of Childhood Illness |
| IMET | Independent Monitoring and Evaluation Team |
| IMHEI | Improving Maternal Health in Eastern Indonesia |
| IMHI | Improving Maternal Health in Indonesia |
| IMR | Infant Mortality Rate |
| IP | Infection Prevention |
| JAMKESMAS | National Social Health Insurance for the Poor |
| KAP | Knowledge Attitude Practice |
| K1 | First antenatal visit |
| K4 | Fourth antenatal visit |
| KN | Post natal visit |
| KPAD | District AIDS Committee |
| KPAP | Provincial AIDS Committee |
| LAMT | Local Area Monitoring and Tracking |
| MC | Managing Contractor |

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| MCSDP | Maternal and Child Survival Development and Protection |
| MDG | Millennium Development Goals |
| M&E | Monitoring and Evaluation |
| MOH | Ministry of Health |
| MOU | Memorandum of Understanding |
| MPS | Making Pregnancy Safer |
| MMR | Maternal Mortality Ratio |
| MNCH | Maternal Neonatal Child Health |
| MTR | Mid Term Review |
| MW | Midwife |
| NCTN | National Clinical Training Network |
| NGO | Non Government Organisation |
| NTB | West Nusa Tenggara Province |
| NTT | East Nusa Tenggara Province |
| PHC | Primary Health Care |
| PHO | Provincial Health Office |
| PMTCT | Prevention of Mother to Child Transmission |
| PNC | Post Natal Care |
| POGI | Indonesian Obstetricians' and Gynaecologists' Association |
| PP | Papua Province |
| PPH | Post Partum Haemorrhage |
| PPWS | Local Area Monitoring and Tracking |
| SWAp | Sector Wide Approach |
| TAG | Technical Advisory Group |
| TBA | Traditional Birth Attendant |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nations Children Fund |
| USAID | United States Agency for International Development |
| WCHPP | Women's and Child Health Program in Papua (and West Papua) |
| WHO | World Health Organisation |
| WRA | Women of Reproductive Age |
| VCT | Voluntary Counselling and Testing |

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# Executive Summary

The **Women's and Child Health Program** (WCHPP) in Papua and West Papua Provinces (PP and WPP) (2006-2009) builds on the previous Improving Maternal Health in Eastern Indonesia (IMHEI) Project in Papua and Nusa Tenggara Timur (NTT) and aims to improve the health and nutrition status of women of reproductive age and children under five in the catchments of 17 heath centres in Papua and WPP. Implementation of the AUD 6.25 million program is managed by UNICEF and operates in two districts and seven subdistricts of Papua (Jayapura and Jayawijaya) and in two districts and six subdistricts of WPP (Manokwari and Sorong).

The **terms of reference** for the midterm review (MTR) team included: assessment of the extent to which WCHPP has met its objectives and outputs as set out in the design and the annual project and district monitoring and evaluation frameworks; assessment as to whether the Project should be extended for a further two years from July 2009 to June 2011 and if appropriate recommend any changes to the program design accordingly; and assessment of the possibility of integration of the UNICEF approach with the Australia Indonesia Partnership in Maternal and Neonatal Health (AIPMNH). The MTR team undertook the joint review in conjunction with the Independent Monitoring and Evaluation Team (IMET) which has been tasked since 2005 to monitor and evaluate all UNICEF's maternal, neonatal and child health (MNCH) projects.

The MTR team (with IMET) reviewed documentation; developed tools and templates for data collection; conducted field trips to the two focal districts in each province; visited 6 of the focal health centres as well as hospitals, polindes, pustu and posyandu in the catchment areas; met with Provincial and District Health personnel; consulted stakeholders and relevant non-government organisations; conducted a lessons learned workshop with key stakeholders and a debrief session with AusAID; produced an Aide Memoire and prepared a comprehensive report. Feedback received from UNICEF and AusAID was incorporated into the final draft of the report.

There is **some evidence of women's and child health improvement** in UNICEF supported locations, but the WCHPP pre-socialisation KAP study (2008) indicates that, in some aspects of MNCH knowledge and intended pregnancy practice, there is no difference between focal and control areas even though UNICEF has worked in these same areas for over ten years. This is as much due to the nature and context of Papua and West Papua as a reflection on the effectiveness of implementation of WCHPP (and previous MNCH projects). Implementation pace is slow and this has been exacerbated by the lack of management capacity and resources at UNICEF Jakarta, in the field office in Jayapura and in the districts; and some lack of capacity in District Health Offices. The 4$^{th}$ WCHPP progress report indicates that slightly more than 50% of available funds have been spent with 13 months of implementation remaining.

Gains made, if any, following AusAID/UNICEF inputs during the past ten years, may have been negated by the **difficult implementation environment**. The dearth of donors and NGOs working in Papua and West Papua provinces means that AusAID and UNICEF assistance is desperately needed. There are also increasing opportunities to align with new and proposed GOI and multilateral initiatives which can improve sustainability and maximise potential impact of WCHPP activities.

UNICEF is well respected and technically acclaimed by counterparts in the two provinces and in the field. The lessons learned workshop with stakeholders indicated that **UNICEF brings many strengths** to the program – it is a trusted, credible partner of GOI; it works through the GOI systems; it integrates MNCH activities with broader PHC elements where possible e.g. HIV/AIDS, water & sanitation, child protection; it is effective in testing new ideas; and has access to UN 'family' and international best practice.

The **main UNICEF strategies** implemented through WCHPP are: working with the government through the Maternal and Child Survival Development and Protection (MCSDP) team coordination and District Team Problem Solving planning (DTPS) processes; community mobilisation activities; the midwife/traditional birth attendant (TBA) partnership; co-located posyandu and kindergartens; support for midwifery training and supervision; local area monitoring and tracking (LAMT); and pre-pregnancy program for adolescents. These strategies are in line with GOI policy but they need to be adapted to the Papuan context and to the different needs of each district. Development of a replication strategy is needed to ensure that all innovative strategies tested are appropriate for the Papuan context, are packaged for replication and are promoted nationally. The MTR team considers there have been missed opportunities to partner with NGOs and civil society organisation particularly for community mobilisation activities.

The **current WCHPP design** seems to target the MOH 'demand' and management strategies but does little regarding 'supply'. On the supply side, the design has focused mainly on APN training and almost excludes BEONC, CEONC (except for some in-service training) and family planning (except for analysis) despite these being critical to the overall MPS. The four districts have been the focus of UNICEF support for over ten years and despite the WCHPP design suggesting expansion to new subdistricts and targeting poor urban and rural households within difficult to reach areas, this has not occurred. There seems to be no provision for poverty criteria used in selection of geographical location of program activities and no direct focus on poverty alleviation.

The **geographic location of WCHPP** has it operating in 8 health centre catchments (of a total of 49) in Papua and in 9 HC catchments (out of 29) in WPP. This makes attribution of success to WCHPP almost impossible to estimate. Effectiveness of WCHPP, according to the indicators in the M&E framework, seems to be based on measurement of the indicators for the whole district. Expanding WCHPP to all subdistricts of the district would have more impact and allow for more accurate monitoring across the district. UNICEF are looking to do this in 2009.

**Management problems** particularly recruitment and retention of staff have hindered implementation. The current vacancies at district level together with the impending departure of key staff in Jakarta and Jayapura does not augur well for continuity of implementation and also has implications for timely completion of activities by 2009. Historically, the process for recruitment of UNICEF staff is long and slow. It is difficult to attract quality applicants to Papua; lack of financial incentives and the high cost of living; the short duration of the contract and insecurity regarding future funding and direction for the program; and the perceived lack of support in the field are significant factors. Other

management problems identified by the MTR team include: Jakarta based reporting; lack of attention to M&E framework reporting; and the need to evaluate MNCH strategies and revise according to the Papuan context. UNICEF have agreed to speed up the recruitment process and use consultants for interim tasks where possible, however it is still unclear how this will be done and for what tasks consultants will be used as it is not included in the Annual Work Plan (Nov 2008) for 2009.

The **main barriers to accessing quality MNCH services** are: the service quality and attitudes of trained midwives; coverage of midwives; and perceived and actual cost of midwifery services. The MTR team considers that future MNCH programs must include assistance to PHO/DHO to establish systems of follow-up, support, supervision and accreditation as well as support for APN training. The actual cost of delivery services by midwives (in the village and in health centres) needs further investigation and advocacy to community leaders and DHO, to increase access to services by all women (especially the poor).

**Feedback from PHO and DHO** indicates that, while they appreciate the assistance from WCHPP, transaction costs are high and perceived benefits sometimes minimal. There is an urgent need for UNICEF to align planning and scheduling of activities with the planning processes of GOI so that DHO knows what resources are available for their upcoming year. Priority DHO need is for technical assistance with planning and management of their own MPS strategies and these integrated with WCHPP activities.

The **MTR team recommends** that UNICEF be granted a six month extension (until December 2009) to consolidate work to date in the four focal districts, with the longer term view (after 2009) of the possibility of continuing implementation of selected MNCH strategies through a sub-contracting mechanism under AusAID's AIPMNH program. It is anticipated that the exit strategy workshop in December 2008 provided a plan for how activities would be prioritised, rationalised and consolidated for the final year of the project as well as a strategy toward expanding to a district-wide focus in 2009.

In the **medium and long term,** MTR team recommends that AusAID consider a long term program commitment to MNCH in Papua and West Papua Provinces, and plan for a 5-10 year engagement; that AusAID consider integrating management of a re-designed WCHPP into AIPMNH; and that AusAID commission a team to undertake a design of broader assistance for MNCH in Papua and West Papua. Implementation of outputs would be managed by AIPMNH and activities subcontracted to appropriate multilateral (including UNICEF), NGOs or other agencies (including the private sector such as mining companies where there is a health and community development focus).

# 1. Introduction and background

The Women's and Child Health Program in Papua and West Papua Provinces (WPP) (2006-2009) builds on the previous Improving Maternal Health in Eastern Indonesia (IMHEI) Project in Papua and Nusa Tenggara Timur (NTT) and aims to improve the health and nutrition status of women of reproductive age and children under five in the catchments of 17 heath centres in Papua Province (PP) and WPP. Implementation of the AUD 6.25 million program is managed by UNICEF and operates in two districts and 19 subdistricts in PP (Jayapura and Jayawijaya districts) and in two districts and 8 subdistricts of WPP (Manokwari and Sorong districts). The WCHPP covers a population of 3.96 million; and 19.3% of the geographical area of Indonesia.

The problem to be addressed in this program is the high maternal and infant mortality rates in Eastern Indonesia generally and the high rates in Papua and West Papua provinces specifically. Table 1 describes the extent of the problem in PP and WPP compared with Indonesia, and the targets to be achieved in Indonesia nationally in the long term.

**Table 1. Data on Key Indicators related to Maternal Mortality Rate in WCHPP Area[1]**

| Indicator | Papua Province | West Papua Province | Indonesia | Indonesia Targets (2009) |
|---|---|---|---|---|
| MMR (per 100,000) | 628 | 317 | 119 | 226 |
| IMR /1,000 live births | 48.7[2] | 46.8[3] | 35 | 26.9 |
| 4th Antenatal visit (K4) % | 31.02 | 29.54 | 81.76 | 84 |
| Use of skilled birth attendants for delivery (Pn) % | 30.78 | 55.46 | 79.32 | 82 |

The Ministry of Health's (MoH) main strategy for addressing maternal mortality is The Making Pregnancy Safer Initiative (MPS). Improved maternal and child health is to be achieved through: improving access to and coverage of quality care (e.g. midwives); building effective partnerships for advocacy; family empowerment to improve knowledge and encourage use of maternal and neonatal services; and by encouraging community involvement in ensuring provision and use of maternal and neonatal health services.[4]

MoH describes the key problems to be addressed to improve MMR as: lack of village midwives; the geographical barriers to service delivery e.g. remoteness of some communities especially in PP and WPP; cultural barriers to use of professional care during pregnancy; and budget cuts to District APBD mid-year [5].

[1] From MoH Presentation to the External Agencies Coordination Meeting to accelerate reducing MMR (March 2008); Data from Provincial Health Offices' MCH Report

[2] 2004 data set Papua Department of Health and BPS Provincial Office in WCHPP Design Document, p. 29

[3] Op. Cit.

[4] WCHPP Design Document, p.13

[5] From MoH Presentation to the External Agencies Coordination Meeting to accelerate reducing MMR (March 2008)

## *1.1 Terms of reference*

The terms of reference for the MTR team included: assessment of the extent to which WCHPP has met its objectives and outputs as set out in the design and the annual project and district monitoring and evaluation frameworks; assessment as to whether the Project should be extended for a further two years from July 2009 to June 2011 and if appropriate recommend any changes to the program design accordingly; and assessment of the possibility of integration of the UNICEF approach with the AIPMNH. The MTR team undertook the joint review in conjunction with the IMET which has been tasked since 2005 to monitor and evaluate all UNICEF's MNCH (MNCH) projects. Full terms of reference are described in Annex 1.

## *1.2 Methodology*

The MTR team (with IMET) reviewed documentation and developed tools and templates for data collection; met with key stakeholders in Jakarta; conducted field trips to the two focal districts in each province; visited 6 of the focal health centres as well as hospitals, polindes, pustu and posyandu in the catchment areas; met with Provincial and District Health personnel; consulted stakeholders from relevant non-government and multilateral organisations; conducted a lessons learned workshop with key stakeholders (AusAID, UNICEF/WCHPP and MOH); held a debrief session with AusAID; produced an Aide Memoire; and finalised a comprehensive report. UNICEF's feedback on the report was invited and any additions, deletions or inaccuracies were edited before the final draft was submitted to AusAID. The list of people consulted during the MTR has been attached as Annex 2. Reports on field visits form Annex 3. The documents utilised for the review are listed in Annex 9.

**Limitations to achievement of the MTR Plan and Process**

The short time allocated for the MTR and the joint nature of the process with the IMET have limited opportunities for consultation with some stakeholders. The time and effort spent on joint exercises with UNICEF staff in Jakarta and with Provincial and District Health Office personnel in Jayapura meant that MTR were not able to interview these groups specifically on current WCHPP implementation issues and future directions for WCHPP. This was accomplished in West Papua Province and this was beneficial to the MTR result.

Senior UNICEF management in Jakarta and Jayapura was difficult to engage regarding current implementation and future plans and responses to the draft report and recommendations were disappointing. Some documentation requested was also not able to be provided e.g. annual workplans from the focal districts and the WCHPP annual workplan. Logistics for travel and meetings did not always go according to plan.

# 2. Progress of Implementation

This section answers the questions:

1) What is the likelihood that implementation of the current activities will achieve the outputs and objectives ?
2) What is the likelihood that the implementation schedule will be achieved given the current pace of implementation and current funds utilisation ?

## *2.1 Achievement by output*

The MTR team consulted with UNICEF staff, District and Provincial health personnel in three districts, Ministry of Health (Jakarta) staff, health centre and polindes staff as well as villagers to ascertain the progress toward implementation and satisfaction with planned activities. The following table describes achievements, comments on progress and alludes to issues of concern which are discussed in Section 3. Assessment of the likelihood of the activities achieving the objective is discussed at the end of each component.

| Logframe Output | Achievements | Comments |
|---|---|---|
| **Objective 1 Increased community awareness and initiatives in adopting good health practices** | | |
| ***Output 1.1*** Multi-faceted MNCH social mobilisation campaign, will have been developed in the 4 supported districts covering also Desa Siaga development. | TNS commissioned (May 2008) by UNICEF to conduct Social Mobilisation pre-test (KAP) in 24 IMHI districts including PP and WPP (4 subdistricts in each). Conclusion – people know the advantage of having midwives (MW) over TBA for pregnancy/delivery care but cost and accessibility preclude them from using MW.<br><br>Study suggests: emphasising risks rather than building up MW image; promoting MW/TBA partnership; and targeting husband and mother/mother-in-law (as well as community leaders). | It is assumed that AusAID funds used only for PP and WPP part of study and not for all IMHI districts. Rp. 220,000 budgeted for study.<br><br>Some results show more positive results in control areas than program areas – what are implications of this for WCHPP ??<br><br>It is unclear if campaigns will be adapted to the different social and cultural needs of each district or if any analyses have been done by district. KAP was across all IMHI districts (no Papuan specific data).<br><br>Unclear what implications there are for WCHPP re cost and accessibility barriers to MW care and preference for TBA.<br><br>Unclear how UNICEF will use these results in socialisation activities – especially in areas that have already had socialisation activities. |
| ***Output 1.2*** Communities are increasingly mobilised to use women's and child health services. | IEC materials have been developed by Ogilvy and are almost completed – not viewed by MTR team.<br><br>Training of facilitators/trainers in Desa Siaga by UNDP | KAP study (1.1) should have informed IEC material development. Lack of synchronised implementation.<br><br>From field visits, community members do not know term 'desa siaga' but have heard about plans needed for emergencies. MOH advises that components of blood donor, savings and transportation must also be addressed in this strategy, not just MNCH focus.<br><br>Health centre PPWS forms (*Lembar KIA3)* allow for pregnant woman to select form of |

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| | | transport to health centre in event of emergency. It seems that individual preparation (involves paying for fuel for ambulance) is taking precedence over village/community preparedness and responsibility. |

**Likelihood of outputs meeting objective:**

This component, to date, has been managed mainly at UNICEF Jakarta level with some village activity prior to KAP and IEC material delivery. An effective strategy for reaching communities with the messages and materials will be crucial in achieving increased community awareness of MNCH messages, and it is unclear how UNICEF intends to do this; nor how these activities will harmonise with *Respek* and other GOI village level initiatives. MTR team learnt that Project Concern International (PCI) has experience and success in working at village level socialising on MNCH issues in Nabire District and could be considered for implementing these activities through a sub-contracting arrangement.

| **Objective 2 Decentralised health systems strengthening for improved access to and quality of Women and Child Health Care Services** | | |
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| ***Output 2.1*** DTPS plans are reviewed and updated for 2007 and 2008, taking into account the national MPS programme and latest budgetary figures and situations. | DTPS reviews accomplished in three of the four districts.<br><br>Family planning (FP) situational analysis conducted by UNFPA in all four districts: findings – FP not considered a priority at district/health centre; limited contraceptives available; lack of training for service providers; lack of IEC materials; high demand for FP.<br><br>It is acknowledged that FP is a political issue in PP and WPP, but must be addressed within a framework of women's and family health. | DTPS is a process for problem solving around MPS. Activities planned from this should be integrated into district health plans. Unclear if this planning is for selected subdistricts or for whole district. Unclear how to assess success if measurement of indicators include the whole district including non-focal subdistricts.<br><br>With contraceptive prevalence rate of 37.2% in PP and 39.1% [6]WPP and as FP is a vital aspect of MPS strategy, unclear what implications the results of this study have for WCHPP and what will be next steps for WCHPP.<br><br>Bappenas want to revitalised FP; MOH has new National Strategic Plan (2007-2009) to be socialised. BKKBN mandate is to reach the poor with FP services. Unclear re WCHPP relationship with BKKBN. |
| ***Output 2.2*** Province and district level management and coordination mechanisms are | Both Technical Advisory Group (TAG) and Joint Health Council concepts are in early stages of development although TAG has | 18 members of TAG in Jayapura seems keen to 'advise' but considered by MoH to be at too low a level to be effective. |

[6] Demographic Health Survey (2007)

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| identified and strengthened. | been revived in Jayapura district. Advisory role of TAG to DTPS process + monitoring role. TAG has no training role. | |
| ***Output 2.3*** Supervision system reviewed and refined in all 4 focus districts. | Provincial trainers trained in clinical and managerial supervision and midwife coordinators at 20 health centres to be trained. Supervision system yet to be reviewed. Some supervision of village midwives (BDD) in Jayapura district only. Some training done on maternal and perinatal audit (AMP). | System review will be vital to strengthen peer review process for transfer of learning between midwives and to re-focus supervision from predominantly management to equal emphasis on clinical skills. Checklists on clinical skills available but tendency to focus on management. |
| ***Output 2.4*** Continue strengthening of the in-service training system in Papua and Irian Jaya Barat for newborn care, APN, BEONC, IMCI, Infant and Young Child Feeding and HIV-AIDS prevention. | Trainers have been trained in APN, BEONC, CEONC, FP and Advanced Trainer Skills to train Clinical Trainers in APN;<br>WCHPP has supported APN training. | No emphasis on training site strengthening yet nor follow-up on quality of training provided (see Section 3 on Training).<br><br>Stakeholders state that APN is the most important training needed. Health centres visited seem to have a system for rotating midwives through APN and D1 to D3 training.<br><br>Given findings of KAP pre-test that cost and accessibility are barriers to mother's use of midwives, consideration may have to be given to some attention to attitudes of midwives to their work and their clients. |
| ***Output 2.5*** Logistic system developed for health centres and village midwives. | A logistics manual was compiled during IMHEI (2004 – 2005) and is awaiting printing by UNICEF. Some training has been done in Jayawijaya and followed up with monitoring visit to 4 Health Centres by DHO of the logistics system in 2008. | MOH has not yet completed integration into the manual of DTPS and supportive supervision logistics for MNCH programs[7] so not possible to complete.<br><br>The logistics monitoring report (2008) by DHO Wamena highlighted that the cold chain system is not functioning at 2 HCs (Kurulu and Asologaima) of 4 HC visited and that immunisations at these HC have not been available for the last 6 years. Kurulu HC was previously supported by IMHEI and now in WCHPP. |
| ***Output 2.6*** Supported Health Centres and Districts use complete, consistent, and quality health data. | PPWS tracking of pregnant women introduced in most health centres.<br><br>Computerised data collection to be introduced soon (when computers programmed and delivered). | Manual use of PPWS observed in Prafi subdistrict. Some evidence of tracking being used in Sawoy (stickers on houses).<br><br>Computerised system could be problematic without access to IT assistance and reliable electricity supplies.<br>Midwives in HCs in Wamena and Prafi were trained as data entry operators. This may be inappropriate use of a midwives' |

[7] Dr Imran Pambudi (MoH) – written communication during MTR (2008).

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| | | time. |
| ***Output 2.7*** Technical support for pre-pregnancy intervention continue to be provided to achieve third and fourth service contact and evaluation of the model in 2 subdistricts in Papua. | Piloted in two subdistricts (Depapre and Sentani). Peer educators trained in 8 villages and HC involved in services to girls with anaemia. Successful in terms of District and community leaders' commitment to continue funding. APBD annual funds of Rp. 50m for this strategy. | Consideration could be given to including boys in future pre-pregnancy activities. |
| ***Output 2.8*** Post Partum hemorrhage (PPH) and other preventive and curative interventions for complications in pregnancy and deliveries and post partum phase in one sub-district. | Midwives in 4 subdistricts trained in use of magnesium sulphate for PPH.<br><br>Technical visit re use of Misoprostol | MOH states that there is no approval of use of Misoprostol by Indonesia Food & Drug Administration nor MoH.<br><br>WHO reports that Misoprostol use by midwives supported (not by cadres). Useful as it does not require injecting or refrigeration. Currently only used in pilot district in Aceh Province.<br><br>May also be implications for AusAID Family Planning Guidelines since this drug is also an abortifacient. In Australia, the drug does not have Therapeutic Goods Administration (TGA) approval for use to control postpartum haemorrhage (MJA, 2007)[8].<br><br>Emphasis on BEONC is considered a more effective approach. |
| ***Output 2.9*** IMCI implementation in Papua & West Papua districts supported. | Not yet begun. Awaiting national evaluation results. This output may not be achievable although it is a priority national strategy. | WHO reports that pilots of IMCI in health centres being conducted by HSP/USAID in 6 provinces (but not including Papua).<br><br>WHO keen to get IMCI into pre-service training. |

**Likelihood of outputs meeting objective:**

Significant assistance is being provided to District and health centre level to improve midwifery and child health services, and some strengthening of supervision and in-service training has begun. Further attention to improving access to services is needed. The KAP study revealed that cost and access are the main barriers to women seeking MNCH care at health centres and with midwives. The three factors affecting quality of midwifery services are knowledge, skills and attitude of midwives. Training is providing knowledge and skills (although systems for ensuring followup and quality control of practice has yet to be developed), but attitude of the midwife to the client to improve access needs to be addressed through a rights perspective and a customer service process. Further

[8] de Costa et al., *Early medical abortion in Cairns, Queensland*. MJA Vol 187 (3) 6 August 2007

investigation of the costs likely to be incurred during delivery and for services generally would improve the likelihood of attainment of this objective.

| **Objective 3 Human capacity for health systems management and service deliveries, strengthened to provide quality, accessible women and child health care services** | | |
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| ***Output 3.1*** Trained districts and Health centre health workers are appropriately applying improved practices in the work-place. | Human resources assessment of midwife coverage underway.<br>APN training supported by UNICEF in all 4 districts:<br>Jayapura 80 of total 108 trainees in dist.<br>Jayawijaya 48 of 145 trainees<br>Manokwari 43 of 175 trainees<br>Sorong 43 of 96 trainees<br><br>4 provincial lactation trainers trained . | HR assessment addresses coverage but does not include assessment of quality.<br>APN training through P2KS does not include follow-up to check quality of training.<br><br>Unless systems are developed for assessing quality of training, improved practice will not be measurable and this output cannot be achieved |
| ***Output 3.2*** TBAs and cadres are able to practice appropriate newborn care and women and child health care messages. | Workshops conducted in all districts. Study tour to Takalaar district. Malaria training given. TBAs assisting midwives with ANC and PNC. Good progress towards achievement of output. | TBAs met during field visits able to describe messages and appreciate training and partnership approach with midwife.<br><br>In some sub-districts, TBAs are not given cash incentive from JAMKESMAS allocation.<br><br>The strategy needs to be PP WPP specific. |
| ***Output 3.3*** Informed leaders and decision-makers providing increased leadership and advocacy support for women's and child health and nutrition program. | MCH booklets distributed to community leaders and some socialisation done in Sorong and Jayawijaya. | Communication with community leaders planned as part of Communication Strategy developed for all IMHI districts. |

**Likelihood of outputs meeting objective:**

The likely result from achievement of these outputs is increased access to TBAs. It is not clear how the implementation of these activities could improve **quality** of midwife services. Advocacy to community leaders is a vital task and must be done in a way that is effective and appropriate in the Papuan context.

| **Objective 4 Supportive management contributing to sustainable and effective programme outcomes** | | |
|---|---|---|
| ***Output 4.1*** Effective and targeted program M&E. | Quality of M&E said by UNICEF to have improved with support for PPWS. Routine data is available on MNCH indicators showing improvements in 3 of the 4 districts. Computers provided in 2 districts. | District M&E frameworks not sighted. Difficulties attributing improved indicators to UNICEF efforts when in so few subdistricts. |
| ***Output 4.2*** Effective programme and partners harmonization. | Monthly multi-donor meetings convened by UNDP and joint program meetings in Jayawijaya with WHO, UNFPA, ILO, | Minimal engagement re *Respek*, Save Papua, and New Deal for Papua programs; and with other related programs and NGOs |

| | | |
|---|---|---|
| | UNDP.<br>Intersectoral collaboration around issues of malaria, PMTCT and EPI. | working in MNCH area e.g. FHI, AusAID funded HIV program. |
| ***Output 4.3*** Improve coordination capacity of province and district through MCSDP team. | 2 meetings per year in Jayapura only. | This is potentially a good forum for MNCH planning as it is headed by Bappeda but seems to be inactive. Introduced by UNICEF internationally as an intersectoral mechanism for child survival. |
| ***Output 4.4*** UNICEF staff salaries, travel and office management. | Currently, 2 of the 4 district health officer positions are vacant (Wamena, Manokwari); one administration position vacant (Manokwari); and there are at least 2 impending departures. | Serious and long-standing recruitment, retention, procurement and workload problems will hinder achievement of outputs and objectives.<br>Provincial and district staff are also involved in management of activities from related UNICEF programs e.g. HIV/AIDS, child protection and water/sanitation. |

**Likelihood of outputs meeting objective:**
Less than 50% of activities due for implementation until now have been completed. This is due to capacity issues on both PHO/DHO and UNICEF sides. Lack of progress may also be due to the changed context for MNCH in PP and WPP and the need to update assumptions, partnerships and strategies.

## *2.2 Progress toward objectives meeting purpose*

The purposes of WCHPP are:
1) *Women of reproductive age in Papua (and West Papua) are increasingly making appropriate decisions about their own and their child's health and nutrition* (Components 1 and 3);
2) *Community and district health services in program areas of Papua and (West Papua) are strengthened to support and provide accessible quality health care to women of reproductive age and children under five years* (Components 2 and 4).

It was not possible to use the M&E framework to assess progress toward attainment of objectives as use of this tool for measuring progress of indicators has not yet begun. This is of concern as the program has past the midway mark.

The Independent Monitoring and Evaluation Team (IMET) has estimated that less than 65% of program activities expected to have been implemented by now have been achieved; and that the UNICEF view that 60% of total activities will be implemented by the end of the program (June, 2009) is unlikely. This does not augur well for the achievement of the objectives and it is unlikely that much progress can be made towards achieving the purpose without significant extension to the program.

Generally, outputs are working towards achieving the objectives and goals. Capacity for implementation of activities by some district teams, and activities aimed at creating demand for, and utilisation of services are the weakest outputs. Unless a more effective strategy is found for working

at the community level and access to midwives is improved (i.e. cost and coverage addressed), progress toward purpose 1) will be doubtful. Achievement of purpose 2) is reliant on supporting district health office staff to plan and manage implementation of MNCH strategies, including increasing coverage of midwives and establishing systems for supporting and improving the quality of midwifery services.

**Pace of implementation and funds utilisation:** Implementation pace is slow even taking the unique context of Papua into consideration and this has been exacerbated by the lack of management capacity and resources at UNICEF Jakarta, in the field office in Jayapura and in the districts; and lack of capacity for planning and management of interventions in the District Health Offices. The 4th WCHPP progress report (May, 2008) reveals that slightly more than 50% of available funds have been spent with 13 months of implementation remaining. The 5th Progress Report (submitted during the MTR Report feedback period in December 2008/January, 2009) states that approximately 30% of funds have now been utilised and US $1.7 million remains to cover activities during the final 13 months (7 months plus an extension for 6 months, if granted by AusAID).
Note: Some funds disbursed to DHO have been refunded due to inability to carry out the activities. This implies that 1) the activity was not a priority for the DHO; or 2) it was not planned (owned) by the DHO and was therefore not a priority or valued. This is discussed further in Section 3.

# 3. Discussion of Issues

This section discusses the key issues impacting on implementation of WCHPP and provides the evidence and context for the suggested recommendations and future direction for the program in later sections of the report. The MTR team has identified these main issues as the WCHPP design; UNICEF management issues; barriers to accessing MNCH services; and Provincial and District capacity for health systems strengthening.

## *3.1 Program Design*

The original intent of the WCHPP design was to provide for 'an integrated programmatic approach that addresses the issues of access to and affordability of quality health services by the poor, and the health needs of women of reproductive age, newborns, infants and children under five years'.[9] This was to align with the MoH program priorities for Making Pregnancy Safer as described in Table 2. Further description of MPS is provided in Annex 5 – GOI P4K Program details.

[9] WCHPP Design Document, Executive Summary, p. i

**Table 2 MoH program priorities for reducing MMR (2008)[10]**

| Supply | Demand | Management |
|---|---|---|
| -Qualified ANC<br>-Qualified Birth - Attendants (APN)<br>-Qualified PNC<br>-BEONC[11]<br>-CEONC[12]<br>-Qualified FP Services | P4K (family empowerment - birth and complication preparedness)<br><br>Midwife – TBA Partnership | DTPS – Making Pregnancy Safer<br><br>MCH – Local Area Monitoring<br><br>Supervision through Midwife Coordinator |

The current WCHPP design seems to target the MOH demand and management strategies but does little regarding supply. On the supply strategies, the design has focused mainly on APN training and almost excludes BEONC, CEONC (except for some in-service training) and family planning (except for analysis) despite these being critical to the overall MPS. This is in contrast to the previous Safe Motherhood and IMHEI projects. A comparison of strategies for all three projects in the 4 focal districts forms Annex 7. If WCHPP is to fully align with MOH MPS, the design will need to take more account of the supply side.

As noted in Section 2 and agreed by UNICEF staff, family planning is a difficult issue to address in the PP and WPP context, but UNICEF (together with UNFPA) should be able to advocate and prepare for DHO family planning programs. Another entry point , the social mobilization messages could also include FP messages that are appropriate for PP and WPP. Other issues regarding supply such as quality of training and cost of MNCH services are addressed below.

**Geographic location of WCHPP**

Since PP and WPP became separate provinces, there has been further splintering of districts and subdistricts and this has increased administration and bureaucracy. The current four districts have been the focus of UNICEF support for over ten years and despite the WCHPP design suggesting expansion to new subdistricts and targeting poor urban and rural households within difficult to reach areas[13], this has not occurred. There seems to be no provision for poverty criteria used in selection of geographical location of program activities and no direct focus on poverty alleviation e.g. family planning as a priority poverty alleviation strategy to address unmet contraceptive need and unwanted pregnancy. This lack of focus on poverty is also intrinsically linked to the cost of MNCH services which prohibit access to services and needs urgent attention.

The WCHPP currently operates in 8 health centre catchments (of a total of 49) in Papua and in 9 HC catchments (out of 29) in WPP. This makes attribution of success to WCHPP almost impossible to

[10] Presentation (2008): Main Program to Accelerate Reducing Indonesian MMR; by Director Maternal Health, MOH at *External Agencies Coordinating Meeting to Accelerate Reducing MMR*

[11] Basic emergency obstetric and neonatal care (at health centre level)

[12] Comprehensive obstetric and neonatal care (at hospital level)

[13] WCHPP Design Document, p.4

estimate. Effectiveness of WCHPP, according to the indicators in the M&E framework, seems to be based on measurement of the indicators for the whole district. Expanding WCHPP to all subdistricts of the district would have more impact and allow for more accurate monitoring across the district. UNICEF, in its response to the draft MTR report, states that it has planned for this for 2009 during an 'exit strategy workshop' in February 2009 to be convened with field officers. Some discussion with DHOs will also be required. It is also of concern to the MTR that the annual workplan (in the 5th Progress report, November 2008) does not seem to provide any budget re-allocation for this expansion to new subdistricts. There is no reference in the Annual Workplan for 2009 of this approach nor is there any apparent intention to use the AusAID changeframe to address this proposed change.

It was also anticipated that the exit strategy workshop in December 2008 would provide a plan for how activities would be prioritised, rationalised and consolidated for the final year of the project as well as a strategy toward expanding to a district-wide focus in 2009.

Given UNICEF's longstanding support for the four current districts, progressive expansion to other districts is long overdue. The current Letters of Intent (MOUs with districts) should include benchmarks for success; and while MTR acknowledges that, if WCHPP expands to all subdistricts of the four districts, the same districts will remain a focus for some time yet, an exit strategy will be needed for phasing out of current districts and subdistricts at some stage.

**Changed operating environment for WCHPP**

The WCHPP program was designed early in 2006 and since then, there have been significant changes to the program's operating environment (see Section 5.1).

The MTR team met with NGOs working on related projects in the WCHPP districts and in Papua generally. For example, PCI through Project CHOICE (**C**hild **H**ealth **O**pportunities **I**ntegrated with **C**ommunity **E**mpowerment) operates in Banten Province , but MNCH activities are also implemented in Nabire District in Papua Province. The main strategies used are community empowerment and health system strengthening aiming to mobilise and strengthening local community capacities in water and sanitation, disaster risk management, as well as maternal and child health. Evaluation of CHOICE identified important lessons learned which may be applicable to WCHPP. These include: useful lessons on implementing social mobilisation activities, training and managing MNCH activities, especially the need to continually evaluate strategies used. A full list of lessons learned form Annex 8.

Family Health International (FHI) is involved in in-service training for health staff, including midwives, in the area of HIV/AIDS, particularly health system strengthening. Implementation of FHI supported activities is in 10 districts, including a number of WCHPP districts. FHI is keen to integrate basic reproductive health and family planning in Papua and WPP. The integration of reproductive health is a national policy and could be an appropriate partner for WCHPP.

Both of these NGOs provide opportunities for WCHPP to harmonise with these initiatives to maximise impact and for more effective implementation. There may also be opportunities for sub-contracting arrangements.

***Recommendation: That future design of Papua MNCH programs consider:***

- ***Equal attention to the supply and demand issues of MNCH;***
- ***Take into account the rapidly changing Papuan political, social and cultural context particularly harmonizing with programs to accelerate Papua;***
- ***Consider locating the program in the poorer districts, and in all subdistricts of a district;***
- ***Take full account of the assumptions and lessons learned from this MTR.***

## *3.2 UNICEF Management*

The unique features of UNICEF's current strategic approach to health and nutrition programs include: 'a field presence; technical assistance to established national priorities; model development and evidence-based advocacy backed up by policy support; and grassroots partner for implementation and innovation'[14]. UNICEF is considered a credible and trusted partner of GOI, and well respected and technically acclaimed by counterparts in the two provinces and in the field and the assistance to district and provincial health authorities and health centres is much appreciated. From its long history of support for MNCH programs in Indonesia, UNICEF is renowned for 'working through the government' in that MNCH activities are planned with partners through the MCSDP and DTPS processes, activities that cannot be funded through the district APBD are funded through the GOI financial system, and implemented by district health personnel.

### 3.2.1 Recruitment and Retention of staff

Despite the fact that UNICEF has been working in these districts through a series of projects for more than ten years, there has always been a problem with recruitment and retention of staff at all levels. Currently there are staffing problems at all levels – central, provincial and district. Two of the four district based Health Officer positions are currently vacant and this, together with the impending departure of key staff in Jakarta and Jayapura does not augur well for continuity of implementation and also has implications for timely completion of activities by 2009. Historically, the process for recruitment of staff is long and slow. UNICEF has stated in its response to the draft MTR that recruitment is occurring as quickly as possible and that consideration will be given to utilising consultants for some management and monitoring tasks. However, it is noted that 1) there is no mention in the 5th Progress Report of any strategy to how these positions will be recruited 'quickly'; and 2) no budget was found in the Annual Workplan for recruiting consultants.

Factors contributing to the recruitment problems include: difficulties in attracting quality applicants to Papua; lack of financial incentives, especially given the high cost of living; the short duration of the contract and insecurity regarding future funding and direction for the program; and the perceived

[14] UNICEF Country Programme Action Plan 2006-2010, p.11

lack of support in the field for the District based staff (no car or internet (in some districts), having to do their own administrative work and often it is difficult for Javanese/Indonesian staff to gain the trust and good working relationships with indigenous partners.

Poor retention of staff results from lack of professional development and capacity building for their roles; minimal opportunities for information and learning exchanges across districts and with provincial partners; and lack of opportunities for overview and strategic input into program planning on UNICEF's side. Even though WCHPP is designated a 'program' it has all the features of a 'project' especially the short duration which is impacting on recruitment and retention of program staff.

### 3.2.2 Reporting

Six monthly reporting to AusAID appears to be done from UNICEF Jakarta. Usually the central level would have a quality control function but reports would be generated by the Provincial level with input from the UNICEF staff reports from the field. This has also been exacerbated by the number of centrally managed activities, some of which have applied to all UNICEF MNCH programs. For example, the KAP pre-test was conducted in both IMHI and WCHPP locations and the Communication Strategy (and IEC materials) have also been centrally managed. This is not ideal given the diversity of Papuan cultural groups, beliefs, attitudes and languages. It also means that it is difficult to provide the reports and feedback to the district and provincial counterparts. The MTR notes that, while Papua specific results have been requested from the company who conducted the KAP study, "BCC materials will be designed in Jakarta and disseminated to selected areas of Papua"[15]. This is not international best practice.

### 3.2.3 Monitoring and Evaluation

As with all AusAID supported programs, a M&E plan and framework is required to monitor UNICEF performance in implementing activities in the logframe and for measuring progress towards the program purpose. This was developed during the design phase and UNICEF have contributed baseline data to this, but measurement of indicators has not yet been accomplished so there is no way the MTR team can assess progress towards attainment of objectives. There seems to be confusion over indicators that measure UNICEF performance for the activities in the logframe and indicators which will measure progress toward the purpose or goal. Obviously for the latter, data will be required from the districts but for UNICEF's activities in the logframe, most indicators can be measured by UNICEF during and after evaluation of the pertinent strategies implemented. It is unclear to the MTR team who is responsible for M&E and for updating the framework. It seems as though the M&E framework was not developed with the counterparts and is not in line with the DHO indicators of MNCH success. The attribution of any progress to UNICEF inputs is unlikely when the program operates in so few subdistricts.

UNICEF's response to the M&E issues raised by the MTR includes their intention to:

[15] UNICEF 5th Progress Report, November 2008, p.8

1) strengthen the DHO M&E framework (it is unclear how this will occur); and
2) meet with AusAID to discuss M&E for WCHPP (presumably for strengthening the logframe M&E indicators).

In addition to this, UNICEF should be more rigorous in the progress reports with explanations of the meaning of data and charts presented, as well as to analyse the results. For example, Chart 1 in the 5th Progress report (p.17) is titled "Achievement of MPS Indicators" yet there is limited achievement, with actual decreases in some indicators. This needs to be explained in the narrative. The text with the charts described on p.25 states that "not much difference was observed" (after the intervention) but there is no discussion about a strategy to address this. This also relates to the need for evaluation of interventions (see below).

### 3.2.4 Evaluation and Revision of MNCH Strategies

This is related to the M&E issue (above). The main strategies of WCHPP include: working with the government through the MCSDP team coordination and DTPS planning processes; community mobilisation activities; the midwife/traditional birth attendant (TBA) partnership; co-located posyandu and kindergartens; support for midwifery training and supervision; local area monitoring and tracking (LAMT); and pre-pregnancy program for adolescents. There are also potential other strategies from UNICEF's broader program that can be offered to DHOs as a 'menu' of possible strategies to enhance and integrate into their MNCH approach. This could increase the role for UNICEF in MNCH in PP and WPP. See Annex 6 for the menu of UNICEF strategies.

These strategies are in line with GOI policy but UNICEF, as managers of implementation, need to evaluate their effectiveness in the Papuan context and revise them as needed. For example, how can the midwife/TBA partnership be implemented in Papua where there are so few midwives? -- and what does community empowerment mean in the Papuan context and in locations where there is a mix of transmigrated Indonesians as well as indigenous Papuans? There are likely to be other differences between districts such as geography, communication and electricity issues which may impact on the effectiveness of certain strategies. UNICEF also needs to consider development of a replication strategy to ensure that all innovative strategies tested are appropriate for the Papuan context, are packaged for replication and are promoted nationally. UNICEF has agreed in the response to the draft MTR Report to develop a strategy 'to assist DHO to plan for replication of MNCH strategies" (5th Progress Report, p.32) but also needs to evaluate their own innovations and strategies. It is noted that the Annual Workplan for 2009 does not include provision for evaluating strategies and revising these accordingly.

### 3.2.5 Pace of Implementation

The pace of implementation has been slow even given the difficult Papuan context, and this has been exacerbated by lack of management capacity and resources at central UNICEF level and in the provincial program office. MTR team were informed that UNICEF management resources are guided by an AusAID formula which allows for 25-30% of program funds to be spent on program support (staff salaries and travel). This has hindered effective support from Jayapura UNICEF office and to the DHO. Given that DHOs are requesting more assistance with planning, implementation and

replication of MNCH strategies, this formula needs to be reviewed for Papua. The MTR team also acknowledges that the absorptive capacity of the DHO is also a factor in the slow pace of implementation. This is discussed below. Consideration should be given to contracting NGOs or other agencies to assist with implementation.

***Recommendation: That UNICEF renegotiate with AusAID the formula for allocation of funds for management support with the view to improving staffing at provincial and district levels and accelerating Program implementation.***

***Recommendation: That UNICEF review the staff recruitment process and consider:***
***- maintaining current salary levels but offering financial or in-kind incentives for remote living in Papua***
***- increasing support for district level staff e.g. appoint teams so they can support each other, ensure provision of vehicle, internet and administrative support***
***- consider recruiting district level staff from a lower level and build capacity and commitment on-the-job; and provide opportunities for professional development.***

***Recommendation: That UNICEF localise reporting to the Jayapura field office with Jakarta providing quality control.***

***Recommendation: That UNICEF evaluate and revise MNCH strategies implemented in Papua and West Papua with the view to adjusting them for the Papuan context; and develop a replication strategy to assist DHO to plan for replication of MNCH strategies.***

***Recommendation: That, to increase the pace of implementation, UNICEF consider contracting out some planned MNCH activities to NGOs or other agencies with experience in working in the Papuan context.***

## *3.3 Accessing MNCH services*

### 3.3.1 Community awareness and empowerment

The objective of this output is to communicate with and encourage communities to take responsibility for safe pregnancy; communities to support the couple to plan for their pregnancy and delivery through saving money, having a transport plan for emergencies, preparing for blood donation if needed, and ensuring family planning is addressed after the birth (Desa Siaga). The traditional way of doing this is through training cadres to work with couples to do this referring them where possible to midwives and/or health centre staff for appropriate care.

There has been some confusion over the definition of 'Desa Siaga' – there being two versions of this – 1) village preparedness for all emergencies (Poskesdes); and 2) village preparedness for MNCH emergencies only (P4K). Even within the latter interpretation, WCHPP addresses only some of part of the activities e.g. the savings and the transport plan. A series of IEC activities has been

implemented by WCHPP but these preceeded the KAP survey and the development of IEC materials. There are lessons learned from PCI implementation of Desa Siaga which could be applied to WCHPP (See Annex 8).

The MTR became aware of significant cultural issues related to Desa Siaga which will need to be addressed to enhance community willingness to use midwifery services. In one village, community leaders expressed the view that if women were contented within their relationships, they experienced no complications with deliveries. Those that did have complicated labours were encouraged to be counseled with their husband and extended family (during the labour) and that this, and prayer, would resolve the complications without having to resort to health centre or hospital care. This is a dangerous belief and needs to be addressed through IEC. Similarly, the widespread preference for family members and/or TBAs to deliver babies needs to be part of ongoing discussion by community facilitators trained to do this work.

The need to review and revise strategies is apparent from the above examples. There is also a need for the community socialization process to be ongoing. The field visits demonstrated that where the process had been implemented, community leaders have changed and or been replaced so the communication will need to be repeated. As this is a vital component of the program in that 'demand' is generated for safe pregnancy services, implementation of these activities may be more effective if NGOs who are well experienced in working within Papuan communities are contracted to undertake this work.

### 3.3.2 Quality of midwife training

Training to improve quality of services is an appropriate and quick approach to saving women's lives, as poor quality of services is one of the most common reasons for low utilization of service providers and facilities (Safe Motherhood Fact Sheet, 2002). However, training does not always translate into better performance or achievement of service targets due to several barriers.

**Training as Reward**

In two districts visited (Sorong and Jayawija), training is viewed as a reward for midwives' high performance and not seen as fulfilling a need. One of the selection criteria used for identifying village midwives for normal delivery care training (APN) in Sorong and in Jayawijaya is that the midwife must have high workload (presumably high number of deliveries each month) and that she is likely to stay on in the village. The use of reward could lead to inequity of access to training opportunity. For e.g., one village midwife interviewed complained that the village midwife who works with her in the same village (who was a high achiever) was sent for regular training whereas she has not had any training since graduation in 1996. This approach suggests that there are no strategies in place to manage underperforming midwives.

In contrast, in Sawoy health centre, in Jayapura, training is not treated as a reward for midwives. A training system is in place whereby midwives are rotated through APN training.

**Support for transfer of Learning**

Midwives cannot be expected to apply learning in the workplace following training, if they are not supported with the appropriate equipment and/or drugs. For e.g. in district Jayawijaya, midwives received training in the use of magnesium sulphate (MgSO4) but did not have the drug to use in their practice.

**Lack of adaptation to local needs**

The APN training needs to be adapted to local context without compromising the principles of good practice. The APN training that is currently taught is facility-based practice and adaptation to home-based delivery is needed. The majority of village midwives cannot apply infection prevention (IP) protocol (as taught in APN) in home-based deliveries. Similarly, midwives in the district hospital in Wamena reported that they were not able to follow IP protocol, as they do not have enough supply of chlorine and equipment.

**Quality of Supervision**

Supervision is an important activity in the performance improvement process. Training of supervisors was conducted but re-training was proposed in Jayawijaya. Peer review process to reinforce clinical skills was one of the 2008 work plan activities but implementation is patchy and quality of sharing between midwives is questionable in sub-district Wamena, as one village midwife who had not attended NDC training was found to be using 'out-of-date' practice for APN. In Sorong, there is no planned approach to using peer dissemination or transfer of learning of new techniques and procedures for village midwives. However, peer education does take place at the hospital in Sorong and Jayawijaya (Wamena).

### 3.3.3 Capacity for training

## Inservice training

The bulk of clinical training funded by UNICEF is conducted by the Provincial Training Centre (P2KS) Jayapura. The P2KS has trained 548 midwives in NDC training between 2006 and 2008. This is equivalent to 5 intakes of 10 midwives per intake, per month. For each APN training, the P2KS charges Rp72,500,000[16]. Thus, the P2KS has the capacity to train in APN and the users have the funding to support the P2KS.

**Quality checks**

Of serious concern is that the P2KS has not put in place quality checks on its products and has not collaborated with PHO to ensure clear roles and responsibilities for follow-up post training. P2KS is also not able to provide up to 3 cases of normal delivery for each midwife during the 10 days APN training. In one sub-district visited, many midwives reported that they were considered competent following 2 normal deliveries. In Wamena, additional 10 days clinical practice time is provided to midwives who needed the additional time to gain APN competency.

**Lack of Network communication**

The P2KS in Jayapura is part of the National Clinical Training Network (NCTN), which is a body that establishes standards in clinical reproductive health skills and in training skills. One weakness

[16] This fee does not include per diem and transport for the trainees.

noted is that the NCTN does not have a system of communication and guidance to the training centres within its network. Communications within the network mainly occurs informally and once a year during the Obstetrician and Gynaecologist specialist group (POGI) conference. The NTCN does not have funding for supervision visits nor for communications with the training centres.

**Lack of PHO/DHO guidance for P2KS**

The P2KS is to be commended for its commitment to, and hard work in building the capacity of MNCH staff. The P2KS, as an NGO, needs to work closely with health offices and not independently, as appears to be the case for Jayapura. Even though the P2KS has taken an active role in deciding future developments[17], the PHO has a leadership role to uphold, as the client of the P2KS, in determining the capacity building needs of its staff at all levels of service delivery. UNICEF as the key funding body could also monitor and provide technical advice so as to shape development of the client/ provider relationship.

In West Papua, the P2KS is being established and will conduct its first intake NDC training in February 2009. The P2KS trainers will report to PHO. This is a good move to ensure closer collaboration between users and providers of training.

**Replication of training**

The benefits of training will be diluted and cannot be replicated by local government when APBD funding is not available for e.g. in districts Sorong and Jayawijaya.

## (b) Preservice education

In Jayapura, the school of midwifery is small with 1 functioning laboratory and 5 classrooms. They are also short of teaching and learning equipment and models for clinical practise; and there is competition for clinical practice sites between other professions such as medical and nursing students.

The midwifery school has evolved from training lower high school (SMP) *Bidan C* graduates to Diploma I (D1) graduates in 2008. Currently, Diploma III (D3) is the minimum qualification for all practising midwives. The local government is committed to upgrading all D1 midwives to D3 qualification.

**Limited Capacity**

The majority of midwifery educators have Diploma IV (D4) qualification, which is one grade higher than the course they are teaching. The school will have one lecturer with Masters Degree in MNCH and Reproductive Health by end of the year. To support the educators in the classrooms and labs, newly graduated D3 midwives are recruited and provided further training.

Recently, the school was instructed by the provincial government to commence training D1 in midwifery. The first intake of 50 students commenced at the school in September 2008. The D1 midwifery training will also start up in three districts Timika, Nabire and Biak. At the time of interview, the school has a total of 191 students with a teacher-student ratio of 1:20 instead of the nationally recommended ratio 1:12.

[17] Their 2009 plan is to train trainers in Universal Precautions; Early Detection of Cervical Cancer; PMTCT; IMCI; and the management of Low Birth Weight babies.

Only one midwifery educator is trained as a APN trainer with the P2KS in Jayapura. This is important, as it allows integration of APN into midwifery education. However, as there is only one educator who is a APN trainer, the APN training at the school is not recognised by P2KS. All midwives graduated from the school are put through APN training. Each class has 30 to 50 students. The average recommended class size is 20 students[18].

## Papua Midwifery Education Proposal

The Papua and West Papua governments have received permission from the Central Board of Manpower to revitalize the former one-year midwifery training program for nurses whereby nurses will undergo a 15-month midwifery program. This aims to expand access to MNCH services in Jayapura, Jayawijaya, Sorong and Biak (3 of the 4 are WCHPP districts).

The technical appraisal of the proposal posed the need for more trained midwives versus the need to distribute existing midwives more equally. The latter may be addressed to some extent through recommendations from the current HR study (WCHPP), but following consultations in West Papua Province, the allocation of these trained nurse/midwives to village locations may need to be reconsidered. WPP PHO stated that in the past, these nurse/midwives are not interested in working in a village setting and usually want to be based in urban areas. Due to the need for a variety of training options to increase midwife coverage, the MTR supports the training proposal subject to the proposal revisions suggested by the technical appraisal and re-consideration of the distribution strategy for the trained nurses.

***Recommendation: That AusAID consider providing support for the Papua midwifery education proposal for training nursing school graduates in D1 midwifery through the Papua Provincial Health Office and the Politeknik Kesehatan Jayapura.***

***Recommendation: That in future MNCH program designs, assistance for DHO to establish systems to ensure quality of training be a priority output.***

***Recommendation: That in the interests of increasing quantity and quality of midwives for MNCH, AusAID consider support for pre-service training for midwives within a comprehensive HR framework, in future MNCH programs.***

### 3.3.4 Barriers to Accessing MNCH services

The KAP pre-test (2008)[19] found that only 50% of respondents thought it was important to deliver with a midwife if they had money to cover the cost. The main reasons for not accessing a midwife were cost, lack of accessibility, lack of awareness of the risks involved in pregnancy and delivery, and inherent trust in the TBA. Thirty-five percent (35%) of respondents do not want to go to a midwife for delivery and post natal care regardless of cost or accessibility issues. This infers that:

[18] Interview with Susana Ramandey, Secretary of midwifery school, Jayapura, Papua, 22 Oct 2008.

[19] Improving Maternal Health in Indonesia :An Audience Measurement Survey, *A Preliminary Result Presentation The General Public segment, August 2008, TNS Presentation*

there is much community mobilization work to do (and to re-do) to convince communities and to improve access to midwives; and that midwives need to work on being more acceptable to pregnant and delivering women.

There is also the issue of how to promote the need to access midwives during pregnancy in areas where there are none, or where village midwives are not available and transport and/or geography precludes travel to a health centre. MTR team observed large village signs (funded by UNICEF) which proclaim that TBAs are prohibited from cutting the cord after delivery. The question is who cuts the cord if no midwife attends. The policy seems unrealistic in this instance. This needs to be addressed in community mobilization sessions and through IEC.

**Cost barriers to access to deliveries by skilled birth attendants**

In Sorong, it was reported by the midwife coordinator at the Majaran health centre that implementation of the Takalar model to TBA-midwife partnership has resulted in increased deliveries by skilled birth attendants. However, the TBA does not receive payment for assisting at the deliveries. The TBAs in Depapre and Wamena also do not receive payment in the partnership. In contrast, Javanese TBA receives Rp150,000 per delivery[20]. In transmigration areas, TBAs were reported to receive Rp600,000 per delivery. In one sub-district visited, the HC staff have discussed the possibility of using 30% of village funds (*tabulin)* for TBAs who help in the deliveries. One of the roles for Cadres is to persuade women to attend Posyandu. However, in one sub-district, Cadres would not register pregnant women if the women do not attend the Cadres' Posyandu. Family members were noted to also help women deliver at home and are often not targeted for support in increasing deliveries by skilled birth attendants.

The amount received by midwives is Rp50,000 per normal delivery. In contrast, midwives in Manokwari receive Rp350,000 per delivery and this is given to midwives monthly. This is higher than JAMKESMAS (2008) allowance for normal delivery at Health Centre with the unit cost of Rp50,000 for one-day stay at HC and Rp200,000 for normal vaginal delivery (*Lampiran III*, JAMKESMAS 2008:1). In Sorong, midwives reported that they were not receiving JAMKESMAS money for deliveries.

In one village visited by the MTR team, the health centre charged the pregnant woman's family the cost of the fuel for the ambulance to transport her from her home to the health centre (RP50,000) for a complicated delivery. This was a cost for the family and not the community as proposed by Desa Siaga. There were numerous examples recounted where 1) the village midwife had not made it in time for the delivery despite being called; and 2) where the mother had been willing, but had delayed (due to cost, lack of transport or cultural beliefs) getting to the health centre/hospital with dire consequences – usually the death of the baby.

***Recommendation: That increasing the poverty focus of WCHPP could allow for more attention to cost and accessibility barriers to midwifery care and enhance access to services by the poor through Jamkesmas.***

[20] JAMKESMAS (2008) pays a unit cost of Rp250,000 per delivery at Health Centre and facilities below.

## *3.4 Health System Strengthening*

### 3.4.1 Working with the DHO

During the ten years UNICEF has been supporting MNCH programs in Papua, the two differential roles of UNICEF have been testing of new MNCH models of service delivery and management; as well as provision of funds for district planned activities and UNICEF planned activities according to the program's logframe. The district counterparts have expressed some frustration with aspects of this approach which is captured in the following feedback from discussions with counterparts in both provinces (see also Field Visit reports, Annex 3):

- 'Sometimes we don't know what the money is for ---- there is more money than time to use it'. This implies that some UNICEF planned activities may not fit the plans or schedules of the DHO.
- 'It's a small amount of money for the effort'. The transaction cost of liquidating the small UNICEF funds is not always worth the effort. DHOs requested assistance or incentives to accomplish this task. MOH has responded to this 'district health office will always prioritise local budget over UNICEF budget'[21].
- 'In order to scale up MNCH activities, we need technical assistance with planning, implementation and financial management'. Currently UNICEF support at district level is outside the DHO and manages other UNICEF program activities as well as WCHPP. Technical assistance inside the DHO (as well as the current Health Officer position) would greatly assist with scaling up to all subdistricts.
- 'If UNICEF can test new ideas, we can replicate'. DHO value the technical assistance given by UNICEF in this role. This enhances likelihood of sustainability of outcomes.
- 'There's no problem for us if UNICEF funds stop'. This statement points to the need eventually for an exit strategy from WCHPP districts and criteria for moving to other districts based on need/poverty and DHO readiness.
- From West Papua Province – 'our priority is to increase the number of midwives (through innovative contracting and training strategies) but in the meantime, support is needed for TBA and family members (where there are no midwives) to assist with deliveries' e.g. orientation in infection control, access to sterile equipment, assistance to map pregnant women, and estimate the due date. This seems a reasonable request in areas where there are no midwives.
- 'Some UNICEF activities are at too high a level'. This implies that some activities may not be planned in consultation with PHO/DHO and the readiness of the DHO for the activities and how they fit the DHO plan/schedule may be an issue.
- 'Posyandu and kindergarten combination is a good 'demand' strategy to get pregnant women to come to the posyandu/polindes and should be supported by UNICEF'. MTR team notes that support for posyandu (except for some training of cadres) is not included in the design of WCHPP (as in previous projects) but is supported through UNICEF's Child Protection program.

[21] Written communication from Dr Imran Pambudi (MOH), October 2008.

All provincial and district health officers consulted were keen to have UNICEF-supported planning and management (including financial) technical assistance within their DHO. This planning process could include MNCH and health activities for all donors and NGOs in the district and is in-line with the Paris Declaration (effectiveness, harmonization and alignment) and is virtually a sector wide approach (SWAp) at district level – one plan and one M&E framework for all players.
This single annual plan for DHO activities to be supported by UNICEF, any UNICEF 'testing' activities as well as any replication of tested strategies, would facilitate the bundling of cash transfers into larger units which has also been suggested by IMET. The TA in the DHO could assist with monitoring of activities, and assist with the liquidation of funds following implementation.

**Alignment of UNICEF and DHO planning and scheduling**
The UNICEF planned annual workplan (current logframe activities) and funding for the activities are negotiated with district health officers and integrated into the district plans. The activities and APBD funds for district planned activities and schedules obviously take priority over the UNICEF initiated activities. In addition to this basic problem, UNICEF's planning and funding period is not aligned with GOI's planning process so UNICEF submits a proposal and funding to Bappenas in August but GOI (and the DHO) needs it for their planning the previous February. This could be rectified if WCHPP DHO with planning for MNCH (through the DTPS process) and funded selected DHO planned activities instead of UNICEF planned activities. A more flexible design and logframe would allow for this.

***Recommendation: That UNICEF urgently follow-through on the proposed realignment of planning cycles with GOI i.e. develop plans with DHO in February.***

***Recommendation: That WCHPP / UNICEF assist DHO with planning of their MNCH activities, fund DHO planned activities and have one annual joint workplan per district to enable bundling of cash transfers into larger units.***

UNICEF has stated in its response to these recommendations that realigning plans with the DHO in February is not appropriate and this is probably fair comment since the project is to end in December 2009 (if AusAID agrees to a six month extension).

# 4. WCHPP Impact and Lessons Learned

## 4.1 Impact

In the absence of 2007 data in the M&E matrix, slow implementation, and the limited and variable data from the districts, it is impossible to gauge any impact of the program. There are also few evaluative data in the six monthly progress reports and the MNCH strategies have not yet been evaluated for effectiveness. It is also difficult to separate out improvements in MNCH that are due to WCHPP and not the previous UNICEF programs. It is clear that impact can be increased through

harmonization with other initiatives about to be implemented in PP and WPP and through broadening the menu of MNCH related strategies offered by UNICEF.

## 4.2 Lessons Learned

The MTR team conducted a lessons learned exercise to maximize the chance to consult with a key stakeholder group convened to discuss the IMET findings. UNICEF and WCHPP staff from Jakarta and Jayapura, a MoH representative, representatives from the GTZ SISKES program and IMET and MTR pooled knowledge and field work findings to generate some lessons learned so far. The group brainstormed achievements of WCHPP, what worked well and why, what did not work well and why not, and generated lessons learned according to the program's design, implementation and management. The results of this exercise are documented in Annex 4. The exercise also allowed for determination of UNICEF's strengths and weaknesses and most of the findings reflect what has been reported in the issues section of this report.

**Table 4 UNICEF Strengths and Weaknesses**

| UNICEF Strengths | UNICEF Weaknesses |
|---|---|
| **Trusted, credible partner of GOI** | **Inflexible and slow staff recruitment practices and policies** |
| **Work through the GOI systems (MCSDP, DTPS, funding mechanism)** | **Management of program implementation in the field difficult, especially monitoring and evaluation and quality control** |
| **Integration of MNCH activities with broader PHC elements possible e.g. HIV/AIDS, water & sanitation, child protection** | **Limited strategic thinking to guide implementation; lack of strategy revision and adaptation** |
| **Good at testing new ideas** | **Limited critical reflection, and building and learning from the past** |
| **Access to UN 'family' and international best practice** | **Lack of replication strategy** |

## 4.3 Sustainability

The strategic importance of the WCHPP lies in its alignment with GOI policies, processes and funding mechanisms. Activities are implemented by DHO staff and UNICEF manages the inputs. Sustainability could be further enhanced through UNICEF assisting and integrating MNCH planning and implementation of all MNCH and UNICEF testing activities through the DHO annual workplan and M&E framework. Broadening the MNCH program and planning at health centre level to accommodate related PHC issues would also increase sustainability. For example, formalize the planning of DHO activities for families on malaria, water and sanitation, health education, integrated sexual and reproductive health (particularly HIV/AIDS and VCT, ART and PMTCT) could impact on maternal and child health. Integrating other UNICEF programs ('convergence'[22]) such as child protection, posyandu/kindergarten strategies and immunization would also increase UNICEF's potential for technical assistance and influence. This is also a program adjustment recommended in the UNICEF mid term review.

[22] UNICEF Indonesia 2006-2010 Country Action Plan, Mid Term Review Report, p.59

Training sustainability can be improved through the development of quality systems that can select, train, accredit and support trainees following training as well as provide ongoing supervision and audits.

The program has not been designed for sustainability. Given that this 3-year program is a continuation of MNCH projects in mainly the same location since 1998, the program should have demonstrated greater sustainability of its activities. WCHPP has not progressed gains made in IMHEI. It may be that WCHPP requires a longer timeframe than 3 years, to allow UNICEF to maintain staff stability that was not possible in short projects such as IMHEI and WCHPP.

***Recommendation: That a broad menu of UNICEF strategies (see Annex 6) be considered by DHO for inclusion into the DHO MNCH program of activities; and that UNICEF provide technical assistance with implementation of the broader strategies to enhance maternal and child health.***

## *4.4 Gender Analysis*

The program design called for a Gender and Poverty Study within the first two months with the intention of a gender strategy evolving from this study. While much good work has been achieved with the Gender Based Violence strategy and activities, there are many gender issues identified by the MTR and IMET, particularly at community level, which need to be addressed through WCHPP programming. Some of these will entail revision of existing MNCH strategies.

***Recommendation: That WCHPP management staff, in consultation with each DHO, build on the findings of the Gender and Poverty study and known gender issues, and develop a gender strategy to address MNCH gender issues relevant to each district.***

# 5. Future Directions

## *5.1 Current context for future MNCH programming*

Under decentralisation, district level governments are struggling to find, fund and successfully manage the human resources required to implement their mandate. Public awareness and participation in health issues remains poor and public demand for health sector improvements remains weak[23]. The changing context for implementation provides an opportunity for Australia to reconsider the way of working in PP and WPP to assist Indonesia to achieve MDGs. Opportunities for innovative partnerships are emerging:

- UNICEF has recently undergone a **Mid Term Review** and plans to adjust the Health and Nutrition program through increasing the focus on: capacity development at national and

[23] Australia Indonesia Partnership Country Strategy 2008-2013

district level; advocacy; community level convergence (integrating strategies under a PHC umbrella); and seek an increasing role as 'technical partner'.

- The **Australia Indonesia Partnership Country Strategy 2008-2013** aims to increase the impact of poverty-focused programs to improve health (and other sectors) services to the poor through focusing on a limited number of provinces, including Papua and West Papua, to promote synergies across activities such as better planning and administration, and improved services. Australia is also keen to use Indonesian processes and systems to better harmonise and coordinate activities.

- AusAID is about to embark on an innovative ten year program to develop partnerships with selected provinces and district governments to effectively manage resources to achieve MDG targets for maternal and child health. The Australian Indonesia Partnership in Maternal and Neonatal Health (**AIPMNH**) aims to gradually shift from supporting service delivery in the short term to improving mechanisms to strengthen health systems. Implementation under a Managing Contractor will begin soon in NTT with possible expansion to NTB and other provinces.

- The AusAID-funded **HIV Cooperation Program for Indonesia** (HCPI) focuses in Papua on capacity building of the Provincial and District AIDS commissions (KPAP and KPAD), increasing knowledge about HIV and promoting behaviour change in the general population, amongst young people and high risk groups (sex workers and mobile workers). Given the generalised HIV epidemic in Papua and the risk to women of reproductive age, alignment with this program to promote VCT and PMTCT activities is possible.

- The Papua Province **Governor's initiative** and support for multi-development partner engagement advocates that development partners support the provincial plans (including in the health sector) and focus efforts on strengthening health system management.

- The Ministry of Health is funding the '**Save Papua**' program (P2KTP) which provides mobile teams of health service providers (including midwives) to visit remote areas not currently served by health facilities. One objective of the program is to map these remote areas. In some areas, midwives are located temporarily to the remote area where pregnant women are waiting to deliver. MoH invites WCHPP to 'respond to the findings of Save Papua Programs'.

- GOI's '**New Deal Policy**' was introduced through Presidential Instruction 5/2007 and prioritises poverty alleviation, health, education, infrastructure and affirmative action for indigenous Papuans.

- World Bank, together with national organisations, PMD and Home Affairs are implementing the ***Respek*** strategic plan for village development to empower communities to plan and implement their priority development projects. Activities include training of facilitators

(UNDP), cadre trainers, technical experts; and block grants of Rp.100m per village for development work.

- Linked to Respek, the Papuan **Women's Empowerment Project** will begin in 2009 and will be a comprehensive program to support women's empowerment through increasing their participation in Respek. Activities, through Oxfam and women's organisations, will include support for strengthening Papuan women's organisations, training in leadership and advocacy, and working with local governments and PNPM-Respek implementation staff to promote gender equality. There are opportunities to harmonise MNCH initiatives with this program.

## *5.2 Possible program modalities for future MNCH programming*

The MTR team considered a variety of options for the way forward for MNCH programming in Papua and West Papua. Three management models were considered:

1. Status quo with UNICEF continuing to manage of the MNCH program of activities with increased focus on district level strengthening of planning and management of MNCH strategies.
2. MNCH activities managed by a Managing Contractor experienced in working in the Papuan context.
3. AusAID managed MNCH activities subcontracted to NGOs, agencies and consultants.

## *5.3 Preferred option*

The MTR team considers that AIPMNH offers a unique opportunity to operate all AusAID MNCH programs under the one umbrella and that consideration be given to realigning WCHPP with AIPMNH for a longer term program (say, 10 years). This means that implementation of outputs would be managed by AIPMNH and activities subcontracted to appropriate multilateral (including UNICEF), NGOs or other agencies (including the private sector such as mining companies where they have a health and community development focus).

Further, the MTR considers that the long partnership with the four districts in Papua and West Papua suggests that a district sector-wide approach (SWAp) could be trialed whereby districts are assisted to plan their MNCH program with technical assistance from AusAID and selected activities which cannot be funded through the APBD are funded directly through the Bappeda and DHO process. This would decrease the transaction cost now incurred by the districts of implementing and liquidating UNICEF planned activities; the newly designed program would be flexible enough to operate on one annual workplan and one M&E framework – that of the DHO.

## *5.4 Transition strategy – short term and long term*

In the light of the proposed preferred option for the future, the MTR team recommends that :

***Recommendation: In the short term Oct – Dec 2008:***

1. ***UNICEF immediately fill the vacancies of key positions i.e. Health Officer in Manokwari and Wamena;***

2. ***UNICEF be granted a six month extension (until December 2009) to consolidate work to date in the four focal districts, with the longer term view (after 2009) of the possibility of continuing implementation of selected MNCH strategies through a sub-contracting mechanism under AIPMNH;***

Note: In response to this recommendation, AusAID has said it is likely to agree to a 6-month extension subject to a satisfactory response from UNICEF on addressing the serious staffing issues; improving the M&E mechanism; providing a revised work plan and budget; and providing a comprehensive response to the report and AusAID's response. To date this does not appear to have been accomplished.

3. ***UNICEF be supported, through current WCHPP resources and within the next 3 months to:***

   ***a) evaluate MNCH strategies, particularly for appropriateness for the Papuan context, and to revise them accordingly for program work plan Jan-Dec 2009;***

   ***b) establish a Monitoring and Evaluation Framework in order to document and synthesise the program's lessons learned, success stories, challenges and the potential to achieve its outcomes.***

   ***The revised MNCH strategies and the M&E Framework will be subject for discussion and approval of AusAID before the implementation period January-December 2009.***

***Recommendation: In the medium and long term Jan-Dec 2009 and post Dec 2009***

4. ***AusAID consider a long term program commitment to MNCH in Papua and West Papua Provinces, and plan for a 5-10 year engagement;***

5. ***AusAID consider integrating management of a re-designed WCHPP into AusAID's innovative MNCH program – AIPMNH;***

6. ***To design broader AusAID's assistance for MNCH in Papua and West Papua, AusAID, through AIPMNH Managing Contractor (MC), contract a design team to design a MNCH program for Papua and West Papua - according to the current context and Provincial/District MNCH needs; integrated into the broad AIPMNH program; harmonised with current Papuan acceleration programs and other local government or other donors' poverty reduction initiatives in Papua and Papua; and engaging all sub-districts in the four focal districts as well as the option to expand to other districts (based on need and DHO readiness)***

7. ***Once the MC of AIPMNH is mobilized, AusAID and UNICEF identify technical assistance (TA) in district level health planning, financial management and implementation of MNCH strategies (possibly sub-contracted by the MC of AIPMNH) to be located in***

***WCHPP focal District Health Offices (Jayapura, Jayawijaya and Sorong) and in the West Papua Provincial Health Office.***

8. ***Following review of UNICEF strategies and the acceptance of the new program design, that AusAID consider subcontracting, through AIPMNH MC, implementation of selected MNCH strategies through UNICEF and other agencies according to their strengths, expertise and experience in working in the Papuan context.***

# 6. Conclusion

UNICEF has been operating at DHO and community levels of the health system for many years in Papua and is considered a trusted GOI partner; has capacity for technical assistance particularly with testing new MNCH strategies; can access to the 'UN family' and international best practice; and can offer the 'menu' of strategies available from their 8 program areas which could impact on MNCH in PP and WPP. AusAID should take the opportunity to maintain an ongoing role for UNICEF in MNCH programming in Papua.

The MTR team considers that although implementation pace of WCHPP is slow, staff recruitment is challenging and capacity of counterparts is variable, there are some positive developments with DHOs and signs that APBN funding for MNCH is slowly increasing in some districts. Training for midwives is well supported by WCHPP and can improve access to safe deliveries for pregnant women if: distribution of midwives and coverage can be improved; quality of the training can be systematically assessed; and community mobilization activities are stepped up and made more culturally appropriate. The midwife-TBA partnership is well accepted by communities and health centre staff (where midwives exist).

UNICEF-managed WCHPP has begun the process of support for the DHO and it is time to take that support to new levels with a stronger focus on assistance to DHO to plan and manage district their MNCH programs in the context of primary health care at health centre level; and to encourage increased investment by the districts to fund MNCH programs.

## *6.1 List of recommendations*

**Management**

That UNICEF renegotiate with AusAID the formula for allocation of funds for management support with the view to improving staffing at provincial and district levels and accelerating Program implementation.

That UNICEF review the staff recruitment process and consider:

- maintaining current salary levels but offering financial or in-kind incentives for remote living e.g.in Papua
- increasing support for district level staff e.g. appoint teams so they can support each other, ensure provision of vehicle, internet and administrative support

- consider recruiting district level staff from a lower level and build capacity and commitment on-the-job; and provide opportunities for professional development.

That UNICEF localise reporting to the Jayapura field office with Jakarta providing quality control.

That UNICEF urgently follow-through on the proposed realignment of planning cycles with GOI i.e. develop plans with DHO in February.

That WCHPP management staff, in consultation with each DHO, build on the findings of the Gender and Poverty study and known gender issues, and develop a gender strategy to address MNCH gender issues relevant to each district.

**Design**

That future design of Papua MNCH programs consider:

- Equal attention to the supply and demand issues of MNCH;
- Take into account the rapidly changing Papuan political, social and cultural context particularly harmonizing with programs to accelerate Papua;
- Consider locating the program in the poorer districts, and in all subdistricts of a district;
- Take full account of the assumptions and lessons learned from this MTR;

That AusAID consider providing support for the Papua midwifery education proposal for training nursing school graduates in D1 midwifery through the Papua Provincial Health Office and the Politeknik Kesehatan Jayapura.

That in future MNCH program designs, assistance for DHO to establish systems to ensure quality of training be a priority output.

That in the interests of increasing quantity and quality of midwives for MNCH , AusAID consider support for pre-service training for midwives within a comprehensive HR framework in future MNCH programs.

**Implementation**

That UNICEF evaluate and revise MNCH strategies implemented in Papua and West Papua with the view to adjusting them for the Papuan context; and develop a replication strategy to assist DHO to plan for replication of MNCH strategies.

That, to increase the pace of implementation, UNICEF consider contracting out some planned MNCH activities to NGOs or other agencies with experience in working in the Papuan context.

That increasing the poverty focus of WCHPP could allow for more attention to cost and accessibility barriers to midwifery care and enhance access to services by the poor through Jamkesmas.

That WCHPP / UNICEF assist DHO with planning of their MNCH activities, fund DHO planned activities and have one annual joint workplan per district to enable bundling of cash transfers into larger units.

That a broad menu of UNICEF strategies (see Annex 6) be considered by DHO for inclusion into the DHO MNCH program of activities; and that UNICEF provide technical assistance with implementation of the broader strategies to enhance maternal and child health.

**Future Directions**

*In the short term: Oct – Dec 2008:*

1. UNICEF immediately fill the vacancies of key positions i.e. Health Officer in Manokwari and Wamena;
2. UNICEF be granted a six month extension (until December 2009) to consolidate work to date in the four focal districts, with the longer term view (after 2009) of the possibility of continuing implementation of selected MNCH strategies through a sub-contracting mechanism under AIPMNH;
3. UNICEF be supported, through current WCHPP resources and within the next 3 months to:
   a) evaluate MNCH strategies, particularly for appropriateness for the Papuan context, and to revise them accordingly for program work plan Jan-Dec 2009;
   b) establish a Monitoring and Evaluation Framework in order to document and synthesise the program's lessons learned, success stories, challenges and the potential to achieve its outcomes.
   The revised MNCH strategies and the M&E Framework will be subject for discussion and approval of AusAID before the implementation period January-December 2009.

*In the medium and long term: Jan-Dec 2009 and post Dec 2009*

4. AusAID consider a long term program commitment to MNCH in Papua and West Papua Provinces, and plan for a 5-10 year engagement;
5. AusAID consider integrating management of a re-designed WCHPP into AusAID's innovative MNCH program – AIPMNH;
6. To design broader AusAID's assistance for MNCH in Papua and West Papua, AusAID, through AIPMNH MC, contract a design team to design a MNCH program for Papua and West Papua - according to the current context and Provincial/District MNCH needs; integrated into the broad AIPMNH program; harmonised with current Papuan acceleration programs and other local government or other donors' poverty reduction initiatives in Papua and Papua; and engaging all sub-districts in the four focal districts as well as the option to expand to other districts (based on need and DHO readiness)
7. Once the MC of AIPMNH is mobilized, AusAID and UNICEF identify technical assistance (TA) in district level health planning, financial management and implementation of MNCH strategies (possibly sub-contracted by the MC of AIPMNH) to be located in WCHPP focal

District Health Offices (Jayapura, Jayawijaya and Sorong) and in the West Papua Provincial Health Office.

8. Following review of UNICEF strategies and the acceptance of the new program design, that AusAID consider subcontracting, through AIPMNH MC, implementation of selected MNCH strategies through UNICEF and other agencies according to their strengths, expertise and experience in working in the Papuan context.