Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS)

Six Monthly Progress Report

December 2013

Australian Aid

Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) is managed by Coffey on behalf of Department of Foreign Affairs and Trade

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Abbreviations

ADINKES	Association of Heads of Department of Health
AIPHSS	Australia Indonesia Partnership for Health Systems Strengthening
APBD	District Government Budget
BPJS	Social Insurance Implementing Agency
BOK	Special Operational Funds
BUKD	Unit for Basic Health Services
CPMU	Central Program Management Unit
CSO	Civil Society Organisation
DFAT	Department of Foreign Affairs and Trade
DHA	District Health Account
DHO	District Health Offices
GoA	Government of Australia
GoI	Government of Indonesia
HPN	Health Policy Network
INA - CBG	Indonesia Case Based Groups
ISP	Implementing Service Provider
IU	Implementing Unit
JATIM	East Java
JKN	National Health Insurance Scheme
KEPMENKES	Decree of the Minister of Health
LITBANGKES	Directorate of Research and Development (Ministry of Health)
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NHA	National Health Account
NTT	East Nusa Tenggara
P2JK	Centre for Health Financing and Social Health Insurance, Ministry of Health
PERKA BKN	Decree of Head of State Personnel Agency

PHA	Provincial Health Account
PHC	Primary Health Care
PHO	Provincial Health Office
PIM	Program Implementation Manual
PME	Planning, Monitoring and Evaluation
PMU	Program Management Unit (generally refers to PMU staff at province and district level)
POSKESDES	Village Health Post
PPJK	Centre for Health Financing and Health Insurance
PPSDMK	Centre for Human Resource Development
PR	Principal Recipient
PSC	Program Steering Committee
PTS	Program Technical Specialist
Pusdiklatnekas	Education and Training Centre for Health Human Resources
Puskesmas	Primary Health Care Centre
PUSRENGUN	Centre for Planning and Utilization of Health
QMU	Queen Margaret University
RO REN	Ministry of Health, Bureau of Planning and Budgeting
SBD	Sumba Barat Daya
SOP	Standard Operating Procedure
SR	Sub-Recipient
SPM	Minimum Service Standards
SSR	Sub-sub-Recipient
ToR	Terms of Reference
TTU	Timor Tengah Utara
TWG	Technical Working Group
UHC	Universal Health Coverage
UI	University of Indonesia
UNU	United Nations University

Executive Summary

This report is the second progress report on the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) program and covers the period July to December 2013. The report describes the status of the AIPHSS program at conclusion of the first year, including a description of activity outputs at the national and sub national levels, progress towards intermediate outcomes, and recommendations for the following six months[1].

Implementation of AIPHSS activities has increased since the last six month report and nine new Tasking Notes have been implemented. The Tasking Notes have included large (scale and budget) activities from national level sub-recipient (SR) work plans.

All provincial and district level Program Management Unit (PMU) offices (eight district level and two provincial level) have been established and are operational. A total of 51 staff have been recruited (12 at the national level, including the CPMU and 39 at the province and district levels). Due to a freeze in further recruitment requested by the Health Section of the Department of Foreign Affairs and Trade (DFAT), the Implementing Services Provider (ISP) and Central Program Management Unit (CPMU) are reviewing the staff structure to improve efficiency. Some restructuring will be undertaken in the next reporting period. Both government partners have agreed that the Grant Agreement is no longer a viable fund channelling modality, consequently all funding will be managed by the ISP.

Component 1 strives to improve the use of evidence for policies that improves access to primary health care for the poor**.** Activities involve high level technical experts providing evidence-based advice to Ministry of Health (MoH). Key activities implemented under this component include:

- Support for the introduction of the national health insurance scheme;
  - Funding of a Technical Expert for the BPJS Secretariat;
  - 20 policy notes produced by the Technical Expert for the BPJS Secretariat;
  - Financial and administrative support to the BPJS Secretariat and related technical working groups which contribute to policy formulation for Jaminan Kesehatan Nasional (JKN) or Universal Health Coverage (UHC);
  - Recruitment of a technical consultant to provide high level advice to refine and improve the Indonesia Case Based Groups (INA CBGs) as a payment provider mechanism for hospitals for JKN;
  - Trained 1,609 staff from 336 public hospitals on INA CBG software as a provider payment system in readiness for JKN in 2014.
- Health Workforce Information System Plan
  - Recruited two consultants to undertake revisions of national guidelines and information systems. The two products will be finalised and submitted to PPSDM for formal approval in December 2013

[1] As this is the first year of implementation it is not possible to provide statistical data against intermediate outcome indicators, therefore progress towards likely achievements against intermediate outcomes are presented.

- Technical assistance for improved capacity in strategic planning and projections of the health workforce;
  - Recruited two international experts to work closely with the PPSDM to develop a long term capacity development program.
- Institutionalisation of National Health Account (NHA);
  - Funded one high level workshop to disseminate NHA accounts across the MoH.
- Support for the Health Sector Review (HSR):
  – Recruited seven (7) international and 12 national consultants to conduct analyses for 7 different Health Sector topics. AIPHSS is supporting the Ministry of Planning to provide one of the most comprehensive evidence based Health Sector Reviews to date. Recommendations from the Review will contribute to the next Five Year Medium Term Development Plan and used by the MoH to develop their Five Year Strategic Plan.

Component 2 activities address health financing, health workforce and regulatory reforms. The reforms being undertaken are through activities initially implemented at the national level, and to be piloted in AIPHSS districts in 2014. Activities have also commenced at the district and provincial levels. Key activities implemented under this component include:

- Institutionalisation of District Health Accounts (DHAs);
  – Technical assistance is provided by the Program Technical Specialist (PTS) to establish DHAs as a tool for evidence based planning in four districts in East Java (Jawa Timur / JATIM). Multi sectoral stakeholder workshops have resulted in formation of local DHA teams. The district teams will be trained to conduct analyses of the DHAs.
- Regulatory reform to support improved service delivery at the primary health care levels and readiness for JKN. The reforms will be presented to a high level inter-ministerial forum in March 2014 for approval;
  – The ISP has contracted five (5) expert teams to undertake re-drafting of fundamental health legislation and regulations under decentralisation which have created bottlenecks in protecting primary health care. The specific areas include (1) standardising competencies for heads of district health offices; (2) changing the legal status of health centres to report directly to district health offices (DHOs); (3) changing legislation that allows health centres to retain revenue; (4) changing the legal status of primary health care centres to become semi-autonomous units (5) review and revision of minimum service standards (see below).

Component 3 consists of activities that strive to ensure primary health care facilities have qualified and empowered staff to deliver high quality primary health care services. Activities approved and funded thus far are large scale and require time for completion. Sound partner management of these activities is expected to result in significant positive impacts on access, quality and governance of primary health services. Key activities implemented under this component include:

- Funding of a Distant Learning Education Program to upgrade to a Diploma III qualification for nurses and midwives in remote regions:
  – Preparation of 456 training modules to will be transferred to multi-media learning system;
  – Training of 30 tutors in program delivery;
  – Materials produced through AIPHSS have been used to roll out further distance learning programs in two other provinces.
- Reform of the Minimum Service Standards.

  - Support for four workshops to finalize a draft of the Minimum Service Standards which is now ready for expert review. The complex reform process required inter-ministerial coordination between the MoH and Ministry of Home Affairs (MoHA), which is responsible for Minimum Service Standards under decentralisation law. The draft reforms will be presented to an inter-ministerial board for approval in March 2014.

- Design of a program for Revitalization of Puskesmas (primary health care centres) for improved public health and prevention functions, and management of non-communicable diseases. This is closely related to the regulatory reform activities and will be piloted in AIPHSS districts in 2014
  - 10 draft terms of reference have been written, these will be used to prepare an implementation plan in the next reporting period.

Component 4: No activities have been implemented in this component. It is recommended that the partners formally resolve how this component will contribute to the program goals, and if necessary delete from the AIPHSS program. The Health Poly-Technical Colleges (Poltekkes) have had minimum involvement in the AIPHSS program thus far.

Component 5: This component was designed to engage strengthened health policy networks (HPNs) and civil society organisations (CSOs) in delivery of evidence for policy, and advocacy for policy reform. However, early 2013 the DFAT Health Section in Jakarta decided not to continue with the CSO work and focus more on strengthening health policy networks (HPN). An assessment of the research capacity of the HPN member institutions and their "Fit for Purpose" are currently being undertaking. All 18 member institutions were sent an email questionnaire and eight were visited for more in depth interviews and group discussions. Results will be delivered in early January 2104.

Technical direction for the AIPHSS program continues to be provided by the PTS who has been actively engaged at the senior policy level bringing to the attention of the Secretary General the potential gains that can be expected. The PTS has also been engaging with the highest level national MoH bureaucrats (Echelon 1) to foster ownership and engagement. He has visited the provinces and districts to advocate and socialise AIPHSS with local governors and has been successful in gaining political buy-in nearly all AIPHSS locations.

Day-to-day technical management of the program is provided by a small pool of consultants supporting the PTS. In 2014 there will be a marked increase in the number, frequency and technical diversity of activities. Consequently technical management and coordination will become increasingly complex. In anticipation of this enhanced complexity a new mechanism of bi weekly technical management meetings will commence in mid-January 2014.

A Monitoring and Evaluation (M&E) Plan describing the AIPHSS M&E system was submitted to DFAT July 2013, and the first Annual M&E Report submitted in October 2013. The M&E system is now established and all 20 M&E (PME) staff have been trained in the use of tools for data collection, reporting templates and reporting cycles. Operational support and management of PME staff during 2014 will focus on reporting of results and progress at output, outcome and impact levels.

Total program expenditure to the end of December 2013 was AUD 5,654,704 representing 18.7% of the total ISP budget of $29,958,961. Actual expenditure in the six month reporting period (including 1 milestone payment) was AUD 3,119,603. With the establishment of the provincial and district offices, disbursement to support activities at the subnational level commenced in November and to date two disbursements have provided a budget of AUD 165, 000. As expected, start-up, establishment and initial management costs early in the program comprise a significant proportion of overall expenditure. However, as the program progresses, a higher proportion of costs will be attributed to activity implementation, particularly in the provinces and districts.

Program risks are monitored on an ongoing basis with particular attention to risks which have a high possibility of impacting on partner relations and ultimately program implementation. The ISP has effectively managed and monitored some very large budget activities through the Tasking Note system. The ISP and CPMU have pro-actively informed DFAT of these risks for greater scrutiny and implementation negotiations. The full risk matrix is reviewed and presented as part of this report.

Lessons learned during the six month reporting period contributed to nine recommendations for consideration by the Technical Working Group and Program Steering Committee. It is recommended that:

1. A pre-Technical Working Group (TWG) is developed to facilitate TWG understanding of the technical direction of the program, identify which activities do not fit into the program objectives and recommend actions for the TWG. It would be led by the PTS and consist of a small number of technical experts to conduct rigorous technical analysis of work plans and ToR.
2. The guideline on vertical linkages of the TWG process written by the CPMU be formalised and integrated into the PIM.
3. Following the decision to cancel the Grant Agreement the ISP, CPMU and DFAT to urgently formalise new management and finance procedures at the national level and socialise these with the SRs.
4. The AIPHSS management team (CPMU, ISP, and DFAT) support the PTS to establish a mechanism for technical management.
5. AIPHSS management team to prepare a knowledge management plan in the next quarter.
6. DFAT to negotiate with Puslitbangkes to urgently provide the baseline data and provide a plan of action for data collection on a six monthly basis.
7. Undertake a review of the performance framework and make necessary adjustments.
8. Both partners to make serious efforts to understand the differing positions and perceptions and take actions to build trust and mutually support program management. This can be pursued through the development of a robust partnership agreement, to be pursued early 2014.

1 Introduction

The Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) is a Government of Indonesia (GOI) Program supported by the Australian Government Department of Foreign Affairs and Trade (DFAT). The partnership aims to strengthen key health system building blocks (health financing, health workforce, and service delivery) and improve the use of evidence in policy making. These system improvements will strengthen the quality of, and access to, primary health care services for the poor and near poor in five provinces of Indonesia and in the longer term contribute to improving the health status of poor people.

The AIPHSS management model represents a significant change in the way DFAT and the Ministry of Health (MoH) have previously worked together. The Partnership is funded by the Australian Government, but managed by a Central Program Management Unit (CPMU) which reports to the Director of the MoH Bureau of Planning and Budgeting (the Principal Recipient - PR), under the overall direction of the Secretary General of the MoH. The Partnership structure includes Sub-Recipients (SRs) (technical units within the MoH at the national level including: the Centre for Human Resource Development (PPSDMKK), the Centre for Health Financing and Social Health Insurance (P2JK), and the Unit for Basic Health Services (BUKD)), and Sub-Sub Recipients (SSRs) (the Provincial Health Offices (PHOs)), and Implementing Units (IUs) (District Health Offices (DHOs)), and functional sections of SRs responsible for discrete aspects of national level SR workplans.

AIPHSS has five components as shown in Table 1. Component 1 supports the increased use of evidence in policy formulation; Component 2 supports the improvements to the management of health workforce and health financing; Component 3 supports improved service delivery through Puskesmas and their networks; Component 4 supports accreditation of midwife and nurse Diploma 3 programs in health polytechnics, and Component 5 supports the Health Policy Network (HPN) and Research Institutes, and originally included Civil Society Organisations (CSOs). However support for CSOs was subsequently dropped from the AIPHSS in early 2013[2].

Table 1: AIPHSS Component Objectives

End of Program Outcome	Improved utilisation and improved quality of primary health care and appropriate referral to minimise mortality and morbidity amongst the poor and near poor, especially for women, children and infants. This is intended to contribute to achieving the health MDGs in 20 districts in five provinces
Component 1	The Ministry of Health uses evidence-based data to make national and sub-national level policy decisions on health financing and health human resources to improve access to and the quality of primary health care for the poor and the near poor.
Component 2	Health Offices in 20 districts in five provinces and at the national level implement health financing and human health resources policies and programs more effectively and efficiently to improve access to and the quality of primary health care for the poor and the near poor.

[2] Reference to CSOs in the component description has been maintained because there remains the possibility that one or more CSOs may participate in research activities in the future.

Component 3	Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in 20 districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary care services and referral for the poor and the near poor.
Component 4	The centre for Health Workforce Education and Training ensure that selected government health polytechnics run accredited nursing and midwifery study programs to produce qualified nurses and midwives.
Component 5	Universities, research institutes and CSOs are able to deliver evidence-based data, advocate for health financing and health workforce with the central and local policy-makers, and provide technical assistance and training to districts and Puskesmas to increase health access for the poor and the near-poor.

2 Implementation Progress

The second Six Month Progress report documents progress and performance for the most recent reporting period, July to December 2013. Reference is also made to overall progress since commencement on 26 November 2012, and identifies key issues to consider for the subsequent reporting period January to June 2014.

2.1 Impact and End-of-Program Indicators

The program will contribute to improved health status of poor people. Impact Indicators are:

- Prevalence of Diarrhoea for under 5 year reported diagnosed by a health professional at district level;
- Maternal mortality ratio at national level;
- Under 5 mortality rate;
- Infant mortality rate;
- Neonatal mortality rate.

The main Health Outcome will be improved utilisation and quality of primary health care and appropriate referral to minimise mortality and morbidity amongst the poor and near poor, especially for women, children and infants. This is intended to contribute to achieving the health MDGs in 20 districts in five provinces.

Outcome indicators are:

- Number of visits by poor and near poor people to the primary health care services; per 10,000 population,
- Percentage of children (12-23months) of poor and near poor receiving third DPT-HepB Immunisation,
- Percentage of facility-based deliveries of poor and near poor people,

- Number of maternal and neonatal cases with basic complications managed by Puskesmas PONED,
- Percentage of the population with hypertension diagnosed by a health professional, as a proportion of population with hypertension as a result of blood pressure measurement by Riskesdas enumerators.

These cannot be assessed in this report. Impact evaluations will be conducted for key health systems interventions which are in the early stages of implementation. External experts will be contracted to undertake these evaluations.

Note: in 2014 the implementation of the National Health Insurance program (JKN) may require AIPHSS to adjust work plans to meet the new policy and health systems context and the performance framework and relevance of indicators may need to be reviewed.

2.2 Intermediate Outcome and Output Indicators

As this is the first year of establishing the program and activities are in the early stage of implementation changes in intermediate outcomes are not expected at this stage. This report contains a description of activities currently being implemented and likely to contribute to intermediate outcomes.

The following sections report on achievements for each component. The current activity inputs indicate that most activities being implemented in the reporting period are likely to produce results which are required to meet the intermediate outcomes.

A number of inconsistencies in the program logic have been detected between activities, output and outcome indicators. There are two reasons for these - (1) some activities that are deemed important were included in AIPHSS without appropriate reference to the performance framework; and (2) there are some weak logical linkages in the performance framework which require adjustment.

Going forward, technical and management teams will need to ensure that the quality of outputs meet the required standards and the selection of activity inputs are aligned with the performance framework in order to achieve program goals and objectives.

Component 1 intermediate outcome indicator:

1.1 Proportion of high level national level policy documents and regulations related to access and quality of PHC for poor and near poor people using up-to-date evidence (such as National Health Accounts (NHA), Health workforce data etc) and evidence based policy briefs.

The main focus under this component has been to provide high quality technical assistance in health financing and human resources that will provide evidence based guidance and lead to strengthened policy and planning capacity of the MoH in preparation and management of JKN. This support has resulted in the provision of policy guidance, technical capacity development, technical tools, and evidence based policy documents to inform national level policy makers on access to health care for the poor. Specific support provided,

Strengthening Health Workforce

- Revising of national health workforce planning guidelines: These guidelines are enforced under regulations that require agreement across three different ministries. They inform hospitals and health centres nationally on how to calculate human resource needs.

- Updating the health workforce information system: Following from the above activity, information systems for managing national data is crucial for evidence based planning and policy formulation. The combination of the two activities will provide a much needed update to the national information and planning systems.

- National level capacity development in policy and planning: Senior officials in PPSDM have admitted that skills at the national level for planning and projection are poor, as is strategic management of human resources. The JKN reform will require the strong human resource policies and plan, and sound strategic management of human resources. The ISP has engaged international experts to provide long term technical support.

Strengthening Health Financing

- Technical support for provider payment systems INA CBGs[3]: This is fundamental to the success of the JKN scheme as it is the provider payment system for hospitals. The ISP, and DFAT officers, provided extensive support for through international technical assistance, capacity development, and socialisation of INA-CBGs.

- Socialisation and capacity building for the application of INA CBGs: The technical assistance provided for INA CBGs was consequently followed by a national socialisation and training of staff from 336 hospitals that will participate in the insurance scheme and provide health care for the poor.

- Policy options to include the poorest in the national health insurance scheme: The ISP supported an international workshop to explore options for the inclusion of the informal sector under the national health insurance scheme. This is the first time that such a meeting has been held in relation to the impacts of the JKN on the poorest and hardest to reach communities. The meeting led to policy options which are being considered by the BPJS.

- Provider payment systems for primary health care: Recent progress on capitation payment calculations was presented to key national and provincial level governments and health offices and variations between urban and rural expenditures[4] were explored. Further steps for continued refinement of capitation payments were identified.

  Capitation for primary health care: Capitation calculations will be required to set the basis for provider payments to Puskesmas under JKN. A workshop supported by the ISP in September established the initial base rates, however several important issues (such as funding, information systems and M&E) remain outstanding. An important finding during this workshop was that a phase-in strategy for 2014 has not been detailed.

[3] United Nations University (UNU) contract to develop INA-CBGs will not go ahead. A new phase of technical assistance is currently being planned by between DFAT and the MoH.

[4] These urban and rural variations are important for addressing equity differentials

Table 2: Progress towards Program Outputs and Outcomes for Component 1

Green=the activity is contributing satisfactorily to achievement of the target indicator
Amber=the activity behind schedule
Red= the activity is failing

Outcome Indicator 1.1 Proportion of high level national level policy documents and regulations related to access to and quality of PHC for poor and near poor people using up-to-date evidence (such as National Health Accounts (NHA), Health workforce data etc) and evidence based policy briefs.					
Output Indicator	Activity	Output	Outcome Indicator	Status	
1.1. Number of policy briefs produced as a result of AIPHSS activities.	<u>Health Workforce</u> Technical assistance for revision of workforce regulations across Ministries.	One guidelines and three new regulations (Kepmenkes 81/2004, Permendagri 12/2008, PermenPAN-RB 26/2011, Perka BKN 11/2011, and Permenkes)	1.1.	Completed	
	Technical assistance for Integrated model for workforce work force information system	Two technical guidelines (national level and district levels), one updated national database		Completed	
	International technical assistance for planning and projection methods Technical assistance for health workforce strategic planning	One technical proposal for 2014		Ongoing, the consultants will return in Jan 2014 to prepare a detailed design with partners	
	<u>Health Financing</u> Support for the introduction of the national health	20 policy notes	1.1.	Completed	

Outcome Indicator 1.1 Proportion of high level national level policy documents and regulations related to access to and quality of PHC for poor and near poor people using up-to-date evidence (such as National Health Accounts (NHA), Health workforce data etc) and evidence based policy briefs.					
Output Indicator	Activity	Output	Outcome Indicator	Status	
	insurance scheme				
	Administrative support to BPJS	Two Short Term administrative staff provided for working groups, meetings and workshops for the secretariat.(Implemented 26 meetings led by implemented)		Ongoing until end of March2014	
	1 senior technical adviser	Regular Technical inputs to vice minister, 20 ToRs for BPJS working groups (20 policy notes see above)		Will end in March 2014. A review of this input revealed that the TA in its current form is no longer required, however continued intermittent TA is required by the MoH for INA-CBGs, M&E and international level publications on JKN.	
1.2. Number of workshops, tools and products produced by the secretariat for the Social Insurance Implementing Agency	1 workshop for the Technical Calculation for Premiums	Technical tool for calculating premiums	1.1	Completed	
	1 workshop for the finalisation of the Methodology for Calculation of Premiums for non PBI			Completed	
	Mid-term review report on	1 report with recommendation for improving INA CBGs			

Outcome Indicator 1.1 Proportion of high level national level policy documents and regulations related to access to and quality of PHC for poor and near poor people using up-to-date evidence (such as National Health Accounts (NHA), Health workforce data etc) and evidence based policy briefs.					
Output Indicator	Activity	Output	Outcome Indicator	Status	
(BPJS) managed task forces.	the development of INA CBGs. 1 inter-ministerial workshop on international lessons on coverage of informal sector in universal health coverage. 2 workshops on capitation payment models. . Socialisation and training for INA CBGs	 Policy options for BPJS and MoH for extending coverage of the informal sector Capitation model for primary health care 1,609 hospital staff trained in the using Case Based Groups (INA CBG's) in preparation for the launching of JKN		Completed Completed Completed Completed	
1.3. Number of completed research studies funded by AIPHSS.	Technical assistance for a Health Sector Review	One consolidated report based on seven evidence based policy papers to inform the national midterm development plan	1.1	On-going , draft 1- mid Jan 2013, draft 2 end of Feb 2013, final draft May 2014	

Note: recommend that output indicator 1.1. be adjusted to include "regulations and guidelines "in order to capture the range of outputs under this component

Component 2 intermediate outcome indicators

2.1 Percentage of district government budget (APBD) allocated to health per capita.

2.2 Percentage of the district APBD health budget allocated to primary healthcare services.

2.3 Proportion of special operational funds (BOK), universal free delivery care for women (JAMPERSAL), Health Insurance for the poor and near poor (JAMKESMAS) and district APBD health allocation to Puskesmas disbursed to Puskesmas' by the end of each quarter

2.4 Quarterly realisation rate of BOK, JAMPERSAL, JAMKESMAS and district APBD budget allocated to primary healthcare services.

2.5 Per capita distribution of primary health care budget by the proportion poor and near poor by district and sub district

2.6 Percentage of vacant positions in primary healthcare facilities against primary health care standard for doctors, midwives, nurses and other health workers

2.7 Ratio of doctors, nurses and midwives in each sub district 'kecamatan' by the proportion of poor and near poor in the sub district.

There have been less activities under this component which is more focused at the provincial and district levels. The activities implemented are;

Health financing

- Evidence based planning: The district health accounts (DHAs) are in the early stage of establishment in 3 districts in JATIM. Analysis of DHAs is intended to improve evidence based resource allocation and planning. Local policy makers and program managers can use the evidence to advocate for increased funding for health and in particular primary health care.

Health Governance

- Revision of Minimum Standards: This is being implemented at the national level and will have an impact on the district levels. The Minimum Standards are an obligatory function of local governments against which their performance is measured and funding allocated. The current Standards do not provide adequate coverage of services and are not fit for the change in epidemiological transition in health. The revision being drafted will be presented to an inter-ministerial board for approval in March 2014, if approved they will have a national impact. The monitoring of regulatory reform needs to be clear due to the time lag for regulatory change to effect changes on the ground can take several years. The ADINKES reforms will be trialled in AIPHSS districts and provide the legal basis for the Puskemas Revitalisation activity.

Table 3: Progress towards Program Outputs and Outcomes for Component 2

Outcome Indicators

2.1. Percentage of district government budget (APBD) allocated to health per capita.
2.2. Percentage of the district APBD health budget allocated to primary healthcare services.
2.3. Proportion of special operational funds (BOK), universal free delivery care for women (JAMPERSAL), Health Insurance for the poor and near poor (JAMKESMAS) and district APBD health allocation to Puskesmas disbursed to Puskesmas' by the end of each quarter
2.4. Quarterly realisation rate of BOK, JAMPERSAL, JAMKESMAS and district APBD budget allocated to primary healthcare services.
2.5. Per capita distribution of primary health care budget by the proportion poor and near poor by district and sub district
2.6. Percentage of vacant positions in primary healthcare facilities against primary health care standard for doctors, midwives, nurses and other health workers
2.7. Ratio of doctors, nurses and midwives in each sub district 'kecamatan' by the proportion of poor and near poor in the sub district.

Output Indicator	Activity	Output	Outcome indicator	Status	
2.1 Number of AIPHSS provinces and districts which have made a legal basis for PHA/DHA	Institutionalisation of DHA in Sampamg, Bondowoso, Situbondo and Bangkalan	Four districts trained in DHA. Early drafts of DHA tables are in process.	2.1; 2.2; 2.3; 2.4; 2.5	On-going , PERDA requires further time to prepare and pass through local government	
2.2 Number of AIPHSS districts for which health workforce database updated within last 12 months in the PPSDMK database	Will commence in 2014				
2.3. Number of District Governments that have	Technical team contracted to	Four workshops to review minimum	2.1; 2.2; 2.5; 2.6; 2.7	On-going final revisions are	

Outcome Indicators

2.1. Percentage of district government budget (APBD) allocated to health per capita.
2.2. Percentage of the district APBD health budget allocated to primary healthcare services.
2.3. Proportion of special operational funds (BOK), universal free delivery care for women (JAMPERSAL), Health Insurance for the poor and near poor (JAMKESMAS) and district APBD health allocation to Puskesmas disbursed to Puskesmas' by the end of each quarter
2.4. Quarterly realisation rate of BOK, JAMPERSAL, JAMKESMAS and district APBD budget allocated to primary healthcare services.
2.5. Per capita distribution of primary health care budget by the proportion poor and near poor by district and sub district
2.6. Percentage of vacant positions in primary healthcare facilities against primary health care standard for doctors, midwives, nurses and other health workers
2.7. Ratio of doctors, nurses and midwives in each sub district 'kecamatan' by the proportion of poor and near poor in the sub district.

Output Indicator	Activity	Output	Outcome indicator	Status	
issued Perda based on Kepmenkes on minimum service standards (SPM) as the basis for budget allocation	draft minimum service standards at districts levels (ADINKES)	service standards at district, one draft version of minimum standards		being undertaken and the draft will be presented at an inter-ministerial board for approval in march 2014	
	Technical team contracted to undertake revision of legislation to place hospitals and Puskemas directly under the management of DHO.(ADNKES)	Four workshops one draft of new legislation	See notes below	As above	
	Technical team contracted to revise and develop new competencies to ensure that heads of Puskesmas and DHOs have appropriate technical and management skills in health	Five workshops, one draft set of competencies and related legislation .	See notes below	On-going final revisions and consultations are taking place, will be presented to the inter-ministerial board for approval in March 2014	

Notes: Both outcome and output indicators need to be reviewed in the Performance Framework. Currently they do not present a logical linkage from output to outcomes.

- Intermediate outcome indicator needs to be reviewed as 2014 should see commencement of the new national health insurance scheme, so JAMKESMAS, JAMPERSAL will not continue.
- The ADINKES regulatory reform if successful will produce significant outcomes, but current indicators and outcomes do not adequately capture the impact of regulatory reform. The performance framework will require adjustments

Component 3 intermediate outcome indicators

3.1 Percentage of out of pocket expenditure by poor and near poor individuals on health care.

3.2 Average length of service of Puskesmas doctors, midwives and nurses by the proportion of poor and near poor in the sub district.

3.3 Percentage of doctors, midwives and nurses at work during hours that they should be.

There have been few activities under this component which is at the province and district levels. Activities implemented are:

Health Governance:

- Revision of legal status of Primary Health Care Centres: Four forms of legal revisions are being undertaken which will have a wide impact on the health systems at the decentralised level. The reforms with provide the health centres with a legal basis to:
  - Retain revenue at the health centre. Currently any surplus revenue is appropriated by the local district government.
  - Allow health centres to be managed directly under district health offices as opposed to local government office which is the current status.
  - Allow health centres to become semi-autonomous so they are permitted to develop contracts with different payers, this is essential for the national health insurance scheme which requires health centres to be part of a network of service providers that can be contracted.
  - Produce a legally binding set of competencies as a recruitment basis for heads of district health offices. There is a current problem with heads being politically appointed without the skills to manage public health and policy programs.

Strengthening Health Financing:

- Establishing evidence based health financing: District Health Accounts will allow local policy makers and planners to better information and evidence about the health financing in their district. This information be used to advocate for increased funding for primary health care, increase efficiencies in resource allocation and asses equity problems in resource allocation.

Human Resources

- Improved quality of care in rural areas: Rural areas are particularly affected by lack of access to quality health care. Health staff are often unable to upgrade skills and knowledge required to provide the quality of care required to improve health outcomes. The PJJ distance learning program is a large scale intensive activity directly requested by the Minister of Health to address the problem of quality of care provided by nurses and midwives in rural areas starting in NTT. The PPSDM team implementing this have informed AIPHSS that inputs from this activity have been used for early stage roll out in Kalimantan Timur.

Table 4: Progress towards Program Outputs and Outcomes for Component 3

Outcome Indicators 3.1. Percentage of out of pocket expenditure by poor and near poor individuals on health care. 3.2. Average length of service of Puskesmas doctors, midwives and nurses by the proportion of poor and near poor in the sub district. 3.3. Percentage of doctors, midwives and nurses at work during hours that they should be.					
Output Indicator	Activity	Output	Outcome indicator	Status	
3.1. Number of Districts which have made a legal basis for retention of revenue by Puskesmas.	Technical team contracted to revise legislation of primary health care under decentralisation law	Four workshops and one draft legislation developed	See notes below	On-going, the final draft will be presented at an inter-ministerial board for approval in March 2014	
	Puskesmas revitalisation	Piloting of new regulation to test the effects of revenue retention	See notes below	In design, ToRs are being prepared for implementation	

Outcome Indicators 3.1. Percentage of out of pocket expenditure by poor and near poor individuals on health care. 3.2. Average length of service of Puskesmas doctors, midwives and nurses by the proportion of poor and near poor in the sub district. 3.3. Percentage of doctors, midwives and nurses at work during hours that they should be.				
Output Indicator	Activity	Output	Outcome indicator	Status
3.2. The number of health centre staff trained on administrative SOP for referral to Puskesmas PONED and other higher level facilities.	Will commence in 2014			
3.3. The number of Puskesmas staff who have attended distance education and training/ refresher courses on planning and budgeting or leadership and management.	Distance Education Upgrading Program (PJJ)	456 modules produced, 20 tutors trained, An online delivery system established, Tutor training packages prepared , Guidelines for instructional material, prepared Technical specifications for infrastructure prepared Guidelines for the recognition of prior learning produced	See notes below, potentially 3.2 and 3.3.	On-going the program will formally commence in 2014.

Note:

- It is recognised that that PJJ may fit more clearly under component 4, however the indicator for this is current placed in component 3. This should be reviewed and the performance framework adjusted accordingly.

- The regulatory revisions do not fit clearly under the indicators in this component however there is no other clear indicator under which to place some of the regulatory activities being undertaken. The performance framework should be revised to include the appropriate output and outcome indicators

- The Puskesmas revitalisation design needs to elaborate which specific indicators it will address, the activity will address both components 1,2 and 3 as it is a design that has an operational research component intended to provide evidence of impact on primary health care

Component 4 intermediate outcome indicators

4.1 Number of Poltekkes that have midwifery study programs accredited by BAN PT

4.2 Number of Poltekkes that have nursing study programs accredited by BAN PT

Component 4 Output Indicators

4.1 Number of Poltekkes in AIPHSS locations who have improved the standard of their libraries, academic services and student support in order to implement the D3 curriculum for midwifery and nursing.

4.2 Number of midwifery and nursing lecturers who have been trained in their study program, research and community service needed for accreditation.

Status - No activity to date.

The partners should reconsider the inclusion of this component as the Poltekkes have had very little involvement with AIPHSS and CPMU have informed the ISP that Poltekkes have substantial funds for regular activities and all Poltekkes activities appear to be regular activities that should be funded through the APBN. Initial discussions have taken place between the ISP, CPMU and DFAT and there is general consensus that the component should be reconsidered. This will be presented to the PSC in January 2014.

Component 5 intermediate outcome indicators

5.1 Number of independently commissioned publications, reviews, technical assistance, or advocacy activities delivered by the HPN

Two assessments have been undertaken to assess the level of support to be provided to the HPN in 2014.

- A baseline assessment has commenced which will examine the research capacity of the HPN member institutions to conduct health systems research.
- A review has been commissioned to provide independent advice to DFAT on whether the structure, participation, governance and focus areas of the HPN in Indonesia, are “fit for purpose” in terms of being suitable to best achieve the goals of the HPN and DFAT’s support for it. Findings from this review will be used by DFAT in deciding continued support to this existing network.

Table 5: Status and progress towards program Outcomes for Component 5

Outcome indicator 5.1. Number of independently commissioned publications, reviews, technical assistance, or advocacy activities delivered by the HPN				
Output Indicator	Activity	Output	Outcome indicator	Status
Number of studies conducted by HPN and research institutes related to health financing and health workforce	Health seeking behaviour study conducted by UGM Health expenditure tracking study UGM	One research report on health seeking behaviour One research report on health expenditure tracking	5.1.	Behind schedule Two reviews in relation to the HPN have been commenced but are not yet complete. Early results are deemed to be very poor quality , the UGM has been instructed to improve both reports

3 The Changing Context for AIPHSS

3.1 Political Context

The two main political events relevant to program implementation are the Indonesian Presidential elections in 2014 and the Australian federal parliamentary elections that were held in September 2013.

3.1.1 Indonesian National Elections in 2014

Presidential and national parliamentary elections will be held in May 2014. Senior policy makers are unlikely to make policy decisions in the lead up to the elections. However, all new ministers are required to submit Five Year Strategic Plans, and Medium Term Development Plans for their sector. This may result in changes in priorities and shifts in resource allocation. The ISP is continuing to support the MoH to ensure that current activities are completed.

3.1.2 Change of Government in Australia

The Liberal National Party now holds government in Australia after the elections in September 2013. A significant change in the international development assistance area was the absorption of AusAID into DFAT. This shift has led to internal uncertainties within the organisation. In addition, there has been a stronger alignment of the aid program to support economic growth, trade linkages and regional security.

3.2 Policy Context: Introduction of UHC

The Indonesian government will commence implementation of UHC from Jan 2014. This is a landmark reform which will have a substantial impact on the health system and policy context in which AIPHSS is operating. The attention of government partners will likely be focused on new priorities related to UHC, while implementation of AIPHSS activities may slow down or have reduced ownership by partners. Another potential outcome is that the AIPHSS may be requested to increase activities which focus on gaps and problems arising from the implementation of UHC. In this case the AIPHSS program will need to be poised for adaptive planning which may require reviews of work plans on a six monthly basis.

3.3 Program Context: Change of Funding Modalities

The MoH and DFAT have agreed that funding AIPHSS activities under a Grant Agreement is no longer feasible and all funding will be channelled through the ISP. This change has affected the roles and responsibilities of the CPMU, SRs, SSRs and the ISP. The changes require that the CPMU focus on planning and monitoring, coordination and administration between SRs and the sub-national partners. Separation of technical management (CPMU and DFAT) and funding/budget management responsibilities (ISP) is not a sound management structure. It is suggested that the ISP be involved to a much greater extent in technical management and decision making to ensure alignment of technical and budget expenditure functions.

Currently, funds are channelled through the ISP for provincial and district level activities. Bank accounts have been established by the PMU staff at each site, and managed by the PMU staff who have received training on the systems and processes for funding activities. However, in the absence of the Grant Agreement there is no funding mechanism at the central level except through the Tasking Note mechanism. This will increase the workload of the ISP enormously and has the potential to create a bottleneck in activities as they will all need to be processed through a system of requests through the CPMU, DFAT and subsequent issuing of a Tasking Note to the ISP. In addition, this system is not well understood at the central level and in November led to some confusion in funding a large socialisation activity.

The ISP will meet with the CPMU early 2014 to review this process and explore options to ensure that activities are not delayed. A program of socialisation at the central level will also be developed.

4 Stakeholder Engagement and Ownership for Program Sustainability

The primary stakeholders in the AIPHSS are defined as the:

- SRs and IUs at the national level;
- SSRs in provincial and district health offices;
- Senior policy makers at all levels.

In the 2013 Annual Monitoring and Evaluation (M&E) Report ownership was defined as:

1. Articulating a strategic vision for their technical component of AIPHSS;
2. Engaging actively in implementation and allocating sufficient resources to their management;
3. Giving due consideration to the sustainability or continuation of activities beyond AIPHSS support.

To date, no primary stakeholder has provided a strategic vision statement or document for their component of the AIPHSS program. Nonetheless all have participated in developing work plans and indicated which activities they are interested in implementing through AIPHSS. Some have prepared ToRs for initial activities. Whilst this does not demonstrate “strategic” vision it shows engagement and involvement in decision making as well as priority setting of activities. Considerable work remains to be done to ensure alignment of activities with program outcome objectives.

PPSDMK has been the most active and engaged SR, followed by P2JK which has an active relationship with the DFAT Senior Health Analyst. BUKD has had the weakest level of direct engagement. The PTS through the Puskesmas Revitalisation activity has had more interaction with senior managers from the MOH than either CPMU or DFAT.

Sub national partners are now more engaged as there are PMU teams in each locality. This is evident through the preparations for the local Technical Working Groups (TWGs) and planning the implementation of work plan activities.

Sustainability is more difficult to ensure but can be done through rigorous selection and preparation of activities, the quality of engagement by the partners and the alignment of the activities with the strategic priorities of each partner, and through cost sharing. For example through regular engagement with the ISP and DFAT it has been observed that the PPSDMK activities are aligned with

wider PPSDM policies and open statement by senior officials in PPSDM of the weak capacity in human resource planning and strategic management within PPSDMK.

Similarly the regular DFAT engagement and joint planning with P2JK has demonstrated that activities are fully aligned with their current priorities of institutional change related to the establishment of BPJS, implementing NHA, DHA and preparing for implementing UHC.

There are two areas of weaker engagement and ownership by MoH partners.

Firstly, the Bureau of Planning and Budgeting, (Roren) is both the PR also included in the program as an SR. However Roren has not demonstrated any engagement specific to the implementation of activities. Under Roren, the regulatory reform of the Minimum Service Standards is being undertaken by the Association of Heads of Department of Health (ADINKES. The CPMU and the ISP maintain the management relationship with the ADINKES.

Secondly, Component 5 currently only includes support for the HPN. The component is viewed by SRs and the sub national levels as something separate and not a component that they are engaged with. This may change once the current reviews of the HPN are finalised and specific research activities conducted by the HPN members commence. Following dissemination of the results of the HPN reviews a process for setting a research agenda will be developed which should involve consultation with the SRs and sub national partners.

5 Progress in Program Management

The second reporting period has seen continued progress in program management and implementation. Seven full time CPMU staff commenced in July 2013 with additional recruitment of 39 provincial and district PMU staff in August 2013. Two provincial and eight district AIPHSS offices were established in August and September 2013 in the respective government health offices.

The ISP and CPMU, SRs, and SSRs have worked closely to improve management and operational systems. The ISP and CPMU are managing an increasing number of activities and improving operational efficiency. The systems developed in the Program Implementation Manual (PIM) and supported by the ISP are in place and provide a framework for implementation, including planning cycles, development and review of the ToRs, a quality assurance process, financial management systems and monitoring and reporting of activities. The ISP and CPMU jointly oversee complex activities such as regulatory reform undertaken by ADINKES, and Distance Learning Education (PJJ) whilst providing DFAT with risk assessments, regular reporting and taking risk prevention measures.

The Program Technical Specialist (PTS) provides technical direction and valuable program linkages with senior policy makers. The PTS has five technical advisers to assist with daily technical management of the work plan activities at the national and sub national levels. The ISP has established a growing network of international and national technical consultants that provide technical assistance. In addition to increased engagement from senior level policy makers, the program has successfully supported design and preparations for implementation of the UHC scheme.

Importantly, lessons have emerged since the commencement of the program which will be used to strengthen program management, implementation and technical integrity to ensure that outputs lead to end of program outcomes. Changes that have occurred since the last reporting period are:

- The Grant Agreement at the central level will not go ahead, all activities (national and sub national levels) in the AIPHSS program will be funded through the ISP;

- A broader approach to the health system building blocks has been adopted to include explicit recognition that AIPHSS seeks to improve *service delivery* and that it will impact *governance* through reviews and revision of related regulation;
- Stronger engagement by the Secretary General (SecGen). All key decisions must be approved by the SecGen.

The CPMU has become more active in engagement with the district and provincial PMU teams. The support provided by the CPMU to the provincial and district PMU coordinators for the local Technical Working Groups (TWG) has demonstrated improved leadership and management support. However, the CPMU continues to rely heavily on the ISP to facilitate program implementation and remains overly focused on bureaucracy as a form of management.

Since the Grant Agreement has been cancelled the role and tasks for CPMU have become clearer. The CPMU can now focus on:

- Management of the work plan process;
- Reviewing work plan activities against APBN and APBD budgets;
- Reviewing all budgets, unit costs and negotiating revisions with SRs and sub national offices;
- Monitoring activity implementation;
- Managing all government related administrative and bureaucratic processes for AIPHSS;
- Reviewing and preparing budget disbursement for the ISP ;
- Preparing Program Management reports for DFAT, including expenditure reports and BAST reports for GoI.

Key achievements in program management in this reporting period

- Establishment of the CPMU team and PMU offices and mobilisation of teams at the SR level and in each provincial and district location;
- Completed PIM specifying all management procedures and tools;
- Sub national offices equipped and staff trained in all aspects of program management, finance management and M&E;
- Increased activity implementation at national and sub national levels
- Increased involvement from senior policy makers including the SecGen in the AIPHSS program, with the SecGen providing strategic guidance;
- Integration of the CPMU and ISP as one team;
- Draft SR and SSR Work Plans for 2014 completed.

Actions for the next reporting period

- On-going review and strengthening of Program management systems;
- Close monitoring of activity implementation through the M&E teams and reporting systems;
- Revision of the PIM to reflect the cancelled Grant Agreement and other updates since implementation;
- Review of the Annual Work Plans every six months to ensure that activities meet the program objectives and changes within the health policy and systems context;
- Strengthen national level (SR) activity planning and implementation procedures;

- Strengthen national level (SR) activity budget approval and accountability procedures.

5.1 ISP Support

The ISP continues to provide management and operational support including: procurement and management of technical assistance (TA), program communications, funds channelling for the provinces and districts, implementation of Tasking Notes for SR activities, and M&E.

Currently all activities at the national level must be implemented through Tasking Notes. This system will continue for all national level activities until the ISP is provided with a contract amendment. Activities at the sub national level do not require a tasking once the work plans have been approved by the TWG and PSC.

To date 34 activities specified in 21 Tasking Notes have been implemented. Nine new Tasking Notes have been implemented in this six month reporting period. These included large (scale and budget) initial activities in SR work plans. The activities range in complexity and almost all have related sub activities (meetings, workshops and trainings). In order to complete full specification of the activities additional technical support has been required for the development of the ToR and budgets. Since the commencement of the program, a total of 150 sub activities have been implemented, of which 70 sub activities have been implemented in the current reporting period (see Annex 1 Activity Report from the ISP Activity Database).

As noted above, the Grant Agreement will not proceed at national or sub national levels, therefore all activity funding is channelled through the ISP. As a response, the ISP has identified the need for additional resources under its management to ensure the quality of ToRs and budgets for SRs, provinces and districts. The ISP has indicated to DFAT that it considers staff numbers at district level to be excessive in certain categories (finance and M&E). District Partners could be encouraged to take greater responsibility for many of these functions (avoiding duplicate or parallel systems). However, technical resources, particularly at provincial level are minimal. A careful but thorough review of staff needs at all levels could produce a more streamlined, effective and efficient staff structure without increasing actual staff numbers.

Key achievements of the ISP in this reporting period are:

- Recruitment, contracting, induction and training of all AIPHSS PMU staff;
- Provision of support to the PMU to finalize the PIM;
- Refurbishment and equipping the CPMU and all sub national AIPHSS PMU offices;
- Contributing to the introduction and development of longer term capacity building program for PPSDMK in collaboration with the Queen Margaret University (QMU) in the UK;
- Supported revision of the PPSDMK Work Plan ;
- Development and application of a financial management system at the sub national levels;
- Facilitation of the implementation of priority activities at the national and sub national levels.

Actions for the next reporting period:

- Review and strengthen HR recruitment and management procedures.
- The ISP will work with DFAT and the MoH to provide greater support in technical management of the program in partnership with the CPMU and the PTS.

- Strengthen systematic quality assurance processes to ensure activities contribute directly to program objectives.

5.2 Progress at the Provincial and District Levels

The sub national offices have been established however some key appointments remain vacant namely, Coordinators (four) and Procurement and Finance Officers (five) (see Annex 2 for Staff Organogram). In November, the ISP underwent a third recruitment phase for the 11 remaining provincial and district vacant positions. DFAT advised the ISP that only the Coordinator positions can be filled. In addition, the ISP and CPMU have been informed that no further staff are to be recruited without a strong case and the current team configurations will need to adapt to manage the program implementation. This leaves key vacancies in Procurement and Finance Officers. ISP and CPMU have been advised to review the team structure and train up staff to perform at officer level. As noted above, the ISP and Coffey had already advised DFAT of the poor design of the district and provincial staff structures. Consequently the structure will be reviewed early 2014. Required changes will need to be socialised sensitively with the PMU teams and government partners at the sub national levels.

The ISP and CPMU conducted a seven day orientation and training in October for all PMU staff to ensure they understood the program objectives, management, operational systems, and roles and responsibilities. The training also involved government partners from each location and led to strengthening the relationships between the PMU teams and their government counterpart making sure that a participative approach to program planning and implementation was undertaken.

The program has progressed faster in JATIM where the PMU teams are more complete. In East Nusa Tenggara (NTT) Ngada has made the most progress and is in line with JATIM but the other districts in NTT have been slower due to the lack of district coordinators. There are only two staff members in Sumba Barat Daya and recent civil unrest has slowed down partner interaction and decision making. At provincial level in NTT has also experienced a very slow however the situation is slowly improving.

The key achievements at the sub national levels are:

- A decree (based on the Subsidiary Agreement) from each of the governors offices which provides a legal foundation for the AIPHSS in each locality;
- Endorsement of Partnership work plans with the local government partners;
- Development of local TWGs which are responsible for ensuring that AIPHSS work plan activities are aligned with local government and sectoral priorities;
- ToR preparation for initial activities;
- Implementation of initial activities in most districts in JATIM and Ngada in NTT. Activities being implemented are:
  - DHA has been planned and implemented in all districts of JATIM;
  - Proposal development for the referral system in preparation for JKN in Sampang and Bondowoso;
  - Socialisation of the transformation of current financing systems to JKN in Situbondo;

Actions for the next reporting period:

- Strengthening the management and operational systems of AIPHSS at the subnational level;
- Establishing the technical and policy linkages with the national and sub-national levels.

5.3 Technical Management

During this reporting period technical management of the program has emerged as a weakness and action is required to strengthen this in 2014 since there will be a significant increase in activity implementation. The PTS will remain focused on the higher level technical direction, however he will require day to day technical management of activities, such as reviewing of ToRs, reviewing outputs and technical information emerging from consultants and ensuring the technical coordination across components, SRs and sub national levels activities. To address this gap, fortnightly technical management meetings are planned, led by the PTS and supported by the ISP Manager and CPMU Coordinator.

To date, the AIPHSS TWG meetings have not provided an effective level of technical scrutiny of work plans and activities. However they have acted as a forum for political buy-in from key stakeholders. Some activities in the work plan do not fit with AIPHSS objectives. To rectify this, CPMU, PTS and DFAT will need to renegotiate activities with the SRs and sub national partners. Renegotiation is likely to create frustration. It is recommended that a smaller technical group i.e. pre-TWG, provide the detailed scrutiny of the work plan and activities and prepares a report for the wider TWG.

5.3.1 The role of the PTS

The PTS provides technical and strategic direction and undertakes regular analysis of the work plans, providing a strategic framework and linkages with senior policy makers in MoH. During this reporting period the PTS has continued to make assessments of the work plan activities submitted by the SRs and SSRs. Several work plan analysis meeting have taken place at the national and subnational levels which have resulted in improvements in the ToRs and filtering of activities. None-the-less, activities continue to be submitted that do not fit clearly fit with AIPHSS performance framework. The PTS has expressed difficulty in re-negotiating workplan activities with senior MoH staff. In addition, decisions to implement activities are sometimes made directly between DFAT and SRs which undermines the PTS.

Progress made by the PTS

- Building closer linkages with senior policy makers for AIPHSS;
- Rationalisation and providing coherence to the work plans
- Developing closer linkages with the sub national government partners and advocating for AIPHSS and health systems strengthening;
- Early stage development a flagship primary health care revitalisation and operational research project.

5.3.2 Role of the PTS technical consultants

The PTS is supported by four technical consultants whose role is to review activity ToRs, work plans, technical outputs and produce knowledge products such as policy briefs. Initially the advisers received little guidance from the PTS or CPMU management team which resulted in minimal impact from their inputs. However, as planning and implementation has increased at the sub national offices the advisers have provided support in negotiating activities, assistance in preparing the TWGs and reviewing ToRs. The advisers will also start to receive outputs from completed activities which they will be required to review in partnership with the clients.

5.3.3 Progress in Knowledge Management

There has been no progress in the development of a Knowledge Management Plan in the current reporting period. This has been discussed with the PTS who proposed the development of a Knowledge Management Framework which would identify and elaborate technical linkages across components to increase technical efficiencies. Activities to explicitly achieve this have not been identified although linkages already exist and can be made. For example the ADINKES supported regulatory reform[5] is linked to the Puskemas Revitalisation which can also inform the Health Sector Review to ensure they are included in the next Five Year Strategic Plan.

Improvements required for the next reporting period are:

- Fortnightly technical management meetings led by the PTS;
- Strengthen technical coordination with the SRs and the sub national levels;
- Partners to agree on a pre-TWG technical review of the workplans in preparation for the TWG;
- Develop a mechanism where lessons learned from consultants are reviewed and applied in continuous manner to strengthen the technical contribution of AIPHSS;
- PTS to lead development a Knowledge Management Plan for AIPHSS.

5.4 Monitoring and Evaluation

During this reporting period the M&E systems were established and the key achievements are:

- Collection of baseline data for the Performance Framework by the Directorate of Research and Development, MoH (Litbangkes) was progressed but remains incomplete[6];
- An activity tracking database was developed by the ISP and PME staff trained to manage the database;
- Quality control procedures, tools and instruments for M&E were developed in partnership by the ISP and CPMU[7];
- Submission of the AIPHSS M&E Plan and Annual Report.

When fully implemented the M&E system will involve each of the following levels of activity:

- **Activity and Output Monitoring:** This is the responsibility of PME officers at each level. This system needs much closer monitoring and proactive engagement from CPMU and PME teams to ensure data is collected in a timely manner;
- **Performance Framework Reporting**: Reporting against the Performance Framework (PF) is coordinated by Litbangkes. The mechanism of how Puslitbangkes will collect and report data against the PF is not clear. Further discussions are necessary to clarify the role of Litbangkes in M&E of AIPHSS;

[5] Uptake of regulatory reform can take up to two years therefore program monitoring needs to continue beyond the development of the product.
[6] The quality of this remains poor, the PTS has sent extensive feedback to Puslitbangkes to make improvements. At the time of this report, a revised report had not been received by the ISP.
[7] Further integration and application of quality assurance process in the next reporting period is essential

- **Selected High Level Impact Evaluations**. This is planned for some of the larger activities being undertaken by AIPHSS. Preparation for these will be undertaken in the next reporting period.

5.5 Program Communications

Program communications provide active promotion and information sharing about the AIPHSS program as wells the development of communications products and supporting district and provincial levels teams in program communications. The integration of AusAID into DFAT has meant changing the branding and publication guidelines. This process has affected the production of a number of publication materials which were delayed until the guideline was developed and shared by DFAT.

Key achievements in this reporting period are:

- **Communication Guidelines:** All PMU teams, in particular PMU coordinators, were provided with communication guidelines and protocol and informed of their role in contributing to AIPHSS Communications.
- **AIPHSS Video Graphic**[8]**:** A video graphic was produced. It is informative and popular, and presents easy-to-understand information for both technical and non-technical audiences. This video was launched by DFAT at the IAKMI National Conference in Kupang in September 2013.
- **Website www.aiphss.org** : PMU teams are actively contributing to communicating program progress by sending articles about their activities in the field as well as upcoming events. The website is proving to be a useful means of information sharing for AIPHSS and frequently accesses at the provincial and district level government offices[9].
- **AIPHSS Intranet**: This provides the program with a low-cost technology based management tool to share program information, management and operational tools, consultant reports, ToRs, templates, presentations and program related documents. The users of the intranet are all AIPHSS teams including ISP, PMUs and selected DFAT members as well as SecGen. It is hosted at www.aiphss.org and regularly updated by ISP.
- **AIPHSS Bulletin & E-newsletter:** The ISP regularly publishes bilingual Bulletin 'Kabar AIPHSS'. The content is based on inputs from PMU teams and DFAT and presents AIPHSS related information including program progress. The Bulletin is distributed to key stakeholders via PMU in printed form as well as an e-newsletter. Province and District teams have sent positive feedback and requested more printing (double the quantity). The Bulletin is also considered a favourite communication product in districts with limited access to internet like Sumba Barat Daya.
- **AIPHSS Brochure and other media**: A brochure for AIPHSS 2014 has been drafted with new content and branding and is waiting for DFAT/CPMU inputs to finalise it. Additional media such as calendars, book notes, paper folders were also produced to meet the publication demand from the PMU at each level.
- Relevant information was also channelled to media outlets to encourage public attention; the AIPHSS Program was also published through Bulletin and website of the Eastern Indonesia Forum (BaKTI).

[8] This video graphic is available online at the you tube and AIPHSS website (www.aiphss.org) and frequently played at the program related meeting/events.
[9] A number of District Health offices at the district in NTT, such as Ngada with limited internet access, have been using AIPHSS website as a reference to update them about AIPHSS program

- Improvements required for the next reporting period are:
  - Updates from the field: PMU coordinators need more support to improve their writing and information sharing skills.
  - A Knowledge Management Plan is urgently needed to link program communications and knowledge sharing (program stories, best practices/lesson learnt, policy exchange forums, partnership forums, publications of policy briefs and other technical briefs).

6 Progress in Budget Disbursement and Expenditure

All expenditure in Year One has been channelled through the ISP (see Annex 3 for full financial breakdown). The following section is based on ISP expenditure records. Total program expenditure July - December 2013 was AUD3,119,603 representing 10.41% of the total ISP budget of $29,958,961. Expenditure was in line with budget forecasts and was adjusted monthly in accordance with activity implementation to provide DFAT an accurate up-to-date estimation of expenditure requirements in a very dynamic funding environment. For example, the ISP was only provided with a lead time of approximately one week before it was required to fund the CBG Socialisation, a group of activities that required approximately AUD900,000. Note that only one payment milestone has been submitted for the previous six months (the Annual M&E Report, with the invoice submitted December 2013).

Table 6: Expenditure Summary July – December 2013

Description	Actual July - December
Milestone payments	171,904
Reimbursable payments	
Long term adviser cost	421,069
Short term adviser costs	10,048
Additional - Personnel	12,649
Additional - non personnel	2,503,932
TOTAL	**3,119,603**

Table 7 below presents the expenditure against component for Year One of program implantation (November 2012 – November 2013). Program management costs as a percentage of total

expenditure are high but this is partly related to AIPHSS start-up, early recruitment activities and program establishment costs (including ISP opening and provincial/district office refurbishments and equipping) and a low level of activity implementation in the other components. With implementation of subnational activities commencing in November 2013, and implementation of other AIPHSS activities in the near future the proportion of the total expenditure represented by program management will decrease substantially.

Table 7: 12 month Expenditure by Component November 2012 – November 2013

Component	Expenditure AUD
Component 1	477,217
Component 2	408,781
Component 3	278,591
Component 4	
Component 5	35,265
Program Management	2,213,040
Total	3,661,008

7 Cross Cutting Issues

7.1 Gender and Social Inclusion

During the PMU Orientation week in August 2013, all central, provincial and district teams received compulsory training on gender and social inclusion, HIV awareness and DFAT's child protection policies. The ISP has undertaken police checks on all staff to ensure staff have clean criminal records. Nothing has been reported to the ISP.

At the program management level there have been no further changes in the PMU staffing levels since the M&E annual report in October 2013. Of those so far appointed, 34% are women (M=33, F=17). Only 13% of central level staff are women (M=7, F=1), in East Java 34% are women (M=19, F=9) and in NTT 50% are women (M=7, F=7). Women generally occupy more junior level positions, 68% of staff level positions (M=6, F= 13) are women compared to only 8% of technical / officer level positions (M=22, F= 2) and 29% of coordinator level positions (M=5, F= 2). Interestingly, women are more strongly represented in Finance and Procurement positions (43%) (M=12, F= 9) compared to 27% of PME positions (M=16, F=6).

7.2 Partnership

During this reporting period the partnership has seen further tensions developing between Roren/CPMU and DFAT. This appears to be due differing perceptions on performance, efficiencies and role. These perceptions have led to a sense of mistrust which is a high risk for the program. The ISP has been able to mediate on several occasions but there is clearly a need for further partnership building between partners.

In light of the mutually recognised need for partnership improvement, the ISP project manager, CPMU coordinator and two representatives from DFAT attended a two day training session on “Partnership Training: making partnerships work”. The workshop highlighted the benefits of working through a true partnership and at completion of the training all participants agreed that there was much scope for improvement in the partnership approach for AIPHSS. As a result, management representatives from the three partners confirmed a commitment to working toward establishing a Partnership Agreement in 2014. This will be most relevant after the AIPHSS Review in early 2014 to include any recommended changes the program may receive.

7.3 Sustainability

The sustainability of AIPHSS has several dimensions. These are:

- the degree of ownership and participation by the SRs, senior policy makers at the national and sub national levels;
- alignment with government priorities;
- the technical quality and relevance of outputs from activities. It is also essential that outputs are produced at a rate of practical absorption;
- the quality of technical management that guides outputs towards policy process and uptake;
- quality of evidence produced by AIPHSS that can provide the government with evidenced based solutions for improving the equity in health financing;
- improved strategic planning in human resources and availability of human resources for the poor and improved primary health care services.

A key element to all dimensions is working within the government systems to ensure relevance and appropriate change. All aspects required to achieve sustainability are in place but need to be continually assessed and improved.

8 Risk Management

The ISP monitors risks on a daily basis and has been proactive in minimising risks to DFAT and GoI partners. In the last six months, the ISP has been tasked to undertake large and more complex activities (for example: PJJ, ADINKES, Health Sector Review (HSR), and negotiations of the United Nations University contract). For all activities, the ISP reviews and scrutinises ToRs and activity budgets in detail to ensure there are no errors or over calculation in budgets. In addition, the ISPs working relationship with the CPMU has been clarified and the CPMU Procurement and Finance Officer is now taking a more proactive role in reviewing ToRs and budgets. However, in the absence of the Grant Agreement, the ISP has been required to take on a larger role in review and monitoring of activity implementation, which is very resource intensive task.

During this reporting period the CPMU has shown increasing leadership particularly since the appointment of permanent staff to the CPMU and establishment of the Provincial and District offices.

Since the Grant Agreement is no longer continuing there is now a lack of clarity on the processes of how workplan activities will be funded at the national level. Tasking Notes are the only channel remaining for the partnership to fund SR activities. This risks creating a bottleneck as each activity will require a tasking note to release funds. The ISP, CPMU and DFAT will review the process for 2014 to identify a more efficient system of operation in light of the anticipated escalation of activity implementation.

The ISP also committed a significant effort to ensure the provincial staff were trained on risk process for all elements of the program implementation (financial, M&E as well as overall management). During the AIPHSS Orientation week a comprehensive session in fraud management was presented which included discussions with the DFAT Risk and Fraud Management specialist.

The full risk matrix for the AIPHSS is presented in Annex 4.

9 Summary of Lessons Learned and Recommendations for the Next Reporting Period

9.1 Governance

Lesson 1: The national TWG has not provided the required level of technical scrutiny of activities and unlikely to do so in its current format.

Recommendation 1: develop a pre TWG group consisting of a small number of technical experts that conduct rigorous technical analysis of the work plans and ToRs, and produce a brief report for the national TWG. The report will assist the TWG to understand the technical direction of the program, likely impacts and possible evidence that will be produced, and which activities do not fit into the program objectives and recommend actions. The pre-TWG will also recommend decisions required from the TWG members.

Lesson 2: The TWG at the sub national levels are in the early stage of development and may not align with the program priorities or provide the vertical linkages with provincial and national levels risking fragmentation.

Recommendation 2: The CPMU at the national level has been providing good guidance to sub national PMU. The CPMU should produce a written guideline on how vertical linkages can be achieved through the TWG process which should be formalised and integrated into the PIM.

9.2 Program Management

Lesson 3: The cancelation of the Grant Agreement has led to gaps in clear procedures for the management and funding of activities at the national level. This has already led to miscommunications and tensions between partners.

Recommendation 3: The ISP, CPMU and DFAT urgently formalise new management and finance procedures and socialise these with the SRs.

9.3 Technical Management

Lesson 4: The day-to-day management and oversight of technical activities has emerged as a gap which cannot be filled by the PTS. The ISP is in a good position to provide this support in partnership with the CPMU, under the guidance of the PTS.

Recommendation 4: The AIPHSS management team support the PTS to establish a mechanism for technical management

Lesson 5: The Knowledge Management of the AIPHSS program has not progressed.

Recommendation 5: AIPHSS management team to prepare a Knowledge Management Plan in the next quarter.

9.4 Monitoring and Evaluation

Lesson 6: The quality of the baseline report from Puslitbangkes is very poor and needs improving. This now an urgent issue for AIPHSS as activities have already started and AIPHSS does not have baseline data.

Recommendation 6: DFAT to negotiate with Puslitbangkes to urgently provide the baseline data and provide a plan of action for data collection on a six monthly basis.

Lesson 7: There are a number of inconsistencies between some Performance Framework indicators and some activities.

Recommendation 7: Undertake a review of the Performance Framework and make necessary adjustments.

9.5 Partnership

Lesson 8: The tension between the partners can be disruptive to program progress and lead to mistrust. This poses a risk to the overall program and relations between DFAT and MoH which may have wider impacts beyond the AIPHSS and affect other health programs.

Recommendation 8: Both partners to make serious efforts to understand the differing positions and perceptions and take actions to build trust and mutually support program management. This can be pursued through the development of a robust partnership agreement, to be pursued early 2014.

9.6 Priorities for the next reporting period

- AIPHSS launching in January 2014
- Finalise provincial and district work plans and present to the TWG and PSC
- Establish a technical management mechanism

- Conduct re-structuring of PMU staff at the national level
- Develop a knowledge management plan
- Finalise the Puskesmas revitalisation design

Annex 1

AIPHSS Activity Report from ISP Activity Database

LIST OF AIPHSS ACTIVITIES

PERIOD: 1 JULY 2013 - 31 DECEMBER 2013

NUMBER	TITLE	STATUS	COMPONENT	START DATE	FINISH DATE
401	Health Account Development				
40101	DHA Module Revision	Completed	2.1	7/11/2013	8/11/2013
502	Provider Payment Tracking (Capitation)				
50201	Preparation of Health Facility Rate Workshop	In Preparation	1.1	20/09/2013	20/09/2013
601	Revision of PP 38 and Permenkes 922 th 2008 Health Sector Decentralization Regulation - TA Team 1				
60104	Development of Framework of Annexes PP No. 38 / 2007	In Progress	2.1	1/07/2013	31/10/2013
60105	Final Discussion for Revision of PP 38 th 2008; Kepmenkes 922 th 2008	In Progress	2.2	1/11/2013	30/11/2013
602	Revision of PP 41 and Permenkes 267 / 2008 Technical Guideline for Establishment of Local Health Office - TA Team 2				
60203	Final Discussion for Revision of PP 41 th 2007	In Progress	2	1/11/2013	30/11/2013
603	Revision of Permenkes 741 th 2008; Kepmenkes 828 th 2008; Kepmenkes 317 th 2009 regarding Health Sector Minimum Service Standard (SPM) - TA Team 3				
60303	Final Discussion for Revision of Permenkes no 741 th 2008; Kepmenkes 828 th 2008; Kepemenkes 317 th 2009	In Progress	2	1/11/2013	30/11/2013
604	Development of Standard Competency for Local Health Officer - TA Team 4				
60403	Piloting Tools Need Assessment Local Health Officers	In Progress	2.2	1/09/2013	30/09/2013
60404	Development of Standard Competency for Local Health Officer	In Progress	2.2	1/10/2013	30/11/2013
60405	Development of Training Module for Local Health Officers	In Progress	2.2	1/11/2013	31/12/2013
605	Puskesmas Revitalization and Strengthening through Program Integration - TA Team 5				
60507	Piloting Tools Need Assessment for Puskesmas Strengthening	In Progress	3.4	1/09/2013	30/09/2013
60508	Development of Guideline for Puskesmas Strengthening through Program Integration	In Progress	3.4	1/10/2013	30/11/2013
60509	Development of Module and Training for Puskesmas Strengthening	In Progress	3.4	1/11/2013	31/12/2013
701	Long Distance Study Program (PJJ) - Planning				
70103	Guidelines Preparation for Long Distance Learning for Nursing and Midwive (Part of TOR 2)	Completed	3.4	27/07/2013	29/07/2013
702	Long Distance Study Program (PJJ) - Support for Development				
70229	Preparation of Multimedia Materials for Distance Education in Nursing and Midwifery D3	In Progress	3.4	7/07/2013	31/08/2013
70230	Development of Infrastructure for Distance Education	In Progress	3.4	1/08/2013	30/09/2013
70231	Workshop on management and administration of distance education	In Progress	3.4	12/12/2013	14/12/2013
70228	Production and Digitalisation of Modules (Part of TOR 7)	In Progress	3.4	20/07/2013	30/09/2013
70211	Preparation of Teaching Materials Module - RAB#7	Completed	3.4	18/07/2013	20/07/2013
70232	Training for Distance Education Tutors	Completed	3.4	16/07/2013	5/10/2013
70233	Training for Learning Assistant Officers	Completed	3.4	8/07/2013	25/10/2013
702	Long Distance Study Program (PJJ) - Support for Development				
70212	Training for Tutor of Long Distance Learning for Nurses and Midwives Phase II-RAB#11	Completed	3.4	4/09/2013	7/09/2013
70208	Coordination Meeting for Preparation PJJ-RAB#4	Completed	3.4	8/07/2013	10/07/2013
70209	Preparation of Training Curriculum for Support Officer -RAB#12	Completed	3.4	8/07/2013	11/07/2013
70210	Training for Tutor - RAB#1	Completed	3.4	16/07/2013	19/07/2013
70213	Training for Tutor- Finalization of Curriculum and Modules RAB#11	Completed	3.4	9/09/2013	11/09/2013
70214	Preparation of Guidelines for the Curriculum Implementation RAB#6	Completed	3.4	10/09/2013	12/09/2013
70215	Curriculum and Module Preparation for Learning Support Services phase II-RAB#12	Completed	3.4	12/09/2013	15/09/2013
70216	Preparation of Training Workshop- RAB#12	Completed	3.4	16/09/2013	18/09/2013
70217	Preparation of Guidelines for the Curriculum Implementation Draft 2 - RAB#6	Completed	3.4	16/09/2013	18/09/2013
70218	Training for Tutor Group 1-RAB#11	Completed	3.4	22/09/2013	28/09/2013
70219	Training support services finalization curriculum and modules-RAB#12	Completed	3.4	23/09/2013	23/09/2013
70220	Training for Tutor Group 2- RAB#11	Completed	3.4	29/09/2013	5/10/2013
70221	Development for Recognition Prior Learning - RAB#5	Completed	3.4	1/10/2013	3/10/2013
70222	Training for Learning Assistant Group 1- RAB#12	Completed	3.4	6/10/2013	11/10/2013
70223	Training for Learning Assistant Group 2- RAB#12	Completed	3.4	20/10/2013	25/10/2013
70224	Development for Recognition Prior Learning RAB#2 - RAB#5	Completed	3.4	14/11/2013	16/11/2013
70225	Sounding Curriculum Implementation Long Distance Learning	Completed	3.4	21/11/2013	23/11/2013
70226	Sounding Recognition Prior Learning Long Distance Learning	Completed	3.4	28/11/2013	30/11/2013
801	Support Pusrengun Health Workforce Strategic Plan (SDMK 2015-2019)				
80102	Two international consultants to participate in National Health Workforce meeting	In Progress	2.2	21/10/2013	26/10/2013
80105	Health Workforce and Health Systems IT Adviser	In Progress	2.2	3/07/2013	3/12/2013
1002	IAKMI National Congress				
100201	Support for provision of a booth and publications	In Progress	1.1	5/09/2013	7/09/2013
1002	IAKMI National Forum IV				
100201	IAKMI National Forum IV at Kupang, NTT	Completed	6	4/09/2013	7/09/2013
1101	Support to BPJS Secretariat (Activities)				

LIST OF AIPHSS ACTIVITIES

PERIOD: 1 JULY 2013 - 31 DECEMBER 2013

NUMBER	TITLE	STATUS	COMPONENT	START DATE	FINISH DATE
110136	BPJS Technical Calculation for Premi PBI Meeting	Completed	1.1	16/07/2013	16/07/2013
110140	BPJS Discussion about Non PBI Premi for worker (Private)	Completed	1.1	1/08/2013	1/08/2013
110145	BPJS Discussion about Action Plan Finalization 2nd Meeting	Completed	1.1	6/09/2013	6/09/2013
110147	BPJS Discussion about Action Plan Finalization 3rd Meeting	Completed	1.1	13/09/2013	13/09/2013
110135	BPJS Taskforce Coordination Meeting	Completed	1.1	10/07/2013	10/07/2013
110137	BPJS Taskforce Coordination Meeting	Completed	1.1	17/07/2013	17/07/2013
110138	BPJS Taskforce Coordination Meeting	Completed	1.1	24/07/2013	24/07/2013
110139	BPJS Taskforce Coordination Meeting	Completed	1.1	31/07/2013	31/07/2013
110141	BPJS CBGs Meeting with Rick Marshall	Completed	1.1	19/08/2013	19/08/2013
110142	BPJS CBGs Meeting with Rick Marshall	Completed	1.1	23/08/2013	23/08/2013
110143	BPJS Taskforce Coordination Meeting	Completed	1.1	28/08/2013	28/08/2013
110144	BPJS Taskforce Meeting	Completed	1.1	4/09/2013	4/09/2013
110146	BPJS Taskforce Meeting	Completed	1.1	11/09/2013	11/09/2013
110148	BPJS Taskforce Meeting	Completed	1.1	18/09/2013	18/09/2013
110149	BPJS Action Plan in Taskforce by UKP4 Meeting	Completed	1.1	25/09/2013	25/09/2013
110150	BPJS INA CBGs Meeting	Completed	1.1	25/09/2013	25/09/2013
110151	BPJS Taskforce Meeting	Completed	1.1	2/10/2013	2/10/2013
110152	BPJS Taskforce Meeting	Completed	1.1	4/10/2013	4/10/2013
1101	Support to BPJS Secretariat (Activities)				
110153	BPJS Meeting Preparation Presentation Minister of Health to Vice President	Completed	1.1	11/10/2013	11/10/2013
110154	BPJS Taskforce Coordination Meeting	Completed	1.1	16/10/2013	16/10/2013
110155	BPJS Team of Simulation Preparation Meeting	Completed	1.1	16/10/2013	16/10/2013
110156	BPJS Finalization INA CBGs Tariff Meeting	Completed	1.1	22/10/2013	22/10/2013
110157	BPJS Taskforce Coordination Meeting	Completed	1.1	23/10/2013	23/10/2013
110158	BPJS Finalization INA CBGs Tariff Meeting Part-2	Completed	1.1	25/10/2013	25/10/2013
110159	BPJS Taskforce Coordination Meeting	Completed	1.1	30/10/2013	30/10/2013
110160	BPJS Finalization Premi Capitation Meeting	Completed	1.1	31/10/2013	31/10/2013
110161	BPJS Taskforce Coordination Meeting	Completed	1.1	6/11/2013	6/11/2013
110162	BPJS Setgab Meeting	Completed	1.1	6/11/2013	6/11/2013
110163	BPJS Taskforce Coordination Meeting	Completed	1.1	13/11/2013	13/11/2013
110164	BPJS Taskforce Coordination Meeting	Completed	1.1	20/11/2013	20/11/2013
110165	BPJS Taskforce Coordination Meeting	Completed	1.1	27/11/2013	27/11/2013
1102	Support to High Level Forum on Extending Coverage to Achieve Universal Health Coverage				
110201	Support to High Level Forum on Extending Coverage to Achieve Universal Health Coverage	Completed	2.1	9/09/2013	2/10/2013
1405	Refurbishment of AIPHSS PMU Office Provinces and Districts (Equipment)				
140501	Refurbishment of AIPHSS PMU Office Provinces and Districts	In Progress	6	26/07/2013	31/08/2013
1406	Support to CPMU Program Management				
140605	Coutessy Call / Audience Meeting to Province and Districts by PMU and AusAID	Completed	6	15/07/2013	20/07/2013
140606	Coutessy Call / Audience Meeting to Province and Districts by PMU and AusAID	Completed	6	6/10/2013	17/10/2013
1407	Refurbishment of AIPHSS PMU Office (PHO and DHO)				
140704	Renovation of District PMU Offices - Kab. Flores Timur	Completed	6	11/09/2013	18/10/2013
140701	Renovation of Provincial and District PMU Offices - Jatim	Completed	6	12/08/2013	23/10/2013
140702	Renovation of District PMU Offices - Kab. TTU	Completed	6	2/09/2013	3/10/2013
1407	Refurbishment of AIPHSS PMU Office (PHO and DHO)				
140703	Renovation of District PMU Offices - Kab. SBD	Completed	6	6/09/2013	12/12/2013
140705	Renovation of District PMU Offices - Kab. Ngada	Completed	6	13/09/2013	18/10/2013
140706	Renovation of District PMU Offices Phase II - Kab. Sampang	Completed	6	3/10/2013	4/11/2013
140707	Renovation of Provincial PMU Office - NTT	Completed	6	20/11/2013	20/12/2013
1408	Support to PMU Program Management - Recruitment				
140807	AIPHSS Interview Recruitment for PMU Provincial level-East Java	Completed	6	1/07/2013	3/07/2013
140808	AIPHSS PMU Staff Orientation 2013	Completed	6	25/08/2013	31/08/2013
140808	AIPHSS PMU Staff Orientation 2 - 2013	Completed	6	29/09/2013	6/10/2013
140809	AIPHSS Interview Recruitment for PMU Provincial level-East Java	Completed	6	6/11/2013	8/11/2013
140810	AIPHSS Interview Recruitment for PMU Provincial level-NTT	Completed	6	10/11/2013	13/11/2013
1501	AIPHSS Coordination Meetings				
150103	AIPHSS Coordination Meeting for Implementation Program	Completed	6	31/07/2013	1/08/2013
1701	Technical Monitoring of the Implementation of National Health Insurance				
170101	Development of an Instrument and Module for Monitoring and Reporting on the implementation of JKN	In Preparation	1.1	4/09/2013	31/10/2013
1702	Initial preparation for the Implementation National Health Insurance				
170201	Policy Paper - Development of Concept, Implementing Guidelines, and Pilot Project Technical Guidance	In Preparation	1.1	4/09/2013	31/10/2013
170202	Program Progress Monitoring (Aceh, DKI, Jabar)	In Preparation	1.1	4/09/2013	31/10/2013

LIST OF AIPHSS ACTIVITIES

PERIOD: 1 JULY 2013 - 31 DECEMBER 2013

NUMBER	TITLE	STATUS	COMPONENT	START DATE	FINISH DATE
1804	PMU DHO Meeting (NTT)				
180401	Coordination Meeting Cross Program / Sector	Completed	6	13/09/2013	13/09/2013
2101	Strengthening of Health System Financing (NTT)				
210101	PELATIHAN DHA	In Preparation	2.1	9/12/2013	14/12/2013
3401	Strengthening the Development System of HRH at Puskesmas (Flotim)				
340101	Training on Managerial Improvement for Puskesmas Team (PML Puskesmas)	Completed	3.3	16/11/2013	27/11/2013
4502	Comprehensive Assessment of Health Workforce Education and Training				
450201	Enumerator Training	In Preparation	2.2	2/12/2013	4/12/2013
8001	Health Sector Review				
800103	Bappenas Health Sector Review Meeting	Completed	1.1	26/11/2013	26/11/2013
8003	HPN National Forum				
800301	HPN National Forum	Completed	5.1	4/09/2013	7/09/2013
8101	Fit for Purpose HPN				
810101	Fit for Purpose HPN - University of Indonesia	In Progress	5.1	18/11/2013	18/11/2013
8101	Fit for Purpose HPN				
810102	Fit for Purpose HPN - University of Gadjah Mada	In Progress	5.1	19/11/2013	20/11/2013
810103	Fit for Purpose HPN - University of Padjadjaran Bandung	In Progress	5.1	25/11/2013	25/11/2013
8101	Health Policy Network				
810101	HPN Fit for Purpose	In Progress	5.1	19/08/2013	8/11/2013
810102	HPN Institutional Capacity Assessment	In Progress	5.1	19/08/2013	8/11/2013
810103	HPN Oversight of Study	In Progress	5.1	19/08/2013	8/11/2013
8102	Capacity Assessment of HPN				
810201	Capacity Assessment of HPN - University of Indonesia	In Progress	5.1	18/11/2013	18/11/2013
810202	Capacity Assessment of HPN - University of Gadjah Mada	In Progress	5.1	19/11/2013	20/11/2013
810203	Capacity Assessment of HPN - University of Maranatha	In Progress	5.1	25/11/2013	25/11/2013
9001	Sponsor two participants from UI to IHEA				
900101	Sponsor two participants from UI to IHEA	Completed	0	7/07/2013	10/07/2013
9003	Development of AIPHSS Activity Database				
900302	Development of AIPHSS Activity Database - Phase II	Completed	7	15/09/2013	15/10/2013

LIST OF AIPHSS SUB ACTIVITIES

PERIOD: 1 JULY 2013 - 31 DECEMBER 2013

NUMBER	TITLE	STATUS	COMPONENT	START DATE	FINISH DATE
60104	Development of Framework of Annexes PP No. 38 / 2007	In Progress	2.1	1/07/2013	31/10/2013
140807	AIPHSS Interview Recruitment for PMU Provincial level-East Java	Completed	6	1/07/2013	3/07/2013
80105	Health Workforce and Health Systems IT Adviser	In Progress	2.2	3/07/2013	3/12/2013
70229	Preparation of Multimedia Materials for Distance Education in Nursing and Midwifery D3	In Progress	3.4	7/07/2013	31/08/2013
900101	Sponsor two participants from UI to IHEA	Completed	0	7/07/2013	10/07/2013
70208	Coordination Meeting for Preparation PJJ-RAB#4	Completed	3.4	8/07/2013	10/07/2013
70209	Preparation of Training Curriculum for Support Officer -RAB#12	Completed	3.4	8/07/2013	11/07/2013
70233	Training for Learning Assistant Officers	Completed	3.4	8/07/2013	25/10/2013
110135	BPJS Taskforce Coordination Meeting	Completed	1.1	10/07/2013	10/07/2013
140605	Coutessy Call / Audience Meeting to Province and Districts by PMU and AusAID	Completed	6	15/07/2013	20/07/2013
70210	Training for Tutor - RAB#1	Completed	3.4	16/07/2013	19/07/2013
70232	Training for Distance Education Tutors	Completed	3.4	16/07/2013	5/10/2013
110136	BPJS Technical Calculation for Premi PBI Meeting	Completed	1.1	16/07/2013	16/07/2013
110137	BPJS Taskforce Coordination Meeting	Completed	1.1	17/07/2013	17/07/2013
70211	Preparation of Teaching Materials Module - RAB#7	Completed	3.4	18/07/2013	20/07/2013
70228	Production and Digitalisation of Modules (Part of TOR 7)	In Progress	3.4	20/07/2013	30/09/2013
110138	BPJS Taskforce Coordination Meeting	Completed	1.1	24/07/2013	24/07/2013
140501	Refurbishment of AIPHSS PMU Office Provinces and Districts	In Progress	6	26/07/2013	31/08/2013
70103	Guidelines Preparation for Long Distance Learning for Nursing and Midwive (Part of TOR 2)	Completed	3.4	27/07/2013	29/07/2013
110139	BPJS Taskforce Coordination Meeting	Completed	1.1	31/07/2013	31/07/2013
150103	AIPHSS Coordination Meeting for Implementation Program	Completed	6	31/07/2013	1/08/2013
70230	Development of Infrastructure for Distance Education	In Progress	3.4	1/08/2013	30/09/2013
110140	BPJS Discussion about Non PBI Premi for worker (Private)	Completed	1.1	1/08/2013	1/08/2013
140701	Renovation of Provincial and District PMU Offices - Jatim	Completed	6	12/08/2013	23/10/2013
110141	BPJS CBGs Meeting with Rick Marshall	Completed	1.1	19/08/2013	19/08/2013
810101	HPN Fit for Purpose	In Progress	5.1	19/08/2013	8/11/2013
810102	HPN Institutional Capacity Assessment	In Progress	5.1	19/08/2013	8/11/2013
810103	HPN Oversight of Study	In Progress	5.1	19/08/2013	8/11/2013
110142	BPJS CBGs Meeting with Rick Marshall	Completed	1.1	23/08/2013	23/08/2013
140808	AIPHSS PMU Staff Orientation 2013	Completed	6	25/08/2013	31/08/2013
110143	BPJS Taskforce Coordination Meeting	Completed	1.1	28/08/2013	28/08/2013
60403	Piloting Tools Need Assessment Local Health Officers	In Progress	2.2	1/09/2013	30/09/2013
60507	Piloting Tools Need Assessment for Puskesmas Strengthening	In Progress	3.4	1/09/2013	30/09/2013
140702	Renovation of District PMU Offices - Kab. TTU	Completed	6	2/09/2013	3/10/2013
70212	Training for Tutor of Long Distance Learning for Nurses and Midwives Phase II-RAB#11	Completed	3.4	4/09/2013	7/09/2013
100201	IAKMI National Forum IV at Kupang, NTT	Completed	6	4/09/2013	7/09/2013
110144	BPJS Taskforce Meeting	Completed	1.1	4/09/2013	4/09/2013
170101	Development of an Instrument and Module for Monitoring and Reporting on the implementation of JKN	In Preparation	1.1	4/09/2013	31/10/2013
170201	Policy Paper - Development of Concept, Implementing Guidelines, and Pilot Project Technical Guidance	In Preparation	1.1	4/09/2013	31/10/2013
170202	Program Progress Monitoring (Aceh, DKI, Jabar)	In Preparation	1.1	4/09/2013	31/10/2013
800301	HPN National Forum	Completed	5.1	4/09/2013	7/09/2013
100201	Support for provision of a booth and publications	In Progress	1.1	5/09/2013	7/09/2013
110145	BPJS Discussion about Action Plan Finalization 2nd Meeting	Completed	1.1	6/09/2013	6/09/2013
140703	Renovation of District PMU Offices - Kab. SBD	Completed	6	6/09/2013	12/12/2013
70213	Training for Tutor- Finalization of Curriculum and Modules RAB#11	Completed	3.4	9/09/2013	11/09/2013
110201	Support to High Level Forum on Extending Coverage to Achieve Universal Health Coverage	Completed	2.1	9/09/2013	2/10/2013
70214	Preparation of Guidelines for the Curriculum Implementation RAB#6	Completed	3.4	10/09/2013	12/09/2013
110146	BPJS Taskforce Meeting	Completed	1.1	11/09/2013	11/09/2013
140704	Renovation of District PMU Offices - Kab. Flores Timur	Completed	6	11/09/2013	18/10/2013
70215	Curriculum and Module Preparation for Learning Support Services phase II-RAB#12	Completed	3.4	12/09/2013	15/09/2013
110147	BPJS Discussion about Action Plan Finalization 3rd Meeting	Completed	1.1	13/09/2013	13/09/2013
140705	Renovation of District PMU Offices - Kab. Ngada	Completed	6	13/09/2013	18/10/2013
180401	Coordination Meeting Cross Program / Sector	Completed	6	13/09/2013	13/09/2013
900302	Development of AIPHSS Activity Database - Phase II	Completed	7	15/09/2013	15/10/2013
70216	Preparation of Training Workshop- RAB#12	Completed	3.4	16/09/2013	18/09/2013
70217	Preparation of Guidelines for the Curriculum Implementation Draft 2 - RAB#6	Completed	3.4	16/09/2013	18/09/2013

LIST OF AIPHSS SUB ACTIVITIES

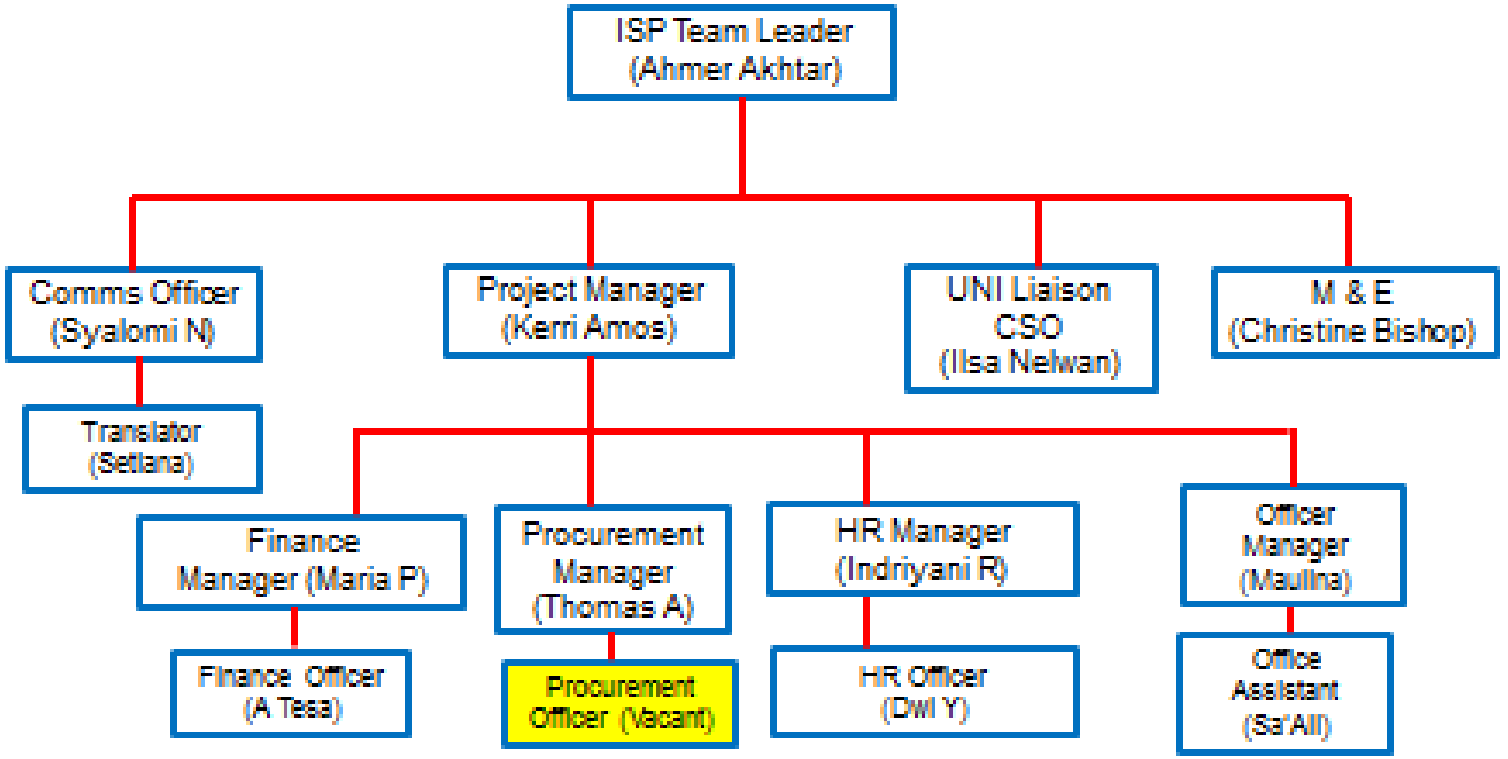
PERIOD: 1 JULY 2013 - 31 DECEMBER 2013

NUMBER	TITLE	STATUS	COMPONENT	START DATE	FINISH DATE
110148	BPJS Taskforce Meeting	Completed	1.1	18/09/2013	18/09/2013
50201	Preparation of Health Facility Rate Workshop	In Preparation	1.1	20/09/2013	20/09/2013
70218	Training for Tutor Group 1-RAB#11	Completed	3.4	22/09/2013	28/09/2013
70219	Training support services finalization curriculum and modules-RAB#12	Completed	3.4	23/09/2013	23/09/2013
110149	BPJS Action Plan in Taskforce by UKP4 Meeting	Completed	1.1	25/09/2013	25/09/2013
110150	BPJS INA CBGs Meeting	Completed	1.1	25/09/2013	25/09/2013
70220	Training for Tutor Group 2- RAB#11	Completed	3.4	29/09/2013	5/10/2013
140808	AIPHSS PMU Staff Orientation 2 - 2013	Completed	6	29/09/2013	6/10/2013
60404	Development of Standard Competency for Local Health Officer	In Progress	2.2	1/10/2013	30/11/2013
60508	Development of Guideline for Puskesmas Strengthening through Program Integration	In Progress	3.4	1/10/2013	30/11/2013
70221	Development for Recognition Prior Learning - RAB#5	Completed	3.4	1/10/2013	3/10/2013
110151	BPJS Taskforce Meeting	Completed	1.1	2/10/2013	2/10/2013
140706	Renovation of District PMU Offices Phase II - Kab. Sampang	Completed	6	3/10/2013	4/11/2013
110152	BPJS Taskforce Meeting	Completed	1.1	4/10/2013	4/10/2013
70222	Training for Learning Assistant Group 1- RAB#12	Completed	3.4	6/10/2013	11/10/2013
140606	Coutessy Call / Audience Meeting to Province and Districts by PMU and AusAID	Completed	6	6/10/2013	17/10/2013
110153	BPJS Meeting Preparation Presentation Minister of Health to Vice President	Completed	1.1	11/10/2013	11/10/2013
110154	BPJS Taskforce Coordination Meeting	Completed	1.1	16/10/2013	16/10/2013
110155	BPJS Team of Simulation Preparation Meeting	Completed	1.1	16/10/2013	16/10/2013
70223	Training for Learning Assistant Group 2- RAB#12	Completed	3.4	20/10/2013	25/10/2013
80102	Two international consultants to participate in National Health Workforce meeting	In Progress	2.2	21/10/2013	26/10/2013
110156	BPJS Finalization INA CBGs Tariff Meeting	Completed	1.1	22/10/2013	22/10/2013
110157	BPJS Taskforce Coordination Meeting	Completed	1.1	23/10/2013	23/10/2013
110158	BPJS Finalization INA CBGs Tariff Meeting Part-2	Completed	1.1	25/10/2013	25/10/2013
110159	BPJS Taskforce Coordination Meeting	Completed	1.1	30/10/2013	30/10/2013
110160	BPJS Finalization Premi Capitation Meeting	Completed	1.1	31/10/2013	31/10/2013
60105	Final Discussion for Revision of PP 38 th 2008; Kepmenkes 922 th 2008	In Progress	2.2	1/11/2013	30/11/2013
60203	Final Discussion for Revision of PP 41 th 2007	In Progress	2	1/11/2013	30/11/2013
60303	Final Discussion for Revision of Permenkes no 741 th 2008; Kepmenkes 828 th 2008; Kepemenkes 317 th 2009	In Progress	2	1/11/2013	30/11/2013
60405	Development of Training Module for Local Health Officers	In Progress	2.2	1/11/2013	31/12/2013
60509	Development of Module and Training for Puskesmas Strengthening	In Progress	3.4	1/11/2013	31/12/2013
110161	BPJS Taskforce Coordination Meeting	Completed	1.1	6/11/2013	6/11/2013
110162	BPJS Setgab Meeting	Completed	1.1	6/11/2013	6/11/2013
140809	AIPHSS Interview Recruitment for PMU Provincial level-East Java	Completed	6	6/11/2013	8/11/2013
40101	DHA Module Revision	Completed	2.1	7/11/2013	8/11/2013
140810	AIPHSS Interview Recruitment for PMU Provincial level-NTT	Completed	6	10/11/2013	13/11/2013
110163	BPJS Taskforce Coordination Meeting	Completed	1.1	13/11/2013	13/11/2013
70224	Development for Recognition Prior Learning RAB#2 - RAB#5	Completed	3.4	14/11/2013	16/11/2013
340101	Training on Managerial Improvement for Puskesmas Team (PML Puskesmas)	Completed	3.3	16/11/2013	27/11/2013
810101	Fit for Purpose HPN - University of Indonesia	In Progress	5.1	18/11/2013	18/11/2013
810201	Capacity Assessment of HPN - University of Indonesia	In Progress	5.1	18/11/2013	18/11/2013
810102	Fit for Purpose HPN - University of Gadjah Mada	In Progress	5.1	19/11/2013	20/11/2013
810202	Capacity Assessment of HPN - University of Gadjah Mada	In Progress	5.1	19/11/2013	20/11/2013
110164	BPJS Taskforce Coordination Meeting	Completed	1.1	20/11/2013	20/11/2013
140707	Renovation of Provincial PMU Office - NTT	Completed	6	20/11/2013	20/12/2013
70225	Sounding Curriculum Implementation Long Distance Learning	Completed	3.4	21/11/2013	23/11/2013
810103	Fit for Purpose HPN - University of Padjadjaran Bandung	In Progress	5.1	25/11/2013	25/11/2013
810203	Capacity Assessment of HPN - University of Maranatha	In Progress	5.1	25/11/2013	25/11/2013
800103	Bappenas Health Sector Review Meeting	Completed	1.1	26/11/2013	26/11/2013
110165	BPJS Taskforce Coordination Meeting	Completed	1.1	27/11/2013	27/11/2013
70226	Sounding Recognition Prior Learning Long Distance Learning	Completed	3.4	28/11/2013	30/11/2013
450201	Enumerator Training	In Preparation	2.2	2/12/2013	4/12/2013
210101	Training DHA	In Preparation	2.1	9/12/2013	14/12/2013
70231	Workshop on management and administration of distance education	In Progress	3.4	12/12/2013	14/12/2013

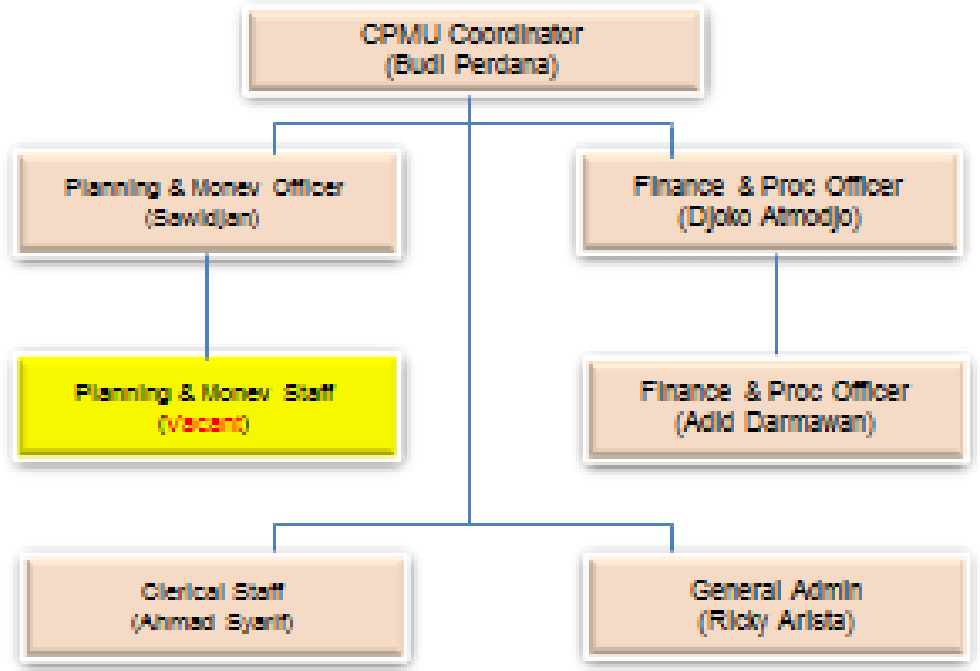
Annex 2

AIPHSS Staff Organogram

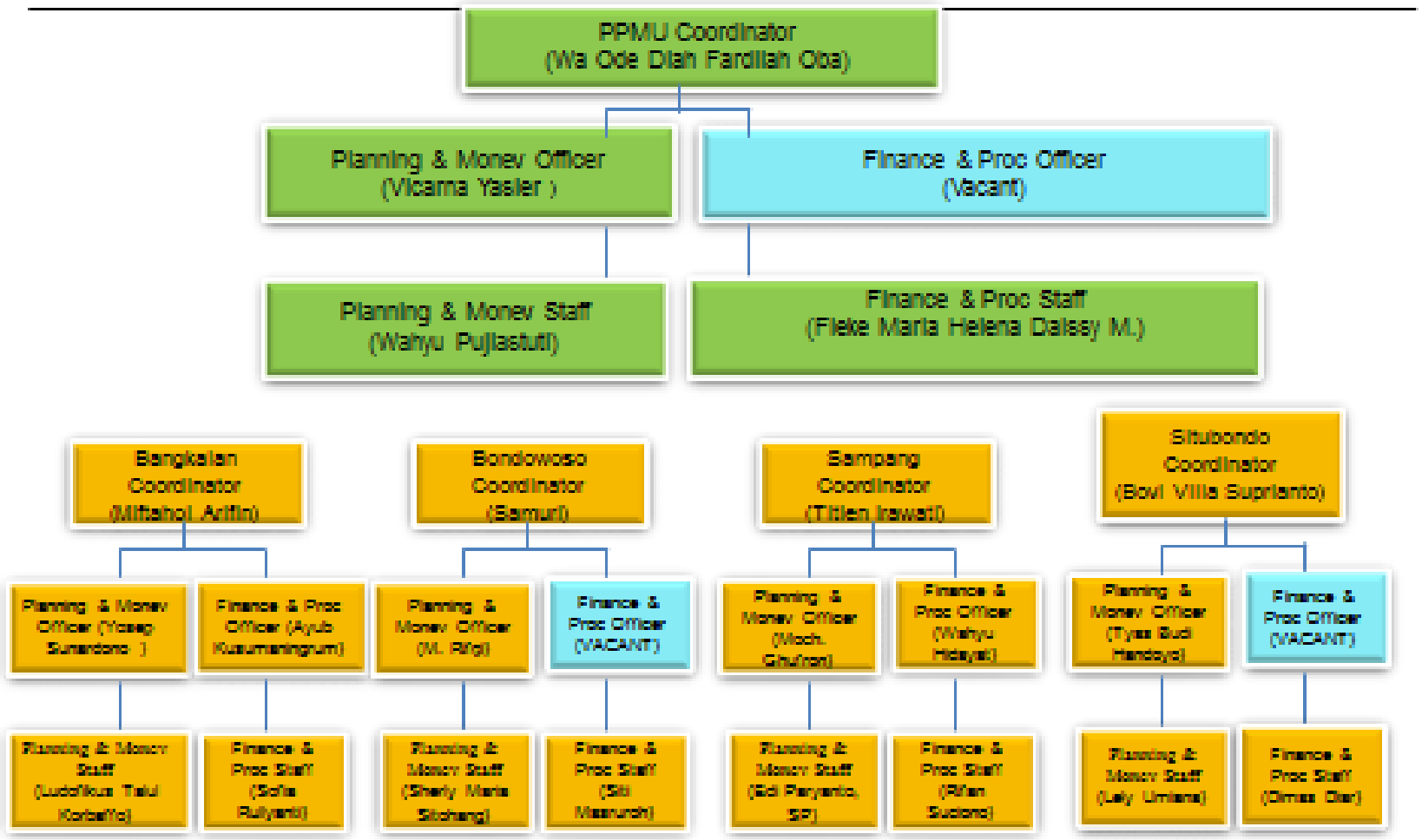
ISP Staff Mapping



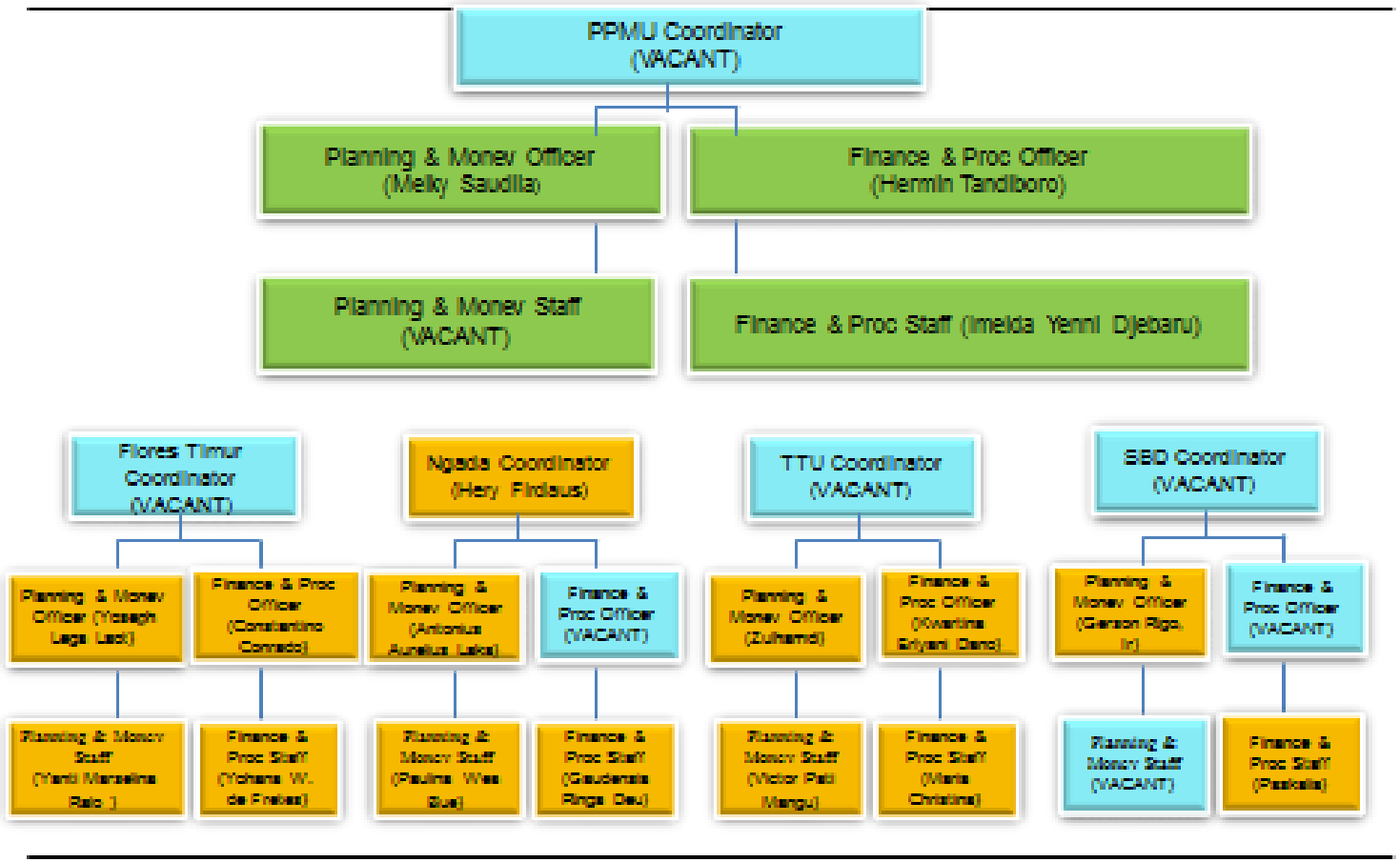
CPMU Staff Mapping



Staff Mapping – EAST JAVA



Staff Mapping – NTT



Annex 3

Financial Expenditure Matrix

Project name:	**Indonesia Australia Partnership for Health Systems Strengthening**
Contractor:	**Coffey International Development Pty Ltd**
Contract number:	**65401**
Contract total:	**$29,958,691**
State date:	**26/11/2012**
End date:	**30/06/2016**
Currency:	**AUD**

Contract Expenditure Summary Sheet - Actuals and Estimates

Basis of Payment		Year 1								
Description	**Financial Limit**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**TOTAL Year 1**
		Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	
(a) Management Fees										
Milestone Payments										
M1 - Socialisation and Evaluability Workshop Convened	171,904					171,904				**171,904**
M2 - Mobilisation of AIPHSS Team and Office Establishment	171,904			171,904						**171,904**
M3 - Monitoring and Evaluation Plan	343,809								343,809	**343,809**
M4 - Progress Report, including Adviser Performance Assessments	171,904								171,904	**171,904**
M5 - Technical Assistance Annual Plan	171,904								171,904	**171,904**
M6 - Progress Report, including Adviser Performance Assessments	171,904									
M7 - Annual Monitoring and Evaluation Report	171,904									
M8 - Progress Report, including Adviser Performance Assessments	171,904									
M9 - Technical Assistance Annual Plan	171,904									
M10 - Progress Report, including Adviser Performance Assessments	171,904									
M11 - Analysis of MoH Procurement Systems and Transition Strategy	171,904									
M12 - Annual Monitoring and Evaluation Report	171,904									
M13 - Progress Report, including Adviser Performance Assessments	171,904									
M14 - Technical Assistance Annual Plan	171,904									
M15 - Progress Report, including Adviser Performance Assessments	171,904									
M16 - Annual Monitoring and Evaluation Report	171,904									
M17 - Progress Report, including Adviser Performance Assessments	171,904									
M18 - Annual Monitoring and Evaluation Report	171,904									
M19 - Progress Report, including Adviser Performance Assessments	377,310									
M20 - Program Completion Report	171,904									
Sub-total Milestone Payments	**3,815,395**	-	-	171,904	-	171,904	-	-	687,617	**1,031,426**
Reimbursable Payments										
(b) Long Term Adviser Costs	4,169,866			112,359	69,078	69,655	69,420	71,527	71,855	463,894
(c) Short Term Adviser Costs	120,500					495	759	779	1,072	3,107
(d) Additional Reimbursable Costs - Personnel	585,830			89,740	3,318	3,384	45,621	5,385	396	147,843
(e) Additional Reimbursable Costs - non Personnel	21,267,100			89,052	66,134	131,170	177,891	157,344	267,241	888,832
Sub-total Reimbursable Payments	**26,143,296**			291,151	138,530	204,704	293,692	235,035	340,564	**1,503,676**
Contract Financial Limit	**29,958,691**			**463,056**	**138,530**	**376,608**	**293,692**	**235,035**	**1,028,181**	**2,535,101**

Project name:	**Indonesia Australia Partnership for Health Systems Strengthening**
Contractor:	**Coffey International Development Pty Ltd**
Contract number:	**65401**
Contract total:	**$29,958,691**
State date:	**26/11/2012**
End date:	**30/06/2016**
Currency:	**AUD**

Contract Expenditure Summary Sheet - Actuals and Estimates

Basis of Payment		Year 2												
Description	**Financial Limit**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Apr-14**	**May-14**	**Jun-14**	**TOTAL Year 2**
		Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	
(a) Management Fees														
Milestone Payments														
M1 - Socialisation and Evaluability Workshop Convened	171,904													
M2 - Mobilisation of AIPHSS Team and Office Establishment	171,904													
M3 - Monitoring and Evaluation Plan	343,809													
M4 - Progress Report, including Adviser Performance Assessments	171,904													
M5 - Technical Assistance Annual Plan	171,904													
M6 - Progress Report, including Adviser Performance Assessments	171,904							171,904						**171,904**
M7 - Annual Monitoring and Evaluation Report	171,904						171,904							**171,904**
M8 - Progress Report, including Adviser Performance Assessments	171,904											171,904		**171,904**
M9 - Technical Assistance Annual Plan	171,904										171,904			**171,904**
M10 - Progress Report, including Adviser Performance Assessments	171,904													
M11 - Analysis of MoH Procurement Systems and Transition Strateg	171,904												171,904	**171,904**
M12 - Annual Monitoring and Evaluation Report	171,904													
M13 - Progress Report, including Adviser Performance Assessments	171,904													
M14 - Technical Assistance Annual Plan	171,904													
M15 - Progress Report, including Adviser Performance Assessments	171,904													
M16 - Annual Monitoring and Evaluation Report	171,904													
M17 - Progress Report, including Adviser Performance Assessments	171,904													
M18 - Annual Monitoring and Evaluation Report	171,904													
M19 - Progress Report, including Adviser Performance Assessments	377,310													
M20 - Program Completion Report	171,904													
Sub-total Milestone Payments	**3,815,395**	-	-	-	-	-	171,904	171,904	-	-	171,904	171,904	171,904	**859,521**
Reimbursable Payments														
(b) Long Term Adviser Costs	4,169,866	73,312	91,076	71,934	70,520	62,325	51,901	86,224	86,224	86,224	86,224	86,224	86,224	938,413
(c) Short Term Adviser Costs	120,500	957		204	8,220		668	7,650				9,680		27,378
(d) Additional Reimbursable Costs - Personnel	585,830	9,853				1,314	1,482	44,831	40,031	39,873	1,631	7,631	1,031	147,677
(e) Additional Reimbursable Costs - non Personnel	21,267,100	238,838	380,908	395,420	593,135	159,316	736,316	1,523,786	1,445,708	1,033,338	715,057	750,647	639,941	8,612,410
Sub-total Reimbursable Payments	**26,143,296**	322,960	471,984	467,558	671,874	222,955	790,367	1,662,491	1,571,963	1,159,435	802,912	854,182	727,196	**9,725,878**
Contract Financial Limit	**29,958,691**	**322,960**	**471,984**	**467,558**	**671,874**	**222,955**	**962,271**	**1,834,395**	**1,571,963**	**1,159,435**	**974,816**	**1,026,087**	**899,100**	**10,585,399**

Annex 4

Risk Matrix

Risk	Likeli-hood	Conseq -uences	Rating	Risk Mitigation Approach	Party responsible for managing risk
Government Relations					
Difficulties in the bilateral relationship or decreased level of support between the Governments of Australia and Indonesia cause the suspension of the program.	P	Ma	High	• Monitor the bilateral relationship and through close working relationships with partners try to ensure that the aid program continues while relationship issues are addressed. • AIPHSS activities closely aligned with DFAT's Australia Indonesia Partnership Country Program Strategy (AIPCPS) periodically reviewed by the two governments. • Decisions or initiatives leading to implementation changes discussed and agreed by DFAT and Kemkes prior to introduction. ISP confirms both parties are in agreement.	DFAT DFAT, KEMKES, ISP
Ineffective use of resources due to lack of cooperation between Kemkes, other relevant ministries and subnational government partners.	U	Mo	Moderate	• Program activities coordinated through GoI planning processes. • Involvement of cross-sectoral partners in TWG and sub-national coordination meetings. • ISP Manager and CPMU coordinator to work in collaboration with the PTS in the development of ToR to ensure they well planned, accurate budgets and appropriate QA processes are adhered to. • Vigilant monitoring of activities and budgets in collaboration with CPMU.	CPMU, ISP
External Risks					
GoI election in 2014 causes political disruption to program activities.	P	M	Moderate	• Level of political disruption monitored and response coordinated with DFAT. • Maintain contact with CPMU to ensure an understanding of any priority and budget changes due to change in government.	ISP, DFAT, CPMU
Security and safety issues affect work program of ISP personnel or contracted Advisers.	U	M	Low	• The Security Plan is discussed at regular team meetings, updated accordingly and disseminated to personnel whenever there are significant changes. Staff are aware of their responsibility to read and understand the Security Plan. • All staff are to register with DFAT's smartraveller.gov.au to receive security updates for Indonesia. • Security situation in all AIPHSS sites is monitored. Restriction of travel if security threat is posed.	ISP, CPMU

Risk	Likeli-hood	Conseq uences	Rating	Risk Mitigation Approach	Party responsible for managing risk
Economic deterioration impacting exchange rates and increasing program costs resulting in a reduction in funds available to implement activities.	U	Mo	Moderate	• Exchange rates monitored and budgets revised accordingly. • Significant impact items advised to DFAT as early as possible. • Closely monitor budgets to ensure they remain within the activity expectations and a preparedness to prioritise activities if budget restrictions are required.	ISP, Coffey International Development
Program Outcome Risks					
National policy making processes do not use evidence from research to inform future policies and policy implementation.	P	Mo	High	• ISP Manager works closely with CPMU and PTS on approaches to advocate knowledge to policy development. • ISP, PTS and CPMU to develop a knowledge management strategy with multiple channels of disseminating evidence including health officials, researchers, civil society, parliamentarians, and the media. • ISP work with the PTS to identify and support champions within GoI who have authority and interest to bring about evidence informed policy change. • Alignment of knowledge management strategy with policy planning schedule (i.e. RENSTRA). • Ensure M&E systems monitor the activity outputs.	ISP Manager, CPMU, LITBANGKES, PTS
Agencies have difficulty identifying their strategic priorities resulting in inefficient allocation of program resources.	P	Mo	High	• Ensure AIPHSS is alignment with partner priorities. • Review workplan against strategic priorities at the TWG and PSC mechanisms.	PTS, CPMU, DFAT
Over-reliance on DFAT as a source of funding for activities that should be funded by GOI	U	M	Low	• Budget limits and budget use is made clear during planning processes. • Use of PTS as expert adviser to provide advice on prioritisation of activities with available budget. • ISP to work closely with the CPMU and monitor work plans to ensure proposed program activities are not routine activities.	CPMU, DFAT

Risk	Likeli-hood	Conseq uences	Rating	Risk Mitigation Approach	Party responsible for managing risk
Lack of commitment to strengthening reform in SRs and SSRs	P	Ma	High	• Consistent coordination and building strong relationship with SRs and SSRs • Facilitating ownership and leadership from government counterparts • On-going funding subject to sufficient commitment, participation and leadership from SRs and SSRs.	CPMU, DFAT
Capacity to implement systemic change in districts is limited.	P	Mo	High	• Implementation capacity of SSRs monitored and additional support provided if required. • Engagement of Technical Assistance to Provinces and Districts to provide appropriate support in the development of ToR and budgets. • Progressive scaling up of activities to ensure that absorptive capacity is not exceeded.	CPMU, ISP
AIPHSS unable to demonstrate achievement of outcomes.	U	Mo	Moderate	• M&E activities implemented in accordance with M&E Plan. • Regular review M&E approaches or activities to ensure that the program activities are achieved. • Engagement of TWG and PCS to review workplans and ensure that all activities have a clear linkage to program indicators and outcomes. • Performance monitoring by TWG and including agreed outcomes and changes to indicators in performance framework.	ISP TWG, M&E Adviser
Research agenda is captured by academic elites; agenda does not follow priority policy areas.	U	Mo	Moderate	• Identify and support champions within GoI who have authority and interest to initiate research to inform policy. • Liaison with program partners at districts and provinces to ensure research agenda is responsive to actual problems. • Work closely with the PTS, SRs and SSRs in the development of a research agenda that meets policy priority areas.	CPMU; PTS; University Liaison and CSO Coordinator

Risk	Likeli-hood	Conseq uences	Rating	Risk Mitigation Approach	Party responsible for managing risk
HPN, Research Institutes advocacy with no linkage to policy.	P	M	Moderate	• Targeted assistance to universities to support presenting findings in an accessible format for policy-makers. • Capacity development of researchers and CSOs in methods, analysis and writing research. • Encourage participation of government in the development of research and advocacy.	University Liaison and CSO Coordinator, PTS
Universities develop poor quality research which cannot be utilised to support policy change.	L	Mo	High	• Capacity assessment of HPN partners which will inform capacity building approach. • Capacity development of HPN in research methodologies. • Inclusion of HPN and peer support mechanisms in the development of research. • ISP/CPMU has a quality assurance system to check against quality of research proposition prior to funding and quality of delivered outputs.	ISP, CPMU, DFAT, University Liaison
Introduction of new provinces and districts exceeds both financial and management resources	U	Ma	Moderate	• Consideration given to logistics and communications in selection of new provinces and districts. • Ongoing assessment of resources need and preparedness to adjust staffing levels in accordance with increased implementation requirements. • Assessment whether the DFAT budget is sufficient to expand to other provinces.	CPMU, DFAT
Improvements in PHC do not reach the poor; no change in service utilisation by the poor.	P	Mo	High	• Level of service utilisation monitored annually; adjust indicators if necessary to ensure they target the appropriate information source. • Ensure that activities are pro poor and equity focused. • Ensure that greater financial resources are allocated to the districts level implementation and capacity development.	CPMU, ISP

Risk	Likelihood	Consequences	Rating	Risk Mitigation Approach	Party responsible for managing risk
Misappropriation of Funds or other form of Fraud.	P	Mo	High	• Zero tolerance to fraud and clear policy on the Coffey approach to be included in the PIM. • Capacity Building of CPMU, SR and SSRs, and CSOs in Coffey's Fraud approach. • Development of a joint approach with the CPMU on fraud management with clearly defined steps for reporting and resolution. • Undertake information sessions to ensure all parties have a good understanding of grant and funds channelling processes. • Clear guidelines for participation in the program, and agreement on financial management rules and controls at outset in the CPMU Program Implementation Manual. • Close monitoring of programs to ensure appropriate use of funds and six monthly audits. • Training of CSOs, CPMU, SR, and SSRs in financial management for reporting. Provide handbook (guidelines) of reporting requirements. • Training on Fraud Control provided to all staff. Contractor Fraud Management Policy strictly enforced. Regular compliance audits.	ISP/Coffey International Development, CPMU
CPMU Management					
Workload demands on CPMU staff lead to delays in important decisions and insufficient attention to implementation details.	U	Mo	Moderate	• ISP to work closely with the CPMU staff to ensure a mutually supportive approach to program management. • Monitor demands on CPMU staff time. • ISP to provide support, planning and prioritisation of activities to assist effective implementation.	CPMU, ISP, DFAT

Risk	Likeli-hood	Conseq uences	Rating	Risk Mitigation Approach	Party responsible for managing risk
Ineffective coordination between ISP, CPMU, SRs, and SSRs.	P	Mo	High	• District and provincial teams to lead coordination and Socialisation of AIPHSS to all parties have a mutual understand of the AIPHSS goal and purpose, and respective roles. • Regular coordination meetings with SRs and SSRs. • ISP to support CPMU communication about AIPHSS. • Joint planning and building ownership of activities with SRs and SSRs.	CPMU, ISP, SRs, SSRs
National-level oversight of provinces and districts does not provide strategic direction	P	Mo	High	• Provide regular opportunities for coordination between SRs and SSRs. • Regular coordination meetings to ensure technical and horizontal linkages through activities. • Coordination with other district programs including other DFAT programs.	CPMU, ISP, PTS
Implementation capacity of PHOs and DHOs is limited.	P	M	Moderate	• Monitor absorptive capacity and adjust activity schedule accordingly. • Explore options for additional support for government partners as required as required. • ISP to support the CPMU at central, province and districts to develop realistic work plans.	CPMU, DFAT
ISP Support					
Unanticipated expenses that will compromise the budget and cash flow	U	Mo	Moderate	• Effective coordination with CPMU on budget planning and control processes. • Stringent review of workplans to ensure activities remain within the program priorities. • Training for CPMU staff on budgeting and planning as part of PIM training.	CPMU, ISP
ISP overburdened due to changes in funding agreements and ISP funds channelled through ISP	P	M	Moderate	• Ensure that the staffing levels in the ISP are sufficient to manage the changes; liaise with DFAT if additional contract staff are required. • Establish clear mechanisms and procedures for financial management of activities at the national level are developed and applied. • Review current staffing structure and revise to ensure resources are correctly allocated between PMU and ISP and the central level. • Close collaboration with CPMU on review of budgets and work flows.	ISP, CPMU

Risk	Likeli-hood	Conseq uences	Rating	Risk Mitigation Approach	Party responsible for managing risk
ISP unable to establish effective working relationships with partners for program implementation	U	M	Low	• Engage the PTS to liaise on any perceived relationship issues. • Work with the PTS to ensure partner priorities are clear and the ISP understands where support is needed. • Regular coordination between ISP, CPMU, DFAT and PTS to review program relationships. • Development of a Partnership Agreement in 2014 • Encourage open communication on all issues and continue the positive relationship building with all partners	DFAT, ISP, CPMU, PTS
Procurement					
Terms of Reference developed by SRs and SSRs provide insufficient basis to contract services.	L	Mo	High	• Guidelines and templates for TOR provided to SRs and SSRs • Engage PTS TA to review all ToR before recommendation to implement activities. • Capacity Building of SRs and SSRs on formulation of TOR • Where appropriate utilise technical assistance to help develop TORs for activities requiring more detail.	ISP, CPMU, PTS
SRs, SSRs, or other parties seek to inappropriately influence procurement of TA or services.	P	Mo	High	• ISP emphasises transparent procurement practices in accordance with Commonwealth Procurement Rules and GOI procurement guidelines.	ISP, CPMU

Likelihood – **R**are (R), **U**nlikely (U), **P**ossible (P), **L**ikely (L), **A**lmost certain (A)
Consequences – **N**egligible (N), **M**inor (M), **Mo**derate (Mo), **Ma**jor (Ma), **S**evere (S)