Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS)

Fourth Six Monthly Progress Report

December 2014

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

Table of contents

Annexes

Abbreviations

ADINKES	Association of Heads of Department of Health (Asosiasi Dinas Kesehatan)
AIPHSS	Australia Indonesia Partnership for Health Systems Strengthening
AIPMNH	Australia Indonesia Partnership for Maternal and Neonatal Health
BAPPENAS	Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional (Bappenas) - State Ministry of National Development Planning
BOK	(Operational Funding) Biaya Operational Kesehatan
BPJS	Agency for the Organisation of Social Insurance (Badan Penyelenggaraan Jaminan Social)
BUKD	National Agency for Primary Health Care
CPMU	Central Program Management Unit
DFAT	Department of Foreign Affairs and Trade
DHA	District Health Account
DHO	District Health Office
GFTAM	Global Fund to Fight Tuberculosis, AIDS and Malaria
GIS	Geographical Information Systems
GoI	Government of Indonesia
HPN	Health Policy Network
HPU	Health Policy Unit
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSR	Health Sector Review
IPR	Independent Progress Review
ISP	Implementing Service Provider
IT	Information Technology
JATIM	East Java (Jawa Timur)
JKN	National Health Insurance Scheme (Jaminan Kesehatan Nasional)
M&E	Monitoring and Evaluation
MEP	M&E Plan
MoH	Ministry of Health

MoHA	Ministry of Home Affairs
MSS	Minimum Service Standards
NIHRD	National Institute for Health Research and Development
NCDs	Non Communicable Diseases
NTT	East Nusa Tenggara (Nusa Tenggara Timur)
PERMATA	Primary Health Care Strengthening and Maternal and Newborn Health
PF	Performance Framework
PHA	Provincial Health Account
PHO	Provincial Health Office
PJJ	Distance Education Upgrading Program
PMU	Program Management Unit (PMU staff at province and district level)
Poskesdes	Village Health Post (Pos Kesehatan Desa)
PPJK	Centre for Health Financing and Insurance
PPSDMK	Centre for Human Resource Development in Health (Pusat Perkembangan Sumber Daya Manusia Kesehatan)
PS	(AIPHSS) Program Secretary (Roren)
PSC	Program Steering Committee
PTS	Program Technical Specialist
Puskesmas	Community Health Centre (Pusat Kesehatan Masyarakat)
Renstra	Strategic Plan (Rencana Strategis)
RJPMD	Regional Mid Term Development Plans (Rencana Jangka Menengah Pembangunan Daerah)
ROREN	Ministry of Health, Bureau of Planning and Budgeting (Biro Perencanaan dan Peranggaraan)
SBD	Sumbat Bara Daya
SG	Secretary General
SLO	Senior Liaison Officer
SOP	Standard Operating Procedures
TA	Technical Assistance
ToR	Terms of Reference
TTU	Timor Tengah Utara
UHC	Universal Health Coverage
UI	University of Indonesia

Executive Summary

This is the fourth Six Monthly Progress Report for the Australian Indonesian Partnership for Health Systems Strengthening (AIPHSS). The purpose of this report is to inform the partnership of progress in implementation and highlight issues and responses in program management. This report also provides an analysis of financial disbursement to date, reviews program risks and summarises priorities for the next reporting period. Reporting is against the component structure and Performance Framework (PF) in place as at June 2014.

The program is beginning to demonstrate how a combination of technical assistance and flexible funding has the potential to make valuable contribution to health policy development and systems strengthening on a national scale. This is being achieved through AIPHSS supporting emerging priority activities and policy reforms led by government in a dynamic policy environment. Through investments in activities, which are linked to larger government reform, the AIPHSS acts as a catalytic mechanism allowing for faster and responsive change in key health systems policy areas. This approach is being increasingly valued by the Ministry of Health (MoH), as demonstrated by an increasing engagement and ownership by senior officials and other staff responsible for implementation of AIPHSS activities. In addition to this, a number of the AIPHSS investments are developing models and pilots which are being considered by the MoH for scale up at a national level. These are initiatives that can contribute to longer term strengthening of primary health care. Examples of these are the distance learning model for nurses and midwives; the accreditation model for primary health care centres (Puskesmas); and the model of primary health care centres based on the new minimum service standards.

The formulation of a Reform Agenda[1] facilitated by the Program Technical Specialist through consultation with senior Ministry of Health Officials (PTS) has been an important factor in providing a clearer focus for certain reforms in primary health care and service delivery. It reflects a review of challenges, and assessment of weaknesses, of the current health system providing a clear direction for the AIPHSS program. The Reform Agenda is now being used as a tool to select activities for work plans. Furthermore, it provides a guiding framework for government implementing partners to enable a health systems approach to program planning to address the identified bottlenecks.

The program is beginning to influence “systems thinking” amongst some senior and junior officials whereby the focus is on increasingly making the linkages between long term improvements in health workforce, service delivery and governance to develop a systems strengthening approach rather than the normal fragmented and vertical approach to planning and implementation.

A high level Independent Progress Review (IPR) completed in April 2014 also resulted in a refinement and strengthening of the program direction. During this period of change the program has maintained reasonable momentum and completed a number of major activity milestones, both planned and emergent. Key outputs during this period have included the provision of technical assistance to conduct legal revisions of health functions under decentralisation law 23/2014; revised Minimum Service Standards (MSS) for Health; and finalisation and dissemination of the Health Sector Review (HSR).

[1] The Reform Agenda is not a formal MoH document but it was developed by the PTS with guidance and inputs from senior officials in MoH.

Summary of Program Contributions by Component Objectives[2]

Component Objective 1 (Leadership & Governance)

Evidence Based Policy: The results of major activities under this objective are proving to be the strongest performing and most sustainable in the program. Notably the process of the HSR has led to the uptake of the HSR recommendations and targets into the new National Mid Term Development Plan for 2014-2019. These targets and recommendations where subsequently also used to inform the MoH five year Strategic Plan (Renstra).

Sectoral Reform: The approval by parliament of the revisions to health functions under decentralisation law 23/2014 is a major achievement by the AIPHSS. The results will influence the governance of health at the central, provincial and district levels by clarifying roles and responsibilities at each level. AIPHSS supported this through contracting the Asosiasi Dinas Kesehatan (ADINKES) which used technical experts in health legislation and coordinated closely with senior officials to undertake a review and prepare new drafts of the legislation. A close collaboration was maintained with senior officials in the Ministry of Home Affairs who were leading the reform process through parliament, this arrangement resulted in AIPHSS program making a positive contribution in sustainable sectoral reform.

Access to primary health care: The revision of the MSS for health will influence the delivery of primary care services nationally and will be used as a performance measure for local governance.[3] It has been recognised for some time that there were many technical problems with the MSS, these included an over emphasis on maternal and child health, unattainable indicators, unclear definitions of targets and indicators. These problems resulted in gaps in service delivery and governance related to the MSS. In terms of service delivery these gaps led to a neglect of public health and promotion, non-communicable diseases, environmental health and other areas of basic health services. Gaps in governance and performance meant that local government were unclear about resource allocation and what they are required to deliver to meet their minimum responsibilities for basic health services.

The new MSS provide a model of basic services which cover the life cycle, starting from pre pregnancy to elderly care including screening services for non-communicable diseases, nutritional services and greater emphasis on prevention and promotions as a contribution to wider community development.

The impact of the new MSS on service delivery means a new model of basic services will be developed which will influence how health system inputs such human resources, health financing, information systems, drugs and equipment will need to be reoriented to meet the delivery of the new MSS. Related to this will be the change required at the District Health Office (DHO) to ensure that management, monitoring and evaluation of the MSS is conducted, this will require strengthening the resources and capacity of many district health offices.[4]

Currently the revisions are going through technical refinements of the indicators and preparation of associated costing and guidelines which need to developed in order to implement the MSS. These technical changes will continue into the next reporting period.

Component 2: Health Financing and Human Resources

Strengthening National Financing Systems: The AIPHSS has provided technical support for the launching of the National Health Insurance (JKN) and the institutionalisation of National Health Accounts (NHA). AIPHSS provided financial support to the MoH to implement a national training for all hospitals participating in JKN to manage the new hospital provider payment systems. This was a high priority for the government when launching JKN. Currently the hospital provider payment system uses a Malaysian

---

2 Annex 1 provides a summary of key achievements as may be useful for Quality at Implementation Reporting purposes (QAI)

3 This is highlighted in an evaluation of the MSS conducted by the MoH National Body for Research and Development, Badan Penilitian dan Perkembangan in 2011.

4 The 2015 work plan will implement capacity development of district health offices in AIPHSS districts

model, based on Malaysian disease profiles. The provision of international TA through AIPHSS provided the MoH with an analysis of the strengths and weaknesses of this system and an approach of how to progress towards an Indonesian system based on local disease profile. In the next reporting period this technical support will continue. A training program to strengthen the capacity of the team responsible for the management of the provider payment system will be rolled out in 2015.

NHA provide an evidence base for advocacy and reallocation of financial resources for health. Negotiations are currently underway with the specialist unit in the University of Indonesia (UI) for the production of 2012, 2013 and 2014 NHAs which will be implemented in the next reporting period.

Evidence Based Local Financing Policy and Planning: At the sub national level the focus has been on the implementation of District Health Account (DHA) systems. Local teams have been trained in conducting DHA in Jawa Timur (JATIM) which is in the early stages of establishing DHA. Nusa Tenggara Timur (NTT) is more advanced in DHA due to previous work to establish DHA through the Australian Indonesian Partnership for Maternal and Neonatal Health (AIPMNH). There is emerging evidence that data analysis undertaken by the DHA has led to policy decisions for increasing the health budget in some districts such as in Ngada. The DHA data was also used to advocate for the use of tobacco tax to be used for public health programs.

Strengthening National Human Resources for Health (HRH) Level Capacity: The policies and management for HRH are fragmented and influenced by an array of ministries, professional associations and the private sector. The strategic management of national HRH requires strong leadership and an organisation equipped to address problems of information, production, quality and distribution, and regulating a dynamic private sector which is independently responding to the rising demands for health care and for more sophisticated levels of health services.

The AIPHSS program recruited an international team of experts to undertake a scoping mission of the Department for Human Resource and Development (PPSDM) to conduct a needs assessment and develop a long-term capacity development program for strategic management of human resources and health workforce planning.

The program will deliver training in 2015 to senior managers and executives in managing Human Resources (HR) policy and strategic management with a focus on primary health care as well as deliver a ten year projection of human resource needs in accordance with the needs of National Health Insurance (JKN).

Other important areas of focus in this reporting period have been on the national Human Resource Management Information Systems (HRMIS) and Facility Based Workforce Planning methods. An integrated information system is essential in supporting evidence based HR policy and planning, the current system is fragmented whereby many different departments are responsible for managing their own HR information system, leading to duplication and waste. AIPHSS contracted a specialist group to assess the current system and develop a blueprint including a new coding system for all human resource categories and develop a system which be integrated with other departments and other ministries. This has been completed and approved by the MoH partners who will now use the blueprint to design a computer based management system in the next reporting period. The revitalised integrated system provides the foundation for improved management and use of information for decision making and planning for health workforce across MoH departments and other ministries.

Local Policy Development (District level): Technical assistance was provided to the Provincial Health Office in JATIM to draft a new regulation which addresses problems of mal-distribution of health staff at the provincial level. The causes of mal-distribution are complex; they include nepotism, medical specialists unwilling to be placed in areas where they cannot run a private practice, poor management of human resources including a poor performance management, lack of effective monetary and non-monetary incentives. The regulation aims to address some of these problems through stating which stakeholders should be involved in decision making about the placement of human resources, establishing structured human resource management practices such as competency based recruitment, performance management, strengthening registration and licensing to ensure better quality of human resources.

Component 3: Service Delivery

Strengthening primary health care quality: The Distance Education Program (PJJ) for nurses and midwives in NTT has been ongoing for one year. The intended overall outcome is to increase skills and knowledge of existing nurses and midwives to Diploma III level which in turn will improve the quality of care delivered at primary care and community levels. The program has been rolled out in two districts in NTT and an initial cohort of trainees have commenced. This initial start-up of distance education is a first for the health sector and important system issues are still being addressed. Lessons from this activity show that delivering distance education in remote areas requires intensive system preparation and monitoring.

Two new major activities commenced in this reporting period which aim to develop models to improve the quality and management of Puskesmas. Firstly a team of consultants has been recruited to develop an accreditation system for Puskesmas, this is intended to provide a tool and system which can measure and improve the quality of a Puskesmas. The same system will be used as a by the Badan Penyelenggaraan Jaminan Social, BPJS (Agency for the Organisation of Social Insurance) as a standard certification to contract a primary health care provider.

Secondly another team of consultants is reviewing and revising the primary health care information systems. This is being developed at the national level and tested in AIPHSS provinces and districts.

Strengthening capacity of primary care delivery: The introduction of JKN is having a system wide impact with shifting responsibilities for the financing and delivery of health care services. Many of the sub national levels have felt they were poorly informed about the changes and were confused about how to make the transition from existing insurance schemes and manage shifting responsibilities. Through AIPHSS funded activities at the sub national levels, the local partners have undertaken socialisation of JKN and clarified the implications at a primary health care level. New guidelines which identify how to manage capitation of health care related to JKN have been also been developed in two districts.

Another important learning point has been in public health promotion and prevention activities. These are at risk of being ignored due to JKN which is focused on curative care. To manage this risk the AIPHSS has increased the emphasis on training and resources allocated for strengthening promotion and preventive health care in Puskemas.

Key contributions towards expected intermediate outcomes under this component have been at the sub national levels with primary health care systems being strengthened through: revision of referral systems, puskesmas accreditation, training for financial management in health centres, socialisation of the impact of JKN, training of health centre staff to undertake health promotion and strengthening the role of puskesmas for community development.

Program Management

Governance

The Program Steering Committee (PSC) meeting took place on 24 November 2014. This was attended by all Implementing Units (IUs), the State Ministry of National Development Planning (Bappenas), and the Ministry of Home Affairs (MoHA). The key outcomes of this meeting included formal acknowledgement of the Reform Agenda and approval of the current workplans. A decision was also taken to engage the Agency for Administration of Social Insurance (Badan Penyelenggaraan Jaminan Kesehatan, BPJS) and the national Ministry for Planning (Bappenas) in the AIPHSS program. It was also agreed that from mid-2015, the PSC will incorporate the Primary Health Care Strengthening and Maternal and Newborn Health (PERMATA) program.

Provision of Technical Assistance (TA)

In this reporting period, the Implementing Service Provider (ISP) has contracted 28 technical consultants, including three international advisers for HR and Health Financing. Recruitment is underway for TA in Health Technology Assessment (HTA) and Case Based Groups (CBG) for the management provider of hospitals under the JKN. The process of development of Terms of Reference (ToRs) for TA is currently under review. Poor understanding and/or capacity in this area has contributed

to delays in recruitment during this period. Revised ISP systems (effective November 2014) for TA processes also require sustained socialisation and follow up. Given the increased tasking of the ISP additional human resources will be required to meet demand in TA in the upcoming period.

Monitoring and Evaluation

A new Monitoring and Evaluation Plan (MEP) and Performance Framework (PF) were deemed necessary subsequent to the enactment of the IPR recommendations and the introduction of the Reform Agenda. The plan and the associated Theory of Change (ToC) are still under development. The interim draft M&E plan and program logic will respond to the stronger policy focus of the program and to provide a clearer articulation of the a 'Facility' type approach and its pathways of change. All responsibilities for the management of the Monitoring and Evaluation (M&E) activities now lie in the ISP.[5]

Disbursement and Expenditure

The total expenditure for the July – December 2014 period is AUD 4,514,089[6] which is 77% of the forecasted amount of AUD 5,861,622. In part this reflects over ambitious workplans, with a consistent pattern of underspend and over projection. The slow implementation has created difficulties in regular budget and forecasting as the ISP prepares fund requirements in advance, but it is often advised a key activity will be delayed at quite late notice.

Priorities for the next reporting period

1. Strengthen TA management systems including stronger technical quality controls by the PTS and PTS consultants to monitor and review the technical progress of consultants and reports.
2. Improvements in ISP TA management including new senior staff to manage TA planning and recruitment and developing clear information packages on TA recruitment that will be socialised and provided to IUs
3. Support the development of realistic workplans to facilitate planning and budgeting, and work to increase the rate of implementation.
4. Increase the production of knowledge products and dissemination of results.
5. Ensure new M&E system is finalised, socialised and implemented providing improved progress and performance reporting information.
6. Strengthen relationship with BUKD through closer interaction by the Senior Liaison Officer and the new Technical Director with staff in BUKD.
7. Support revised management and governance structures maintaining a focus on ensuring clarity in roles and responsibilities particularly where decision making impacts upon implementation and accountability.
8. Gender Analysis, strategy and workplan.

[5] Before November 2014 the Central Program Management Unit (CPMU) led on program M&E

[6] Note that at the time of reporting it was only possible to obtain actual costs for July – November and December costs remain as per the forecast

Introduction

The Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) is a Government of Indonesia (GoI) led 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, governance and service delivery) and improve the use of evidence in policy making. These system and policy improvements will contribute to strengthening the quality of, and access to, primary health care services for the poor and vulnerable in Indonesia and in the longer term contribute to improving the health status of poor people. Currently the program is being implemented in two provinces and eight districts as well as at the central level.

The AIPHSS program aims to achieve its objectives primarily through the provision of Technical Assistance (TA). This TA is directed at conducting research and analyses; providing data and evidence to policy makers; building the capacity of health planners, managers and service providers to overcome health systems bottlenecks in health financing, service delivery, governance and health workforce. TA is provided largely in response to partner developed workplans which are developed annually. In keeping with a responsive facility arrangement, additional tasks may be included as needs are identified throughout the year.

An Implementing Service Provider (ISP) contracted by DFAT provides the services for overall management, operations, program communications, monitoring and evaluation, procurement and management of TA. The ISP also acts as the main fund channelling mechanism for the AIPHSS.

At central level, the key Implementing Units (IUs) are the Bureau of Planning and Budgeting (Roren), the Centre for Human Resource Development (PPSDMK), the Centre for Health Financing and Social Health Insurance (PPJK), and the Unit for Basic Health Services (BUKD). The program is also implemented in the provinces of Nusa Tenggara Timur (NTT) and Jawa Timur (JATIM) with four districts in each province through the Provincial Health Offices (PHOs), and District Health Offices (DHOs). The targeted districts are Sumba Barat Daya (SBD), Ngada, Flores Timur and Timor Tengah Utara (TTU) in NTT; and Situbondo, Bondowoso, Sampang and Bangkalan in JATIM.

Changing Context

Political Context

In this reporting period a new government has been elected and a new Minster of Health is now in place. The policy directions from the new government have not had any significant impact on the AIPHSS program at this stage. The government has announced nine major policy agendas titled “Nawa Cita”. The most relevant of these to the health sector are a commitment to develop a “Healthy Indonesia” a commitment to strengthen and build Indonesian Human Resources. The new minister has provided an indication that areas of focus will be strengthening primary health care in particular in rural and undeserved areas. There is likely to be continued and high level interest in JKN, maternal and child health.

Policy Context

There have been some important changes in the policy context in this reporting period. Most notably regulatory reform has resulted in changes to the decentralisation law UU 23/2014 which outlines the responsibilities for health at the central, provincial and district levels supported by AIPHSS. In addition regulatory reform activities have resulted in a revision of the Minimum Service Standards (MSS). Both

of these changes in legislation will have a national level impact over time. In 2015 the AIPHSS will pilot these changes at the sub national levels.

Other relevant policy changes are the new village law which will direct funding at a village level for community development. The government announced in December 2014 that a total of INR 850 million will allocated to priority villages. This will potentially influence local health policy context at district and sub district levels as local leaders are free to plan and allocate resources according to local needs.

Partnership Context

In this reporting period there has been a significant change in the acceptance and profile of AIPHSS in the Ministry of Health (MoH). The program has become more visible, valued and understood by partners as a flexible mechanism for the provision of TA to the MoH to meet emerging high priority policy demands and system problems; problems which cannot be met by the regular MoH planners due to the rigidity of government planning and financing systems. An increase in the demand for national and international TA (planned and unplanned) in 2015 is anticipated and the AIPHSS is well positioned to continue supporting the government's sectoral reform and health systems strengthening agenda.

There is a palpable change amongst some partners in terms of the acceptance understanding of a "health systems approach". This was demonstrated in recent questions arising from IUs at the sub national level in JATIM during socialisation of the new PERMATA program, partners expressed concern this was a return to the traditional vertical programs which they were already implementing and they in fact needed a health systems approach i.e. the strengthening of the key building blocks such as health workforce, health financing and governance. This is encouraging as it is one aim of the program is to instil the health systems approach and thinking amongst IU when planning services and developing health policy.

In this reporting some implementing partners reported a level of dissatisfaction of the TA management by the ISP. This was largely related to the delays in recruitment of some consultants and the management of contracts. As a response the ISP will increase the number staff in the ISP TA management team which was not set up to manage the volume of TA requests that are being now being processed. In addition the ISP is developing fact sheets that provide information on TA recruitment processes and timeframes.

Implementation of Independent Progress Review recommendations

Following the Independent Progress Review (IPR) in January 2014, the ISP senior management team has implemented the recommendations below. This has required socialisation of the changes with the central government and implementing partners at all levels. These key changes include:

Focusing on strategic reforms negotiated at the central level.

The partners have agreed that AIPHSS will progressively shift focus to supporting national level policy development and the Government of Indonesia (GoI) health sector Reform Agenda. The Program Technical Specialist (PTS) was tasked to facilitate the development of a Reform Agenda which has been socialised to implementing partners. There was an initial concern expressed by the sub national government partners about the shift of geographical focus. These concerns were addressed by

briefing the partners on the new Primary Health Care and Maternal and Newborn Health[7] (PERMATA) program which will commence in mid-2015 and continue to provide support at the sub national level. To ensure continuity, the AIPHSS program will continue to operate at the sub national level until PERMATA is fully operational.

Restructuring Program Management

Further to the 2014 IPR, a new senior level governance structure has been established in the program. This includes the Secretary General (SG) of MoH as the overall Program Director (PD) and the development of a new position of Technical Director (TD) to lead the technical management of the program and facilitate linkages across the implementing units. The TD is further supported by a Senior Liaison Officer (SLO) to support coordination across and outside the MoH. The Head of the Bureau of Budgeting and Planning (Roren) acts as the Program Secretary (PS). The PTS will maintain high level strategic oversight of the program and facilitate policy influence and uptake. The new management structure is displayed in Annex 2.

The management structure and terminology which mirrored Global Fund to Fight Tuberculosis, AIDS and Malaria (GFTAM) have now been fully removed. The Program Management Units (PMU) at the central level have merged with the ISP to provide a single management unit. Similarly, provincial and district level teams are now under the direct management of the ISP and are much reduced in terms of staffing with only 22 staff now at the sub national level offices (2 in each district office and 3 in each province office).

Increasing the range of partners

DFAT have held initial discussions with the administrative body for Social Health Insurance BPJS) regarding their inclusion in AIPHSS through the provision of international TA. Also proposed is the inclusion of the Health and Nutrition Unit in BAPPENAS.[8]The addition of these agencies to the AIPHSS program was discussed and approved by the Program Steering Committee (PSC) in a meeting held during November 2014.

Clarifying internal roles, responsibilities and levels of authority

Following the restructure of the ISP, there has been an attempt to clarify the roles of DFAT, the ISP, PTS and PMU in the management of the program. There was a concern that DFAT's involvement in the day to day management of the AIPHSS program created confusion in management decisions. This has changed following the IPR which recommended that DFAT step back from day to day management and focus more on partnership management, strategic decision making and policy dialogue.

The management leadership, operational decisions and accountability now rest clearly with the ISP Team Leader. The reality of implementing this change with government partners, SLO and PTS remains complex and although accountability has shifted entirely onto the ISP, key decisions remain with Roren, PTS and DFAT. With the appointment of a new Technical Director (TD) it is expected that this role will address the gaps and fragmentation in higher level decision making and accountability.

---

[7] PERMATA is the new DFAT program to be implemented in 2015 which aims to address maternal and newborn death and childhood stunting, including family planning, nutrition and access to quality care and to strengthen primary health care systems to better address the double burden of disease Indonesia faces.

[8] These agencies were included to undertake cross sectoral coordination for health policy and health financing.

Increasing Technical Resources

The new program structure includes senior technical specialists for PPSDMK, PPJK, and BUKD.[9] The ISP is currently in negotiations with international TA for Human Resources for Health (HRH) to provide intermittent input for a period of eighteen months with an international Health Financing expert to commence in January 2015 to provide technical assistance to PPJK and BPJS.

Health Policy Unit

The Secretary General has proposed the establishment of a Health Policy Unit (HPU) which will be linked to special advisers in the MoH. The purpose is to supply high level rapid policy advice to the minister on emerging policy issues. The MoH has requested two technical advisers and support staff to establish the new unit by January 2015. They MoH has also requested ad hoc technical input from external advisers, this is a role that could potentially be filled by the expert teams involved in development of the Health Sector Review (HSR). The Terms of Reference (ToR) for the new policy unit has been submitted to DFAT for approval.

Implementation Progress and Challenges

Summary of Activities Implemented by Component Objectives

This report uses the component objective structure as defined in the Performance Framework (PF) June 2014 (Annex 6 summarises progress against intermediate and outputs indicators). A revised Monitoring and Evaluation Plan (MEP) submitted to DFAT in November 2014 proposes modifications to the component structure to more accurately capture the current scope of the AIPHSS program following the implementation of the IPR recommendations.[10] The revised framework will be used for all subsequent reporting of the program.

Component 1: Leadership and Governance

The Ministry of Health, Universities and research institutes use evidence and up-to-date information to make 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.

The activities conducted under component 1 encompass the scope of evidence and information, policy influence and regulatory change designed to overcome policy and system bottlenecks identified by partners. The emerging results demonstrate positive progress towards intermediate outcomes.

National Level

Three major activities at the national level were implemented as planned and on schedule. The first of these major activities was the HSR, an evidence-based sectoral analysis undertaken by expert teams and coordinated by Bappenas and the ISP. This has proven to be influential in the preparation of the National Mid Term Development Plan 2014-2019 which subsequently influenced the MoH Five Year Strategic Plan (Renstra). The connection of the HSR, National Mid Term Development Plan and the MoH Renstra represents an evidence based policy development process that has been significantly influenced by resources and services (financial, technical and management) provided by the AIPHSS.

[9] Further negotiations with BUKD are required before agreement to recruit a technical adviser.

[10] The Performance Framework (PF) used in this report is the same as the previous Six Monthly Progress report. The PF has also been revised in the new MEP which is awaiting approval by DFAT.

The approach taken by the AIPHSS focused on a process that placed the GoI firmly in lead, ensuring engagement with the internal policy process. This approach is in contrast to the last HSR conducted in 2011 which predominantly placed the emphasis on technical aspects only and did not achieve the same level of uptake. The timing of providing these technical analysis and evidence has been vital in being able to influence policy. An important lesson learnt is that the timely provision of demand driven evidence into a policy process led by government is a key pathway to achieving evidence based policy uptake.

The HSR process has been very well received by government partners and the Deputy Minister for Human Resources Development and Cultural Affairs, Bappenas stated at the HSR dissemination in November 2014 that it was considered as “good practice model in evidence based health policy development”.

Secondly the revision and approval of the decentralisation Law 23 and revision of / changes to MSS are major achievements in national health sector reform. The changes to legislation which AIPHSS inputs focused on are the health section of the law. These include defining clearly the role and responsibilities of health care at each level of government; this was not stated clearly in the previous Law 32/2004. The implications are that accountability of health functions will be clearer; the legislation has also introduced sanctions at the different levels of government if they do not deliver against their responsibilities. This is an important factor of the legislation as in many districts local governments have sidelined health since decentralisation which has contributed to poor or static health development in many regions. In areas where the local governments are poorer and do not have the adequate resources the legislation states that national government will provide targeted support to assist those districts to improve performance. The role of MoHA in this legislation has been vital as this ministry has the power to enforce such legislation at local levels.

The changes new MSS are also an important contribution in the development of more holistic services at a primary health care level. The analysis undertaken by the ADINKES expert teams revealed that the previous MSS did not provide appropriate indicators, they were overly focused on maternal and child health did not address non communicable diseases (NCDs), did not address public health and promotion. Furthermore, operational definitions were unclear and the MSS were poorly integrated with local regional development plans. The revisions have attempted to address these problems and provided a set of standards based on the life cycle approach which provides services from pre-birth to elderly care including screening for major NCD risk factors such as diabetes and high blood pressure which may lead to preventable morbidity.

The approach of using the Asosiasi Dinas Kesehatan AADINKES) has been important in demonstrating an alternative pathway to achieving more efficient regulatory reform. In part, this was possible because *Asosiasi Dinas Kesehatan* (ADINKES) is an association of senior health officials and technical experts with a deep knowledge of the health system, Indonesian health legislation and decentralisation. Their skill sets coupled with strong relationships with senior officials in the MoH and the Ministry of Home Affairs (MoHA) were fundamental in achieving regulatory change in a period of just nine months and gaining approval in parliament in an election year.

Overall a focus on regulatory change is emerging as an important feature of the AIPHSS program which is proving to be an essential factor in the sustainability of outputs and program outcomes.

Activities Completed

Health Sector Review (HSR):

Scope: Ten teams of experts produced a sectoral analysis which provided evidence based recommendations and targets for the RJPMN process.

Key Output: Ten reports, one consolidated report, ten policy briefs, four technical notes and a dissemination forum.

Achievement: The HSR documentation was completed in June 2014 and final dissemination took place in November 2014. Results of the dissemination have led to a further demand for the reports by

the Secretary General providing an opportunity for the uptake of recommendations amongst the senior management in the MoH institutions.

Next Steps: Further dissemination of the reports followed by a policy dialogue series aimed at targeting policy makers with evidence from the review.

MoH Five Year Strategic Plan (Renstra):

Scope: The HSR was used as an evidence base to provide targets and strategies for the National Mid Term Development Plan (RJPMN) by Bappenas (National Development Planning Board). The targets and strategies were then used to guide the development of the MoH Five year Strategic Plan (Renstra). AIPHSS provided TA to the MoH for the production of the Renstra which will guide implementation of all national health programs. AIPHSS will undertake an evaluation to demonstrate the correlation between recommendations made in the HSR, RJPMN and the subsequent RENSTRA

Key Output: A draft Renstra 2015-2019 was submitted to Bappenas in October 2014.

Achievement: The Renstra has been shaped by the HSR and contributes to evidence based planning and programming in the MoH. According to the HSR team leader who was involved in the previous HSR and RJPMN process in previous years the linkage with the RJPMN was not as strong. The analysis undertaken by the 2014 HSR and the links with the RJPMN technocratic process meant that MoH units were consulted and involved in shaping the strategies and indicators. This led to not only good coordination between the MoH and Bappenas ministries but also a Renstra which is more aligned with the RJPMN indicators and more likely to be accepted by technical units in the MoH. This process of alignment did not take place in the previous HSR which meant that although analyses were good the evidence was not adequately used at the planning and programming levels.

Next Steps: The Renstra will be assessed against the vision and mission of the new president. Once approved all departments in the MoH who will be required to apply the plan. The contribution of the Renstra to AIPHSS outcomes will be evaluated in 2015.

Decentralisation and Regulatory Reform:

Scope: The AIPHSS contracted ADINKES to undertake legal reform in the following areas:

- Clarifying the role and responsibilities of national, provincial and district level government in the provision of health under the decentralisation law UU23;
- The revision of MSS to be provided at the health centre level;
- Changing organisational reporting of a health centre and a district hospital from the district government office to the district health office;
- Developing standard competencies for heads of a health centres and district health offices; and
- Regulation which allows a health centre to become a semi-autonomous unit.

Key Outputs: All of the above revisions have been completed and included in the revised law UU23/2014.

Achievements: The revised law was approved in September 2014 and the legislation has now been enacted in law. The legislation will have wide scale national impact on health governance and basic services delivered at primary health care. Key services that will be provided through the new MSS

- Couples of fertility age: health screening and reproductive health care;
- Pregnant mothers: pregnancy care package;
- Maternal care : maternity care package;
- Newborns : Newborn health care package;
- Under five children: Under five children health care package;
- Students: Health promotion and health examination;

- Adolescents: Health examination and early detection of priority health problems;
- Adults: Health screening and early detection of high risk health problems and cancers;
- Elderly: Health screening and early detection of some high risk health problems.

Next Steps: AIPHSS will support dissemination of the law which will be undertaken by MOH, MoHA and ADINKES. This will include a policy dialogue meeting to discuss the implications with senior policy makers across related ministries. Specific steps that will funded by AIPHSS to progress the implementation and application of the new MSS

- Development of procedures and criteria to implement each of the new MSS
- Costing of the new MSS
- Training in the implementation and application of the new MSS at the sub national levels

Sub National Level

New Provincial Level Regulation on Human Resource Distribution:

Scope: Technical consultants were provided to the Provincial Health Office (PHO) in Java Timur (JATIM) to draft a new regulation which addresses problems of mal-distribution of health staff at the provincial level. The causes of mal-distribution are complex and include personal bias in placements and medical specialists being unwilling to be placed in areas where they cannot run a private practice. Additional factors include poor management of HR including a poor performance management and lack of effective monetary and non-monetary incentives. The new legislation focuses on limiting the influence of local governments in the distribution of staff and outlining standard approaches to the management of HR. This legislation is specific to JATIM however the provincial health officials have been coordinating with MoH at the national. There is potential for replication if the PPSDMK facilitates wider dissemination of the legislation once finalised.

Key Output: The legal drafting was finalised and approved by the local government in September 2014 and socialisation and implementation is currently being conducted in JATIM.

Achievements: The legislative change for Human Resources for Health (HRH) at the sub-national level. It is the first time that the problems mentioned above have been addressed at the provincial level.

Note: The AIPHSS provincial team reports resistance from the local Bureau of Civil Service (Bureau Kepegawian Daerah or BKD) which does not want to accept the changes for government civil servants at the local health centre claiming it can only apply to private sector employees. Further advocacy by the local government supported by AIPHSS is ongoing with this agency to implement this local legislation. This demonstrates lessons learned regarding how policy change in HRH requires the cooperation and linkages between different government departments, as responsibility is shared between different government departments.

Next Steps: The new legislation needs to be disseminated at the national level followed by implementation by the provincial government.

Health Systems and Regional Mid Term Development Plans (RJPMD):

Scope: This activity has been implemented in NTT at the provincial level. Technical consultant was contracted to lead a cross sector team to integrate the National and Regional Health System (SKN) into the next Five year RJPMD. The objective was to ensure that the local health systems are responding to and aligned with national priorities and to include a health systems approach within the regional development plans.

The consultant team conducted an analysis of the RJMD plan against the national health systems framework revealing that the RJPMD did not appropriately include improvements to health financing,

human resources, health information systems, health regulations, research and development. The analysis has been finalised and inputs were subsequently prepared for the local government (Bappeda) to improve the RPJMD prior to being submitted to the plenary session at the Parliament. In NTT the consultant reported that Bappeda was less open than expected to accepting the inputs prepared by the team, because internally, they do not clearly understand the position of the national and regional health system within the regional development planning system. Therefore further socialisation and advocacy by the provincial health office to Bappeda will be necessary in the next reporting period.

Key output: Analyses of local health systems in provincial level mid-term development plans.

Achievements: To date evidence is unclear as to what extent the analyses have influenced the targets or strategies for health in the local RJPMDs.

Next Steps: The M&E of the program will evaluate the contribution of these analyses to evidence based policy at sub national levels. This will be assessed through specific evaluations conducted in 2015, these will assess to what extent the analyses have been successfully used in regional development plans.

Component 2: Health Financing and Human Resources

Health offices in twenty districts in five provinces and at national level implement health financing and human resources for health 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.

Measureable progress towards stated outcomes from the activities under this component will require considerably more time. It will be complex to measure the direct influence on policy and programs for access and quality to primary health care. This component includes the combination of strengthening the capacity for HR planning at national and sub national levels; introducing regulation to address bottlenecks in the distribution of HRs; strengthening financial management and analysis through District Health Accounts (DHAs); and improving information systems for evidence based decision making to collectively contribute to improvements in HRH and health financing policies and programs. The challenge is to monitor the application of outputs by planners, managers and service providers in order understand the contribution at an outcome level.

The majority of AIPHSS HRH investment is focused at the national level. With the exception of inter sectoral teams and HRH regulatory change no other activities were included in the 2014 work plans at sub national levels. A more strategic approach to the development of HRH policy planning and management at a sub national level is required, it will be important to coordinate this with PERMATA in 2015.

The Health financing component at the national level has been slow in implementation during this reporting period. This has been due to poor engagement by the senior management in IU, this is most likely due to other internal priorities within PPJK. The ISP has attempted to coordinate through the PTS to progress implementation however this has not had much influence on implementation[11]. The ISP continues to coordinate with staff in PPJK and is currently negotiating the implementation of NHA through contracting UI.

The health financing activities proposed by the IU appear ad hoc and lack strategic direction. There is therefore a risk that it will be difficult to demonstrate change against component objectives and outcomes, in particular Health Technology Assessment (HTA) and Case Based Groups (CBGs) which do not have a direct impact on primary health care. Nevertheless both activities represent highly

[11] The role of the new TD is expected to facilitate this type of partner bottleneck which requires more time and influence from a higher level source.

important policy and system strengthening activities that need to be addressed in the context of JKN and have been requested by the Secretary General, MoH.

At sub national levels the AIPHSS support has assisted building capacity within puskesmas for financial management. These types of skills are essential for service delivery levels to commence the shift towards JKN and prepare the systems changes that are required for the future.

Health Workforce, National Level

Capacity development in human resource planning methodologies:

Scope: A technical consultant has been engaged for a period of twelve months to update a national health workforce planning guideline (Permenkes 81) which provides methods and guidance for the calculation of HR at a health facility level. The process of updating this has required several rounds of revisions and stakeholder consultations by the consultant working closely with the Centre of Human Resource Planning.

Key Output: The draft guidelines have been finalised and field testing commenced in November 2014.

Achievements: The activity will strengthen capacity at an individual through the training of staff to apply the new methodologies, at an organisational level the revised methods will provide a tool for calculation of facility based human resources, updated planning and information will contribute to the management of the HR systems. The M&E team will consult with IUs to develop appropriate measures of change and application of the guidelines.

Next Steps: The results of field testing in AIPHSS districts will be used to complete the guidelines which will then be formalised by the MoH legal department and issued nationally.

Improving Human Resource Management Information Systems (HRMIS):

Scope: Two activities have been implemented:

1. Geographical Information Systems (GIS) for HRMIS: Training was provided to staff at national and district levels to provide skills to input HR data into a GIS system, which will be used for human resources planning; and
2. Enrichment Model for HRMIS: This is the first stage of a significant activity to strengthen the HRMIS for improved planning and policy. The output to date is a blueprint model for a comprehensive integrated HRH within the whole PPSDM which previously had six sub departments using different information systems.

Key Outputs: 99 staff trained in GIS applications for HR planning; one blueprint for an integrated HRMIS in the MoH.

Achievements: The blueprint has provided a key step towards a modernised HRMIS within the MoH which will be integrated and standardised across departments.

Next Steps: To establish the database and information technology architecture for the HRMIS system and provide staff with training in its management.

Capacity development for PPSDMK:

Scope: Two senior international consultants were recruited to conduct a scoping mission to develop a capacity development approach for the PPSDM. The scoping mission took place over five days in October involving consultations with the MoH, ISP, DFAT and the PTS.

Key Output: A capacity development plan to strengthen HRH policy, planning and management over eighteen months. The four areas for capacity building are:

1. Training program in policy development for senior executives of PPSDM.
2. Organisational Development of PPSDM.
3. Planning and projection methodologies.

4. Production of a ten year HRH projection based on Burden of Disease, HR required for Universal Health Coverage (UHC) and the Changing Demand for Health Services.

Achievements: Commencing a comprehensive capacity development program for the MoH HR department.

Next Steps: The proposal has been accepted by the PPSDM, the next steps are to refine the proposal and commence implementation in January 2015.

National and Provincial Human Resource Coordination Teams:

Scope: The objective of these teams is to address inter sectoral coordination on HR to facilitate needs based planning, equitable distribution and prevent high rates of turnover. The teams have been initiated in all AIPHSS districts and at the national level and have met on few occasions.

Key Outputs: None. No reports have been produced to date.

Achievements: None.

Next Steps: The lack of progress has been raised with national counterpart in PPSDMK. They will request the teams to produce monthly progress reports to assist in monitoring their effectiveness. Currently there is no measurement of the effectiveness of these teams as no reports have been provided. It is the view of the ISP that these teams are not providing any useful outputs and should be reconsidered for receiving AIPHSS funds.

Health Financing, National Level

Institutionalisation of National Health Accounts (NHA):

Scope: An international consultant was contracted to undertake a rapid assessment of the Institutionalisation of National Health Accounts (NHA) which is a system of measuring expenditure on health which allows government to undertake evidence based planning and resource allocation.

The production of NHAs has been contracted out to the University of Indonesia (UI) however, due to GoI procurement procedures it is very difficult for GoI to contract directly and continue with a multi year contract.

Key Outputs: Recommendations to continue funding University of Indonesia (UI) for NHA for the next two years which produces the NHA for the MoH and Provide support to PPJK to strengthen its stewardship of NHA.

Achievements: Continuation of the institutionalisation process of NHA, however this is not a sustainable solution and the MoH must seek a permanent solution for multi-year contracts to outside agencies.

Next Steps: ISP will contract UI for a period of 18 months whilst supporting the MoH in undertaking an assessment of procurement for third party multi-year contracting for technical services.

In addition, there were nine significant recommendations for PPJK to follow up. Whilst they were accepted in principle it is not yet understood if PPJK has commenced planning to undertake the recommendations. The ISP will continue to monitor implementation to ensure that the impact of the DFAT funding is maximised.

Technical Assistance for JKN:[12]

Scope: In December 2013 an international expert provided a review of the CBG system, which is the basis of hospital provider payment system required for JKN scheme to pay hospitals for patient treatment. The report outlined numerous areas of improvement which required a response from the MoH, however no action has been taken by MoH.

Key Output: A ToR for capacity building in CBGs based on the expert review has been finalised by the ISP.

Achievements: Progress towards strengthening the hospital provider payment system for JKN.

Next Steps: An international team of experts is being engaged to provide a program of capacity building over a period of twelve months. The areas of focus will be

1. An executive development program to improve competencies in strategic management of HR; provide updated evidence on the management of HR at national level.
2. An organisational development program which will aim to improve organisational management and work more effectively across of the five different units within the PPSDMK.
3. The development of a new needs based HR planning method for national level health workforce
4. The production of a 10 year health workforce projection

Health Technology Assessment (HTA):

Scope: HTA is an approach which undertakes cost effectiveness of medicines and medical technology. This information is important for JKN to assess which medicines and treatments can be included in the package of services and for cost control. Capacity to institutionalise HTA is currently weak, there is an HTA secretariat in PPJK that is tasked with developing guidelines and compiling evidence on health through systematic reviews, however the overall policy framework for HTA remains unclear.

Key Outputs: None

Achievements: None

Next Steps: The ISP has received a proposal from PPJK to support the secretariat which is being refined and will be implemented in early 2015.The ISP is also preparing a ToR to engage an international expert as an adviser for the institutionalisation of HTA who will be recruited in January 2015.

Sub national Level

District Health Accounts (DHA):

Scope: Activities related to DHA are carried over activities from 2013. In NTT the Provincial Health Account (PHA) team provided support in Ngada, Flotim and TTU to undertake DHA and their application for decision making and resource allocation. In Flores Timur a cross sectoral DHA team was recently formed that has commenced data collection and analysis of DHA data. In Ngada data collection has been undertaken and now at the stage of data entry. DHA training has been conducted in all four districts of JATIM.

Key Outputs: 4 new teams trained in DHA preparation and analysis.

Achievements: The DHA data will provide an evidence base for reallocation of health financing resources. For example, in Ngada and Flores Timur the data facilitated a decision by local policy makers to introduce a tobacco tax as a way to increase fiscal space for public health.

[12] Support for CBGs is a high level request from Ministry it is not directly related to health financing for primary care as it relates specifically to hospital provider payments. This type of activity demonstrates how AIPHSS needs to be flexible even to high priority demands that fall outside the scope of the AIPHSS component objectives.

Next Steps: Monitor the uptake of DHA analysis and evidence at local levels.

Implementation of National Health Insurance (Jaminan Kesehatan Nasional (JKN)):

Scope: Two activities have been implemented at the district level.

- Dissemination of the changes due to JKN to local health officials in Sampang, Bangkalan, Bondowoso, Situbondo, Sumba Barat Daya, and Flores Timur;
- Development of technical guidelines for puskesmas capitation payments related to JKN in Ngada and TTU.

Key Outputs: Two technical guidelines for the application of capitation for JKN payments and awareness raising of JKN changes.

Achievements: Progress in orienting the puskesmas to the requirements of JKN. Through the AIPHSS support the districts are amongst some of the earliest to develop the above mentioned guidelines.

Strengthening Financial Management in Health Centres:

Scope: Flores Timur and TTU are undertaking activities to strengthen the financial management of operational funds (Biaya Operational Kesehatan, (BOK)). The objective is to strengthen the ability of the head of a health centre to supervise the financial managers, ensuring systems are in place, accountable and transparent according to official guidance.

Component 3: Service Delivery

Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in twenty districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor.

The results of the HSR revealed that the Burden of Disease (BoD) in Indonesia has clearly shifted to Non-Communicable Diseases NCDs. Alongside this, the demand for health care under JKN is predicted to surge over time but the primary care system is poorly prepared to meet this rising demand. Activities implemented under this component have the potential of contributing to a model of strengthened primary health care preparing it to meet the future demands in the era of JKN whilst protecting the role of primary health care in promotive and preventive services.

Important activities are being implemented at the national and sub national level all designed to strengthen primary health care. However the linkages between the central and district levels require special attention to ensure that the central level policy is well implemented at the sub national levels and vice versa that national level policy is informed by local implementation realities. The AIPHSS program under this component is well placed to facilitate this policy and implementation linkage. This will be important once the PERMATA program commences and should be an early stage coordination strategy between the two programs.

Another important factor is the linkages across units at the national level which will impact on service delivery at the sub national levels. For example the HRH planning methods should be linked with the new MSS which in turn must be costed to ensure that appropriate funding is available to local governments. This coordination across the various building blocks is important for systems strengthening as well and policy and implementation alignment to improve primary health care. In the next reporting period vertical and horizontal coordination is essential for reaching program outcomes under this component.

National Level

Distance learning program for nurses and midwives:

Scope: PPSDMK has developed a model of distance learning to upgrade the capacity of nurses and midwives in rural areas to diploma 3 level over a four year period in two districts of NTT.

Key Outputs: Establishment of a distance education program that will be used as model for national scale up

Achievements: The program was launched by the Minister of Health in July 2014 with the first cohort of 87 students. The ISP is the fund channelling mechanism to provide the student scholarships and course funds to the Poltekkes in Kupang. This is the first distance education model developed by the MoH aimed at building the capacity of frontline staff in rural and remote areas. The development of this education provides the MoH with a model and system to reach remote areas to support health staff in upgrading skills to improve the quality of service provision. One of the advantages of distance based course is that do not leave to leave their location and workplace for lengthy periods of time for training purposes, which means they can continue to provide services in regions where there staff shortages.

Next Steps: The ISP has contracted four experts (in distance education and information technology (IT) management) to review and finalise the program Guidelines which includes details on operations and funding for all components of the program. In addition, there are still 16 modules to be written and 147 to be digitalised which will be completed by March 2015. An external evaluation will be conducted in 2015 to inform planning for national scale up. Nevertheless early stage findings through implementation show that the digitalisation and the multi-media system that have been established and can be used if needed for scale up; there is a clearly a challenge in the internet communications in rural and heard to reach areas and this affects the progress of the students, the government internet systems are likely to be ineffectual ; the coordination between local district health offices with the local training schools is essential in the effective management of the program and the students; the management and assessment of the students is essential and local training schools must take this seriously.

Accreditation of Puskesmas for JKN:

Scope: A team of six consultants has been provided to BUKD to produce a new national accreditation tool to be applied at health centres. This is necessary for health centres to improve quality and to be credentialed for the JKN. The activity is ongoing and expected to be competed in 2015-2016.[13]

Key Outputs: Draft accreditation tool which still requires further additions and changes to include the requirements under JKN.

Achievements: Four districts in JATIM have been in testing of the tools in health centres.

Next Steps: The tool requires testing and refinement in other AIPHSS districts. The accreditation tool will be used by the MoH and BPJS as a credentialing mechanism for Puskesmas to become an approved provider of health care for JKN. This system will need to formalised through an external accreditation body which is yet to be established by the government.

Integrated System of Recording and Reporting in Health Centres:

Scope: Commencing in December 2014 a team of six consultants have been recruited to review, simplify and update the current reporting dataset at a health centre level. The information system at the primary health care level has been a long standing problem with large amounts of forms and data collected without clear value. Once the new system is applied at the district levels it will need to be harmonised with the system already established through the Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) program in NTT.

Key Output: None

Achievement: None

Next Steps: Monitor the implementation by the consultant team.

[13] The PTS has proposed that the accreditation system being established by the BUKD is used as the means for implementing the Puskesmas Model study being designed by the PTS. This will need agreement and technical cooperation with BUKD.

Sub National Level

Strengthening referral systems:

Scope: The development of a referral system at the regional and district levels is an essential component of strengthening primary health care and particularly in relation to the new JKN system. Two teams of eight consultants have been undertaking analysis in NTT and JATIM provinces and districts.

Key Outputs: Standard Operational Procedures (SOP) for referral in the AIPHSS target districts and provinces with associated local regulation providing a legal basis for the new SOPs to be applied by hospitals, health centres and local governments.

Achievements: The development of a revised referral system in AIPHSS districts and provinces aligned with the JKN.

Revitalisation of Primary Health Care:

Scope: A range of different activities being implemented at districts levels and includes:

- Strengthening puskesmas for community development: The traditional role of a puskesmas has always been to act as a unit to facilitate community development. Training for health staff to undertake community development activities have taken place in Bondowoso and TTU. The objective is to improve staff competencies in the delivery of outreach services with a focus on health promotion and prevention
- Forum for strengthened community participation in JKN: Implemented in Flores Timur, Ngada and TTU, the activity has resulted in signed agreements that Puskesmas will provide quality services under JKN.

Key Outputs: Puskesmas staff trained community development and in community participation two districts

Achievements: Further assessment is required before achievement can be measured.

Challenges in Implementation in this reporting period

The key challenges remains around technical management, especially the preparations of clear ToRs from partners and the slow decision making by IUs. The program has also been constrained in its capacity to measure progress given the absence of an agreed theory of change (ToC) and corresponding PF and associated targets and indicators. Key issues and responses have been as follows:

1. Process of decision making with key implementing units (PPJK and BUKD) is often protracted and not in sync with program timeframes. This will be addressed with closer coordination and communication with the IUs and also the provision of TA to support the units in planning, preparing ToRs and facilitating faster implementation.
2. During the second half of the reporting period the implementing units were firmly focused on disbursement of GoI funds therefore availability for decision making and implementation related to AIPHSS resulted in unexpected delays. Senior staff will need to provide an informed critique of workplans and scheduling which should anticipate known periods of MoH disbursement and associated activities. In the year ahead, improved planning should result in better paced activities, with an increased rate of implementation initially but then accounting for reduced capacity in the second half of the year.
3. Requirements for developing detailed and clear Terms of Reference (ToRs) continue to require significant inputs and time; whilst essential for quality, this leads to delays and at times frustration amongst the partners. This will be a addressed through additional technical resources within the AIPHSS team to provide support to the implementing partners to assist in writing ToRs monitoring quality and ensure progress of activities.

4. The lack of clarity between the ISP and the PMU identified at the IPR has continued during this reporting / transition period. Whilst not surprising during a period of significant restructure, this has caused confusion and uncertainty amongst partners, particularly with regards to finance, recruitment and procurement. With the restructure and single ISP team commencing 1 November 2014 these issues will be much reduced although significant efforts toward socialisation of the changes and any resulting new systems will be required.
5. The shifts in the program design and associated M&E Framework left the program without any clear and defensible framework against which to measure and report on progress and results. In essence, this 'activity report' reports progress in activity implementation against the Annual Implementation Plan (April 2014) using the structure proposed in the June 2014 draft version of the AIPHSS Performance Framework. Given the dual reporting system in the AIPHSS program (six monthly progress reports alongside annual M&E Reports) this should be adequate, but could certainly be improved with some clearer statement of indicators of success. As a responsive facility, the AIPHSS provides only guidance (against the Reform Agenda) on activities and their subsequent (but not predetermined) outputs. The program cannot therefore claim a logic deductive link between activities and outcomes, more a contribution as is more easily measured through higher level M&E functions.

Stakeholder Engagement and Ownership for Sustainability

AIPHSS is characterised by multiple stakeholders in the different IUs across the MoH at national level and in two provinces and eight districts. Stakeholder management and engagement has become a complex but vital task that requires ISP, DFAT, SLO and PTS to work closely to manage expectations across the stakeholders. With the new focus on national policy development, a wider range of stakeholders will need to be engaged, as health policy development can only be achieved with the coordination and influence with other sectors; the role of the PSC will also be key.

The focus in this reporting period has been to support the main stakeholders in the implementation of the AIPHSS workplans and maintain close coordination to monitor implementation. The level of stakeholder engagement has increased but there are specific relationships with PPJK and BUKD that require further strengthening in order to increase the rate of implementation and enhance ownership and sustainability of the AIPHSS outputs and outcomes. The level of engagement is affected by the workload of each of the IUs to implement their regular programs and budgets which must be utilised before the end of the calendar year. This has resulted in a slower rate of implementation in this reporting period and made it difficult to access IUs and gain decisions about the implementation of AIPHSS activities. The changes in the AIPHSS management structure now allows the ISP to have a more direct engagement with the IUs at the national and sub national levels. This has commenced through the socialisation of the ISP team structure as well as the operational and management systems, this will facilitate faster implementation.

Roren: Bureau of Budgeting and Planning

Following the management restructure and the removal of all GFTAM related terminology and structure there is no principal recipient and Roren is now designated as the Program Secretary (PS). As a result, the head of Roren is required to undertake the internal administration and coordination required to implement the AIPHSS program. Roren remains the primary MoH counterpart for the AIPHSS program and the ISP, but with reduced control over implementation and reduced accountability. The quality of engagement with the Roren has improved following the appointment of a new head who takes an active interest in the program and keenly supports the coordination, requesting regular feedback and facilitating problem solving. In addition, Roren is a now an official IU with several important activities related to governance, planning and budgeting, MSS and follow up of HSR related activities under its responsibility.

PPSDMK: Department of Health Workforce and Development

The relationship and engagement with the PPSDMK remains very positive. During this reporting period the ISP secured new international HRH experts who undertook a scoping mission to prepare a large scale capacity development program of PPSDMK. The participation and openness of the senior PPSDMK team was positive and eager to progress with the capacity development plans.

The PPSDMK is one of the more complex IUs as it has several sub-units which have activities in the AIPHSS workplan. However, there is a lack of overall cohesion amongst these different sub-units and the resulting PPSDMK workplan appears fragmented without a clear strategy.[14] In the next reporting period, further efforts through technical coordination meetings and through the organisational development training will be used by the ISP to strategically align these different sub unit workplans.

PPJK: Department of Health Financing and Insurance

The quality of the relationship has improved in the current reporting period but there was only one activity implemented, this was the rapid assessment of the institutionalisation of NHA. There appears to be a lack of strong leadership, poor technical capacity and limited availability of staff in PPJK to engage with AIPHSS. This slow progress in one of the key AIPHSS building blocks poses a risk in the program being unable to demonstrate contribution to intermediate outcomes in health financing within the life of the program.

AIPHSS will provide further international TA to the PPJK in 2015 which will assist in progressing activities. As the ISP is now permitted to establish a more direct working relationship implementation of activities should accelerate in 2015, but will require close monitoring giving the constraints mentioned.

BUKD: Department Basic Health Services

BUKD have had increased engagement with the AIPHSS program, commencing with the development of the system for national accreditation of health centres. Despite the increased engagement, the relationship remains uneasy with BUKD being one of the most critical and vocal IUs of any operational issue which does not meet with their expectations. All communications with BUKD must be through written letters and includes feedback on ToRs, queries related to budgets and changes to work plans. BUKD also prefer that these formal letters are provided by Roren, not the ISP which they view as an external non-governmental agency. This situation slows implementation, negates the implementation flexibility that ISP can provide and creates tensions in communication between the ISP and BUKD. Further efforts will be required by the ISP Team Leader, PTS and the SLO to strengthen the quality of engagement and relationship with BUKD and develop a more direct working relationship with BUKD staff.

NIHRD: National Institute for Health Research and Development

The NIHRD was initially involved in the early stages of the program to assist in the preparation of a baseline. The quality of the baselines produced by the NIHRD team was too poor to be sued by the program. Since then the involvement has only been through the HSR where the NIHRD took the lead for producing the Burden of Disease study which they completed with international experts. The current relationship remains open and cordial but not further activities have been planned. However the NIHRD are an important unit within the MoH and maybe considered for further involvement for research and analysis in 2015.

Bappenas: National Ministry of Planning

The ISP has maintained a very positive relationship with Bappenas exemplified throughout the HSR process. This positive and productive engagement will be maintained through the next reporting period. DFAT have proposed that Bappenas is now included as a formal IU in the AIPHSS program.

[14] There is a technical management responsibility here that has not appropriately addressed the lack of strategy. There is an assumption that Reform Agenda provides this, however, the Reform Agenda serves well as an organising framework but not a strategy.

National Administration Body for Social Insurance (Badan Penyelenggaraan Jaminan Sosial, BPJS)

The BPJS is an important new stakeholder in the era of JKN as it is responsible for administration and provider payments. DFAT and the PTS have held an initial meeting with senior management in BPJS and a proposal to provide part time international TA to BPJS for strengthening quality control is being prepared and will be implemented in early 2015.

Progress and Changes in Program management

Program Management

The role of the ISP has changed substantially with all management responsibilities including the management of ten subnational offices now falling under the ISP. The PMU at the central level has been discontinued and there is now a single management office. The ISP functions as one team with all staff reporting through to the Team Leader who in turn will report to the TD once recruitment is finalised in late 2014.

Under the previous management model (prior to November 2014) there was moderate confusion amongst the partners with regards to systems of management as well as points of contact. There were also barriers to implementation felt by the ISP team, as the PMU presented a barrier to developing direct relationships with the implementing partners, as all management was intended to be through the PMU. In this single management model, the ISP can now directly approach the partners for clarification on activities such as ToR, budgets and implementation issues and provide direct support in the development technical requirements. As part of the process, the ISP has commenced socialisation[15] of the restructure to partners to provide clarification on the role and support that can be provided as well as an introduction to all ISP team members. Indications to date are that this will open communication and lead to a strengthened relationship between the IUs and the ISP.

ISP Management functions

Under the restructure, the ISP undertook a re-recruitment process for the national level and ten sub-national offices to select staff in accordance with the revised ISP organogram. During August – September 2014, all sub-national positions were deemed vacant and advertised internally. All positions were successfully filled and the new positions commenced on 1 November 2014 (with the exception of one administration staff member for the ISP office within the MoH). See Annex 2 for new management and ISP structure.

As the PMU has been integrated, all processes now follow the ISP systems for financial management and controls, HR, procurement, management and reporting. As such, the ISP continues to manage the procurement of goods and services as well as contracting all TA and subcontractors in support of activity implementation (see Annex 3 Procurement Update).

Technical Assistance

The ISP has contracted 28 technical consultants in this reporting period, including the provision of three international advisers for HR and a Health Financing adviser. The TA pool has expanded and a database to facilitate contracting of technical consultants is in the process of development. This

[15] To date socialisation has only occurred with PPSDMK which the ISP organised directly. The ISP has been requested by the SLO that socialisation should be coordinated through Roren and ISP should not undertake direct communication on this issue.

database contains the details of approximately 120 international and Indonesian advisers who have been contracted [16] by the ISP for a range of health systems technical requirements. To maintain an updates with the TA pool the ISP sends regular emails to all experts that have been contracted to date to advise of upcoming opportunities in accordance with the TA plan to garner expressions of interest amongst their networks.

During the AIPHSS Review and Planning Workshop in October 2014, the ISP received feedback that the TA procurements systems were causing delays in implementation of some activities.[17] The main reason for the perceived delays was found to be a low level of understanding of the detailed processes and information required to procure and contract quality technical advisers. The ISP has responded to the feedback and commenced a socialisation of procedures including simple language fact sheets to the IUs to ensure better understanding of requirements and likely timeframes of recruitment to better manage expectations. Further improvement can be made through the ISP teams working more closely with the IUs in planning their requirements.[18] The ISP is confident that this focus on relationship building and socialisation of processes will be improved in the next reporting to satisfactorily address these issues.

Challenges in Procurement of TA

External consultants, as required by the AIPHSS are expected to have high level of quite specialised skills and experience. The availability of such high calibre TA, particularly at short notice, is often quite limited. Furthermore, almost all AIPHSS activities require specialist knowledge with experience of internal MoH health systems, policies, guidelines, tools and manuals. The majority of these skill sets lie within ex MoH staff or some within the university sector, these skills are not readily available in the private market. Therefore, the most appropriate way to respond rapidly to TA needs has emerged as a collaborative effort between the users and the ISP using a network approach to source the right specialists to deliver technical products. In this way the ISP procurement rules are applied alongside the recommendations by the IUs, in the case where no advisers are available then the open recruitment option is undertaken in agreement with IUs.

The experience in this reporting period has however required a phase of increasing the TA database with a system of regular calls of interest through a mailing list system to all consultants currently in the ISP pool. The Coffey Adelaide office has supported the recruitment attempts through web based advertisement and supporting the process particularly for international TA. An increased effort to formally register, pre-interview and ‘pre-qualify’ a pool of consultants for the AIPHSS (and potentially PERMATA) has been identified as a priority during this period.

In this reporting period delays in some TA activities have revealed weaknesses in the TA management systems that are now being addressed. The main issues are lack of clarity about who is responsible for the review of ToRs and revision. As the ISP has not been charged with technical responsibilities to date this has been the domain of the PTS. However it is clear that the PTS is engaged at a higher technical level advisory, therefore another level of resource is required for the day to day management of reviews, revision and coordination with the IUs to avoid delays. This issue has been raised with DFAT as it is clear that additional resources are required to fill the gaps in TA management and potentially development of the TA database. These additional resources will be added to the ISP alongside new technical resources for the IUs.

---

[16] Many of these consultants have been directly appointed as the implementing often propose consultants with the appropriate technical expertise

[17] There is an ongoing problem in regards to the quality of Terms of Reference (ToR), and the expectation of almost immediate recruitment of TA. The ISP provides regular support to the IU’s to improve the quality of the ToR which has seen some improvements.

[18] To date, this approach has been very effective in relationship management with PPSDM through the management of the Enrichment Model, PJJ and other activities such as ADINKES revision of the regulations.

Financing Activities

Following the management restructure, the ISP finance team has shifted from two staff to a total of seven, with a finance manager, three finance officers and three finance staff. This larger team will enable the ISP to provide direct support to the IUs on activity planning and budget preparation, financial management and acquittals. In addition, the ISP will undertake direct capacity building of the subnational offices to ensure that partner financial needs are met for implementation (such as budget preparation). It should be noted this is in fact not an increase but a feature of the management restructure where previous structure had two individuals involved in supporting finance monitoring and fund disbursal. The implication is on the ISP senior management to oversee the performance of a much larger team.

During this reporting period an audit was conducted on all sub national offices to assess the first twelve months of operations. In general, operations were satisfactory although there was some inconsistency in record keeping and feedback indicated that the division between the CPMU and ISP had created difficulties in operations and lack of clarity in regards to which system prevailed. There is a need for greater communication between the central and subnational levels to ensure that clear financial processes are followed in accordance with the ISP system. The ISP finance team have developed a schedule over the next quarter to provide intensive training and support to the subnational teams as well as mentoring and training at the central level to clarify inconsistencies identified in the audit.

Due the changes in program and the removal of a grant mechanism, the previous Program Implementation Manual (PIM) contains large sections which are no longer relevant. The ISP is currently revising the PIM to ensure it accurately reflects all the financial and operational changes and provides the national and subnational offices with the implementation guidance that fits with the new program structure and aligned with the ISP operational procedures[19].

Workplan Preparation

In this reporting period a new workplan preparation process was undertaken through a Review and Planning workshop in October 2014. The review revealed that a number of 2014 activities were not implemented and needed to be carried over to 2015. The work plan preparations were completed in November however, as would be expected, following the PSC further revisions were necessary which were finalised in December 2014. The work plans have now been aligned with the Reform Agenda developed by the PTS. These will be detailed in the Implementation plan due late February 2015.

Prior to the program restructure, the CPMU had been responsible for all workplan and budget preparations. This function is now the responsibility of the ISP with the Planning and Budgeting Officer reporting directly to the ISP TL. The previous process was reported by partners as being overly complex with numerous revisions of workplan formats. The process will be reviewed by the ISP and improvements made where required. The ISP will need to adopt an adaptive workplan process due to regular changes to activities and the addition of new activities, quarterly reviews of the workplan will be undertaken and adjustments made as required. Critical to ensuring coherence and contribution to identified outcomes will be the development and more transparent application of activity selection criteria and clear correlation with end of program outcomes.

Cross Program Linkages

In collaboration with DFAT, the ISP is developing linkages with the other DFAT funded programs. In particular the collaboration with the Bureaucratic Reform program has led to sharing information and policy documents developed through the HSR. A joint collaboration is being explored in Flores Timur

[19] In accordance with the ISP contract, there is a POM which outlines all operational process. The PIM will mirror the POM but will be more extensive and specific to the needs of the AIPHSS.

where both programs have offices and activities reacted to strengthening district health offices. Furthermore the ISP is collaborating with the Knowledge Sector Initiative (KSI) to explore a mutually supportive approach to capacity development for evidence based policy and planning in the MoH and potentially sub national levels.

AIPHSS is also working closely with DFAT and the current AIPMNH team to participate in coordination meetings to ensure that the foundations are in place for the linkages between the new PERMATA program and AIPHSS.

Progress in Monitoring and Evaluation

Progress in Monitoring and Evaluation (M&E)

The priorities for M&E over the last six months have been to re-develop and establish the M&E system during a period of significant M&E organisational change and internal program transition. Key achievements during this reporting period have been:

1. Development and delivery of the draft AIPHSS M&E Plan and performance framework.
2. Implementation and analysis of three baseline capacity assessments.
3. Facilitation of an M&E workshop to review and revise program theory and pathways of change for the program which resulted in a rearticulation of the program outcomes.
4. Redesign of the proposed M&E tools and reporting systems.
5. Technical inputs to the MoH National Quarterly M&E meeting.
6. Implementation of the Health Policy Network (HPN) conference participant survey which assessed participant's perceptions on the role and function of the HPN.[20]
7. Addition of two new M&E staff.

Baseline Capacity Assessments

Three baseline capacity assessments were conducted in October and November 2014 in Information Use, M&E skills and Human Resources for Health. The Health Economics and Financing capacity assessment has been delayed until agreement for its implementation is reached with PPJK. The Health Financing Management assessment will be implemented prior to the financial management training for puskesmas in provinces and districts in 2015. The overall baseline assessment reports will be available in February 2015. The baseline capacity assessments will enable analysis of how AIPHSS interventions targeted at individual, organisational and systems levels will influence outcomes. These results will also provide context of how policy is being implemented by AIPHSS IUs and how information is being used for evidenced based decisions.

Shift in M&E and the New M&E Plan

Recommendations from the IPR resulted in the AIPHSS shifting greater focus on policy and strategic reform at the national level. This represents a shift from the original design document which focused interventions at the sub-national level. This shift means monitoring and evaluating will need to measure institutional change, policy dialogue and policy implementation as well as partner relationships across line ministries. The ISP functions more like a facility which provides specialist technical advisory services to the MOH to address identified bottlenecks. Program effectiveness and efficiency will also now be monitored and evaluated. Institutional and organisational assessments with tools to measure the influence and uptake of policy and AIPHSS products have been developed to support the monitoring and evaluation needs of the revised program.

[20] A survey to assess HPN conference participant's perceptions on the role of the HPN was administered at the annual HPN conference held on the 24 and 25 September 2014. Results indicate that the majority respondents (approx. 50%) perceived the HPN as forum for discussion on health system research rather than a network of academics to bridge gaps between researchers and decision makers to better support public health policy.

Technical Support to MoH

The M&E Adviser gave a presentation at the quarterly national MoH M&E meeting on global best practice for the monitoring of national health strategic plans. The M&E Adviser has been assisting Roren with the development of the M&E plan for the new five year strategic plan; this support has strengthened Roren's engagement with the AIPHSS program.

Management of M&E

In the previous reporting period it was reported that decision making in the M&E of AIPHSS had been problematic due to the dual management system and M&E decision resting mainly with the CPMU with influence from the PTS. Since November 1, 2014 the new program structure took effect and the decision making rests firmly within the ISP with the M&E Adviser taking the lead. It is expected that in the next reporting period there will be significant improvements in data collection, management and analysis for monitoring and reporting program performance.

Progress in Communications, Knowledge Management and Uptake

Program communication in this reporting has focused on the production of publications, the management of high level visits, dissemination and developing a closer link with the M&E to showcase program progress and results.

Publications

- Infographics on PJJ and AIPHSS 2014 achievement produced and distributed to public via website and number of events.
- Posters to showcase PJJ and AIPHSS 2014 achievement also produced and distributed.
- Posters of Universal Health Coverage (JKN) finalised and delivered to MoH for further distribution.
- Universal Health Coverage (JKN) comics finalised and delivered to MoH for further distribution.
- Success stories from Provinces and districts produced and distributed through website and various events.
- Updates (articles) from the field uploaded and published via AIPHSS website www.aiphss.com.

Supporting High Level Visits

Minister of Health Visit: In July 2014 the ISP supported an official visit by the Minister of Health to AIPHSS funded PJJ program sites in NTT. The Minister was accompanied by DFAT Health Director along with a number of echelon one officers and related local government officers in NTT and Flores Timur. The minister fully acknowledged and sent her open appreciation for the AIPHSS support of the PJJ initiative as one of the most successful innovations from the Minister of Health during the last two years.

DFAT Minister-Counsellor Visit: In August 2014, DFAT Minister –Counsellor Jean Bernard Carrasco paid an official visit to JATIM Province to engage with DFAT funded program including AIPHSS Program. Briefing material including AIPHSS success stories from the province and district were prepared for the visit.

Dissemination

Health Policy Network (HPN): The ISP supported the dissemination of AIPHSS activities from JATIM and NTT at the annual HPN forum which took place in Bandung August 2014. Approximately 570 participants from Government (MoH, Province/District), academics, research organisations and health related community groups were present and exposed to AIPHSS activities.

A small survey conducted by the ISP showed that participants valued the forum as

- An opportunity to widely disseminate research findings and discuss implications on policy an opportunity to collaborate with other universities and research centres
- Improve networking and communication
- Identify policy directions for government counterparts

The forum is useful for dissemination purposes and DFAT health programs should use this opportunity on an annual basis. The further funding of forums and HPN related activities should be considered for the Knowledge Sector Initiative which has a specific focus on capacity development of universities and evidence to policy.[21]

Health Sector Review Seminar: The dissemination which took place in November involved the design and compilation of policy briefs, a consolidated report and a dissemination forum in the form of a policy dialogue. This dissemination represents the first in a planned policy dialogue which will be implemented in 2015.

Communications for Knowledge Management and Learning Approach

Progress in knowledge management has been slow. The ISP has consistently reported the lack of a knowledge management approach since early 2013. This lack of progress has been affected by an informal understanding that the PTS is responsible for knowledge management. This has created a bottleneck as the PTS and the PTS technical advisers have failed to produce any knowledge products (policy briefs, technical briefs to date). The only knowledge products that have been produced by AIPHSS have been through the 10 policy briefs and four technical briefs through HSR and the 22 policy notes produced by an international health financing adviser.

In order to progress this, the ISP has now prepared a draft Communications for Knowledge Management and Learning Approach which outlines what and how the ISP will implement to communicate and disseminate AIPHSS progress and results (see annex 4 for Communication for Knowledge Management and Learning Approach[22]). The approach links M&E with knowledge management and communications to deliver different learning platforms that can potentially harmonised with PERMATA. Additional external experts are in the process of being contracted to prepare knowledge products for dissemination in 2015. The knowledge management of the program will be a high priority focus for the ISP in the next reporting period.

Progress in Budget Disbursement and Expenditure

Annual budgets are based on the annual work plans developed by central and subnational partners, as approved by the PSC. The ISP collates the work plan budgets to make estimations on the annual requirements and a month-by-month allocation, providing monthly-adjusted updates to DFAT. To date, there has been significant slippage in work plan implementation and the capacity of the partners is often over estimated, with a consistent pattern of underspend and over projection. The ISP manages this by maintaining close contact with the IUs on activity expectations however there are still frequently quite large fluctuations in forecasts as activities are postponed or changed.

The total expenditure for the July – December 2014 period is AUD 4,514,089[23] which approximately 80 per cent of the forecast amount of AUD 5,861,622. There reason for the difference is due to activities not being implemented as planned. As implementation is entirely the responsibility of the partners, the ISP has a supportive role and cannot determine when activities will occur; this impacts on disbursement and accurate forecasting. Some minor variation would also occur due to savings the ISP is able to make through procurement but this would not account for the majority of the variation.

---

21 The HPN did produce policy briefs however their quality was not assessed by the ISP or PTS.
22 In the next reporting period a consultant will be recruited to develop a more comprehensive strategy and plan
23 Note that at the time of reporting it was only possible to obtain actual costs for July – November and December costs remain as per the forecast.

As can be seen from Table 1 below, expenditure has been lower in the current reporting period for program activities – this can be partially explained due to the completion of the ADINKES and HSR activity in early July. These were both costly activities that mainly occurred in the January – June period and whilst IU activities have increased, it has not been commensurate to the size of these two activity budgets. Another influential factor is the increased release of government funds for the period from July – December. GoI planning and funding cycles are always greater in the latter part of the year therefore the IUs are focused on the implementation of their regular activities and AIPHSS receive less attention which affects AIPHSS implementation and disbursement. This will remain a consistent issue but does provide a window of opportunity for early 2015 to accelerate activities.

Table 1 – Forecast versus actual costs

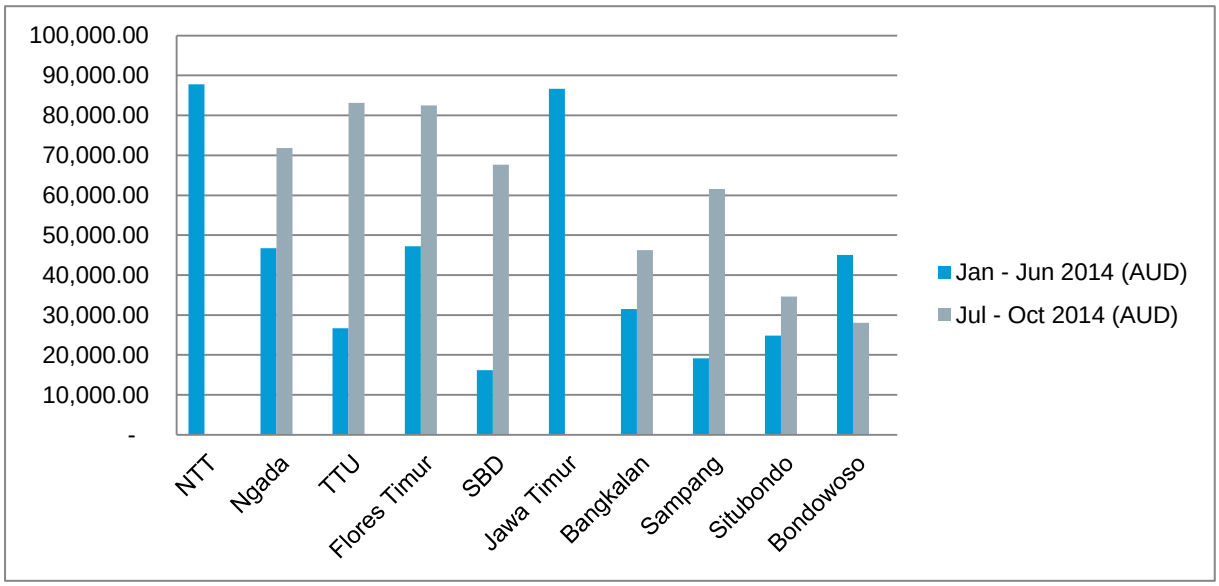
	Actual costs in AUD January – June 2014	Forecast in AUD July – December	Actual July – November in AUD plus estimates for December 2014
LTA	424,101	526,945	451,897
STA	4,657	9,680	27,836
Adviser support	157,039	52,081	45,145
Interim human resources	618,333	547,686	469,910
Program Activities	2,647,657	2,992,220	1,721,110
Operational costs	438,138	848,316	1,148,791
Grant (HPN)	5,568	328,181	61,741
Workshops	-4,171	20,000	0
Communication	27,337	192,704	109,373
Government to Government	0	0	0
Milestones	515,713	$343,809	$478,286
TOTAL	$4,834,372	$5,861,622	$4,514,089

The comparison between the January – June and July – December period demonstrates a consistent disbursement for these two periods. However, if the ADINKES activity and HSR had not been included then we would have seen an increase in disbursement and IU activity in the current reporting period for program activity costs. This would be the expected trend of increased expenditure as the program matures.

There has been an increase in operational costs which is due to the increase in implementation at the provinces and districts.[24] Figure 1 below illustrates the increase per province and district for the period January – June 2014 versus July – October 2014 (actuals available at the time of reporting). Although the activities are essentially the same in JATIM and NTT, transport costs in NTT have resulted in a higher budget for activity implementation. Note that the expenditure for the Provincial JATIM and NTT office has been minimal for this reporting period.

[24] Sub-national budgets are coded within the operational costs.

Figure 1 – Sub national expenditure Jan – June and July – Oct 2014



A breakdown of costs by components shows the largest expenditure to date has been under component 1 which includes the ADINKES and HSR activities and component 3 which is most closely aligned with the building block for HRH and PJJ. These have all been large budget activities that have run over a long period of time.

Cross Cutting Issues: Gender Equality and Women's Empowerment and Social Inclusion

The higher-level impact of AIPHSS is a reduction in maternal, neonatal and child health mortality. The program contributes to health systems strengthening and policy development for primary health care which is largely utilised by women and children, and influenced by the decision making of men. As with most health programs, this is a highly gendered program.

At the central level activities will be implemented to strengthen maternal surveillance contributes to data and information for planning interventions targeted at women. Furthermore a new model of care for neonates at primary care levels will be developed in 2015, rolled out nationally by the Directorate of Women and Children in the MoH, thus improving access and quality of services for women and neonates at primary care levels.

The ISP M&E system now regularly collects gender disaggregated information on all activities which include workshops and meetings. New gender sensitive indicators which have now been included in the performance framework which will allow for an evaluation of gender inclusive of how AIPHSS activities are influencing health systems to be more gender responsive.

The support for more equitable human resource polices to address mal-distribution in poor and remote areas at the primary care level can also contribute to equity gaps between rural and urban regions of Indonesia, particularly for women.

The AIPHSS team do however recognise that much more could be done to mainstream gender across the program.[25] Reflective of MoH, DFAT and Coffey policies and priorities, the AIPHSS needs to ensure that gender is integrated into all aspects of programming. In the next reporting period the

[25] The ISP planned to undertake a gender analysis on the program in February 2013, however this was rejected by Roren at that time.

ISP will therefore recruit a gender advisor to assess the program from a gender perspective, further enhance gender sensitivity of the program and to assess how AIPHSS can further contribute to gender sensitive health policy development. Where it is assessed as necessary, the gender advisor will provide mentoring session for key teams on how to consider gender in planning, programming and evaluation activities.

Risk Management and priorities for the next Reporting Period

The important risks for the next reporting period are:

Governance

Risk 1: The Technical Working Group has been abolished but no formal mechanism has been established to date to replace the technical oversight of the workplan to ensure the horizontal (across MoH Units) and vertical linkages (sub national levels) This may result in fragmentation between the national sub national levels activities which not lead to improvements in health systems.

Recommendation 1: PTS and new TD to undertake an analysis of technical links that are necessary across the MoH units and vertically with the sub national levels and ensure these linkages are established through the quarterly technical reviews.

Program management

Risk 1: TA requests will increase but capacity to manage large volumes of TA and the associated management systems are not able to keep up with the pace of demand leading to bottlenecks in implementation, this will impact on disbursement as well as increase tensions with the IUs.

Recommendation: Ensure that appropriate resources / system development are channelled at TA management. Undertake a review of TA management systems to clarify roles and responsibilities and ensure forward planning of TA recruitment.

Risk 2: The IUs remain very slow in decision making about the implementation of activities and which affects implementation in general but poses a specific high risk of losing international consultants who are unable to wait lengthy periods for decisions. The result is activities not being implemented and essential capacity development activities will not take place leading to poor program performance and program results.

Recommendation: ISP, SLO and PTS to work in close partnership with the IUs to ensure good communication to maintain the rate of implementation. ISP to maintain regular contact with the international consultants to keep them informed of progress and keep them engaged with the program.

Change Management:

Risk 1: The introduction of a new TD may lead to confusion amongst the IUs about the role of the PTS and the TD in terms of who is responsible for technical leadership in the AIPHSS program.

Recommendation: Ensure that the ToRs for both positions are clear with responsibilities clearly divided. Roren to socialise the new position, role and responsibilities of the TD to all IUs. See annex 5 Risk Matrix for an updated list of identified program risks and recommendations for mitigation.

Priorities for the Next Reporting period

The overall focus on in the next reporting period for the ISP will be increase implementation; ensure effective management of TA, increase the dissemination of results and uptake; and enhance relationships for effective implementation.

Specific Priorities

1. **Strengthen TA management systems to provide efficient recruitment and management of consultants and provide stronger quality control.**

   Key Strategy: Conduct a review of TA management systems and ensure the workflow processes are clear and system for ToR preparations is strengthened. Recruit a new technical specialist for the BUKD, PPJK and a TA coordinator within the ISP to strengthen overall TA Management resources.

2. **Support the development of realistic workplans to facilitate planning and budgeting, whist working to increase the rate of implementation**

   Key strategy: Close coordination with implementing partners to increase the rate of activity implementation and regular monitoring of the implementation rate. Provide support to IUs for activity planning and budgeting and ToR preparation to speed up activity implementation.

3. **Increase the production of knowledge products and dissemination of results.**

   Key Strategy: Implement the communications for knowledge management and learning approach (annex 4) and recruit a professional writer to produce knowledge products for dissemination forums.

4. **Ensure new M&E system is socialised and implemented providing improved progress and performance reporting information.**

   Key Strategy: M&E team to undertake socialisation of key evaluations and immediately implement data collection and monitoring system

5. **Strengthen relationship with BUKD.**

   Key Strategy: Undertake the socialisation of ISP and AIPHSS with the BUKD team and through the SLO hold more regular coordination meetings to improve communications and manage expectations and problem solving.

6. **Support revised management and governance structures maintaining a focus on ensuring clarity in roles and responsibilities particularly where decision making impacts upon implementation and accountability.**

   Key Strategy: Communication and socialisation.

7. **Gender Analysis, strategy and workplan.**

   Key Strategy: Recruit a gender advisor to review AIPHSS program and provide a strategy and workplan to guide future planning, implementation and M&E.

Annex 1

Quality at Implementation

AIPHSS Quality at Implementation

Relevance: The focal areas of the component objectives are Governance, Health Financing, Human Resources and Service Delivery at the primary care level these are consistent with Ministry of Health's Strategy and highly relevant in addressing the underperformance and equity problems related to health systems and health policy development.

Effectiveness: The AIPHSS program has shifted focus to national level policy development with a new Reform Agenda. The success of the HSR, legislative change and MoH strategic plan demonstrate effectiveness of the program at a policy and strategy level. The majority of activities in the AIPHSS work plans will contribute to the program intermediate outcomes. As AIPHSS is a horizontal program which will strengthen systems capacity in the four health systems building blocks, the revised theory of change describes the pathways for this program to contribute to broader systems improvements and end of program outcomes in the health of women and children.

Efficiency: The AIPHSS management has been restructured, staff has been reduced and there is now one single management and operational system. This will greatly enhance efficiency of the program. The rate of implementation and disbursement has been slow during this reporting period due to slow decision making and availability of the partners at the national level. There is a need to increase the technical capacity within the AIPHSS program to improve the level of technical support provided to the implementing units for the preparation of Terms of Reference (ToR) and undertake quality control of technical products.

With a restructure into a single model of management and opening of lines of communication with the implementing units (IUs), the ISP can now provide more direct support in implementation and anticipates an increase in new activities.

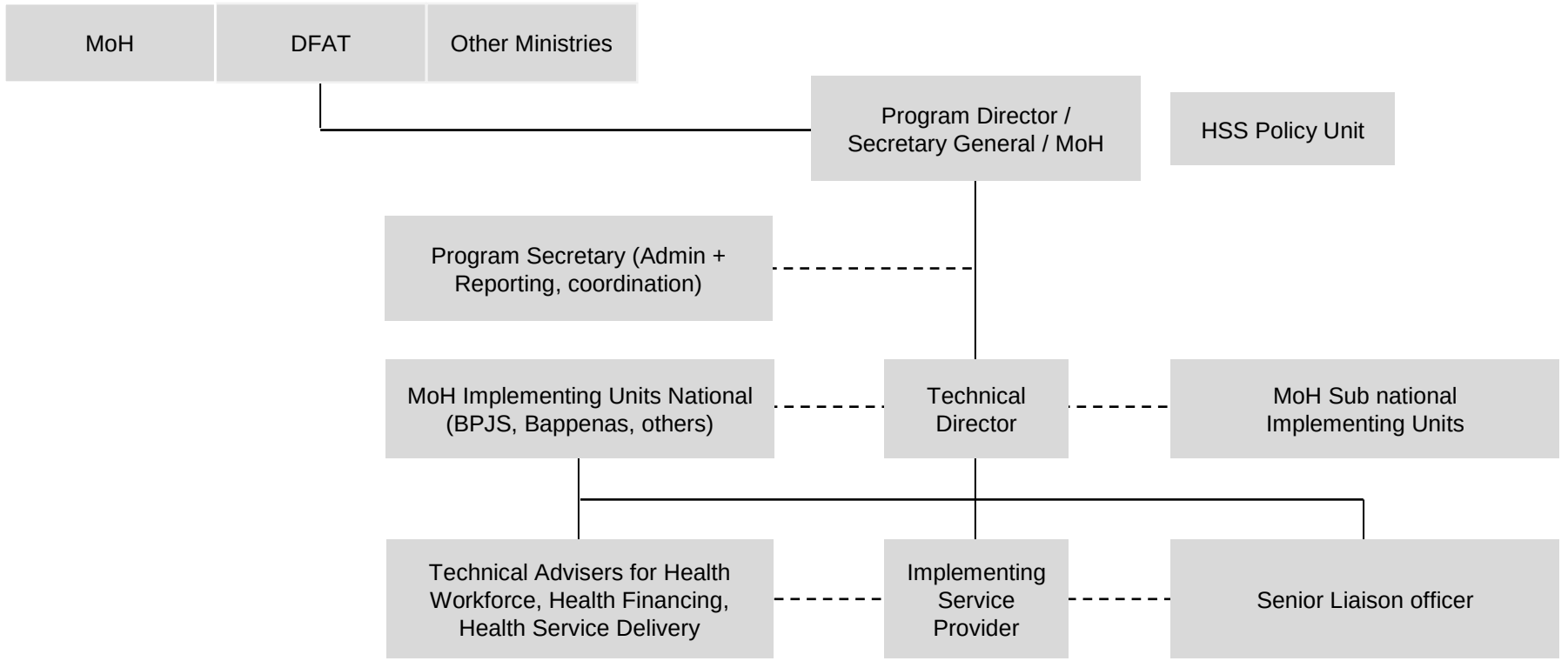
Sustainability : AIPHSS is a GoI led program where all key decisions about activities are made by partners. All implementation is conducted through regular GoI systems in accordance to regulations. The focus on governance and regulation in the program provides a very good pathway to sustainability, for example the ADINKES led legislative revision are changes to national law, the results of the HSR have been included in the National Mid Term Development Plan, technical provision for the development of MoH strategic plan, new legislation at the sub national levels for human resources, all represent highly sustainable activities that will contribute long term health systems strengthening. As the program progresses and more activities are implemented the probability of sustainability of changes led by the program are likely to increase as well as achieving progress towards the intermediate program outcomes.

Annex 2

New Management Structure

New Senior Management Structure

Program Governance: Program Steering Committee; Inter-sectoral Coordination

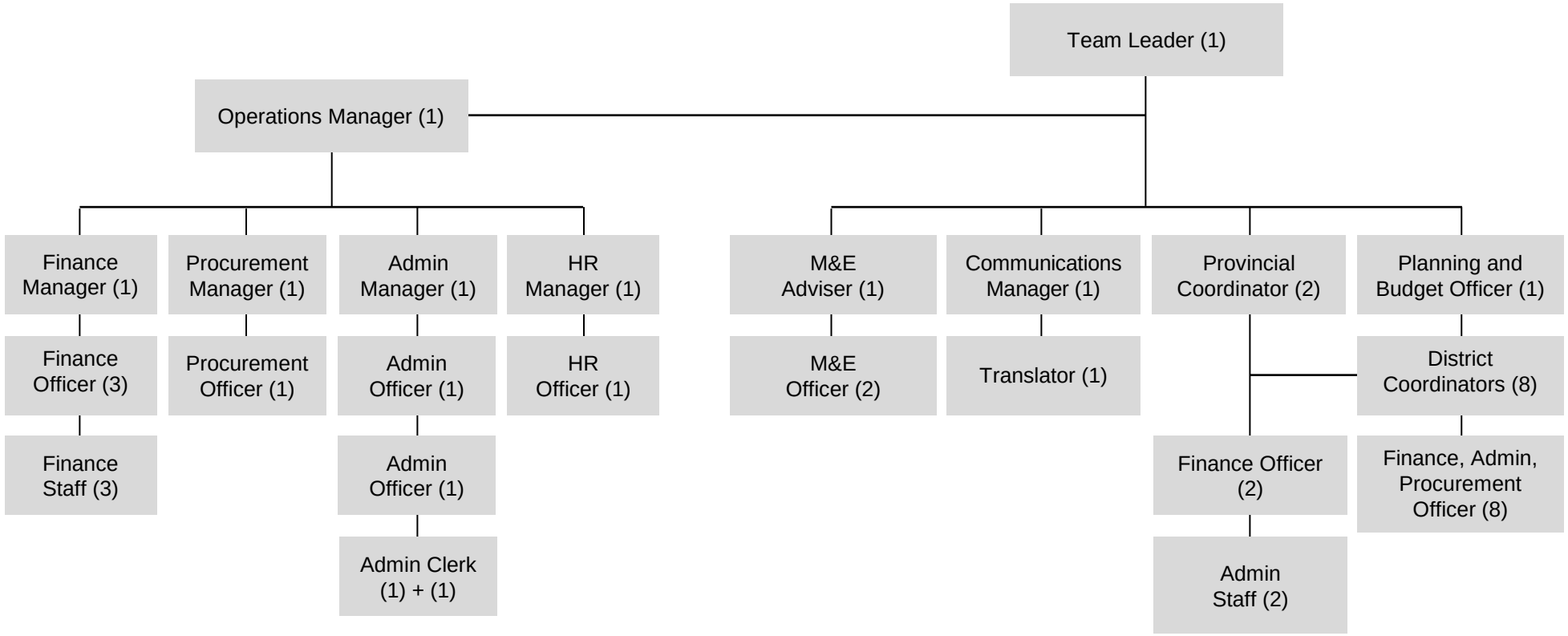


Note: Technical Advisers will be contracted by the ISP to support the implementing units. They will be contractually accountable to the ISP Team Leader, but technical supervision will be provided by the Technical Director.

Represent reporting lines

Represents Coordination

ISP Management Structure



Annex 3

Procurement Update

Summary of procurement activities 2014

Support to Regulatory Reform of Decentralisation of Health Sector

ISP contracted ADINKES for nine months (Sep 2013 – April 2014 plus one month no cost extension).

Resulted in the distribution of role for central, province and district for Health Sector has included in the new Law No. 25 / 2014.

Follow up activity for ADINKES: Socialising the regulatory reforms undertaken by ADINKES to commence application ad implementation in AIPHSS provinces and districts will be implemented in work plan 2015.

PPSDM IT Capacity Development – Geospatial Information Systems (GIS) Training

Contract with Badan Informasi Geospacial (BIG) to deliver the GIS training.

No	Training	Number of Staff	Status
1	Training of GIS Basic level staffs from Districts – Batch I	20	Completed
2	Training for GIS Advance level for Staffs from Central BPPSDM Kesehatan – Batch II	10	Completed
3	Training for GIS Advance level for Staffs from Central BPPSDM Kesehatan and Staffs from District Kesehatan – Batch III	30	Completed
4	Training for GIS Manager level for Staffs from Central BPPSDM Kesehatan – Batch IV	10	Completed
5	Training for GIS Manager level for Staffs from Districts Kesehatan – Batch V	18	Completed
6	Training for Web GIS Open Sources for Staffs from Districts – Batch IV	19	Completed
	Training for Web GIS Open Sources for Staffs from central BPPSDM Kesehatan Districts – Batch IV	20	Planning on 5 December

Brief Summary Related to Long Distance Learning High Education Healthcare (PJJ)

Since September 2013, the ISP has been providing support to PPSDM for the Long Distance Learning High Education Healthcare Program (PJJ). To date this includes support for training the tutors, module writing, printing, digitalisation and converting to multimedia; procurement of IT Infrastructure of Long Distance Learning (IT PJJ); support in the development of guidelines for all aspects of PJJ governance and fund channelling for the Poltekkes and scholarships for the 87 nominated students. Details on the levels of support are as follows:

Writing Modules

The ISP provided support to Pusdiklatnakes – PPSDMK for writing Modules of the Diploma III Nursing and Midwifery of Healthcare which is being implemented by Poltekkes Kupang, Nusa Tenggara Barat for eight semesters or four years. There will be a total of 434 module written with progress as below:

Topic	Total number of module titles	Completed	Not yet completed
Midwifery	214	211	3
Nursing	220	207	13
Total	434	418	16

Based on Petunjuk Operasional Kegiatan (POK) 2014 of Pusdiklatnakes – PPSDMK, financing proposed of the total number of module titles to AIPHSS – ISP for around 380 writing module titles (190 modules each for Nursing and Midwifery)

The writing of the outstanding modules will take place in early 2015.

Printing Modules

ISP has supported the printing of Modules for semester 1 and 2 for both Midwifery and Nursing and as well shipment to Poltekkes Kupang, Nusa Tenggara Timur. Due to the lack of storage space in Poltekkes, the ISP will only support printing costs in accordance with the annual module requirements to avoid loss and damage that may occur whilst in storage.

As the modules for year one have been completed, the ISP anticipates the next printing will occur for year two in approximately April or May 2015.

Modules Digitalisation

A significant number of modules still need to be digitalisation, as described below:

Education	Total number of module titles	Has been digitalised	Has not been digitalised
Midwifery	214	125	89
Nursing	220	162	58
Total	434	287	147

The digitalisation will take place in early 2015.

Multimedia Modules

Conversion of the modules into multimedia has not yet commenced. PPSDMK will review the remaining activity budget to determine what is available for outstanding modules in semester 1 and 2 only. The cost of multimedia module development is RP 5.000.000 per module.

Procurement of Information Technology Infrastructure of Long Distance Learning (IT PJJ)

ISP undertook a limited tender and contracted PT. Matrica Consulting Service for the installation of IT infrastructure. Implementation started April 2014 and was completed in October 2014 with installation of equipment at the Data Centre, PPSDMK Jakarta, Poltekkes Kupang, USBJJ Flores Timur and Sumba Barat Daya. PT. Matrica Consulting Service need to coordinate with PPSDM for the application baseline to the IT Infrastructure for all locations of PJJ including the training for PPSDM IT Staffs and handover the IT Infrastructure. These tasks are expected to be completed in December 2014.

Enrichment Model

ISP subcontracted to consulting company to HRH Data Set Blueprint of HRH information system model which contains:

HRH information system concept.

Architecture of HRH Information system.

Design of data base.

Procedures of cross program and cross sector data exchanges at district/city, provincial and central levels.

Geospatial based information (GIS).

Through the implementation of HRH Information system, it is expected that the HRHIS functions will be integrations across sectors which will strengthen information flows and create a chain of data dependency between sectors and across program.

The Blue Print of HRH information system still requires further activities in order to be implemented properly, gradually and consistently. The Blue print is based on cross program and cross sector studies with the deepening study of the two targeted provinces, i.e. East Nusa Tenggara and East Java as the pilot project. Based on the studies, the recommendations of HRH information system development stages were divided into two main stages: pilot project scope and national scope. This will be explored further for 2015.

Update of Technical Assistance (TA) Activity July 2014 – November 2014

International TA (mobilised since 1 July 2014 to date)

No	Name	Role	Implementing Unit	Status
1	David Peachey	Capacity development in Health Workforce Policy and Planning in the context of universal health coverage in Indonesia	Pusrengun BPPSDMK	Finish
2	Orvill Adams	Capacity development in	Pusrengun BPPSDMK	Finish

No	Name	Role	Implementing Unit	Status
		Health Workforce Policy and Planning in the context of universal health coverage in Indonesia		
3	Ravindra P Rannan Eliya	NHA Specialist	PPJK	Ongoing

National TA (mobilised since 1 July 2014 to date)

No	Name	Role	Implementing Unit	Status
1	Yassierli	TA for Renstra Team	Roren	Finish
2	Soenarjo Soejoso	TA for Renstra Team	Roren	Finish
3	Bambang Hartono	TA for Renstra Team	Roren	Finish
4	Agus Mulyadi	TA for Renstra Team	Roren	Finish
5	Trihono	Team Leader	ROREN	Finish
6	Agnes Savitri Agni	Puskesmas Revitalisation for Strengthening the Community Based Health Promotion Upaya Kesehatan Berbasis Masyarakat (UKBM) District Sampang	Dinas Kesehatan Sampang	Ongoing
7	Widodo Jatim Pudjirahardjo	Preparing inputs for strengthening of health systems in the Strategic Plan of provincial health office SKPD (regional government work unit) – District Sampang	Dinas Kesehatan Sampang	Ongoing
8	Arum Atmawikarta	HSR Team	Bappenas	Ongoing
9	Chiquita Smaradevi Abidin	HSR Team	Bappenas	Ongoing
10	Fitri Inayati	HSR Team	Bappenas	Ongoing
11	Tjahjono Kuntjoro	Responsible for process refining Puskesmas Accreditation	BUKD	Ongoing
12	Restri Rahmawati	Support the Consultant Team of preparing NSPK for Puskesmas Accreditation	BUKD	Ongoing
13	Soenoe Juwana	Help Team Leader in	BUKD	Ongoing

No	Name	Role	Implementing Unit	Status
		the process of refining the draft of NSPK for Puskesmas Accreditation		
14	Nanda Agung Puspawardhani	Responsible for the overall process of financial administration and secretariat process	BUKD	Ongoing
15	Setiawan Soeparan	TA Development of PJJ	Pusdiklatnakes BPPSDMK	Ongoing
16	Pauline Pannen	TA Development of PJJ	Pusdiklatnakes BPPSDMK	Ongoing
17	Hardjito	TA Development of PJJ	Pusdiklatnakes BPPSDMK	Ongoing
18	Uwes Anis Chaeruman	TA Development of PJJ	Pusdiklatnakes BPPSDMK	Ongoing
19	Pardjono Kromoredjo	TA HRH Manual	Pusrengun	Ongoing
20	Andreas Ande	TA for Referral System	Dinas Kesehatan Ngada	Ongoing
21	Emilia Seran	TA for Referral System	Dinas Kesehatan Ngada	Ongoing
22	Frederik Fernandez	TA for Referral System	Dinas Kesehatan Ngada	Ongoing
23	Pius Weraman	TA for Referral System	Dinas Kesehatan Ngada	Ongoing
24	Frederik Fernandez	TA for Referral System	Dinas Kesehatan Flotim	Ongoing
25	Rafael Paun	TA for Referral System	Dinas Kesehatan Flotim	Ongoing
26	Dominikus Minggu	TA RPJMD	Dinas Kesehatan SBD	Ongoing
27	Sabina Gero	TA Perkesmas NTT	Dinas Kesehatan NTT	Ongoing
28	Donny Alverino	M&E Assessment	AIPHSS	Ongoing

Contract with Firm or Institution (contracted since 1 July 2014 to date)

No	Name	Role	Implementing Unit	Status
1	Badan Informasi Geospasial (BIG)	Training of GIS 2014 for Badan PPSDMK Staff	Secretariat Badan PPSDMK	Just finish Milestone
2	PT. Matrica Consulting Service	Infrastructure Development of Long Distance Learning High Education Healthcare	Pusdiklatnakes	Finish the Implementation of Milestone 1,2,3,4,5,6,7. Now focus on Milestone 8 plus Milestone 9 (1 year

No	Name	Role	Implementing Unit	Status
				maintenance period)
3	PT. Taramitra Informatama	Enrichment Model Human Resource of Health Information System	Secretariat Badan PPSDMK	Finish Milestone 1,2,3,4 and 5 of the Contract. Now awaiting approval from Set Badan PPSDMK for Milestone 4.
4	Universitas Padjadjaran Bandung	Health Policy Network Forum	HPN Expert	Finish the Implementation. Milestone 1 has been paid, and now we waiting the Report from UNPAD and Acquittal for Milestone 2.
5	Poltekkes Kupang	Provision of Financial of Support of Study for Students of DIII Nursing and Midwifery Studies at Health Polytechnic of the Ministry of Health, Kupang	Pusdiklatnakes	Milestone 1 of Contract already paid. Milestone 2 report has been submitted and approved by Pusdiklatnakes and waiting for payment. Remaining: Milestone 3 and 4, scheduled to be submitted on October and November 2014.
6	BAKTI	Event Organiser for Health Sector Review Dissemination Seminar	Communication Specialist	On Progress. The HSR Dissemination is scheduled on 27 November 2014 at H. JS Luwansa Jakarta

Annex 4

Communications for Knowledge Management & Learning Approach

Draft AIPHSS Communications for Knowledge Management and Learning Approach for 2015

Introduction

The purpose of this document is to provide the senior AIPHSS Team (ISP, DFAT) and the MoH partners with a knowledge management and learning approach for the AIPHSS program. The approach utilises AIPHSS technical outputs, experimental knowledge gained through implementing activities, analysis produced by the monitoring evaluation and turning these into knowledge products for learning and dissemination through program communications.

The Indonesian Health Policy Context

The AIPHSS program exists in dynamic health policy context, recently the Government of Indonesia (GoI), through the National Development Planning Agency (Bappenas) has prepared the 2015-2019 Medium Term Development Plan (RPJMN). The RJPMN has undertaken a situational analysis covering lessons learnt from and achievements of the previous 2009-2014 RPJMN, the projection of future challenges and potential problems, and the direction of the development agenda during the coming five years.

In 2014 a Health Sector Review was conducted to provide an evidence-based evaluation and analysis to inform the formulation of the 2014-2019 RPJMN. It looks in particular at how the changing demand for health care services relate to current supply of health care services and changes that are likely to be needed in the health sector in future.

- Changing demand for health services
- Fertility, family planning, and reproductive health
- Maternal and child health
- Human resources for health
- Health financing
- Institutional analysis in the context of decentralisation
- Pharmaceuticals, devices and technology assessment
- Quality and safety of health care
- Nutrition and food security
- Supply side readiness.

There is clear evidence of a rapid transition of the disease burden due to increasing non-communicable diseases (NCDs), alongside an unfinished agenda of communicable diseases control (CDC) and static mother and child health (MCH) outcomes. Inequity is a key challenge with wide gaps in health status between social economic groups and between geographical areas.

A new national health system (SKN), which promotes primary health care as the key building block of the Indonesia health care system, was introduced in 2012. In addition, Indonesia has committed to universal health coverage (UHC) by 2019 and has adopted a social health insurance system (JKN), based on the National Social Security System (SJSN) Law-40/2004, whose implementation started in January 2014.

Another important development is the regulatory reform work led by Ministry of Home Affairs (MoHA) to revise Indonesia’s decentralisation laws and regulations. This work formulates a new division of health functions between the central, provincial and district governments. The current Minimum

Service Standard (SPM – Kepmenkes-741/2007) has also been revised. Changes in these functional divisions will affect the structure of health institutions, the standard staffing of the institutions as well as the financing of health programs, especially at the district level.

The RJPMN has provided the Ministry of Health (MoH) with a framework for the preparation of the MoH five year strategic plan. In addition the MoH as an institution is undergoing an organisational restructure.

Public health challenges

The public health challenges over the next five years and beyond which the health sector needs to focus on are the following:

- addressing the inequality of health outcomes
- reducing the maternal mortality rate
- reducing the neonatal mortality rate
- reducing the total fertility rate
- reducing wasting and stunting
- developing a public health program to reduce NCDs with a focus on reducing smoking, obesity and salt intake
- reducing the prevalence of tuberculosis (TB), malaria and HIV
- eliminate the remaining neglected tropical diseases.

It will not be enough to set targets. This was done in the last RPJMN and key targets were not achieved. The clinical and public health interventions to address these areas are known. Policies to implement them are in place and where they are implemented they are successful. If the health outcomes achieved in the best performing geographical areas and socioeconomic groups were achieved nationally, Indonesia would be one of the best performing countries in the region.

Achieving equity in health outcomes and ensuring best practice is delivered evenly across the country to all socioeconomic groups is the single most important step that the health sector can take.

Another important step is to introduce a performance management system that will focus on delivery and ensure that annual targets for key health outcomes and interventions, both clinical and systemic, are set for the MoH, regions and districts. The MoH needs to work with the MoHA to ensure all provinces and districts have good annual health plans to deliver the targets, backed by a performance monitoring framework, which the MoH can help the MoHA to monitor. This should be linked to the annual health sector reviews that are produced by the districts and the centre each year. At the district and provincial levels these should be changed to show progress against key targets and compare district and provincial performance with other districts and provinces.

How does Health Systems and AIPHSS Fit in the current Health Policy Context

Key to achieving many of the targets that are set out in the RJPMN and the MoH strategic plan will be a health system which is fit to deliver a modern health service that is equitable and accessible. Strengthening the Health Systems and support policy reform are key aims of the Australian Indonesian Partnership for Health Systems Strengthening (AIPHSS). The AIPHSS program has four key objectives

1. **Governance**: The MOH, provincial and district health offices in AIPHSS intervention areas have improved capacity to analyse and use information for evidenced based decisions in policy and planning to improve access, utilisation and quality health services for the poor and near poor

2. **Health Financing:** The MOH, provincial and district health offices in AIPHSS intervention areas have improved capacity to manage and monitor health finances to support the policy , planning and implementation of health services
3. **Human Resources for Health:** The MOH, provincial and district health offices in AIPHSS intervention areas have improved capacity to analyse and use HR performance information for the purpose policy, planning, implementation of equitable and quality health services
4. **Health Service Delivery:** Puskesmas staffs in AIPHSS intervention areas have improved capacity to deliver quality primary health care services and provide appropriate referral to improve the health status of the poor families

Aims of the AIPHSS Knowledge Management Approach

The AIPHSS Communications for Knowledge Management and Learning Approach (CKMLA) is an intentional process that is viewed as important for the success and sustainability of the AIPHSS program. The approach intends to enable the capture, dissemination and use of innovations implemented through AIPHSS that have the potential to enhance health systems strengthening and health policy and health sector reform; promote the sharing of experiences and lessons learnt from their development and implementation; and connect communities of policy makers and practitioners to share and learn from the AIPHSS program. The approach will promote collaboration and learning; promote the use of knowledge and evidence to inform policy and advocacy and improve programs and practice.

Linking Monitoring and Evaluation Knowledge Management and Communications

The M&E system is designed to capture program data and information, synthesise it and provide analysis of program progress. This is done at the level of individual activities, building blocks and progress to higher level outcomes. This information is highly valuable and necessary to translate into knowledge and learning in order to gain the maximum value from an M&E system. As part of the intentional process of capturing and disseminating AIPHSS progress and innovation the M&E system will contribute to the supply of evidence and information for knowledge products and different dissemination mechanisms.

It is important to establish this relationship between M&E, Knowledge Management and communications, but is useful to clarify some of the differences. [26]

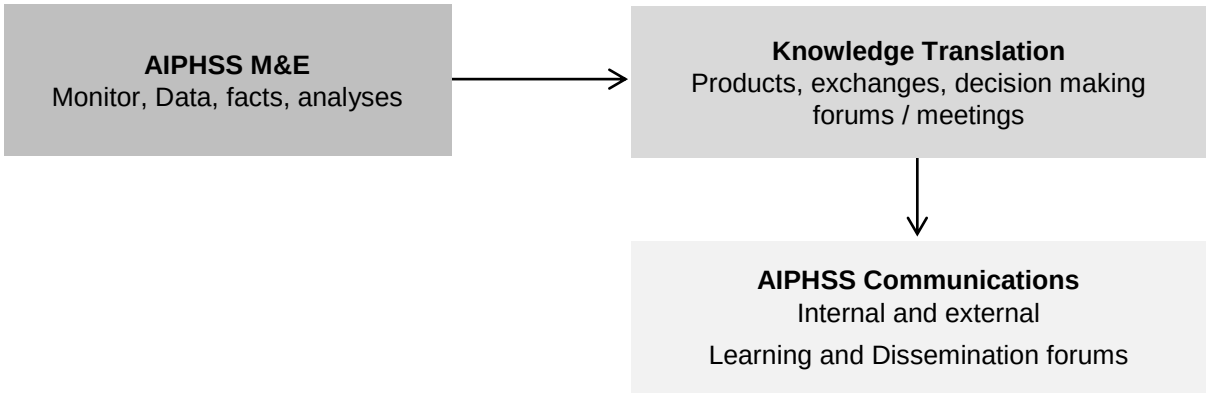
- Data are facts, observations, or measures that have been recorded but not put into any meaningful context
- Information is data that has been arranged in a systematic way to yield order and meaning
- Knowledge is the capability to act and take informed decisions based on the information available
- Communication is the act of exchanging thoughts, knowledge, messages, data or information, as by speech, signals, writing, or behaviour.

AIPHSS approach will link M&E which produces data, facts and analyses about the progress and outcomes of AIPHSS activities and produces information. This information will be translated into

[26] K4Health accessed 28/102014

knowledge products such as policy briefs, policy notes, technical briefs and subsequebtly disseminated through learning and dissemination forums with various audiences.

Diagram 1. Linking M&E, Knowledge Management and Communications



Types of Knowledge Produced by AIPHSS

The AIPHSS program commenced implementing activities in January 2013. During this period of outputs have emerged that have the potential to influence change in health policy and health sector reform as well as health systems at national and sub national levels.

The different types of knowledge will be technical knowledge; experiential knowledge and lessons learned (captured under the 5 key areas below). These types of knowledge are already being captured by the program and will continue to be produced via a range of different media such as policy briefs, technical briefs, success stories and significant change stories.

Human Resources for Health: Activities Include strengthening the National Health Workforce Information Systems; analysis of the quality of educational facilities; technical assistance for the improvement of workforce planning methodologies; regulatory reform at province levels to limit the ability of local interfering in the placement of health staff; the establishment of inter-sectoral human resource teams to address human resource policy change.

Health Financing: Technical support for the improvements in hospital provider payment systems, technical support for national, district and provincial health accounts. At the district level we have an example of using DHA to advocate for an increase in tobacco tax at a local level.

Service Delivery: Accreditation of Health centres in readiness for JKN; Strengthening provincial and district referral systems; Puskesmas Revitalisation.

Governance: Revision of Minimum Standards for Health; Revision of roles and responsibilities for health functions under decentralisation; Setting standard competencies for heads of health centres and heads of District health offices.

Evidence to Policy: Preparation of National Health Sector Review for the RJPMN; Health Seeking Behaviour Study; Health Expenditure Bottleneck Study.

Key AIPHSS Outputs

Health Sector Review (HSR) findings and recommendations

- Model for Long Distance Education (PJJ) for Nurses and Midwives
- Regulatory revision of minimum service standards, health functions under decentralisation; standard competencies for head of puskesmas and district health offices; puskesmas and district hospitals functionally reporting to District health offices
- Puskesmas Accreditation and Referral Systems
- Innovation from East Java on Local Health Workforce Regulatory Reform
- District Health Account in NTT & Jatim.
- Support to RPJMD process (4 districts in Jatim & 3 districts in NTT)
- Health Seeking Behaviour Study
- Health Expenditure Bottleneck Study

Mechanisms for Knowledge Dissemination, Learning and Uptake

Special Learning Platforms[27]

Purpose

These forums will be designed as active learning platforms where partners are able to review, critically discuss and exchange their opinions and ideas for health systems strengthening and health policy reform. In addition forums where program results can be assessed strategically, where there is a process of questioning and analysis, and learning can be highly influential with targeted audiences.

There will be two types of learning forums internal and external. Internal forums will include monthly technical review meetings led by the M&E team to link information on progress with the program planning, where partners alongside the AIPHSS team can critically review progress and share information across the different implementing units at the sub national levels.

Other internal forums are within the MoH such as the RAPIM (Rapat Pimpinan) which is held on a monthly basis and chaired by the Minster with all the Echelon 1 staff. This forum provides an opportunity to insert key messages through policy briefs or presentations on highly strategic issues emerging from the AIPHSS program.

Other internal forums will be designed to share knowledge and information with DFAT and other DFAT funded programs. It is important for AIPHSS to demonstrate to DFAT (including senior management) how the AIPHSS program is strengthening health systems, and achieving, health policy and health sector reform. Another objective is to see synergies with other DFAT programs to enhance the sustainability and impact of DFAT investments.

External forums will take place on a 6 and 12 monthly basis where a wider external audience will be invited to participate in the dissemination of AIPHSS activities and provide a platform for critical feedback and learning across a range of different stakeholders. These platforms will aim to:

[27] These external forums will set the foundation for subsequent forums to be established by PERMATA

Share and disseminate information about AIPHSS program outputs, experiences and lessons learned

- Encourage linkages between complex program areas that can be strengthened to improve coordination and better inform an overall strategy to improve the health systems and health policy reform
- Create an environment for the analysis and use of knowledge and information for health systems strengthening and health policy reform
- Identify areas of further health system and policy research priorities that can be identified from information gaps and lessons learned.

Policy Dialogue Series

There is ample evidence that suggests one of the most effective ways of reaching policy makers with evidence and knowledge is through the use of policy dialogue mechanisms. The AIPHSS program will undertake a policy dialogue series which will be conducted every 6 weeks[28] based on key policy topics that emerged from the Health Sector Review and other AIPHSS activities. It is envisaged that the collaboration for the dialogue will be led by MoH and Bappenas, with inputs from different stakeholders as related to the specific policy topic.

Specific Forums

Internal DFAT seminars

Objectives:

- To present progress and potential outcomes to DFAT audience; and
- Facilitate cross program coordination e.g. AIPHSS/Permata; KSI; AIPD; scholarships.
- Suggested approach: seminar is chaired by John Leigh, topic is selected together with DFAT health team and presented by DFAT with the AIPHSS team taking a lead role in presenting this information

Policy Dialogue Series: Kick off with HSR seminar led by Bappenas and MoH-November 2014

Objectives:

- Wide scale dissemination of HSR findings to high level policy decision makers, echelon 1 or 2 form different government departments; and
- Provide a high level policy dialogue opportunity on the role of health sector and national development plan 2014-2019.

Approach: Hi level Policy Dialogue, with panel and presenters discussing key topics on health policy from the HSR. Potential topics following HSR dissemination:

1. Regulatory reform of health decentralisation-Implications for service delivery:
    - Implementing the revision of minimum service standards for health; and
    - Strengthening leadership competencies of district health offices and health centres.
    - Primary health care for future demands
    - Comprehensive Health Financing
    - Overcoming bottlenecks in human resources distribution policy and planning
    - Addressing frontline services for JKN: Supply side readiness

[28] Approximately 10 dialogue series are planned using the different HSR reports as a basis for the dialogue

- Monthly Progress Review: Learning Platform

Objectives:

- Share progress with key stakeholders internal and external;
- Critique and analysis of progress; and
- Encourage linkages between program areas, especially PERMATA and across other sectors.
- Led by the AIPHSS team: Chaired by the Program Director, Secretary General of MoH and includes echelon 2 staff from key implementing units, Bappenas, BPJS, MoHA, sub national partners

Annual Health Policy Network Seminar: Learning Platform

Objective: Showcasing AIPHSS successes and lessons learnt program and presenting to wide health systems and policy research audience.

AIPHSS Annual Seminar: Learning Platform

Objective:

Annual review of AIPHSS achievements

- Review strategic direction and implications of major outputs for health systems strengthening, policy and sectoral reform
- Review Cross sectoral linkages
- Establish this event as a key Learning Platform for AIPHSS

Approach: Chaired by Sec Gen, John Leigh, PTS:

- Key leads for each Building Block, Echelon 1 or 2 from related implementing Unit to address the key activities implemented by AIPHSS, the added value and potential HSS and policy reform outcomes; and
- Provide a policy dialogue and learning forum to gain feedback and inputs from wider audience.

MoH Internal senior executive meeting (Rapim)

Objective:

- Provide targeted inputs to senior executives on specific AIPHSS outputs/products using policy briefs or presentations by the PTS.

AIPHSS Annual Plan for Knowledge Dissemination and Learning Platforms

Mechanism for dissemination	Lead Agency	Supported by	Frequency	Target audiences	Purpose
Internal AIPHSS reviews	AIPHSS team		Monthly	Internal AIPHSS team, MoH Partners	This internal forum is linked to a monthly M&E meeting which will involve implementing units. The opportunity is to use a monthly review of progress as an internal learning platform. This enhances the value of M&E information, data into analysis for learning and programming
DFAT internal seminar	DFAT chaired by John Leigh with strong AIPHSS team support		2-3 times per year or as requested by DFAT	Internal DFAT, DFAT Funded Programs	To ensure that senior management in DFAT is informed about the progress and achievements of AIPHSS
Policy Dialogue Series Kick Off HSR Dissemination	MoH Bappenas+MoH	Bappenas MoH Different experts would lead the forum and provide knowledge and evidence emerging from the AIPHSS program (or others such as KSI, AIPMNH other DFAT programs)	6 weekly, ten policy dialogue series are planned using the health sector review, but other key products emerging from AIPHSS activities may be used	Targeted policy audience Approximately 200participants from three clusters: 1.Legislative bodies (DPR RI), Related Ministries (MENKES, MENDAGRI, BAPPENAS, MENPAN), Private sector 2.Professional Organisations (IDI, IAKMI, ADINKES etc), Universities, Research Institutions 3.Non-Governmental Organisations (National and	The policy dialogue series intends to feed into the currently dynamic health policy environment. The intention is to address some key policy debates and provide a forum where data and evidence emerging from the AIPHSS is used to initiate debate, create an opportunity for the uptake of AIPHSS outputs

Mechanism for dissemination	Lead Agency	Supported by	Frequency	Target audiences	Purpose
				International NGOs), Donors, United Nations and Media *Refer to HSR list for detail	
6 Monthly Progress Review	MoH	AIPHSS	6 monthly	Internal MoH unit, sub national partners and other sector stakeholders	This is an internal AIPHSS partner forum only to assess program implementation. Other key programs such as PERMATA will be involved once established
AIPHSS Annual Seminar	MoH	AIPHSS	Annual	AIPHSS Annual Seminar. MoH departments, multi, MoHA, MoF, Bappenas, Menkokesra, MoE, Professional Organisations, international development partners, sub national partners,	This will be a key forum for AIPHSS and MoH to showcase the findings, progress and achievements of AIPHSS on an annual basis
HPN Seminar	HPN	AIPHSS	Annual	HPN audiences, mostly research audience	To use the Health Policy Network as a dissemination forum for key outputs and lessons learned
Internal MoH Meeting (RAPIM)	DFAT/PTS/TD	AIPHSS Team	TBC, usually held on a monthly basis	Minister of Health, Secretary General and Echelon 1	To provide key information produced through AIPHSS directly into a policy decision making forum

Annex 5

Risk Matrix

RISK REGISTER: Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS), Health, Indonesia	
Risk Owner: ISP	
Date of Last Review: December 2014	**Date of Next Review: March 2014**
Do any risks need to be escalated? *(List the Risk No/s.)No*	**To whom are they being escalated?**
Are any risks being de-escalated? No	**To whom are they being de-escalated?**
Risk Ratings and Treatments Approved by: ISP	

Risk Category- Corporate, Results, Reputational, Fiduciary	Program/ Initiative	CAPF Headlines Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s	Target rating when Proposed Treatments are in place		
						Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)
results	AIPHSS	1.1 saving lives	1	Difficulties in the bilateral relationship due to decreased level of support between the Governments of Australia and Indonesia results in the suspension of the program.	Monitor the bilateral relationship with partners to ensure that the aid program continues while relationship issues are addressed; encourage a partnership approach where problems are resolved amicably with a joint benefit; AIPHSS activities closely aligned with DFAT's Australia Indonesia Partnership Country Program Strategy periodically reviewed by the two governments. Decisions or initiatives leading to implementation changes discussed and agreed by DFAT and MoH prior to introduction.	Major	Unlikely	Moderate	Yes	No further treatment at this stage as the current controls address the risk.	ISP and DFAT as necessary	Ongoing	Minor	Unlikely	Moderate

Risk Category- Corporate, Results, Reputational, Fiduciary	Program/ Initiative	CAPF Headlines Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s	Target rating when Proposed Treatments are in place		
						Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)
results	AIPHSS	1.1 saving lives	2	National policy making processes do not use evidence produced by AIPHSS activities due to poor uptake of results which results in policies being ill informed and not evidence based.	ISP TL to work closely with PTS and Communication's Manager on approaches to advocate knowledge to policy development. ISP and PTS 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 evidence with key decision making forums in MoH and Bappenas	Major	Likely	High	No	Support the MoH in the development of the Policy Unit with the special advisers to the Minister. Ensure that evidence from AIPHSS activities is supplied to the policy unit for decision making purposes. Development of a Knowledge Platform and Policy Dialogue Series.	PTS, TL and Communications Manager	Mar-15	Moderate	Likely	High
results	AIPHSS	1.1 saving lives	3	Implementing partners have difficulty identifying their strategic priorities for AIPHSS due to poor understanding of the Reform Agenda resulting in inappropriate activity implementation	Socialisation of the Reform Agenda; Engage the TA to the PTS to liaise with the partners to support the identification of priority activities and develop effective activity ToR; Review work plan activities against AIPHSS strategic priorities and the Reform Agenda.	Major	Likely	High	Yes	PTS to actively engage with the partners to ensure the Reform Agenda is known. Provide adequate technical support to the IUs. Promotion of the Agenda	PTS; ISP Communication Manager	Dec-14	Moderate	Possible	High

Risk Category- Corporate, Results, Reputational, Fiduciary	Program/ Initiative	CAPF Headlines Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s	Target rating when Proposed Treatments are in place		
						Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)
				and allocation of program resources.						document on the ISP website so that its is easily accessible to all partners.					
results	AIPHSS	1.1 saving lives	4	HPN and Research Institutes do not contribute to the knowledge-to-policy environment due to low research capacity at the individual institutions which results in poor quality research which cannot be used for policy purposes	Liaise with DFAT on assistance to universities to support presenting findings in an accessible format for policy-makers. - Funding for the annual HPN Forum which includes a learning and capacity building element. Facilitate linkages with the HPN member and international university to develop a capacity building relationship.	Minor	Possible	Moderate	Yes	Provide funding support as determined by DFAT.	ISP TL, DFAT and HPN Coordinator	Early 2015	Minor	Possible	Moderate
results	AIPHSS	1.1 saving lives	5	Workload for the ISP staff is excessive due to the many and various demands of the IUs in preparation of the activity documentation results in delays in important decisions and implementation	ISP to work closely with the IUs to ensure a mutually supportive approach to program management. ISP TL to monitor demands on staff time and extra staff recruited if necessary. Work with the IUs to ensure planning and prioritisation of activities is timely so that there are not excessive demand on ISP staff.	Moderate	Possible	High	Yes	No further treatments. Working with the IUs and strengthening relationships and understanding of roles is an ongoing process.	ISP TL, SLO	Ongoing	Moderate	Possible	Moderate

Risk Category- Corporate, Results, Reputational, Fiduciary	Program/ Initiative	CAPF Headlines Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s	Target rating when Proposed Treatments are in place		
						Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)
results	AIPHSS	1.1 saving lives	6	Ineffective coordination between ISP and IUs due to lack of clarity in roles through the restructure results in miscommunications and delays in activity implementation	Socialisation of the roles and function of the ISP after the restructure; Regular coordination meetings with IUs. Engagement with the SLO to liaise with the IUs to ensure that activity development and support requirements are communicated; Joint planning and building ownership of activities with IUs	Moderate	Possible	High	Yes	Necessary to have continual communications with the IUs to ensure activities progress and determine the support required.	ISP TL and Operations Manager	Dec-14	Moderate	Possible	High
results	AIPHSS	1.1 saving lives	7	Implementation at the provincial and district level is slow due to limited capacity at the sub national offices resulting in a delays in system improvements and uneven progress.	Monitor absorptive capacity at the subnational level and adjust activity implementation accordingly. Ensure the provinces and districts develop realistic work plans.	Major	Possible	High	Yes	Maintain coordination with the subnational teams to ensure work plans are being implemented on schedule; consolation with subnational partners if any delays occur to develop alternative support mechanisms that may be required.	ISP TL and Coordinators	Ongoing	Moderate	Possible	High
results	AIPHSS	1.1 saving lives	8	ISP overburdened due to changes in funding agreements and funds channelled through ISP resulting in delays in	Ensure that the staffing levels in the ISP are sufficient to manage the changes; liaise with DFAT if additional staff are required. - regular reviews of ISP workloads in particular TA	Moderate	Possible	High	Yes	Recruit TA Manager responsible for all aspects of TA process are managed efficiently and effectively	TL and Operations Manager				

Risk Category- Corporate, Results, Reputational, Fiduciary	Program/ Initiative	CAPF Headlines Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s	Target rating when Proposed Treatments are in place		
						Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)
				processes and frustration for the partners.	management needs to be strengthened due to the increase in volume of TA in 2015										
results	AIPHSS	1.1 saving lives	9	IUs seek to inappropriately influence procurement of TA or services due to lack of understand of ISP processes resulting in pressure on the ISP to utilise less transparent procurement methods and conflict with the Is	ISP socialises transparent procurement practices in accordance with Commonwealth Procurement Rules (CPR) and GOI procurement guidelines to the partners: Communications with DFAT to provide support on Commonwealth Procurement Rules processes and communicate with senior GoI on the ISP approach to procurement. Support the partners in the development of activity ToR and undertaking transparent tendering processes.	Moderate	Likely	High	Yes	Engage the SLO to liaise with Is when difficulties arise and undertake further socialisation of the ISP processes if necessary.	SLO and TL	Ongoing	Moderate	Likely	High
results	AIPHSS	1.1 saving lives	10	Terms of Reference developed by IUs provide insufficient basis to contract services due to lack of clarity in activity	Guidelines and templates for ToR provided to IUs; Engage PTS and technical advisers to review all ToR before recommendation to ISP to support the activities. Capacity Building for	Moderate	Likely	High	Yes	No further treatment at this stage as the current controls address the risk.	ISP team	ongoing	Moderate	Possible	High

Risk Category- Corporate, Results, Reputational, Fiduciary	Program/ Initiative	CAPF Headlines Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s	Target rating when Proposed Treatments are in place		
						Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)
				requirements resulting in difficulties for the ISP in procurement and contracting activities which delay implementation	the IUs on formulation of ToR; Where appropriate utilise technical assistance to help develop ToRs for activities requiring more detail.										
results	AIPHSS	1.1 saving lives	11	Technical quality of the AIPHSS activities and products is poorly monitored due to lack of technical resources and insufficient attention from the PTS which results in poor products being accepted by partners that will not lead to improvements in the HSS buildings blocks and wastes resources	PTS and TA to review quality of products with the IUs, providing feedback for improvements as required.	Moderate	Possible	High	Yes	Further technical support is required to review the volume of technical products in 2015. Additional TA to be recruited to support the each of the IUs	TL and PTS	With every products development	Moderate	Possible	High

Annex 6

Progress against intermediate outcome and output indicators

Component Objective 1 (Governance): The Ministry of Health, Universities and research institutes use evidence and up-to-date information to make 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.

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

Intermediate Outcome:

1. Number and proportion of Health Sector Review recommendations which have been incorporated into new and revised policy, strategic plans and guidelines
2. Proportion of MoH Departments, Provincial and District Health Offices using new/updated policies, guidelines, strategic plans, standards, forums and tools developed by the MoH and/or disseminate by the MoH in AIPHSS supported provinces and districts disaggregated by activity and HSS building block

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
1.1 Number and proportion of policies, strategic plans, tools and guidelines disseminated by the MoH which address policy barriers to the provision of equitable and affordable health services during the AIPHSS program	Dissemination of HSR results	300 attendees 10 policy briefs and Four technical notes	1 & 2	Finalised 28 November 2014
	ADINKES regulatory reform drafts	Four new regulation, One updated law (law 23/2014)	2	Approved in October 2014
	MoH Five Year Strategic Plan	One	1	Completed
1.2 Number of policies, guidelines, standards, forums and tools produced as a result of AIPHSS activities disaggregated by HSS building blocks and activity type.	Provincial regulation on distribution of human resources, (PERDA)	One Draft provincial regulation	2	On schedule
	Regional Mid-term Development Plan which includes the health system strengthening	Three Sector reviews as input to the Regional development in what?	2	On schedule,

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
	Regulation on technical guidelines for implementation of JKN (Flores Timur)	One district regulation related to JKN		
1.3 Number of new studies including operational research studies, evaluations, or case studies conducted by MoH Health Policy Network (HPN), and research institutes related to health financing, health workforce, primary health care quality and access for the poor.	2 Health Seeking behaviour Study and Health Expenditure Tracking Study	Do not link with outcome level in this component		
1.4 Number and proportion of AIPHSS provinces and districts which have made a legal basis for PHA/DHA	Regulation completed in districts in both provinces	Four districts with regulation, others are on going		On schedule

Component Objective 2 (Health Workforce, Health Financing): Health offices in twenty districts in five provinces and at 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.

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

Intermediate Outcome:

1. Increased proportion of district annual budgets allocated to health
2. Increased proportion of the district APBD health budget expended for primary healthcare services compared to baseline in 2012
3. Increase in the number of districts preparing and submitting Annual Health Profiles to the PHO detailing health workforce information

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
2.1. Increase in the number and proportion of districts and provinces producing PHA /DHA in AIPHSS intervention provinces and districts	Eight Districts conducting health accounts in JATIM and NTT	Eight teams trained in the conducting DHA in JATIM and NTT.	1, 2	Completed
2.2. Number of AIPHSS District Governments that have issued Perda based on Kepmenkes MSS as the basis for budget allocation	None	None	1, 2	Approval of the legislation has been provided by national parliament , next stage is socialisation
2.3.Increase in the number and proportion of Provincial and District staff trained in financial management practices by AIPHSS activities	Two district s have been trained and produced technical guidelines for financial management in health centres	One	2	
2.4. A HRMIS is established within AIPHSS at the central, provincial and districts and is updated on a quarterly basis.	Blueprint of Integrated system developed under the enrichment model for HRMIS	One Blueprint of HRMIS system	3	Completed
	GIS Training	99 Staff trained in GIS for HR mapping	3	

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
2.5. Increase in the number of provincial and district staff trained on planning, budgeting and management disaggregated by gender, designation and location by AIPHSS	None	None	1,2	This activity has been removed from the work plans

Component Objective 3 (Service Delivery): Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in twenty districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor .

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

Intermediate Outcome:

1. Increase in the proportion AIPHSS supported Puskesmas that meet the new minimum service standards for the delivery of identified core services
2. Increase in the number and proportion of Puskesmas in AIPHSS supported provinces and districts who have achieved Puskesmas accreditation

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
3.1. Increase in the number of AIPHSS supported districts which have SOP for referral to Puskesmas PONED and/or other specialist level facilities	Eight districts have SOPs	Eight SOPS	1,2	Ongoing
3.3. Increase in the number and proportion of AIPHSS supported districts who have a referral monitoring system in place with annual reviews	Eight districts and JATIM completed analysis of referral systems, ongoing preparations of guidelines	Nine analysis and models of referral systems ,	1, 2	Ongoing
3.4. Number of graduates from the Distance Education Upgrading Program (PJJ) disaggregated by location, gender and designation	Establishment of PJJ system to deliver distance training in NTT	120 trainers 456 modules 300 digitalised models Established Website and on line system IT Infrastructure Specialised PJJ unit in PPSDMK 80 students selected	1, 2	Funding of students to continue until 2016
3.5. Number of puskesmas in AIPHSS locations assessed using new accreditation tool	Review of Puskesmas accreditation tool at the national level	On going	2	Ongoing,

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
	Socialisation of accreditation undertaken in 4 districts in JATIM			
	Training for the national support team to implement the Puskemas accreditation	20 staff trained	2	