Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS)

Third Six Monthly Progress Report

June 2014

Australian Aid

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
BAPPEDA	District Development Planning Board (Bandan Perencanaan Pembangunan Daerah)
BAPPENAS	Badan Perencanaan Pembangunan Nasional (National Development Planning Board)
BAST	financial report
BPJS	Agency for Social Security (Badan Penyelengaraan Jaminan Kesehatan)
BUKD	National Agency for Primary Health Care
CPMU	Central Program Management Unit
DFAT	Department of Foreign Affairs and Trade
DHA	District Health Account
EDP	Executive Development Programme
Global Fund	Global Fund to fight Tuberculosis, AIDS and Malaria
GIS	Geographical Information Systems
GoI	Government of Indonesia
HPN	Health Policy Network
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources 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)
LITBANGKES	Directorate of Research and Development

M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
NIHRD	National Institute for Health Research and Development
NTT	East Nusa Tenggara (Nusa Tenggara Timur)
P2JK	Centre for Health Financing and Social Health Insurance, Ministry of Health
PERDA	Provincial regulation on distribution of human resources
PHA	Provincial Health Account
PJJ	Distance Education Upgrading Program
PMU	Program Management Unit (generally refers to 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)
PR	Principal Recipient
PSC	Program Steering Committee
PTS	Program Technical Specialist
Puskesmas	Community Health Centre (Pusat Kesehatan Masyarakat)
PUSRENGUN	Centre for Planning and Utilization of Health (Pusat Perencanaan dan Penggunaan Kesehatan)
QMU	Queen Margaret University
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)
SR	Sub-Recipient
SSR	Sub-sub-Recipient
TA	Technical Assistance
TNA	Training Needs Assessment

ToR	Terms of Reference
TTU	Timor Tengah Utara
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

This document presents the third Six Monthly Progress Report from the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Implementing Services Provider (ISP). The report provides an update on implementation progress covering the period January – May 2014. The report includes an update on the changing program context, outputs delivered in the reporting period, progress in program management, risk management, financial disbursement and priorities for the next six month reporting period.

Contextual Changes

The political and policy context changes have created a different operational environment for AIPHSS. The Indonesian presidential election in 2014 is likely to affect the significant regulatory reform activity which is being implemented by the Asosiasi Dinas Kesehatan (ADINKES) as well as decision making at the senior levels of the Ministry of Health (MoH) in anticipation of the new president and subsequent change in the ministry.

An Independent Progress Review (IPR) was conducted in January 2014 which reviewed the AIPHSS purpose and goals, the implementation structures and the Partnership arrangements. Six main recommendations were made:

1. The program should focus on strategic reforms negotiated at the central level. Support to the provincial and districts levels should continue but funded through other Australian Government Department of Foreign Affairs and Trade (DFAT) programs. AIPHSS districts and provinces should be used for demonstration and pilots for future policy changes relating to health financing, health workforce and service delivery.

2. The management structure and terminology which mirrors the Global Fund to fight Tuberculosis, AIDS and Malaria (Global Fund) should be deleted from the AIPHSS program. The Program Management Units (PMU) at the central level should be combined into one single unit with stronger leadership and performance management. The provincial and district level PMUs should be rationalised in line with any sub-national interventions.

3. The AIPHSS should prioritise support to the development of the next five year strategic plan including supporting a MoH Policy Unit (if established). The AIPHSS can support a reform agenda and deliver policy change that will strengthen services for the poor at the lowest level of health services.

4. Increase outreach to partners outside the MoH to other agencies, particularly in health financing and human resources.

5. DFAT should reach an agreement on internal roles, responsibilities and levels of authority to make decision on behalf of the organisation. The level of technical input to operational issues needs to be reconsidered.

6. DFAT health team and senior management team should more effectively leverage non health programs to support health systems strengthen. Priority should be given to social protection, decentralisation and the knowledge sector program.

The recommendations were presented to the Secretary General of the MoH in May 2014, who has agreed to the changes and planning for the implementation of the recommendations has commenced.

Implementation Progress by Component Objectives[1]

Activities implemented in this reporting period are a combination of roll-over activities from 2013 and new activities for 2014.

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.

National level

Health Sector Review (HSR): Nine teams of experts[2] have produced a health sector analysis for the National Mid Term Development Plan led by the National Development Planning Board (BAPPENAS). The policy and program recommendations are currently being finalised and will be contribute to development of the plan. Planning has commenced with the Bureau of Planning and Budgeting (ROREN) which is responsible for the preparation of the MoH Strategic Plan to incorporate the HSR recommendations with the MoH's next Five Year Strategic Plan.

Regulatory Reform: The ADINKES[3] has been contracted to reform five major areas of health legislation which have been recognised as areas to address poor access to health services at district and primary health care levels. These reforms are:

- Clarifying the role and responsibilities of national, provincial and district level governments in the provision of health under the decentralisation law 38
- The revision of minimum standard of services 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 a district health offices
- Regulation which allows a health centre to become a semi-autonomous unit which will provide them with some financial autonomy.

All the draft regulations have been prepared and accepted by the Department of Health. The next step is for the MoH to take on responsibility for presenting the legislation to the parliament in coordination with the Ministry of Home Affairs (MoHA).

Sub National Level

New Provincial Level Regulations on Human Resource Distribution: Technical assistance was provided to the East Java (JATIM) Provincial Health Office to draft new regulations which addresses problems of distribution of health staff at the provincial level. The drafting process is ongoing and will be completed in the next reporting period.

Health Systems and Regional Mid Term Development Plans (RJPMD) in Kupang, East Nusa Tenggara (NTT): A technical adviser has led a cross sector team to work alongside the local government in Kupang to integrate the National and Regional Health System into the next five year RJPMD. The analysis has been finalised and inputs were subsequently prepared for the District Development Planning Board (BAPPEDA) to include in the RJPMD. Further socialisation and advocacy by the provincial health office to BAPPEDA will be necessary in the next reporting period.

[1] There are now three component objectives following a revisions to the performance framework, see note in section 3.1.
[2] Of the nine different topic analyses for the HSR, six were funded through AIPHSS – Burden of Disease, Pharmaceuticals, Finance, HRH, Institutionalisation, Family planning and reproductive health. The remaining three topics were funded by World Health Organization, UNICEF, World Bank and World Food Program.
[3] ADINKES is a network of former heads of District Health Offices throughout Indonesia.

Improved Capacity of Senior Executives to Manage Health Workforce Policy Change: In February 2014 a team of international experts led by Professor Barbara McPake from the Queen Margaret University (QMU) developed an Executive Development Programme (EDP) for senior executives for the Centre for Human Resource Development in Health (PPSDMK)**.** The objective was to design an action learning program for senior executives across different ministries to address health workforce policy problems. The program was to commence in May 2014, however a decision was made to delay until January 2015 following the presidential election.

Health Policy Network (HPN) Fit for Purpose Review: This assessment was completed in February 2014 and the report submitted to DFAT. The results are being discussed between DFAT and the ISP to decide on the next steps for the HPN.

Component 2: Health Financing and Human Resources: 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.

Capacity development in human resource planning and projection methodologies: Technical assistance was provided to the Centre for Planning and Utilization of Health (PUSRENGUN) by an international expert from the QMU, Centre for International Health, to provide training in health workforce planning methodologies. This activity did not meet the stated requirement to produce a human resource projection using an appropriate methodology. This has resulted in the need for the design of a series of new trainings to be conducted by local consultants.

Improving Human Resource Information Systems (HRIS): Geographical Information Systems (GIS) for HRIS: A year-long training program to train staff in the use of GIS commenced in March 2014. Further sessions will be provided in June, November and December 2014.

Enrichment model for Human Resources for Health (HRH) information systems: This activity involves the updating of a coding system for all HRH workforce categories and entering them into a wider database. This is related to the GIS training which will use the database to map HRH categories by type and location producing a comprehensive map of human resources within the health sector.

Training Needs Assessment (TNA) of Human Resources Education: A survey of education and training of health workforce in Indonesia was undertaken to determine the strengths of the current education system as well as identifying which areas require special attention to improve the quality and adequacy of education and training of the health workforce. The data collection has been completed with the preliminary results being presented at a regional World Health Organization (WHO) meeting in May 2014.

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.

Strengthening referral systems: Technical assistance has been provided in NTT and JATIM to conduct a situational analysis of the referral system and of the implications of Universal Health Coverage (UHC) to the referral process. In NTT, a consultant is in the final stages of completing the analysis which will result in new guidelines that will be endorsed by the provincial health office and BAPPEDA[4].

Distance learning program for nurses and midwives: The three year distance learning program managed by the PPSDMK has developed a model of distance learning to upgrade the capacity of nurses and midwives in rural areas to Diploma 3 level. To date 456 modules have been updated and

[4] It is important that the PTS and local PMU teams coordinate with the Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) to ensure the referral analysis builds and uses the achievements already made by AIPMNH.

transferred onto multi-media, 120 tutors have been trained and the Information Technology (IT) infrastructure necessary to implement this is currently being procured and installed. The program has been reviewed and approved by the Ministry of Education and will be launched by the Minister of Health on 19 June following which the first cohort of 87 students can commence. The ISP and the Central Program Management Unit (CPMU) are currently negotiating the scholarship implementation with Distance Education Upgrading Program (PJJ) which will include funding to the Institutions, students and management committee who will also monitor progress and effectiveness of the program. AIPHSS will fund the initial program in Kupang which will be run in parallel to another program in Kalimantan, funded by local government.

Accreditation of Puskesmas: The National Agency for Primary Health Care (BUKD) is reviewing a system of accreditation of health centres to improve the quality of primary health care facilities. A tool has been reviewed and a team has been trained to support district level teams in trials of the accreditation tool. No further information is available on this activity.

All AIPHSS expenditure continues to be channelled through the ISP for activity implementation (see Annex 1 for full financial breakdown). Disbursement has been based on the partner work plans but slow preparation due to difficulties in finalising the activity and technical Terms of Reference (ToR). In collaboration with the CPMU, the ISP has continued to support the Sub-Recipients (SRs) to finalise ToR and gain a better understanding of where the barriers to disbursement lie.

Total program expenditure January – June 2014 (including estimate for June) is AUD4,490,562 representing 14.98% of the total ISP budget of $29,958,961. Expenditure has been significantly lower than forecasts which has required the ISP to make significant adjustments to monthly forecasts in accordance with frequently revised activity implementation. In this dynamic funding environment the ISP has been required to exercise extreme financial flexibility as the ISP is often requested to expend or hold large payments at the last moment.

Risk Management

The ISP has continued to monitor risks on a day to day basis and reports to DFAT monthly for major reports to be included in the Risk Register. The major activities (ADINKES, PJJ, HSR and the ISP restructure) are implemented with strong oversight from the ISP and CPMU to ensure all activities are in accordance with agreed budgets and plans. The comprehensive AIPHSS Risk Matrix is in Annex 2.

Recommendations for the Next Reporting Period

The key recommendations for the next reporting are:

Governance

The IPR noted that the inputs from the Technical Working Groups (TWGs) at all levels are ineffective in providing the technical scrutiny required for decision about which activities should be funded. This leads to activities being approved for funding which do not impact on health systems improvements.

Recommendation 1: Apply the recommendation from the IPR to disband the TWG at all levels and assign a core group of experts to provide the technical scrutiny of all new activities. This should be initiated sensitively in close collaboration between the Director of Health, DFAT and the Secretary General of the MoH.

The IPR also noted that the current composition of the Program Steering Committee (PSC) does not provide effective strategic analysis and direction to the AIPHSS.

Recommendation 2: Selectively reduce the PSC members to only include senior members from the key stakeholders for AIPHSS. Consideration could be given to the benefit of adding new members from the Badan Penyelengaraan Jaminan Kesehatan (BPJS), MoHA, BAPPENAS, with inclusion of new 'observer status' members from the World Bank and the United States Agency for International Development (USAID) which have health systems strengthening programs in Indonesia.

Program Management

The IPR noted that the current program management structure remains inefficient and compounded by the lack of decision making and diluted accountability at all levels. This has also been stated by the ISP in previous reports.

Open discussions with transparent information and communication with a justification of providing improved program performance must be undertaken by DFAT with the government partners. The IPR recommendations have been approved by the Secretary General of the MoH and now require implementation. The new structure must be fully negotiated and agreed with the ISP and PMU staff alongside the development of new ToRs and areas of accountability.

There is significant risk that the reduction of staff at the sub-national level may cause frustration, confusion and lack of motivation amongst the staff and government counterparts during the transition period and negatively affect relationships and slow down implementation.

Recommendation 3: Adopt the recommendation from the IPR to delete the Global Fund structure and negotiate a new program structure with the MoH which integrates the CPMU and the ISP as a single management unit. This will increase efficiency in management, accountability and decision making to improve program performance. Terminology should revert to that of their statutory functions in the government institution, or to that of specific function in a Committee (e.g. Chair of the PSC). For example SRs should be referred to according to their MoH functional unit (e.g. Directorate) and the ISP could be renamed as the Technical and Management Unit.

Change Management

Recommendation 4: The ISP to prepare a Human Resource Change Management Strategy and coordinate with the CPMU to communicate this with the sub-national PMU teams and government partners. Ensure all teams are fully supported through the change process and closely monitor the rate of implementation taking corrective action if necessary.

Technical Management

The current approach and resources for the technical management of the program is insufficient to respond the technical requirements of AIPHSS. Whilst the Program Technical Specialist (PTS) has done an excellent job under the circumstances, each Directorate would benefit from a dedicated adviser with specialist skills and experience relevant to that particular function. Coordination and management of the specialist advisers to be the responsibility of the Director of the reformed ISP.

Recommendation 5: Appoint a Director to the ISP (Technical and Management Unit) and assign the Technical and Management Unit with the role of day to day technical and operational management to monitor and facilitate the delivery of AIPHSS. Recruit national and international technical experts with skills and experience relevant to the functions of each of the Directorates to provide longer term support.

Monitoring and Evaluation

Due the current capacity within the CPMU, the establishment of a robust monitoring system is slow which is affecting systematic data collection for monitoring and reporting of program performance.

Recommendation 6: Apply the recommended program structural changes which will provide the Monitoring and Evaluation (M&E) Adviser with decision making authority over the M&E system.

The current proposed restructure of AIPHSS to national level will require a revision to the Performance Framework but with the current contracting period of support from the ISP, it will be difficult to demonstrate the end of program outcomes and contribution to health systems strengthening.

Recommendation 7: Negotiate an extension of the ISP contract until 2018 to allow time for implementation of the new activities which can be measured to assess change at a systems and outcome level.

1 Introduction

The Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) is a Government of Indonesia program supported by the Australian Government Department of Foreign Affairs and Trade (DFAT). The Partnership aims to strengthen key health system building blocks (health financing, health workforce, and service delivery) and improve the use of evidence in policy making. These system improvements will strengthen the quality of, and access to, primary health care services for the poor and 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 management model represents a significant change in the way DFAT and the Ministry of Health (MoH) have previously worked together. The Partnership is funded by the Australian Government, but managed by a Central Program Management Unit (CPMU) in the Indonesian Ministry of Health, which reports to the Director of the Bureau of Planning and Budgeting (ROREN, the Principal Recipient (PR)), under the overall direction of the Secretary General of the MoH. The Partnership structure includes;

- Sub-Recipients (SRs): technical units within the MoH at the national level including the Centre for Human Resource Development (PPSDMK), the Centre for Health Financing and Social Health Insurance (P2JK), and the National Agency for Primary Health Care (BUKD); and
- Sub-Sub Recipients (SSRs): the Provincial Health Offices (PHOs); and
- Implementing Units: district health offices; and
- functional sections of SRs responsible for discrete aspects of national level SR work plans.[5]

Currently the provinces of East Nusa Tenggara (NTT) and East Java (JATIM) have been selected with four districts in each province targeted for AIPHSS activities in 2014. The targeted districts are:

- Sumba Barat Daya, Ngada, Flores Timur and Timor Tengah Utara (TTU) in NTT;
- Situbondo, Bondowoso, Sampang and Bangkalan in JATIM.

The purpose of this report is to provide an overview of;

- the changing context in the last six months
- AIPHSS implementation progress at the output level
- progress in program management and financial disbursement
- risks and mitigation approaches for implementation of AIPHSS in next reporting period
- key priorities for the next reporting period.

[5] Following the Independent Progress Review this structure is expected to discontinue and new structure formulated in the next reporting period

2 Changing Context

2.1 Political Context

The most significant change in the political context has been the commencement of the presidential election process. The legislative election, which is a precursor to the presidential election, took place in April 2014. This is likely to affect the AIPHSS regulatory reform activity which is being implemented by the Asosiasi Dinas Kesehatan (ADINKES). Other potential effects will be the appointment of a new Ministry of Health and changeover of senior staff which may affect the policy priorities and strategic direction of the MoH.

2.2 Policy Context

Indonesia has adopted a national health insurance system or National Health Insurance Scheme (JKN) based on National Social Security System) Law-40/2004. Its implementation started in January 2014 and the target is to achieve Universal Health Coverage (UHC) by 2019. This will have widespread impact at all levels of the health system. The majority of health financing functions has now shifted to the newly established Badan Penyelengaraan Jaminan Kesehatan (BPJS) which is the body responsible for the administration of the JKN.

2.3 Post Independent Progress Review Context

An Independent Progress Review (IPR) of AIPHSS was conducted in the January 2014 with the main objectives to review the:

- Relevance of AIPHSS purpose, goal and focus
- AIPHSS structures processes and relationships
- State of the Partnership between Australia and Indonesia in regards to AIPHSS.

The final report was released at the end of April and made six primary recommendations which, if adopted by DFAT and the MoH will result in a significant change to the current management structure and a strategic re-focus of the AIPHSS program. The six recommendations are summarised below:

1. The program should focus on strategic reforms negotiated at the central level. Support to the provincial and districts levels should continue but funded through other DFAT programs. AIPHSS districts and provinces should be used for demonstration and pilots for future policy changes relating to health financing, health workforce and service delivery.
2. The management structure and terminology which mirrors the Global Fund to Fight Tuberculosis, AIDS and Malaria (Global Fund) should be deleted from the AIPHSS program. The Program Management Units (PMU) at the central level should be combined into one single unit with stronger leadership and performance management. The provincial and district level PMUs should be rationalised in line with any sub-national interventions.
3. AIPHSS should prioritise support to the development of the next five year strategic plan including supporting a MoH Policy Unit (if established). AIPHSS can support a reform agenda and deliver policy change that will strengthen services for the poor at the lowest level of health services.
4. Increase outreach to partners outside the MoH to other agencies, particularly in health financing and human resources.
5. DFAT should reach an agreement on internal roles, responsibilities and levels of authority to make decision on behalf of the organisation. The level of technical input to operational issues needs to be reconsidered.

6. DFAT health team and senior management team should more effectively leverage non health programs to support health systems strengthening. Priority should be given to social protection, decentralisation and the knowledge sector program.

The recommendations were presented to the Secretary General of the MoH in May 2014, who has agreed in principle to the changes and planning for the implementation of the recommendations has commenced.

3 Implementation progress

3.1 Summary of Activities Implemented by Component Objectives

Note: Revised Component Objectives

The previous Six Monthly Progress report highlighted changes required to the Performance Framework. One of these changes was the need to rationalise the five component objectives and align them more clearly with health systems building blocks. The components have now been combined into three component objectives and aligned with the related health system building block. Further changes are detailed in the revised Performance Framework which was submitted to DFAT in April 2014.

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.

Activities Implemented

Health Sector Review (HSR): Seven teams of national and international experts have been providing technical assistance since November 2013 to prepare evidence based analyses for the Indonesian Health Sector Review. Each team submitted a draft report in March which has been consolidated into the first draft report and presented at a technical coordination meeting led by the National Development Planning Board (BAPPENAS) on 6 and 7 May 2014. The HSR has been a substantial activity implemented by AIPHSS to deliver a comprehensive sectoral analysis in the context of UHC and epidemiologic transition. The HSR process has been fully integrated with the national policy development process led by BAPPENAS and will provide a list of policy recommendations and targets to be included in the next five year National Mid Term Development Plan.

Concurrently to the finalisation of the HSR, the AIPHSS team is preparing to integrate the results of the HSR with the MoH next five year Strategic Plan (Renstra). Early stage meetings have been held with the Head of ROREN (who is responsible for formulating the Renstra) to commence the recruitment of a technical team to draft the Renstra. The expert teams currently working on the HSR will be used to assist with the integration of HSR recommendations and targets into the MoH Renstra. This represents an important phase of moving from evidence based policy development to planning and implementation.

Regulatory Reform: ADINKES has been contracted to provide technical assistance to reform five areas of health legislation which could address poor access to health services at district and primary health care levels. These reforms are:

- Clarifying the role and responsibilities of national, provincial and district level government in the provision of health under the decentralisation law 38
- The revision of minimum standard of services 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 a district health office
- Regulation which allows a health centre to become a semi-autonomous unit which will provide them with some financial autonomy.

Due to the potential nationwide impact of these regulatory reforms, they underwent a screening process by the echelon 1 staff in the MoH and the Minister of Health in February and March 2014. Several changes were requested and the regulations were finalised in May 2014, ready for handover to the MoH and subsequent submission to parliament for approval. Their success is now contingent on the leadership within the MoH and the Ministry of Home Affairs (MoHA) continuing to lobby parliament for approval, however the approval of these reforms may be stalled until the new president is in place later in 2014. The AIPHSS monitoring and evaluation (M&E) team will continue to monitor the status of the draft regulations throughout the next reporting period.

New Provincial Level Regulation on Human Resource Distribution: 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, and include nepotism, medical specialists unwilling to be placed in areas where they cannot run a private practice, poor management of Human Resources (HR) such as poor performance management, lack of effective monetary and non-monetary incentives. The regulation aims to address some of these problems by stating which stakeholders should be involved in decision-making about the placement of HR, establishing structured HR management practices such as competency based recruitment, performance management, strengthening registration and licensing to ensure better quality of HR. The legal drafting is ongoing and expected to be finalised in May after which the regulation will be submitted to the provincial government for approval.

Health Systems and Regional Mid Term Development Plans (RJPMD): This activity has only been implemented in Kupang, at the NTT provincial level. A technical adviser was recruited to lead a cross sector team to work alongside the local government in Kupang to integrate the National and Regional Health System into the next five year regional mid-term development plan. The team conducted an analysis of the current RJPMD against the national health systems framework revealing that the RJPMD did not include appropriate 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 District Development Planning Board (BAPPEDA) to improve the RPJMD prior to being submitted to the plenary session at the local Parliament. 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.

Improved Capacity of Senior Executives to Manage Health Workforce Policy Change: Indonesia faces health workforce policy problems of distribution, production and supply to meet the future needs, maintaining quality, the management of health workforce and aligning the health workforce with the JKN. In February 2014, AIPHSS provided technical assistance to the MoH to engage with these policy issues. A team of international experts led by Professor Barbara McPake from the Queen Margaret University (QMU) conducted a consultation mission to develop an Executive Development Programme (EDP) for senior executives in the PPSDMK. The objective was to design an action learning program for senior executives across different ministries to address health workforce policy problems. A draft program design was prepared which included the provision of master classes for senior executives to show available global evidence and information to consider when developing actions for policy change. The program was to commence in May 2014 but has been delayed due to the presidential election. As the election will lead to a change in the Minister of Health and senior management, the head of PPSDMK has advised a delay until January 2015 when new senior executives will be in place.

Health Policy Network (HPN) Fit for Purpose Review: This assessment was completed in April 2014 and submitted to DFAT. The results are being discussed between DFAT and the Implementing Service Provider (ISP) to decide on the next steps for the HPN.

Component 2: Health Financing and Human Resources

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.

Activities Implemented

Capacity development in human resource planning and projection methodologies: In March 2014, technical assistance was provided to staff of the health workforce planning and development unit (PUSRENGUN) by an international expert from the QMU, Centre for International Health to provide training in health workforce planning methodologies. The expert had been requested to deliver technical training in the use of planning methodologies to the PUSRENGUN team. However, due to a misunderstanding between the expert and the team only a general overview of different methods was presented by the expert. This did not meet the stated requirement to produce a HR projection using an appropriate methodology. Consequently PUSRENGUN has conducted initial trainings using local consultants whilst a revised Terms of Reference (ToR) is completed and international HR consultants are recruited.

Improving Human Resource Information Systems (HRIS):

1. Geographical Information Systems (GIS) for HRIS: This is an extension from the initial training conducted under Tasking Note 7. A year long program of GIS training has been planned, with the first round commencing in March 2014. Further training will be provided in April, May, June, November and December.
2. Enrichment model for HRH information systems: This activity involves the updating of a coding system for all HRH workforce categories and entering them into a wider database. This is related to the GIS training which will use the database to map HRH categories by type and location producing a comprehensive map of HR within the health sector. A competitive tender was used to identify and procure a technical organisation which can undertake this activity with the contract to commence in May 2014 and continue until October 2014.

Training Needs Assessment (TNA) of Human Resources Education: The Standards and Accreditation Unit of PPSDMK have modified and applied a World Health Organization (WHO) instrument to assess the quality of health education facilities in Indonesia. The TNA will make an assessment of the current education and training of health workforce in Indonesia to determine the strengths of the current education system as well as identifying areas that require special attention to improve the quality and adequacy of education and training. The activity covered six health professionals in the public and private sectors and used teams of researchers from school and professional associations. The data collection has been completed and the preliminary results were presented at a regional WHO meeting in May 2014.

District Health Accounts (DHA): These are carry-over activities from 2013. In NTT the provincial health account team provided support to teams in Ngada, Flores Timur and TTU to undertake DHA assessments and apply them for decision making and resource allocation. In Flores Timur a cross sectoral DHA team was formed and has commenced data collection and analysis of DHA data. In Ngada, data collection is complete and now at the stage of data entry.

Component 3: Service Delivery

Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in 20 districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor.

Activities Implemented

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 disseminated 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	Technical assistance to conduct HSR	7 Technical reports 1 Draft consolidated report	1 and 2	Completed 30 June 2014
	ADINKES regulatory reform activities	5 Draft reforms	2	Completed in June 2014
	Scoping mission for EDP for PPSDMK	Draft design of EDP	2	Delayed by PPSDMK
	Technical and Administrative Support to BPJS	2 policy notes	2	Completed in April 2014
	Communications Support to develop communication tools for launching of JKN	1 Video graphic		Completed February 2014
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)	1 Draft provincial regulation	2	On schedule
	Regional Mid-term Development Plan which includes the health system	1 Sector review as input to the Regional development in NTT. 7 policy briefs	2	Finalised in NTT province

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 disseminated by the MoH in AIPHSS supported provinces and districts disaggregated by activity and HSS building block				
Output Indicator	**Activity**	**Output**	**Intermediate Outcome Indicator**	**Status**
1.3 Number of new studies including operational research studies, evaluations, or case studies conducted by MoH HPN, and research institutes related to health financing, health workforce, primary health care quality and access for the poor.	National assessment of health educational facilities conducted by PPSDMK	1 report	2	Draft report prepared by PPSDMK and consultant, needs to be finalised
1.4 Number and proportion of AIPHSS provinces and districts which have made a legal basis for Provincial Health Accounts/District Health Accounts (PHA/DHA)	None		2	
1.5 Number and proportion of districts which have made a legal basis for retention of revenue by Puskesmas	None The Ministry of Finance has issued a new regulation which allows health centres to retain revenue for health care	None	2	This indicator is no longer relevant for AIPHSS

Strengthening referral systems: Technical assistance has been provided in NTT and JATIM to conduct a situational analysis of the referral system and of the implications of UHC to the referral process. In NTT, a consultant is in the final stages of completing the analysis which will result in new guidelines that will be endorsed by the provincial health office and BAPPEDA[6]. In JATIM a technical team has been recruited to commence analysis of the referral system in each district and at the

[6] It is important that referral is part of the AIPHSS/AIPMNH/Permata coordination to ensure the referral analysis builds on and uses the achievements already made by AIPMNH.

regional level. An initial workshop held in Surabaya in April 2014 invited all hospital directors in JATIM and the BPJS to begin an assessment of the referral system and how it will be affected by UHC. The technical assistance for referral systems is expected to result in the production of new referral guidelines which will be piloted in AIPHSS districts and legalised as local regulation.

Distance learning program for nurses and midwives: This is a carry-over activity from 2013. The three year distance learning program managed by the PPSDMK has developed a model of distance learning to upgrade the capacity of nurses and midwives in rural areas to Diploma 3 level. To date 456 modules have been updated and transferred onto multi-media, 120 tutors have been trained and the Information Technology (IT) infrastructure necessary to implement this in NTT is currently being procured and installed. The program requires a final review by the Ministry of Education following which teaching of the first cohort of students can commence mid-2014. The AIPHSS M&E team has been coordinating with the PPSDMK to prepare evaluations of the quality of modules and an end of activity evaluation.

Accreditation of Puskesmas: Funding was provided to BUKD to commence a review of the accreditation system of health centres to improve the quality of primary health care facilities. A tool has been reviewed and a team has been trained to support district levels team in trials of the accreditation tool. No further information is available on this activity.

3.2 Progress against the Intermediate Outcome Indicators and Output Indicators

Component 1

Table 2: Progress towards Program Outputs and Intermediate Outcomes for Component 1
Red=Behind schedule or failed activity; Amber=on going requires closer monitoring; Green= Completed or on schedule

Component Objective 2

Table 3: 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 Government 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 Provincial Health Office 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	District health accounts in JATIM and NTT Follow up workshop in Flores Timur in the application of DHA for decision making	4 teams trained in the conducting DHA in JATIM and NTT.	1 and 2	Completed
2.2. Number of AIPHSS District Governments that have issued	None	None	1 and 2	This cannot be conducted until approval from central level

Intermediate Outcome:

1. Increased proportion of district annual budgets allocated to health
2. Increased proportion of the District Government 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 Provincial Health Office detailing health workforce information

Output Indicator	Activity	Output	Intermediate Outcome Indicator	Status
PERDA based on Kepmenkes SPM as the basis for budget allocation				
2.3.Increase in the number and proportion of Provincial and District staff trained in financial management practices by AIPHSS activities	None	None	Unclear link with outcome indicators	
2.4. A HRIS is established within AIPHSS at the central, provincial and districts and is updated on a quarterly basis.	Training in health workforce planning methodology	1 adviser report 22 participants attended the Human Resources for Health Planning methods workshop	2	Behind schedule. This activity failed to deliver training for a planning method to be used by PPSDMK. Further TA is being provided to conduct this training.
	GIS Training	50 participants trained in the advanced application of GIS.		Further training to continue throughout the year.
	Enrichment model to upgrade HRIS coding system			To commence in May 2014
	TNA of HR (application of WHO assessment tool)	1 draft report with preliminary results		
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 and 2	Dependent on RORENN preparing new planning and budgeting tool

Component Objective 3

Table 4: 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	Technical assistance for analysis of referral in JATIM and NTT	Workshops Ongoing	1 and 2	NTT will be finalised in June. JARIM will be completed in Agust2014
3.3. Increase in the number and proportion of AIPHSS supported districts who have a referral monitoring system in place with annual reviews	Analysis of referral system in NTT Analysis of referral system in JATIM	2 analytical reports	1 and 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 and 2	Behind schedule was to be finalise in Dec 2013
3.5. Number of Puskesmas in AIPHSS locations assessed using new accreditation tool	Review of Puskesmas accreditation tool	1 report on accreditation review	2	New Indicator added
	Training for the national support team to implement the Puskesmas	31 participants attended workshop training	2	

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**
	accreditation			
	Development of Puskesmas Information System	35 participants attended a review of the Puskesmas Information System		

4 Stakeholder Engagement and Ownership for Sustainability

There are differences in the quality of stakeholder engagement between the national levels and sub-national levels. At the sub-national levels a combination of slow implementation, frequent changes to work plans and the cancellation of financial incentives has negatively affected engagement by stakeholders. If the recommendations from the IPR are accepted and applied there will be a reduction of activities at the sub-national levels which is likely to cause further frustration and may negatively impact on the ownership and sustainability of current activities.

At the national level, engagement varies between the different implementing units and executive levels of the MoH. The program is accepted at the senior levels including the Secretary General and the Minister of Health both of whom see the program as a flexible and responsive mechanism for technical support in health systems strengthening. Acceptance at the senior level is essential but insufficient to achieve ownership and sustainability which requires positive and active engagement from the echelon 1 and 2 executives in the implementing units.

ROREN: Bureau of Planning and Budgeting

ROREN has a dual role as the PR and as a recipient of funding for activities based on work plans however, no ROREN staff has ever participated in AIPHSS planning. The quality of engagement by ROREN so far has not been optimal. There has been poor guidance and support to the CPMU Coordinator and ROREN has not provided the expected level of coordination of implementing units and access to senior management within the MoH as anticipated. Engagement from the head of ROREN has improved slightly since she has had to sign off on the financial report (BAST) that is required for all international development assistance programs and as a response to the IPR. In addition, the ADINKES activity and potential impact on regulatory reforms has required significant scrutiny by the head of ROREN. Further engagement is expected through the integration of the HSR and with the MoH 5 year strategic plan for which ROREN is the lead unit. The designated ROREN program manager for AIPHSS has provided negligible support to AIPHSS and has had a detrimental effect on relationships between other implementing units and DFAT.

PPSDMK: Department of Health Workforce and Development

Engagement with the PPSDMK has always been positive, the units and staff are responsive, leading decision making and taking ownership of the AIPHSS activities. Recently, the failure of an international technical expert to deliver on training for planning methodologies has resulted in the PPSDMK's reluctance to engage further with the international technical advisers but are open to

engaging with new international support. Overall engagement with the ISP and AIPHSS remains positive and implementation is completely led by PPSDMK.

PPJK: Centre for Health Financing and Insurance

This unit has worked closely with the DFAT senior health analyst and other members of the DFAT health team in previous reporting periods. The Centre for Health Financing and Insurance (PPJK) has been a positive partner and will continue to be a key technical unit for the AIPHSS program. However during this reporting period the unit has been more focused on receiving the funds with less effort expended in the collaborative and strategic identification of program activities. This is due to two reasons, firstly there has been a changeover in leadership in PPJK and secondly the launching of UHC has meant that most of the MoH health financing functions has shifted to the BPJS. PPJK needs to redefine its role within the MoH and within the wider framework of health financing policy. AIPHSS may be in a position to support PPJK through the implementation and funding of new activities which assist PPJK in defining their new role and clarifying accountabilities and responsibilities for the monitoring of the BPJS.

BUKD: National Agency for Primary Health Care

The BUKD unit has previously been slow to participate in AIPHSS coordination. Senior managers have had very little direct contact with the CPMU. Nevertheless the Program Technical Specialist (PTS) has been able to establish a better relationship and more frequent contact and new activities are being implemented.

NIHRD: National Institute for Health Research and Development

The NIHRD was contracted by DFAT to conduct AIPHSS baseline surveys. In the ISP contract the NIHRD was also assigned a role in the management of research grants. The baseline study produced by NIHRD has not met expectations. This means that AIPHSS has commenced implementation without a firm baseline for monitoring and evaluation purposes. For this reason DFAT has cancelled the contract and further engagement with the NIHRD is yet to be defined.

BAPPENAS: National Development Planning Board

As the lead ministry for the HSR, the ISP has worked closely with BAPPENAS since November 2013 to provide technical assistance and support technical coordination for the HSR. The ISP has developed a positive relationship with BAPPENAS which has complete ownership of the HSR. BAPPENAS is leading the integration of the HSR results with the national policy development process. BAPPENAS is likely to continue as a collaborating partner for AIPHSS in the next reporting period.

5 Progress in Program Management

In this reporting period the CPMU and the ISP teams have continued to work closely on all management and operational functions. The relationship between the teams has matured with roles and responsibilities becoming clearer and each team working to their strengths. The delineation of management and operational function now falls into three categories of program management: sole CPMU management functions, sole ISP functions and combined ISP and CPMU functions. These are presented below.

5.1 CPMU Management Functions

AIPHSS 2014 Planning Process: The 2014 work plans are a combination of activities which have rolled over from 2013 and new activities for 2014. The preparation of the work plan has been coordinated by the CPMU Planning, monitoring and evaluation officer with the support of the PTS and technical consultants. This process has been criticised by the implementing units at all levels for the continuous changes and lengthy procedure. At the same time, the 2014 work plan was influenced by inputs from the Technical Working Group (TWG), DFAT, and changes made by the national implementing units. Overall the planning process has been highly inefficient and is one of the root causes of the slow implementation of AIPHSS. It is expected that the new management structure recommended by the IPR will lead to a more efficient, strategically focused and collaborative planning process.

Coordination at the central and sub-national levels[7]*:* Three levels of coordination have emerged more clearly in this reporting period: the central level, sub-national level and linkages between central and sub national levels. Central level coordination has always been the primary focus for CPMU but the ability of the CPMU, under the authority of ROREN, to coordinate these units continues to be difficult. Attempts have been made by the head of ROREN to coordinate the central level units to reach decisions about activities, sequencing or changes but the meetings have often been poorly attended by senior managers or cancelled.

The CPMU Coordinator is responsible for management and coordination with the sub-national levels through the PMU coordinators. During the first quarter of this reporting period the CPMU Coordinator engaged closely providing regular guidance and feedback, however following the IPR this interaction became less frequent. This is related to the recommendation to reduce activities at the sub national levels and the CPMU feeling that they should not overburden the-sub national levels if AIPHSS was going to change focus to the national level. In addition is the cancellation of incentives[8] to government counterparts to implement AIPHSS which has made coordination more challenging for the CPMU. Counterparts have expressed they are less likely to pay attention to the AIPHSS program activities without incentives. In addition, the IPR recommended changes to the management structure which will impact on the current CPMU staff; this has affected the behaviour and level of engagement from the CPMU Coordinator who is now more focused on managing change and reporting to the head of ROREN and the Secretary General.

[7] It should be noted that a considerable amount of the CPMU work is taken up by the bureaucratic demands of a government ministry. This is another source for slow progress and decision making in AIPHSS.

[8] With the cancellation of the grant to MoH, the incentive scheme that was to accompany grant administration will not be implemented.

5.2 ISP Management Functions

Procurement, Management of sub-contracts and Procurement of Technical Assistance (TA): The ISP has continued to manage all procurement of goods and services as well as the management of all subcontractors. Currently there are five large subcontracts for the provision of technical services:

- ADINKES for the delivery of technical services for regulatory reform;
- Enrichment Model for PPSDMK, for the delivery of technical information systems services of the Human Resource Information System in PPSDMK;
- QMU for delivery of technical services in Human Resource Policy and Planning;
- Information technology infrastructure for the PJJ Distance Learning Program;
- Training contracts in GIS for HRIS management teams at the national and sub-national levels;

The ISP has successfully procured and managed 41 individual consultants to date; 27 are currently active technical consultants at both national and sub-national levels.

One external group contracted by the ISP failed to deliver in this reporting period. An adviser from the QMU was not able to deliver a technical training for health workforce planning and projection methodologies. The ISP has not made payments to QMU for this input and will not continue the contract beyond the current reporting period.

The ISP has also updated a technical assistance pool using the Coffey consultant database system. A range of health system categories have been established and advertisements for national and international consultants to register have been issued via various online media. The ISP will continue to increase and expand the network of Indonesian and international consultants that has been built up through the current provision of technical assistance to the AIPHSS program.

The problems identified in the previous reporting period relating to the procurement of TA have continued with some improvements. In general the poor quality of ToR for TA, sequencing, costing and an expectation of rapid recruitment of scarce technical resources have continued. The ISP has been providing regular support to the PMU and implementing partners at the national and sub national level to provide information and feedback on ToRs, provide information on costing inputs, the sequencing of activities and clarifying outputs from technical consultants. Some improvements have been observed through these efforts and the support will continue to be provided by the ISP team.

During this reporting period the ISP conducted an audit of the ADINKES financing systems. The reports revealed weak financial management and poor bookkeeping practices but did not reveal any evidence of fraud. The ISP provided the ADINKES management team with a list of recommendations and a deadline for response; ADINKES have responded and conformed to all the ISP requirements. The management of this activity has required substantial support from the ISP and it is recommended that ADINKES is not contracted for any technical services in the future.

Program Communications: The ISP Communications Officer has continued to provide all AIPHSS program media communication services. This has been conducted through the production of two AIPHSS newsletters, further refinements to the AIPHSS websites, compiling monthly updates from the sub-national PMU teams and the provision of technical support to the MoH communications unit related to communications for UHC. Two new areas for communications are currently being developed which will generate new communication products in the next reporting period:

- Supporting the dissemination of outputs and knowledge products from the HSR
- Stronger linkages with M&E to communicate progress and results.

During this reporting period changes have been made to logos and external communication protocols following a change in the Australian government and the changeover to DFAT.

5.3 Combined ISP & CPMU Management Functions

Management of finance by ISP and CPMU: AIPHSS financial management and oversight is undertaken by the ISP and PMU finance teams. The ISP's main responsibilities are disbursement, fiduciary risk management and financial reporting. The CPMU undertake verification of all budgets, acquittals, preparation of program management reports to the Secretary General and reporting against the BAST. Following the cancellation of the grant agreement there are two different systems for financing activities. The first is the finance system for the sub-national levels which is based on monthly forecasting and transfer of funds to the PMU offices that was developed in the previous reporting period and is functioning smoothly. The second is the national level finance system which was developed in this reporting period. Steps involved in activity financing are:

a) The ToR and budget is prepared by the implementing partner and submitted to the CPMU

b) CPMU verifies the activity is in the work plan, checks budget formulation, conducts a review to ensure there is no duplication of activities and checks unit cost

c) Once approved by the CPMU the request for disbursement is sent to the ISP

d) ISP makes a final verification of the budget and disburses funds using a cheque or direct bank transfer payment to the vendor

e) On activity completion, the implementing unit has five days to return any outstanding funds and 14 days to deliver all documents for acquittal to the CPMU

f) CPMU finance staff review the acquittal to ensure it is accurate and complies with all financial requirements

g) Final handover of all documents to the ISP to complete the acquittal process.

Experience in the application of the above system has revealed two main areas where slowing of activity implementation occurs; these are steps (a) and (b) which generally require several revisions by the implementing partners which results in slow disbursement of funds.

Management of complex activities by the ISP and CPMU: Some of the activities conducted by AIPHSS are of a complex nature requiring intensive joint risk management by the ISP and CPMU. The ISP provides the financial management and procurement services and the CPMU provides coordination, and experience and knowledge of government processes. The main activities requiring this type of approach have been the ADINKES legislative reform activity and the Distance Learning Program managed by PPSDMK.

Implementation of the Distance Education Program is conducted by a special unit based in the PPSDMK and represents large scale Swakelola[9]. The activity commenced in August 2013 and was unrealistically due to be completed by December 2013. Currently there are two remaining deliverables which are being finalised, the instalment of all IT infrastructures for distance learning and the development of a scholarship funding mechanisms.

Technical management: Management of technical inputs remains weak and therefore one of the higher risks to the AIPHSS program. This is due to the absence of a clear technical management system in the original program design as well the failure of the TWG as a mechanism to ensure program quality. It was assumed that the PTS would be able manage these functions alongside the implementing partners with that of the TWG.

The range, volume and complexity of the activities is in excess for one adviser to provide the necessary technical oversight or ensure the quality required by AIPHSS. A small pool of technical advisers to the PTS has been active since mid-2013 to assist with the technical management of the program but this has proven to be insufficient and a new approach is required. Following the IPR

[9] Government led implementation where the ISP provides funding directly to government counterparts.

recommendations the ISP has suggested to DFAT that day to day management be assigned to the ISP followed by the recruitment of long term technical advisers to work closely with each of the implementing units at national level. With this approach the implementing partners will receive the support required and the ISP would be able to direct the more effective delivery of the program technical functions coordinating with and supporting the sub-national levels. Overall strategic direction and uptake will continue to be the responsibility of the PTS, DFAT and the Program Steering Committee (PSC).[10]

5.4 Monitoring and Evaluation

During this reporting period a new M&E Adviser was appointed who has a strong background in the development of health information systems and the M&E of health system strengthening programs. The M&E Adviser commenced by providing an orientation to the PMU teams at all levels of how to monitor and evaluate a health system strengthening program which focuses on building the capacity at a systems level in HR for health, health financing, information use for evidenced based decisions (leadership and governance) and health service delivery. The main activities for M&E in this reporting period have been:

- The revision and submission of the 2013 M&E report
- The finalisation of the Performance Framework, indicators and performance indicator reference sheets
- Establishing baselines for the capacity development objectives. which will measure progress in key AIPHSS building blocks
- Improving the reporting systems to capture and disseminate regular data on program progress
- Linking M&E results with program planning, technical management and quality assurance
- Monitoring the effective management of the M&E systems in partnership with the PMU teams
- Developing tools to assess the uptake and influence of policy and associated documents produced by AIPHSS
- Developing shared approach to the monitoring and evaluation of the PJJ activities with the PPSDMK
- Finalise the outcome and impact baseline data with the Directorate of Research and Development (LITBANGKES)
- Improving the communication strategy for the reporting of AIPHSS results.

The major challenges in M&E have been the following:

1. Work plan development: Work plans activities have been developed with a poor analysis of the current health sector socio-economic and political context or of the current burden of disease. Little baseline information on the health financing, HR for health or information use for evidenced based decisions was available making the selection of appropriate and targeted interventions difficult. In addition, the work planning process is still ongoing and plans have been developed which still have no clear timeframes for implementation. The work plans are very likely to change once the recommendations from the IPR take effect. This makes the overall development of a monitoring and evaluation plan difficult and will affect reporting of end-of-program achievements.

[10] The ISPs successful management of the technical assistance for the health sector review has demonstrated that the ISP has the capacity and understanding of technical issues and policy process to manage and direct technical assistance across health system and policy specialties and work with a diverse range of government and international partners.

2. Changing M&E Practices: Until quite recently the approach to AIPHSS M&E has been to monitor whether activities have been completed according to an allocated cost and within an allocated time. Considerable efforts have been made to strengthen the understanding of the CPMU, PTS in the current best practice approaches to the M&E of capacity strengthening programs and of the current approaches to monitoring and evaluating policy influence and uptake. A similar approach to disseminate the changes in the science of M&E practices for policy uptake will need to be taken with the implementing partners within the MoH and other ministries.
3. Establishing the AIPHSS monitoring system: The CPMU has the authority and decision making responsibility for all M&E activities. The ISP M&E Adviser has been providing guidance and support to strengthen the regular monitoring system which is urgently required in order to monitor progress. However the current management arrangements and capacity within the CPMU has limited the establishment of a robust monitoring system and slowed the implementation of monitoring and evaluation activities. It is expected once the recommendation from the IPR are applied the new management arrangement will lead to changes in decision making in M&E.

6 Progress in Budget Disbursement and Expenditure

All AIPHSS expenditure continues to be channelled through the ISP for activity implementation (see Annex 1 for full financial breakdown).

The following section is based on ISP expenditure January to May 2014 with an estimation of expenditure for June. Disbursement has been based on the partner work plans but slow preparation due to difficulties in finalising the activity and technical ToR has resulted in a final disbursement that is approximately 70% of what was previously expected of the work plan totals in January. In collaboration with the CPMU, the ISP has continued to support the SRs to finalise ToR and gain a better understanding of where the barriers to disbursement lie. Some issues appear to be surrounding the roles of the SR, ISP and CPMU with confusion in process for requesting funds. The ISP Manager has had frequent meetings with the SRs to explore avenues of support which will encourage activity implementation.

Another process which confounds disbursement is the requests for activity funding that do not utilise the agreed one-door-approach where all requests should go to the Secretary General prior to being forwarded to DFAT and subsequently the ISP. The ISP frequently received requests for funds that have not been approved by Secretary General which then require the ISP to go back to the partners to ensure the correct process is followed and approval is garnered from Secretary General. It is essential that the agreed process is adopted by all partners to ensure that expenditure is signed off for the BAST.

Total program expenditure January – June 2014 (including estimate for June) is AUD4,490,562 representing 14.98% of the total ISP budget of $29,958,961 as seen in Table 5 below. Expenditure has been significantly lower than forecasts due to the above reasoning which has required the ISP to make significant adjustments to monthly forecasts in accordance with frequently revised activity implementation. In this dynamic funding environment the ISP has been required to exercise extreme financial flexibility as the ISP is often requested to expend or hold large payments at the last moment. For example, in the beginning of May the ISP was to pay two milestones of approximately AUD185,000 for the ADINKES activities when it received a request from the AIPHSS PR to hold all funding until further notice. At the time of this report, the ISP has still not received notice to continue funding but must continue to hold sufficient funds in the ISP accounts in anticipation of imminent payment to suppliers.

Table 5: Expenditure Summary January – June 2014

Description	Actual January - May	Estimate June	TOTAL Jan – June 2014
Milestone payments	349,809	171,904	521,713
Reimbursable payments			
Long term adviser cost	351,544	75,514	427,058
Short term adviser costs	4,657		4,657
Additional - Personnel	154,903	1,031	155,934
Additional - non personnel	2,767,734	962,695	3,730,429
TOTAL	**3,278,838**	**1,211,724**	**4,490,562**

7 Cross Cutting Issues: Gender and Social Inclusion

The objectives of gender and social inclusion within the health sector (Guide to Gender and Development, AusAID, 2008) include the following:

1. To improve women's access to health care, by supporting basic health care services, particularly maternal and child health, primary health care and disease control
2. To improve women's access to economic resources
3. To promote women's participation and leadership in decision making at all levels
4. To promote the human rights of women and assist efforts to eliminate discrimination against women
5. To incorporate a gender perspective in Australia's aid activities.

AIPHSS addresses the above objectives in the following key activities:

Health Sector Review

The HSR refers to the burden of disease for both males and females. Each expert team was requested to produce recommendations related to gender as a cross cutting issue in the report, but only fertility, family planning and reproductive health analyses produced gender related data and policy recommendations that impact on the reproductive health of women. However, significant discussion on how the health sector as a whole can improve supply side readiness, encourage greater participation (by men and women) in social insurance and developing strategies to control both non-communicable and communicable diseases for all was detailed in the report.

Sex disaggregated data was poorly reported in the HSR making it difficult to develop policy recommendations and targeted interventions to address women's constraints to the access and utilization of health services beyond maternal, neonatal and child health and reproductive health services. Future reviews should provide a stronger focus on gender analysis to deliver gender specific policies and targets to address gender inequities in accessing and utilising health services. Future equity analysis could also focus more on gender specific equity as well as socio economic groups.

Distance Education Upgrading Program (PJJ)

One of the key barriers to equity of access to quality health care for women is the availability of some key health workers (midwives, nurses and reproductive health specialists) with the right level of competencies to prevent morbidity and mortality related reproductive health risks. In many instances the uneven distribution of competent human resources (who are concentrated in wealthier urban areas) results in the neglect of women's health needs in poor, rural and island communities. Approximately 78 per cent of all public hospitals in Indonesia have the essential guidelines required to support the national Comprehensive Emergency Obstetric and Neonatal Care, however, there are insufficient number of midwives, nurses and specialists at hospitals to support the shift from home deliveries to safer institutional deliveries. As such, facility-based deliveries remain relatively low at 63 per cent. PJJ aims to improve the competencies of nurses and midwives in rural areas through a distance education modality with the support from local health polytechnics. The Indonesian Government intends to use the model developed through support from AIPHSS to scale up similar distance learning programs for nurses midwives throughout the country which may impact more widely on the availability of competent human resources to women in poor rural and island regions of Indonesia.

Human Resource Information System

In order to address the inequities in access and utilisation experienced by women there is the need for sex disaggregated data on the availability and skill of HR in the health sector. Good HR management is essential to maintaining the necessary supply of qualified staff however information on the number of staff, their position, location, gender, age, year of hire, training and salary level is often unreliable thus limiting the ability of the health sector to plan systematically.

AIPHSS is supporting the Human Resource Management Information System to comprehensively capture information for the purpose of improving the planning of HR within the health sector. In addition, disaggregated data on seniority, occupation, management, field positions and educational attainment will allow analysis on whether there are particular job classifications from which women are excluded. Such information can then be used by policy makers to promote women's participation and leadership in decision making.

8 Risk Management

The AIPHSS model based on the Global Fund structure presents many challenges in implementation. Blurred lines of responsibility and decision making have impacted upon planning and workplan development. The IPR in January also added another layer of uncertainty as partners waited for the final review recommendations. This has resulted in slow planning and implementation as partners have focused on non-program activities. Intensive support has been provided by the ISP and CPMU to encourage the development of appropriate AIPHSS activity implementation.

The ISP has continued to monitor risks on a day to day basis and reports to DFAT monthly for major reports to be included in the Risk Register. The major activities (ADINKES, PJJ, HSR and the ISP restructure) are implemented with strong oversight from the ISP and CPMU to ensure all activities are in accordance with agreed budgets and plans. The comprehensive AIPHSS Risk Matrix is in Annex 2.

9 Recommendations for the Next Reporting Period

The key recommendations for the next reporting are:

Governance

The IPR noted that the inputs from the TWGs at all levels are ineffective in providing the technical scrutiny required for decision about which activities should be funded. This leads to activities being approved for funding which do not impact on health systems improvements.

Recommendation 1: Apply the recommendation from the IPR to disband the TWG at all levels and assign a core group of experts to provide the technical scrutiny of all new activities. This should be initiated sensitively in close collaboration between the Director of Health, DFAT and the Secretary General of the MoH.

The IPR also noted that the current composition of the PSC does not provide effective strategic analysis and direction to the AIPHSS.

Recommendation 2: Selectively reduce the PSC members to only include senior members from the key stakeholders for AIPHSS. Consideration could be given to the benefit of adding new members from BPJS, MoHA, BAPPENAS, with inclusion of new 'observer status' members from the World Bank and the United States Agency for International Development (USAID) which have health systems strengthening programs in Indonesia.

Program Management

The IPR noted that the current program management structure remains inefficient and compounded by the lack of decision making and diluted accountability at all levels. This has also been stated by the ISP in previous reports.

Open discussions with transparent information and communication with a justification of providing improved program performance must be undertaken by DFAT with the government partners. The IPR recommendations have been approved by the Secretary General of the MoH and now require implementation. The new structure must be fully negotiated and agreed with the ISP and PMU staff alongside the development of new ToRs and areas of accountability.

There is significant risk that the reduction of staff at the sub-national level may cause frustration, confusion and lack of motivation amongst the staff and government counterparts during the transition period and negatively affect relationships and slow down implementation.

Recommendation 3: Adopt the recommendation from the IPR to delete the Global Fund structure and negotiate a new program structure with the MoH which integrates the CPMU and the ISP as a single management unit. This will increase efficiency in management, accountability and decision making to improve program performance. Terminology should revert to that of their statutory functions in the government institution, or to that of specific function in a Committee (e.g. Chair of the Program Steering Committee). For example SRs should be referred to according to their MoH functional unit (e.g. Directorate) and the ISP could be renamed as the Technical and Management Unit.

Change Management

Recommendation 4: The ISP to prepare a Human Resource Change Management Strategy and coordinate with the CPMU to communicate this with the sub-national PMU teams and government partners. Ensure all teams are fully supported through the change process and closely monitor the rate of implementation taking corrective action if necessary.

Technical Management

The current approach and resources for the technical management of the program is insufficient to respond the technical requirements of AIPHSS. Whilst the PTS has done an excellent job under the circumstances, each Directorate would benefit from a dedicated adviser with specialist skills and experience relevant to that particular function.

Coordination and management of the specialist advisers to be the responsibility of the Director of the reformed ISP.

Recommendation 5: Appoint a Director to the ISP (Technical and Management Unit) and assign the Technical and Management Unit with the role of day to day technical and operational management to monitor and facilitate the delivery of AIPHSS. Recruit national and international technical experts with skills and experience relevant to the functions of each of the Directorates to provide longer term support.

Monitoring and Evaluation

Due the current capacity within the CPMU, the establishment of a robust monitoring system is slow which is affecting systematic data collection for monitoring and reporting of program performance.

Recommendation 6: Apply the recommended program structural changes which will provide the M&E Adviser with decision making authority over the M&E system.

The current proposed restructure of AIPHSS to national level will require a revision to the Performance Framework but with the current contracting period of support from the ISP, it will be difficult to demonstrate the end of program outcomes and contribution to health systems strengthening.

Recommendation 7: Negotiate an extension of the ISP contract until 2018 to allow time for implementation of the new activities which can be measured to assess change at a systems and outcome level.

Annex 1

ISP Expenditure spread sheet

Annex 2

Risk Matrix