Support from the Government of Australia for an Evidence-Based Approach to Planning for Maternal, Newborn and Child Health in Indonesia
Cover photograph: UNICEF/ Estey
Summary

Indonesia’s progress in maternal, newborn and child health (MNCH) has been disappointing due to a number of factors. Despite considerable efforts within the country and support from development and academic partners over recent decades, major constraints (“bottlenecks”) and wide disparities persist. These challenges include low prioritization of MNCH; complex and unreliable funding arrangements; poor accountability and weak technical capacity at district level; inadequate collection and use of data; a lack of human resources and sufficient supervision of those in place; low health literacy and related health behaviour; and poor quality of care. Based on lessons learned in an earlier pilot of the Investment Case approach, UNICEF and the University of Queensland Consortium (UQc),¹ in collaboration with central and district government partners, developed a new set of activities at national and sub-national levels. The new “evidence-based planning” (EBP) approach again focuses on supporting prioritisation, planning and budgeting of MNCH activities at district and sub-district level, but is also allied to national advocacy and reviews of existing planning and fund-channelling processes. Bottleneck analysis, use of local data and engagement of both health and non-health authorities are key elements of the process, which is being supported in ten districts of Papua province over 2012-2014. Progress so far has been encouraging, with enthusiastic uptake at provincial and district level, identification and implementation of locally prioritized interventions, the establishment of a multi-sectoral provincial technical support team and buy-in from several national Ministries. Moreover, acknowledging concurrent implementation of related activities in Indonesia, the EBP approach is being promoted in related initiatives supported by multilateral agencies and administered through Bappenas and the Ministry of Home Affairs. Independent, formal evaluation of the EBP in Indonesia has started and will be completed by mid-2014.

¹ UQ Consortium (UQc) is led by the University of Queensland, and involves the Nossal Institute for Global Health, and COMPASS (University of Melbourne’s Centre for International Child Health, Menzies School of Health Research, and Burnet Institute’s Centre for International Health).

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Socioeconomic inequities in coverage
Household wealth quintile: ● Poorest 20% ○ Richest 20%

Demand for family planning satisfied
Antenatal care 1+ visit
Antenatal care 4+ visits
Early initiation of breastfeeding
ITN use among children <5 yrs
DTP3
Measles
Vitamin A (past 6 months)
ORT & continued feeding
Careseeking for pneumonia

Coverage levels are shown for the poorest 20% (red circles) and the richest 20% (orange circles). The longer the line between the two groups, the greater the inequality. These estimates may differ from other charts due to differences in data sources.

Source: www.countdownmnch2015.org

UNICEF and the University of Queensland Consortium (UQc) to institutionalize an evidence-based approach to planning and budgeting of MNCH services.
MNCH outcomes and inequities

The most recent data on MNCH in Indonesia can be summarised as follows:

- The under-5 mortality rate (U5MR) has decreased to an estimated 40 deaths per 1,000 live births in 2012, a decline of 47.1% since 1990. But the MDG 4 target is 28 or less such deaths by 2015.
- Geographic and socio-economic disparities in Indonesia’s U5MR have increased.
- Disparities also exist for health system performance indicators such as timely vaccination rates (ranging from 82% to 29% for DTP3) and health status indicators such as stunting among under-fives.
- The maternal mortality ratio (MMR) had decreased to 220 per 100,000 live births in 2010, a decline of 63.3% since 1990; the MDG 5 target is 150 or lower, by 2015. Similar disparities in the MMR and in maternal health service uptake exist.2

On the demand side, there is low and disparate uptake of critical health related practices such as breastfeeding, complementary feeding and hand washing. Disparities are worse for some practices than others, being low, for example, for breastfeeding and contraceptive uptake, but higher for antenatal care, vaccination and skilled birth attendance. Similar differences occur in the supply of interventions known to save lives and improve child development, and in the quality of care between and within districts. However, quality of care is a major issue across all levels of the health sector in Indonesia. Total health expenditure has increased dramatically, but mostly due to an explosion in unregulated private health services.

2 Data taken from baseline assessment by Independent Evaluators, Silvia Devina and Don Matheson, March 2013.
The obstacles to reducing inequities in MNCH in Indonesia are not unique, but issues specific to this context are again widely acknowledged. Some of these are listed in Box 1.

These characteristics have the most significant impact on the poorest households and are not unique to the health sector. Improving MNCH outcomes requires the engagement of multiple health and non-health actors at all levels. DFAT’s programme thus supports a systems approach to the funding and implementation of Indonesia’s decentralised social sector programmes.

Box 1: Challenges to reducing inequities in MNCH in Indonesia

1. Poor engagement of national and local non-health authorities with an influence on MNCH budget allocation, planning and policy implementation.
2. Substantial funding, but complex mechanisms for its allocation and disbursement (Figure 2), resulting in delayed and limited availability of resources for MNCH.
3. Decentralization that often bypasses authorities at province level and relies on district health teams with less technical and management capacity.
4. Politicized use of available funds, resulting in the purchase of tangible or short-term inputs to win votes, rather than fostering long-term outcomes and improved quality and equity.
5. Weak information systems and use of data to inform local decision-making and prioritization.
6. Low capacity to plan, implement and monitor MNCH activities; low incentives to improve MNCH outcomes, and weak accountability for the use of available funds.
7. A grave lack of specialist and referral-level services in poor rural areas.
8. A shortage of even basic skilled human resources in the locations with greatest need, and difficulty retaining personnel deployed to those areas; almost universal poor quality of care.
9. Poor uptake of services by the most vulnerable women and children; lack of appropriate MNCH services both at community level and in health facilities, and poor referral systems.
10. Weak engagement of the most vulnerable communities and poor health literacy, combined with persistent traditional MNCH practices that place women and children at risk.
Figure 2: Sources and flow of funds within Indonesia’s health sector

Evidence-Based Approach to Planning for Maternal, Newborn and Child Health in Indonesia

3 Figure taken from baseline assessment by Independent Evaluators, Dr. Silvia Devina and Prof. Don Matheson
Evidence-Based Approach to Planning for Maternal, Newborn and Child Health in Indonesia

DFAT support for EBP evolved from earlier support for an “Investment Case” (IC) approach for MNCH in South and East Asia. The current DFAT grant commenced in June 2011 and also supports work in Nepal, the Philippines, Bangladesh and India. Funds are channelled through UNICEF, supported by its regional office and global headquarters, and through UQc working with domestic research institutions such as Universitas Gadjah Mada (UGM) in Indonesia. Funding ends in June 2014.

The IC and EBP approaches arose from global recognition that technical, service-focused health interventions have had limited long-term impact. The first iteration of the IC was co-funded by the Gates Foundation. EBP targets MNCH policy, planning, prioritisation, budgeting, implementation, monitoring and evaluation, at national and sub-national levels. The focus on MNCH has high-level support from Indonesia’s government, which introduced several major financing and human resources for health initiatives in recent years. The objective is to provide a compelling foundation for a new and sustained approach to MNCH, based on locally generated data and evidence, and driven by local stakeholders. This is particularly relevant given Indonesia’s move towards Universal Coverage of Health Services (UHC), beginning in early 2014.

Experience with the IC in two districts (Merauke, in Papua and Sikka, in NTT) and two cities (Pontianak, in West Kalimanatan, and Tasikmalaya, in West Java) informed the current EBP initiative. Challenges noted in these pilots involved both national and sub-national bottlenecks and included fragmentation of responsibilities and weak coordination among national and local agencies involved in MNCH; uncertain or delayed funding from multiple different channels, and lack of local discretion on funding for any health initiatives; lack of national government buy-in, and non-engagement of province-level authorities. Moreover, the tool employed was complex and too difficult for subnational partners. These problems called for a refining of the approach, more evidence and intensive advocacy at all levels. UNICEF and UQc learned from these experiences and incorporated those lessons in the design of the current, DFAT-supported initiative.

A second iteration of the IC/EBP is being implemented with support from local government and academia at province and district levels in Papua. Although this province’s MNCH indicators are among the nation’s worst, additional “OTSUS” resources emanating from its semi-autonomous status offered the potential to circumvent the national funding bottlenecks identified previously. The initiative involves collaboration with health and non-health authorities at each level, and uses a simplified approach to prioritising, planning and budgeting MNCH activities at district level. Indonesia has several complex and parallel planning and financing mechanisms and there is little appetite for yet another externally driven initiative. Accordingly, UNICEF is also supporting a review and improvement of the existing national District Team Problem Solving (DTPS) approach, and assessment of the acknowledged problems with complex finance flows from the centre to the periphery. Finally, UNICEF and UQc’s support includes deliberative engagement with national, provincial and district health and non-health authorities.

What is DFAT support providing to EBP?

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What has been undertaken so far?

UNICEF and UQc’s EBP approach is working at several levels on a wide variety of policy, advocacy, technical and research activities. As the only UN agency with access to both high echelons of government in Jakarta, and a field programme at community level in the most remote parts of the country, UNICEF is uniquely able to support an initiative such as EBP in Indonesia. UQc provides quality technical support for training and implementation of the EBP approach. The following activities have been undertaken at national level and in seven Papua districts during 2012 and 2013:

1. A detailed analysis of the MNCH situation and related policy, financing, planning and budgeting in Indonesia, undertaken in 2012 by international and local experts (Professor Don Matheson and Dr Silvia Devina). This has provided a foundation for the design of subsequent areas of focus and more detailed follow-up reviews in 2013-14 (including of the existing DTPS approach and of fund channelling in Indonesia’s health sector, both in process).

2. Even in the decentralised Indonesian health system, UNICEF and UQc acknowledged that promoting a neglected area such as MNCH in and beyond districts in Papua requires high-level support. Moreover, the focus on prioritisation, planning and budgeting will benefit other sectors, as can be inferred from DFAT’s support for similar governance and financial management initiatives in other sectors. The former IC and current EBP approaches have thus engaged national authorities including the Directorate of Maternal and Child Health and Bureau of Planning at the MoH; the Directorate of Public Health and Nutrition at Bappenas, and Directorate General of Regional Development at the Ministry of Home Affairs (MOHA); and in Papua, the office of the governor, Provincial Planning Agency (Badan Perencanaan Pembangunan Daerah/ Bappeda), Provincial Health Office (PHO), Jayapura Health Polytechnic, and the PHO Health Training Institute. Regular meetings and advocacy for EBP and for MNCH have, for example, been supported by:

   a. Engaging with provincial government authorities on the development of a local EBP technical support team, through the provincial health office and province Bappeda.
b. Engaging with Bappenas and the MoH to support UNDP efforts to reduce Indonesia’s MMR through the Millennium Acceleration Framework (MAF). This process incorporates similar multi-stakeholder participation and use of local data to identify bottlenecks, develop solutions, plan and budget accordingly. It is proposed for roll-out in 64 high-burden districts across nine provinces suggested by the MoH after the current pilot in Central Java.

c. Providing an opportunity for UGM to present its fund channelling work to Bappenas.

d. Active promotion of EBP in the context of the USAID-funded Kinerja (Performance) project. Papua is one of five provinces where this project, led by MOHA and focusing on governance, accountability and multi-stakeholder engagement, is being implemented across several sectors. It includes a focus on the health sector and has high-level support from the provincial government.

UNICEF and UQc acknowledge the complex environment yielded by the variety of activities with a focus on planning (DTPS, MAF, Kinerja and others) and are actively working with each of the responsible development partners and government agencies to ensure the principles of EBP at local level are included in each. This is producing results – Bappenas is now using IC/bottleneck analysis terminology and the MoH acknowledges that EBP can strengthen the DTPS process.

3. In Papua, in addition to establishing the province Bappeda as the lead agency for EBP, the EBP partners established a Provincial Support Team (PST), including Bappeda and Health Department personnel representing government and the health sector, and experts from the local University of Cendrawasih (UNCEN) representing academia. This team was trained in mid-July 2012 and again in mid-2013, and has taken over UGM’s role assisting districts to assess current strengths and weaknesses in planning, and is introducing new, MNCH-supportive planning and budgeting at district level. While the capacity of some members of the PST remains weak, and its activities have not yet been funded outside the project, the securing of its existence with a Governor Decree was a major achievement in 2013.

4. EBP involves assessment of existing planning processes, use of bottleneck analysis and local data (especially graphs and charts, which is challenging for some participants) to identify obstacles to MNCH services, development of agreed solutions, then planning, budgeting and implementing them. Examples of priority areas at national level are shown in Figure 3. Local ownership and use of local data are key elements, appreciated by district teams. Based on lessons learned from the IC pilot in 2010-2011, extensive revision of the planning, budgeting and impact estimate tools was undertaken for EBP.

The local district planning context was more explicitly considered in this process. In addition, a newly expanded focus on the various sources of funding and restrictions associated with each was included. To build its capacity, EBP has relied increasingly on support from the PST. Regular visits to train and follow up on EBP activities in Jayawijaya, Yapen and Boven Digoel districts were conducted over 2012 and 2013, and in Biak, Supiori, Paniai and
Figure 3: Poor progress in many areas of child health in Indonesia, suggesting areas for prioritization

### CHILD HEALTH

**Immunization**
- **Percent of children Immunized against measles**
- **Percent of children Immunized with 3 doses DTP**
- **Percent of children Immunized with 3 doses Hib**

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Source: WHO/UNICEF

**Pneumonia treatment**
- **Percent of children <5 years with suspected pneumonia taken to appropriate health provider**
- **Percent of children <5 years with suspected pneumonia receiving antibiotics**

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Source: www.countdownmnch2015.org

### NUTRITION

**Wasting prevalence** (moderate and severe, %) 15 (2000)
**Low birthweight incidence** (moderate and severe, %) 9 (2000)

**Underweight and stunting prevalence**
- **Percent of children <5 years who are underweight**
- **Percent of children <5 years who are stunted**

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Source: www.countdownmnch2015.org

**Early initiation of breastfeeding** (within 1 hr. of birth, %) 44 (2000)
**Introduction of solid, semi-solid/soft foods (%)** 85 (2000)
**Vitamin A supplementation** (two doses coverage, %) 80 (2000)

**Exclusive breastfeeding**
- **Percent of infants <6 months exclusively breastfed**

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Source: www.countdownmnch2015.org
Jayapura districts in 2013. These districts collectively represent the geographic and demographic diversity of Papua province. Areas of priority were selected by local teams, and the support of other local authorities (such as Family Planning, Women’s Empowerment, and Social Welfare) at district and community levels was engaged. There are indications that these districts are developing capacity to undertake EBP independently, but this will be a focus of the evaluation in 2014.

5. Advocacy for evidence-based interventions, initially piloted with UNICEF and other development partners’ support and now being scaled up with funding from local resources. These include maternity waiting homes; various health-worker trainings; equipment procurement; socialisation of Indonesia’s health and maternity insurance schemes, and improvements to the content and quality of care. This advocacy is being undertaken not only within the local health sector but also with the local Bupati, Bappeda and members of parliament, and again relies on local data and evidence. In Jayawijaya, funding for MNCH almost doubled from 2012 to 2013. In Yapen, a district-level EBP has been established, led by the head of the Bappeda; MNCH funding increased more than four times in 2013, due to major equipment procurement using local budget.

6. Review of the current status of DTPS in six provinces, in concert with the MoH (in process). DTPS will possibly be re-introduced in 64 high-burden districts prioritized by the MoH; the updating of the DTPS modules can draw on the Papua experience with EBP with bottleneck analysis as a key improvement.

7. Identification of solutions to problems with funding sources and flows through work with national and local health and non-health authorities. Notwithstanding semi-autonomous Papua’s access to resources unavailable to other provinces, lack of timely funding to support the health sector is a major issue. This work in progress by UGM will analyse fiscal transfers and timing, and recommend solutions to ensure that adequate funds are available, and that they arrive early enough each year to support prioritised activities.
UNICEF and UQc fully acknowledge the difficult environment for an initiative that focuses on upstream concepts like evidence-based planning, budgeting and advocacy in Indonesia. Human resources (numbers and capacity, turnover, and in Papua, representation of Papuans in various teams), lack of data, the local political environment and systemic financial complexities in a decentralised context all create major challenges. Evaluating and sustaining a new process that prioritises activities previously considered routine (planning and budgeting) is difficult. Intensive advocacy at all levels and the engagement of relevant authorities beyond the technical departments at the MoH, and at Bappenas and MOHA are required, and related data collection must be institutionalised. It is inadequate to rely on second- or third-level officials to promote the issues being targeted by this programme; fortunately the advent of the MAF and *Kinerja*, and DFAT’s broader focus on the areas of governance, prioritization, information systems and financial management are related. A final challenge is to ensure that funds are allocated by local authorities for EBP itself. One of the early findings of the DTPS review was that no budget was allocated to the DTPS process. It is imperative that planning itself is prioritised by local government.
Where to from here?

UNICEF, UQc and academic partners at national (UGM) and local (UNCEN) levels have established excellent working relationships with provincial government and health and planning authorities. While activities have focused on geographically and demographically distinct districts, familiarisation with EBP is being undertaken in all districts in Papua province, a result of the high-level advocacy undertaken in the capital, Jayapura.

Objectives have been agreed with counterparts at all administrative levels, and include:

- Improved (timely) flow of national funds earmarked for health and MNCH to district level, and a proportional increase in the volume of such funds;
- Increased engagement and capacity of province health and government authorities in health sector planning and oversight;
- Improved collection and use of data to influence allocation of funds for MNCH at all levels, and for communication of planning priorities (i.e. EBP).
- An increase in the evidence base for MNCH-related activities in health and other sectors.

Agreed indicators for each of these objectives are being developed.

Ultimately EBP is one of several levers to encourage relevant authorities in Indonesia to improve these key areas of challenge, possibly through major reforms to laws on decentralisation and financing of social sector programmes, performance-based assessment and sustained improvement of human resource capacity. The actual planning process used to prioritise MNCH and other health sector activities at district level will no doubt incorporate developments in this area, as well as changes stimulated by Kinerja, MAF and other initiatives in the short and medium term.