Final evaluation 2011 – Brief Report

Consolidation Programme Health/Policy Analysis and Formulation in the Health Sector, Indonesia

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On behalf of BMZ Federal Ministry for Economic Cooperation and Development

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This report was produced by independent external experts.
It reflects only their opinion and assessment.

Heidelberg, den 25.11.2011

Tabular overview

The evaluation mission

Evaluation period	07/2011 - 01/2012
Evaluating institute / consulting firm	Arge Sustainum – Institut für nachhaltiges Wirtschaften/ Health Focus GmbH
Evaluation team	PD Dr Michael Marx (international consultant) and Faisal Djalal (national consultant)

The development measure

Title according to the offer	Consolidation Programme Health/Policy Analysis and Formulation in the Health Sector (PAF)
Number	2003.2287.5 2007.2139.9
Overall term broken down by phases	Overall term: 01/2006 – 12/2011 Phase 1: 01/2006 – 10/2008 Phase 2: 11/2008 – 12/2011
Total costs	7,835,000 EUR Phase 1: 1,480,000 EUR Phase 2: 6,355,000 EUR (includes combined financing by AusAID in the amount of 835,000 EUR)
Overall objective as per the offer, for ongoing development measures also the objective for the current phase	Health policies and implementing regulations should better meet the needs of a decentralised health system.
Lead executing agency	Ministry of Health Indonesia (*Departmen Kesehatan*)
Implementing organisations (in the partner country)	Central units in the Ministry of Health: Phase 1: Centre for Health Policy Development and

	Analysis (*Puskabangkes*) Phase 2: Planning Office Centre for Data and Information (Pusdatin), Centre for Finance, Ministry of Health Research and Development Unit (*Litbangkes*)
Other participating development organisations	
Target groups as per the offer	The population that requires effective and accessible health care, especially the poor.

The rating

Overall rating *On a scale of 1 (very good, significantly better than expected) to 6 (the project/program is useless, or the situation has deteriorated on balance)*	2
Individual rating	Relevance: 2; Effectiveness: 2; Impact: 3; Efficiency: 2; Sustainability: 3

The independent final evaluation of the consolidation programme Health/ Policy Analysis and Formulation in the Health Sector in Indonesia (PAF) was conducted between 7 and 26 October 2011 by Dr Michael Marx and Faisal Djalal. The total duration of the project was six years (01/2006-12/2011) with a budget of 7,835,000 EUR. The evaluation relied on the Guideline on Evaluating the Success of Projects / Programmes of the GIZ/ GTZ (March 2009), the evaluation grid of the Federal Ministry for Economic Cooperation and Development (BMZ) and the underlying criteria of the Organisation for Economic Co-operation and Development (OECD). A secondary analysis of existing documents and studies and qualitative methods was employed for data collection. Guideline-based, semi-structured individual and group interviews of key informants at central and decentralized levels were also used. The preliminary results were discussed with the partners and the entire project team in a workshop.

Indonesia was hit particularly hard by the economic crisis in Asia from the middle of 1997 onwards. As a consequence, the proportion of the poor amongst the local population more than doubled (from 11% to 24%) and public services, particularly for education and health, declined (SSP 2004). In the wake of profound political change and democratisation, steps towards transparent and participatory governance have been taken. In January 2001, legislation on decentralisation came into effect. This transferred broad powers to the districts with respect to their resource allocation and management of their health services. The role of the national Ministry of Health was then meant to be limited to monitoring the health plans of districts and provinces, to the verification of results through indicators, to the development and monitoring of standards and guidelines, and quality controls. In this context, the Ministry of Health required support for the realignment of the responsible health policy-making offices (*Puskabangkes* until the end of 2009) and to develop effective working methods for a systematic combination of national and local levels in the analysis and formulation of policies and implementation measures, and for the identification of funding needs. The programme was originally designed as a sector focus programme. However, the sector focus changed at the end of the first phase.

The overall objective of the project was the following: "Health policies and implementing regulations should better meet the needs of a decentralised health system." The goal of Phase 1 was: “The Centre for Health Policy Development and Analysis (*Puskabangkes*) has the expertise, personnel capacity, budget and proven tools to perform its duties." The component objective of the second phase corresponded with the overall objective, since it is the last phase of an individual project. The executing agency was the Ministry of Health (*Departemen Kesehatan*). The implementing agencies in the partner country were central

units of the Ministry of Health (Phase 1: Centre for Health Policy Development and Analysis (*Puskabangkes*), Phase 2: Planning Office, Centre for Data and Information (*Pusdatin*), Centre for Finance, Ministry of Health Research and Development Unit (*Litbangkes*)). Activities of the Project for Health System Development (SISKES) and Human Resource Development in the Health Sector (HRD) were transferred into the second phase of the project PAF, which led to design changes. The expected synergies and systemic effects that would result from a close integration of the treated topics could not be fully developed due to the premature abandonment of the sector focus.

Effect hypothesis (reconstructed): The project aimed to improve the living conditions of the population, in particular poor and disadvantaged population groups (target groups) by facilitating access to adequate health care services. This should be achieved by means of a policy formulation in the health sector based on results-oriented empirical data. This formulation was considered a prerequisite for the creation of enhanced service availability and an increase in the health budget at the national level and in the districts (GTZ 2004). To this aim, the project promoted the establishment of transparent and participative work practices, evidence-based decision-making processes and a new culture of communication within the Ministry and between central and decentralized levels of health care. The direct effects were measured based on five pre-defined indicators. The desired indirect effects show significant gaps in the causal relationships, for example, providing more efficient and demand-oriented health services of good quality, thereby indirectly reducing morbidity among mothers and newborns, especially amongst the poor. The influencing factors at this level are multiple and are partly outside the direct control of PAF.

Overall, the logic of the results chain in the last offer and the programme documents of the last funding period is comprehensible and plausible. The causality includes the necessary spectrum of elements: inputs, activities, services, use of services, direct and indirect effects. The individual measures and their interaction are in accordance with internationally accepted approaches. The programme approach with the five subject areas (Good Governance & Gender, Health Financing, Human Resources for Health, Health Information Systems, Service Delivery, Knowledge Management) largely reflects the "6 Building Blocs" (the WHO definition of a health system). The approach is derived from a feasibility study from 2005 and from the Indonesian National Health Strategy. The adjusted results chain reflects the architecture of the project and is the basis of this evaluation. Good governance in the health and health insurance sector was a central focus of this project. Special attention was paid to the interlinkage of central and local stakeholders.

Technical implementation: The technical implementation can be regarded as adequate according to national and international standards, both in regard to the use of qualified professionals as well as in relation to the quality and quantity of the products developed. The selected systemic approach reflects the current state of discussion of development policy in the health sector. The procedures were largely process, value and health-system oriented. Capacity building of partners: In both phases, the project involved extensive measures for capacity development (CD). Strategically, three levels were targeted: first, individual skill development; second, institutional capacity development with the aim of structuring, harmonizing and consolidating processes; and, third, social CD with a focus on the development of networks within the fragmented cooperative structures at the Ministry of Health. The process of implementation was clearly defined by a participatory approach, meaning that issues and actions were identified and planned mutually by all stakeholders. As a conceptual framework, PAF put great focus on the area of Knowledge Management (KM) in the consolidation phase to ensure the efficiency and use of developed products and instruments.

Relevance: The project is designed in accordance with and with focus on national and international policies and the basic direction of development policy of the Federal Government. It is suitable for solving critical development issues and problems which are target group specific. The general poverty reduction goals and the sector goals are mutually coherent. The project is also consistent with the objectives of the partner organizations [Human Resources Development and Empowerment Board (BBPR-HR), Centre for Data and Information (*Pusdatin*), Ministry of Health Research and Development Unit (*Litbangkes*); University Gadjah Madha (UGM), University of Indonesia (UI)].

The project contributes to the reduction of inequality in the health sector. Risks of exclusion, of men for example, cannot be detected. The overall result is **good (level 2)**.

Effectiveness: At phase level and among the different subject areas, four out of five indicators have been achieved. Important unforeseen factors were the sudden change of sector focus by the BMZ, the closure of *Puskabangkes* and phases of inefficient cooperation between the Ministry and international partner organizations. Unintended positive effects could develop due to the great flexibility of the project. These include a dynamic partnership with the University Gadja Madha and a new area of cooperation with other centres and agencies of the Ministry. Due to the delayed implementation of a comprehensive cost study, the remaining time was not sufficient for the completion, communication and institutional implementation of this study. **Good** results without significant defects **(level 2)**.

Impact: Due to the systems approach, i.e. the combination of different mechanisms and levels (e.g. removal of access barriers via health insurance approaches, standardisation to improve the quality of care, accountability and reporting requirements (HIS), transparency and use of evidence-based information on resource allocation), the target groups are sustainably empowered to use their rights and the services they are entitled to. This may contribute to a reduction of barriers to development (empowerment of women and lower income groups). The expected synergies and systemic effects that would result from a close integration of the treated topics could not be fully developed due to the premature abandonment of the sector focus. In particular, the results of an extensive cost study could not be anchored in the system and produce the desired effect. Overall, the impact must be assessed as **satisfactory**; it is dominated by positive results **(level 3)**.

Efficiency: In a direct comparison with other GIZ funded health projects in Indonesia, the PAF budget seemed balanced. The funds dedicated to all topics compare unfavourably with similar measures in Indonesia and other GIZ supported countries. A single cost study in the last two years absorbed about 60% of total costs. This appears out of balance as compared to other topic areas, where the outputs and effects of which seem to be well balanced with regard to the use of funds. This contrasts with the great potential of this measure - the long-term effects of which are still outstanding. **Good** result, with no significant defects **(level 2)**.

Sustainability: The risks of the project were considered too low, especially in connection with the anticipated changes at the level of the support structure. The time frame set for the measures in Nusa Tenggara West (NTB) for the renewal and consolidation of the results was inadequate. Sustainable, long-term use of the products and instruments developed by the measures cannot be guaranteed. The successful acquisition of funding from the Global Fund for the work by *Pusdatin* in the area of HIS (software, training) and the securing of training courses in the area of Human Resources for Health (HRH) through the support of the Ministry of Health (scholarship commitments) are appropriate to secure the effectiveness of the project after its completion. Sustainability with regard to policy advice was achieved through the integration of policy papers into legal texts, through the creation of a national framework for HIS and through the involvement of Indonesian universities in the generation of evidence for policy decision making processes. Sustainability is **satisfactory**, positive results prevail **(level 3)**.

The overall rating: **good** outcome without major defects **(level 2)**.

Recommendations:

GIZ - headquarters: The GIZ should apply the quality assurance instruments for planning

more consistently. A risk analysis and the formulation of important assumptions should be an integral part of programme management. In situations with unstable partner settings, these risks and assumptions should also be included in the monitoring. The problem or question about use of developed products should be carefully considered in planning measures. A respective needs analysis should be supplemented by an analysis of the users and the future ownership of the respective product.

GIZ - country office: In connection with GIZ internal problems on content of or disagreement between two projects, the country office should support and mediate in order not to jeopardize potential synergies. An early introduction of national staff to the rules and the policies of the GIZ should be offered and consistently be supported by the GIZ country offices.

According to the logic of Capacity WORKS, individual CD-related measures should be combined with supportive measures of cooperative and policy systems for institutional development. The experiences from this project should be published accordingly. The knowledge management tools require a follow-up, upgrade, and certain marketing. Since this is not planned, opportunities for further development of web-based instruments should be looked into by the country office.

With regard to the cost analysis, a no-cost extension has been requested and evidently approved. The responsibility for the mandate during this extension period should be assigned to the *Social Protection Project* (SPP). During this time, increased technical support should be ensured (e.g. by a health economist) in order to, in addition to the technical completion, firmly anchor the study into the Indonesian health system and ensure the future use of the instrument.

BMZ and GIZ headquarters: It would be desirable if the BMZ and the GIZ engaged in longer-term commitments and allotments (time and budget) vis-à-vis their partners. Also, in health sector projects a focus should be on process consulting, process assistance, and cross-sectoral approaches.

For a sustainable consolidation of achievements, an appropriate follow-up, e.g. in the form of a longer follow-up phase, should be planned for and supported.

Holistic development cooperation should also include measures by the Kreditanstalt für Wiederaufbau (KfW). Here, the BMZ could provide more than mere rhetoric.

Ministry of Health: The Ministry of Health should accept more support from development partners in the field of process facilitation and organizational development. In view of the

cooperative landscape and the complex challenges of health care, cross-sectoral strategies should be pursued.

Closer connections to international concepts and experiences in the context of sector reform are also essential, even for an institution that is still statist in its core, in order to be able to keep up with and to enable speedy reforms. Study tours might be an option. Greater involvement of the private sector could develop larger synergies, such as through service agreements.

Cooperation with universities and other research institutions has proven to be fruitful and is essential, especially in view of the demand for health reform that is guided by evidence.

The cost analysis and the instruments created should be used as key tools in the allocation of resources.

Overall objective: Health policies and implementing regulations should better meet the needs of a decentralised health system

Objective Phase1: The Centre for Health Policy Development and Analysis (*Puskabangkes*) has the expertise, personnel capacity, budget and proven tools to perform its duties.

I1: Revised quality standards and "minimum service standards" are implemented and financed in the health facilities of at least two provinces.

S: „Minimum Service Standards“ were revised and coordinated with the Ministry of Home Affairs.

I2: The broad-based health service in accordance with national standards for primary and secondary health facilities has improved in at least two provinces (annual surveys).

S: National surveys are carried out by the Centre for Data and Information and thus sufficient data is provided for measuring the improvement at the end of the project.

I3: The health status of the population (surveyed in selected population groups) has improved in at least two provinces (annual surveys).

S: Surveys on the health status of the population were not analysed with regard to the effects of the project.

	Indicator fulfilled
	Indicator partly fulfilled
	Indicator not fulfilled

I: Indicator

S: Status

Consolidation Programme Health/Policy Analysis and Formulation in the Health Sector (PAF), Indonesia

Duration: 2006 – 2011

Indicators planned/actual

Cross-cutting issues

Poverty reduction **(MSA)**	Gender **(G1)**	Environmental and resource protection **(UR 0)**	Good governance **(PD/GG 1)**	Public-Private Partnership
Contribution through improved access to health care services	Measurable contribution by the project (Indicator 3)	Was not part of the project; no adverse effect observed	Direct contribution through policy consultations and cooperation with GIZ's project GG	Private sector has not been targeted yet by the national health policy

Phase 1 (2005-2007)

I1: The mandate of the Centre and its procedure for participative coordination of policy analysis and policy formulation is regulated in a decree.

S: MoU was signed in November 2009 shortly before closure of the Centre

I2: By comparison with 2004 (EUR 250,000), the operative budget of the Centre has increased (value at the end of 2005).

S: The operative budget increased from 250,000 EUR to 1.23 million EUR in 2007.

I3: The demand of the “Centre” for qualified personnel (human resources development plan after 6 months) is at least 70 % satisfied.

S: Qualification demand of the Centre and for its personnel determined ; coverage could not be determined.

I4: The management and other departments of the Ministry, provinces and districts justify the adaptation or development of policies, implementation guidelines and budget lines with results from the “Centre‘s” Management Information System (with data from at least four pilot districts).

S: Analysis of the health sector in preparation for the 5-year development plan of 2009-2014 und the revision of the policy paper concerning the structure of the National Health System

I5: Standards for services developed and implemented jointly with the Centre and the financial resources of health facilities lead to improved health services in at least four pilot districts (annual surveys).

S: The Centre did not directly contribute to the development of standards.

Phase 2 (2008-2011)

I1: At least 2 studies on health policy issues initiated by the Centre for Health Policy Development and Analysis have been produced and are used for decision-making processes by important internal and external decision-makers and stakeholders .

S: 3 major studies implemented in the consolidation phase

I2: At least 4 policy papers on major health policy issues supported by the project are available (selection of issues: health financing, division of work in the decentralized system, health staff management, hospital management and accreditation, maternal and child health).

S: Indicator was “exceeded”; 11 policy papers were drawn up (13 until 12/2011)

I3: The policy papers supported by the project are in line with the gender guideline of the Ministry of Health and verifiably refer to it.

S: Contributed to the gender policy of the Ministry of Health , which is used for the revision of the guidelines.

I4 (new): A representative number of health facilities (at least 80%) in all 10 districts in NTB confirm that they implement or use the guidelines supported by the project.

S: 56% (objective 80%) of the health facilities in NTB are using deliverables of predecessor projects.

I5 (new): Maternal and infant mortality rates are systematically recorded in all 142 primary (PUSKESMAS) and all the 7 secondary (hospital) health facilities (100%) and at village level (80% of villages = 787 out of 984 currently existing villages) and are incorporated in strategic policy making at all levels (audit, verbal autopsy, references in national policies).

S: 100% of all RS and PKM; 91% of all villages are using an information system for maternal and infant deaths.

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