GAVI ALLIANCE

EVALUATION OF GAVI SUPPORT TO CIVIL SOCIETY ORGANISATIONS

17 January 2012

COUNTRY EVALUATION REPORT - INDONESIA

Prepared by:

Cambridge Economic Policy Associates LLP

CEPA

CONTENTS

ACRONYMS AND ABBREVIATIONS

Acronym	Full description
APR	Annual Progress Report
CBO	Community Based Organisation
CEPA	Cambridge Economic Policy Associates
CSO	Civil Society Organisation
EPI	Expanded Programme on Immunisation
FBO	Faith Based Organisation
FMA	Financial Management Assessment
GAIN	National Immunisation Acceleration Movement
GAVI	GAVI Alliance
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHP	Global Health Partnership
HDI	Human Development Index
HSCC	Health Sector Coordination Committee
HSFP	Health Systems Funding Platform
HSS	Health Systems Strengthening
HW	Health Worker
IBI	Indonesian Midwives Association
ICC	Inter-agency Coordination Committee
IEC	Information, Education and Communication
IMC	International Medical Corps
INS	Injection Safety Support
ISS	Immunisation Services Support
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTA	Management and Technical Assistance
NGO	Non Governmental Organisation
NVS	New and underused Vaccines Support

Acronym	Full description
PKK	Family Empowerment and Welfare[1]
PR	Principle Recipient
TAP	Transparency & Accountability Policy
TBA	Trained Birth Assistant
TOT	Training of Trainers
TWG	Technical Working Group
UCI	Universal Child Immunisation
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

[1] Network in Indonesia of wives of governors/ village leaders.

EXECUTIVE SUMMARY

CSOs are recognised as an important actor in the immunisation system in Indonesia, their primary role being to provide complementary services to support the government's Expanded Programme on Immunisation (EPI), through community mobilisation and advocacy. The delivery of vaccines and immunisations is generally a government led process, except in some cases where CSOs provide immunisation services through their own health clinics and hospitals (for example, a few large faith based organisations (FBOs) run hospitals/ clinics).

GAVI approved both CSO Type A and B support for Indonesia in April and June 2008 respectively. Type A support of $100,000 was approved and disbursed. Of the $3,900,500 Type B support approved, only $1,270,500 has been disbursed to date. Type B funding supports a range of activities undertaken by six CSOs[2], including training on integrated maternal and child health (MCH), EPI, health promotion, and community mobilisation for health workers and community leaders.

Type A and B support are generally regarded as relevant and important for Indonesia. However, there are a number of problems reported with the programme design and implementation which have hampered its effectiveness.

For Type A support, the mapping exercise was completed in 2009, and its utility in supporting government/ other partners identify appropriate CSOs to work with is yet to be seen. Indonesia has not used any of the Type A funding for nomination of CSOs in the Health Sector Coordinating Committee (HSCC) which, we understand, already involves some participation from CSOs.

For Type B support, two international CSOs[3] resigned due to disagreement over their management costs, following approval from GAVI. This resulted in a delay in the commencement of the programme, while two new CSOs were selected as replacements.

Some stakeholders have expressed concerns about the selection process of Type B CSOs. While we understand that the selected CSOs have had long term relationships with the government[4], in our limited assessment, they work well. PKK in particular has an extensive network at the local level and we understand is often the first port of call for both government and other donors for mobilising communities.

However, the main issue has been the delay in the disbursement of Type B funds which has resulted in a disruption of the activities for some of the CSOs[5], implying a dilution of any results achieved. These CSOs will have to re-start/ re-programme their activities in the event of the second tranche disbursement from GAVI.

A majority of stakeholders in Indonesia were of the view that GAVI should continue to channel its CSO support through the government, given that it ensures government accountability and

[2] Family Empowerment and Welfare (PKK), National Scout Movement (Pramuka), Indonesian Midwives Association (IBI) and Consortium which is comprised of Muslimat, Aisyiyah and Perdhaki.

[3] PATH and International Medical Corps (IMC).

[4] Particularly PKK, whose members are comprised of the wives of government and community leaders.

[5] In particular, the two CSOs, PKK and Pramuka, who started implementation in 2009.

ownership and facilitates coordination between local government and CSOs. It is also interesting to note that the government has provided six 'stimulant packages' of approximately $1,100 each for five further CSOs that were unsuccessful in the initial selection for Type B funding. These funds, albeit small, have been used to support the outreach activities of the CSOs and were funded from the management costs of Type B funding.

Key suggestions to improve the programme design and implementation include clarifying the programme objectives to country level stakeholders; merging Type A and B support to reduce country burden and management costs (including sequencing the activities so that Type B funding can benefit from the mapping of CSOs under Type A); and increasing flexibility once the programme is underway (especially when CSOs have faced hurdles in implementation and some degree of re-programming would be beneficial to make maximum use of the available funds).

1. INTRODUCTION

This report provides an evaluation of GAVI Civil Society Organisation (CSO) support in Indonesia and forms a part of CEPA's overall CSO evaluation report. The report has been prepared by CEPA, with input from our country partners – Dr. Ridwan Malik and Eliha Mahsuna.[6]

1.1. Objectives of the country study

Indonesia is one of five country studies of this evaluation.[7] The specific objectives of the country study are as follows:

- to understand the relevance of GAVI CSO support in the country, the alignment of country funded programmes with broader immunisation/ health sector plans and priorities, as well as the suitability of various aspects of the programme design;
- to document the country's experience in implementing the programme, including identifying factors that have promoted or impeded effectiveness;
- to collate information on the results achieved through the funding to date; and
- solicit feedback on the suggestions for improving the effectiveness of the programme going forward.

The country study forms an important source of evidence for our evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support.

1.2. Methodology

The country study draws on information from: (i) country-level documentation; and (ii) interviews with local stakeholders during a visit to Indonesia during 18-21 October 2011.

1.3. Structure of the report

The report is structured as follows: Section 2 provides the country context and overview of GAVI support in Indonesia. Sections 3, 4 and 5 respectively present an evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support in Indonesia. Section 6 provides some recommendations on improving GAVI CSO support, based on country-specific experience and feedback.

The main report is supported by annexes on: bibliography (Annex 1); list of consultations (Annex 2); background statistics on the country health sector (Annex 3); summary results through Type B funding (Annex 4) and factors impacting effectiveness (Annex 5).

[6] Dr. Ridwan Malik and Eliha Mahsuna were employed through PT Martabat Prima Konsultindo Ltd for the purposes of this consultancy.

[7] The other country studies are on DR Congo, Ethiopia, Afghanistan and Pakistan. The CEPA team is visiting the former two countries, and local partners have been appointed for the latter two countries.

2. COUNTRY CONTEXT AND GAVI SUPPORT

2.1. Brief background on Indonesia

Indonesia is an archipelago comprising 33 provinces, each with their own political legislature and governments.[8] Indonesia has faced significant challenges in recent years, which have affected the health sector – in particular, the South East Asian financial crisis of the late 1990s as well as more recent decentralisation of Indonesia in the early 2000s.[9]

Table 2.1: Indonesia – key statistics[10]

Indicator	Value (year)
Population size	239,870,937 (2010)
Gross National Income (GNI) per capita	$2,500 (2010)[11]
Human Development Index (HDI)	108 (2010)

2.2. Health and immunisation sector

Indonesia's health sector is comprised of both public and private actors. Total health expenditure per capita in Indonesia has varied considerably over time, although has grown from $10 in 1998 to over $55 in 2009.[12] Public health expenditure (which includes external resources for health) as a percentage of total health expenditure has grown from 35% in 1995 to 51.8% in 2009.[13] Public health expenditure as a proportion of the total government budget has also grown steadily over the same period from 4% to almost 7%.[14] External resources for health make up 1.8% of total health expenditure in 2009.[15] Further data are presented in Annex 4.

The EPI was introduced to Indonesia in 1977 and was considered a strong government led system which achieved universal child immunisation (UCI) status against polio, measles, diphtheria, tetanus, pertussis and tuberculosis in 1990.[16] However, our interviews with stakeholders suggest that the EPI has suffered a setback from Indonesia's decentralisation since the early 2000s. In 2010, the Ministry of Health (MoH) instigated a National Immunisation Acceleration Movement (GAIN UCI 2010-14) to achieve UCI in all villages by 2014.[17]

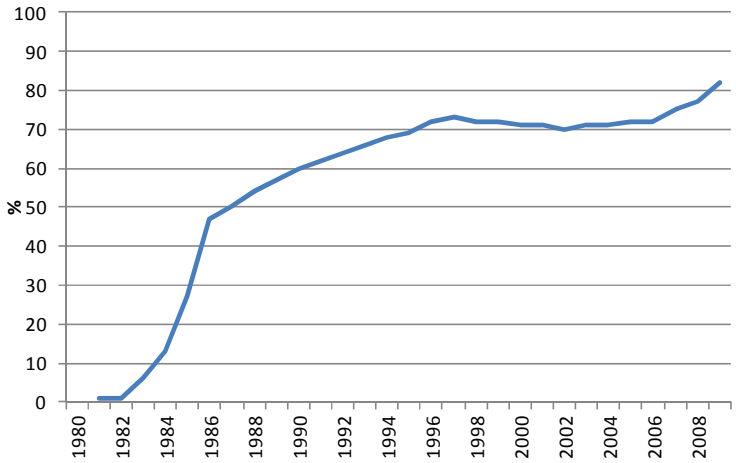
WHO estimate that routine immunisation services are delivered by approximately 7,800 health centers, 22,000 sub-health centers and 6,600 mobile clinics, in addition to public and private

[8] There are 440 districts, 5,227 sub-districts and over 69,000 villages.
[9] WHO EPI Situation Analysis (2010). Available at: http://www.ino.searo.who.int/en/Section4/Section12_80.htm
[10] Data from: http://data.worldbank.org/country/ethiopia and http://hdrstats.undp.org/en/countries/IDN
[11] Measured using the Atlas method at current US$.
[12] Refers to total health expenditure (public and private) per capita at current US$. Source: http://databank.worldbank.org
[13] Source: http://data.worldbank.org/country/indonesia
[14] Source: http://data.worldbank.org/country/indonesia
[15] Source: http://data.worldbank.org/country/indonesia
[16] WHO EPI Situation Analysis (2010). Available at: http://www.ino.searo.who.int/en/Section4/Section12_80.htm
[17] Indonesia Annual Progress Report 2010

hospitals.[18] Furthermore, over 50,000 village midwives supervise around 260,000 integrated village posts (*posyandu*) in providing routine immunisation.[19]

As indicated in Figure 2.1, there have been improvements in DTP3 coverage, which reached 82% in 2009[20] with approximately 80% of districts achieving more that 80% DTP3 coverage and only 2% of districts achieving less than 50% DTP3 coverage.[21] Under-5 mortality rate has steadily decreased from 121 per 1,000 in 1980 to 35.3 in 2010.[22]

Figure 2.1: Percentage of children aged 12-23 months immunised with DTP3 in Indonesia (1980-2009)[23]



The HSCC was established in 2008 and is comprised of the government, multilateral donors, professional associations and CSOs.[24] The CSO members in 2010 and 2011 were the National Scout Movement (Pramuka), Family Empowerment and Welfare (PKK), Indonesian Midwives Association (IBI) and Muslimat NU.[25] The HSCC is solely focussed on GAVI funding. In addition, we understand that the HSCC deals with matters that have been implemented, implying limited input from members at planning stage.

2.3. CSO context and role in immunisation

There are a large number of CSOs in Indonesia working across development sectors, including specific aspects of health.[26] However, a limited number of CSOs appear to be involved in immunisation and are generally engaged as part of their broader focus on maternal and child health (MCH). Most of the CSOs work in specific regions and feedback suggests that their activities are not closely coordinated. Their support to the EPI complements the government's initiatives and is generally limited to community mobilisation and advocacy activities.

[18] We note that a few large faith based organisations (FBOs) run hospitals/ clinics.
[19] WHO EPI Situation Analysis (2010). Available at: http://www.ino.searo.who.int/en/Section4/Section12_80.htm
[20] Source: http://data.worldbank.org/country/indonesia
[21] http://www.gavialliance.org/country/indonesia/
[22] Source: http://databank.worldbank.org
[23] Data from http://databank.worldbank.org/
[24] The Inter-agency Coordination Committee (ICC) has been merged with the HSCC.
[25] Indonesia Pediatric Society (Ikatan Dokter Anak Indonesia) was also a member of the HSCC in 2010.
[26] The Type A mapping report identified a total of 221 CSOs working in Indonesia.

2.4. Overview of CSO and other GAVI support in Indonesia

GAVI approved both CSO Type A and B support for Indonesia in 2008. Table 2.2 below provides information on the amounts and timings of approval and disbursement of funds for both types of support.

Table 2.2: Summary of Type A and B support

Type of support	Type A	Type B
Date of proposal submission	6th March 2008	6th March 2008
Date of Approval	21st April 2008	1st June 2008
Date of (first)[27] disbursement	30th July 2008	10th November 2008
Total funds	$100,000	$3,900,000
Amount disbursed (as on July 2011)	$100,000	$1,270,500
Channelling of funds	Govt.-MoH	Govt.-MoH

Source: Finance Data, July 2011, GAVI

Indonesia has also received support from GAVI for a Vaccine Introduction Grant ($100,000 in 2002), New and underused Vaccine Support (NVS) ($17,511,000 from 2002 to 2008 for Hepatitis B monovalent vaccine), Health Systems Strengthening (HSS) ($7,961,000 in 2008), Immunisation Services Support (ISS) ($12,636,000 from 2003 to 2007) and Injection Safety Support (INS) ($9,856,843 from 2002 to 2005).

As of the 1 January 2011, when the GAVI eligibility criteria were revised, Indonesia is not eligible for new forms of GAVI support.[28] However, Indonesia has been offered an opportunity in 2011 to apply for GAVI support for the introduction of new and underused vaccines.

[27] Date of first disbursement is for the Type B funds

[28] http://www.gavialliance.org/about/governance/programme-policies/country-eligibility/

3. EVALUATION OF POLICY RATIONALE AND PROGRAMME DESIGN

3.1. Relevance of GAVI CSO support in Indonesia

GAVI CSO support was welcomed in Indonesia by all stakeholders, as CSOs play an important 'demand creation' role through advocacy and community mobilisation. CSO role in delivery is limited to a few large FBOs that run their own hospitals and clinics.

Both Type A and B support are, in principle, regarded as useful for Indonesia – however, there appears to be limited/ no awareness of the support for nomination of CSOs in the HSCC/ ICC (under Type A funding) – rather the HSCC members are stipulated annually by Ministerial Decree. This aspect of Type A support also has limited relevance in Indonesia as stakeholder feedback suggests that the HSCC does not function as a participatory, planning and coordinating body for the health sector (and an ICC does not exist) – rather, it focuses solely on GAVI, as noted in Section 2.2. CSO members are eligible to attend all HSCC meetings, however the value of their participation is questioned by many stakeholders, particularly as a lot of the meetings focus on GAVI's other programmes.

Our interviews suggest that Type B CSO support is closely aligned with the government health sector plans and country needs. Community empowerment is one of the four pillars of the country health sector strategy, and is one of the key activities funded under Type B support.

In terms of alignment with GAVI HSS support – while the target areas for both forms of support are the same, unfortunately there has been limited leverage between them, as the implementation timings are not aligned and the programmes are managed by separate departments within the MoH (implying reduced coordination). For example, both CSO and HSS funds will be used for the training of midwives (albeit on different topics – CSO support on community mobilisation and HSS support on delivery of vaccines) and it would make sense to deliver these trainings in a more synchronised/ coordinated manner to save costs.

3.2. Programme design

Some aspects of the design of GAVI CSO support have worked well in Indonesia, while others have not. We provide a summary below.

Programme design aspects that have worked well

- *Channelling of funds through government*. GAVI's approach of channelling funds through the government has been viewed positively by most stakeholders, as it encourages ownership by the government and the supervision, monitoring and evaluation (M&E) of CSO activities. In addition, it is useful to note that: (i) government guidelines require that all external resources for health be routed via government for accountability; and (ii) funds routed via government are tax free (otherwise subject to local tax). However:
    - Some issues were noted with this approach, including: (i) additional bureaucracy which has led to delays in the disbursement of funds from government to

CSOs[29]; (ii) funds being disbursed in multiple (four) instalments; (iii) strict and frequent reporting requirements required from the MoH[30]; and (iv) high degree of government involvement in programme implementation resulting in additional costs to the CSOs[31]. We however note that the government has attempted to streamline the fund receipt and disbursement process by reducing the number of departments involved in the process.[32]

- CSOs mostly receive donor funding directly, including from the Global Fund (see Box 3.1 below on technical assistance provided to CSOs by UNDP to facilitate effective management of the Global Fund grant)[33]. It was also noted that a neutral body may help to ease the natural tensions that arise between government and CSOs. While stakeholders noted that other modalities of support may be considered (such as routing funds directly to CSOs or via bilateral donors or GAVI Partners), it is widely recognised that it is essential for the government to be fully engaged in CSO support.

[29] The first delay at the country level occurred after the government received the first tranche of funding for Type B support in September 2008. This was due to political pressure around funding CSOs through external resources for health and also the need to develop a grant implementation manual before commencing the transfer of funds. This implied that funds were not disbursed to the CSOs until August 2009, eight months after the planned disbursement date. The second delay occurred between January and March 2011 which was caused by the replacement of staff managing the CSO grant.

[30] For example, CSOs are required to submit four reports and receive four disbursements for each year's funding. While this is agreed with CSOs beforehand, this was reported as being onerous, especially given the small budget available.

[31] Some CSOs noted that they are obliged to invite government representatives to all programme activities and pay for their transport and per diem costs. We note that this may have benefits as well as costs as government representatives may provide additional technical and management support.

[32] Initially, GAVI CSO Type B funds were routed from GAVI to the Directorate of Disease Control and Environmental Health within the MoH, who then disbursed funds to the Centre for Health Promotion who disbursed funds to the CSOs. Since 2009, funds have bypassed the Directorate of Disease Control and Environmental Health and been routed directly from GAVI to the Centre for Health Promotion and then to the CSOs.

[33] Other donors that have provided funding to CSOs directly or via implementation partners, include the Global Fund, USAID, UNFPA and the Netherlands as well as international NGOs such as PATH and IMC.

Box 3.1: UNDP's technical assistance for Global Fund grant recipients[34]

Global Fund (GF) Principle Recipients (PRs) in Indonesia include both government, and more recently, civil society organisations. UNDP provides technical assistance services to both government and CSOs for effective grant management (being appointed by the country PRs and not GF).[35]

We understand that the focus of the TA for government is primarily on grant management (e.g. financial management, procurement, supply management), while for CSOs, the support also extends to programmatic support and human resources (HR) management. In addition, UNDP also undertook a capacity assessment of CSOs prior to the commencement of the programme, and provided some capacity building support. Thus, in general, TA support for CSOs has been more wide-ranging.

CSO performance is graded against a pre-determined performance framework, which defines the eligibility for the next tranche of funds. We understand that both government and CSO grants have been performing well.

Based on discussions with UNDP,it is our view that this model of additional TA delivery to support grant recipients presents a useful approach for more effective grant management, especially when funds are routed directly to CSOs.

- *Quantum of funding.* The amount of funding for Type A and B support is viewed as acceptable for the proposed activities. After 'completing' (see more details below) Type A activities, Indonesia currently has a residual balance of funds of approximately $3,000. In addition, some Type B implementing CSOs (PKK and Pramuka) have completed Type B year 1 activities with a small residual balance of funds which was sent back to the government. However, the overall envelope of funding restricts the scope of the activities that can be carried out, and hence limits the potential for results.

Programme design aspects that have not worked so well

- *Clarity of objectives.* Some stakeholders noted that GAVI should have more clearly defined its objectives of supporting CSOs and identified country specific issues prior to the CSO programme. This was mainly suggested by the GAVI Partners in response to uncertainty over what GAVI was trying to achieve from supporting CSOs.
- *Integration of CSO support.* Stakeholders generally indicated that Type A and B support could be integrated to reduce management costs. Some also suggested that CSO and HSS support could be integrated to further reduce management costs, especially given the structure in the MoH where three separate directorates are responsible for the management of the these two programmes.[36]

[34] This information is based on our in-country consultations and has not been verified further.

[35] Another interesting aspect of the GF grant is that CSOs have become PRs only recently, and were previously sub-recipients to the government PR. This has helped build capacity and experience amongst the CSOs on fund management.

[36] 1. Directorate of Immunisation and Quarantine, CDC, is the unit responsible for coordinating between Ministry of Health and the Immunisation Programme Support Component (ISS, NVS, and INS). 2. Directorate of MCH is the unit responsible for coordinating between Ministry of Health and HSS Component. 3. Centre of Health Promotion is the unit responsible for coordinating between Ministry of Health and the CSO Component.

- *Timing of Type A and B support.* Because Type A and B support were approved and funds disbursed simultaneously, Indonesia was not able to benefit from the Type A mapping exercise to support the identification of suitable CSOs for Type B support. It was noted that it would have been useful if Type A and B support had been implemented sequentially in the country.
- *Limited flexibility for mid-course correction.* Indonesian stakeholders commented that limited flexibility for course correction mid-way into the support has caused some difficulties.
    - The two new CSOs that replaced PATH and IMC had to take up similar activities to achieve the same proposed outputs, even though these were not perfectly in line with their areas of work.[37]
    - Further to GAVI's approval of Indonesia's proposal for Type B support, it was recognised that the targets for training midwives could not be achieved as there were not enough suitable midwives in the project area. It was indicated in our stakeholder consultations that the HSCC/ government, as well as the CSOs, were reluctant to approach GAVI in relation to this issue. They are particularly cautious given Indonesia's recent experience with the stoppage of ISS funding due to data discrepancy.

  It can be argued, that within reason and allowing for GAVI's and the government's approval, it would make sense to include some simple and efficient mechanisms to allow for some reasonable changes to be made to the programme – in the event that there are any major issues/ course correction is required.

In addition, a general issue highlighted is that the APR format and requirements are difficult to understand given language barriers. This is cited as one of the reasons why the 2008 and 2009 APRs were not of a high enough quality and had to be re-submitted.

[37] In one instance this is perceived to have created a conflict of interest for IBI in particular who were required to train trained birth assistants (TBAs) who normally compete with midwives (IBI members).

4. EVALUATION OF PROGRAMME IMPLEMENTATION

4.1. Role of GAVI institutions

4.1.1. GAVI Secretariat

The key issue raised by the government and CSOs in relation to Type B support was the delays in GAVI's approval and disbursement processes. These include delays in approving the initial country proposal and 2008 and 2009 APRs, as well as a delay in the second tranche of funding (due to the ongoing/ recently completed TAP/ FMA).[38] These delays have had a significant impact on the implementation of Type B support as follows:

- Initially, there was a delay of three months in the approval of the country proposal and a further delay of five months until funds were disbursed to Indonesia. This delay implied that CSOs could not start their activities as planned.
- In addition, there was a delay in the disbursement of the second tranche of funding from GAVI which meant that CSO activities either stopped or were funded temporarily from other sources (with the expectation that the GAVI disbursement would come through). As noted below, this has proven problematic for the CSOs and has resulted in additional costs for some CSOs.[39]

The funding delays have led to some resentment of GAVI by the CSOs, one noting that 'they felt GAVI was full of false promises and had 'belittled' them by not providing the necessary information on the next tranche of funding'. This CSO noted that as they had other expected sources of funding, they would assess whether they were in a position to conduct the phase 2 of GAVI activities when the funds became available, indicating they would not prioritise it.

4.1.2. GAVI Partners

Despite the government viewing WHO and UNICEF as important contributors to the CSO programme, they have had limited involvement apart from attending meetings and being a signatory to the APRs. GAVI Partners noted that in order to play an effective role, GAVI needs to clearly mandate their role in its agreement with the government.

4.1.3. Functioning of the GAVI model

Stakeholders generally stated that GAVI would benefit from more of a country presence which would help them to overcome many of the identified issues with the programme.

[38] At the time of the country visit, we understand that the second tranche of funding has not been disbursed.

[39] In particular, Pramuka, who had trained trainers as part of the first tranche of funding were supposed to then train their members as part of the second tranche of funding. However, the two year gap between training the trainers and them delivering the trainings has resulted in the need for them to be re-trained before the second phase of activities gets underway.

4.2. Country implementation

4.2.1. Type A support

The mapping exercise was conducted in a timely fashion after funds were received and no real issues were highlighted. However, some stakeholders noted that a more comprehensive and substantial situational analysis would have been useful as in practice, the mapping exercise only includes the contact details and reported activities of the CSOs who responded to government advertisements.

The nomination process of CSOs to the HSCC, as described in the proposal for Type A support, does not appear to have been conducted. Rather, CSOs are selected to join the HSCC via a Ministerial Decree which primarily includes CSOs which receive GAVI funding.

4.2.2. Type B support

Selection of CSOs

Initially, a workshop for CSOs was held to inform them about the opportunity to apply for GAVI CSO Type B support. While 40 CSOs attended this workshop, only 11 applied for CSO support – as some noted that the time available to prepare proposals was not sufficient.

From the 11 proposals submitted, four CSOs were selected by a Technical Working Group (TWG), coordinated by the Centre for Health Promotion within the MoH and the HSCC. The government also worked alongside selected CSOs to develop their proposals and align them with the health sector plans. Stakeholders noted that the government selected CSOs so as to ensure that different types of CSOs were selected, for instance: faith based organisations (FBOs); non-governmental organisations (NGOs), youth orientated organisations, etc.

Of the CSOs selected, two were indigenous (National Family Movement (PKK) and Pramuka) and two were international (PATH and International Medical Corps (IMC)).[40] However, the two international CSOs resigned from the project due to contractual disagreements on a suitable level of management costs.

In order to replace PATH and IMC, the original CSOs that initially submitted proposals were asked to re-submit proposals to the government in line with the activities that had been proposed by PATH and IMC. These proposals were assessed by the TWG and HSCC. It was noted that this process took almost a year to complete, resulting in the Indonesian Midwives Association (IBI) replacing IMC and a group of CSOs, referred to as 'Consortium', comprised of Muslimat, Aisyiyah and Perdhaki replacing PATH. More information on the final selected CSOs is provided below (Table 4.1).

[40] It was noted that the indigenous CSOs were selected because of their extensive local networks, while the objective of selecting international CSOs was to facilitate knowledge transfer.

Table 4.1: Type B implementing CSOs

CSO	Background	Type B supported activities
PKK	Organisation focussing on community mobilisation comprised of the wives of government and community leaders at all levels of society	• Training of members and community volunteers in community mobilisation for increasing immunisation and MCH coverage • M&E for training undertaken
Pramuka	Organisation for the Scouts, Girl Guides, Rovers and Rangers	• Training of trainers (TOT) for Scout instructors on increasing immunisation and MCH coverage • Training and developing IEC materials for Scouts on the importance of immunisation • Community and family education by members
IBI	Professional association of midwives. Midwives deliver immunisations in Indonesia as one of a broader range of services	• Conducting a baseline survey on awareness of immunisation and identifying any limitations to increasing coverage levels • Developing training materials for midwives • Training of midwives, community volunteers and TBAs on immunisation and MCH
Consortium: • Muslimat • Aisyiyah • Perdhaki	Faith based organisations that either own or manage private health facilities which deliver immunisations	• Conducting a baseline survey on awareness of immunisation and identifying any limitations to increasing coverage levels • Training community level health workers and volunteers in immunisation and MCH

We understand that the selected CSOs for Type B funding have had a long term relationship with the government. In particular, PKK comprises wives of government and community leaders and is closely linked to the government machinery (and is also not a CSO in a strict sense). It was suggested that while at the surface it may appear that the government has 'cherry-picked' the CSOs for this funding, in practice, the selection was affected by the limited time available for the government and CSOs to put together proposals as well as the government's desire to select 'safe' CSOs who would deliver results – given this was a new activity for the government department managing the CSO programme as well[41].

In CEPA's limited assessment, the selected CSOs work well – PKK in particular has an extensive network at local levels and we understand is often the first port of call for both government and other donors for mobilising communities. The other CSOs selected have also worked closely with other donor organisations active in Indonesia. While the selected CSOs do not have much prior experience in immunisation, they are generally viewed positively by stakeholders and are well regarded in Indonesia.

In addition to the proposed Type B activities, six 'stimulant packages' of approximately $1,100 have been provided to five CSOs that were unsuccessful applicants for CSO Type B support. This has been funded out of the management elements of the Type B proposal. These stimulant packages have been used to target key groups who have dropped out of routine immunisation as

[41] The Centre of Health Promotion.

well as to build the capacity of the CSOs involved, particularly in terms of grant management and dealing with the government.

Government management of GAVI grants

The Centre for Health Promotion, within the MoH, oversees the GAVI CSO grant. In addition, the MoH have contracted a team, referred to as the 'GAVI Secretariat', to manage the grant. This is a large team, comprising an administrative assistant, M&E officer, finance officer and liaison officer; and is funded out of the management elements of the Type A and B proposal.

While we note that the government made some efforts to involve the Centre for Health Promotion and the other MoH directorates that manage GAVI grants, it was reported among some stakeholders that there was a lack of coordination, particularly between EPI and MCH departments. Stakeholders commented that greater benefits from the programme could be achieved if the other departments were made aware of the activities being undertaken as part of the CSO programme.

Implementation hurdles faced by CSOs

While CSOs did not highlight many major challenges with implementing the proposed activities, it was mentioned that inflation of transport costs since 2008 have impacted the available funds for some of CSOs' activities. This effect was emphasised for the GAVI CSO programme relative to their other programmes due to many areas of work being far away from their headquarters.

5. EVALUATION OF PROGRAMME RESULTS

5.1. Type A support

While the mapping exercise has been completed and circulated amongst government departments, its use is still to be determined. We are not aware of any plans to update the mapping exercise at present. It was also noted that it would have been more useful if the report had also been circulated outside of government as other health sector actors may have been able to utilise the report.

5.2. Type B support

Results framework – outputs, outcomes and impacts

Of the four implementing CSOs, PKK and Pramuka commenced their activities in 2009 and IBI and Consortium commenced their activities in 2010 and are still implementing their year 1 activities. While the delay in the second tranche of funding from GAVI has not yet affected the implementation of IBI and Consortium's activities, it has halted the activities of PKK and Pramuka for over a year. This has had a particularly detrimental impact on the programme due to the nature of activities undertaken – both PKK and Pramuka have trained staff/ members who were supposed to then educate and train others in the second phase of implementation. Due to the delay in the disbursement of the second tranche of funding from GAVI, both PKK and Pramuka have reported that they will have to re-train staff or train new replacement staff before any year 2 activities can take place. As such, a large proportion of year 1 funding may have been largely wasted (approximately 25% of the disbursed $1,270,500 was routed to PKK and Pramuka).

Annex 4 provides the summarised progress on outputs, collated from the information in the APRs. However, through the country consultations we were able to obtain more substantive information on the activities undertaken by each CSO, as listed below. While we cannot verify the actual achievement of these detailed outputs, our sense from the consultations with the CSO-recipients, government and locally-based donors is that considerable progress against the proposed activities has been made by most of the CSOs. Table 5.1 provides a summary of the overall outputs achieved through the CSO funding in Indonesia.

Table 5.1: Summary of outputs

Key outputs through CSO Type B funding in Indonesia
• Trainings have been delivered to: o community volunteers (cadres) in 2,400 villages in capacity building and health promotion who have reached 7,200 families; o 35 trainers of trainers, 70 mid-level managers, 267 private health workers, 450 private sector staff and 216 community and religious leaders on the importance of immunisation and MCH; o 78 trainers of midwives and 365 midwives on immunisation and MCH; and o 10 national level, 45 provincial level and 80 district level trainers on community mobilisation for Scout groups. This led to 32 Scout groups being trained and 320 families receiving information on the importance if immunisation.

Key outputs through CSO Type B funding in Indonesia
• Other activities that have been undertaken include: development of training modules; M&E studies; baseline studies; coordination meetings; and the development and distribution of IEC and advocacy materials. • In addition, out of the management costs for Type B support, 41 non-GAVI CSOs were trained in EPI and MCH and asked to submit proposals for funding to immunisation dropout rates in selected areas. 5 CSOs received support as a result.

This conclusion however has the following caveats: (i) we cannot contextualise this progress in terms of for example what proportion of the activities in an area have been trained; and (ii) we cannot comment on how these outputs compare with plans, given limited information on plan indicators, and also changes to the indicators caused by delays in country approval and disbursement. Additional caveats are noted in Annex 4.

It is difficult to conclude on the translation of these outputs into outcomes and impacts – as also noted from the scanty information provided in the country APRs (see Annex 4). In terms of affecting district/ national coverage, it is difficult to say if Type B support has had any impact, given the small size of its funding and very localised nature of activities.[42] In addition, attributing any results to CSO activities would be difficult, particularly as any statistics would not distinguish between government and CSO contributions.

Other

Some stakeholders, including the CSOs themselves, have noted that CSOs have improved their own capacity to coordinate themselves, respond to grants and financially manage themselves. CSOs have also reported that other districts not involved in the CSO programme have highlighted that they would like to receive the same type of support. The Type B CSOs have also expressed a desire to scale up coverage of Type B activities to a national level.

Sustainability

MoH and CSO relationship has improved as a result of GAVI CSO support and there is some evidence that GAVI CSO support has had a catalytic impact on the number of government funded projects involving CSOs in the health sector. In particular, we were informed by country stakeholders that more funds have been allocated to CSOs in the recent reprogramming of the HSS programme. In addition, 18 CSOs have been funded by the government as part of a healthy behaviour campaign which was designed using lessons learned from the GAVI CSO programme.

[42] CSOs did report anecdotal evidence that immunisation coverage had increased in the project areas.

6. RECOMMENDATIONS

In terms of the current status of the programme, the delayed disbursement of the second tranche has caused considerable disruption for the work of PKK and Pramuka; and hence in order to achieve some results in Indonesia through the ongoing work of the other CSOs, it would be essential for GAVI to avoid any delays in the disbursement.

Other recommendations to improve the effectiveness of the programme include the following:

- *Integration of CSO support.* Merging Type A and B support would benefit the programme through simplifying the application and reporting processes and reducing the associated management costs. Merging CSO support with HSS support may further simplify this process and align the demand creation activities of CSO support with the supply side focus of HSS support.[43] Stakeholders noted that some HSS funds should be earmarked for CSOs to ensure the government prioritises their funding. Difficulties involved with merging the programmes across MoH directorates would also need to be identified and addressed.

- *Increased programme flexibility.* More flexibility from GAVI and clearer guidelines on how Indonesia could use the available Type B funds, particularly in relation to the resignation of PATH and IMC and the selection of two new CSOs, would have helped implementation allowing the programme to cater to the specialities of implementing CSOs. In addition, excess funds for some activities could have been put to better use.

- *More fully engage with GAVI Partners.* GAVI Partners highlighted that they would have been able to contribute more substantially to the programme had they been more involved in the programme at an earlier stage.

- *Increased GAVI country presence.* GAVI should have more of a country-level focal point to deal with the government, CSOs and GAVI Partners. It is not necessarily the case that a focal point should be based in Indonesia, however, to make best use of the position, they should be familiar with the country context and able to inform GAVI of the country-level issues and opportunities.

- *Performance based funding should be utilised.* Performance based funding for CSOs was suggested by a number of stakeholders as a way of properly incentivising CSOs to focus on the programme and maximise the usefulness of the funding available. As with the UNDP case study above, performance based funding has been used to good effect with CSOs in Indonesia.

[43] In terms of integrating CSO support with the HSFP, consultees were generally not aware of the ongoing discussions (as can be expected), although the feedback gained from stakeholders did not suggest any opposition to this approach.

ANNEX 1: LIST OF REFERENCES

- Annual Progress Reports: 2008, 2009, 2010
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- International Human Development Indicators (2011): http://hdrstats.undp.org/en/countries/ETH
- WHO (2010): "EPI Situation Analysis"
- WHO (2011): "Global Health Observatory database"
- World Bank (2011): "World Bank Database"

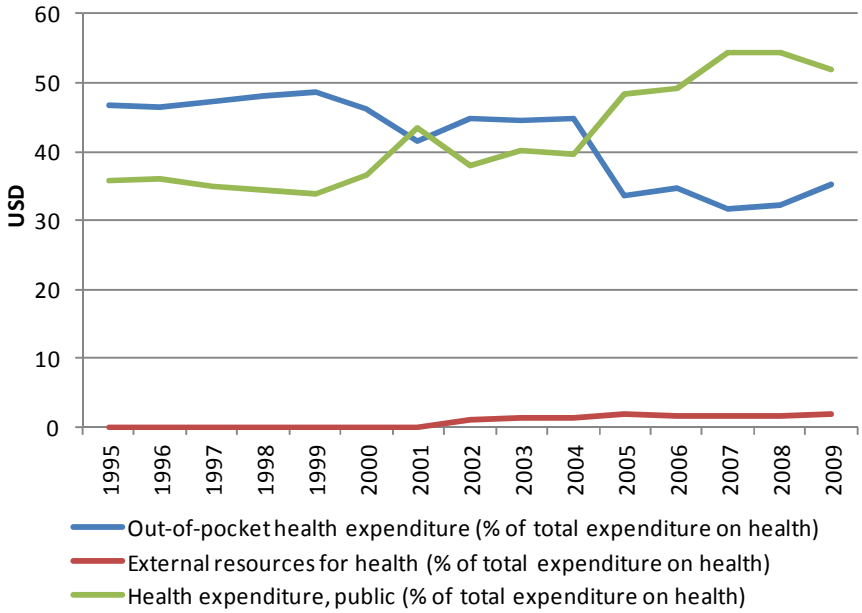
ANNEX 2: LIST OF CONSULTATIONS

Individual	Organisation	Position
Government and Ministry of Health		
Andi Muhadir	Directorate of Surveillance, Immunisation, Quarantine and 'Matra' Health	Director
Theresia Sandra Diah Ratih	Directorate of Surveillance, Immunisation, Quarantine and 'Matra' Health	Manager of EPI, Head of Sub-Directorate of Immunisation
Prima Yosephine	Directorate of Surveillance, Immunisation, Quarantine and 'Matra' Health	Head of Division of Standardisation for Sub-Directorate of Immunisation
Jehezkiel Panjaitan	Directorate of Maternal Health	Division of Coaching and Evaluation for Sub-Directorate of Postpartum Maternal Health Care
Rarit Gempari	Center of Health Promotion	Head of Empowerment and Community Participation
Muhani	Center of Health Promotion	Staff of Sub-Directorate of Community Participation
Lovely Daisy	Directorate of Child Health	Head of Division of Standardisation for Sub-Directorate of Infant Survival
Made Diah	Directorate of Child Health	Head of Administration Sub Section
Lia Meiliyana	Directorate of Child Health	Staff of Sub-Directorate of Infant Survival
Eli Zabet	Directorate of Child Health	Staff of Sub-Directorate of Survival of Toddler and Pre-school Children
Bilaterals and mulitilaterals		
Marisa Ricardo	UNICEF	Health Specialist – EPI Officer
Kenny Peetosutan	UNICEF	Health Specialist – EPI Child Survival and Development Cluster
Bardan Jung Rana	WHO	Head of WHO's Immunisation Program Development
M. Shahjahan	WHO	Technical Officer Health System Development (HSD)
Imam Subekti	AUSAID	Senior Policy Officer
Ria Arief	AUSAID	Program Manager Health System Strengthening (HSS)
Mildred Pantouw	USAID	Maternal and Child Health (MCH) Project Management Specialist
Puti Marzoeki	World Bank	Senior Health Specialist
Danya Delita H	UNDP	Assistant Country Director/ Head

Individual	Organisation	Position
		Poverty Reduction Unit and MDGs
Haikin Rahmat	UNDP	Adviser for Strengthening Partnership and Relationship
GAVI Partners		
Dian Safitri	Secretariat of Coordination Integration and Immunisations	CSO Coordinator
Budi Perdana	Secretariat of Coordination Integration and Immunisations	Executive Secretary
Tiodora	Secretariat of Coordination Integration and Immunisations	HSS Coordinator
Type B implementing CSOs		
Tuminah W	IBI	Project Coordinator
Mulyono Adi	Scout Movement	
Evy Sudarminah	Scout Movement	
Azizah Aziz	Consortium (Muslimat)	Head of GAVI Consortium
Helvi Nurzaini	Consortium (Aisyiyah)	
Medowati	Consortium (Perdhaki)	
Felix Gunawan	Consortium (Perdhaki)	
Hamdi A	GAVI Consortium	
Intan Endang	PKK	
Andre	PKK	
Jan Andrianto	PKK	
Others		
Nyoman S	Parisada Hindu Dharma Indonesia (PHDI) – Hindu Organization	Head of Inter-agency Cooperation
Yuyun Sri Heryani	Indonesian Child Welfare Foundation (YKAI)	Head of Program
Lian	Perwakilan Umat Budha Indonesia (Walubi) - Buddhist Organization	
Ike Diyah	Indonesian Family Planning Association, West Java (PKBI)	
Nuraina Paimoen	Al Hidayah	
Irawaty Manullang	Indonesian Christian Association for Health Services (ICAHS)	
Vistamika Wangka	Indonesian Christian Association for Health Services (ICAHS)	Project Manager
Neneng R	Fatayat Nahdhatul Ulama	

ANNEX 3: STATISTICS ON THE HEALTH SECTOR

Figure A3.1: Sources of health expenditure as a percentage of total health expenditure[44].



[44] Data from http://databank.worldbank.org/

ANNEX 4: DESK REVIEW OF RESULTS OF TYPE B FUNDING

This annex provides a summary of the progress reported in the APRs against the activities and expected results detailed in the Indonesia country proposal for Type B support. It is entirely desk-based, although the results were largely reinforced by our in country consultations.

It should be noted that this draft analysis is based entirely on reported progress on indicators by countries, and CEPA has not sought to verify/ validate any of these (and indeed this is not possible given the mandate and timelines of our evaluation). We have however used our judgement, based on the information provided, to present a summary status on the progress achieved.

Structure of analysis

We have structured our analysis as follows:

- We present two tables – the first focusing on activities and outputs, and the second on outcomes and impacts. We have tried to construct these in a consistent manner following CEPA's results hierarchy, given the varying presentations across countries.
- These tables do not intend to map the progress against *all* activities undertaken, but rather, provide an overview of the *main* country level activities and progress achieved.
- We have tried to map both activities that can be assessed quantitatively (e.g. number of trained health workers) as well as activities that can be assessed based on whether they have been completed or not (e.g. conducting a baseline survey).
- We have attempted to summarise the extent of progress achieved by the following categories: "Considerable progress", "Some progress" and "Unknown"[45] – however this represents CEPA's subjective opinion based on the information in the proposal and APR documents available, and may not be completely accurate given the poor quality of information contained in these documents (see limitations below).

[45] Our categories for summary progress are self-explanatory, however please note that where it is not clear either (i) what progress has been achieved; and / or (ii) the context for the progress (i.e. where targets or milestones are not noted), we have marked the progress as "unknown", despite APRs reporting on the progression of activities.

Limitations

There are a number of limitations to our analysis, as detailed below:

- The latest APRs we have been able to analyse was the 2010 APR. It is likely that further progress will be reported in future APRs (especially 2011, given ongoing funding support in the countries).
- Activities, outputs, outcomes and impacts (baselines and targets) are generally not clearly laid out in the country proposal and APRs. For example, sometimes these are noted on a general basis rather than defined by specific targets and timelines. Also, the context for some of these results is not clear – i.e. what part of the problem are these activities and their results aiming to solve?
- It is often unclear how the results hierarchy, or logical framework, has been constructed. For example, activities proposed do not always match outputs or outcomes proposed/ reported.
- As timelines and other factors have changed during the implementation of activities, target timelines, and sometimes the targets themselves, have changed.
- It is difficult to track progress along the results hierarchy as the information in the APRs does not always relate directly to the proposals (including inconsistencies between subsequent APRs).
- While we recognise that outcome and impact indicators may not be possible to measure as part of this evaluation, often they are not reported in the APRs. Where this is the case, we have inserted the summary status 'unknown' into the tables.
- The categorisation of summary progress is based on our subjective opinion – and is not directly comparable across countries, as the level and quality of information varies considerably across countries.

Country level summary

The tables below provide a work-in-progress summary for Indonesia:

Table A4.1: Progress on outputs

Proposed activities	Progress against outputs	Summary status
Conduct training and refresher training on integrated MCH, EPI and health promotion/community mobilization	• In 2010, 104 trainings of EPI and MCH were delivered • In 2010, 140 refresher trainings on EPI and MCH delivered • In 2010, 41 non-GAVI CSOs were trained in EPI and MCH and asked to submit proposals for funding to deliver immunisations and MCH services. 5 CSOs received support as a result • In 2010, capacity building and training on health promotion activities for village level cadres reached 2,400 villages	**Some progress; although added value of some trainings may be questioned due to funding delays, as detailed in the report**
Undertake the IEC (Information, Education and Communication) to the target audiences	• In 2010, advocacy materials were developed and distributed	**Some progress; although added value of some trainings may be questioned due to funding delays, as detailed in the report**
Conduct surveillance strengthening	• In 2010, M&E studies were conducted in 5 locations	**Some progress; although added value of some trainings may be questioned due to funding delays, as detailed in the report**

Table A4.2: Progress on outcomes and impacts

Proposed outcomes and impacts	Reported progress	Summary status
Increased immunisation coverage in 5 selected provinces to increase by 10%	• Progress on immunisation coverage not reported.	**Unknown**

ANNEX 5: FACTORS IMPACTING EFFECTIVENESS

There are a number of factors which have affected the effectiveness of the CSO programme in Indonesia. These factors are summarised in the table below. Positive factors are indicated by '+' while negative factors are indicated by '-' and factors which have been viewed differently by different stakeholders are indicated by '±'.

Table A5.1: Summary of factors affecting effectiveness

Type	Factors
GAVI-specific factors	– Delays in disbursements – Lack of communication – Inflexibility of funding
Country-specific factors	– Delays in disbursements – Error in population data – Language barriers
Programme-specific: Type A	– Simultaneous funding to Type B support – Mapping report not shared outside of government
Programme-specific: Type B	– Resignation of CSOs ± Channelling of funding – Delays in disbursements ± Size of funding