United Nations Fund for Population

Final Evaluation of UNFPA Indonesia’s 7th Country Programme (2006-2010)

Final Draft

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<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
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<td>AWP</td>
<td>Annual Work Plans</td>
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<tr>
<td>Bappeda</td>
<td>Badan Perencanaan Pembangunan Daerah/Regional Development Planning Agency</td>
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<td>Bappenas</td>
<td>Badan Perencanaan Pembangunan Nasional/The National Development Planning Agency</td>
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<td>BKKBN</td>
<td>Badan Koordinasi Keluarga Berencana Nasional/ National Population and Family Planning Board</td>
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<td>BPP&amp;KB</td>
<td>Badan Pemberdayaan Perempuan &amp; Keluarga Berencana/ Women's Empowerment and Family Planning Board</td>
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<td>BPS</td>
<td>Badan Pusat Statistik/BPS-Statistics Indonesia</td>
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<td>CCST</td>
<td>Contraceptive Commodity Security Teams</td>
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<td>CP</td>
<td>Country Programme (UNFPA)</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>CPD</td>
<td>Country Program Document</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<td>DDA</td>
<td>Daerah Dalam Angka/Subnational Statistical Yearbook</td>
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<td>EOC</td>
<td>Emergency Obstetric Care</td>
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<td>FBO</td>
<td>Faith-Based Organization</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GOI</td>
<td>Government of Indonesia</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IERH</td>
<td>Integrated Essential Reproductive Health</td>
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<td>ICPPD</td>
<td>International Conference on Population and Development</td>
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<td>IFPPD</td>
<td>Indonesian Forum of Parliamentarians for Population and Development</td>
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<td>IUD</td>
<td>Intra-Uterine Device</td>
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<tr>
<td>JAMKESMAS</td>
<td>Jaminan Kesehatan Masyarakat/ community health insurance programme</td>
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<td>MDG</td>
<td>Millenium Development Goal</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MoWECP</td>
<td>Ministry of Women’s Empowerment and Child Protection</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>MTR</td>
<td>Mid-Term Review</td>
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<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>NTB</td>
<td>Nusa Tenggara Barat</td>
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<td>NTT</td>
<td>Nusa Tenggara Timur</td>
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<tr>
<td>P2TP2A</td>
<td>Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak/Centre for Integrated Services for Women and Children’s Empowerment</td>
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<tr>
<td>Perda</td>
<td>Peraturan Daerah/local regulations</td>
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<td>PDS</td>
<td>Population and Development Strategies</td>
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<td>PKBI</td>
<td>Perkumpulan Keluarga Berencana Indonesia/Indonesian Planned Parenthood Association</td>
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<tr>
<td>PKK</td>
<td>Pemberdayaan Kesejahteraan Keluarga/Family Welfare Movement</td>
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<td>POLRES</td>
<td>Kepolisian Resort/District Police Office</td>
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<td>POLSEK</td>
<td>Kepolisian Sektor/Sub-District Police Office</td>
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<tr>
<td>Puskesmas</td>
<td>Pusat Kesehatan Masyarakat/Community Health Centre</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RPK</td>
<td>Ruang Pelayanan Khusus/Special Service Room</td>
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<td>RPJM</td>
<td>Rencana Pembangunan Jangka Menengah/ Mid-Term Development Plan</td>
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<td>R&amp;R</td>
<td>Recording and Reporting System</td>
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<td>RTIs</td>
<td>Reproductive Tract Infections</td>
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<td>ToT</td>
<td>Training of Trainers</td>
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<td>Sekda</td>
<td>Sekretaris Daerah/Regional Secretary</td>
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<td>SKPD</td>
<td>Satuan Kerja Perangkat Daerah/Local Government Division</td>
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<td>SPR</td>
<td>Standard Progress Report</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UPPA</td>
<td>Unit Perlindungan Perempuan dan Anak/Specially-dedicated women and children service units at province and district police offices</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VAW&amp;C</td>
<td>Violence Against Women and Children</td>
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<tr>
<td>Acronym</td>
<td>Full Name</td>
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<td>WEO</td>
<td>Women’s Empowerment Office</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

Overview

The following report presents findings of the evaluation of the Seventh Country Programme of Cooperation between UNFPA and the Government of Indonesia (GOI). Signed in May 2006, the Seventh Country Programme (CP7) covers three major areas: 1) Reproductive Health, 2) Population and Development Strategies and; 3) Gender. The total programme allocation of CP7 was $25 million, of which $23 million is from regular sources. Following a Mid-Term Review, and revised Country Programme Action Plan (CPAP), the following five outcomes were included in CP7:

Outcome 1: An improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health information and services at national and sub national levels.

Outcome 2: Strengthened demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information.

Outcome 3: Increased access to high-quality, integrated, client-oriented and gender-sensitive reproductive health (RH) and Adolescent Reproductive Health (ARH) services and information.

Outcome 4: Enhanced understanding of policy makers, planners and parliamentarians at national and sub national levels on the linkages between population, reproductive health, gender, poverty and development through improved availability and increased utilization data on population, reproductive health and adolescent reproductive health, STIs including HIV/AIDS, gender and poverty.

Outcome 5: Strengthened institutional mechanisms, socio-cultural values and practices to promote and protect the rights of women and girls and to advance gender equity and equality.

In line with the UNFPA Policies and Procedures, an evaluation was undertaken in the final year of CP7. The objectives of the evaluation are:

- To investigate to what extent the programme has resulted in demonstrable effects on defined target outcomes and outputs.
- To provide inputs for the development of the Eighth Country Programme (2011-2015).

The evaluation covered activities implemented under UNFPA’s regular support to the GOI. The evaluation findings are expected to improve the design of programme interventions and the formulation of management modalities for the UNFPA Eighth Country Programme (2011-2015). The evaluation covered 11 out of 21 districts in 5 of 6 CP7-supported provinces.

It is noted that there are limitations to the evaluation, including the period in which the evaluation took place. The evaluation was conducted only two years after the Mid-Term Review (MTR), where the country programme outcome and output indicators underwent significant changes based on the recommendations of the MTR. This evaluation also focused more on programme component outputs in reproductive health, population and development.
strategies and gender. Country programme design and programme implementation modality were not covered in this evaluation.

A team composed of three independent consultants was engaged to undertake the evaluation. Each consultant was responsible for evaluating one of the three programme components. A qualitative evaluation approach was employed in order to clarify and confirm general trends seen in regular reporting data, as well as to help to explain these trends. As such, the evaluation methodology preferred in-depth interviews and small group discussions with government and NGO partners at national and subnational levels. Interviews targeted key government partners including the National Development Planning Agency (Bappenas), the Local Development Planning Agencies (Bappeda), Ministry of Health (MOH), Ministry of Women’s Empowerment and Child Protection (MoWECP), the National Population and Family Planning Board (BKKBN), BPS-Statistics Indonesia (BPS), as well as NGOs, schools and other implementing partners. Group discussions were primarily used with members of the Database Fora, with RH Commissions and Contraceptive Commodity Security Teams, puskesmas teams, Centre for Integrated Services for Women and Children’s Empowerment (P2TP2A) teams, as well as with hospital staff, police units and schools, among others. In addition, the evaluation team undertook interviews with the UNFPA Representative, UNFPA national programme officers and associates in Jakarta, as well as with selected stakeholders from related development organizations. The final report submitted by the evaluation team was then edited and finalized by the country office.

CP7 was undertaken in a highly dynamic context in which Indonesia is working to put in place decentralized governance structures focused at the district level. New legal frameworks related to health, population and gender have been developed, and non-governmental organizations (NGOs) are taking on increasingly important roles to complement government services. The evaluation findings should be understood in this changing context.

Cross Cutting Conclusions

Questions of Alignment, Ownership and Sustainability

There is strong evidence that CP7 is well aligned with government priorities, particularly at the national level. In particular, CP7 relates to the government 2005-2009 National Medium-Term Development Plan (RPJM), and to the broad 2006-2010 United Nations Development Assistance Framework (UNDAF). In each of its three component subprogrammes, CP7 relates closely to government strategic planning frameworks and plans and indeed, in several instances has supported their development.

In its design process, CP7 focused more on consultation with central level partners. This approach was taken with the understanding that the National Medium-Term Development Plan is the main reference for development planning at the subnational level, ensuring links between national and local priorities.

The limited consultation with provincial and district level partners resulted in CP7 being less well aligned at the local levels. The Strategic Management Review conducted in 2008 also emphasized this point, where the absence of a local level multi-year planning framework, and differences between government and CP7 planning timeframes, were contributing factors to the limitations found in achieving optimum local level alignment.
Issues of ownership are highly complex in CP7 management. On the one hand, Bappenas, as the lead planning and coordinating agency, and the CP7 supervising partner at the local levels, exercises strong oversight of the CP7 management structure. While this certainly reflects and positively contributes to government ownership, there are ways in which the management structure has hampered programme coherence and performance, diverting resources from functions that arguably, could have added more technical value to the programme.

CP7 has put in place an exceptionally elaborate programme management structure. This structure consists of 70 full time staff and consumes approximately 16 per cent of the total programme budget. These staff (two to three per each province and district) function from secretariats commonly located in each of the national partner offices and from the provincial and district level Bappeda offices. At the subnational level, programme managers report to Bappeda. This extensive programme management structure was mainly put in place to address perceptions that executing the programme would require significant extra work on the part of government employees.

The programme managers and other UNFPA-financed nationally recruited staff undertake a range of generic management functions including monitoring (programmatic and financial) and reporting. However, as noted in the strategic management review, “lack of clarity in their roles and effective lines of reporting, limited support and training and (at times) strained relations with government colleagues”, have compromised their effectiveness, even in these general programme management functions. Although, theoretically, staff have the potential to be critical actors in coordinating and following up on capacity building, opportunities for strengthening capacities would have further advanced with more provision of technical assistance than what had been offered through the CP7 programme.

As such, the management functions performed by CP7 staff are largely akin to the functions performed by government implementing partners. Under the current circumstances with low investment in technical assistance generally, ironically, the role of national executing staff in the project can be seen to distance the government from its management and ownership of the programme. At the same time, the heavy management structure can be understood to distance UNFPA technical oversight of CP7 in important ways.

Finally, ownership clearly has an important role to play in sustaining programme achievements and approaches. In the public sector, strong alignment on the one hand, and the relatively small financial investments of CP7 on the other would suggest positive potentials for sustainability. However, the evaluation revealed a wide range of perceptions on sustainability.

Doubts about sustainability under these circumstances reflect the limited understanding of the programme linkages to government priorities and plans on the one hand, and the lack of documentation and evidence of programme achievement on the other.

It is still too premature to draw valid conclusions on the sustainability of CP7 support through its programmes for NGOs. Assessment of potential NGO programme sustainability was not an objective of this evaluation. However, it is not too early for the programme to put forward a strategic position about NGO sustainability and to begin to invest in strategies that would promote sustainability of NGO programmes over time.
In conclusion, while CP7 management modalities were a central focus of the strategic management review, the reorientations to the programme during the Mid-Term Review and the revisions to the CPAP did not make the adjustment to these modalities necessary to promote a high quality, government-owned programme.

**Contributions towards Replication and Scale Up**

In each of its three components, CP7 has taken important steps to introduce new programme approaches, such as the introduction of comprehensive services for management of gender based violence, introduction of adolescent RH services, support for RH Commissions, and the establishment of data base forum.

This new programming initiative would have benefitted more if it had been approached as specific pilot undertakings with a strong evaluation and documentation focus and sufficient investment in standardizing its design, in the monitoring, evaluation and documentation of outcomes, and in the provision of technical assistance to ensure quality.

At the same time, most interventions (data base forum is an exception) lacked the sharing of programmatic experience across districts and provinces. This should not be considered a luxury, but rather a critical strategy to promote ownership and scale-up, and strengthen the quality of programmes. In the context of decentralization, creating an environment of shared learning is particularly important towards addressing the challenges of standardization, and the risks of duplication of efforts. Sharing cross-region experiences can also help to stimulate buy-in across districts, and between different levels in order to encourage replication.

**Issues Related to Quality**

The overall quality of CP7 programming is highly variable. One example can be seen through the RH programme component—where there was an opportunity to compare IERH approaches between programme-supported puskesmas and those which didn’t receive CP7 support, significant differentiation in quality was not observed.

Across each of the programme components, there were inconsistencies in the quality of programme implementation, which was mainly the result of insufficient emphasis on capacity building. Investment in technical support to CP7 interventions was rather minimal and as noted above, project modality did not sufficiently engaged technical aspects.

Stronger efforts to ensure the quality of CP7 capacity building initiatives must also be a lesson learned for future activities in this realm. The evaluation found that training approaches supported by the project were not sufficiently distinct from mainstream approaches. Weaknesses in training preparation, selection of participants, training intensity and the lack of attention to training follow up are particularly noteworthy. There is still a need to develop a strategy to strengthen training capacities which would, in turn, provide a sustainable resource for ongoing training and support—which is also challenged by the high turnover of government staff. At the same time, adaptation of centrally-developed training materials lacked coordination and technical assistance.

Similarly, monitoring of programme progress were infrequent and had limited technical rigor. While implementing partners reported feeling generally encouraged by the attention they received through the monitoring visits, few partners could relate a concrete technical
outcome of monitoring, and there was little continuity in perspective from one visit to the next.

**Issues Related to Synergies between Programme Components**

The consolidation of programme components did not go far enough in linking the expected outcomes in ways that would create synergies between population and development strategies (PDS), reproductive health (RH) and gender. While result expectations and similarly, financial investments were consolidated following the Mid-Term Review, these efforts did not favor the potentials for synergy between different programme components implemented in the same geographical areas. Coordination efforts among central and district level agencies and staff were notably insufficient. This has contributed to the fragmentation of results across the three components and ultimately to the coherent impact of the programme.

Finally, while the potential for PDS to contribute to the evidence base for RH and gender programming and policy is clearly acknowledged in the design of the component, in practice, this potential has gone unrealized. PDS (particularly DDA) is limited in its potential to provide an evidence base for RH and Gender programming and policy. The implementation of policy research to support better RH and Gender programming and policy through the PDS is partially completed as it supported only two researches out of the planned five. The evaluation concludes that significant achievements of the CP7 relate to the introduction of new areas of programming. These areas are sufficiently aligned with GOI priorities and with the overall vision of ICPD. However, despite steps taken to address important design weaknesses at the mid-term of CP7, critical limitations have persisted. These limitations relate to the need to address continued fragmentation of project resources, to improve programme management structure, and to strengthen capacity building strategies.

Redirection of programme resources in future UNFPA-supported programmes will benefit from serious attention to the relationship between ownership and implementing modalities, to the redefinition of the strategic benefits of UNFPA support, and to concrete potentials for synergy between the three components.

**General and Specific Recommendations**

It is strongly recommended that UNFPA and the GOI work closely together to redefine a strategic niche for UNFPA support. This niche will undoubtedly focus on generation of strategic information, and support for consultation towards policy formulation on the one hand, and the implementation of locally adapted, technically strong pilot approaches which are rigorously evaluated to provide a strong evidence base for scale-up. The repositioning of UNFPA support in Indonesia requires significant and sustained, high level engagement from both UNFPA and GOI.

It is further recommended that UNFPA focus its strategic programme in a significantly more limited geographical area (no more than nine districts in three provinces), selecting a limited number of well defined piloting objectives, in which changes attributable to programme investments can be accurately measured, providing rich insights for programme scale up and policy formulation. The role of the PDS programme component one of which is in providing evidence for evaluation of GBV and RH programming, and their linkages should be further developed. A focused, resourced strategy to promote programme learning across geographic areas and primary and secondary partners is also recommended.
The evaluation team strongly recommends that UNFPA emphasize its globally recognized strategic focus on capacity building, through the development of modalities which prioritize the provision of expert technical assistance. An explicit capacity building strategy for each output should be developed, including a rigorous training approach designed to ensure sustainability of interventions, and routine, technical monitoring of implementation. This will require a concerted redirection of funds, the development of new working modalities and rigorous attention to the building of a quality technical assistance network. In this regard, UNFPA and GOI may consider focusing a capacity building strategy at the province level. Experience from the AusAID health programme in NTT may offer important lessons in this regard, and should be thoroughly explored with GOI partners at all levels.

In line with this, it is recommended that UNFPA and GOI consider alternative management modalities which favor government ownership and implementation on the one hand, and require more limited budget. Project staffing should favor strong technical engagement and oversight. Reference to and further discussion of the 2008 Management Review would likely be beneficial in determining the appropriate structure.

Specific recommendations for each programme component for the design of CP8 include:

**Reproductive Health**

- To support the development of the National Reproductive Health Strategy for 2011-2015:
  - Link CP8 Piloting Efforts to Specific Objectives of the RH Strategy.
  - Ensure rigour of implementation and evaluation, as well as adequate dissemination of piloting efforts.
- To support the development of decrees and guidelines related to laws on health (Law No. 36) and population (Law No. 52).
- To continue to support national and local efforts of IFPPD. Give significant consideration to adjusting national level IFPPD approaches, given the challenges in effectively reaching national parliamentarians. Promote coordination between IFPPD and other locally based coordination mechanisms, including RH and HIV Commissions and CCSTs.
- To support BKKBN to develop a national behavior change communication strategy tailored to accommodate different population segments.
- To support policy formulation to reduce barriers to use the full range of family planning methods:
  - Consider opportunities to support revised scopes of practice for private sector IUD and implant provision.
- To support the design and implementation of a nationally representative survey on adolescent health:
  - Apply survey results to policy formulation, particularly for at-risk youth.
  - Consider opportunities for coordination/collaboration with UNICEF and WHO.
- To invest in a rigorous pilot of ARH education in schools, focusing on a limited number of districts, ensuring the standardization of curricula, strengthening teacher capacity, and policy support. Evaluate the pilot in how it effectively contributes to intended outcomes, and on the level of acceptability of curricula content from the perspective of students, parents/community, and policy makers.
- Until policies change, the focus ARH service delivery strategies should be directed at the non-governmental sector, while continuing to advocate for the liberalization of policies on delivering a full range of services for youth in the government sector.
- To shift support away from full IERH implementation at puskesmas
• To support GOI efforts to reduce maternal mortality through interventions focused on increasing access to emergency obstetric care.
• To reduce the number of expected outputs from Country Programme Document (CPD).

Population and Development Strategies

• To strengthen the design of the PDS programme so that it supports the establishment of a standardized District Information System (Figure 3). Since DDA is limited in its ability to provide data for planning purposes, products of existing systems (stored in BPS or sector departments) should be expanded to meet the evidence-based planning and decision making needs at local levels.
• The roles of training and functions of DBF should be strengthened and optimized in order to support locally defined data needs, and to reinforce linkages between the PDS programme and the data needs of the UNFPA-supported RH and gender programmes.
• DBF is a success story of PDS, with potential for expansion and replication. Specific guidelines should be developed to establish DBF at different administration levels based on this experience.
• Consider further investments in CP7-supported PDS activities, including continuing training and technical assistance for planners and policy makers, and promoting the availability of data for evidence-based planning/decision making.
• Prioritize districts with successful PDS experience for selection in the CP8, instead of selecting new districts.
• Two data sources (population census and vital registration) have potential for further examination. As for the population census, BPS should be supported to prepare and analyze data from the 2010 Population Census. It is also necessary to strengthen capacities in carrying out the vital registration system, as well as to support the dialogue on the aspects of the Population Registration.
• Policy research, as part of the activity supported by PDS, has not been implemented until now. Support is needed to redefine policy research as a key strategy of PDS.

Gender

• Strengthen capacity building approaches so that training is combined with other forms of technical assistance (such as frequent on-site technical assistance visits including feedback and action planning, observation of model services).
• Support local government and NGOs to improve programming on prevention of GBV programme, including rigorous monitoring and evaluation.
• Integrate curricula focused on awareness raising, skills building, and procedural orientation about GBV and trafficking in pre-service training programmes (universities and academies) focusing on health, social worker and police training institutions.
• Intensify advocacy of police national headquarters to enhance the capacity of members of the police in UPPA and to increase the number of the policewomen in POLSEK.
• Increase partnership with the social office in providing psychosocial services/assistance to victims.

In addition to these recommendations for CP8, each programme component recommended specific exit strategies to be undertaken in the months before the conclusion of CP7.
I. Introduction

The following report presents findings of the evaluation of the Seventh Country Programme of Cooperation between UNFPA and the Government of Indonesia (GOI). Signed in May 2006, the Seventh Country Programme (CP7) covers three major areas in reproductive health, population and development strategies, and gender. The programme was carried out in 21 districts and 6 provinces, as illustrated in Figure 1 below, offering different programme packages in different settings. Implementation of activities based on signed annual work plans (AWPs) commenced in the third quarter of 2006 at both national and subnational levels.

Figure 1: Geographical Focus of the Seventh Country Programme

The total programme allocation of CP7 was $25 million, of which $23 million is from regular sources. Financial commitments across the programme components are as follows:

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<th>Programme Component</th>
<th>Allocation (in Million USD)</th>
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<td>Reproductive Health</td>
<td>14.7</td>
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<td>Population and Development Strategies</td>
<td>5.4</td>
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<td>Gender</td>
<td>3.7</td>
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<tr>
<td>Programme Coordination and Assistance</td>
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Six outcomes and ten outputs were initially developed and agreed in the form of support in the areas of reproductive health, gender, and population and development. However, in 2007, a strategic management review initiated by the UNFPA Country Office identified the need for significant adjustments to CP7 that would result in greater strategic focus and improve the management performance of the programme. The suggested adjustments were made through a consultative midterm review (MTR) that took place in mid-2008, and resulted in the revision of the Country
Programme Action Plan (CPAP). The revision entailed a reduction of six outcomes to five and ten outputs to six--consequently changing the programme activities along with it. These changes influenced the evaluation in two ways; in the measurement of achievements and in the scope of the evaluation. As the programme outcomes and outputs underwent significant changes, therefore the baseline set at the beginning of the programme cycle could not be used as the baseline in which achievements are measured against at the end of the cycle. Furthermore, the new phase of programme implementation began in January 2009 after the action plan was revised, therefore, observations on the performance of programme implementation covers a time period of 18 months, between January 2009 and July 2010. The following five outcomes were included in the revised CPAP of the Seventh Country Programme:

**Outcome 1:** An improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health information and services at national and sub national levels.

**Outcome 2:** Strengthened demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information.

**Outcome 3:** Increased access to high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information.

**Outcome 4:** Enhanced understanding of policy makers, planners and parliamentarians at national and sub-national levels on the linkages between population, reproductive health, gender, poverty and development, through improved availability and increased utilization data on population, reproductive health and adolescent reproductive health, STIs including HIV/AIDS, gender and poverty.

**Outcome 5:** Strengthened institutional mechanisms, socio-cultural values and practices to promote and protect the rights of women and girls, and to advance gender equity and equality.

Inputs to the programme largely focused on training, material and management support. The latter was provided by specifically-contracted programme staff based in CP7-supported districts and provinces. A results framework for the programme is included in Annex 1.

CP7 is aligned with UNDAF outcomes: a) strengthening human development to achieve the MDGs; b) promoting good governance; and c) protecting the vulnerable and reducing vulnerabilities. These outcomes are also aligned with the Indonesia Government’s Medium-Term Development Plan 2004-2009 (Rencana Pembangunan Jangka Menengah/RPJM), the first national MDGs Progress Report, and the Poverty Reduction Strategy Paper (PRSP).

CP7 was undertaken in a highly dynamic context in which Indonesia is working to put in place decentralized governance structures focused at the district level. New legal frameworks related to health, population and gender have been developed, and non-governmental organizations (NGOs) are taking on increasingly important roles to complement government services. The evaluation findings should be understood in this changing context.

This evaluation does not cover areas of UNFPA support that are complementary and synergistic to the core CP7 programme. In particular, the HIV/AIDS Prevention and Adolescent Reproductive Health Programme, initially supported by the Indonesia Partnership Fund for HIV and AIDS, as well as tsunami relief efforts, are not covered in this report. An evaluation of the HIV/AIDS prevention programme, conducted in late 2008, complements the current evaluation (Irvin and Nasir, 2008).
II. Evaluation Overview

In line with the UNFPA Policies and Procedures\(^1\), an evaluation was undertaken in the final year of CP7. The objectives of the evaluation are:

- To investigate to what extent the programme has resulted in demonstrable effects on defined target outcomes and outputs.
- To provide inputs for the development of the Eighth Country Programme (2011-2015).

The evaluation covered activities implemented under UNFPA’s regular support to the government. The evaluation findings are expected to improve the design of programme interventions and the formulation of management modalities for the UNFPA Eighth Country Programme (2011-2015). UNFPA headquarters, the regional and country offices, the Government of Indonesia, donors, partner agencies and other relevant stakeholders are expected to utilize the lessons learned.

After a review of the available progress data and a series of consultations for each of the three thematic groups (RH, PDS, and Gender), focus areas of the evaluation were identified. Considerations for selection of evaluation focus areas include the amount of financial resources spent, potential of replication or continuation of programme interventions, and utility of lessons to be incorporated in the Eighth Country Programme (CP8). Based on these thematic group consultations, the evaluation is expected to answer the following questions:

**For the Reproductive Health Programme Component:**

- What have been the achievements of the selected community health centres (or puskesmas) in adopting the concept of integrated essential reproductive health (IERH)?
- Has there been an increase in quality, client-orientation including adolescent-friendly services and gender-sensitivity in the selected programme districts?
- To what extent has UNFPA programmes contributed towards an improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health at sub-national levels?
- Have the Reproductive Health (RH) Commission and Contraceptive Commodity Security (CCS) Working Group been effective in carrying out their expected roles?
- To what extent does UNFPA’s work—to increase demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information—contribute to increased access to RH and ARH services?

**For the Population and Development Strategies Programme Component:**

- What has been the progress towards incorporating disaggregated data on population, reproductive health, adolescent reproductive health, STIs including HIV/AIDS, gender, and poverty in Subnational Statistical Yearbooks?
- What have been the sustainable results of the series of trainings organized for subnational planners?
- To what extent have the efforts on improving the quality and scope of the Subnational Statistical Yearbooks contributed to an increased utilization of disaggregated data in district-level planning and policy making?

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\(^1\) Country Programme Monitoring and Evaluation guidelines and UNFPA’s evaluation policy (DP/FPA/2009/4) and the 7th Country Programme Action Plan
For the Gender Programme Component:

- What has been the progress in enhancing the capacity of government, non-governmental organizations (NGOs) and civil society organizations (CSOs) to prevent and manage gender-based violence? Is there an effective coordination mechanism?
- To what extent does gender-based violence (GBV) prevention and management include a monitoring and evaluation system that is integrated and functioning in provinces and districts, as well as in related sectors, work plans, and local budgets?
- What is the quality of the service points (medical, law-enforcement, shelter/psycho-social assistance) in 18 priority sub districts and are they providing an integrated minimum standard assistance to victims/survivors of GBV?

A detailed description of the research questions for each of the focus areas is described in the Terms of Reference (Annex 2). Based on the Terms of Reference and key evaluation questions, the following diagram reflects the evaluation framework:

**Figure 2: The 7th Country Programme Evaluation Framework**

The evaluation uses the OECD DAC (Organisation for Economic Co-Operation and Development - Development Assistance Committee) standards for development evaluation (OECD DAC, 2010), particularly in analyzing programme relevance, effectiveness, and sustainability. The issue of efficiency and the long term impact of the programme, were not closely observed in this evaluation. The evaluation did not compare the programmatic expenditure against programme implementation. Also, the evaluation did not closely study the intended or unintended impacts that programme interventions may have triggered in the economic and socio-cultural spheres in the areas of UNFPA support.

**2.1 Methodology**

The evaluation covered 11 districts in 5 out of 6 CP7-supported provinces. Selected sites were chosen based on focus areas of GBV and RH, as well as logistical and time considerations. A balance was
sought between areas close the provincial capital and more remote areas, and between good and less successful performance areas, based on management understanding of implementation experience. Preference was given to districts where intervention focused on integrated essential reproductive health (IERH), GBV and Sub-national Statistical Yearbook (or Daerah Dalam Angka/DDA), following the Mid-Term Review. Within selected districts, a number of control sites were visited in order to offer perspectives on the value of the UNFPA support.

A team composed of three independent consultants was engaged to undertake the evaluation. The evaluators were selected by UNFPA Indonesia in consultation with the CP7 evaluation working groups and the CP7 management team. Each consultant was responsible for one of the three programme components (Reproductive Health, Population and Development Strategies, Gender). The consultant responsible for the reproductive health component was also assigned as team leader. Two of three members of the team, responsible for population and development and gender components were Indonesian national experts. The final report submitted by the evaluation team was then edited and finalized by the country office.

For each of the programme areas, the evaluators designed tools to respond to the objectives of the evaluation. The tools used by the evaluators are in the form of in-depth interview question guidelines. In developing the tools, the evaluation team drew upon a variety of programme documentation including the original and revised CPAP documents, the Strategic Management Review report, thematic evaluations, standard progress reports, and data from programme reporting, provided by UNFPA (see Data Collection Instruments in Annex 3). In addition, evaluation team members drew upon additional resources available in the general literature, produced by relevant organizations and projects (see list of documents consulted in Annex 4).

Concerns about the validity of the data obtained from regular reporting underscored the need for a qualitative evaluation approach that sought to clarify and confirm the general trends seen in the data, as well as to help to explain these trends. As such, the evaluation methodology preferred in-depth interviews and small group discussions with government and NGO partners at national and subnational levels.

The process leading up to the evaluation highly involved UNFPA stakeholders, particularly implementing partners. The review of the terms of reference for the evaluation, as well as recommendations on the institutions and individuals to be interviewed, were based on consultations with members of UNFPA thematic working groups, which include UNFPA partners in government and civil society. Requests were made to government and NGO partners one to three weeks prior to the evaluation team’s arrival. Within this context, interviews were conducted on a voluntary basis, and respondents were not specifically quoted. Respondents were encouraged to speak frankly about the strengths and weaknesses of the programme. To minimize bias, preliminary findings through interviews are cross-checked with other interview respondents as much as possible to ensure triangulation. At times, UNFPA-supported staff members participated in the interviews, particularly for the RH programme, as the evaluator required interpretation services which were largely provided by project staff. Unfortunately, it was not possible for the evaluation team to observe specific project-supported activities such as trainings and monitoring visits. Evaluation results and recommendation are shared with the UNFPA government and civil society partners as one of the entry points to the discussions in the development of the Eighth Country Programme. Finally, the evaluation took the opportunity to interview key stakeholders from selected international organizations including UNICEF, UNDP, AusAID, USAID and The Ford Foundation.

Interviews targeted key government partners including the National Development Planning Agency (Bappenas), the Local Development Planning Agencies (Bappeda), Ministry of Health (MOH), Ministry of Women’s Empowerment and Child Protection (MoWECP), the National Population and Family Planning Board (BKKBN), BPS-Statistics Indonesia, as well as NGOs, schools and other implementing
partners. Group discussions were held with members of Database Fora, with RH Commissions and Contraceptive Commodity Security Teams, puskesmas teams, Centre for Integrated Services for Women and Children's Empowerment (P2TP2A) teams, as well as with hospital staff, police units and schools, among others. In addition, the evaluation team undertook interviews with the UNFPA Representative, UNFPA national programme officers and associates in Jakarta. While country programme managers based in central government offices in Jakarta were specifically interviewed during the course of the evaluation, project officers based in coordination units at province and district levels were not. However, these staff provided invaluable insights during the course of the evaluation.

Field work for the evaluation was conducted from 13 April to 6 May 2010. A list of the people met by the evaluation team visits is available in Annex 5. Due to time and logistical constraints, it was not possible to visit Nanggroe Aceh Darusalam Province.

While the evaluation is intended to inform the design of CP8, the timing of the evaluation was not synchronized with the CP8 development process. The CP8 Country Programme Document (CPD) had been prepared prior to the evaluation’s commencement based on extensive consultations and existing reviews. By the time the evaluation field work was completed, discussions for the formulation of the CPAP were still underway. It is strongly advised that further consultation and development of the CPAP document reflect the recommendations of this report, and that efforts are made to harmonize important programming processes in the future.

Ethical Considerations

The evaluation team, to the best of its ability, has adhered to the UN Ethical Guidelines for Evaluation, especially with respect to independence, impartiality, avoidance of any real or perceived conflicts of interest, and respect for respondents’ right to provide information in confidence. Although the report contains information that some respondents may consider to be sensitive, findings are presented in a way that ensures that none of this information can be traced to its source and that relevant individuals are protected from reprisals.
III. Indonesia Country Context

Governance: The Challenges of Decentralization

Implementation of CP7 took place during a very dynamic period in Indonesia’s history. In 1998, with the end of President Suharto’s decades-long autocratic rule, Indonesia took important steps towards democratization. Important among the changes that have taken place since Suharto’s fall have been a dramatic restructuring of the Indonesian political system. With the intention of improving public services and promoting accountability and democratic participation within a stunningly diverse economic and cultural context, in the early part of the twenty-first century, Indonesia moved to devolve political authority from the central to the district level.

Challenges in administration of the new governance structure have been widely noted. Among them are the weak lines of authority between central and district levels, which result in significant inefficiencies across the system on the one hand, and create important potentials for discordance between national and local interests. The role of the province remains particularly unclear. While provinces are charged with providing administrative monitoring and coordination of the district level, they have neither administrative nor financial authority over the districts. As such, provinces lack the means to develop regional programmes and scale up reforms from one district to another (UNDP, 2009).

The reforms are taking place in a context in which there is little experience of democratic governance among local officials, as well as a generally inexperienced civil society. The lack of a clear plan or roadmap for these sweeping changes has further hampered progress in effectively establishing new systems (Usman, 2001).

The Health Sector

Decentralization has also created opportunities and challenges in the health sector. While there is ample evidence that decentralization has increased public participation in local government, planning and management functions have been weakened under decentralization. The Ministry of Health is challenged to set standards, monitor, supervise and coordinate the functions of local health authorities. Districts, now responsible for budgeting and developing their own health plans, are struggling due to inadequate capacity, and limited control over human resources. Local health spending varies widely, depending on the priorities attributed by local parliaments to different issues and needs. This has created an important role for civil society in health sector advocacy.

Notably, essential health status indicators are improving measurably for the country overall. In the past 50 years, life expectancy has increased dramatically, and infant and child mortality have decreased significantly. However, Indonesia is under-performing on basic health indicators such as maternal mortality reduction, childhood nutrition and female literacy and access to clean water and sanitation (World Bank, 2008). Disparities across the country are also marked in terms of access to and utilization of quality health services (World Bank, 2008).

Despite substantial increases in recent years, Indonesia continues to spend less than 3 per cent of its GDP on health, substantially lower than many other countries of similar income level. Approximately 65 per cent of all spending on health is private and, of that, 75 per cent is direct out-of-pocket spending (World Bank, 2008). National health insurance has expanded significantly since 2005, offering improved access to a range of services.

Reproductive Health Priorities
In the reproductive health sub-sector, stagnation on a number of key indicators is apparent. Maternal mortality remains among the highest in East Asia at 228 maternal deaths per 100,000 live births, with significant disparities across the country. The Indonesian government has recently signaled its concern that it will not be able to meet its MDG-5 target of maternal mortality ratio of 102 maternal deaths per 100,000 live births by 2015. The extensive training and deployment of community midwives over the past 20 years has not had the desired impact on rates of maternal death. A wider range of approaches has been recommended, particularly those centering on improving timely access to emergency obstetric care (Mize et al., 2010).

The plateauing of contraceptive utilization has been signaled over a number of years including in the National RH Strategy (2005-2010), and most recently in a high level report issued with support from UNFPA (Hull and Mosley, 2009). The report calls for the revitalization of Indonesia’s family planning programme through the reversal of four critical trends as outlined below.

- A flat trend in contraceptive prevalence in recent years, with evidence of decay in practice among the least educated women and a reversal of decades of decline in the measure of unmet need in the latest IDHS.
- Narrowing of the contraceptive method mix to temporary hormonal methods (primarily injectables) due to major declines in the promotion of longer acting implants and IUDs and the failure of the program to support and extend surgical sterilization for people wishing to have a permanent end to childbearing.
- High rates of unintended pregnancy among both married and unmarried women manifested by: the reported high number of induced abortions among both groups and the fact that one in six mothers report that their last birth was not wanted at the time it occurred.
- Persistent regional disparities in contraceptive availability with many poor provinces and districts lagging behind their richer counterparts, and isolated regions suffering from shortages of staff and materials for family planning services.
The 2009 Law on Population is expected to increase support for family planning and to strengthen the leadership and management role of the National Population and Family Planning Board (BKKBN) across the country. It is widely recognized that a key factor in the stagnation of Indonesia’s family planning programme over recent years has been the limited capacities of BKKBN as a consequence of decentralization. A study sponsored by UNFPA, on BKKBN’s role, function and structure under the decentralized system, found that there is less capacity to coordinate and implement the family planning programme than before decentralization, particularly in districts where the family planning programme has been merged with other sectors. The study also confirms that the understanding among local leadership of the importance of family planning programmes in supporting sustainable development is a key factor in determining the support and resources allocated for district level family planning programmes.

Also critical, as signaled by Hull and Mosley, is a growing need for family planning among unmarried populations. Projections from Bappenas and BPS demonstrate that the proportion of unmarried women in the 20-24 age group grew from 19 to 51 per cent between 1971 and 2005 (Hull and Mosley, 2009, p. 11). Urbanization, and change in social norms, are likely to continue to increase need for family planning among this group, as well as among younger populations, particularly in rural areas. However, unmarried couples are specifically excluded from the recent health legislation (Health Law No. 36) related to reproductive health services. Furthermore, gaps in understanding the level of knowledge, attitudes, and practices concerning sexual and reproductive health among youths and unmarried couples, stifle effective policy dialogue across the country.

**Gender Based Violence**

Gender equity and violence against women have been addressed by national policy for decades in Indonesia; however, significant progress has been made in recent years by the MoWECP and the BKKBN. Government Regulation No. 41/2007 has provided for improvements in authority and resources, including the stipulation that there should be a women’s empowerment and family planning body – referred to as Women’s Empowerment and Family Planning Board (BPP&KB) - in all provinces and districts.

In 2006, the MoWECP in cooperation with BPS-Statistics Indonesia, conducted a survey on violence against women and children (VAW&C) in Indonesia. The rate of violence against women in the country was 3.07 per cent, or 307 acts of violence per 10,000 women. The national rate of violence against children was 3.02 per cent, or 302 acts of violence per 10,000 children. There are significant differences in rates across the country with lowest rates in Central Kalimantan and highest rates found in Papua.
IV. Findings, Conclusions, Recommendations

4.1 Reproductive Health (Outcomes 1, 2, 3)

Reproductive health objectives are reflected in three expected outcomes within CP7. These outcomes address the policy environment, demand creation and service delivery.

The current report focuses on government-implemented activities related to demand creation and RH service delivery. Through the DFID-funded Partnership Programme, and later through core CP7 funds, UNFPA has supported behavior change communication and service support to adolescents and youth between 15 and 24 years of age, working together with 7 NGOs in 15 districts across 5 provinces. The programme sought to reduce the risk of reproductive health problems and HIV/AIDS, emphasizing at-risk youth. Programme strategies include building capacity of NGOs and reproductive health service providers, supporting NGOs to educate and empower young people through peer education and outreach, support groups and youth networks, developing and disseminating IEC materials, and developing referral systems. An evaluation of the programme was conducted in late 2008. Results of the evaluation point to the important role of NGOs in providing RH services for youth, particularly given the limitations resulting from government policies that restrict access to services for unmarried couples. At the same time, the evaluation calls for enhanced programme and technical support from UNFPA to strengthen NGO capacity (Irvin and Nasir, 2008). As the 2008 evaluation placed focus on NGO programmes, the following sections on demand creation and service delivery will focus on support for government-implemented programmes.

4.1.1 Outcome 1

An improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health information and services at national and subnational levels.

CP7 has included a number of strategies to influence the policy environment so that it is more favorable to reproductive health and rights. Efforts have included specific advocacy events targeting pre-defined issues and constituencies (for example the international conference of Muslim leaders on population and development policy), and macro-level policy research designed to highlight national needs and issues (for example, the high level report on Revitalizing Family Planning in Indonesia). These activities have generally been directed at the national level, in collaboration with central level partners. Since the Mid-Term Review, considerable effort has been made to develop a national action plan and to support endorsement of subnational strategies and guidelines towards the introduction of adolescent reproductive health (ARH) in high school curricula.

Through CP7, programmes aimed to strengthen mechanisms for ongoing advocacy in areas of population and development, reproductive health and gender equality. Here, two primary strategies have been employed: 1) support to national and subnational reproductive health commissions and contraceptive commodity security teams to advocate for necessary political and financial resources for their activities and; 2) support to the Indonesian Forum for Parliamentarians on Population and Development (IFPPD) to strengthen understanding and responsible action on population and development, reproductive health and gender, among parliamentarians at national and subnational levels.

The latter strategies are the focus of the current evaluation.
4.1.1.1 Guidelines Used to Introduce ARH in Schools

Overview

CP7 has supported the development of a national action plan and the endorsement of subnational strategies and guidelines on ARH. Three provinces (NTB, West Kalimantan and West Java) have been targeted to develop and disseminate local ARH strategies and to apply the guidelines towards the introduction of ARH in local high schools (3 schools in each of the 9 districts).

The evaluation did not specifically assess efforts to introduce adolescent reproductive health in schools, as a UNFPA-commissioned evaluation, carried out in late 2009, has already done so. The current report draws on the findings of the 2009 evaluation (Utomo, 2010) and to some extent, from discussions with district and provincial representatives, as part of this final evaluation exercise.

Findings: Effectiveness

This effort has faced a number of setbacks due to significant political and management challenges. Notably, at the national level, the draft National Action Plan on ARH was developed in coordination with the Ministry of Health, the Ministry of Education and BKKBN. However, endorsement from the Ministry of Social Welfare has not been forthcoming. After many months of inaction, the three line ministries have only very recently endorsed the plan separately—indicating differing perspectives within the government on this issue. Although the National Action Plan was signed by the BKKBN and MOH in May, 2010, many questions remain about the extent to which it will be implemented. Recent remarks by the Minister of Education indicating objection to teaching sex education in schools (Jakarta Post, June, 2010), are of particular concern.

At the subnational levels, draft guidelines on the inclusion of ARH in school curricula, developed with CP7 support, have been circulated to districts for their use in the introduction of ARH topics in high schools. Guidelines recommend the integration of topics within biology, sports, and sociology classes.

The 2009 evaluation of ARH education in CP7-supported secondary schools noted that in the absence of a nationally approved curricula, a vast array of different curricula and pedagogical tools have been developed by districts. However, the report also noted that the content and teaching approach of curricula is not standardized (Utomo, 2010).

Curricula content appear largely focused on general health and development issues (e.g., hygiene, smoking, anemia, body awareness), on discouraging early sexual activity by reinforcing traditional standards of morality, and by raising fears about the risks and consequences of STIs and HIV. The curricula generally offered little in providing guidance to support adolescents to make safe choices beyond abstinence. The curriculum developed by IPPF/PKBI in Lombok is noteworthy for its inclusion of broader sexual health issues and specific attention to prevention of unwanted pregnancy through family planning methods.

Weak and non-standardized curricula result from the absence of a capacity building strategy focused on the training of teachers and in strengthening skills in developing curricula content. The monitoring of and support for teaching has been under-emphasized in the programme, as have efforts to share curricula elements across districts and provinces.

Despite the level of fragmentation and questions about quality, efforts to introduce curricula have received considerable local support. While CP7 provided support for introduction of curricula in 27 schools, more than 40 schools in 9 districts are reportedly delivering ARH education. Furthermore,
local contributions for printing syllabi and curricula are highly encouraging, as are local efforts to seek policy support for ARH curricula at the local levels. 

Nationally, the piloting of introducing ARH in schools has important policy implications and potential for scale up of ARH education in schools. However, piloting efforts have not been sufficiently standardized or rigorously evaluated to provide the necessary evidence to advance this agenda. The need for evidence on the effectiveness and acceptability (among youth, parents/communities and policy makers) of specific curricula content and teaching approaches remains an important priority.

4.1.1.2 Reproductive Health Commissions and Contraceptive Commodity Security Teams

Overview

The National Reproductive Health Strategy (2005-2010) and the National Contraceptive Commodity Security Strategy call for the establishment of national, provincial and district coordination mechanisms to promote cross-sectoral responses to local issues and priority needs in reproductive health. Recognizing the multi-sectoral nature of RH programming, these coordination mechanisms aim to bring together a wide range of public and private sector stakeholders to consider and bring collective financial and technical resources to achieve results that are beyond the capacity of any individual actor. While the Contraceptive Commodity Security Teams (CCST) focus specifically on mobilizing support to forecast and secure adequate supplies of family planning commodities on an ongoing basis, the mandate of the RH Commissions is generally broader.

CP7 has supported the establishment of these coordination mechanisms at subnational levels. This also includes support for the National RH Commission, a commission that has been largely inactive since its establishment, based on a Ministry of Health Decision in the early part of the decade. In contrast, the National AIDS Commission, formed under a Presidential Decree, is widely perceived to be functioning, albeit variably, at all levels.

Key stakeholders in RH coordination at the subnational levels include representatives of the health, education, and women’s empowerment sectors, as well as the social welfare department, local family planning boards, Bappedas as well as locally elected government (Governor or District Head). Non-governmental organizations, local hospitals, professional associations and representatives of the Provincial/District AIDS Commissions are generally encouraged to participate. Typically, the RH Commission and Contraceptive Commodity Security Teams are chaired by a representative of Bappedas or a representative of the local government office. By design, RH Commissions generally form subcommittees that will work to focus on key priorities of the National RH Strategy such as family planning, maternal-child health, adolescent reproductive health, and other related issues.

CP7 support towards strengthening these coordination mechanisms is very limited. Budgets generally cover minimal costs of meetings and a transportation allowance for participants.

Findings: Effectiveness

Based on UNFPA Indonesia standard progress reports, 4 of 6 provinces (67 per cent) and 17 of 21 districts (81 per cent) have established RH Commissions. Four out of six provinces (67 per cent) and 14 of 21 districts (67 per cent) have formed Contraceptive Commodity Security Teams. However, formal establishment of the coordination groups is not an indicator of their overall effectiveness. In the majority of provinces and districts, the RH Commissions appear to be struggling to understand their roles and to engage in meaningful coordination. Among functioning CCSTs, despite training through CP7, only 50 per cent have produced a five-year forecast of contraceptive needs and few have secured local resources to pay for commodities or for running costs of the CCSTs themselves.
The efforts to establish functioning RH Commissions and CCSTs have been hindered by a number of challenges. Local level RH commission members conveyed that the national level RH commission—responsible for providing clear terms of reference to local level commissions—did not provide them with enough guidance on the core functions of the commission. There is considerable confusion on the purpose of coordination, as well as on the distinction between coordination and implementation of line management responsibilities. In a number of cases, commission members questioned the need for the RH Commission. In one case, a senior Bappeda official indicated that it was more efficient to advocate for RH programme budgets unilaterally, rather than to work through a cumbersome commission structure.

Similarly for CCSTs, there is confusion about the role of the teams. Historically, BKKBN has managed forecasting of contraceptive commodities and secured funds for family planning commodities. BKKBN continues to play a lead role in this area, raising questions about the importance of a multi-agency structure. In some cases, the absence of immediate budget pressures for meeting contraceptive needs\(^2\) detracts from a sense of urgency in advocating for commodities security generally.

Questions about possible duplication of the functions of the RH Commissions and CCSTs were also raised, in the context of representatives’ limited time for coordination activities. Both RH Commissions and CCSTs have also suffered from turnover of members, and a tendency to assign specific individuals rather than organizational representatives to the groups. While connections to and influence on decision makers is considered an important criteria for membership, representatives’ time availability to participate in the groups is not sufficiently assessed.

However, there are notable exceptions. With strong local commitment and at times, significant encouragement from local CP7 staff, a number of RH Commissions have started to take form. These commissions are characterized by having their activities recognized through a local decree, having regular meetings (at least quarterly), and for an important few, having taken steps towards the development and approval of joint workplans, substantive strategies, local regulations (perda), as well as implementing decrees/budgets related to reproductive health. A good example from West Nusa Tenggara (NTB) is that the Provincial RH Commission has developed and disseminated a Provincial Strategy for ARH. In Tasikmalaya, the District RH Commission has succeeded in advocating for perda on RH, and is in the process of advocating for implementing decrees/budgets to support a wide range of RH activities. These local initiatives may indicate a growing collective consciousness, and an appreciation of the benefits of sharing information and joint planning.

At the same time, even the most active of the groups questioned their mandate and expressed concerns about continuing collaboration beyond UNFPA funding. Given the small amount of funding provided through the programme, this raises important questions about the level of ownership and potential for sustainability of the commissions. The RH Commission in Tasikmalaya specifically noted a need to consolidate understanding of their mandate, and to extend their coordinated efforts beyond increasing budgets for service delivery, towards broader policy making and planning.

4.1.1.2 The Activities of the Indonesian Forum of Parliamentarians on Population and Development

Overview

Another important strategy used to create an enabling policy environment for reproductive health has been through the support to the Indonesian Forum of Parliamentarians on Population and

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\(^2\) Some CP7 provinces currently receive a full subsidy from central government for procuring contraceptives
Development (IFPPD). CP7 has supported IFPPD activities at Central level, as well as in 6 provinces and 8 districts (2 districts in West Java Province, 1 district in South Sumatra Province, and 5 districts in NTT province). Notably, 6 districts (in South Sumatra and NTT Province) and 2 provinces (West Kalimantan and NTT) are partly supported with local funds.

At the local levels, IFPPD secretariats are established in the office of the local parliament and co-chaired by a member of parliament and an employee of IFPPD. Costs for office space are covered by parliament and considered a local contribution. IFPPD integration in local structures helps to promote close working relationships and facilitate a shared agenda between local IFPPD offices and local parliamentarians. In some cases, small funding for specific activities have also been provided by the parliamentary offices for jointly planned initiatives. At the national level, the central IFPPD office is located separately from the office of parliament. Compared to IFPPD offices at province and district levels, the national office is widely considered to have a weaker working relationship with parliamentarians, in part because of its less intensive access to its target population.

Core strategies of IFPPD focus on keeping parliamentarians well-informed about key issues relevant to reproductive health, population and development, and gender, and facilitating contacts with key constituencies, including government, academics, activists, NGOs and different segments of the general public. As such, IFPPD identifies relevant resources, assesses their quality and helps to disseminate them, particularly to parliamentarians and key constituencies. In addition, IFPPD provides input towards the development of local regulations and provides ongoing advocacy to ensure that budgets are available to fund priority initiatives.

Findings: Effectiveness

With support from CP7, IFPPD has been actively supporting the passage of the Law on Health (No. 36) and the Law on Population (No. 52) at the national level, as well as local regulations on HIV prevention and care, on anti-trafficking, and on protection of women and children from domestic violence. In some areas, efforts focused on prevention of HIV among youth. IFPPD is also recognized as supporting the strengthening of the BKKBN mandate at in many districts, where budgets for operations have increased and more field workers employed.

While some IFPPD offices have also been involved in advocating for a number of other RH issues, it is recognized that it is challenging to promote the RH agenda when there are a range of other priorities in the health sector. Very little attention, to date, has been given to the issues of maternal mortality reduction or to adolescent reproductive health.

Local IFPPD offices mainly focus on parliamentarians, and have little contact with local RH Commissions and other coordination mechanism focused on government. While coordination between IFPPD and RH Commissions, CCSTs and Database Fora is generally encouraged and considered potentially beneficial, in practice, linkages have been highly sporadic.

A major challenge for IFPPD is the significant turnover of parliamentarians under the current electoral system. For example, in East Nusa Tenggara (NTT) province, approximately 90 per cent of parliamentarians are newly elected. This makes it very difficult for IFPPD to establish continuity and to build on previous successes.

Conclusions Related to RH Outcome 1

CP7 has contributed to a number of important achievements in the policy arena. At national level, the programme has supported a number of strategic, high level consultations which have helped to shape the RH policy agenda among moderate religious groups in particular, and with regard to the
revitalization of family planning nationally. While recent approval of National ARH Guidelines is significant, remaining questions on political commitment will undoubtedly require further policy support and increasingly rigorous programmatic attention. Support for national and local consultation on the Health Law, and the Population Law during CP7 is also noteworthy.

The role of IFPPD in this regard is significant and offers ongoing promise of continued policy dynamism at both national and subnational levels. At the same time, insufficient attention has been paid to issues of maternal health and adolescent RH. As an NGO with limited financing from sources other than UNFPA, the sustainability of IFPPD as an organization is a persistent concern.

CP7 has also taken steps to pilot the introduction of ARH education in schools. Efforts have been highly fragmented and insufficiently standardized, limiting the ability to draw preliminary conclusions on how the curricula is effective or acceptable. However, indications of local interest are considered highly promising, and present strong potential for continued effort in this area.

The success of the coordination mechanisms supported through CP7 has been limited to date. However, there are early signs of potential for effective cross-sectoral collaboration in reproductive health at local levels. There is still considerable work to be done to strengthen functional RH Commissions, and to consider consolidating the CCSTs as working groups of more broadly mandated commissions.

The case can be made that these groups are at a critical point where additional support is essential to sustainability. Efforts would benefit greatly from technical assistance in strategic planning of commissions particularly in clarifying their mandate, roles and strategic advantages. Furthermore, commissions that are committed to working together would benefit greatly from learning from the experience of other commissions. The sharing of experiences among RH Commissions operating at district and province levels may prove to be a positive example for national-level commissions.

4.1.2 Outcome 2

Strengthened demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information

Overview

CP7 recognizes demand creation for family planning and other RH services as an ongoing priority of GOI and of UNFPA. The importance of continued attention to demand creation is reaffirmed within the Law on Population, the National RH Strategy and a number of other policy documents. Demand creation among target populations, with attention to particular method choices, is recognized as an important strategy to address the plateauing of family planning utilization in Indonesia.

In addition, an important strategy to increase demand for family planning and other RH services addresses resistance among key population groups. As such, CP7 has supported activities with religious and community leaders to support an enabling environment that promotes reproductive health and rights.

BKKBN is the primary government agency responsible for demand creation activities. CP7 has supported a wide range of activities, including development and dissemination of print and audio-visual communications through a wide range of media and other communications channels. These channels include, but are not limited to, television, radio talk shows, as well as women and youth groups.
Findings: Effectiveness

Through BKKBN, UNFPA has supported the development and dissemination of a wide range of print and audio-visual material related to reproductive health and gender. According to data obtained from activity reports, 8 public service announcements were developed and aired more than 10,500 times. In addition, over 110 television shows and close to 1800 radio talk shows were aired on RH themes in the 6 target provinces. In addition, over 114,000 pieces of IEC print material have been distributed through BKKBN at all levels. Face-to-face demand creation efforts have reached an estimated 15,000 men, women and adolescents with information about reproductive health, family planning, HIV and gender based violence prevention. There is significant variation in the volume of different communication activities in different CP7-supported districts.

These materials and communications strategies represent a standard part of the implementation of BKKBN's mandate. BKKBN has been engaged in demand creation for many years and by many accounts, has been highly successful (Shiffman, 2004; Hull and Mosley, 2009). Communication material is often produced at the central level and disseminated nationally. While significant capacity is recognized here, there are concerns expressed at local levels, that materials do not consistently reflect specific local realities and are not tailored to local audiences in terms of language and cultural representations. Also, print material has often preferred quality design and printing, rather than ensuring large quantities for widespread distribution.

CP7 support for demand creation has not focused on strengthening the capacities of BKKBN. According to BKKBN-based project staff, the support that CP7 has provided is akin to budget support. While the guidance of UNFPA staff are appreciated, there has been limited technical assistance or institutional capacity building provided through the programme, and little strategic input into demand creation approaches for different target populations.

Conclusions Related to Outcome 2:

Ongoing development and implementation of demand creation efforts at local levels are of continued importance and should remain a key role of BKKBN. However, given limited resources, CP7 support for demand creation has not added significant value. The absence of a capacity building approach that improves BKKBN ability to identify and develop strategies to effectively reach different target populations undermines the strategic value of the assistance, particularly given the limited resources.

While practice varies within the public sector, a demand creation strategy focusing exclusively on discouraging sexual activity among adolescents will fail to address the needs of high risk youth. In this regard, UNFPA support to NGOs is understood to have significant potential in addressing these needs.

4.1.3 Outcome 3

Increased access to high-quality, integrated, client-oriented and gender-sensitive reproductive health, and ARH services and information.

CP7 undertook a number of strategies to achieve outcome three related to service quality. Within the public sector, efforts focused on supporting high quality, integrated reproductive services through community health centres (puskesmas).
Despite CP7’s early intentions, very little investment has been directed towards the improving blood supplies in district hospitals to prepare for obstetric emergencies. Due to infrastructure limitations and other constraints, CP7 provided training on Emergency Obstetric Care (EOC) in 8 of 21 districts. Following the MTR, the indicator for this area was revised to reflect a marginal surveillance role only. As a result of the limited activity, this aspect of the programme was not specifically evaluated.

4.1.3.1 Integrated Essential Reproductive Health in the Public Sector

Overview

Integrated Essential Reproductive Health (IERH) has been an important element of UNFPA approach to service delivery support since the Sixth Country Programme (or CP6, 2001-2005). While CP6 sought to introduce quality IERH approaches, evaluation of CP6 noted important remaining challenges with regard to the quality and scope of IERH activities. In particular, staff attitudes about adolescent reproductive health (ARH) as well as readiness of facilities to ensure privacy were noted as important weaknesses. As such, support for IERH was continued in CP7.

As recognized in the National RH Strategy, components of the IERH approach include maternal-child health with a focus on basic emergency obstetric and neonatal care (BEONC), family planning (FP), prevention of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), including HIV/AIDS, and adolescent reproductive health (ARH).

Further, as encouraged through the Ministry of Health Circular Letter to Governors and Heads of Regencies (No. 659/MoH/VI/2007) on 13 June 2007, all victims of domestic violence should have access to medical services. Each provincial and regency hospital, as well as community health centers (puskesmas), are expected to be able to provide examination and medical treatment, either through a One Stop Crisis Center (PPT) at the hospital or the provision of medical and non-medical services at puskesmas. As such, provision of screening and medical services for victims of gender-based violence (GBV) came to be considered an important component of a holistic RH approach.

The National RH Strategy places the components of IERH within a reproductive rights paradigm, and considers each component as part of a life-cycle approach. At the same time, emphasis is placed on the separate components of IERH, rather than on the benefits of integration. The National RH Strategy further recognizes the importance of inter-sectoral coordination, community participation and outreach, as important elements of ARH and GBV programme implementation in particular.

As with CP6, CP7 supports the implementation of IERH at the subdistrict level, focusing on services provided through puskesmas. Puskesmas are integrated primary health care units offering a range of services to communities in their catchment areas. Puskesmas are supervised by the District Health Office (DHO) and provide supervisory support to skilled birth attendants working at the village level. Puskesmas staff also conducts outreach to villages for sanitization on a variety of health topics. On average, puskesmas cover a population of approximately 30,000, but some, cover much larger populations.

At the same time, CP7 has provided support for the development of guidelines and training material for implementation of IERH. In particular, a series of five booklets were produced on different aspects of the IERH approach. These guides are considered an important resource for IERH implementation nationally.

CP7 is thus considered closely aligned with national-level priorities in reproductive health. At the same time, district level priorities that are developed locally vary considerably. While the programme offers some flexibility in implementing different components of IERH, a number of stakeholders noted
that insufficient attention was given to locally defined priorities such as a focused strategy to strengthen emergency obstetric care services to reduce maternal mortality. Since the consolidation of the CP7 following the Mid-Term Review (MTR), IERH has been a focus of UNFPA support in three puskesmas in each of nine focus districts (total 27 Puskesmas).

In 2007, UNFPA commissioned an independent evaluation of IERH (Widayatun, et. al., 2007) focusing specifically on the impact of the abovementioned approach on reproductive health and the promotion of reproductive rights in target communities. While the study offered a number of important insights into the quality of implementation of IERH and its acceptability among target populations, the absence of a sound evaluation methodology posed limitations in verifying conclusions on the impact of the approach. Therefore, the policy implications that were drawn from evaluation findings are considered limited.

Findings: Effectiveness

Understanding of the Approach

Among District Health Offices (DHO) and heads of puskesmas, there is variation on the understanding of the concept of IERH. The majority of staff interviewed appreciates the ideal of a “one-stop-shop” where clients can receive a range of services. Some leaders and staff describe the approach as linked to the 16 indicators that are reporting requirements for the subnational statistical yearbook (Daerah Dalam Angka).

Health staff reportedly appreciated a new approach to the flow of services promoted through IERH. In the new service flow, the client indicates his or her need at a registration office, and is then directed to the appropriate service. In several puskesmas, after receiving programme-supported training, a number of service providers reportedly can now provide many different RH services (hence the one-stop-shop), thereby improving continuity of care for the client. In some puskesmas, a “counseling specialist” has been designated with specialized counseling skills, primarily to work with youth.

Most heads of puskesmas describe the approach in terms of the introduction of “new” services, particularly ARH and GBV. Few mentioned voluntarily counseling and testing (VCT) for HIV, although introduction of these services has been supported through the programme.

A minority understand IERH as a more integrated service model, where reproductive health is seen as a complex of related, and sometimes difficult to disclose needs. With this understanding, counseling is seen as an entry point to identify a range of services that the client may need. Those who see IERH in this way similarly see ARH and GBV as the most complex elements—requiring intensive and skilled counseling in order to screen clients and respond to their varied needs.

Implementation of “New” Services

Adolescents Reproductive Health (ARH)

ARH services are provided in puskesmas, as well as through outreach activities undertaken by puskesmas staff to schools and other venues where communities gather. In several puskesmas, groups of adolescents come weekly for awareness-raising sessions on various topics. In general, these topics focus on general health and development issues (e.g., hygiene, smoking, anemia, body awareness), and on discouraging early sexual activity by reinforcing traditional standards of morality, and by raising fears about the risks of STIs, including HIV.
With CP7 support, many puskesmas also undertook minor renovations/decorations of their counseling room, which is primarily used for counseling of adolescents. Among the puskesmas that were visited, these spaces had varying degrees of auditory privacy with only a curtain separating services in several settings. Television and video equipment were available in several puskesmas, and required renting in others.

Supplies of Information, Education and Communication (IEC) materials, that are readily accessible for adolescent clients to take, were available in very few puskesmas. While some print material has been developed and distributed, it was often kept in locked cupboards to be distributed by health staff. While printed materials were of very high quality, the quantity of the materials were limited.

Discussion of ARH topics is considered very challenging for health staff, given that adolescent sex is considered highly taboo in most of Indonesia. Further, in a context where it is illegal to provide family planning services to unmarried couples, a number of staff conveyed that they felt limited in their ability to help young people, particularly those who were already or considering becoming sexually active. However, some found creative ways to overcome limitations by referring young clients to NGOs or by offering services after working hours.

**Gender-Based Violence (GBV)**

Different puskesmas had different perspectives on GBV services. In most cases, counseling and referral services were provided for clients who present themselves as “GBV victims”. While for others, screening was seen as a key part of the integrated service, designed to identify cases that were not being addressed.

In most cases, puskesmas reported having established coordination with local police stations and district or provincial hospitals for case referrals. In some instances, victims of violence were also referred to the puskesmas from police stations, to receive treatment for physical injuries, although this was relatively uncommon. Overall, staff reported that relatively few clients access GBV services through the puskesmas (although the highest frequency of cases received by a puskesmas is approximately one case per month).

**Voluntary Counseling and Testing (VCT)**

VCT services are also recognized as a component of IERH in a number of puskesmas, although the establishment of VCT services appears to have received relatively less emphasis compared to ARH and GBV. Where VCT services are present, the focus is on counseling and referral of clients. Few puskesmas have functioning laboratory facilities to complete the testing process. Laboratory support for VCT is still focused largely at the hospital level. According to data obtained from UNFPA reporting, although VCT services are available in each district targeted for IERH, not all puskesmas offer the VCT service. The demand for VCT services is still low, with the majority of districts reporting only one to three clients receiving VCT services in 2009.

**Staff Perceptions of Changes**

Although puskesmas staff perceived that the IERH approach is challenging in its implementation, they consistently expressed preference towards the approach. Many perceive that the approach promotes high quality standards of care. According to one head of puskesmas, “clients come now not only for medical services but to share their problems”. She also noted that IERH “increases knowledge and capacity of staff”.
Linkages with community, particularly with peer groups for adolescents, and with police and shelters for GBV, are generally recognized as an important dimension of the IERH approach. However, there is significant variation in the extent to which outreach components have been systematized. Many heads of puskesmas noted that funding for outreach is particularly limited.

A number of heads of puskesmas also reported that IERH presents a management challenge – particularly in cross-sector coordination. Varying levels of support from police and from schools is one example of how cross-sector coordination can be a challenge.

IERH Training and Technical Assistance

CP7-supported training has focused on the “newer” dimensions of IERH, namely GBV and ARH. Trainings varied from one puskesmas to another, generally ranging from 2 to 7 days for GBV and 7 to 10 days for ARH. Some health staff reported receiving training on other IERH topics such as BEONC, family planning and syndromic-based approaches to STIs. The numbers of staff that were trained also varied in each site. In several puskesmas, leaders indicated that they received a general orientation (two to three days) to the IERH approach.

The training methodology also varied considerably across the programme. Some puskesmas staff indicated that they were trained by trainers from the District Health Office, while others were trained by a combination of teams from the District Health Office, BKKBN (or BPPKB), Provincial Health Office, and Ministry of Health. Few puskesmas staff indicated that they were trained by certified trainers.

There were a number of limitations found in the training approach. DHO and puskesmas heads and staff reported that a needs assessment was not conducted prior to training. Also, there was no follow up to trainings, which could have presented opportunities for on-site coaching. Trainings applied classroom-based approaches and had limited supervised clinical practice. Participants were expected to continue to work on clinical skills after training, sometimes before certificates were issued. Training roll-out to other staff at puskesmas was consistently described as “sensitization”, provided by IERH-trained staff that may not have adequate skills to train others.

Retention of trained staff was considered an important problem, as reassignment of civil servants is a common occurrence in present-day Indonesia. In the majority of puskesmas, not all staff assigned to IERH services had been trained, and prospects for receiving refresher training were unclear. Lack of attention to the institutionalization of training capacity at district and province levels has left programmes highly vulnerable to staff turnover.

With the exception of limited monitoring from DHO and occasionally from province and central levels (see below), there was no additional technical support provided through the programme.

Monitoring and Supervision

Similarly, monitoring and supervision of IERH activities were considered highly variable. Some puskesmas reported receiving semi-annual DHO monitoring visits, while others reported less frequent monitoring. Overall, the quality of monitoring was considered weak, with limited problem solving and action planning, and very little continuity from one visit to the next. While UNFPA monitoring tools were considered very comprehensive, a number of respondents noted that they were very difficult to use.

Internal monitoring stressed on the use of standardized checklists and regular service statistics collection and analysis. In the majority of supported puskesmas, graphs were prominently hung in
counseling or waiting areas, with data on different services. Importantly, a small number of puskesmas had also taken steps to develop a retrievable client record system for ARH and other services.

Comparison of Project-Supported and Non-Project-Supported Puskesmas

The evaluation provided an opportunity to visit puskesmas which were not supported under the CP7 IERH component. In each of three cases, the IERH activities were similar to those supported by UNFPA. Trainings were supported by government resources at similar levels of intensity, and generally, leaders and health staff that were interviewed had comparable understanding of the IERH approach. Furthermore, steps had been taken to implement new service components - particularly related to ARH services and outreach.

As there was no opportunity to observe services, review client records or seek client perspectives on the quality of services, it is not possible to conclude that the services in CP7-supported sites were of higher quality than those provided in non-project sites. However, no significant distinctions were found between CP-7 supported sites and those that were not.

Conclusions Related to Outcome 3

UNFPA has provided support for implementation of the Government IERH approach since 2001. The alignment of CP7 with national priorities in reproductive health service delivery is significant and is expected to contribute to long-term ownership and sustainability. Technical input to the development of nationally accepted guidelines on IERH represents an important programmatic contribution, with the potential for impact beyond CP7-supported geographic areas.

However, there is variation of the alignment of priorities at the district and provincial levels. In a number of areas struggling with high rates of maternal mortality in particular, interventions focused at the puskesmas level is considered less of a priority compared to strategies that impact emergency obstetric services at the intersection of communities and hospitals.

With limited ongoing technical assistance at the service delivery level and significant weaknesses in the CP7 training approach, differences between programme-supported services and those supported through regular government budgets and systems are unremarkable. Furthermore, the lack of reliable programme documentation and rigorous evaluation makes it difficult to offer programmatic and policy lessons relevant for scale up.

The effectiveness of the government strategy in service delivery for youth-friendly services is highly questionable, as the strategy focuses on preserving traditional values and thus does not address the needs of at-risk youth. This finding was also noted in the evaluation of NGO implementation of UNFPA programmes on ARH and HIV/AIDS (Irwin and Nasir, 2008). Nationally representative data on the knowledge, attitudes and practices of young people, as well as an evaluation of how different approaches are effectively applied in different populations, is necessary in the development of evidence-based policy and programmes.

Suggested Recommendations for RH for Country Programme 8

Strategic support in policy development. To further UNFPA alignment to Indonesia’s reproductive health priorities, UNFPA Indonesia should support the development of the National Reproductive Health Strategy for 2011 to 2015. By supporting the development of Indonesia’s reproductive health strategies for the next five years, UNFPA, through its Eighth Country Programme (2011-2015), can link upcoming piloting efforts to specific objectives of the 5-year strategy. Piloting efforts should also
be accompanied with strengthened efforts in ensuring the quality of implementation and in seeking sustainability and replication of piloting efforts. To support policy development efforts at the subnational level—particularly those linked with laws on health and population issues—UNFPA should continue to support multi-stakeholder consultations aimed at the consolidation of decrees and guidelines to improve governance in the delivery of health and population services. The Indonesia Forum of Parliamentarians (IFPPD) has played a key role in this effort and strengthened collaboration and support should be continued. To promote evidence-based planning and programming in adolescent reproductive health and HIV/AIDS, the availability of nationally representative statistics on the knowledge, attitudes and practices of young people is crucial. Supporting national-scale researches and surveys on adolescent reproductive health would be a key entry point in better planning and implementation of policy and programmes to accommodate the regional variations of the population across Indonesia. This effort can also be an entry point to consider opportunities to work together and coordinate with other agencies and organizations working in reproductive health, such as UNICEF and WHO in Indonesia.

**Streamlining programmatic focus to make way for strategic and effective interventions.** Taking stock of the lessons learned drawn from implementation throughout the Seventh Country Programme, it is important for UNFPA to revisit its thematic and geographic priorities to ensure better implementation in the achievement of objectives. Placing stronger emphasis on the quality of interventions rather than quantity, outputs and priority areas should be streamlined—focusing on areas of strategic advantage. Strengthening institutional capacities for better service delivery continues to be a key priority for UNFPA. One of the recommended strategies is to strengthen the capacity of the BKKBN, the government agency that will play a leading role in the government agenda to revitalize the national family planning programme and to advance delivery in reproductive health. UNFPA, through CP7, has supported BKKBN in its efforts to create the demand for quality reproductive health services through the development and dissemination of information, education and communication materials. However, lessons from CP7 implementation has shown that there is still a need to strengthen BKKBN capacities to develop a behavior change and communication strategy that can accommodate the local contexts in various communities across Indonesia. The gap in the delivery of and access to adolescent reproductive health (ARH) services should indicate the continued need to pilot ARH curriculum in schools—concentrating on fewer districts while intensifying efforts to standardize the curricula, strengthening the capacity of teachers, as well as policy support. As policies on ARH continues to limit the government in delivering ARH services, UNFPA should focus on working with non-government organizations on ARH service delivery strategies. At the same time, UNFPA Indonesia should continue efforts to advocate for the amendment of ARH policies that will allow the government to deliver the full range of RH services for youths. Through previous country programmes for the past 10 years, UNFPA Indonesia has supported IERH implementation at the puskesmas level, which has now become a national government programme. The RH component in the Eighth Country Programme should continue to support government efforts in reducing maternal mortality by shifting the focus of intervention from full IERH implementation in the puskesmas to placing further emphasis on increasing access to emergency obstetric care.

**Recommendations for RH Programme Exit Strategies**

As the CP7 programmes in reproductive are coming to a close, UNFPA Indonesia should develop an exit strategy, through close consultation with its national and subnational government partners, as an effort to ensure the sustainability of programmes. The strategy should be transitional in nature, preparing government partners to take over efforts to sustain programmes with its own resources. The actions below are among the recommended strategies that take into account feasibility while providing the greatest effective leverage.

- **To support strategic planning of government commissions and forums on reproductive health and population.** To strengthen coordination and collaboration within the government on
issues of reproductive health and population, there continues to be a need to enhance the capacities of existing commissions—such as the Reproductive Health Commissions, and forums—such as the IFPPD, in strategic planning.

- **To establish a pool of trainers for IERH.** To develop a core team of trainers in six provinces who will be able to provide high quality training on IERH topics on an ongoing basis. Trainers should be selected based on general training capacity requirements and accessibility to the IERH system in Indonesia, prioritizing certified trainers wherever possible. Ensure opportunities for the team to conduct hands-on training and follow up, with support from more experienced (“master”) trainers.
4.2 Population and Development Strategies (Outcome 4)

The Population and Development Strategies (PDS) Programme has three key activities: 1) support for the improvement of Subnational Statistical Yearbook known as Daerah Dalam Angka (DDA); 2) establishment of the Database Forum (DBF); and, 3) support for a series of trainings. At the central level, support has been given to the publication and dissemination of population projections, as well as the implementation of the 2007 Indonesia Demographic and Health Survey. The programme has also supported a series of activities related to the preparation of the 2010 Population Census.

4.2.1 Outcome 4

Enhanced understanding of policy makers, planners and parliamentarians at national and subnational levels on the linkages between population, reproductive health, gender, poverty and development through improved availability and increased utilization data on population, reproductive health and adolescent reproductive health, STIs including HIV/AIDS, gender and poverty.

Overview:

The CP7 strategy in enhancing government population and development strategies supports efforts that improve availability and increase capability to utilize disaggregated data on population, reproductive health and adolescent reproductive health, STIs and HIV/AIDS, gender, poverty and enhanced understanding of planners, policy makers and parliamentarians on their linkages with development. The main strategies to achieve this output include:

1. Capacity building of implementing partners to provide service statistics timely, comprehensively, well organized, and should focus on the existing system and practices
2. Capacity building of policy makers and planners at sub-national levels to utilize data on population, RH, FP, gender and poverty for planning, budgeting, monitoring, evaluation and policy making should focus on the existing system and practices.
3. Capacity building of planners and policy makers, and sensitizing policy makers, planers and parliamentarians at national and sub-national levels on linkages between population, reproductive health including family planning, gender, poverty and socio-economic development.

PDS Evaluation Framework

The evaluation framework for PDS uses two approaches; first, the framework attempts to describe the interrelationship of the PDS three key activities (see figure 2); secondly the framework describes how CP7-supported activities in population and development can link to the district information system (see figure 3).

As shown in Figure 2, PDS is considered a highly dynamic set of interventions. For example, a series of trainings aimed to increase knowledge on how to make disaggregated data available and thus usable, may create the need for new data or highlight the need for more advanced training. The DBF can then be used as the forum where these evolving needs are discussed, resulting in enhanced data systems tailored to local partners capacities and requirements. As such, the goal of the PDS
programme is to improve planning and decision making through enhanced understanding of policy makers, planners and parliamentarians at national and subnational levels on the linkages between population, reproductive health, gender, poverty and development.

According to expected outcomes, PDS programme implementation at the district level should be focused on the development of a district information system as shown by Figure 3. By supporting trainings and DBF activities, CP7 is expected to strengthen the availability of disaggregated data (both service/facility based and population based) and to improve the quality of data through standardization. Data from various sources can be easily accessed and used by potential users when it is located in an integrated data repository. CP7 has also focused on strengthening local capacities to develop their subnational statistical yearbooks (or Daerah Dalam Angka/DDA). DDA is a report published by BPS-Statistics Indonesia containing local level data and statistics. Through the DDA, there is still a need to improve the quality of information on different sectors, including data on reproductive health and gender. A illustrated in Figure 3, PDS provides its support in a cross-cutting way, to improve programme planning and decision making for other CP7-supported interventions.
**Findings: Effectiveness**

**Daerah Dalam Angka: Design, Training, and Database Forum**

The Indonesian Subnational Statistical Yearbook (*Daerah Dalam Angka/DDA*), is widely recognized by various stakeholders at the provincial and district levels as a joint product of BPS-Statistics and the local government. Support to improve this existing publication can ensure its sustainability.

Through CP7, in collaboration with the central level BPS-Statistics, disaggregated data (particularly facility-based data) related to population, reproductive health, and gender issues was added to the existing province and district level DDA. UNFPA implementing partners were responsible for providing data from their service/facility-based data systems. Publication and distribution of the DDA in both hard copies and soft copies (CD) were mainly supported by local government through Bappeda, while CP7 supported local government to widen distribution by providing additional copies.

CP7 supported two types of trainings through BPS-Statistics. The first was training for sector personnel (including implementing partners and district level BPS-Statistics) to help ensure the production of quality disaggregated data on population, reproductive health, and gender. The second training aimed to strengthen district planners and policy maker capacities to utilize data for planning and decision-making purposes. The capacity building event was in the form of a Training of Trainers (ToT), which to be followed by a training aimed at sector personnel in which participants of the ToT are to be trainers.
There were district variations on the effectiveness of the training. Through interviews with programme implementers, it was found that not all training participants met the criteria for training thus affecting the capacity of participants to absorb training materials. The variation in the skills of trainers also influenced the training outcomes. This is reflected by the ability of trained participants to include agreed-upon indicators in the DDA, and by their ability to utilize existing data in the planning processes—which will be discussed in greater detail in the following sections. By the end of 2009, only 37 per cent of targeted planners and policy makers had been trained.

Provincial and district-level Database Forums (DBFs) were supported by local decrees, signed by the governor at the provincial level, and by the head of district or municipality at the district level. DBFs generally meet every three months to discuss and agree on the indicators to be included in the DDA. DBF members and various sector representatives (mainly implementing partners of the CP7), meet under the direction of the governor (or the provincial government secretary) or the head of district/municipality (or the district/municipal government secretary). Although the structure, activities, and function of each DBF varied by district, the overall purpose of the forums was to define, synergize, and organize disaggregated data on population, reproductive health, and gender.

**Successes in the Development of the Daerah Dalam Angka**

A number of measures are used to indicate the success of the DDA, including publication in provinces/districts supported by UNFPA, distribution to potential users, inclusion of agreed indicators (mostly related to implementing partners), and utilization of DDA data/information by potential users (particularly for planning purposes). In all provinces/districts visited, the DDA for 2009, which primarily includes data from 2008, has been published and distributed in both hard and soft copies (implementation ranged from July to October 2009). For wider access to potential users, the DDA has also been uploaded in local government websites.

The target for 2009 was to incorporate 75 per cent of identified disaggregated indicators in the DDA in all CP7-supported provinces and districts. Although all of the provinces and districts provided disaggregated data of thematic areas related to UNFPA-supported programmes (population, reproductive health, and GBV), not all data/indicators were included in the DDA. Variations in the capacity of implementing partners in providing the necessary data is one of the factors that influenced the programme’s partial achievement to include 75 per cent of targeted indicators in the statistical yearbook (see Table 2 and Table 3). This also resulted in variations in provincial and district level data availability. The rate of turnover of government personnel—including those who had been trained through the programme—were also one of the setbacks in reaching programme targets.

Table 2 shows the percentage of identified indicators which were included in the 2009 DDA for five provinces. The percentage of identified indicators included in the DDA varied by province, with the lowest percentage (42 per cent) for Nusa Tenggara Timur, and the highest percentage (100 per cent) for West Java.
Table 2. Percentage of identified indicators included in the 2009 DDA for five provinces.

<table>
<thead>
<tr>
<th>Province</th>
<th>Target number of identified indicators to be incorporated into the 2009 DDA</th>
<th>Number of identified indicators included in the 2009 DDA</th>
<th>Percentage of target indicators included in the 2009 DDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nusa Tenggara Timur</td>
<td>19</td>
<td>8</td>
<td>42%</td>
</tr>
<tr>
<td>West Kalimantan</td>
<td>52</td>
<td>36</td>
<td>69%</td>
</tr>
<tr>
<td>Nusa Tenggara Barat</td>
<td>62</td>
<td>49</td>
<td>79%</td>
</tr>
<tr>
<td>West Java</td>
<td>39</td>
<td>39</td>
<td>100%</td>
</tr>
<tr>
<td>South Sumatra</td>
<td>10</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>182</strong></td>
<td><strong>137</strong></td>
<td><strong>75%</strong></td>
</tr>
</tbody>
</table>

(Source: UNFPA Indonesia programme documents and the DDA 2009 for Nusa Tenggara Timur, West Kalimantan, Nusa Tenggara Barat, West Java, and South Sumatra)

Table 3 shows the percentage of identified indicators included in the 2009 DDA for 17 districts. The percentage of target indicators varied widely, from the lowest percentage (10 per cent) for Manggarai, to the highest percentage (100 per cent for each area) for West Sumba, Timor Tengah Selatan, Alor, and Central Lombok. In all, 11 of the 17 districts included more than 75 per cent of the identified indicators. Table 3 also shows that two districts (West Sumba and Central Lombok) would have exceeded the 100 per cent target if they included additional indicators as their achievement. Additional indicators were defined and agreed upon by local DBF.

Table 3. Percentage of identified indicators included in the 2009 DDA for 17 districts.

<table>
<thead>
<tr>
<th>District</th>
<th>Target number of identified indicators to be incorporated into the 2009 DDA</th>
<th>Number of identified indicators included in the 2009 DDA</th>
<th>Percentage of target indicators included in the 2009 DDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Sumba</td>
<td>15</td>
<td>17 (15)</td>
<td>113% (100%)</td>
</tr>
<tr>
<td>Kupang</td>
<td>38</td>
<td>18</td>
<td>47%</td>
</tr>
<tr>
<td>Timor Tengah Selatan</td>
<td>27</td>
<td>27</td>
<td>100%</td>
</tr>
<tr>
<td>Alor</td>
<td>16</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>Manggarai</td>
<td>96</td>
<td>10</td>
<td>10%</td>
</tr>
<tr>
<td>Sintang</td>
<td>54</td>
<td>35</td>
<td>65%</td>
</tr>
<tr>
<td>Landak</td>
<td>52</td>
<td>50</td>
<td>96%</td>
</tr>
<tr>
<td>Pontianak</td>
<td>71</td>
<td>42</td>
<td>59%</td>
</tr>
<tr>
<td>Sambas</td>
<td>52</td>
<td>29</td>
<td>56%</td>
</tr>
<tr>
<td>Singkawang</td>
<td>56</td>
<td>48</td>
<td>86%</td>
</tr>
<tr>
<td>Central Lombok</td>
<td>27 (27)</td>
<td>69</td>
<td>256% (100%)</td>
</tr>
<tr>
<td>Dompu</td>
<td>61</td>
<td>35</td>
<td>57%</td>
</tr>
<tr>
<td>Lombok Barat</td>
<td>40</td>
<td>36</td>
<td>90%</td>
</tr>
<tr>
<td>Lombok Timur</td>
<td>34</td>
<td>27</td>
<td>79%</td>
</tr>
<tr>
<td>Indramayu</td>
<td>21</td>
<td>17</td>
<td>81%</td>
</tr>
<tr>
<td>Tasikmalaya</td>
<td>53</td>
<td>39</td>
<td>74%</td>
</tr>
<tr>
<td>Ogan Komering Ilir</td>
<td>30</td>
<td>25</td>
<td>83%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>743</strong></td>
<td><strong>496</strong></td>
<td><strong>67%</strong></td>
</tr>
</tbody>
</table>

(Source: UNFPA Indonesia programme documents and district level DDAs for 2009)
Table 4 and Table 5 provide two examples of how province and district level partners adapted the DDA to their local needs—by setting the number of indicators that they consider necessary to include in the DDA. Table 4 shows that the local database forum in NTT agreed to incorporate 66 indicators on population, reproductive health and gender in the 2009 DDA. This is much higher than the originally set goal targeted by the programme (19 indicators, see Table 2). By 2009, the province succeeded in including only 8 out of 66 of the locally set targeted indicators (12 per cent). The low rate of success is on one hand, the result of ambitious target setting by members of the database forum that did not take into account capacity limitations of implementing partners in providing the necessary indicators for reproductive health, family planning, or HIV/AIDS. The absence of technical support during the design process also contributed to the gap between the target and the actual achievement.

In Tasikmalaya District, a higher percentage of agreed-upon indicators were included in the 2009 DDA; of the 53 targeted of identified indicators, 39 (74 per cent) were included (Table 5). Gender indicators were the most difficult to obtain; therefore, almost 50 per cent of those for Tasikmalaya were not included in the DDA.

Table 4. Analysis of the identified indicators for Nusa Tenggara Timur.

<table>
<thead>
<tr>
<th>Indicator group</th>
<th>Target indicators included in the 2009 DDA</th>
<th>Number of indicators actually included in the 2009 DDA</th>
<th>Percentage of target indicators included in the 2009 DDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Core</td>
<td>23</td>
<td>4</td>
<td>17.39%</td>
</tr>
<tr>
<td>2. Additional</td>
<td>7</td>
<td>3</td>
<td>42.86%</td>
</tr>
<tr>
<td>3. Reproductive health</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Family planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. IMS/HIV/AIDS</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Gender</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>8</td>
<td>12.12%</td>
</tr>
</tbody>
</table>

Table 5. Analysis of the identified indicators for Tasikmalaya.

<table>
<thead>
<tr>
<th>Indicator group</th>
<th>Sources</th>
<th>Target number of indicators to be included in the 2009 DDA</th>
<th>Number (%) of indicators not included in the 2009 DDA</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>BPS, local government departments in education, health and social, population and work force affairs.</td>
<td>16</td>
<td>4 (25%)</td>
<td>Data not available from sector</td>
</tr>
<tr>
<td><strong>Reproductive health</strong></td>
<td>Local health department</td>
<td>8</td>
<td>0</td>
<td>Data not valid</td>
</tr>
<tr>
<td>• Maternal and child health</td>
<td>Local family planning department</td>
<td>8</td>
<td>2 (25%)</td>
<td></td>
</tr>
<tr>
<td>• Family planning</td>
<td>Local health department</td>
<td>3</td>
<td>1 (33%)</td>
<td></td>
</tr>
<tr>
<td>• Adolescent reproductive health</td>
<td>Local health department</td>
<td>5</td>
<td>1 (20%)</td>
<td></td>
</tr>
<tr>
<td>• Sexually transmitted infections</td>
<td>Local health department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Local level parliament, BPS staffing and training divisions, Women's Crisis Centre, cooperatives, industry and trade division, economics and development division, local government development and unity division, and police (POLRES)</td>
<td>13</td>
<td>6 (46%)</td>
<td>Data not available, only qualitative, low quality</td>
</tr>
</tbody>
</table>

**Total**                                                                         | 53                                                         | 14 (26%)                                                 |                                                     |                                              |


Table 4 and Table 5 further show that the availability of data and statistics on population is higher than the availability of reproductive health and gender data for indicators of the DDA, a consequence that is heavily influenced by gaps in the data collection systems in the national and subnational government levels. Population indicators are largely supplied by BPS data sources, while RH and
gender indicators rely on data provided by implementing partners, which has less statistical rigour and standards compared to the BPS data system.

Factors that contributed to the success of the DDA

The revised DDA (with new disaggregated data of additional indicators) is recognized by various stakeholders as an improvement over previous editions. This recognition eased the introduction of the DDA to potential users. The expertise of BPS personnel at the provincial and district levels was beneficial to the quality and timely distribution of the DDA. The interest and support of local governments, particularly the involvement of Bappeda, also contributed to DDA ownership and distribution.

Inclusion of new indicators in the DDA was dependent on the capacity of BPS to collect identified/agreed indicators primarily derived from existing or newly developed data collection systems of implementing partners. Through CP7 support, BPS provided training on data collection to implementing partners to ensure data quality, and provided oversight in data provision. An understanding between the BPS and implementing partners regarding their respective roles in the development of the DDA was also an important factor for achievement.

Challenges in the development of DDA

A number of districts want to use the DDA to showcase the successes of their programmes. It is often considered sensitive to share indicators that reflect weak performance, and as such, officials may be reluctant to include indicators related to RH, ARH, STIs including HIV/AIDS, gender and poverty. In doing so, they lose a valuable opportunity to highlight needs and gaps related to these important areas.

In addition, the development of the DDA was hindered by a number of other factors, including high turnover of local government personnel responsible for data provision, inappropriate targeting of personnel for data collection training, inadequate support from decision-makers to provide the data needed for the DDA, and inadequate data sources/information systems from implementing partners.

Challenges in the utilization of the DDA

The usefulness of the DDA in planning and policymaking depends on the adequacy of the system to respond to the information needs of planners and policymakers in a timely way. This is compromised by outdated data (from as far back as two years prior to publication) and is often not in a format that can be used for planning. The weak capacity of planners and other potential users, to apply data from the DDA as input to their planning needs, is another factor that prevents the utilization of DDA. Finally, there is not enough demand for high quality data in planning. A review of a number of planning documents revealed that the DDA is primarily used to describe general province or district profiles, rather than for more rigorous analysis of successes and needs.

Training

Trainings conducted by the BPS to meet PDS programme outputs are aimed: 1) to help ensure the production of quality data on key CP7 priorities in population, reproductive health, and gender; 2) to build the capacity of sector personnel to utilize the data, and; 3) to enhance the understanding of planners, policymakers, and parliamentarians about the importance of using DDA data in development planning. Indicators used to measure the output included: (1) proportion of identified planners, policymakers, and parliamentarians exposed to the linkages between population, reproductive health, gender, and development; and (2) proportion of identified planners and policy
makers in each district and province trained in utilizing available data for subnational development plans (Rencana Strategis Daerah and Rencana Kerja Pemerintah Daerah).

**Target set by 2009**

The population and development component of the Seventh Country Programme had set specific targets aimed to be achieved by 2009. These targets included the finalization of knowledge products, trainings for sub-national planners and advocacy efforts targeted at policy makers and parliamentarians, aimed at raising awareness on the linkages between population, reproductive health and gender. By 2009, the programme also aimed to carry out trainings for sub-national planners to use data for development planning and to finalize and launch the guidelines for data utilization in the districts where UNFPA is working during CP7.

However, not all of the targets were achieved by 2009. Based on the standard progress report by the BPS, since 2008, only 54 per cent of identified planners have been trained on data understanding and utilization (the goal for 2009 was 75 per cent) and only 12 per cent of identified policy makers have been trained on data understanding (the goal for 2009 was 50 per cent) (See Table 6).

Overall, among planners, province and district training achievement were similar, i.e., 55 per cent for province and 53 per cent for district. The province achievement ranged from 20 per cent in West Java, to 200 per cent in NTT. Half of the six provinces have exceeded the 75 per cent target. Achievements also varied by district ranging from the lowest of 11 per cent in Lombok Tengah, to the highest of 240 per cent in TTS. Nine out of 21 districts have reached target of 75 per cent.

Among policy makers, achievements from trainings were generally lower--only 12 percent out of the 50 per cent target was met. The achievements of the training for policy makers were lower in provinces (6 per cent) than in districts (13 per cent). In fact, training for policy makers was only conducted in NTB province, with the achievement of 37 per cent--still less than the target of 50 per cent. Policy maker training achievement by district ranged from the lowest zero per cent (Tasikmalaya, Alor, TTS, Lombok Barat, Lombok Timur and Landak) to the highest 120 per cent (West Sumba). Only six districts exceeded the target of 50 per cent.
Table 6. Planners and policymakers trained by 2009, by province and district.

<table>
<thead>
<tr>
<th>Province/district</th>
<th>Planners identified</th>
<th>Receiv-ed training up to 2009</th>
<th>Percentag e target</th>
<th>Policy makers identified</th>
<th>Receiv-ed training up to 2009</th>
<th>Percentag e target</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Sumatera</td>
<td>24</td>
<td>10</td>
<td>41.7</td>
<td>23</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Ogan Komering Ilir</td>
<td>62</td>
<td>44</td>
<td>71.0</td>
<td>23</td>
<td>20</td>
<td>87.0</td>
</tr>
<tr>
<td>West Java</td>
<td>154</td>
<td>31</td>
<td>20.1</td>
<td>145</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Indramayu</td>
<td>NA</td>
<td>24</td>
<td>-</td>
<td>NA</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Tasikmalaya</td>
<td>34</td>
<td>13</td>
<td>38.2</td>
<td>20</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Nusa Tenggara Timur</td>
<td>23</td>
<td>46</td>
<td>200.0</td>
<td>11</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Kupang</td>
<td>20</td>
<td>20</td>
<td>100.0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Sumba Barat</td>
<td>22</td>
<td>22</td>
<td>100.0</td>
<td>5</td>
<td>6</td>
<td>120.0</td>
</tr>
<tr>
<td>Manggarai</td>
<td>60</td>
<td>25</td>
<td>41.7</td>
<td>60</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Nusa Tenggara Barat</td>
<td>30</td>
<td>13</td>
<td>43.3</td>
<td>38</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Lombok Timur</td>
<td>54</td>
<td>48</td>
<td>88.9</td>
<td>27</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Lombok Barat</td>
<td>54</td>
<td>38</td>
<td>70.4</td>
<td>29</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Lombok Tengah</td>
<td>443</td>
<td>50</td>
<td>11.3</td>
<td>443</td>
<td>11</td>
<td>2.5</td>
</tr>
<tr>
<td>Dompu</td>
<td>30</td>
<td>56</td>
<td>186.7</td>
<td>20</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>Nangroe Aceh Darussalam</td>
<td>39</td>
<td>39</td>
<td>100.0</td>
<td>NA</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Bandung Barat</td>
<td>18</td>
<td>6</td>
<td>33.3</td>
<td>6</td>
<td>6</td>
<td>100.0</td>
</tr>
<tr>
<td>Aceh Besar</td>
<td>19</td>
<td>10</td>
<td>52.6</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Aceh Jaya</td>
<td>14</td>
<td>9</td>
<td>64.3</td>
<td>7</td>
<td>5</td>
<td>71.4</td>
</tr>
<tr>
<td>Aceh Barat</td>
<td>55</td>
<td>20</td>
<td>36.4</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>West Kalimantan</td>
<td>24</td>
<td>24</td>
<td>100.0</td>
<td>38</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>K. Pt. Pontianak</td>
<td>112</td>
<td>39</td>
<td>34.8</td>
<td>25</td>
<td>10</td>
<td>40.0</td>
</tr>
<tr>
<td>Landak</td>
<td>22</td>
<td>32</td>
<td>145.5</td>
<td>7</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sambas</td>
<td>30</td>
<td>45</td>
<td>150.0</td>
<td>8</td>
<td>8</td>
<td>100.0</td>
</tr>
<tr>
<td>Singkawang</td>
<td>24</td>
<td>31</td>
<td>129.2</td>
<td>13</td>
<td>9</td>
<td>69.2</td>
</tr>
<tr>
<td>Sintang</td>
<td>52</td>
<td>39</td>
<td>75.0</td>
<td>52</td>
<td>10</td>
<td>19.2</td>
</tr>
<tr>
<td>Total</td>
<td>1479</td>
<td>795</td>
<td>53.8</td>
<td>1053</td>
<td>122</td>
<td>11.6</td>
</tr>
<tr>
<td>Province</td>
<td>294</td>
<td>163</td>
<td>55.4</td>
<td>255</td>
<td>14</td>
<td>5.5</td>
</tr>
<tr>
<td>District</td>
<td>1185</td>
<td>632</td>
<td>53.3</td>
<td>798</td>
<td>103</td>
<td>12.9</td>
</tr>
</tbody>
</table>

Factors that contributed to or hindered training

Two training modules were developed by the central BPS. The modules were used by trainers at the provincial and district levels as references for training on DDA data provision (Training module for the preparation of data on population, reproductive health and gender), and for building the capacity of planners and decision makers to understand and utilize the data (Curriculum for the utilization of statistical data for planner and policy makers). Trainers adapted the training modules as necessary to meet sector or regional needs.

The use of the same reference material for training provided participants with common awareness and understanding in terms of the content of the training, but not necessarily with the same results. The latter depended on the skills of the trainers in adapting the training modules to meet the needs of the sector or region. The success of training heavily depended on the appropriate selection of training participants. These factors contributed to the district variation of training achievements. Although most of participants (both for DDA providers and planners) reported having gained a better understanding of DDA data provision and usage (as also shown by training pre and post-test results), some stated that they could not relate the training content with the specific needs of their regions and sectors. This is reflected in the district variation in identifying and including indicators in the DDA (Tables 2-5).

Training to improve general understanding of DDA should be followed up with ongoing strengthening of the sector data system, requiring follow up training and on-site technical assistance—which has been identified as a need by BPS-Statistics. Based on a BPS evaluation of data sources from CP7-supported partners, follow-up training to improve the quality of data was given to staff from different programme sectors. The training was held in 18 districts, aimed to follow up and strengthen activities that had been implemented in 2008, including assisting district BPS offices to be able to gather data for the DDA efficiently and effectively. Training was also conducted on data compilation, data entry, tabulation, as well as processing and analyzing new indicators. Similarly, training for planners and policy makers should be followed up with hands-on practice on using data for planning and decision making. A review of district and implementing partner planning documents found that there is limited use of data in these documents.

Given the low training coverage for planners and policy makers, questions regarding appropriate selection of training participants, and considering the complications in changing planning mechanisms so that it can incorporate evidence-based approaches, there are limitations in evaluating the achievements of this the training programme. Further assessment is required to evaluate whether the training will result in better data utilization and better planning in the long term.

The Database Forum

Establishment of provincial and district-level DBFs has been considered a noteworthy innovation of the PDS programme. DBFs were designed to play a principal role in coordinating and sharing data for

---

1 Module titles: Modul Pelatihan Penyiapan Data Sektor Kependudukan, Kesehatan Reproduksi dan Gender, and Bahan Ajar Pemanfaatan Data Statistik Bagi Perencana dan Pengambil Kebijakan.
2 Evaluations were conducted in ten districts: Alor, Timor Tengah Selatan, Kab. Kupang, Manggarai, Central Lombok, Dompu, Kota Pontianak, Sambas, Singkawang, and Sintang. Data sources included implementing partners in the areas of health, education, women’s empowerment, social services, family planning, and law enforcement.
3 Eighteen districts were included: Ogan Komering Ilir, Indramayu, Alor, Timor Tengah Selatan, Kupang, West Sumba, Manggarai, East Lombok, Central Lombok, Dompu, Banda, Aceh besar, Aceh jaya, Aceh barat, Kt ponti, Sambas, Singkawang, and Sintang.
development planning and policymaking. By 2009, all 21 districts and 5 of the 6 provinces supported by the CP7 had established and legalized DBFs (except West Java) (see Table 7).

Table 7. Provinces/districts with DBFs by date of establishment.

<table>
<thead>
<tr>
<th>Year of establishment</th>
<th>Number of province/district</th>
<th>Name of province/district</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>5</td>
<td>Indramayu, Central Lombok, Dompu, Landak, Sambas, Ogan Komering Ilir, Tasikmalaya, Timor Tengah Selatan, Kupang, Nusa Tenggara Barat, East Lombok, Banda Aceh, Aceh Besar, West Kalimantan, City of Pontianak, Singkawang, Sintang</td>
</tr>
<tr>
<td>2007</td>
<td>12</td>
<td>South Sumatera, West Sumba, Manggarai, Nangroe Aceh Darussalam, Aceh Barat</td>
</tr>
<tr>
<td>2008</td>
<td>5</td>
<td>Nusa Tenggara Timur, Alor, Aceh Jaya</td>
</tr>
</tbody>
</table>

DBFs are much appreciated by all members, particularly implementing partner representatives, BPS, Bappeda, and Sekda personnel. Together with the trainings, the forums have promoted common ownership and the improvement of data provision and utilization, and understanding of the DDA. As a result, DBF members in some regions plan to replicate their forums in other districts, as well as at the lower administration (subdistrict) level.

The central-level BPS responded to these intentions by organizing a series of workshops at provincial level for district DBF members to share experiences and identify good practices. The results of the workshop were used by central level BPS as input for guidelines on the forum. The drafting of a Ministry of Home Affairs Decree will serve as the legal basis for DBF replication and expansion. The central BPS expects the decree to be finalized and approved by the Minister of Home Affairs in 2010.

Factors that contribute to or hinder the success of DBFs

Support of local government (District Head/Regional Secretary/Bappeda) through legal recognition of the forum and active participation from DBF leaders and members is a key factor to the success of DBF implementation. The success of each DBF also depends on the qualifications of its members, how long it has been operating, its capacity to respond and address issues raised in forum discussions, and how the forum communicates with other local government members (SKPD) and decision-makers on agreed issues, among others. On the contrary, minimum support of local government, improper selection of DBF members, high member turnover, and failure to accomplish tasks can hinder DBF performance.

Conclusions

PDS programme

CP7 performance in supporting the thematic area of population and development strategies (PDS) varies by region (province/district), which may be related to varied implementation of the three key activities of the programme (DDA, trainings, and DBFs). The programme is dynamic, linking activities of the subnational statistical yearbook, trainings for data utilization and data base forums, while optimizing the roles of various institutions (Figure 2)—which is a key factor in meeting programme goals (outcome/output). However, the evaluation found limitations to how programme implementers linked the three key activities, as elaborated in previous sections. It is unlikely that the programme will meet the targeted outcomes and outputs within the remaining time frame of the CP7, which ends in
The evaluation also found that with existing resources, there is potential to sustain and strengthen the PDS programme in the future.

Taking a closer look at one of the sub-components of the PDS programme, CP7 support for the development and dissemination of subnational statistical yearbooks (DDA) was found to result in greater ownership among partners which is reflected in the consultative implementation processes and drive to advocate for the use of the DDA in the local planning policy making. There are also visible improvements in the quality of data—especially for disaggregated data, and its distribution to the general public through websites. However, the evaluation found that the usage of the DDA as a reference for evidence-based planning and policy making is still limited. Challenges in publishing the yearbook in time for local planning processes resulted in planning and decision making to proceed without using the DDA as a reference point. The format in which the data is presented was also perceived by “users” difficult to use—which may also be linked with the user capacity to interpret and analyze the data for planning and decision making. Users also claim that there is variation in the data that is available in the yearbook, since not all disaggregated data that has been targeted by the programme to be included in the DDA is available.

On the issue of trainings that were carried out with CP7 support, the evaluation found that the results of the training depend on the skills of trainers in adopting modules to meet local needs. Since the content of training modules was designed for specific types of personnel, training achievements depend on the appropriate selection of participants. Many districts were found to be unable to select appropriate participants for training, both for trainings that aim to strengthen capacities to develop the DDA and to use the data for planning and policy making. This is partially due to the low commitment of the implementing sectors. Although training has contributed to increasing partner capacities in understanding issues linked with data and statistics, as well as the knowledge of existing data systems among implementing partners, high turnover of personnel and the level of commitment from decision makers within implementing partner agencies has compromised the overall effectiveness of the PDS component. The programme placed too much focus on the training designed by Central BPS-Statistics, without sufficient attention to other contributing factors including local needs and capacities.

Another sub-component of PDS support in CP7 is the database forum (DBF). The evaluation found that DBFs are appreciated by all stakeholders in the coordination and sharing of local data and statistics, promoting common interests related to data and information needs. However, the performance of forums varied by region, depending on the support of local decision makers, membership, and experience—since not all DBFs were established at the same time. The forums have been used as a space to discuss various issues related to district/sector needs, such as the possibility of additional indicators to be included in the DDA, the need for follow up activities related to the development of the DDA and capacity development trainings. There is also potential to establish DBFs in additional districts and at the subdistrict level.

**Suggested Recommendations for PDS for the Eighth Country Programme**

To strengthen national and subnational information systems, in order to promote evidence-based planning and decision-making. At the national level, there are two data sources that should be explored for further capacity strengthening. These are the population census and the vital registration system. To optimize the use of data from the population census carried out in 2010, UNFPA Indonesia should continue support to strengthen the institutional capacity of BPS-Statistics Indonesia in the preparation and analysis of data findings from the census for the general public as well as for planning and policy making. The next country programme should also support capacity building and promote dialogue on the aspects of vital/population registration systems. At the subnational level, PDS should tap into its potential to support the establishment of a standardized District Information System as elaborated in previous sections (see Figure 3). The evaluation found
that trainings and technical assistance continue to be a necessity to strengthen the capacities of institutions, as well as planner and policy makers, and therefore should be continued. Capacity building efforts should also put emphasis on reinforcing linkages between the three country programme components of population and development, reproductive health and gender. There should also be stronger efforts to promote the availability and usage of data to meet evidence-based planning and decision making needs of local governments. For the remaining part of CP7, limitations in the timely production of DDA to planning cycles may be overcome by exploring the potential to prepare and use data from existing systems already stored in BPS and sector departments for evidence-based planning and decision making.

**To explore the potential to replicate country programme achievements.** The Database Forum (DBFs) is perceived as a success story of the PDS Programme in CP7, promoting dialogue and coordination of local data and statistics needs. UNFPA and its partners should explore the potential for replicate these forums at the subnational levels. Specific guidelines on how to establish DBF at different administration levels should be developed based on experiences drawn from CP7 implementation.

Overall, in the Eighth Country Programme, the PDS programme should prioritize districts with successful PDS experience for selection in the CP8, instead of selecting new districts. To further enhance programme objectives in promoting data usage for evidence-based planning and decision making, the programme should further explore potential to support policy researches to ensure data availability for policy making and to strengthen local capacities for data preparation and interpretation.

**Recommendations for PDS Exit Strategy**

Not all districts covered in CP7 will be supported in CP8. For those districts that will not be covered by CP8, it is recommended that UNFPA develop exit strategies as a means to consolidate and sustain achievements in PDS. Among the three activities of the PDS programme component, the DBF is considered a best practice, widely appreciated by stakeholders at the district level. Therefore it is recommended to develop a district level exit strategy for DBF.

During the remainder of CP7, DBFs can be used to underscore the importance of using data for district development and towards finding solutions to sustain best practices by mobilizing local/other resources. It is recommended that the following issues be raised through DBF to help guide decision makers at district level (Bupati/Walikota/Sekda) for solutions:

a. Have PDS programme activities (Figure 2) been implemented properly to meet the stated outcome/output? Is there sufficient common understanding among DBF members/stakeholders that the PDS programme is linked to District Information System (DIS) in order to meet its stated outcomes/outputs? What is the status of existing DIS? Are there alternatives that are more suitable to district needs?

b. Is there agreement on the continuation of the PDS programme or is there an alternative? Can local or other potential resources be mobilized to support PDS programme?

There are two projects involving the Ministry of Home Affairs and BPS-Statistics that are now underway that may also involve most of CP7 provinces/districts, which are also in line with PDS programme objectives. The two projects are Sustainable Capacity Building for Decentralization (Ministry of Home Affairs) and The Change and Reform for the Development of Statistics, also known as the STATCAP-CERDAS project (BPS-Statistics).

The first project involves intersectoral capacity building of government institutions at different levels of administration (central, province and district). Specifically, capacity building is directed towards 10
cross-cutting functions: general administration, budgeting, inspection, law stipulation, organization development, human resources management, information communication, development planning, monitoring and evaluation, and procurement. The project covers 38 districts/municipalities in 10 provinces, including a number of CP7 districts.

The second project or STATCAP-CERDAS is a five-year program to modernize BPS to meet future challenges of the statistical agency. The project will be implemented from 2010 to 2014, and aims to enhance the statistical system of Indonesia by improving the quality of statistical products produced by BPS-Statistics Indonesia, as well as increasing the confidence of users to utilize statistics through effective engagement and understanding of user needs.

By integrating with these two ongoing projects, provinces and districts may realize important opportunities to sustain achievements of the PDS programme.
4.3 Gender (Outcome 5)

Outcome 5: Strengthened institutional mechanisms, socio-cultural values and practices to promote and protect the rights of women and girls and to advance gender equity and equality.

Output 5.1 Enhanced capacity of government, non-government organizations and civil society organizations, community and the media to prevent and manage gender based violence and other harmful practices based on the statutory, judiciary, customary and religious texts relating to the rights of women and girls (G101).

Overview:

The establishment of gender based violence (GBV) prevention and management services has been a central focus of the CP7 Gender component. The establishment of these services requires a multitude of interventions ranging from strengthening human resources to the establishment of multi-sector coordination mechanisms and policy advocacy. UNFPA’s commitment has focused on improving the range of services, strengthening the capacity of service providers, strengthening local commitment to GBV management, and advocating for increased budget allocations to ensure sustainability through increasing the understanding of the key stakeholders about GBV and the special approaches required.

Following the Mid-Term Review in December 2006, two gender component outputs were merged into one. The overall focus of the programme - prevention and responses to gender based violence - did not change, but the emphasis of the programme shifted to enhancing the capacity of the Government and civil society to address gender-based violence. A roadmap that focused on strengthening the capacity of stakeholders to provide services to victims of GBV was adopted. Less focus was placed on IEC and BCC, and part of the prevention work was transferred to the advocacy and demand creation outcomes under the RH programme. This resulted in the revision of the output indicators which became:

1. Three service points (medical, law-enforcement, shelter/psycho-social assistance) in 18 priority sub districts (nine districts) are delivering an integrated–minimum standard assistance to victims/survivors of GBV.
2. GBV prevention and management include monitoring and evaluation systems that are integrated in provinces and districts related sectors work plans and local budget.

Five interrelated strategies were developed to guide the achievement of the output by 2010:

1. Strengthen capacity and partnership between the government, law enforcement, NGOs and CSOs through a provision of systematic and ongoing technical assistance to enhance the capacity of three service points at district and subdistrict level to provide immediate and integrated services with the use of minimum standard services to victims/survivors of GBV/VAW.
2. Provision of technical assistance to assist report and recording (R&R) chain from sub-district to national level works.

7 G104: Increased awareness among communities and the media of the statutory, judiciary, customary and religious texts and laws relating to the rights of women and girls; G101: Enhanced capacity of the Government and women’s institutions to reduce gender-based violence and other harmful practices

8 The indicators that were used prior to the midterm revision were: 5.1.a Five service points (medical, law-enforcement or shelter/psycho-social assistance) in each district capable of delivering comprehensive assistance to victims of GBV; 5.1.b National and sub-national strategies and work plans (including monitoring and evaluation mechanism) at each district and province in place to reduce GBV occurrence; 5.1.c At least once a month an article/public statement (by Government, NGOs or civil society members/organizations) published/aired on the rights of women and girls, prevention of GBV and other harmful practices in each district and province
3. Strengthen multi sector working mechanism and coordination for GBV at district and subdistrict level.
4. Capacity building focused on increased ability of Bappeda, staff of planning unit of related sectors, GBV Working Group, Local Committee of Budgeting to advocate for additional proportion of the budget for GBV/VAW management in sectors planning, budgeting, monitoring and evaluation.
5. Advocacy for policy making of the management of GBV/VAW to policy makers and parliamentarians (Commission of Social/Health/Welfare, Committee of Budget) at district level.

Since the Mid-Term Review, CP7 focused on supporting the Ministry of Women’s Empowerment and Child Protection (MoWECP) to develop and provide a minimum standard of services to victims of violence against women and children (MSS VAW&C) at the district level. The target was set to strengthen the service delivery points at the sub-district level (two sub districts in each district) of nine targeted districts.³ The selection of the nine districts out of the original 21 districts was based on the commitment of the district Women’s Empowerment Office (WEO). Two other determinants were taken into consideration namely: (1) the absence of any services related to GBV response (Sintang, Landak, Sumba West and Alor), and; (2) the potential to significantly improve existing services in a relatively short time with targeted interventions (Manggarai, West Lombok, East Lombok, West Aceh and Singkawang). The focus on nine instead of 21 districts resulted in an increase of the budget allocation for the nine districts from $7,000 annually to around $ 22,000 annually. The programme approach after the Mid-Term Review is the focus of the current evaluation.

Table 9: Overview on GBV Indicator 1: Three Service Points in 18 Priority Sub Districts

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health providers</td>
<td>18 Community Health Centers</td>
<td>18 Community Health Centers</td>
</tr>
<tr>
<td></td>
<td>(78% of which showed sustainability)</td>
<td></td>
</tr>
<tr>
<td>Police Offices</td>
<td>17 Sub-district police</td>
<td>17 sub-district police</td>
</tr>
<tr>
<td></td>
<td>(62% of which showed sustainability)</td>
<td></td>
</tr>
<tr>
<td>Community Based Centers</td>
<td>5 community based centers</td>
<td>14 community based centers</td>
</tr>
<tr>
<td></td>
<td>(28% of which showed sustainability)</td>
<td></td>
</tr>
</tbody>
</table>

Under CP7, UNFPA support focuses on building the capacity of district stakeholders such as the WEO, the District Health Office (with the puskesmas and district hospital), District Police Office (POLRES) (with the women and children service unit or UPPA) and the subdistrict police office (POLSEK), as well as local NGOs and Faith Based Organizations (FBOs) in establishing/delivering services for victims of violence against women. This approach later influenced the newly released Ministry of Women Empowerment and Child Protection Regulation No.1/2010 on the Minimum Standard of Integrated Services for Victims of Violence against Women and Children, which specified the services into five spheres: complaint mechanism, health recovery, social rehabilitation, law enforcement and repatriation/social reintegration.

Findings: Effectiveness

The initial plan established in 2006 for capacity building focused on the establishment of a pool of trainers at the province level. This pool would be trained at the central level by the central ministries and upon their return to the province, would train personnel at the district level. In practice, the lack of hands-on experience in handling GBV cases made it a challenge to establish a pool of

³ Support during the CP7 cycle was also provided to 2 districts under UN Joint Programme (Belu and Jayapura) but the programme and interventions there are here not evaluated.
qualified trainers. The dissemination of knowledge was also hindered by the frequent transfer of personnel that were selected as trainers to other positions or even other provinces. The training module that was intended to be shared with district officials remained in the custody of the trainer even though this person was no longer involved in the GBV programme. In those cases when the trainer did provide the trainings to district officials, the effectiveness of the training was reduced due to budget constraints which shortened the training duration.

Follow up support in providing training and mentoring from the central level was often absent, due to the shortages of human resources at the central level. To overcome this setback, consultations between WEO officers and programme managers at MoWECP and UNFPA resulted in the recruitment of an external consultant in 2009 to closely monitor and evaluate progress across 18 subdistricts to achieve the goals of the first indicator and provide technical assistance on how to improve these services. Although the impact of the this technical support on overall skills of GBV service providers was not closely observed in this evaluation, in-depth interviews showed that providers perceived that training and mentoring improved their skills in service delivery and increased their confidence in working with and understanding GBV victims. However, the high turnover rate of trained staff continues to have a detrimental impact on the quality and sustainability of the newly introduced services.

In 2009, after the first monitoring visit of the consultant to the nine districts, it was realized that the Women Empowerment Officers in charge of GBV coordination and programming at the district level lacked the necessary understanding of comprehensive GBV programming, including prevention, one-stop crisis centre or integrated service centre, coordination and monitoring-reporting—evaluation, and were unclear about how to translate the disseminated G101 roadmap into annual work plans. In an effort to address this gap, a short course on GBV programming was organized by UNFPA for the district Women’s Empowerment Officers. Based on in-depth interviews, participants of the training perceived that the trainings had a positive effect in addressing the knowledge gaps in local level coordination and programming of GBV prevention and response.

**Prevention**

UNFPA complements local government efforts that are focused on GBV prevention by providing support for interventions that focus on GBV case response through its programmes in CP7. However, respondents conveyed their perception that local government activities in the prevention of GBV are generally ineffective, highlighting the lack of monitoring of these efforts and raising the question of whether or not these efforts—such as counseling—have yielded results. Seeing the gaps in local government efforts on GBV prevention, UNFPA developed two modules to support dissemination of the Laws on Domestic Violence and Anti Trafficking for the Family Welfare Movement (PKK), tapping into PKK’s potential to reach grass root level communities nationwide to disseminate knowledge on laws concerning GBV issues. The domestic violence module has been adopted in Alor and the anti-trafficking module was adopted in East Lombok. However, PKK branches in other areas have shown little interest in adopting the module mainly due to the absence of technical support from the central level.

**Health Providers**

Health services are provided by subdistrict puskesmas and the district general hospital. Through CP7, health services for victims of violence have been introduced in two puskesmas and the district hospital in each of the nine districts. In each of the targeted centers, CP7 has supported the introduction of the following services:
- In-house training for health workers (doctors, nurses, midwives) to identify victims of violence and to provide medical treatment and counselling.
- Victim-oriented counselling on violence.
- Recording and reporting.

In 2006, UNFPA and the MOH developed a training module on management of GBV victims in health settings. Provincial Health Officers and doctors of provincial hospitals were trained as trainers to share their knowledge with the districts under their coordination. The follow up training for the district level was organized for the following year, but as mentioned above, by that time many of the trainers were no longer available. After the Mid-Term Review, trainings for health personnel were provided by experienced GBV experts.

Under the law, health providers are responsible for the provision of medical services for victims of GBV (free for poor people and victims of trafficking). Victims can also seek counselling services at the puskesmas and hospitals, as well as obtain information on their rights under the law and how to report their cases to police. In addition, they receive information on reproductive health, including HIV/AIDS and other STIs.

Overall, puskesmas and hospitals visited during the evaluation are meeting the minimum standards of service to victims of GBV. Puskesmas use medical records with a body map to record signs of physical violence, and provide appropriate information on referral to other support services such as the police and/or shelter services. Each of the CP7-focused health centres has at least three to four trained staff to manage GBV cases.

The achievements of CP7 are more obvious when compared to GBV services available in non-CP7 control areas. Despite national policies supportive of GBV services, in puskesmas and district hospitals near CP7 subdistricts that had not received CP7 support, specialized services for GBV were largely unavailable, and health workers had not received special training in the treatment of GBV victims. Non-programme sites furthermore had no system in place to record cases. Only Singkawang district has responded to this issue by implementing special services for victims of GBV in non-pilot health facilities, although resources are limited in those facilities as compared to those supported through CP7.

**Psychosocial services**

Psychosocial support and social rehabilitation services for victims of violence were also introduced as part of the GBV intervention of CP7. These services are provided in partnership with NGOs and FBOs, since these organizations were considered to have the potential to provide services for victims of GBV.

In addition to the NGO partners, CP7 purposefully selected West Aceh, Alor, Landak, and Sintang to be among the nine target districts as they did not have a strong local NGO active in the area of GBV. By design, these four districts were supported to establish a model on the provision of psychosocial services through PKK, rather than through NGOs. A series of activities was supported including a study visit to a similar model in Yogyakarta, the dissemination of a manual on how to establish these services, and training.

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10 Such as the Ministry of Health Circular Letter nu.659/2007 on encouragement to establish one stop crisis center at hospital and victim services at Puskesmas.
11 PKK is Family Welfare Movement, started in the 1960s in Central Java with the goal of alleviating village poverty. It expanded into other provinces in the following two decades and has been involved in community health, family planning and education. Nationally, the head of PKK is the President’s wife; locally the head is usually the wife of the governor or mayor. PKK was formally established nationwide in December 1972 by the Ministry of Home Affairs Circular No.SUS.3/6/12.
12 The PKK have cadres almost in every village in Indonesia and their mandate is family welfare and women’s empowerment.
In Manggarai and Landak, the approach was designed in response to the explicit request from local officials to work with the established community/tribal justice system. The psychosocial services for GBV victims were to be provided by the Customary Court / Forum. Both fora (Manggarai has a Forum Lonto Leok and Landak has Dayak Tribal Council), conducted mediation and fined perpetrators of domestic violence. CP7 worked to introduce the gender perspective to council members. Overall, it is questionable whether the investments have been efficient, as evidenced by the small number of GBV cases which have been brought to the council (one to five per year). Further evaluation is necessary to understand the effectiveness of the tribal council as a mechanism to resolve domestic violence and GBV cases.

Another approach, working with the pesantren (Islamic boarding schools), was applied in West Nusa Tenggara (NTB), a dominantly conservative Muslim province in east Indonesia. In NTB, the Pesantren model is a replication of Puspita (women’s crisis center) applied within the Pesantren.13

For the Pesantren model, UNFPA supported training, on-site technical assistance, and a study visit to more established centers for senior staff from the four selected pesantren. Notably however, only one (Darul Nadwah) out of the four pesantren has delivered up-to-standard services. Constraints in providing technical assistance were related to ideological differences between the NGO providing technical assistance and other pesantren. Small grants were also provided to the four pesantren which were used to renovate the space assigned to function as an overnight shelter and counselling room. The local WEO in West Lombok and East Lombok supported the replication of Puspita in the three other pesantren (Nurul Hakim, NW and Anjani).

Overall, the psychosocial services of pesantren are more robust compared to the government-led psychosocial service such as P2TP2A. The commitment of the leaders of the involved NGOs is often a decisive factor in the stronger commitment and deeper understanding of the GBV issues.

**Table 10: Overview of Psychosocial and Shelter Services Provided in CP7 Areas**

<table>
<thead>
<tr>
<th>Shelter and psychosocial</th>
<th>Psycho-social</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government run</strong></td>
<td></td>
</tr>
<tr>
<td>Shelter (East Lombok), P2TP2A (Singkawang, West Aceh)</td>
<td></td>
</tr>
<tr>
<td><strong>Civil Society run</strong></td>
<td></td>
</tr>
<tr>
<td>PSM (West Sumba), Convent’s Gembala Baik(Manggarai), Pemantik (Manggarai)</td>
<td>FPKHP (West Sumba)</td>
</tr>
<tr>
<td><strong>Religious organizations</strong></td>
<td></td>
</tr>
<tr>
<td>Pusat Kesehatan Pesantren (East Lombok), East Lombok (Anjani), Darun Nadwa (West Lombok), Nurul Hakim, (West Lombok)</td>
<td></td>
</tr>
<tr>
<td><strong>Community run</strong></td>
<td></td>
</tr>
<tr>
<td>Ihsan Gaseh Sayang (West Aceh)</td>
<td>Lonto Leok (Manggarai), Forum Adat Dayak (Landak),</td>
</tr>
</tbody>
</table>

Among the nine districts, Alor district showed very little progress in the establishment of psychosocial support services. This is primarily due to the lack of local ownership of the initiative, following the departure of a key GBV proponent in 2008. Since then, the commitment to establish a P2TP2A in 2009 is yet to be translated into real action.

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13 The Puspita has been developed by Puan Amal Hayati (PAH), a faith-based NGO, under CP6.
With regards to improving the quality and range of psychosocial services provided at the district level, the achievement has been below the initial expectation. The establishment of fully functioning shelters for victims of GBV is considered successful in only four out of the nine districts. With the support of CP7, West Aceh and West Lombok managed to establish shelter services and Singkawang and East Lombok (which already offered these services prior to CP7), improved the range of services offered.

Specifically, it is found that local partner NGOs and FBOs are comprised of volunteer workers with different educational backgrounds, and only in rare cases do these NGOs have staff with the professional qualifications necessary to provide psycho-social support. Interviews with counselors revealed that the concept of psycho-social support is limited to "listening to the victim". Similarly, another constraint relates to the institutional weakness of NGOs that are active in the area of GBV. This is partly due to their being composed of volunteer staff and because most of them are relatively new to the issue of GBV. Overall, the psycho-social services provided are still very much at a nascent stage and continue to depend on volunteer non-professional counselors whose sole training on psycho-social support has been through the UNFPA-supported training activities. Although discussion was facilitated among the service providers to promote sharing of experience and constraints in managing cases, this approach was not fully effective since the providers’ themselves lack sufficient experience and expertise. It would be more effective to facilitate knowledge sharing among the target service providers with more established service providers. However, it is important to note that sustainability of the shelters appears to be promising, since the operational costs have been shouldered either by the shelter or by the government and overall commitment from the shelter staff is high.

Law Enforcement

The Indonesia National Police Regulation No.10/2007 decreed by the Head of the National Police mandated the establishment of a Women and Children Service Unit (UPPA) at provincial and district police offices. These UPPAs are to have a special service room (RPK) to interview victims of GBV. Most UPPAs are equipped with female police officers, who graduated from the Police Women School (Sepolwan) and received specialized training in how to deal with GBV cases and how to manage the UPPA.

To increase the quality of services delivered through the women and children service unit (UPPA), CP7 supported activities to equip the unit to provide a better working environment for officers responsible for service delivery. In Alor and West Sumba, the UPPAs were established as a result of CP7 advocacy and funding. The commitment of the CP7 programme to equip the special service rooms for GBV victims was perceived as the driving force for the POLRES—situated in the district capital—to provide space for the room in the building. In-depth interviews with the police also showed that establishment of the RPK was perceived to have had a positive effect on the deepening the understanding among members of the police force that GBV is a serious issue that deserves specialized attention. Furthermore, CP7 succeeded in ensuring that most officers at the UPPA-POLRES in the nine selected districts attended courses on VAW&C. The trainings and follow-up activities (e.g., periodic workshops), succeeded in establishing a core group of officers who are knowledgeable about VAW&C and the law enforcement regulations governing the victims. Most of the police officers that were interviewed in POLSEK and POLRES have conveyed that, their understanding on the laws concerning GBV and other gender issues, have increased. A number of these police officers also expressed the change of their personal views on GBV cases, from the
tendency to blame the victim to a heightened awareness to apply a human-rights and gender sensitive approach to victims of GBV.

The POLSEK—situated in subdistricts—must also address VAW&C cases. However, the POLSEK does not have a women and children service unit and a police woman is rarely assigned to a POLSEK. Most of the officers (a POLSEK normally employs between 15 and 20 police officers), are policemen who graduated from the provincial police school and did not receive any courses on how to handle cases of VAW&C.

In response to the gap in the capacity of police officers working at the subdistrict level, noted in the Mid-Term Review, CP7 refocused its programme interventions on building the institutional capacity of POLSEK to handle GBV cases. Starting in 2008, a series of trainings were carried out aimed at strengthening the capacities of criminal investigators and POLSEK officers in managing VAWC cases. The CP7 also supported efforts for better coordination among stakeholders at the district level—including representatives of community health centres, psychosocial support providers, as well as POLSEK officers—on how to improve the management GBV cases.

Based on evaluation findings, CP7 initiatives to strengthen law enforcement capacities in responding to GBV are found to be dire need of strengthened monitoring to ensure knowledge dissemination of trainings. Through qualitative investigation, it was found that trainings were not accompanied by the transference of knowledge within the POLSEK—which is considered the responsibility of police officers14 who received training to share the training content to those that did not. The special service rooms that are available for victims of GBV are small and do not provide privacy for victims. One of the challenges is also institutional, where the programme is influenced by the mechanisms set in place within the chain of command of the police. No female police officers were available at the subdistrict POLSEK for victims of GBV—who are mainly women. The police chain of command have not assigned female police officers at the subdistrict POLSEK, however female officers are assigned at the district POLRES. In this case, POLRES officers have a referral system in place to refer GBV cases to the local hospital or community health centre, or if necessary, to the POLRES. A severe GBV case—such as rape—may be forwarded to the district level police headquarters. In some cases, a female police officer from district POLRES may be sent to the subdistrict POLSEK to handle the case—under the consideration that a female GBV victim would be more comfortable communicating with a female police officer.

Despite these continued challenges, interviews have shown that the decision to pay special attention to incorporate the gender programme to strengthen the POLSEK is deemed appropriate, since most of the cases, which are mainly considered as “non-severe”, are settled at this level. Important initial steps have been taken to improve the capacity of the POLSEK. Given the short time of implementing activities at the subdistrict level, police officers interviewed perceived an increased awareness on the recognition of GBV as a crime that requires police officers to apply a different approach to its case management compared to other types of crimes.

At the national level, the programme supported the Supreme Court to conduct trainings for local judges in understanding the scope of the Law on Elimination of Domestic Violence and the Law on Anti Trafficking. Due to limitations in the time and resources of the evaluation, observations on how the training impacted local judge decisions in handling domestic violence and trafficking cases was excluded from the current evaluation.

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14 One or two police officers from each POLSEK are provided with training in handling GBV/VAWC cases.
Challenges: Case management by the police

Only a small proportion of reported VAW&C cases actually reach the courts. From all reported cases, victims would drop charges 80 to 90 per cent of the time. For example, POLSEK Singkawang Selatan reported that out of eight cases only one went to court. Similarly, in the East Lombok POLRES, only 10 out of 108 cases went to court. Interviewed police officers emphasized that the Domestic Violence Law is not in place to dissolve marriages and thus the first priority is mediation. According to the police officers, often the victim sees filing a complaint as a way to stop the abuse, instead of filing charges and bringing the abusive spouse to justice. Often after the police talked with the perpetrator and the perpetrator pledged to stop committing violence, the victim would drop the charges. However, in cases where the victim suffered life threatening injuries, the case would be prosecuted.

To date, there are no clear mechanisms in place for the police to mediate domestic violence concerns, nor are there any criteria on when mediation is deemed appropriate. One common practice is that the police ask the suspect to sign an agreement letter stating that he will not commit any violence in the future. Adherence to this letter of agreement may be overseen by the community leader and family members.

Since the Domestic Violence Law is based on a complaint mechanism rather than the criminal code, victims are allowed to withdraw the complaint at any time. However, in severe cases, the police apply the penal code as well in order to ensure that even if the charges based on the Domestic Violence Law become irrelevant, the penal code would be in effect to prosecute the perpetrators. However, the capacity of the police, to follow up on mediated cases, are still lacking. Police officers interviewed reported they have no difficulties referring cases to prosecuting attorneys and therefore would often do so. Recognizing the important role of prosecuting attorneys and judges in GBV cases, CP7 provided support to efforts that promoted comprehensive coordination of local stakeholders involved in the management of GBV cases, involving prosecuting attorneys and judges in the GBV prevention and management network.

Gender Based Violence Prevention/Management Networking System (P2TP2A)

Coordination for effective integration of different GBV related services is one of the main indicators of success of the CP7 GBV strategy. P2TP2A is responsible for the coordination and management of VAW&C cases. A P2TP2A is usually headed by the Governor or District Head’s wife and co-chaired by the Head of the Women Empowerment Office. As such, the P2TP2A is theoretically well-positioned to advocate for funds from the local government budget. These funds are to be used to provide basic support to victims of VAW&C. This support can include a range of services including paying for a medical examination, or accessing legal aid in instances when the victim wants to bring the case to court. P2TP2A offices usually also provided counseling services, referral, and in some cases, temporary shelter.

Through CP7, UNFPA introduced the P2TP2A concept in seven districts. East Lombok and Singkawang had already established the P2TP2A, and provided technical assistance to establish the P2TP2A. West Sumba remodeled the existing “Forum for Improving Women’s Quality of Life” based on the functions of P2TP2A. West Lombok, Sintang, Landak and West Aceh took up the P2TP2A model as a coordination mechanism. Manggarai and Alor have shown commitment and received technical assistance, but to date, no officer has been assigned to be in charge of the P2TP2A and no office space has been allocated for them. In West Lombok and East Lombok, the P2TP2As have a full-time staff member who is effectively coordinating services and mobilizing service providers such as hospitals and puskesmas, NGOs, police, prosecutors, and judges (law enforcers). These two P2TP2As have been effective in holding regular coordination meetings at least monthly, and case
management/conference\(^{15}\) meetings. The P2TP2A in East Lombok is also providing shelter services and providing support in accessing free legal aid. During these meetings, P2TP2A staff monitors and evaluates the progress of GBV cases that have come to their attention.

The P2TP2As in Sintang, Landak, and Singkawang of West Kalimantan are relatively under-developed. Most are run by voluntary boards and do not have permanent staff. Most of the coordination meetings are still dependant on UNFPA support (West Aceh, Landak, Sintang, and Singkawang), and have not been able to a secure regular funds from the local government. With no financial and human resource support from the local government, the P2TP2A may be faced with a challenge in ensuring sustainability of these efforts in the absence of UNFPA support.

**Recording and Reporting System**

The national recording and reporting (R&R) system for VAW&C in Indonesia was developed in 2006. This paper-based registration system has been developed to help the MoWECP to compile data from GBV service providers throughout the country. Services providers are requested to provide a quarterly summary of their service statistics and share this with the district Women’s Empowerment Office. The district WEO has the responsibility of compiling all available data and sharing it annually with the provincial WEO, which in turn forwards the information to the MoWECP.\(^{16}\)

Since 2006, CP7 have supported trainings to the puskesmas, POLRES, district WEO and other psychosocial service points in order to introduce the recording and reporting mechanism. The puskesmas, POLRES and psychosocial service delivery points have also received the standard forms for reporting and the puskesmas. The psychosocial service delivery points received enough case-record forms to last at least five years.

An initiative to increase ownership of recording and reporting functions by raising this issue as a topic during the quarterly coordination meetings appears to have increased commitment. Interviewed WEO officers stated that the CP7 subdistricts have been more forthcoming with the quarterly data than non-CP7 sub districts. In seven out of the nine districts the P2TP2A/Women Empowerment Officer managed to include the data in the Subnational Statistical Yearbook (DDA).

The reporting of referrals is rarely and inconsistently recorded. The puskesmas and the POLSEK do not record cross sector victim referrals. In the current state, they only record victims that had been referred to a higher level institution, for example from puskesmas to hospital or from POLSEK to the UPPA-POLRES. This is due to the generic template used for the recording and reporting of cases at the POLSEK and the puskesmas, which does not include a section that records referrals to other institutions (cross sector).

There evaluation found that the R&R system runs consistently in UNFPA-supported areas and has potential to provide a critical evidence-base advocacy for higher level of support from local authorities to address VAW&C. The data for 2008 and 2009 in Table 11 below was generated by the R&R system.

\(^{15}\) Case management /conference is a meeting among the GBV service providers to discuss how a case is managed by each service providers, victim’s progress and follow up plan for the victim/survivor.
Table 11: Data from R&R System on GBV Victims Supported in through Different Providers

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centers (Puskesmas and District Hospitals)</td>
<td>468</td>
<td>371</td>
</tr>
<tr>
<td>Police Offices</td>
<td>488</td>
<td>326</td>
</tr>
<tr>
<td>Community Based Centers</td>
<td>482</td>
<td>841</td>
</tr>
</tbody>
</table>

(Source: Data from Health and Community-based Centres and Police Recording and Reporting System in UNFPA-supported areas from 2008 to 2009)

Service providers demonstrate strong commitment to the R&R systems. At the same time, however, it was observed that it is still a challenge to record whether a victim receives the full range of different types of support services (through the police, the shelter and psychosocial and health). This needs to be improved further in CP8. The trend of victims going to community-based centers (for psychosocial services) instead of the hospital or the police needs to be further analyzed, especially given findings that this service is the weakest.

Finally, it is noted that the United Nations Children’s Fund (UNICEF) has also provided support to the MoWECP to develop an R&R system that records cases of Violence Against Children. This computer-based registration system was finalized in 2009 and though the objective is similar, the format of the system is slightly different. In practice, these systems overlap and this has created some confusion among service providers, as they are now supposed to fill in two R&R forms. This problem was most obvious in NTB, where both UNFPA and UNICEF are piloting GBV&C programmes.

*Other findings*

The challenge of coordination between UNICEF and UNFPA in the area of gender based violence extends beyond the R&R system. In NTB, both UNFPA and UNICEF are working to address VAWC in West Lombok and East Lombok (UNFPA more in the area of violence against women, and UNICEF more in the area of violence against children). Both programmes share partners and follow similar approaches, but coordination between the two agencies has been weak to date. There is also a need for improved coordination on these issues at the national level.

In most of the nine districts, services for victims of GBV are new and government budget allocation has been minimal. In most cases, government budget only covers the costs for the dissemination of policies. UNFPA provided small grants to equip facilities, which has contributed to motivating centre managers to continue the provision of GBV services even after CP7. In addition, UNFPA is working to support service providers to offer improved and fully integrated services, through coordination of health, law enforcement and psychosocial support.

While some knowledge sharing has taken place among the WEO officers of the nine targeted districts, no formal knowledge sharing mechanisms are in place. This is considered a missed opportunity since the districts could have learned from the progress that other districts (e.g. Singkawang, West Aceh and West Lombok) have made in addressing GBV.

In addition, CP7 has supported ongoing advocacy for the concrete implementation of the recent legislation on anti-trafficking and domestic violence at local levels. For example, under the anti
trafficking Law No.21/2007, all victims of trafficking are to have access to free medical services. Government Regulation No.4/2006 on Service Delivery and Cooperation for Recovery Assistance of Victims of Domestic Violence has a similar provision. East Lombok District, using a District Head Decree, has ensured that all victims of violence against women have access to medical services. Singkawang District Hospital, however, is not able to provide free services, even to the poor, despite being ordered to do so under the Jamkesmas policy.17

Finally, with regard to the second indicator related to GBV monitoring and evaluation, this has received little priority following the Mid-Term Review, when efforts shifted to focus on achieving the first indicator. The M&E tools and mechanisms, which were developed internally by UNFPA, were disseminated to district WEO officers, but as mentioned above, with the exception of West Aceh, most of these officers have difficulty in fully understanding the concept of GBV. Therefore, by 2010, the M&E tools have only been used to monitor and evaluate the progress of the programme and have not been applied for advocacy purposes.

Conclusion

As stated in the Domestic Violence Law and Anti Trafficking Law, and also enforced in Ministry of Health and National Police policies, the district level is expected to be able to provide service to victims of VAWC. CP7 has succeeded in enhancing the capacity of local Government, non-government organizations and civil society organizations in the targeted nine districts in delivering support service to victims of GBV.

Forty-nine per cent of UNFPA resources for the gender programme are focused on achieving access to three types of services - health, police and psychosocial - in the nine targeted districts. It is noted that increasing access to psychosocial services in the remote districts is particularly unique. The evaluation found that the effectiveness of the psychosocial component has been mixed, with some success achieved in engaging FBOs in NTB and failure in engaging the PKK in the remote districts. The tribal council in Manggarai and Landak, though important in addressing GBV for the local community, are used as the last resort therefore resources have been spent unnecessarily.

The police and the health service are structured to subdistrict level and a range of services are delivered. CP7 has succeeded in raising knowledge and awareness about GBV in a context where limited government funding is available. It is expected that because these services are integrated into ongoing service delivery systems, that they will be sustained by government partners, although quality will likely be a concern, in the absence of ongoing technical assistance.

Despite significant investment in training delivered through CP7, a lack of attention to rigorous and ongoing technical assistance has been detrimental to the programme. Many interventions were not continued or institutionalized following training sessions.

In addition, interventions focused on prevention were approached in a non-systematic way, particularly following the Mid-Term Review. While some activities were pursued through the CP7 advocacy component, prevention activities were not supported through the gender programme, and internal coordination between the demand creation and service delivery was not sufficiently strong to promote reduction of GBV.

The Ministry of Women’s Empowerment has concentrated on developing minimum standards of services and the reporting and recording system. The monitoring and evaluation mechanism is yet to

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17 Jamkesmas is a national scheme for the poor that provides free access to health facilities without cost-sharing.
be a priority. The M&E tools developed for the gender programme has not been adopted at the national level.

Finally, the concept of integrated services is not yet well understood by service providers. Coordination of comprehensive health, psychosocial and police support is not yet introduced, despite early efforts to apply this concept.

**Recommendations for Gender Programme in the Eighth Country Programme**

**Strengthening institutional capacities.** Taking stock of lessons learned in the Seventh Country Programme, there is still a need to refine capacity building approaches so that training is combined with other forms of technical assistance (such as frequent on-site technical assistance visits including feedback and action planning, observation of model services). The next country programme should also aim to promote quality programming, including rigorous monitoring and evaluation, on the prevention of gender-based violence. These efforts should be targeted at local government capacities—mandated with GBV prevention efforts, as well as local NGOs. To strengthen capacities of health, social and police institutions, the programme should aim at integrating curricula focused on awareness raising, skills building, and procedural orientation about GBV and trafficking in pre-service training programmes (universities and academies) focusing on health workers, social workers, and police officers.

**Advocacy and partnerships.** For the next cycle, the programme should intensify advocacy to the National Police Headquarters to provide an instruction to enhance the capacity of police officers who are working in the Women and Children Protection Units (UPPA) and to increase the number of the policewomen in UPPA and POLSEK. UNFPA, through its gender programme, should also increase partnership with the social office in providing psychosocial services/assistance to victims.

**Recommendations for Gender Programme Exit Strategies**

The evaluation found that there are a number of actions that the gender programme can carry out as part of its exit strategy, taking into consideration the issue of feasibility and optimum impact. At the national level, to ease the set up of a monitoring and evaluation system for gender-based violence following the recent launch of the Minimum Standard of Integrated Services for victims against women and children in 2010, partners can adopt the UNFPA GBV programming monitoring and evaluation framework and tailor it to meet the programme quality assurance requirements of their respective departments. Knowledge products on the minimum standards should also be widely disseminated in the districts of UNFPA intervention during CP7. In capacity strengthening, the evaluation found potential in West Nusa Tenggara to support faith-based organizations in delivering high quality psychosocial counseling services. There is also a need to intensify training of Women Empowerment Officers in managing coordination aimed at sustaining comprehensive and integrated VAWC services. As the programme cycle closes, UNFPA should also support and facilitate knowledge sharing of lessons learned drawn from experiences in handling VAWC, across sectors and across districts of UNFPA intervention areas.
Cross Cutting Conclusions, Recommendations

By mid-2010, the programme has achieved 76 per cent of the total budget execution. Among programme components, expenditure rates varied marginally from 78 per cent (gender) to 75 per cent (reproductive health). Similarly, the UNFPA-managed umbrella funds have been expended at approximately 77 per cent. While budget execution has been sluggish, acceleration in spending can be expected as the programme nears completion.

The following issues appear to be cross-cutting in at least two, if not each of the three programme components. As such, they influence CP7 in important ways and should be the focus of consideration in the design of Country Programme 8. Notably, a number of these cross-cutting issues were also raised in the management review conducted in 2008.

It is the general consensus among the evaluation team that while modifications made to CP7 following recommendations of the Management Review and Mid-Term Review were significant, they did not sufficiently redirect programme activities towards a more strategic positioning of UNFPA-supported programming in Indonesia. The team fully appreciates the sensitivity of making profound mid-term alterations to the design of CP7. At the same time, it is also the conclusion of the team that the programme did not take sufficiently bold steps to redress key issues affecting the quality of implementation of CP7, and the potential for the programme to yield lessons to inform replication and policy formulation.

Questions of Alignment, Ownership and Sustainability

There is strong evidence that CP7 is well aligned with government priorities, particularly at the national level. In particular, CP7 relates to the government 2005-2009 National Medium-Term Development Plan (RPJMN), and to the broad 2006-2010 United Nations Development Assistance Framework (UNDAF). In each of its three component subprogrammes, CP7 relates closely to government strategic planning frameworks and plans and indeed, in several instances has supported their development.

In its design process, CP7 focused more on consultation with central level partners. This approach was taken with the understanding that the National Medium-Term Development Plan is the main reference for development planning at the subnational level, ensuring links between national and local priorities.

The limited consultation with provincial and district level partners resulted in CP7 being less well aligned at the local levels. The Strategic Management Review conducted in 2008 also emphasized this point, where the absence of a local level multi-year planning framework, and differences between government and CP7 planning timeframes, were contributing factors to the limitations found in achieving optimum local level alignment.

Issues of ownership are highly complex in CP7 management. On the one hand, Bappenas, as the lead planning and coordinating agency, and the CP7 supervising partner at the local levels, exercises strong oversight of the CP7 management structure. While this certainly reflects and positively contributes to government ownership, there are ways in which the management structure has hampered programme coherence and performance, diverting resources from functions that arguably, could have added more technical value to the programme.

CP7 programme management structure consists of 70 full time staff and consumes approximately 16 per cent of the total programme budget. These staff (two to three in each province and district) function from secretariats commonly located in each of the national partner offices and from the provincial and district level Bappeda offices. At the subnational level, programme managers report to
Bappeda. This extensive programme management structure was mainly put in place to address perceptions that executing the programme would require significant extra work on the part of government employees.

The programme managers and other UNFPA-financed nationally recruited staff undertake a range of generic management functions including programmatic and financial monitoring and reporting. However, as noted in the strategic management review, “lack of clarity in their roles and effective lines of reporting, limited support and training and (at times) strained relations with government colleagues”, have compromised their effectiveness, even in these general programme management functions. Although, theoretically, staff have the potential to be critical actors in coordinating and following up on capacity building, opportunities for strengthening capacities would have further advanced with more provision of technical assistance than what had been offered through the CP7 programme.

As such, the management functions performed by CP7 staff are largely akin to the functions performed by government implementing partners. Under the current circumstances with low investment in technical assistance generally, ironically, the role of national executing staff in the project can be seen to distance the government from its management and ownership of the programme. At the same time, the heavy management structure can be understood to distance UNFPA technical oversight of CP7 in important ways.

Finally, ownership clearly has an important role to play in sustaining programme achievements and approaches. In the public sector, strong alignment on the one hand, and the relatively small financial investments of CP7 on the other would suggest positive potentials for sustainability. However, the evaluation revealed a wide range of perceptions on sustainability.

Doubts about sustainability under these circumstances reflect the limited understanding of the programme linkages to government priorities and plans on the one hand, and the lack of documentation and evidence of programme achievement on the other.

It is still too premature to draw valid conclusions on the sustainability of CP7 support through its programmes for NGOs. Assessment of potential NGO programme sustainability was not an objective of this evaluation. However, it is not too early for the programme to put forward a strategic position about NGO sustainability and to begin to invest in strategies that would promote sustainability of NGO programmes over time.

In conclusion, while CP7 management modalities were a central focus of the strategic management review, the reorientations to the programme during the Mid-Term Review and the revisions to the CPAP did not make the adjustment to these modalities necessary to promote a high quality, government-owned programme.

**Contributions towards Replication and Scale Up**

In each of its three components, CP7 has taken important steps to introduce new programme approaches, such as the introduction of comprehensive services for management of gender based violence, introduction of adolescent RH services, support for RH Commissions, and the establishment of data base forum.

This new programming initiative would have benefitted more if it had been approached as specific pilot undertakings with a strong evaluation and documentation focus and sufficient investment in standardizing its design, in the monitoring, evaluation and documentation of outcomes, and in the provision of technical assistance to ensure quality.
At the same time, most interventions (data base forum is an exception) lacked the sharing of programmatic experience across districts and provinces. This should not be considered a luxury, but rather a critical strategy to promote ownership and scale-up, and strengthen the quality of programmes. In the context of decentralization, creating an environment of shared learning is particularly important towards addressing the challenges of standardization, and the risks of duplication of efforts. Sharing cross-region experiences can also help to stimulate buy-in across districts, and between different levels in order to encourage replication.

**Issues Related to Quality**

The overall quality of CP7 programming is highly variable. One example can be seen through the RH programme component—where there was an opportunity to compare IERH approaches between programme-supported puskesmas and those which didn’t receive CP7 support, significant differentiation in quality was not observed.

Across each of the programme components, there were inconsistencies in the quality of programme implementation, which was mainly the result of insufficient emphasis on capacity building. Investment in technical support to CP7 interventions was rather minimal and as noted above, project modality did not sufficiently engaged technical aspects.

Stronger efforts to ensure the quality of CP7 capacity building initiatives must also be a lesson learned for future activities in this realm. The evaluation found that training approaches supported by the project were not sufficiently distinct from mainstream approaches. Weaknesses in training preparation, selection of participants, training intensity and the lack of attention to training follow up are particularly noteworthy. There is still a need to develop a strategy to strengthen training capacities which would, in turn, provide a sustainable resource for ongoing training and support—which is also challenged by the high turnover of government staff. At the same time, adaptation of centrally-developed training materials lacked coordination and technical assistance.

Similarly, monitoring of programme progress were infrequent and had limited technical rigor. While implementing partners reported feeling generally encouraged by the attention they received through the monitoring visits, few partners could relate a concrete technical outcome of monitoring, and there was little continuity in perspective from one visit to the next.

**Issues Related to Synergies between Programme Components**

The consolidation of programme components did not go far enough in linking the expected outcomes in ways that would create synergies between population and development strategies (PDS), reproductive health (RH) and gender. While result expectations and similarly, financial investments were consolidated following the Mid-Term Review, these efforts did not favor the potentials for synergy between different programme components implemented in the same geographical areas. Coordination efforts among central and district level agencies and staff were notably insufficient. This has contributed to the fragmentation of results across the three components and ultimately to the coherent impact of the programme.

Finally, while the potential for PDS to contribute to the evidence base for RH and gender programming and policy is clearly acknowledged in the design of the component, in practice, this potential has gone unrealized. PDS (particularly DDA) is limited in its potential to provide an evidence base for RH and Gender programming and policy. The implementation of policy research to support better RH and Gender programming and policy through the PDS is partially completed as it supported only two researches out of the planned five. The evaluation concludes that significant achievements of the CP7 relate to the introduction of new areas of programming. These areas are sufficiently aligned with GOI priorities and with the overall vision of ICPD. However, despite steps taken to address important design weaknesses at the mid-term of CP7, critical limitations have persisted.
These limitations relate to the need to address continued fragmentation of project resources, to improve programme management structure, and to strengthen capacity building strategies.

Redirection of programme resources in future UNFPA-supported programmes will benefit from serious attention to the relationship between ownership and implementing modalities, to the redefinition of the strategic benefits of UNFPA support, and to concrete potentials for synergy between the three components.

**General Recommendations**

It is strongly recommended that UNFPA and the GOI work closely together to redefine a strategic niche for UNFPA support. This niche will undoubtedly focus on generation of strategic information, and support for consultation towards policy formulation on the one hand, and the implementation of locally adapted, technically strong pilot approaches which are rigorously evaluated to provide a strong evidence base for scale-up. The repositioning of UNFPA support in Indonesia requires significant and sustained, high level engagement from both UNFPA and GOI.

It is further recommended that UNFPA focus its strategic programme in a significantly more limited geographical area (no more than nine districts in three provinces), selecting a limited number of well defined piloting objectives, in which changes attributable to programme investments can be accurately measured, providing rich insights for programme scale up and policy formulation. The role of the PDS programme component one of which is in providing evidence for evaluation of GBV and RH programming, and their linkages should be further developed. A focused, resourced strategy to promote programme learning across geographic areas and primary and secondary partners is also recommended.

The evaluation team strongly recommends that UNFPA emphasize its globally recognized strategic focus on capacity building, through the development of modalities which prioritize the provision of expert technical assistance. An explicit capacity building strategy for each output should be developed, including a rigorous training approach designed to ensure sustainability of interventions, and routine, technical monitoring of implementation. This will require a concerted redirection of funds, the development of new working modalities and rigorous attention to the building of a quality technical assistance network. In this regard, UNFPA and GOI may consider focusing a capacity building strategy at the province level. Experience from the AusAID health programme in NTT may offer important lessons in this regard, and should be thoroughly explored with GOI partners at all levels.

In line with this, it is recommended that UNFPA and GOI consider alternative management modalities which favor government ownership and implementation on the one hand, and require more limited budget. Project staffing should favor strong technical engagement and oversight. Reference to and further discussion of the 2008 Management Review would likely be beneficial in determining the appropriate structure.

**General Considerations for the Eighth Country Programme**

It is strongly recommended that UNFPA and the GOI work closely together to redefine a strategic niche for UNFPA support. This niche will undoubtedly focus on generation of strategic information, and support for consultation towards policy formulation on the one hand, and the implementation of locally adapted, technically strong pilot approaches which are rigorously evaluated to provide a strong evidence base for scale-up. The repositioning of UNFPA support in Indonesia requires significant and sustained, high level engagement from both UNFPA and GOI.
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**Design Process Considerations for Country Programme 8**

Design of CP8 is already very much underway. On the one hand, pursuing this critical planning exercise without the benefit of the results of CP7 is marginally understandable, given the extent to which programme concerns were well documented at the mid-term and there appears to be reasonable recognition and consensus about ongoing limitations. However, strong concerns remain as CP8 unfolds, in particular regarding persistent risk of fragmentation, the lack of a clear and robust capacity building orientation, and how a capacity building strategy would impact on the definition of CP8 modalities.

Delays in the process of developing the National RH Strategy (2011-2015) further caution against moving forward too quickly. To date, consultation on the strategy has been minimal, creating a risk of misalignment on the one hand and diminishing opportunities for careful definition of evidence-based priorities, opportunities for piloting, and rigorous stakeholder coordination. More attention in particular should be given to the definition of a meaningful and well defined policy agenda and discussion about linkages to evidence required at the field level.

Similarly, it is further recommended that consultation involve target provinces and potential district partners, to ensure alignment with local policy and programme needs, and to build a team of partners that share a common vision. This team will be indispensable in guiding implementation over the years to come.
Finally, it is considered very important that CP8 design efforts involve senior GOI and UNFPA leadership in ways that encourage the significant strategic shifts required on the one hand and pertinent discussion about programme modalities moving forward.

Exit Strategies

Finally, with roughly six months remaining in CP7, the evaluation recommends that opportunities be taken to promote sustainability of CP7 and to share programme learning towards informing future UNFPA and GOI programming. The latter includes, but is not limited to strategic positioning of CP8.

First and foremost, a detailed plan for sharing lessons from CP7 should be developed. The plan should include findings and conclusions from this evaluation as well as and other key evaluations and reports.

Multiple thematic meetings on different programmatic and management topics relevant to CP7 should also be conducted as part of the programme learning plan. In many cases, these should showcase government partners sharing experience from implementation of CP7, and should engage both current CP7 partners and expected CP8 partners. Workplanning towards maximizing and sustaining achievements can also be developed at this time.
## ANNEX 1: RESULTS AND RESOURCES FRAMEWORK, UNFPA Indonesia CPAP 2006-2010

### National priority (2006-2010):
(a) to create socio-political conditions that enable the poor to fulfill their basic rights and to improve their standards of living; (b) to strengthen the socio-political and economic participation of the poor in public decision making; and (c) to give protection and security to vulnerable groups, including female-headed households.

### UNDAF outcome:
(a) strengthening human development to achieve the MDGs; (b) promoting good governance; and (c) protecting the vulnerable and reducing vulnerabilities.

<table>
<thead>
<tr>
<th>Country programme outcome</th>
<th>Country programme output</th>
<th>Output indicators</th>
<th>Implementing Partners</th>
<th>Indicative resources by output (per annum, USD)</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>2.94</td>
</tr>
<tr>
<td>Reproductive Health (RH)</td>
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### Outcome 1:
An improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health information and services at national and sub national levels.

#### Output 1.1 (R 101):
National guidelines and sub national strategies on Reproductive Health, Adolescent Reproductive Health (ARH), Sexually Transmitted Infections (STIs) and HIV/AIDS are developed to ensure access of these services irrespective of marital status, gender, age and sexual orientation.

#### Output indicators:
- 1.1.a National guidelines on ARH developed and adopted in 3 provinces
- 1.1.b Development of guide for inclusion of ARH into local curricula.
- 1.1.c Mechanism to promote Reproductive Health, HIV AIDS prevention and Contraceptive Commodity Security are functioning in 6 provinces and 16 districts.

#### Implementing Partners:
- Ministry of Health; BKKBN; Ministry of Women’s Empowerment; National AIDS Commission (NAC); Provincial AIDS Commission (PAC); National Implementing Agency for Aceh (BRRI); District AIDS Commission (DAC);
- Joint United Nations Programme on HIV/AIDS; other United Nations agencies;
- Civil society organizations.

#### Regular Resources:
- 0.54
- 0.54
- 0.54
- 0.54
- 2.7

#### Other Resources:
- 0.048
- 0.048
- 0.048
- 0.048
- 0.24
## Output 1.2 (R 105):
Increased capacity of lawmakers, decision makers, religious and community leaders, civil society and the media to mainstream issues related to reproductive rights, reproductive health, adolescent reproductive health, STIs, HIV/AIDS and gender into policies and programmes

### Output indicator:
1.2.a A minimum of the 5 biggest political parties that participate in the 2009 General Elections are provided with information on RH, population and gender issues at national and sub-national level

1.2.b Relevant Commissions in local parliaments and relevant government agencies at the district and province level received orientation on guidelines for formulating Perdas on HIV/AIDS and Human Trafficking.

1.2.c At least of 25 religious leaders in each district and all religious marriage counselors at the sub-district level received training on how to communicate RH, FP and gender related issues (including the wrongness of domestic violence) to their followers and/or prospective couples

<table>
<thead>
<tr>
<th>Regular Resources</th>
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<tbody>
<tr>
<td>BKKBN; MOH, MOWE, MONE; National AIDS commission; provincial AIDS commission; district AIDS commission; Joint United Nations Programme on HIV/AIDS; other United Nations agencies</td>
</tr>
<tr>
<td>Civil society organizations such as IPPPO, PKBI, Population Commission, and IPADI</td>
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<tr>
<td>Regular Resources</td>
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<tr>
<td>0.54</td>
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<tr>
<td>Other Resources</td>
</tr>
<tr>
<td>0.048</td>
</tr>
</tbody>
</table>
**RH- CP Outcome 2:**  
Strengthened demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information  

<table>
<thead>
<tr>
<th>Output 2.1 (R 305):</th>
<th>Output Indicators:</th>
<th>Output indicators:</th>
</tr>
</thead>
</table>
| Increased awareness and knowledge among women, men and vulnerable groups, of issues related to reproductive rights, reproductive health, adolescent reproductive health, STIs, HIV/AIDS and gender (incl. GBV) | 2.1.a Number of (1) TV shows and radio programmes broadcasted and (2) IEC materials distributed that promote RH/FP especially IERH and prevention of GBV | • BKKBN; MOH, MOWE, MONE, National AIDS commission; provincial AIDS commission; district AIDS commission;  
• Joint United Nations Programme on HIV/AIDS; other United Nations agencies and civil society organizations. |
| 2.1.b The number of men, women and adolescents attended activities that promoted RH/FP and prevention of GBV in districts where the IERH and/or GBV program is implemented | 2.1.b The number of men, women and adolescents attended activities that promoted RH/FP and prevention of GBV in districts where the IERH and/or GBV program is implemented | |

**Regular Resources**  
| 0.54 | 0.54 | 0.54 | 0.54 | 2.7 |

| Other Resources | 0.048 | 0.048 | 0.048 | 0.048 | 0.24 |

**RH- CP Outcome 3:**  
Increased access to high-quality, integrated, client-oriented and gender-sensitive reproductive health and ARH services and information  

<table>
<thead>
<tr>
<th>Output 3.1 (R 205):</th>
<th>Output Indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthened maternal and neonatal care, with focus to emergency obstetric care, and increased availability of youth-friendly RH information and services, including those focusing on STIs and HIV/AIDS.</td>
<td>3.1.a At least 3 puskesmas in 9 selected districts provide IERH services and VCT services for respective puskesmas are identified. 3.1.b Updates on the status of 24/7 EMOC of district hospitals are made available bi-annually. 3.1.c Strengthened capacity of selected NGOs in providing services for their target groups.</td>
</tr>
</tbody>
</table>

**Regular Resources**  
| 1.08 | 1.08 | 1.08 | 1.08 | 1.08 | 5.4 |

| Other Resources | 0.096 | 0.096 | 0.096 | 0.096 | 0.48 |
### Population and Development Strategies (PDS)

<table>
<thead>
<tr>
<th>Input</th>
<th>Output 4.1. (P 101):</th>
<th>Output Indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved availability and increased capability to utilize disaggregated data on population, reproductive health and adolescent reproductive health, STIs and HIV/AIDS, gender, poverty and enhanced understanding of planners, policy makers and parliamentarians on their linkages with development.</td>
<td>4.1. a. Sub-national Statistical Year Book (Province/District in Figures, DDA) in each district and province incorporated disaggregated data on population, reproductive health, adolescent reproductive health, STIs including HIV/AIDS, gender, and poverty is available for planning and program implementation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.1. b. Proportion of identified planners, policy makers and parliamentarians exposed to on the linkages between population, reproductive health, gender and development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.1. c. Proportion of identified planners and policy makers in each district and province trained in utilizing available data for sub-national development plans (Rencana Strategis Daerah &amp; Rencana Kerja Pemerintah Daerah).</td>
</tr>
</tbody>
</table>

#### Output Indicators:

- BPS-Statistics Indonesia; Ministry of Home Affairs; BKKBN; provincial and district authorities
- Selected national research institutions
- UNFPA Technical Support Division; UNFPA Country Technical Services Team, Bangkok; UNFPA regional projects

<table>
<thead>
<tr>
<th>Regular Resources</th>
<th>Other Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1 1 1 1 5</td>
<td>0.08 0.08 0.08 0.08 0.08 0.4</td>
</tr>
</tbody>
</table>

**Amounts:**

- Regular Resources: 5
- Other Resources: 0.4
<table>
<thead>
<tr>
<th>GND- CP Outcome 5:</th>
<th>Output 5 (G 101):</th>
<th>Output Indicators:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthened institutional mechanisms, socio-cultural values and practices to promote and protect the rights of women and girls and to advance gender equity and equality</td>
<td>Enhanced capacity of Government, non government organizations and civil society organizations, community and the media to prevent and manage Gender Based Violence and other harmful practices based on the statutory, judiciary, customary and religious texts relating to the rights of women and girls.</td>
<td>5.1.a The three (3) service points (medical, law-enforcement, shelter/psycho-social assistance) in 18 priority sub districts (9 districts/municipal) are functioning in deliver an integrated–minimum standard assistance to victims/survivors of GBV</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.1.b GBV prevention and management include monitoring and evaluation system are integrated and functioning in provinces and districts related sectors work plans and local budget.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ministry of Women’s Empowerment; Ministry of Health; Ministry of Social Affairs; BKKBN; parliamentarians; provincial and district authorities</td>
<td>0.66 0.66 0.66 0.66 0.66 3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• United Nations agencies</td>
<td>0.08 0.08 0.08 0.08 0.08 0.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Civil society organizations; media; police</td>
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</table>

Background
The 7th UNFPA Indonesia Country Programme (7th CP) was signed in May 2006. The main components of the 7th CP (2006-2010) are: (a) Population and Development Strategies; (b) Reproductive Health including family planning, maternal health, adolescent reproductive health (ARH) and HIV/AIDS; and (c) Gender. The Country Programme Action Plan (CPAP) of the 7th CP was signed by Government of Indonesia and UNFPA in May 2006 and in the third quarter of 2006 the implementing partners started the implementation of activities that were planned under the 2006 Annual Work Plans (AWPs) both at national and sub-national levels covering 21 districts and 6 provinces. The effective implementation of the 2007 activities was slightly delayed and most districts and provinces were implementing activities to full capacity in the second quarter of 2007. Six Outcomes and ten Outputs had initially been developed within the above mentioned focus areas. In 2007 together with the relevant government partners the original 10 outputs were reformulated into 6 Outputs now reflecting the main focus areas of the 7th CP.

In 2007, a strategic management review was undertaken. This review identified a number of interventions and adjustments to the 7th CP that would result in greater strategic focus and improve the management performance. The far-reaching adjustments were made through a consultative midterm review that took place in mid-2008. As a result of the midterm-review that took place mid-2008 indicators were revised and the RH and Gender programme narrowed their interventions to a more manageable number of districts. However, not all of the strategic management review recommendations could be feasibly implemented in the current 7th CP. In the fourth quarter of 2008 the HIV/AIDS programme was evaluated. The evaluation stressed the need to provide more hands-on technical support to NGOs. In 2009 a beginning was made to provide this support and in 2010 the NGOs are implementing new and more target behavior change interventions to populations most vulnerable to HIV infection and unwanted pregnancies. These reports are expected to be used as reference for this evaluation.

Evaluation rationale, objective, purpose and users
In line with the UNFPA Policies and Procedures: Country Programme Monitoring and Evaluation guidelines and UNFPA’s evaluation policy (DP/FPA/2009/4) and the 7th Country Programme Action Plan, an evaluation will be administered at the end of the 7th Country Programme. Evaluation at UNFPA aims to strengthen national evaluation capacity through using participatory and inclusive approaches in carrying out evaluation activities, building on national evaluation mechanisms where they exist, and utilizing national capacity to the extent possible.

There are two main objectives of the summative evaluation. Firstly, to investigate whether the programme has caused demonstrable effects on specifically defined target outcomes and outputs. And secondly, the evaluation findings and recommendations are to provide inputs for the development of the 8th Country Programme (2011-2015). The findings are expected to improve programme design, programme interventions and the overall set-up of the programme management of the 8th Country Programme. UNFPA headquarters, the Government of Indonesia, donors, partner agencies and other relevant stakeholders will benefit from the lessons learned.

Selection of focus areas to evaluation
Article E-19 of the UNFPA Policies and Procedures: Country Programme Monitoring and Evaluation guidelines prescribe that “as a general principle, a sufficient number of programme outcomes, key strategies and thematic areas of the country programme should be evaluated in order to inform programme design and

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implementation”. The PPM also stipulates that the following evaluations are mandatory\textsuperscript{20}:

1) Demonstration/Pilot Projects
2) Major Country Programme Outcomes\textsuperscript{21}

Therefore the final 7\textsuperscript{th} CP evaluation will cover the following five Country Programme Outcomes:

**Outcome 1**: An improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health information and services at national and sub national levels.

**Outcome 2**: Strengthened demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information.

**Outcome 3**: Increased access to high-quality, integrated, client-oriented and gender-sensitive reproductive health and ARH services and information.

**Outcome 4**: Enhanced understanding of policy makers, planners and parliamentarians at national and sub national levels on the linkages between population, reproductive health, gender, poverty and development through improved availability and increased utilization data on population, reproductive health and adolescent reproductive health, STIs including HIV/AIDS, gender and poverty.

**Outcome 5**: Strengthened institutional mechanisms, socio-cultural values and practices to promote and protect the rights of women and girls and to advance gender equity and equality.

Data for most of the outcome and output indicators have been collected by the UNFPA Country Office and the available data will form a key-input for the evaluation report. In addition to verifying and presenting the reported results of the programme, the evaluators are to look into the quality results to increase the credibility and validity of the reported results.

After a review of the available progress data and a series of consultation rounds for each of the three thematic groups (PDS, RH, and Gender) selected focus areas of the evaluations have been identified. Considerations during these have been amount of financial resources spent, potential of replication/continuance of initiated programme interventions in 8\textsuperscript{th} CP and need of the availability of lessons learned to feed into the 8\textsuperscript{th} CP. The result of these discussions has been that the evaluators are requested to answer the following questions:

**For Population and Development Strategies Programme:**
1. What has been the progress towards incorporating disaggregated data on population, reproductive health, adolescent reproductive health, STIs including HIV/AIDS, gender, and poverty in sub-national statistical yearbooks?
2. What have been the sustainable results of the series of trainings organized for sub-national planners?
3. To what extent the efforts made on improving the quality and scope of the sub-national statistical yearbooks have contributed to an increased utilization of disaggregated data in planning and policy making at the district level?

**For Reproductive Health Programme:**
1. What have been the achievements of the selected Puskesmas in adopting the concept of integrated Essential Reproductive Health?
2. Has there been an increase in quality, client-orientation including adolescent-friendly services and gender-sensitivity in the selected programme districts?
3. To what extent UNFPA’s work has contributed towards an improved policy environment and commitment to promote reproductive rights and comprehensive, high-quality, gender-sensitive reproductive health and adolescent reproductive health at sub national levels? Have the RH commission and CCS working group been

effective in playing their expected roles?
4. To what extent UNFPA’s work to increase demand for high-quality, integrated, client-oriented and gender-sensitive reproductive health and adolescent reproductive health services and information has supported the increased access to RH and ARH services?

For Gender Based Violence Programme:
1. What has been the progress in enhancing the capacity of Government, non-government organizations and civil society organizations to prevent and manage Gender Based Violence? Has there been effective coordination mechanism?
2. To what extent is GBV prevention and management include monitoring and evaluation system integrated and functioning in provinces and districts related sectors work plans and local budgets?
3. What is the quality of the service points (medical, law-enforcement, shelter/psycho-social assistance) in 18 priority sub districts and are they providing an integrated—minimum standard assistance to victims/survivors of GBV?

A more detailed description of the research questions for each of the focus areas is described in Annex 2a.

Evaluation team composition
The team will comprise of up to 4 evaluators. The evaluation will be managed by one team-leader supported by three thematic (RH, PDS, and GBV) experts. The evaluators will be selected by UNFPA Indonesia in consultation with the 7th CP evaluation working groups and the 7th CP Management Group (see below). The team-leader is responsible for the final report (which should include an overview of the results of the 7th CP) and is to provide technical support and overview to the three experts during the field-research and writing of their respective reports. The evaluators should all possess interview skills, analytical skills, facilitation skills and possess excellent English writing skills.

Profile of Evaluation team-members

1. Team Leader
Key tasks:
- Elaborate an analytical framework for the evaluation
- Lead in translating analytical framework into data collection and analysis tools
- Lead in proceeding analysis works
- Lead in undertaking basic activities to support the evaluation
- Guide other team members in order to complete the work in accordance with the Terms of Reference in timely fashion
- Continuously review the work of individual members, provide guidance and ensure a coordinated analysis
- Settle any disagreement and disputes among the evaluation team, if any, and find the best solutions
- Be the spokesperson of the team in relation to the UNFPA Country Office, government partners and other counterparts
- Ensure that field visits and meeting schedules are adequate to fulfill the terms of reference
- Consolidate the team members’ contributions into a final evaluation report
- Prepare evaluation report and serve as principle presenter in front of key audiences

Qualification
- Post graduate degree in social sciences, public health or any related field to UNFPA’s mandate
- At least 10-15 years work and/or research experience
- Extensive experience as an evaluation team-leader
- Proven analytic, communication/presentation skills and evaluation skills
- Excellent writing skills
- Previous experience in the health sector in low and middle income countries
- Excellent capacity in English (both writing and speaking)

2. **Public Health specialist**

**Key tasks:**
- Assess the design, implementation and results of the IERH programme
- Develop evaluation tools
- Prepare a conceptual and practical framework for the comprehensive assessment of quality of health care services
- Provide assistance to the evaluation through analysis of UNFPA’s programme and national priorities
- Provide assistance to the team leader in preparing the evaluation report through the preparation of chapters evaluating the 7th CP RH programme

**Qualification:**
- Post graduated degree in Public Health
- At least 10 years in health field
- Proven skills on evaluation of health projects
- Familiarity with health care system of Indonesia
- Excellent capacity in Indonesian (both writing and speaking) and English
- Prove ability to work within multi-disciplinary teams

3. **Demography/planning specialist**

**Key tasks:**
- Assess the design, implementation and results of the PDS programme
- Develop evaluation tools
- Provide assistance to the evaluation through analysis of UNFPA’s programme and national priorities
- Provide assistance to the team leader in preparing the evaluation report through the preparation of chapters evaluating the 7th CP PDS programme

**Qualification:**
- Ph.D or Masters Degree in public administration, demography, social science or another related study
- Health or related field
- At least 10 years work and/or research experience
- Proven analytic and evaluation skills
- Proven communication/presentation skills
- Previous experience in working with BPS, Bappeda’s or in the area of collecting and utilizing data for planning
- Excellent capacity in English (both writing and speaking); excellent knowledge of Bahasa Indonesia is required.

4. **GBV service provider evaluator**

**Key tasks:**
- Assess the design, implementation and results of the GBV programme
- Develop evaluation tools
- Prepare a conceptual and practical framework for the comprehensive assessment of quality of GBV management services
- Provide assistance to the evaluation through analysis of UNFPA’s programme and national priorities
- Provide assistance to the team leader in preparing the evaluation report through the preparation of chapters evaluating the 7th CP GBV programme

**Qualification:**
- At least five to ten years experience in GBV management in Indonesia
- Previous research experience
- Excellent Bahasa Indonesia skills

**Expected services and Outputs to be delivered**

A final evaluation report written in English which has followed the specified tasks and thereby complying with the objectives set out above. The main text of the reports should be 60 to 75 pages in length. In addition, the report should have an executive summary (4 to 5 pages), containing the main findings, conclusions, lesson learned and recommendations and a fully filled in Results and Resources Framework.

An introductory section of the report should be devoted to the object of the evaluation, its purpose, its intended audience, the questions asked, the methodology used, and the limitations. A separate section of the report describing context, program activities, and donors and their contribution. Every section of the report should consist of findings (and the arguments and criteria which led to the findings), conclusions, and recommendations. The annexes of the reports should contain (but not be limited to):

1) Results and Resources Framework
2) ToR for the evaluation
3) Evaluation Framework
4) List of reference documents
5) List of people interviewed, by affiliation

**Methodology**

The evaluators will design the evaluation methodology required to respond to the review objectives in collaboration with the UNFPA Country Office and the Gender 7th CP evaluation working group. Methodology should specify the following:

- Key information sources – Identification by evaluators of stakeholders (UNFPA staff, partner agencies, implementing partners, community members including youth and other vulnerable groups
- Data collection instruments
- Types of data collection instruments
- Reference indicators and relevant benchmarks
- Reporting and communication mechanisms during the course of consultation and discussion with UNFPA Jakarta office

**Evaluation management and schedule**

The evaluation team will work under the direct supervision of the UNFPA Country Office Representative for Indonesia who will provide necessary information and guidance for planning the evaluation. UNFPA Indonesia will provide relevant documents and information for pre-reading upon signing the contract between UNFPA Indonesia office and evaluators.

UNFPA will provide logistical support and arrange meetings and field visits as per the agreed plan. Evaluators will be expected to work 6 days a week. Travel to field visits will be arranged. UNFPA will also make available office space; the evaluators are however expected to bring their own laptops.

In order to secure involvement by the relevant authorities in the management and implementation of the 7th CP Evaluation the following organization will be established:
• A Management Group (MG) with four members selected by the JSC and a member of the UNFPA Youth Advisory Panel
• Three thematic 7th CP evaluation working groups with each complemented by one representative of the UNFPA Youth Advisory Panel

The Management Group will supervise all aspects of the evaluation. It comprises of the UNFPA Assistant Representative, UNFPA M&E Officer, Bappenas Echelon 2 official, MoWECP Echelon 2 official, BKKBN Echelon 2 official, MOH Echelon 2 official, BPS Echelon 2 official, NGOs officials, 1 member from the UNFPA Youth Advisory Panel. The UNFPA Assistant Representative together with the Bappenas Echelon 2 official will chair the Management Group. The tasks of the management group will be: a) to review the drafted terms of references; b) endorse the selected evaluators; c) provide inputs during the debriefing session by the consultants; and d) review the draft reports e) consult during key evaluation stages with UNFPA Representative and Bappenas Deputy of Human Resources and submit final report for their endorsement. The Management Group takes the final decisions regarding approval of the reports after consultation with the UNFPA Representative and Bappenas.

Three 7th CP evaluation working groups (RH, PDS and Gender) will be established and consist of UNFPA National Programme Officers, the Programme Officers of the respective government agencies and the Programme Component Officers. Each Working Group is tasked with: a) the development of Terms of References; b) draft and finalize the program of the evaluation; c) select the evaluators; d) provide feedback on the draft reports; and e) and provide support to the evaluators during their evaluation.

The daily management of the evaluation will be the responsibility of the UNFPA M&E Officer in close coordination with the 3 thematic working groups and the National Programme Coordination Unit (NPCU). The M&E officer will be supported by one programme associate. All above-mentioned groups share a common responsibility in ensuring that the Standards for Evaluation in the UN System set by the United Nations Evaluation Group (UNEG) are met (See UNEG website: http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=22)

Timeline

An important consideration in deciding the timeline is the fact that in September 2010, UNFPA Indonesia should submit the 8th CP to the UNFPA Executive Board for approval. Once approved the implementation of the 8th CP is expected to start being implemented early 2011. Therefore the evaluation reports should be available by mid-May to ensure that sufficient time is available to accommodate the main recommendations, built forward on good practices and address identified obstacles and challenges.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>March 29</td>
<td>Initial orientation of team, interviews in Jakarta with government and non-government stakeholders</td>
</tr>
<tr>
<td>April 4-April 18</td>
<td>Fieldwork</td>
</tr>
<tr>
<td>April 19-23</td>
<td>Supplemental interviews at central level, joint team analysis and drafting report</td>
</tr>
<tr>
<td>April 26</td>
<td>Presentation initial findings to stakeholders</td>
</tr>
<tr>
<td>April 27-1 May</td>
<td>Report writing and submission of first draft</td>
</tr>
<tr>
<td>May 7</td>
<td>Reply on first draft by UNFPA and Government of Indonesia</td>
</tr>
<tr>
<td>May 10-12 May</td>
<td>Editing of report and submitting final report</td>
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</tbody>
</table>

Remuneration
Payment will be made based on individual evaluator’s previous salary history and work experience. The expected number of working days is 33.

**Submission of application**
Please provide us with an update CV **before 25 of March 2010**.

UNFPA provides a work environment that reflects the values of gender equality, teamwork, respect for diversity and integrity. We therefore strive for a balanced gender distribution in the evaluation team.

If you have any questions regarding the terms of reference, please contact:
Mr. Bastiaan van de Loo: vandeloo@unfpa.org
Ms. Ramot Aritonang: aritonang@unfpa.org

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ANNEX 2a: Thematic Research Questions, Terms of Reference, Evaluation of UNFPA Indonesia’s 7th Country Programme (2006-2010)

I. UNFPA’s Reproductive Health Programme

RH Programme design, management and implementation

a) To what extent was the IERH programme aligned and/or contributed to national and district priorities? Were the proposed and implemented interventions evidence-based? What were the main assumptions and risks identified which could impact foreseen results?
b) To what extent did the programme design assure mechanisms to reach the poor and marginalized?
c) To what extent the puskesmas were able to integrate the 4 components of the IERH? Identify their challenges and lessons learned. (What and how were the roles from the government at national and province level to support the IERH programme in Puskesmas?
d) To what extent was the participation of policy makers in ensuring the sustainability of IERH programme in the puskesmas?
e) Were there any policies to support the IERH programme and how was the implementation of those policies?
f) To what extent were UNFPA’s and its partners (financial, technical and management) capacity in the development and management of the IERH programme considered?
g) Were all strategic stakeholders included in the development and implementation of the programme?
h) To what extent was there flexibility in addressing emerging issues experienced during the course of the CP?
i) To what extent was the IERH programme intertwined with other UNFPA 7th CP outputs?
j) To what extent was results-oriented programming and monitoring taken into consideration during the development and implementation of the programme?
k) Were the monitoring mechanism appropriate and were the results of monitoring appropriately used to make necessary adjustments?
l) To what extent has the province and district RH commissions contributed to the promotion of reproductive health and rights?
m) To what extent has the CCS working group contributed to address family planning needs of the people?
n) What are the specific roles of the National RH Commission and CCS working group in assisting the commissions and working groups at sub national levels (prov and districts)?

Effectiveness and efficiency

a) To what extent have the expected results been achieved?
b) What factors have played facilitating and constraining roles in achieving the expected results?
c) Is there a clear difference in quality and extent of services between pilot-puskesmas and non-pilot puskesmas in selected districts?
d) How have efforts of other Outputs contributed towards the achievement of the results made on providing integrated essential reproductive health services?
e) What is the opinion of stakeholders (policy makers, service providers, clients) about the results?
f) To what extent were management decisions based on the progress reported in pilot-districts?

Sustainability and programme replication

a) Did the local governments allocate sufficient resources to guarantee achieved results will be sustainable?
b) Did the programme design and implementation include strategies to ensure sustainability?
c) To what extent can it be expected that lessons-learned, good practices and innovative interventions provide inputs into the GoI’s initiatives to increase the quality of access and services?

d) Is there any evidence in programme districts and non-programme districts that the IERH programme will be replicated to non-pilot puskesmas and districts upon the end of UNFPA funding?

e) What are the facilitating and constraining factors that affect the sustainability and programme replication?

II. UNFPA’s Population and Development Strategies Programme

PDS Programme design, management and implementation

a) To what extent has the PDS Programme (improvement of district database, establishment of district data forum at the district level, and support to the conduct of large survey i.e. 2007 Indonesia DHS, and 2010 Population and Housing Census, Policy studies and Re-estimation of Fertility from 2002/2003 and 2007 Indonesia DHS) been aligned and/or contributed to national and district priorities?

b) What were the main assumptions and risks identified which could impact foreseen results?

c) Were the proposed and implemented interventions in the districts evidence-based?

d) To what extent was the PDS programme (improvement of district database, establishment of district data forum at the district level, and support to the conduct of large survey i.e. 2007 Indonesia DHS, and 2010 Population and Housing Census, Policy studies and Re-estimation of Fertility from 2002/2003 and 2007 Indonesia DHS) expected to contribute to the outcomes and outputs of the United Nations Development Assistance Framework (UNDAF)

e) To what extent were UNFPA’s and its partners (financial, technical and management) capacity in the development and management of the PDS programme considered?

f) Were all strategic stakeholders included in the development and implementation of the programme?

g) What were the expected results of the PDS programme?

h) To what extent was there flexibility in addressing emerging issues experienced during the course of the CP?

i) To what extent was the PDS programme intertwined with other UNFPA 7th CP outputs?

j) In what way did the programme design respond/took into consideration specific local and or national needs and conditions?

k) To what extent was results-oriented programming and monitoring taken into consideration during the development and implementation of the programme?

l) Were the monitoring mechanism appropriate and were the results of monitoring appropriately used to make necessary adjustments?

m) To what extent has the PDS programme (improvement of district database, establishment of district data forum at the district level, and support to the conduct of large survey i.e. 2007 Indonesia DHS, and 2010 Population and Housing Census, Policy studies and Re-estimation of Fertility from 2002/2003 and 2007 Indonesia DHS) effectively integrated gender equality, young people and human rights?

n) Did the programme design and implementation include strategies to ensure sustainability?

Effectiveness and efficiency

a) To what extent have the expected results been achieved through the attainment of indicators?

b) Have the allocated budget sufficient to ensure achievement of the outputs?

c) What factors have played facilitating and constraining roles in achieving the expected results?

d) Is there a clear difference in quality and range of indicators in District in Figures Publications between pilot and non-pilot districts (should have similar characteristics with the pilot districts)

e) Is there a difference in quality and range of indicators in areas where the Database Forum was operating smoothly compared to those that did not have an active/existing Database Forum?
f) How have efforts of other Outputs contributed towards the achievement of the results made on increasing the utilization of data?

g) What is the opinion of stakeholders (policy makers, planners, data users and data collectors/processors) about the results?

h) Were financial and human resources used in the most efficient way?

**Sustainability and programme replication**

a) Are the achieved results sustainable?

b) Will local governments allocate sufficient resources to guarantee achieved results will be sustainable?

c) To what extent can it be expected that lessons-learned, good practices and innovative interventions provide inputs into the GoI’s initiatives to increase the quality and utilization of data for planning and policy making?

d) Is there any evidence in programme districts and non-programme districts that the PDS programme or part of it will be replicated to non-pilot districts upon the end of UNFPA funding?

e) What are the facilitating and constraining factors that affect the sustainability and programme replication?

**III. UNFPA’s Gender Based Violence programme**

**GBV Programme design, management and implementation**

a) To what extent has the Gender Programme been aligned and/or contributed to national and district priorities?

b) What were the main assumptions and risks identified which could impact foreseen results?

c) Were the proposed and implemented interventions evidence-based?

d) What were the expected results and impact of the Gender programme?

e) To what extent was the Gender programme expected to contribute to the outcomes and outputs of the United Nations Development Assistance Framework (UNDAF)?

f) To what extent were UNFPA’s and its partners (financial, technical and management) capacity in the development and management of the Gender programme considered during the programme design phase?

g) To what extent was the Gender programme intertwined with other UNFPA 7th CP outputs?

h) In what way did the programme design respond/took into consideration specific local needs and conditions?

i) To what extent was results-oriented programming and monitoring taken into consideration during the development and implementation of the programme?

j) Were the monitoring mechanism appropriate and were the results of monitoring appropriately used to make necessary adjustments?

k) To what extent has the Gender programme effectively integrated, young people and human rights?

l) Did the programme design and implementation include strategies to ensure sustainability?

**Effectiveness and efficiency**

a) To what extent have the expected results and impact been achieved?

b) What factors have played facilitating and constraining roles in achieving the expected results and impact?

c) Is there a difference in quality and range of GBV management services in areas where UNFPA had its interventions and those that did not benefit from UNFPA’s support?

d) How have efforts of other Outputs contributed towards the achievement of the results made on increasing the quality of GBV management services?

e) Were financial and human resources used in the most efficient way?
Sustainability and programme replication

a) Are the achieved results sustainable?

b) To what extent can it be expected that lessons-learned, good practices and innovative interventions provide inputs into the GoI’s initiatives to increase the quality of GBV management services?

What are the facilitating and constraining factors that affect the sustainability and programme replication?

Reference material

- 7th Country Programme Document
- 7th Country Programme Action Plan
- United Nations Development Assistance Framework
- Situation Analysis (2010)
- Strategic Management Review
- HIV/AIDS Evaluation
- Midterm Review Reports
- Standard Progress Reports
- Quarterly Workplan Monitoring Tools
- National RH Strategy
- Guide for RH commission and CCS working group
- CCS strategy
- IERH package (7 books)
- Report on IERH operational research by LIPI
- Reports on IERH evaluation by Mitra Inti
Annex 3: Data Collection Instruments

Data for the evaluation was collected by using a qualitative approach, through in-depth interviews. An interview question guideline was developed and then reviewed by the country office. See below for the interview guidelines.

All Program Components
Central Level Bappenas
Date:
Meeting Participants:
1.  In your view, what are the most important successes of CP7?
   a.  To what extent was the program aligned with the priorities of the government?
   b.  In what ways has the program ensured synergy between the three components of the partnership (RH, Gender and PDS)
   c.  What have been the key challenges to achieving results at the component outcome level and at the program level?
   d.  To what extent do you think that program resources have been appropriately/efficiently used. Please explain/give examples.
   e.  To what extent do you think that the program has responded to recommendations of the management review and the MTRs?
      i. What, if anything should have been done to respond more effectively?
2.  To what extent did the program assure mechanisms to reach the poor and vulnerable?
3.  In your opinion, what are the key lessons for CP8?
4.  Moving forward, and given its limited financial resources, how do you think UNFPA can be most valuable to the Government of Indonesia?
   a.  What areas of support are highest priority for the government?
   b.  Where is UNFPA’s strategic advantage, compared to other development partners?
      i. What is the best way to maximize its technical support role?
   c.  What approaches are most conducive to optimizing this advantage?
   d.  What are the challenges/risks in moving to this approach?
   e.  Do you have guidance on what percentage of program resources is reasonable/customary to spend on project staff?
5.  Do you have guidance for UNFPA about coordination with other UN partners?
Reproductive Health Programme Evaluation
Central Level MOH
Date:
Meeting Participants:

1. In your view, what are the most important successes of CP??
   a. In general, to what extent was the program component aligned with the priorities of the MOH?
   b. To what extent did the IERH programme contribute to national and district priorities?
      i. What do you consider the key management challenges in implementing this approach?
      ii. What do you consider the technical challenges in implementing this approach?
         • Probe different components (MNH/EOC, STIs/HIV/VCT, AFHS)
      iii. Were the technical guidance documents/tools developed useful? Which tools? In what ways, specifically?
      iv. In your opinion, how effective was the monitoring of the IERH initiative? At what levels was the monitoring most/least effective? Why?
      v. As challenges were identified, to what extent do you think the program supported appropriate solutions? Please explain.
      vi. To what extent do you think that the IERH approach is sustainable at the district level? Why?
      vii. Do you think there is sufficient evidence to warrant scaling up this approach? Why or why not?
         • If yes, How will MOH pursue this (technical, budget etc…)
   c. To what extent has the RH commissions contributed to the promotion of reproductive health and rights?
      i. What are the key achievements at district and province levels?
      ii. What are the key challenges at district and province levels?
      iii. Do you think the commissions are sustainable? Why/not?
      iv. What are the status of the national RH commission? What are the prospects for revitalizing this? Please explain.

2. To what extent was there flexibility in addressing emerging issues experienced during the course of the CP? Please give an example.

3. In your opinion, is there strong evidence that the program is reaching the poor/vulnerable? Please explain.

4. To what extent do you think that program resources have been appropriately/efficiently used. In what ways?

5. To what extent do you think that the program has responded to recommendations of the management review and the MTRs?
   a. What, if anything should have been done to respond more effectively?

6. What are the key lessons for CP8?

7. Moving forward, and given its limited financial resources, how do you think UNFPA can be most valuable to the Government of Indonesia?
   a. What areas of support are highest priority for the government?
   b. Where is UNFPA’s strategic advantage, compared to other development partners?
      i. What is the best way to maximize its technical support role?
   c. What approaches are most conducive to optimizing this advantage?
   d. What are the challenges/risks in moving to this approach?
Reproductive Health Programme Evaluation
Central Level BKKBN

1. In your view, what are the most important successes of CP7?
   a. In general, to what extent was the program component aligned with the priorities of the BKKBN?
   b. To what extent were activities to increase understanding of policy makers successful?
      i. Please give specific examples of where involved policy makers brought changes at the local level.
      ii. What do you consider the key challenges in mobilizing parliamentarians to be effective champions of reproductive health and rights?
      iii. What tools/resources were most effective in offering technical guidance to this initiative?
      iv. How effective was the monitoring of this? At what levels was the monitoring most/least effective?
      v. As challenges were identified, to what extent do you think the program supported appropriate solutions? Please explain.
      vi. To what extent do you think this approach is sustainable at the district and province levels? Why?
      vii. How will BKKBN sustain this work in the future? What are the continued capacity building requirements? What steps have been taken to secure appropriate budget and other resources?
   c. To what extent were activities to increase understanding of religious leaders successful?
      i. Please give specific examples of where involved religious leaders brought changes at the local level.
      ii. What do you consider the key challenges in mobilizing religious leaders to be effective champions of reproductive health and rights?
      iii. What tools/resources were most effective in offering technical guidance to this initiative?
      iv. How effective was the monitoring of this? At what levels was the monitoring most/least effective?
      v. As challenges were identified, to what extent do you think the program supported appropriate solutions? Please explain.
      vi. To what extent do you think this approach is sustainable at the district and province levels? Why?
      vii. How will BKKBN sustain this work in the future? What are the continued capacity building requirements? What steps have been taken to secure appropriate budget and other resources?
   d. To what extent has the RH commissions contributed to the promotion of reproductive health and rights?
      i. What are the key achievements at district and province levels?
      ii. What are the key challenges at district and province levels?
      iii. Do you think the commissions are sustainable? Why/not?
      iv. What are the status of the national RH commission? What are the prospects for revitalizing this? Please explain.
   e. We also understand that the new Law on Population continues not to recognize the rights of young people to RH services. Can you please comment on that?

2. To what extent was there flexibility in addressing emerging issues experienced during the course of the CP?
3. To what extent did the program assure mechanisms to reach the poor and vulnerable?
4. To what extent do you think that program resources have been appropriately/efficiently used. In what ways?

5. To what extent do you think that the program has responded to recommendations of the management review and the MTRs?
   i. What, if anything should have been done to respond more effectively?

6. What are the key lessons for CP8?

7. Moving forward, and given its limited financial resources, how do you think UNFPA can be most valuable to the Government of Indonesia?
   a. What areas of support are highest priority for the government?
   b. Where is UNFPA’s strategic advantage, compared to other development partners?
      i. What is the best way to maximize its technical support role?
   c. What approaches are most conducive to optimizing this advantage?
   d. What are the challenges/risks in moving to this approach?

Reproductive Health Programme Evaluation
District Health Department
Date:
Meeting Participants:

IERH
1. We are interested in learning about the IERH initiative. What do you consider the key management challenges in implementing this approach?
2. What do you consider the technical challenges in implementing this approach?
   • Probe different components (MNH/EOC, STIs/HIV/VCT, AFHS)
3. Were the technical guidance documents/tools developed useful? Which tools? In what ways, specifically?
4. In your opinion, how effective was the monitoring of the IERH initiative? What kinds of issues were identified through monitoring?
5. As challenges were identified, to what extent do you think the program supported appropriate solutions? Please explain. Probe for whether issues identified through monitoring were solved.
6. If for some reason, UNFPA were unable to continue to support IERH programming in the future, would the district be willing to support these costs?
   • What kinds of IERH related activities would the district consider supporting itself?
7. What steps are being taken to mobilize government budget for continued IERH programming? Has a government regulation been developed (Probe for interaction with parliamentarians)?
8. In your opinion, to what extent did the IERH programme contribute to district priorities?

RH Commissions/Coordination Mechanism:
9. We would like your opinions about the RH commissions. In your opinion, to what extent has the RH commission/coordination mechanism been an effective?
   i. Who participates in the RH commission/coordination meeting?
   ii. Is there a TOR for the commission? (ask to see it)
   iii. What kinds of issues are discussed at commission/coordination meetings?
   iv. When was the last meeting of the commission/coordination mechanism?
   v. What decision were made at this meetings?
If UNFPA was not able to fund commission/coordination meetings in the future, would these meetings continue with government funds?

Has a government regulation been developed related to the commission/coordination mechanism?

To what extent was there flexibility in addressing emerging issues experienced during the course of the CP? Please give an example.

In your opinion, is there strong evidence that the program is reaching the poor/vulnerable? Please explain.

To what extent do you think that program resources have been appropriately/efficiently used? In what ways?

What are the key lessons for CP8?

Reproductive Health Programme Evaluation
District Bappenas
Date: 
Meeting Participants:

1. In your view, what are the most important successes of CP7?
   a. In your opinion, to what extent was the program aligned with the priorities of the district government?
   b. Were there district priorities in RH, Gender and PDS that were not covered by the program?
   c. Were there aspects of the program that were not focused on district priorities? Which aspects in particular?

2. Please describe how the program was monitored.
   a. Who conducted monitoring at the Puskasmas, Shelters, boarding schools (vary question)?
   b. How often
   c. Are there monitoring tools that are used? Please show.
   d. How are the results of monitoring shared
      i. Probe for on site feedback and supervision

3. What have been the key management challenges in implementing the program?
   a. What solutions have been brought? How were the solutions identified?

4. What have been the key technical challenges in implementing the program?
   a. What solutions have been brought? How were the solutions identified?

5. To what extent do you think that program resources have been appropriately/efficiently used. Please explain/give examples.

6. How successful do you think the program has been in reaching poor and marginalized people? What evidence do we have that this is true?

7. What experiences from the project is the government most interested in continuing? Why? What evidence do we have that this has been successful?

8. If UNFPA would be unable to continue to provide funding to this area in the future, would the government be willing to use its own resources?

9. What steps have been taken to secure government resources to continue this?

List of key questions of GBV program in field.

A. Health center/hospital
   1. Have the officer(s) been trained properly? What subjects?
   2. Is there any manual training, procedure, or guidance was developed? How effective?
   3. Is there any case/victim monitoring record system been used?
   4. Any constrain been facing during providing services to victims?
   5. What intervention been taken in order to make the service sustain for the future?
B. Psychosocial (rehabilitation) assistance
1. Have the officer(s) been trained properly? What subjects?
2. Is there any manual training, procedure, or guidance was developed? how effective?
3. Is there any case/victim monitoring record system been used?
4. Any constrain been facing during providing services to victims?
5. What intervention been taken in order to make the service sustain for the future?

C. Legal support
1. Have the officer(s) been trained properly? What subjects?
2. Is there any manual training, procedure, or guidance was developed? how effective?
3. Any constrain been facing during providing services to victims?
4. What intervention been taken in order to make the service sustain for the future?

General
1. Is there any local regulation adopted to support services running?
2. In what way(s) each service linked up? And how they incorporated?
3. Is there GBV data base developed? How effective and what constrain(s) been facing?

GUIDELINE TO CONDUCT CP-7 EVALUATION:
PDS PROGRAMME COMPONENT

The following guideline will be referred by consultant in implementing CP-7 PDS Programme Component Evaluation. Two approaches in evaluation PDS programme component include in depth interview and document review. Both in depth interview and documents review should be oriented to agreed and determined frameworks, firstly CP-7 evaluation framework (Figure 1), and specifically for PDS Component evaluation are framework on the interrelationship of three key activities of PDS Programme (Figure 2), and Role of PDS Programme to support District Information System (Figure 3).

Indepth Interview

Basically in depth interview, or can also be conducted in form of conference (if we face many respondents (more than two)), will be guided to selected focus areas of the evaluation (Annex 1 for PDS Programme) and to answer the three research questions of PDS Programme Evaluation, i.e.:

- What has been the progress towards incorporating disaggregated data on population, reproductive health, adolescent reproductive health, STIs including HIV/AIDS, gender, and poverty in sub-national statistical yearbooks?
- What have been the sustainable results of the series of trainings organized for sub-national planners?
- To what extent the efforts made on improving the quality and scope of the sub-national statistical yearbooks have contributed to an increased utilization of disaggregated date in planning and policy making at the district level?

The above three key questions may be elaborated to include detailed questions as shown in Annex 2.

Key interview respondents include key persons, stakeholders of PDS Programme Component, at central level (UNFPA Office, BPS Office, Bappenas and other related institution like Unicef and UNDP), at provincial level
(BPS Office, Bappeda of province administration, other stakeholders), and at district level (BPS Office, Bappeda of district administration, other stakeholders).

**Documents review**

Documents review will be used as another approach and complemented to indepth interview for CP-7 PDS Programme Component Evaluation. Document sources include PDS Programme annual report, publications related to PDS key activities, e.g., training documents, DDA, DBF report, planning documents of implementing CP-7 partners, etc.

**Figure 1**

**FINAL 7th COUNTRY PROGRAM EVALUATION FRAMEWORK**

**Figure 2.** Interrelationship of the three key activities of PDS programme: DBF, Trainings, DDA
Focus areas for PDS Programme evaluation

**The population and development strategies (Outcome, Output)**

**OUTCOME 4**: Enhanced understanding of policy makers, planners and parliamentarians at national and sub-national levels on the linkages between population, reproductive health, gender, poverty and development through improved availability and increased utilization data on population, reproductive health and adolescent reproductive health, STIs including HIV/AIDS, gender and poverty.

**OUTPUT 4.1**: Improved availability and increased capability to utilize disaggregated data on population, reproductive health and adolescent reproductive health, STIs and HIV/AIDS, gender, poverty and enhanced understanding of planners, policy makers and parliamentarians on their linkages with development.

**The main strategies to achieve this output include:**

a. Capacity building of implementing partners to provide service statistics timely, comprehensively, well organized, and should focus on the existing system and practices.

b. Capacity building of policy makers and planners at sub-national levels to utilize data on population, RH, FP, gender and poverty for planning, budgeting, monitoring, evaluation and policy making should focus on the existing system and practices.

c. Capacity building of planners and policy makers, and sensitizing policy makers, planners and parliamentarians at national and sub-national levels on linkages between population, reproductive health including family planning, gender, poverty and socio-economic development.

**Key Activities for P101 for remaining 7th CP will include:**

1. Identify availability and needs of data, material and guideline for implementing partners.
2. Support training for service statistics personnel from implementing partners.
3. Support the improvement and publication of “Daerah dalam Angka” (District in Figures) by incorporating population and reproductive health data in DDA.
4. Strengthening structure, task and function of Database forum and support the issuing of Ministerial Decree of Database forum.
5. Survey/Research to support policy formulation on population, reproductive health, including Family Planning and ARH, HIV/AIDS, gender and poverty.

6. Conduct workshop/training to utilize data on population, reproductive health including family planning, gender and poverty for planning, budgeting, monitoring & evaluation and policy making in the provinces for sub national planners, policy makers and planners including information sharing with regional programme.

7. Training sub national planners and policy makers and conduct seminars for parliamentarians to strengthen their knowledge on the linkages between population, gender, RH, ARH, HIV/AIDS, poverty and socio-economic development

Thematic Research Questions
UNFPA’s Population and Development Strategies Programme

PDS Programme design, management and implementation

o) To what extent has the PDS Programme (improvement of district database, establishment of district data forum at the district level, and support to the conduct of large survey i.e. 2007 Indonesia DHS, and 2010 Population and Housing Census, Policy studies and Re-estimation of Fertility from 2002/2003 and 2007 Indonesia DHS) been aligned and/or contributed to national and district priorities?

p) What were the main assumptions and risks identified which could impact foreseen results?

q) Were the proposed and implemented interventions in the districts evidence-based?

r) To what was the PDS programme (improvement of district database, establishment of district data forum at the district level, and support to the conduct of large survey i.e. 2007 Indonesia DHS, and 2010 Population and Housing Census, Policy studies and Re-estimation of Fertility from 2002/2003 and 2007 Indonesia DHS) expected to contribute to the outcomes and outputs of the United Nations Development Assistance Framework (UNDAF)

s) To what extent were UNFPA’s and its partners (financial, technical and management) capacity in the development and management of the PDS programme considered?

t) Were all strategic stakeholders included in the development and implementation of the programme?

u) What were the expected results of the PDS programme?

v) To what extent was there flexibility in addressing emerging issues experienced during the course of the CP?

w) To what extent was the PDS programme intertwined with other UNFPA 7th CP outputs?

x) In what way did the programme design respond/took into consideration specific local and or national needs and conditions?

y) To what extent was results-oriented programming and monitoring taken into consideration during the development and implementation of the programme?

z) Were the monitoring mechanism appropriate and were the results of monitoring appropriately used to make necessary adjustments?

aa) To what extent has the PDS programme (improvement of district database, establishment of district data forum at the district level, and support to the conduct of large survey i.e. 2007 Indonesia DHS, and 2010 Population and Housing Census, Policy studies and Re-estimation of Fertility from 2002/2003 and 2007 Indonesia DHS) effectively integrated gender equality, young people and human rights?

bb) Did the programme design and implementation include strategies to ensure sustainability?
Effectiveness and efficiency

a. To what extent have the expected results been achieved through the attainment of indicators?
b. Have the allocated budget sufficient to ensure achievement of the outputs?
c. What factors have played facilitating and constraining roles in achieving the expected results?
d. Is there a clear difference in quality and range of indicators in District in Figures Publications between pilot and non-pilot districts (should have similar characteristics with the pilot districts)
e. Is there a difference in quality and range of indicators in areas where the Database Forum was operating smoothly compared to those that did not have an active/existing Database Forum?
f. How have efforts of other Outputs contributed towards the achievement of the results made on increasing the utilization of data?
g. What is the opinion of stakeholders (policy makers, planners, data users and data collectors/processors) about the results?
h. Were financial and human resources used in the most efficient way?

Sustainability and programme replication

f) Are the achieved results sustainable?
g) Will local governments allocate sufficient resources to guarantee achieved results will be sustainable?
h) To what extent can it be expected that lessons-learned, good practices and innovative interventions provide inputs into the GoI’s initiatives to increase the quality and utilization of data for planning and policy making?
i) Is there any evidence in programme districts and non-programme districts that the PDS programme or part of it will be replicated to non-pilot districts upon the end of UNFPA funding?
j) What are the facilitating and constraining factors that affect the sustainability and programme replication?
Annex 4: Bibliography

Key External Documents


Ministry of Health, UNFPA. Guideline of Integrated Services for Women and Children Victims of Violence in Hospital Settings. 2009


Ministry of Social Affairs. Manual of Protection and Trauma Assistance Center. 2007

Ministry of Women’s Empowerment, Minimum Standard of Services of Integrated service for women and children victims of violence 2010

Ministry of Women’s Empowerment. Strategic Plan of Ministry of Women’s Empowerment, 2010 - 2014

National Population and Family Planning Board (BKKBN), National Strategy on Security of Contraceptive Availability (JKK)


Statistics Indonesia, BKKBN, MOH, Macro International. Indonesia Demographic and Health Survey.2007

The Jakarta Post. “Minister Against Sex Education in Schools”. June 10, 2010


Usman, Syaikhu. “Indonesia's Decentralization Policy: Initial Experiences and


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BPS Provincial Data/District “In Figures” (Lombok Timur dalam Angka):

- Nusa Tenggara Barat (2009)
- Lombok Barat (2009)
- Lombok Tengah (2009)
- Lombok Timur (2009)
- Nusa Tenggara Timur (2009)
- Kupang (2009)
- Timor Tengah Selatan (2009)
- Sumatra Selatan (2009)
- Ogan Komering (2009)
- Tasikmalaya (2009)

Country Program Document (Country Program 8)

Country Program Action Plan (Country Program 7)

Country Program Action Plan (Country Program 7), Revised 2008


Mid Term Reviews:


Standard Progress Reports (Badan Pusat Statistik Pusat):

- Standard Progress Report G101, Bappenas and UNFPA, 2009
- Standard Progress Report P101, Bappenas and UNFPA, 2009
- Standard Progress Report R101 and R205, Bappenas and UNFPA, 2009
- Standard Progress Report R105 and R301, Bappenas and UNFPA, 2009
- Standard Progress Report, IFPPD, 2009


Annex 5: List of Persons Met for the Evaluation of the 7th Country Programme

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Designation</th>
<th>Met with</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mr. Zahidul Huque</td>
<td>Representative - UNFPA Indonesia</td>
<td>RH Evaluator (Team Leader), PDS Evaluator</td>
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<td>2.</td>
<td>Ms. Martha Santoso Ismail</td>
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<td>3.</td>
<td>Mr. Subandi Sardjoko</td>
<td>Director of Population, Women Empowerment and Child Protection – BAPPENAS</td>
<td>3 evaluators</td>
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<td>4.</td>
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<td>Mr. Richard Makalew</td>
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<td>7.</td>
<td>Ms. Lany Harjanti</td>
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<td>9.</td>
<td>Ms. Elisabeth Sidabutar</td>
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<td>10.</td>
<td>Ms. Ramot N. Artonang</td>
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<td>3 evaluators</td>
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<td>11.</td>
<td>Mr. Ali Ismarraman</td>
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<td>12.</td>
<td>Mr. Ogi Safarqan</td>
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<td>13.</td>
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<td>15.</td>
<td>Mr. Heru P. Kasidi</td>
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<td>Ms. Retno Prasetyadi</td>
<td>Deputy Assistant of Violence against Women - MOWECP</td>
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<td>17.</td>
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<td>RH Adviser and NPO MNH – AUSAID</td>
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<td>18.</td>
<td>Mr. Abdurrahman Syebubakar</td>
<td>Programme Manager Policy Cluster – Poverty Reduction Unit – UNDP Indonesia</td>
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<td>19.</td>
<td>Mr. Rusdi Ridwan</td>
<td>National Programme Manager – NPCU – Bappenas</td>
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<td>20.</td>
<td>Mr. Muchtar Bakti</td>
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<td>21.</td>
<td>Ms. Sumarni</td>
<td>Centre of Training and Education (Pusdiklat MA) – Indonesia Supreme Court</td>
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<td>22.</td>
<td>Ms. Sita Widyawati</td>
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<td>23.</td>
<td>Ms. Annie Trisusilo</td>
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<td>24.</td>
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<td>27.</td>
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<td>Country Representative, The Ford Foundation</td>
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<td>29.</td>
<td>Mr. S. Happy Hardjo</td>
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<td>30.</td>
<td>Ms. Astrid Gonzaga Dionisio</td>
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<td>31.</td>
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<td>32.</td>
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<td>33.</td>
<td>Mr. Ahmad Pua Too</td>
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<td>RH Evaluator (Team Leader), PDS Evaluator, GBV Evaluator</td>
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<tr>
<td>34.</td>
<td>Mr. Haryo B Wicaksono</td>
<td>District Programme Manager (DPM) – East Lombok</td>
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<td>35.</td>
<td>Mr. Anusapati</td>
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<td>Mr. Aan. P. Suryanatha</td>
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<td>37.</td>
<td>Mr. H.M. Jamluddin</td>
<td>BKKBN Office, NTB</td>
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<td>Mr. Kusuma Supake</td>
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<td>47</td>
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<td>Ms. Titi Handayani</td>
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