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UNICEF Indonesia:
Formative Evaluation
of the Child Survival
Development (CSD)
Cluster, 2016-2020

Final Report

20 December 2019

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The contents of this evaluation report are the sole responsibility of the evaluators.

ETHICS STATEMENT

Dalberg Advisors has ensured the integrity and quality of this evaluation study. We sought informed and voluntary consent from individuals who participated in the interviews and meetings and have maintained the confidentiality of the respondents. The information, findings, recommendations and lessons learned enclosed in this report are independent and impartial. The consultants accept all responsibility for any errors or omissions.

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ACRONYMS

Acronym	Meaning
<i>AIMI</i>	Association for Nursing Mothers in Indonesia
<i>ANC</i>	Antenatal Care
<i>BAPPEDA</i>	Badan Perencanaan dan Pembangunan Daerah (District Planning and Regional Development Agency)
<i>BAPPENAS</i>	Badan Perencanaan Pembangunan Nasional (National Development Planning Agency)
<i>BMGF</i>	Bill and Melinda Gates Foundation
<i>BMS</i>	Breastmilk Substitutes
<i>C4D</i>	Communications for Development
<i>CFO</i>	Chief Field Officer
<i>CMAM</i>	Community-Based Management of Acute Malnutrition
<i>CPAP</i>	Country Programme Action Plan
<i>CPD</i>	Country Programme Document
<i>CSD</i>	Child Survival and Development
<i>CSO</i>	Civil Society Organisation
<i>DAC</i>	Development Assistance Committee
<i>DBM</i>	Double Burden of Malnutrition
<i>DHO</i>	District Health Office
<i>DRR</i>	Disaster Risk Reduction
<i>EAPRO</i>	East Asia and the Pacific UNICEF Regional Office
<i>ECD</i>	Early Childhood Development
<i>ERG</i>	Evaluation Reference Group
<i>FGD</i>	Focus Group Discussions
<i>FO</i>	Field Office
<i>GAVI</i>	Global Alliance for Vaccines and Immunisation
<i>GoI</i>	Government of Indonesia
<i>HCF</i>	Healthcare Facilities
<i>HFA</i>	Hyogo Framework for Action
<i>HIV</i>	Human Immuno-deficiency Virus
<i>HSS</i>	Health Systems Strengthening
<i>IDP</i>	Internal Displaced Person
<i>IHME</i>	Institute of Health Metrics and Evaluation
<i>IMAM</i>	Integrated Management of Acute Malnutrition
<i>IMNCI</i>	Integration Management of Newborn and Childhood Illness
<i>IYCF</i>	Infant and Young Child Feeding
<i>KPIs</i>	Key Performance Indicators
<i>LLIN</i>	Long-Lasting Insecticide Nets
<i>LRI</i>	Lower Respiratory Infection
<i>LMIC</i>	Lower Middle-Income Country
<i>MCH</i>	Maternal and Child Health
<i>MHM</i>	Menstrual Hygiene Management
<i>MMR</i>	Maternal Mortality Rate
<i>MNCH</i>	Maternal, Newborn and Child Health
<i>MoEC</i>	Ministry of Education and Culture
<i>MoH</i>	Ministry of Health
<i>MoP</i>	Ministry of Planning
<i>MoRA</i>	Ministry of Religious Affairs

<i>MoU</i>	Memorandum of Understanding
<i>MSS</i>	Minimum Service Standards
<i>NCD</i>	Non-communicable diseases
<i>NTT</i>	East Nusa Tenggara
<i>ODF</i>	Open Defecation Free
<i>OECD</i>	Organisation for Economic Cooperation and Development
<i>PA</i>	Programme Associate
<i>PAUD</i>	Early Education Centres
<i>PCV</i>	Pneumococcal Conjugate Vaccine
<i>PHO</i>	Provincial Health Office
<i>PFP</i>	Private Fundraising and Partnerships Division
<i>PME</i>	Programme Monitoring and Evaluation
<i>PMTCT</i>	Prevention of Mother-To-Child transmission
<i>PPTCT</i>	Prevention of Parent-To-Child Transmission
<i>PTA</i>	Parent Teacher Association
<i>RPJMN</i>	Rencana Pembangunan Jangka Menengah Nasional (National Medium-Term Development Plan)
<i>SAM</i>	Severe Acute Malnutrition
<i>SDG</i>	Sustainable Development Goals
<i>SQUEAC</i>	Semi-Quantitative Evaluation of Access and Coverage
<i>SMART</i>	Standardised Monitoring and Assessment of Relief and Transition
<i>STBM</i>	Sanitasi Total Berbasis Masyarakat (Community Based Total Sanitation)
<i>TB</i>	Tuberculosis
<i>T2DM</i>	Type 2 Diabetes Mellitus
<i>ToC</i>	Theory of Change
<i>ToR</i>	Terms of Reference
<i>UCG</i>	Universal Child Grant
<i>UHC</i>	Universal Health Coverage
<i>UKS</i>	Usaha Kesehatan Sekolah
<i>UNEG</i>	United Nations Evaluation Group
<i>UNICEF</i>	United Nations Children's Fund
<i>VMW</i>	Village Malaria Workers
<i>VNR</i>	Voluntary National Review
<i>WASH</i>	Water, Sanitation, and Hygiene
<i>WHO</i>	World Health Organisation
<i>WinS</i>	WASH in Schools

EXECUTIVE SUMMARY

Object

UNICEF Indonesia contracted Dalberg Advisors to conduct an independent, formative evaluation of the Child Survival and Development (CSD) cluster in preparation for its next Country Programme Document (CPD) 2021-25. UNICEF Indonesia's health, nutrition, and water, sanitation and hygiene (WASH) are grouped under the CSD cluster. The CSD is the largest component of UNICEF's country programme in Indonesia, planned at a total of USD 45 million over five years, and managed by over 50 staff (out of USD 146 million over five years, and 150 personnel for UNICEF Indonesia as a whole). The CSD works to achieve more equitable access to evidence-based health, nutrition, and WASH services for women and children, at national levels and in the focus provinces of Papua, West Papua, East Nusa Tenggara (NTT), West Nusa Tenggara (NTB), South Sulawesi, West Sulawesi, Central Sulawesi¹, Maluku, North Maluku, Central Java, East Java, and Aceh. This work is led out of Jakarta, with sub-national activities led out of seven regional and sub-regional offices in Jayapura, Manokwari, Makassar, Ambon, Kupang, Surabaya and Banda Aceh.

The evaluation is well-timed as the Country Programme Action Plan (CPAP) 2016-2020 is ending and it is critical to reflect on the relevance, effectiveness and sustainability of UNICEF CSD's areas of work, 'ways of working', and the additionality of its cluster approach. Over the course of the current country programme, the CSD cluster has shifted most of its work from 'downstream' programmes focused on providing services closer to the end beneficiary to 'upstream' systems strengthening efforts or at least to 'downstream' programmes with links to 'upstream' results. The mandate of the cluster mechanism – as different from the work of individual sectors – has also evolved. In 2016, the focus of the cluster was enabling individual sectors to operate effectively, for example, through performing a 'backstopping' role of filling gaps in technical expertise and leadership and strengthening processes. As the health, nutrition, and WASH programmes have grown, this has become less relevant, and the cluster mechanism could be adjusted to support in other ways.

Purpose, Objectives, and Scope

The purpose of the evaluation is to understand whether the CSD cluster approach is relevant, effective, and sustainable, and fit-for-purpose given a rapidly changing context. In doing so, it aims to achieve four key objectives:

1. Review to what extent the CSD has achieved its planned outputs, how its 'ways of working' have contributed to this, and what additional capacities may be required going forward²
2. Understand to what extent, and when, the CSD cluster approach (as compared to separate programme areas) is relevant, effective, and sustainable in supporting UNICEF's planned results for children in Indonesia
3. Review whether and when the CSD cluster activities have had an additional effect, compared to the single sector approach
4. Provide evidence-based recommendations that will advise the country programme management on how to shape the new CPD and future programming to achieve better results for children in the areas of the CSD programme component

The primary audience for this evaluation is the UNICEF country programme management and the national Government of Indonesia (GoI), who will use the results of this evaluation to inform future programmatic focus areas. The secondary audience for the evaluation is other partners, such as the sub-national governments, civil society, the private sector, academia, youth and

¹ Added as a focus province due to the 2018 earthquake and tsunami.

² While Objective #1, #3, and #4 represent the original list from the ToR, Objective #2 was added partway through the engagement after discussions with UNICEF senior management. The intent was to highlight as assessment of 'ways of working'.

religious groups. These organisations engage both directly and indirectly with CSD in its programme implementation.

This evaluation focused on the CSD cluster as defined in the CPAP 2016-2020. The analysis included the seven output areas of the current CSD cluster and touched on other UNICEF Indonesia programme areas and shared functions outside of CSD where necessary for answering CSD-related questions. While the evaluation team (ET) assessed programme areas to understand the incremental effect of the cluster approach and how effective it has been, it did not evaluate all programme areas within the cluster. Geographically, this evaluation covered UNICEF's work at the national level, as well as at the sub-national level through its presence in field offices (FOs) around the country.

The ET and evaluation reference group (ERG) agreed on certain elements as out-of-scope. Activities conducted and results achieved before 2016 have not been included as evidence, except for programmes or efforts that began before 2016 but were intended to continue into the 2016-2020 timeframe. All outputs were reviewed; however, programme deep-dives focused primarily on malaria, immunisation, breastfeeding, Integrated Management of Acute Malnutrition (IMAM), open defecation (OD), and WASH in schools (WinS) programming. While no geographic areas were excluded from the analysis, the ET only conducted in-person site visits in Jakarta, Kupang, and Makassar and interviewed UNICEF staff in Banda Aceh over the phone. Finally, the methodology and findings do not explore impact and efficiency criteria given the formative nature of the evaluation and the lack of data with which to make cost-benefit assessments.

Methodology

This evaluation followed a participatory, utilisation-focused and theory-based approach, relying on a non-experimental and primarily qualitative design. It also relied on a case study approach for questions where the level of complexity required in-depth review (i.e., the effectiveness of 'ways of working' and additionality of the cluster mechanism).

The research questions and evaluation framework drove the data analysis process. Data collection methods included (i) desk review, (ii) key informant interviews with internal UNICEF staff as well as external stakeholders (e.g., government, civil society organisations (CSOs) UNICEF Country Offices) both at the national and sub-national level, (iii) a UNICEF staff survey (response rate = ~44%), (iv) field office visits to Kupang and Makassar, and (v) consultation and validation sessions with internal and external stakeholders on the preliminary findings and, eventually, recommendations

The evaluation framework was developed based on a selection of the criteria set out in the OECD/DAC 'Principles for Evaluation of Development Assistance' – relevance, effectiveness, and sustainability – against the normative principles of human rights, equity and gender equality. 'Relevance' was evaluated due to the changing nature of Indonesia's landscape (rural to urban, decentralisation of governance) as well as changes in UNICEF's strategy ('downstream' to 'upstream'). 'Effectiveness' was considered to understand the factors that might best enhance the design of the next CPD. 'Sustainability' was considered to determine the extent to which UNICEF is creating long-lasting change that would persist in its absence. Given the formative nature of the evaluation and the fact that the current CPAP has not yet been fully implemented, 'impact' was not a key consideration. Similarly, 'efficiency' was deprioritised due to a lack of data for a cost-benefit analysis and the increasingly 'upstream' nature of the CSD's work.

Key findings

Relevance

Almost all areas of the CSD cluster's current programme remain relevant to Gol's national child-related priorities (as outlined for the RPJMN 2020-2024) and the most critical risks and causes of child mortality and morbidity.

While Indonesia has made significant progress towards its national targets for eliminating malaria and becoming Open Defecation Free (ODF), work remains. However, this progress may imply a shift in priority, focus, or type of support that UNICEF seeks to provide in coming years (e.g., towards the maintenance of elimination of malaria and open defecation in provinces that are close to achieving the targets, while continuing more intensive support in others).

As Indonesia rapidly urbanises and the effects of climate change increase, new issues will require exploration, including rising incidences of obesity and tobacco consumption among children leading to increased rates of non-communicable diseases (NCDs), worsening air pollution, and a rise in diseases such as dengue. The effects of climate change will exacerbate disaster risk, reinforcing the need to prioritise UNICEF’s work on risk-informed programming as well as disaster preparedness.

Overall, programme integration is not clearly articulated in the CSD cluster, with low clarity on its intent and vision among UNICEF staff. The activities that can be attributed to the CSD cluster, as opposed to any specific sector, have not been articulated clearly and have evolved, making it difficult to link them to the overall objectives of the CSD cluster. Currently, the integrated approach of the CSD cluster targets coordination of management, functions, and processes more so than integrated programming as appears to initially have been intended.

While the current CSD cluster approach remains valid to the coordination of health, nutrition, and WASH priorities within the Ministry of Health (MoH), it is not set up to adequately respond to the original demands from government and other partners for more integrated programming that were among the initial reasons for its creation in 2011. The current focus on coordination as the primary mode of integration leaves room for approaches that might better enable other types of integration (e.g., advocacy, programming) where appropriate. The government’s most recent experience with stunting highlights the importance of a shared vision and logical framework, which is missing from the CSD approach.

While the UNICEF Private Fundraising and Partnerships (PFP) team reported that certain types of funders - specifically foundations - expressed interest in the narrative of integration, the majority of UNICEF funding remains sectoral (~89% for 2019 to date)³.

Effectiveness

Almost all⁴ 2018 output targets for nutrition, health, and WASH have been achieved, and all 2019 output targets have been or are on track to being achieved; in some cases (e.g., nutrition, maternal, newborn, and child health (MNCH), and health systems strengthening), 2020 outputs targets have been achieved. UNICEF’s country programme has demonstrated effectiveness through its contributions to meeting these targets.

UNICEF’s nutrition programme provides direct support to 10 districts in 4 provinces (Aceh, Central Java, NTB, and NTT) and operates at a provincial scale in one province (NTT). It has contributed to output targets related to IYCF, management for Severe Acute Malnutrition (SAM) and CMAM through technical assistance and evidence generation as described below. It has also engaged in advocacy leading to the inclusion of nutrition priorities in the RPJMN.

UNICEF’s WASH programme provides direct support to 11 districts in 6 provinces (Aceh, NTB, NTT, South Sulawesi, West Papua, and Papua) and operates at a provincial scale in all 6 provinces. It has been supporting the MoH to strengthen the implementation of its National Sanitation Programme (STBM) by supporting evidence generation, the standardisation of practices, and the development of guidelines for implementation. While it has had many key successes advocating for the elevation of WinS among government priorities (e.g., inclusion in MoEC strategies and roadmaps, leveraging

³ CSD funding trackers, interviews. This excludes USD 1,100,000 from Cargill for flexible use between Health and Immunisation. While this is a ‘cross-team’ grant, the ET did not classify this as ‘cross-sectoral’.

⁴ The one exception was “% confirmed malaria cases in public and private health facilities receiving ACT in selected districts” (1.5.2), where 2018 achievement was 76% vs. a target of 80%

government funding), these advocacy efforts have been more challenging due to the need to work across multiple ministries in which the WASH team has varying levels of leverage.

UNICEF's health programme provides direct support to 89 districts in 11 provinces (Aceh, Central Java, East Java, NTB, NTT, West Sulawesi, South Sulawesi, North Maluku, Maluku, West Papua, and Papua). It operates at a provincial scale in all 11 provinces). It has directly supported on the development of costed MNCH action plans, Integrated Management of Newborn and Childhood (IMCI) and Triple Elimination (of HIV) guidelines, and the technical assistance required to roll these out at the provincial level. UNICEF has made key contributions in the area of malaria, testing and generating evidence around malaria elimination and providing capacity building and technical assistance to provinces currently working to eradicate the disease. On immunisation, UNICEF also provides critical technical assistance and support on vaccine availability, while supporting on-demand generation and addressing vaccine hesitancy on key campaigns (e.g., 2017-2019 Measles-Rubella campaign that achieved 87% coverage).

UNICEF has been effectively deploying its 'ways of working' to achieve its results. It can improve knowledge management in some areas (e.g., STBM evaluation highlighting need to streamline and better leverage knowledge products), incorporate communications for development (C4D) strategies even more across the cluster (e.g., expand efforts in nutrition programmes), and seek opportunities to leverage non-financial private sector partnerships wherever appropriate for increasing the effectiveness of its advocacy and innovation.

A review of CSD pilots selected based on available documentation showed that they all demonstrated the effectiveness of the intervention. Of these, two-thirds resulted in changes in national or sub-national policy or guidelines, and two-thirds scaled nationally or were incorporated into a Gol programme with a planned national scale-up. Where UNICEF has been able to scale pilots successfully, government buy-in has been key. In particular, it has been important to focus on something that is already a government priority or for which there is a clear link to the government's existing or planned efforts. Adequate government capacity, both financial and human, has also been significant.

The CSD cluster works primarily as a mechanism for coordinated management, functions, and processes, with little integrated activity. There is evidence that the CSD cluster has had some additional effect at the level of systems and processes that would likely enable better work within the sectors; however, the ET was not able to explicitly link these benefits to results or outputs. Clear cases in which the cluster approach is more appropriate than a single-sector approach include national data system strengthening and programme design and implementation when government demand (e.g., interesting in multi-sectoral approaches to stunting) or structures (e.g., the Gol's integrated school-based health program) requires it.

Sustainability

National planning and budgeting are anchored on the government's SDG priorities. Thus, the CSD approach is embedded in these processes in that BAPPENAS-level planning takes a more holistic view – although WASH sits across multiple directorates within BAPPENAS, while health and nutrition activities are more streamlined. However, activity-level planning and budgeting happen at a ministerial – and, ultimately, sub-directorate – level. The WASH activities on which the CSD currently focuses sit across multiple ministries, including the MoH and Ministry of Education and Culture (MoEC), suggesting some departure from the CSD approach of integrating these activities alongside those of health and nutrition.

The existence of a CSD chief has improved UNICEF’s capacity to increase fundraising, however, most fundraising remains sectoral (89% in 2019)⁵ and the ET found no evidence to suggest that the CSD’s coordinated approach leveraged additional funding outside of its fundraising activities.

Cross-cutting issues

Although some examples of UNICEF gender- responsive⁶ programme design and tailoring emerged in programme documentation or through interviews, the lack of documentation of the results these efforts and thorough gender analyses suggests that there is room for a more systematic approach to gender.

UNICEF Indonesia focuses its sub-national work in areas with weaker development indicators and its programmes do often include some component targeting more vulnerable populations (e.g., STBM, IMAM, Malaria). However, a lack of disaggregated data in government data prevents it from tailoring its upstream work to equity considerations beyond region and gender (e.g. children with disabilities, groups facing unique stigmas).

At the national level, UNICEF may need to expand its capacities to better leverage C4D expertise, increase gender intentionality, and prepare for any expansion into new areas of work. At the sub-national level, increased capacities in C4D, public finance management, and data analytics will be essential in continuing to support to government partners.

Conclusions

The areas of focus under the CSD programme remain relevant to Gol development priorities and the most pressing issues facing Indonesian children in alignment with the SDGs.

Overall, the CSD programme and ‘ways of working’ have been effective in facilitating UNICEF’s contributions to the achievement of CP outputs. The majority of interventions tested through its pilot-to-scale approach have been successfully scaled through national policies or incorporated into national plans for scale (e.g., IMAM, malaria elimination, malaria in pregnancy). However, it was not possible to assess whether these were always the most efficient ways in which to achieve results. Furthermore, the process for prioritisation and broader guidelines to ensure consistency with UNICEF global guidance on piloting was not always clear.

While the CSD cluster mechanism has served as a stabilising structure and coordination mechanism as the individual sectors (health, nutrition, and WASH) have grown, it is only recently beginning to contribute to results for children more directly (e.g., through the development of integrated programming or multi-sectoral support on Gol data systems strengthening). Now that the CSD sectors are in a stronger position in terms of systems and processes, there are fewer ways in which the current implementation of the cluster approach is additional vs the single sector approach; the technical oversight and the CSD chief’s fundraising role are potential exceptions. However, there is room improve the cluster’s ability to facilitate increased integrated advocacy and programming, which will become more relevant in tackling some of the newer areas of work (e.g., NCDs, air pollution, disaster risk reduction).

The CSD sectoral work has taken steps to enhance the sustainability of its impact during this country programme by shifting its sectoral work to focus more on change at a systemic level vs. service delivery on the ground. Some programmes (e.g., malaria, STBM, IMAM) have been more effective at this. Even for those that maintain some downstream portfolio outside of pilots (e.g., immunisation) aim to strengthen capacity within the government system at the same time.

⁵ (UNICEF, Child Survival Development Monthly Funding Status Update, 2019) . This excludes USD 1,100,000 from Cargill for flexible use between Health and Immunisation. While this is a ‘cross-team’ grant, the ET did not classify this as ‘cross-sectoral’.

⁶ Gender responsive: identifies and addresses the different needs of girls, boys, women and men to promote equal outcomes.

However, humanitarian emergencies present a growing external threat to the sustainability of all UNICEF activities, reinforcing the need to invest in emergency preparedness internally and within government systems across the health, nutrition, and WASH sectors.

Recommendations

The evaluation team prioritised the following four recommendations along two timeframes:

- *Short-term:* For implementation before the launch of the next country program
- *Medium-term:* For implementation at the launch of the country program

Recommendation #1: (Short-term): While the vast majority of areas of work under the current CSD programme remain relevant to national GoI child-related priorities, the ICO senior management and CSD leadership should explore some adaptations based on emerging priorities in Indonesia to ensure continued relevance in the next country programme:

- Consult with national and sub-national government partners on potential new – or nascent, and growing – areas of work as discussed in the findings and conclusions to understand where UNICEF partnership would be valuable vs that of other development partners (i.e., NCDs, dengue, air pollution, impact of climate change on disasters and emergency preparedness)
- Continue shifting priority, focus, or type of support for issues as sufficient progress is made against national impact targets (e.g., to maintenance for areas where progress has been made on malaria while maintaining more intense support to persistent high-burden areas; to maintenance for areas where progress has been made on ODF, but continuing elimination activities in Java and other areas where the issue persists)

Recommendation #2: (Short-term, unless otherwise stated): Although UNICEF's 'ways of working' have effectively facilitated its contributions to the achievement of 2018 and 2019 country programme outputs, they can continue to be sharpened. Based on the evidence available, this evaluation has surfaced a few ways in which UNICEF senior management can invest in strengthening 'ways of working' across the office:

- (Medium-term, cross-cluster) Ensure consistency of pilot-to-scale approach by clarifying and documenting its process for prioritising pilots and putting in place design guidelines based on UNICEF's PPP Manual (e.g., a clearly stated targeted change upfront as well as a perspective of when/why a pilot might be shut down)
- (CSD-specific) Review knowledge management approaches across programmes, focusing on fewer knowledge products that are disseminated more effectively in cases where not all products have had a clear purpose or translating evidence into changes in policy or programming has been less effective (e.g., WinS, some aspects of STBM)
- (Cross-cluster) Expand use of C4D, including ensuring that all programmes are at least reviewed upfront to identify potential C4D needs or opportunities
- (Cross-cluster) Strengthen strategies, and networks required to advocate to government and other actors in cases where private sector stakes are key (e.g., regulation of breastmilk substitutes)
- (Cross-cluster) Expand use of partnerships with the private sector when relevant for advocacy where private sector actors are influencers (e.g., product labelling or regulations), innovation where private sector actors can facilitate access to technology (e.g., use of mobile or communications technology to reach target populations), and awareness generation where private sector actors have faster or more far-reaching channels of communication than government (e.g., use of newspapers and other media for disseminating messages)

Recommendation #3: (Short-term): To further enhance UNICEF's effectiveness in achieving results for children, UNICEF senior management should invest in the following capacities:

- Increase C4D capacity to enhance UNICEF's ability to develop and provide technical advice on campaigns aimed at behaviour change and demand generation (e.g., vaccine hesitance, ODF, breastfeeding practices)

- Increase data analytics capacities at the sub-national level to support the government in using real-time data to inform its interventions
- Increase public finance management and budgeting capacities at the sub-national level to support the government in evidence-based planning and decision-making around resources required and more efficient allocation of those funds
- Build a stronger understanding of and ability to conduct gender analyses aimed at highlighting the relevant differentiated needs of boy and girls (and women and men) during programme design. These should be aimed at increasing capacity of staff to act on global UNICEF guidance (e.g., 2018 Gender Programmatic Review Toolkit)

Recommendation #4: (Medium-term): As concluded in the evaluation, there is currently relatively little integrated activity within the CSD cluster, as it serves as more of a coordination mechanism. However, even within a coordination mechanism, there is an opportunity for increased collaboration. To better deliver on results for which a multi-sectoral approach would be beneficial, UNICEF senior management should explore methods to promote and increase accountability for collaboration and increase accountability across Cluster and Section Chiefs by:

- Within the office-wide Programme Strategy Note (PSN), outline a shared office-wide vision for how, to what end, and in what instances different teams will collaborate; how teams can collaborate along different 'ways of working' (e.g., advocacy, evidence generation); and how responsibilities will be assigned and managed in these cases. This should be underpinned by a shared logical framework for the vision, specifying each sector's contribution
- Select a few concrete areas in which to focus on improving collaboration first. Based on internal and external interviews, these could be data and analytics (i.e., better leveraging data internally to both improve UNICEF's strategies and strengthen GoI systems) and coordination on multi-sectoral initiatives or government departments which currently interact with multiple UNICEF focal points in a fragmented way (e.g., UKS programme, Sub-Directorate of Adolescent Health)
- Identify a 'focal sector' for each shared priority (e.g., nutrition team could coordinate activities around stunting, although multiple sectors would be involved)
- Create designated forums or channels for identifying opportunities for collaboration (e.g., repurpose CSD or other weekly meetings to focus solely on collaboration at least once a month)
- Make cross-sectoral collaboration a more explicit part of Cluster Chief and Section Chief performance reviews (e.g., consider the extent of cross-sectoral inputs during programme design)

I. BACKGROUND

Context

Children under 19-years-old make up over a third of Indonesia's population, which is diverse, majority urban, and the 4th largest in the world. At 271 million inhabitants as of 2018⁷, Indonesia is the world's 4th most populous nation. The country is home to 1300 ethnic groups⁸, 300 different native languages⁹ and six major religions¹⁰. 55% of the total national population lives in urban areas, and the average per capita income is \$3900 in current USD¹¹. Over 35% of the population is under the age of 19, making Indonesia a relatively young nation¹².

Despite rapid economic growth and a transition into a middle-income country, Indonesia's children continue to experience significant deprivations, fuelled by vast social inequities. Indonesia's GDP growth has averaged ~5% p.a.¹³ over the past decade, and the country is rapidly transforming from a rural to an urban economy. The country's cities have grown at 4% per year, faster than any other country in Asia¹⁴. Despite these developments, more than 11 million children live below the national poverty line¹⁵. On average, one in 30 children die before reaching the age of five; in the least developed areas of the country, this figure is as high as one in ten¹⁶. Many of these deaths are caused by preventable diseases, environmental conditions that spread infections, and poor behavioural patterns such as open defecation. Poor systems delivery and weak infrastructure exacerbate the situation. For example, only 5% of wastewater in Indonesia is treated¹⁷, and 26,000 schools have no access to toilets¹⁸.

Health, nutrition, and WASH indicators reveal a high prevalence of stunting, wasting, and overweight, which have created a double burden of malnutrition (DBM) and an increased risk of non-communicable diseases (NCDs). Immunisation rates are low and poor WASH conditions are consistently observed in institutions and schools. Both stunting and wasting remain prevalent, affecting 30% and 10% of children under five, respectively, as of 2018¹⁹; 7% of children under five are either overweight or obese²⁰. The government's 'National Stunting Reduction Movement' has begun to address these issues, but severe acute malnutrition (SAM) is estimated to affect two million children under five²¹. Government data also suggests a decline in the complete basic immunisation coverage from 59% in 2013 to 58% in 2017²². Access to basic sanitation services²³ also continues to be low (~64%), having improved only two percentage points over the last decade.

Inadequate access to basic healthcare, driven by low public investment and a complex policy environment, compound the challenge, which is particularly acute in Indonesia's rural areas. More than 40% of community health centres in Papua, Maluku, and West Papua do not have physicians and dentists²⁴, dramatically limiting effective health care delivery. The shortcomings have clear consequences; recent lapses in routine immunisation coverage, for example, have resulted in

⁷ [World Population Review, Indonesia Population 2018, 2018](#)

⁸ Jakarta Globe, Unity in Diversity: Indonesia's Six Largest Ethnic Groups, 2016

⁹ University of Washington Asian Languages and Literature, Indonesian n.d.

¹⁰ Indonesia-Investments, Religion in Indonesia n.d.

¹¹ [World Bank, GDP per capita, 2018](#)

¹² ¹² Badan Pusat Statistik, Indonesian National Socioeconomic Survey (SUSENAS), 2018

¹³ [World Bank, GDP growth \(annual %\), 2018](#)

¹⁴ World Bank Indonesia's Urban Story 2016

¹⁵ The Economist Intelligence Unit, Megatrends to 2030: A document for UNICEF Indonesia, 2016

¹⁶ Prof. Gani, Ascobat and Prof. Budiharsana, Meiwita P., The Consolidated Report on Indonesia Health Sector Review, 2018, 2019

¹⁷ World Bank Improving service levels and impact on the poor: A diagnostic of water supply, sanitation, hygiene and poverty in Indonesia, 2017

¹⁸ UNICEF and Ministry of Education and Culture, PROFIL SANITASI SEKOLAH, 2017

¹⁹ Laporan Nasional Riskesdas, Badan Penelitian Dan Pengembangan Kesehatan 2019, Nutrition, 2018

²⁰ Laporan Nasional Riskesdas, Badan Penelitian Dan Pengembangan Kesehatan 2019, Nutrition, 2018

²¹ UNICEF Indonesia Website, Nutrition n.d.

²² Prof. Gani, Ascobat and Prof. Budiharsana, Meiwita P., The Consolidated Report on Indonesia Health Sector Review 2018, 2019

²³ Badan Pusat Statistik, Indonesian National Socioeconomic Survey (SUSENAS), 2018

²⁴ Prof. Gani, Ascobat and Prof. Budiharsana, Meiwita P., The Consolidated Report on Indonesia Health Sector Review 2018, 2019

outbreaks of diphtheria and polio. Low public investment in healthcare and the complexities of policy delivery in a populous and geographically fragmented country appear to be the primary causes of the problem. Public healthcare facilities have grown at 2% p.a., meaningfully trailing the growth of private facilities which have increased at 7% p.a.²⁵.

The challenges faced by Indonesia's children are further exacerbated by the country's high vulnerability to natural disasters, especially in Java and Sumatra. Indonesia is located on the Pacific Ring of Fire and is one of the world's most natural disaster-prone areas²⁶. Indonesia is vulnerable to earthquakes, tsunamis, volcanic eruptions, landslides, floods, droughts and fires. Over the past 30 years, Indonesia has faced an average of 289 significant natural disasters annually leading to 8000 average annual deaths²⁷. Indonesia spends up to 0.3% of its GDP on disaster relief, with some provinces spending up to 45%²⁸. Java and Sumatra are at the highest disaster risk in the country and are especially vulnerable to droughts, earthquakes, floods, landslides, and volcanoes²⁹. Frequent disasters make it difficult to set up infrastructure, allocate resources, and run programmes for CSD.

The GoI has recognised many of these issues in the child-related development targets it has set in its draft medium-term development plan (RPJMN 2020-2024). This plan is developed by the Ministry of National Development Planning (BAPPENAS) and implemented through multiple ministries under the coordination of the Ministry of Women's Empowerment and Child Protection. The Ministry of National Development Planning (BAPPENAS) develops annual, medium-term (five-year) and long term (10-year) plans for the government in consultation with the president, vice-president and various ministries. Key focus areas under the recently launched medium-term development plan include maternal and child health status and nutrition (e.g., maternal mortality ratio, infant mortality rate, prevalence of wasting and stunting in children), disease prevention and control (e.g., HIV incidence, malaria elimination status, prevalence of smoking and obesity), the health system (e.g., basic immunisation, accredited health facilities) and water and sanitation (e.g., households with access to proper and safe sanitation and drinking water). These programmes are coordinated by the national Ministry for Women's Empowerment and Child Protection³⁰. Furthermore, the Ministry of Social Affairs runs an Integrated Child Social Welfare Programme (PKSAI) to streamline case management, increase social worker capacity and enhance community engagement in early identification of vulnerable children.

Along with UNICEF, several other development actors have been working alongside the GoI to address many of these priority issues. The most active players in the health sector include the Global Fund, GAVI, the World Health Organisation (WHO), the United Nations Fund for Population (UNFPA), the United States Agency for International Development (USAID), and the United Nations Development Programme (UNDP). The World Bank, the World Food Programme (WFP), and Scaling Up Nutrition (SUN) movement are active in nutrition. The World Bank, the Asian Development Bank (ADB), the Australian Department of Foreign Affairs and Trade (DFAT), and USAID have made investments across different issues in water, sanitation, and hygiene.

UNICEF is at a crucial juncture in its partnership with the GoI; the coming year presents a unique policy window for the organisation to significantly advance its impact on serving children in Indonesia. UNICEF's mandate in Indonesia has the potential to address human rights and the well-being of the fourth-largest child population in the world, totalling over 80 million³¹. 2018 and 2019 have been critical years for policy reform and initiative development as Indonesia concluded its general elections and finalises the RPJMN 2020-2024 and budget priorities.

²⁵ Prof. Gani, Ascobat and Prof. Budiharsana, Meiwita P., The Consolidated Report on Indonesia Health Sector Review 2018, 2019

²⁶ Global Facility for Disaster Reduction and Recovery, Indonesia n.d.

²⁷ The Earth Institute at Columbia University, Indonesia Natural Disaster Profile n.d.

²⁸ Global Facility for Disaster Reduction and Recovery, Indonesia n.d.

²⁹ The Earth Institute at Columbia University, Indonesia Natural Disaster Profile n.d.

³⁰ [ECPAT International, Rencana Aksi Nasional Perlindungan Anak 2015-2019, 2016](#) 2019

³¹ UNICEF Indonesia Website, What we do

Furthermore, in 2019 Indonesia conducted its second Voluntary National Review (VNR), which assessed progress towards the SDGs. UNICEF can take advantage of this unique policy window to further develop its partnership with the government and work increasingly closely with government officials to advance child rights and increase social sector fiscal allocations for children as it finalises the next iteration of its CPD.

Object of the Evaluation

UNICEF intends to conduct an independent, formative evaluation of the CSD cluster in Indonesia. In its 2016-2020 CPAP between the Gol and UNICEF, collaboration opportunities were identified in the areas of maternal and child health, nutrition, water and sanitation, education, child protection, social policy, emergency preparedness, and disaster risk reduction. These areas of partnership were aligned to key strategic documents at the time, including Indonesia’s National Medium-Term Development Plan (RPJMN 2015-2019), the UNICEF Strategic Plan (2014-2017), and the United Nations Partnership for Development Framework (2016-2020). They were agreed jointly by the Gol and UNICEF. UNICEF Indonesia’s health, nutrition, and WASH is grouped under the CSD cluster. The CSD’s work is led out of Jakarta, with sub-national activities conducted out of seven regional and sub-regional offices in Jayapura, Manokwari, Makassar, Ambon, Kupang, Surabaya and Banda Aceh. CSD is the most significant component of UNICEF’s country programme in Indonesia, planned at a total of USD 45 million over five years, and managed by over 50 personnel (out of USD 146 million over five years, and 150 staff for UNICEF Indonesia as a whole, respectively). The CSD cluster works to achieve more equitable access to evidence-based health, nutrition, and WASH services for women and children, in Papua, West Papua, NTT, NTB, South Sulawesi, West Sulawesi, Central Sulawesi, Maluku, North Maluku, Central Java, East Java, and Aceh.

The cluster works primarily to support the national and sub-national government stakeholders with their strategies and national programmes through involvement of implementing partners and multilateral agencies (see Appendix E for stakeholders involved).

In 2018, the CSD’s donors and funding contributions are shown in Figure 1 below. Notably, bilateral (e.g., USAID, DFID, DFAT) and multilateral (e.g., GAVI, and soon the Global Fund) funding is shifting away from Indonesia as it transitions to Middle-Income Country (MIC) status. This will likely strain fundraising going forward and make it difficult to maintain 2019 levels absent identification of additional sources.

Figure 1: UNICEF Indonesia CSD cluster funding (excluding emergency funds), USD³²



In its 2016-2020 CPAP, the CSD programme component aims to:

- Engage the health, nutrition and WASH sectors to strengthen systems, reduce preventable child deaths and address the underlying causes of childhood illness and undernutrition
- Design strategies to improve access to and quality of essential services, especially for the most marginalised populations

³² UNICEF, Indonesia Budget Documents; This only includes non-emergency funds

- Demonstrate the effectiveness of new interventions and explore how they can be tailored to diverse settings
- Establish partnerships across all regional and sub-regional offices, reflecting the diverse range of contexts in Indonesia

The CSD cluster aims to achieve the above ambitions through a single CSD outcome of “women and children having equitable access to evidence-based health, nutrition, and WASH services”. The CSD cluster outlined the following seven outputs needed to achieve the CSD outcome:

- *Output 1.1:* Governments and partner institutions have enhanced capacity and commitment to deliver quality services at scale to protect children from undernutrition and overnutrition
- *Output 1.2:* Governments and partner institutions have enhanced capacity and commitment to deliver quality services at scale, in urban and rural areas, to support the elimination of open defecation, access to safely managed water and sanitation and the promotion of hygiene practices
- *Output 1.3:* Governments and partner institutions have enhanced capacity and commitment to deliver WASH services in institutions at scale including the use of sustainable basic sanitation, safe drinking water, and improved hygiene behaviours
- *Output 1.4:* Government and partner institutions have enhanced capacity and commitment to deliver quality basic and comprehensive Maternal, Newborn and Child Health (MNCH) services including Prevention of Parent-To-Child Transmission (PPTCT) at scale
- *Output 1.5:* Government and partner institutions have the capacity and commitment to deliver quality services at scale to control vaccine-preventable diseases, malaria, and HIV, including a focus on young key populations, elimination of neonatal tetanus, measles, and malaria
- *Output 1.6:* Governments and partner institutions have improved capacity and accountability for health resource allocation based on evidence-based planning and in monitoring equity and implementation management of health in the era of Universal Health Coverage (UHC)
- *Output 1.7:* Government and partner institutions are prepared, have the adequate sectoral capacity and provide an effective and coordinated response for WASH, nutrition, and health in emergencies

In pursuit of the above outcome and outputs, the CSD cluster aims to achieve ambitious results through its partnership efforts with the government and civil society organisations.

The associated targets and performance indicators are detailed in the Summary Results Framework of the 2016-2020 CPAP, in Appendix J.

Theory of Change

The ET consulted several theories of change (ToCs) in developing this report, including output-level ToCs, the UNICEF Indonesia ToC, and a draft ToC for the CSD cluster.

The ET primarily relied on output-level ToCs (summarised in Appendix K) for assessing effectiveness. These were especially important for contextualising the CSD’s results and achievements in a broader narrative in cases where the CP results framework was more limited and linking these achievements to specific strategies or ‘ways of working’ was challenging. Given how much the programmes have grown and evolved with a changing context in Indonesia, these output-level ToCs (developed in May 2017) often provided a more representative view of the CSD’s current activity. Although the CSD developed a cluster-wide ToC at a workshop between February 28 and March 1, 2017, the output-level ToCs were ultimately most useful for reviewing individual sector work given their level of detail.

The ET also referred to UNICEF’s country-level theory of change to contextualise the expectations and intentions of the pilot-to-scale approach in the CSD’s work.

II. PURPOSE, OBJECTIVES, AND SCOPE

Purpose

The purpose of the evaluation is to understand whether the CSD cluster is relevant, effective, and sustainable, and is fit-for-purpose in a rapidly changing context. The evaluation will study the implications of the CSD cluster operating in a rapidly changing context characterised by a reduction of traditional donors, growth of the private sector, rapid urbanisation, and strengthening, yet variable, performance of government delivery across different regions. The evaluation also aims to help UNICEF understand whether the clustered CSD approach is additional in its intent to achieve better results for children.

The evaluation is timely given the evolution of the CSD cluster since the last CPAP, and the intention of UNICEF to use the findings from this study to inform the next CPD 2021-25. The CSD cluster staff increased from 35 to 52 between December 2016 and November 2019. Significant changes have been observed during this period, including most importantly, the appointments of section chiefs for health, nutrition, and WASH in the last few years. Funding and programmes have also grown. The mandate of the CSD cluster has also evolved; in 2016, the focus of the cluster was primarily on enabling the individual sectors to operate effectively, for example, through performing a 'backstopping' role of filling gaps in technical expertise and leadership and strengthening processes. As the health, nutrition, and WASH programmes have grown, this has become less relevant, and the cluster mechanism could be adjusted to support in other ways. The evaluation is well-timed as CPAP 2016-2020 is ending and it is critical to reflect on the relevance, effectiveness and sustainability of UNICEF CSD's areas of work, 'ways of working', and the additionality of its cluster approach as UNICEF senior management and the GoI look towards the next CPAP.

The primary audience for this evaluation is the UNICEF country programme management team and the national government, who will use the results of this evaluation to inform programmatic focus areas. The secondary audience for the evaluation will be other partners, such as the sub-national governments, civil society, the private sector, academia, and youth and religious groups. These organisations engage both directly and indirectly with CSD its various programme implementation.

Objectives

The evaluation aims to achieve four key objectives:

1. Review to what extent the CSD has achieved its planned outputs, how its 'ways of working' have contributed to this, and what additional capacities may be required going forward³³
2. Understand to what extent, and when, the CSD cluster approach (as compared to separate programme areas) is relevant, effective, and sustainable in supporting UNICEF's planned results for children in Indonesia
3. Review whether and when the CSD cluster activities have had an additional effect, compared to the single sector approach
4. Provide evidence-based recommendations that will advise the country programme management on how to shape the new (Country Programme Document) CPD and future programming to achieve better results for children in the areas of the CSD programme component

Scope

The primary scope of this evaluation is the CSD cluster, as defined in the CPAP 2016-2020. The evaluation focused on the seven output areas of the current CSD cluster. It also touched on other

³³ While Objective #1, #3, and #4 represent the original list from the ToR, Objective #2 was added partway through the engagement after discussions with UNICEF senior management. The intent was to highlight as assessment of 'ways of working'.

UNICEF Indonesia programme areas outside of CSD where necessary for answering a CSD-related question. Additional areas addressed include UNICEF's cross-cutting work on data and analytics, planning, monitoring and evaluation, C4D, and urban programming, amongst others. While the Evaluation Team (ET) assessed programme areas to understand the incremental effect of the cluster approach, it did not evaluate all programme areas within the cluster. Geographically, this evaluation covered UNICEF's work at the national level, as well as at the sub-national level through its presence in five field offices (FOs) around the country.

Certain elements were agreed to be out-of-scope with the ERG. Activities conducted, and results achieved before 2016 have not been included as evidence, except for programmes or efforts that began before 2016 but were intended to continue into the 2016-2020 timeframe. All outputs were reviewed; however, programme deep-dives focused primarily on malaria, immunisation, breastfeeding, Integrated Management of Acute Malnutrition (IMAM), open defecation, and WASH in schools (WinS) programming. While this was not initially addressed in the ToR, the ET and ERG agreed that limiting this aspect of the scope would be necessary for enabling the ET to conduct an in-depth assessment given the size of the overall CSD programme. While no geographic areas were excluded from the analysis, the ET only conducted in-person site visits in Jakarta, Kupang, and Makassar and interviewed UNICEF staff in Banda Aceh over the phone. Finally, the methodology and findings do not explore impact and efficiency criteria given the formative nature of the evaluation and the lack of data with which to make cost-benefit assessments. Justification for these scope selections is provided in the methodology.

III. METHODOLOGY

This evaluation followed a participatory, utilisation-focused and theory-based approach, relying on a non-experimental and primarily qualitative design. It also relied on a case study approach for questions where the level of complexity required in-depth review (i.e., the effectiveness of 'ways of working' and additionality of the cluster mechanism).

Participatory approach: The approach involved working closely with UNICEF and government stakeholders involved in the CSD programme. UNICEF staff at both the country office and FOs were engaged through inception calls, internal presentations, and validation workshops. A smaller group – the CSD chief, CSD sector heads, Programme Monitoring and Evaluation (PME) chief, senior management, EAPRO regional representatives – sat on the Evaluation Reference Group (ERG) to provide iterative feedback on an almost weekly basis. Through these consultations, the ET, shared and refined first the approach during the inception phase, the emerging findings, and eventually proposed recommendations on an iterative basis with the ERG. At the national level, the GoI was invited to a workshop to validate some initial findings as well as to discuss areas on which to focus further. At the sub-national level, senior GoI stakeholders were consulted during visits to some field office locations.

Utilisation-focused approach: Priorities were determined based on what was required to facilitate senior management decision-making on how to shape CSD elements of the new country programme. The evaluation team worked iteratively with the ERG and senior management to ensure that the work remained relevant to the intended uses of the evaluation (i.e., evidence-based recommendations to inform the next CPD, adjusting focus as necessary throughout the process. For example, after the first validation workshop, an additional objective was added to the scope to ensure adequate focus on the CSD team's 'ways of working'.

Case study approach: Case studies were used for two key questions where developing findings for the broader programme required an in-depth examination of multiple examples. Specifically:

- **Programme results and 'ways of working':** We conducted detailed reviews of six programmes, two per sector - Integrated Management of Acute Malnutrition (IMAM), Breastfeeding (within Infant and Young Child Feeding (IYCF)), Malaria, Immunisation, STBM, Wash-in-Schools (WinS) and Menstrual Hygiene Management (MHM) - to assess the effectiveness of the CSD's 'ways of working' and focus on cross-cutting issues. Programmes were selected in close consultation with the CSD team, based on the following criteria: represents some of the sector's most critical work, has demonstrated some results, and has been well-documented enough to allow for a detailed review. The sample was then balanced to ensure it was representative of different 'ways of working' and contributions to equity of gender equality. It was not possible to find programmes that fulfilled all these requirements, as data was limited in several instances.
- **Integration and additionality of the CSD cluster:** We developed case studies to examine the extent and drivers of coordination and integration across the CSD within two FOs: Banda Aceh and Kupang. These were selected to optimise for: a) different approaches to coordination or 'integration', b) different levels of success with coordinated and integrated activity, and c) data availability. Banda Aceh was the one clear case of integrated programming within the CSD programme cited across the UNICEF office. Out of the two field offices the ET visited for data collection (sampling for FO visits included in data collection methods below), Kupang had representatives from all three CSD sectors as well as the education cluster, allowing for additional comparison. Banda Aceh was cited as the flagship case of integrated programming across the UNICEF Indonesia office

Theory-based: Approach involved close review of output-level theories of change constructed by the CSD team for questions related to effectiveness. Where possible, the ET drew links between contributions at the output level of the CP result framework to the overall CSD outcome.

The upstream nature of much of the CSD team’s work and the availability of data required a qualitative design to be adopted. To address the limitations of qualitative approaches, the evaluation team used mixed sources and types of data where possible to triangulate findings and surface differing data points. Where findings rely primarily on interviews, the evaluation team reviewed all notes to identify trends across multiple informants, surfacing disagreements, where necessary, to ensure a balanced view. Perspectives raised by only one relevant informant were treated as examples or suggestions for further exploration. The evaluation matrix provides a perspective on the level of confidence associated with each set of findings based on data availability and consistency. Where the confidence is low, it is indicated in the findings section of the body of the report. Due to the diversity of question type (e.g., level of depth, outcome-focused vs operational), it was not possible to develop a generic rubric.

While most data used was qualitative, the ET leveraged available quantitative data where possible. Including, data on the current status of a variety of relevant national indicators (e.g., Institute of Health Metrics and Evaluation database) to inform review of current and potential areas of work; data on extent of achievement of CSD outputs; data from an internal UNICEF survey on the additionality of the CSD cluster conducted during the evaluation; and UNICEF budget data to demonstrate extent of cross-sectoral funding.

The data analysis process was driven by targeted research questions and the evaluation framework.

Evaluation Criteria

The evaluation framework has been developed based on a selection of criteria set out in the OECD/DAC ‘Principles for Evaluation of Development Assistance’. Criteria chosen include relevance, effectiveness, and sustainability, against the normative principles of human rights, equity and gender equality. The criteria were selected with consideration of the purpose of the evaluation and availability of data.

Table 1: Summary of evaluation criteria explored

Evaluation criteria	Description or Rationale for Exclusion
Relevance	<u>Extent to which the CSD programme component is aligned and suited to Gol’s priorities and policies under the new RPJMN 2020-2024.</u> The ET assessed the relevance of current and potential future areas of work as well as the relevance of the cluster approach.
Effectiveness	<u>Extent to which the CSD cluster has achieved its planned outputs and the extent to which its approach enables UNICEF to attain these results.</u> The ET assessed the CSD cluster’s achievements against the CP results framework, the effectiveness of different strategies (including the pilot-to-scale approach), and the additionality of the cluster approach.
Sustainability	<u>Extent to which the CSD cluster’s integrated approach is resulting in elements that might contribute to the longevity of the impact of its work with the Gol (e.g., national ownership, leveraged funding).</u> The ET assessed the extent to which the CSD engages in activities that would make its impact more sustainable and the extent to which the CSD cluster approach is nationally owned and whether it contributes to increased leveraged funding.

Impact	N/A – Deprioritised (as per ToR) for this evaluation because the current CP has not yet been fully implemented and impact cannot be fully measured. Moreover, the focus on upstream results makes it difficult to highlight impact or attribute UNICEF actions to national-level impact indicators. Regardless, the ET did use these indicators to measure overall progress towards the CSD’s outcomes, linking these to the CSD’s outputs as possible.
Efficiency	N/A – Deprioritised (as per ToR) due to a lack of data with which to develop a cost-benefit analysis across the CSD component or benchmarks against which to conclusively measure whether programmes could be delivered at lower costs

In addition to the criteria, the evaluation also addresses cross-cutting issues, including the CSD cluster’s contribution to equity and gender equality. See Appendix C for the evaluation matrix containing the full list of questions, the evidence used to answer each, and high-level assessment of the strength of evidence.

Evaluation Questions

The following list of questions was developed in collaboration with the ERG and reflects questions prioritised from those originally included in the Terms of Reference (ToR). Given an agreement to focus detailed programmatic review on six agreed-upon areas as well as the seven CP outputs, some questions have been tailored to acknowledge that findings will be based on generalisable insights across these six case studies. Some final adjustments were made in light of the evaluability of the CSD cluster.

1. Relevance: Extent to which the CSD programme component is aligned and suited to Gol’s priorities and policies under the new RPJMN 2020-2024

- 1.1. What areas of the CSD programme are still valid and which are not and should be deprioritised?
- 1.2. What new areas of work should be considered in developing future CSD programming?
- 1.3. Are the regions in which the CSD programme operates sub-nationally still valid?
- 1.4. To what extent is programme integration clearly articulated in terms of linking cross-sectoral outputs to the overarching outcome?
- 1.5. To what extent is the CSD cluster approach still valid and aligned to the socio-economic context, priorities of government and other funders in Indonesia, and broader global UNICEF approach?

2. Effectiveness: Extent to which the CSD cluster and its integrated approach enables UNICEF to attain its planned results

- 2.1. To what extent have the CP outputs been achieved so far and what have been UNICEF’s contributions?
- 2.2. For those programmes reviewed, where – in terms of ‘ways of working’ – is CSD more effective and less effective in achieving programme results for children?
- 2.3. For those programmes reviewed, what were the key drivers of successful pilots to go to scale in CSD as well as stumbling blocks?
- 2.4. How, where, and when is the CSD cluster additional? Where and when is it not, and where would a single sector approach be more appropriate?
- 2.5. What is the optimal balance between national and sub-national workstreams and how should this be reflected in the structure and core capacities of the cluster?
- 2.6. Are there coordinated intra-cluster efforts or cross-cluster opportunities, such as with education, social policy or child protection, that should be further developed?

3. **Sustainability: Extent to which CSD approach is resulting in elements that might contribute to the longevity of impact of its work with the Gol (e.g., national ownership, leveraged funding)**
 - 3.1. To what extent is the integrated approach of CSD owned and embedded in the national planning and budgeting systems as compared to single sector approaches?
 - 3.2. To what extent is the CSD cluster approach, as compared to a single sector approach, contributing to increased leveraged resources for child rights at the national and sub-national level?
 - 3.3. Which existing partnerships should be leveraged and what new partnership opportunities should be explored, including with the private sector and potential financial partners/donors?
4. **Cross-cutting issues: Some key evaluation questions that apply across multiple criteria**
 - 4.1. How is the CSD programme contributing to gender equality among target populations?
 - 4.2. How is the CSD programme contributing to equity among target populations?
 - 4.3. What new capacities would be required within the cluster to take forward future programme areas?

Data Sources, Collection Methods and Sampling

Appendix C contains a detailed Evaluation Matrix linking questions to judgment criteria and data collection methods and sources. The evaluation team used the following methods:

Desk Review: The evaluation team conducted a desk review of ~90 documents related to (i) the vision, strategy, and achievements of the CSD program, (ii) the Gol's priorities around children's development, (iii) data around the causes and enablers of mortality and morbidity for children in Indonesia, and (iv) broader trends affecting the future development of children in Indonesia. The outcomes of this desk review informed the findings of this report, especially where triangulation was required. Appendix N contains a list of all documents reviewed.

Inception consultations: As part of the participatory approach of the evaluation, the evaluation team conducted in-person inception meetings with the ERG, the CSD chief and sector chiefs, the members of the Health, Nutrition, WASH teams, and the members of the data and analytics team, as well as a virtual inception call with the chiefs of field offices (CFOs) and CSD specialists based in the field offices.

Key informant interviews: The evaluation team conducted ~95 semi-structured interviews with ~10 participants – of which, ~59% were women and 41% were men – during the data collection visit between 17 and 26 July 2019 and via Zoom interviews which took place from mid-July to mid-September 2019. Interviewees included (i) most UNICEF CSD staff and some non-CSD staff in the Indonesia country and visited field offices, as well as several UNICEF staff members in the regional and other country offices (e.g., Vietnam); (ii) Gol representatives at the national and sub-national level; (iii) implementing partners and one funder. Almost all interviews included two members of the evaluation team to ensure as much detail as possible was captured with larger groups, one interpreter as required, and the participant(s). Where requested by the participants, interviews were conducted in groups - this was typically the case where teams wanted to discuss questions together or individuals newer to their roles wanted to ensure that somebody with more institutional knowledge was present. For each CSD sector, the evaluation team conducted two interviews: one with sector chiefs present and another without. In all cases, individuals had the opportunity to reach out via email or request an additional 1-on-1 interview if they wanted to share more. In each initial interview, the evaluation team stressed the confidentiality of the conversation and noted that care would be taken not to attribute comments to any individual.

For internal UNICEF interviews, the evaluation team tried to speak with every individual or team suggested by the ERG, including several from inside and outside the CSD team who approached ERG

members with an interest in contributing. No sampling strategy was applied, ensuring a balanced view across findings that, by their nature (e.g., the management structure of the CSD cluster, the strength of internal systems and processes), rely primarily on internal UNICEF inputs. For Gol and implementing partners interviewees, UNICEF CSD teams proposed two sets of interviewees: one more relevant for the specific programmes being reviewed and one more relevant for answering questions around integration. In terms of selection, the ET relied on the UNICEF CSD team to suggest those government and implementing partner counterparts that were most relevant for their programme work across outputs. Appendix F contains the semi-structured interview tools and list of interviewees.

UNICEF staff survey: For the more internally focused questions around the additionality of the coordinated approach of the CSD cluster, the evaluation team surveyed UNICEF staff. The survey was sent to 173 UNICEF Indonesia staff, with a response rate of ~44% (76 complete responses). No sampling strategy was applied, as the goal was to provide all staff with the opportunity to share their perspectives; however, data was collected to allow for segmentation of results by cluster, sector, office, and gender, as necessary. This survey provided an anonymous view across a standardised set of questions and statements which UNICEF staff might have felt uncomfortable answering directly within a group setting or even an individual interview while still on UNICEF premises. It sought to understand to what extent different elements of an integrated CSD approach were being implemented and, where they were being implemented, to what extent they were enabling CSD sectors to better execute against the core activities underlying their theories of change. G contains the list of survey recipients, survey tool used, and key results.

Field office visits: Field office visits primarily informed findings around additionality of the integrated CSD cluster approach at the sub-national level, the balance between national and sub-national work, and capacities required to be effective at the sub-national level. The sampling strategy was decided in collaboration with the ERG with the following criteria in mind:

- **Varying modalities of integration:** Offices chosen had adequate representation across CSD (i.e., specialists for at least two of the three sectors) and some representation of other clusters (i.e., Social Policy, Child Protection, Education). However, the sample was balanced to ensure representation of different models of integration (e.g., more vs less integrated programming or more vs less learning across sectors)
- **Geographical representation:** Regions with varying developing indicators (e.g., basic child vaccination rates), varying population concentrations (e.g., urban-rural mix)
- **Practical considerations:** As discussed earlier, some locations were inaccessible in the timeframe of the evaluation given entry restrictions (i.e., Banda Aceh and Papua). Given the importance of the integrated programming in Banda Aceh to the first sampling criteria, virtual meetings with a cross-section of stakeholders that would have been consulted in person.

Of a total of 7 potential offices, 4 were considered accessible. Logistical constraints made it impossible to visit Banda Aceh, Papua, and West Papua within the data collection timeframe. Of the remaining 4, Ambon was eliminated due to size – the other 3 have larger programmes –, and Surabaya was eliminated because not all three sectors were represented. The evaluation team visited the remaining two FOs, Kupang (from 17 to 19 July 2019) and Makassar (from 24 to 26 July 2019), to collect data in person from UNICEF field office staff, provincial- and district-level Gol partners, and other implementing partners. To ensure variation in modalities of integration, the ET also conducted multiple virtual interviews with UNICEF field office staff (in July 2019) and District Planning and BAPPEDA (in August 2019) to collect equivalent inputs in Banda Aceh, which houses the only example of integrated CSD programming across sectors. The key limitation of the sampling approach was that it excluded two of the top choices for FO visits based purely on the criteria. However, this was addressed through virtual interviews. As noted above, the UNICEF staff survey was also shared with staff in field offices. Chiefs of field offices participated in the first validation workshop (see below), where those who had not been consulted in person had the opportunity to respond to the

initial findings from the field visits. Appendix F contains a list of stakeholders consulted during each site visit.

Consultation and validation analysis: Consultation and validation occurred at two stages. First, before a draft of the report had been completed, an external meeting was held on 14 August 2019 with GoI stakeholders to present initial findings and solicit additional perspectives (~40 attendees). On the same date, an internal meeting was held with UNICEF staff to validate initial findings (~50 attendees). Following a second round of data collection and analysis, the evaluation team circulated a draft version of this report to UNICEF for comments and presented the findings and recommendations for validation to the ERG on 17 September 2019. Participants comments on accuracy and strength of evidence for the findings, and practicality of the recommendations were used to finalise the draft. A final validation call was held with the ERG on 3 December 2019 to refine and prioritise recommendations. Appendix H contains the list of participants in validation meeting.

Gender, Equity and Human Rights-Based Approach

The evaluation team developed its methodology, including the evaluation questions and data collection plan with gender, equity, and broader human rights considerations in mind. During this process the evaluation team adhered to UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluations (2014) and UN-SWAP Evaluation Performance Indicators. In addition to explicitly considering cross-cutting questions on gender and equity, the team reflected on these areas where relevant in other questions. Though participants were chosen based on relevance and programme knowledge, the team ensured adequate gender representation and made sure to speak with the gender focal points sitting outside of the evaluation object (CSD cluster). As previously discussed, field office visit selection included consideration of equity. In all cases, the team provided a professional interpreter when requested. Though most recommendations are neutral, gender and equity were prioritised in arriving at the appropriate full list.

Ethics

The evaluation was conducted in line with the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluations (2016) as well as UNEG Ethical Guidelines and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2015). The evaluation team acted with respect for the human rights, diversity and dignity of all research participants, as well as broader cultural sensitivities. This included providing a clear context for each interview and how the information would be used, ensuring interviewee anonymity, and protecting interviewee privacy. Participants were selected with the objectives of the evaluation in mind, and the team made efforts to speak with a set of stakeholders representative of those who would be most directly affected by recommendations. In the case of UNICEF staff, this meant speaking with anyone who expressed an interest. The evaluation team did not collect primary data through interviews with children as part of this evaluation.

The evaluation team exercised independent judgment and impartiality, raising any concerns around this responsibility or observed conflicts of interest to the UNICEF evaluation manager. As previously discussed, the team consulted a range of data sources and stakeholders and employed a mix of strategies to ensure the credibility of this report.

Evaluability, Other Risks, and Limitations

The ET faced and worked to address several limitations in conducting this evaluation. While some of these were highlighted through a high-level evaluability assessment during the inception phase (see Appendix B), others emerged during the data collection phase.

In the first place, time and political restrictions prevented the ET from reviewing all CSD programmes at the same level of depth and from visiting all FOs. While the ET did review all the

CSD outputs to assess the extent to which they had been achieved, the size and complexity of the CSD component required a more in-depth review (e.g., for assessing the effectiveness of different 'ways of working') of a somewhat shorter list of case studies. As previously discussed, these were chosen in consultation with the ERG based on an agreed-upon set of criteria to ensure that a large and representative enough sample was selected to inform findings. Similarly, FO office visits were selected in collaboration with the ERG according to the previously described sampling strategy. As the team would not have been able to secure permissions and visas to travel to Banda Aceh to collect data for a case study, a virtual visit was arranged via phone including a similar set of stakeholders as those consulted in the two FOs visited in person. All other FOs were consulted as a group during the inception phase and at the first validation workshop.

A significant limitation to the theory-based approach was the absence of an agreed-upon theory of change for the integrated CSD cluster and, in many cases, clearly outlined logic linking programme interventions and activities to CP outputs and outcomes. In terms of the theory of change, the ERG ultimately advised that questions related to the effectiveness of CSD programming be answered at an output or programme level. This decision reflected an understanding of the CSD cluster as a coordination mechanism as opposed to a set of integrated programming. Consequently, the ET relied primarily on the output-level ToCs to conduct its analysis. However, even this approach posed challenges as, while these ToCs provide an overall view of key strategies that were being used at the time of their construction (May 2017), they have not necessarily informed programming launched since then. Furthermore, they do not always include clear linkages to the output indicators articulated in the CPD. While the ET made efforts to address this by first contextualising its findings in the logic of the output-level ToCs – which are a better, though not perfect, representation of current activities – and triangulating evidence across internal and external interviews and documentation, this remains a limitation of the evaluation report. The ET did not use a ToC for assessing the additionality of the CSD cluster because most 'cluster-wide activities' were at the level of internal systems and processes and could not be clearly linked to the outcomes and results of a ToC.

Data availability also posed a challenge, particularly the limited number of previous evaluations and the inconsistent documentation of programme activities and their intended link to results. While the team leveraged previous evaluations where possible (e.g., STBM programme evaluation, 2018 partnerships evaluation) and reviewed the outputs of UNICEF's internal 2017 mid-year review, most programmes had not been previously evaluated. In reviewing the CSD outputs and associated programming, the ET found that, while results achieved were often captured, this was not always the case for the activities conducted and their intended link to these results. The ET recreated views of these activities by triangulating between internal interviews, donor reports, and external documents. However, these gaps did ultimately limit the ET's ability to assess the CP effectiveness, particularly in terms of how specific strategies or 'ways of working' have been more or less successful in delivering results.

Given the reliance on interviews for some key inputs of the evaluation, the ET also sought to minimise bias, especially with regards to overly positive representations of programme effectiveness and entrenched positions on the additionality of the cluster. To mitigate biased views of programme effectiveness, the ET only incorporated interview perspectives that could be corroborated by programme documentation, external interviews, or an external understanding of the achievements and results. On the additionality question, mitigation steps included consulting widely across the UNICEF national and sub-national teams (including an anonymous survey) and limiting findings to those that could be observed and were corroborated by the experience of multiple informants within a relevant group (e.g., segment of survey respondents, members interviewed within a specific team, CFOs).

Finally, an important contextual limitation to note is that the CSD programme has grown significantly and its areas of work have shifted significantly for some sectors, especially

nutrition and WASH. This is to be expected given the shifting Indonesian context, i.e., towards Middle Income Country (MIC) status, and UNICEF Indonesia's ongoing shift towards more upstream work. However, it does limit the comparability of programmes and the availability of data on progress in some cases. In response, while the evaluators based their findings on those CSD activities for which there was most data, they also highlighted newer, less data-rich work where necessary to provide a fair representation of the CSD cluster's current portfolio of activities.

Appendix B contains a view of the evaluability analysis presented in the inception report, updated for observations that emerged through the evaluation (e.g., appropriateness of using a ToC for analysing additionality).

IV. EVALUATION FINDINGS³⁴

1. Relevance

Extent to which the CSD programme component is aligned and suited to Gol's priorities and policies under the new RPJMN 2020-2024, and the 2030 agenda of the SDGs

The CSD programme component is strongly aligned with the Gol's priorities under the new RPJMN 2020-2024 and the 2030 agenda of the SDGs. Almost all its core focus areas have been highlighted as priorities in the RPJMN 2020-2024 and the RPJMN is developed with the achievement of Indonesia's SDG goals by 2030 in mind.

1.1 What areas of the CSD programme are still valid and which are not and should be deprioritised?

Across Health, Nutrition, and WASH, UNICEF Indonesia is currently focusing on long-standing issues affecting child survival and development in Indonesia that are key priorities for the Gol.

Within Health, it is focusing on immunisation, malaria, maternal, newborn, and child health (MNCH), prevention of mother-to-child transmission (of HIV) (PMTCT), and health systems strengthening (HSS). Nutrition interventions are primarily focusing on stunting, infant and young child feeding (IYCF) and maternal nutrition, acute malnutrition, and nutrition for adolescents (e.g., obesity). The primary focus areas within WASH are currently open defecation, safe management of sanitation, and access to basic WASH facilities in schools and community health centres. Across the CSD, UNICEF is also playing a growing role in emergency preparedness. The table categorises the current CSD areas of work by validity based on the ET's analysis.

Table 2: Summary of current CSD areas of work by validity

Sector	Area of work categorisation	
	Remains valid	Remains valid, but the progress suggests potential for shifts in focus
Health	Immunisation, MNCH, PMTCT, health systems strengthening	Malaria
Nutrition	IYCF, Stunting, acute malnutrition, nutrition for adolescents	
WASH	Safe management of sanitation	Open defecation
Cross-cutting	Emergency preparedness	

The following analysis was conducted through four lenses: causes and risk factors for child morbidity and mortality, government priorities, progress towards targets, and level of donor activity. The ET took the current CSD portfolio as a starting point. We assessed the validity of different areas based on whether they remained challenges to child wellbeing and were highlighted as government priorities, as well as whether they would be adequately addressed in the absence of UNICEF involvement. Where significant progress had been made on a government priority, we suggested potential shifts for UNICEF to consider while continuing to support in these areas.

Progress towards targets

In the cases of malaria, ODF, and exclusive breastfeeding (within IYCF), steady progress towards targets suggests the potential for a shift in UNICEF's focus (e.g., intensified focus on persistently high-burden areas) or type of support (e.g., towards maintenance in regions that

³⁴ Evaluation questions that were not part of the original ToR are: (i) Relevance: What new areas of work should be considered in developing future CSD programming?, (ii) Relevance: Are the regions in which the CSD programme operates sub-nationally valid?, and (iii) Effectiveness: To what extent have the CP outputs been achieved so far and what were UNICEF's contributions to its CP outcomes?

have met their targets). 450 districts reported suspected malaria cases in 2010. Since then, 266 have become malaria-free, 93 have been downgraded from high or moderate to moderate or low transmission, and 38 have witnessed a reduction in annual parasite incidence of three times or higher. The disease is now primarily limited to five provinces (Papua, West Papua, East Nusa Tenggara, Maluku, and North Maluku) in Eastern Indonesia, that together see 70% of its national cases³⁵. UNICEF is currently active in all five provinces. Similarly, Indonesia is close to becoming open defecation free (ODF), with ~10% of the population engaging in open defecation in 2017, down from ~33% in 2000. Regional disparities continue to exist, with rural areas exhibiting an average of 16% as compared to 4% in urban areas³⁶. On the other hand, the low rate in urban areas can mask the fact that Java is home to ~50% (~13 million) of open defecators in absolute terms. There may hence be a need to continue malaria efforts in the five provinces mentioned above and ODF efforts primarily in regions where they continue to be high (Papua, Sulawesi, Aceh, Maluku, Java)³⁷. This progress and regional disparity across both the issues have also been reflected in UNICEF Indonesia's Situation Analysis in 2019.

Causes and risk factors for child morbidity and mortality

All other CSD areas of work remain valid in terms of causes and risks to child morbidity and mortality and relationship to the Gol's national priorities and efforts to meet its SDG goals.

- **Health: Increased effort will be required to accelerate Indonesia to its SDG goals for some issues on which UNICEF is currently focusing on, such as HIV and immunisation.** The percentage of total under-five deaths attributable to HIV/AIDs has increased from 2% to 8% between 1990-2016³⁸. In addition, less than a third of pregnant women currently receive an HIV test³⁹, increasing the likelihood of mother to child transmission. Indonesia ranks fourth in the world by the count of unimmunised children, with many deaths due to the increasing occurrence of measles⁴⁰. UNICEF Indonesia's Situation Analysis also highlighted that only ~60% of children received complete basic courses of immunisations, with the coverage lowest in Aceh, Maluku and Papua. Diarrhoea and pneumonia continue to be a leading cause of death among children under-fives, at 25% and 16% of these deaths attributable to them, respectively. Indonesia's maternal mortality rate (MMR) is the highest in Southeast Asia at 305 deaths per 100,000 live births, far from the SDG goal of 70 deaths⁴¹. This is despite improvements in antenatal care (ANC). 77% of women receive all four required ANC visits, and 91% deliver with a skilled attendant⁴². As mentioned in the Situation Analysis, this points to the quality of care being a critical issue; most maternal deaths now occur in hospitals, rather than in homes.
- **Nutrition: Indonesia is far from meeting its SDG goals for stunting and undernutrition; both issues UNICEF is actively working on; the rising prevalence of overweight amplifies the challenge.** Although the prevalence of stunting in children under 5-years improved from ~37% to ~31% between 2013 and 2018, continued focus will be required to achieve the 10% goal that the Gol has set for 2030⁴³. In addition, the prevalence of wasting in children under 5-years continues to be one of the highest in the world at 10%, more than twice the SDG goal of less than 5%. Half of those children under five-years experiencing wasting are affected by severe wasting.⁴⁴ This is despite improvements in the rate of exclusive breastfeeding in the first six months of life (74.5% as of 2018), exceeding the WHO target of 50% by 2025.⁴⁵ UNICEF's

³⁵ Prof. Dr. Ascobat Gani, Prof. Dr. Meiwita P. Budiharsana, UNICEF, Health Sector Review 2018, 2019)

³⁶ WHO and UNICEF, Joint Monitoring Programme Data

³⁷ Only regions in which UNICEF is already working have been mentioned

³⁸ Institute for Health Metrics and Evaluation and The Lancet, Findings from the Global Burden of Disease Study 2017,2017

³⁹ Prevention of mother-to-child transmission (PMTCT) of HIV, 2018

⁴⁰ Institute for Health Metrics and Evaluation and The Lancet, Findings from the Global Burden of Disease Study 2017

⁴¹ WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division, Trends in Maternal Mortality

⁴² IDHS, 2017

⁴³ Kesehatan K, Penelitian B, Kesehatan P. Hasil Utama RISKESDAS 2018. Jakarta [ID]: Balitbangkes Kementerian Kesehatan. 2018.

⁴⁴ Kesehatan K, Penelitian B, Kesehatan P. Hasil Utama RISKESDAS 2018. Jakarta [ID]: Balitbangkes Kementerian Kesehatan. 2018.

⁴⁵ Kesehatan K, Penelitian B, Kesehatan P. Hasil Utama RISKESDAS 2018. Jakarta [ID]: Balitbangkes Kementerian Kesehatan. 2018.

Situation Analysis points to inadequate infant and young child feeding practices as a possible reason for this, highlighting that nearly half of all children are not receiving the nourishment that they require during the first two years of life to grow and develop optimally. In addition, the nutritional status of the mother during pregnancy also impacts the child's nutritional status - ~49% of mothers suffer from maternal anaemia.⁴⁶ Undernutrition is compounded by the prevalence of overweight in children over 5-years, which has increased from 1.5% to 11.5% over 2000-13⁴⁷. Adolescents are at a higher risk of underweight and overweight, with a third of girls entering pregnancy undernourished or at high risk of being undernourished. In addition, malnourished girls are more likely to be malnourished as women and to give birth to low birth weight infants. The high prevalence of child malnutrition (under- and over-nutrition) today could contribute to a growing incidence of NCDs (e.g., diabetes, cardiovascular diseases) over the next 15 years, making it increasingly necessary to combat both these issues.

- **WASH: Challenges with accessing basic sanitation services and clean drinking water persist, circumstances which will likely disproportionately disadvantage girls.** Access to basic sanitation services⁴⁸ continues to be low (~64%), with an increase of only two percentage points over the last decade. For example, only one in three schools have access to basic water services. In addition, a UNICEF-Gol study⁴⁹ found faecal contamination in 89% of drinking water sources and 67% of household drinking water sources in one of the best performing provinces of Indonesia⁵⁰. The Situation Analysis also highlights that ~95% of all faecal waste in Indonesia is untreated and goes into the environment due to inferior quality septic tanks, lack of adequate emptying and disposal or dysfunctional wastewater treatment. This has had a significant impact on children, with 9% of under-five deaths at risk due to unsafe water, sanitation, and handwashing and ~10% of under-five deaths due to diarrhoea, a faecal-borne illness⁵¹. In addition, there is evidence that inadequate sanitation, water and washing facilities are barriers to children's attendance and performance in schools, particularly for girls when their menstrual health management (MHM) needs are not addressed.

Government priorities

Those issues identified as remaining valid also align with the Gol's national focus areas. The Indonesian government has been actively focusing on these core issues and aims to continue doing so in its next five-year plan, with explicit public health targets. Indonesia integrates SDG goals as part of its national-level planning process, and BAPPENAS has a strong focus on Health, Nutrition, and WASH indicators for children, recognising the intersection across these three and their impact on maternal and child mortality. While WASH in institutions indicators are not as clearly articulated in planning documents, these are highlighted as priorities in other sources (e.g., MoEC roadmaps and guidelines, national action plans for school children and adolescent health). Figure 3 below highlights the targets for the next five years as part of RPJMN. As a foundation to the targets, President Joko Widodo's has announced that he will continue focusing on human capital development in his second term (2020-2024). Reducing maternal-infant mortality and stunting in highlighted under this pillar.

⁴⁶ WHO, WHA Global Nutrition Targets 2025: Anaemia Policy Brief, 2014

⁴⁷ SDG Indicators, Metadata repository, 2019

⁴⁸ Metric: Proportion of population with basic handwashing facilities on premises

⁴⁹ Ministry of Health, UNICEF, 2015

⁵⁰ Best performing in terms of water and sanitation access

⁵¹ Institute for Health Metrics and Evaluation and University of Washington, Financing Global Health 2018

Figure 1: View of Gol's priorities and targets for 2020-24^{52,53}

No	Development Indicators	Baseline 2020	Target 2024
1	Maternal and child health status, and nutrition		
a	Maternal mortality ratio per 100.000 live births	305 (SUPAS, 2015)	183
b	Infant mortality rate per 1.000 live births	24 (IDHS, 2012)	16
c	Prevalence of stunting on children under-5 years old (percent)	30.8 (2013)	19
d	Prevalence of wasting on children under-5 years old (percent)	10.2 (2013)	7
2	Disease prevention and control		
a	Tuberculosis incidence per 100,000 population	319 (2017)	190
b	HIV incidence per 1,000 uninfected population	0.24 (2014)	0.18
c	District/city with malaria elimination status	285 (2018)	405
d	Prevalence of smoking at age 10-18 years	9.1 (2018)	8.7
e	The prevalence of obesity on population aged 18+ years (percent)	21.8 (2018)	21.8
3	Health System, Food and Drug Control		
a	Complete basic immunization for infants 12-23 months (percent)	57.9	80
b	First-rate health facilities accredited (percent)	40	85
c	Hospital accredited (percent)	63	95
d	Puskemas with types standardized of health personnel (percent)	23	83
e	Puskemas with no doctor (percent)	15	0
f	Puskemas with availability of essential medicine (percent)	86	96
g	Drugs met quality standard (percent)	80.9	92.3
h	Foods met quality standard (percent)	71	90
4	Water and Sanitation		
a	Households with access to proper and safe sanitation (percent)	N/A	90
b	Households with access to proper and safe drinking water (percent)	N/A	75.34

UNICEF's current portfolio of activities in Indonesia broadly aligns with provincial priorities in the regions in which it operates. Most provinces (i.e., six or more out of 11) prioritised immunisation, malaria, maternal, newborn and child health, health systems strengthening, preventing stunting, addressing acute malnutrition, infant and young child feeding, and safe management of sanitation. Access to clean water is also a priority for nearly all provinces, aligning

⁵² Ministry of National Development Planning / National Development Planning Agency, Draft Medium Term Dev't Plan (RPJMN) 2020-2024, 2019

⁵³ 1.a SUPAS, 2015; 1.b IDHS, 2015; 1.c Riskesdas, 2018; 1.d Riskesdas, 2018; 2.a World Bank, 2017; 2.b 2014; 2.c Sitohang, V., Malaria elimination in Indonesia: Halfway there, 2018; 2.d Riskesdas, 2018; 2.e Watson et al. Nutrition in Indonesia Background Paper for the Health Sector Review, 2018; 3.a IDHS, 2017. Remainder of baseline figures are from BAPPENAS records as presented in a meeting on RPJMN 2020-2024

with UNICEF's plans to increase activity in that space. On the other hand, fewer provinces (i.e., four or less out of 11) highlighted adolescent nutrition, emergency preparedness, WASH in institutions, and prevention of mother-to-child transmission (PMTCT)⁵⁴.

Donor activity

While many donors in Indonesia focus on health, these efforts do not conclusively justify the CSD stepping away from its existing focus areas. All the health issues UNICEF covers are also being tackled by at least one other large development agency (e.g., Global Fund and malaria, GAVI and immunisation, WHO and MNCH, USAID and HIV). However, some key players channel some funds through UNICEF, suggesting some added value from UNICEF beyond what these agencies could achieve on their own. For example, GAVI provided USD ~1.6 million funding in for immunisation in 2019. Some potential areas of comparative advantage for UNICEF include its focus on children, its close working relationship with the Gol, and its regional presence. For WASH and especially nutrition, there is room for UNICEF to play an essential role in its areas of focus given the smaller landscape relative to the health sector. The nutrition sector is particularly fragmented, with limited attention having been directed towards the impending double burden of malnutrition challenge in Indonesia to date.

Overall, while our landscaping of donor focus areas in Indonesia highlighted potential partners – several of which the CSD has already engaged – it did not suggest clear areas where UNICEF should reduce its involvement.

1.2 What new areas of work should be considered in developing future CSD programming?⁵⁵

The following analysis was conducted primarily through the lens of causes and risk factors for child morbidity and mortality. In identifying areas for new or increased focus, we analysed data on current and future key causes and risks of driving child morbidity and mortality. While many of these areas (e.g., NCDs, dengue, and climate change and disasters) were also raised by Gol stakeholders in interviews, BAPPENAS leadership clarified that they would only submit an official perspective on newer priority areas following longer deliberation with the UNICEF team. Consequently, we have not used Gol priorities as a strict filter here as they have not been finalised.

As Indonesia urbanises – fuelled by an increase in domestic migration and population growth –, NCDs, air pollution, climate change augmented disaster, and diseases exacerbated by water and air pollution will become more valid. These issues have also been highlighted in relation to key deprivations across different age groups in UNICEF's Situation Analysis and increasingly prioritised by the Gol:

- **NCDs: Deaths due to NCDs are rising in Indonesia, with exposure to NCD risk factors increasing among children and adolescents.** NCDs such as diabetes, heart disease, and respiratory diseases accounted for 73% of deaths in Indonesia in 2016. While NCDs are not a leading cause of death for children and adolescents in Indonesia, these populations are significantly at risk. For example, obesity and overweight at a young age increase the occurrence of Type 2 Diabetes Mellitus (T2DM) later in life and have been on the rise amongst Indonesian adolescents⁵⁶. Risk factors for NCDs (e.g., tobacco use, physical inactivity, diet) also arise during adolescence. For example, in 2014, 19% of youth aged 13–15 smoked, with most of them having started the habit when they were between 12 and 13 years old⁵⁷. Obesity and smoking among children are also key priorities for the Gol over the next five years, as shown in Figure 3 above, as it aims to tackle the rise of NCDs. These issues have also been highlighted in UNICEF Indonesia's Situation Analysis, 2019.

⁵⁴ Provincial RPJMDs, UNICEF FO staff

⁵⁵ Question not originally included in ToR.

⁵⁶ Pulungan, AB et. al, Type 2 diabetes mellitus in children and adolescent: an Indonesian perspective., 2018

⁵⁷ The Economist Intelligence Unit, Megatrends to 2030 – A Document for UNICEF Indonesia, 2016

- Air pollution: *Air pollution continues to be a significant enabler of child mortality and morbidity in Indonesia.*** Air pollution disproportionately affects children, who are more vulnerable than adults, primarily due to the nascent development of their respiratory systems. It is among the top three risk factors for under-five death, with deaths attributable to Lower Respiratory-tract Infections (LRIs) projected to be ~6% by 2040⁵⁸, and ranks fourth amongst all causes of death (current ranking is third). The Situation Analysis also highlights this issue, noting that post-neonatal and under-five mortality rates per 100,000 due to lower respiratory infection were 212.2 and 13.3, respectively between 2013-17⁵⁹. Prenatal and early life exposure to air pollution also increase the risk of lung and cardiovascular diseases later in adulthood⁶⁰. UNICEF Indonesia's Situation Analysis also mentions that air pollution contributes to lower birth weights and stunted growth as well as respiratory diseases for children. Given Indonesia's rapid urbanisation rate, outdoor air pollution is unlikely to decrease in the period to 2030 without any intervention, and children will continue to be affected, suffering long-term consequences of constant exposure⁶¹. Amplifying the negative effects of air pollution is the recurrent haze crisis in Indonesia. Southeast Asia's 2015 haze crisis has had severe health implications, with children particularly vulnerable to repeated and prolonged exposure to particulate matter. For example, Sumatra and Kalimantan had a Pollution Standard Index of 2000 during that time, when anything above 300 is considered hazardous to human health⁶². BAPPENAS has hence committed to developing evidence-based policy recommendations to mitigate the health effects of air pollution, with a focus on clear measures for children⁶³.
- Climate change and disasters: *Climate change is likely to amplify the risk and prevalence of disasters in Indonesia, which will continue to disproportionately impact children and require stronger efforts towards preparedness.*** Climate change is expected to increase both the frequency and intensity of natural disasters in Indonesia in the period to 2030, negatively impacting health, nutrition, and WASH indicators for children. Rising sea levels will disproportionately affect children and families living in urban slums and informal settlements, as these are often located in disaster-prone areas. This will be compounded by the reduction in food security due to floods and adverse weather conditions. UNICEF's Situation Analysis also points out that national disasters are directly related to food insecurity and malnutrition. A UNICEF field study in East Java and NTT found that a quarter of the rural children surveyed had to drop out of school due to lack of finances as a result of crop failure. For children in the 5-14 age group, deaths due to exposure to natural disasters is likely to increase with the percentage annual increase estimated at 10% between 2015-40⁶⁴. To mitigate these issues, Indonesia has signed up to the Sendai Framework for Disaster Risk Reduction (DRR), to reduce disaster risk and losses by 2030 substantially. This framework has a stronger focus on urban areas and builds on the previous Hyogo Framework for Action (HFA) in 2005⁶⁵. The RPJMN 2015-2019 also aimed to support the development of green cities and increase community resilience to climate change impacts, with the next five-year plan having a similar focus⁶⁶. However, there is a capacity gap within the government, along with limited youth participation and awareness on climate issues. The Situation Analysis identifies advocacy and awareness-raising with young people on the climate crisis as one of the areas in which UNICEF can work.
- Dengue: *Dengue, a vector-borne disease, is predicted to be a leading cause of death for children by 2040.*** Institute for Health Metrics and Evaluation (IHME) projections indicate that

⁵⁸ Institute for Health Metrics and Evaluation and University of Washington, Financing Global Health 2018

⁵⁹ UNICEF and Seoul National University College of Medicine, Country Profiles on Children's Health and Environment in East Asia and Pacific Region: Indonesia n.d.

⁶⁰ Vital Strategies, Air Pollution: A Threat to Children's Health in Indonesia, 2018

⁶¹ The Economist Intelligence Unit, Megatrends to 2030 – A Document for UNICEF Indonesia, 2016

⁶² Mighty Earth, Harvard-Columbia study finds that 2015 haze in Indonesia likely caused 100,300 premature deaths, 2016

⁶³ Vital Strategies, Indonesia Calls for Action on Air Pollution and Children's Health, 2018

⁶⁴ Institute for Health Metrics and Evaluation and University of Washington, Financing Global Health 2018

⁶⁵ United Nations University, 12 years after the tsunami: the progress of disaster risk reduction in Indonesia, 2017

⁶⁶ Naik & Randolph, 2018

deaths due to dengue will continue to rise for children aged 5-14 years old, representing ~17% of deaths in this age group by 2040 (an increase from ~4% in 2018)⁶⁷. Although the Gol has not explicitly called out dengue in existing plans, Gol stakeholders in the MoH did reference it as an increasing concern, and the UNICEF Situation Analysis highlighted that increased rainfall and higher temperatures due to climate change will increase the disease's incidence and geographic reach. In urban slum areas, inadequate sanitation, overcrowding and contaminated water will worsen the situation.

1.3 Are the regions in which the CSD programme operates sub-nationally still valid?⁶⁸

UNICEF has seven regional and sub-regional presences across Indonesia, representing multiple provinces:

Table 3: UNICEF sub-national presence and coverage

Sub-national presence	Province(s) covered
<i>Jayapura and Manokwari</i>	Papua, West Papua
<i>Kupang</i>	East Nusa Tenggara, West Nusa Tenggara
<i>Makassar and Ambon</i>	South Sulawesi, West Sulawesi, Central Sulawesi, Maluku, North Maluku
<i>Surabaya</i>	Central Java, East Java
<i>Banda Aceh</i>	Aceh

The regions in which UNICEF is active continue to be the most relevant in terms of low performance on health, nutrition, and WASH indicators, although some emerge as more important for one sector than for others. The figure below presents how the provinces in which UNICEF works perform on relevant indicator relative to the rest of the country. Red icons mean that a province ranks in the worst 40% percentile on an indicator relative to other provinces and yellow means that it ranks in the best 40% percentile. We have called out disparities within provinces where certain regions diverge from the overall province indicator. See Appendix I for a list of how different provinces perform across a more comprehensively list of indicators.

Figure 2: Regional disparity in extent of Health, Nutrition, and WASH problems across Indonesia^{69,70}

⁶⁷ The Economist Intelligence Unit, Megatrends to 2030 – A Document for UNICEF Indonesia, 2016; Institute for Health Metrics and Evaluation and University of Washington, Financing Global Health 2018

⁶⁸ Question not originally included in ToR

⁶⁹ The extent of the problem is based on a data quintile for each indicator with red indicating the top two quintiles and yellow indicating the bottom two quintiles. Within province disparity is indicated by additional icons

⁷⁰ UNICEF, UNICEF Indonesia Website, 2017



Most of the data supports UNICEF’s current sub-national footprint, but Java and Kalimantan – which we have added as an additional province performing poorly on some indicators despite not being a UNICEF focus provide – require some additional explanation.

Despite significant progress compared to other provinces on a percentage basis, Java, the most populous island, continues to be home to a large number of people suffering from low health, nutrition, and WASH indicators. High urbanisation rates have also exacerbated emerging issues like obesity and tobacco use among children. Java is one of the most densely populated places globally, accounting for over half of Indonesia’s population. In terms of performance, Java has made significant progress when compared to other provinces. West Java has one of the lowest maternal mortality ratios (MMR) in the country, with MMR below 100. Central Java has a relatively lower adolescent birth rate and high immunisation rates, when compared to other provinces. However, Java’s high population belies the scale of some issues. For example, while open defecation rates are ~10% in Central Java and ~33% in Papua, in terms of absolute numbers, Central Java has three times as many open defecators as Papua (3 million vs. 1 million). Java also has one of the highest rates of tobacco use – as well as obesity – among children, issues that are becoming increasingly prevalent in more urban regions⁷¹.

Across Eastern Indonesia, Kalimantan is the only province with low indicators across Health, Nutrition, and WASH, on which UNICEF is not focusing, with West Kalimantan the worst performing. Kalimantan is the next most urbanised island-region after Java-Bali, with an urban population share of 43.5% in 2016. Of particular interest is West Kalimantan, which has the highest rate of adolescent births (104 per 1,000) and the largest proportion of under-five wasted children (18.7%)⁷².

1.4 To what extent is programme integration clearly articulated in terms of linking cross-sectoral outputs to the overarching outcome?

Overall, programme integration is not clearly articulated in the CSD cluster, with low clarity on its intent and vision among UNICEF staff. While a draft ToC for the integrated CSD cluster exists and captures the cluster’s key activities, especially where these are similar across sectors, it does not articulate or link cross-sectoral outputs to the overarching CSD outcome. Furthermore, some key stakeholders within the CSD were not aware of it. Each of the seven CSD sector outputs has its own ToC, and most staff members interviewed did not distinguish the key objectives and

⁷¹ Institute of Health Metrics and Evaluation Database n.d.

⁷² Institute of Health Metrics and Evaluation Database.n.d.

activities of their respective sectors from those of the CSD cluster. Many of the staff interviewed, whether within or outside CSD, also referred to the lack of a shared vision for the cluster as a constraint to collaboration.

The specific activities that could be attributed to the CSD cluster, as opposed to specific sectors, have not been articulated clearly and have evolved, making it difficult to link them to the overall objectives of the CSD cluster. Given there was no documented or shared view of what these activities were, the ET recreated the list of CSD cluster activities through consultation with UNICEF staff across the three sectors. However, there were varying opinions across UNICEF staff on whether and to what extent the activities were occurring, and therefore it was difficult for any activities to be linked to the overall objective of the CSD cluster.

Currently, the CSD cluster-wide targets coordination of management, functions, and processes more so than integrated programming as appears to initially have been intended.

1.5 To what extent is the CSD cluster approach still valid and aligned to the socio-economic context, priorities of government and other funders in Indonesia, and broader global UNICEF approach?

While the current CSD cluster approach remains valid for the coordination of health, nutrition, and WASH priorities within the MoH, it is not set up to adequately respond to the original demands from government and other partners for more integrated programming that were part of the justification of its creation in 2011. The current focus on coordination as the primary mode of integration leaves room for approaches that might better enable other types of integration (e.g., advocacy, programming) where appropriate. The government's experience with stunting highlights the importance of a shared vision and logical framework.

The primary way in which the CSD cluster works is as a mechanism for coordinated management, functions, and processes, with little integrated activity. While management and systems may be coordinated, advocacy and programming are less so. The CSD's primary objective has been to facilitate better work at the sector-level through stronger systems, functional capacities. *Question 2.4 provides a more detailed analysis of how the CSD cluster is additional to the activities of the individual sectors.*

From a coordination perspective, the CSD cluster approach is valid in that health, nutrition, and health-related WASH issues are the responsibility of the MoH; however, working on WASH issues requires engagement across multiple ministries. The CSD cluster allows for a coordinated health-nutrition-WASH interface with the GoI through the MoH. This is also true for the regional offices the ET visited, where the Provincial Health Office (PHO) and District Health Office (DHO) are responsible for health, nutrition, and WASH programming. However, at the national level, the WASH mandate sits across multiple ministries, namely the MoH and the MoEC. At the subnational level, this varies – for example, GoI representatives in Makassar shared that the WASH strategy is set by BAPPEDAS, while those in Kupang shared that, although they provide data on the status of sanitation, WASH implementation sits with the provincial public works office. Thus, the coordination value the CSD cluster approach varies by topic at the national level and more broadly at the sub-national level.

While the Indonesian socio-economic context and government priorities continue to call for more 'integrated approaches', the current CSD cluster approach is not optimised to enable or incentivise these. The overall objectives of taking an integrated approach, such as finding innovative ways to tackle issues that span across different sectors, remain valid for the Indonesian context, where many development priorities will require an integrated approach. For example, ~30% of Indonesian children under five-years-old were stunted as of 2018⁷³; as a result, stunting has become a national and presidential priority for the GoI. Addressing high stunting rates requires efforts across

⁷³ WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division, Trends in Maternal Mortality n.d.

the health, nutrition, and WASH sectors. Other emerging areas, such as the growing incidence of NCDs and the improvement of water quality systems, would also require some level of coordination across sectors, reinforcing the need for UNICEF mechanisms to facilitate an “integrated approach” when required. However, while UNICEF is testing integrated approaches to address stunting in Indonesia, this represents the only example of such integrated programming within the cluster. Interviews with UNICEF staff and a review of how the CSD cluster operates suggest that this is because it is designed more as a management solution (e.g., centrally managed approvals, funding allocation, information systems) and less as an integrated design, planning and programme implementation tool.

When asked how UNICEF could better align the CSD cluster approach to the needs, priorities, and prior experience of the government, senior BAPPENAS stakeholders pointed to the recent national planning around reducing stunting. This mandate transcends government structures, with a focus that extends beyond the CSD scope to include areas such as food security and agriculture. The efforts were driven by a clear vision from the President’s office, and the integrated planning process was anchored on a shared logical framework, cutting across 23 ministries of the national government, with a focus on end outcomes instead of individual ministry roles or budget allocations. Highlighting lessons from this experience, interviewees pointed to the importance of the shared vision and logical framework and the recognition that integration needed to span more ministries than those traditionally assumed to be responsible for these outcomes.

While the UNICEF PFP team reported that certain types of funders - specifically foundations - expressed interest in the narrative of integration, the majority of UNICEF funding remains sectoral. However, the CSD has been able to demonstrate to at least two funders – both foundations – how a multi-sectoral approach can better align with their priorities and secure multi-sectoral grants. 89% of UNICEF’s funding for 2019 to date is sectoral⁷⁴. There are some examples of funding for CSD cross-sectoral work (for 2019, USD 1,200,000 for an office-wide integrated programme grant from the IKEA Foundation, USD 330,000 for cross-sectoral advocacy from the Bill and Melinda Gates Foundation (BMGF)) and cross-sectoral functions (for 2019, USD 500,000 for data)⁷⁵. Although cross-sectoral grants have increased since 2016, those responsible for fundraising, within both the PFP and CSD teams, could not highlight many examples of funders approaching with an interest in providing multi-sectoral funding. However, this may suggest that the burden is on UNICEF teams to proactively advise funders on how to support multi-sectorally as was the case for the IKEA grant. In those cases where funding has been provided for cross-sectoral work the sectors included were not limited to those under the CSD cluster but included other clusters (e.g., IKEA grant included Social Policy and Child Protection clusters as well).

Lastly, the CSD cluster’s structure of integrating health, nutrition, and WASH departs somewhat from how these sectors are reflected in the UNICEF Strategic Plan for 2018-2021. UNICEF’s strategic plan for 2018-2021 highlights five goal areas in support of the SDG goals. While Health and Nutrition sit under *Goal Area 1: ‘Every Child Survives and Thrives’*, WASH falls under *Goal Area 4: ‘Every Child Lives in a Safe and Clean Environment’*. This implies that, while WASH may have some similar priorities with Health and Nutrition sectors, it is now globally aligned to shift towards a broader focus on disaster and risk reduction (DRR) and environmental sustainability.

2. Effectiveness

Extent to which the CSD cluster has achieved its planned outputs and the extent to which its approach enables UNICEF to attain these results.

Across the CSD sectors, all 2018 CP output targets have been achieved, and all 2019 targets have either been achieved or are on track. Progress on most outcome indicators has also been

⁷⁴ UNICEF, Child Survival Development Monthly Funding Status Update, 2019 . This excludes USD 1,100,000 from Cargill for flexible use between Health and Immunisation. While this is a ‘cross-team’ grant, the ET did not classify this as ‘cross-sectoral’.

⁷⁵ UNICEF, Child Survival Development Monthly Funding Status Update, 2019

substantial, suggesting that some (e.g., breastfeeding) may be deprioritised nationally going forward; however, others (e.g., HIV testing for pregnant women) may receive increased attention. UNICEF has contributed meaningfully across these outputs. In the cases of open defecation, MNCH, and HIV, its contributions can be logically linked to progress on national-level outcome targets, given their scale and focus. The cluster has shifted most of its work from 'downstream' programmes to 'upstream' systems strengthening efforts or at least to 'downstream' programmes with links to 'upstream' results. Several interventions tested through its pilot-to-scale approach have been successfully scaled or incorporated into national plans for scale (e.g., IMAM, malaria elimination, malaria in pregnancy); however, there is limited evidence to assess whether these pilots are the most efficient way to achieve results. The analysis suggests that the CSD cluster can strengthen its impact by increasing its use of communication for development (C4D) and focusing on broader dissemination of fewer pieces of evidence (e.g., in the case of STBM) .

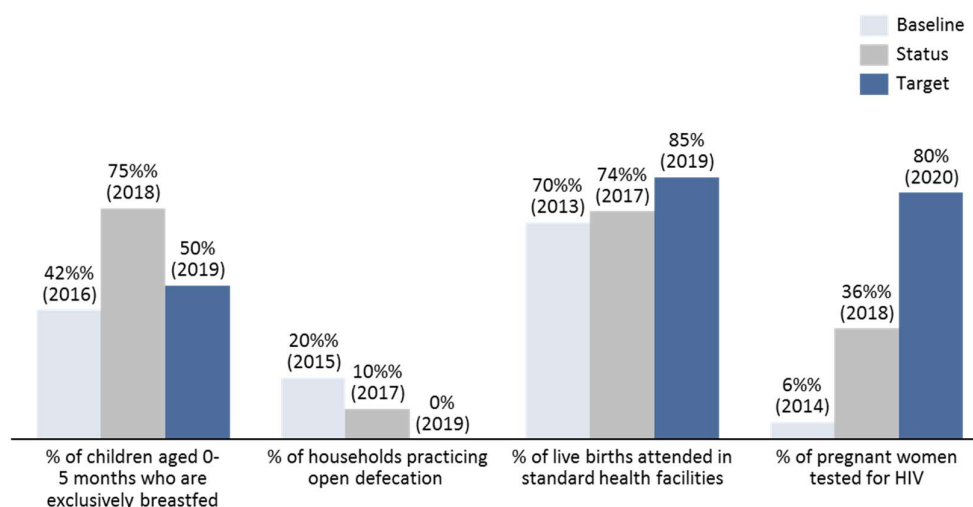
2.1 To what extent have the CP outputs been achieved so far and what have been UNICEF's contributions?⁷⁶

Almost all⁷⁷ of the 2018 CP output targets in nutrition, health, and WASH have been achieved, and all 2019 targets either have been achieved or are on track; in some cases (e.g., for nutrition, MNCH, and health systems strengthening), the 2020 targets have already been met. See Appendix J for a detailed review of progress against outputs indicators.

The sectors within CSD – Health, Nutrition, and WASH – share the first outcome (#1) in the Indonesia CP: “Women and children have more equitable access to evidence-based health, nutrition, WASH and HIV services and adopt appropriate care practices from pregnancy to adolescence”.

The most recent status of the associated national-level outcome indicators is as follows:

Figure 3: Progress against CP outcome indicators⁷⁸



Two important caveats to analysing the CPAP results framework are the variation in type of indicator between sectors (e.g., number of knowledge products vs national-level targets around screening and provision of treatment) and the fact that, for some programmes (e.g., immunisation, malaria), the CSD has conducted activities beyond the original scope. As such, the ET did not seek to make comparisons between the levels of achievement across sectors and

⁷⁶ Progress on outputs sourced from UNICEF internal reporting systems; corroboration and clarification were sought in internal and external interviews and internal programme documentation. External documentation is footnoted.

⁷⁷ The one exception was “% confirmed malaria cases in public and private health facilities receiving ACT in selected districts” (1.5.2), where 2018 achievement was 76% vs. a target of 80%

⁷⁸ Riskeddas, SUSENAS, WHO and UNICEF Joint Monitoring Programme

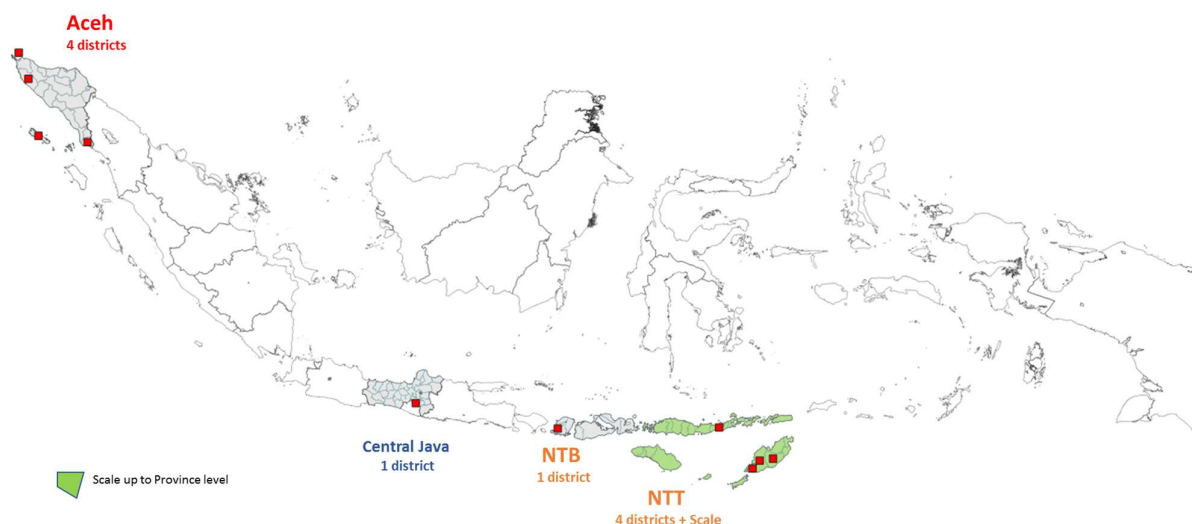
included narrative summarising UNICEF contributions that may not be evident from the results framework.

See Appendix J for a detailed review of the achievement of CSD outputs.

A. Nutrition

UNICEF’s nutrition programme provides direct support to 10 districts in 4 provinces (Aceh, Central Java, NTB, and NTT) and operates at a provincial scale in 1 province (NTT).

Figure 4: UNICEF nutrition programme footprint⁷⁹



Output 1.1: Governments and partner institutions have enhanced capacity and commitment to deliver quality services at scale to protect children from undernutrition and overnutrition.

2018, 2019, and 2020 CP output targets for Nutrition have been met. UNICEF has contributed to IYCF, management for severe acute malnutrition (SAM) and community-based management of acute malnutrition (CMAM) through technical assistance and evidence generation as described below. It has also engaged in advocacy leading to the inclusion of nutrition priorities in the RPJMN.

UNICEF’s contributions included advocating to the GoI to strengthen legislation and monitoring mechanisms on breastfeeding practices along with the development of standardised IYCF counselling training packages. For example, UNICEF’s efforts resulted in the amendment of breastfeeding guidelines to prohibit marketing of breastmilk substitutes for children aged less than one-year-old. While this is an improvement, it remains far from meeting the International Code of Marketing of Breastmilk Substitutes target of children aged less than three-years-old⁸⁰. UNICEF also successfully advocated strengthening data collection around breastfeeding, including tracking of children who are exclusively breastfed in all districts in Indonesia. Alongside these advocacy efforts, UNICEF supported the development of counselling training packages and funded the initial round of training. The MoH accredited this training package in 2019 and agreed to scale it through the establishment of a pool of master trainers in 260 districts using government funds.

UNICEF also helped the GoI increase the coverage for children suffering from SAM through the IMAM programme using a pilot-to-scale approach. The pilot demonstrated that children with SAM could be cured through outpatient treatment and that CMAM services could be effectively integrated into the existing health system. UNICEF used this evidence to advocate for the scaling up

⁷⁹ UNICEF Indonesia n.d.

⁸⁰ The previous guidelines were targeted at children below the age of six months

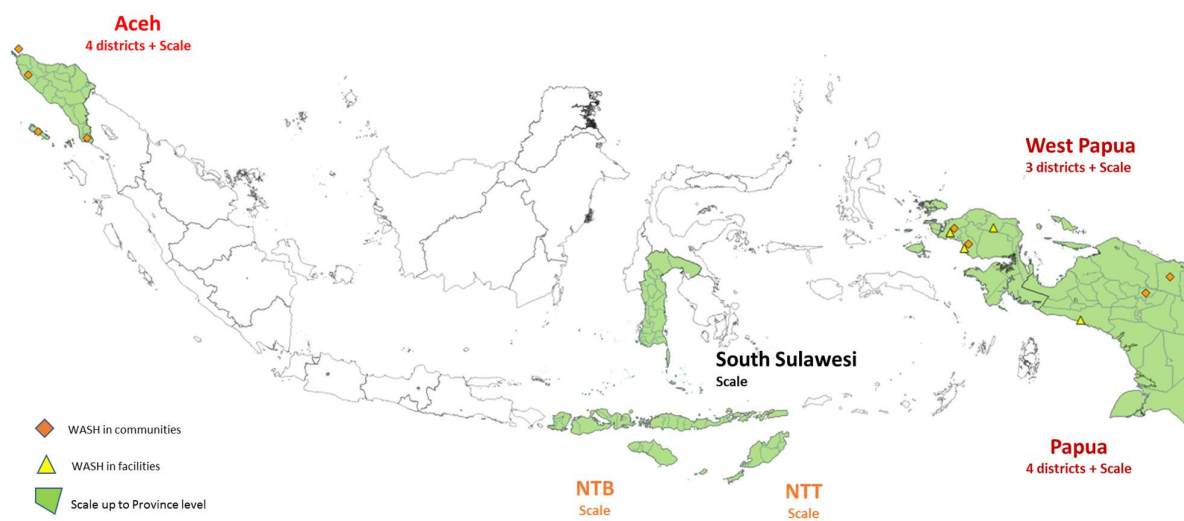
of the CMAM model. The MoH has endorsed the National Guideline on SAM Management, to which UNICEF was a contributor, and approved the IMAM programme as one of the eight essential nutrition-specific interventions to support the national stunting reduction movement across 260 stunting priority districts by 2020.

UNICEF continues to be a leader in the Indonesian nutrition sector and is increasingly working on issues that have received less attention to date (e.g., adolescent nutrition). UNICEF served as the lead agency to support the government's Nutrition Sector Review to determine targets and strategic direction for nutrition for the RJMPN 2020-2024. UNICEF also continued to serve as Donor Convener for the Scaling Up Nutrition Movement (SUN). In the area of adolescent nutrition, UNICEF designed an integrated intervention package to address the double burden of malnutrition in partnership with MoH. In 2019-2020, these interventions will be assessed in two districts to generate robust local evidence to support future scale-up of adolescent nutrition programmes.

B. WASH

UNICEF's WASH programme provides direct support to 11 districts in 6 provinces (Aceh, NTB, NTT, South Sulawesi, West Papua, and Papua) and operates at a provincial scale in all 6 provinces.

Figure 5: UNICEF WASH programme footprint⁸¹



Output 1.2: Governments and partner institutions have enhanced capacity and commitment to deliver quality services at scale, in urban and rural areas, to support the elimination of open defecation, access to safely managed water and sanitation and the promotion of hygiene practices.

The 2018 CP Output 1.2 targets have been met, and progress towards the 2019/2020 targets is on track.

Indonesia has made progress towards meeting the SDG goal of 0% open defecation rate by 2030; however, work remains as 10% of the population continues to engage in this practice (4% of the urban population, 16% of the rural population)⁸². UNICEF has contributed by supporting on evidence generation through knowledge products and pilots - especially in the provinces where it is operating at scale - and technical assistance on national guidelines.

UNICEF has been supporting the MoH to strengthen the implementation of its National Sanitation Programme (STBM) by supporting the standardisation of practices and developing

⁸¹ UNICEF Indonesia

⁸² WHO and UNICEF, Joint Monitoring Programme, 2017

guidelines for implementation. UNICEF supported the GoI in the development and socialisation of the National STBM Roadmap and was a critical advocate for and technical contributor to the revision of the 'ODF Verification Guidelines/Standard'. The National STBM Roadmap emphasises the role of different ministries and departments and sets targets for sub-national governments to mobilise resources to accelerate the STBM implementation. The 'ODF Verification Guidelines/Standard' enabled the uniform application of rural sanitation standards and practices around ODF certification. UNICEF is also supporting the GoI on practical guidelines on post-ODF maintenance. At the sub-national level, UNICEF's work in this space has directly and indirectly influenced 28 non-project districts⁸³ to develop plans to implement STBM.

UNICEF has also contributed to strengthening the evidence in the WASH sector but could increase its impact by more effectively disseminating the findings. Between 2016 and 2018, UNICEF released 10 publications focusing on interventions in the WASH sector (e.g., scoping study on public financing for faecal sludge management). However, while these documents were used to advocate to the government to strengthen GoI's political commitment towards WASH, there is limited evidence to show how these different documents have been used and for what purposes. The 2018 evaluation of the STBM programme highlighted the need to improve on dissemination as well as internal knowledge management⁸⁴.

At the sub-national level, UNICEF is testing models to mobilise funding from religious groups to reach vulnerable populations. For example, UNICEF supported three provinces (Aceh, South Sulawesi, and NTB) in leveraging *Zakat* funds (Islamic alms) to facilitate access to basic sanitation facilities for poor households. UNICEF supported in the mobilisation of USD 571,000 for WASH in West Nusa Tenggara province through Islamic Charity Funds and is continuing to test viable models for scale.

More recently, UNICEF Indonesia has also been testing new approaches to integrated programming. As part of an IKEA-funded malnutrition pilot, UNICEF's STBM-stunting efforts have directly and indirectly contributed to over 40 villages achieving ODF status in Aceh.

Output 1.3: Governments and partner institutions have enhanced capacity and commitment to deliver WASH services in institutions at scale, including the use of sustainable basic sanitation, safe drinking water and improved hygiene behaviours.

The 2018 CP Output 1.3 targets have been met, and progress towards the 2019/2020 targets is on track. Both the targets and UNICEF's contributions are focused on the ongoing provision of technical support to strengthen data collection and monitoring. Despite key critical advocacy successes detailed below, below; the UNICEF WinS programme has thus far had more difficulty translating its piloting efforts into implementation at a national scale.

UNICEF successfully advocated for the inclusion of WinS guidelines in national plans as well as the allocation within the national budget for improving WinS. UNICEF's documentation of the status of WinS in 2016 was an essential driver of a renewed commitment by the GoI, including the development of a national roadmap. In 2018, the Directorate of Primary Education in the MoEC published a National WinS guideline. WinS is also being integrated into the national sanitation acceleration plan, Percepatan Pembangunan Sanitasi Permukiman (PPSP)⁸⁵, as well as in the RPJMN in 2019⁸⁶. UNICEF has been working to strengthen and analyse the indicators used in the Educational Management Information System (EMIS) to reflect the reporting needs of SDG Goal 4, around a safe learning environment for children. These activities have supported the development of a national baseline for WinS and are on track to deliver a fully operational knowledge platform by 2020. Using

⁸³ Districts UNICEF is not actively working in

⁸⁴ UNICEF and Bill and Melinda Gates Foundation, Sanitation Programme Indonesia 2013-2017 Evaluation Report, 2017

⁸⁵ Sanitation Acceleration Development Programme - Districts and cities involved in the PPSP Programme are required to develop City Sanitation Strategy (SSK), 2009

⁸⁶ Ministry of Education and Culture, PETA JALAN SANITASI SEKOLAH DALAM KERANGKA, 2017

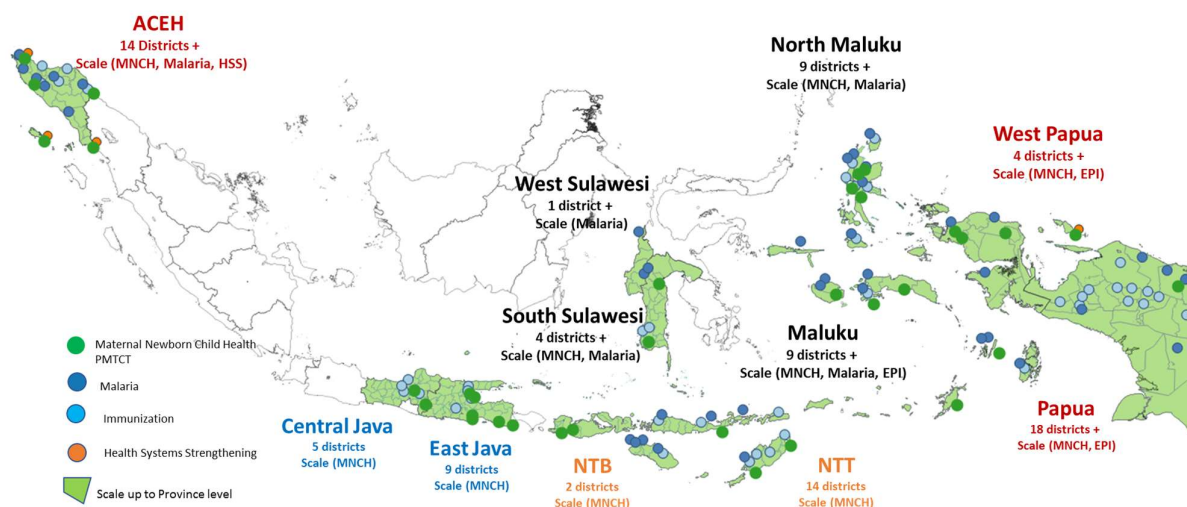
the WinS SDG baseline as a reference, UNICEF successfully advocated the MoEC to allocate 9% (~30 million) of the total Education Special Allocation Fund for improving WinS in 2018.

Despite these successes, as compared to the STBM program, UNICEF has had difficulty significantly scaling its piloting work in WinS beyond its points of direct intervention. This is due, in part, to fragmented government ownership. The WinS programme involves coordination across the Ministries of Health, Education, Religious and Home Affairs, making it more challenging to conduct targeted advocacy and implement at scale. This is especially true because the WASH teams influence varies across these ministries. Currently WinS is limited to ~300 schools (out of ~200,000+). While some of its efforts have had wide reach provincially, district- level coverage has been low (e.g., MHM comic book and awareness building pilot scaled to 34 provinces, but only 2 districts per province).

C. Health

UNICEF’s health programme provides direct support to 89 districts in 11 provinces (Aceh, Central Java, East Java, NTB, NTT, West Sulawesi, South Sulawesi, North Maluku, Maluku, West Papua, and Papua) and operates at a provincial scale in all 11 provinces).

Figure 6: UNICEF health programme footprint⁸⁷



Output 1.4: Government and partner institutions have enhanced capacity and commitment to deliver quality basic and comprehensive MNCH services, including PPTCT at scale.

The 2018 and 2019 CP Output 1.4 targets have been met, and progress towards the 2020 targets is on track, with 2 of 4 already having been exceeded. In 2018 79% of live births were attended in standard health facilities, up from 70% in 2013. This progress suggests that the country is on track to reach the target of 85% by 2019. Although Indonesia is unlikely to meet its ambitious target of 80% of pregnant women tested for HIV by 2020, it is important to note the significant progress it has achieved (36% in 2018, up from 5.6% in 2014, and expected to

⁸⁷ UNICEF Indonesia

be ~40% by the end of 2019). UNICEF has directly supported on the development of costed MNCH action plans, Integrated Management of Newborn and Childhood (IMCI) and Triple Elimination (of HIV) guidelines, and the technical assistance required to roll these out at the provincial level.

UNICEF supported the GoI in the development of costed MNCH plans for nine districts in nine provinces and of national guidelines for dissemination and implementation at the sub-national level. UNICEF contributed to multiple guidelines, including those on Essential Newborn Care (ENC), Post-Natal Care (PNC), and Integrated Management of Newborn and Childhood Illnesses On-The-Job Training (OJT-IMNCI). For the latter, UNICEF assisted in the dissemination of OJT-IMNCI guidelines across 21 (62%) provinces and initiated the implementation in nine selected districts in nine provinces. The completion of the first batch of OJT IMNCI in two districts in Papua and West Papua provinces has resulted in a four-fold increase in the availability of skilled front-line health workers for childcare.

On HIV, UNICEF supported in the development and assessment of the Triple Elimination guidelines, the creation of the Fast-Track dashboard, and scaling up of the national PMTCT efforts. UNICEF supported the expansion of the PMTCT strategy to include HIV, Syphilis and Hepatitis- B (Triple Elimination). It completed a baseline assessment for the Triple Elimination Strategy and assisted the MoH in mapping existing health service capacity for HIV testing, antiretroviral therapy (ART) provision and viral load testing, including laboratory capacity and positioning in 12 districts of nine provinces. UNICEF also supported the development of a Fast-Track dashboard that provides real-time progress against the 90–90–90 indicators⁸⁸ and was launched across all 34 provinces in October 2018. UNICEF has also provided direct support for scaling up national PMTCT efforts. Examples include technical inputs for a new HIV strategy for Papua and support to the MoH for implementing the revised Early Infant Diagnosis (EID) guidelines in four cities: West Jakarta, Bandung, Surabaya and Sorong.

Despite the progress made on HIV, several challenges persist in the Indonesian healthcare system. There is a lack of provision of comprehensive HIV services (e.g., testing, ARV treatment and monitoring, the early testing of babies born to mothers infected with HIV). In 2017, only 13% of an estimated 12,000 pregnant women living with HIV were receiving ART to prevent the transmission of HIV to their unborn children.⁸⁹ Alongside this, referral services between hospitals and health centres are inadequate, particularly in remote areas.

Output 1.5: Government and partner institutions have the capacity and commitment to deliver quality services at scale to control vaccine-preventable diseases, malaria and HIV, including the elimination of neonatal tetanus, measles, HIV, syphilis and malaria.

The 2018 CP Output 1.5 targets for malaria and HIV have been met, and progress towards the 2019 targets is on track; there is no data available to assess the progress made on immunisation output targets. Two of the three 2018 targets for malaria-related indicators were achieved, including the percentage of pregnant mothers screened for malaria and receiving treatment and provincial reach of its model for malaria elimination activities. Achievement of the target on percentage confirmed malaria cases in public and private health facilities receiving ACT (treatment) in selected districts (indicator 1.5.2) was close, with 76% in 2018 vs an 80% target. However, progress towards the 2019 target of 87% is on track⁹⁰.

⁸⁸ 90-90-90 indicators is a target set by UNAIDS: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART). By 2020, 90% of all people receiving ART will have viral suppression.

⁸⁹ UNAIDS, Indonesia Country Snapshot, 2018

⁹⁰ Official national data not available; Instead proxy for confirmed malaria cases receiving standard treatment (ACT and Primaquine) used, which understates achievement

Indonesia has made considerable progress on malaria elimination, with more than 50% of districts declared malaria-free as of 2018 (1.5.8) including in UNICEF-supported areas⁹¹. For example, between 2015 and 2018, the number of malaria cases reported has reduced by 70% and 49% in Aceh and NTT, respectively, two of UNICEF's provinces of focus. Over the same period, there has been a 33% rise in the number of districts certified malaria-free in Aceh, where UNICEF is also working.

A vital UNICEF contribution has been the testing and generation of evidence around models for malaria elimination. For example, UNICEF tested a Village Malaria Workers (VMWs) model for malaria elimination, in which local trained volunteers assist with household surveillance activities within 24 hours of a new malaria case being identified in addition to their original mandate of active case detection. The documentation of this model and related tools contributed to the development of a Ministerial Decree on Malaria Diagnosis and Treatment by VMWs, issued by the MoH in 2018. UNICEF also supported on malaria elimination through the development and dissemination of national guidelines and the development of a national assessor team on QA based on lessons learned targeting malaria transmission among high-risk groups in Aceh.

While UNICEF has already met its HIV in young key populations (YKP) target for 2019 (i.e., the status of an implementation model for the HIV prevention and treatment among YKP), data on other targets was incomplete at the time of writing this report.

In the case of immunisation, there is insufficient data to assess the progress made to date. There was no data for the indicator 1.5.4, percentage of health centres with high-risk communities that are provided 100% of their resupply vaccine stock for the whole year. The CSD team reported indicator 1.5.5, percentage of health centres with high-risk communities that have costed immunisation micro plans to increase outreach sessions, as no longer relevant due to a shift in strategy.

On immunisation, UNICEF supported the Gol on its Measles-Rubella (MR) campaign (2017-2019) to address vaccine hesitancy in 24 out of 31 provinces. From 2017 to 2019, the Gol conducted the world's most extensive MR campaign, targeting 68 million children. In 2016, in advance of the Java-focused first phase, UNICEF supported demand generation at both the national and sub-national levels, deploying UNICEF staff to each province to troubleshoot challenges in securing buy-in from key stakeholders. It also supported the Gol in developing and deploying RapidPro, a vaccine campaign real-time monitoring tool. This has since been used in over 500 districts. In this first phase, coverage reached almost 100%, and there was a sharp reduction in measles cases⁹². During the second phase of the campaign (2018-2019), UNICEF deployed 50 technical support staff (20 UNICEF staff, 30 consultants) to support on addressing social and political communication issues across 28 provinces outside of Java. Coverage plateaued in the second phase due to halal-related vaccine hesitancy heightened by pre-election political activities⁹³, suggesting the need for generating more evidence around how best to address vaccine hesitancy outside of Java. However, the overall coverage achieved across phases was 87%.

In addition to demand generation, UNICEF supported the Gol on vaccine availability and provincial capacity for routine immunisation. UNICEF also assisted in updating a national inventory of the cold-chain equipment and establishing remote temperature monitoring and vaccine stock management systems. More recently, UNICEF advocated for the removal of regulatory and procurement barriers for the Pneumococcal Conjugate Vaccine (PCV) vaccine, which if successful could enable the Gol to procure vaccines at one-sixth of the original price.

⁹¹ Sitohang, V., Malaria elimination in Indonesia: Halfway there, 2018

⁹² Pronyk, Paul et. al, Vaccine Hesitancy in Indonesia, 2019

⁹³ UNICEF, Innovations in advocacy and monitoring to accelerate immunisation coverage in Indonesia, 2018. It should be noted that official government data for 2018 puts coverage at 85%, but WHO and UNICEF use their 75% estimate.

Output 1.6: Governments and partner institutions have improved capacity and accountability for health resource allocation based on evidence-based planning and in monitoring equity and implementation management of health services in the era of universal healthcare (UHC).

Almost all 2020 CP Output 1.6 targets have been met and the final one, “1.6.3 – the design and implementation of a model for provinces to support districts in adopting the principles of evidence-based planning to reach Minimum Service Standards (MSS) indicators”, is on track (to be piloted in East Java).

UNICEF provided technical and capacity building support at the national and sub-national levels on evidence-based planning and implementation, including working through partners to support planning and budgeting in six provinces. At the national level, UNICEF has been supporting BAPPENAS by providing technical support for the Health Sector Review (HSR). At the provincial level, UNICEF created minimum service standards (MSS)-related capacity development modules in collaboration with the MoH. These have been implemented at the district-level in Papua and West Papua provinces. UNICEF prepared a review of the approach and its usefulness in supporting decentralised planning and budgeting. These efforts have been profiled nationally and are complementing emerging thinking on how to optimise the planning and accreditation processes across the country.

UNICEF also collaborated with the Ministry of Planning to assess the fiscal sustainability of the Aceh Local Health Insurance (JKA) programme. The resulting set of recommendations informed national and sub-national policymakers on the 2019 integration of local and national health insurance schemes aimed to achieve full coverage.

D. Emergencies

Output 1.7: Government and partner institutions are prepared, have adequate sectoral capacity and provide an effective and coordinated response for WASH, nutrition and health⁹⁴ in emergencies⁹⁵.

UNICEF Indonesia has consistently met its UNICEF Corporate Core Commitments and IASC Cluster Coordination responsibilities for all emergencies in which UNICEF sectoral assistance is requested. However, it is important to note that the obligation makes no mention of the timing of the response. UNICEF staff interviewed noted that the Central Sulawesi response, while ultimately meeting its targets, took longer to launch than ideal due to delays related to pre-approval required from multiple line ministries and because necessary local partners had not been pre-identified and/or prepared for what would be required.

UNICEF’s WASH response focused on the immediate provision of safe water, basic sanitation and community engagement around hygiene practices with particular attention to gender needs, cultural appropriateness of the services as well as addressing the needs of people with special needs. It also supported in the provision of WASH services for schools and internally displaced populations (IDPs). UNICEF exceeded its Jan-June 2019 target of providing access to safe drinking water (~205,000 achieved vs target of 110,000) in response to humanitarian emergencies in Central Sulawesi and Lombok, where 1.9 million people remained affected at the start of 2019⁹⁶.

UNICEF’s Nutrition response included strengthening the cluster coordination mechanism and nutritional assessment and surveillance system and enhancing access to essential emergency nutrition services such as IYCF counselling and management of SAM. Most recently, UNICEF exceeded its January-June 2019 target of providing caregivers of children under-two-years with IYCF

⁹⁴ While Health was initially included under this output, all health emergency work is now mentioned under the respective health related outputs (1.4-1.6)

⁹⁵ While achievements in health are included here for the purpose of narrative flow, these are typically reported within the health-related outputs and not Output 1.7

⁹⁶ UNICEF, Indonesia Humanitarian Situation Report, 2019

counselling (~112,000 achieved vs. target of 55,000) in response to humanitarian emergencies in Central Sulawesi and Lombok⁹⁷.

UNICEF's Health response included the provision of bed nets and Rapid Diagnostic Test (RDT) kits for malaria, as well as technical support to re-establish child services in four affected districts – Palu, Donggala, Sigi, and Parigi Moutong – and capacity development on IMNCI for primary care workers at IDP camps. As part of its response to humanitarian emergencies in Central Sulawesi and Lombok, it provided 150,000 long-lasting insecticide mosquito nets (LLINs) and 150,000 RDTs, trained ~230 health workers covering 3,247 newborns, 6,547 infants and 9,946 under-five children, and supported in reaching ~1.8 million children with the measles vaccination.⁹⁸

2.2 For those programmes reviewed, where – in terms of 'ways of working'⁹⁹ – is CSD more effective and less effective in achieving programme results for children?

To further explore how UNICEF's strategies contributed to programme results, the ET reviewed six programmes in detail. We selected these programmes in consultation with sector teams, to reflect a representative mix of 'ways of working' across some of the sectors' largest programmes and included two programmes per sector:

- *Health:* Immunisation and Malaria
- *Nutrition:* Breastfeeding and Integrated Management of Acute Malnutrition (IMAM)
- *WASH:* Sanitasi Total Berbasis Masyarakat (Community Based Total Sanitation, STBM) and WASH in Schools (WinS)/Menstrual Hygiene Management (MHM)

We analysed the effectiveness of 'ways of working' UNICEF employed across these six programmes in delivering results. For each program, we developed a detailed view of the 'ways of working' employed, reviewed results achieved relative to programme goals and CSD output-level ToCs and identified drivers of success and stumbling blocks.

While there were examples of success for most 'ways of working' across all programmes, we have highlighted those programmes as especially useful with the most (consistent) examples of success.

The following table provides a summary of the different 'ways of working' and criteria used for assessing them. The list of 'ways of working' is based on the seven strategies outlined in the UNICEF 2014-2017 Strategic Plan in effect when the CSD developed its most recent output-level ToCs. Following consultations with the CSD staff and a review of CSD programme documentation, the ET expanded the list to include C4D, a strategy highlighted by all CSD teams as important for the success of future programming. The ET only assessed effectiveness where there was evidence of results and some way of linking them to UNICEF efforts (e.g., through programme documents, donor reports, evaluations, and interviews with internal and external stakeholders. In addition to discussing 'ways of working', the ET assessed the extent to which UNICEF's activities were 'downstream' vs. 'upstream'. For the purpose of this report, 'upstream' activities are defined as those intended to have a system-wide, sustainable effect on the national capacities of public sector duty bearers to fulfil their responsibilities to rightsholders in the relevant sector. These can include activities conducted at the district-level if the goal is to generate evidence or momentum for national scale. For this evaluation, the most observable results of these activities were changes in commitments, policy, budgetary allocation, and plans for implementation. On the other hand, 'downstream' activities are those that focus closer to the rightsholders and do not target an effect outside of the area – for this evaluation, district – in which they are implemented.

Table 4: Analytical approach for 'ways of working' assessment

⁹⁷ UNICEF, Indonesia Humanitarian Situation Report, 2019

⁹⁸ UNICEF, Indonesia Humanitarian Situation Report, 2019

⁹⁹ Adjusted from in ToR to explicitly focus on 'ways of working'.

Way of working	Definition	Criteria for assessment
Advocacy	Engaging with government stakeholders and influencers at both the national and sub-national level to influence decision-making on policy planning and budgeting	<ul style="list-style-type: none"> • Extent to which UNICEF advocacy has contributed to changes in GoI policy or programming (national or sub-national), including strengthening of programme monitoring and evaluation • Extent to which UNICEF advocacy has contributed to increased financial commitments (national or sub-national)
Evidence generation and policy dialogue	Using quality data and monitoring to generate evidence on the extent of the problem and lessons on solutions to strengthen advocacy	<ul style="list-style-type: none"> • Extent to which UNICEF evidence generation has been incorporated into GoI policy or programming (national or sub-national) • Extent to which UNICEF evidence generation has led to increased commitment (national or sub-national)
Capacity building (and technical assistance)	Strengthening systems and capabilities of district and provincial government stakeholders and providing technical support to the national government on building modules and guidelines	<ul style="list-style-type: none"> • Extent to which UNICEF efforts have been focused 'upstream' and influenced the capacity of GoI or other implementers at scale (e.g., by informing national guidelines and training) • Note: limited data available on reach or quality of trainings
Partnerships, implementing partners, religious organisations, and private sector	Partnering with stakeholders for stronger advocacy and effective implementation of programmes	<ul style="list-style-type: none"> • Extent to which UNICEF partnerships have focused on or contributed to 'upstream' results (including through 'downstream' activities with upstream linkages)
C4D	Systematic, planned and evidence-based strategic process to promote positive and measurable individual behaviour and social change that is an integral part of development programmes, policy advocacy and humanitarian work	<ul style="list-style-type: none"> • Extent to which UNICEF efforts contributed to increased awareness in target populations at scale • Extent to which UNICEF efforts contributed to increased uptake of relevant intervention at scale
South-South and triangular cooperation	Sharing of experiences and expertise across countries through a formal channel or event (including UNICEF regional cooperation and UNICEF-facilitated regional cooperation between other stakeholders)	<ul style="list-style-type: none"> • Extent to which lessons learned through UNICEF-facilitated opportunities for regional cooperation were incorporated into GoI policy or programming • Extent to which UNICEF-facilitated opportunities for regional cooperation contributed to increased GoI commitment (typically at a national level) • Extent to which lessons learned through UNICEF regional cooperation were incorporated into programming
Innovations	Enhancing the use of new technologies to strengthen systems, improve service delivery and engage communities, citizens and civil society organisations in public decision-making. Identifying and working with partners to adapt and scale up the most promising programme innovations	<ul style="list-style-type: none"> • Extent to which UNICEF innovation introduced accelerated progress towards relevant national or programme indicators • Extent to which UNICEF innovation introduced addressed a long-recognised challenge or bottleneck with limited widely practiced solutions
Service delivery	Directly implementing programmes in districts	<ul style="list-style-type: none"> • N/A – not reviewed, though overall shift from 'upstream' to 'downstream' discussed

Across the six programmes reviewed, UNICEF’s advocacy efforts appear to have been especially effective in the malaria and IMAM programmes. UNICEF’s advocacy efforts have resulted in policy changes and national guideline adoptions for these three programmes. For example, UNICEF advocacy for the IMAM programme contributed to the approval of IMAM as one of the eight essential nutrition-specific interventions for promoting child well-being, endorsement of the National Guidelines on SAM, and agreement to scale up IMAM across 260 stunting priority districts by 2020 as part of the National Stunting Programme. For the malaria program, UNICEF’s advocacy resulted in establishment of local policy interventions, including a Mayoral Decree, for maintaining Sabang’s malaria elimination status, securing local financing for the ‘Village Fund’, which had previously only been used to fund infrastructure projects, and establishment of provincial malaria elimination advocacy teams to lead and monitor malaria elimination in 22 districts in NTT. While the ET found evidence of successful examples of advocacy for STBM, most of these appeared to have predated the current CP.

Despite successes described in question 2.1, the WinS and breastfeeding programmes have faced some challenges. While UNICEF’s WinS advocacy has been successful in the inclusion of WinS guidelines as part of multiple national plans, the strengthening of monitoring processes (e.g., as part of the EMIS), and USD 30 million allocations by the MoEC, the reach of WinS programming and interventions has been limited thus far (i.e., 300 out of 200,000 schools over 7 years, according to

Drivers of Stumbling Blocks for Effective Advocacy

Drivers of effective advocacy have included working on Gol’s top priorities against which the government is already acting and using evidence generated in pilots to advocate for an increase in political commitment and/or funding. The UNICEF programmes reviewed clearly align to existing national government programmes. This has enabled upfront alignment with government stakeholders and a clearer channel to upstream results. UNICEF grounds many of its advocacy efforts in lessons learned from pilots, often engaging government stakeholders throughout the pilot lifecycle. For example, in the IMAM programme, UNICEF used evidence from the CMAM pilot to advocate for the public health authorities to scale the programme at the sub-national and, in the future, national level. Similarly, the malaria programme leveraged evidence from piloting malaria elimination models in various districts (e.g., VMW model in Sabang) to advocate for the adoption of malaria elimination interventions and guidelines.

Advocacy has been less effective in the absence of an established government programme without a clear owner or when multiple ministries are involved. This is a case for challenges faced by both the WinS and breastfeeding programmes. For example, leadership for the WinS programme falls between the MoH and the MoEC, and efforts also involve the Ministry of Religious Affairs and the Ministry of Home Affairs. This fragmentation, combined with the lack of a dedicated budget line for WinS in any ministry, has slowed progress. While breastfeeding has historically been a Gol priority, the involvement of ministries beyond the MoH who have been more difficult to

UNICEF records). For the breastfeeding program, while UNICEF has successfully advocated for the prohibition of marketing of breastmilk substitutes for children less than one-year-old, this falls short of the targeted international standard of the prohibition of marketing to children less than three-years-old.

While evidence generation has been used across all six programmes, it appears especially effective in three programmes (IMAM, malaria, and breastfeeding). Some results of evidence generated across these programmes include: adoption of the IMAM programme as part of national stunting programme scale-up, contribution to the National Guideline on SAM Management, adoption of malaria in the pregnancy programme, contribution to the Ministerial Decree on malaria elimination, contribution to the National Guideline on quality assurance for malaria diagnostic, and the MoH accreditation of the IYCF training package.

For UNICEF’s OD/STBM programme, while the Gol has incorporated lessons learned in rolling out its programme across the country, there is some room to streamline and better leverage its knowledge products. The role of the learnings from UNICEF’s work in strengthening the government STBM programme is well-

documented and represents an instance of CSD impact at a national level. However, it is not clear how all the 10 knowledge products produced over the course of this work were used. An evaluation of UNICEF's work highlighted the need for UNICEF to streamline its knowledge management (e.g., produce fewer evidence products) and improve strategic dissemination of evidence generated amongst relevant stakeholders. WinS has had similarly mixed results, with initial evidence creation efforts generating more government commitment than the more recent knowledge products.

Drivers of Success for UNICEF's Evidence Generation Efforts

Beyond strategic dissemination, drivers of success for UNICEF's evidence generation efforts are like those for advocacy and include grounding the evidence in contextualised pilots and directing these efforts towards issues prioritised by GoI nationally or for which a plan for national scale exists. As previously discussed, UNICEF used evidence generated through the CMAM pilot and a series of publications and journal articles as the basis for its successful advocacy for scale-up of the IMAM programme within the national stunting programme. For the malaria programme, UNICEF co-authored a journal article about the risk of P.knowlesi transmission as discovered during the VMW malaria elimination pilot in Sabang. This risk was later included in treatment policy and in routine programme reporting and monitoring. Other malaria pilots/models that have generated actionable evidence include the malaria in pregnancy pilot and malaria elimination activities in Aceh. These models are also being employed within the GoI's national efforts to eliminate malaria. On the other hand, for the WinS programme, while UNICEF's initial documentation of the issue (e.g., data on lack of separate bathrooms for boys and girls in schools) in 2016 spurred action that led to the development of a national

Most programmes reviewed targeted 'upstream' results with their capacity development and technical assistance efforts; in some cases, this included providing 'downstream' support during pilots that eventually led to change at the national level. The IMAM, STBM, and malaria programmes have been most focused¹⁰⁰ on delivering 'upstream' results. For IMAM, UNICEF supported the development of the national guidelines for SAM management, which were recently endorsed by MoH, and worked with Action Against Hunger to develop a Standard Operational Procedure (SOP) for the CMAM programme to serve as the operational guideline for programme implementers. CMAM training at the province and district levels informed learnings for the national scale-up. For STBM, UNICEF supported the MoH on the development of the STBM roadmap as well as national guidance and strategies on

ODF verification and post-ODF maintenance. For malaria, UNICEF has developed training modules across malaria in pregnancy, participatory learning and action (PLA), and quality assurance; direct trainings have typically been linked to pilots that have either scaled or are included in national plans to scale (e.g., malaria in pregnancy, VMW model for malaria elimination). The breastfeeding programme has also had an upstream focus, but the results are in the earlier stages. For example, UNICEF supported the MoH to develop a set of national guidelines on IYCF practices to be released in 2020. UNICEF also developed an integrated IYCF counselling training package which was accredited by the MoH in 2019 and funded the initial training of 34 province facilitators to further train facilitators at the sub-national level; however, the implementation of cascading trainings at the district level has been slow with little transparency on the rate of scale-up.

¹⁰⁰ This is relative to each programmes own portfolio of capacity development and technical assistance, and not relative to the absolute amount of activities across programmes

The immunisation and WinS programmes focus on ‘downstream’ activities more than other programmes – though, still primarily target ‘upstream’ results. For immunisation, while UNICEF has provided technical support at the national level on routine immunisation programmes, campaigns, surveillance, and supply chain, and has shifted away from service delivery, it still provides direct capacity development for implementation support at the province level. While the WinS programme has developed seven training modules and guidelines that have been endorsed by various ministries, including a National WinS Guideline in 2018, the uptake of these guidelines appears limited with ~1000 schools using the national guideline as of 2019¹⁰¹. Like the immunisation

programme, the WinS programme also involves direct support (i.e., with WinS interventions in a subset of schools) that is not yet linked to an ‘upstream’ result.

Evidence of Cascading Effect of Programmes

In most cases, the ET did not find evidence of the rate of scale-up of trainings or adoption of guidelines; thus, while it is reasonable to consider those results embedded in current or planned national programmes most effective (e.g., IMAM, STBM), it is difficult to speak to the impact of other capacity development and technical assistance activities beyond the initial ‘upstream’ output. The two examples where it was clear that results of upstream activities had not achieved ideal scale (i.e., WinS guideline adoption, breastfeeding trainer reach) suggest that GoI endorsement is not sufficient and reinforces the importance of embedding efforts in current or planned

One of the few requests in terms of ‘ways of working’ that came up across multiple GoI interviews was additional capacity development and technical assistance at the provincial level. These requests, which were made primarily by health-related stakeholders, related to strengthening the provincial governments capacity to mediate the translation of national guidance and policy to the district level (e.g., for implementing the

minimum service standards).

While the majority of the CSD’s partnerships continue to be downstream (18/24 of active and signed partnerships as of October 2019, 12 of which are health-related), the cluster has demonstrated some effectiveness in translating downstream partnerships into upstream results. The Formative Evaluation of UNICEF Indonesia’s Partnership Strategies (2016-2020) conducted in 2018 (referred to going forward as the 2018 partnerships evaluation) found that “CSO partnerships which [were] linked to government institutions at the central level (e.g., STBM) [were] effective because ‘downstream’ activities [were] guided by ‘upstream’ policies and standards, while ‘upstream’ institutions and their policies learn from the geographical, economic and cultural specificities to which ‘downstream’ operations need to adjust”¹⁰². The evaluation referred to the CSD as a ‘service-delivery’ cluster, highlighting some immunisation and malaria partnerships (e.g., PPNI, Gapai) as examples without an ‘upstream’ component and in which results were limited to the area of the intervention. While the dominance of partnerships for ‘downstream’ support persists, especially for the purpose of piloting interventions, some of these have been able to produce ‘upstream’ results with clear pathways to national scale (e.g., for CMAM, models for malaria elimination, STBM) and others have at least translated into national policies and guidelines (e.g., models for malaria elimination, triple elimination, Islamic financing for WASH).

However, it should be noted that these links between ‘downstream’ and ‘upstream’ are not often clearly stated as upfront goals in the documents reviewed. Consequently, it is not always clear whether these partnerships are established for the purpose of delivering ‘upstream’ results or in response to donor-driven ‘downstream’ project opportunities, as the 2018 partnerships evaluation suggests. CSD pilot-to-scale efforts appear to be better documented as or after they succeed. The ET saw very little explicit documentation of the intended plan for scale – whether the development of a national policy or scaled-up adoption of an intervention across

¹⁰¹ UNICEF WASH Team

¹⁰² ACT for Performance BV, Netherlands and MDF PI, Indonesia, Formative Evaluation of UNICEF Indonesia’s Partnership Strategies (2016-2020), 2018

districts or provinces. Furthermore, the process for prioritising and selecting which pilots and, consequently, which partnerships to take on across the CSD is unclear. The effectiveness of the pilot-to-scale approach is discussed further in question #2.3.

Drivers for C4D Success

While there are fewer C4D examples across which we can identify common success factors, emerging drivers include the clear identification of the behaviour change intended and a strong understanding of the drivers of the existing behaviours. For example, the immunisation team leveraged its pre-existing knowledge about vaccine hesitancy and how to engage key stakeholders during the 2019 polio outbreak response and the WASH team used a combined baseline / Knowledge Attitude and Practice survey to unpack the social norms and individual drivers of behaviour change for sanitation in the STBM programme and partnered with the Burnet Institute, a medical research institute, to understand MHM consumer needs. Use of a broad range of channels also appears important (e.g., use of youth engagement platform, U-reporters, as part of STBM's Tinju Tinja campaign as well as celebrities and comedians; use of churches to disseminate C4D material for polio immunisation). Related to channels, a common

C4D is used less than the other 'ways of working' relative to the importance of behaviour change and community engagement to overcoming health, nutrition, and WASH challenges. The STBM and immunisation programmes have used C4D most extensively and the malaria and WinS programmes also have examples of success. A core approach of the STBM programme is behaviour change communication and both the MR and polio campaigns required UNICEF to support on-demand generation and overcoming vaccine hesitancy. Vaccine hesitancy has proven complicated to overcome in Indonesia – as seen

in phase two of the MR campaign; however, it is a critical bottleneck and the health team has reported that it will continue to invest in understanding how best to address it. The malaria programme implemented a community-based malaria control programme in North Maluku (using the Participatory Learning and Action (PLA) approach) that led to a 3-fold increase in local budgets to support malaria control and contributed to a reduction in malaria incidence from 33.8 to 2.13 per 1000 between 2009 and 2016, with no malaria deaths recorded since 2009¹⁰³. The WinS programme has been exploring ways to raise awareness about MHM and other sanitation topics in school, including an MHM comic book which has been successful in raising awareness of MHM among boys and girls where it has been used.

Increased demand for C4D support both at the national and sub-national level is constrained by the limited number of C4D specialists across the office. UNICEF Indonesia's one C4D resource is unable to meet the demand across programmes, which is increasing as a result of demands from government at both the national and sub-national level (e.g., government's review of UNICEF's malaria work highlighted need for more support on C4D) and internal UNICEF recognition of the potential impact of C4D on current programming (e.g., the nutrition team reflections on the need for more C4D in its breastfeeding programme). For example, the nutrition team has not been able to adequately leverage C4D expertise for its efforts to increase exclusive breastfeeding among parents. While this was partly because the importance of a strong C4D strategy became apparent over the course of the programme, the lack of C4D capacity prevented a ramp-up in efforts even as this learning emerged. Staff from the health and WASH teams also highlighted plans to incorporate more C4D elements into their programming.

South-south and triangular cooperation was used across all programmes, with all three sectors leveraging other UNICEF offices in the region and Health and WASH convening other stakeholders alongside the Gol. For the WinS programme, the 5th Annual International Learning Exchange (ILE) held in 2016 presented a good opportunity to benchmark the performance of Indonesia to others and renew Gol commitment. The MoEC declared a coordinating group for WinS and the meeting spurred the development of a national roadmap. In the case of immunisation, UNICEF is using inputs from a multinational convening on MR campaigns to inform a study it has

¹⁰³ C4D Malaria Abstract

commissioned on vaccine hesitancy. On HIV, the CSD is in discussions with representatives from the Malaysia Country Office to attend a provincial meeting in Indonesia and present on learnings from their experience.

Gol stakeholders and UNICEF staff regarded this way of working as important for exchanging best practice and new ideas; however, it was difficult to isolate any specific contributions as these exchanges are often part of an on-going relationship and complement existing efforts. Though the WinS example suggests that south-south and triangular cooperation can drive increased government commitment and accountability, there is limited evidence to suggest that these would be sustained.

Innovation was the least observed way of working across programmes. This is likely because much of the CSD's work involves either generating evidence on, contextually adapting, or advocating for existing solutions. Nevertheless, the immunisation, malaria, and WinS/MHM programmes have demonstrated effective use cases including - reaching difficult populations, data collection and monitoring and raising awareness in target populations. For immunisation, UNICEF used digital health technologies to identify out-of-family children and link them to health services, with the innovation established, utilised, accepted, and embedded in the ministry. To support the implementation of Indonesia's MR and polio campaigns and overcome challenges associated with paper-based reporting across such a wide geographic area, UNICEF supported the MoH to introduce a digital health innovation known as RapidPro. The system captures numbers of daily vaccinations reported by health facility staff using mobile phones, aggregates data by geo-location for data visualisation and provides daily notification of coverage and progress towards targets¹⁰⁴. In developing the previously mentioned comic book for raising MHM awareness, the WinS/MHM programme first used a Human Centred Design (HCD) approach to conduct surveys and generate evidence on what would be most effective.

While the ET acknowledges that many of the issues on which the CSD works have known solutions or interventions, the previous examples suggest room for innovation to ensure that these solutions reach or are demanded by the relevant populations in the Indonesian context.

Based on the programmes reviewed, the CSD portfolio has shifted towards being comprised primarily of 'upstream' activities or 'downstream' activities with planned 'upstream' linkages; the immunisation and WinS/MHM programmes are exceptions because some key activities do not appear to link to 'upstream' results. As discussed earlier, the immunisation programme provides more 'downstream' support than others – albeit through partners. The WinS/MHM programme has also included some heavy 'downstream' components that have had minimal 'upstream' linkages to date (e.g., MHM comic books); however, it is important to note that the goal has been to drive 'upstream' results. In both cases, available funding opportunities have played some part in driving this focus. Even those programmes that have shifted 'upstream' continue to deliberately work 'downstream' in two cases: pilot-to-scale and emergency response.

The CSD should continue transitioning as many 'downstream' activities to the Gol or other implementing partners as possible. However, it will likely remain important for the team to continue with 'downstream' work in the case of emergencies and prioritised pilots with planned linkages to eventual 'upstream' results. UNICEF is unique amongst multilateral agencies in terms of its field presence and humanitarian mandate. The CSD provides critical 'downstream' support to stabilise emergencies and reduce negative impact on progress made towards improving health, nutrition, and WASH outcomes in Indonesia. Pilots are also an important justification for

¹⁰⁴ UNICEF, Programmes for Elimination of Measles & Rubella, 2019

downstream activities; while the CSD may need to better prioritise pilots (to be discussed in question #2.3), there is evidence that its 'downstream' activities have been able to drive 'upstream' change.

2.3 For those programmes reviewed, what were the key drivers of successful pilots to go to scale in CSD as well as stumbling blocks?

The pilot-to-scale approach is core to much of UNICEF Indonesia's work, featuring prominently in its theory of change as an often-important step. UNICEF Indonesia's pilots typically involve adapting global or regional best practice and standards to diverse contexts in Indonesia, documenting the results, and supporting any revisions in policies/guidelines/ training/ monitoring tools required to facilitate national scale. Government buy-in is a crucial driver of successful pilots – this is achieved in the form of requiring government sign-off for the establishment of a pilot and focusing on an issue for which there is a clear link to the government's existing or planned efforts. Focusing on existing government efforts is related to another key driver of success: a clear channel through which the programme might be scaled at the national level. This has typically come in the form of an existing programme or plan for scale. Finally, those pilots that have scaled also first had an impact on government policies or guidelines. Stumbling blocks included limited financing, with the most successful pilots complementing government funds with donor funds, and inadequate capacity (e.g., health workers) for expanding the programme. Most pilots did not fully cost the resources required for government or develop a comprehensive capacity development plan upfront. While the lack of planning in these specific areas did not affect the success of all pilots, it suggests an opportunity for safeguarding against potential failures.

The UNICEF Programme Policy and Procedure (PPP) Manual provides the following guidance:

- "Pilot projects are activities designed to test the feasibility and/or the effectiveness of an intervention".
- Two levels of results to consider are: "the proof that the model intervention has the expected effect... [and] the adoption of the model intervention – where positive in effect and feasible – into national or sub-national policies and development plans".
- "Two critical results of a pilot project would almost always be a credible research document that provides proof of the worth of an intervention... [and] a pre-identified change in national or sub-national policies or development plans or programmes".¹⁰⁵

Using the PPP guidance, we analysed CSD pilots to identify key drivers of successful pilots to go to scale as well as stumbling blocks. We supplemented a review of three pilot efforts within the six programmes analysed for the previous question (#2.2) with three additional case studies included in UNICEF's Pilot-to-Scale Thought Paper. While the CSD team tracks a more comprehensive list of pilots internally, the ET limited detailed analysis in this question to pilots for which it had multiple sources of documentation. Appendix M gives a summary of the extent of effectiveness of the different pilots reviewed across three dimensions, as adapted from the UNICEF PPP document.

All pilots reviewed have demonstrated the effectiveness of the intervention; however, the majority did not produce a 'credible research document', with four out of six presenting their results through donor reports. This does not appear to have prevented them from driving policy change or scaling.

Most of these pilots have also resulted in changes in national and sub-national policy or adoptions of guidelines. Except for the MHM and Perinatology Mentorship Initiative (PMI) pilots, all others have resulted in the government incorporating the intervention as a policy or guideline for scale at the national level (e.g., Issuance of Ministry decree No. 90/2015 for Cluster Island Approach (CIA), MoH approval and endorsement of the National Guideline on SAM Management) or other

¹⁰⁵ UNICEF, Programme Policy Procedure Manual, 2007

government action at the sub-national level (e.g., MTB issued Bupati Decree No 06/2014 on the Cluster Island Approach, NTT provincial government developed a roadmap for scaling up IMAM services across all of its 22 districts and municipalities by 2020). A potential driver for the relatively lower effectiveness of the MHM pilot is the previously discussed lack of clear ministerial ownership or an existing national programme in which to operate. All other pilots reviewed could leverage existing government structures or programmes. However, it should also be noted that, while the MHM pilot did prove that its intervention raised awareness amongst boys and girls, it was not able to demonstrate a change in girls' practices; this may also have had an impact on what UNICEF was able to influence.

Of those that have resulted in changes to policy or adoptions of guidelines, all but one has scaled nationally or have been incorporated into a Gol programme with a clear plan for national scale. As previously discussed, the MoH has agreed to scale up IMAM services across all stunting priority districts (260) by 2020 as part of the National Stunting Programme. The Malaria in Pregnancy (MiP) pilot, launched in 2006, has become a nation-wide programme as of 2017¹⁰⁶. Similarly, the learnings from the malaria work in Aceh are informing the scale-up of the Gol's national malaria programme. On the other hand, while the Cluster Island Model had scaled from one pilot district to seven districts in Maluku and North Maluku as of 2014, progress stalled for some time; DFAT and others are now supporting the Gol to implement the model in other parts of the country.

As might be expected, those pilots that have not yet had an impact on any policies or guidelines have also been slower to scale. In the case of WinS, while the MHM comic book being piloted has been distributed to ten schools in 34 provinces each, the overall intervention is far from having scaled across Indonesia's 200,000+ schools. The PMI had not initially scaled beyond the pilot districts; however, UNICEF staff report that the government has adapted the initial model and is making plans to roll this out nationally¹⁰⁷.

Where UNICEF has been able to scale pilots successfully, government buy-in has been key; in particular, focusing on something that is already a government priority or for which there is a clear link to the government's existing or planned efforts. For example, the CMAM pilot is being scaled in alignment with the National Stunting Program, the MiP pilot was embedded in the country's malaria in pregnancy programme, and the Models for Malaria Elimination pilot is being scaled alongside the Gol's national plan to eliminate malaria. Successful pilots also engaged government stakeholders throughout the pilot lifecycle. For example, for the CMAM pilot, UNICEF held multiple workshops, coordination meetings and discussions with the government and public health stakeholders in Kupang to generate buy-in.

Securing funding beyond government budgets has also been important. The MiP scale-up was funded by the Global Fund and USAID along with national and district budget allocations. The CMAM scale-up is being funded (up till 2021) by the Australian and Swiss Committees for UNICEF.

Beyond the absence of the success factors mentioned above, stumbling blocks to scale included inadequate capacity. As might be expected, in the absence of the success factors discussed above, some pilots have struggled to scale. For example, MHM is not as high a government priority as many of the other areas in which UNICEF has piloted interventions (e.g., malaria, stunting, open defecation, MNCH) and there is no existing national programme with a clear plan for scale into which UNICEF could channel the evidence generated from a pilot. The pilots that did not have financial support beyond UNICEF or government budgets also struggled to scale. For example, the CIA relied on funding from district and national budgets and has been slow to scale further, and the PMI originally relied on UNICEF budget. It appears that most of the time, budget considerations only come up at the time of handover. The internal UNICEF Pilot-to-Scale Thought Paper found that no

¹⁰⁶ This does not include Java and Bali, where malaria infection risk is negligible.

¹⁰⁷ Three district hospitals in Papua and four district hospitals in West Papua.

pilot reviewed, including those in the CSD cluster, had fully costed the resources required by the government, The PMI also faced capacity challenges, as the initial model was very time-intensive for health workers involved; this is an element that the GoI has reportedly adjusted as it looks to adapt the model for further scaling.

2.4 How, where, and when is the CSD cluster additional? Where and when is it not, and where would a single sector approach be more appropriate?

The CSD programme was established to “explore innovative ways to address the lack of progress in key health, nutrition, WASH and HIV indicators through one consolidated and integrated CSD outcome including seven closely related outputs”¹⁰⁸. It was created in 2011 in response to demand from the government and other partners for more integrated programmes¹⁰⁹.

However, while the original intent of the CSD cluster appears to be grounded in a desire for more integrated programming, as previously discussed, programme integration is not well-articulated in terms of linking cross-sectoral outputs to the overarching outcome. The ET was not able to find documentation explaining how the CSD cluster was meant to operate or what specific elements it consisted of and ultimately had to recreate this view during the inception phase through interviews with UNICEF staff. Through this exercise, it became clear that programmatic integration has not been a primary goal of the CSD cluster during the current CP; instead, the cluster has acted more as a coordination mechanism to enable the sector teams to carry out their activities.

The table below outlines a range of opportunities for coordination or ‘integration’, the relevant elements observed within the CSD cluster, and the criteria the ET used to assess whether a single sector or coordinated/integrated approach¹¹⁰ was best-suited. The analysis includes only opportunities for which coordinated or integrated examples were observed or raised in interviews (e.g., does not include evidence generation as this was not observed).

Table 5: Analytical framework for assessing additionality of CSD cluster approach¹¹¹

Opportunity for “integration”	Description	Relevant elements observed within the CSD	Criteria for assessing effectiveness of coordinated/integrated vs single-sector approach
Management structure (i.e., layer of management overseeing health, nutrition, and WASH)	Organogram and reporting lines	<ul style="list-style-type: none"> At the national level, CSD chief overseeing chiefs of health, nutrition, and WASH At the sub-national level, CSD specialist overseeing sector specialists 	<ul style="list-style-type: none"> Strengthened strategic and financial planning Existence of value-added activities carried out by CSD chief and specialists that would not happen in their absence Increased technical oversight (including backstopping, where necessary)
Shared systems, functions, and processes	Systems, processes, and functions that are common across the health, nutrition, and WASH teams	<ul style="list-style-type: none"> Standardised fundraising tracking tools Weekly team meetings at the national level Data and Analytics team (also involves other clusters) CSD communications resource 	<ul style="list-style-type: none"> Stronger systems Operating efficiencies (i.e., due to shared systems and functions) Opportunities for cross-sectoral learning (e.g., through joint weekly meetings)

¹⁰⁸ UNICEF, Country Programme Action Plan 2016-2020, 2012

¹⁰⁹ Terms of Reference Document

¹¹⁰ The evaluation surfaced many different interpretations of integrations across UNICEF staff, the GoI, and other external stakeholders. We use coordination and integration interchangeably here because some aspects of the CSD cluster approach are coordinated and others – although, few – have been integrated. Elsewhere we try to limit the use of the word ‘integrated’ except where the CSD is acting as one.

¹¹¹ Based on UNICEF internal interviews and some strategic documents

			<ul style="list-style-type: none"> • Opportunities for inclusive / collaborative programme design
Gol interface	Way in which CSD teams communicate and work with Gol counterparts	<ul style="list-style-type: none"> • Primarily sectoral at the national level • More, though not always, coordinated through the CSD specialists at the sub-national for offices visited 	<ul style="list-style-type: none"> • Alignment to preferences expressed by Gol partners • Alignment to Gol structure and way of working • Levels of duplication or confusion in communications
Advocacy	Way in which CSD teams conduct advocacy towards the Gol	<ul style="list-style-type: none"> • Primarily sectoral at the national level • More, though not always, coordinated through the CSD specialists at the sub-national for offices visited 	<ul style="list-style-type: none"> • Alignment to preferences expressed by Gol partners • Alignment to Gol structure and way of working • Levels of duplication, conflicting messages, missed opportunities for synergies
Data & analytics	Way in which CSD teams support Gol data systems and leverage data internally	<ul style="list-style-type: none"> • Primarily sectoral till 2018 • New Data & Analytics team supporting on multi-sectoral Gol initiatives and data system strengthening 	<ul style="list-style-type: none"> • Relevance of approach to issue (e.g., do root causes span across multiple sectors?) • Alignment of approach to existing government programmes, or way of working
Programming	Way in which CSD teams design and implement programmes	<ul style="list-style-type: none"> • Primarily sectoral design and implementation • Integrated programme design and implementation currently being modelled at sub-national level through IKEA-funded nutrition programme in Aceh • Co-located programming in other FOs 	<ul style="list-style-type: none"> • Relevance of approach to issue (e.g., is aggregation and calibration required across sectors?) • Alignment of approach to existing government programmes, or way of working

In summary, the primary way in which the CSD cluster works is as a mechanism for coordinated management, functions, and processes, with little integrated activity. While management and systems may be coordinated, advocacy and programming are less so. The CSD's primary objective has been to facilitate better work at the sector-level through stronger systems and functional capacities. While there is evidence that the CSD cluster has had some additional effect at the level of systems and processes that would reasonably enable better work within the sectors, the ET was not usually able to identify evidence that would explicitly link these benefits to results or outputs in the analysis below.

Management structure: based solely on effectiveness, it is not clear whether a cluster or single sector approach would be best suited for the CSD programme. The structure has been additional at the sub-national level in terms of providing technical oversight; however, even at the sub-national level, the cluster management structure is perceived as less effective for some FOs.

While the CSD chief has played an important role in identifying and addressing gaps across the cluster at both the national and sub-national level, it is not clear that this role would be absent in a single sector approach. From a management perspective, the CSD chief's early priorities during the 2016-2020 CP included right-sizing the CSD staffing pyramid, better-defining work plans and national staff responsibilities (e.g., new Health Systems and PMTCT roles), strengthening regional presence in critical areas (e.g., MNCH, EPI, nutrition), and strengthening fundraising efforts in response to reductions in bilateral and other aid. These and other efforts have helped build the foundation for the CSD's growth (e.g., from 35 to 52 staff, doubling the number of national officers in the country office, increasing multi-sectoral coverage in Aceh and Surabaya). While having a CSD chief with a line of sight into the health, nutrition, and WASH teams and the authority to make decisions across the three sectors may have facilitated quicker decision-making

and action on these elements, there is no evidence to suggest that this could not have been achieved over time with a single-sector approach (e.g., via office-level strategy decisions, or coordination between sector chiefs).

In terms of technical oversight, the CSD chief has played an important backstopping role at the national level in the past; however, in steady-state (i.e., when sector chief roles are filled), there has been some duplication in technical oversight. In 2016, when there was no health or immunisation lead, the CSD chief took on these roles (two years for health and four years for Immunisation). In this sense, the CSD cluster approach ensured continued leadership in these areas while UNICEF sought to fill vacancies in a way that may not have been possible with a single-sector approach. However, when all sector chief positions are filled, there may be a need for a more precise delineation between roles, specifically for the health team. Staff from the health team in the ICO reported confusion in terms of which responsibilities sat with the CSD chief vs the health sector chief (e.g., advocacy at different levels within the MoH) and who to approach for technical advice. However, this does not necessarily suggest that a single-sector approach is required. ~43% of CSD staff at the national level (n=14) agreed that the CSD cluster increased the level of technical support the health, nutrition, and WASH sectors receive, with the health team agreeing most (44% of the team agreed) and the nutrition team agreeing least.

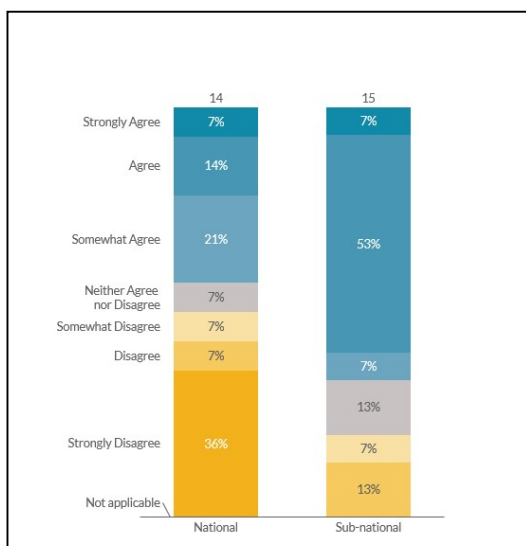


Figure 7. CSD responses to the statement 'The CSD cluster, when compared to having Health, Nutrition, and WASH as single sectors has increased the level of technical support the Health, Nutrition, and WASH sectors receive' for the CSD Cluster

At the sub-national level, the CSD specialist does provide additional technical oversight to sector specialists; this was most reported by the health team, whereas it was less clearly the case for the WASH team. In interviews across Kupang, Banda Aceh, and Makassar, FO staff consistently reported relying on their national-level counterparts for technical support. Moreover, while there was a perception that the CSD specialists – who were typically health experts in the field offices visited – were well-placed to provide technical support to health programmes, the relationship with the nutrition and WASH teams was sometimes more managerial or administrative. ~67% of CSD staff at the sub-national level (n=15) agreed that the CSD cluster increased the level of technical support received by the health, nutrition, and WASH sectors, with the health team agreeing most (77% of the team agreed). 67% of WASH team respondents disagreed. Responses also varied by field

office, with staff in Banda Aceh were most positive and staff in Makassar least positive.

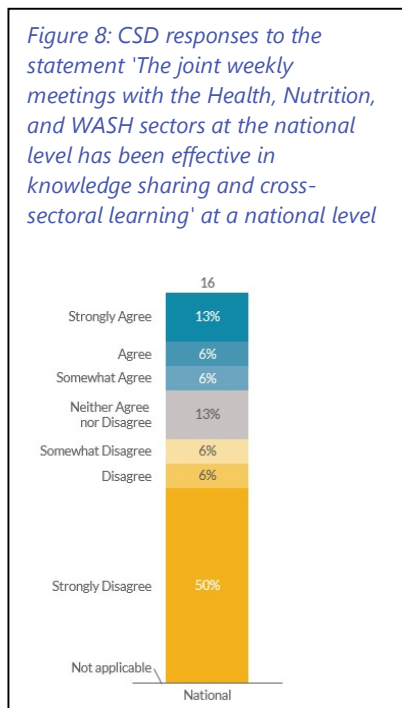
Shared systems, functions, and processes: there is no strong evidence to suggest that either the cluster or single-sector approach is more effective in terms of UNICEF-wide shared systems, functions, and processes; however, this may reflect a lack of appropriate or effective systems, functions, and processes within the cluster as opposed to lower effectiveness of the cluster approach overall.

In terms of office-wide functions and systems, the CSD cluster has limited impact on the level of effort or coordination required relative to a single-sector approach. Interviews with the PM&E, Private Sector Fundraising, and Operations teams confirmed that the health, nutrition, and WASH sectors are served separately, much like other clusters, and this primarily involves coordination with the sector chiefs even if the CSD chief must also approve. However, despite this, ~70% of survey respondents across these teams (n=13) somewhat agreed, agreed, or strongly

agreed with the statement that having a CSD cluster vs single sectors has made it easier for them to collaborate with the health, nutrition, and WASH sectors.

The CSD cluster could leverage its size, aggregated demand, and pooled fundraising to invest in shared functions. Thus far, the CSD cluster has taken steps towards a separate integrated CSD communications function and recently hired a communications specialist. The impact of this decision is not yet clear but embedding the function within the team may enable better prioritisation of requests and more coordinated identification of opportunities.

~71% of CSD staff at the national level did not believe that their weekly team meetings – the



most consistently cited shared CSD process – have enabled knowledge sharing and cross-sectoral learning and there are limited examples of collaborations emerging from this or other formal CSD processes. CSD staff in the ICO consistently characterised their weekly meeting as an opportunity for the sector teams to provide updates on current and future work. While some members of the WASH team found these useful for developing a better understanding of what other sectors were working on and the relevance to their work, staff across all three teams noted in interviews that there was little identification of opportunities for collaboration. Those who had been at UNICEF for longer referred to the previous format of weekly meetings (pre-2016) in which CSD members came together to explicitly discuss potential areas for collaboration rather than provide sectoral updates. 57% of CSD staff at the sub-national level believe that weekly team meetings were effective for cross-sectoral learning.

Other elements of standardisation exist across the CSD (e.g., integrated monthly budget tracker). However, while these may enable the sectors to be more effective, there is no

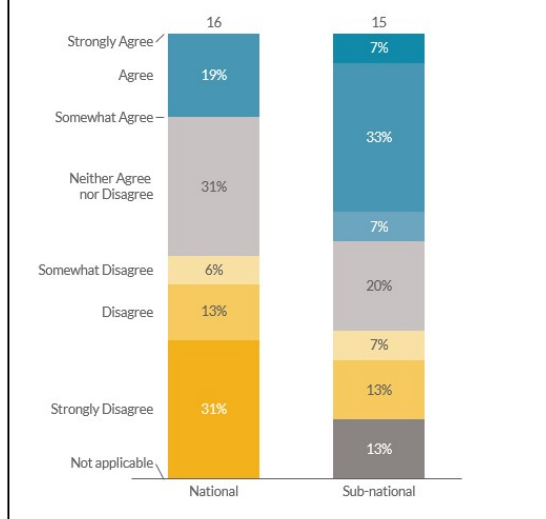
evidence to suggest that a single sector approach could not achieve the same.

Interfacing with government partners: at the national level, a single-sector approach to interfacing with government partners appears more appropriate. The appropriateness of a cluster approach vs a single-sector approach at the sub-national level appears to depend on the FO.

At the national level, communication happens primarily along sectoral lines; while some Gol stakeholders suggested that UNICEF staff could coordinate better internally, they generally preferred the current sectoral approach for UNICEF-Gol interactions. Stakeholders at the highest levels of BAPPENAS appreciated having a focal point across the CSD to streamline messaging, and interactions and one could imagine this would hold at even more senior levels. However, all CSD sector teams reported that their interactions with the Gol were primarily sectoral. In the case of the health team, these were even at the output-level. Only 30% of survey respondents from the national-level health team believed that there was demand from the Gol for the CSD sectors to communicate as a single unit; none of the respondents from the national-level nutrition and WASH teams agreed. This view was confirmed by Gol stakeholders, all of whom pointed to their sectoral counterpart as their main entry point to UNICEF. Government partners interviewed were satisfied with this arrangement. Still, a few suggested that UNICEF staff could better coordinate communication internally as they found that sometimes coordination between government actors in the health sector was not mirrored between the relevant UNICEF counterparts. The dominant preference for a single-sector approach appears to be driven by a preference for a dedicated focal point with the necessary technical expertise to participate in consultations fully. One exception was the Sub-Directorate of Adolescent Health, in which representatives pointed to fragmented efforts

across UNICEF teams and the lack of one point of contact as key drivers of why work-planning had slowed. In this case of a multi-sectoral area (i.e., adolescent health) for which multiple UNICEF expertise areas are relevant, fulfilling the Gol preference for one point of contact would require more coordination between sectors. A few UNICEF staff interviewed also suggested that there may be opportunities for joint meetings where multiple areas of expertise may be relevant but could not highlight an example of this happening between sectors.

Figure 9: Responses to the statement 'There is demand from Indonesia's national government for Health, WASH, and Nutrition sectors to mostly communicate with them as a single unit'



At the sub-national level, CSD staff reported more demand for coordinated communication from Gol representatives; however, this varied by region suggesting that while a cluster approach may be more appropriate for interfacing with government partners at the sub-national vs national level, it is not necessarily more appropriate than a single sector approach in all regions. A higher percentage of sub-national CSD staff believed that government counterparts wanted the CSD to communicate as a single unit (46% agreed, with 20% neither agreeing nor disagreeing). Again, this varied across FOs, with Banda Aceh and Kupang respondents more positive and Makassar respondents less positive. These sub-national variations mirror the relative level of integration presented by government partners in interviews. For example, in Kupang, BAPPEDAS, PHO, and DHO representatives all characterised their work across

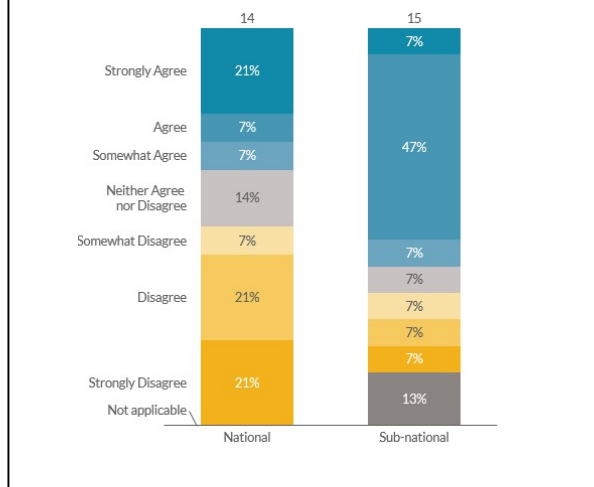
health, nutrition, and WASH in an integrated manner. On the other hand, the PHO representatives consulted in Makassar focused more on health and nutrition, with relatively less mention of WASH programmes.

Data and analytics: although the Data & Analytics team is new, its successes thus far suggest that the cluster approach can be more effective than a single-sector approach for strengthening overarching national data systems.

'Data and analytics' is an area in which the cluster approach has delivered results beyond what sectors could have achieved separately. Since its formalisation in 2018, the Data and Analytics team has been working with BAPPENAS to develop a Health and Development dashboard (Sept 2019 launch) and with a broader group to develop one SDG National Portal (Oct 2019 launch). This is a case in which, given the integrated nature of the desired product, the CSD cluster approach was better suited for supporting the Gol than a sectoral one. The additional value that the Data and Analytics team can provide internally to the CSD teams has not yet been tested.

Advocacy: at the national level, the ET did not find enough evidence to suggest that either the cluster or single-sector approach is better suited for advocacy, although there may be opportunities to better coordinate and prioritise efforts across the sectors. The appropriateness of a cluster approach vs a single-sector approach at the sub-national level appears to depend on the FO, but overall UNICEF sub-national staff believed that a cluster approach was more important for advocacy than for broader communications.

Figure 10: CSD responses to the statement 'The CSD cluster, when compared to having Health, Nutrition, and WASH as single sectors has made it easier for Health, Nutrition, and WASH sectors to communicate with national level government stakeholders for advocacy purposes'



Due to a lack of cases of coordinated or integrated advocacy at the national level, there is little evidence of whether an integrated or single-sector approach would be more effective in these cases. Across most of the health and nutrition sub-directorates within BAPPENAS and the line ministries consulted, there was little demand expressed for coordinated advocacy. However, the BAPPENAS leadership expressed a desire for a collective vision across CSD that could be used to streamline and prioritise activities, including advocacy. This does not necessarily imply a cluster approach to advocacy itself; rather a cluster approach to deciding which advocacy to pursue.

CSD staff consulted at the sub-national level suggested that the CSD cluster streamlines advocacy vs a single sector, especially for the

health (65% agreed) and WASH team (75% agreed). Again, responses varied by FO, with Banda Aceh more positive and Makassar less positive.

Programme design and implementation: the one flagship CSD example of integrated programming (Aceh malnutrition programme) as well as the examples of when an integrated approach could streamline efforts and make it easier to work with government (e.g., UKS interventions) suggest that a cluster approach is most appropriate when issues have multi-sectoral root causes or government structures and approaches already reflect sectoral integration.

In terms of CSD examples of integrated programme design and implementation, interviews surfaced only the office-wide, IKEA-funded project testing integrated approaches to reducing stunting in Banda Aceh. This is an office-wide programme driven by the CSD cluster. While it is too early to assess results achieved, it has demonstrated a viable model for structuring programmes when a multi-sectoral approach is required and generated some lessons for future efforts. For example, while multiple sectors across the office were involved during the proposal stage to define integrated outcomes, some teams key to anchoring the outcomes did not feel that they were adequately consulted in time to affect the scope.

The lack of examples limited the extent to which the ET could assess when and why an integrated or single-sector approach might be more appropriate; however, the nature of the issues being addressed, and the structure of an existing government programme being supported are important factors driving demand from the GoI. Currently, many of the CSD's largest focus areas remain primarily sectoral (e.g., immunisation, malaria, open defecation). However, this has been shifting towards the end of the current CP. As previously discussed, the anti-stunting movement is an example of a government priority for which a multi-sectoral approach is necessary to achieve Indonesia's targets. Going forward, others might include support on implementing the minimum service standards and other aspects of systems strengthening. In terms of mirroring existing government structure, the school-based health program, UKS, is an example of a case in which, at the very least, coordinated programme design and implementation could help avoid duplication.

While the lack of integrated programming is partially driven by the sectoral nature of many of the issues on which the CSD focuses (e.g., immunisation, malaria, open defecation), other drivers at the national level include a lack of official processes or mechanisms to enable

integration and a lack of incentives to encourage or mandate it. As discussed above, the weekly CSD team meetings do not appear to be used to identify opportunities for collaboration. Beyond this, staff did not highlight any other official processes or mechanisms that might facilitate integration. Management-level CSD staff noted that reporting against predominantly sectoral outputs – except for the emergency output – did not incentivise cross-sectoral collaboration. Since priorities and budget allocations are set at the national level, these limitations also constrain what is possible at UNICEF FOs.

2.5 What is the optimal balance between national and sub-national workstreams and how should this be reflected in the structure and core capacities of the cluster?

Given the decentralised approach of the Indonesian government and UNICEF’s shift from direct ‘downstream’ support to an ‘upstream’, system strengthening approach, the ideal balance between national and sub-national workstreams would enable UNICEF staff to leverage its FO activities to drive change at a national scale. The means having a meaningful enough presence at the sub-national level to facilitate more tailored evidence generation, advocacy, and capacity building, while maintaining a strong connection at the national level to ensure alignment with Gol priorities and a channel to policy and programming change as scale. This may require increased opportunities for FOs to provide inputs into national-level planning and a rebalancing of some capacities currently concentrated at the national level (e.g., C4D, data analytics, public finance management).

In terms of UNICEF’s footprint, the importance of piloting for evidence generation and the value of building understanding and relationships on the ground underscores the value of having FOs for leading advocacy, implementation, and general stakeholder engagement at the provincial and district levels. Both Gol representatives and UNICEF staff at the national and sub-national level highlighted this as an important strength and differentiator. As discussed in the findings for Question 1.3 on the validity of regions in which UNICEF operates, the current FOs are in the most relevant locations based on the burden of various child deprivations in those regions. Thus, it appears that UNICEF has struck an appropriate balance between its national and sub-national footprint.

Because all programme cooperation between UNICEF and the Gol is signed off on by national line ministries, UNICEF’s national level drives decision-making around CSD priorities and budget allocations in consultation of the FOs. This is reasonable given the structure of the partnership. However, given the decentralised nature of government funding, ensuring that there is not significant misalignment at the sub-national level is, of course important. Interviews with the FO staff suggest that the existing national planning processes do not comprehensively incorporate sub-national priorities. CFOs seek to be more involved so that they can better respond to different, changing priorities at the province, and district levels as these emerge through consultations with governors, mayors, BAPPEDA, and other local stakeholders. While the optimal balance is not necessarily one that allows for significant divergence from overall UNICEF priorities as this would fragment the agency’s potential impact, there may be room to incorporate these sub-national perspectives further (e.g., more joint working sessions internally or exercises that involve developing a decentralised view of government priorities to see how these map against central UNICEF priorities and how it deploys its staff).

Interviews with Gol representatives highlighted the impact of an impending shift in how foreign loans and grants can be channelled (i.e., decentralising the process so that they can flow directly to the sub-national level) on decentralised decision-making. Currently, the Gol’s PP10/2011 ordinance (Procedures for Procurement of Foreign Loans and the Acceptance of Grants) prohibits the direct transfer of funds from development partners (e.g., foreign loans/grants) to sub-national governments. Funds are instead transferred from the national level to provinces and districts, with the provinces retaining some autonomy on fund allocation across the different

districts. The GoI has announced plans to amend this ordinance to enable direct transfers to districts and provinces. While funding support from development partners is significantly outweighed by the GoI's domestic budget, this could have some impact on the extent to which sub-national government are able to dictate priorities for funding outside of UNICEF's agreement with the GoI, especially for those regions that receive a disproportionate amount of aid in Indonesia.

In terms of capacity, it is, of course, important to have some technical capacity in WASH, nutrition, and health in all offices covering provinces in which these UNICEF programmes are active; however, it is also important to ensure adequate capacity at the sub-national level to support and engage with government stakeholders at this level as necessary. The CSD has made progress in expanding the reach of its technical experts across sectors since 2015 (e.g., hiring a WASH specialist in Banda Aceh and a nutrition specialist in Surabaya), although can continue to address some gaps (e.g., nutrition specialist coverage in Banda Aceh). UNICEF staff within the country office and FOs highlighted public finance management and data analytics as areas in which capacity was insufficient relative to the needs expressed by government partners at the sub-national level. This is further elaborated in the findings for Question 4.3 on core capacities required to take the cluster forward.

Finally, CFOs consulted also noted some inconsistencies in performance management and other guidance provided from the national level due to the current reporting structure whereby each CFO reports to a different member of the senior team in the country office. Though not a direct response to the question of balance between national and sub-national workstreams, this is one important channel for ensuring a proper flow of information between the country and field offices.

2.6 Are there coordinated intra-cluster efforts or cross-cluster opportunities, such as with education, social policy or child protection, that should be further developed?

Many of the programmatic areas of work suggested for prioritisation in Question 1.1 will require an integrated approach (e.g., NCDs, diseases exacerbated by water or air pollution, and climate change augmented disasters) and even more will require at least some level of coordination within the CSD cluster as they will ultimately target the same groups of children. Furthermore, there are cross-cluster opportunities already highlighted as priorities by both the GoI and UNICEF globally towards which the CSD can and, in many cases, is already planning to direct further energy. For example, the health sector is exploring how to plug more into the office's work on child marriage; the nutrition team is ramping up its work around adolescent development and overweight and obesity. The Ministry of Education-led UKS school health programme focusing on issues across health, nutrition, WASH, and child protection is another opportunity for focal points within the CSD and other clusters to collaborate.

From a functional perspective, the Data and Analytics team currently sitting in the CSD – but soon to transition to the Social Policy cluster – should also be further developed. This team was developed to strengthen in-house data and analytics capacity and increase the quality and mainstreaming of data and analytics work within the ICO by promoting office-wide collaboration. Since its formalisation in 2018, the team has been working with BAPPENAS to develop a Health and Development dashboard (Sept 2019 launch) and with a broader group to develop one SDG National Portal (Oct 2019 launch). Despite these achievements, interviews with the CSD sector teams revealed that they had not been sufficiently engaged in agenda-setting for the Data and Analytics team. While some staff – particularly from the health team – did have more regular communication with the data team, most felt that the current work did not respond directly to what they most needed to support their government counterparts successfully. While this does not negate the support the data team has provided to the GoI to date, it does suggest that more engagement is required across the CSD cluster to align on what work UNICEF should undertake in order for the data team to play a genuinely

cross-sectoral role. Until this is done, staff buy-in and collaboration will continue to vary across the office.

3. Sustainability

Extent to which the CSD cluster's integrated approach is resulting in elements that might contribute to the longevity of impact of its work with the GoI (e.g., national ownership, leveraged funding)

The CSD's sectoral work has taken steps to enhance the sustainability of its impact during this country programme by shifting its focus 'upstream' and thinking about how to embed its work in national programmes and systems. Some programmes (e.g., malaria, STBM, IMAM) have been more effective at this. Even those that maintain some 'downstream' portfolio outside of pilots (e.g., immunisation) aim to strengthen capacity within the government system at the same time. The CSD's cluster approach is mirrored in national systems, with some exceptions around WASH activities that outside of the mandate of the MoH or health-related directorate in BAPPENAS.

3.1 To what extent is the integrated approach of CSD owned and embedded in the national planning and budgeting systems as compared to single sector approaches?

National planning and budgeting are anchored on activities aligned to the government's SDG priorities. Thus, the CSD approach is embedded in these processes in that BAPPENAS-level planning can take a more holistic view – although WASH sits across multiple directorates within BAPPENAS, while and health and nutrition activities are typically more streamlined within the MoH. However, activity-level planning and budgeting happen at a ministerial – and, ultimately, sub-directorate – level. The WASH activities on which the CSD currently focuses sit across multiple ministries, including the Ministry of Health (MoH) and Ministry of Education and Culture (MoEC), suggesting some departure from the CSD approach of integrating these activities alongside those of health and nutrition.

BAPPENAS, the independent central planning ministry, determines the national plan but not all topics covered by the CSD fall under the same directorate within BAPPENAS. At the start of every presidential term, BAPPENAS puts together a 5-year plan for the national government, and at the beginning of each year, it puts together the government's annual plan¹¹². BAPPENAS employs expert directors on 40+ topics to provide critical inputs during the planning phase. Once BAPPENAS determines the national plan, each director coordinates with relevant ministries to enforce the national plan items related to his other topic. While health and nutrition sit under the same directorate – the Directorate for Public Health and Nutrition – WASH is anchored in the Directorate for Development of Urban, Housing, and Settlement Areas¹¹³. Although there is a CSD focal point for coordination across health, nutrition, and WASH within BAPPENAS, this does not impact the planning and budgeting systems.

The Ministry of Finance (MoF) leads budgeting, while BAPPENAS leads activity-level funding in coordination with individual ministries and other government agencies. Once the MoF determines the total available budget for new programmes, BAPPENAS leads the process of determining programme-wise allocation of the budget in collaboration with the MoF. BAPPENAS decides programme-level funding based on government priorities and allocates programmes to appropriate ministries, along with ministry-level budget ceilings, for detailed planning and execution. BAPPENAS formally engages four coordinating ministries to refine priorities and allocations. While

¹¹² BAPPENAS website

¹¹³ Org chart on the BAPPENAS website. Maybe a government Ministry org chart?

health and nutrition sit under a single coordinating ministry – the Coordinating Ministry for Human Development and Culture - WASH issues sit across multiple coordinating ministries including the Coordinating Ministry for Human Development and Culture and the Coordinating Ministry for Economic Affairs¹¹⁴. After BAPPENAS and the MoF send each non-coordinating ministry its allocation, ministries can plan and spend their overall budget on a discretionary basis, working with BAPPENAS and the MoF to finalise the ministry-level budget. Once again, while health- and nutrition-related activity sit primarily within the MoH, WASH activities sit between multiple ministries, including the MoH and MoEC.

3.2 To what extent is the CSD cluster approach, as compared to a single sector approach, contributing to increased leveraged resources for child rights at the national and sub-national level?

While there are a few examples of multisectoral funding involving the CSD, most fundraising remains sectoral. There is little evidence that the CSD cluster approach, as compared to a single sector approach, has contributed to increased leveraged resources. Although the CSD budget has grown by 120% from USD 8.4 million in 2017 to USD 18.2 million¹¹⁵ in 2019, most (89%)¹¹⁶ of the funding raised by the CSD (as opposed to the non-earmarked funds) was intended for sectoral purposes rather than flexible use across multiple sectors.

Funders typically approach with an interest in one sector, and often in a specific issue within that sector. This view was shared by UNICEF staff – including the full range of those involved in fundraising (CSD chief, CSD sector chiefs, resource mobilisation team, PFP team), government partners, and the few funders with whom the ET spoke. Those involved in fundraising at UNICEF Indonesia generally agreed that, while the integrated narrative can be helpful with some types of funders (e.g., foundations), this narrative could still be relevant in the case of sectoral fundraising as one can link the outcomes of a single-sector programme to those of other sectors.

As mentioned previously, there are few examples of an individual grant being allocated across sectors. In the most-cited case of cross-sectoral funding within the CSD cluster (i.e., IKEA Foundation grant), while the agreed-upon programming was ultimately multisectoral, the initial donor interest was nutrition-specific. Furthermore, CSD sectors were not the only ones involved in this grant, suggesting that such opportunities are not specific to the intersection of health, nutrition, and WASH. Nevertheless, the IKEA case could be used as an example for funders of what is possible from a multi-sectoral lens and as a model for UNICEF for how to approach funders with this lens in mind.

The CSD chief, in addition to the sector chiefs, has been an important contributor to budget growth, especially for the immunisation programme and health sector more broadly. More specifically, the CSD chief has been the primary focal point for all but one active grant for EPI, MNCH, and malaria programming, representing ~80% of the health team's 2019 allocation¹¹⁷. Thus, one could argue that the existence of a CSD chief with skills, time, and the mandate to fundraise for the cluster has contributed to an increase in resources but cannot attribute this to the cluster approach.

The ET found no evidence to suggest that the CSD cluster approach leveraged additional funding outside of its fundraising activities.

¹¹⁴ OECD Journal on Budgeting, *Budgeting in Indonesia*

¹¹⁵ This excludes emergency funding

¹¹⁶ UNICEF, Child Survival Development Monthly Funding Status Update, 2019. This excludes USD 1,100,000 from Cargill for flexible use between Health and Immunisation. While this is a 'cross-team' grant, the ET did not classify this as 'cross-sectoral'.

¹¹⁷ UNICEF CSD Team, CSD Grant Information, 2019; Interviews

3.3 Which existing partnerships should be leveraged, and what new partnership opportunities should be explored, including with the private sector and potential financial partners/donors?

As found in the 2018 partnerships evaluation, the CSD team has a strong working relationship with its GoI counterparts at the national and sub-national level. As it engages in newer areas of work, it should take care to develop similar relationships with additional relevant stakeholders, even if the MoH remains its primary counterpart. This has already proven important in the case of the WASH sector, where its cross-cutting activities have required it to engage more with line ministries outside of those with whom the CSD cluster has typically worked (e.g., the Ministry of Religious Affairs (MoRA) and MoEC). Going forward, especially as the WASH team carries out UNICEF's WASH humanitarian cluster-lead duties and works with the government to strengthen its coordination and response, it is important that the CSD build select GoI relationships with line ministries not explicitly focused on child rights and well-being (e.g., Ministry of Public Works and Public Housing). However, both GoI interviewees and UNICEF staff noted that broadening relationships outside of the MoH could also strengthen advocacy efforts carried out by the nutrition and health teams around topics with stakes across multiple ministries (e.g., food advertising and labelling requirements).

Faith-based organisations emerge as an opportunity for further developing and deepening relationships. Given the influence they hold in communities, faith-based organisations can be an important channel for communication, demand generation, and even financing (e.g., partnering with local *Zakat* (Islamic alms) organisations to improve low-income families' access to finance for WASH interventions). Across all three sectors, the CSD team has leveraged faith-based groups or faith leaders to disseminate messages and reach target populations, especially caregivers (e.g., demand generation efforts to overcome vaccine hesitancy, channels to connect with parents on the importance of breastfeeding, raising awareness about MHM). These partnerships will become more critical if the CSD increases its C4D work.

Private sector partnerships are a potential missed opportunity. Although the 2018 partnerships evaluation noted that the relevance of private sector partnerships has increased in recent years, there are few examples of the CSD partnering with these organisations to leverage non-financial resources – only two surfaced during interviews. One area of opportunity highlighted by these examples is partnering for innovation especially in terms of expanding the reach of key messages or services (e.g., with PT Telkomsel to test raising awareness of MHM in schools through digital monitors). The second area of opportunity is partnering for advocacy, whether focused on other private sector actors or directly at target populations themselves (e.g., leveraging the convening power of the Jawa Post newspaper to help reach the goal of a 95% vaccination rate for the target age group during the 2016 immunisation campaign in East Java). Private sector partnerships may become more important as the CSD increasingly tackles issues heavily influenced by the private sector's product design and advertising (e.g., in the case of the nutrition and health sectors with regards to issues of obesity and overweight and tobacco usage).

When consulted, the CSD team pointed to some constraints for engaging the private sector (e.g., UNICEF policies on engaging with food and beverage companies, WASH private sector interest focused on 'downstream' activities), but ultimately agreed that there was room to do more especially as the programme shifts to be more relevant in an urban context. In this spirit, the CSD is increasingly considering market-based solutions as part of its toolkit. The health and nutrition teams are both in the process of advocating to shift market dynamics to supply or reduce the cost of the pneumococcal conjugate vaccine (PCV) and Ready-to-use Therapeutic Food (RUTF) respectively. While this does not always mean engaging directly with the private sector, it does involve leveraging the private sector to achieve CSD goals.

Beyond type of partner, the nature of the relationship – in this case, long-term vs short-term – is also important. The 2018 partnerships evaluation found that “most of the Civil Society Organisations (CSOs) partnerships [across all clusters] are linked to pilots or one-time activities”, noting that partnerships should go beyond specific grants or events and include ongoing activity around advocacy and capacity-building. Key informants highlighted the importance of developing more longer-term partnerships beyond that with the GoI, noting the importance of non-financial relationships for advocacy and having ongoing relationships when faced with unplanned requests. This is especially important in the case of emergency preparedness, where quick response time is critical to appropriately managing the situation. For example, in the response to the 2018 Central Sulawesi Earthquake, it took longer – in some cases, months to activate the necessary partnerships than ideal.

4. Cross-cutting Issues

4.1 How is the CSD programme contributing to gender equality among target populations?

Given the CSD’s focus on ‘upstream’ results and enhancing the government’s capacity to deliver ‘downstream’ results, we reviewed three potential ways in which it could contribute to gender equality. They included (i) increasing focus on issues that disproportionately affect women, (ii) designing and tailoring programmes with the differentiated needs of men and women in mind (i.e., gender intentional programming), and (iii) influencing or supporting government partners to collect gender-disaggregated data to better track ‘downstream’ results and inform interventions. The latter two forms of contribution reflect the practice of ‘gender mainstreaming’ as defined in UNICEF’s operational guidance on promoting gender equality, whereby gender-disaggregated data is used to identify gaps in gender equality to be addressed through targeted strategies and monitoring¹¹⁸.

Across all three sectors, the CSD has worked on issues that disproportionately involve or affect women and girls (e.g., maternal and child health, malaria in pregnancy, breastfeeding, MHM). While progress has been slow in the case of MHM, as discussed in Question 2.2, all these programme areas are associated with results (outlined in Question 2.1) that implicitly contribute to gender equality. Given their focus, these programmes should typically be tailored to the differentiated needs of women and girls.

Beyond areas that focus on girls and women, some examples of UNICEF gender-responsive¹¹⁹ programme design and tailoring emerged in programme documentation or through interviews. For three programmes across nutrition and WASH (i.e., breastfeeding, MHM, and STBM), documents explicitly discuss efforts to be gender-responsive. Examples referenced included supporting the development of a community-based support group model aimed at increasing awareness of the role of fathers in supporting breastfeeding, giving special consideration to how the introduction of latrines affected women and girls as separate from men and boys and tailored approaches to raising MHM awareness in boys and girls. The STBM programme revealed potentially gender-transformative elements (e.g., exploring how to increase the participation and leadership of women in community mobilisation). In the case of the immunisation program, the health team shared examples of gender intentionality in interviews (e.g., incorporating gender-differentiated messaging – such as messages aimed at male caregivers – at the community level).

However, the lack of documentation of the results of these efforts and thorough gender analyses suggests that there is room for a more systematic approach to gender. In the UNICEF 2018-2021 Gender Action Plan, ‘gender analysis’ is highlighted as a key pillar for making UNICEF a more gender-responsive organisation. This analysis is defined as “routine mapping of the nature and

¹¹⁸ UNICEF, Gender Equality – Accelerating Progress and Opportunities for Everyone, 2011

¹¹⁹ Gender responsive: identifies and addresses the different needs of girls, boys, women and men to promote equal outcomes

scale of gender equalities as they affect UNICEF priority results” and “systematic deployment of UNICEF’s Gender Programmatic review tool to assess gendered barriers as well as opportunities for effective programmes at scale”¹²⁰. While gender considerations are addressed in the office-wide Situation Analysis, the CSD programme documentation reviewed did not typically include systematic analyses of how gender-differentiated needs may affect the potential intervention required and how the programme would respond.

All programmes reviewed analysed gender-disaggregated data to understand how girls and boys are affected by an issue or included in the solution; still, UNICEF can encourage government parts to collect better gender-disaggregated data. While UNICEF does not typically capture entire data sets – as the focus is on strengthening the Gol’s data systems –, programme documentation and research papers reveal efforts to analyse gender disparities across all programmes reviewed. However, the ability to monitor gender differences in nutrition and WASH is constrained by the existence or quality of the government’s gender-disaggregated data. For example, the nutrition team shared that most of the government data with which they work are not gender disaggregated. The STBM evaluation found that UNICEF could enhance its gender-sensitive approach by “asking for gender-disaggregated data in statistics and application of monitoring systems”¹²¹. While not linked to a gender-disaggregated data point, the WASH team’s successful advocacy for the Gol to track data on the availability of menstrual pads in schools is a good example of how UNICEF can work with the Gol to improve the quality of data available to inform gender-sensitive interventions. UNICEF’s partnership with the Gol may be leading to some incremental change on data collection; however, this has not yet been documented.

4.2 How is the CSD programme contributing to equity among target populations?

While UNICEF Indonesia does focus its sub-national work in areas with weak development indicators and its programmes do often include some component targeting more vulnerable populations (STBM, IMAM, Malaria), a lack of disaggregated data in government data prevents it from making more targeted contributions to equity beyond region and gender (e.g. children with disabilities, groups facing unique stigmas). One lesson learned from UNICEF Global’s 2014–2017 experience was: “there is a clear need to scale up equity-focused programming and advocacy, and to target interventions to focus on the most disadvantaged children, including adolescent children, children with disabilities, and minorities. Increased investment in equity measurement through disaggregated data will also be of critical importance”. Thus, we reviewed UNICEF’s contributions to equity across four sets of activities adapted from the Stewart paper: initial mapping of inequity, monitoring of inequity, equity-focused advocacy, and equity-focused planning in programmes¹²².

The ability to analyse disaggregated deprivations by age group, region, and, to a lesser extent, gender has allowed UNICEF to map, monitor, advocated for, and target its activities towards these groups. The draft 2019 Situation Analysis of Children Adolescents and Women in Indonesia intended to inform future programmes presents an analysis along these lenses. As previously discussed, UNICEF FOs focus on the most disproportionately affected regions of the country. The malaria and immunisation programmes, in particular, support the Gol in addressing issues in more remote or affected populations (e.g., Models for malaria elimination in Aceh and East Nusa Tenggara, Technical assistance for the acceleration of malaria elimination in Papua, West Papua, and East Nusa Tenggara, efforts to increase immunisation coverage in Aceh and Papua). UNICEF is also increasingly looking to tackle the issues that most affect adolescents (e.g., MHM and obesity) in addition to those that most affect the under-5 population. Finally, while there is room to systematise and deepen gender analysis in UNICEF programming, many programmes collect gender-disaggregated data

¹²⁰ UNICEF Gender Action Plan 2018–2021, 2018

¹²¹ UNICEF and Bill and Melinda Gates Foundation, Sanitation Programme Indonesia 2013–2017 Evaluation Report, 2017

¹²² Adapted from: Stewart, Frances, Approaches Towards Inequality and Equity: Concepts, Measures and Policies, 2013

(e.g., malaria, IMAM, immunisation) or focus their interventions through women and girls (e.g., MHM, breastfeeding).

Across the six programmes reviewed, three included examples of targeting vulnerable populations beyond the gender, region, and age; these were components of the programme rather than being the subject of the entire programme design. For example, the models for malaria elimination in Aceh and East Nusa Tenggara programme addressed malaria elimination among remote migrant populations in Aceh such as mining workers and logging workers, who are not registered with local government authorities and faced reduced access to appropriate healthcare services. The IMAM programme strengthened community mobilisation strategies to identify and enrol the most vulnerable groups of children at risk of SAM (i.e., those with limited access to integrated health post (Posyandu) services. The STBM programme has leveraged Islamic charity funds to increase access to sanitation services; by definition, these funds can only be allocated to those in the most impoverished segments.

However, UNICEF staff reported that a lack of data on child deprivation disaggregated at other levels (e.g., socially excluded groups, children with disabilities) means that they are unable to track or target interventions towards these groups systematically. For example, individuals with disabilities have emerged as a priority group for addressing inequity in Indonesia. Disabilities affect at least 4.3% of the Indonesian population (and, potentially, as high as 11%)¹²³ and, as of 2012, SUSENAS found that only 60% of children with disabilities had a birth certificate (compared to 75% of children without disabilities), limiting their access to public services. However, there is no disaggregated data on the number of children with disabilities, making it difficult to track or target them even though evidence shows that they face disproportionately worse outcomes. In this case, the Social Policy cluster is working with Statistics Indonesia to improve data collection specifically for children with disabilities, but there may be opportunities to enhance data collection and monitoring for other relevant populations.

4.3 What new capacities would be required within the cluster to take forward future programme areas?

At the national level, UNICEF may need to expand its capacities to better leverage C4D expertise, increase gender intentionality, and prepare for expansion in focus areas. There is high demand across the CSD cluster for C4D expertise at the national level, which the current capacity is unable to meet. This work falls primarily on one C4D specialist within the communications team, implying that requests from other clusters cannot be met. The lack of gender intentionality in some programmes, especially health, points to the need to assess capacities in gender analysis. Beyond building necessary expertise in any new areas of focus, UNICEF will need to continue investing in its institutional emergency preparedness, as well as the skills required to support the Gol with its preparedness activities.

At the sub-national level, C4D and data analytics were highlighted by UNICEF staff as capacities for which current support was inadequate. The limited C4D capacity at the national level also affects the sub-national level as FOs are increasingly receiving requests to support on work related to behaviour and communication and UNICEF teams are seeing the value in building these capacities in government and other partners. There is also room to enhance the support FOs provide to sub-national governments on data analytics, which is currently channelled from national-level teams. For example, BAPPEDA in the two FOs visited for this evaluation – Kupang and Makassar – requested more support on real-time data and mapping out critical challenges across districts to inform more targeted support.

UNICEF's 2019 Situation Analysis also highlights potential gaps in public finance management that may require additional UNICEF support – and thus, stronger UNICEF capacities – in the

¹²³ Australia Indonesia Partnership for Economic Governance, Disability in Indonesia: What can we learn from the data?, 2017

future. Given their more implementation-focused role before decentralisation, local governments have had less of a history of developing the capacity for planning and managing public finances. Furthermore, with the exception of the education sector, most sectors experience inadequate and/or unsustainable financing. This and the lack of financial oversight can exacerbate the management challenge¹²⁴.

¹²⁴ Coram International, Situation Analysis of Children and Adolescents in Indonesia, 2019

V. CONCLUSIONS

Overall, the CSD programme and 'ways of working' have been effective in facilitating UNICEF's contributions to the achievement of CP outputs. Its areas of focus remain relevant to Gol development priorities and the most pressing issues facing Indonesia children in alignment with the SDGs. While the CSD cluster mechanism has served as a stabilising structure and coordination mechanism as the individual sectors (health, nutrition, and WASH) have grown, it is only recently beginning to contribute to results for children more directly (e.g., through the development of integrated programming or multi-sectoral support on Gol data systems strengthening).

Relevance

The CSD programme component is strongly aligned with the Gol's priorities under the new RPJMN 2020-2024 and the 2030 agenda of the SDGs. Almost all its core focus areas have been highlighted as priorities in the RPJMN 2020-2024, and the RPJMN is developed with the achievement of Indonesia's SDG goals by 2030 in mind.

At the sub-national level, the CSD programme focuses on those provinces most marginalised or affected by the issues it seeks to address (e.g., many of the Eastern provinces). Through its FOs, UNICEF also focuses on building local government capacity and testing interventions across provinces which have the lowest health, nutrition, and WASH indicators. The strong alignment to priorities at the national level masks a potential mismatch on UNICEF's broader set of areas of work and those that might be most relevant within a specific province. Although the evaluation team did not do a detailed review of all needs at the provincial level, UNICEF staff in the FOs highlighted this tension in their summaries of government priorities according to provincial RPJMDs and consultations with their government counterparts. However, there is a clear trade-off between setting UNICEF's priorities nationally and providing flexibility to tailor priorities to the needs of local government counterparts. Given UNICEF's limited resources and its aim to deliver upstream results at a national scale where possible, its decision to prioritise national alignment is reasonable.

While most of the CSD areas of work remain relevant, some shifts will be necessary, primarily due to progress made on long-standing issues or the rising importance of newer issues as the Indonesian context changes. While this report provides recommendations on some key areas of work to consider, the CSD team will ultimately need to refine its portfolio through government and other partner consultations, recognising that it will likely evolve during the next country programme as it has over the current one. Recent progress on malaria and ODF suggest room for the CSD to further tailor its efforts and focus on maintenance-related support or those areas where these issues continue to persist (e.g., Papua, West Papua, East Nusa Tenggara, Maluku, and North Maluku for malaria; Papua, Sulawesi, Aceh, Maluku, and Java for ODF). Reducing focus will likely imply shifting work from the village and district level in some areas towards the provincial level to maximise impact. The CSD should also explore some newer areas of work, though not necessarily all at once. These include rising incidences of obesity and tobacco consumption among children leading to increased rates of NCDs, worsening air pollution, a rise in diseases such as dengue, and the increasing importance of emergency preparedness, all of which have been highlighted in UNICEF's 2019 Situation Analysis. Both shifts in current work and exploration of new areas of work should begin before finalising its next Country Programme Document. However, UNICEF should complete its consultations with the Gol on its priorities before building out any new programming as it may be necessary to prioritise further based on available and projected resources.

Addressing an increasing number of topics runs the risk of fragmentation if not undertaken under one collective vision, a concern that some government partners and internal UNICEF staff have already expressed regarding the CSD portfolio. However, it is also possible to take a fragmented approach to address one problem or an integrated systemic approach to many issues. Going deep on a few key issues vs addressing multiple interconnected problems is ultimately a choice for senior management, but even if the CSD maintains its current number of focus areas, it

would be important to highlight the specific three to five collective goals to which all activities should align. Another critical aspect of a collective vision is a commonly understood ToC with buy-in from UNICEF CSD staff as well as Gol.

While the importance of an integrated approach remains valid, especially for addressing increasingly multi-sectoral issues and responding to broad demand from government partners, this does not necessarily translate into the current structural solution (i.e., managing health, nutrition, and WASH under one cluster). Stakeholders across UNICEF, government, and other implementing partners recognised the importance of integration. However, they sought a strategic vision, coordination internally, and multi-sectoral approaches where relevant. Few external partners were concerned with how this was achieved, suggesting higher flexibility to explore other ways of doing so beyond the current approach. As addressed in the findings on effectiveness, it is unclear that the existing CSD structure has enabled those elements of integration most requested. In terms of programming, as the CSD has grown to respond to the demands of Indonesia's urbanising context, so too have the mandates of each of its sectors (health, nutrition, WASH), suggesting a weaker justification for clustering these three sectors in particular than may have existed six years ago. The grouping is reasonable in that the health-related components of these programmes all fall within the MoH and may have been especially important for ensuring that nutrition and WASH were prioritised alongside health issues when these two UNICEF programmes were smaller. However, these teams now have a well-established place within the UNICEF-Gol partnership and their own counterparts within the government. The WASH team is increasingly engaging government stakeholders outside of the MoH, and the nutrition team may need to do the same as it tackles newer issues. In terms of government demand for integration, the Gol stakeholders consulted did not typically limit the scope to these sectors, but often included education and child protection as well.

Effectiveness

Across the CSD sectors, all 2018 CP output targets have been achieved, and all 2019 targets have either been achieved or are on track. Progress on most outcome indicators has also been strong, suggesting that some (e.g., breastfeeding) may be deprioritised nationally going forward; however, others (e.g., HIV testing for pregnant women) may receive increased attention. UNICEF has contributed meaningfully across these outputs. In the case of open defecation, MNCH, and HIV, its contributions can be logically linked to progress on national-level outcome targets, given their scale and focus.

A review of 'ways of working' highlights the value of aligning advocacy and evidence generation to government priorities and programmes and the challenge presented by fragmented Gol ownership of or stakes in specific issues. Advocacy and evidence generation are often combined and, consequently, demonstrated some similar success factors. The most successful examples reviewed involved key Gol priorities, clear ownership from the government, and an existing national programme or initiative (e.g., models for malaria elimination, IMAM, some breastfeeding efforts). This reinforces the importance of aligning CSD areas of work to Gol priorities; even the best evidence generation efforts require a clear channel through which to scale and it would be impossible for UNICEF to create one independently in a country as large and complex as Indonesia. Fragmentation of government ownership is an important related stumbling block. The involvement of multiple ministries can make it difficult for any particular party to take ownership fully (e.g., coordination between MoEC and MoH with regards to WinS; lack of progress on breastmilk substitute marketing policies due to conflicting perspectives between ministries). In these cases, UNICEF will need to make a judgment as to the likelihood of reaching alignment through its current efforts, whether other stakeholders might be more effective at doing so, or whether efforts are best directed elsewhere.

The CSD cluster's work includes some examples of how C4D can be an important tool for driving behaviour change. Experience with C4D across the CSD programmes ranges from

those that have used it intensively in the past (e.g., STBM, immunisation) to those for which the potential value of a behaviour change strategy has emerged more recently (e.g., breastfeeding). Given that all the areas on which the CSD focuses require either a child or a caretaker to opt-in, C4D is a critical element for any programme. The fact that the CSD cluster's demand for C4D support outstrips the available capacity within UNICEF Indonesia reinforces this.

The pilot-to-scale approach has delivered some important 'upstream results'; drivers of success include plugging into government priorities or existing government programmes, securing funding beyond government budgets, and ensuring adequate capacity. Of the pilots reviewed, most were successful in leading to a national guideline, plan, or decree (e.g., CMAM, models for malaria elimination, MiP, CIA) and two-thirds were successful in scaling or being included in national plans to scale. Some drivers of success were similar to those for advocacy and evidence generation, given that these 'ways of working' are closely linked to the success of the pilot-to-scale approach. Other factors (e.g., funding, capacity) point to the importance of the 'test the feasibility' component of UNICEF's PPP guidance. Based on the ET's review of available documentation and the findings of UNICEF's pilot-to-scale thought paper, the focus of CSD pilots tends to be on proving effectiveness with feasibility often solved for second.

The fact that some pilots have been able to deliver significant results does not necessarily justify the number of or process for selecting pilots. The pilots reviewed demonstrated that the CSD has been successful in translating pilot activities to scale in terms of policy change and programming. However, it was not possible to assess whether each successful pilot represents the most efficient way to have achieved the relevant result. It is possible that, in addition to pilots that have not scaled, there are pilots that have eventually scaled but perhaps were not the best use of resources relative to other activities the CSD could undertake. While UNICEF staff interviewed demonstrated that a lot of thought goes into pilot selection (e.g., consultations with government, reflecting on geographic footprint relative to existing pilots), the ET did not observe a standardised process for prioritising pilots across the CSD.

While the CSD cluster approach is additional in some cases, for the most part, the single sector approach dominates. While integrated programming appears to have been one initial driver for the establishment of the CSD cluster, the primary way in which the cluster works now is as a mechanism for coordinated management, functions, and processes, with little integrated activity. This reflects cluster priorities in 2016, which included backstopping for key vacancies (e.g., immunisation lead), strengthening and co-locating regional presence, and strengthening fundraising. There has been relatively little 'cluster activity' in the areas of advocacy, programme design and implementation, and even general communications with Gol counterparts at the national level. While the cluster approach appears more relevant at the sub-national level – based on interviews with UNICEF and the Gol and UNICEF survey responses – it is not always most relevant for every FO.

Data and analytics, programming for multi-sectoral issues or multi-sectoral government programmes, advocacy at the sub-national level, and potentially communications with government at the sub-national level are areas for which a cluster approach may be most appropriate. The most apparent areas for which a cluster approach may be appropriate are programmes that require coordination or integration either because of the subject matter (e.g., stunting), existing programme structure (e.g., UKS as a touchpoint for many services for children), or existing government structure (e.g., data and analytics support that focuses on an integrated data system). Beyond these cases, the ET found a split in demand from Gol stakeholders and relevance to Gol approach – important drivers of the effectiveness UNICEF's work – between the national and sub-national levels. At the national level, advocacy and communications are primarily sectoral. Both UNICEF staff and their Gol counterparts generally believed it should remain this way, in part because of the complexity of working on each issue in a country as large and diverse as Indonesia. Only Gol stakeholders working on multi-sectoral issues with no consistent UNICEF focal point disagreed. At

the sub-national level, the cluster approach was more relevant, especially for advocacy. However, there was significant variation by FO. In Banda Aceh, UNICEF staff saw more value in the cluster approach, while in Makassar, they strongly disagreed. The fact that the Banda Aceh presence is grounded in an integrated programme and PHO and DHO interviews in Makassar highlighted integration across all three CSD sectors less than others suggests that some 'pull factor' – whether government demand or an existing programme is needed for the cluster approach to be most appropriate.

This variation at the sub-national level is even more pronounced when reviewing how UNICEF staff perceive the level of technical oversight they receive. While FO staff generally reported getting more technical oversight as a result of the CSD cluster than the national staff, this was heavily skewed by the health team. Most WASH respondents disagreed. As with advocacy and Gol communications, staff in Banda Aceh were more positive and compared to those in Makassar.

In terms of management structure and shared systems and processes at the national level, now that the previously discussed 2016 priorities have been fulfilled and the CSD sectors are in a stronger position, there are fewer ways in which the cluster approach is additional vs the single sector approach; the technical oversight and the CSD chief's fundraising role are potential exceptions. While the CSD chief's role itself appears to be additional (e.g., more technical oversight and additional focus on fundraising, particularly for the health team), the CSD cluster does not appear to regularly enable more collaboration or integration. This is limited by the sectoral nature of CSD outputs in the results framework, a lack of a clear vision for what collaboration or integration is meant to achieve, and a lack of incentives compelling staff to prioritise integration and mechanisms to harness collaboration. These barriers are translated through budget allocations and programming decisions.

While it is impossible to specify the exact optimal balance between national and sub-national workstreams, there is a case for strengthened capacities (e.g., C4D, data analytics, public finance management) and increased involvement in decision-making at the sub-national level (e.g., in deciding what issues to focus on at the sub-national level). Given UNICEF's national mandate, decision-making should remain primarily centralised. However, UNICEF's unique role in the field relative to other development actors means that staff in the FOs should have some flexibility to respond to local demand within the broader national priorities set at the country office level.

Finally, there is room to rationalise reporting lines between the CFOs and the country office and reduce the variance in the guidance provided.

Sustainability

The CSD's sectoral work has taken steps to enhance the sustainability of its impact during this country programme by shifting its focus 'upstream' and thinking about how to embed its work in national programmes and systems. Some programmes (e.g., malaria, STBM, IMAM) have been more effective at this. Even those that maintain some 'downstream' portfolio outside of pilots (e.g., immunisation) aim to strengthen capacity within the government system at the same time. UNICEF should continue its close vetting process with the Gol to avoid the risk of generating activities without a home in government plans. The CSD approach is embedded in national processes in that BAPPENAS-level planning can take a more holistic view; however, within BAPPENAS directorates and line ministries, health and nutrition tend to fall under the same actor, while WASH sits across multiple bodies.

As the CSD has shifted its focus towards 'upstream' work, most of its results are embedded in Gol policies and guidelines or owned by government counterparts. As discussed in the 'effectiveness' findings, the CSD's work has shifted primarily 'upstream', and its 'downstream' efforts are typically intended to link to 'upstream' results (i.e., pilot-to-scale approach) or in response to an emergency (e.g., malaria support during emergencies in Lombok and Sulawesi in 2018). Across the programmes closely reviewed for this evaluation, UNICEF's support, recommendations, and tested

interventions have been embedded in national and sub-national government systems (e.g., STBM, malaria elimination approaches, IMAM). An important strategy to achieve this has been finding ways to feed into existing government programmes or national policies with a clear pathway to scale. There are examples of UNICEF successfully advocating for governments to allocate more funding to CSD issues (e.g., MoEC allocation of 9% (~USD 30 million) of the total Education Special Allocation Fund to improving WinS, allocation of PHO funding to scale up IMAM in ten districts, use of local financing from the 'Village Fund' to support activities on malaria elimination and maintenance), but these are much less prevalent than the non-financial results.

For planning and budgeting, nutrition and health sit under the same directorate (BAPPENAS) and the same ministry (MoH); however, WASH issues span multiple directorates and ministries. Thus, the combination of health and nutrition is embedded in national systems, but not entirely with WASH. Within the government, planning is done collaboratively, but budgets are allocated by ministry and sub-directorate. While BAPPENAS representatives acknowledged that ministry-level budgeting and accountability does pose a challenge to the integration required to meet all of Indonesia's SDGs, their recent experience with stunting suggests that there are ways to integrate effectively within the existing system. Thus, the sustainability of the CSD's work with the Gol does not appear to be tied to the cluster approach of health, nutrition, and WASH. In the same way that the CSD focal point in BAPPENAS coordinates across the relevant sectors, UNICEF could establish a role or mechanism to ensure coordination across health, nutrition, and WASH without centralising management across them. In terms of financing, while the CSD has been able to raise funding from the IKEA Foundation for a multi-sectoral programme, there are few other examples to suggest that the coordinated approach of CSD, as compared to the single sector approach, has contributed to an increase in leveraged resources. While this may shift over time, UNICEF staff's experiences fundraising – both within CSD and the PFP team – suggest that most funders currently approach with an interest in a specific sector.

The CSD team should seek to deepen its existing successful partnerships into longer-term relationships to enhance the sustainability of its work – especially where these may be important in an emergency – and explore the relatively untapped potential of the private sector. UNICEF can explore private sector partnerships around innovation, advocacy, and reaching larger or untapped audiences for demand generation. For some sectors, options may be limited by UNICEF policies (e.g., nutrition and food and beverage companies); in these cases, it may be helpful for the PSF team to help identify and facilitate conversations with these restrictions in mind.

Humanitarian emergencies are a growing threat to the sustainability of all UNICEF activities, reinforcing the need to invest in emergency preparedness. In a world in which natural disasters are becoming more frequent, emergency preparedness is critical. It is difficult to identify the optimal trade-off between these investments and ongoing development activities, but, as a humanitarian organisation, UNICEF must be ready to act as a first responder and mobilise its partners to do the same. Interviews with UNICEF staff suggest that the CSD needs to both strengthen the capabilities amongst its team and ensure continuity across those designated as emergency preparedness focal points within the different sectors.

Cross-cutting Issues

Across all three sectors, the CSD has worked on issues that disproportionately involve or affect women and girls (e.g., malaria in pregnancy, breastfeeding, menstrual health management); however, a lack of documentation of gender analyses suggests room for a more systematic approach. For three programmes across nutrition and WASH (i.e., breastfeeding, MHM, and STBM), documents explicitly discuss efforts to be gender intentional. Overall, the available documentation did not include thorough analyses of how gender-differentiated needs may affect the potential intervention required and how the programme would respond. All programmes reviewed analyse gender-disaggregated data to understand how girls and boys are affected by an issue or included

in the solution. However, UNICEF can encourage government counterparts to collect better gender-disaggregated data.

While UNICEF Indonesia focuses its sub-national work in areas with poorer development indicators and its programmes do often include some component targeting more vulnerable populations (STBM, IMAM, Malaria), a lack of disaggregated data prevents it from making broader contributions to equity beyond region and gender. In terms of choice of target populations for its programming, the CSD has typically considered equity through its office-wide choice of FO locations primarily in more marginalised and affected areas. UNICEF staff reported that a lack of data on child deprivation disaggregated at other levels (e.g., ethnicity, children with disabilities) means that they are unable to track or target interventions towards these groups systematically and there is little data to quantify the broader contribution to equity.

In addition to potentially investing to ensure gender analysis capacity across the sectors, the CSD will need to invest in additional C4D capacity at the national level to support the growing demand for employing these skills in programming. At the sub-national level, demand for C4D and data analytics highlights an increased interest from both sub-national UNICEF staff and GoI partners to invest in strengthening the FO toolkit for responding to demands in the field. Furthermore, as regional government actors continue to exercise the increased decision-making responsibilities delegated through the decentralisation process, there is room for additional UNICEF support in public finance management to help optimise and monitor the use of limited resources. From consultations with UNICEF staff, this capacity would need to be strengthened internally. For any capacities considered, UNICEF should carefully reflect on the appropriate balance between strengthening these in the country office vs the field.

VI. LESSONS LEARNED

Overall, UNICEF's strategic shifts over the course of the 2016-2020 CP (i.e., from 'downstream' to 'upstream' and from operating at pilot-level on the ground to operating at scale through a combination of 'downstream' and 'upstream' activity) has enabled it to contribute to the achievement of the CP 2018 outputs and the GoI's progress towards achieving the 2020 targets. The ET identified a few lessons to inform these efforts going forward:

- **'Downstream' activities and partnerships are not inherently bad; however, almost any 'downstream' activity can be interpreted as having an 'upstream' goal so UNICEF guidelines should require this to be articulated upfront:** Previous evaluations and ongoing internal discussions have focused a lot of attention on UNICEF's shift from 'downstream' to 'upstream' programming, perhaps without fully appreciating the blurred line between the two. For example, on-the-ground service delivery very clearly sits on one side of the spectrum, while advocacy at the highest levels of the MoH is on the other. However, conducting staff trainings at the district level can quickly shift from 'downstream' to 'upstream' if those trainings enable UNICEF to test a model or develop guidelines that may be rolled out nationally. Thus, one cannot look just at the initial set of activities within a programme to determine how systemic the final impact might be. Nevertheless, those designing such programmes should highlight these links upfront; otherwise, it becomes difficult to assess whether their approach is the most effective for achieving the targeted systemic impact until after the fact.
- **Periodic reviews of UNICEF structures like the CSD cluster are critical for ensuring that their initial objectives and continued validity are clear to all:** Although most could speculate, few team members in the CSD could confidently point to the original reasons for bringing the nutrition, health, and WASH teams under one cluster. While this may be fair since most were not working with UNICEF at the time of the cluster's establishment, it underscores a broader lack of clarity around what the coordinated approach of the cluster is meant to achieve today vs what each of the sectors is responsible for. Without this clarity, it is unreasonable to expect the cluster approach to deliver on those initial objectives fully. Ultimately the cluster served as a coordinating mechanism and a foundation on which the sectors could grow over time. This evaluation has provided the space for UNICEF staff more broadly to reflect on the objective of the cluster approach going forward.
- **Facilitating integration across UNICEF Indonesia's clusters requires going beyond coordination or management structures to incentivising behaviours and creating forums and channels through which staff can practice these behaviours:** An important lesson of this evaluation was that, although co-location can increase staff members' awareness and understanding of each other's work, it often does not lead to spontaneous integration as it relies on individuals to take on this responsibility. This may work where a strong culture of collaboration already exists or where staff have enough capacity outside of their existing work to explore and experiment. However, if an organisation is seeking to transition towards more integration, it is necessary to do more. In UNICEF's case, the right incentives must first be put in place for (i) rewarding especially proactive staff (e.g., a pool of funding reserved for the most innovative ideas for collaboration) and (ii) aligning all staff at least towards a bare minimum (e.g., linking performance reviews to the extent of cross-cluster consultation taken on in the programme design phase). To complement incentives, it is important to create spaces in and processes through which staff are meant to practice these behaviours and only these behaviours (e.g., meetings or off-sites focused exclusively on identifying opportunities for collaboration, a mandated step in the programme design phase for soliciting inputs from different clusters).
- **UNICEF's ability to effectively design and implement equity-focused approaches is closely linked to the strength of government data systems:** It is now widely accepted

that effectively mainstreaming gender and equity into programming requires access to data disaggregated along relevant segments (e.g., men vs women, specific marginalised populations). In UNICEF's partnership with the Gol, it focuses on strengthening government data systems rather than creating parallel ones. Prioritising gender- and equity-disaggregated data collection and monitoring in these efforts will enhance both UNICEF and its government partners' abilities to address the differentiated needs of different populations.

VII. RECOMMENDATIONS

The ET has developed the recommendations outlined below through a participatory process with the ERG. The ET presented the first draft of recommendations to the ERG before a validation workshop of preliminary findings. Following these initial inputs, the ET shared revised versions of the recommendations in subsequent drafts of the evaluation report, incorporating feedback from the ERG during each round. The final validation of the recommendations was conducted on a teleconference for ERG members on December 4th, 2019; this group refined and prioritised the final list.

Given that this evaluation aims to inform the next country programme from 2021-2025, we have suggested relative prioritisation of our recommendations along two timeframes:

- *Short-term:* For implementation before the launch of the next country program
- *Medium-term:* For implementation at the launch of the country program

Recommendation #1: (Short-term): While the vast majority of areas of work under the current CSD programme remain relevant to national GoI child-related priorities, the ICO senior management and CSD leadership should explore some adaptations based on emerging priorities in Indonesia to ensure continued relevance in the next country programme:

- Consult with national and sub-national government partners on potential new – or nascent, and growing – areas of work as discussed in the findings and conclusions to understand where UNICEF partnership would be valuable vs that of other development partners (i.e., NCDs, dengue, air pollution, impact of climate change on disasters and emergency preparedness)
- Continue shifting priority, focus, or type of support for issues as sufficient progress is made against national impact targets (e.g., to maintenance for areas where progress has been made on malaria while maintaining more intense support to persistent high-burden areas; to maintenance for areas where progress has been made on ODF, but continuing elimination activities in Java and other areas where the issue persists)

Indonesia has made progress on some long-standing issues such as malaria and open defecation. UNICEF can consider shifting its strategy and type of support on some of these areas as described above to ensure longer-term sustainability of its impact.

(Refer to Findings of Question 1.1 and 1.2 and Relevance Conclusions on areas of work)

Recommendation #2: (Short-term, unless otherwise stated): Although UNICEF's 'ways of working' have effectively facilitated its contributions to the achievement of 2018 and 2019 country programme outputs, they can continue to be sharpened. Based on the evidence available, this evaluation has surfaced a few ways in which UNICEF senior management can invest in strengthening 'ways of working' across the office:

- (Medium-term, cross-cluster) Ensure consistency of pilot-to-scale approach by clarifying and documenting its process for prioritising pilots and putting in place design guidelines based on UNICEF's PPP Manual (e.g., a clearly stated targeted change upfront as well as a perspective of when/why a pilot might be shut down)
- (CSD-specific) Review knowledge management approaches across programmes, focusing on fewer knowledge products that are disseminated more effectively in cases where not all products have a clear purpose or translating evidence into changes in policy or programming has been less effective (e.g., WinS, some aspects of STBM)
- (Cross-cluster) Expand use of C4D, including ensuring that all programmes are at least reviewed upfront to identify potential C4D needs or opportunities

- (Cross-cluster) Strengthen strategies, and networks required to advocate to government and other actors in cases where private sector stakes are key (e.g., regulation of breastmilk substitutes)
- (Cross-cluster) Expand use of partnerships with the private sector where relevant for advocacy where private sector actors are influencers (e.g., product labelling or regulations), innovation where private sector actors can facilitate access to technology (e.g., use of mobile or communications technology to reach target populations), and awareness generation where private sector actors have faster or more far-reaching channels of communication than government (e.g., use of newspapers and other media for disseminating messages)

Interactions with the UNICEF team and government stakeholders highlighted the trade-off between the number of pieces of evidence generated by the CSD team and how successfully they were disseminated. Assuming a fixed capacity within the team, this suggests a need to either focus on fewer pieces of evidence and disseminate these better or better leverage partnerships to ensure that evidence is appropriately tailored to and reaches the necessary audiences.

The CSD cluster's work includes some examples of how C4D can be an important tool for driving behaviour change: the behaviour and social change approach for STBM, demand generation for immunisation, community-based malaria control programmes, and methods for raising awareness about MHM (e.g., HCD-informed comic books).

Partnerships with the private sector also remain relatively untapped. Although the CSD's partners will remain predominantly CSOs, the few examples of private sector partnerships (e.g., leveraging Jawa Post for demand generation during an immunisation campaign) suggest room for further exploration.

The pilots reviewed demonstrated that the CSD has been successful in translating pilot activities to scale in terms of policy change and programme implementation. While UNICEF staff interviewed demonstrated that a lot of thought goes into pilot selection, the ET did not observe a standardised process for prioritising pilots across the CSD. In the interest of employing best practices and to respond to concerns from senior government stakeholders that UNICEF may be spreading itself thin, the CSD team should document its approach for prioritising pilots as well as additional guidelines for design and implementation.

(Refer to Findings of Question 2.3 and 2.4, and Effectiveness Conclusions on 'ways of working' and pilot-to-scale)

Recommendation #3: (Short-term): To further enhance UNICEF's effectiveness in achieving results for children, UNICEF senior management should invest in the following capacities:

- Increase C4D capacity to strengthen UNICEF's ability to develop and provide technical advice on campaigns aimed at behaviour change and demand generation (e.g., vaccine hesitance, ODF, breastfeeding practices)
- Increase data analytics capacities at the sub-national level to support the government in using real-time data to inform its interventions
- Increase public finance management and budgeting capacities at the sub-national level to support the government in evidence-based planning and decision-making around resources required and more efficient allocation of those funds
- Build a stronger understanding of and ability to conduct gender analyses aimed at highlighting the relevant differentiated needs of boy and girls (and women and men) during programme design. These should be aimed at increasing capacity of staff to act on global UNICEF guidance (e.g., 2018 Gender Programmatic Review Toolkit)

To meet the increasing demand for C4D support, UNICEF will need to invest in additional support at the national level (i.e., beyond the one C4D specialist in the communications team). This would also allow more C4D support to clusters outside of CSD.

Interactions with sub-national teams highlighted missed opportunities to leverage UNICEF's data analytics and C4D expertise effectively. This was due to ad-hoc, request-based processes and a lack of capacity to address existing requests, as shown in findings for question 4.3. UNICEF's 2019 Situation Analysis also highlights potential gaps in public finance management that may require additional UNICEF support – and thus, stronger UNICEF capacities – in the future.

The CSD team's current approach to gender is ad-hoc and inconsistent across programmes, although programmes focusing on gendered issues (e.g., MHM, breastfeeding, MNCH) naturally have a more deliberate approach. Few appear to have engaged in a comprehensive gender analysis during programme design. For the next CPD, the CSD cluster should hence be more intentional and consistent in assessing gender implications in programme design and implementation.

(Refer to Findings of Question 2.2, 2.5, 4.1, 4.3, Effectiveness Conclusions on 'ways of working' and optimal balance between national and sub-national workstreams, and Cross-Cutting Conclusions on contributions to gender equality and additional capacities required going forward)

Recommendation #4: (Medium-term): As concluded in the evaluation, there is currently relatively little integrated activity within the CSD cluster, as it serves as more of a coordination mechanism. However, even within a coordination mechanism, there is an opportunity for increased collaboration. To better deliver on results for which a multi-sectoral approach would be beneficial, UNICEF senior management should explore methods to promote and increase accountability for collaboration and increase accountability across Cluster and Section Chiefs by:

- Within the office-wide Programme Strategy Note (PSN), outline a shared office-wide vision for how, to what end, and in what instances different teams will collaborate; how teams can collaborate along different 'ways of working' (e.g., advocacy, evidence generation); and how responsibilities will be assigned and managed in these cases. This should be underpinned by a shared logical framework for the vision, specifying each sector's contribution
- Select a few concrete areas in which to focus on improving collaboration first. Based on internal and external interviews, these could be data and analytics (i.e., better leveraging data internally to both improve UNICEF's strategies and strengthen GoI systems) and coordination on multi-sectoral initiatives or government departments which currently interact with multiple UNICEF focal points in a fragmented way (e.g., UKS programme, Sub-Directorate of Adolescent Health)
- Identify a 'focal sector' for each shared priority (e.g., nutrition team could coordinate activities around stunting, although multiple sectors would be involved)
- Create designated forums or channels for identifying opportunities for collaboration (e.g., repurpose CSD or other weekly meetings to focus solely on collaboration at least once a month)
- Make cross-sectoral collaboration a more explicit part of Cluster Chief and Section Chief performance reviews (e.g., consider the extent of cross-sectoral inputs during programme design)

Currently, the structure, definition of outputs, and incentive mechanisms do not encourage a cross-sectoral approach across the UNICEF Indonesia office, with performance linked to outputs that are defined sectorally. It is clear through a review of the CSD cluster and interviews with its staff that deliberate steps must be taken to encourage collaboration as this is not happening organically within the current structure.

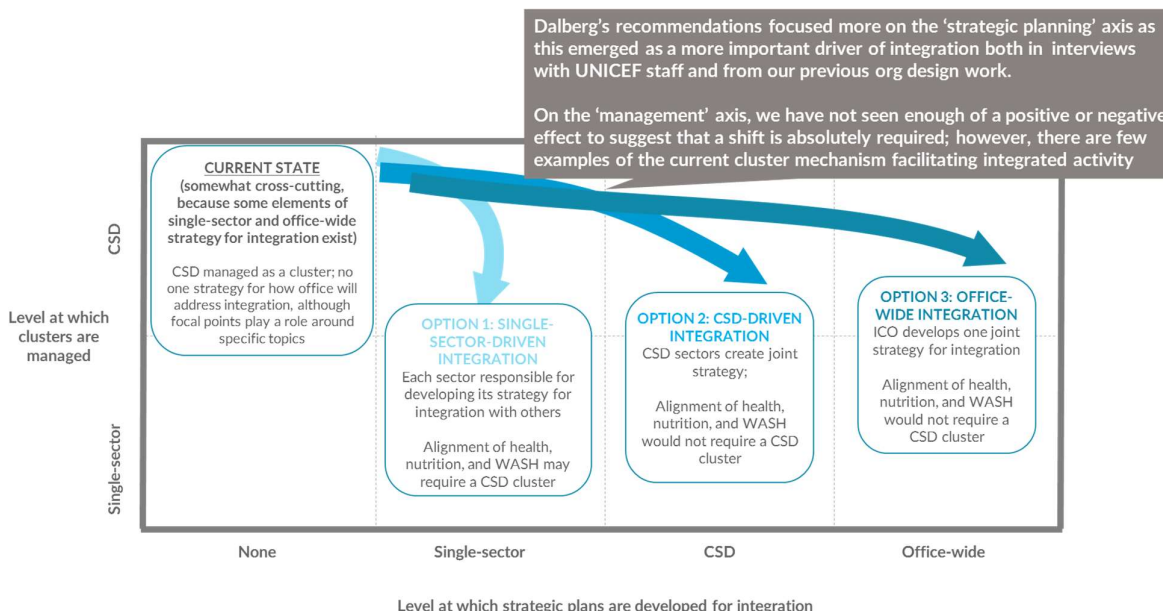
In taking these steps towards stronger cross-office collaboration, UNICEF senior management should also reconsider whether the CSD cluster mechanism is a necessary or useful frame for

achieving this objective. The coordination function currently played by the CSD cluster is less relevant today than it may have been in 2016. None of the recommended approaches above requires the existence of an integrated cluster. On the other hand, separating the cluster into sectors would also recognise WASH’s growing role separate from health and nutrition in Indonesia (e.g., on climate change, emergencies) and empower the Chief of WASH to better address changing priorities, while increasing the focus on nutrition. The latter is important for Indonesia given the national anti-stunting priority and worsening DBM in the country.

The figure below presents options for promoting collaboration and integration across the ICO. The x-axis captures the level at which integrated strategies are developed; internal and external interviews suggested that this was a key determinant of the current level of integration within the CSD cluster. Currently, while there is some office-wide prioritisation of areas for collaboration, there is no holistic strategy at the CSD or office-wide level. Recommendation #4 above suggests an office-wide integration strategy. This would allow for stronger collaboration across all clusters, while allowing for more intersection points between health, nutrition, and WASH if that makes most sense. A single-sector strategy would be inherently fragmented, and a CSD-driven strategy could overlook links with and between other clusters.

The y-axis captures management options: assuming no interest in creating other clusters in the office, the two options are to either maintain a CSD coordinating cluster or shift a single-sector approach with sector chiefs reporting to the Deputy Representative. While the ET concluded that the CSD cluster does not necessarily drive integration, it did not find evidence that it hindered integration. However, if senior management moves ahead with an office-wide integration plan – or even a CSD-driven integration plan – there is little strategic rationale for having a CSD cluster. The alignment between health, nutrition, and WASH can be enshrined in and monitored through the strategic plan itself.

Figure 11: Management and strategic options for integration



(Refer to Findings of Question 2.4 and Effectiveness Conclusions on additionality of CSD cluster approach)

VIII. APPENDICES

A: Terms of reference

Kindly refer to dropbox link [here](#).

B: Evaluability review

To establish clarity of the CSD cluster, we will need to build a bottom-up shared view of 'CSD cluster activities' and how these support the sectors

Evaluability criteria 1: Clarity of the intervention and its objectives

Associated risk on reliability / credibility of evaluation
■ Low ■ Medium ■ High

Question	Extent of evaluability	Mitigation steps
<i>Is the original justification of the CSD cluster approach clear and understood?</i>	We understand the original justification of the CSD cluster approach to be: <ul style="list-style-type: none"> • Demand from government (e.g., BAPPENAS) and other partners for integrated programs, and • Mapping to the UNICEF Strategic Plan at the stage of CSD cluster design This is based on initial interviews and CPAP 2016-2020. Documentation from the original decision unavailable	This was further validated through stakeholder consultations during this evaluation. Ultimately the evaluation was grounded in understanding additionality
<i>Are the objectives of the CSD cluster approach clear and understood by the stakeholders?</i>	While the initial objectives were commonly discussed and agreed upon at the previous SMR, these are not clearly outlined and there are some varying views on the specific activities intended to achieve these	We developed a bottom-up understanding of existing CSD activities based on initial interviews. In case of disagreement, we evaluated the extent to which these activities were taking place as a first step to our data collection
<i>Is there a logical and clear theory of change that articulates how and under what conditions the CSD cluster activities influence particular processes of change?</i>	While there is a draft CSD cluster ToC from a previous internal workshop, it has not been validated with all current key stakeholders. Furthermore, several stakeholders expressed that an evaluation grounded in the current activities and processes across the cluster would be more credible than one based in an overarching CSD cluster ToC	After developing the understanding the CSD cluster is more of a coordination mechanism, we chose to rely on output-level ToCs to review the achievements at sector-level. For the additionality question, we were unable to elaborate logical links between the observable coordination activities intermediate outputs. However, we did map out a view of the activities that are happening and assess whether these can be linked to improved ways of working within the sectors that may lead to additional impact.

Source: [UN Evaluability Assessment Template](#)

The evaluation is well-timed and commands clear interest from key stakeholders; however, validating the analysis will require aligning some differing perspectives among key stakeholder

Evaluability criteria 2: Feasibility, credibility, and stakeholder interest

Associated risk on reliability / credibility of evaluation
■ Low ■ Medium ■ High

Question	Extent of evaluability	Mitigation steps
<i>Does the timing of the evaluation fit into the program cycle?</i>	The timing of the evaluation is logical since CPAP 2016-2020 is ending and it is critical to reflect on whether the CSD cluster approach has been additional	Not applicable
<i>Has the CSD cluster approach been previously evaluated?</i>	While a mid-term review of the CSD cluster was undertaken, it did not answer the specific question on the additionality	We reviewed evaluations and mid-term reviews where available, but previous evaluative inputs were limited
<i>Can external and internal factors (political, economic, security etc.) hamper the evaluation?</i>	For the most part, external and internal factors that will tactically hamper the evaluation. Key stakeholders in Jakarta and across the field offices are available for consultations. However, there are some strong differing perspectives among key stakeholders that will require special attention to be paid to alignment in the process. Internal shifts in ways of working (e.g., more upstream work) or some individual actions taken by the sectors may make it difficult to attribute particular changes to the CSD cluster approach.	We worked with the evaluation lead to ensure all are involved in the validation. We grounded analyses in understanding key external and internal shifts, and limited comparative analyses to similar conditions and provide context with conclusions where relevant
<i>To what extent is there a clear interest among stakeholders to use the evaluation's findings?</i>	There is clear interest among UNICEF Indonesia's country program stakeholders to conduct this evaluation and there is capacity to use the evaluation's findings to effectively design the next phase	Not applicable

Source: [UN Evaluability Assessment Template](#)

Although baseline data is unavailable, we will be using case studies and relying heavily on stakeholder consultations to triangulate analyses

Evaluability criteria 3: Availability of data

Associated risk on reliability / credibility of evaluation
■ Low ■ Medium ■ High

Question	Extent of evaluability	Mitigation steps
<p><i>Will baseline data be available to track change?</i></p>	<p>While there is baseline data for the output targets in UNICEF's results framework, there is no baseline data available with which to compare change for the additionality question ■</p>	<p>For additionality, we used case studies to isolate examples within which to assess synergies, efficiencies and additionality. We reviewed clear cases presented by the UNICEEF team (e.g., Banda Aceh collaboration), but also explored other cases that emerge through interview (e.g., integration with other clusters)</p>
<p><i>Are other existing data sources available to conduct the evaluation?</i></p>	<p>While there is a lot of documentation on the individual sectors themselves and the process aspects of the CSD cluster activities, there may be limited and varying evidence of some modalities of integration¹ (e.g., program design), making it difficult to develop a consistent view of additionality for those specific cases. The evaluation will be based on stakeholder perceptions. There is hence the possibility of inherent perception biases since UNICEF staff will be reflecting on their own efforts ■</p>	<p>We used the available documents (e.g.: mid-term review reports of sectors, programme documentation, available partnership and STBM evaluation) to assess outputs. However, we relied heavily on the interviews for the additionality question, triangulating results through an anonymous online survey, interviews across multiple UNICEF teams and external stakeholders</p>

Note: 1) Modalities of integration refers to the different types and ways in which the sectors within the CSD cluster are working together to improve the outcomes for children in Indonesia (e.g., weekly meetings, collaborative fundraising, integrated programming etc.)
 Source: [UN Evaluability Assessment Template](#)

C: Evaluation matrix

As per the instructions in the ToR, the final list of questions explored reflects a shorter, refined list (vs. the long list included in the ToR) developed by the evaluation team in close collaboration with the ERG. These were approved by UNICEF senior management.

Table 6: Evaluation Matrix

Evaluation question	Judgment criteria	Primary data collection methods	Secondary data sources	Strength of evidence for associated findings
<p>1.1 Relevance: What areas of the CSD programme are still valid and which are not and should be deprioritised?</p> <p>1.2 Relevance: What new areas of work should be considered in developing future CSD programming?</p> <p>1.3 Relevance: Are the regions in which the CSD programme operates sub-nationally valid?</p>	<ul style="list-style-type: none"> Extent to which analysis based on the following lens shows a clear case for continued work or deprioritisation <ul style="list-style-type: none"> Contribution to mortality and morbidity Government priorities Focus of other active donors Progress towards national or sub-national targets Effectiveness in implementing UNICEF programmes 	<ul style="list-style-type: none"> Expert interviews KIIs with government partners and UNICEF staff 	<ul style="list-style-type: none"> IHME data Government of Indonesia planning documents Documents on other donor activities UNICEF programme documents and donor reports 	<p>High: based on a review of demonstrated areas of focus and credible external data; further validated with external experts</p>
<p>1.4 Relevance: To what extent is programme integration clearly articulated in terms of linking cross-sectoral outputs to the overarching outcome?</p>	<ul style="list-style-type: none"> Extent to which cross-sectoral outputs are included in UNICEF Indonesia theories of change and results frameworks and clearly linked to the overarching CSD outcome 	<ul style="list-style-type: none"> KIIs with CSD team members 	<ul style="list-style-type: none"> UNICEF Indonesia Theory of Change catalogue (2017) UNICEF Indonesia CPAP 	<p>High: based on assessment of official results framework and explicit statements across CSD staff (<i>nature of the question relies on internal evidence</i>)</p>
<p>1.5 Relevance: To what extent is the CSD cluster approach still valid and aligned to the socio-economic context, priorities of government and other funders in Indonesia, and broader global UNICEF approach?</p>	<ul style="list-style-type: none"> Extent to which cluster structure and activities it enables responds to priorities stated or demand expressed by government partners and/or funders Extent to which cluster structure responds to increasing cross-sectoral 	<ul style="list-style-type: none"> KIIs with CSD team, government partners, donors, and implementing partners 	<ul style="list-style-type: none"> EIU report and other context documents UNICEF SP Government documents describing on 	<p>High: based on explicit statements from government partners, expert interviewees, credible external desk research, and official UNICEF Strategic Plan</p>

	<p>nature of issues facing children in Indonesia</p> <ul style="list-style-type: none"> • Extent to which cluster structure aligns with global UNICEF approach as captured in latest Strategic Plan 		<p>internal systems and processes</p>	
<p>2.1 Effectiveness: To what extent have the CP outputs been achieved so far and what have been were UNICEF's contributions?</p>	<ul style="list-style-type: none"> • Extent to which CSD has met targets outlined in results framework 	<ul style="list-style-type: none"> • KIIs with CSD teams • KIIs with government and implementing partners 	<ul style="list-style-type: none"> • UNICEF programme documents and donor reports • Previous evaluations 	<p>High for extent of achievement: based on observable achievement of results as officially reported by UNICEF</p> <p>Adequate for contribution: based on observable UNICEF actions and high-level ET assessment of how these these contributed to overall CP outputs (triangulating across GoI, UNICEF, and implementing partner interviews). ET highlighted where contributions were clear based on focus and extent of UNICEF actions and avoided specifying a link where evidence was insufficient.</p>
<p>2.2 Effectiveness: For those programmes reviewed, where – in terms of 'ways of working' – is CSD more effective and less effective in achieving programme results for children?</p>	<ul style="list-style-type: none"> • Extent to which certain "ways of working" can be identified as key drivers/enablers for achievement of objectives • Criteria specific to each 'way of working' included in the body of the report 	<ul style="list-style-type: none"> • Case studies • KIIs with CSD teams • KIIs with government and implementing partners 	<ul style="list-style-type: none"> • Programme documents and donor reports • Previous evaluations • Journal articles related to UNICEF evidence generation efforts 	<p>Low: based on a review of demonstrated progress against results framework for overall program, and, for six agreed-upon programme areas, deeper review of some demonstrated results and explicit statements from UNICEF staff and government and implementing partners. (note: data availability varied across the six programmes reviewed, from one that had been previously evaluated to one that required the overarching view to be built primarily through KIIs, but findings were based on similar observations across multiple programmes</p>

<p>2.3 Effectiveness: For those programmes reviewed, what were the key drivers of successful pilots to go to scale in CSD as well as stumbling?</p>	<ul style="list-style-type: none"> • Extent to which pilots demonstrated the effectiveness of the intervention being tested, resulted in some change in national policies, and/or scaled through national policy or programming • Extent to which certain common elements could be identified as success factors or stumbling blocks across the examples reviewed 	<ul style="list-style-type: none"> • KIIs with CSD teams 	<ul style="list-style-type: none"> • Programme documents and donor reports • UNICEF global guidance on pilots 	<p>Adequate: based on documentation of effectiveness and observable changes in policy or programming. Success factors and stumbling blocks highlighted presented consistently across the examples.</p>
<p>2.4 Effectiveness: How, where, and when is the CSD cluster additional in light of the objectives of the cluster? Where and when is it not, and where would a single sector approach be more indicated?</p>	<ul style="list-style-type: none"> • Extent to which integrated approach of CSD translated into observable additional activities beyond those that would exist with a sectoral approach (at the national and sub-national level) (e.g., strengthened processes, integrated approaches to implementation and advocacy) • Extent to which CSD staff perceived additional benefits from working within the CSD cluster vs. as a single sector (e.g., technical expertise, ease of communication with GoI) • Additional criteria specified in the body of the report 	<ul style="list-style-type: none"> • Case studies • KIIs with UNICEF staff, GoI and implementing partners • FGDs with UNICEF staff • UNICEF office-wide survey (national and sub-national) 	<ul style="list-style-type: none"> • Programme documents • Previously completed evaluations 	<p>For national level, Adequate: based on a survey and KIIs with UNICEF staff and government and implementing partners, as well as demonstrated results where relevant. It became clear through the data collection phase that there were few integrated activities that could be linked directly through the logical framework to accelerated upstream results</p> <p>For sub-national level, Adequate: based on a review of survey and KIIs with UNICEF staff and government and implementing partners, as well as demonstrated results in case studies</p>

<p>2.5 Effectiveness: What is the optimal balance between national and sub-national workstreams and how should this be reflected in the structure and core capacities of the cluster?</p>	<ul style="list-style-type: none"> • Extent to which relative roles of national and sub-national teams reflect Gol approach to decentralisation and current/future regulations around national vs. provincial vs. district-level responsibilities • Extent to which sub-national teams have been able to respond to Gol demand for support in areas identified as government priorities • Where there are gaps, extent to which the limitation is # of staff, presence of specific capacities, decision-making power / mandate 	<ul style="list-style-type: none"> • KIIs with Gol partners and UNICEF staff 	<ul style="list-style-type: none"> • Government documents / policies 	<p>Low: Based on a review of government policy and KIIs with UNICEF staff and government partners, as well as some demonstration of level of FO's ability to respond to government demand. Data and time available did not allow for as comprehensive a review as would have been required to respond a question of optimal national and sub-national balance</p>
<p>2.6 Effectiveness: Are there coordinated intra-cluster efforts or cross-cluster opportunities, such as with education, social policy or child protection, that should be further developed?</p>	<ul style="list-style-type: none"> • Existence of coordinated intra-cluster efforts or cross-cluster opportunities that have already demonstrated traction, whether in terms of government interest or upstream results 	<ul style="list-style-type: none"> • KIIs with UNICEF staff 	<ul style="list-style-type: none"> • Programme documentation • UNICEF internal documents (e.g., CSD vision documents) 	<p>Adequate: highlighted only functional opportunities that had demonstrated results or programming opportunities surfaced through analysis for question 1.1 (<i>this is not necessarily comprehensive, per formulation of the question</i>)</p>
<p>3.1 Sustainability: To what extent is the integrated approach of CSD owned and embedded in the national planning and budgeting systems as compared to single sector approaches?</p>	<ul style="list-style-type: none"> • Extent to which Gol structure, planning processes, and budgeting approaches reflect an integrated vs. sectoral approach • Where there is evidence of an integrated approach, the extent to which this is specific to health, nutrition, and WASH 	<ul style="list-style-type: none"> • Desk review • KIIs with Gol partners and UNICEF staff 	<ul style="list-style-type: none"> • Government documents on internal processes and systems 	<p>Adequate: based on review of observable budgeting and planning processes across BAPPENAS and line ministries. However, KIIs did not allow ET to explore differences between how systems and processes are meant to be implemented and any nuances in practice</p>
<p>3.2 Sustainability: To what extent is the CSD cluster approach, as compared to a single sector approach, contributing to increased leveraged resources for child</p>	<ul style="list-style-type: none"> • # of CSD grants or \$ raised for cross-sectoral topic areas • # of CSD grants or \$ raised as a result of cross-sectoral efforts • Extent to which the integrated CSD narrative has been important to 	<ul style="list-style-type: none"> • KIIs with UNICEF staff 	<ul style="list-style-type: none"> • UNICEF Indonesia grant information • Other inputs from CSD, resource mobilisation, and PFP teams 	<p>High: based on review of actual UNICEF fundraising data and perspectives from UNICEF staff, government partners, and at least one funder (<i>note: finding concluded a lack of evidence of contribution to increased leveraged</i>)</p>

rights at the national and sub-national level?	potential funders (per those working on resource mobilisation)			<i>resources, but this does not eliminate the possibility completely)</i>
3.3 Sustainability: Which existing partnerships should be leveraged and what new partnership opportunities should be explored, including with the private sector and potential financial partners/donors?	<ul style="list-style-type: none"> Extent to which specific partnerships have been especially successful in delivering results Extent to which certain types of partnerships (e.g., with certain types of partners, in pursuit of certain types of outputs, developed through a certain type of engagement) have been especially successful in delivering results Extent to which there are newer partnerships that have already demonstrated traction, whether in terms of government interest or upstream results 	<ul style="list-style-type: none"> KIIs 	<ul style="list-style-type: none"> Programme documents Previously completed evaluation on partnerships 	Adequate: based on review of some partnerships that have demonstrated results and observed gaps in the composition of CSD partners, as reinforced by perspectives of UNICEF staff. <i>(note: given that evaluation team did not conduct a full review of all partnerships, the question is answered primarily at the level of 'types' of partnerships as opposed to specific partnerships and suggests principles for use in further review)</i>
4.1 Cross-cutting: To what extent is the CSD programme contributing to gender equality among targeted populations?	<ul style="list-style-type: none"> Extent to which programmes reviewed incorporate key gender mainstreaming elements (e.g., gender analyses) as discussed in UNICEF global guidance Extent to which objectives and achievement of programmes reviewed are gender-sensitive / gender-transformative 	<ul style="list-style-type: none"> KIIs 	<ul style="list-style-type: none"> Programme documents UNICEF global guidance on gender equality 	Low: based on available gender-disaggregated data, which was relatively low. <i>(note: data availability highlighted as a key finding itself)</i>
4.2 Cross-cutting: To what extent is the CSD programme contributing to equity among targeted populations?	<ul style="list-style-type: none"> Availability of gender-disaggregated data for programmes reviewed Extent to which objectives and achievement of programmes reviewed take equity into consideration Existence of equity-related metrics in results frameworks or articulated objectives of programmes reviewed 	<ul style="list-style-type: none"> KIIs 	<ul style="list-style-type: none"> Programme documents UNICEF global guidance on equity 	For gender, Adequate: based on review of explicit references to gender programming for six agreed-upon programmes, demonstrated programming gender-focused programming, and broader perspectives from UNICEF staff on existing areas of programming. Lack of data made it difficult to conclude absolute 'extent' of

				<p>contribution, but did allow ET to highlight overarching gaps</p> <p>For equity, Adequate: based on explicit reference to and demonstrated selection of target populations in programming and FO locations, and broader perspectives from UNICEF staff. Lack of data made it difficult to conclude absolute 'extent' of contribution, but did allow ET to highlight overarching gaps</p>
<p>4.3 Cross-cutting: What new capacities would be required within the cluster to take forward future programme areas?</p>	<ul style="list-style-type: none"> For those future programme areas recommended in question 1.1, required skills or topic expertise currently missing from UNICEF Indonesia team at national or sub-national level 	<ul style="list-style-type: none"> Kills with UNICEF staff 	<ul style="list-style-type: none"> Findings from previous questions UNICEF organisational chart 	<p>Adequate: based on review of articulated roles and responsibilities across UNICEF organisational chart and explicit statements from UNICEF staff at national and sub-national level. Limited by the inability to build a view of 'unleveraged' capacities across individuals</p>

D: Additional data issues

- **Limited data on Nutrition in IHME datasets:** The evaluation anchored on the IHME data to identify the predicted causes of and risks to child mortality over the next 10 years. While this data set has detailed information on multiple diseases and external factors that could be causes and risks, there is limited focus on nutritional factors as compared to Health and WASH. The evaluation team referred to other data sources for nutrition indicators, however these did not have predictions or the same extent of granularity.
- **Funder perspective was not anchored on interviews with funders:** Based on UNICEF’s advice, the evaluation team did not interview UNICEF Indonesia’s funders to understand the relevance, effectiveness, and sustainability of the CSD cluster from a funding perspective. This perspective was hence built out based on internal UNICEF staff interviews and UNICEF funding data.
- **Lack of MEL framework/data processes to analyse ‘ways of working’:** The evaluation team relied on qualitative interviews to understand how the different ‘ways of working’ contributed to overall programme successes. However, the lack of data and disaggregation of the different ‘ways of working’ in the programme analyses made it difficult to quantify the effectiveness of one way of working and measure the differential contribution of different ‘ways of working’.

E: Review of key stakeholders

Table 7: Mapping of key stakeholders

Stakeholder	Interest in or Contribution to UNICEF Country Programme	Involvement in Evaluation	Who	Classification of rightsholders, primary duty bearers, and secondary duty bearers
<i>Internal Stakeholders</i>				
Indonesia Country Office	The UNICEF country office is responsible for planning and programme implementation. It is the primary stakeholder of the evaluation and has a direct stake in the evaluation and recommendations for the future CPD	UNICEF staff at the country office engaged through inception calls and internal presentations and validation workshops. A smaller group including the CSD chief, CSD sector heads, Program Monitoring and Evaluation (PME) chief and senior management	Multiple	Secondary Duty Bearer

		<p>sat on the Evaluation Reference Group (ERG) to provide iterative feedback on an almost weekly basis. UNICEF staff at the country office level were also key interviewees for the survey undertaken to assess the CSD cluster.</p>		
Indonesia Field Offices	<p>The UNICEF field offices are direct stakeholders in the evaluation as they lead CSD's sub-national activities.</p>	<p>UNICEF staff at the field office engaged through inception calls and internal presentations and validation workshops. UNICEF staff at the field office level were interviewed during the in-person field visits to Kupang and Makassar. Additionally, staff from all the field offices were also key respondents for the survey undertaken to assess the CSD cluster. Chiefs of field offices participated in the first validation workshop, where those who had not been consulted in person had the opportunity</p>	Multiple	Secondary Duty Bearer

		to respond to the initial findings from the field visits.		
East Asia and the Pacific Regional Office (EAPRO)	The EARPO oversees and provides technical guidance to the country office. Being an active stakeholder in the creation of the Country Programme, the EARPO has an interest in the evaluation of the CSD programme.	EAPRO regional representatives – sat on the Evaluation Reference Group (ERG) to provide iterative feedback on an almost weekly basis. Additionally, staff from EARPO were interviewed to understand their view of how well the CSD cluster worked in their respective countries.	Regional advisors	Secondary Duty Bearer
Headquarters	The UNICEF Headquarters is responsible for the Country Programme and its strategic positioning given the challenging governance environment. The learnings from the evaluation have wider implications for UNICEF's role in a transitioning/developing country context.	N/A	N/A	Secondary Duty Bearer
<i>External Stakeholders</i>				
Beneficiaries	Children and caretakers are the ultimate recipients of UNICEF support and assistance in Indonesia. They have a major stake in UNICEF assessing whether its programmes and interventions are appropriate and effective.	N/A	N/A	Rightholders

Government of Indonesia (National level)	Gol at a national level plays a key role in defining and implementing against the CP priorities. They have an interest in the evaluation as the learnings will help them in working with UNICEF to develop the future CP.	At the national level, the Government of Indonesia (Gol) was invited to a workshop for validation of some initial findings as well as discussion of areas on which to further focus.	BAPPENAS; Ministry of Health; Ministry of Education and Culture; Ministry of Home Affairs	Primary Duty Bearer
Government of Indonesia (sub-national level)	Gol at a sub-national level manages funding and programming at the district and provincial levels.	At the sub-national level, senior Gol stakeholders were consulted during visits to some field office locations.	BAPPEDA; PHO; DHO; Mayor's Office; Governor's Office	Primary Duty Bearer
CSOs / Implementing Partners	CSOs contribute to the execution of specific areas of the Country Programme. Some have more direct and solid involvement in the UNICEF programmes, such as those that are implementing UNICEF models or providing direct support/services to beneficiaries as UNICEF's implementing partners. Others may be working with UNICEF in advocacy and policy reform. The learnings from the evaluation may be of interest to CSOs to maintain strategic and operational relationships with UNICEF, particularly those that have implications for future efforts.	CSOs / Implementing partners engaged as interviewees for the evaluation. They provided their view on how the CSD cluster has affected their interaction with the UNICEF Health, Nutrition, and Wash teams and whether it was useful to have the three teams work together compared to separately.	Multiple	Secondary Duty Bearer
Donors / multilateral agencies	Donors have an interest in understanding how their funds are being utilised and whether the	Centers for Disease Control and Prevention engaged as an	Centers for Disease Control and Prevention (CDC); USAID;	Secondary Duty Bearer

	<p>results they are generating are positively contributing to the beneficiaries. The learnings from the evaluation will also help them assess their future collaboration opportunities with UNICEF.</p>	<p>interviewee for the evaluation.</p>	<p>Nutrition International; GAVI The Vaccine Alliance; Belgian Committee for UNICEF; New Zealand Committee for UNICEF; European Commission/EC; Australian Committee for UNICEF; Swiss Committee for UNICEF; United States Fund for UNICEF; Finnish Committee for UNICEF</p>	
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F: Interview guide and list of interviewees, including in site locations

Interview guides

Interview guide on 'ways of working'

Key progress of CSD sections

- 1) Which two indicators capture progress on some of your sector's largest areas of work?
- 2) How do these indicators map to the CPAP output indicators and programme output indicators?
- 3) Which documents are most relevant to get a perspective on the extent of achievement of the targets for both the indicators?
- 4) Could you share the results framework, if any, for your sector?
- 5) What are some good practices that the results framework follows? What challenges have you faced in developing and tracking these indicators?

How we work

- 1) What is UNICEF's different 'ways of working'? What, according to you, makes some 'ways of working' more effective than others? Does this list of 'ways of working' resonate with what the way your section works with its key stakeholders?
 - Capacity development
 - Evidence generation & policy dialogue
 - Advocacy
 - Partnerships
 - Innovation
 - Service Delivery
 - Communications for Development (C4D)
 - South-South & Triangular co-operation

- 2) As we look to identify relevant programmes for assessment under each of the sections, which two programmes would you recommend that most closely align to the following prioritisation criteria:
 - a. Have received significant amount of funding compared to other programmes in the section
 - b. Include a combination of programmes with different extents of success
 - c. Are key contributors to the specific output metrics/indicators that the section aims to achieve (as per CPAP)
 - d. Have established programme level metrics/indicators which are being actively tracked to determine programme performance
 - e. Include a broad and representative sample of the different 'ways of working' (e.g. evidence generation, advocacy, capacity development, etc.)
 - f. Have adopted a gender lens to the strategies deployed and end outcomes to be achieved
 - g. Have some part of the programme being implemented in rural districts or provinces (i.e. sub-national)
 - h. Have availability of information and documentation of programme activities and achievements

(Note: Our in-going hypothesis is that there will be few programmes that meet all the above prioritisation criteria; as such we request you to use these as a broad guide when recommending programmes for assessment under the respective sections)

- 3) What did these programmes aim to achieve?
- 4) Which 'ways of working' and associated activities contributed towards the achievement or non-achievement of these outcomes? Why were they successful? What challenges did you face for the different 'ways of working'?
- 5) What, according to you, makes some 'ways of working' more effective than others within the programmes selected?
- 6) What new capacities need to be developed to ensure future achievement of outcomes and make the 'ways of working' more effective?
- 7) Which documents are most relevant to get a perspective on the extent of achievement of these programmes through the 'ways of working' mentioned?

Others

- 1) In what ways have you worked with other sectors (e.g., Education, Social Policy etc.)? What were some challenges in working with them and how can they be improved?
- 2) What partnerships at the national and sub-national level has your sector leveraged? How can these partnerships be further leveraged? Are there additional partnerships you think need to be leveraged?

Interview guide on CSD cluster additionality *(written from Kupang perspective, adequately tweaked for Makassar and Jakarta)*

About our engagement: Dalberg is a strategic advisory firm specialising in international development. We work with large foundations, non-profits, social enterprises, and international organisations like UN, USAID etc. For this engagement, we are conducting an independent formative evaluation of UNICEF's Child Survival and Development cluster to understand whether and how the approach of structuring the three sectors (Health, Nutrition, and WASH) together is helping achieve better outcomes for children in Indonesia compared to the single sector approach. This evaluation will inform the design of UNICEF's Country Action Programme Plan 2021-25.

All responses can be anonymous on your request.

About the interview: The purpose of this interview is to understand:

- *For UNICEF staff:* interventions/activities your team has undertaken as part of the CSD cluster and whether and how they have helped Health, Nutrition, and WASH teams improve children's outcome in Kupang
- *For govt. stakeholders:* how UNICEF's CSD cluster has affected your interaction with the UNICEF Health, Nutrition, and WASH team and whether this approach is useful for both national level policy design as well as sub-national level work/implementation/decision-making
- *For CSOs:* how UNICEF's CSD cluster has affected your interaction with the UNICEF Health, Nutrition, and WASH team and whether you think it is useful to have the three teams work together compared to separately

A. UNICEF staff

General questions¹²⁵

- 1) How long have you been working with the UNICEF WASH team?
- 2) What are your roles and responsibilities as part of the WASH team in the CSD cluster?
- 3) What work does UNICEF WASH team do in this region?
- 4) Who are the government stakeholders you interact with and how often?
- 5) Who are the CSOs you interact with and how often?
- 6) What is your understanding of the CSD cluster approach and its objectives?
- 7) What are some activities (internal and external) that the WASH team is part of/has undertaken as part of the CSD cluster?
- 8) On a scale of 1-10 what according to you is the extent of 'integration' between the three sector teams?

Evaluation questions

Relevance

- 1) To what extent is there demand from the government stakeholders in Kupang to take a cluster approach?
 - a. How are the current CSD activities more or less relevant to the government's development objectives than individual sector outputs?
- 2) Which funders do you interact with for your work in Kupang?
 - a. How are their objectives aligned to the cluster approach and activities?
 - b. Would it be easier to build relationship with the funders if you were working as independent sectors?
- 3) What key trends have driven or are expected to drive changes in child development in Indonesia?
 - a. What are the implications of these trends on the CSD cluster approach? How does it make the approach more or less relevant?
- 4) How relevant are the CSD cluster's activities to your sector's objectives?

Effectiveness

- 1) To what extent were CSD cluster activities helpful or unhelpful in achieving sector outcomes?
 - a. If helpful, what factors (regional, stakeholder related etc.) made it helpful and would you have been able to achieve these outcomes without the CSD cluster?
 - b. If unhelpful, what factors made it unhelpful and would a single sector approach have been more effective?
- 2) Where are the CSD's cluster activities more or less effective in achieving sector outcomes?
 - a. Evidence generation for strong and relevant policy design
 - b. Technical advice and capability building for implementation at scale
 - c. Active advocacy for an engaged, informed ecosystem
- 3) Which CSD cluster activities are the most or least helpful in achieving your sector's objectives?

¹²⁵ These questions are written from WASH perspective but were appropriately adjusted during the interviews

Sustainability

- 1) To what extent is the CSD cluster approach adopted by national and sub-national governments? (e.g., through embedment in planning, budgeting processes, etc.)
- 2) What are the key partnerships required to advance the CSD clustered approach in Indonesia?

Final questions

- 1) What are some CSD cluster activities that can be undertaken to make the cluster more effective?
- 2) What CSD cluster activities should be stopped and are a hinderance to the functioning of the sectors?
- 3) Would you like to the CSD cluster approach to continue in the next phase if there are some design and structural changes?

Next steps

- 1) Sharing of documents if relevant
- 2) Connect to other staff members if relevant

B. Government stakeholders

General questions

- 1) What are some interventions/focus areas of your department in this region?
- 2) In what capacity and how often have you interacted with the UNICEF team? Which teams do you interact with?
- 3) How is UNICEF supporting you in this region?

Evaluation questions

Relevance

- 1) To what extent is there demand from the government at the national and sub-national level to take an integrated/cluster/collaborative approach to solving Health, Nutrition, and WASH outcomes?
- 2) What are government's development objectives for Health, Nutrition, and WASH in the region?
- 3) What key trends have driven or are expected to drive changes in child development in Indonesia? How does this increase or decrease the need for a cluster approach?

Effectiveness

- 1) To what extent, in your opinion, has UNICEF taken a 'cluster/collaborative' approach to solving children's outcomes in Indonesia?
- 2) How has UNICEF CSD's cluster activities supported the government to better improve children's outcomes in Indonesia?
- 3) Could these outcomes be improved without a cluster approach? Why or why not?
- 4) Which UNICEF CSD cluster activities are the most or least helpful for the government?
- 5) How has the UNICEF CSD cluster activities made it difficult/less effective for the government to improve children's outcomes in Indonesia?

Sustainability

- 1) How is the national and sub-national government adopting a 'cluster approach' to Health, Nutrition, and WASH? (e.g., through embedment in planning, budgeting processes, etc.)
 - a. How often do you interact with other sectoral ministries?
 - b. What is the nature of the cluster approach?
 - c. How can the UNICEF support the government in strengthening its own cross-sectoral approach?
 - d. If it isn't adopting, is there scope to adopt a cluster approach in the future?

Final questions

- 1) What are some activities UNICEF can undertake to support the government better?
- 2) What CSD cluster activities should UNICEF stop and are not useful for the government?

C. CSOs

General questions – written from WASH perspective but same applies to other areas

- 1) How long have you been working in this organisation?
- 2) What are some interventions/focus areas of your organisation in this region?
- 3) In what capacity and how often have you interacted with the UNICEF team? Which teams do you interact with?
- 4) How is UNICEF supporting you in this region?

Evaluation questions

Relevance

- 1) How is UNICEF's approach to working collaboratively between the Health, WASH, and Nutrition teams relevant to your organisation's work in the region?
- 2) What key trends have driven or are expected to drive changes in child development in Indonesia? How does this increase or decrease the need for a cluster approach?

Effectiveness

- 1) How has the UNICEF's activities supported your organisation to better improve children's outcomes in Indonesia?
- 2) Could these outcomes be improved without a cluster approach? Why or why not?
- 3) Which activities are the most or least helpful for your organisation?
- 4) How have the activities made it difficult/less effective for your organisation to improve children's outcomes in Indonesia?

Sustainability

- 1) What changes has your organisation made to take an integrated approach?

Final questions

- 1) What are some activities UNICEF can undertake to support your organisation better?
- 2) What activities should UNICEF stop and are not useful for your organisation?

Next steps

- 1) Sharing of documents if relevant
- 2) Connect to other staff members if relevant

Interviewees

The following are CSOs/NGOs and subnational government stakeholders that the evaluation team interviewed during the evaluation.

Organisation	Interviewee	Gender	Location	Mode
Implementing partners				
BaKTI	Pak Hamzah Sinring	Male	Makassar	In-person
	Ibu Arafah	Female		In-person
HAKLI	Pak John Takesan	Male	Kupang	In-person
	Pak Carolus Gambut	Male		In-person
Ikatan Perempuan Positive Indonesia	Baby Rivona	Female	Jakarta	In-person
IKM FK UNHAS (University partners)	Dr. Mohammad Firdaus	Male	Makassar	In-person
Indonesian Nutritionist Association / PERSAGI	Dr. Minarto	Female	Jakarta	In-person
Poltekes Kemkes Kupang (Health University)	Ibu Telly Margaretha	Female	Kupang	In-person
	Ibu Vivi Atty	Female		In-person
	Ibu Cory Limbong	Female		In-person
	Pak Florentianus tat	Male		In-person
	Pak Rafael Paun	male		In-person
PPNI	Pak Willy	Male	Kupang	In-person
	Ibu Ella	Female		In-person
Southeast Asiam Ministers of Education Organisation (SEAMEO)	Dr. Luh Ade Wiradnyani	Female	Jakarta	In-person
Strategi Pengkajian Edukasi Alternative Komunikasi (SPEAK)	Pak Dormaringan Saragih	Male	Jakarta	In-person
	Ibu Wiwit Heris	Female	Jakarta	In-person
YASATU	Ibu Arianti Inangele	Female	Kupang	In-person
	Pak Hari Andretan	Male		In-person
YPM LML	Ibu Rosa	Female	Makassar	In-person
Government stakeholders (subnational)				
BAPPEDA	Ibu Anna Assan	Female	Kupang	In-person
BAPPEDA, South Sulawesi	Pak Andi Irawan Dermayasamin)	Male	Makassar	In-person
	Pak Reza Ergy Pahlevi)	Male		Virtually
	Pak Andi Irawan Bintang	Male		Virtually

Deputy Mayor	Pak Hermanus Mann	Male	Kupang	In-person
District Health Office	Ibu Dina Ludji	Female	Kupang	In-person
	Ibu Putu Yuni	Female		In-person
	Ibu Sri Wahyuningsih	Female		In-person
	Pak Ngurah	Male		In-person
	Pak Rudy Priyono	Male		In-person
Mayor	Pak Jefri Riwu Kore	Male	Kupang	In-person
Provincial Health Office	Dr Dominikus Minggu Mere, MKes	Male	Kupang	In-person
Provincial Health Office, Maluku	Dr. Ritha Tahitu	Female	Makassar	Virtually
Provincial Health Office, North Maluku	Dr. Andi Sakurawati	Female	Ambon	Virtually
Provincial Health Office, South Sulawesi	Dr. Erwan Sulistiyo	Male	Makassar	In-person
	Pak Agus Salim Makka	Male		In-person

At the national level, the evaluation team interviewed the following people from Gol, UNICEF Indonesia office, UNICEF regional offices, and funders:

Interviewee	Designation	Gender	Location	Mode
Government stakeholders (national)				
Dewi Amila Solikha	CSD focal point, Public Health and Nutrition, BAPPENAS	Female	Jakarta	In-person
Dr Ann Natalia Umar	Section Head of Sub-directorate HIV, AIDS, and STIs, Ministry of Health	Female	Jakarta	In-person
Dr H. Khamim	Director of Directorate of Primary Schools, Ministry of Education and Culture	Male	Jakarta	In-person
Dr Nancy Dian Anggraeni	Head of Sub-Directorate for Malaria, Ministry of Health	Female	Jakarta	In-person
Dr. Edward Sigalingging	Head of Sub-director Health, Directorate of Synchronization of Local Government Planning III, Ministry of Home Affairs	Male	Jakarta	In-person
Dr. Erna Mulati	Director of Family Health, Ministry of Health	Female	Jakarta	In-person
Dr. M. Zamzani	Consultant, Ministry of Home Affairs	Male	Jakarta	In-person
Dr. Syamsu Alam	Deputy EPI Manager for Immunisation, Ministry of Health	Male	Jakarta	Virtually
Pak Pungkas Bahjuri Ali	Director for Public Health and Nutrition, BAPPENAS	Male	Jakarta	In-person
Pak Sundoyo	Head of Bureau of Law and Organisation, Ministry of Health	Male	Jakarta	In-person
Tri Dewi Virgiyanti	Director for Urban Housing and Development, BAPPENAS	Female	Jakarta	In-person
Wara Pertiwi O	Head of Sub-directorate of Adolescent Health, Ministry of Health	Female	Jakarta	In-person
Dr. Yudith	Head of Sub-directorate for Immunisation, Ministry of Health	Female	Jakarta	Virtually

UNICEF Indonesia				
Airin Roshita	Nutrition Specialist	Female	Jakarta	Virtually
Amanda Bissex	Chief, Child Protection	Female	Jakarta	In-person
Andi Yoga Tama	CFO	Male	Banda Aceh	In-person
Ann Thomas	Unit Chief WASH	Female	Jakarta	In-person
Badwi M Amin	CSD Specialist	Male	Makassar	In-person
Blandina Rosalina Bait	Nutrition officer	Female	Kupang	In-person
Charlotte Lie-Piang	Knowledge Management Specialist	Female	Jakarta	In-person
Dayce Sjaflan	Partnerships Manager	Female	Jakarta	Virtually
Debora Comini	Representative	Female	Jakarta	In-person
Dwi Purwestri	ECD Officer	Female	Kupang	In-person
Emilie Minnick	Gender Focal Point	Female	Jakarta	In-person
Ermi Marten	Health Officer	Female	Kupang	In-person
Fernando Carrera	Chief, Social Policy	Male	Jakarta	In-person
Frieda Addienayuni	OIC, Chief of Private Fundraising and Partnership	Female	Jakarta	In-person
Henky Widjaja	CFO	Male	Makassar	In-person
Ida Kalanda	Deputy Representative Operations	Female	Jakarta	In-person
Irma Anintya Tasya	Malaria/EPI Officer	Female	Ambon	Virtually
Jee Hyun Rah	Unit Chief Nutrition	Female	Jakarta	In-person
Jennifer Hahn	Resource Mobilisation Specialist	Female	Jakarta	In-person
Marcella Christina	OIC, Chief PME	Female	Jakarta	In-person
Maria Endang Sumiwi	Health Specialist (Malaria)	Female	Jakarta	Virtually
Mitsunori Odagiri	WASH Specialist	Male	Jakarta	Virtually
Mohammad Ruhul Amin	Immunisation Specialist	Male	Jakarta	In-person
Wildan Setiabudi	WASH Officer	Male	Makassar	In-person
Amelia Tristiana	Child Protection Specialist	Female	Makassar	In-person
Muliana Muhidin	Health Officer	Female	Makassar	In-person
Paul Proynk	Chief of CSD	Female	Jakarta	In-person
Peter Leth	Chief PME and Evaluation Manager	Male	Jakarta	In-person
Reza Hendrawan	WASH Specialist	Male	Jakarta	Virtually
Riccardo Polastro	Regional Evaluation Advisor, EAPRO	Male		

Richard Wecker	Emergency Specialist	Male	Jakarta	In-person
Robert Gaas	Deputy Representative	Male	Jakarta	In-person
Rosita La Ode Pado	WASH officer	Female	Kupang	In-person
Sisca Wiguno	Health Consultant	Female	Ambon	Virtually
Sowmya Kadandale	Unit Chief Health	Female	Jakarta	In-person
Sri Sukotjo	Nutrition Specialist	Male	Jakarta	Virtually
Suci Wulandari	Data Centre Specialist	Female	Jakarta	In-person
Tayyeba Nasir	HR Manager	Female	Jakarta	In-person
Try Laksono Harysantoso	CFO	Male	Papua	Virtually
VAMA Chrisnadarmani	CSD Specialist	Female	Kupang	In-person
Wendy Rich-Orloff	ECD Specialist	Female	Kupang	In-person
Yudhistira Yewangoe	CFO	Male	Kupang	In-person
Yuliana Hasim	Health Officer (MNCH)	Female	Makassar	In-person
Tira Aswitama	CSD Specialist	Female	Banda Aceh	Virtually
Dita Ramadonna	Health/Malaria Officer	Female	Banda Aceh	Virtually
Rufina BT Pardosi	Nutrition Officer	Female	Banda Aceh	Virtually
Muh Afrianto Kurniawan	WASH Officer	Male	Banda Aceh	Virtually
Funders				
William Hawley	Malaria Specialist, Centres for Disease Control and Prevention (CDC)	Male	Jakarta	In-person
UNICEF global				
Asako Saegusa	Regional Advisor, Planning and KM, EAPRO	Female	Bangkok	Virtually
Chris Kuniyoko	Regional Advisor, Health, EAPRO	Male	Bangkok	Virtually
Christiane Rudert	Regional Advisor, Nutrition, EAPRO	Female	Bangkok	Virtually
Robin Nandy	Principal Adviser and Chief of Immunisation, UNICEF Headquarters	Male	New York	Virtually
Evariste Kouassi Komlan	Regional Advisor, WASH, EAPRO	Female	Bangkok	Virtually
Friday Nwaigwe	Chief of CSD, UNICEF Vietnam	Male	Hanoi	Virtually
Lesley Miller	Deputy Representative, UNICEF Vietnam	Female	Hanoi	Virtually

G: Survey questionnaire and list of recipients

Survey questionnaire

Kindly refer to dropbox link [here](#).

List of recipients

The survey was sent to all UNICEF Indonesia employees. The list is mentioned below:

S.no	Name	S.no	Name
1	Abdul Fikri	88	Lina Nur Maulani
2	Abdullah Modhesh	89	Lina Sofiani
3	Adi Nugroho	90	Lucia Kosasih
4	Adinda Silitonga	91	Lukita Setiyarso
5	Agel Pradessa Riro	92	Luli Marthalena
6	Agnes Sriwulan	93	Maraita Listyasari
7	Airin Roshita	94	Marcella Christina
8	Albert Widjaja	95	Maria Endang Sumiwi
9	Alfred Ronsumbre	96	Markus Harmiko
10	Ali Aulia Ramly	97	Markus Harmiko
11	Alvius Daud Mayoh Sikirit	98	Martha Gercelina Silaen
12	Amanda Bissex	99	Masumi Maehara
13	Amelia Tristiana	100	Meliana Istanto
14	Aminuddin Ramdan	101	Miriam Musa
15	Andi Yoga Tama	102	Mitsunori Odagiri
16	Angga Dwi Martha	103	Mohammad Ruhul Amin
17	Ann Thomas	104	Muhamad Alvin Pahlevi
18	Annisa Elok Budiyan	105	Muhammad Haidar
19	Annisa Primalia Nanda	106	Muhammad Kurniawan
20	Anta Maulana Senaputra	107	Muhammad Zainal
21	Aprilliana Handayani	108	Mukhlis Salman
22	Arie Rukmantara	109	Muliana Muhiddin
23	Armunanto Armunanto	110	Munzil Rahmi Ramli
24	Arte Pisceksa	111	Naning Pudji Julianingsih
25	Artha Camellia	112	Neni Nuraeni
26	Astrid Gonzaga Dionisio	113	Niken Andriani
27	Aulia Rahman	114	Nikensari Setiadi
28	Badarus Samsi	115	Nina Ariyani Annisa
29	Badwi M Amin	116	Nugroho Warman
30	Belly Lesmana	117	Paul Pronyk
31	Bheta Arsyad	118	Peter Leth
32	Birgitta Maria Sabina	119	Pia Marie Helena Fagerstrom
33	Blandina Rosalina Bait	120	Priyo Sejati
34	Bobby Marwal Syahrizal	121	Raditya Rizky Henrile
35	Ceriel Gerrits	122	Ratih Marinda
36	Charlotte Lie-Piang	123	Ratih Woelandaroe
37	Chizuru Iwata	124	Ratnawati Muyanto
38	Daisy Duru-lheoma	125	Reza Hendrawan
39	Dayce Sjaflan	126	Richard Wecker
40	Debora Comini	127	Rihana Bakri
41	Della Ayu Anandita	128	Rima Kesuma

S.no	Name	S.no	Name
42	Derry Ulum	129	Rinaldo Gultom
43	Desny Zacharias	130	Rizky Syafitri
44	Dhiana Anggraeni	131	Robert Gass
45	Dinda Veskarahmi	132	Robert Mira Mangngi
46	Dini Ratih Larasati	133	Rooswanti Soeharno
47	Diny Heryani	134	Roslina Rosliana
48	Dita Ramadonna	135	Rostia La Ode Pado
49	Dwi Purwestri	136	Rufina Pardosi
50	Dwi Satriyo Basuki	137	Rustini Floranita
51	Elwine Pattihahuan	138	Said Ikram
52	Emilie Minnick	139	Sisca Wiguno
53	Ening Handayani	140	Siti Eliza Mufti
54	Ermi Ndoen	141	Sowmya Kadandale
55	Febryanthie Sheila M Apituley	142	Sri Sukotjo
56	Fernando Carrera	143	Sri Yulianti
57	Franky Tarumta Barus	144	Stephanie Alexandra
58	Frieda Addienayuni	145	Suci Wulandari
59	Gibthi Ihda Suryani	146	Sugiarto Hiu
60	Gilbert Sigar	147	Suhaeni Kudus
61	Grace Kartika Candra	148	Sumiarni Anwar
62	Gregor Henneka	149	Supangkat Job
63	Haditya Mukri	150	Suparlan Wiyono
64	Hasril Walad	151	Syahfitri Utari
65	Helga Gerosa	152	Tayyeba Nasir
66	Hellen Geertruida Parera	153	Teguh Santoso
67	Henky Widjaja	154	Ticiana Garcia-Tapia
68	Hertiatusti Winiaswasti	155	Tira Aswitama
69	Hiroyuki Hattori	156	Try Laksono Harysantoso
70	Husny Muttaqin	157	Valerie Crab
71	I Made Suwancita	158	Vama Chrisnadarmani
72	Ida Kalanda	159	Vania Santoso
73	Ilham Akbar	160	Wei Xia
74	Irma Anintya Tasya	161	Wendy Rich-Orloff
75	Ita Suhita	162	Wieske Sapardan
76	James Kruglinski	163	Wikan Pribadi
77	Jee Hyun Rah	164	Wildan Setiabudi
78	Jennifer Hahn	165	Yadikun Yadikun
79	Johana Sidharta	166	Yanti Koesnan
80	John Arnold Alfonso	167	Yohan Prasetyo
81	Juna Wauran	168	Yuanita Marini Nagel
82	Kate Rose	169	Yudhistira Yewangoe
83	Kenny Peetosutan	170	Yukari Tsunokake
84	Ketty Catalina Chandra	171	Yuli Setiawati
85	Kezia Rahmaningtyas	172	Yuliana Hasim
86	Khairun Nisa	173	Yuniarti Fanggaldae
87	Kinanti Pinta Karana	174	Zainul Alim

H: List of participants in validation workshops

S.no	Name of participant	Designation	Organisation	Gender
1	Ade Ahmad Atiriddin			
2	Adinda Silitonga	CSD	UNICEF	Female
3	Agatha Danasti	Interpreter	CMM	Female
4	Alieflyo P	Directorate Housing, urban and Settlement	BAPPENAS	Male
5	Aline Ardhiani	UNICEF Consultant	UNICEF	Female
6	Andi Yoga Tama	Chief of Field Office Banda Aceh	UNICEF	Male
7	Annisa Fitria	Staff	Secretariat BAPPENAS - UNICEF	Female
8	Artha Camelia	Health Specialist	UNICEF	Male
9	Baby Rivona Nasution	National coordinator	Ikatan Perempuan Positive Indonesia	Female
10	Bobby M. S.	Health Specialist	UNICEF	Male
11	Dr. Milwiyandri		Ministry of Health	Female
12	Dr. Rian Hermana	Directorate of Prevention and Control of direct infectious diseases	Ministry of Health	Male
13	Hakimi	Sub directorate Immunisation	Ministry of Health	Male
14	Hengky Widjaja	Chief of Field Office Makassar	UNICEF	Male
15	Hiroaki Yagami	Evaluation Officer, Reginal Planning Section, Bangkok	UNICEF, EAPRO	Male
16	Ies Dwiartini	Programme Coordinator	Secretariat BAPPENAS - UNICEF	Female
17	Inti W.	Directorate for Public Health and Nutrition	BAPPENAS	Female
18	Kenny Peetosutan	EPI Specialist	UNICEF	Female
19	Lies Komariah	Staff	Secretariat BAPPENAS - UNICEF	Female
20	M. Elviworega H.	Bureau of Overseas Cooperation	Ministry of Health	Female
21	Marcella Christina	Budget and Planning Specialist	UNICEF	Male
22	Nadia I. S.	Directorate Housing, urban and Settlement	BAPPENAS	Female
23	Nikensari Budiutami	Monitoring officer	UNICEF	Female
24	Novina Amelia	Staff	Secretariat BAPPENAS - UNICEF	Female
25	Nurul Madina	Directorate Development, Health Environment and Housing	Ministry of Public Work and Housing	Female
26	Paul Pronyk	Chief of CSD	UNICEF	Male
27	Peter Leth	Chief of PME	UNICEF	Male
28	Pungkas Bahjuri Ali	Director for Public Health and Nutrition	BAPPENAS	Male
29	Putri Sonaria	Staff of Bappenas - UNICEF, WASH Working group	WASH WG	Female
30	Rif'an	Programme Coordinator	Secretariat Regional Development, Ministry of Home Affairs - UNICEF	Male

31	Ruhul Amin	EPI Specialist	UNICEF	Male
32	Santi Laria S.	Directorate Region Development	Ministry of Home Affairs	Female
33	Sarikasih Hanefa	Directorate of Prevention and Control of direct infectious diseases	Ministry of Health	Female
34	Siti Hana	Directorate of Nutrition	Ministry of Health	Female
35	Sugiarto	Directorate Region Development	Ministry of Home Affairs	Male
36	z Yani	Bureau of Overseas Cooperation	Ministry of Health	Female
37	Try Laksono	Chief of Field Office Jayapura	UNICEF	Male
38	Wahyu P.		Ministry of Education and Culture	Male
39	Wieske Sapardan	Programme Associate CSD	UNICEF	Female
40	Yudhistira Yewangoe	Chief of Field Office Kupang	UNICEF	Male

I: Additional figures for areas of work findings

Figure 12: SDG goals (and sub-goals) on which the CSD cluster is supporting





2 ZERO HUNGER 	Nutrition 2.2.1 Undernourishment 2.1.2 Food insecurity 2.2.1 Stunting 2.2.2 Wasting
3 GOOD HEALTH AND WELL-BEING 	Health 3.1.1 Maternal mortality 3.1.2 Skilled birth attendance 3.2.1 U5MR 3.2.2 NMR 3.3.1-3 HIV/TB/Malaria incidence 3.3.4 Neglected Tropical Disease (NTDs) cases 3.8.1 Coverage with essential health services 3.8.2 Catastrophic health expense 3.9.1 Ambient air pollution mortality 3.9.2 WASH mortality 3.a.1 Tobacco use 3.b.1 Full immunization coverage 3.b.3 Essential medicine availability 3.c.1 Health worker density 3.d.1 IHR preparedness
6 CLEAN WATER AND SANITATION 	WASH 6.1.1 Safely managed water 6.2.1 Safely managed sanitation 6.3.1 Waste water treatment
13 CLIMATE ACTION 	Cross-cutting 13.1.1 Disaster-related deaths 13.2.1 Climate change policy and plans in place

Figure 13: Top five enablers of child mortality (percentage of total deaths) in 2030

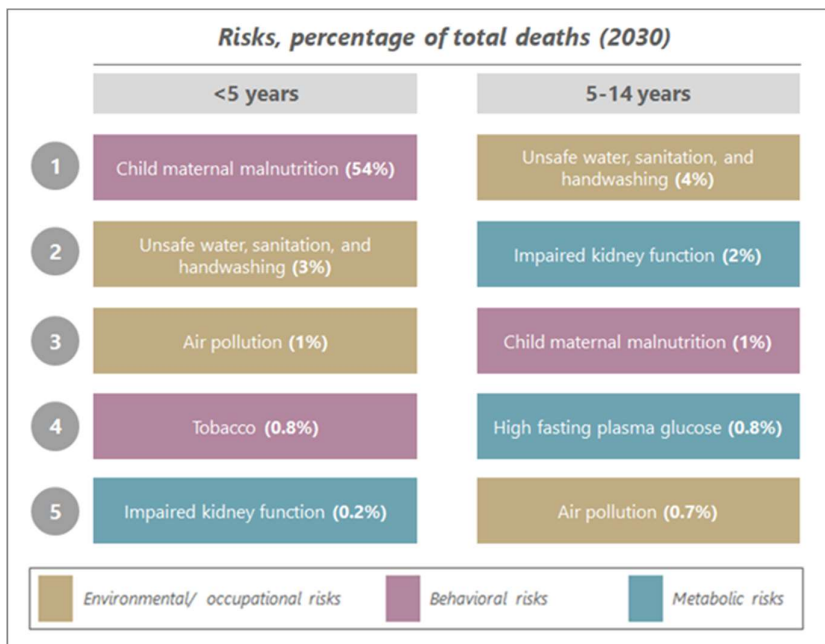


Figure 14: Top five causes of death (percentage of total deaths) by age group in 2030

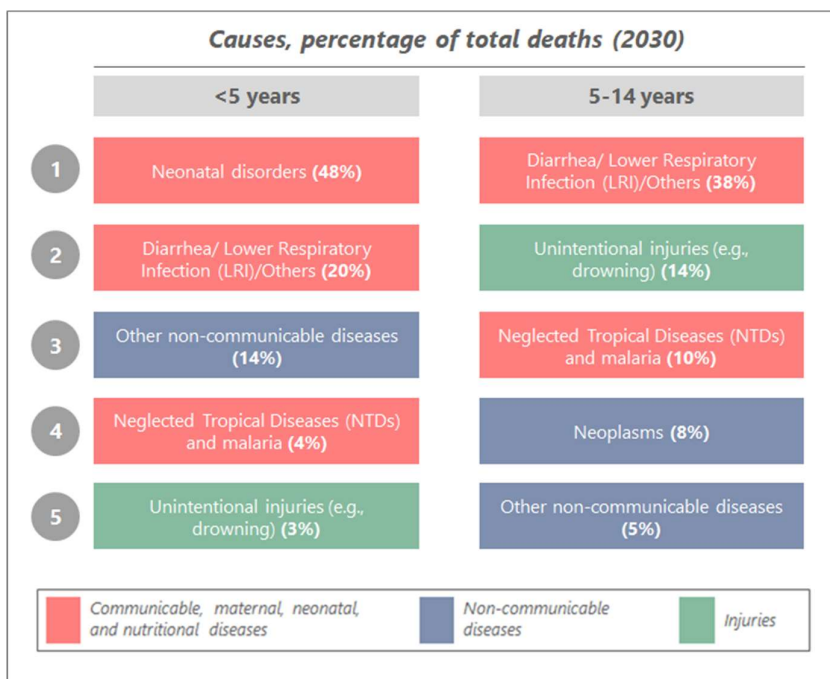


Table 8: Select focus areas of development agencies

Development agencies	Focus areas	Funding (USD)	Area of work
Health: Across the development agencies all health problems are being covered - while WHO has a comprehensive focus on health, Global Fund, UNFPA, and USAID together cover HIV, TB, malaria and other infectious diseases, with GAVI and UNDP focusing only on			

immunisation. Additionally, most agencies seem to have an upstream focus.

Global Fund ^{126,127}	Antiretroviral HIV therapy, tuberculosis treatment, and mosquito net distribution for malaria prevention	48 million (2019)	Upstream
GAVI ¹²⁸	Immunisation (treatment for HPV ¹²⁹ , IPV ¹³⁰ , JEV ¹³¹ , measles) and healthcare systems strengthening, including Civil Society Organisations (CSOs) support	~180 million (2000-19)/~10 million every year on an avg.	Upstream
World Health Organisation (WHO) ¹³²	Communicable diseases, non-communicable diseases, MNCH, preparedness for public health emergencies and disasters	26 million (2014-15)	Upstream
United Nations Fund for Population (UNFPA) ¹³³	Integrated sexual and reproductive health including HIV prevention through family planning	7.8 million (2018-19)	Upstream
United States Agency for International Development (USAID) ¹³⁴	Controlling the spread of infectious diseases and preventing epidemic outbreaks, notably HIV/AIDS, TB, pandemic influenza, emerging pandemic threats, and neglected tropical diseases (NTDs)	N/A	Upstream
United Nations Development Programme (UNDP) ¹³⁵	Digitised immunisation vaccine supply chains	N/A	Upstream

Nutrition¹³⁶: Few development agencies and large nonprofits are focusing on Nutrition in Indonesia primarily on undernutrition and food supplements, with some of them working in partnership with UNICEF

World Bank ¹³⁷	"Nutrition and Early Years Project" - targeted nutrition interventions by districts and utilisation of such interventions (e.g. IFA supplement consumption for pregnant women)	400 million (2018-22, loan)	Upstream
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¹²⁶ (Global Fund website, 2019)

¹²⁷ Contributed 0.9 million to UNICEF for malaria program

¹²⁸ (GAVI website, 2015)

¹²⁹ Human Papilloma Virus

¹³⁰ Inactivated Polio Virus

¹³¹ Japanese Encephalitis Virus

¹³² (WHO Country Cooperation Strategy, 2014-2019)

¹³³ (Improving Maternal and Child Health in the Urban Context, 2017)

¹³⁴ (Country Development Cooperation Strategy, 2014-18)

¹³⁵ (UNDP website, 2017)

¹³⁶ Besides the agencies mentioned, UNFPA and USAID have limited programme emphasis on nutrition for maternal and newborn survival

¹³⁷ (World Bank website, 2019)

Nutrition International (in partnership with UNICEF) ¹³⁸	Child survival via vitamin A and zinc supplements; mother and newborn survival via salt iodisation, iron and folic acid, and rice fortification	N/A	Downstream
Department of Foreign Affairs and Trade (DFAT) ¹³⁹	Nutritional assistance to indigenous children; while each of DFAT's objectives are linked to SDGs there is no explicit focus on SDG 2 on 'Zero Hunger' and nutrition falling under poverty or health related SDGs	N/A	Upstream
Global Alliance for Improved Nutrition (GAIN - partners with UNICEF)	Reducing micronutrient deficiencies in women and infants	N/A	-
World Food Programme	Evidence generation and awareness on food security and nutrition	15 million (2016-2020)	Upstream
<i>WASH: Multiple development agencies are focusing on WASH, however most of the funding is primarily towards water and quality management, which is different from UNICEF's approach towards WASH. These players also work collaboratively on these issues.</i>			
World Bank	"National Urban Water Supply Project"- improving access to water sources through piped connections	100 million (2018-22, loan)	Upstream
Asian Development Bank (ADB) ¹⁴⁰	Water quality management; child hygiene awareness building	N/A (multiple projects)	Upstream
DFAT ¹⁴¹	Access to safe drinking water through community-based sanitation and hygiene programmes	17 million (across Indo-Pacific)	Upstream
USAID ¹⁴²	Strengthen PDAMs ¹⁴³ , make water supply more affordable, and improve sanitation services	N/A	Upstream

Table 9: High and low priority provinces by focus areas

Focus area	Highest priority provinces (most affected province in red)	Lowest priority provinces (least affected province in green)
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¹³⁸ (Nutrition International website, 2018)

¹³⁹ (Aid Programme Performance Report , 2018)

¹⁴⁰ (Asian Development Bank website, 2015)

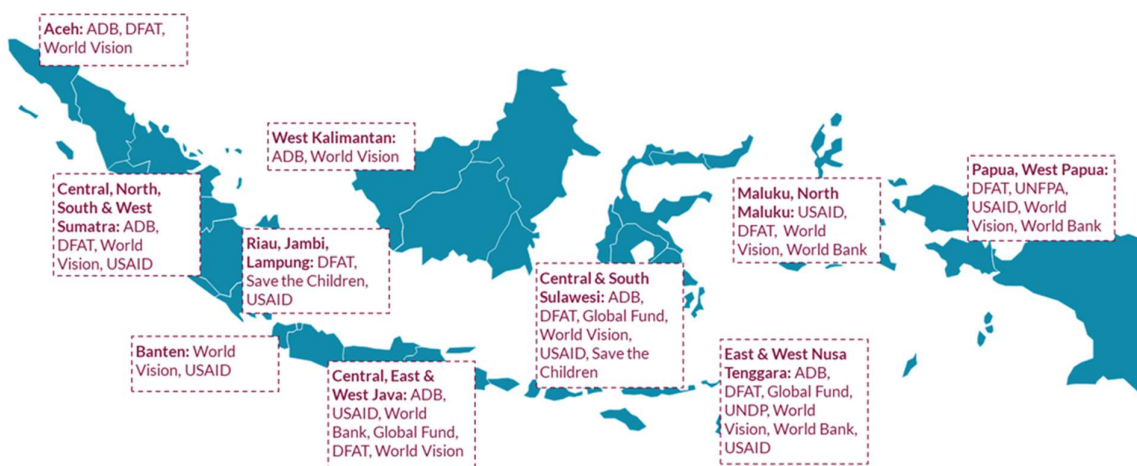
¹⁴¹ (Aid Programme Performance Report , 2018)

¹⁴² (Country Development Cooperation Strategy, 2014-18)

¹⁴³ Perusahaan Daerah Air Minum (Indonesian water supply companies)

Health		
Adolescent birth rate (per 1000 women aged 15-19)	Kalimantan (South, Central, West), Sulawesi (North, West), West Papua, West Nusa Tenggara	Aceh , Sumatra (North and West), East Nusa Tenggara, Maluku, Central Java
Percentage of children aged 12-23 months who received complete basic immunisation	Aceh, Sumatra (North and Central), Papua and West Papua, Sulawesi Tenggara, Maluku, North Maluku	Kalimantan (North and South), West Nusa Tenggara, Central Java
Prevalence of tobacco smokers (5-17 years)	Java (Central and West), Central Sulawesi, South Sumatra, West Nusa Tenggara	Aceh, North Sumatra, West Papua, Maluku, North Maluku, East Nusa Tenggara, East Kalimantan
Nutrition		
Prevalence of moderate and severe overweight in under five children	Papua , Sumatra (except West), Riau, East Kalimantan	East Nusa Tenggara, West Papua, Maluku , North Maluku, South Sulawesi
Prevalence of moderate and severe stunting in under five children	Aceh, North Sumatra, South Kalimantan, Nusa Tenggara (East and West), West Papua, Sulawesi (South and West)	East Kalimantan , North Sulawesi,
Prevalence of early initiation of breast-feeding	Papua and West Papua, North Sumatra, Sulawesi (West, Central, and North), Maluku , North Maluku	Java, Nusa Tenggara (East and West), North Kalimantan, South Sulawesi
WASH		
Share of villages/wards implementing Community Based Total Sanitation (STBM)	Aceh, North Sumatra, Kalimantan (East and North), Maluku, North Maluku, North Sulawesi, Papua	South Sumatra, Nusa Tenggara (East and West), Java (East and Central)
Percentage of schools with basic water services	Papua, West Papua, Maluku, North Maluku, East Nusa Tenggara , Sulawesi (West and Tenggara), Kalimantan (North and West)	Java , South Kalimantan
Percentage population practicing open defecation	Papua , Aceh, West Nusa Tenggara, West Sumatra, West Kalimantan, Sulawesi (Central and West), Maluku	Riau, Kalimantan (North, East , South), West Papua

Figure 15: Provinces of Indonesia by active development players (non-exhaustive)



Notes: (1) This mapping indicates active project sites for the listed organisations in the fields of Health, WASH, and Nutrition, where the information has been made publicly available. Hence, it is not necessarily exhaustive. (2) For USAID, ADB, DFAT, World Vision and Save the Children, these activity sites may be integrated with climate change adaptation and disaster resilience efforts.

Table 10: International agencies by programme details and provinces (non-exhaustive)

Development agencies	Programme details	Provinces active
ADB	Technical assistance for a water sensitive approach to infrastructure	South Sulawesi
	Urban slum development (including access to water and health services)	South Sulawesi, Kalimantan, Java, Nusa Tenggara, Maluku, Yogyakarta
	Sewage system improvements	South Sulawesi, Aceh, West Java, West Nusa Tenggara, North Sumatra, South Sumatra, Central Sumatra
USAID	WASH related activities (water management, sanitation infrastructure, etc.)	North Sumatra, West Java, Central Java, East Java, South Sulawesi, North Maluku, and Papua
	Reducing maternal/ newborn deaths via greater access to health systems and drinking water, and controlling the spread of infectious diseases/ preventing epidemic outbreaks	North Sumatra, Riau, Banten, Jakarta, West Java, Central Java, Yogyakarta, East Java, East Nusa Tenggara, South Sulawesi, North Maluku, Maluku, West Papua, Papua
DFAT	WASH activities, as part of Water and Sanitation for Low Income Communities Project (PAMSIMAS Phase 2 and 3, AUD70 million; 2013-2022)	Central Java, East Java, West Java, South Sumatra, West Sumatra, Nusa Tenggara Timur, Aceh, Papua, Lampung, North Maluku, South Sulawesi, South Sumatra
	Nutritional assistance to children of indigenous ascent:	Jambi

World Bank	Primary healthcare system support	Nusa Tenggara Timur, Maluku, Papua
Global Fund	HIV therapy, TB treatment, and mosquito net distribution	Jakarta, East Jawa, West Jawa, South Sulawesi and East Nusa Tenggara
World Vision	Activities related to improving child healthcare, family economic welfare, child education, and reducing violence against children	North Sumatra, Bengkulu, West Kalimantan, Banten, East Jawa, West Nusa Tenggara, East Nusa Tenggara, Central Sulwaesi, South Sulawesi, North Maluku, Papua, West Papua
Save the Children	Disaster relief clinics Youth employment	Sulawesi West Jawa, Lampung

J: Current CPAP Country Programme Action Plan's Summary Results Framework

Output 1.1: Governments and partner institutions have enhanced capacity and commitment to deliver quality services at scale to protect children from undernutrition and overnutrition.

S.no	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.1.1	Existence of national protocols for the management of SAM based on WHO standards	There is no national protocol that is in-line with global recommendations on the community-based management of acute malnutrition (CMAM) (2015)	CMAM guideline and roadmap is finalised and endorsed for scale up to 260 districts in 2020 (2019)	<u>Achieved 2019 target</u> with CMAM guidelines finalised and endorsed
1.1.2	Status of implementation model for the community-based management of acute malnutrition and its translation to national guidelines to influence scale-up	Baseline nutrition survey completed (2015)	Evaluated CMAM model and revised national CMAM guidelines exist (2020)	<u>Achieved 2020 target in 2019</u> with CMAM model finalised and published WHO bulletin
1.1.3	Number of knowledge and information products developed to inform policies, strategies and guidelines to address adolescent undernutrition and over-nutrition	0 (2015)	4 (2019)	<u>Exceeded 2019 target</u> with more than four knowledge products created
1.1.4	Number of technical guidelines and capacity development products available and in use at province and district level to scale up nutrition services.	0 (2015)	5 (2020)	<u>Exceeded 2020 target in 2019</u> with more than five technical guidelines
1.1.5	No. of related nutrition	0 (2018)	4 (2019)	<u>Achieved 2019</u>

	priorities included in RPJMN			<u>target</u> with four priorities included: stunting, wasting, obesity, double burden
1.1.6	NON-CP INDICATOR: National legislation on the international code of marketing of breastmilk substitutes are adopted and monitoring and enforcement mechanism is identified	Legislation prohibiting marketing of BMS for children less than six months , is passed, institutionalised with monitoring and enforcement mechanisms identified (2015)	Legislation prohibiting marketing of BMS for children less than three years , is passed, institutionalised with monitoring and enforcement mechanisms identified (2020)	<u>On track</u> : Legislation prohibiting marketing of BMS for children less than one year

Output 1.2: Governments and partner institutions have enhanced capacity and commitment to deliver quality services at scale, in urban and rural areas, to support elimination of open defecation, access to safely managed water and sanitation and the promotion of hygiene practices.

S. no	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.2.1	National strategy to eliminate open defecation available with a systematic approach to gender	Strategy is in place but little or no oversight from National and Provincial levels; no systematic annual progress review, no knowledge capture and dissemination mechanism (2015)	Implementation of the Knowledge Management capture and dissemination as well as systematic review mechanism initiated at National level and in one quarter of provinces (2019)	<u>On track</u> : Data unavailable (2019) <u>Exceeded 2018 target</u> of National level and in 3 Provinces by 3
1.2.2	Number of provinces where programme cooperation is documented, disseminated and used as the basis for evidence-based advocacy on acceleration of community-based WASH approaches	3 (2015)	5 (2019)	<u>Achieved</u> : 6 as of July 15, 2019 (2019) <u>Exceeded 2018 target</u> of 4 provinces by 2
1.2.3	Number of significant WASH knowledge and information products incorporated into government and partner data and knowledge management systems and dissemination pathways	4 (2015)	6 (2019)	<u>On track</u> : 4 as of July 15, 2019 (2019) <u>Exceeded 2018 target</u> of 5 products by 3
1.2.4	NON-CP INDICATOR: Number of non-project districts with plans to implement STBM (CATS) as a result of UNICEF advocacy		12 districts (2017 target)	Exceeded target with 28 districts having plans to implement STBM

Output 1.3: Governments and partner institutions have enhanced capacity and commitment to deliver WASH services in institutions at scale including the use of sustainable basic sanitation, safe drinking water and improved hygiene behaviours.

S. no	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.3.1	WASH in schools knowledge platform to increase access to data, information and knowledge, best practices and improved coordination is expanded and strengthened	WASH in schools coordination meeting twice per year (2015)	WinS process and output indicators reviewed by WinS oversight team and mid-course corrections made (2019)	<u>Achieved 2019 target</u> <u>Achieved 2018 target</u> of strengthened EMIS in place and more focused monitoring and corrective feedback to schools
1.3.2	Status of development of operational guidance (to assess, strengthen, implement, monitor and sustain) for functioning WASH facilities in health centres	Not yet systematic (2015)	Review meeting of progress and mid-course corrections made (2019)	<u>On track: Data unavailable</u> (2019) <u>Achieved 2018 target</u> to put in place strengthened monitoring and analyse data gathered
1.3.3	NON-CP INDICATOR: Conduct advocacy to increase funding allocation on WASH in Schools		N/A	USD 30 million

Output 1.4: Government and partner institutions have enhanced capacity and commitment to deliver quality basic and comprehensive MNCH services including PPTCT at scale.

S. no	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.4.1	Costed implementation plan for maternal, newborn and child health care available	A costed national MNH plan exists at national level (no child health) (2015)	Costed MNCH action plans exist at national and in at least 9 districts in 7 provinces of UNICEF cooperation. (2019)	<u>Achieved 2019 target</u> with 2 districts and 2 provinces having a costed newborn action plan. 7 districts in 7 provinces have Bupati/Mayor Decree that state key district priority actions for MNH which is aligned with national MNH action plan. <u>Partially achieved 2018 target</u> with an MNCH action plan at the national level and only 1 district, instead of 7 districts in the 7 provinces
1.4.2	Proportion of health centres supported by provincial health authorities to offer HIV testing and ARV treatment for pregnant women, newborns and infants	23/40 (2015)	40/40 (2020)	<u>Achieved 2019 target</u> of 35 out of 40 health centres supported
1.4.3	Number of provinces assisting at least two of their districts in using national IMCI guidelines for planning and monitoring IMCI implementation in their facilities	0 (2015)	7 (2020)	<u>Exceeded 2020 target</u> by 2 with total 9 provinces including Aceh, Central Java, East Java, NTB, NTT, Maluku, North Maluku, Papua, and West Papua
1.4.4	Number of provinces assisting at least two of their districts to develop an emergency obstetric and newborn care action plan and able to	0 (2015)	7 (2020)	<u>Exceeded 2020 target</u> by 2 with total 9 provinces

	monitor its implementation			
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Output 1.5: Government and partner institutions have the capacity and commitment to deliver quality services at scale to control vaccine preventable diseases, malaria and HIV, including elimination of neonatal tetanus, measles, HIV, syphilis and malaria.

S. no	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.5.1	% pregnant mothers screened for malaria and receiving treatment during ANC services	61 (2014)	87 (2019)	On track: 40% by September 2019 Achieved 2018 target of 85% screened
1.5.2	% confirmed malaria cases in public and private health facilities receiving ACT in selected districts	95 public (2015)	87% public and private (2019)	2019: On track: 83% as of Sept, 2019. Official national data not available; Instead proxy for confirmed malaria cases receiving standard treatment (ACT and Primaquine) used, which understates achievement Partially achieved 2018 target with achievement of ~76% instead of 80% (target was changed from 87% to 80% in 2018)
1.5.3	Model for malaria elimination developed and documented in Aceh, South Sulawesi, West Sulawesi, Papua, West Papua, NTT, Maluku and North Maluku	0 (2015)	7 (2019)	2019 Data unavailable Achieved 2018 target of 5 provinces covering Aceh, Jakarta, Bali, Maluku, North Maluku
1.5.4	Percentage of health centres with high-risk communities that are provided 100% of their re-supply vaccine stock for the whole year	0 (2015)	20 (2016)	2019: Data unavailable Partially achieved 2016 target due to the delayed start of the REC initiative, resulting in relevant data not being collected by the DHOs.
1.5.5	Percentage of health centres with high-risk communities that have costed immunisation microplans to increase outreach sessions	0 (2015)	20 (2016)	2019: N/A. Approach shifted from outreach sessions to SMS messages; change not yet reflected in CP indicators Partially achieved 2016 target due to the delayed start of the REC initiative, resulting in relevant data not being collected by the DHOs.
1.5.6	Status of implementation model for the HIV prevention and treatment among young key populations (YKP) to inform national guidelines and to influence scale-up	Bandung model in progress (2015)	Programme transition and finalisation of Integrated Biological and Behavioural Survey (IBBS) (2019)	Achieved 2019 target with IBBS completed Achieved 2018 target of scaling up of HIV services for YKP and YKP indicators are included in IBBS
1.5.7	NON-CP INDICATOR: Number of UNICEF	11 (2015)	N/A	16 of 34 provinces (2019)

	supported provinces for immunisation coverage			
1.5.8	NON-CP INDICATOR: # of districts that have been certified malaria free	N/A	All (2020)	285 of 514 (2017)

Output 1.6: Governments and partner institutions have improved capacity and accountability for health resource allocation based on evidence-based planning and in monitoring equity and implementation management of health services in the era of universal healthcare (UHC).

S. no.	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.6.1	Number of provinces that have produced an action plan to integrate local health insurance with national health insurance to improve the implementation health care (UHC)	0 (2015)	2 (2020)	<u>Achieved 2020 target</u> with all existing local government's health insurance have been merged to the national health insurance
1.6.2	Number of provinces supporting districts in adopting the principles of evidence-based planning and the Minimum Service Standards (MSS)	2 (2015)	5 (2020)	<u>Exceeded 2020 target</u> with 6 provinces supporting on the planning and budgeting of MSS
1.6.3	Number of provinces supporting districts in adopting the principles of evidence-based planning to reach Minimum Service Standards (MSS) indicators.	0 (2018)	1 (2020)	<u>On-track for 2020</u>

Output 1.7: Government and partner institutions are prepared, have adequate sectoral capacity and provide an effective and coordinated response for WASH, nutrition and health¹⁴⁴ in emergencies.

S. no	Indicator	Baseline (year)	Target (target year)	Status (relevant year)
1.7.1	Proportion of declared emergencies in which UNICEF sectoral assistance is requested where obligations of the UNICEF Corporate Core Commitments for children and the IASC Cluster Coordination roles are met in health, nutrition and WASH	100 (2015)	100 (2020)	<u>On track for 2020</u> <u>Achieved 2016 target</u> of supporting the government to respond to the Aceh earthquake in December 2016

¹⁴⁴ While Health was initially included under this output, all health emergency work is now mentioned under the respective health related outputs (1.4-1.6)

K: Theory of Change

Output-level ToC summaries (UNICEF)

Ending malnutrition: To end all forms of malnutrition throughout the life cycle with a special focus on the first 1,000 days of life and adolescent girls, UNICEF is supporting the government to deliver quality services to protect children from undernutrition and overnutrition. To reinforce the enabling environment – specifically the weak policy and regulation enforcement, the inadequate policy and guidelines, the lack of data and evidence to guide equity programmes and the limited budget allocation, UNICEF engages in partnerships for evidence generation and advocacy to first improve knowledge and attitude of policy-makers about nutrition and later to enhance the political will of the government to address malnutrition. As a result, UNICEF is expecting adequate legislation, policy and guidelines to address malnutrition and increased budget allocation and expenditure on nutrition.

Parallely, regarding the lack of inter-sectoral convergence, UNICEF engages in advocacy and partnerships to generate awareness on multi-sectoral response and to establish a coordination forum that helps clarify roles, responsibilities and accountabilities for more integrated nutrition programmes.

On the supply side, the lack of qualified service providers and the limited access to nutrition services, along with the inadequate capacities and low levels of monitoring and evaluation, is being addressed by improved training and resource management in nutrition services to enhance the capacity of service providers to increase access. To deal with the limited supply, UNICEF is partnering for innovation and advocacy that will lead to improved capacity and political will, for increased availability of essential nutrition commodities.

Finally, to increase the lack of awareness and negative perception of nutrition services, capacity development and partnerships are used to increase the availability of quality counselling packages and the knowledge and attitudes on nutrition, so caregivers and adolescents adopt better food and nutrition behaviours. All this is done for several different programmes. such as SUN Movement. IYCF. CMAM. adolescent nutrition. integrated programmes. amongst others.

Eliminate open defecation: Open defecation, where people do not defecate in a toilet but in the open, on a beach, into a river and so on, is a massive problem in Indonesia, though its importance is not acknowledged widely enough. Every year approximately 150,000 children die in Indonesia before they celebrate their 5th birthday. UNICEF has also shown that the risk of stunting is much higher when a household does not use an improved latrine (almost nine million children affected by stunting).

This can be drastically reduced by good sanitation and hygiene, as 88% of diarrhoea deaths are linked to incomplete water, sanitation and hygiene provisions. To improve this, the first issue is to support the national programme Community-led total sanitation (STBM). UNICEF works with national and subnational authorities to both improve Open Defecation Implementation and Verification (including guidelines) by improving coordination between institutions involved. UNICEF Indonesia is supporting a pilot for accelerating STBM in 18 districts (6 directly and 12 indirectly via provincial support) in poorer and remote areas. By technically assisting the government, UNICEF attempts to increase their focus on WASH issues and to have the *bupatis* committed on these issues.

Resulting from this commitment, the districts will issue local policies banning open defecation (OD) and the district budget (APBD) will be allocated to STBM. This can allow proper allocation for training local workers on monitoring OD implementation. UNICEF will also support the technical capabilities of the local workers on WASH issues and knowledge capture and will provide useful data on programme cycles and metrics.

At the same time, a participatory process is carried out at a community level, so communities are aware and commit to the OD elimination, elaborate their plan based on their assessment and implement them and so people change their beliefs and practices and they become OD-free villages. UNICEF also works with other partners such as religious leaders, women groups, scouts, local champions to support the local push forward on sanitation. Finally, the improved inter-

Promoting WASH in schools: UNICEF is providing support by including WASH indicators in the education management information system (EMIS) and developing corresponding guidelines. The programme is working with the Ministry of Education (MoE) to analyse WinS data and produce WinS profiles, which will allow the development of policy briefs and a roadmap with WASH-promoting recommendations.

The roadmap should push other actors (including BAPPENAS) to include WinS into SSK and to have WinS guidelines developed at the national level. UNICEF's support to BAPPENAS will serve to pilot the guidelines and to guide the training programmes that the districts are capable of developing WinS plans included in SSK. Also, by promoting the improvement of the national implementation guidelines that include cross-ministerial responsibilities; this will contribute to precise and uniform approaches to WinS and MHM.

At the same time, UNICEF is working to advocate at the local level by generating evidence on the impact of WinS on health and education and its drivers of sustainability and to show that the approach is working through documenting the results of the programme. This aims to raise awareness, so WinS is incorporated in the budget and planning systems at the district level. In parallel, students are meant to have improved access to information on hygiene practices and MHM, leading to better hygiene practices.

Overall, having harmonised guidelines on WinS promotion will facilitate local governments prioritising WinS on planning and budgeting, which will promote increased functionality of well-adapted toilettes and handwashing. This will contribute to more efficient implementation and ultimately to increased girls' attendance and healthier, better-performing students.

Maternal, newborn, and child health: To enhance Maternal and Newborn Child Healthcare (MNCH) services, UNICEF is supporting the government through a mix of strategies: capacity development combined with partnerships with professional organisations, CSOs and academia, and programme integration with multi-sectoral stakeholders. These strategies will come together to generate evidence through modelling for quality improvement on maternal and newborn care and mentoring of healthcare providers of essential newborn care in selected facilities, mentoring for implementation of audit for maternal and perinatal deaths, modelling District Team Problem Solving (DTPS) and mapping and tracking MNCH logistics and human resources. Evidence generation will be developed by combining results of above implementation strategies through annual reviews and development of policy briefs targeting decision-makers that will serve as a support for policy advocacy and advice to promote local policies.

By strengthening the capacity of sub-national government partners in evidence generation and harmonising national with local policy, better legislation will be an issue and ensure resource generation and allocation for MNCH programmes on a long-term basis. By enabling the district health office (DHO) programme managers to regularly monitor the integrated MNCH package (including facility data analysis to enable more effective programme implementation and timely course correction in plans and strategies), we will contribute to assuring the availability of essential commodities and capable staff to deliver MNCH services. By that, health facilities will be able to deliver quality basic and emergency maternal care – including PMTCT, neonatal and child health services.

The programme targets policy change so that an integrated MNCH strategy and implementation plan is effectively implemented in each facility and monitored by health offices at the sub-national and national level. This will lead to a change in health system delivery where MCH care setting in targeted areas offers PMTCT service and designated EONC facilities are functioning.

The expected improvement is the implementation of integrated plans and increased resource allocation so that MNCH facilities will offer 24/7 services.

By enhancing capacity and commitment of government and partner institutions to deliver quality basic and comprehensive MNCH services, which include the integration of services with PMTCT, UNICEF will work together with government to improve the well-being of mothers and children. Together, the programme will improve access and

Immunisation: To promote quality services at scale to control vaccine-preventable diseases, UNICEF is providing technical advice to the government and partnering with WHO to improve the national policy on immunisation to include data-driven planning and budgeting.

By providing technical advice, and in consultation with Bappenas and the Ministry of Finance, in partnership with WHO, a draft of the national policy on immunisation will be reviewed to make it more comprehensive.

UNICEF is also partnering with the World Bank to consistently advocate for simplified financial procedures that allow more timely and data-driven purchase process.

The Capacity of health workers is being enhanced on that purpose by capacity building and regular assessment on compliance of SoPs, so a plan addressing gaps and cascade trainings are held at district and village level for EPI teams.

This enhanced capacity together with better and well-equipped monitoring practices will result in better stock management and more efficient immunisation results.

Finally, to increase parents' access to information and to mobilise local leaders to promote vaccination demand from the communities, EVMA is being used for capacity building to equip leaders and health workers better to encourage parents to seek to vaccinate their children.

Eliminating malaria: Although some regions have made significant progress towards eliminating malaria, it is still accountable for significant mortality and morbidity among children.

To improve local government commitment and resources, UNICEF is supporting the use of evidence on stratification and promoting the formation of a coalition, so local regulations for malaria elimination are advocated. At the same time, technical assistance is being provided to contribute to having both national and implementable local technical guidelines available.

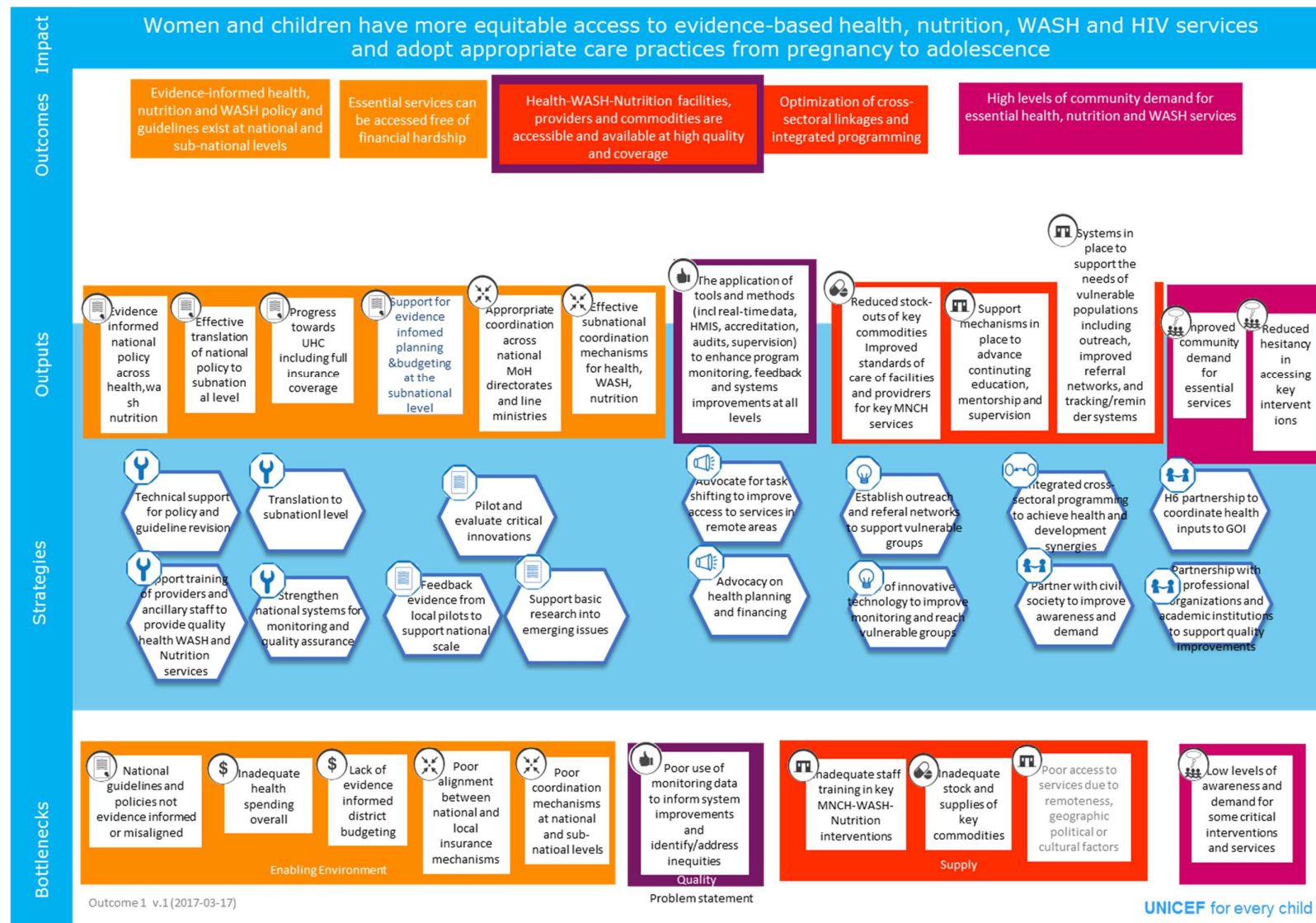
UNICEF is also promoting more effective programme management by promoting coordination meetings where routine data on integrated malaria services will be analysed.

To ensure a continuous supply of commodities in front line services, UNICEF is contributing to evaluate this policy and to make the role of the private providers more integrated and coordinated in the system (pilot). Working with National Pharmacy aims for better implementation of the policy.

UNICEF is supporting clinical expert committees so that continuously updated expertise is available at the local level. Evidence is being generated on malaria elimination to strengthen surveillance activities effectively.

Finally, to improve community engagement, UNICEF is working at the community level to understand community practices, to help the population understand the sources of transmission and to change their practices to minimise their risks.

Figure 16: Draft CSD ToC (UNICEF)



L: Additionality case studies

Banda Aceh

The IKEA Foundation-funded project¹⁴⁵ in Banda Aceh which holistically addresses acute malnutrition is an often-cited example of a strong programme integration, involving all CSD sectors, along with Social Policy and Child Protection. The project is a three-year partnership that started in 2018. It aims to apply cross-sectoral programming to address the unfinished agenda of child malnutrition, with a focus on maternal and child anaemia. The geographic focus of the work is on eight districts, four of which are in high-intensity districts that will be provided ground-level support. The other four will be learning districts where facilitated engagements will create touchpoints for cross-district knowledge sharing. Across these sectors, the project is implementing the IYCF program, STBM program, Universal Child Grant (UCG) program, Maternal and Child Health (MCH) program, and Parenting, among others.

Overall, the project design, funding, and implementation have taken an integrated approach, with the following successes and challenges:

- **While the programme design was integrated (beyond CSD outcomes) and aligned to government priorities, there were some concerns around the participatory nature of design:** Multiple sectors, including those outside of CSD, were involved during the proposal stage to define integrated outcomes. The issue of malnutrition is also aligned with the local government's priority (e.g., the government wants to extend the project to other districts). However, some teams felt that their inputs on design were not fully considered because they were consulted later in the process when the opportunity for scope modification was limited.
- **Funding allocation was also integrated with additional cross-sectoral resources. However, at the sub-national level, funding was sectoral.** Since the proposal was co-developed with the funders, it received integrated programme funding, with some staff that work cross-sectorally at the sub-national level. However, this funding is allocated to specific sectors, which has led to some implementation silos. For example, each sector has separate contracts with implementation partners, making coordination harder for the CFO. A central programme level contracting, and resource management process can help avoid such issues in future
- **Project delivery is also integrated in on-ground implementation and communication with the government, with some inefficiencies due to vacancy in the CSD specialist's position.** Implementation has been integrated, where relevant –e.g., in the nurturing parenting project, training for parents provides information on all sectors relevant for child development. In addition, the presence of cross-sectoral resources makes it easier to exchange lessons across sectors. Sectors across the Aceh FO coordinate their communications with the government, sharing an integrated narrative on all external communications. However, in the initial absence of a CSD specialist, the CFO has largely played the role of a CSD specialist in driving the implementation of the project. With the recruitment of a CSD specialist, the roles of the CSD specialist and CFO can be further streamlined.

Kupang

The Kupang field office actively supports the sub-national government through programmes in all three CSD sectors, along with a large programme in Early Childhood Development (ECD)

¹⁴⁵ This is project is the only project in Banda Aceh

as well. It actively supports the government on the stunting agenda with the following specific issues and programmes across the sectors:

- *Health:* Triple elimination of HIV, Hepatitis, and Syphilis; Malaria prevention and cure; Immunisation
- *Nutrition:* Integrated Management of Acute Malnutrition (IMAM); Adolescents' nutrition
- *WASH:* WASH in schools; WASH in communities and community health centres; STBM
- *ECD:* Holistic early childhood development

Across these sectors, UNICEF is deploying multiple 'ways of working', with Nutrition and ECD team using the pilot-to-scale approach. UNICEF provides *capacity building and technical support* to the provincial and district health offices to translate the mission and vision of the Governor to an implementation plan along with activities. The FO recommends to the government on which districts to focus on based on a mapping of least developed districts using data analytics. The Nutrition team is supporting the sub-national government in scaling the IMAM pilot through upstream technical assistance and advocacy. Similarly, the ECD team is conducting a model on holistic early childhood interventions and has seen success in its 24 subdistricts. The FO also has partnerships with multiple implementing partners such as YASATU, HAKLI, PPNI, among others.

The three sectors within the CSD cluster are working primarily independently with no integration in programme design or funding, and with some level of collaborative implementation and communication. The Health, Nutrition, and WASH sectors in Kupang have separate sectoral outputs that are defined at the national level. Similarly, funding is also sectoral and linked to the outputs. This has restricted the extent to which the office has been able to respond to the sub-national government's demand for an integrated approach, especially with regards to the stunting agenda. Despite this, there have been some attempts at collaborative implementation and communication with the sub-national governments. For example, the WASH team also provides technical assistance and capacity building support on nutrition and health aspects to community health centres. Similarly, all team members represent the full Kupang FO when communicating with sub-national governments and not their sector. This implies that the sector officers speak on behalf of other sectors as well in government meetings, representing UNICEF as a cohesive unit and not separate sectors.

This contrasts with the ECD programme that has taken an integrated approach across the office in solving early childhood issues in Kupang. The ECD team is working with 100 Early Education Centres (PAUD) and linking them to the Integrated service delivery post (Posyandu) for growth monitoring and community health centres. It is encouraging every PAUD to have toilets, handwashing, and potable water. At enrolment, children are checked for immunisation and birth registration and referred if they do not have it. During monthly Parent-Teacher-Association (PTA) meetings, they added parenting sessions, and PAUDs invited speakers from relevant offices depending on the topics (e.g., nutrition, child development, health, etc.). This has been done organically and informally by seeking inputs from the CSD cluster sectors through the programme lifecycle, without any particular structures for integration, likely driven by the fact that ECD is inherently a fully-integrated topic and therefore requires an integrated solution.

The following table compares the aspects of programme design, funding, and implementation between the CSD cluster and the ECD programme at the Kupang FO.

Table 7: Extent of integration across CSD cluster and ECD sector

Programme stage	CSD cluster	ECD sector ¹⁴⁶
Programme design	Lack of integrated programme design or outcomes and outputs. Each sector has nationally-defined sectoral outputs. These outputs relate to the seven CSD cluster outputs, which are also sectoral (Output 1.1 - Nutrition; Output 1.2, 1.3 - WASH, Output 1.4, 1.5, 1.6, 1.7 - Health)	The programme proposal touches upon aspects of WASH, through mention of 'child safe buildings', and health and nutrition as part of the child's holistic development. Outputs are integrated and focus on the holistic development of the child.
Funding allocation	Funding allocation is linked to sectoral outputs, with no additional budget for the CSD specialist to provide cross-sectoral support	Funding is linked to the integrated outputs, with additional 5% cross-sectoral staff and output budget
Programme implementation	The sectors primarily work independently on their own outputs and liaise with the relevant sub-national governments. There is limited flexibility to respond to the demands of the sub-national government for a more cross-sectoral approach. Instead, only the CSD specialist plays the role of providing a cohesive narrative on stunting to the sub-national governments through interactions with the sectoral teams.	While the proposal at the national level encouraged integration, the ECD team in Kupang has flexibility to respond to the sub-national demands for cross-sectoral approach, in part due to its control over the budget. For example, they added gardens and ways to address malnutrition as part of the program, on the Governor's request. Similarly, while there are no systems in place, the ECD team has taken initiative at the FO level to include CSD sector in the programme planning and implementation stages through informal emails and meetings.

M: Review of a selection of CSD pilots

Table 11: Review of selection of CSD pilots

Program	Intent	Pilot effectiveness			
		Evidence of intervention effectiveness?	Credible research document?	Pre-identified change in gov't policies or plans/programmes for scaling?	Scaled up?
CMAM (as part of the	Develop implementation	Yes (proved that SAM could be cured through	No (UNICEF Annual report to Australian	Yes (MoH has approved and endorsed the	In progress: National scale-up to take

¹⁴⁶ This perspective is based on interviews with the ECD team in Kupang FO and review of ECD documents

IMAM programme)	model and build capacity for scale-up	outpatient treatment; demonstrated that CMAM services could be effectively integrated into the existing health system)	Committee: Scaling up the Integrated Management of Acute Malnutrition in Indonesia)	National Guideline on SAM Management; PHO of NTT has allocated funding to scale up IMAM in ten districts)	place between 2018-21 aligned with scale-up plan on National Stunting Program
MHM	Generate evidence on the effect of C4D awareness generation interventions targeting menstrual awareness amongst both girls and boys (intervention included an introductory session on menstruation followed by distribution of MHM comic books)	Somewhat (significant increase in MHM knowledge was observed among both girls and boys, however no evidence that girls' MHM practices were improved)	Yes (Research paper titled: 'Not just a girl problem: Improving menstrual knowledge and attitude among adolescent girls and boys in Indonesia: pre- and post-evaluation of a school-based intervention')	No	No
Malaria – Models for Malaria Elimination	National scale-up of malaria elimination efforts based on the experience in Aceh	Yes (# of malaria cases reported reduced by 70% and 49% in Aceh and NTT respectively between 2015-18)	Yes (Co-authored article on P.knowlesi, published in the Malaria Journal in 2018)	Yes (P.knowlesi included in treatment policy; Ministerial Decree on Malaria Diagnosis and Treatment by Village Malaria Workers)	Yes (Part of Gol's national plan to eliminate malaria by 2030)
MNCH - Malaria in Pregnancy	Integrating malaria screening and treatment into routine antenatal care	Yes (benefited both malaria elimination efforts by bringing malaria diagnosis and treatment to the village level through village midwives and has benefited comprehensive maternal health programmes)	No (USAID Donor Report)	Yes (MiP intervention included in national guidelines both in the Integrated Antenatal Care Services Guideline of the Sub Directorate of Maternal and Neonatal Health and in the Guideline of Malaria Integrated Programme of the Sub Directorate Malaria)	Yes (Scaled nationally as of 2017)
MNCH - Cluster Islands Approach	Develop hub and spoke referral system	Yes (Reduce travel time and enhanced coverage with quality maternal-	No (USAID Donor Report)	Yes (Issuance of Ministry decree No. 90/2015 that emphasised the implementation of	Partial (Scaled from one district to seven districts); Gol exploring

		newborn care services ¹⁴⁷ ; improved the enabling environment for vulnerable mother and children)		the Cluster Island Approach for service provision in remote settings)	national scale with donor support
MNCH - Perinatology Mentorship Initiative	Improve clinical skills for MN care in hospitals	Yes (mentorship initiative has contributed to improvements in the clinical skills and knowledge; increased ability to provide treatment for life-threatening conditions such as asphyxia and complications due to low birth weight)	No (USAID Donor Report)	No	Gol discussing plans for additional scale

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O: Biodata for core evaluation team

Note: this only includes the day-to-day ET and does not include MEL, sector, and other experts the consulted on a more ad hoc fashion over the course of the evaluation.

Name	Nationality	Location	Gender
Malavika Bambawale	Indian	Singapore	Female
Layusa Isa-Odidi	American, Canadian, Nigerian	Melbourne	Female
Seerat Kaur	Indian	Mumbai	Female
Aarya Shah	Indian	Mumbai	Male
Keeran Sivarajah	Malaysian	Kuala Lumpur	Male
Sarvesh Singh	Indian	Mumbai	Male

The team was constructed to bring together diverse perspectives from a range Dalberg’s Asia Pacific and ensure a gender balance, as well as at least one Bahasa-speaking contributor. It should be noted that the majority of Dalberg’s work in Indonesia is led from Singapore and Melbourne, given geographic proximity of these markets.