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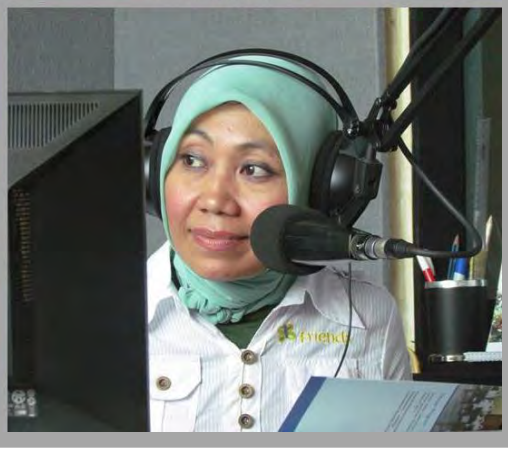
KINERJA
Improving Public Services

KINERJA - IMPROVING PUBLIC SERVICE DELIVERY
Final Report









October 2010 — September 2015

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Terms and Abbreviations

adat	Traditional/indigenous
AJI	Alliance of Independent Journalists
ANC	Antenatal Care
AOR	Agreement Officer Representative
APBD	District Government Annual Budget (*Anggaran Pendapatan dan Belanja Daerah*)
APEKSI	Indonesian Association of Municipal Governments (*Asosiasi Pemerintah Kota Seluruh Indonesia*)
Bappeda	Local Government Agency for Regional Development Planning (*Badan Perencanaan Pembangunan Daerah*)
Bappenas	National Development Planning Agency (*Badan Perencanaan dan Pembangunan Nasional*)
BEE	Business-Enabling Environment
BHS	Basic Health Services
BITRA	Indonesia Foundation for Rural Development (*Bina Ketrampilan Pedesaan*)
BKD	District Personnel Board (*Badan Kepegawaian Daerah*)
BKPM	Investment Coordination Board (*Badan Koordinasi Penanaman Modal*)
BOK	Health Operational Assistance (*Bantuan Operasional Kesehatan*)
BOS	School Operational Assistance (*Bantuan Operasional Sekolah*)
BOSP	Educational Unit Operational Cost Analysis (*Biaya Operasional Satuan Pendidikan)*
BPMD	Regional Investment Board (*Badan Penanaman Modal Daerah*)
Bupati	District Head
COP	Chief of Party
CORDIAL	Center for Indonesian Human Resource Development
CSI	Customer Satisfaction Index
CSO	Civil society organization
CSR	Corporate Social Responsibility
DCOP	Deputy Chief of Party
DEO	District Education Office
DHO	District Health Office
Dinas Kesehatan	Health line agency
DPRD	Local Legislative Council at either the provincial, district or municipal level (*Dewan Perwakilan Rakyat Daerah*)
EDS	School Self-Evaluation (*Evaluasi Diri Sekolah*)
EGI	Economic Governance Index
FGD	Focus Group Discussion
FIK-ORNOP	Nongovernmental Organization Information and Communication Forum in South Sulawesi (*Forum Informasi dan Komunikasi Organisasi Non-Pemerintah Sulawesi Selatan*)

FIPO	Fajar Institute for Pro-Autonomy
FY	Fiscal Year
GeRAK	Anti-Corruption Movement (*Gerakan Anti Korupsi*) Aceh
GOI	Government of Indonesia
HSS	Health System Strengthening
I&EBF	Immediate and Exclusive Breastfeeding
IDR	Indonesian Rupiah
IKM	Customer Satisfaction Index (*Indeks Kepuasan Masyarakat*)
IO	Intermediary Organization
IPPM	Institute for Community Development and Empowerment (*Institut Pengembangan dan Pemberdayaan Masyarakat*)
IR	Intermediate Result
ISO	International Organization for Standardization
JPIP	Jawa Pos Institute for Pro-Autonomy
JURnal Celebes	Journalist Network for Environmental Advocacy (*Perkumpulan Jurnalis Advokasi Lingkungan*)
Kabupaten	District
Kecamatan	Subdistrict
KemenPAN-RB	Ministry for State Administrative and Bureaucratic Reform (*Kementrian Pendayagunaan Aparatur Negara dan Reformasi Birokrasi*)
Kemitraan	Partnership for Governance Reform
KIA	Maternal and Child Health (*Kesehatan Ibu dan Anak*)
KIP	Public Access to Information (*Keterbukaan Informasi Publik*)
KM	Knowledge Management
Konsil LSM	Indonesian NGO Council
KOPEL	Legislative Monitoring Committee (*Komite Pemantau Legislatif*)
Kota	Municipality
KPPOD	Indonesia Regional Autonomy Watch (*Komite Pemantauan Pelaksanaan Otonomi Daerah*)
KUA	Subdistrict Religious Affairs Office (*Kantor Urusan Agama*)
LAN	State Administrative Bureau (*Lembaga Administrasi Negara*)
LBA	Local Budget Analysis
LBI	Local Budget Index
LBS	Local Budget Study
LEGS	Local Education Governance Specialist
LHGS	Local Health Governance Specialist
LPA	Child Protection Agency (*Lembaga Perlindungan Anak*)
LPKIPI	Indonesian Institute for Education Innovation Training and Consulting (*Lembaga Pelatihan dan Konsultan Inovasi Pendidikan Indonesia*)
LPKP	Institute for Community Research and Development (*Lembaga Pengkajian Kemasyarakatan dan Pembangunan*)
LPSS	Local Public Service Specialist
LSPPA	Women and Children's Development and Study Agency (*Lembaga Studi dan Pengembangan Perempuan dan Anak*)
M&E	Monitoring and Evaluation
Madanika	Building Peace and Justice (*Membangun Perdamaian dan Keadilan*)
MCH	Maternal and Child Health

MDGs	Millennium Development Goals
MOEC	Ministry of Education and Culture
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MORA	Ministry of Religious Affairs
MOU	Memorandum of Understanding
MSF	Multi-Stakeholder Forum
MSME	Micro, Small and Medium Enterprise
MSS	Minimum Service Standards
NGO	Non-governmental organization
OSS	One-Stop Shop
Pemekaran	Proliferation of districts
PEO	Provincial Education Office
Permendagri	Ministry of Home Affairs Regulation (*Peraturan Menteri Dalam Negeri*)
PHO	Provincial Health Office
PKBI	Indonesian Family Planning Association (*Perkumpulan Keluarga Berencana Indonesia*)
PKPA	Center for Child Protection and Research (*Pusat Kajian dan Perlindungan Anak*)
PKPM	Center for Community and Education Research (*Pusat Kajian Pendidikan dan Masyarakat*)
PMP	Performance Management Plan
PNC	Postnatal Care
Pokja	Working group (*Kelompok Kerja*)
POPI	Provincial OSS Performance Index
Posyandu	Integrated Services Post (*Pos Pelayanan Terpadu*)
PPID	Local Government Public Information Official (*Pejabat Pengelola Informasi Daerah*)
PPLKB	Family Planning Field Program Controller (*Pengendali Program Lapangan Keluarga Berencana*)
PPMN	Indonesia Association for Media Development (*Perhimpunan Pengembangan Media Nusantara*)
PSD	Public Service Delivery
PTD	Proportional Teacher Distribution
PUM	Directorate General for Administration at the Ministry of Home Affairs
PUPUK	Association for the Advancement of Small Businesses (*Perkumpulan Untuk Peningkatan Usaha Kecil*)
Puskesmas	Community Health Center *(Pusat Kesehatan Masyarakat)*
RFA	Request for application
RISKESDAS	National Basic Health Survey (*Riset Kesehatan Dasar*)
RKAS	School Work Plan and Budget (*Rencana Kerja Anggaran Sekolah*)
RPJMD	Local Mid-Term Development Plan (*Rencana Pembangunan Jangka Menengah Daerah*)
RTI	Research Triangle Institute
SBM	School-Based Management
SD	Elementary School (*Sekolah Dasar*)
SDU	Service delivery unit
Sekda	Regional Secretary (*Sekretaris Daerah*)

Seknas FITRA	National Secretariat of the Indonesian Forum for Budget Transparency (*Sekretariat Nasional Forum Indonesia untuk Transparansi Anggaran*)
SI	Social Impact
SIAP 2	Strengthening Integrity and Accountability Program 2
SIM-NUPTK	Management Information System for Teachers and Teaching Staff
SKPD	District Technical Working Unit (*Satuan Kerja Perangkat Daerah*)
SMERU	SMERU Research Institute
SMP	Junior High School (*Sekolah Menengah Pertama*)
SOP	Standard Operating Procedure
SOW	Scope of work
SPP	Public Service Standards *(Standar Pelayanan Publik)*
STTA	Short-Term Technical Advisor
SUM	Scaling Up for Most-at-Risk Populations
SUSENAS	National Socioeconomic Survey *(Survei Sosial Ekonomi Nasional)*
TAF	The Asia Foundation
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TOT	Training of Trainers
UGM	Gadjah Mada University (Yogyakarta)
UKM	Regional Forum for Small and Medium Enterprises (*Forum Daerah Usaha Kecil Menengah*)
UNAIR	Airlangga University (East Java)
UNfGI	University Network for Governance Innovation
UNHAS	Hasanuddin University (South Sulawesi)
UNICEF	United Nations Children's Fund
UNSYIAH	Syiah Kuala University (Aceh)
UNTAN	Tanjungpura University (West Kalimantan)
USAID	United States Agency for International Development
USG	United States Government
Walikota	Municipality Head/Mayor
WHO	World Health Organization
WRI	Women's Research Institute
YAPIKMA	Foundation for Intensive Empowerment of Public Health (*Yayasan Pemberdayaan Intensif Kesehatan Masyarakat*)
YAS	Prosperous Justice Foundation (*Yayasan Adil Sejahtera*)
YIPD	Local Government Innovation Foundation (*Yayasan Inovasi Pemerintahan Daerah*)
YKH	Hometown Foundation (*Yayasan Kampung Halaman*)
YKP	The Women's Health Foundation (*Yayasan Kesehatan Perempuan*)

Definitions:

Districts: In this document, the term "districts" refers to both *kabupaten* (districts) and *kota* (municipalities) for purposes of simplicity. The term "target districts" refers to the geographical areas that received technical assistance.

A midwife leads a pregnancy class for expectant mothers in Aceh Singkil.

The USAID/Indonesia Local Governance Service Improvement (Kinerja) program, led by RTI International, focused on improving the delivery of public services in three sectors: health, education and business-enabling environment (BEE). When the program was launched in October 2010, Indonesia had witnessed a largely successful democratic transition during the previous decade. However, while district governments had been significantly strengthened during that time, many still lacked sufficient capacity to deliver high-quality public services. The Kinerja program

Box 1: Top 10 program achievements

- **524** schools supported by Kinerja
- **257** community health centers (*puskesmas*) supported by Kinerja
- **415** SDUs (184 schools, 200 *puskesmas* & 31 one-stop shops [OSS]) replicated Kinerja good practices
- **75** districts implemented Kinerja's innovation reforms
- **257** multi-stakeholder forums (MSFs) were established at district & SDU level in treatment districts (on average, 30% participation by women)
- **281** active citizen journalists (CJs) – by 2015, 36% were women
- **237** service charters were signed at partner SDUs (176 schools & 61 *puskesmas*) – of which 218 were monitored by MSFs.
- **5,115** (or 83%) of promises made in 218 monitored service charters were implemented
- **216** new district-level regulations passed to improve services in health, education and BEE
- **36** civil society organizations (CSOs) involved in the program

(NB: The figures cited above include both treatment and replication districts/SDUs, unless otherwise specified).

sought to address this issue by improving local government (LG) performance with the following three-element strategy:

1. **Incentives** - strengthen demand-side entities for better services;

2. **Innovations** - build on existing innovative practices and support LGs to test and adopt promising service delivery approaches, and

3. **Replication** - expand successful innovations nationally and support Indonesian intermediary organizations (IOs) to deliver and disseminate improved services to local government.

With its demand-oriented program design, Kinerja consulted with a variety of representatives – from the national government, USAID, other development partners and non-governmental organizations (NGOs) with experience in each of Kinerja's target sectors – to develop a limited open menu of innovation packages that reflected national-level priorities and programs from which LGs could choose. During the implementation period, Kinerja applied good-governance practices in public service delivery (PSD) at both district and community levels, providing technical assistance to LGs and service delivery units (SDUs) in 20 randomly-selected districts in four target provinces (Aceh, East Java, South Sulawesi and West Kalimantan).

The Kinerja program also incorporated a monitoring and evaluation (M&E) plan that aimed to study the level of impact achieved through these interventions. To that end, Kinerja's M&E partner, Social Impact, collected baseline data in 2010 and endline data in 2013 as part of a rigorous impact assessment (which was documented in a 2015 report entitled *Impact Evaluation of USAID/Indonesia's Kinerja Program*) to determine which interventions worked, why, and how.

Program achievements

Health

Kinerja's health program focused on improving maternal and child health (MCH) through incorporating good governance principles into MCH services in 19 treatment districts. Kinerja's interventions in the health sector comprised: safe delivery, immediate and exclusive breastfeeding (I&EBF) and a request-based pilot project on adolescent reproductive health to combat underage marriage in Bondowoso, East Java.

- Simeulue recorded zero maternal deaths for the first time ever in 2013. The head of the district health office (DHO) credited Kinerja's distinctive approach to traditional birth attendant (TBA)-midwife partnerships as being a key contributing factor;

- Aceh Singkil was one of the first districts in Indonesia to ever win a United Nations Public Service Award (UNPSA) in 2015 for fostering TBA-midwife partnerships to reduce maternal and infant mortality;

- Puskesmas Beji in Tulungagung banned the sale and promotion of formula milk within both the community health center (*puskesmas*) itself and in the surrounding area in May 2013. Within two months of the ban, the rate of exclusive breastfeeding had jumped from 55 percent to 88 percent;

- In 2012, the district Religious Affairs Office in Bener Meriah added information on I&EBF into its pre-nuptial counseling programs, which all Muslim couples planning to marry must attend. During the first six months of 2013, the program recorded a 100 percent success rate of new mothers who had attended the program breastfeeding their babies;

- Two years after Kinerja's reproductive health program was introduced in 2012, the rate of underage marriages in Bondowoso had fallen from 50.9 percent to 43.3 percent.

Education

Kinerja's education program consisted of Educational Unit Operational Cost Analysis (BOSP), School-Based Management (SBM) and Proportional Teacher Distribution (PTD), each of which was recognized by the Ministry of Education and Culture (MOEC) and LGs as critical issues that needed to be addressed to improve basic education services. Kinerja provided assistance in the education sector to 17 treatment districts.

- Simeulue and Kota Banda Aceh developed BOSP formulas and distribution systems in 2014 to achieve a more equitable distribution of BOSP funds, especially for students from low-income families;

- The LG in Bulukumba consistently stood out for its commitment to addressing funding gaps in its schools. In 2014, the district education office (DEO) allocated IDR 23.2 billion for elementary and junior high schools, up from IDR 14 billion the year before;

- Two of Kinerja's partner schools, one in Bener Meriah and the other in Kota Probolinggo, were presented with awards by their respective DEOs for their adherence to the SBM principles of transparency and accountability;

- A total of 155 partner schools published their budgets, via school committee meetings, by displaying them on school information boards;

- By the end of Kinerja's implementation period in June 2015, four of the program's six PTD districts (Barru, Bondowoso, Luwu Utara and Sambas) had collectively transferred more than 600 teachers to underserved schools;

- In 2014, Luwu Utara progressed to the final round of the UNPSA for its achievements in PTD, and won a Fajar Institute of Pro-Autonomy (FIPO) Award for the creation of the so-called *Warung Demokrasi* (literally "Democracy Café"), which provided a platform for public feedback on LG programs including PTD.

BEE

A business-enabling environment is crucial to accelerate private-sector development, especially among micro, small and medium enterprises (MSMEs). Led by its implementing partner, The Asia Foundation (TAF), Kinerja's BEE component aimed to improve business licensing at district-level one-stop shops (OSS), which the Government of Indonesia (GOI) had promoted since decentralization began in 1999. In addition, TAF was also responsible to support budget and policy advocacy through the Local Budget Study (LBS). Kinerja's BEE program was implemented in eight treatment districts: Aceh Singkil and Simeulue (Aceh); Melawi (West Kalimantan); Probolinggo and Tulungagung (East Java), and Barru, Kota Makassar and Luwu Utara (South Sulawesi).

- A total of 58 local-level regulations were issued as the legal basis to improve the licensing services and upgrade OSS status;
- On average, the time needed to obtain basic licenses was reduced by 50 percent in Kinerja's partner districts;
- Unofficial fees and bribes were virtually eliminated in Kinerja-supported OSS, due to strong standard operating procedures (SOPs) and new complaint systems that were developed and put in place;
- TAF and its local IOs developed the Provincial OSS Performance Index (POPI) survey in 2013 to evaluate the performance of district-level OSS in each province. The POPI surveys have proved beneficial in encouraging LGs to improve performance at their respective OSS.

Good Governance

Kinerja complemented its efforts to improve the provision of services in health, education and BEE by supporting initiatives that cut across the three sectors with the aim of improving the governance of public services. To this end, the program sought to engage the participation of civil society and media to promote and oversee the issue of public service-related governance, and supported the application and integration of minimum service standards (MSS) to promote reforms in health and education.

Kinerja's **media** program focused on building relationships with mainstream media to improve coverage of PSD issues; training and mentoring citizen journalists (CJs), and supporting LG public information officials (known as PPID). Kinerja also fostered links between CJs and mainstream media outlets to provide access to wider audiences and to raise public-service issues that may otherwise have gone unreported.

- Kinerja's 281 CJs produced 1,106 media products (such as articles, radio talk shows and videos) during the program's lifetime;
- Kinerja hosted two CJ festivals, in Kota Makassar in 2013 and Surabaya in 2014, to promote the use of media as an advocacy tool to improve public services. More than 600 CJs, students and bloggers attended the first festival, and around 300 attended the second;
- LG appreciation for CJs and their role in supporting PSD improvements was sometimes translated into financial support to enable CJs to continue working. In 2015, the LGs in Aceh Tenggara (Aceh) and Sambas (West Kalimantan) contributed toward the printing costs of local CJ tabloids, *Lintas Leuser Antara*, and *Suare Warge*, respectively, both of which focus on the delivery of health-care, education and business-licensing services.

With regard to **MSS**, Kinerja provided technical assistance to LG stakeholders to improve the application of service standards in the planning, budgeting, monitoring and evaluation of health and education services, as well as to improve the governance of these services based on national standards laid out in Regulation No. 65/2005 on Guidelines for the Preparation and Implementation of MSS.

- By the end of 2014, when Kinerja's monitoring of MSS ended, LGs in all of Kinerja's 20 treatment districts were applying MSS analysis to their planning documents, and all but one were applying MSS analysis to their budgets;[1]

- Approximately 70 percent of districts also successfully monitored and evaluated their MSS achievements;

- In 2015, Kinerja provided technical assistance to the Ministry of Health (MOH) after officials sought advice on determining estimated costs for integrating MSS costing into district-level annual work plans and budgets.

One of the Kinerja program's distinctive features was its focus on demand-side stakeholders – namely the end-users of public services – as well as on the LGs providing the services. The program promoted civil society engagement by establishing or revitalizing local community-based **multi-stakeholder forums (MSFs)** at both at the district level and at schools (school committees) and *puskesmas* to monitor service delivery and advocate for service improvements.

- A total of 257 MSFs were formed or revitalized by Kinerja and its partners at the SDU and district level during the life of the program (173 school committees/MSFs in education; 73 MSFs in health; six in BEE, and five CJ discussion forums);

- A total of 237 service charters were developed at Kinerja's partner schools (61) and *puskesmas* (176) in coordination with service users and MSFs. Implementation of 92 percent of these (218) were monitored by MSFs;

- Five district-level health and education MSFs (in Bondowoso, Bulukumba, Jember, Luwu Utara and Sekadau) were merged to enable them to better use their collective power to advocate for better services.

Replication

Kinerja's program design supported replication in two ways; first, by basing all its interventions on good practices developed by previous development programs and second, by implementing its interventions through local organizations, which could continue to provide services beyond the program's lifetime as well as, potentially, to further districts in new provinces. The program's strategy included documenting and disseminating good practices in health, education and BEE, and adapting and implementing those good practices at new SDUs both within its 20 original treatment districts and in additional districts.

- Kinerja staff documented a total of 40 good practices during the program's lifetime (12 in health, five in education and 23 – in health, education, BEE, MSS and good governance - contained in 17 technical modules);

- Kinerja also produced eight promotional films and 22 testimonial videos from partners and beneficiaries;

[1] Due to low commitment, the LG in Luwu, South Sulawsei, did not incorporate the district's MSS costing results into its annual budget.

- Kinerja good practices were replicated 450 times at 399 non-partner SDUs (200 *puskesmas* and 184 schools) in treatment and additional districts;

- In May 2015, TAF and the provincial government of South Sulawesi organized a mass-licensing event in all 24 districts across the province. More than 41,000 business licenses were distributed, free of charge, to small-business owners on the day, surpassing the already optimistic target of 30,000 licenses;

- By the time the program closed in September 2015, one or more of Kinerja's interventions had been replicated by LGs and SDUs in a further 55 districts in six provinces (the four target provinces plus North Sumatra and Southeast Sulawesi).

In addition to its replication efforts at the district level, Kinerja also disseminated its good practices at the national level and, in its final year of programming, at the international level.

- Kinerja collaborated with the Ministry for State Administrative and Bureaucratic Reform (KemenPAN-RB) in 2014 to organize a Symposium on Innovation in PSD in Jakarta, which was attended by Indonesia's then-Vice President Boediono. The following year, KemenPAN-RB invited Kinerja to attend a similar symposium in Surabaya, East Java;

- In 2015, Kinerja produced five policy papers (four relating to the health sector and one on education), which were well-received by MOH and MOEC officials;

- Senior Kinerja staff attended and gave presentations about the program's governance-related work at seven international conferences and forums between November 2014 and October 2015.

Lessons Learned & Recommendations

Kinerja staff learned a great deal through the successes achieved and challenges faced during the course of the program. These are described at relevant points in the following chapters, but they helped to produce many valuable lessons that, it is hoped, will be of benefit to program donors, designers, managers and implementers in the future. This section only lists the recommendations; each of the lessons behind these recommendations is examined in full in the Lessons Learned and Recommendations chapter at the end of this report.

Program Design

1. The suitability of randomized control trials (RCTs) for large-scale, multi-sector programs in Indonesia should be re-assessed.
2. Control districts may not be appropriate for social development programs.
3. Governance programs would have a greater likelihood of increased impact if implemented over a longer period of time.
4. Program timelines should be aligned with LG funding cycles.
5. Quantitative indicators should be based on data that are available and reliable.
6. Gender must be systematically incorporated into both program design and implementation.
7. M&E teams should be thoroughly involved in programs, and should give input to management on program direction.

8. Knowledge management should be a key part of program design.

Program Management

1. Cost share is an effective method of increasing ownership among government partners.
2. Programs should invest in IO capacity building, both prior to and during implementation.
3. Programs should be supported by a combination of CSOs, academic institutions, and technical experts.

Program Content and Implementation

1. Governance should be mainstreamed within all sectors.
2. Meaningful civic engagement is easier and faster to achieve in areas with strong civil society.
3. Service standards are useful in measuring public service quality and improvement.
4. OSS are a foundation on which other local economic development interventions can be built.
5. Where possible, large-scale and multi-sectoral programs should be implemented in stages.
6. Future (governance) programs that aim to respond to the needs of their partners should strive to achieve a balance between uniformity and flexibility in intervention choices.
7. Programs should work with all levels of government simultaneously.
8. Programs should strive to achieve "meaningful" replication to promote greater sustainability.
9. Replication is more effective when using pilots in combination with working with decision makers.

Children play in a village in South Sulawesi.

This final report documents achievements and lessons learned from the U.S. Agency for International Development's (USAID) Local Governance Service Improvement (Kinerja) program during its initial implementation period of September 30, 2010 through February 28, 2015, plus a no-cost extension through to an end date of September 30, 2015.[2] Kinerja was a governance program focused on improving PSD in Indonesia, awarded as Cooperative Agreement No. AID-497-A-10-00003 to RTI International and its consortium of five partners: The Asia Foundation (TAF), Social Impact (SI), SMERU Research Institute (SMERU), Gadjah Mada University (UGM) and the Partnership for Governance Reform (Kemitraan).

Program Overview

Context

Indonesia had witnessed a largely successful democratic transition during the decade leading up to the launch of the Kinerja program in 2010. However, the country continued to face a number of issues that posed a threat to its reverting to more autocratic forms of governance, such as weak rule of law, low levels of transparency and accountability, inadequate representation and persistent corruption. While district governments had been significantly strengthened over the same time period, with increases in their local budget resources and service delivery responsibilities, there remained some

[2] It should be noted that the term Kinerja in this report refers to the so-called Kinerja Core program; it does not refer to the Kinerja Papua program, which was added in March 2012 and granted a cost extension from USAID for the period September 2015 through March 2017.

critical gaps in LG capacity, most notably a lack of attention to the quality — or performance — of local service delivery. The Kinerja program was designed to close this "performance gap" and strengthen accountability and good governance among LGs by testing and replicating interventions in three sectors: health, education and BEE.

Objectives

To achieve improved performance in PSD, Kinerja employed three types of interventions:

1. **Incentives** — Strengthen demand-side entities for better services;
2. **Innovations** — Build on existing innovative practices and support LGs to test and adopt promising service delivery approaches, and
3. **Replication** — Expand successful innovations nationally and support Indonesian IOs to deliver and disseminate improved services to LGs.

Kinerja sought to apply good governance practices in PSD at both district and community levels, while its interventions were aligned with national government priorities that all regions were required to implement and that had widespread applicability with LGs. To that end, Kinerja aimed to support and enhance existing LG programs through a limited open menu of key sectoral interventions that formed the basis for the incentives, innovations and replication packages.

With better incentives, greater innovation and more avenues for replication, it was expected that LGs would deliver services that were less expensive and better and/or more responsive to local needs and preferences.

Implementation districts

One of the first tasks to be undertaken, in January-February 2011, was the selection of treatment districts in Kinerja's four target provinces of Aceh, East Java, South Sulawesi and West Kalimantan. The selection followed a highly sophisticated and innovative approach that was expected to show the extent to which governance programs actually impact sector outcomes. Regional secretaries (*Sekda*), heads of district-level Local Government Agency for Regional Development Planning (Bappeda) offices and other key government staff, as well as staff from sectoral agencies within provincial government (PG), civil society organizations (CSOs) and the media attended the selection ceremonies.

Out of 99 eligible districts across the four provinces, five treatment districts were chosen in each province according to a randomized-selection methodology previously agreed by USAID and Kinerja, making a total of 20 treatment districts for the program's implementation[3] (see Annex 2).

District governments that were considered for selection had submitted Letters of Interest that included: (1) a commitment to cost sharing; (2) a statement indicating that their district had not undergone regional demarcation or territorial reform (*pemekaran*) in the past three years and did not have plans for *pemekaran* during the life of the program, and (3) a statement indicating that they did not have an active donor program operating the same cross-sectoral approach in the district. In South

[3] Each of the 20 treatment districts chose interventions in health and/or education. Intervention to support BEE was limited to a total of eight districts, as TAF had previously provided intensive BEE support in various districts in Aceh, while the German Society for International Cooperation (GIZ) was implementing a similar program in West Kalimantan.

Sulawesi, for example, the number of districts eligible for selection was reduced to 13 due to the presence of the Australian Agency for International Development's (AusAID) Australian Community Development and Civil Society Strengthening Scheme program. In Aceh, six districts were excluded because of their participation with AusAID's Local Governance and Infrastructure for Communities in Aceh (LOGICA) program.

The idea of random selection for a program was foreign to government stakeholders and the results of the selection process were initially met with mixed reactions among Kinerja's provincial partners.[4] However, after intensive discussions and support for the program from the national level, each of the PGs accepted the final selection of districts.

In addition to the 20 treatment districts, Kinerja also randomly selected 20 control districts in response to a new strategy within USAID, which sought rigorous impact assessments of large-scale democracy and governance programming. The original aim was that Kinerja's M&E partner, SI, would produce impact evaluation (IE) results at the end of the second year (2012) and the final year (2014). However, due to a lack of good-quality and timely secondary data, Kinerja's demand-based program design and the small sample size of districts, SI conducted just one district-level impact assessment, using baseline data for 2010 and endline data for 2013. (These methodological challenges and the findings of the IE are described more fully in the M&E chapter later in this report).

Randomized selection also impacted the program in terms of where the treatment districts were located. Indonesia is a vast archipelago, which provides a challenge for any program implementing interventions in several provinces, but Kinerja faced an additional challenge by ending up with several very remote districts that were situated at great distances from other districts even in the same province. Not only did this have a negative impact on inter-district peer-to-peer learning, it also presented Kinerja with a massive logistical challenge in attempting to conduct efficient implementation and oversight in all program areas.

The issues surrounding the randomized selection of districts generally and treatment versus control districts specifically are examined in greater detail in the Lessons Learned and Recommendations chapter at the end of this report.

Kinerja Approach

Kinerja's governance approach comprised the following three main elements: (1) strengthen and enhance existing national- and district-level policies and programs (as opposed to introducing new programs); (2) support demand-side as well as supply-side stakeholders, to strengthen accountability mechanisms and enable LGs to better respond to people's needs, and (3) implement program activities through local IOs to build their capacity and encourage sustainable partnerships with LGs.

Program interventions

[4] In Aceh, although initially apprehensive about random selection, the Governor was pleased that areas that had not received development assistance in the past were selected. The PG in South Sulawesi was happy that the majority of its major ethnic groups were represented in the selection, but disappointed that the randomized approach put the program in two neighboring districts, Luwu and Luwu Utara. Kinerja faced its greatest challenge in East Java, where the PG felt objective criteria, namely the Human Development Index (HDI), should have been used to determine which districts received assistance.

The complexity of Kinerja's demand-driven program design provided a challenge to balance the demands from LGs with the need to limit the types of different interventions to a feasible number. To address this issue, Kinerja created a limited, open menu of innovation packages from which LGs could choose.

Kinerja staff undertook an extensive consultative process at the start of the program to identify core intervention areas within the three broad sectors of health, education and economic growth. Consulted stakeholders included the GOI, USAID and a wide range of donors as well as NGOs within these sectors, to discuss the kinds of governance interventions and complementary activities Kinerja could apply to improve PSD.

When designing the shape of its interventions, Kinerja took into account national legislation that was interpreted and applied at the district level, as well as the links between district-level health and education initiatives and major national government programs introduced by MOH and MOEC,[5] respectively. Therefore, Kinerja developed its district-level interventions to intersect with these national programs and build on existing innovations and training packages, and tailor its support to assist LGs and communities to make the most effective use of resources, to target services well and to monitor and improve the quality of services.

Kinerja focused on access to basic education in the education sector, and maternal and newborn child health (MNCH) in the health sector. Each of these areas were major priorities for both national and district governments in meeting the Millennium Development Goals (MDGs) and fulfilling health- and education-related MSS, as stipulated by the GOI. To this end, Kinerja developed three innovation packages to support basic education – BOSP, SBM and PTD – alongside an integrated package, I&EBF, Safe Delivery and partnerships between traditional birth attendants (TBAs) and medically-trained midwives to support the health sector.

In the business sector, the program's focus was to create a BEE through improved business licensing that would allow MSMEs to flourish. Again, the focus was in line with national government priorities, which aimed to drive economic growth at the local level. Prior to the launch of the Kinerja program, considerable work had already been carried out in the areas of diagnostic assessments, as well as service innovations involving local regulatory reform and consolidated business support through OSS. As a result, Kinerja prepared to build directly on the base of these established OSS innovations and regulatory reforms.

When implementation began, Kinerja initially worked at a few pilot SDUs in each of its treatment districts (three *puskesmas* and 20 schools per district) to act as intervention trials, while at the same time supporting LGs to build their capacity and knowledge about the interventions they had selected. This approach allowed LGs to see how governance-related innovations could be practically applied before assuming ownership and scaling up the interventions at additional SDUs in their districts.

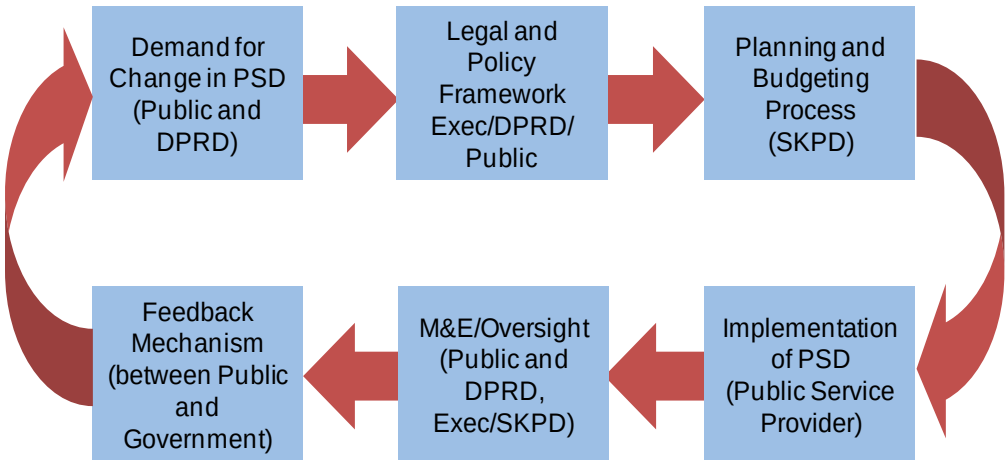
Strengthening demand-side stakeholders

[5] When the Kinerja program was launched in 2010, MOEC was known as the Ministry of National Education. The ministry's structure and name was changed in October 2011. In the interests of simplicity, this report uses the ministry's current title throughout.

Kinerja understood that in order to achieve the best and most sustainable outcomes in terms of improved PSD, it was necessary to stimulate local demand for better service delivery among the end users of those services as well as strengthening the links between that demand and improved LG response. Stimulating demand without a subsequent LG response or, alternatively, providing services that remain unused by the public are both equally ineffective.

Therefore, the program encouraged active civil society engagement by supporting the formation of MSFs at both district and subdistrict levels to ensure strong community-LG partnerships. The role and responsibilities of MSFs, as well as some of their key achievements during Kinerja's lifetime, are covered in greater detail in the Good Governance chapter of this report, but the diagram below illustrates how Kinerja's incentive (demand stimulation, community empowerment), innovation (tools directed at district governments) and replication (facilitation of LG adoption of good practices) packages fit into the PSD development cycle.

Figure 1: The Public Service Delivery Cycle



Note: DPRD = Local Legislative Council; Exec. = Executive Leadership; SKPD = District Technical Working Unit.

Each of Kinerja's innovation packages had a set of governance steps that included community input, planning, budgeting, monitoring, oversight and feedback mechanisms needed to successfully implement the innovations.

Intermediary Organizations

One of the more notable aspects of Kinerja's approach was that the program delivered all its packages through district service providers, or IOs, to build their capacity and encourage long-term sustainability. Qualified service providers were identified in each of the districts through recommendations from Kinerja's consortium partners, through organizational assessments conducted by the program's provincial and district staff, and from recognized international development partner assistance programs in Kinerja sectors. With an open bidding process in place, the CSOs were encouraged to apply for grants in their respective areas of interest. During the program's lifetime, a total of 46 grants were awarded to 36 different IOs to implement Kinerja's innovation packages in health, education and BEE, as well as the program's cross-cutting areas that included media and MSFs. (See Annex 4 for a complete list of Kinerja's IOs and their respective areas of expertise).

Working through IOs presented Kinerja with a number of challenges, however, which made it hard on occasion to guarantee the quality of the programs delivered. The key challenge was the fact that many CSOs – especially those in remote districts – lacked capacity in technical, governance, financial and/or administrative areas. While Kinerja did receive applications from some NGOs with the desired capacity, they were usually located in more central areas and were unable, whether for logistical and/or management reasons, to work in more remote regions or to provide direct support to weaker IOs already based in those regions.

In order to address this issue, Kinerja established a Capacity Development Task Force (CDTF), which was organized through the program's East Java Provincial Office. Through until its closure in June 2015, the CDTF delivered a series of workshops for Kinerja's IOs and CSO partners offering in-depth technical and administrative/financial briefings and trainings. The workshops were intended to provide technical guidance on the tools and methodologies used to implement Kinerja packages as well as to support the IOs to develop detailed annual work plans.

The trainings undoubtedly helped to increase the capacity and capabilities of a number of IOs, as evidenced by some of the achievements made during Kinerja's final operational year:

- The Women's Health Foundation (*Yayasan Kesehatan Perempuan* – YKP) produced an information handbook on reproductive health;
- Pontianak-based research institute LPS-AIR produced a study entitled *Lessons Learned Pendampingan Aktivitas: Peningkatan Peran Media dalam Advokasi Perbaikan Kualitas Pelayanan Publik Berbasis Standar dan Responsif Gender* (Lessons Learned from Mentoring Activities: Enhancing the Role of the Media in Advocating for Improved Quality Gender-Responsive and Standard-Based Services); and
- CORDIAL produced a guide for replicating SBM in schools in Barru, South Sulawesi.

Several IOs also developed their own funding proposals after attending CDTF workshops in April 2015, and a few began to bid on development programs funded by donors such as USAID and the Australian Department for Foreign Affairs and Trade (DFAT).

Despite these achievements, the issue of IO capacity was an ongoing challenge for the program and one that ideally should have been addressed before implementation began. This was highlighted by the stark contrast between Kinerja's experience with its health and education IOs and that of TAF with its BEE grantees. TAF had worked with its four implementing partners since 2005 and had already invested in building their capacity with a specific focus on the local business sector. As a consequence, TAF and its IOs entered the collaboration with Kinerja at a far more advanced stage in terms of capacity, knowledge and implementation.

Cost Share

Kinerja's cost share commitment was considerable: Initially the figure represented 17 percent of contract value. Kinerja's cooperative agreement with USAID stipulated that cost share should primarily come from the host country's government resources. RTI's plan was structured accordingly, in consultation with USAID.

In order to fulfill the program's cost-share obligation, RTI prepared a separate cost-share plan to identify potential partners in the private sector, as well as raising cost share from LGs (to achieve government ownership of programs), grantees and via voluntary contributions.

The program developed a marketing strategy, hired a local consultant to map potential private-sector industries in partner districts and a consultant to record and document the cost share raised. Activities to attract support were targeted at:

- International companies with affiliates in Indonesia, including Freeport-McMoRan and its national NGO partner, the Amungme and Komoro Community Empowerment Agency (*Lembaga Pemberdayaan Masyarakat Amungme dan Komoro* – LPMAK), Siemens, IBM-ExxonMobil, the Gates Foundation, Coca-Cola and Chevron;
- National firms, including Bank CIMB Niaga, PT Kaltim Prima Coal, PT Java Power, the Putera Sampoerna Foundation, PT Tempo Inti Media, PT Telekom and NTV.

Kinerja's efforts to reach out to the private sector - both in districts and nationally – were largely unsuccessful. The only cooperation agreement that the program managed to establish was with utility firm PT Java Power in Probolinggo, East Java, which supported the provision of health-care services in the district through its corporate social responsibility (CSR) program (see the Replication chapter later in the report for further details). Obtaining CSR funding from other private firms proved to be too complicated; some of the problems faced included the timing of proposals, which could only be forwarded on certain application dates that fell outside Kinerja's implementation cycle; some companies had existing arrangements with other development partners (such as ExxonMobil and Putera Sampoerna); several companies only wanted to support programs in the vicinity of their operations, which were not necessarily Kinerja areas, or they wanted to have tailor-made support, requiring a great deal of additional programming that would have detracted from Kinerja's focus on program implementation.

The program's efforts to attract research students from international institutions proved equally unproductive. In 2013, Kinerja contacted three research institutes – the Lee Kuan Yew School of Public Policy in Singapore; USAID's Research and Innovation Fellowship program (which is linked to nine universities in the U.S.) and the Center for Advanced Training in Rural Development (*Seminar fuer Landwirtschaftliche Entwicklung* – SLE) at Humboldt University, Berlin. However, each of the schools confirmed that they could only send researchers in late-2014, which was too late in Kinerja's programmatic cycle. The program learned a valuable lesson from these unsuccessful efforts: International cooperation needs to be established at the very beginning of a program or, better still, commitment should be obtained as part of the initial proposal stage.

Kinerja was, however, successful in securing five graduate students (four international and one Indonesian) to undertake internships. In addition, Kinerja also established a cooperative relationship with Australian Volunteers International, which provided three volunteer staff during the program's lifetime.

Given these various challenges, Kinerja decided to focus its efforts on raising cost share via the direct implementation of its program interventions.

By the start of 2015, Kinerja believed it had surpassed its cost share obligation RTI hired two experts to check if Kinerja's listed cost share covered all seven criteria as required by 22 CFR 226. They concluded that three categories of program contributions were questionable: LG budget allocations, mass media records (including many that had been reported by grantees but not marked in RTI records as mass media but rather as grantees' contributions) and trainings provided by LGs. Added to these high-risk cost-share categories, exchange rate fluctuations between the U.S. dollar and the Indonesian rupiah ultimately meant that the program's cost-share total at that point was in fact short of its original commitment.

Health

Based on these findings, RTI requested cost share relief for the Core program from USAID. In March 2015, USAID granted RTI's request. Kinerja has met its cost share obligation.

Women attend an Integrated Health Post session to weigh their new babies in Aceh Singkil.

Kinerja's health program focused on improving maternal and child health (MCH) through incorporating good governance principles into MCH services. Kinerja's work can be broadly split into three areas of support: safe delivery; I&EBF; and reproductive health.

The Kinerja health program covered a total of 19 districts. Kinerja worked with both *puskesmas* and DHOs in all districts, with an average of three partner *puskesmas* per district being selected based on geographical criteria. In general, one urban *puskesmas* was selected, along with one rural *puskesmas* and one coastal *puskesmas* in each district.

Puskesmas Management

Kinerja initially worked directly at the *puskesmas* level to improve the management of maternal health services. Kinerja worked directly with a total of 61 *puskesmas* and provided technical assistance on four interventions related to *puskesmas* management. Two of these interventions - the development of service charters and technical recommendations following the completion of complaint surveys – are described in greater detail in the MSF section of the Good Governance chapter.

The remaining two interventions were as follows:

1. Development and implementation of service SOPs. Most *puskesmas* and other health facilities in Indonesia already had medical SOPs in place, but few had developed service SOPs. Kinerja defines service SOPs as SOPs that do not outline medical procedures but rather the services to be provided. Kinerja focused on service SOPs relating to service flows (that is, procedures for registration, services, payment, medication and referral) and ante-natal care. All service SOPs developed with Kinerja's support were created in a transparent and consultative manner, involving all *puskesmas* staff, and once finalized, were displayed on the *puskesmas* walls in order to ensure compliance from staff and to build awareness of health rights among patients seeking health care.

> ***"With Kinerja's support, a really significant** change has taken place at our* puskesmas *- a change in mindset, a change in thinking. We **don't just think about doing our rout**ine tasks; **we now think of ourselves as 'agents of change',** that we can introduce innovations to the* puskesmas ***to make it better."***
>
> Head of Puskesmas Semparuk in Sambas, West Kalimantan

2. Development and implementation of complaint-handling mechanisms. In addition to supporting the running of complaint surveys, Kinerja provided technical assistance to partner *puskesmas* on establishing complaint-handling mechanisms or improving existing ones. In general, support was focused toward suggestion boxes, feedback forms and SMS feedback systems.

Key Achievements

- Eighteen out of 19 partner districts developed and signed regulations on *puskesmas* management, safe delivery, and I&EBF. The final district, Kota Banda Aceh, elected not to develop a new regulation, as the LG felt the existing Islamic law was sufficient;

- All 61 partner *puskesmas* in the Kinerja program signed service charters. This was an important achievement for Kinerja, as adopting public input as a primary driver of public policy is still a

novel intervention in the Indonesian context. Eighty-five percent of pledges made were implemented;

- The implementation of public complaint surveys became a pre-condition for achieving financial autonomy (BLUD) status in the district of Sambas. BLUD status allows *puskesmas* to retain the revenue they earn from services to purchase medical supplies, pay for basic facility maintenance and even hire additional personnel;

- Partner *puskesmas* throughout Aceh, East Java and West Kalimantan are now using Kinerja's "control cards" to monitor the implementation of ante-natal SOPs and provide an opportunity for patient feedback. Kinerja's partner *puskesmas* in East Java liked the control cards so much that multiple centers chose to develop additional control cards for other MCH services, such as intra-natal and post-natal care;

- The LG in Sambas, West Kalimantan, found Kinerja's approach to be so beneficial that they gave a multi-year contract to Kinerja's IO, the Indonesian Family Planning Association (*Perkumpulan Keluarga Berencana Indonesia* -PKBI). By the end of 2015, the PKBI had assisted the scaling up of Kinerja's interventions to all 27 *puskesmas* (after beginning in just six *puskesmas*) in Sambas, and was in talks with the DHO to expand its assistance to the district's two public hospitals.

Safe Delivery

Kinerja's safe delivery program focused on two interventions:

1. Developing or revitalizing partnerships between TBAs and midwives. The objective of TBA-midwife partnerships is to decrease maternal mortality rates through safe delivery with skilled attendants, by combining the medical knowledge of midwives and the community connections of TBAs. Most partnerships stipulate a shift in the role of TBAs away from clinical procedures to supporting the non-medical aspects of delivery, such as providing massages and prayers. TBA-midwife partnerships have long been an Indonesian government program, but a top-down approach has kept them from reaching their full potential for impact. Through partnerships that are genuinely participatory and offer compelling reasons for participation, TBAs are more inclined to encourage local women to give birth at health centers with the assistance of midwives.

2. Developing or revitalizing pregnancy information systems (*kantung persalinan*) at the *puskesmas* level. Literally meaning "delivery pocket", *kantung persalinan* is a rudimentary paper-based information management system that files medical summaries of expectant mothers by their due dates. Through using *kantung*, *puskesmas* are better able to plan for upcoming needs and anticipate potentially risky deliveries by ensuring that midwives are aware of patients' needs and will be available during the delivery.

Box 2: Aceh Singkil wins 2015 UNPSA

On May 7, 2015, the Aceh Singkil DHO learned that it had won second place in the 2015 UNPSA for reducing maternal and infant mortality by fostering partnerships between TBAs and medically-trained midwives.

The UNPSA constitute the most prestigious international recognition of excellence in public service, rewarding the creative achievements and contributions of public service institutions that lead to more effective and responsive public administrations worldwide.

Aceh Singkil is one of 23 districts in the province of Aceh, and its 110,000 residents are served by 11 community health centers scattered across the district. Before these partnerships were introduced in 2012, many babies were delivered by TBAs.

Although medically-trained midwives were available, TBAs held trusted positions within the community, and their low cost made them an attractive alternative to a large number of families, especially those in more remote areas far from health facilities. However, TBAs often lacked any kind of medical training or understanding of proper birthing procedures. As a result, they were ill-equipped to handle complications that threatened the health of mothers and their babies.

With Kinerja support and assistance, the Aceh Singkil DHO launched a pilot project in 2012 to forge partnerships between TBAs and midwives at two *puskesmas* in the district. Since then, the program has gained momentum and widespread support, resulting in more women choosing to have their babies in health centers where they are treated by midwives assisted by TBAs. In 2013, the maternal mortality rate in the district fell to zero, and as of the end of June 2015, partnerships had been implemented in a total of 29 villages, with LG plans in place to roll them out across the entire district.

Responding to the win, the DHO Head expressed his thanks to all those who had made the program such a success: "The people of Aceh Singkil are very grateful to have received this award. This initiative has helped to improve the quality of health-care services in the district, and we offer our wholehearted thanks to USAID-Kinerja for its support."

Representatives from the Aceh Singkil LG were presented with their award at the 2015 UNPSA ceremony and forum in Medellín, Colombia, on June 23-26, 2015.

Key Achievements

- Simeulue recorded zero maternal deaths for the first time ever in 2013. The head of the DHO credited Kinerja's distinctive approach to TBA-midwife partnerships as being a key contributing factor;
- At Puskesmas Sukamaju in Luwu Utara, South Sulawesi, the number of births assisted exclusively by TBAs fell from 39 in 2011 to just two in 2014;
- For its innovative approach to TBA-midwife partnerships, Aceh Singkil was awarded second place in Asia Pacific in the PSD category of the 2015 United Nations Public Service Awards (UNPSA) in 2015. This was the first time Indonesia had won a UNPSA (see Box 2 above).

Immediate & Exclusive Breastfeeding

Kinerja's emphasis on the importance of I&EBF was based on breastfeeding's proven role in reducing infant death, improving nutritional status, and reducing the frequency of diarrheal illness. Awareness of the benefits of I&EBF is low in Indonesia, and nationally, only 30 percent of babies are exclusively breastfed. This is primarily due to a preference for formula milk among parents, who often believe it is healthier and better for the baby, in addition to formula milk being more "practical". Formula milk is also somewhat of an aspirational issue, with many parents choosing not to breastfeed because of its association with poverty and rural lifestyles.

Kinerja's breastfeeding interventions aimed to increase the percentage of I&EBF, to incorporate immediate breastfeeding into SOPs and to demonstrate the links between a mother's nutritional status and her baby's health. Kinerja's primary focus was on raising awareness of I&EBF among both health workers and the community.

I&EBF promotion covered a wide range of activities, including:

- Developing new and improving existing promotional materials such as posters, leaflets and banners;
- Revitalizing and improving *kelas ibu hamil* (pregnancy classes) to make them more fun and participatory, and to ensure they include accurate information on breastfeeding;
- Training non-health professionals such as vegetable sellers, bridal make-up artists and herbal medicine sellers on the importance of breastfeeding;
- Including breastfeeding counseling in ante-natal care check-ups;
- Banning the promotion and sale of formula milk at *puskesmas*;
- Establishing breastfeeding rooms or corners in *puskesmas*, hospitals, government offices and public places such as stations and markets, and
- Selecting breastfeeding ambassadors to promote breastfeeding in the community.

Key Achievements

- Since beginning to work with Kinerja, *puskesmas* have become more aware of the importance of interventions such as I&EBF. Puskesmas Sungai Raya Kepulauan in Bengkayang, West Kalimantan, for example, assisted more than twice as many women in 2013 as in 2012 to immediately breastfeed their babies after birth (208 in 2012 versus 451 in 2013);

- The *puskesmas* and MSFs in Kota Makassar supported the development of ASI advocacy groups such as *Bapak Peduli ASI* (Fathers who Care about Breastfeeding) and *Kelompok Peduli ASI* (Groups who Care about Breastfeeding), complete with T-shirts, stickers and songs promoting the importance of I&EBF among families and the public at large. The fathers in these groups advocated for the banning of the promotion and sale of formula milk near health facilities, carried out spot-checks that made sure *puskesmas* were not selling formula milk (illegal under Indonesian law), and made house visits to expectant and new mothers to discuss breastfeeding;

- Although concrete data are difficult to obtain, anecdotal evidence in Kota Makassar suggests that I&EBF promotion efforts are having the intended effect. The head of a *posyandu* (integrated health service post) said, "Before, nine out of 10 babies in seven subdistricts were fed with formula milk. Now, that figure has been almost entirely reversed, with eight out of 10 babies receiving breast milk today. The impact is clear – from their weight, height, skin condition and the frequency of illness – between babies fed formula milk and babies who are breastfed;"

Box 3: Clinic plays central role in breastfeeding increase

As part of a broader campaign to increase breastfeeding, Kinerja partner Puskesmas Beji in Tulungagung, East Java backed out of its contract with a formula milk company; as of May 2013, the clinic's staff were no longer permitted to serve as distributors for the product.

The bold decision, taken by the head of the *puskesmas*, brought the community health center in line with demands from a citizen oversight board and also coincided with a new district regulation that prohibited the distribution of formula milk at public health facilities.

"In truth, I was the one who originally signed the contract, so it only follows that I should be the one to break it [...] I am providing an example to all of my staff – nothing is difficult if we have a strong desire [to change]," said Puskesmas Beji Director.

The effects have been dramatic. Between May and July 2013, Puskesmas Beji saw the percentage of mothers undertaking exclusive breastfeeding rise from 54.65 to 87.5 percent.

In addition to prohibiting hand-outs of formula milk, Puskesmas Beji took aim at a local belief that babies only cry when they are hungry, and that formula milk is a necessary dietary supplement.

"We provided counseling to pregnant women and their families, beginning with their pre-natal checkups, and continuing through delivery and beyond," said a midwife at Puskesmas Beji. "We also developed a class for pregnant women in two villages as a pilot, namely Sobontoro and Beji, as a way to underscore the importance of exclusive breastfeeding."

Local media, including radio stations Perkasa FM, LIUR FM and Kembang Sore FM, covered the story and in doing so helped to raise awareness of the importance of breastfeeding and drew attention to positive policy decisions.

- A local "super food" known as *daun katuk* (*sauropus androgynous*) has historically been used throughout Indonesia to stimulate breastmilk production in new mothers. One of Kinerja's partner districts, Probolinggo, decided that the effects of *daun katuk* were too good to ignore, and developed a regulation requiring all health facilities to grow the plants in small on-site gardens. Seedlings are given to expectant mothers to plant in their own gardens at home, and meals of *daun katuk* and another nutrient-rich leaf, *daun kelor* (*moringa oleifera*), are regularly given to mothers who have just delivered at *puskesmas*;

- The local Religious Affairs Office in Bener Meriah began working with the DHO and nearby *puskesmas* in 2012 to add information on I&EBF into their pre-nuptial counseling programs. All Muslim couples planning to marry must attend such counseling sessions, which are held around five times a year. The Religious Affairs Office now provides booklets on how Islam supports breastfeeding, and even invites local midwives to provide breastfeeding information during the sessions. During the first six months of 2013, the program recorded a 100 percent success rate among new mothers, who had attended pre-nuptial counseling, breastfeeding their babies.

Consolidation and Scaling Up

In addition to these key intervention areas, Kinerja also supported districts to develop regulations on key issues of maternal and child health, such as guaranteeing access to ante-natal care, enshrining the right of mothers to breastfeed, and outlining the importance of safe delivery. These regulations aimed to ensure the sustainability of the changes that resulted from the Kinerja program.

In response to the findings of an audit conducted by USAID in 2013-2014, Kinerja focused its efforts on ensuring that reforms were sufficiently institutionalized within not just its partner *puskesmas* but within DHOs. The health team thus focused on improving DHOs' understanding and knowledge of Kinerja's interventions and the best way to implement them, with a particular emphasis on how to scale up and undertake M&E.

Reproductive Health

Following a request by the District Head of Bondowoso, East Java, Kinerja carried out a pilot project in 2012 in response to his concerns about high maternal mortality rates and the number of junior high school drop-outs due to the prevalence of early marriage in the district. The District Head was interested in addressing these problems through prevention of early marriage and campaigns for reproductive health for the young people in the area. He further emphasized that he wished to improve the district's standing on the HDI by improving the quality of health and education services, in particular for young adults. Factors such as poverty, local beliefs that allow children of a certain age group to be married, and the lack of access to information and reproductive health services also play a significant role in perpetuating this situation. Since Kinerja's main focus in Bondowoso was to support the delivery of MCH services, it was mutually agreed that Kinerja would focus on the important issue of reproductive health education for young people. The program aimed to increase awareness of students and stakeholders regarding the need for reproductive health information to prevent early marriage in Bondowoso.

The government of Bondowoso assumed ownership of Kinerja's activities, and was involved in all stages, from selecting pilot schools and developing policies through to providing funds and participating in events. In 2012, 200 junior high school students attended information sessions about delaying marriage, 25 teachers from 12 schools were trained on reproductive health, and 20 students from five schools became peer educators. These teachers and students trained more teachers and students from another 28 schools in 2012 alone. In addition to working with local stakeholders, Kinerja's IO, the Women's Health Foundation (*Yayasan Kesehatan Perempuan* - YKP) also used print media and radio to communicate the activities to the general community. YKP, together with another local organization*, Kampung Halaman*, conducted training for students on poster and video making, as well as organizing competitions to use different media to communicate the issues. The response was very positive. For each training session, where only 50 seats were available, more than 300 students signed up.

By 2014, the program was expanded to even more schools and reproductive health and early marriage information had become part of the student enrolment activities. All incoming junior high school students in July 2014 took part in these sessions. The peer education program also dramatically expanded, and by the end of 2014, a total of 279 students had been trained to become peer educators across all 23 subdistricts in Bondowoso.

Local efforts to ensure the program's sustainability were given a real boost in 2015 by the attention they began to attract internationally. First, Kinerja supported KemenPAN-RB to nominate Bondowoso for the 2015 UNPSA for its progress in promoting reproductive health and tackling the problem of early marriage; the district made it through to the second round. In March 2015, to coincide with International Women's Day, a feature article about Lina – one of the founding members of the Blue Sky Community – was published on Buzzfeed (click on Lina's photo above to access the article).

Students at an elementary school in Luwu Utara, South Sulawesi.

Kinerja's education program consisted of the BOSP, PTD and SBM packages. These three interventions were chosen because they were recognized by MOEC and LGs as critical issues that needed to be addressed in order to improve services in basic education. Kinerja made use of tools that had previously been developed by LGs with assistance from other PSD development programs to introduce innovative education reforms, with a focus on facilitating implementation, oversight, feedback and response mechanisms. The program provided assistance in the education sector to a total of 17 treatment districts: SBM (9), PTD (6) and BOSP (3).[6]

Educational Unit Cost Analysis

Kinerja worked with DEOs in three partner districts (Bulukumba, Kota Banda Aceh and Simeulue) to calculate the financial gap between annual national government funding and the operational expenditures required to meet nationally-mandated MSS through the BOSP package. Since 2005, the national government has provided School Operational Assistance (*Bantuan Operasional Sekolah* - BOS) to support elementary and junior high schools nationwide to meet their operational costs. According to several surveys, however, the BOS payments were insufficient to meet many schools' operational

[6] Barru in South Sulawesi elected to implement both SBM and PTD, but was only counted once in the overall total of 17 districts.

needs.[7] Many districts were willing to cover financial shortages in order to improve educational outcomes for students, but they did not know how to calculate the gap between the two.

Utilizing the BOSP analysis tools that were originally developed by USAID's Decentralized Basic Education program, Kinerja assisted DEO officials and other relevant stakeholders to analyze their educational unit costs as a basis for determining overall education allocations. The analysis was used to assess whether financial gaps existed; if they did, the LG could fill them using district or provincial annual budget funds and/or community contributions.

Box 4: Simeulue addresses BOS gaps

With Kinerja support, the LG in Simeulue calculated in 2012 that annual per student operational costs for its elementary schools stood at IDR 675,543 and for junior high schools, at IDR 787,133. As national government BOS funding amounted to only IDR 580,000 per student at elementary school and IDR 710,000 per student at junior high school, resulting gaps emerged of IDR 95,543 and IDR 77,133 for elementary and junior high school students, respectively.

Although Simeulue had yet to issue a formal regulation on BOSP, the LG began distributing an additional IDR 15,000 per student in a preliminary step toward addressing the gaps. In 2013, the LG then increased its funding allocation to IDR 77,000 for students at junior high schools, while the DEO earmarked an additional IDR 79,543 per student per year in 2014 to address the remaining shortages in elementary schools.

Key Achievements

- In Simeulue, the LG began to disburse funding to schools even before its formal regulation on BOSP was issued. In 2012, the government distributed IDR 15,000 per student per quarter in a preliminary step toward addressing the financial gaps that Kinerja's analysis later revealed. In 2013, the funding increased to quarterly payments of IDR 77,000 per student in junior high schools to fill the gap;

- Simeulue also developed a BOSP distribution system in 2014 that took into account the poverty status of each school's student body in order to achieve a more equitable distribution of BOSP funds;

- Similarly, Kota Banda Aceh developed a revised BOSP distribution formula to provide additional funding to small schools and schools with large numbers of students from low-income families;

- Bulukumba consistently stood out for its commitment to addressing funding gaps facing its schools. In 2014, for example, the DEO allocated IDR 23.2 billion for elementary and junior high schools, up from IDR 14 billion the year before.

School-Based Management

SBM is a reform that seeks to increase autonomy for schools in making decisions about their management, including use of funds, materials and human resources. Under the national government's BOS program, referred to above, school committees were established at schools nationwide to run SBM programs, with authority over non-salary operational expenditures. By channeling funds directly

[7] In 2012, when the Kinerja program began implementing its BOSP package, the national government paid the following in BOS payments: IDR580,000 per student per year at elementary schools, and IDR710,000 per student per year at junior high schools. As of January 2015, the national government increased these annual amounts to IDR800,000 per elementary school student, and IDR1,000,000 per junior high school student.

Box 5: School enhances participation, accountability in school funding

One of the biggest challenges for schools in Indonesia as they strive to meet national service standards lies in the availability of adequate resources. Although the national government provides some funding to support schools' daily operations, this is often inadequate and a lack of public trust can limit schools' abilities to raise additional funds from parents and community donations.

However, one school in Melawi, West Kalimantan demonstrated that increased transparency and accountability opens doors for new funding opportunities from the local community and the private sector.

Starting in 2011, SMPN 1 Belimbing assessed its ability to meet nationally-mandated service standards, and identified critical areas in need of further attention, such as teacher and student discipline and financial management, under Kinerja's SBM component.

To address these needs, Kinerja's local office as well as its IO partner, the Institute for Society and Development Studies (*Lembaga Pengkajian Kemasyarakatan dan Pembangunan* – LPKP) helped the school facilitate discussions with parents, the school committee, community leaders and representatives from local businesses to develop a transparent annual budget.

This open and participatory process not only raised community awareness of the financial difficulties facing the school, but also promoted a sense of ownership of the budget they had drafted together. As a result, the school was able to raise an additional IDR 125 million in donations from parents, community members and local businesses in order to improve the school's facilities and provide extra lessons.

The principal of SMPN 1 Belimbing expressed her optimism about the long-term benefits of Kinerja's SBM program. "School-based management helps to boost schools' power to improve their services and also helps them and their local communities to build a common understanding on the expected quality of education services," she said.

to schools, education stakeholders such as parents, principals and school committees were empowered to choose the best way to allocate funding to address the challenges they faced.

Despite this initiative, many schools were failing to implement these plans and/or did not consistently produce financial reports. Through its SBM package, Kinerja adopted a more holistic approach to assist all school stakeholders, together with members of the local community, to establish better governance through an institutionalized and integrated planning and budgeting process that would help identify each school's respective needs and priorities.

Kinerja's SBM package comprised the following six stages: (1) the introduction of education service standards; (2) a community complaint index and school self-evaluation; (3) the participatory preparation of school plans and budgets involving school principals, teachers, school committees and community leaders; (4) the transparent and accountable application of these school plans and budgets; (5) the strengthening of school committees to oversee the implementation of the school plans, and (6) the strengthening of school committees to conduct advocacy with decision makers on the implementation of agreed service charters.

Nine treatment districts implemented Kinerja's SBM intervention: Aceh Tenggara and Bener Meriah (Aceh); Jember and Kota Probolinggo (East Java); Barru (South Sulawesi), and Bengkayang, Kota Singkawang, Melawi and Sekadau (West Kalimantan).

Key Achievements

- Despite being a relatively novel concept in Indonesia, a total of 176 Kinerja-supported schools conducted public complaint surveys to gather feedback on education services. The schools then developed service charters based on the survey results. (Please see the MSF section in the Good Governance chapter for more information about complaint surveys and some of the issues commonly dealt with in service charters);

- Overall, 81 percent of all complaints raised through the surveys were addressed. Most of the partner schools integrated the survey results into their annual plans and budgets and secured funding to improve their services;

- With technical assistance from Kinerja, a total of 155 partner schools published their budgets, via school committee meetings, by displaying them on school information boards;

- Strong partnerships between schools and community members developed in many partner districts. In Bener Meriah, where resource limitations were a significant challenge, community representatives who were members of the district-level MSF successfully advocated the local legislative council (DPRD) for additional funding based on needs identified in complaint surveys. As a result, the LG allocated IDR 8 billion in 2014 to address the lack of classrooms, toilet facilities and essential materials, such as desks, chairs and books;

> ***"With [SBM's] focus on public services, and*** *especially its emphasis on public engagement, the management of schools [in Kota Probolinggo] has become more open, while school programs are better planned, directed* ***and more participatory."***
>
> Head of the DEO, Kota Probolinggo, East Java

- Two of Kinerja's partner schools, one in Bener Meriah and the other in Kota Probolinggo, were presented with awards by their respective DEOs for their adherence to the SBM principles of transparency and accountability.

Proportional Teacher Distribution

Evidence gathered through MOEC's BERMUTU pilot program (2007-2013), which was funded with support from the World Bank, showed that although many districts had an oversupply of teachers, large discrepancies existed between urban and rural areas: Most teachers tended to be concentrated in urban schools, while only a few were willing to work in more remote regions. Through its PTD package, Kinerja assisted DEOs in six districts[8] to review and analyze relevant education data in order to address these imbalances at elementary and junior high schools in order to achieve a more even distribution of teachers – both in terms of overall numbers as well as in specific subject areas.

In its approach, Kinerja aimed to create an environment in which DEO staff collaborated with relevant stakeholders in their administrations through district-level MSFs to implement incentive strategies to encourage teachers to work in remote or otherwise underserved areas. It should be noted, however, that PTD involved political, social and economic considerations – not only for district governments but also for teachers – which in practice meant that the best-performing districts were those that had the strongest commitment to the program. The implementation cycle for PTD, from working out initial calculations of where teachers were based through to conducting actual transfers, was also extremely time-consuming. This was due primarily to challenges in obtaining valid, current

[8] Aceh Singkil (Aceh); Bondowoso (East Java); Barru, Luwu and Luwu Utara (South Sulawesi), and Sambas (West Kalimantan).

teacher data. Despite these combined challenges, Kinerja achieved considerable success with its PTD implementation, as detailed below.

Key Achievements

- Five Kinerja partner districts completed PTD calculations and issued supporting regulations, while four of the five (Barru, Bondowoso, Luwu Utara and Sambas) had successfully conducted teacher transfers by the end of June 2015;[9]

- Barru reassigned 326 elementary, junior high and senior high school teachers in 2014. Although Kinerja's PTD package did not include senior high schools, Barru was keen to maximize the benefit of the program's technical support by implementing transfers throughout its school system;

- As of the end of June 2015, the DEO in Barru was reviewing a further 40 teachers for transfer to underserved schools;

- Luwu Utara transferred 128 elementary school teachers to underserved schools in early 2014, and proceeded to reassign a further 37 teachers to junior and senior high schools in 2015. Luwu Utara's achievements in PTD were recognized in 2014 when the district became a finalist in the UNPSA, marking the first time that an Indonesian entry had made it through to the final round of the prestigious awards;

- Kinerja and its media IO JURnal Celebes supported the development of *Warung Demokrasi* (Democracy Café) in Luwu Utara, which invested a great deal of time and energy advocating for the implementation of PTD. These efforts were rewarded in 2014 with a Fajar Institute of Pro-Autonomy (FIPO) Award for Public Participation (see Box 9 in the Media section of the Good Governance chapter for further details);

Box 6: Bappenas impressed with Kinerja's PTD, SBM reforms in Barru

Kinerja supported field visits in May 2015 for Bappenas' Director for Poverty Reduction, to two of Kinerja's treatment districts in South Sulawesi: Barru and Luwu Utara. Kinerja Chief of Party accompanied *the Director* to Barru, where they met with the district head and the head of the DEO.

DEO Head confirmed that the district was continuing to implement Kinerja's PTD component, adding that in addition to the 326 teachers that had already been reassigned to underserved schools at the start of FY 2015, another 40 teachers had been earmarked for transfer. *The DEO Head* also said that Barru's PTD program had been developed on the district's positive experience of implementing Kinerja's SBM package, which he maintained was now being implemented at all schools across Barru.

The Bappenas Director said he was very impressed with what he had seen and heard, based on the accounts related to him by LG officials. He was especially interested to see the way in which Kinerja responded to the requests of its LG partners rather than imposing a particular program, and how through building their capacity, LGs were encouraged to assume ownership of the entire implementation process. He acknowledged that in this way, Kinerja helped to change the mindset of government staff and created a sense of enthusiasm among them to provide excellent services.

In particular, *he* said he was keen to work more closely with Kinerja in the future, to learn more about program's governance approach with its emphasis on establishing linkages between LGs and civil society to work together to improve public services.

As a direct result of these visits, Bappenas organized a two-day workshop in June 2015, entitled "LG and CSO Collaboration to Improve Access to and the Quality of Services in the Frame of Poverty Alleviation". Kinerja supported the workshop by providing two resource persons: the deputy district head of Luwu Utara and the head of the DEO in Bener Meriah, each of whom recounted their experiences of collaborating with Kinerja to improve the governance of education services in PTD and SBM, respectively.

[9] Considering the challenges faced in implementing PTD, this was a significant achievement, and one that was all the more impressive considering the fact that prior to the start of the Kinerja program, only two districts in Indonesia had completed the PTD cycle and actually transferred teachers: Kota Gorontalo in Gorontalo province and Tanah Datar in West Sumatra.

- In Bondowoso, the DEO reassigned 98 teachers in 2015 (four kindergarten, 82 elementary, 10 junior high, and two senior high school teachers). This achievement was all the more impressive given that less than a year before the transfers the DEO was faced with a net shortage of teachers and had to initially source new teaching staff from elsewhere;

- The Sambas DEO transferred 18 elementary school teachers in May 2015, with plans in place to reassign more teachers later in the year and again in 2016.

A young woman gets her first business license during a licensing festival in South Sulawesi.

The BEE is important to accelerate private sector development, particularly micro and small enterprises (MSEs), which according to research carried out in 2011, comprised 96 percent of Indonesia's workforce but only contributed 57 percent to the economy.[10] Business licensing is an important aspect of BEE that is also related to PSD at the local level. The GOI began promoting the establishment of OSS for business licensing with decentralization in 1999, and this accelerated during the following decade.

Although the number of established OSS had increased significantly by the launch of the Kinerja program in 2010, most of them lacked authority, clear business processes and good governance. Therefore, Kinerja's BEE intervention directly addressed each of these three areas, as detailed below. To support the implementation of BEE, one of Kinerja's core partners, TAF, provided technical assistance to improve the quality of service provision at OSS in eight of Kinerja's 20 treatment districts.[11]

[10] IFC (2011) *Strengthening Access to Finance for Women-Owned SMEs in Developing Countries.*

[11] Aceh Singkil and Simeulue (Aceh); Probolinggo and Tulungagung (East Java); Barru, Kota Makassar and Luwu Utara (South Sulawesi), and Melawi (West Kalimantan).

License Simplification & Increasing OSS Authority

Gaining basic licenses such as building permits and company registration can be a complicated process in Indonesia. Kinerja aimed to make this process easier, faster and more transparent, and one of the most effective ways to achieve this was by simplifying licensing requirements.

By reducing the different types of licenses required – through repealing or merging licenses – the burden on private firms to obtain various licenses and the opportunity for LG officials to engage in corruption is significantly reduced. With the authority for licensing transferred to the OSS, private firms do not need to go to various local government departments to obtain various types of licenses, while the time, cost and number of requirements to obtain them can be reduced and governance improved.

Box 7: Kinerja's support for OSS

The concept of an OSS is contained in its name: It should be a single place where entrepreneurs can attend to all their business-licensing requirements. In practice, however, this was rarely the case. Kinerja found a wide range of different ideas about what constituted an OSS, which reflected a lack of understanding about the goal of simplifying business licensing

In some districts, for example, OSS were little more than a front office. Once a businessperson placed a request, it was sent to various government agencies to undergo time-consuming processing. In these districts, TAF and its implementing partners worked with LGs to transform the OSS into contained units that could handle all aspects of business licensing. Kinerja also worked with government stakeholders to undertake policy reviews and initiate the necessary changes to make their licensing centers efficient.

In other districts, such as Tulungagung, the OSS were functioning well and issuing licenses with good management tools and SOPs. In these cases, Kinerja supported the LGs to refine and improve their management and governance systems.

Kinerja also supported districts to upgrade their OSS' organizational status, to increase the power of the OSS vis-à-vis other local technical offices. This was a highly political and difficult task and needed a good understanding of the political environment in a district.

Key Achievements

- A total of 58 local-level regulations were issued as the legal basis to improve the licensing services and upgrade OSS status;

- In order to streamline approval processes and make the licensing system less confusing, in many districts there was a dramatic reduction in the number of licenses that needed to be obtained by businesses. For example, in Luwu Utara, a district head regulation was issued to reduce the types of business licenses from 150 to 57 and to transfer the licensing authority of all licenses to the OSS. In several sectors, the types of licenses required were significantly reduced – 28 types of licenses in health sector were reduced to three, 11 different types of licenses in tourism and the livestock sector, respectively, were reduced to one each, and 10 types of licenses in the forestry and plantation sectors were reduced to just three;

- There was a reduction in the time required to issue basic licenses such as building permits, company registration certificates, and trade location permits. On average, the time needed to obtain basic licenses was reduced by 50 percent in Kinerja's partner districts. In Simeulue, for example, it previously took 30 days for a building permit to be issued, but by 2012, it only took 14 days, while the time needed to produce a company registration certificate fell dramatically from 30 days to just one day.

Improving OSS Business Processes

Kinerja supported two main interventions to improve OSS business processes: The first was the development of SOPs and service standards (*standar pelayanan* - SP) on processing business-license applications and a control card to monitor SOP/SP implementation. The newly-developed SOPs and SPs include specific time, cost and document requirements that are shorter, cheaper and simpler than previously existing ones. The program also supported parallel processing of license applications to reduce the overall time for licensing even further.

The second intervention was the establishment of OSS technical teams, which comprise representatives of LG offices to review the technical aspects of license applications. The teams assist in simplifying the licensing process and give the OSS full control. In addition, capacity building and training was provided to OSS staff and technical team members to implement the SOPs, SP and complaint mechanisms.

Box 8: Barru cuts through red tape with new OSS

Business licensing is often cited as one of the most challenging hurdles facing SMEs, which make up the bulk of Indonesia's economy.

A lack of procedural clarity and the need to acquire approval from a variety of separate government entities creates confusion, inefficiency and a temptation to use bribery to facilitate the processing of routine documents.

To remove these barriers and make registering a business and applying for operational licenses easier, the administration in Barru, South Sulawesi, launched a new OSS in November 2012.

The South Sulawesi Governor and Barru District Head attended the event and distributed more than 1,800 licenses, free of charge, to local small business owners.

The Kinerja program, through its implementing partner TAF and IO for BEE in South Sulawesi, the Prosperous Justice Foundation (*Yayasan Adil Sejahtera* - YAS), provided additional technical assistance to improve operating and management systems at the new regulatory clearinghouse.

This assistance was recognized by Barru District Head at district anniversary celebrations in February 2013, when he highlighted the impact of the support provided by Kinerja and its partners.

"The USAID-Kinerja program has contributed to the improvement of public services and the investment climate in Barru, especially in the [business] licensing sector, which in 2010 only issued about 590 permits with a combined capital value of approximately IDR 42 billion. Compare this to what was achieved in 2012, when we issued around 4,900 various licenses with a total capital value of IDR 471 billion," he said.

Kinerja supported KemenPAN-RB's nomination of Barru for the 2014 UNPSA for its achievements in BEE. The district went on to become one of three Kinerja-supported districts to make it to the final round – a first in Indonesia at the time.

Key Achievements

- Technical guidelines for Micro and Small Enterprise Licenses (IUMK) were formulated and adopted by the Ministry of Home Affairs (MOHA);
- Some OSS existed on paper but only began operating fully after receiving technical assistance from Kinerja. One such example was in Simeulue, where the OSS had no authority to issue licenses through until 2011. The following year, however, it was granted authority to issue 12 different types of licenses and then in 2013, its authority was increased to cover 48 types of licenses;
- Unofficial fees and bribes were virtually eliminated in Kinerja-supported OSS, due to strong SOPs and new complaint systems being developed and put in place. Basic licenses that were free *de jure* are now also free in practice;

- Kinerja supported the establishment of new office buildings for a number of OSS, such as in Aceh Singkil, Barru and Luwu Utara;

- TAF supported the creation of an internship program for OSS staff, allowing them to see for themselves how OSS were run in other districts. Selected staff from the OSS in Simeulue and Aceh Singkil, for example, spent a week working at the OSS in Kota Banda Aceh in 2014.

Improving OSS Governance

To improve the governance of OSS, Kinerja supported two key areas: the development of complaint-handling mechanisms and the implementation of enhanced customer satisfaction surveys (*indeks kepuasan masyarakat* - IKM). These feedback mechanisms allow the OSS to improve their service quality. Kinerja also worked to improve the transparency of licensing information and to support better interactions among the government, the OSS, the private sector and local communities, through face-to-face dialogue, festivals and radio programs.

> ***"Many businesses used to operate illegally*** *because the procedures to get a license were so complicated. But now that things are simpler, many businesses have legalized their operations. Small businesses are growing rapidly, and the best outcome is the significant* ***increase in investment."***
>
> Member of the Business Licensing Working Group, Barru

Key Achievements

- All eight partner OSS were supported to implement IKM with enhanced methodology and have made licensing information publicly available;

- Six OSS established complaint-handling mechanisms, such as complaint boxes and SMS feedback systems;

- TAF and its local IO partners developed the POPI survey in 2013 to evaluate the performance of district-level OSS in each province and disseminate the results to all of them. The POPI survey has been beneficial in encouraging LGs to improve their OSS performance.

Local Budget Study

TAF engaged Seknas FITRA to conduct a Local Budget Study (LBS) in 2011 and again in 2015. The study consisted of a Local Budget Index (LBI) – to measure the quality of governance throughout the budget cycle – and Local Budget Analysis (LBA) – to measure the budget allocation and execution quality – in each of Kinerja's 20 treatment districts.

Based on the LBI for 2015, in general the quality of budget governance among the 20 Kinerja districts had improved compared to 2011. With regard to improved transparency, although all of the Kinerja districts had appointed local government PPIDs and formulated SOPs in information provision, the results of budget-document accessibility tests were not significantly improved from 2011. In terms of participation, there was significant improvement in public participation forums in several stages of the budget cycle, beyond the traditional development planning meetings (*musrenbang*). With regard to accountability, most of Kinerja's partner LGs improved their timeliness in submitting and issuing various budget documents. Similarly, the audit results of the State Audit Agency show improved quality of local financial management – no Kinerja district received a disclaimer or unaccepted opinion.

Ninety percent of Kinerja districts had established procurement service units and utilized electronic procurement systems. However, in gender equality, the participation of women in budget forums was still limited and had not significantly improved from 2011. This may have been caused by another finding, that 55 percent of the Kinerja districts had not established any of the gender budgeting institutions (working groups, focal points, gender responsive teams) required by the national government that could advocate for higher women's participation.

With regard to the quality of budget allocations, the LBA showed that local revenues received by the 20 Kinerja districts in 2011-2014 were significantly higher than in the 2008-2011 period. However, these increases were not reflected in a broadening of "fiscal space" - the discretion of LGs in allocating their budget funds. A greater proportion of personnel expenditure led in fact to a decrease in fiscal space. The LBA also found that most of Kinerja's LGs were not following the Village Law's requirement to allocate 10 percent of budget funds to villages.

Local budget allocations for the education sector have increased to almost double the minimum constitutional requirement – 20 percent of the total budget. However, the way the funds are allocated within the sector does not necessarily reflect essential needs. For example, allocations for priority programs such as basic education and improved education quality have actually decreased and are very small.

Unlike education, allocations for health are still very limited. On average, only 11 percent of local budgets (including personnel) in Kinerja districts are allocated to the health sector, despite the Health Law stipulating that a minimum of 10 percent (excluding personnel costs) should be allocated. Although the proportion of health budget spending on personnel has decreased, the ratio of local populations to the number of health workers, nurses and midwives has also dropped, which should lead to an increase in the quality of services.

Women fill out a complaint survey at an elementary school in Bener Meriah, Aceh.

Media

Kinerja's media program covered three main topics: building relationships with mainstream media to improve coverage of PSD issues; training and mentoring CJs; and supporting LG PPIDs. Kinerja also worked to foster links between CJs and mainstream media outlets to provide access to wider audiences and to raise PSD issues that may have otherwise gone unreported.

Through its IO partners, Kinerja trained and mentored community members in its partner districts to engage with PSD issues through citizen journalism. Kinerja-supported CJs wrote articles and developed other media products such as short documentary films and radio talk shows that explored the provision of health-care, education and business-licensing services. CJs successfully engaged with substantive issues concerning PSD by taking part in Kinerja activities, as well as those carried out by LGs, to ensure that they developed media that genuinely addressed regional problems and advocated for solutions. These CJs continue to be active in 2016, despite Kinerja's formal CJ support ending in December 2014.

Kinerja also supported PPID offices as the local implementers of the national Freedom of Information Law in order to encourage further transparency of the delivery of public services.

To help drive the use of PPID offices, Kinerja entered a collaborative relationship with the World Wide Web Foundation at the start of 2015 to pilot a study in Kota Banda Aceh to improve citizen access and use of public data. Through a series of workshops and meetings, the Kota Banda Aceh PPIDs became more skilled at collecting LG data and developed, in conjunction with the local DEO, a digital data format for storing education data that could be accessed by the public.

In order to better understand how open access to information can support good governance, provincial PPID forums were held in Aceh and West Kalimantan during 2014 and 2015. The forums helped LGs to formulate lists of what data can be made public (Public Information Lists), how to ensure provincial and local PPID offices work together, and how members of the public can request information.

Key Achievements

- In total, 281 people trained by Kinerja's IOs actively worked as CJs. A total of 1,106 media products (written articles, radio talk shows and documentary videos) were developed by Kinerja-supported CJs up until December 2014, when Kinerja ceased recording CJ activity. Sixty-six CJs were active in Aceh, 53 in East Java, 74 in South Sulawesi, and 88 in West Kalimantan;

- Fourteen districts produced regulations on PPID, six districts established SOPs for handling information requests, and six established Public Information Lists;

- Twenty-seven non-media CSOs wrote articles on LG performance in FY 2014;

- A number of local newspapers, including *Tribun Timur, Palopo Pos*, *Cakrawala*, *Ujung Pandang Express*, *Radar Bulukumba*, *Serambi*, *Waspada*, *Pontianak Times*, and *Radar Jember*, and online media outlets such as BeritaNusa.com and KabarMakassar.com provided dedicated columns for CJs to raise complaints related to service delivery issues. Local radio and television stations also worked closely with Kinerja's IO partners and CJs, with many establishing regular features on PSD. LGs in these districts were generally very responsive to this kind of public pressure;

> ***"They [CJs] feel called to action if there is an important issue that hasn't yet been reported to*** *the public. They understand that in order for public services to improve, citizens must provide* ***oversight."***
>
> From Kinerja media IO PUSKAPOM

- In May 2013, Kinerja and its IO JURnal Celebes organized a Citizen Journalism Festival at Hasanuddin University, Kota Makassar, South Sulawesi. It was attended by over 600 people and featured workshops and panel discussions. The festival was supported by several Kinerja partners that made significant contributions to cost share, such as Kompas/Kompasiana.com, The Jakarta Post Digital, BaKTI, Oxfam, the Canadian International Development Agency's (CIDA) Better Approaches to Service Provision through Increased Capacities in Sulawesi (BASICS) program and the Information Commission;

- On October 18-19, 2014, Kinerja hosted its second annual Citizen Journalism Festival in Surabaya, East Java. Around 300 CJs, bloggers and students took part in activities on using media as an advocacy tool. More than 15 institutional partners, including government offices, NGOs, private companies and national media outlets, helped support the event;

- Also in October 2014, Kinerja co-hosted an event with the U.S. Embassy's cultural center, @america, in Jakarta. The event featured CJs from all five Kinerja provinces, including Papua,

and from a broad variety of backgrounds, which helped to highlight that anyone can take up the initiative to write about public services;

- Appreciation among LGs regarding the role of CJs is translated in some cases into practical, financial support that enables CJs to continue working. Government officials in Aceh Tenggara, for instance, contributed toward the printing costs of a new weekly tabloid, *Lintas Leuser Antara*, which was established in 2015 by local CJs. Similarly, the LG in Sambas provided a grant to CJs in May 2015 to enable them to publish their tabloid, *Suare Warge*, which focuses on the delivery of public services in health, education and business;

Box 9: Luwu Utara wins award for boosting public participation

At a ceremony held in September 2013, the district of Luwu Utara, South Sulawesi took home a prestigious FIPO Award for the best innovation in public participation.

Kinerja's media IO, JURnal Celebes, supported citizen oversight group Fakta to host regular public discussions in a local coffee shop. This casual forum, called *Warung Demokrasi*, was designed to allow community members to voice their concerns regarding public-service issues and to provide government officials with important public feedback.

The discussions at *Warung Demokrasi*, which were also broadcast live on local radio, became an important driver behind the effective implementation of a number of district policies, including a district head regulation on PTD.

Concerned about disparities in educational quality between rural and urban areas in Luwu Utara, representatives from teachers associations, district education officials and other concerned individuals held discussions on equitable teacher distribution and pushed the government to avoid delays in reassigning teachers to where they were needed most.

Luwu Utara Deputy District Head said she was optimistic about the long-term benefits of public discussion forums like *Warung Demokrasi*, explaining that they helped to boost community participation in providing public-service oversight.

She added that *Warung Demokrasi* also offered direct benefits for the government. "Public discussion forums help the government to create more effective governance through dialogue. Via this medium, the local government is able to communicate its programs," she added.

In addition to enhancing public participation, the coordinator of Fakta, Suharto, said that airing *Warung Demokrasi* discussions live on local radio also improved access to information for people living in remote areas.

Having received the FIPO award, both Luwu Utara's deputy district head and Fakta's coordinator said they hoped *Warung Demokrasi*'s success would motivate the government to optimize its services and maintain strong ties with the local community.

- Kinerja supported a fellowship program for local professional journalists in partner districts, through which the reporters received funds to write about PSD issues and put the articles on their media outlets. The objective was to increase exposure of PSD issues to the participants and society. The program trained between eight and 10 journalists from each district, two of whom were selected to participate in the fellowship.

Minimum Service Standards

In 2005, the national government issued Regulation No. 65/2005 on MSS, which targeted core public services such as health and education. Kinerja's technical assistance on MSS aimed to improve the capacity of district governments, particularly DHOs and DEOs, to apply service standards in public administration. The program specifically aimed to improve the use of MSS – especially in the planning, budgeting, implementation and M&E of programs at district, departmental and service-unit levels – to ensure that these basic fundamentals of good governance would continue to be applied after the end of the Kinerja program. With technical assistance, district administrations grew more capable of

completing complex analysis to meet their planning and budgetary needs. Kinerja worked with core partner Kemitraan on MSS.

Through activities such as comparative studies and workshops at the provincial and district levels, Kinerja increased stakeholders' awareness and understanding of the importance of using service standards in delivering services to the public. Kinerja trained staff from district health and education offices and working units to enhance their technical capacity to develop strategies and action plans to implement service standards, and provided on-site support through coaching and mentoring. MSS data on health and education was compiled by LGs, and Kinerja assisted them to analyze the gaps between their targets and reality. Plans to fill these gaps ("costing" plans) were developed, and district offices formulated circulation letters to support the integration of MSS into their services. Kinerja also supported SDUs to improve their annual planning and budgeting by conducting needs analyses and integrating MSS. Finally, Kinerja assisted LGs and SDUs to monitor and evaluate their MSS achievements.

In 2013, SMERU conducted a study of the indicative impacts of MSS application in a select number of partner districts. The study showed that technical assistance had improved understanding of MSS indicators, particularly related to Kinerja's intervention packages, and promoted improvements in MSS database systems, prioritization of activities and MSS costing integrated into local planning and budgeting documents, and actualization of service charters at the SDU level. It also found that successful MSS integration in planning and budgeting documents required advocacy efforts to ensure that technocratic activities were supported by political policy on local budgets.

Key Achievements

- One hundred percent of Kinerja partner districts are now successfully applying MSS analysis to their planning processes;
- Ninety-five percent of partner districts also apply MSS analysis to their budgeting processes;
- As of December 2014, when Kinerja's monitoring of MSS ended, approximately 70 percent of districts had successfully conducted M&E of MSS achievements;
- Kinerja was invited by MOH to their Mid-Term Evaluation meeting in Palembang, South Sumatra, in August 2015. Kinerja's Public Service Standard Specialist participated in the meeting and, together with an official from the DHO in Jember, presented Kinerja's good practice of integrating MSS into district health budgets and provided information on how to monitor and evaluate budgets in order to determine the extent to which local activities contribute to the fulfillment of MSS in health. Notably, Kinerja's presentation was one of only four good practices chosen by MOH for inclusion at the evaluation meeting.

Multi-Stakeholder Forums

As previously mentioned in this report, one of the key aspects of the Kinerja program's approach that set it apart from other development programs was the focus on demand-side stakeholders – namely, local communities – to encourage citizens to become actively involved in productive dialogue with their LG and public service providers. Kinerja supported efforts to increase people's awareness of their rights to access basic services and to articulate demands for better services. The key part of this process was the establishment or revitalization of strong community forums – MSFs - which provided input to LGs, mediated problems, and provided oversight of SDUs.

Box 10: Common issues raised during complaint surveys

Kinerja and its IOs ran complaint surveys at both schools and *puskesmas*, and the complaints gathered were used to develop service charters and technical recommendations.

Service charters are commitments for improvements that are based on complaints that schools and *puskesmas* can solve themselves, such as:

- Staff turn up late and leave early
- Staff are unfriendly and rude
- Teachers hit students
- No rubbish bins
- No seats in the waiting room
- No list of fees for services displayed on the wall

Technical recommendations, on the other hand, are based on complaints that schools and *puskesmas* cannot solve themselves and that require the assistance of the LG, such as:

- No ambulance
- No delivery room
- No dentist
- Lack of medicines
- Lack of textbooks
- Dilapidated buildings in need of repair

MSFs were established in all 20 of Kinerja's partner districts, both at SDU and district levels. They played an active role in conducting complaint surveys, supporting the drafting of service charters, monitoring their implementation, and making technical recommendations to LG technical offices.

Service charters were the end product of complaint surveys, during which hundreds of service users provided feedback on the SDU's services and facilities. Complaints generally covered infrastructure, management and service provision issues (see Box 10 above). Each service charter, which was essentially a series of "promises" developed in coordination between a given school or *puskesmas* and the local community, outlined improvements that were to be made. Once signed, the service charters were printed and displayed, either in *puskesmas* waiting rooms or on school notice boards, to support transparency. Problems identified during complaint surveys that could not be solved internally by the *puskesmas* or school itself were listed as a series of technical recommendations. District-level MSFs would then discuss the recommendations with the local DHO/DEO for follow-up.

> ***"I had never set foot inside the DPRD complex,*** *let alone presented in front of a committee, so of course I was nervous* ***– but at the same time, I knew that this was important for my community, and that to me is what mattered."***
>
> MSF member, Bener Meriah

Each MSF had a management team, including a head of the forum, and was supported by Kinerja's IOs to develop work plans. Over time, as an increasing number of LGs began to recognize the value of MSFs and the contribution they made to their own efforts to improve health and education services, many forums were granted legal status by government decrees, which not only allowed them access to government funds to support their oversight and monitoring activities but also provided a significant boost to their future sustainability.

Key Achievements

- Two hundred and fifty-seven MSFs were formed or revitalized by Kinerja and its partners at the SDU and district level. This number includes 173 MSFs working on education, 73 working on health, six working on business, and five CJ discussion forums;

- A total of 237 service charters were developed by Kinerja's partner schools and *puskesmas* in coordination with service users and MSFs. Sixty-one service charters were developed at *puskesmas* and 176 at schools;

- Ninety-two percent (218) of Kinerja-supported service charters were successfully monitored by MSFs. Of the 6,157 promises made in these service charters, 5,115 were implemented (approximately 83%). Overall, 81 percent of promises made by schools were met, while 85 percent of promises made by *puskesmas* were met;

- Five district-level health and education MSFs (in Bondowoso, Bulukumba, Jember, Luwu Utara and Sekadau) were merged to promote the integration of PSD issues and enable MSFs to better use their collective power to advocate for change.

Box 11: MSFs revive town hall tradition

In April 2014, Kinerja IO ESENSI supported the first-ever *Sipulung Tudang*, or town hall meeting, on standards-based public services in Kota Makassar, South Sulawesi.

Modeled on traditional community meetings in the province, the Kinerja-supported event drew in more than 150 participants, including senior decision makers, to discuss public-service issues and the importance of public participation in the enactment of improvements.

During the meeting, the secretary of the city administration spoke on behalf of the mayor, while the Deputy Mayor talked about improving the quality of public services with a particular focus on health, education and BEE. In addition, MSF members used the occasion to present eight recommendations for public service improvements, such as community involvement and the implementation of feedback mechanisms.

Similar events were held in Kinerja's four other target districts in South Sulawesi in the weeks that followed.

The Deputy District Head of Luwu Utara, Indah Putri, and her staff.

Strategy

As mentioned at the start of this report, replication was a fundamental aspect of Kinerja's overall strategy and program design. From the beginning, Kinerja aimed to improve the quality – or performance - of LG service delivery by testing and replicating interventions to improve measurable service delivery performance in education, health and BEE.

Kinerja's basic design supported replication in two ways; first, by basing all its interventions on good practices developed by previous development programs, such as SBM and BOSP, and second, by implementing its sectoral interventions via IOs, which could continue to provide services beyond the life of the Kinerja program and, potentially, to additional districts beyond those targeted by the program.

The program's replication strategy comprised three main elements: (1) documenting and disseminating good practices; (2) adapting and implementing good practices both at additional non-partner SDUs within its 20 treatment districts (scaling up) as well as at SDUs in an additional 30 to 45 districts in its target provinces,[12] and (3) institutionalizing good practices with the development and implementation of new policies.[13]

[12] Following a USAID Regional Inspector General (RIG) audit in 2014, the number of districts targeted for replication was reduced to 25.

[13] There can be a significant time period between the development of a policy and its subsequent ratification and implementation, so providing support for policy implementation greatly depends upon a project's remaining time frame.

In addressing the first element of the strategy, Kinerja documented a total of 40 good practices; 17 of these (12 in health and five in education) encompassed each of the program's interventions in both sectors, utilizing case studies from its work in treatment districts. The remaining 23 good practices were incorporated in a series of 17 technical modules that offer detailed information on how to implement similar programs in health and education, as well as other areas such as citizen journalism, financial administration and MSF-based advocacy. Additionally, 15 good practices relating to OSS were compiled and documented by Kinerja's BEE partner, TAF.

In addition, Kinerja produced eight promotional films and 22 testimonial videos, offering visual accounts of its work and interviews with its LG and civil society partners. All these good practices were uploaded onto Kinerja's website - the films and videos were also uploaded onto a dedicated YouTube channel – while hard copies of these materials were distributed to government and CSO stakeholders at high-profile events and workshops. (See Annex 5 for a complete list of the good practices, technical modules and films, as well as other publications produced during the program).

In terms of implementation, one of the key aspects of Kinerja's replication approach was the emphasis on making LGs the drivers of change and reform in their districts: Apart from possessing the necessary political commitment to successfully implement their respective replication packages, district governments were also expected to assume financial responsibility for all associated costs. Having concentrated its efforts on consolidating achievements at partner SDUs and scaling up in its 20 original treatment districts, Kinerja withdrew direct support at the end of December 2014 to focus on replicating its good practices in additional districts.[14]

District- and Provincial-Level Replication

Kinerja secured significant achievements in its replication efforts in health, education and BEE, specific details of which are provided below. Throughout the program's lifetime, Kinerja replicated good practices 450 times at 399 non-partner SDUs (200 *puskesmas*, 184 schools and 15 DHOs) in both treatment and additional districts. This total of 450 replicated good practices far exceeded the program's target of 344.

In terms of replication to additional districts, Kinerja also surpassed its revised target of 25 (10 districts for health and education combined and 15 districts for BEE). As the program entered its final three operational quarters in October 2014, it had already exceeded that figure, having replicated its reform packages to a total of 35 non-partner districts. By the end of June 2015 and the closure of its field offices, Kinerja had replicated good practices to a further 20 non-partner districts, bringing the total number of replication districts to 55 across six provinces (Aceh [18], East Java [15], North Sumatra [1], South Sulawesi [12], Southeast Sulawesi [3] and West Kalimantan [6]). (Please see Annex 3 for a full list of the replication districts together with the sectoral interventions they implemented).

Therefore, Kinerja focused on replicating good practices, supporting policy development and, as far as possible, supported policy implementation.

[14] Kinerja continued to offer limited support to seven treatment districts on an ad hoc, per request basis: Bulukumba, Kota Banda Aceh, Probolinggo and Sambas for health, and Bondowoso (PTD), Jember (SBM) and Simeulue (BOSP) for education.

Health

Kinerja's health program was widely replicated both within partner districts and in new districts throughout Indonesia, even reaching entire new provinces where Kinerja had not previously worked. A total of 200 non-partner *puskesmas* replicated at least one of Kinerja's health good practices. The most commonly-replicated good practices were government regulations on safe delivery and breastfeeding; complaint surveys and the resulting service charters; service SOPs and control cards for ante-natal care; TBA and midwife partnerships; MSFs; complaint boxes, and *kantung persalinan* information management systems.

Kinerja focused on 10 districts for health replication to increase the likelihood of self-sufficiency among LGs, as the table below illustrates. Seven of these districts were given priority support due to high levels of government commitment. Priority support involved working closely with Kinerja's consultants and staff to carry out trainings, workshops and supervision.

Table 1: Replication of Kinerja's Health Interventions:

Kinerja Package	Province	Replication District
Service standard operating procedures (SOPs), safe delivery information system (*kantung persalinan*), and pregnancy maps	Aceh	Aceh Selatan
Service SOPs and pregnancy classes		Aceh Tamiang*)
I&EBF promotion and Service SOPs		Gayo Lues*)
Complaint surveys and breastfeeding promotion	East Java	Banyuwangi*)
I&EBF promotion and Service SOPs		Lamongan
Breastfeeding promotion and pregnancy classes		Lumajang
Pregnancy classes		Pacitan*)
Service SOPs, *kantung persalinan*, pregnancy maps, and complaint handling	North Sumatra	Pakpak Bharat*)
Traditional birth attendant (TBA)-midwife partnerships and *kantung persalinan*	West Kalimantan	Kubu Raya*)
Gender and adolescent reproductive health education		Sambas*)

***) Replication district priority work areas**

Key Achievements

- Kubu Raya was one of Kinerja's best-performing replication districts for health. Having carried out a district-wide analysis of TBAs in late-2014, the LG issued a district head decree to implement partnerships between TBAs and medically-trained midwives at all *puskesmas* across the district. In order to secure the support of birth attendants for this initiative, the regulation stipulates that TBAs will be paid IDR 50,000 ($4) for each expectant mother that they refer to a *puskesmas* and IDR 250,000 each time they assist a midwife with a delivery at a *puskesmas*. Additionally, service SOPs, control cards, *kantung persalinan*, MSFs and complaint mechanisms were introduced at three pilot *puskesmas*, and plans were developed by the Kubu Raya DHO to introduce these good practices at the district's other 17 *puskesmas* and many village health posts (*poskesdes*) over 2015 and 2016. Kubu Raya also elected its first two breastfeeding ambassadors in 2015 – the wives of the district head and deputy district head;

- In Aceh Selatan, despite only launching replication activities in February 2015, the LG demonstrated its strong commitment to replicate Kinerja's good practices by issuing, before the end of March 2015, subdistrict decrees for the establishment of MSFs at each of the district's 23 *puskesmas*, going well beyond the program's five pilot health centers;

- Probolinggo introduced service SOPs and control cards in all of the district's 27 *puskesmas*, way beyond Kinerja's original three partner *puskesmas*. Breastfeeding ambassadors were also elected for each subdistrict (27 in total);

- Kota Makassar replicated its innovative *Bapak Peduli ASI* (Fathers who Care about Breastfeeding) initiative from Kinerja's three pilot *puskesmas* to 17 additional *puskesmas* in 2015 using the DHO's own budget. Breastfeeding ambassadors were also elected and MSFs established at each *puskesmas*. The DHO also signed an MOU with the local Religious Affairs Office to incorporate information on safe pregnancy, childbirth and breastfeeding into pre-marital counseling for couples;

- With less than six months' support from Kinerja, due to their late joining of the program in 2015, two *puskesmas* in Pakpak Bharat adopted ANC SOPs, *kantung persalinan*, pregnancy maps, patient flowcharts, medical referral flowcharts and mechanisms, and complaint-handling mechanisms with an SMS Gateway system and suggestion boxes in the waiting rooms. Both *puskesmas* also published an SOP on complaint handling to complement the introduction of the above mechanisms;

- Also with just six months' support in 2015, the DHO of Aceh Selatan introduced Kinerja's good practices at five *puskesmas* across the district. Complaint surveys were conducted at all five health centers and service charters were developed. The five *puskesmas* also developed *kantung persalinan* and pregnancy maps, and implemented control cards, which were evaluated by MSFs after two months. Three *puskesmas* developed and published service SOPs on ante-natal care;

- Three *puskesmas* in Pacitan worked quickly after first receiving support from Kinerja in December 2014, and implemented not only service SOPs on ante-natal care but innovative control cards for pregnant women that included a take-home section containing information on ante-natal nutrition. One of the *puskesmas* also introduced a suggestions box for the first time and a feedback board – cheekily entitled "*Curhat dong!*" or "Come on, let us know!" – for patients in the waiting room;

- The signing of service charters in Lumajang in April 2015 was attended by more than 150 people, including the Regional Secretary. The enthusiasm surrounding the event was followed by an intense burst of activity by staff at one of the district's two pilot health centers, Puskesmas Yosowilangun: Despite having only started to replicate Kinerja good practices at the beginning of January 2015, the *puskesmas* had fulfilled 75 percent of the 19 commitments in its service charter by the end of June 2015.

Education

Kinerja's education programs were replicated both within original partner districts and in new districts throughout 2014 and 2015. Replication was not as speedy as it was for health, as the program's education interventions generally required a longer period of time and higher levels of LG

commitment to implement. This was especially true of PTD; as a result, Kinerja decided not to replicate the package beyond its original partner areas. Nevertheless, Kinerja's BOSP and SBM packages were replicated to 11 new districts: seven within Kinerja provinces and four districts in two additional provinces (Southeast Sulawesi[15] and North Sumatra), as shown in the table below.

Table 2: Replication of Kinerja's Education Packages:

Kinerja Package	Province	Replication District
SBM	East Java	Kota Mojokerto *)
		Mojokerto *)
		Pacitan
	Southeast Sulawesi	Bombana
		Buton
		Kota Baubau
BOSP	East Java	Kota Batu
	North Sumatra	Pakpak Bharat
	South Sulawesi	Jeneponto
		Kota Palopo*)
		Sidenreng Rappang *)

***) replication district priority work areas**

BOSP

Kinerja provided technical support to five district governments to replicate the BOSP package: Pakpak Bharat in North Sumatra; Kota Palopo, Jeneponto and Sidenreng Rappang in South Sulawesi, and Kota Batu in East Java. Due to the program's limited resources, however, priority attention was given to Kota Palopo and Sidenreng Rappang.

As previously mentioned in this report, the national government increased its annual BOS allocations in 2015 - from IDR 580,000 to IDR 800,000 for elementary school students and from IDR 710,000 to IDR 1 million for junior high school students; however, this was still not sufficient to fulfill many schools' operational requirements. In Kinerja's three replication districts in South Sulawesi, for example, their respective BOSP calculations – for both elementary and junior high schools – resulted in an average shortfall per student per year of around IDR 180,000. To address the issue, Kinerja assisted the replication districts to understand their respective unit costs as well as to develop a budget incorporating all the costs related to BOSP implementation. As of the end of June 2015, each of the DEOs planned to review their respective unit costs later in the year and, where necessary, recalculate them to fill the gaps.

By the end of 2015, BOSP implementation in the replication districts was going well. LGs appeared to be highly committed and intended to continue implementation even after Kinerja withdrew. In Kota Palopo, Bappeda staff confirmed that the agency would allocate money from their annual budget to the DEO for BOSP in 2016. After receiving technical assistance from Kinerja to support the

[15] Kinerja collaborated with CIDA-BASICS to implement SBM in Southeast Sulawesi. In October 2014, the Provincial Education Office expressed its commitment to replicate SBM at schools in each of the province's 17 districts, but by the end of June 2015, only the three districts listed in Table 2 were implementing the package.

original pilot schools, the Jeneponto district administration instructed the DEO to choose three new elementary and junior high schools in every subdistrict for future BOSP development.

In Pakpak Bharat, the DEO finalized BOSP calculations at the end of June 2015, and drafted a district head decree.

In contrast to the districts in South Sulawesi and North Sumatra, progress on BOSP replication in Kota Batu (East Java) was halted when the head of the DEO decided not to conduct BOSP calculations, believing that the increases in the BOS allowance would cover all student costs.

School-Based Management (SBM)

Four of Kinerja's eight original partner districts for SBM had replicated the program to additional schools by the end of 2014. Kota Probolinggo was particularly successful in replicating SBM – 119 new schools in the district were implementing SBM when the Kinerja program closed. The district allocated IDR 257 million in the 2014 budget to support the program. Bener Meriah also continued to expand SBM; the DEO finalized its executive decision on the appointment of 10 replication schools in April 2015, conducted training and provided a budget of IDR 122 million for the replication.

Despite a good deal of support from Kinerja, Jember made disappointing progress in replicating SBM. By the end of June 2015, only six schools were continuing to implement the package, and the DEO failed to incorporate SBM into the district's work plan or budget. This seems to be due to a lack of commitment by the DEO borne out of competing priorities.

Box 12: Kota Probolinggo gears up for good governance

In Februray 2014, more than 30 school principals and district education administrators attended a workshop in preparation for plans to apply the SBM program to an additional 99 public elementary and junior high schools in the city.

Growing out of previous USAID-Kinerja support for 20 schools, the two-day TOT held at the DEO aimed to prepare a new group of facilitators to coach schools through the proven good governance model.

The event featured sessions on a number of SBM components, including incorporating public complaint survey results, school self-evaluations and MSS into annual school plans and budgets. Principals from Kinerja's pilot schools explained how the program had helped them to foster a culture of partnership with the community – partnerships that had led to major improvements in their facilities and the overall educational environment.

Starting in 2012, the Kinerja program provided technical assistance to elementary and junior-high school principals to develop school work plans in a more participatory process involving local stakeholders, and in preparing transparent, accountable and integrated financial statements. The results from preliminary support were so impressive that government officials across the archipelago and from as far away as Myanmar sought out the program's partner schools as the subject of study tours.

The director of basic education at Kota Probolinggo's DEO, said, "With support from USAID-Kinerja, we've achieved great results thus far. The schools that partnered with this program in the pilot phase are far better than they ever were before. What we want to replicate is not just the physical improvements to infrastructure, but also the method of strengthening management skills and incorporating public input and oversight."

The head of curriculum and student development in the DEO's basic education department said, "This training has been really useful for me in terms of deepening my understanding of not only what the SBM program is, but how it is applied in practical terms."

Kinerja's newly-supported replication districts of Kota Mojokerto, Mojokerto, and Pacitan saw excellent development despite being supported by Kinerja for only nine months, from October 2014 through June 2015. All 10 pilot schools in each of the three districts incorporated Kinerja's SBM package into plans and budgets for 2016. They then carried out complaint surveys, and subsequent service charters and complaint indexes were drafted and signed. By the end of June 2015, all the

complaints coming under the direct management of the schools had been addressed and resolved by school principals and school supervisors.

In Pacitan, such was the enthusiasm for replicating SBM beyond its 10 pilot schools that in March 2015, principals from 32 schools covered their own costs and visited two schools in Kinerja's good practice district of Kota Probolinggo to carry out a comparative study and learn more about SBM implementation. Following the visit, the Pacitan district head confirmed that they planned to replicate SBM at all elementary and junior high schools.

In Kota Mojokerto, the DEO exhibited a similarly strong commitment to replicating SBM district-wide by incorporating the package into its 2015 budget allocation and requesting Kinerja's assistance to train representatives from an initial 70 new schools in May 2015.

In Southeast Sulawesi, where the PG made a commitment to replicate Kinerja's SBM package in 17 districts, three districts began to implement the package during October-December 2014 with planning and budgeting. By the end of June 2015, however, these three districts were still the only ones implementing SBM. Following a Kinerja-led training, on request by the PG, the remaining 13 districts stated that they would incorporate SBM into their 2016 budgets.

Business-Enabling Environment

Throughout the replication phase of Kinerja's BEE interventions, TAF and its four local partners promoted the replication of six types of business-licensing innovations: (1) increasing the licensing authority of OSS by increasing the types of licenses authorized to the OSS and/or upgrading the OSS' organizational status; (2) reducing the overall number of types of licenses required by LGs; (3) developing SOPs or service standards to process license applications; (4) establishing OSS technical teams; (5) establishing complaint-handling mechanisms; and (6) conducting customer satisfaction surveys to provide feedback on various aspects of OSS services.

All of these interventions were expected to enable business operators to obtain business licenses more easily, quickly and cheaply (including fewer illegal charges), and to improve the governance of licensing services.

Overall, Kinerja's program target to replicate good practices in BEE to 15 non-partner districts was far surpassed during the reporting period. By the end of Kinerja, 31 replication LGs (206% of the target of 15) and three scale-up LGs had adopted at least one of Kinerja's six BEE interventions. Eleven LGs adopted at least three BEE interventions, and four LGs adopted all of the interventions. A total of 96 local level regulations were issued on BEE topics in Kinerja replication districts, which are listed in the table below.

Table 3: Replication of Kinerja's BEE Interventions:

Province (Supporting IO)	District	Increasing OSS Authority	License Simplification	SOP/SP	Technical Team	Complaint Handling	IKM
Aceh (BITRA)	Aceh Jaya	X		X	X	X	
	Aceh Selatan	X	X	X	X	X	
	Aceh Timur		X	X		X	X
	Pidie Jaya		X	X		X	X
	Kota Subulussalam			X	X	X	X
West Kalimantan (Madanika)	Kapuas Hulu	X	X	X			X
	Kayong Utara		X	X	X	X	
	Ketapang	X		X	X	X	
	Kubu Raya			X			X
East Java (PUPUK)	Banyuwangi			X	X	X	
	Kota Blitar		X	X		X	
	Blitar	X		X		X	
	Kota Kediri	X	X	X	X	X	
	Kediri	X		X			
	Lamongan	X			X	X	X
	Pamekasan			X			X
	Sampang	X		X	X	X	
	Situbondo			X		X	X
	Trenggalek	X	X	X	X	X	
South Sulawesi (YAS)	Bantaeng	X	X			X	
	Bone		X			X	X
	Enrekang				X	X	
	Jeneponto	X	X	X		X	
	Luwu*	X	X	X	X	X	
	Kota Palopo	X				X	X
	Pangkep	X					
	Sidenreng Rappang				X	X	X
	Sinjai	X	X	X	X	X	X
	Soppeng	X	X	X	X	X	X
	Takalar		X	X		X	
	Wajo	X	X			X	

* Luwu was a Kinerja district, although it did not implement a BEE component. Hence, the activities in the district were not counted as part of "replication", but rather a "scale-up" of Kinerja interventions.

Key Achievements

- In Pidie Jaya, Aceh Province, the LG issued two district head decrees on complaint handling and license simplification. The latter resulted in the number of different licenses required by the LG, and authorized to the OSS, being reduced from 73 to 21;
- In East Java, with intensive facilitation from PUPUK Surabaya, 18 local-level regulations were issued by eight LGs (including the three new districts) in 2015. Two LGs, Kota Kediri and Trenggalek, adopted five of the six BEE interventions – an impressive achievement;

- In South Sulawesi, the Bantaeng government issued a district head decree in 2014 to reduce the number of different types of licenses and to transfer licensing authority to the OSS. The LG has now reduced the total number of license types from 40 to 21, and transferred processing authority for all of them to the OSS;

- An interesting district head decree in Soppeng, South Sulawesi, stated that any new types of business-related licenses in the future should be merged with one of the existing 19 types. This is a positive sign and indicates that the LG genuinely wishes to de-complicate local bureaucratic procedures;

- Significant budget allocations were provided to improve OSS in replication districts in South Sulawesi. Wajo allocated IDR 45 million; Jeneponto allocated IDR 107 million; and Toraja Utara allocated IDR 90 million of local budget funds for OSS replication activities in 2015;

- Kinerja's replication-supported OSS in South Sulawesi were well-represented in the 2015 FIPO Awards. The winner of the best business-licensing services award, Sinjai, saw a dramatic increase in investment in the district following a reduction in the types of licenses from 65 to 25. Investment increased from IDR 88 million in 2012 to IDR 341 million in 2014. Several well-performing OSS in other BEE replication districts in the province, such as Enrekang, Soppeng, Bantaeng, Sidenreng Rappang and Bone, were also recognized at the Autonomy Awards ceremony.

Provincial Forums

Kinerja's provincial-level replication of its BEE component began in 2012 through the revitalization of the Aceh OSS Forum (which had been established in 2009) and the establishment of provincial OSS Forums in the program's three other target provinces. The first activity undertaken by the forums was the implementation of the POPI surveys, which were used as a baseline for the forums to understand the status of business licensing in each district. The OSS Forum members discussed and adjusted the methodology, indicators and questionnaire based on the respective situation in each province. The surveys were conducted by forum members themselves, with support from TAF's local partners, in 2012 and 2013, and the results were disseminated at OSS Forum workshops.

Mass-Licensing Day

To increase the benefits of Kinerja's BEE interventions in providing business licenses quickly and cheaply, and to promote the role of the OSS in providing licenses, the provincial government of South Sulawesi (led by the Provincial Investment Coordination Board - BKPMD) in collaboration with TAF and its grantee YAS, held a mass-licensing event in all 24 districts in the province on May 7, 2015 (see Text Box 11 below).

The main event took place in Kota Makassar and was attended by the Minister for State Administrative and Bureaucratic Reform, the South Sulawesi Governor, Kota Makassar Mayor, a commissioner from the national Ombudsman, a director from the Ministry of Transportation, the Acting Deputy Director of the Democracy, Rights and Governance (DRG) Office of USAID Indonesia, Kinerja's Chief of Party (COP), TAF's Country Representative for Indonesia, as well as representatives from several private banks, business associations, and other government officials. Indonesia's Vice President also joined the event via video link.

Box 13: Mass-Licensing Day provides legitimacy to MSMEs

The World Bank's study on the ease of doing business for 2014 ranked Indonesia 120 out of 189 economies, far below most other Southeast Asian countries. Moreover, a study commissioned by Regional Autonomy Watch (KPPOD) in 2015 found that in order to obtain a trade permit (SIUP) in Jakarta, an applicant was expected to pay up to IDR 500,000 ($40) and wait for around two weeks, despite the existence of a national regulation stipulating that SIUPs are free of charge and should be processed within three working days.

The Head of the BKPMD said the Free Mass-Licensing Day had been organized as many MSMEs still lacked the formal documentation needed to develop their businesses and secure bank loans. "During the course of this free licensing event, we have helped MSMEs to the tune of around IDR 360 billion," he said.

Among the thousands of license recipients were a husband and wife who run a small bakery in Jeneponto District. With their new permits legalizing their business in hand, they said they looked forward to establishing a contract with a local supermarket chain that wanted to sell their bread and rolls. "Next week, I will contact [the supermarket] and hopefully we can start sending them our bread," the husband said.

Another recipient was a Kota Makassar resident, who owns a business called the Ridha Collection, which supplies uniforms for factory workers. She launched the business in 2008 and now has five employees. She had long dreamed of being in a position to join open bidding tenders for contracts at large factories. However, she was ineligible as she did not possess the necessary business permits. Having obtained three licenses at the mass-licensing event - a trade permit (SIUP), company registration certificate (TDP) and a location permit (SITU) - she explained that the first thing she planned to do was to apply for the tender to make uniforms for workers at the local PT MARS chocolate factory.

The primary aim of the event was to provide basic business licenses, and other licenses, free of charge to MSMEs. In total, 41,117 licenses were issued on the day, surpassing the already optimistic target of 30,000. The five districts that issued the most licenses were Jeneponto (4,783), Kota Makassar (4,527), Barru (3,860), Sinjai (2,547) and Soppeng (2,298). Each of these districts was either directly supported by Kinerja or had replicated the program's BEE component.

The mass-licensing event was well covered by national, provincial and local media – some of whom reported the event in their headlines. At the national level, the media outlets that covered the event included *Antara*, *The Jakarta Post*, *Kompas*, *Suara Pembaruan*, *Detik.com*, *Koran Tempo*, national public radio (RRI), *Metro* TV and *Bisnis Indonesia* TV. At the sub-national level, mass media coverage was provided in *Fajar*, *Tribun Timur*, *Rakyat Sulsel*, *Kabar Makassar*, *JURnal Celebes*, *Parepos*, and other online media. In addition, several LGs – including Barru, Luwu, Luwu Timur, Sidenreng Rappang and Palopo – disseminated the event through half-page advertorials in local newspapers.

Co-operation with Development Partners

During its five years in operation, Kinerja collaborated with a number of development partners to address and promote different aspects of its overall program goals. This section does not provide an exhaustive list of all such collaborative efforts; it merely offers an overview of the key initiatives that Kinerja undertook in conjunction with other donors.

One such partner was the **World Bank** (WB). Kinerja used the bank's Tools of Reporting and Information Management by Schools (TRIMS) to map general conditions as well as levels of MSS achievement in partner and non-partner schools in three Kinerja treatment districts that were implementing SBM - Bener Meriah, Barru and Kota Singkawang. Acknowledging the benefits TRIMS offered in promoting greater transparency in educational data and assisting schools to develop their work plans, the LGs in Bener Meriah and Kota Singkawang rolled out TRIMS training in 101 and 145 additional schools, respectively.

As part of its wider national-level policy dialogue on service standards (see below), Kinerja entered into an agreement in 2013 with **AusAID's LOGICA** program to implement a province-wide health-based MSS training program in Aceh. In accordance with the agreement, Kinerja continued to provide technical assistance on MSS costing to DHOs in its five partner districts - Aceh Singkil, Aceh Tenggara, Bener Meriah, Kota Banda Aceh and Simeulue - while LOGICA delivered similar assistance to LG stakeholders in the province's 18 remaining districts. LOGICA also trained its district facilitators and Kinerja's local public service specialists (LPSS) in MSS e-costing and budget advocacy, which was used to lobby DPRD legislators in each of Aceh's 23 districts to integrate health MSS into their 2014 annual budgets.

One of Kinerja's longest collaborations was with the **CIDA-BASICS** program. The partnership, which lasted from March 2013 through June 2015, produced joint activities that included trainings and TOTs on complaint surveys, MSS in health and education, SBM and citizen journalism, which were implemented in North Sulawesi and/or Southeast Sulawesi provinces. Some of the activities were aimed at increasing the knowledge and capacity of BASICS' CSO partners, such as Kinerja-facilitated TOTs on conducting complaint surveys as well as citizen journalism in North and Southeast Sulawesi provinces in 2013, while others were directed at assisting government stakeholders to replicate Kinerja's reform packages, such as the SBM implementation in Southeast Sulawesi in FY 2015, as mentioned in the education section above.

Box 14: BPBD adopts Kinerja complaint surveys for disaster mitigation

By way of highlighting how Kinerja's good practices can be applied to various sectors, the program entered into collaboration in 2015 with a Padang-based NGO, the Community Empowerment and Learning Institution (LP2M), to apply the program's complaint-survey model to the field of disaster management. Kinerja conducted a TOT on complaint surveys for 25 members of a local disaster task force, comprising representatives from LP2M plus 14 other NGOs in West Sumatra and officials from the province's Disaster Management Agency (BPBD).

A follow-up workshop was held in April 2015 with LG and community stakeholders to identify the kinds of complaints that might be raised. With local mitigation efforts focused on earthquakes and tsunamis, the workshop participants finalized two questionnaires: one for people living in high-risk areas of the district and the other for those in lower-risk areas.

The questions were divided into three sections to reflect the three phases of disaster management: disaster preparedness, emergency response, and rehabilitation and reconstruction. LP2M and officials from the BPBD then went ahead and surveyed around 3,500 people in four of Padang's subdistricts: two high risk and two lower risk.

Two complaint indexes, one from each survey, were produced and formed the basis of a second workshop in June 2015. Having analyzed the complaints, the participants produced two sets of solutions: internal solutions for the BPBD, and external recommendations for relevant government departments and senior LG officials, including Padang's mayor.

The internal solutions were incorporated into two service charters (for high-risk and lower-risk areas) by Padang's disaster mitigation task force, and were submitted to the head of the BPBD for signing in July 2015.

Also as part of its cooperation with the BASICS program, and in conjunction with MOHA, Kinerja helped to compile a series of eight resource booklets on the application and integration of health and education MSS into LG planning and budgeting for MOHA's use. Nine Kinerja good practices were featured in two of the booklets, which were distributed to all districts nationwide. An official launch ceremony took place in April 2014, which Kinerja followed up by organizing two dissemination events for LG stakeholders in North Sulawesi and Southeast Sulawesi.

Kinerja also established a cooperative relationship with the European-based **World Wide Web Foundation** at the start of October 2014 to evaluate public data needs and to design solutions to

promote public access to government data through LG PPID offices. Details of the successful Open Government Program (OGP) pilot with the DEO in Kota Banda Aceh in November-December 2014, follow-up workshops to repeat the process with the DHO in April 2015 and discussions with the provincial Aceh PPID about replicating the program to other districts in the province are provided in the Good Governance chapter.

Kinerja also collaborated with the **German Society for International Cooperation (GIZ) -** first in 2011 and then in 2015. In 2011, Kinerja coordinated GIZ's Support for Good Governance (SfGG) project, and adapted tools and methods that had come out of the latter's Complaint-Handling Study. After further amendments, the tools served as an effective bridge to encourage government and civil society stakeholders to form working partnerships. In 2015, Kinerja cooperated with GIZ to support KemenPAN-RB's broad efforts to reform Indonesia's civil service by developing a regional innovation "knowledge hub", with a specific focus on good governance and excellence in PSD. The initiative, which was the result of a recommendation put forward at a Kinerja-organized national symposium on public service innovation in June 2014, was also carried out in cooperation with the **Java Post Institute of Pro-Autonomy (JPIP)**, the **Association of Indonesian Municipalities (APEKSI)** and international agency **FutureGov**.

At the start of October 2014, Kinerja helped to design a study to frame existing initiatives to support the promotion and replication of innovation in public services. The study collected feedback from potential users such as LGs, PGs, CSOs and academics. Kinerja presented the study's results in February 2015 to national stakeholders, including MOHA, KemenPAN-RB and the State Administrative Bureau (LAN). FutureGov then developed a draft outline of what the knowledge hub would look like, its scope and agenda, what basic services it would cover, and its working and funding mechanisms. The partners had hoped to launch the first knowledge hub in East Java[16] in June 2015, but it soon became apparent that this timeline was too ambitious and that more work needed to be done first.

The hub's ongoing development comprised three main events: (1) a public service innovation boot camp; (2) discussion rounds or clusters on innovative practices, and (3) a knowledge market. The boot camp took place in May 2015 at Brawijaya University in Malang, to help frontline users (SKPD officials) CSOs and academics better understand the needs and expectations of end users.

Kinerja and GIZ then went on to organize three discussion clusters across East Java in May-June 2015, to offer LG representatives an opportunity to disseminate and exchange public service innovations. Following the discussions, all the participants agreed to take the work forward by holding regular quarterly meetings, with East Java's Public Service Commission (*Komisi Pelayanan Publik* – KPP) taking the lead. The final event, the knowledge market, took place on June 30, 2015 at Kinerja's sustainability workshop in Surabaya, where information about the knowledge hub was presented to a wider audience and new stakeholders were encouraged to join. With the bulk of the preparatory work completed and Kinerja entering its close-out phase at the start of July 2015, it was collectively agreed that GIZ would assume overall responsibility for the final stages in the hub's development.

[16] The partners agreed to launch the first pilot hub in East Java, and then establish similar hubs in other provinces across the country.

Co-operation with Private Sector/CSR Funding

As part of its efforts to improve the delivery of health-care services in general and MCH in particular, Kinerja established a working relationship in April 2014 with private company Java Power, which supports Puskesmas Paiton in Probolinggo through its CSR program. At the start of the collaboration, Kinerja organized training on complaint surveys and baseline surveys for health volunteers at the *puskesmas*, and facilitated the establishment of an MSF. By the end of May 2014, the first complaint survey had been carried out with the involvement of the DHO, health center staff, the MSF and around 150 respondents and a service charter signed, which resulted in immediate improvements at the *puskesmas* in terms of service standards in patient care and offering greater transparency on treatment costs.

In addition, following the example set by Kinerja partner Puskesmas Sumberasih – which was recognized by the PG as the second-best *puskesmas* in East Java in 2014 – Puskesmas Paiton installed a fingerprint scanner to reduce patient check-in times and began to enter patients' medical records, insurance and billing information into an integrated, paperless database.

In addition to these rapid achievements, Java Power confirmed early in 2015 that besides continuing to support Puskesmas Paiton, it would be expanding its CSR program to fund the replication of Kinerja good practices - namely MSFs, complaint surveys, service charters, SOPs and control cards - at 11 additional *puskesmas* in the district in 2015, and a further 18 in 2016. During April-June 2015, therefore, Kinerja provided a series of small-scale trainings for the DHO, staff from all 11 *puskesmas* and new MSF members to help improve MCH and health center management through the development and finalization of service SOPs and control cards.

Just before Kinerja ended program activities in September 2015, the program was informed that the MSFs had begun to monitor the implementation of service charters and that other activities were being implemented as planned.

National-Level Replication Efforts

UGM university network

Gadjah Mada University (*Universitas Gadjah Mada* – UGM) in Yogyakarta was selected as Kinerja's partner to implement Kinerja's knowledge management activities and facilitate replication by capturing and analyzing good practices in Kinerja's core sectoral and governance innovations. Together with Syiah Kuala University (UNSYIAH) in Aceh, Airlangga University (UNAIR) in East Java, Hasanuddin University (UNHAS) in South Sulawesi and Tanjungpura University (UNTAN) in West Kalimantan, the University Network for Governance Innovation (UNfGI) was established in August 2011 to conduct research, publish related works and integrate empirical evidence on improved PSD in university curricula and research, and to lobby for the wider replication of these good practices to decision makers at the regional and national level through the wide university network.

The first task was the establishment of an interactive databank on good practices and associated case studies in health, education and BEE, and determining the key factors that make LGs successful. UNfGI developed an initial list of 14 good practices and identified six factors that could support the implementation and sustainability of further good practices: (1) leadership; (2) political will and LG support; (3) the presence of a local champion or agent of change; (4) community participation; (5) links to donor organizations, and (6) national regulations and/or policies.

With the aim of disseminating the information contained within the databank to as wide an audience as possible, UNfGI set up a website, igi.fisipol.ugm.ac.id, in March 2012. From its creation until the end of the formal partnership between Kinerja and UGM in September 2013, the website recorded 28,354 unique visitors. Recognizing the website's value for a wide range of stakeholders, it was agreed that the site and all of its content would be maintained for the remainder of the Kinerja program's lifetime. As of the end of September 2015, the original 14 good practices had increased to a total of 91, covering health (37), education (24), economy (19) and good governance (11), and the number of unique visitors to the website had increased to 52,912.

UGM supported the development and publication of policy briefs to highlight the most significant innovations. The policy briefs were divided into two broad categories – one to provide policy guidance for use at the district level and the other to provide information on the prerequisites needed for successful replication. The university network also produced several good practice books on education, health, BEE and good governance, which were distributed to a range of stakeholders, including government agencies at the national level and universities, to serve as models for replication.

UNfGI also organized two competitions: one for students at each of the partner universities to improve their abilities in conducting research, especially on PSD, and the second for the wider public, which attracted submissions from NGOs, university lecturers and civil servants. All the papers that made it to the final selection round were uploaded onto the UNfGI website, while the three winners from each of the competitions were announced at a National Innovation Summit in November 2012. Organized by UGM, the summit included a seminar and presentations, allowing representatives from national and district governments, together with academics and community members, to discuss and exchange information on 12 good practices – nine of which were Kinerja-supported implementations.

The UNfGI disbanded shortly after Kinerja's partnership with UGM ended in September 2013, as the five universities involved had not managed to establish a strong organizational structure. This was due primarily to UGM's centralized approach, according to which it retained decision-making power over the other universities rather than treating them as equal partners.

National Policy Dialogue on Service Standards

Kinerja's national-level policy dialogue on service standards aimed to (1) strengthen coordination with national ministries/agencies through regular meetings, and provide updates on the program's interventions and achievements; (2) develop policy papers to offer input on national policy surrounding service standards, particularly as it affects the application of MSS at the district level, and (3) obtain support from the national network for the dissemination of Kinerja's good practices to improve the chances for long-term sustainability.

Some of Kinerja's earliest meetings with national-level stakeholders focused on examining the array of service-standard initiatives and policies promoted by national government agencies – many of which were unclear and some even conflicting - in order to develop guidelines for district governments and to guide the program's approach when working with LGs to fulfill MSS in health and education. After holding a series of talks with MOHA, KemenPAN-RB, MOH and MOEC, Kinerja produced a white paper in 2011 entitled *Mapping Service Standards*, which provided an overview of existing voluntary and mandatory service standards, examined those that were in conflict and laid out a list of priority service standards to assist LGs in their decision-making.

In the **health** sector, Kinerja intensified its relations with MOH during the last year of programming. Between October 2014 and June 2015, Kinerja program staff produced and submitted four policy papers to MOH's Directorate General for Nutrition and MNCH:

- *Menuju Tata Kelola P4K, Pembelajaran dari Kinerja-USAID* (Toward Good Governance of the Planning and Prevention of Complications in Childbirth Program, Lessons from USAID-Kinerja);
- *Rencana Aksi Daerah Percepatan Penurunan Angka Kematian Ibu* (Regional Action Plan to Accelerate the Reduction of Maternal Mortality Rates);
- *Penerapan Standar Pelayanan Minimal Bidang Kesehatan Tahun 2015-2019: Pembelajaran dari Program Kinerja-USAID* (Recommendations for the Application of Minimum Service Standards in the Health Sector 2015-2019: Lessons Learned from the USAID-Kinerja Program);
- *Multi-Stakeholder Forum (MSF): Strategi Perlibatan Masyarakat untuk Meningkatkan Kualitas Pelayanan Kesehatan di Tingkat Kabupaten/Kota dan Kecematan* (Multi-Stakeholder Forums [MSFs]: Community Engagement Strategy to Improve the Quality of Health Services at Subdistrict and District Levels).

The ministry's response to all the policy papers was positive: MOH officials expressed an interest in utilizing a number of Kinerja's materials such as training modules and good practices in their own existing material. With regard to MSS, the ministry acknowledged the importance of applying MSS to its own health programs and in March 2015, MOH officials visited Kinerja district Probolinggo in East Java to see first-hand how Kinerja good practices in service standards were being implemented at the *puskesmas* level.

Joint discussions on MSS took place in June 2015, when MOH expressed an interest in adopting Kinerja's MSS costing tools for its National Action Plan on MCH. Kinerja also provided technical assistance to the ministry after officials sought advice on determining estimated costs for integrating MSS costing into district-level annual work plans and budgets. Kinerja met with MOH again in July 2015 to discuss the last policy paper on MSFs. As with the other three papers, MOH officials responded well, saying they were interested to learn more about how community involvement in the form of MSFs can help improve health-care services.

As a result of this series of meetings, Kinerja was invited to attend the annual Indonesia Health Policy Forum (*Forum Kebijakan Kesehatan Indonesia* – FKKI) in Padang, West Sumatra, as well as MOH's Mid-Term Evaluation meeting in Palembang, South Sumatra, both of which took place in August 2015. At the FKKI gathering, which included discussions on Indonesia's progress toward meeting the MDGs, Kinerja gave a presentation on Aceh Singkil's TBA-midwife partnership program, which three months earlier had been internationally recognized with a UNPSA.

At the Mid-Term Evaluation meeting, Kinerja's Public Service Standard Specialist and a DHO official from one of the program's former treatment districts, Jember in East Java, gave a presentation on integrating MSS into the district's health budget, and provided information on how to monitor and evaluate budgets in order to determine the extent to which local activities contribute to the fulfillment of MSS in health. Significantly, Kinerja's presentation was one of only four good practices chosen by MOH for inclusion at the evaluation meeting, offering a clear indication that the ministry had come to appreciate the knowledge and expertise that Kinerja had gained in the health sector during the previous four years of program implementation.

Kinerja and MOH also explored joint development of the so-called MCH Dashboard - an electronic version of the *kantung persalinan* information system that had been implemented by a large number of Kinerja-supported *puskesmas* to safeguard the well-being of pregnant women and their babies. The dashboard's development entered its final stages in July 2015 and MOH expressed a commitment to implement it widely in its own programs. However, issues such as an implementation timeline and Kinerja's role in that implementation were left unresolved as the program had now entered its final close-out quarter. This was a disappointing conclusion in light of the close working relations that Kinerja had established with MOH officials during the program's final year. However, this experience highlighted the importance of building and fostering relations with national-level technical ministries throughout the course of a project's programming, and it is a topic that is included in the Lessons Learned and Recommendations chapter.

Kinerja faced similar challenges over time limitations in its national policy dialogue with MOEC on **education**. In February 2015, Kinerja was invited to attend the National Education Symposium, which was organized by MOEC in collaboration with the Civil Society Coalition for the Transformation of Education (KMSTP), supported by USAID's ProRep (*Program Representasi*) program. The symposium was opened by Education and Culture Minister Anies Baswedan, who highlighted the importance of involving civil society when drafting education policies. The event resulted in a number of recommendations being put forward on issues such as access to and the affordability of education, as well as PTD and the quality of the national curriculum. Among other senior government officials, educational campaigners and CSOs, the deputy district head of Kinerja district Luwu Utara also attended the symposium, where she shared her experience of implementing PTD with Kinerja's support.

Box 15: Third RTI study published - on social accountability

In addition to the five policy papers produced by Kinerja's technical team in 2015, the program also presented to national and development partners the findings of an RTI study into social accountability (SA). Entitled *Social Accountability in Frontline Service Delivery: Citizen Empowerment and State Response in Four Indonesian Districts*, the study, which was conducted in two districts in Aceh and two districts in West Kalimantan, set out to gain a better understanding of "the contexts and political processes through which accountability is negotiated" in order to determine "the best fit between SA tools and local circumstances". Drawing on Kinerja's unique approach in working with both supply- and demand-side entities, and highlighting the impressive achievements gained since the start of the program, the study put forward six recommendations, as follows:

- Use contextual data as a guide, but be prepared for unexpected outcomes;
- Demonstrate the utility of citizen engagement through collaboration on shared problems to increase provider responsiveness;
- Leverage civil service/administrative reforms to provide institutional incentives and sanctions for provider responsiveness;
- Ensure that invited spaces directly engage providers with citizens;
- Go beyond enumerating progress on SA tools' implementation as a gauge of sustainability;
- Seek out contexts where SA tools are novel and address pressing needs to promote sustainability.

Kinerja presented the results of RTI's study in February 2015 to Bappenas, the Australian Department of Foreign Affairs and Trade (DFAT) and USAID to assist in their own program design and development.

While attending the symposium, Kinerja submitted a policy paper to MOEC entitled *Pelayanan Publik Sektor Pendidikan: Tata Kelola DGP, BOSP & MBS* (Public Services in the Education Sector: Governance in PTD, BOSP & SBM), which presented the main practical challenges involved in each of the three educational packages and proposed recommendations based on the program's approach and experience in the field. At a meeting to discuss the paper with MOEC's Directorate General for

Elementary Education in July 2015, ministry officials responded well to the recommendations and said they would aim to incorporate some of them into their own programming.

Kinerja also supported field visits in May 2015 for the National Development Planning Agency's (Bappenas) Director for Poverty Reduction, to two of its former treatment districts in South Sulawesi: Barru and Luwu Utara. The visits were a great success and led Bappenas to organize a two-day workshop in June 2015 entitled "LG and CSO Collaboration to Improve Access to, and the Quality of, Services in the Frame of Poverty Alleviation". Kinerja provided two resource persons for the workshop: the deputy district head of Luwu Utara and the head of the DEO in Bener Meriah, Aceh, who recounted their experiences of collaborating with Kinerja to improve governance in PTD and SBM, respectively.

In August 2015, Australia's DFAT invited Kinerja to attend a workshop at MOEC entitled "Improving Indonesian Education through Innovations in Teacher Management and Community Participation". The workshop presented findings from a study carried out by the National Team for the Acceleration of Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan* – TNP2K), which echoed Kinerja's emphasis on the important role civil society can play in improving public services by recommending the involvement of local communities to help improve teacher management and education services.

To support the national government's priorities in **business-licensing reform** to enhance the country's investment climate, TAF engaged Bekasi-based NGO Akademika to (1) formulate guidelines for license simplification, learning from the experience of Kinerja's BEE innovation and replication activities; (2) document Kinerja's good practices in BEE; (3) finalize and print a revised OSS TOT module and, following a request by MOHA in February 2015, to (4) develop technical guidelines for the implementation of micro- and small-enterprise licenses.

License Simplification

MOHA Circular No. 500/5961/SJ instructs comprehensive implementation of business services through the establishment of OSS, transferring licensing authority to OSS, the formulation and implementation of an SOP for each permit, and license simplification. However, there are no national guidelines for simplification of various types of business licenses. Based on the lessons and experience of TAF and its local partners in piloting license simplification through Kinerja's BEE program, Akademika developed guidelines via consultations with national and local governments, as well as with its four BEE implementing partners. Initially, MOHA intended to adopt and issue the guidelines as an official document. However, inter-ministerial dynamics at the national level meant that MOHA was no longer mandated to promote license simplification. Nonetheless, the guidelines have been issued and can be used by LGs and other development partners to nationally replicate Kinerja's BEE achievements.

Good Practice Documentation

TAF supported Akademika to identify good practices in OSS development at the district and provincial levels, mainly through interviews with relevant stakeholders. A report was developed along the lines of the UNPSA and Kinerja good practices. The report identified several important strategic aspects of OSS development and good practices, such as the importance of selecting the "right person" to lead an OSS, particularly in its early development; the significance of having OSS with sufficient licensing authority; a strategy to reduce the different types of licenses, and the importance

of OSS forums in promoting the further establishment and development of OSS, particularly through inter-district learning.

In addition to these strategic aspects, the report also identified good practices in technical aspects of OSS development. These include the establishment of effective OSS technical teams; the formulation of good SOPs and service standards; the importance of licensing to informal businesses; engagement with the community in OSS management and obtaining feedback from OSS users. The report also records the perceptions of OSS users, who acknowledged that OSS made it easier for them to obtain business licenses. Although some businesspeople admitted to still using middlemen to obtain and extend their licenses, others said they now chose to go directly to OSS.

OSS TOT Module

As part of Kinerja's BEE replication, there was a need to expand the capacity of provincial-level stakeholders in providing OSS development support to additional districts. Based on discussions with MOHA's Education and Training Agency (Badan Diklat), TAF and its local partners developed a TOT module on OSS, and conducted four TOTs for a total of 107 government and civil society participants in Kinerja's four target provinces in May 2013. The participants of the TOTs went on to engage in Kinerja's replication activities, either through provincial OSS Forums or by offering direct support to replication districts.

Following a request by Badan Diklat, Akademika revised the module in 2014 to incorporate recently-issued national regulations, and it was finalized via a series of consultations with MOHA. In addition, Akademika also supported Badan Diklat to revise the module to train OSS staff and technical team members and to provide reading materials on OSS development for senior officials.

Technical Guidelines for Micro and Small Enterprise Licensing

MOHA's Directorate General for Regional Development (Bangda) is mandated to coordinate the implementation of Presidential Regulation No. 98/2014 on Licenses for Micro and Small Enterprises (IUMK). The spirit of the regulation is to provide micro and small enterprises with a one-page license, free of charge, within a day at the subdistrict level. Akademika developed technical guidelines to be used by LGs to issue IUMK. The key aspects of the technical guidelines include criteria for and eligibility of IUMK recipients, budget and infrastructure to provide the licenses, institutional division of roles and responsibilities, M&E, and forms and templates.

Akademika developed the guidelines through a series of national and sub-national workshops in consultation with various stakeholders, including officials of various directorates general within MOHA and other national ministries and the Investment Coordination Board (*Badan Koordinasi Penanaman Modal* – BKPM). The Director General of Bangda issued a letter to all governors, mayors and district heads in May 2015 based on the guidelines. The guidelines have since been used as the main reference for the dissemination of IUMK provision conducted by national ministries in several provinces.

Cooperation with LAN

The State Administrative Bureau (LAN) runs Indonesia's national training center for government staff. Kinerja first began to work with LAN in 2013 to disseminate its good practices and service

delivery modules[17] and, in so doing, contribute to the program's wider replication objectives. At the same time, LAN expressed its intention to revise its curriculum, with the aim of changing its overall training strategy from a simple recitation of rules and regulations to Kinerja's more practical approach - based on empirical findings from Kinerja's implementation experience - to better enable LG officials to improve public services.

LAN launched the revision process in 2014. As an initial step in supporting those efforts, Kinerja arranged several joint visits for senior LAN officials to see first-hand the work Kinerja was implementing in partner districts. Program staff also invited LAN to replication workshops and training sessions to learn more about Kinerja's good practices and provided training sessions specifically for master trainers from LAN and other technical ministries at the national and provincial level on improving PSD and the principles of good governance.

Before the curriculum itself could be amended, Kinerja assisted LAN with the revision of its Head of the State Administrative Bureau Regulation (PerKa LAN) No. 10/2011 on Guidelines for the Implementation of Public Service Training, which outlined LAN's curriculum. The focus of Kinerja's efforts was to make LAN's training sessions more practical and relevant by incorporating case studies from Kinerja districts, introducing aspects of a more competency-based curriculum, and developing different training packages for various target groups, including management and front-line service staff.

In early 2015, Kinerja and LAN held several focus group discussions (FGDs) on various topics and reached agreement in a number of areas, including the substance of the proposed amendments to the regulation, and creating an entirely new paradigm - comprising 13 points - with which to improve LAN's curriculum. The final draft of the amended regulation – PerKa LAN No. 28/2015 - was approved in March 2015, but it remained unsigned until the end of September 2015, coinciding with the formal end of the Kinerja program. This meant that the original plan, namely to have Kinerja conduct a TOT for provincial- and national-level master trainers in the new curriculum as soon as the new regulation was signed, did not take place. However, USAID had recently granted Kinerja an 18-month cost extension for its separate program in Papua, so LAN and Kinerja agreed that the TOT would go ahead, albeit later than planned, in 2016. At the time of writing, the collaboration between Kinerja and LAN is continuing, with Kinerja assisting LAN to develop new modules for the curriculum, which will be adapted and trialed for government officials in Papua.

Cooperation with KemenPAN-RB

One of Kinerja's primary national-level partners was KemenPAN-RB, specifically the ministry's Office for Public Services. Apart from the program's cooperation with KemenPAN-RB and other development partners on developing the innovation knowledge hub, as detailed earlier in this chapter, continual efforts went into a range of other initiatives, including the development and formulation of national policy regarding civil society engagement and public-service innovation.

Starting in October 2013, KemenPAN-RB launched a process to revise several of its regulations, concerning the development of customer satisfaction indexes (*Indeks Kepuasan Masyarakat* - IKM) at the SDU level, improving public services through community participation (complaint surveys), and

[17] Kinerja's service delivery modules provided information on how to establish partnerships between LGs and civil society and covered such topics as strengthening the demand for improved services, LG accountability, and the use of community-based feedback/complaint mechanisms.

on service standards. Kinerja was invited to participate in the review process and provide input based on its own experience in the field.

Kinerja managed to convince the ministry to retain complaint surveys and other public oversight mechanisms in the amended regulation on community participation, due to the demonstrated impact that the program's surveys had had in improving public services. Following the regulatory review, KemenPAN-RB issued the newly-revised regulations in May 2014, with amendments that reflected Kinerja's input. Later that year, Kinerja also participated in several FGDs, organized by KemenPAN-RB and in collaboration with GIZ, APEKSI and LAN, to draft a new regulation on innovation in public services. After follow-ups to finalize the draft, PAN-RB Ministerial Regulation No. 30/2014 on Guidelines for Public-Service Innovation was issued toward the end of 2014.

This new ministerial regulation was a direct outcome from a national symposium, organized by Kinerja in collaboration with KemenPAN-RB and other development partners, which took place in Jakarta in June 2014. The two-day Symposium on Innovation in Public Service Delivery, which attracted more than 500 participants from across Indonesia, provided districts with the opportunity to showcase their achievements and discuss ways in which national and provincial governments could help to ensure the replication and sustainability of good practices, such as through innovation competitions, financial incentives and national/provincial regulations and policies. Representatives from a number of Kinerja's IOs also attended the event, allowing them to promote their programs and establish links with interested LGs.

Notable guests at the symposium included Indonesia's then Vice President who opened the event, the minister and deputy minister of KemenPAN-RB and U.S. Ambassador to Indonesia. A total of 54 resource persons from various district governments participated in the symposium's talk shows and FGDs about their experiences in implementing public service innovations. The symposium also included an exhibition highlighting some of the innovations implemented at both national and district levels. The symposium ended with the submission of summary findings and recommendations to KemenPAN-RB to guide future cooperation between the ministry and the donor community.

Kinerja was invited to host a booth at a similar symposium the following year in Surabaya that on this occasion was jointly organized by KemenPAN-RB and East Java Governor Soekarwo. Nearly 500 people visited Kinerja's booth during the three-day event, which allowed the program to widely disseminate information about its reform packages and good practices to improve services in health, education and BEE.

Another key area in which Kinerja assisted KemenPAN-RB was in supporting the latter's nominations for the annual UNPSA, which is the most prestigious international recognition of excellence in public service. For the 2014 UNPSA, Kinerja helped the ministry to develop applications for three of its partner districts: Aceh Singkil, Barru and Luwu Utara, based on their respective achievements in fostering TBA-midwife partnerships, improving business licensing and PTD. A total of five Indonesian districts were selected as finalists that year; although none went on to win an award, it was the first time that any Indonesian nominee had made it to the final round. Moreover, the five finalists included all three Kinerja-supported districts.

The program supported the ministry's UNPSA nominations again for 2015. This year, KemenPAN-RB included five Kinerja districts among its nominations: Three were updated nominations of its 2014 finalists, plus new nominations for Bondowoso and Bener Meriah for their achievements in adolescent reproductive health and SBM, respectively. Aceh Singkil progressed to the final round for the second consecutive year; then in May 2015, the UN announced that it had been selected as second-place winner in the Improving the Delivery of Public Services category for its success in "Fostering Partnerships between Traditional Birth Attendants and Midwives to Reduce Maternal and Infant Mortality".[18]

In the wake of Aceh Singkil's UNPSA win, KemenPAN-RB invited Kinerja to join a workshop in August 2015 to offer practical advice to district officials from across the country on how to develop strong UNPSA applications. Representatives from the top nine innovative districts in 2014 and the top 40 in 2015 attended the workshop. In its presentation, Kinerja outlined the steps involved in putting a UNPSA application together based on its experience supporting KemenPAN-RB's nominations. The program also presented the lessons it had learned when developing Aceh Singkil's two consecutive applications, as well as reviewing and highlighting the strengths and weaknesses in draft applications that some of the top 40 innovators had already developed for the 2016 UNPSA.

Box 16: U.S. Embassy heralds Aceh Singkil's UNPSA win

In order to mark Aceh Singkil's historic achievement of becoming one of the first two districts in Indonesia ever to win a UNPSA, the U.S. Embassy invited a delegation from the district to discuss the TBA-midwife partnership program at a celebratory event at the embassy's cultural center, @america, in Jakarta on June 3, 2015.

The event, which was organized by USAID-Kinerja, consisted of three elements: a photographic exhibition, a screening of Kinerja's film about the program and a talk show, hosted by Kinerja's Deputy Chief of Party.

The talk show participants comprised some of the key stakeholders in the program, including Aceh Singkil District Head and DHO Head, together with a midwife, a TBA, a village head, and the head of one of the district's *puskesmas*-level MSFs.

During his opening remarks, the USAID Mission Director praised the innovative partnerships, while the Head of Aceh's Provincial Health Office announced that the PG planned to adopt and replicate similar TBA-midwife partnerships across the province.

With TBA-midwife partnerships replicated to a total of 29 villages in Aceh Singkil in 2014-2015 – as part of a longer-term plan to expand it throughout the entire district – it is hoped that the international recognition of the program's effectiveness in reducing maternal and infant mortality will inspire governments in other Indonesian districts and provinces to adopt similar measures.

In order to harness the momentum around the achievements being made at the district level and to encourage further innovation, Kinerja together with GIZ assisted KemenPAN-RB to establish the Public Service and Innovation Information System (SINOVIK) awards in 2014 – an Indonesian equivalent to the UNPSA. During initial discussions with the ministry, KemenPAN-RB accepted Kinerja's suggestion that the format for SINOVIK applications be the same as that for the UNPSA; in this way, districts could use the same application material for both award programs. In 2015, of the 10 districts that won SINOVIK awards, three were supported by Kinerja: Aceh Selatan, Banyuwangi and Lumajang; while in 2016, the fingerprint recognition technology introduced at one of Kinerja's partner health centers in Probolinggo, Puskesmas Sumberasih (see Box 18), has been recognized as one of SINOVIK's top-99 innovations from across Indonesia.

[18] Aceh Singkil was one of two Indonesian districts to win a UNPSA in 2015: Sragen District in Central Java was also selected as a second-place winner for its Integrated Service Unit on Poverty Relief.

JPIP/FIPO/PP Pro-Autonomy Awards

To feed into its own replication efforts, Kinerja established a close partnership with the Java Post Institute of Pro-Autonomy (JPIP) in East Java, which had established a successful annual seminar and award program in 2001 that utilized a blend of public policy research and media attention to spur innovation in PSD at district and provincial levels, improve the performance of existing programs and replicate proven good practices to new districts.

The JPIP awards had become a prestigious event, attracting the attendance and participation of national government representatives, including cabinet ministers. In describing the program, the JPIP's Deputy Executive Directorsaid: "We push district governments to compete in improving public services using our approach, which provides recognition for their performance [The awards] have become a great motivator for district leaders because they are a measurement of their performance. They were elected in local elections but from then on, they also have to prove their performance through, for example, the autonomy awards."

Box 17: Pro-autonomy programs featured in four new books

Two of the books, produced by FIPO and PPIP, presented findings and results from award-winning districts in South Sulawesi and West Kalimantan, respectively:

- *Refleksi 5 Tahun Otonomi Awards: Hasil Monitoring and Evaluasi Kinerja Kabupaten/Kota di Sulawesi Selatan 2013* (Reflections on 5 Years of Autonomy Awards: Monitoring and Evaluation Results of Performance among Districts/Cities in South Sulawesi 2013);
- *Mengapresiasi Inovasi: Sembilan Terobosan Kabupaten/Kota Peraih Otonomi Awards 2013 di Kalimantan Barat* (Appreciating Innovation: Nine Breakthrough District/City Recipients of Autonomy Awards in 2013 in West Kalimantan).

The two other books, published in 2014-2015, were produced by JPIP. The first of these, entitled *Meramu Otonomi Awards* (Gathering Autonomy Awards), offers an in-depth, step-by-step guide on how to establish and implement an autonomy award program. Drawing upon its own experience, JPIP explains the various steps involved, from setting up an assessment institution through to the award stage. In the book, JPIP stresses the importance of independence, pointing out that it cooperates with PGs, donor organizations, companies and the national government, but not with district governments.

The second, entitled *Media dan Pelayanan Publik: Cara Media Memperbaiki Pelayanan Publik di Jawa Timur* (Media and Public Services: The Way Media Improves Public Services in East Java), offers practical examples of how the media can be a powerful tool for advocacy. Whatever the type of media, whether mainstream or social, the book argues that media outlets have an important role in promoting service improvements if they gain and maintain the public's trust.

Recognizing the award program's importance in spurring further innovation among LGs and providing a strong foundation for sustainability, Kinerja awarded a grant to JPIP in November 2011 to strengthen both its own award program and that of its sister organization, the Fajar Institute for Pro-Autonomy (FIPO) in South Sulawesi, with a particular focus on improving their assessment mechanisms. Kinerja's support for JPIP and FIPO also incorporated a plan to expand the provincial award program to West Kalimantan. Drawing on their extensive experience, JPIP and FIPO were instrumental in the establishment of the Pontianak Post Institute of Pro-Autonomy (PPIP), which held its first annual award ceremony in December 2013.

Apart from Luwu Utara, which won a FIPO award in 2013 for Public Participation with its *Warung Demokrasi*, a number of other Kinerja districts in the three provinces were recognized with autonomy awards for their public service innovations between 2012 and 2015.

In October 2014, Kinerja commissioned the JPIP to conduct a study on the sustainability of good practices. The study, entitled *Study on Sustainable Innovations and Good Practices of District/City Governments*

Winning Autonomy Awards in East Java, assessed the sustainability of innovations in East Java districts that had received an award for improved public services between 2004 and 2013. Of the 55 innovations recognized during this period, 47 were still being implemented or had been expanded; only eight had been discontinued.

Researchers found that autonomy awards were an effective means of promoting innovation, as they inspired healthy competition among LGs to improve their performance. Moreover, any improvements made were further consolidated if recognized with an award. The study also provided evidence that innovations were most often initiated and sustained by district heads and their administrations. Very few innovations had been encouraged by outside influences, such as the national government, PGs or development partners.

The results of the study validated Kinerja's twin-track supply and demand approach as it emphasized the need to:

- Incorporate meaningful public feedback in policy initiatives;
- Support leadership that prioritizes performance improvements, and
- Select and maintain managers capable of driving innovations and inspiring improvements in PSD.

Kinerja's direct support of JPIP ended in January 2015. In its final report, JPIP gave an account of the progress made at the district level across the country as a result of the Pro-Autonomy program, citing the increasing willingness among both local and provincial governments to allow the institutes to monitor and evaluate them in order to improve the provision of services to their respective communities. The JPIP also expressed its appreciation for Kinerja, explaining that the program's staunch support had helped all three institutes to be regarded as trusted and credible organizations in the eyes of the governments it assessed.

> ***"We at the** ministry fully support initiatives like the [Pro-**Autonomy] Awards program [...] by** highlighting what is possible, the program helps to raise the bar for government performance so that decentralization can deliver the maximum **possible benefit for the people."***
>
> Former KemenPAN-RB Minister

International-Level Replication Efforts

With four years of operational experience behind it, Kinerja saw its profile raised to the international level. The program's senior management staff and technical specialists and partners found themselves in high demand, which offered the opportunity to disseminate information about Kinerja's approach, achievements and good practices to audiences outside Indonesia. This section presents a list of the international events and conferences that Kinerja either attended or helped to facilitate between November 2014 and October 2015.

- Kinerja assisted KemenPAN-RB to conduct an event with the Organization for Economic Cooperation and Development (OECD) in Paris, France, in November 2014, together with representatives from South Africa, Portugal and Thailand, to discuss their experience in establishing regional knowledge hubs to expand innovations in PSD;

- Kinerja's COP attended the 19th OECD Development Assistance Committee (DAC) Meeting in Paris on November 4-6, 2014, where she gave a presentation entitled "Kinerja Approach and Achievements";

- The program's COP also attended a second OECD event, *Innovating the Public Sector: From Ideas to Impact*, in Paris on November 12-13, 2014. The COP shared the findings from JPIP's sustainability study and presented Kinerja's governance approach. As a result of discussions with the OECD at this gathering, documented good practices from Kinerja's 2014 UNPSA finalists (Aceh Singkil, Barru and Luwu Utara) were accepted and uploaded onto the OECD's Observatory of Public Service Innovation (OPSI) database in June 2015;

- The Head of the Aceh Singkil Health Office presented information about Kinerja's health interventions as a member of a KemenPAN-RB mission at the Association of Southeast Asian Nations' (ASEAN) Republic of Korea Commemorative Summit in Busan, Korea, on December 10-12, 2014;

- Kinerja's Media Specialist traveled to the Philippines in March 2015 to attend the annual RightsCon summit, which was entitled *Defending and Extending Digital Rights in Southeast Asia*. Kinerja presented a session organized by the World Wide Web Foundation entitled "A Right to Data? Legal and Practical Challenges at the Intersection of Freedom of Information and Open Data";

- Kinerja's COP and the program's Agreement Officer's Representative from USAID accompanied the Indonesia/Aceh Singkil delegation, led by KemenPAN-RB, to Medellín, Colombia, to attend the 2015 UNPSA Forum and Award Ceremony on June 23-26, 2015. Aceh Singkil had a booth at the forum, allowing members of the delegation to share information about the TBA-midwife partnership program in Aceh Singkil and Kinerja's other good practices to government representatives and other visitors from around the world;

- The program's COP attended a three-day seminar in August 2015 at the headquarters of the Asian Development Bank (ADB) in Manila. Entitled *External Support for Decentralization Reforms and Local Governance Systems in Asia Pacific: Better Performance, Higher Impact?* The COP participated in two sessions: the ADB conference on the ADB/GIZ/FutureGov Forum on Innovations in Public Services – Doing Things Differently, and External Support for Decentralization Reforms and Local Governance Systems. RTI's Jana Hertz also attended the conference, where she presented the institute's Social Accountability study (see Box 15);

- Kinerja's Technical Specialist for Health gave a presentation on TBA-midwife partnerships at the Global Maternal and Neonatal Health Conference, jointly organized by USAID and Save the Children, in Mexico City in October 2015.

The head of Sambas District Health Office and the head of their NGO partner, PKBI.

Encouraging the sustainability of Kinerja's interventions across health, education, and business was a focus from the beginning. To ensure Kinerja's programs gained momentum and retained it, replication targets were also set as part of the Performance Monitoring Plan (PMP) for both scaling up within partner districts and replication into other districts throughout Indonesia. Kinerja used a number of methods to support sustainability, as described below.

Kinerja implemented its programs primarily through local institutions to encourage sustainability of interventions. These institutions were Indonesian CSOs that worked at the local (district) or provincial level in Kinerja's partner areas. This means that not only was local capacity and knowledge built, but that the CSOs became well-known to the LGs, leading to the potential for ongoing partnerships. For example, Kinerja's IO for health in Sambas, the Indonesian Family Planning Association (*Perkumpulan Keluarga Berencana Indonesia* - PKBI), was directly engaged by the LG to replicate Kinerja's health program from six pilot *puskesmas* to the district's remaining 21 *puskesmas* between 2013 and 2016. Partnerships like this are mutually beneficial and contribute to long-term improvements in public service provision. Kinerja's staff and consultants were also primarily local residents, which again meant that governments would be able to engage them as expert staff in the future. At the end of 2015, lists with the names and contact details of former staff and consultants were provided to LGs and uploaded on Kinerja's website to ensure their information remained accessible. A number of former Kinerja staff are already working as consultants with LG offices, such as in Kota Makassar, South Sulawesi, Bener Meriah, Aceh and Tulungagung, East Java.

Throughout the program, Kinerja also worked closely with provincial governments to ensure that knowledge of both good governance and Kinerja's interventions would become part of government-led trainings. Provincial governments are responsible for quality assurance and oversight as well as the capacity-development of not just provincial but also district government employees, which means they play a crucial role in passing on skills to wider audiences. This transfer of knowledge and skills is vital to the sustainability and replication of Kinerja's interventions. The PG of East Java was particularly receptive to and enthusiastic about Kinerja's technical assistance.

Box 18: Clinic treats long lines, delays with dose of technology

Like many community health centers that serve as the backbone of Indonesia's health-care system, Puskesmas Sumberasih in Probolinggo, East Java, is charged with serving the full range of its community's needs – from simple emergency services, to basic health checkups, dentistry and obstetric services. In tackling this broad challenge, however, it has brought to bear the twin tools of good governance and effective data management.

With Kinerja support, a group of community, traditional and religious leaders gathered together to form a citizen oversight board at the *puskesmas* in November 2012, revitalizing a previous group that had been formed in the past. As one of its first activities, this new MSF implemented a public complaint survey among the health center's patients, involving some 100 respondents. The results were then analyzed in consultation with the clinic staff and a service charter, outlining steps to address the complaints, was signed in December 2012.

"From the complaint survey, we learned that many of our patients were unhappy with the long waiting times. Although we had been using the electronic patient database *SIMPUSTRONIK* since 2007, we added fingerprint recognition to our patient intake process as a result of the complaints," said Puskesmas Sumberasih Head.

"This has helped to reduce check-in times from three minutes to a matter of seconds, even if a patient has forgotten to bring their ID card. All they have to do is scan their finger, and their recent medical history is automatically called up in the database. Although this seems like a small change, it is multiplied by nearly 100 patients that we serve every day, and so the efficiency really adds up," he added.

The DHO has since introduced fingerprint recognition technology to more than 10 additional *puskesmas* in Probolinggo, while Puskesmas Sumberasih's successful implementation of the technology continues to inspire. At the time of writing this report, Sumberasih had been chosen by KemenPAN-RB as one of the country's top-99 innovations for the 2016 SINOVIK awards.

Additionally, Kinerja acknowledged that working with the national government would be a major driver of sustainability. By providing support to bodies related to civil servant training, such as LAN and KemenPAN-RB, Kinerja could ensure principles of good governance are well-embedded in national training and learning programs. Kinerja also contributed to policy development by developing and sharing policy briefs with MOH, MOEC and Bappenas.

In June 2015, Kinerja held two sustainability workshops to further encourage partner and replication governments alike to continue to implement Kinerja's interventions. The South Sulawesi workshop, held in Kota Makassar, was attended by 120 people, including senior government officials and local MSF members. The East Java workshop, held in Surabaya, was attended by 160 people from 34 of the province's 38 districts, including three district heads. Both workshops were enthusiastically received and reconfirmed LGs' strong commitments to improving public service provision.

Some examples of how Kinerja's interventions are continuing since program activities ended can be found in Aceh. Both Kota Banda Aceh and Simeulue distributed a second round of BOSP allocations in mid-2015, and the PEO intends to replicate the BOSP package to new districts during 2016 with the assistance of former Kinerja IOs and staff. The PEO has also stated that it aims to implement BOSP at senior high schools as well, after supervisory responsibility for the schools was transferred from the district to the provincial level in 2015. In Aceh Singkil, the district continues to expand its award-winning midwife-TBA partnerships and is increasing support for breastfeeding promotion,

inaugurating 10 new breastfeeding ambassadors in late 2015, bringing the total to 120 across the district. In Bener Meriah, the district-level MSF gained legal status by a district head decree and has been very active in assisting the government with improving education quality. In 2015, the MSF began analyzing the availability of schoolteachers in all elementary and junior high schools in the district, for example, and even conducted capacity-building workshops for school committee members at all elementary and junior high schools in three different subdistricts.

In East Java, too, LGs are continuing Kinerja's interventions. The LGs of Tulungagung, Jember and Kota Probolinggo all provided funds to district-level MSFs in 2015 to evaluate the implementation of service charters and technical recommendations at replication *puskesmas*. Tulungagung and new replication district Pacitan have also been working with Kinerja's former provincial public service specialist to improve *puskesmas* health services. Probolinggo district also recently issued a new regulation on public education that mandates the implementation of Kinerja's public service-oriented SBM approach. The district has also recruited Kinerja's former local public service specialist to assist them.

Not to be left behind, interventions in South Sulawesi are also proving sustainable. In Kota Makassar, for example, the DHO has allocated funding to finalize the Local Action Plan on I&EBF and to evaluate SOPs on ante-natal care at all 43 *puskesmas* in the district. The DHO has also been overseeing the establishment of MSFs and *Bapak Peduli ASI* (Fathers who Care about Breastfeeding) groups and the election of breastfeeding ambassadors at 17 replication *puskesmas*. In the business sector, replication activities to improve OSS remain strong in South Sulawesi, where former Kinerja IO YAS is continuing to provide support to 10 LGs.

In West Kalimantan, Sambas continues to actively strive to improve MCH services through good governance. All 27 *puskesmas* in Sambas have now implemented various elements of Kinerja's interventions, and the government remains in close contact with former Kinerja staff. In replication district Kubu Raya, the DHO has stated it will be expanding its comprehensive TBA-midwife partnership program throughout the district during 2016 and 2017, and has already allocated funds to ensure TBAs receive adequate financial support to join the program.

The South Sulawesi Governor inspects an ornament produced by a local SME at the Kinerja-supported mass-licensing day in May 2015.

Strategy

RTI International engaged Social Impact as an independent subawardee focused solely on M&E activities for the Kinerja program, while Kinerja's consortium partner SMERU Research Institute served as the local evaluation partner. The design of the Kinerja program reflected a major shift within USAID toward rigorously evaluating the impacts of large-scale democracy and governance programming. As a result, the M&E strategy comprised three discrete but integrated components:

1. Evaluating overall program effects in health and education across 20 treatment and 20 control districts in Kinerja's four target provinces, using pre-existing national datasets.[19]

2. Evaluating the effects of the SBM package at 48 randomly-selected treatment schools and 48 randomly-selected control schools within three districts in West Kalimantan that implemented the package.[20]

3. Within all 20 treatment districts, tracking key indicators related to the intermediate results for (1) promoting the adoption of improved service delivery approaches; (2) strengthening

[19] The BEE intervention was not included in the district-level IE due to a lack of available business-related data in pre-existing national datasets.

[20] Apart from examining the impact of Kinerja's SBM intervention in these three districts, the evaluation also sought to build on the small but growing body of SBM literature to provide relevant policy information to USAID and other donors (including the World Bank and DFAT).

incentive systems for improved local government service delivery, and (3) facilitating the larger-scale replication of improved practices.

SI designed a Performance Management Plan (PMP) for managing and documenting all aspects of Kinerja performance management. Kinerja's Impact Evaluations (IEs) were geared toward identifying the actual effects of the program accurately and credibly.

Both IEs utilized randomized control trial (RCT) designs. While the SBM study utilized a rigorous mixed-methods design with primary data collection and robust sample sizes, the district-level study suffered from a number of methodological challenges that limited the ability to identify and attribute changes to the Kinerja program. Chief among these were low statistical power, a demand-driven implementation approach that generated significant heterogeneity in treatment, and reliance on secondary data that did not cover Kinerja's full implementation period.

This chapter goes on to explore these challenges in greater detail as well as presenting the key findings and achievements for each of the three components listed above.[21]

District-Level Evaluation

For the district-level IE, the team used two national datasets - the National Socioeconomic Survey (SUSENAS) and the National Basic Health Research Survey (RISKESDAS) - with district-level representativeness for most indicators, to measure baseline (2010) and endline (2013) outcomes in treatment and control districts. To examine the overall effects of the Kinerja program, the evaluation team used two regression models to estimate programmatic impacts. Both approaches controlled for baseline variation between treatment and control districts.

Despite accessing individual-level data from the RISKESDAS and SUSENAS datasets, the clustering of this data across only 40 districts (in a country containing more than 500) greatly reduced power, requiring in some cases up to a 19-percentage-point change in indicators to achieve standard confidence in identifying a statistically significant difference in treatment and control districts. Moreover, Kinerja's demand-driven program approach (which meant that not all districts received the same "uniform" treatment) resulted in different scope and intensity of implementation in each district; this "heterogeneity of treatment" increased expected variations in outcomes and resulted in decreased power to detect statistically significant outcomes. Finally, the evaluation's reliance on secondary data resulted in using baseline, and particularly, endline data that did not align optimally with the program's implementation timeline. The evaluation team attempted to mitigate these limitations by using as much available data as possible, including other secondary sources.

The qualitative study, conducted by SMERU, focused on changes observed at the district and SDU levels in the education and health sectors. Eleven districts were selected for the study and visited during baseline (2011) and endline (2014) data collection. This study was also impeded by several factors: First, based on a request by USAID, these districts were analyzed regarding their Round-1 packages (see Annex 2) which excluded investigation into subsequent Round-2 packages in those districts. Second, the baseline and endline tools for the qualitative study were not identical, considering that the baseline was conducted before Kinerja's interventions had been finalized. The baseline,

[21] The findings of the district-level IE (component 1) and SBM IE in West Kalaimantan (component 2) are taken from SI's *Impact Evaluation of USAID/Indonesia's Kinerja Program (April 2015)*, which offers in-depth information about both assessments.

therefore, provided context but not an adequate comparison for endline data. Finally, endline data were gathered over the course of several months, meaning that some program effects may not have been captured in those districts visited earlier in the 2014 fiscal year.[22]

At the district level, the evaluation team found little evidence of changes attributable to the program, though the team did see positive changes on nearly all education and health indicators in treatment areas. Additionally, qualitative data revealed important improvements in intermediate health and education outcomes at the district and SDU levels, which was consistent with the M&E team's monitoring data (detailed in the Performance Indicators section of this chapter).

Progress was made on the intermediate outcome to improve the health and education regulatory environment in Kinerja's districts. All districts passed improved regulations regarding issues ranging from maternal and child health to the distribution of teachers. Progress was also made in establishing successful participatory processes regarding education reforms for PTD and BOSP. For example, education stakeholders from the community helped schools and district governments analyze operational needs and plan how to meet gaps in funding. This inclusive approach ensures transparency and promotes understanding of program activities.

Improvements in health management and good governance at the SDU level were noted in the qualitative study, and clients' behavior (over the long term, affecting district-level outcomes) had changed according to specific health indicators tracked in monitoring data.[23] These indicators increased from 2012 to 2015 in most partner units, revealing changed behavior at the unit level but not yet at the district level.

It is likely that client behavior (tracked by district-level indicators) had not yet changed at the district level due to the limited timeframe for both data collection and programming, which underscores the need to increase the length of programming to affect behavior. Another issue concerned data accessibility and reliability, which continues to be a challenge for districts, health centers and schools, despite improved data-management systems. This made it difficult to identify and integrate lessons learned and to refine programming as needed.

School-Based Management Evaluation

The SBM IE utilized a mixed-methods RCT design to measure changes in development outcomes attributable to Kinerja's SBM intervention in three sampled districts in West Kalimantan: Bengkayang, Melawi and Sekadau. Specifically, the study focused on the effect of the SBM intervention on four key outcome areas: role clarification; transparency/accountability; committee participation, and community involvement.

The study comprised two data collection waves, with baseline data collected in October 2011 and endline data collected in October 2014. Fieldwork included collection of survey data from principals, school committee members and parents, as well as from direct observation to triangulate data on key

[22] October 2013 through September 2014.

[23] The Kinerja PMP tracks the following indicators at the partner *puskesmas* level, documenting these as "goal-level indicators": % of pregnancies assisted by qualified health-care workers; % of pregnancies receiving complete antenatal care (four visits); % exclusively breastfed. This data is reported in PWS KIA reports.

outcome areas. The evaluation team utilized a multiple regression model to estimate school-level average treatment effects of the SBM intervention.

To complement the SBM IE, qualitative data collection in Bengkayang, Sekadau, and Melawi focused on changes observed specifically in school participation and performance according to key respondents. SMERU, together with evaluation stakeholders, selected two partner schools to visit during baseline (2011) and endline (2014) data collection. Fieldwork included FGDs, in-depth interviews, secondary data collection and observation.

Although the SBM IE had strong internal validity and attribution, a few important limitations were considered by the evaluation team. First, the concentrated geographic distribution of the schools could have facilitated spillover (or sharing of program implementation or outcomes between treatment and control areas) during the life of the Kinerja program. Control schools may also have been "contaminated" due to replication activities in the final years of the program. Second, the external validity of the evaluation was limited by the small number of districts and schools undergoing assessment. Results may have been different under different local conditions or if implemented by a different local IO. Nevertheless, findings from this study were consistent with other SBM studies, suggesting that the external validity threats were not so severe.

Overall, the evaluation team found consistently positive program effects from the Kinerja SBM intervention across respondent types, which was verified through direct observation and qualitative findings:

- School committees are functioning better. There are more committee members and meetings, and members know more about the role of the committees and receive more information regarding school management. There was some evidence of increased involvement of school committees in financial management and consistently increased perceptions of committee roles in Kinerja-supported schools, particularly among principals. At the same time, school management and committee documents are more widely available, and there is more information on student activities and opportunities for involvement provided to parents and communities.
- Parents are more satisfied with schools and, in particular, with school committees. The evaluation showed satisfaction with school committees that were active and engaged with the community. However, female parents were more likely than male parents to be unclear about the role of the school committee. Other studies of SBM around the world have shown that schools with committees that are more intricately linked to communities also exhibited higher rates of community and parent satisfaction in education service delivery.
- Parents from treatment schools seem to be equally or less likely to be involved in school management. This might reflect decreased levels of engagement or accountability among parents. However, our data, particularly in the case where parents are better informed and more satisfied regarding school management, seem to suggest that school management is more transparent and that parents are happier with the results and so feel less of a need to engage with the school. Interestingly, males were more likely than females to visit schools the previous year and this year. Males were also more likely to have looked at the bulletin board last year.

The evaluation also identified remaining challenges to effective school management, particularly related to engaging parents and the community directly in school management. The team also did not find evidence of improvement in higher-level outcomes, including school facilities, enrollment,

attendance, or parental aspirations for their child's education, though they did find evidence of an increased number of books. The lack of change in higher-level outcomes may have been affected by a relative lack of engagement from West Kalimantan school principals in the Kinerja program, often due to a lack of understanding about how technical assistance could ultimately benefit the school in terms of performance and materials.

Performance Indicators[24]

The Kinerja program made progress towards the consolidation and replication of its interventions in partner and non-partner districts and SDUs, as measured by 48 performance indicators. These efforts led to the achievement of Intermediate Result 1 ("Improved Service Delivery Approaches Adopted"), Intermediate Result 2 ("Incentive Systems for Improved Local Government Service Delivery Strengthened"), and Intermediate Result 3 ("Replication of Improved Practices Reaches Larger Scale"). Achievement of these Intermediate Results and their corresponding Sub-Intermediate Results, as detailed in the Kinerja PMP, led to progress in the Program Goal of "Improved Public Service Delivery".

Twelve out of the 17 performance indicators directly related to the consolidation of Round 1 and Round 2 interventions (Indicators 1 - 17) have achieved 100% or more of its program targets (71%). Three of the 17 indicators have achieved at least 95% of the program target (18%). Six out of 10 indicators directly related to replication (Indicators 18 - 27) have achieved more than 100% of their program targets.[25] In addition, goal-level data reveals limited progress in this quarter to explain Kinerja's progress against the Program Goal. Details about progress towards Kinerja's supply, demand, and replication interventions are included below.

Indicator Type	Indicator Number	PMP Results Framework Location	% Achieved Program Target
Activity Indicator: *Round 1 and 2 implementation and consolidation*	1 - 17	Intermediate Result 1 Intermediate Result 2	71%
Activity Indicator: *Replication*	18 – 27	Intermediate Result 3	60%
Goal Indicator	28 – 38	Program Goal	Not available[26]
Impact Indicator	39 – 48	Distant Goal	Not applicable[27]

Activity Indicators

[24] This section refers to progress in performance indicators as of April-June 2015.

[25] Explanations of under and over-achievement are included, as necessary, in the Quarterly Report for Q3 FY 2015.

[26] As detailed in Kinerja's Quarterly and Annual Reports, goal-level data were difficult to obtain from district governments during the Kinerja program. Data that were collected and verified by the M&E team was included in the reports and analyzed here, where applicable.

[27] Impact indicators were not designed with targets. Changes in these indicators in treatment and control areas are detailed in '*Impact Evaluation of USAID/Indonesia's Kinerja Program*'.

Indicators 1 to 17 provide a clear picture of progress made towards consolidation of Round 1 and Round 2 interventions in Kinerja's partner districts. Consolidation progress is documented below through the supply and demand perspective (as opposed to through intervention).

Supply Side

Indicators 5, 6, 8, 15, 16, and 17 capture Kinerja's supply side achievements. Five of these indicators either achieved or exceeded the program target (Indicator 5 achieved 97% of the program target). Overall, the program has institutionalized a total of 185 Kinerja-supported good practices at the district-level (Indicator 5) and 822 Kinerja supported good practices at the SDU- level (Indicator 8). A total of 250 technical recommendations for public service improvement were submitted to the appropriate LG units (Indicator 6). Finally, throughout the program, a total of 121 planning documents, 155 budgeting documents, and 107 financial reports were made available to school stakeholders (Indicators 15, 16, and 17, respectively).

Demand Side

Indicators 4, 7, 9, 10, 11, 12, 13, and 14 capture the demand side achievements. Six (Indicators 7, 10, 11, 12, 13, and 14) of the eight indicators (75%) have achieved and/or exceeded the program target (Indicator 12 achieved 95% of the program target). In this quarter, the M&E team documented additional achievements for indicator 11. During the Kinerja program, MSFs and Kinerja IOs submitted completed monitoring forms of service charters signed by Kinerja-supported SDUs. Of the 6,157 promises made in the 218 service charters from *puskesmas* and schools, 5,115 promises were completed/ implemented (83%, documented in Indicator 7 and 11). More specifically, in partner schools that have been monitored, a total of 81% of the complaints have been addressed by school management or school committees, whereas in partner *puskesmas* that have been monitored, a total of 89% of the complaints have been addressed by health unit management and active MSFs. This slight difference in implementation rates may be due to the fact that schools often include more complaints in their service charters than *puskesmas*.

Kinerja also promoted the use of complaint handling mechanisms in order to improve PSD. A total of 78 Kinerja-supported complaint handling mechanisms including SMS Gateways, complaint boxes, and control cards have been implemented at the SDU-level throughout the program (Indicator 10). The MSFs help run the complaint survey process, of which there are 257 in Kinerja's partner areas at the district- and SDU- level (Indicator 12). Additionally, there were a total of 32 Kinerja IOs that reported on LG performance (Indicator 13). A total of 281 active citizen journalists also reported on LG performance (Indicator 14). The Kinerja program also supported mechanisms that incentivize district governments or SDUs to improve their performance. A total of 19 incentive mechanisms were developed (Indicator 9). While these mechanisms were meaningful achievements for the program, the indicator will remain underachieved (currently at 50%). This is due to the fact that the majority of Kinerja's effort was towards supporting partner districts to gain access to *already established* incentive mechanisms at the district, provincial, and international level that they could not otherwise access (due to time, funding, and capacity constraints).

Replication Indicators

Indicators 18 to 27 provide an overview of Kinerja's progress in replicating good practices in non-partner districts and SDUs.[28] Kinerja's replication intervention included a supply and demand focus, similar to Round 1 and Round 2 detailed above. The replication strategy included working with non-partner districts and their SDUs, and also intensified work with partner districts and provinces to promote the spread of Kinerja's interventions to new SDUs. In addition, program strategy also included interventions at the demand side, such as promoting the establishment of MSFs, CJs, and other advocacy and incentive mechanisms in non-partner areas.

Kinerja good practices have been adopted 115 times (479% of program target) by 44 non-partner districts (176% of the adjusted program target, documented in Indicator 18 and 19). The non-partner districts that the Kinerja program has worked with to-date are detailed in the following table:

Partner Province	Replication District/City (Indicator 19)	Replicated Intervention/Good Practice (Indicator 19)
Aceh	All districts/cities (18 in total): Aceh Barat, Aceh Barat Daya, Aceh Besar, Aceh Jaya, Aceh Selatan, Aceh Tamiang, Aceh Tengah, Aceh Timur, Aceh Utara, Bireuen, Gayo Lues, Langsa City, Lhokseumawe City, Sabang City, Subulussalam City, Nagan Raya, Pidie, Pidie Jaya	PPID, MSS, BEE, Health
North Sumatra	1 district: Pakpak Bharat	Education (BOSP), Governance
East Java	10 districts/cities: Pemekasan, Blitar District, Trenggalek, Situbondo, Sampang, Lumajang, Kediri City, Kediri District, Pacitan, and Blitar City	BEE, Governance, Education (SBM)
West Kalimantan	3 districts/cities: Pontianak City, Kayung Utara, and Kubu Raya	Health, BEE
South Sulawesi	12 districts/cities: Jeneponto, Palopo City, Pinrang, Sinjai, Soppeng, Wajo, Bantaeng, Bone, Enrekang, Pangkep, Sidenreng Rappang, Takalar	BEE, Education (BOSP)

Many of these non-partner districts either signed MOUs with Kinerja/Kinerja's grantees or submitted letters of interest regarding technical assistance in replicating good practices during the program life. A total of 56 agreements or "engagements" between district government and Kinerja's grantees were documented for Indicator 24 (233% of program target achieved). Over 43% of the agreements documented throughout the entire program included cost share with district governments (24 agreements, documented in Indicator 25). This achievement reveals support for Kinerja partners and interventions in non-partner districts.

In addition to the replication progress made at the district level, progress was also made at the SDU level. Kinerja good practices were replicated 450 times by a total of 399 SDUs throughout the program

[28] Non-partner districts and SDUs are those units that did not originally receive Kinerja funding (in Round 1 or Round 2). Non-partner districts are most often within Kinerja's partner provinces (West Kalimantan, South Sulawesi, East Java, and Aceh). Non-partner SDUs may be within Kinerja partner districts or outside of Kinerja's partner districts.

(documented in Indicator 20).[29] These good practices included implementation of SBM, formation of service charters, formation of technical recommendations, and maternal and child health promotion (among other good practices).[30] The SDUs that the Kinerja program worked with are detailed in the following table:

Partner Province	# of Replication SDU (Indicator 20)	Replicated Intervention/Good Practice (Indicator 20)[31]
Aceh	Aceh Singkil: 8 *puskesmas* Bener Meriah: 2 *puskesmas*, 19 schools, 15 DHO departments Banda Aceh City: 5 *puskesmas* Simeulue: 7 *puskesmas* Aceh Selatan: 5 *puskesmas* Aceh Tamiang: 1 *puskesmas* Gayo Lues*: 1 puskesmas*	Health, Education (SBM), MSS Health Costing
North Sumatra	Pakpak Bharat: 2 *puskesmas*	Health
East Java	Jember: 45 *puskesmas* Mojokerto District: 1 school Probolinggo City: 3 *puskesmas*, 119 schools Probolinggo: 67 *puskesmas* Pacitan: 3 *puskesmas,* 5 schools Lumajang: 1 *puskesmas* Tulungagung: 16 *puskesmas*	Health, Education (SBM), MSS Health Costing
West Kalimantan	Singkawang City: 1 *puskesmas* Kubu Raya: 4 *puskesmas* Sambas: 10 *puskesmas*	Health
South Sulawesi	Barru: 40 schools Luwu: 9 *puskesmas* Luwu Utara: 10 *puskesmas*	Health, Education (SBM)

Building the capacity of CSOs and Kinerja's grantees for the purpose of long-term sustainability and replication was also a focus of the Kinerja program in its final year of implementation. In addition to tracking the number of grantees that provide technical assistance to non-partner government offices in Kinerja provinces, the PMP also notes the number of grantees (CSOs) that develop updated or improved products, services, and marketing strategies for continual use in the promotion of Kinerja good practices tracked under Indicators 21 and 22. A total of 18 CSOs have developed new or updated products/services for government use (30% program target achieved, documented in Indicator 21). A total of 19 CSOs have developed marketing or outreach strategies targeting LG (79% program target achieved, documented in Indicator 22).

[29] The 399 service delivery units include 200 *puskesmas*, 184 schools, and 15 DHO departments.

[30] For a full list of good practices available for replication at SDUs, see the PMP 2012.

[31] These good practices cover both supply- and demand-side good practices.

Aside from ensuring long-term sustainability at the LG level, Kinerja also hoped to ensure sustainability at the national level. During the program, the Kinerja program team and its affiliated organizations developed 12 policy papers (Indicator 26). The program achieved 200% of the program target, disseminating papers to government partners. For example, a policy brief titled "Multi Stakeholder Forums (MSF): Community Engagement Strategy to Improve the Quality of Health Services at Subdistrict and District Levels" was developed and submitted to MOH's Directorate General for Nutrition and MCH. A hearing with the ministry took place in July 2015.

Finally, Kinerja promoted different mechanisms to ensure wider replication of Kinerja good practices. Replication mechanisms were documented in Indicator 27. A total of 36 mechanisms were counted since the beginning of the replication phase of the program. These mechanisms, explained in detail in Kinerja's Quarterly Reports, represent recurring promotion of Kinerja interventions and good practices at provincial, national, and international levels, ensuring the long term influence of lessons learned through the program.

Goal Level Indicators

Starting in FY 2014, the M&E team reported on goal-level progress related to the PTD, BOSP, SBM, Health, and BEE interventions in Quarterly and Annual Reports. Indicators 28 – 38 relate to the expected outcomes from Kinerja's interventions at the SDU- and district-level from 2012 to 2015. Data sources for these indicators were largely district health, education, and business licensing offices. Occasionally data were collected in-person by the M&E team if the district office did not track required data. The data source for Indicator 34 is the national-level SUSENAS dataset. These indicators and progress against FY targets are discussed below according to sector. However, considering the quality and availability of the data as of this quarter, limited analysis is provided regarding observed changes and how they relate to Kinerja. For more details on these limitations, see the Achievement Table in Kinerja's Quarterly and Annual Reports.

Education

Indicators 28 – 32 measure the outcomes of the three Kinerja education interventions (PTD, SBM, and BOSP). Indicators 28 – 30 measure the outcomes of the PTD intervention and are defined below:

- Indicator 28: Percentage of all public schools meeting minimum service standard for availability of teachers
- Indicator 29: Percentage of all public schools meeting minimum service standard for availability of teachers with academic qualifications
- Indicator 30: Percentage of schools meeting minimum service standard for availability of certified teachers

By the end of the PTD intervention, the Kinerja program estimated that these percentages would increase between 2% and 8% depending on district conditions. Complete data regarding these indicators were not available from the DEO in PTD partner districts during the Kinerja program. Considering the lack of data and lack of quality data discovered by the M&E team during field visits, all data were not available for verification by the end of program activities in 2015. Though data regarding the percentage of schools meeting the MSS requirement for availability of teachers are not available for all districts from the years targeted, several districts have verified data for certain years during the Kinerja program implementation period. These districts and fiscal years are detailed below:

- 41.86% of the SD and SMP public schools in Aceh Singkil met the minimum service standard for the availability of teachers in FY 2013. This number, however, only included PNS teachers (as opposed to other districts that reported PNS + non-PNS teachers[32]). This district overachieved the FY12 target.
- 85.71% of the SD and SMP public schools in Luwu met the MSS for availability of teachers in FY12 (PNS and non-PNS teachers).

Additionally, though data regarding the percentage of all public schools meeting MSS for the number of teachers with academic qualifications were not available from all districts from the years targeted, several districts have verified data for certain years during the Kinerja program implementation period. These districts and fiscal years are detailed below:

- 75.19% of SD and SMP public schools in Luwu met the MSS for availability of teachers with academic qualifications in FY12. This district overachieved the FY12 target.

Finally, data regarding the number of schools that have the required number of certified teachers were not available from partner DEOs. This MSS does not appear to be tracked accurately by any district, as all districts were found to only report the *new number of certified teachers in a given year* (instead of the total number of certified teachers in the entire school).

Indicators 31 – 32 measure the outcomes of the SBM intervention and are defined below:

- Indicator 31: Percentage of all public schools meeting minimum service standard for application of principles of school-based management
- Indicator 32: Percentage of KINERJA-supported schools meeting quality standards for availability of basic educational supplies

By the end of the SBM intervention, the Kinerja program estimated that these percentages would increase from the baseline by a percentage dependent on the number of Kinerja-supported or replicated schools divided by the total number of schools in the district. The targets, therefore, vary widely between districts. These targets were estimated by the Kinerja program team in 2012 depending on local conditions at the baseline. During the Kinerja program, only a limited amount of data was available from the DEO in SBM partner districts. The M&E team conducted a primary data collection because of this challenge to collect and verify data.

For Indicator 31, many districts do not track the implementation of SBM principles in all public schools at this point. Barru was the only district that had set up a system for monitoring these principles, though the monitoring had not been rolled out to all schools as of FY 2014. Each district was also found to define "SBM principles" differently. Some districts do claim a certain percentage of schools as adhering to these principles, but no verifiable evidence exists to support these claims. Hence, only three numbers have thus far been reported: FY12 actual for Jember, FY12 actual for Probolinggo City, and FY 2014 actual for Barru (only considering 60 schools). Though the picture is not complete for these districts, these fiscal numbers do show a change in the percentage of public schools meeting MSS for the application of SBM principles.

For Indicator 32, the Achievement Table in Kinerja's Quarterly Reports shows some (but not all) fiscal year data from Bengkayang, Jember, and Kota Probolinggo. Though this picture, also, is not

[32] PNS refers to *Pegawai Negeri Sipil* or civil servants.

complete for these districts, these fiscal numbers do show a change in the percentage of Kinerja-supported schools meeting quality standards regarding basic educational supplies.

Indicator 33 measures the outcome of the BOSP intervention and is defined below:

- Indicator 33
    - Percentage of BOSP (Educational Unit Operational Cost) at elementary school level met by national, provincial, or district government sources
    - Percentage of BOSP (Educational Unit Operational Cost) at junior high school level met by national, provincial, or district government sources

The Kinerja program team did not develop quantitative targets to measure the change in these percentages/outcomes for the BOSP intervention. In 2012, the program team developed qualitative requirements, included in the Quarterly Report Achievement Tables. As of January 2015, the M&E team had verified complete information for Simeulue and Bulukumba. Kota Banda Aceh has not made available the required data/information.

Before the Kinerja program, only 52.38% of educational costs for elementary school students were met by government funding/sources in Simeulue. This percentage increased during the course of the Kinerja program, reaching 100% met by FY 2013. In junior high schools, only 68.18% of educational costs were met by government funding/sources in 2010/2011. By FY 2013, all costs were met by national, provincial, and district sources in Simeulue. This improvement is due in part to the assistance provided through the BOSP intervention in this district. Before the Kinerja program, only 67.71% of educational costs for elementary school students were met by government funding/sources in Bulukumba. This percentage increased during the course of the Kinerja program, reaching 96.16% in FY 2013. A small drop in BOSP was observed in 2014 (to 85.04%). In junior high schools, over 100% of costs were met before the Kinerja program started in Bulukumba. Throughout the program's lifetime, the percentage met increased overall to 124%. This improvement is due in part to the assistance provided through the BOSP intervention in this district.

Health

Indicators 34 – 36 measure the outcomes of Kinerja's health intervention in 19 partner districts. These indicators are defined below:

- Indicator 34: Percentage of babies breastfed exclusively
- Indicator 35: Percentage of pregnancies in KINERJA-supported health clinic areas where the mother received antenatal services at least 4 (four) times during pregnancy
- Indicator 36: Percentage of births in KINERJA-supported health clinic areas assisted by qualified health-care workers

By the end of the health intervention, the Kinerja program estimated that these percentages would increase between 7% and 50% depending on district conditions. The targets for each fiscal year and for the program were provided to the M&E team by the Kinerja program team in 2012 during the drafting of the PMP. Indicator 34 data is reported through SUSENAS. The M&E team purchased 2013 SUSENAS data in October 2014 and completed analysis of the data in this quarter. Eleven out of the 19 partner districts that selected the health intervention (58%) met the program target by the end of the program. These 11 districts include Banda Aceh, Bener Meriah, Sambas, Singkawang, Bondowoso, Simelue, Jember, Probolinggo, Sekadau, Luwu, and Luwu Utara. Before the Kinerja

program, the percentage of babies breastfed exclusively varied between 25.13% and 50.06% across these 11 districts. As of FY 2013, these percentages increased between 13.36 and 43.05 percentage points. Several districts exceeded their program targets. For instance, the baseline measurement for Bondowoso was 25.13% in 2011; however, this percentage increased by 43.05 percentage points during the Kinerja program, reaching 68.18% in FY 2013. This FY 2013 percentage for Bondowoso exceeded the program target of 27.93% (244%). Overall, 7 out of 19 districts (37%) met FY 2012 targets, whereas 13 out of 19 districts (68%) met FY 2013 targets.[33] Finally, only 4 out of 19 districts (21%) met both FY 2012 and FY 2013 targets: Simeulue, Jember, Bulukumba, and Luwu.

As of September 2014, data were collected from all partner districts for the health intervention regarding Indicator 35. Data for FY 2014, however, varied from district to district; districts reported data ranging from 0 to 12 months for the fiscal year. Forty-two percent (eight districts) of the 19 districts that selected the health intervention saw an increase in the percentage of pregnancies where mothers received antenatal services at least four times during pregnancy as of FY 2014, based on partial and/or complete data for the fiscal year.[34] These districts comprise the following: Sambas, Jember, Aceh Tenggara, Probolinggo, Tulungagung, Melawi, Kota Makassar, and Luwu. These districts improved from their baseline targets as of FY 2014. Though these increases indicate good progress in these districts, only the following actually met or exceeded their FY 2013 or FY 2014 targets (only considering those districts with complete data for a given fiscal year): Kota Banda Aceh (FY 2013), Aceh Singkil (FY 2013), Bener Meriah (FY 2013), Sambas (FY 2013), Kota Singkawang (FY 2013), Jember (FY 2013 and FY 2014), Bengkayang (FY 2013), and Luwu Utara (FY 2013). Overall, Jember is the only district that met the program target considering only those districts with complete data for FY 2014. By FY 2014, 73.90% of pregnant mothers in Jember received at least four sessions of ANC services, exceeding the program target of 38.46% (192%). However, five districts met the program target (Kota Banda Aceh, Bener Meriah, Sambas, Kota Singkawang, and Luwu Utara) if complete data for FY 2013 were considered to make this estimate.

As of January 2015, data were collected from all partner districts for the health intervention regarding Indicator 36. Data for FY 2014, however, varied from district to district; districts reported data ranging from 0 to 12 months for the fiscal year. Forty-two percent (eight districts) of the 19 districts that selected the health intervention saw an increase in the number of births assisted by qualified health workers, based on partial and/or complete data for the fiscal year.[35] These districts comprise the following: Simeulue, Jember, Kota Probolinggo, Melawi, Kota Makassar, Bulukumba, Luwu, and Luwu Utara. Though these increases indicate good progress in these districts, only the following actually met or exceeded their FY 2013 or FY 2014 targets (only considering those districts with complete data for a given fiscal year): Sambas (FY 2013), Simeulue (FY 2013 and FY 2014), Jember (FY 2013 and FY 2014), Kota Makassar (FY 2013), Luwu (FY 2014), and Luwu Utara (FY 2013). Overall, only Simeulue and Jember (11%) met the program targets and had complete FY 2014 data by the end of the program. By FY 2014, 81.58% of births in Simeulue were assisted by qualified health workers, exceeding the program target of 75.88% (108%). Additionally, by the same fiscal year, 78.06%

[33] Seven districts meeting FY 2012 targets: Aceh Tenggara, Simeulue, Jember, Bengkayang, Melawi, Bulukumba, Luwu. 13 districts meeting FY 2013 targets: Banda Aceh, Bener Meriah, Sambas, Singkawang, Bondowoso, Simeulue, Jember, Probolinggo, Tulungagung, Sekadau, Bulukumba, Luwu, and Luwu Utara.

[34] If complete or partial FY 2014 data were not available, FY 2013 data were considered to make this estimate.

[35] If complete or partial FY 2014 data were not available, FY 2013 data were considered to make this estimate.

of births in Jember were assisted by qualified health workers, exceeding the program target of 43.91% (178%).

When interpreting the increasing and decreasing trends in Indicator 35 and 36, it is critical to note the significant changes made in government targets for health outcomes between FY 2011 and FY 2012. In FY 2011 and in previous fiscal years, the government used population data from the 2000 census to calculate targets (for pregnant mothers, for example). In FY 2012, the government switched to using the 2010 census. This caused a significant change in the population data and, therefore, calculation of targets for pregnant mothers. Any trends identified in the table must be understood according to this adjustment.

Business-Enabling Environment

Indicators 37 – 38 measure the outcomes of Kinerja's BEE intervention in eight partner districts. These indicators are defined below:

- Indicator 37: Number of business permits issued annually
- Indicator 38: Customer Satisfaction Index (CSI) related to business licensing

By the end of the BEE intervention, the Kinerja program (together with The Asia Foundation) estimated that the number of business permits would increase by smaller percentages each year (from a high of 20% to a low of 10%). They also estimated that the CSI would increase in each partner district by 10%. The targets for each fiscal year and for the program were provided to the M&E team by the Kinerja program team and TAF in 2012 during the drafting of the PMP. As of July 2015, data were not available for Indicator 37. As of January 2015, three had districts achieved their FY 2013 targets for Indicator 38: Barru, Melawi, and Luwu Utara. Several districts did not implement the CSI every year, leading to a limited ability to assess trends for the index per district.

Students at a Kinerja partner school

Kinerja staff learned many valuable lessons during the program's lifetime, and believes that these are worth sharing. Kinerja hopes that these lessons and recommendations - which cover three main areas of program design, program management and program content and implementation - will be taken into account when designing similar projects in the future, particularly governance programs based in Indonesia.

Program Design

1. The suitability of randomized control trials (RCTs) for large-scale, multi-sector programs in Indonesia should be re-assessed. Designing the program using an RCT for location selection led to over-complications and inefficiencies. The concept of randomized selection was an unfamiliar one to many district and provincial governments, and left them confused as to why some had been chosen while others had not. Provincial government stakeholders in Aceh, for instance, viewed the whole process with suspicion, regarding it as akin to gambling, while the PG in East Java proposed its own criteria to dictate where Kinerja should operate in the province – namely, in the five districts with the lowest rankings on the Human Development Index (HDI); East Java even went so far as to inform the five districts in question that this would be the case before consulting with Kinerja. Although these challenges with provincial partners were ultimately resolved, the program felt the impact of randomized selection at the district level, too, when it found itself working with some LGs that lacked the necessary motivation and political will to ensure effective implementation.

The RCT also produced a significant logistical challenge for the program, as it resulted in Kinerja's working locations being spread across whole provinces. Rarely were partner districts located in close

proximity to one another; often, they were many hours of road - or even sea and air - travel away. Even then, Kinerja's partner schools and health centers were located at vast distances within districts – some as many as one day's travel over difficult terrain from the district capital (one of the program's partner health centers in Luwu Utara was one such example). For both Kinerja's staff and IOs, this geographical dispersion made activities hard to schedule and carry out. It also used up significantly more time and money than if districts and SDUs had been chosen more systematically.

2. Control districts may not be appropriate for social development programs. Control districts did not align with the program's replication mandate. Kinerja's program design called for the existence of treatment sites and control sites in each of the four original target provinces in order to assess the degree of impact achieved in the former. This required a "scientific" approach in a rather sterile environment, where the control districts would remain unaffected by Kinerja's presence elsewhere, unaware of information about the program and its results. However, such an environment directly contradicted Kinerja's replication objectives, which demanded that the program widely disseminate information and encourage inter-district and inter-provincial learning. The same situation applied to isolating control schools in West Kalimantan treatment districts, where the desire among LGs to scale-up Kinerja's interventions was strong. Besides the obvious practical difficulties involved, the intended restricting of assistance and support to particular districts and SDUs is questionable from an ethical standpoint.

3. Governance programs would have a greater likelihood of increased impact if implemented over a longer period of time. Kinerja's timeframe was too short for such an innovative and multi-sectoral program, especially with regards to ensuring the sustainability of changes made and encouraging replication. From discussions with district governments and SDUs, it is clear that many wanted to continue to be supported by Kinerja. It is interesting to note that this was not for financial reasons – they were ready to allocate their funds to the program. One senior Bappeda staffer in a remote district supported by Kinerja mentioned that her government had more than enough money; the problem was simply that they did not know what to do with it and needed assistance and direction. If a program's expectation is sustainable replication, it should be less complex (that is, operating in just one sector) and with a longer time frame.

4. Program timelines should be aligned with LG funding cycles. The Kinerja program was launched in the middle of a government funding cycle. This meant that program interventions were unable to be quickly or sufficiently incorporated into LG annual budgets. This reduced the sense of ownership among some LGs over the work they were doing with Kinerja's assistance, which in turn led to longer-term issues, such as reluctance by a few governments to include Kinerja's packages in their annual budget allocations.

5. Quantitative indicators should be based on data that are available and reliable. A number of indicators listed under program goals and distant goals in Kinerja's PMP were determined at the start of the program without first ensuring that such data actually existed. A key example of this was two indicators relating to breastfeeding – percentage of babies breastfed immediately, and percentage of babies breastfed exclusively. These data are not collected by district health offices, and only haphazard data on breastfeeding exist at the *puskesmas* level. Thus, these indicators were almost impossible to meet. Programs should ensure that, during the design phase, all indicators are actually measurable.

Connected to this issue was the difficulty faced by M&E staff to fully measure the Kinerja program's impact at the district level due to limited availability of secondary data. Given the lack of good-quality (accurate) district-level data (and the extreme time and expense of collecting primary data) the M&E

team decided to use the national surveys, RISKESDAS and SUSENAS, as data sources. However, these data are only collected every two years and are not made immediately available. In relation to Kinerja's time frame, only 2010 to 2013 could be covered. October 2010 through December 2011 constituted the program's development phase, while actual implementation of sector packages only began in 2012. Thus, the impact assessment came too soon; the changes made in the few pilot SDUs in the early years of the program were not yet visible at the district level where the data collection was conducted, and it could not include the full cycle of Kinerja's replication work. Therefore, it was unable to sufficiently include all of the program's achieved impacts.

6. Gender must be systematically incorporated into both program design and implementation. Kinerja's original proposal did include a gender element, however a Gender Mainstreaming Strategy was not developed until 2013 following new recommendations from USAID. This meant that the program's initial aims relating to gender were not translated into work plans or activities. This was primarily because of high staff turnover in the position of Gender Specialist, and a broader lack of understanding among Kinerja staff and IOs of the importance of mainstreaming gender into all activities. For example, the practical application of gender in Kinerja's programming was limited to one area: the Bondowoso-based reproductive health intervention. Staff and IOs alike lacked an awareness of how to mainstream gender in all other interventions, with the exception of providing a gender break-down of participants in activities. Ongoing staff development and IO capacity building should include meaningful training and discussion on gender and gender mainstreaming.

7. Monitoring and evaluation teams should be thoroughly involved in programs, and should give input to management on program direction. Kinerja's M&E team was advised to establish a firewall and refrain from offering progress-related programmatic advice to technical specialists and the management team, in order to avoid influencing results. However, it should be noted that there is a difference between influencing results and providing valuable information on how goals can be more effectively and efficiently achieved. M&E teams should be able to give such input as they see necessary. Moreover, it is advised that impact assessments should be conducted by external monitoring teams.

8. Knowledge management should be a key part of program design. Learning materials will not be well-used if developed without a knowledge management strategy in place. Kinerja developed many excellent learning materials and documents during its lifetime, including 17 modules, three good practice books, and one book on Kinerja's most significant changes. However, without a knowledge-management strategy, which would have provided clear aims, distribution plans and funding, these materials did not always reach intended audiences. A knowledge management strategy should be developed at the beginning of all future programs and maintained well in order to support replication and sustainability of interventions.

Program Management

1. Cost share is an effective method of increasing ownership among government partners. From the beginning, Kinerja strongly encouraged LGs to contribute financially to all activities. However, the program initially encountered difficulties in some districts due to the lack of familiarity with the idea of cost sharing, as traditionally donors would fund entire programs themselves without requiring LGs to contribute. Over time, as governments came to understand the concept, they were increasingly willing to play a financial role. During Kinerja's replication period towards the end of

program activities, the majority of funds in fact were contributed by LGs. This led to strong partnerships and higher levels of commitment due to increased feelings of ownership.

2. Programs should invest in IO capacity building, both prior to and during implementation. One of Kinerja's key program goals was to increase the capacity of its CSO implementing partners. It was assumed that IOs would have a certain level of capacity in both technical and governance issues. However, in actuality, the capacity of Kinerja's regional CSO partners was significantly lower than expected in all areas. This was especially true in more remote districts where very few CSOs existed. For example, Aceh Tenggara had only one local NGO, consisting of just two staff with a focus on climate change.

This placed significant extra burden on both Kinerja's technical specialists and administrative/ finance staff, because of the additional support the CSO partners needed to carry out their activities. Building the skills of CSOs to sustainably implement a particular program or apply a particular approach requires many years of support. A suggested approach could involve capacity building during the program's first year and mentoring during the second, with ongoing technical support provided as needed thereafter. This was proven by the success of the BEE CSOs, who had already been supported by TAF for several years before Kinerja began. The partnerships between TAF and its local partners continued with or without donor funding, and both have been continuously building their knowledge and capacity further. This institutional knowledge was used to leverage the successful implementation of BEE during Kinerja.

LGs will also be more willing to recruit CSOs and individuals to assist them in implementing programs when they can trust in their skills and knowledge. This will support sustainability of interventions. If CSO capacity remains low, LGs have been shown to be reluctant to ask for assistance and/or recruit them.

3. Programs should be supported by a combination of CSOs, academic institutions, and technical experts. Some government elements in Indonesia do not have a favorable view of CSOs, and tend to see them as opposition or as too critical. Academic institutions, on the other hand, are considered to have a higher status and more legitimacy. Therefore, by supporting academic institutions and CSOs to work together, programs would raise the status of CSOs in the eyes of LGs. This would assist in changing governments' attitudes towards CSOs, and encourage sustainability through using CSOs as resources for government programs.

Program Content & Implementation

1. Governance should be mainstreamed within all sectors. Incorporating good governance into technical sectors can have a significant impact on improving service quality. However, this is difficult to achieve if the underlying technical skills remain weak – for example, if midwives' ante-natal and delivery skills are low, or if teachers' subject knowledge is minimal. Midwives can follow service SOPs and referral procedures perfectly, but if they do not possess the skills to stop a post-partum hemorrhage, maternal mortality will remain a problem. This reflects the fact that as Kinerja was solely a governance project, sectoral impact was thus only achieved indirectly – the program was unable to build the technical skills of midwives and teachers because it was outside of its mandate. Therefore, improvements in health and education outcomes did occur by applying governance principles, but tended to be more significant in areas where technical skills were already sufficient. This indicates that encouraging good governance in PSD is worthwhile, but that technical skills should be built alongside such efforts.

2. Meaningful civic engagement is easier and faster to achieve in areas with strong civil society. Kinerja's experience confirmed the importance of working with demand-side stakeholders as well as those on the supply side. Service quality improved in health, education and business licensing due to the program's efforts to increase and strengthen the oversight role of community forums, such as MSFs. However, it should be noted that civic engagement improves more quickly and is more sustainable in areas where civil society is already active. For instance, where LGs were more receptive to the idea of working in cooperation with the community and saw community forums as partners, such as in Aceh, Kinerja's MSFs achieved greater success in carrying out their tasks. Multiple district governments in Aceh provided legal status to MSFs, which enabled them to access government funding and in turn allowed them to more effectively oversee PSD quality. This was in stark contrast to West Kalimantan, where not only was civil society weaker and generally unfamiliar with the kind of role they could play toward improving services but likewise LGs did not understand the contribution civil society could make to their service-improvement initiatives. This meant that the time and effort required to build strong MSFs in West Kalimantan was significantly greater than in other areas, such as Aceh.

3. Service standards are useful in measuring public service quality and improvement. When SDUs, LGs and the community are aware of standards and are able to measure services against such standards, PSD is more likely to improve. National standards can be implemented at the SDU level through service SOPs. SOPs are particularly relevant to the health sector, where clinical SOPs have long existed but have not been combined with SOPs on administrative and managerial tasks (such as how to refer patients and how to manage complaints).

At the district level, national standards can be implemented through MSS. Although a number of programs have worked on MSS in the past, Kinerja discovered that LGs were more receptive to incorporating MSS indicators into their work plans when a smaller number of indicators based on specific program interventions were prioritized. LGs had previously felt overwhelmed when faced with the total number of MSS indicators[36] and had struggled when attempting to address them all simultaneously, due to limited skills and finances. By using its more concentrated approach, Kinerja achieved more significant gains in fulfilling key MSS indicators, such as antenatal care and SBM, by focusing government attention on specific issues.

4. OSS are a foundation on which other local economic development interventions can be built. With regard to bureaucracy reform and corruption prevention, an OSS equipped with good business processes and governance can be seen as an ultimate goal. This is certainly not the case for local economic development. Micro, small and medium enterprise formalization, the first step to accelerate development and to reduce inequality, does not automatically happen after the OSS is established. Reforms in other areas – e.g., simplifying the requirements for obtaining credit, access to government programs through competitive processes – are needed to increase the benefits of formalization beyond reducing the risk of being arrested by the local police. Furthermore, as identified by the series of Local Economic Governance Studies, there are other BEE aspects that are considered important for the private sector, such as local infrastructure and access to business development services. Hence, although business licensing reform is still an important initiative that needs to be supported, it must be complemented with other local economic development interventions to accelerate growth and reduce inequality.

[36] There are 22 MSS indicators for health and 27 for education, as determined by MOH and MOEC, respectively.

5. Where possible, large-scale and multi-sectoral programs should be implemented in stages. When Kinerja began implementing in early 2012, it did so in all treatment districts and in all sectors at the same time. However, it would have been more practical to target a limited number of more progressive districts for assistance at the start of the program – one or two per province – before expanding implementation to remaining districts. This would have allowed Kinerja to build strong relationships with a few LGs first, and the results of these initial efforts could then have provided positive examples for peer-to-peer learning among Kinerja's other government partners. It would also have allowed Kinerja's technical staff and IOs to learn valuable lessons about how best to implement the selected interventions; not only would this have reduced the risk of repeating the same or similar mistakes across all districts, it would also have facilitated speedier replication.

Additional logistical challenges would also have been avoided had such an approach been adopted. Developing grants for 16 IOs simultaneously at the start of the program, for instance, effectively postponed Kinerja's implementation until the second year, as inadequate time had been allocated in the program design for relationship-building, training IOs and staff and administering grants. It is therefore advisable, when designing future programs, to designate sufficient time for the completion of all the preparatory work that needs to be in place before implementation can begin. Kinerja also advises that the current grant system, which is both complex and time-consuming, be simplified to enable staff and implementing partners to focus their efforts on achieving the program's overall aims and objectives.

6. Future (governance) programs that aim to respond to the needs of their partners should strive to achieve a balance between uniformity and flexibility in intervention choices. Evaluating the impact of Kinerja's interventions was difficult due to the menu of intervention choices for districts combined with the small number of districts, which did not provide sufficient statistical power and comparability of scale. Kinerja's sophisticated M&E scheme was designed to operate with a focus on uniformity and was, therefore, contrary to Kinerja's governance approach that aimed to respond to LG demands/needs and local conditions. To properly evaluate impact, the implementation of packages needed to be relatively uniform between districts. However, this was contrary to Kinerja's demand-oriented approach, which allowed districts to use their own creativity in implementing the program's packages, as well as adapting them to local and cultural contexts. By offering seven intervention packages to only 20 treatment districts, the resulting number of districts that could be directly compared for evaluation was too small to adequately ascertain the actual impact that Kinerja had on sectoral outcomes.

7. Programs should work with all levels of government simultaneously. Being an LG support program, Kinerja's initial focus was to work solely with SDUs and district governments. However, by the end of 2012, it became clear that the provincial and national governments also needed to be better involved in both planning and implementation to achieve sustainable development and wider replication.

TAF's work in BEE at the provincial level provided Kinerja with an excellent example of how provincial forums can support peer-to-peer learning, foster replication, and improve communication flows. These forums promoted ownership at the provincial level towards program activities, and often resulted in funding allocation and program replication. Unfortunately, Kinerja did not capitalize on this learning and failed to establish similar forums for health and education. This represents a missed opportunity to create and strengthen relationships between IOs, community representatives, and district and provincial government leaders, and is likely to have an impact on replication.

Relationships with national technical ministries, even in a decentralized environment like Indonesia, are fundamentally important. While Kinerja developed strong working relationships with governance-related ministries such as KemenPAN-RB and LAN, its relationships with technical ministries such as MOHA, MOH, and MOEC were mostly limited to involving them in consultations. This was partly due to the fact that the technical ministries did not yet have a strong understanding of or appreciation for good governance and its benefits. Kinerja acknowledges that its own role in this was less than optimal, given that it did not involve the ministries when developing annual work plans. This led to a significant lull between the start of the program and the replication stage, when relationships were re-established through the dissemination of policy papers, good practices, and lessons learned.

Ideally, the relationships with national and provincial governments should have been given increased attention throughout Kinerja's implementation. Relationships could have been better supported with the establishment of one or more steering committees to manage relationships at the national and provincial levels.

8. Programs should strive to achieve "meaningful" replication to promote greater sustainability. Compared to previous programs, which recorded replication achievements according to a broad interpretation,[37] Kinerja employed a much more rigorous approach that recorded the actual implemented replication of the program's interventions (such as the number of times Kinerja good practices were adopted by LGs in non-partner districts or the number of times Kinerja good practices were institutionalized in non-partner SDUs, both within and outside the program's treatment districts). Nevertheless, from a governance perspective, to ensure sustainability, good practices need to include the whole development cycle and not just the replication of one good-practice component. For example, measuring the number of TBA-midwife partnerships adopted by LGs/SDUs does not necessarily indicate their success in terms of either implementation or impact on health outcomes. As already mentioned in this chapter, good governance requires a substantial period of time to become fully integrated into sectoral programs; this means that counting a district's initial attempts to replicate a governance-based initiative does not always guarantee that that replication has been "meaningful" (that is to say, institutionalized and sustainable). The emphasis of Kinerja's M&E system on quantitative results ultimately led to a tendency among staff and IOs to see goals and achievements in terms of number-based totals rather than changes in mindsets and structures.

9. Replication is more effective when using pilots in combination with working with decision makers. Kinerja initially launched its implementation efforts at a few pilot SDUs in each of its treatment districts (three *puskesmas* and 20 schools per district) to act as intervention trials. Piloting in this way is not new to sectoral interventions; what set Kinerja apart from other programs, however, was that it simultaneously worked closely with LGs to build their capacity and knowledge about the interventions that they had selected. This approach enabled them to see how governance-related innovations could be conducted in their districts, which in turn led to their increased commitment to scale up and replicate the interventions at additional SDUs in their districts.

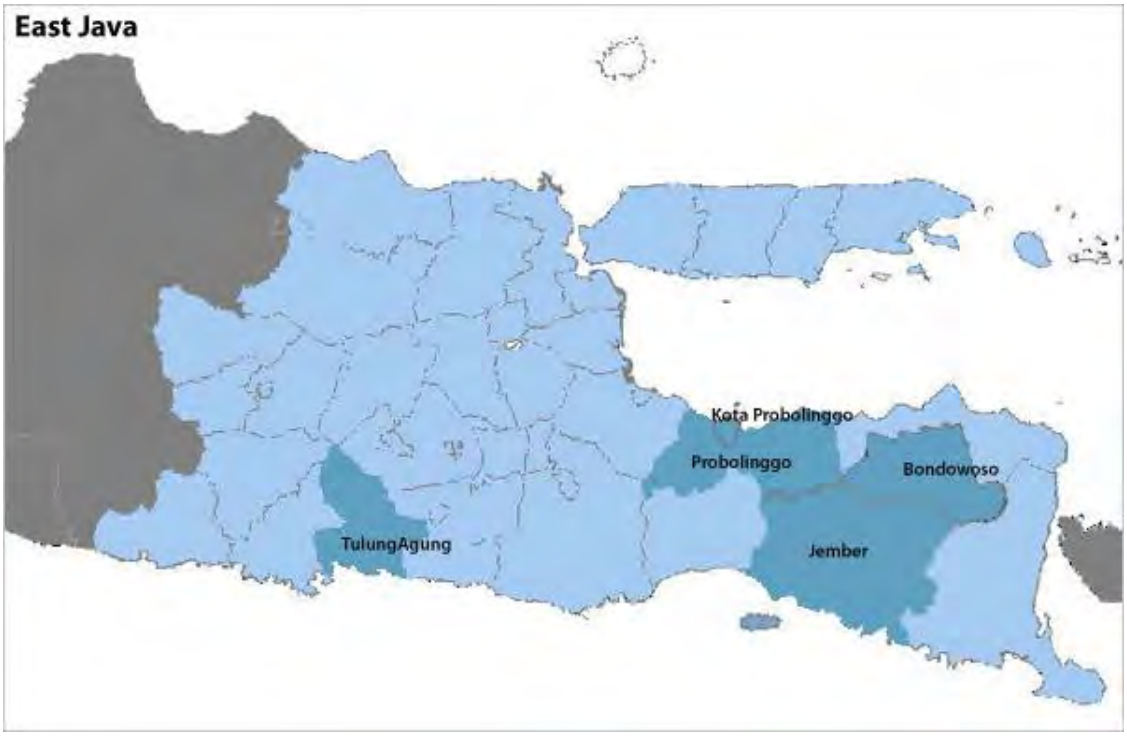
Kinerja's experience proved that when working in sectors such as health or education, it is important to engage with government officials beyond just the district technical offices, as they are not the only stakeholders making decisions. Programs should also work with district-level policy makers and

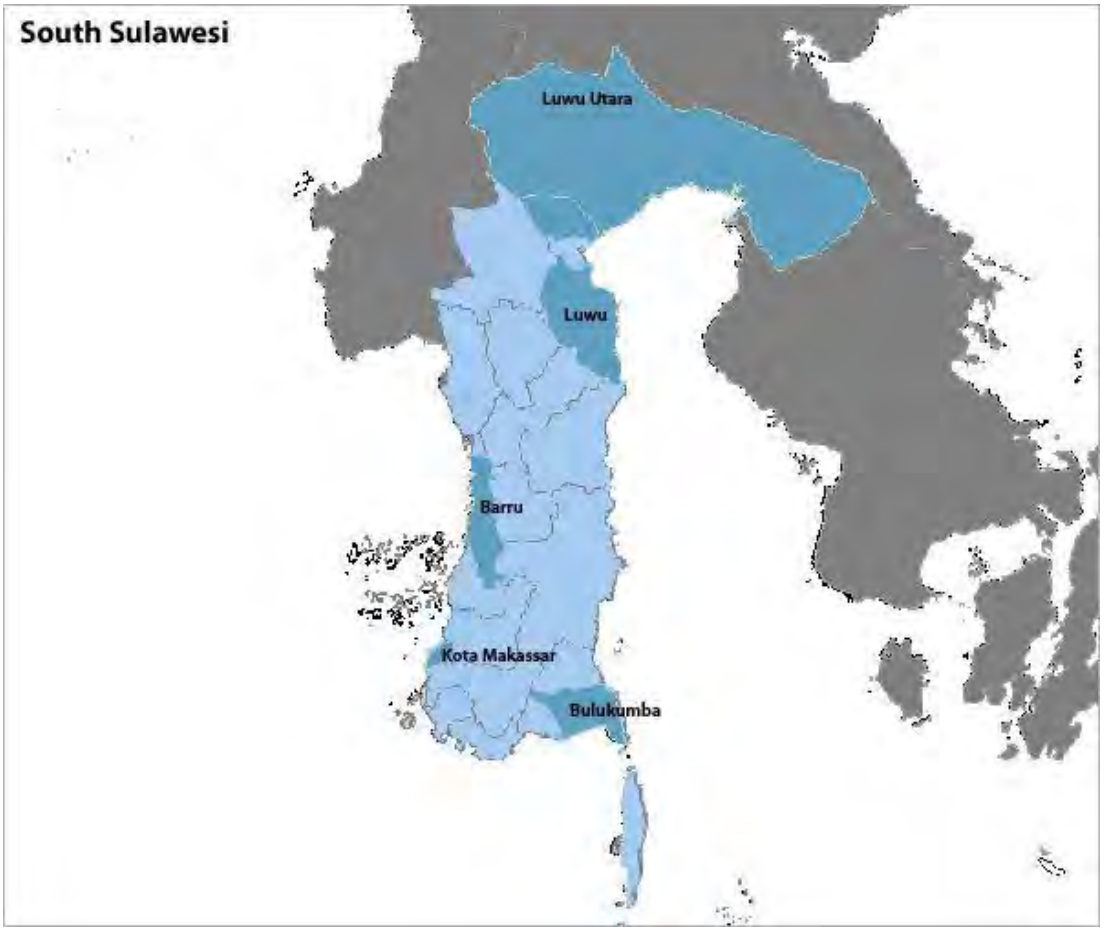
[37] In many projects, just conducting a replication training for LG stakeholders was regarded and recorded as a replication achievement.

legislators, to ensure that plans and budgets issued by the technical offices are understood and approved in order to foster smooth implementation and subsequent scaling-up and replication efforts.

Annex 1: Kinerja Treatment Districts


Aceh
Kota Banda Aceh
Bener Meriah
Aceh Tenggara
Simeuleu
Singkil


East Java
Kota Probolinggo
Probolinggo
Bondowoso
TulungAgung
Jember


South Sulawesi
Luwu Utara
Luwu
Barru
Kota Makassar
Bulukumba


West Kalimantan
Sambas
Bengkayang
Kota Singkawang
Sekadau
Melawi

Annex 2: Kinerja Packages Based on District Consultations

Province	District[38]	Business-Enabling Environment	Education			Health
		One-Stop Shops (OSS) for Business Licensing	Educational Unit Operational Cost Analysis (BOSP)	Proportional Teacher Distribution (PTD)	School-Based Management (SBM)	Immediate and Exclusive Breast Feeding and Safe Delivery
West Kalimantan	Sambas			Second Round		First Round
	Bengkayang				First Round	Second Round
	Sekadau				First Round	Second Round
	Melawi	First and Second Round			First Round	Second Round
	Kota Singkawang				Second Round	First Round
South Sulawesi	Bulukumba		First Round			Second Round
	Barru	First and Second Round		First Round	Second Round	
	Luwu			First Round		Second Round
	Luwu Utara	Second Round		First Round		Second Round
	Kota Makassar	First and Second Round				Second Round
Aceh	Aceh Singkil	First and Second Round		Second Round		First Round
	Aceh Tenggara				First Round	Second Round
	Bener Meriah				Second Round	First Round
	Simeulue	First and Second Round	First Round			Second Round
	Kota Banda Aceh		Second Round			First Round
East Java	Jember				First Round	Second Round

[38] Implementation in Round-1 districts began in October 2011 and in Round-2 districts in October 2012.

	Tulungagung	First and Second Round				Second Round
	Bondowoso			Second Round		First Round
	Probolinggo	First and Second Round				Second Round
	Kota Probolinggo				First Round	Second Round

Annex 3: Replication Districts

Province	District	Sector				
		Education		Health	BEE	Cross Cutting (PPID, MSS)
		SBM	BOSP			
Aceh	Aceh Barat					X
	Aceh Barat Daya					X
	Aceh Besar					X
	Aceh Jaya				X	X
	Aceh Selatan			X	X	X
	Aceh Tamiang					X
	Aceh Tengah					X
	Aceh Timur				X	X
	Aceh Utara					X
	Bireuen					X
	Gayo Lues			X		X
	Nagan Raya					X
	Kota Langsa					X
	Kota Lhokseumawe					X
	Kota Sabang					X
	Kota Subulussalam				X	X
	Pidie					X
	Pidie Jaya				X	
	Banyuwangi			X	X	

East Java	Blitar				X	
	Kota Batu		X			
	Kota Blitar				X	
	Kediri				X	

Province	District	Sector				
		Education		Health	BEE	Cross Cutting (PPID, MSS)
		SBM	BOSP			
East Java	Kota Kediri				X	
	Kota Mojokerto	X				
	Lamongan			X	X	
	Lumajang			X		
	Mojokerto	X				
	Pacitan	X		X		
	Pamekasan				X	
	Sampang				X	
	Situbondo				X	
	Trenggalek				X	
North Sumatra	Pakpak Bharat		X	X		
South Sulawesi	Bantaeng				X	
	Bone				X	
	Enrekang				X	
	Jeneponto		X		X	
	Luwu				X	
	Kota Palopo		X		X	
	Pangkep				X	
	Sidenreng Rappang		X		X	
	Sinjai				X	
	Soppeng				X	
	Takalar				X	
	Wajo				X	
Southeast Sulawesi	Bombana	X				
	Buton	X				
	Kota Baubau	X				
West Kalimantan	Kapuas Hulu				X	
	Kayong Utara				X	

Province	District	Sector				
		Education		Health	BEE	Cross Cutting (PPID, MSS)
		SBM	BOSP			
West Kalimantan	Ketapang			X	X	
	Kota Pontianak				X	
	Kubu Raya			X	X	
	Sambas			X	X	

Annex 4: Intermediary Organizations

Sector	Organization	Area of Expertise	Work Location
Education	CORDIAL	SBM	Barru, South Sulawesi
	Gerakan Anti Korupsi (GeRAK)	BOSP	Kota Banda Aceh and Simeulue, Aceh
	Lembaga Pelatihan dan Konsultasi Inovasi Pendidikan (LPKIPI)	PTD and SBM	Sambas, West Kalimantan and Bondowoso, East Java (PTD); Kota Singkawang, West Kalimantan (SBM)
	Pusat Kajian Pendidikan dan Masyarakat (PKPM)	SBM	Bener Meriah, Aceh
	Yayasan Satyapila	SBM and replication of Kinerja's good practices	Aceh Tenggara and Aceh PEO
Health	Forum Informasi Komunikasi Organisasi Non-Pemerintah (FIKORNOP)	Safe delivery and I&EBF	Luwu and Luwu Utara, South Sulawesi
	Inspiration for Managing People's Actions (IMPACT)	Safe delivery and I&EBF	Southeast Aceh and Aceh PHO
	Komite Pemantau Legislatif (KOPEL)	Safe delivery and I&EBF	Kota Makassar and Bulukumba, and South Sulawesi PHO
	Lembaga Perlindungan Anak (LPA) Tulungagung	Safe delivery and I&EBF	Probolinggo and Tulungagung, East Java
	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jatim	Baseline data collection for adolescent reproductive health (Kespro)	Bondowoso, East Java

Sector	Organization	Area of Expertise	Work Location
	PKBI Kalbar	Safe delivery and I&EBF	Bengkayang, Sambas and Melawi, West Kalimantan
	Pusat Kajian dan Perlindungan Anak (PKPA)	Safe delivery and I&EBF	Simuelue and Aceh PHO
Health	Yayasan Kesehatan Perempuan (YKP)	Kespro program	Bondowoso, East Java
	Yayasan Pemberdayaan Intensif Kesehatan Masyarakat (YAPIKMA)	Safe delivery and I&EBF	South Sulawesi PHO, Luwu, and Luwu Utara.
BEE	Bina Ketrampilan Pedesaan (BITRA)	OSS for business licensing	Aceh Singkil, Simeulue and Aceh PG
	Perkumpulan untuk Peningkatan Usaha Kecil (PUPUK)	OSS for business licensing	Probolinggo, Tulungagung and East Java PG
	Yayasan Adil Sejahtera (YAS)	OSS for business licensing	Barru, Kota Makassar, Luwu Utara and South Sulawesi PG
	Building Peace and Justice (MADANIKA)	OSS for business licensing	Melawi and West Kalimantan PG
	Regional Autonomy Watch (KPPOD)	Local Economic Governance study	South Sulawesi
	National Secretariat of the Indonesian Forum for Budget Transparency (Seknas FITRA)	Local Budget Study (2011 & 2015)	All 20 treatment districts
	Yayasan Akademika	- License simplification guidelines - Documentation of Kinerja's good practices in BEE - Revision of MOHA's OSS TOT - Micro and small enterprises licensing guidelines	National level
	Institute Studi Arus Informasi (ISAI)	Media and citizen journalism	East Java and South Sulawesi
	JURnal Celebes	Capacity building and mentoring for CJs	Kota Makassar, Luwu, Luwu Utara and Barru, South Sulawesi

Media and Citizen Journalism	Yayasan Kajian Informasi, Pendidikan dan Penerbitan Sumatera (KIPPAS)	Media and citizen journalism	Kota Banda Aceh, Aceh Singkil, Simeulue, Bener Meriah and Aceh Tenggara
	Institute for the Study and Research of Regional Information Flows (LPS-AIR)	Capacity building in community media and radio, and promoting freedom of information via PPID offices	Kota Singkawang, Melawi, Sambas, Sekadau, and Bengkayang, West Kalimantan

Sector	Organization	Area of Expertise	Work Location
Media and Citizen Journalism	Pusat Kajian Komunikasi (PUSKAKOM)	Media and PPID offices	Bondowoso, Kota Probolinggo, Probolinggo, Jember and Tulungagung, East Java
	The Java Post Institute of Pro-Autonomy (JPIP)	Research on innovative initiatives and regional Autonomy Awards	East Java
Civil Society Engagement	Forum Bulukumba	MSF capacity building to support BOSP	Bulukumba, South Sulawesi
	Lembaga Pemberdayaan Ekonomi dan Lingkungan Luwu Utara	MSF capacity building to support PTD.	Luwu Utara, South Sulawesi
	Lembaga Pengembangan Potensi Anak dan Perempuan (Pepopeda)	MSF capacity building to support PTD	Barru, South Sulawesi
	Lembaga Pengkajian Kemasyarakatan dan Pembangunan (LPKP)	MSF establishment/ revitalization	Bondowoso, Jember, Kota Probolinggo, Probolinggo and Tulungagung, East Java
	Perkumpulan SEPAKAT	MSF establishment/ revitalization, capacity building and community support	Aceh Singkil, Aceh Tenggara, Bener Meriah, Kota Banda Aceh and Simeulue, Aceh
	Pusat Pengembangan Sumberdaya Wanita (PPSW)	MSF capacity building to support PSD	Kota Singkawang, Melawi, Sambas, Sekadau and Bengkayang, West Kalimantan
	Yayasan Demokrasi untuk Negeri (DAUN)	MSF capacity building to support PTD	Aceh Singkil

	Yayasan ESENSI	MSF establishment/ revitalization and raising public awareness of their rights	Barru, Bulukumba, Kota Makassar, Luwu and Luwu Utara, South Sulawesi
	Yayasan Latimojong Tiga Puluh (L-30)	MSF capacity building to support PTD	Luwu, South Sulawesi

Annex 5: Learning Materials

Kinerja Good Practices

Sector	Title
Education	*Menciptakan Lingkungan Belajar Aman dan Nyaman melalui Manajemen Berbasis Sekolah Berorientasi Pelayanan Publik: Hasil Pembelajaran SMPN 1 Belimbing, Melawi* (Creating a Safe and Comfortable Learning Environment through Public Service-Oriented SBM: Lessons Learned from SMPN 1 Belimbing, Melawi)
	Pemetaan dan Pemerataan Guru melalui Partisipasi Publik di Kabupaten Barru (Implementing PTD with Public Participation in Barru)
	Replikasi Manajemen Berbasis Sekolah Berorientasi Pelayanan Publik di Kota Probolinggo (Replicating Public Service-Oriented SBM in Kota Probolinggo)
	Menguatkan Partisipasi Masyarakat dalam Tata Kelola Manajemen Berbasis Pendidikan di Bener Meriah (Strengthening Community Participation in Education-Based Management in Bener Meriah)
	Biaya Operasional Satuan Pendidikan yang Berkelanjutan: Hasil Pembelajaran dari Kabupaten Bulukumba (Sustainable Educational Unit Operational Cost Analysis: Lessons Learned from Bulukumba)
Health	*Tata Kelola Kemitraan Bidan dan Dukun Membantu Meningkatkan Kesehatan Ibu dan Anak* (TBA-Midwife Partnerships to Improve MCH)
	Meningkatkan Tata Kelola Promosi ASI Eksklusif dan Inisiasi Menyusui Dini (Improving the Governance of Immediate and Exclusive Breastfeeding Promotion)
	Meningkatkan Kualitas Antenatal Care *Menggunakan Kartu Kontrol dan SOP* (Improving Antenatal Care through the Use of Control Cards and SOPs)
	Kantong Persalinan: Inovasi Sistem Informasi Ibu Hamil dan Bersalin (Delivery Pockets: An Innovative Information System for Expectant Mothers)
	Pengelolaan Pengaduan: Sarana Meningkatkan Kualitas Pelayanan dan Manajemen Puskesmas

	(Complaint-Handling Mechanisms: Tools to Improve Service Quality and Community Health Center Management)
	Magang Bidan Desa di Rumah Sakit Umum Daerah Luwu (Internships at Luwu General Hospital for Village Midwives)

Sector	Title
Health	*Meningkatkan Mutu Manajemen Pelayanan Kesehatan Ibu dan Anak melalui Janji Perbaikan Layanan: Hasil Pembelajaran dari Puskesmas Sumberasih* (Improving the Management of MCH Services through Service Charters: Lessons Learned from Puskesmas Sumberasih)
	Mencegah Pernikahan Anak melalui Pendidikan Kesehatan Reproduksi bagi Remaja: Hasil Pembelajaran dari Kabupaten Bondowoso (Preventing Child Marriage through Adolescent Reproductive Health Education: Lessons Learned from Bondowoso)
	Kemitraan Strategis Bidan dan Dukun di Kabupaten Kubu Raya: Replikasi USAID Kinerja (Strategic Partnerships between TBAs and Midwives in Kubu Raya: A USAID-Kinerja Replication District)
	Kerjasama Masyarakat dan Puskesmas Tingkatkan Mutu Manajemen dan Pelayanan Kesehatan Ibu dan Anak di Puskesmas Yosowilangun (Community and Health Center Cooperation Improves the Quality of MCH Services and Management at Puskesmas Yosowilangun)
	Penanganan Terpadu Perempuan dan Anak Korban Kekerasan di Kota Jayapura dengan Melibatkan Masyarakat (Integrated Services for Women and Child Victims of Domestic Abuse – with Community Involvement - in Kota Jayapura)
	Puskesmas Bubakan Tingkatkan Mutu Manajemen dan Pelayanan Kesehatan Ibu dan Anak melalui Mekanisme Pengaduan: Replikasi Program USAID Kinerja (Puskesmas Bubakan Improves the Quality of MCH Services and Management through Complaint-Handling Mechanisms: USAID-Kinerja Replication)
BEE	*Memilih Orang yang Tepat untuk Memimpin PTSP* (Selecting the Right Person to Lead a One-Stop Shop)
	Pelimpahan Kewenangan Pelayanan Perizinan Transferring Authority for Licensing Services)
	Penyederhanaan Jenis Izin (Simplifying Different Types of Licenses)
	Izin sebagai Instrumen Pengendalian (Licenses as Control Instruments)
	Menarik Investor dari Luar Daerah

	(Attracting External Investors)
	Forum PTSP sebagai Ajang Belajar (OSS Forums as Learning Hubs)
	Belajar dari Teman Sebaya (Peer-to-Peer Learning)

Sector	Title
BEE	*Membentuk Tim Teknis yang Efektif* (Establishing an Effective Technical Team)
	Menyusun SOP dan Standar Pelayanan yang Baik (Developing Good Quality SOPs and Service Standards)
	Mengelola Sumber Daya Manusia PTSP (Managing Human Resources in OSS)
	Menjalin Hubungan Baik dan Membangun Dukungan Dari Luar (Establishing Good Relations and Building External Support)
	Mendorong Masyarakat Mengurus Izin (Encouraging the Public to Obtain Licenses)
	Melibatkan Masyarakat dalam Pengelolaan PTSP (Engaging the Community in OSS Management)
	Mencari Umpan Balik Masyarakat (Gathering Public Feedback)
	Pemanfaatan TIK untuk Kemudahan dan Kecepatan Pelayanan (Using Information and Communication Technology [ITC] to Ease and Accelerate Services)
MSS in Health	*Perencanaan dan Penganggaran Kesehatan Berbasis Standar Pelayanan Minimal (SPM) di Kabupaten Bener Meriah, Aceh* (MSS-Based Health-Sector Planning and Budgeting in Bener Meriah, Aceh)
	Integrasi Standar Pelayanan Minimal dalam Anggaran Kabupaten Jember, Jawa Timur (Integrating MSS into the Ditrict Budget in Jember, East Java)
	Partisipasi Masyarakat dalam Perencanaan SPM Kesehatan di Kabupaten Jayapura, Provinsi Papua (Community Participation in Health MSS Planning in Jayapura, Papua)
	Peraturan Walikota Makassar dalam Percepatan Penerapan SPM Kesehatan (Kota Makassar Mayoral Decree Accelerates the Application of MSS in Health)
	Rencana Strategis Berbasis SPM Beri Peluang Peningkatan KIA di Kota Singkawang, Kalimantan Bara (MSS-Based Strategic Plan Offers Opportunity to Improve MCH in Kota Singkawang, West Kalimantan)
MSS in Education	*Distribusi Guru Proporsional di Luwu Utara* (PTD in Luwu Utara)
	Penuhi SPM, Bulukumba Bantu Sekolah Atasi Kekurangan Dana (To Fulfill MSS, Bulukumba LG Helps Schools to Tackle Financial Shortages)
	Manajemen Berbasis Sekolah Berorientasi Pelayanan Publik di Kota Probolinggo (Public Service-Oriented SBM in Kota Probolinggo)

Technical Modules

No	Sector	Title
1.	Health	*Tata Kelola Inisiasi Menyusu Dini dan ASI Eksklusif* (Governance of I&EBF)
2.		*Tata Kelola Persalinan Aman* (Governance of Safe Delivery)
3.	MSS in Health	*Standar Pelayanan Minimal Bidang Kesehatan* (MSS in Health)
4.	Education	*Tata Kelola Manajemen Berbasis Sekolah Berorientasi Pelayanan Publik* (Governance of Public Service-Oriented SBM)
5.		*Tata Kelola Distribusi Guru Proporsional pada Pemerintah Daerah* (Governance of PTD)
6.		*Tata Kelola Biaya Operasional Satuan Pendidikan* (Governance of BOSP)
7.	MSS in Education	*Penghitungan Kebutuhan Pemenuhan Target SPM Pendidikan Dasar* (Identifying Gaps to Fulfill MSS in Basic Education)
8.	Governance	*Pengelolaan Pengaduan Sebagai Metode Efektif Peningkatan Kualitas Pelayanan Publik* (Complaint-Handling Mechanisms as an Effective Method to Improve the Quality of Public Services)
9.		*Panduan Jurnalisme Warga* (Guidelines for Citizen Journalism)
10.		*Pengembangan Forum Multi-Stakeholder* (Developing MSFs)
11.		*Metode dan Teknik Advokasi dan Pengawasan Peningkatan Mutu Pelayanan Publik Berbasis Standar Pelayanan* (Advocacy Methods and Techniques and Supervising the Quality of Standards-Based Public Services)
12.	Organizational Leadership	*Pengembangan Organisasi dan Kepemimpinan* (Developing Organizations and Leadership)
13.	Transparency	*Buku Pegangan Implementasi Undang-Undang Keterbukaan Informasi Publik Bagi Pemerintah Daerah* (Handbook on the Implementation of Freedom of Information Laws for LGs)
14.	PSD	*Modul Tata Kelola Pelayanan Publik Berbasis Standar* (Governance of Standards-Based Public Services)

No	Sector	Title
15.	Public Policy	*Penguatan Peran dan Fungsi DPRD dalam Upaya Perbaikan Pelayanan Publik* (Strengthening the Role and Functions of Local Legislative Councils to Improve Public Services)
16.	Administration	*Modul Keuangan dan Operasional* (Finance and Operations)
17.	Training	*Pengembangan Kurikulum dan Teknik Fasilitasi* (Developing a Curriculum and Facilitation Techniques)
18.	BEE	*Modul Pelatihan Fasilitator Pelayanan Terpadu Satu Pintu* (OSS Services Training for Facilitators)

Policy Papers

No.	Title
1.	*Menuju Tata Kelola P4K, Pembelajaran dari Kinerja-USAID* (Toward Good Governance of the Planning and Prevention of Complications in Childbirth Program, Lessons from USAID-Kinerja)
2.	*Rencana Aksi Daerah Percepatan Penurunan Angka Kematian Ibu* (Regional Action Plan to Accelerate the Reduction of Maternal Mortality Rates)
3.	*Penerapan Standar Pelayanan Minimal Bidang Kesehatan Tahun 2015-2019: Pembelajaran dari Program Kinerja-USAID* (Recommendations for the Application of Minimum Service Standards in the Health Sector 2015-2019: Lessons Learned from the USAID-Kinerja Program)
4.	*Pelayanan Publik Sektor Pendidikan: Tata Kelola DGP, BOSP & MBS* (Public Services in the Education Sector: Governance in PTD, BOSP & SBM)
5.	*Multi-Stakeholder Forum (MSF): Strategi Perlibatan Masyarakat untuk Meningkatkan Kualitas Pelayanan Kesehatan di Tingkat Kabupaten/Kota dan Kecematan* (MSFs: Community Engagement Strategy to Improve the Quality of Health Services at Subdistrict and District Levels)

Studies & Assessments

Research Triangle Institute

No.	Title
1.	Social Accountability in Frontline Service Delivery: Citizen Empowerment and State Response in Four Indonesian Districts (2015)
2.	Capacity Development for Local Organizations: Findings from the Kinerja Program in Indonesia (2013)
3.	The Political Economy of Adopting Public Management Reforms: Patterns in Twenty Indonesian Districts (2013)

The Asia Foundation

No.	Title
1.	*Analisis Anggaran Daerah 2011-2014: Hasil Penelitian di 20 Kabupaten/Kota Program Kinerja (2015)* (Analysis of Regional Budgets 2011–2014: Research Findings from Kinerja's 20 Partner Districts)
2.	*Laporan Kinerja Pengelolaan Anggaran Daerah (Kipad) 2014: Hasil Penelitian di 20 Kabupaten/Kota Program Kinerja* (A Report on the Performance of Regional Budget Management 2014: Research Findings from Kinerja's 20 Partner Districts)

Java Post Institute of Pro-Autonomy

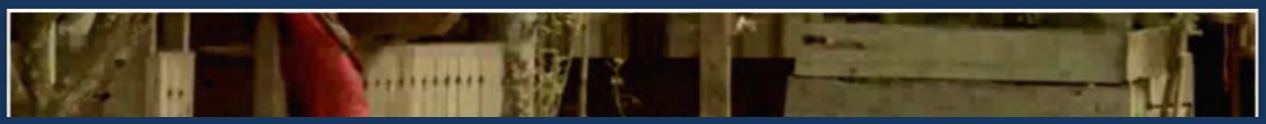
No.	Title
1.	Study on Sustainable Innovations and Good Practices of District/City Governments Winning Autonomy Awards in East Java: 2004-2013 (2015).

Social Impact

No.	Title
1.	Impact Evaluation of USAID/Indonesia's Kinerja Program (2015).
2	Kinerja (SBM) Impact Assessment (2013).

Promotional Films

No.	Title
1.	About Kinerja
2.	About Kinerja (teaser)
3.	Kinerja's Education Program
4.	Kinerja's Health Program
5.	Kinerja's BEE Program
6.	Testimonials (22) from partners and beneficiaries
7.	TBA-Midwife Partnerships in Aceh Singkil
8.	PTD in Luwu Utara
9.	Business License Simplification in Barru
10.	Citizen Journalism to Improve PSD



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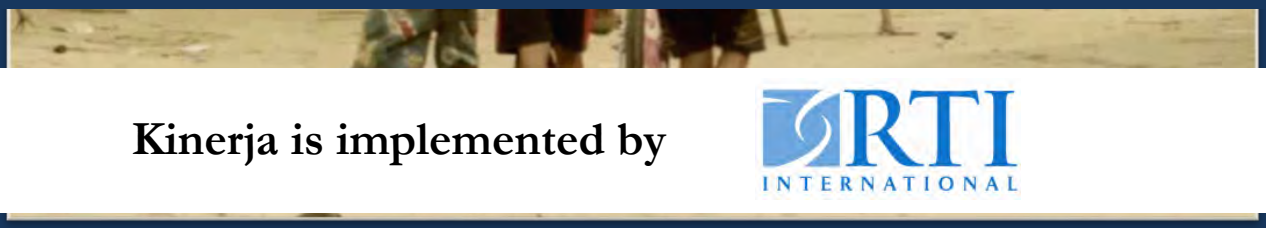
YouTube **USAID-Kinerja**



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