

Real Time Evaluation of the COVID-19 Response in Yogyakarta Indonesia

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Executive Summary of Findings and Recommendations

Key findings and recommendations are briefly presented here. These findings and more specific recommendations are discussed in further detail under each corresponding benchmark.

Summary of overall findings

- First, given the unique context of COVID-19 pandemic, this response straddles the line between humanitarian response and development program. This affects all aspects of the response from design, to implementation, to future direction.
- The key outcome from the point above has been some confusion between various interview participants as to whether this response is a humanitarian response or a development project.
- Overall, responding via remote has been effective and is testament to the strong capacity and action undertaken by CBM CO Indonesia and the relationships fostered between CBM and the partner organisations of YEU and SIGAB. This has been invaluable to the speed and scope of the response.
- While the response has been strong, addressing gaps in communication and coordination would further strengthen this response for the future. These gaps in communication and coordination lie at the heart of all other challenges faced in the response.

Summary of overall recommendations

- Clear articulation of the scope of the COVID-19 response should be communicated to the entire team and partner staff from the outset of the response. All involved should clearly understand how and where the various components of the response fit together and what the overall response includes. This will improve coordination within the response.
- Clarify the expectations of the roles from the outset of the response. This will clarify the responsibilities for each position. This will also recognise the capacity of the partners.
- Continue to build the capacity of the partner organisations. This will continue to strengthen the relationships. Both partners noted that CBM had many skills they would be keen to learn. Further capacity building will also continue to foster trust between the organisation

Limitations

As is the case with any real time evaluation, there are limitations to this evaluation. Most of these limitations stem from the difficulty in conducting the evaluation via remote means, which affected all aspects of the real-time evaluation, to the data collection, to the findings and their presentation. The conditions of the pandemic meant that the ERU and MA members of the RTE team could not travel to Indonesia (borders closed to foreign visitors on 20 March) restricting the team to online coordination and communication.

Data collection: Data collection online was trickier than perhaps expected. The online data collection approach did prohibit the team from organically encountering other actors, as would be the case if the team were operating in the region. Similarly, the types of interview participants selected were predominantly those who were familiar with online platforms and happy to navigate the technology.

The ability to reach remote groups was also more difficult, given that some localities did not have an internet signal, or the signal dropped out during interviews or had to be re-dialled, which presented a huge disruption to the flow of the discussion. This meant that interview time was reduced and some members of the community – particularly the beneficiaries - were difficult to access. Further consideration will have to be given to how best to overcome this difficulty for future real-time evaluations operating via remote communication platforms to avoid overlooking some voices in the response.

Building rapport: This was difficult via remote media. The lack of body language cues meant that it was sometimes difficult to engage the participant or put them at ease.

Engaging beneficiaries: This was difficult given that many beneficiaries lacked smartphones or internet access. Focus groups with immunocompromised groups, or asking people to gather in groups of any kind was risking spreading the virus, and went against the directions of the Health Department and the Indonesian Government.

Language barriers: The implications of this limitation are perhaps more extensive than first anticipated. Most of the communication was in English, for the one member of the team who did not speak Bahasa. This meant that in interviews conducted by this member of the team, the participant had to speak in English, which for many was uncomfortable and raises doubt over some of the meaning of the information collected. This challenge was amplified in focus groups conducted by this member of the team since the discussion was limited to only a few in the group because they were the ones most confident in their English skills. Certainly, the team utilised translators where possible, but it was still a challenge and at times long discussions and the richness of some of this discussion may have been lost in translation.

The language barrier also slowed down the interview schedule, given that team members had to translate, rather than conduct another interview. This affected the timeline of the evaluation process.

Introduction: The COVID-19 pandemic in Indonesia

On 2 March 2020, the Government of Indonesia reported the first two confirmed cases of the coronavirus (hereafter COVID-19).¹ These numbers quickly escalated and spread to surrounding districts. The virus is a respiratory illness with symptoms including, but not limited to fever, coughing, sore throat and difficulty breathing. At the time of writing, the virus is without vaccine and responses to the virus have prioritized preventative measures, which are outlined by the World Health Organisation (WHO) and include limiting physical contact with other people and encouraging regular handwashing and hygiene practices.

The Government of Indonesia responded to the escalating infection rates by initiating the COVID-19 operational Taskforce, under the leadership of the National Board for Disaster Management (BNPB) and additional government agencies. Preventative measures were introduced on 15 March by President Joko Widodo, and encouraged physical distancing strategies that included working, studying and conducting spiritual practices from home and immediate prohibited gatherings of large groups.² By 15 July 2020, the region of Java accounted for almost 60 percent of the total reported COVID-19 cases, with the outbreaks concentrated in East Java and Jakarta, followed by South Sulawesi and Central Java.³

Map 1. Caption: The image shows the geographical regions which have confirmed cases of COVID-19.



Figure: Geographic distribution of confirmed COVID-19 cases in Indonesia, as of 26 March 2020.

Source: <https://www.covid19.go.id/2020/03/26/2112/>

CBM/YEU/SIGAB response to the COVID-19 pandemic in Indonesia

Based on close monitoring of the situation, CBM and partners initiated discussions relating to possible COVID-19 responses in late April (24 April), forming the Emergency Management Team and technical working groups. The response would focus on three districts in Yogyakarta: Wonosari sub-district of Gunungkidul, Ngaglik sub-district of Sleman, and Danuredjan sub-district of Yogyakarta City. Table 1 captures some of the basic demographics of the region.

¹ (Coronavirus Disease 2019 (COVID-19) World Health Situation Report – 1 Date: 27 March 2020 accessed <https://www.who.int/indonesia/news/novel-coronavirus/situation-reports>)

² Ibid.

³ Ibid.

Table 1.

Region	Approx. population	Percentage of population living in poverty	Percentage of population living with disability
Sleman	1,075,575	8.10	0.60
Gunungkidul	742,731	16.60	1.00
Yogyakarta city	414,055	6.85	0.25

Figures located on <http://bappeda.jogjapro.go.id/>

The response was implemented in June 2020 (PPA signed 1 June, and response began 2 June), and was designed to include three outcome areas. These three outcomes are outlined below.

Outcome 1

Outcome 1 was designed to provide comprehensive and accessible information about COVID-19 prevention, and assist recovery. To achieve this outcome, three practical tasks were outlined. The first included media mapping and gap analysis. This involved SIGAB mapping three media products that would be based on needs for older people and accessible to people living with disabilities. The second task involved policy brief development. This outcome would involve SIGAB and DPO consultation to develop policy briefs and good practice at a national level and the organisation of a national webinar on social protection for people with disabilities. The third practical task involved engagement in a webinar on awareness around disability inclusion.

Outcome 2

Outcome 2 was focused on ensuring the most at-risk groups including people with disabilities can access inclusive health services. In light of the lockdown, health services have been difficult for people living with disabilities and at-risk groups (such as the elderly) to reach. To account for this, the response provides both equipment for health care and two avenues for at-risk groups to access health services. The first avenue is the provision of a ventilator to Bethesda Yogyakarta medical facility. The second avenue is an online psychologist to provide counselling services. The third component is the provision of homecare visit for patients from a mobile clinic (YEU will orchestrate).

Outcome 3

Outcome 3 addresses the basic needs of the most at-risk households, including people with disabilities through the provision of a cash transfer program. The program was based on an inclusive and objective targeting tool. This tool would include an assessment of the appropriate financial service providers for the delivery of the cash transfer, such as the Post Office, Bank or Alfamart. At the time of writing this report, Outcome 3 was still refining and cleaning the data that had been collected – as will be discussed in detail within the report.

The COVID-19 real time evaluation in Indonesia

This real time evaluation (RTE) began in late July 2020 with the intention to assess the response of CBM and partners to the unfolding COVID-19 pandemic focusing on the region of Yogyakarta, in the Special Region of Java below the Central Java region (see map 1 on the following page). This evaluation was designed to capture a ‘snapshot’ of the current COVID-19 response. This report is intended to build future capacity between the three organizations, and not intended as criticism. The evaluation team would like to acknowledge the unique set of circumstances that all members of the organisations operate within, and the effort that this response has taken. This evaluation spoke with a variety of stakeholders, from project staff from CBM/YEU/PRY/SIGAB to medical staff, public health officials, technical staff including the Emergency Management Team, the Emergency Response Unit and Member Association staff and four beneficiaries of the project. These interviews were conducted as in-depth informant interviews, or as focus groups. These interviews were conducted on Skype, GoToMeetings, and WhatsApp. All information has been anonymised, and collected with the participant’s verbal consent.

Benchmark 1: Speed and timeliness of the COVID-19 response

1. The speed and timeliness of the response will be according to the needs based on humanitarian imperative and good relative to other actors, with consideration of emergency preparedness measures in place.

1.1 The initial timeline of the response

In previous real time evaluations, the humanitarian crisis has had an immediate affect the communities/areas in which/where CBM and partner organisations work. The COVID-19 pandemic has not followed this same pattern. Instead, the first cases of COVID-19 were identified in Jakarta on 2 March 2020, yet the impact on Yogyakarta was not felt until a fortnight later (15 March 2020) and hospital staff noted that the first cases they diagnosed were not until 29 March. Identifying this timeline is important because it illustrates that the COVID-19 context was not a rapid onset crisis that unfolded within the community but instead it was slowly developing context.

While the extent to which Indonesia and the three districts in Yogyakarta would be impacted by the COVID-19 crisis was not clear initially, the CO began formally monitoring the situation on 16 March, and began to develop a contingency plan in order to protect staff and the beneficiaries, should the situation deteriorate. The Country Office (CO) disseminated the first situation report on 20 March. The Emergency Response Unit also reached out to the CO on this date to inquire about what response might be necessary.

Given the unique context of a global pandemic and the still unfolding challenges, the response undertook a concerted effort to work through smaller technical working teams with the intent that these groups would be more agile and swifter in designing a response. The thematic groups comprised of a range of CBM staff members. The first CBM Global COVID-19 Taskforce call was undertaken approximately six weeks after the first case in Indonesia, and a month after the first case of COVID-19 in Yogyakarta (16 April 2020) which assessed Indonesia as a suitable country to evaluate the COVID-19 response. The first Emergency Management Team was held the following fortnight (24 April 2020) and the technical team meetings began to discuss specifics of the response shortly after (for example, the Cash Transfer Programme discussion began 28 April 2020). These meetings and discussion groups continued through until the COVID-19 response was officially undertaken on 1 June 2020.

The timeline outlined here indicates that from early March when the first cases of COVID-19 were detected to the start of June when the CBM COVID-19 response was initiated, three months elapsed. In humanitarian response, such a delay is difficult to justify, however it is worth noting that the CBM response was quicker than other humanitarian responders, such as Humanity & Inclusion who responded much later. While the COVID-19 has presented a unique set of circumstances (as addressed below), the challenge of responding in a timely manner is still relevant.

1.2 The timeliness and appropriateness of the response

In discussing the timeline between implementation of the CBM COVID-19 response with project staff from CBM, YEU and SIGAB, as well as public health officers, a couple of trends emerged within the data which tended to determine whether or not the interviewee considered the response timely in the current context. Firstly, whether or not the response was determined to be delayed depended on whether the participant was involved in the cash transfer aspect, while those involved in the first two outcomes tended to feel that the response was deemed timely. Another determining factor tended to be whether the participant categorised the response as humanitarian action or more akin to a development project. Both of these aspects are discussed below.

1.2.1. Outcome 1 and 2

The findings relating to Outcome 1 and 2 tend to indicate that the response has occurred within an acceptable timeframe. While nearly all discussions held with interview participants acknowledged that there had been a slight three-month delay between the diagnosis of initial cases of COVID-19, and the roll-out of the response on 1 June, the data indicated that this delay did not impact the appropriateness or timeliness of the response. For example, a focus group with an organisation for people with disabilities (OPD) noted that the response

was not implemented hastily, because the production of published materials relating to the prevention of the spread of COVID-19 would take time to socialise with the community. This step of introducing the community to the material was an important step in the project and required time. The process of education, communication and information within the community, they noted, takes time to work out how to present this material in an accessible way. The group discussed how they had to decide how best to present the information: a leaflet or a booklet? But, what if this isn't interesting enough, the group reasoned and beneficiaries discard the leaflet without absorbing the information? The group finally decided to produce a calendar. This was because a calendar is used daily and is often displayed on the wall for the community to continue to read. This socialisation process however, took time to complete.

Another point raised by this focus group was that the material on disability inclusion required production time, and they noted the need to include the local medical officer in the production of education material covering how to interact with patients with disabilities who contract COVID-19.

A point raised in an interview conducted with medical doctors and hospital staff noted that while they agreed that the response was timely and appropriate when it was first implemented in Yogyakarta, the response would need to be increasingly flexible to remain appropriate in the changing COVID-19 landscape. For example, medical staff noted that the provision of equipment such as a ventilator was appropriate when they diagnosed their first cases of COVID-19 in late March (29 March). However with the prospect of increasing infection rates as foreign workers and overseas travellers return to Yogyakarta, and the closure of a government hospital nearby, and the government decision to treat infected staff in Yogyakarta, the chance of infection rates increasing is high, and the provision of one ventilator will not be sufficient. They concluded that while the provision of central oxygen machines and personal protective equipment is very useful and very much appreciated, if the infection rates continue, the provision of such materials will need to increase accordingly.

1.2.2 Outcome 3: Cash Transfer Programme

The cash transfer programme was identified as being delayed by a variety of participant groups including project teams in both partner organisations and the CO. In addition, it should be noted that the roll-out time for the cash transfer was designed to take into account the government cash transfer program to ensure that the response did not target the same groups within the community as the government's, which was scheduled for April-July and then extended from July-September.⁴ In the partner focus group discussions, it was noted that the cash transfer programme felt delayed because of the multiple steps required to collect the data. The dataset was noted to include responses from approximately 1,300 respondents and the process of cleaning the data reached a bottleneck because all the cleaning was handled by the cash transfer specialist in the CO. The volume of responses made this component of the response slow. It was commented that while this data cleaning process was taking place, the project team was unclear if there was anything they could or should be doing in the interim. The partner group noted that they would have to wait until the data was cleaned and then shared with them for analysis. They noted that for speed, they could be trained to clean the data as well to share the load, but also to build their own capacity. This focus group noted that such a request was reasonable and beneficial citing an example where they had managed the data cleaning process for 600 beneficiaries within three days. A similar discussion was held with the second partner, who noted that the long discussion and consultation process with CBM meant that they agreed that some aspects of the project felt delayed. There were hurdles relating to the construction of the framework to roll out the response in relation to the context of COVID-19. While not specifically mentioned by the partners, the cash assessment process by partners likely contributed to the delay in the implementation of the cash transfer program. In both discussions with partners, and project teams within CBM one of the key underlying problems identified by all the parties interviewed, was that the coordination and the communication around the timeline for the response was not clear enough, and that this communication was around potential hold-ups and the reasoning behind this.

⁴ Penyaluran BLT Dana Desa di Gunungkidul Diperpanjang Hingga September (7 July 2020) *Jogja Tribunnews* Accessed <https://jogja.tribunnews.com/2020/07/07/penyaluran-blt-dana-desa-di-gunungkidul-diperpanjang-hingga-september>

1.2.3 Appropriate versus swift response

A number of project staff noted that they felt that given the unique nature of the pandemic that this response was more like a development program, rather than humanitarian action. As such, a number of project staff noted this hybrid nature of the response and this led to a follow-up discussion about whether the priority of the response was timeliness or appropriateness. For these people who felt that the appropriateness was the most important factor the response was slower to implement than other humanitarian interventions, but this delay was not only acceptable, but deeply necessary to ensure that the response could take into account factors like the ‘new normal’ landscape that was emerging and the need to address it. For example, as an EMT member noted, the response had to be appropriate and therefore that took time, because the project needed to be flexible to respond to an ongoing and emerging reality. A similar sentiment was voiced by a member of one of the technical working groups who felt that the response was not too slow; if anything perhaps too quick, and asked had there been enough time for sufficient consideration of all the factors?

This was part of the unique context of COVID-19, which meant that some people felt the response should be more like a development project than a humanitarian response. The real time evaluation team felt this may have affected how the interview participants viewed the response as timely or appropriate.

1.3 Preparedness and existing networks of the COVID-19 response

The COVID-19 response was able to draw on the lessons of the previous humanitarian responses to ensure that the project was able to benefit as many people as possible, and was straightforward to implement. One of the key strengths of this response was that it relied on existing relationships and given the history of collaboration, particularly between YEU and CBM, this improved the timeliness of the response. For example, a number of project staff praised the existing relationships and working relationship as a means of speeding up the implementation time. Project teams from CBM noted that they knew the capacity of YEU and knew that they could be relied upon to carry out the tasks –however, the real time evaluation team found that if there was some difficulty in employing YEU’s experience. It seems that this experience was difficult to draw on, because of the delays in accessing data and distributing it to the partner organisations. The delay was due in part to the location of the cash transfer specialist, who was located further away. Similarly, the decision to operate in the areas where the partner organisations were already operating was important because it meant they already had a good understanding of the region and the beneficiaries within these districts. Therefore, as one CBM staff member noted, while Jakarta had more cases, the networks and relationships were already set up in Yogyakarta. To opt not to use these existing networks might cause the communities to feel abandoned, but also would delay implementation. The staff member noted that it made more sense to work in Yogyakarta and perhaps extend the current response to cover other areas in the future.

Existing relationships with the government also enabled CBM to respond quickly. Given these good relations, project staff and public officials indicated that they could work well together, as one CBM staff member noted, ‘we know the context we are working in, and we can fill in the gaps [with the government response]’.

The established networks enabled the response to draw on strong existing networks and with partners with known capacity to respond effectively. This factor undoubtedly sped up the response time and appropriateness of the response.

Recommendations

1.2 Communication from CBM/YEU/SIGAB must be clear in relation to the implementation of each stage of the response. All parties involved in the response should clearly understand the timeline for the implementation of the outcomes. In doing so, this will clarify expectations of each organisation and clearly identify boundaries on the role of each group. While Gantt charts were developed with the partners and employed initially, the challenge lay in ensuring this information was communicated clearly to all the project teams and people involved in the response. It did not seem that the Gantt charts were accessible to all members of the team. Improving this accessibility might improve this communication challenge.

1.2.2 For a cash transfer program, there needs to be a prior agreement on who will be responsible for the data collecting and data management process includes capacity assessment beforehand on the partner capacity to do data collection, analysis and others. In doing so, there can be capacity building in data management skills of the partners.

1.2.2 The cash transfer program should be simplified. Tools used to collect data should be tested and refined prior to use in the pandemic. Similarly, ensure there is appropriate orientation on the use of these tools by CBM and partners. In doing so, this transfer of knowledge will build the capacity of the partners as well – something requested by one partners. Furthermore, the teams involved in the cash transfer component need to be appointed beforehand. It also a big burden for the Cash transfer specialist, and he must assist the technical aspects of two projects in the different places (humanitarian response in Palu and Yogyakarta) at the same time. To improve this, there should be stronger communication between the cash transfer teams in CBM and the partners.

1.2.2 Need to share and communicate the data collection tools with the teams and partners more thoroughly prior to crisis, for examples in Market assessment and vulnerability assessment. Consultation with cadre and/or local leader also important to contextualize the tools. Need a session in applying Washington Group Question in KOBOS, or another data collection tools.

1.3 Where possible, drawing on existing networks and relationships can speed up the response, but should also be used as a means of building trust between partners. This might mean drawing on data collected by one organisation and shared between the others. This was done very well in the COVID-19 response.

Benchmark 2: Quality, scale and scope of the COVID-19 response

2. Relief provided is appropriate to the context, of a quality and scale that would be expected of CBM/Partners capacity, and valued by affected population

The scale and quality of the COVID-19 response was deemed appropriate in scale and context and of a quality to be expected of CBM and partners by most participants. It seemed that the response complemented the work undertaken by other actors operating in Yogyakarta, such as the Ministry of Health. Unfortunately, one of the limitations of working remotely was that the RTE team was unable to speak to other NGO actors working in or around the area. Medical personnel who were interviewed noted that they felt that the response provided by CBM/YEU/SIGAB was able to complement the Ministry of Health and the government. Participants noted the decision made by the Indonesian government on 31 March to provide a Rp. 405

trillion package of social and economic stimulus measures including tax incentives, and economic recovery packages. The decision to provide cash transfers to groups such as small business⁵ and farmers⁶ did not target the same people as the CBM and partners response, meaning that the public health officers felt that this response dovetailed with the Government response. The response did not seem to overlap with other actors such as NGOs in the region. As far as most participants were aware, CBM and partners were the only actors operating in these regions, and thus there was no overlap.

2.1 Consultation with key stakeholders

The variety of stakeholders and parties involved in the consultation process in designing and implementing the response, led the majority of participants to conclude that the quality of the response was also appropriate. Discussion groups held with an OPD group and with medical staff both noted that they felt their expertise, building inclusivity, and medical care respectively, had been taken into account. For example, the members from an OPD felt that they had been actively included in the development of the response noting that they had been consulted on aspects of the project that they were not actively involved in. Where there was less clarity in the responses was around the involvement of the beneficiaries in the design period. Some aspects seemed to accommodate the input from the beneficiaries quite well, for example, the project team from one of the partners noted that consulting with people with disabilities while providing feedback on the publication material was extremely useful, but did slow down the process of publishing and distributing that material. Despite the delay, such processes were valuable, they added, because it ensured that the community using the products would be comfortable in using the material. Similar sentiment were noted by an EMT member who noted, that if the response was too fast, valuable information might not be adequately addressed.

In other aspects, the consultation process was less clear. One project coordinator noted that it was not clear to them if a gender consultant had been sought while designing the response. A medical doctor also noted that more should be done to account for the needs of women specifically. Attempts to triangulate this finding further was less clear. Other doctors concluded they felt that the needs of women had been adequately covered in this response, but were not clear on how. Others noted that the needs of pregnant women were accounted for because the home clinic could address these needs.

Similar results were found for the discussion of patients living HIV, or the needs of children. A number of participants did not answer the question, or noted that they personally were not aware of the medical records of patients. To the RTE team, this suggested that how the needs of these people had been accounted for was not communicated, or not made clear to them.

Mental health programs also needed to be considered carefully. Discussion with doctors operating the local area noted that the use of the phone counselling service was not popular initially. However, the interaction with the psychologist/counsellor with the mobile clinic had begun to normalize the process of taking care of mental well-being. This interaction with patients through the mobile clinic was beginning to breakdown the stigma and the doctors hoped this would lead more people to consider the phone counselling. Nearly all the doctors felt that there would be an increase in patients using the phone counselling service in the future.

2.2 Monitoring of the response

The response has been difficult to monitor, given the lockdown in Yogyakarta and COVID-19. There were two reasons that the data identified. Firstly, some aspect of the response had not been in place long before the real-time evaluation took place. Public health officials acknowledged there was a need for monitoring but had admitted they were not sure how the monitoring would take place. They hoped that the CBM/YEU staff could assist them in this. Secondly, the response continued to operate as a hybrid humanitarian

⁵ Adrian Wail Akhil (3 August 2020) 'Government works to provide cash transfers, working capital loans for 12million MSME', The Jakarta Post, accessed 17 Sept. 2020 from <https://www.thejakartapost.com/news/2020/07/30/government-to-provide-cash-transfers-working-capital-loans-for-12-million-msmes.html>

⁶ Dzulfikar Fathur Rahman (29 April 2020) 'Government prepares cash aid production subsidies for farmers in need', The Jakarta Post, accessed 17 Sept. 2020 from <https://www.thejakartapost.com/news/2020/04/29/government-prepares-cash-aid-production-subsidies-for-farmers-in-need.html>

response/development program meaning that some of the project staff felt their energy was better spent focusing on the planning and consider how to monitor the project effectively, rather than rushing into the monitoring, but as a result, the staff member acknowledge that the monitoring would be a little delayed. For example, they noted that they had been intending to link the monitoring process to the inclusive targeting survey, but to do so, they required the postal information of 1300 households. In the wider monitoring framework, the project developed MELF (Monitoring, Evaluation, Learning, Frameworks) to measure project achievement. However, the RTE team did not get any clarity from the project about how far the MELF become a reference for the project implantation, monitoring framework or only become a document without any regular update and reflection during project implementation. In addition, this project does not has any specific person in charge on monitoring, therefore the overall monitoring function be part of project manager's responsibility. In future, where this responsibility falls could be discussed and clarified early in the project. It would be difficult for project manager to lead the implementation and monitor the implementation in the short project period. Furthermore, the RTE team also did not get any clarity how learning from this project documented and shared to the wider stakeholders.

Benchmark 3: Effectiveness of management structure and clarity in communication and decision-making in the COVID-19 response

3. An effective management structure is in place, and providing clarity and well communicated decision-making and direction

Communication and decision-making aspects of the COVID-19 response were discussed in the design phase of the response and during the implementation phase of the project. The overall trend in the data indicated that most interview participants had some understanding of the overview of the management structure and the decision-making process, however there were a number of common gaps in the participants' understandings.

3.1 Design phase

During the design phase of the response, members of the technical working groups, EMT and CO noted that they understood the aspects of the decision-making process that they were involved in, but unclear on the broader structure. The data indicates that there are still some questions about how the balance of power or the hierarchy of decision-making operates within the response. For example, one member of a technical working group noted that they felt that there were some decisions that were being made but it was not clear where, or by which team/unit. When asked to elaborate, the participant noted it was not clear to them where some of the decisions were being made around the cash transfer process, they felt that key decisions were made elsewhere and then the technical team were invited to discuss. Similar sentiments were noted when discussing gender, the participant wondered if a gender consultant had been involved in the planning.

Another challenge was related to clarifying how decisions would be made, when a consensus could not be reached. For example, one EMT member raised this question in relation to the technical working groups. The participant noted that this is part of a new structure and designed to be a means of reviewing, oversee and provided a response to humanitarian challenges, however they would likely require some ironing out of the small challenges such as how should the group manage different voices and perspectives when there is an absence of consensus? Who should be prioritized? Similarly, what is the investment from the various members of each group? The participant provided an example, noting that when it came to feedback on the various drafts and documents, the most detailed responses came from the team focusing on mental health, and what did this mean for the groups that could not/did not provide as extensive feedback? Was their input marginalised? Similar sentiments were raised by other member of the EMT, who noted that there is still some lack clarity around some situations, like for example, if any modification was required given the current context, who would be in charge of giving the final say? Who makes the decisions? The EMT member provided an example, noting that they had concerns about why one village was left out of the response, and by overlooking it, they were concerned that there could be conflict or jealousy within the community. The EMT member asked about how changes to the response could be made, but the process thereafter was not clear to the respondent. When discussing this point with other respondents, it seemed that most respondents felt like the CO has to retain control over this aspect, but it did not seem to be overly clear to the participants.

The partners also noted that they felt included in the decision-making process. One of the ODP noted that they felt that they had been consulted in decision-making across the response, not just in relation to the aspect of the response they were directly involved in, two examples they provided included targeting and what training would be appropriate. This was useful for the transfer of knowledge.

While the data indicates that the partners and CBM communicated well throughout this process - as indicated by the candid and honest discussion - there were some specific aspects of the decision-making process that required further clarification. One focus group conducted with one of the partners a question was raised in relation to the data collection process. The question noted that when the data is collected by the partner, and then provided to CBM for cleaning, who owns this data, and who retains control of the data? This question indicates that there were some questions around the decision-making process that were not clearly communicated to the team, or that perhaps the person to direct questions to was not clear.

Communication between partners and CBM was handled through a variety of means. Most discussions took place via email or online platforms including WhatsApp. Most of the participants interviewed indicated that the use of emails was quite effective, a number of the partner project staff stated there was significant overlap with the content of various emails. Information was duplicated, and the volume of emails did, at times, become overwhelming for the partners. Discussion here led to the idea that the use of Google Documents and ensuring that internal processes could stop email request for the same content requested by multiple member of CBM. This would also improve the speed of the response.

3.1.1 Complaints management

Discussing the complaints process indicated that there were gaps in the understanding people had of the broader structure. For example, a comment from a member of one of the working groups noted that they felt they could raise questions within their technical group, but were unclear on how to raise questions or queries beyond their technical group.

3.2. Implementation of the response

Examining how the partners and field workers implemented the response provided the RTE team with some insight into how the response had been communicated, and how the decision-making process had played out in the implementation of the project. Overall, the communication was quite positive. For example, a medical practitioner noted that they felt that they had been consulted and supported during the response, and that they could raise questions if they had any. Other medical staff noted that they felt that they understood the response and could see how the response was designed to adhere to the guidelines stipulated by the Ministry of Health.

Discussion with the field staff indicated that including the beneficiaries and affected populations was difficult. They noted that it has been hard to involve these communities in consultation prior to the implementation phase of the project. The reason related to nature of the pandemic and the difficult accessing the community in large-scale gatherings, which would be the normal procedure. Despite this difficulty, some aspects of the response, such as the published material, did draw on the feedback from people living with disability. This feedback however, took place once the final draft had been produced, and not in the earlier stages of consultation.

Testimony from the project beneficiaries indicate they felt communication around the implementation of the response had been clear. For example, each of the beneficiaries interviewed noted that they were aware of the number they could call, if they had any questions about the communication during the mobile clinic, or at other times, such as wanting further information, or wished to make a complaint.

These finding seems to indicate that the challenges related to a breakdown in the communication around the decision-making process, and the macro structure rather than the decision-making process. The interview data indicated that the project staff understood that they could raise questions or complaints if they wanted to within their groups. Perhaps providing clearer overview of the process in the initial stages would be beneficial in order to provide clearer communication.

Recommendations:

3.1 & 3.2 The role, responsibility and expectations of CBM, YEU and SIGAB must be clearly outline from the design phase through to the implementation process. Clarifying these roles and responsibilities might be done through clear MOUs between each partner and CBM. In doing so this would remove any confusion between CBM and the partners, but also between the partners themselves. While the ToR and EMT documents were available during the design phase, the RTE team did not feel these documents were specific enough in outlining responsibilities and duties for each of the partners.

3.1 In the design phase of the project, decision-making structures should be clearly identified and articulated to all groups involved. This will help those involved in understanding how and where decisions are made, and who to approach about making amendments or alterations to the project, if needed (such as including another village).

3.1 In the design phase, the mechanisms used to collect the data and from which beneficiaries should be made clear to all organisations involved. This might include clarifying which toolkit will be used and why (such as the Washington Group Questions, or Kobo questionnaire).

Benchmark 4: Assessing the key support functions, resources and risk management of the COVID-19 response

4. Key support functions are sufficiently resourced, and being effectively run. Risks that are being taken are being calculated and documented

This benchmark was perhaps the most difficult to collect data on, mainly because the discussions around resources did not readily extend to the support functions, and the discussion on risks did not arise organically. That being said, the following data was collected, although it was harder to triangulate.

Essentially, program support staff had largely been in place prior to the outbreak of COVID-19 and the humanitarian support staff interviewed from the CO noted that no additional staff had been hired, and that given the long recruitment process that CBM has, that hiring additional staff during a humanitarian crisis such as COVID-19 would be difficult. Many of the CBM interview participants were well informed of their role and seemed comfortable operating their position, which is a testimony to the preparedness of the CO. Unfortunately, no information was provided about the hiring practice of the partners during the COVID-19 response.

4.1 Risk registry

Given the nature of COVID-19 and the ongoing threat it poses to field staff and beneficiaries, risks were taken very seriously. The response implemented a risk registry that was discussed with project staff. The risk registry was known about between members of the CO and the partners, however there were some concerns about the effectiveness and the usability of the registry. These concerns stemmed from a lack of clarity around the registry was constructed and maintained, and the feedback mechanisms of the registry. Specifically, concerns noted that the log frame needs to be expanded further to account for risks that were not covered in the registry, such as the risks relating to mental health stigma. The project teams and medical staff concurred that the risk of mental health stigma extends not just to the beneficiaries receiving the support, but also to the staff providing that support. This should form a significant risk to both beneficiaries and staff and should be reflected in the registry.

This challenge relates to the broader issue that was noted by the team of the lack of monitoring mechanism relating to the registry. There appears to be a lack of formal process for reviewing and updating the registry, or at the very least, this process is not clear or socialized to the project staff. Questions were raised such as, ‘how is the registry updated?’ and ‘how can we capture feedback from the community around the risks they face (such as mental health stigma)?’ Overall, the consensus from the data was to provide a clearer articulation of the feedback and update mechanisms.

Recommendations

4.1 Clarify the feedback mechanism and clearly articulate this feedback process to the people using the registry.

4.1 Updating the registry should become routine. For example, there could be time set aside in team/organisation meetings to raise any threats/risks that the team face. This would involve the ongoing socialisation of the registry and familiarise the team with the process of updating the registry.

4.1 The production of the risk registry should be articulated to all organisations involved. There needs to be further clarity about how various threats/risks were selected while others were not. The selection of risks/threats should be discussed and consultation should occur between the organisations involved.

Benchmark 5: Examining the quality of coordination of the COVID-19 response and relationships

5. Our relationships, under the leadership of ERU, are productive and well-coordinated and we are having a positive influence on other actors

This benchmark was slightly adapted from the template question to focus on the quality of the coordination mechanisms and the relations utilized by the COVID-19 response. The coordination was assessed by the real-time evaluation team at two stages: the design phase, and the implementation phase.

5.1 Coordination during the design phase

The consensus within the data indicated that across all levels of the response, from project staff, EMT members, MA members and CO staff thought that coordination improved over the course of the response. All noted that initially, coordination mechanisms were not clear. All interview respondents noted that initially there were questions about who was involved and in what capacity? How do these groups fit into the response? For the CO, there was a lot of juggling that was well-managed given the unique situation. Staff noted that initially it was a lot for the CO to coordinate, from the high-level technical partners but also coordinate with the partners who are working on the ground with the beneficiaries, which made the task difficult. There was also the need for clarity around internal coordination initially. One example raised in the interviews was related to Outcome 1, which noted that some of the internal coordination did not clearly identify who was undertaking what role and who would discuss what with which other parties.

Responses from participants about how to improve coordination ranged from some EMT members and MA members suggesting more meetings, to the partners suggesting fewer meetings. This led the evaluation team to conclude that what is necessary in this instance is not necessarily more or less meetings, but rather changing how communication is conducted to clarify the coordination mechanisms. On this topic, the preference from the CO and from the partners was for the use of emails, WhatsApp and Google Documents, which could reduce the need for additional meetings. When meetings were necessary, it was requested that a clear agenda could be circulated in advance to ensure that everyone knew what would be discussed, which would help ensure the

right people were in that meeting and reduce the chance of duplicating information. Overall, however, it seems that the bureaucratic processes were managed quite quickly. For example, one project staff member noted that in order to get the CBM response underway required seven signatures, three of which were from CBM Global, which given the challenge of a global pandemic, this was managed quite efficiently.

When asked, how the coordination had improved, and why it became clearer the response from the project staff from across CBM and the partners noted that roles became clearer as the response progressed. Therefore, there is a need clearer expectations for each role and organization, which should also improve coordination.

5.2 Coordination during the implementation phase

Overall, the quality of the relationship between the partners and CBM was strong. All participants interviewed from YEU, PRY, and SIGAB indicated that they were happy with the relationships with the CO. Coordination improved as the response was implemented. There were however some specific aspects of the coordination that could be strengthened for future responses.

Coordination during the implementation phase could be streamlined through the implementation of clearer expectations of the partner organizations. For example, there was some confusion noted by CBM staff that they were not entirely clear on the capacity of some of the partners and OPDs. Similar sentiment was noted by one of the partners that while they were glad to participate and engage in the response, coordination would be further strengthened between themselves and CBM if there was greater recognition of their limited capacity. A focus group with one of the partners also indicated that they were unclear what their responsibilities were regarding the other partner and what this relationship involved.

The preference for how to address these challenges was to improve coordination through the implementation of MOUs with each partner that would clearly outline their role and the expectations related to this role. The RTE team notes that there is a CBM standardized MOU, but according to members of the CO this template is difficult to change and this contributes to slowing down coordination in times of crisis. A more flexible MOU template would be valuable in clearly identifying the capacity of each organization. Another suggestion included undertaking greater capacity building role from CBM to increase the capacity of the partner. This suggestion was raised in relation to the data cleaning relating to Outcome 3 and the cash transfer.

The data also indicated that technical collaboration would be beneficial in order to strengthen online communication and coordination mechanism so that should the need arise, CBM and partners would be able to mobilize very quickly across a specific set of communication platforms.

Recommendations:

5.1 There is a need clearer expectations for each organization from the outset of the response. MOUs could be useful in establishing this.

5.1 The response should also utilize more communication methods in addition to meetings, to maximise time and minimize the chance of redundant meetings. Specifically, the use of Google Docs and WhatsApp provide more agile work modes

5.2 Partner capacity should be recognised, but CBM should work to build capacity in the partner organisations. CBM should also recognise the limits of the partner capacity and be mindful of the ability of partner organisations to contribute towards the response.

Benchmark 6: Connecting the COVID-19 response with long-term programs

6. Connectedness: The response is aligned with DRR or longer-term programming

The data indicated that there is scope for the response to align with longer-term programming. There is a strong relationship that has been developed between CBM, YEU and SIGAB and this can continue to develop through clarifying the nature of that relationship. This relationship incorporate meaningful engagement with people living with disability at a variety of levels within the response (from ODPs providing feedback on the published material, the inclusion of the mobile clinic) and such inclusion should continue to remain a core component of this response. More specific community consultation has been limited thus far but was also hampered by the lockdown regulations. For example, an EMT member noted that there has been limited time for consultation thus far, and that to get around this challenge there has been a reliance on sharing data. The EMT member elaborated noting that while there have not been time for large community consultation; there has been ongoing discussion with beneficiaries as the response has been implemented.

There is a need for ongoing work regarding the socialisation of the online counselling services, and combatting stigma around mental health, which was noted by the majority of health professional and beneficiaries alike. There is scope to link this response into broader efforts to engage in raising awareness around the importance of mental health.

6.1 Future direction of the response and recovery phase

The challenge of providing humanitarian support during a pandemic has meant that much of the response has been slower to implement and delayed in terms of conventional timelines for humanitarian responses. This has meant that much of the response has straddled the space between humanitarian response and development project. The response will likely continue to operate in this grey area into the recovery phase or second phase of the response due to high increases of people who infected, and this hybrid nature of the response was noted in discussions with project staff from the partners and CBM. For example, respondents stated that they believed that recovery phase needed to take into account the question of livelihood protection and the assistance that people will need to adapt to the 'new normal' phase in the post-lockdown landscape. This is particularly pertinent for Yogyakarta where much of the population classified as poor are engaged in daily work, with an income of less than IDR 500,000 per month. Estimates from the rapid needs assessment predict that after COVID-19 approximately 68 per cent of this workforce would likely see a drop in their income of 30-80 per cent. There is a need to consider and prepare for the ongoing need for livelihood support. There is also the need for the recovery phase to be flexible, perhaps even more so than the initial response given that changes within the landscape will continue to develop. One example supplied by a member of the project team of CBM, indicated that the need to provide further support to students with disability would need to be considered, and that the needs of students with disabilities would likely be overlooked in other responses.

6.2 Linking the COVID-19 response into the broader disability movement

The COVID-19 response aligns with the disability movement and this trend will likely continue into the recovery stage, or the 'new normal' of the pandemic. The advocacy work of the response continues to have impact and the potential to influence government decisions going forward, but this influence is complex. For example, public health officials and project staff noted that while they could not influence the department of health directly, they felt could support the local community health centres, who could in turn generate some changes at higher levels. The response also influenced government policy more directly. As a component of Outcome 1, SIGAB will advocate for further disability inclusive measures. The focus group noted that in relation to Outcome 1 they will develop a policy brief on the procedure to ensure inclusive information, communication and education and inclusive social protection. SIGAB will present these findings to the government. Specifically they will present it to the COVID-19 taskforce, and to the government disaster mitigation mediation and civil society.

Recommendations

6.2 Continue to link the response to the broader disability movement. This could be done by clearly aligning this response to internal longer-term programming within each organisation.

6.2 Clarifying what the longer-term response will look like for those involved. Overall, project staff were not clear on this.

Appendix 1. The COVID-19 response timeline

DATE	MILESTONE/EVENT
02 March 2020	Indonesian President Joko Widodo confirms the first two case of COVID-19 reported in Indonesia
10 March 2020	The World Health Organisation sends President Widodo key recommendations and an assurance of the continued support of the WHO for COVID-19 response efforts in Indonesia.
13 March 2020	The Indonesian Government forms the COVID-19 operational Taskforce
14 March 2020	First cases of COVID-19 reported in Yogyakarta
15 March 2020	President Widodo announces national social distancing measures encouraging social distancing.
16 March 2020	CBM Indonesia monitoring of the situation and development of business continuity/contingency plan ERU reaches out to countries to inquire Covid-19 situation and plans for response.
20 March 2020	First sitrep shared by CBM CO
	Feedback from CBM International and Global on the SITREPs and next steps including processes to be used?
31 March 2020	The Government of Indonesia announced a Rp. 405 trillion package of social and economic stimulus measures to respond to the threat of Covid-19 measures on society and the economy. This included support for the health sector, tax incentives, and Rp. 150 trillion for financing the national economic recovery program, including restructuring credit and guarantees and financing for businesses.

2 April 2020	To curb the spread of COVID-19 in Indonesia, the Indonesian government has restricted foreign visitors from traveling to the Indonesian Territory. This travel restriction to Indonesia through immigration control at Indonesia's borders shall adopt the Regulation of Minister of Law and Human Rights No.11 of 2020 about Temporary Prohibition of Entry to the Territory of the Republic of Indonesia for Foreigners until further notice
	CBM Indonesia, partners and ERU initiating dialogue around covid19 humanitarian framework
13 April 2020	Presidential Decree (Keppres) Number 12 of 2020 concerning the Determination of the Non-Natural Disaster of the Corona Virus Disease 2019 (Covid-19) as a National Disaster
16 April 2020	First CBM Global Covid-19 Task Force Call - Decisions in which countries to respond
24 April 2020	First EMT call; Formation of working group to develop detailed proposal including the three technical components
28 April 2020	Small team meeting/technical working group meeting on Cash Transfer component
24 May 2020	President <u>Joko Widodo</u> announced steps for a slow reopening of areas affected by the large-scale social restrictions, dubbed as the "new normal"
1 June 2020	CBM Global Covid-19 Task Force has approved PPA on Inclusive Response to COVID-19 in Yogyakarta.
2 June 2020	CBM/SIGAB/YAKKUM COVID-19 response begins
	On-going technical support and monitoring of the response
	CBM Global guidance around COVID19 programming
20 July 2020	The <u>COVID-19 Response Acceleration Task Force</u> was dissolved by President Joko Widodo and replaced by the <u>COVID-19 Controlment and National Economic Recovery Committee</u> . As a result, this was also the last day of the daily data update broadcast.
27 July 2020	RTE begins with the joint meeting with CBM/YEU/SIGAB and Christian from the ERU
9 September	Focus Group with RTE Team
9 September	Indonesia confirmed 3,307 new cases, bringing the total number to 203,342. 2,242 patients recovered, bringing the total number to 145,200. 106 patients deceased, bringing the tally to 8,336. 489 municipalities and regencies had reported at least one positive case.
10 September	Reflection workshop

Appendix 2. Acronyms

CBM	Christoffel Blindenmission
CO	Country Office (in this case the Indonesia office)
CTP	Cash transfer programme
EMT	Emergency Management Team
ERU	Emergency Response Unit
MA	Member Association (in this case CBM Australia)
OPD	Organisations for people with disability
PRY	Pusat Rehabilitasi YAKKUM
RTE	Real time evaluation
SIGAB	Sasana Inklusi & Gerakan Advokasi Difabel
YEU	YAKKUM Emergency Unit

