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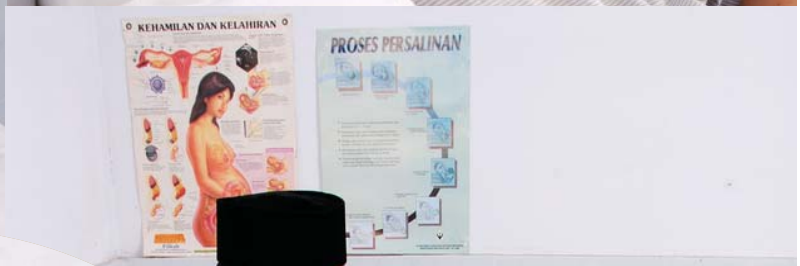
Health Services Program

HEALTH SERVICES PROGRAM
FINAL REPORT 2005-2010



HEALTH SERVICES PROGRAM - FINAL REPORT 2005-2010

This document represents the Final Report for Cooperative Agreement No. 497-A-00-05-00031-00. The HSP Final Report 2005 – 2010 is submitted by JSI Research and Training Institute, Inc. to the United States Agency for International Development in accordance with the terms of the Cooperative Agreement.

Acknowledgement

The JSI Research & Training Institute, Inc. (JSI) is indebted to many institutions and people, who worked with us on the Health Services Program. We would like to express our gratitude to all, especially the United States Agency for International Development and the Government of Indonesia.

We want to thank and convey sincere appreciation to our partners, Abt Associates (Abt), Mercy Corps, The Manoff Group (TMG) and the University of Indonesia-Center for Family Welfare (PUSKA-UI) and a host of collaborating institutions and consultants, who have worked and contributed to the success of the program.

We have learnt a great deal from those who have worked with us over the years and gratefully acknowledge our debt to them, especially our staff for their contributions.

Lastly, we would like to express our sincere gratitude and great appreciation to the people of Indonesia for their warm hospitality, tremendous cooperation and continuing collaboration.

JSI Research & Training Institute, Inc.

This report was developed through the Health Services Program (HSP), funded by the United States Agency for International Development (USAID) and implemented by JSI Research & Training Institute, Inc. in conjunction with Abt Associates, Mercy Corps, Manoff Group, and the Pusat Kesejahteraan Keluarga – Universitas Indonesia (PUSKA-UI).

This report is made possible by the generous support of the American people through USAID. The contents are the responsibility of JSI Research & Training Insttitue, Inc. and do not necessarily reflect the views of USAID or the United States Government.

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EXECUTIVE SUMMARY

The main goal of the Health Services Program (HSP) was to support the scale-up of evidence-based interventions to reduce mortality among mothers, newborns, and children under five in Indonesia. The United States Agency for International Development (USAID) awarded HSP as a five and an half year Cooperative Agreement in 2005 to the JSI Research & Training Institute, Inc. (JSI), along with its partners, Abt Associates (Abt), Mercy Corps, The Manoff Group (TMG) and the University of Indonesia-Center for Family Welfare (PUSKA-UI) and a host of collaborating institutions. The HSP worked with the Government of Indonesia (GOI) to design and implement a dynamic and innovative approach to provide technical assistance to improve maternal, neonatal and child health (MNCH) programming nationwide. Officially launched in April, 2005, HSP served as USAID/Indonesia's flagship maternal, neonatal and child health project under its Basic Human Services Program, which aims to strengthen key public services in the areas of health, nutrition, and the environment. The project design was centered on developing an integrated package of affordable, evidence-based best practice interventions to be made available to districts, and on supporting the nationwide replication of interventions to maximize the potential for national-level impact.

This report presents the design, rationale, results as well as recommendations and lessons learned as a part of the technical assistance the HSP provided in collaboration with the GOI and the Ministry of Health. The approach, developed between 2005 and 2010, provides an implementation roadmap for Districts or Municipalities to implement and scale up a comprehensive and integrated strategy for reducing maternal, neonatal, and child mortality.

Maternal, neonatal and child mortality are influenced by a multitude of interrelated factors, including social, behavioral and clinical determinants, and the availability, quality and utilization of health services. The relationship between determinants or aspect of health services and maternal, neonatal and child mortality is complex and not reducible to a simple explanation. International consensus establishes access to skilled obstetric care around the time of birth, including comprehensive emergency obstetric and neonatal care (CEONC) as essential for reducing maternal and neonatal mortality. [A]

The HSP provided technical assistance for implementation of the GOI/MOH's Making Pregnancy Safer and Child Survival Strategy, which is based on international consensus on reducing maternal, neonatal, and child mortality and morbidity. This consensus calls for a combination of political leadership and community engagement and mobilization to support a health system to effectively deliver a package of high quality interventions. It requires the removal of access barriers, through delivery of free services for women and children, who could not afford them otherwise, provided by skilled and motivated health workers, with accountability at all levels.[1] Community participation and accountability are a means to achieving equity, as well as an indicator of an equitable health system (Kruk and Freedman 2008: 271).

Since 2005, the HSP has taken a health systems approach to work with the GOI/MOH to strengthen its program of interventions for reducing maternal, neonatal and child morbidity and mortality. This approach put into practice three valuable lessons learned over the last 20 years which have informed the international consensus.

The first lesson learned is that reducing maternal and neonatal mortality requires ensuring women have timely access to quality emergency obstetric and neonatal care (EONC) as every pregnancy entails risks that can develop into life-threatening complications for the mother and/or baby. Because many life-threatening complications are neither predictable nor preventable, it is critical all pregnant women have access to skilled birth attendants, who can recognize complications when they occur and make informed decisions to refer women or newborns with complications to EONC services.[B]

A second lesson learned is that skilled care is only effective if it is part of a functioning healthcare system that links women, newborns and children to higher levels of care when needed. A functioning system requires that healthcare services adhere to national clinical guidelines that meet international standards for EONC, skilled birth attendance and integrated management

A. Basic emergency obstetric and neonatal care (BEONC) includes providing parenteral oxytocin, antibiotics and sedatives. It also covers post abortion care, manual placenta removal, forceps and vacuum extraction, prevention of newborn hypothermia and newborn resuscitation. CEONC includes BEONC services plus cesearean section and blood transfusion capabilities.

B. Maternal mortality: The principal causes of maternal death in virtually every country where maternal and neonatal mortality and morbidity remain high are hemorrhage, eclampsia, infection, obstructed labor, and unsafe abortion. Effective response to these life threatening complications requires a skilled provider capable of detecting complications immediately, stabilizing the woman for transport to a BEONC level facility, and having timely access to a CEONC level of care if a c-section and blood transfusion is necessary. Neonatal mortality: Newborns die principally of asphyxia, pre-term births and infection. In the case of newborns, interventions can be initiated by a skilled provider trained in newborn resuscitation and the importance of skin-to-skin contact prior to, and during transport to a higher level of care.

of childhood illness (IMCI). A functioning system also depends on policies that support training and rational deployment of healthcare professionals, especially those with midwifery skills, throughout the country.

HSP worked with the GOI/MOH to revise national policies, standards of care, and protocols in line with internationally recognized evidence-based best practices. This comprehensive package of national standards, guidelines, and protocols are now part of the Ministry of Health's MNCH Toolkit, [C] HSP also worked with the MOH, and District governments, health, planning, and budgeting departments, service providers, and communities to identify existing policies, protocols, and procedures with potential to alleviate the multiple social, economic, behavioral, and clinical determinants contributing to maternal neonatal and child mortality. These included MOH policies and protocols designed to improve access and quality of care; top down (DTPS) and bottom up (*Musrenbang*) Indonesian planning processes; advocacy and community mobilization (PKK) data collection and analysis at the district, sub-district, and village levels; and passage of laws and ordinances to ensure availability and improve targeting of funds for MNCH. HSP contributed to the effort by updating MOH Tools in line with current evidence-based best practices, and improved guides and manuals for facilitating planning, budgeting, and community mobilization and data collection.

The HSP provided technical assistance for the revision and development of training packages for different categories of skilled providers, including a normal delivery, and basic and comprehensive emergency maternal and neonatal care training packages. HSP, in collaboration with the MOH and the National Training Network (JPNK), improved training modules and funded training on basic pregnancy and delivery care for midwives (APN), basic EONC (PONED), and CEONC (PONEK), as well as for supportive supervision and IMCI. The supportive supervision guidelines support a process for integrating village midwives and nurses into the larger health system to ensure greater quality of primary healthcare for women, children, and newborns.

The third lesson learned is that it is essential to have reliable information about the causes and circumstances surrounding maternal, neonatal and child deaths in order to know what kind of improvements are needed in the health system to ensure women's, children's' and newborns' access to life saving care when complications and emergencies arise.

The HSP technical assistance also included a process for improving the quality of maternal and neonatal emergency care in hospitals. At the beginning and end of the project HSP worked in district and provincial hospitals to strengthen delivery of comprehensive emergency obstetric and neonatal care through improvements in data collection and audits, updating of technical and clinical procedures, and on the job training and supportive supervision. In addition to the evidence-based guidelines and protocols, the focus also included improving infrastructure, implementation of the protocols, and accountability through record keeping and audit procedures for greater accountability.

An additional focus was to strengthen the district health information system to address needs for better data on maternal, neonatal and child deaths. A key component of the this area was the use of community-based approaches for active surveillance of pregnant women and newborns. These approaches build on the existing reporting and recording system in districts, known as the Local Area Monitoring (LAM). LAM tracks both coverage of key maternal newborn and child health (MNCH) interventions, such as rates of immunizations and use of prenatal care, as well as key health outcomes, including morbidity and mortality statistics. Data are collected by village midwives with the help of village *kaders* (health volunteers), and reported up to the health facility level, where data are compiled and reported up to the District Health Office (DHO). This active surveillance system also provided a link for mothers and newborns to health services.

The main challenges for Safe Motherhood policy implementation are:

- Limited number of human, financial, and infrastructural resources;
- Safe Motherhood evidence-based practices are not well understood by all stakeholders;
- Limited effectiveness and integration of the multiple activities necessary to reduce MMR and NMR, in particular, and many programs do not follow recommended standards and practices;
- Lack of coordination among partner organizations working at different levels of the health system.

In Indonesia, the epidemiology of maternal, child and neonatal mortality has in many ways resembled the situation globally in recent decades, characterized by broad gains during the second half of the twentieth century followed by stagnating progress in key areas moving into the twenty first century. Indonesia went from sub-Saharan African levels of poverty and social development indicators in the 1960s to those of a middle-income country by the late 1990s.

While there have also been considerable improvements in children under-5 mortality, which has fallen by 40% between 1980 and 1997 (Kristiensen & Santoso, 2006, p. 248-249), neonatal mortality continues to be relatively high.

Despite the gains of the past few decades, MNCH remains a significant challenge in Indonesia, and progress in key indicators has begun to slow in recent years. Maternal mortality

C. A complete list of these tools is found on page 75.

remains among the highest in the Southeast Asia region[2], and there are signs that progress has slowed since the 1990s. While national statistics indicate that the MMR declined from 390 per 100,000 live births in the early 1990s to 228 during the most recent measurement period, the current rate of decline is insufficient to achieve the MDG target of 102.

As with maternal death and morbidity globally, national estimates of rates and causes of maternal death obscure important socio-demographic differences. In 1993-1997, women in the lowest wealth quintile compared to women in the highest quintile were almost four times as likely to experience a maternal death, and this gap has increased 2.5-fold from 1990-1994. Sub-national studies of districts in West Java in 2004-2005 estimated a maternal mortality gap of 479 per 100,000 in rural areas to 226 in urban areas (Ronsmans, Scott, & Adisasmita et al, 2009), and gap of 706 per 100,000 among the poorest income quartile to 232 among the richest (Ronsmans, Scott S, & Qomariyah et al, 2009).

There are six key evidence-based interventions for newborn health – such as coverage of tetanus toxoid immunization, skilled birth attendance, access to emergency obstetric care, and immediate and exclusive breastfeeding – could avoid an estimated 72% of all newborn deaths globally. Scaling-up coverage of a similar package of evidence-based interventions could avoid an estimated 63% of all child mortality, and up to 74% of maternal deaths around the world.[3] Indonesia is no exception, where the vast majority of maternal, neonatal and under-five deaths that occur each year could be prevented with access to low-cost, basic care, using technologies and approaches that are already broadly available around the world.

The most significant advance has been the recent strategic consensus on how to reduce maternal mortality, by guaranteeing universal access to: 1) family planning; 2) skilled care during pregnancy, delivery, and post-partum; and 3) emergency obstetric care when complications arise. This historic consensus recognizes that although there are no quick technological fixes for maternal health outside of the health system, there is a solid evidence base of effective responses.

There is also an emerging awareness of innovative ways to instigate changes in the health system that increase access to skilled care and EONC without taking on the whole system at once. This realization has led to creative solutions to: 1) policy and financing (e.g. as detailed below through HSP's work on changing the legal framework at the district level to mandate allocation of MNCH resources); 2) financing (conditional cash transfer programs in conjunction with opening up underused social security hospital maternity beds in Mexico); 3) human resources shortages (task shifting, such as allowing para-professional surgeons to perform C-sections in Mozambique and Tanzania); and 4) accountability (community-based surveillance systems linked to facility audit procedures in India, Indonesia, and Bolivia).

The Ministry of Health's Making Pregnancy Safer National Strategy Plan, 2001-2010 analyzes how weaknesses in the response of the health system contribute to maternal mortality. It reveals the main causes of maternal death in Indonesia are hemorrhage, infection, eclampsia, prolonged labor and abortion complications. It states that hemorrhage due mostly to retained pieces of the placenta, causes unnecessary deaths because of inadequate management of the third stage labor. Similarly, maternal deaths from infection are an indicator of poor prevention and management of infections. Meanwhile, maternal deaths from abortion complications are an indicator of unmet need for family planning leading to unwanted pregnancies. Additionally, the percentage of deliveries with an interval of less than 24 months also contributes to high levels of maternal and neonatal morbidity and mortality (MOH 2001).

While under-five mortality rate, at 34 per 1,000 live births as of 2006, appears to be on track to meet the MDG target of 30 by 2015, neonatal mortality is not falling fast enough.[4] Between 1986 and 2002, early neonatal mortality in Indonesia decreased by an average of 3.2 percent annually, but deaths on the first day of life did not decrease significantly during this period, indicating problems in neonatal care (Hall et al, 2009). Overall, the current rate of decline of the NMR is not making enough progress to achieve the GOI's target.

As with other health indicators, the burden of neonatal mortality also varies along socio-demographic lines. NMRs are highest in rural regions, among women with low education and in the poorer wealth quintiles. Rates also vary by province, ranging from 14 per 1,000 live births in Nanggroe Aceh Darussalam, Central Java and Bali, to 39 and 46 per 1,000 in South Kalimantan and West Sulawesi during the 1998-2007 period (IDHS, 2007).

The HSP technical assistance was based on the premise that strengthening of health systems is central to reducing maternal, neonatal and child mortality. Contrary to the perceptions of many skeptics that this is an overwhelmingly complex undertaking, the strengthening of the implementation of evidenced based best practices MNCH interventions in Indonesia demonstrates that it is both feasible and effective, even in a highly decentralized health system.

The key components of an effective health systems approach are interventions that:

1. Strengthen policy and political commitment at multiple levels of government, including evidence-based national health policies, standards, and protocols, and legal frameworks at the district (municipal) and village levels.
2. Build capacity and accountability for planning and budgeting based on evidence-based practices and reliable demographic and health profiles of local populations.
3. Strengthen the quality and reliability of health information through improved data collection, analysis, and reporting; active surveillance of pregnant women and newborns to

ensure that services respond to their needs correctly and in a timely fashion; use of data for planning and leveraging resources.
4. Strengthen the skills and accountability of healthcare providers.
5. Strengthen systems that facilitate integration of health services at different levels (e.g. referral, logistics, communications, supervision).
6. Engage civil society, and particularly local communities, in the design, implementation, and monitoring of healthcare.

HSP has been very successful in developing a strong foundation to address the major causes of maternal and neonatal mortality in Indonesia. The USAID Evaluation of HSP which was conducted by GH Tech consultants in October 2008 concluded the following, "HSP met or exceeded all of its targets. The project produced high quality reports and strong communications materials on project progress and achievements. HSP also responded to USAID requests with skill and alacrity (e.g., tsunami, national call to action for health) even though they were outside of their original scope of work".

The following are some of HSP's technical assistance accomplishments:

1. An integrated package of evidence-based national guidelines for reducing maternal and neonatal mortality.
2. A district-level advocacy process for increasing political and financial commitment to maternal, neonatal, and child health in support of Indonesia's Millennium Development Goals 4 and 5, including a process for passing local laws and decrees (*Perda*, *Perbup* and *Perdes*).
3. An improved process for district-level and *Puskesmas* MNCH planning and budgeting based on data for decision-making (DTPS and PTP).
4. An evidence-based integrated maternal-neonatal curriculum for normal delivery care (APN), basic EONC (PONED) and comprehensive EONC (PONEK), and supportive supervision for health providers.
5. An improved and revised integrated management of childhood illness (IMCI) which includes a new protocol for management of newborn illness for 0 to two months old infants and use of zinc for management of diarrhea.
6. Effective district-level BCC strategies focused on birth preparedness, immediate and exclusive breastfeeding and hand washing, utilizing public-private partnerships.
7. A replicable strategy for community mobilization for developing and implementing village and household level birth preparedness and complication readiness plans (P4K, GSI and PKK).
8. Expansion of the Bidan Delima program to improve quality of private midwives through support to the Indonesia Midwives Association (IBI).

(See appendix 1 for complete list of achievements)

Based on the experience of five and an half years of implementation of MNCH interventions, HSP makes the following general recommendations:

1. Continue to support the focus on maternal and neonatal mortality reduction and efforts to achieve MDGs, especially goals four and five: Provide technical assistance to build on the previous investment by HSP in providing support for the national and local roll-out to all levels of a road map and plans to reach MDGs, especially four and five.
2. Prioritize actions that increase access to and availability of quality 24 hours 7 days a week BEONC and CEONC in districts. Currently, nationwide, 59% of births in Indonesia take place at home, of which approximately half are assisted by skilled providers, who may or may not be linked to higher levels of care, increased access to care will increase the chance of a woman and her baby receiving timely and adequate care in the event of a serious complication.
3. Prioritize the strengthening of information systems and data management in communities, *posyandu*, *puskesmas*, and hospitals. At the community and *posyandu* levels, engage local health committees and *kaders* to practice active surveillance by linking the identification and registration of pregnant women and newborns to service delivery and the collection and analysis of information on maternal and neonatal outcomes. At hospitals and *puskesmas* activate and strengthen MOH mandated maternal and perinatal audit systems that are currently not fully operational or effective.
4. Ensure that the private health sector, NGOs and Religious Organizations are integrated into district models for reducing maternal and neonatal mortality: Private providers, NGOs and Religious Organizations are an important source of maternal and newborn care. Since many public sector providers also work in the private sector and with NGOs/ Religious Organizations, distinctions between sectors becomes blurred.[D]
5. Support learning from experiences on reducing maternal and neonatal mortality across Indonesia: Knowledge management should be a strong component of the efforts to reduce mortality and morbidity. It is, therefore, important to broadly disseminate lessons learned and evidenced based best practices that emerge from working in a comprehensive manner at the district level.[5]

D. For example, 44% of live births at home were attended by a skilled birth attendant who may have been a government employee or operating in a private capacity.

INTRODUCTION

Indonesia's key MNCH Burdens

While Indonesia continues to make progress towards reducing the number of maternal deaths, serious efforts are still needed to address Indonesia's high maternal mortality ratio (MMR) if the country is to meet its Millennium Development Goal (MDG) target. Both maternal and neonatal mortality can be traced in part to the continuing high proportion of births that take place without a skilled provider present, and the fact that the majority of births still occur at home. While the presence of a skilled birth attendant has expanded greatly among middle-class women, only one-third of home births in poor households had a provider present. Across wealth groups and over time, institutional deliveries are expanding and the majority take place in private facilities or with private midwives, most of whom in fact conduct dual practice with public sector jobs. Yet even when women do give birth with a skilled attendant, services may be of questionable standard; one study estimated that 40% of maternal deaths occur in hospitals. In general, information on where women die is scarce, so developing effective strategies for addressing maternal death is challenging.

Indonesia is among the Asian countries that have made the most progress in decreasing child deaths, however newborn mortality remains a concern. It is estimated that 60% of infant deaths occur in the neonatal period, slowing overall progress towards child health goals. Birth asphyxia and low birth weight remain the leading causes of neonatal death, and very low rates of immediate breastfeeding contribute to high newborn mortality. Early introduction of formula milk and other foods is a serious problem. With a lack of control over the marketing of breast milk substitutes, even health providers promote infant formula.

Diarrheal disease and acute respiratory infections remain the leading killers of under-five children, with efforts to control them hampered by slow progress on MDGs related to clean drinking water and sanitation. Under-nutrition is a factor in over half of child deaths in Indonesia – around one-third of Indonesian under-five children are stunted due to malnutrition, almost half are anemic, and half have low serum retinol indicating Vitamin A deficiency.

The Government of Indonesia has employed a tiered approach representing a continuum of care from sub-district and village level health facilities up to district and provincial public hospitals. At the sub-district level, 8,000 primary health centers (*puskesmas*) are nominally equipped to provide services, each covering around 30,000 people. *Puskesmas* are supported by over 20,000 satellite health centers (*pustu*), community health posts (*posyandu*) and village-based maternity centers (*polindes*). While this provides a system that should routinely collect health data, reporting and publishing of routine health data dropped off after decentralization. This has prohibited a comprehensive assessment of the technical and allocative efficiency of the public health system.

The Health Services Program

JSI Research and Training Institute, Inc. entered into a Cooperative Agreement with USAID/Indonesia in April 2005 to implement the USAID integrated decentralized maternal, newborn and child health (MNCH) activity – the Health Services Program (HSP). The five and a half year program (April 2005 – September 2010) was designed by USAID/Indonesia to reduce mortality among mothers, newborns and children and to improve the decentralized health system that delivers basic human services, with a focus on services for the poor. HSP was conceived as the flagship health activity under the USAID/ Indonesia Basic Human Services (BHS) program, which was in place at that time. BHS was an integrated strategy combining health, food/nutrition, and environmental management and water services at district and community levels.

HSP has one Cooperative Agreement with USAID/Indonesia, with three amendments, as tabled below. HSP completed its work in Aceh funded under the amendments for Aceh Women and Children (completed in FY07) and NAD MNCH (completed in FY08). Activities in Banten, DKI Jakarta, North Sumatra and West Java were completed on March 31, 2009, as were activities delivered in most districts of East Java. Final activities in Malang and Pasuruan districts of East Java and support to national activities were completed by September 30, 2010.

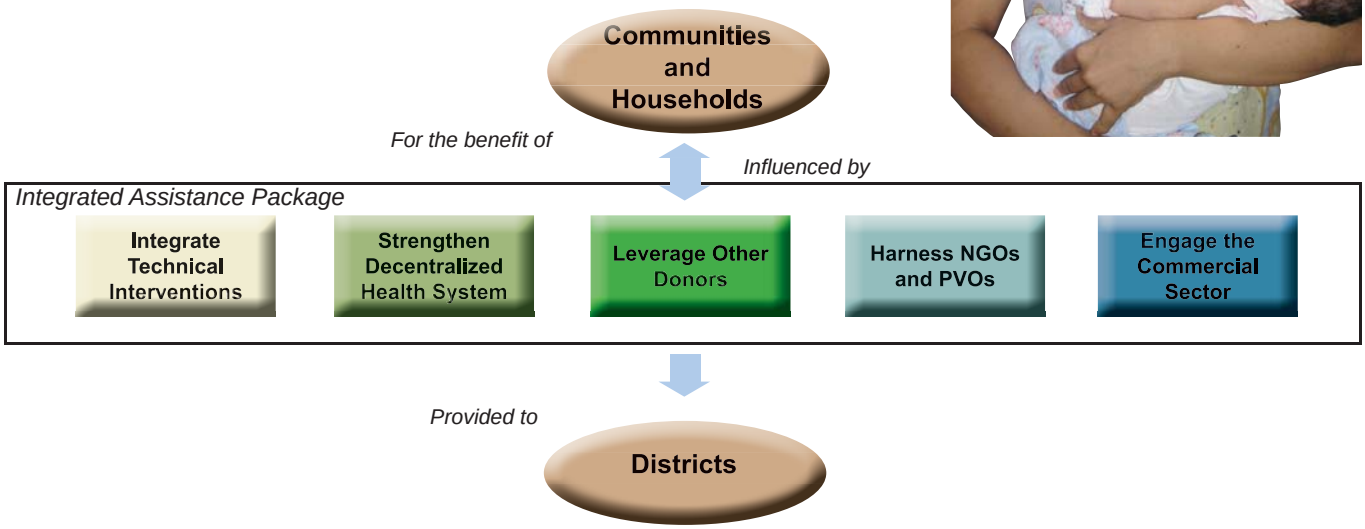
Mothers and children benefited from HSP interventions

Table 1
HSP Cooperative Agreement Coverage

Agreement	Coverage	Period	Budget (US$)
Main	MNCH in five priority provinces: Banten, DKI Jakarta, East Java, West Java, North Sumatra plus replication more widely	1 April 2005 to 30 September 2009	30 million
Extension	MNCH in two districts of East Java: Kab. Malang and Pasuruan	1 October 2009 to 30 September 2010	4.8 million
NAD – Special	MNCH in four districts of Nanggroe Aceh Darussalam (NAD)	1 April 2005 to 30 September 2007	3.6 million
NAD – Women & Children	Women and children protection, with emphasis on psychosocial protection; NAD only	1 April 2005 to 30 September 2007	1.8 million

USAID sought to provide support to the decentralization of the Indonesian health sector through an MNCH program built around a single integrated assistance package to be made available to selected districts. USAID also stipulated that a system for replicating delivery of that package be put in place so as to maximize national impact as quickly as possible. Figure 1 shows the integrated assistance package envisioned. Definition of the package was constrained to MNCH interventions, and priority was given to addressing the needs of poor communities and households.

Figure 1
USAID Integrated Assistance Package in Health



Mothers and children benefited from HSP interventions

CONCEPTUAL FRAMEWORK

Building on Evidence-Based Best Practices Interventions

HSP's technical approach was built on a strong, internationally-recognized evidence base, both to ensure the rigor and effectiveness of its program and to strengthen its credibility with policymakers and other key influentials. At the same time, the HSP recognized the need to ensure that the promotion of international evidence and models sit firmly within the realities of the Indonesia context especially in relation to its Making Pregnancy Safer and Child Health Policy.

HSP reviewed the international data alongside Indonesia health outcomes to create a more comprehensive framework of "evidence-based best practices interventions" (EBIs) to reduce maternal, newborn and child mortality and morbidity to help guide technical assistance and advocacy efforts (see pages 12-13). This table has offered a way for the HSP to discuss technical assistance with its partners, focusing on the technical interventions that are most likely to achieve MNCH impact. The presentation of EBIs has also been important in work with policy makers, so that they understand the efficacy of the various MNCH programs offered by the MOH, and the value of technical assistance.

Applying International Models and Lessons Learned

HSP then developed its conceptual framework for assistance considering a variety of international models and lessons learned, coupled with a strong understanding of the Indonesia context. An initial body of evidence the program considered was the various service delivery models used within Safe Motherhood Care programs around the world. Global experience with maternal and neonatal care has been described by researchers using four basic models of care, and highlighting the key factors required for effective delivery of services (see Figure 2).

To apply this framework to the Indonesia context, a strong understanding of the status of Indonesian governments' maternal, neonatal and child care programming and the current status of MNCH was considered. For more than two decades, the Indonesian government has worked to improve the quality and access of MNCH services. The village midwife (*bidan di desa*, or BDD) program was established in 1989, and aimed to have a certified midwife placed in every village to increase skilled attendance at birth.[5] The Making Pregnancy Safer (MPS) strategy began in 1991, with a strong emphasis on in-service training of the approximately 54,000 community-based midwives.[6] In 1998, almost ten years after BDD were

Figure 2
Safe Motherhood Care: Service Delivery Models

MODEL	REQUIRED FACTORS OF SERVICE DELIVERY	MATERNAL MORTALITY RATIOS BY LOCATION (DEATHS PER 100,000 LIVE BIRTHS)
Model 1 Non-professional delivery at home	• Appropriate normal birth care • Nonprofessional recognizes complications • Access to EOC organized by family or nonprofessional • Functioning EOC available	Forteleza, Brazil (1984); 120 Rural China (1996): 115
Model 2 Skilled attendant delivery at home	• Above factors, but substituting skilled birth attendant for nonprofessional	Malaysia (1970-80s): 50
Model 3 Skilled attendant delivery in basic EOC facility (health center)	• Skilled birth attendant recognizes complications; provides basic EOC in health facility • Facility organizes access to EOC • Functioning EOC available	Malaysia (1970-80s): 43 Netherlands (1983-92): 7 Sri Lanka (1996): 60
Model 4 Skilled attendant delivery in comprehensive EOC facility (hospital)	• Skilled attendant recognizes complications • Skilled attendant provides basic and comprehensive EOC	Mexico City (1988): 114 United Kingdom (1992-95): 10 United States (1990-95): 12

Note: EOC= Essential Obstetric Care
Sources: Koblinsky, Campbell, and Heichelheim 1999; WHO, UNICEF, and UNFPA

introduced, a new paradigm, "Healthy Indonesia 2010," was developed, heavily based on the UN Millennium Development Goals. To achieve Healthy Indonesia 2010, the Ministry of Health used the MDGs to set targets related to enhancing the quality and utilization of health services, including a target that 90% of births be assisted by a skilled provider by 2010.[7] The MOH's more recent actions include integrated program planning and budgeting at the district level, coordination, management of normal deliveries and complications, and the introduction of social safety nets for the poor.[8]

Four successive IDHS surveys (1993, 1997, 2002, and 2007/08) have indicated that mortality (rates per 1,000) for women aged between 15 and 49 declined by 11% (from 2.19 to 1.95) over the past fifteen years, and the MMR has dropped by 5% (from 390 to 228). In a similar time period, the percentage of adult female deaths due to maternal causes has fallen from 19% to 10%.[5] Maternal morbidity is high in Indonesia, as well; a 1998 study found that for every maternal mortality, 908 women sustained life-threatening or serious morbidities.[9]

In Indonesia, six in ten deliveries (approximately 60%) of births are delivered at home,[10] while four in ten deliveries are in a health facility. 10% of these deliveries are in a public health facility, and 36% in a private health facility. As reported in the 2007/8 IDHS, the percentage of deliveries in a health facility (46%) is higher than that reported in the 2002/3 IDHS (40%), indicating women are increasingly visiting health facilities. Research suggests the growth in institutional deliveries is due largely to the private sector, with the provision of delivery services at practitioners' homes as well as their own practice sites (including Polindes) categorized as private.[11]

While most facility-based births are in the private sector, those with severe obstetric complications are typically seen in public sector facilities. The percentage of admissions with near miss[11] or maternal death is far higher in the public sector facilities (only 9% of near miss and 1.6% of the maternal death cases were in private facilities). Vascular dysfunction, measured in terms of blood units transfused, hypovolemic shock, or massive hemorrhage, was the major problem in the near-miss cases.[5]

The most recent IDHS data show that a trained health provider assisted at 79% of births. Sixty-eight percent of these were assisted by a nurse, or midwife, or a *bidan di desa*, and 12% were assisted by a doctor/OBGYN (with approximately 1 midwife per 1,000 people). Three percent of births were assisted by a traditional birth attendant (TBA) for rural areas. In terms of TBA, the evolution in skilled personnel present at deliveries indicates that TBAs are gradually giving way to midwives as the most common assistant. Mothercare research from 1995 further suggested women may seek care for some of the 'less serious' conditions, but only from a TBA, as they view these problems within her domain.[12]

Country information on where women die is scarce. Findings from a study in 12 hospitals revealed that 92% of maternal deaths are due to delay in referral and case management and approximately 40% of maternal deaths occur on the way to hospital.[13]

Although the majority of Indonesian women deliver at home, the presence of a skilled birth attendant (SBA) can prevent mortality and morbidity during normal deliveries, ensure medical emergencies are recognized and support a family in the decision to seek emergency obstetric and neonatal care. It has been postulated that delays in achieving universal coverage in skilled attendance at birth in Indonesia may have been because communities were not sufficiently prepared either to accept the presence of the BDD when she was introduced nor the need to pay more for skilled birth attendance,[14] thus indicating the need for increased community mobilization and behavior change programs. Further, it is difficult for midwives to retain their confidence and skills based on only attending an average of 23 births per year, adding to community perception that BDD are less experienced than TBAs. The stagnation of the increase in SBA was exacerbated by the economic crisis of the late 1990s which, by pushing more families into poverty has undermined willingness to pay for services. The result has been substantial drop-out of the new 'bidans' from the scheme.[11] A WHO report called for midwifery-led centers, where midwives can maintain their standards of care by working as part of a team rather than practicing alone.[11]

Other data suggest that access to emergency care in the case of a complication had not changed during the BDD period – that policy focused mainly on strengthening first level care. Although universal coverage of good quality first level care can substantially reduce the number of complicated cases that need to be referred, and bring down maternal mortality rates, these conditions do not apply universally in Indonesia, and ability to pay expensive hospital costs in the event of a complication may be beyond poor families.

Considering the Indonesia context broadly, the framework in Figure 2 suggests that the country is transitioning from Model 1, where women deliver primarily with traditional birth attendants to Model 2, where skilled midwives assist deliveries in the home, with increasing emphasis on promoting supply/demand models to draw women to facilities as seen in Model 3.[15]

This framework suggests the following key points that have helped to guide HSP models for safe motherhood:[16]

- Assistance at birth by a skilled birth attendant in the home or health facility, with adequate supplies and equipment, supported by a functioning emergency transportation and referral system, can potentially reduce the MMR to 50 or below.
- Deliveries conducted in the home can be successful if the health system, beginning with the referral hospital, provides outreach support to home birth attendants.
- In Model 1, recognition of complications and effective household decision-making on seeking care in case of emergency may be essential; unfortunately, baseline knowledge of the signs of the five major obstetric complications is typically low.

In successful Models 1 through 3, strong government policies usually guide the system of delivery care, linking the levels so that complicated cases can be referred to the appropriate facility in a timely manner. Service costs, and in some cases transport costs, have been free to the client, alleviating financial barriers to accessing care.

Another piece of work that influenced HSP thinking is the WHO standard for access to basic health services, which looks at

SERVICE LEVEL	MANAGEMENT SUPPORT AND STAFFING	MATERNAL SERVICES		
		Prenatal (conception – week 21 of pregnancy)	**Ante & Perinatal (week 22 of pregnancy – first week after birth)**	**Postnatal (birth – 6 wks after birth)**
Household	• Registered blood donor • Emergency transportation facility • Referral fund • *Tabulin/Dasolin* • Women • Husband/ spouse • Neighbor • Trained Midwife • Nurse • Health Cadre • Assisting TBA • Head of Subdistrict/ Village/ LKMD • Community/religious leaders • CBO/NGO • Police/ armed forces • Government Institutions in the village	• I&E on exclusive breastfeeding promotion • Birth preparedness • Plan for emergencies • Early and regular prenatal care, TT • Adopt healthy self-care behaviors individually • Normal pregnancy course monitored by trained midwife • Recognize danger signs of pregnancy and seek appropriate care • FP/RH, STI, HIV/AIDS counseling • Proper antenatal nutrition and balanced diet • Iron, folate and iodine supplementation	• IEC on exclusive breastfeeding promotion • Birth preparedness • Plan for emergencies • Perinatal care (K2-4 & immediate postpartum) • Adopt healthy self-care behaviors individually • Promote & train midwives (APN) • IEC mothers/ family by trained midwife to recognize danger signs in pregnancy and seek appropriate care • IEC by midwife on sepsis prevention, HIV/AIDS, STI • FP/Reproductive health promotion and counseling to seek care	• Plan for emergencies • Postnatal care as per schedule • IEC on exclusive breastfeeding and complementary feeding practices • Adopt healthy self-care behaviors individually • Postpartum care by trained midwife • IEC mothers/ family by trained midwife to recognize postnatal danger signs and seek proper care • Child spacing • Proper postnatal nutrition counseling • Proper and balanced diet
Community/ *Posyandu/ Pustu/ Polindes*	Same as above	• Community IEC emphasizing prevention of complications/ disease and self-care norms • Women are motivated to seek care when they or their children are sick • Exclusive breastfeeding support groups • Community support to ensure available access to services • Community participation in the planning and management of both community- as well as facility-based he		
Educational Institution	• Education institutions and network	• Application of MCH best-practices of service standards in the education and service process • Interships • Clinical practices in facilities/providers' training institutions (in-service training)		
PHC Level 1 *Posyandu/ Puskesmas* (Rural Health Unit)	• General Practitioner • Midwife • Nurse • Nutrition/Sanitarian • Lab. Tech. • Cold chain • Emergency transportation • Facility & standard services • CQIS • Supportive supervision	BASIC MATERNAL CARE		
		Same as above plus: • Targeted ANC services • Basic/simple fetal growth monitoring • Nutritional balance and blood pressure monitoring • IEC and FP/ RH and services	Same as above plus: • Early detection, stabilization and referral of bleeding in early pregnancy • Basic delivery care • Optimum referral for pregnancy/ labor and delivery complications	Same as above plus: • Integrated postpartum & infant care up to 42 days postnatal • IEC and FP/ reproductive health services
PHC Level 2 *Puskesmas* with in-patient care, maternity center	Same as above with special training • Simple urine analysis	BASIC ESSENTIAL OBSTETRIC CARE		
		Same as above plus: • Adequate monitoring of fetal growth and urine analysis	Same as above plus: • Complication management • Post-abortion care	Same as above
First Referral Level (District Hospital)	• OBGYN and interns • Pediatrician and interns • Anesthesiologist • Blood Bank Tech. • Complete lab facility	COMPREHENSIVE ESSENTIAL OBSTETRIC CARE		
		Same as above plus: • Advanced monitoring of fetal growth and pregnancy-related	Same as above plus: • Monitoring fetal well-being (biophysic profile) • Surgical procedure and blood transfusion	Same as above
Second Referral Level (Provincial hospital)	Same as above plus OBGYN (C), Pediatrician(C), PA and CP	COMPREHENSIVE ESSENTIAL OBSTETRIC CARE		
		Same as above and subspecialist service	Same as above plus reconstructive surgery	Same as above

age of Essential MNCH Services

	CHILD SERVICES			MINIMUM SERVICE STANDARDS (SPM) 2010
Internatal (birth – next pregnancy)	**Neonatal (born – 28 days old)**	**Infant – child (28 days – 5 years)**	**Adult (11 – 19 years)**	
• Nutrition support • Sufficient support for neonatal and child growth development (SDIDTK)	• IEC on exclusive breastfeeding • Resuscitation and referral as required • Neonatal visit • Adopt healthy neonatal care (drying and warming, skin-to-skin and kangaroo care) • Plan for emergencies • Recognize danger signs related to complications and illness of neonate and seek immediate care • IEC by midwife to prevent sepsis and HIV/AIDS, • Prevent infectious disease	• IEC on exclusive breastfeeding • Routine check up • Proper care for diarrhea, fever and malnutrition • Recognize danger signs of illness and seek immediate care • Monitor feeding and growth (SDIDTK) • Vit. A Supplementation • Appropriate complementary feeding for malnourished infant from poor family • Detect growth faltering and seek care • Immunization as per schedule	• Health education • IEC on FP/Reproductive health • Promotion/ maintenance of healthy nutrition practices • Encourage and provide iron enriched foods and avoid iron inhibitors • Discourage smoking	2.3: (below district hospital) 4.1: 100% village coverage index
ealth services	• Assistance/management for sick children • Effective mechanism to increase access to health services	• Management for sick children • Motivate community to obtain proper service	Same as above	
	BASIC NEONATAL CARE	Same as above plus • Immunization (polio, DPT, hepatitis) • SDIDTK • IMCI • Early detection, first aid and management for seriously sick LBW (as well as IEC for woman and family)	Same as above and: • Early detection, referral of TB • Deworming • Routine examination	1.1: 95% of antenatal visit coverage 1.2: 90% of skilled birth attendance 1.3: 100% high risk pregnant women referred 2.1: 90% of healthy infant visit coverage 2.2:100% of LBW coverage & management 7.3: 80% of high risk neonates/ complications receiving management 8.1: 90% health facility to conduct emergency services for the community 10.1: ≥1% AFP/Polio/100,000 children <15 years 11.1: >85% recovered from TB pulmonary with sputum+ 12.1: 100% detection of under-five pneumonia 19.2: 80% infants receive early/ exclusive breastfeeding 21.1: 90% of essential drugs available
Same as above plus: • Immunization (TT) • IEC on FP/ reproductive health services, STI/ISR and HIV/ AIDS	Same as above and : • Early detection, first aid and referral of sick infants with complication • Cord care • Skin-to-skin/Kangaroo care • Immunization (BCG)			
	BASIC ESSENTIAL NEONATAL CARE	Same as above	Same as above	1.1 (above 1st level health facility) 1.2 (above 1st level health facility) 4.1 (above 1st level health facility) 7.3 (above 1st level health facility) 8.1 (above 1st level health facility)
Same as above	Same as above plus • Treatment of neonatal tetanus			
	BASIC ESSENTIAL NEONATAL CARE	Same as above plus: • SDIDTK	Same as above	1.1 (above 1st level health facility) 1.2 (above 1st level health facility) 2.3: 90% coverage of monitoring of growth and development among school children
Same as above	Same as above plus: • Incubation • High risk infant management • Management and referral of infant with complication			
	COMPREHENSIVE NEONATAL CARE	Same as above	Same as above	
Same as above	Same as above • CPAP (additional)			

the catchment area for a health service facility, and provides standards for the population ratio that the service facility is capable of serving. As seen in Figure 3, these guidelines provide a series of process indicators that address EOC coverage and quality. These levels have helped to guide HSP programming and intervention points.

for EONC and skilled birth attendance. A functioning system also depends on policies that support training and rational deployment of healthcare professionals, especially those with midwifery skills, throughout the country.

The third lesson learned is that it is essential to have reliable information about the causes and circumstances surrounding maternal and neonatal deaths in order to know what kind of

Figure 3:
Safe Motherhood Care: Service Delivery Models

Amount of essential obstetric care (EOC): • **Basic** EOC facilities • **Comprehensive** EOC facilities	For every **500,000 population**, there should be: **At least 4 Basic** EOC facilities **At least 1 Comprehensive** EOC facility	BEOC 1/30,000 (*Puskesmas* or primary health center); currently there are 7,236 *Puskesmas* and 64,738 midwives (*bidan di desa*) and 16,103 private midwives
Geographical distribution of EOC facilities	Minimum level for amount of EOC services is met in subnational areas	
Proportion of all births in Basic and Comprehensive EOC facilities	**At least 15% of all births** in the population take place in either Basic or Comprehensive EOC facilities	
Met need for EOC: • Proportion of women estimated to have complications who are treated in EOC facilities	**At least 100%** of women estimated to have obstetric complications are treated in EOC facilities	1.1% (1997); 0.7% (1999) admitted to hospital for obstetric complications. One study in an urban area of Kalimantan revealed fewer than 14% of all deliveries take place in an EOC facility, 2% of expected births are admitted to such a facility with a major obstetric intervention (MOI), and 1% of expected births have an MOI for an absolute maternal indication.*
Caesarean sections as a percentage of all births	As a proportion of all births in the population, Caesarean sections account for **not less than 5% nor more than 15%**	1.7% (1997); 1.4% (1999) admitted to hospital with caesarean sections; Current research suggests 6% of urban births and 2% of rural births being delivered by Caesarean
Case fatality rate	The case fatality rate among women with obstetric complications in EOC facilities is **less than 1%**	

* Note: EOC= Essential Obstetric Care
Sources: Koblinsky, Campbell, and Heichelheim 1999; WHO, UNICEF, and UNFPA

At its core, MNCH is linked to poverty. MNCH must, therefore, address the lack of access to services for poor subgroups in particular. The move towards decentralized health governance is an opportunity to address the wide socioeconomic differentials in health.

The first lesson learned is that reducing maternal and neonatal mortality requires ensuring women have timely access to quality emergency obstetric and neonatal care (EONC) as every pregnancy entails risks that can develop into life-threatening complications for the mother and/or baby. Because many life-threatening complications are neither predictable nor preventable (in developing countries an estimated 15% of pregnant women will have a such a complication), it is critical all pregnant women have access to skilled birth attendants, who can recognize complications when they occur and make informed decisions to refer women or newborns with complications to EONC services. Basic emergency obstetric and neonatal care (BEONC) includes providing parenteral oxytocin, antibiotics and sedatives. It also covers post abortion care, manual placenta removal, forceps and vacuum extraction, prevention of newborn hypothermia and newborn resuscitation. CEONC includes BEONC services plus cesearean section and blood transfusion capabilities.

A second lesson learned is that skilled care is only effective if it is part of a functioning healthcare system that links women and newborns to higher levels of care when needed.

A functioning system requires that healthcare services adhere to national clinical guidelines that meet international standards

improvements are needed in the health system to ensure women's and newborns' access to life saving care when complications arise.

There was a consensus within the Ministry of Health on the contents of the Evidence-Based Package of Essential MNCH Services (see page 12-13).

The HSP used the Pathway to Survival which is an internationally-accepted conceptual framework for identifying the steps needed to reduce maternal, newborn and child mortality and morbidity (see Figure 6). The model, adapted here for the HSP program, illustrates key steps in care-seeking along a continuum of care from household to facility. Low demand for and delayed use of care, often linked to low acceptability and affordability, are major obstacles to rapidly scaling up effective MNCH services and reducing maternal, newborn and child deaths. Low continuity and poor compliance are also problems in some settings, even where initial usage rates are high. At the household and community levels, the model focuses on the first three steps that either lead to care-seeking or cause delays in seeking care (problem recognition, decision-making to seek care, and logistics to access services). The fourth step addresses the capacity of the health system to provide timely, appropriate, affordable and high quality services with a trained provider at the appropriate level of care, with the ultimate outcome of good health.

HSP's Design Recognizes the Context of Decentralization

The context of decentralization in Indonesia also deserves special mention. Indonesia is still undergoing a major economic and social transition, shifting authority and responsibility for the health sector from the central to the district level. As a result of Law No. 22/1999 and Regulation 25/2000, Indonesia is, since January 1, 2001, engaged in an unprecedented administrative transition in which much of the authority, functions, responsibilities and accountability is being decentralized directly to the district (*Kabupaten*) level.

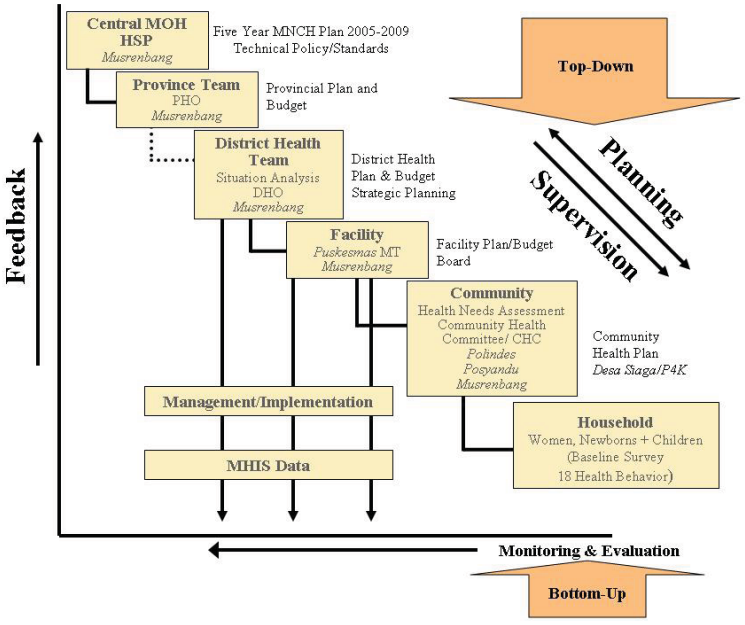
While significant steps have been taken to shift the responsibility and authority for human services closer to the people so that it is more responsive to their specific needs, the evolution of additional policies which are required to operationalize the laws are still being developed. As it stands, the MOH retains the responsibility for setting national policies, regulations, plans and standards, guidelines and regulations, monitoring and evaluation and coordination between all sectors. The provincial health office (*Dinkes Propinsi*) is responsible for technical assistance and facilitation of health management by the district health office (*Dinkes Kabupaten*). The district health office is responsible for planning and implementing health services in accordance with national standards, regulations and guidelines. A National Health System (SKN) was launched by the Minister of Health through the *Kepututsan Menkes*. As a part of this, provinces and districts are encouraged to develop their own Health System (*Sistem Kesehatan Daerah*), as a subsystem of the National Health System. The MOH has recognized the importance of creating an integrated package of services and establishing standards for the performance of essential public health functions. As such, it has developed a series of "obligatory functions" and "minimum standards" to perform "essential services" (SPMs) to a defined level of performance that is required at the district level as the basis for decentralization of responsibility and accountability in the health sector. With assistance from donors, the MOH has developed many of the components of the SPM, including service protocols, standards of care, quality assurance tools (e.g. Performance Quality Improvement Strategy) and supervisory tools. HSP provided support for the enactment of the SPM as a law. However, the SPM is very unevenly applied throughout Indonesia, and many districts require considerable technical assistance to implement it.

At the implementation level, at district and sub-district levels, one of the most obvious problems is the fragmentation of program activities. There are still 14 vertical programs, some are not yet integrated into existing health center (*Puskesmas*) activities. The family planning program (BKBBN), was historically a strong vertical program, which was late in beginning its decentralization process and most functions have been delegated to the Ministry of Health. Integrating these various components of the continuum of maternal, neonatal and child health (MNCH) care at the district level continues to be a challenge. In addition, because of the rapid decentralization process, most districts lack the skills and systems necessary to effectively carry out their new roles. Decision-making processes, particularly in resource allocation, lack transparency and there are few mechanisms to ensure accountability.

In 2006, the national Parliament (DPR) made a significant funding decision that essentially triggered a recentralization of the health system. DPR approved more than $55,000,000 in funds for maternal and child health (42% of the funds were allocated to child health, and 58% to maternal health). Instead of giving funds directly to the district level, as they had in previous years, the DPR transferred these funds to the National Ministry of Health.

The MOH first earmarked a financial allocation of funds for each of its Directorates (such as child health, maternal health and nutrition). Then the MOH determined a financial allocation of funds for the national and provincial levels, allocating funds to each province on the basis of need. Each MOH Directorate then developed a "menu" of activities that could be implemented using Deconcentration funds. These menus emphasize capacity-building programs such as midwife training and *Posyandu* revitalization. In general, infrastructure development and the purchase of commodities were disallowed. Once the national level completed these tasks, each province was given their budget mark and the menus. The provinces had the power to allocate funds per district, and then guided the districts to plan for use of the funds utilizing the menus. Because this funding stream was new, no financial mechanism existed for districts to access the funds; therefore, HSP assisted in the development of guidelines. On average, the funds are increasing district health budgets for MNCH on average more than ten-fold. Figure 4 - developed by HSP - shows the top-down and bottom-up nature of supporting improvements in MNCH in the decentralized context. The district is the focus, given that it has the primary planning and budgeting authority. The central and provincial levels provide policies, minimal standards and set the five-year national health development plan. At the community level, health planning based on community needs assessments is fed up into district plans that ensure that district health programs are firmly rooted in the needs and perceptions of households and communities.

Figure 4:
Top-down Bottom-up Process



PROGRAM OBJECTIVES

Original Objectives

HSP was USAID/Indonesia's flagship maternal, newborn, and child health project. It was designed to reduce maternal, newborn, and child mortality through an integrated assistance package of evidence-based technical interventions that could be made available to districts and a system for replicating the delivery of that package widely, which maximizes the chance of national impact as quickly as possible. The project design emphasized rapid replication and scale-up of existing interventions. The original integrated package was designed around five strategic approaches (Figure 1) focused on decentralized district provision of healthcare: 1) integration of technical components; 2) strengthening of decentralized health systems and services; 3) leveraging of funds from other donors; 4) harnessing of NGOs and Private Voluntary Organizations; and 5) engaging the private sector. The project was to package and make available interventions that included evidence-based approaches to maternal, newborn, child, and reproductive health, infectious diseases, drug and commodity management, and decentralization and strengthening of health systems and services at the district level.

During the first three-and-a-half years of the program, HSP was planned and implemented using a strategic framework shown in Figure 5.

Figure 5: Strategic Framework

	Provide TA on Technical Interventions	Provide TA on Systems Strengthening	Build NGO Partnerships	Harness the Commercial Sector	Leverage Others for Replication
Thrusts					
Strategies	• Training on short-listed interventions • Providing BCC support to short-listed interventions • Mobilizing Community Health Committee	• Strengthening drug and commodity management • Using DTPS to strengthen district planning system • Program MOH *Dekonsentrasi* funds • Strengthening Supportive Supervison	• Building NGO working relationship to roll out short-listed interventions • Supporting capacity-building for selected NGO partners	• Expanding Bidan Delima • Developing PPPs to support MNCH performance	• Networking with donors on mutual interests • Replicating HSP models in new provinces and districts
	• Concentrating on a shortlist of evidence-based interventions • Conducting advocacy to support HSP target outcomes • Focusing activities on the poor • Integrating activities with other USAID partners				

Dissemination of the Maternal, Neonatal and Child Health (MNCH) Program

Scaling up Evidence-Based Interventions

HSP emphasized clinical interventions that are known to have significant impact on maternal, neonatal and child morbidity and mortality. For delivery services, these include active management of the third stage of labor; immediate skin-to-skin contact and immediate initiation of exclusive breastfeeding; delayed cutting of the umbilical cord; prompt provision of Vitamin K and Hepatitis B vaccination to the newborn; and appropriate management of emergency complications. For neonatal care and child services, these included new procedures for treating childhood pneumonia, handwashing as a basic preventative measure for reducing diarrhea incidence as well as that of acute respiratory infection, reiterating the importance of zinc therapy and low-osmolarity oral rehydration therapy (ORT) for all cases of childhood diarrhea, and prescribing antibiotic treatment only for bloody diarrhea such as dysentery and cholera. For sick infants under two months of age – including for diarrhea management – exclusive breastfeeding was emphasized, as was using Kangaroo Mother Care protocols for management of low birth weight. HSP and the Ministry of Health (MOH) developed a consensus document on evidence-based training programs.

HSP identified three main objectives to be achieved in partner districts during the earlier phase of the program:

Objective 1: Increased APBD funds for MNCH, and evidence-based utilization of funds to respond to district priorities

Objective 2: Improved quality of MNCH services
- Improved clinical skills of midwives, *puskesmas* providers, and hospital providers

Objective 3: Improved community behaviors and utilization of services
- Increased skilled birth attendance
- Increased hand washing with soap
- Increased early initiation of breastfeeding

During the first two years of HSP, the program updated, revised and finalized the tools needed to achieve these objectives. In Year One of the program, HSP supported the Government of Indonesia to review and update its Making Pregnancy Safer policy to include Child Survival (including explicit policies for newborn care) components and to develop guidance for its implementation. Aligned to this focus on implementation, HSP provided technical assistance for the piloting of tools in 14 districts, and used the experience to assist the GOI to further develop and revise its modules. In Year Two, HSP expanded implementation to 17 additional districts, and continued to refine and finalize the tools. In its first 14 districts, HSP offered technical assistance to districts that wanted to replicate more broadly these approaches. In Year Three, HSP completed assistance to the second batch of 17 districts, while continuing with some replication activities in the original 14 districts. Also in Year Three, HSP technical assistance was made available outside of HSP districts, where opportunities for replication exist. In Year Four of the program, HSP moved to a phase where sustainability and scale-up came to the forefront. The first half of Year Four saw a focus on the replication of interventions outside project areas and on national level scale up. In August 2008 however, a program review recommended a year-long extension with a greater focus on integration of the tools and components developed in previous years. Some activities in Year Four were accordingly revised to begin modeling the integrated approach.

Figure 6: Evidence-based Interventions to Reduce Maternal, Newborn, and Child Mortality*

Cause of Death...	% of Death (Indonesia Figures)	Evidence-based Intervention	% Reduction in Mortality if EBI Universally Practiced
Post-partum hemorrhage	28% of maternal deaths	Active management of the third stage of labor	60%
Neonatal asphyxia	27% of neonatal deaths	Neonatal Resuscitation	5-30%
Complications of prematurity and LBW	29% of neonatal deaths	Care of LBWs and immediate breastfeeding	20-40%
Neonatal infections	15% of neonatal deaths	Immediate breastfeeding and maternal TT2	17-22%
Diarrhea and Acute Respiratory Infection	37% of under-five deaths	Handwashing and IMCI	40-60%
Measles	7% of under-five deaths	EPI	30-86%
Complications due to Malnutrition	contributes to 54% of under-five deaths	Essential Nutrition Actions (exclusive breastfeeding, feeding of sick children, micronutrients	30-50%

* References on inside back cover.

Implementation process: a systems approach

HSP has taken a systems approach to assisting the GOI in achieving reductions in maternal, neonatal and child morbidity and mortality. The commitment to a systems approach has meant that HSP sought to support the GOI in their programs and to help to strengthen aspects as required. This included support for policies and procedures for carrying out the activities related to MNCH, whether at the level of systems governance or at the level of service delivery.

Instead of introducing a whole range of new approaches, for example, technical assistance was provided to update existing policies or to develop implementation guidelines for those policies as required. In the cases where new tools were developed, this was done so because gaps had been identified by the MOH and technical assistance requested from HSP. In this way, HSP sought to be a partner to the GOI in the achievement of their own goals.

One of the early steps in systems strengthening was to ensure that Indonesian leaders, both political and professional, were not only on board but that their national commitment was translated into action at decentralized levels of administration. Some of the major events are described in other sections of this report. This process of securing political commitment was also repeated in forming partnerships at district levels. A number of agreements were developed between HSP and district governments clarifying the role of HSP in providing support to local MNCH plans and regulations.

Although the formal counterpart for HSP was the Coordinating Ministry of People's Welfare, the main technical partner was the Ministry of Health. Other partners included district governments, NGOs, professional associations, health providers, the private commercial sector and community members. At each level, HSP provided technical assistance that strengthened the ability of the health system and providers to improve the quality and access to services to prevent and treat maternal, newborn and child health problems.

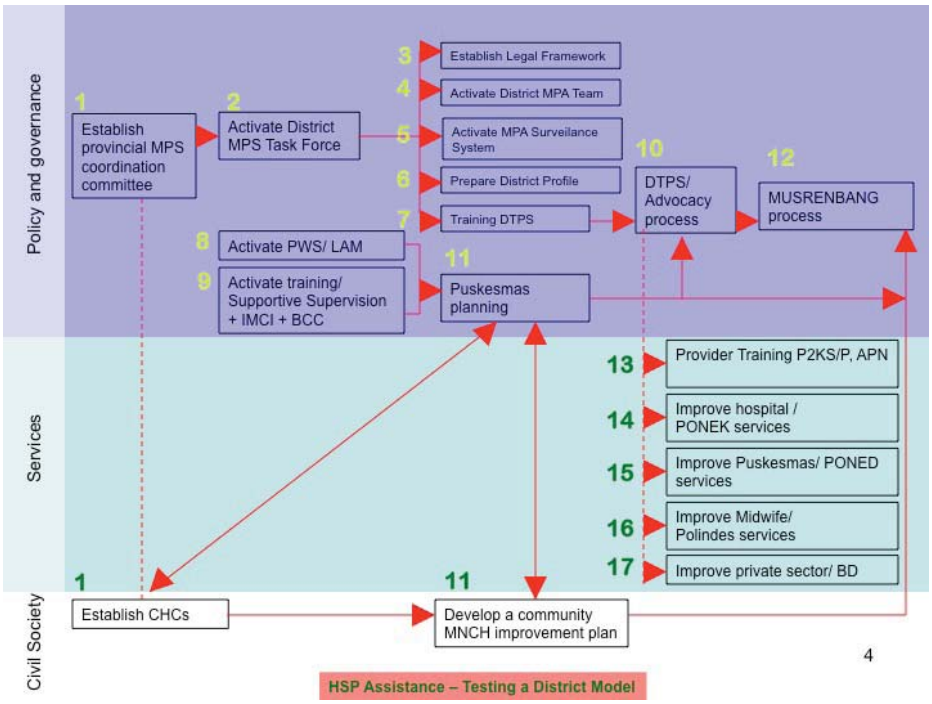
At the national level, and especially during the first phase of HSP, a strong relationship was established with the national MOH. A steering committee assigned responsibility for different program elements amongst the Directorates of the Ministry, and technical sub-committees were formed. These relationships were built through the support for and collaboration on the review and revision of national tools and policies. Examples include the work on updating the IMCI and zinc programs

National events to lay the grounds for maternal, neonatal and child health legislation

with the Directorate of Child Health, breastfeeding promotion with the Directorate of Nutrition, hand washing, breastfeeding, clean water and sanitation promotion with the Center for Health Promotion, and zinc promotion with the Sub-directorate of Diarrheal Control. Activities related to the improvement of midwifery services, DTPS-MNCH and advocacy received strong support of the Directorate of Maternal Health. The Directorate for Specialist Medical Services was also a key player in the revision of PONEK materials and was closely involved in the hospital-based activities for Kangaroo Mother Care and Maternal and Neonatal Emergency Room Care (MNERC) implemented by hospitals with support from HSP. All of these partners were supported by HSP in the development of the Strategic Implementation Guidelines for the Making Pregnancy Safer/Child Survival national policy.

Professional organizations are also a crucial part of the overall system. HSP provided support for relevant professional organizations to lead many of the revisions and updates to technical policies and protocols. Key partners were the

Figure 7: A System Approach



HSP launching was carried out in the national and regional levels

Indonesia Medical Association (IDI), Indonesian Pediatricians' Association (IDAI), Indonesian Midwives Association (IBI), Indonesian Perinatalogists' Association (Perinasia), Indonesian Obstetrician and Gynecologists Association (POGI), Indonesian Public Health Professionals' Association, and the Indonesian National Nurses' Association (PPNI). Support was also provided through the National Clinical Training Network (JNPK) on this basis.

At the district level, the main HSP counterpart was the District Health Office (DHO). Local Health Promotion units led district-wide hand washing and breastfeeding activities, and Family Health units worked to improve the quality of IMCI and midwifery services, both with HSP support. Under support for a more integrated model, partnerships expanded to include key cross-sectoral partners including the District Hospital, the District Development Planning Board (Bappeda) and the district offices of the Family Empowerment Movement (*Pemberdayaan Kesejaheraan Keluarga* or PKK). As part advocacy activities, relationships were also built with champions from the district legislature (DPRD) and with advocates from civil society, including religious organizations, with the aim of improving policy and increasing local budgets for maternal, neonatal and child health.

At the sub-district level HSP worked to strengthen the service provision of the *puskesmas* clinic, which typically covers around 40 villages. In the earlier program phase, HSP provided clinical training in breastfeeding and infection prevention, IMCI and case management of diarrheal disease. Since the March 2009 handover, the program mainly provided support in the area of related to *puskesmas* planning, supervision and management. These activities were aimed at strengthening support to the *posyandu*, and accreditation of lower-level health facilities, and improved use of data.

The partnership with the PKK was also a critical part of support to village levels. HSP supported training for PKK sub-district *kader*, with a view to them taking on the role of facilitators of MNCH activities at the village level. Tapping into the mandate of the PKK's *Pokja* IV to improve MNCH, this approach models a sustainable systems-based approach to community mobilization.

HSP also supported the development of public-private sector partnerships. Activities focused on enhancing the ability of government and community partners to build public-private partnerships with a view to securing sustainable funding sources for MNCH activities. With Corporate Social Responsibility now enshrined in Indonesian law, harnessing these opportunities is an important part of systems strengthening. HSP also supported IBI to strengthen the financial sustainability and network arrangements of the country's largest network of private sector MNCH service providers through Bidan Delima.

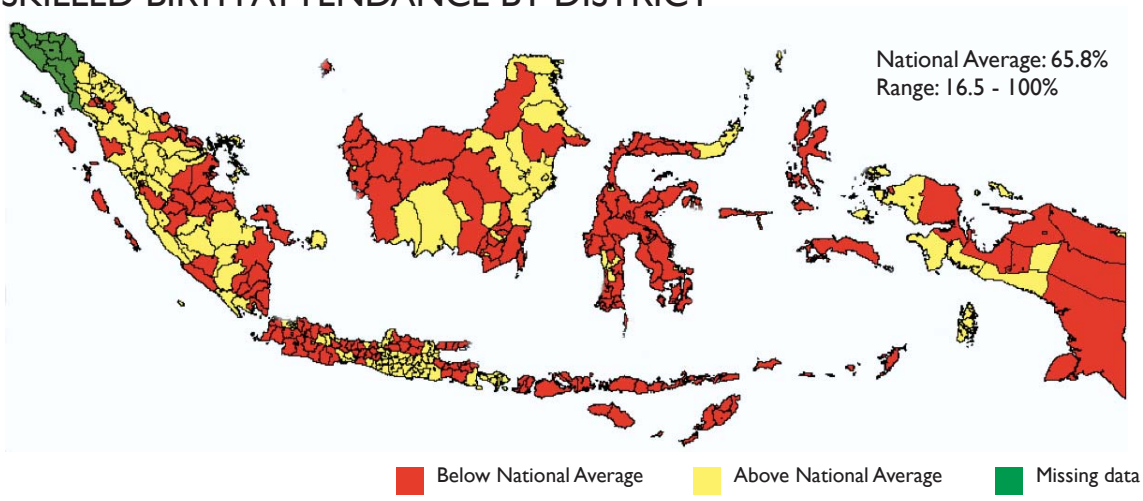
Women are involved in the development of health materials to ensure they reach target audience

Mobilizing the community to improve their own health

National facilitators helped scale up of skills and knowledge throughout Indonesia

HSP INTERVENTION AREAS

SKILLED BIRTH ATTENDANCE BY DISTRICT



Source: Susenas, 2001. "Skilled" is defined as attendance by a midwife, nurse or doctor.

HSP worked in six provinces, which represent 43% of Indonesia's population. HSP provides direct assistance to 31 of the 121 districts in those provinces. We also made available technical assistance to replicate our models more broadly within, and outside, of HSP priority provinces.

In the first year of the program, HSP-developed tools – such as the *Training Kit for Implementing Desa Siaga*, the *Basic Neonatal Care Training Protocols* and the *Guidelines for Management of MNCH Dekon Funds* – were used in all of Indonesia's 33 provinces, including by the USAID-BP Global Development Alliance program in Papua.

POPULATION

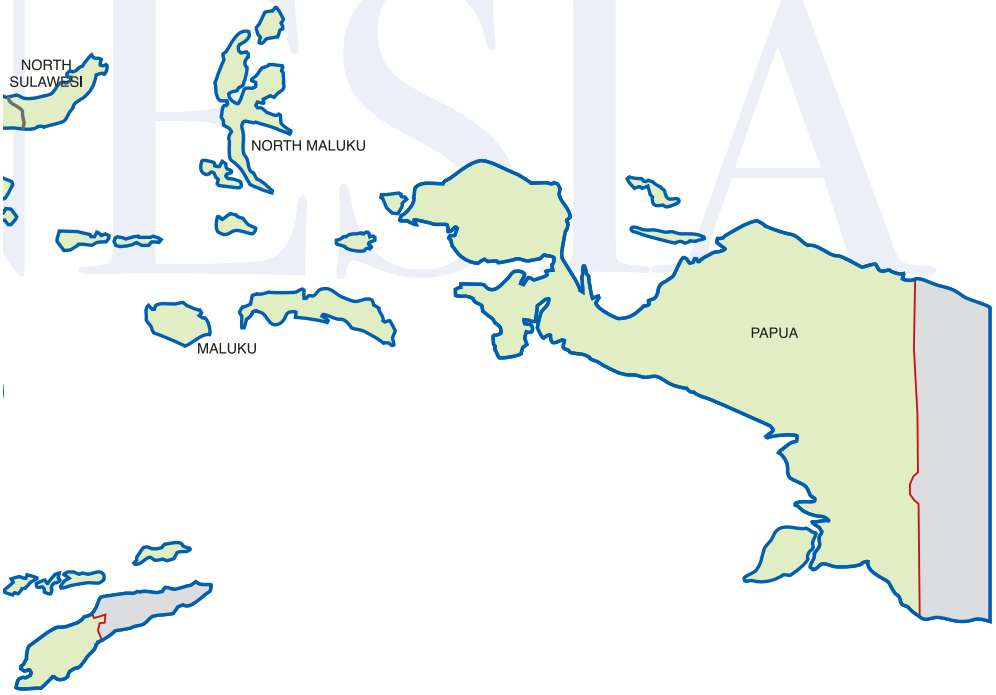
Indonesia	**238.452.952**
Aceh	4.031.589
North Sumatra	11.649.655
DKI Jakarta	8.389.443
Banten	8.098.780
West Java	35.729.537
East Java	34.783.640
All HSP Provinces	**102.682.644**

HSP DISTRICTS

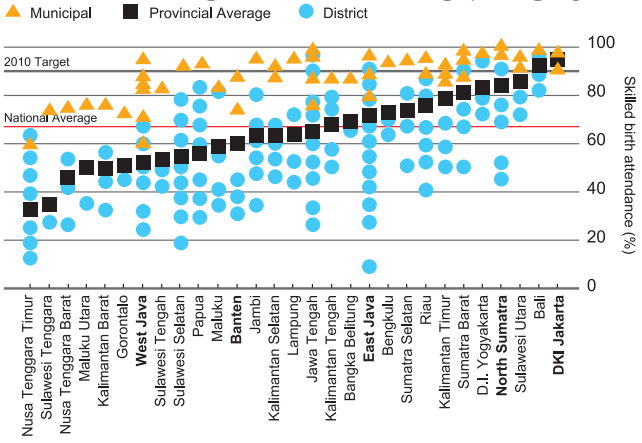
Aceh	4 out of 21
North Sumatra	7 out of 25
DKI Jakarta	2 out of 6
Banten	2 out of 6
West Java	8 out of 25
East Java	8 out of 38

HSP VILLAGES

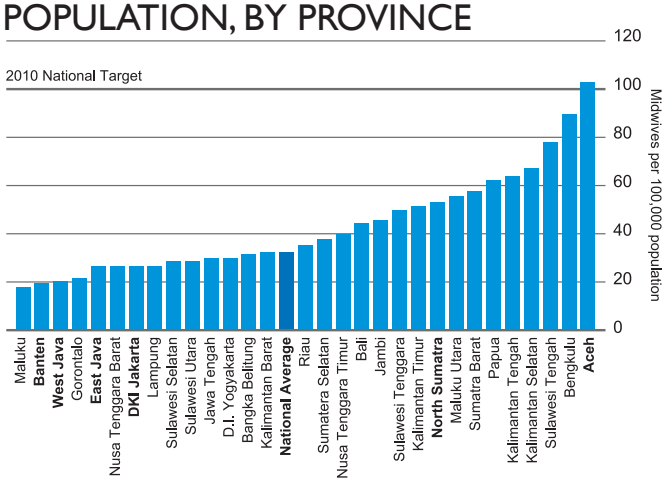
Aceh	50	villages
North Sumatra	84	villages
DKI Jakarta	14	neighborhoods
Banten	24	villages
West Java	96	villages
East Java	96	villages
Total	**364**	**villages**



VARIATIONS IN SKILLED BIRTH ATTENDANCE WITHIN PROVINCES



MIDWIVES PER 100,000 POPULATION, BY PROVINCE



Source: Susenas, 2001. "Skilled" is defined as attendance by a midwife, nurse or doctor.

Changes/adjustments to program objectives

The Tsunami in Aceh occurred three months before the program agreement was signed, and resulted in additions and amendments to the program's original scope of work. These included extending support for improving maternal, newborn and child health to Aceh province, and also implementation of a protection of women and children project. HSP also provided support for 13,000 affected people in Central Java following an earthquake in May 2006.

An August 2008 program review recommended that tools previously developed with HSP technical assistance would benefit from additional application and, in particular, assessment. The review also recommended responding to the MOH call for integrated district-wide implementation of a common integrated package and a common sentinel district-wide Health Information System (HIS) framework. In order to formally sign off on the first phase, a series of handover meetings were held throughout March 2009 in each of the participating provinces (excluding Aceh, which had closed in September 2008). At these meetings, program tools were symbolically handed from HSP to the central MOH who endorsed them as official Government of Indonesia products. They were then handed from the MOH to all 33 Provinces of Indonesia, and so on to the District level.

In response to the recommendations, HSP went to scale in the two districts of Malang and Pasuruan, both in East Java, which had a strong foundation of support to MNCH. During the extension phase of HSP, the program aimed to demonstrate the operation of an integrated program of interventions for reducing maternal and neonatal morbidity and mortality in two districts through the support of district MNCH regulations (*perda*). The approach was based on investments in the tools, models and partners and on lessons learned from the first four years of implementation. HSP documented both the process and the lessons to provide evidence for local government MNCH programming. On the basis of the review, HSP also used the final phase to work more closely with hospitals to make strategic interventions for improving Maternal and Neonatal Emergency Room Care.

The program phases updated from the model outlined in the original project proposal are illustrated as follows:

Figure 8: Phases of HSP

Phase 1 Apr 05 - Sep 07	Phase 2 Oct 07 - Sep 08	Phase 3 Oct 08 - Sep 09	Phase 4 Oct 09 - Sep 10
Implementation of the Integrated Package of Interventions (IPI) in several districts	Completion of district level piloting and implementation, with attention to scale up of interventions to the provincial level	Replication of interventions outside of project areas	Implementation of an integrated package of MNCH assistance in two districts
Revision and piloting of tools and modules	Scale-up to the provincial level	National level scale up	Focus on documentation and studies

Sharing of experience with other donors

Support and commitment of the local government is key to the success of implementation of the integrated maternal, neonatal and child health program

Dissemination of the Maternal, Newborn, and Child Health (MNCH) Program

At a ceremony held on March 2, 2009, over 200 people witnessed Indonesia's Ministry of Health (MOH) officially endorse a set of tools and modules created with technical assistance from USAID's maternal, newborn and child health program. The event was not only an occasion to hand over MNCH tools to district health offices for national scale-up, but also an opportunity to reflect on lessons learned and insights gleaned from four years of collaboration.

Speaking at the event, the MOH Director General of Community Health, expressed his delight at the results of the four-year partnership while describing as "incredible" the number of modules and models developed or updated by the program. He officially endorsed the partnership's manuals and tools and proclaimed the Ministry of Health's commitment to their continued use in the national scale-up.

A symbolic gesture of the actual endorsement of program activities then took place. A board of icons representing the 17 MNCH programs on which HSP has assisted the MOH – including the DTPS guidelines, IMCI modules, Supportive Supervision books, and PONEK training packages – was handed from USAID to the MOH and from there to a representative of the nation's 33 provincial health offices. The following proclamation of commitment was read: "To accelerate the reduction of maternal, newborn and child mortality… we, the directors of provincial health offices from all over Indonesia, herewith state that we accept and will sustain and scale-up the maternal, newborn and child health program… in our areas, adapting it to local conditions and in line with local government policy."

It was then time for the provincial health offices to include their district counterparts. Mirroring the transfer of responsibility from the central to the provincial level, members of Jakarta's five district health offices came to the stage and received a memento representing their role as caretakers of the national maternal, neonatal and child health program. Later that afternoon, DKI Jakarta became the first of five provinces to conclude their provincial hand-over events. Similarly, in Banten two days later, delegation to the district level was repeated as the head of the Banten PHO handed over the MNCH tools to his Tangerang district counterpart on March 4, 2009 in Serang. Symbolic endorsements and hand-overs were then repeated in Medan, North Sumatra on March 10, 2009, in Surabaya, East Java on March 23, 2009 and in Bandung, West Java on March 30, 2009.

On each occasion, USAID representatives spoke about the value and promise of the partnership between HSP and the Ministry of Health. HSP staff presented province-specific program results, while local stakeholders presented testimonials and lessons learned from their area, such as the passage of local MNCH regulations in North Sumatra or working to increase district budgets for health in West Java. Afternoon class sessions – or 'mini-universities' – were also offered, giving participants a more in-depth understanding of specific topics. In these smaller group settings, health officers from replication districts had the opportunity to ask colleagues familiar with the partnership's MNCH programs how best to implement them in their own areas. Participants were given the practical know-how, advice and confidence to begin making the MNCH program and tools part of their daily routines.

As a first step toward institutionalization, participants were also asked to jointly review and approve a set of principles and recommendations for use in the national scale-up effort. Containing specific recommendations for each of the program's practice areas – from the Integrated Management of Childhood Illness to advocating for budget increases – proposals were developed and approved, with representatives of various PHOs coming to the stage and publicly signing the document on behalf of their counterparts across the country.

While thanking the GOI for its enthusiasm and dedication, USAID's Director of the Office of Health cited strong Indonesian support for replication activities already under way across the country as evidence the program was on the right track towards sustainability. Indeed, with pledges from DHOs and PHOs, MOH funds already committed to rolling out programs at the national level and modules and tools created with HSP's assistance now part of the Ministry of Health's national program, the maternal, newborn, and child health program is poised for continued implementation across Indonesia.

Resource person includes community health committee members to give realistic experience

Resource persons are experts in their field

HISTORY OF PROJECT IMPLEMENTATION

Establish program strategy and foundations

HSP was designed to support the Government of Indonesia in its efforts to reduce maternal neonatal and child mortality with a focus on a decentralized district approach and pro-poor strategy. At the time the program opened, health had not been a priority of the GOI with health expenditure amongst the lowest per capita in the region. It was therefore fortuitous that only months after opening program offices, HSP was requested to support the National Call to Action on Health.

Held in Jakarta in November 2005, the National Call to Action for Health was opened by the Vice President and attended by six Ministers, 33 Governors, and Bupati from 63 of Indonesia's (then) 440 districts. Donors and international development partners also attended, with the United States Ambassador pledging US government support. An important milestone of the meeting was the launch of a four pillar strategy for health development by the Minister of Health.

As follow up, HSP supported a National Parliamentarians' Conference on MNCH in Jakarta in February 2006. At that meeting, all 33 governors committed to ensuring that their provinces would provide adequate budget to ensure improvements in maternal, newborn and child health.

This national commitment therefore became the framework through which HSP sought to align its support with the policies and priorities of the GOI. HSP was launched nationally by the MOH on May 10-11, 2006. Professional organizations and NGOs were in attendance along with health officials. Regional launches had previously been held in Nanggroe Aceh Darussalam, Banten, North Sumatra, East Java and West Java throughout April 2006. The launch for DKI Jakarta was held simultaneously with the national event.

Vice President Kalla opening the "Call to Action."

Increase political and budget commitment to MNCH

HSP focused efforts on three principal strategies: increasing district budgets, passing district regulations, and leveraging the private sector through partnerships. In each of the three strategies, HSP supported local stakeholders to research and present MNCH-related problems in their areas, draw up proposals and plans for greater funding, and advocate on behalf of mothers and children before district parliaments and executive bodies.

The DTPS-MNCH series

With HSP support, the MOH distributed more than 3,500 sets of the DTPS-MNCH series. The modules are as follows:

Book 1: Planning Process Guidelines – Guidance for MNCH planners to develop a needs-oriented and evidence-based plan for maternal, neonatal and child health and nutrition.

Book 2: Facilitator's Guide for the Multi-stakeholder Orientation – A step-by-step manual for orienting planners, legislators and advocates to the DTPS-MNCH planning and advocacy process.

Book 3: Facilitator's Guide to the Planning Process – A manual to support facilitators who are leading the MNCH planning and budgeting process.

Book 4: Reference Book for Budget and Policy Advocacy – A collection of handouts on policy, building alliances and other strategies for MNCH advocates.

Book 5: Facilitator's Guide to Budget and Policy Advocacy – A manual to support facilitators who are training MNCH advocates.

From left to right: Minister of Health, Dr. Endang Sedyaningsih, Head of KOWANI, Ibu Dewi Motik, Minister of Women Empowerment, Linda Agum Gumelar, at the talk show during Shared Responsibility for Reducing Maternal and Infant Mortality

District Team Problem Solving (DTPS)

Under decentralization, local governments in Indonesia have been granted greater autonomy to manage service delivery at the provincial and district level. As a result, district governments have taken on vastly expanded responsibilities for planning and managing public health funding in response to local problems. In order to better assist districts to fulfill these essential functions in the area of maternal and child health, with HSP technical assistance, the MOH promoted the District Team Problem Solving (DTPS-MNCH) process. DTPS-MNCH uses a multi-stakeholder team to help the DHO and other key district government stakeholders (such as District Development Planning Board, or Bappeda) to analyze data and identify MNCH problems, prioritize appropriate interventions and develop and submit an evidence-based plan and budget to advocate to local government for improving services to address such problems.

DTPS-MNCH had been introduced to Indonesia by the WHO and UNICEF, but its application was largely restricted to the development of project activity proposals. With HSP technical assistance, the MOH revised DTPS-MNCH for the Indonesian context so that the results of the process contributed to the routine budgeting and planning cycle. These changes have a legal basis in the laws covering Minimum Service Standards (see legal development section). The revision also included considerations of drug and commodity management. A five-part tool, to guide planners and local advocates on effectively planning, budgeting and advocating for improved maternal and child health services in their districts, was developed.

Development of the guidelines was completed in 2006, after which HSP shifted its focus to establishing and supporting DTPS-MNCH planning and district advocacy teams in the 31 districts under HSP support, some of which received additional legal recognition through *Bupati*/Mayoral Decision Letters and from health office heads. To assist with the roll-out of the DTPS-MNCH approach, and to achieve replication, HSP helped train 84 staff from the national MOH, 16 provincial and district health offices as National Facilitators; these Facilitators went on to train colleagues in all of Indonesia's 33 provinces. Apart from the facilitator trainings, HSP supported the five-day DTPS-MNCH planning workshops where planning documents and program budgets were developed, and later used as the basis of advocacy efforts to ensure the integration of MNCH into local health budget. In this way, DTPS-MNCH has ensured that maternal and child health are embedded in the local governance and funding structures. In 19 districts where HSP provided assistance for DTPS and advocacy between 2006 and 2008, an HSP survey found that over Rp. 18 billion (over US$ 2 million) was approved in final 2009 district budgets to support 110 different activities proposed in DTPS plans developed the previous year.

Table 2. HSP Technical Assistance for DTPS and Advocacy and Approved 2009 Funding

		HSP Technical Assistance 2006-2008		Approved Funded in 2009 District (APBD) Budget to Implement DTPS Plans	
		Advocacy	DTPS	Amount (Nominal Rupiah)	# of Activities Funded
West Java Province					
1	Bandung	√	√	631,950,000	4
2	Cirebon	√	√	421,417,500	5
3	Bogor	√	√	4,606,259,700	6
4	Cianjur	√	√	634,190,000	3
5	Purwakarta	√	√	1,080,121,450	5
6	Tasikmalaya	√	√	1,200,000,000	4
7	Sumedang	√	√	241,680,000	3
8	Bandung City	√	√	175,870,233	4
East Java Province					
9	Kediri	√	√	216,014,000	7
10	Malang City	√	√	497,040,000	2
11	Malang	√	√	312,051,300	6
12	Jember	√	√	1,373,841,890	10
13	Pasuruan	√	√	2,454,460,500	5
14	Madiun	√	√	707,295,000	9
Banten Province					
15	Serang	√	√	128,570,000	5
16	Tangerang	√	√	331,255,000	2
North Sumatra Province					
17	Pematang Siantar	√	√	471,920,400	14
18	Tanah Karo	√	√	377,849,400	6
19	Medan City	√	√	2,621,411,000	10
Total				**18,483,197,373**	**110**

Source: Ruby, 2009

DTPS training for facilitators

Puskesmas Planning

Another critical element of HSP support to local level planning and budgeting was support for the multi-stakeholder *puskesmas*-level planning (*Perencanaan Tingkat Puskesmas*, or PTP). This method sought to strengthen and operationalize the approach outlined in the existing MOH manual by incorporating elements of the DTPS approach adopted for the facility level, with an increased focus on the use of evidence for planning. HSP supported training of facilitators, and also the PTP workshops where data was analysed and costed annual plans for improved *puskesmas* management were developed. The aim is to have these plans improve local MNCH service delivery, informed by locally available evidence, problem analysis, identification of solutions, and prioritization of responses.

HSP worked with local authorities to demonstrate how health technical and general planning streams could be linked to increase MNCH budgets. Development plans of villages in the *puskesmas* catchment area are part of planning considerations. The *puskesmas* plan developed through this process is submitted to local governments (sub-district and district levels) in alignment with both the health planning and *musrenbang* cycles and forms the basis for advocacy towards local governments and planning stakeholders and a budget request. PTP both builds on know-how gained from the existing DTPS local planning mechanism but is also an important bottom-up contribution, and serves as a link between village level and district level planning.

Table 3. DTPS and PTP Results

Indicator	Achievements			
	2007	2008	2009	2010
# of districts with MNCH plans and budgets linked to DTPS	24	31	7	3
# of people participated in DTPS workshop	228	613	74	110
# of people participated in PTP workshop	N/A	N/A	419	1,547

Support for PTP activities began in 2009. In total 106 *puskesmas* received training in the methodology with HSP support. While in 2009 only 13 *puskesmas* were trained, by 2010 HSP worked with the districts of Malang, Pasuruan and Serang to demonstrate that PTP could be conducted on a district-wide basis. This is an important component of systems support, as having evidence-based plans from all health centers not only improves management at the facility site but also allows for use of these plans as a meaningful bottom-up contribution to the DTPS process. Support was given to the respective DHOs to conduct PTP for 39 *puskesmas* in Malang, 33 in Pasuruan and 30 in Serang districts.

DTPS and PTP in East Java: Key Components of an Integrated Planning Approach

Support for improved planning using District Team Problem Solving (DTPS-MNCH) and *puskesmas*-level planning (PTP) played a central role in the integrated program of MNCH interventions supported by HSP in Malang and Pasuruan districts, East Java, in 2009-2010. These approaches went along with support for MNCH advocacy and for participatory planning through Indonesia's national bottom-up planning system, *musrenbang.* HSP assisted the DHO and other stakeholders to integrate these approaches together as part of their annual planning process, with the goal of helping to raise the profile of MNCH issues in the district policy process, improve the capacity of planners to coordinate and allocate resources effectively, and better connect technocratic and bottom-up planning processes at each level.

A case study of the planning process in the two districts in March, 2010 – based on interviews with 95 stakeholders representing health providers, planners, other district government agencies, and NGOs – highlighted a number of ways in which PTP and DTPS-MNCH contributed to improved planning and budgeting for MNCH programs. Participants cited a variety of ways in which capacity to analyze data and undertake evidence-based planning improved, and 87% of district-level respondents said they felt DHO planning had improved. DTPS-MNCH participants universally felt the method could be applied to other programs in addition to MNCH, and 93% of *puskesmas* staff said the same of PTP. Following HSP support for the integrated planning approach, the overall district planning process was also seen as longer and involving a broader array of stakeholders, and better integrated across different levels from village to *puskesmas* to district. In the 2010 budget, Malang approved Rp. 772 million and Pasuruan approved Rp. 1.2 billion to implement DTPS-MNCH plans developed the previous year.

Challenges remained in both districts to changing long-engrained resource allocation processes, and political will to dedicate more resources to MNCH. To support this transition, the study recommends continuing to implement and reinforce the use of methods such as DTPS and PTP as part of the district planning process, and continuing to emphasize advocacy and engagement with policymakers as a key component of planning interventions.

Problem listing to prioritize most appropriate actions

Support to Development of National Health Budgeting Guidelines

In 2006, HSP helped the MOH develop guidelines for management of central-level Deconcentration (*Dekonsentrasi* or *Dekon*) Funds, and trained district officials in the procedures to obtain and utilize them. A second revision was supported in 2007. Changes in the system of distributing these funds provided HSP with a unique opportunity to work with the GOI to determine how *Dekon* funds could be used to improve the health of women, infants, and children in Indonesia's provinces and districts.

HSP also provided technical assistance for the revision of the Minimum Service Standards for health. Minimum Service Standards are a methodology by which central governments can ensure that autonomous or semi-autonomous sub-national government entities can be held accountable for providing basic services to the community. With HSP support, the MOH ensured that the Minimum Service Standards included critical maternal, newborn and child health interventions and that they the standards overall had a stronger legal basis for compliance.

Advocacy to support MNCH outcomes

One of the first activities supported by HSP as part of its advocacy strategy was the National Parliamentarians Conference on MNCH in March 2006. With the theme "Our Shared Responsibility", it was hosted by the Indonesian Forum of Parliamentarians on Population and Development (IFPPD) and attended by legislative members of the health, education and budget commissions, as well as provincial governors, and members of provincial legislatures. National and international NGOs were also in attendance.

Specific objectives of the meeting were to educate parliamentarians at the national, provincial and district levels on the importance of MNCH and to provide guidance on making effective policy decisions to accelerate achievement of national goals for MNCH. The meeting sought to define the roles and responsibilities of parliamentarians in promoting MNCH.

As follow up, national parliamentarians went to the local parliaments in all 31 districts supported by HSP. The national parliamentarians led efforts to advocate the importance of MNCH issues at the local level and disseminated their newly acquired knowledge on the role of parliamentarians in supporting improved health outcomes and the most effective program interventions for achieving these goals.

Following this establishment activity, the longer-term aim of HSP work in advocacy was to support networks of district-level advocates who because of their capacity and shared vision, would be able to successfully advocate for improved policy and budgeting for expanded MNCH services. This work at the district level is important in view of the decentralization of Indonesia's health system a decade ago, and represents an opportunity to shape policy at the local level. To advocate for realizing greater political and budgetary commitment for MNCH, HSP facilitated stakeholders in 22 districts to identify MNCH problems in their district, agree on advocacy objectives, and learn a variety of strategies to meet those objectives. Timing of HSP-supported advocacy workshops was aligned with annual planning and budgeting cycles, and prepared participants for sustained advocacy efforts during the June-September period, when district budgets are finalized in the executive branch, and continuing into the September-December period when they are debated in the legislature.

Table 4. Number of Districts Conducting Advocacy Programs

Province	HSP	Non-HSP (replication)
North Sumatra	6	6
Banten	3	2
West Java	7	5
East Java	6	8
Total	22	21

Advocacy activities were aimed at building the capacity of champions within the bureaucracy as well as from civil society to make the case to policymakers for increased funding and support for improved MNCH services, focusing on district government budget resources (known as APBD). The advocacy teams worked to ensure that DTPS funding requests were approved through the political process, and to increase accountability for commitments made on improving MNCH.

Development of Legal Frameworks

Under decentralization, local regulations provide district-specific guidelines for policy-makers to prioritize budgeting for health and to implement health programs, including for maternal, neonatal and child health. They also provide an avenue by which advocacy efforts become institutionalized. HSP worked with District Health Offices, NGOs, parliamentarians, religious organizations and other stakeholders to create alliances around MNCH issues at the district level, with the aim of passing local MNCH laws – *Peraturan Daerah* – or *perda*. Using proven techniques including media campaigns to raise awareness of the need for MNCH-related perda and conducting legal drafting trainings, these alliances formed into advocacy teams, who worked to ensure that draft regulations were passed and that maternal and child health became prioritized within local governance. One of the most important components of every district advocacy team's plan of action was obtaining a hearing with local parliamentarians, with the aim of persuading district

legislature (or DPRD) members to take the initiative in drafting MNCH laws. HSP provided assistance with technical skills to prepare advocacy teams for their hearings, and to review and explain the content of MNCH bills; HSP also provided advice on legal drafting. During hearings, experts were able to provide parliamentarians with advice on the importance of passing regulations to address pressing MNCH needs, and answer questions on MNCH-related issues and on the content and consequences of proposed bills. By June 2010, the work of these HSP-supported advocates resulted in thirteen MNCH-related perda local regulations being passed: four in North Sumatra, five in West Java, three in East Java and one in Banten.

Table 5. *Perda* Passed with HSP Support

No	District/City	Province	Date of Passage
1	Kab. Sumedang	West Java	2 June 2008
2	Kab. Malang	East Java	25 September 2008
3	Kab. Madiun	East Java	17 November 2008
4	Kab. Serang	Banten	20 November 2008
5	Kab. Pasuruan	East Java	13 January 2009
6	Kota Medan	North Sumatra	20 January 2009
7	Kab. Deli Serdang	North Sumatra	16 February 2009
8	Kab. Serdang Bedagai	North Sumatra	25 February 2009
9	Kab. Purwakarta	West Java	10 March 2009
10	Kota Sibolga	North Sumatra	13 March 2009
11	Kab. Bandung	West Java	17 March 2009
12	Kab. Cirebon	West Java	31 March 2009
13	Kab. Bogor (*Perbup*)	West Java	26 May 2008

At the end of the first phase of the program, in March 2009, HSP supported a national advocacy meeting to share lessons learned and best practices amongst participants from 23 of the HSP intervention districts.

This work in supporting the development of local legal instruments for institutionalizing and sustaining support for MNCH in districts has been recognized by the national GOI. HSP was invited to present on *perda* development at the Seminar on Sharing Best Practices of Grant and Allowance Projects in MCH hosted by Indonesia National Development Planning Board (Bappenas). In keeping with the spirit of supporting local champions who were leading efforts, HSP invited a member of the Medan City parliament to explain the process they had followed and the effects of the law on increasing local budgets.

Table 6. Indicators for Achievements in Regulatory Products

Indicator	Achievements			
	2007	2008	2009	2010
# of national, provincial or district-led initiatives in support of basic human services (including SK *Bupati* and agreement with PKK)	49	37	43	40
# of improvements to laws, policies, regulations, or guidelines (indicator added 2010)	n/a	n/a	n/a	330

Free MNCH Services Realized in Sumedang, West Java

On January 21, 2008, Sumedang became the first district in Indonesia to pass a specific directive on maternal, newborn and child health (MNCH), guaranteeing increased funding to improve the health of mothers and children. Formally enacted in April of that same year, the regulation requires the district to allocate 15% of its total budget to maternal, neonatal and child health, in addition to providing free maternal, neonatal and child health services through puskesmas, clinics and hospitals.

Sumedang's extraordinary success was a testimony to the effectiveness of a coalition of advocates that included District Health Office staff, DPRD members, health providers, local NGOs, mass-based religious organizations and the media. A prominent local radio broadcaster and NGO activist led the advocacy team to its first success - a 16% increase in the district budget allocation for MNCH. Part of the success came through using the local radio station to mobilize community support for free MNCH services for the poor. Then, inspired by the passage of a local regulation that mandated 20% of the total district budget be allocated to education, the advocacy team set their sights on passing a local regulation for MNCH.

To assist the advocacy team in making its case before Sumedang's parliament, HSP enlisted the technical input of a health financing expert who also advises the National Parliament on health. In his analysis of Sumedang's 2007 health budget, the expert pointed out inefficiencies in the use of funds, as well as the overall lack of funds to ensure all pregnant women received basic services. His presentation was critical to convincing DPRD members that the power to improve MNCH rested in their hands.

The Advocacy team's ability to convince Local Council members across party lines was also crucial in getting the regulation passed. Nine out of ten party members who debated the bill presented arguments that supported its passage. Commenting on the process, Sumedang's Deputy Parliamentary Head, remarked, "We are obligated to make an effort on behalf of the welfare of our people. Mothers and children are the pillars of our country, and we must support them!"

Leveraging Local Legal Frameworks for MNCH

In the context of Indonesia's decentralized health system, the development of local laws and regulations – including perda (*Peraturan Daerah*, or regional regulations) at the district-level – can be a useful tool for spurring local action to help meet national MNCH goals in Indonesia. This was among the main conclusions of a 2010 case study of HSP-supported efforts to pass MNCH regulations in four districts (Malang, Pasuruan, Cianjur, and Serang) across three provinces (Banten, East Java and West Java), which surveyed some 125 heath sector stakeholders and government decision makers at the village, sub-district, and district levels. In the three districts that passed such perda – two of which were specific to MNCH, and one focused on the health system broadly with MNCH as a component – they were found to provide an effective means to articulate local needs and priorities related to MNCH programming. *Perda* were also broadly perceived by stakeholders as useful for increasing commitment and support from other government agencies, clarifying roles and responsibilities, providing a basis for monitoring MNCH programs, and serving as a basis for advocacy.

In Malang and Pasuruan, passage of the MNCH *perda* was followed by the development of additional regulations – including perbup and village regulations (*Peraturan Desa,* or "perdes") – that played an important role in operationalizing the *perda*. These additional regulations helped to clarify roles and responsibilities to a greater degree than the *perda*, as well as provide operational instructions to implementers and partners. The study also indicated that *perda* and *perbup* were actively used for decision-making regarding MNCH programs, including as justification for funding increases, changes to activities or strategies, and changes in personnel. *Perdes* helped to give formal recognition and an institutional foundation within the village for community-based MNCH activities.

The study found that the approach of developing MNCH regulations is replicable and adaptable to needs and political realities in different settings, and that it can be valuable as part of a broader, integrated district approach to reducing maternal and neonatal mortality. At the same time however, the success of the approach depends on the strength of local support and advocacy. Furthermore, while passing a legislative law was seen as a significant step, a law alone is not enough - successful implementation is likely to require ongoing external reinforcement or technical assistance, such as from higher levels of the health system. Recommendations for future scale-up of the approach include building this capacity amongst existing health authorities.

Table 7.
Number of People Trained in Advocacy 2005-2010

Master Trainers (for the MOH and national NGOs)	19
National Trainers	20
National Trainers (NGOs – WRI's partners)	19
Advocacy Skills	613
Legal Drafting	151
DPRD Orientation	664
Leadership	59
Attended Workshop on the Early Initiation of Breastfeeding and the International Code of Marketing of Breastmilk Substitutes	23,374

Advocacy on Breastfeeding

Breastfeeding is one of the most effective interventions for saving newborn lives. Following previous success in working with the national parliament, in August 2006 HSP supported an advocacy session with parliament members on the International Code on Marketing of Breast Milk Substitutes. As a result of the meeting, Indonesian legislators requested that they be provided with "model language" to ensure that any further revisions to the Health Law Amendment reflect international standards. This high level commitment obtained through this seminar laid the groundwork for the HSP breastfeeding campaigns.

HSP also supported training of health providers and midwives in its coverage area to advocate immediate breastfeeding. Through a 'celebrity' advocate, HSP helped reach over 23,000 stakeholders with information on the life-saving value of initiating immediate and exclusive breastfeeding within an hour of birth, which can reduce neonatal mortality by 23%, and also for the first six months of the child's life. Along with HSP work on raising public awareness of the importance of immediate breastfeeding (see the Behavior Change Communications section), this helped triple breastfeeding rates across the country, which was one of the cornerstones of USAID efforts to reduce infant mortality.

Early Initiation of Breastfeeding advocacy

Building Advocacy Capacity amongst Indonesian MNCH 'Champions'

HSP has also supported efforts by local groups and networks to take action on MNCH, including by building the skills of these potentially influential community groups to act as advocates around these important issue. In 2006, HSP supported the Indonesian While Ribbon Alliance (APPI), to announce the expansion of their mandate to address not only maternal but also newborn and child health, to review achievements and to set advocacy goals for the coming year.

APPI made good on their promises when they, along with representatives of the MOH and National Family Planning

Coordination Board (BKKBN) met Indonesia's First Lady, Ani Yudhoyono, the following February. During the meeting, First Lady Yudhoyono agreed to be a patron of the White Ribbon Alliance and safe motherhood in Indonesia.

Harnessing the power of the Indonesian Women's Congress, the Indonesian Women's Business Association and Dharma Wanita (the association of wives of civil servants) was also part of the HSP strategy for promoting MNCH as part of achieving the Millennium Development Goals. These collaborations are reported under MDGs.

When HSP undertook to support district-wide scale up under the extension period, it knew that achieving broad coverage could not be achieved without the assistance of local advocates. In conjunction with the celebration of Indonesian Mothers' Day, HSP supported the Regency of Malang to launch a revitalization of the *Gerakan Sayang Ibu* (Mother Friendly Movement) as part of their efforts to reduce maternal and child mortality. Over 750 people, mostly women involved in volunteer efforts at sub-district and village levels, participated in talk show style event with the theme: "Utilizing the strength, dignity, high-standing, role and position of women in Malang Regency, we can improve our maternal and child health status for a better quality of life".

The Making Pregnancy Safer – Child Survival team approach

Making Pregnancy Safer (MPS) is the national maternal health policy adapted for Indonesia from the international WHO policy standard of the same name. HSP supported the MOH to make further revisions to this policy by incorporating the Child Survival (CS) strategies that were then under development within the Ministry. HSP also supported the MOH to develop a detailed set of Strategic Implementation Guidelines for the newly packaged MPS-CS policy, including advice on assessing district progress against targets. HSP also supported the dissemination of the Guidelines through a workshop: "Turning Policy into Practice", held in Makassar in November 2006, and their testing in HSP-supported districts during 2007 before they were adopted by the Ministry.

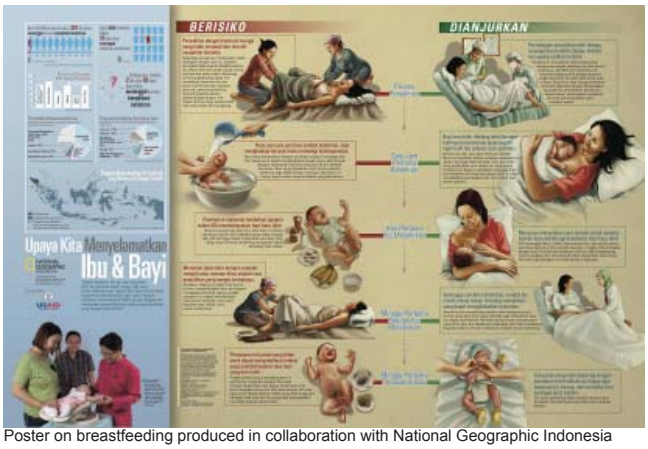
During the extension phase, year five of implementation, HSP facilitated the formation of district and sub-district level MNCH teams in Malang and Pasuruan districts. The teams were institutionalized through the development of a legal instrument known as a *Surat Keputusan* (decision letter) issued by the *Bupati* under the *perda* process (see section on *Perda*). The MPS-CS teams are responsible for providing high-level policy oversight for the implementation, monitoring, and evaluation of activities under the integrated MNCH model; 125 such teams were established at district and sub-district levels. HSP support also helped establish the sub-teams as mandated under the national MPS-CS policy; namely, community mobilization, health system management, Local Area Monitoring and Tracking (LAMAT), and Maternal Perinatal Audit (MPA). MPS-CS district monthly meetings were held, with representation from Bappeda, DHO, the *Bupati*, district hospital, puskesmas, and the *Pemberdayaan Kesejahteraan Keluarga* (PKK or Family Welfare Movement). At sub-district level, HSP helped teams to clarify their role in relation to sub-district administrative authority. Ultimately, at this level, the primary aim is to better coordinate the implementation of MNCH activities among the Camat, the puskesmas, health-sector NGOs, and other local partners such as the PKK.

Poster on breastfeeding produced in collaboration with the National Geographic Indonesia

Advocacy to Parliament on the International Code on Marketing of Breast Milk Substitutes.

Public-Private Partnerships

HSP has worked to harness the private sector through public-private partnerships (PPP) that address MNCH issues. This includes partnerships with Johnson & Johnson, ExxonMobil and Reckitt-Benckiser on a number of issues, ranging from training midwives to hand washing with soap. The HSP PPP team facilitated the establishment of public-private partnerships in support of many MNCH activities conducted over the project's five years. Thanks to these partnerships, a new generation of corporate stewards stands ready to respond to the challenges facing Indonesia's mothers and children. In 2008, corporate partners donated more than Rp. 1,700,000,000 for a variety of large and small-scale events designed to increase community awareness of and involvement in maternal and child health.



Poster on breastfeeding produced in collaboration with National Geographic Indonesia

HSP's Most Successful Corporate Partnerships

Johnson & Johnson has supported IBI's Bidan Delima program since its inception in 2003, when they sponsored the production of Maternal and Neonatal Guidelines for midwives. From then on, the company progressively expanded its support by sponsoring clinical trainings for 1,343 Bidan Delima candidates, 540 facilitators and 86 assessors, and by helping the program expand in seven provinces during 2005-2010. Johnson & Johnson also supported an initiative to recognize the best individuals and organizations in the Bidan Delima program. In 2008, the company embarked on its largest package of support, including public service announcements on four national TV stations. The advertisements, originally developed with USAID support, were designed to create demand for Bidan Delima services and to strengthen the program's brand recognition.

Reckitt-Benckiser, the manufacturer of Dettol soap, and the World Bank's Water and Sanitation Program (WSP) worked with HSP over four years on a number of hand washing with soap campaigns, including a training in Malang that reached over 10,000 students and for which the company provided towels, soap, and hand-washing kits. The company also worked with HSP and the MOH to host a workshop for journalists on the importance of hand washing with soap as an effective measure against infectious disease including diarrhea, planned to coincide with World Hand Washing Day, held on October 15, 2008. Thirty-one journalists from a variety of media outlets attended the event, representing one television station, three radio programs, eight magazines and 11 newspapers. In addition to discussing the importance of hand washing, guest speakers offered strategies for pitching stories on hand washing with soap to appeal to readers and viewers from a variety of backgrounds.

ExxonMobil worked with HSP to support the launching of the Bidan Delima program in Nanggroe Aceh Darussalam in February of 2008. The Governor of Aceh attended and oversaw the inauguration of 85 new Bidan Delima from Banda Aceh, Aceh Barat and Aceh Besar. The event was also attended by Bappeda, members of the District Health Office, professional organizations and the media. ExxonMobil supported printing of Bidan Delima promotional materials.

National Geographic Indonesia entered into an agreement with HSP in 2007 to produce a breastfeeding insert for the November 2007 issue of the magazine. The supplement outlined actions needed to accelerate improvements in maternal and newborn care so that Indonesia can meet its Millennium Development Goals, and included statistics and a map overview of the current situation in Indonesia, with disparities between regions. With 40,000 copies produced per issue, and around 10,000 subscribers, the insert was designed to reach an educated audience positioned to make a difference on MNCH at the policy and funding levels. National Geographic also ran public service announcements on breastfeeding and skilled birth attendance.

Thirty five corporate sponsors, including Merck, Microsoft and Pertamina, among others, contributed US$ 58,000 in event preparation and in-kind donations for Dr Utami Roesli's 48 breastfeeding advocacy events in 2008 attended by 24,000 participants.

In addition to directly partnering with corporations, HSP also trained 163 individuals from District Health Offices, Community Health Committees, and District Advocacy Teams on developing their own proposals to leverage Corporate Social Responsibility programs and conduct corporate fundraising. In addition, staff from the MOH's Health Promotion and the Maternal Health Directorates were also introduced to the concept of PPP, Corporate Social Responsibility programs and fundraising techniques. Members of some 30 community health committees from across HSP-supported districts used their newly acquired skills to submit proposals to corporations such as Swisscontact, the East Java regional forum for development (Forda) and local television stations to assure the sustainability of their MNCH activities. In 2010, 91 puskesmas staff received training on PPP, with a view to them facilitating further proposal development by Community Health Committees. It is hoped that local businesses can also be harnessed for partnerships in support of mothers and babies in communities across Indonesia.

Improving quality of health services

HSP focused on three principal strategies to improve the quality of maternal and child health services: updating basic training packages for clinicians and midwives; improving training standards for midwives at puskemas; and improving training standards for private sector midwives.

National facilitators aattended the HSP-supported neonatal training


International experts are invited to share their knowledge and skills to national facilitators


Review of M

Provider training

HSP continued to build on earlier USAID investments in a number of clinical training packages, coordinating with UNICEF and WHO in support of the MOH to ensure that all packages were up-to-date and included post-training qualification, accreditation and quality assurance components. The aim was to promote quality of services and focused on raising clinical training standards, designing technical updates for obstetric and neonatal care at the hospital and *puskesmas* levels using evidence based interventions, followed by qualification of providers and accreditation of health facilities at every level of MNCH service provision. In providing this support, HSP sought to leverage the power and dedication of some of the country's largest provider associations and in particular the National Clinical Training Network (*Jaringan Nasional Pelatihan Klinis*, or JNPK).

Normal Delivery Care (*Asuhan Persalinan Normal*, or APN) is the in-service clinical training program being implemented on the largest scale in Indonesia. Developed by the JNPK with support from USAID, the program is now a standard component of most District Health Office plans, with an estimated 2,000 midwives trained annually. HSP worked with JNPK to update the APN training package with the integration of a newborn resuscitation module, revision of standards for Active Management of the Third Stage of Labor (AMTSL), and the addition of newborn protocols such as skin-to-skin contact for the first hour and the Vitamin K1 and Hepatitis B vaccinations. HSP also provided technical support that increased the number of provincial and district clinical trainers certified to train in the APN package.

At the *puskesmas* level, HSP worked with partners to institutionalize the use of AMTSL and immediate breastfeeding as part of the APN program. Post-partum hemorrhage accounts for the highest proportion of maternal deaths in Indonesia (28%), but up to 60% of those deaths can be prevented through AMTSL. Suitable for home deliveries, AMTSL consists of three, low-cost steps: 1) administration of an uterotonic drug within one minute after delivery; 2) delivery of the placenta using controlled cord traction; and 3) uterine massage after delivery of the placenta. HSP supported quality assurance measures to ensure that AMTSL is regularly practiced by midwives. In the revision of instruments used to train and accredit midwives, and tools used to facilitate supportive supervision of village midwives attention was focused on the skills, protocols and supplies needed to correctly deliver AMTSL.

Over the life of HSP, over 7,000 providers were trained on the APN package, with an additional 1,421 receiving refresher trainings on AMSTL and IBF. Working closely with USAID's Prevention of Postpartum Hemorrhage Initiative (POPPHI) and the MOH, HSP also supported the scale-up of AMTSL in Indonesia's hospitals. When a national study of hospital deliveries found that steps two and three of the active management process were not as consistently practiced, HSP worked with the MOH and JNPK to expand the correct practice. HSP supported JNPK to revise clinical training materials and to develop an on-the-job training approach to strengthen provider practice of AMTSL.

As part of the update to the national midwife training package on APN, HSP supported production of a video tool that changed the way many midwives practice. The video shows an Indonesian midwife delivering a baby, and demonstrates the correct steps to integrate AMTSL and the early initiation of breastfeeding. Over 15,000 copies of the video were distributed nationwide, and 113 clinical trainers were trained in its use. With HSP support, over 1,200 midwives received a one-day refresher course in the new APN protocols, and more than 600 midwives received refresher courses offered by other donors including JNPK, Mercy Corps and UNICEF. The video garnered international recognition, with requests to adapt it received from Timor Leste, Cambodia, Bolivia, Nicaragua and India.

Similarly, in collaboration with JNPK and District Health Offices, HSP supported JNPK to finalize the manuals and instruments for post-training qualification and accreditation (Q&A) of midwives.

INERC program by Dr. Ari Prasetyadjati Sp. EM and Irene Koek, USAID

Table 8. Overview of Achievements in Provider Training

Indicator	2006-2010
Number of people trained in APN package	7,025
Number of people trained in PONED	895
Number of people trained in PONEK	520
Number of people trained in CTS	115
Number of people trained in P2KS/P refresher in AMSTL, BF	1,421
Number of people trained in the use of IMCI modules (including DHO, PHO, and *puskesmas* staff, as well as health providers and trainers)	389

Participants also learn to manage newborns in the hospital setting

HSP helped the MOH roll out an updated version of the Basic Obstetric and Neonatal Care (PONED) package for use at *puskesmas* across the country. The package includes components on low-birth weight, asphyxia and hypertension and was used to train 895 midwives across HSP intervention sites during the first four years.

Low birthweight is one of the biggest causes of neonatal death in Indonesia. To improve management of low birthweight, HSP supported Perinasia to host a national congress on increasing survival rates and improving the quality of life for these babies in November, 2009.

In addition to improving access and standards for maternal and neonatal health services, HSP also worked to improve child health services, most notably through updating and adapting the WHO's Integrated Management of Childhood Illness (IMCI) package for use in Indonesia. Although Indonesia initially adopted the IMCI approach in 1997, it remained underutilized and some of the international standards for care had since been revised. From 2006 to 2009, HSP supported improvements to IMCI training systems, materials, and methods through collaboration with professional associations such as the Indonesia Pediatric Association (IDAI) and JNPK, in addition to reviewing the coverage and quality of IMCI interventions in selected areas. In 2007, the MOH, WHO, and HSP worked together to update the clinical components of the IMCI training package. The revised protocols for children aged two months to five years feature new procedures for treating childhood pneumonia, ear infections and diarrhea. The protocols for diarrhea emphasize the importance of zinc and oral rehydration therapy (ORT) for all cases of childhood diarrhea, and reiterate the rational prescription of antibiotics. The algorithms for sick infants under two months of age were added for the first time, and immediate and exclusive breastfeeding is promoted. Some 389 providers across Indonesia were trained on the new protocols. Through HSP work on drug commodity management and DTPS, the program has also assisted MOH on issues related to drug equipment and supply for childhood illness.

Participants learn how to properly monitor woman's condition for prevention of postpartum hemorrhage and practice active management of the third stage of labor

Diarrhea prevention and management

Diarrhea remains a leading cause of under-five mortality in Indonesia, accounting for 18% of deaths, or about 40,000 children under five annually. HSP focused on reducing morbidity and mortality from diarrhea on three fronts: improving sanitation, hygiene, handwashing with soap and the use of clean water; identifying/treating those cases that occur; and on immediate and exclusive breastfeeding.

HSP partnered with USAID's POUZN and BASICS to promote the use of zinc for diarrhea treatment to health service providers. A WHO-UNICEF statement issued in 2004 recommends a 10-day course of zinc therapy for children with acute diarrhea, citing evidence that zinc treatment results in a 25% reduction in the duration of diarrhea, and a 40% reduction in treatment failure or death from persistent diarrhea. With support from POUZN, the first three locally produced zinc treatments were introduced to the market in 2008. During the National Pediatric Congress in July 2008, the MOH approved a new slogan and logo for launching zinc as part of the protocols for treating childhood diarrhea. Known as LINTAS DIARE ('*Lima Langkah Tuntaskan Diare*') or 'Five Steps to Fight Childhood Diarrhea', the logo advises providers to use reduced osmolarity oral rehydration solution; give zinc for 10 days; continue breastfeeding and feeding; use antibiotics selectively; and to counsel caretakers about the danger signs in children that require a return for additional medical treatment. To help spread the world, the logo and slogan were used on 6,000 pocket fans distributed among health providers and as part of the IMCI package of modules.

Aside from the addition of immediate breastfeeding to the APN and PONEK modules, HSP also supported the MOH and Studio Driya Media – a local NGO experienced in adult education and active learning methods – to develop community modules on the life-saving benefits of initiating immediate and exclusive breastfeeding. As part of the MOH's strategy to raise awareness of nutrition (KADARZI or *Keluarga Sadar Gizi*), the modules were used to provide community facilitators – midwives, puskesmas staff or community health volunteers – with a range of activities that can be used in community forums. Using low-cost materials, facilitators set up interactive exercises that can be adapted to various cultural settings and used during regular community activities, such as mosque meetings, posyandu days or other village festivities. Over the course of the project, HSP supported trainings on the use of the modules to 81 trainers, 96 Bidan Delima, and 416 public health providers – including DHO staff, village midwives, *puskesmas* staff and CHC volunteers – from 182 villages in 18 districts.

The five steps to fight childhood diarrhea include Zinc therapy

Hospital-based activities

During the first two years of project activities, HSP supported significant contributions to the development of **Comprehensive Obstetric and Neonatal Care Package (or PONEK)** protocols and modules for hospitals. The updated PONEK package includes the development of the neonatal care component, and was led by the Indonesia Pediatrics Association (IDAI) with support from HSP, and instruments for on-the-job training and supportive supervision of practitioners. With HSP support, over 1,000 sets of the modules were distributed nationwide to district hospitals, clinical training sites, professional associations and NGO partners for further replication. Some 510 physicians were trained on these modules. The package was tested in 18 hospitals and eventually scaled-up to over 100 hospitals by the MOH.

Over the next two years however, few further activities at the tertiary health care level were supported by HSP. On the basis of review recommendations, the project extension phase included work with two district hospitals to improve the quality of emergency care for mothers and newborns, which was further replicated in the final months of program support.

Maternal and Neonatal Emergency Room Care, or MNERC, was aimed at improving management of obstetric and neonatal emergencies. To initiate these activities, HSP supported Perinasia to work with the MOH and key professional groups to identify the systems barriers to the provision of better emergency room care. One of the key challenges was clarifying the role of each profession in emergency care delivery and determining standards and standing orders in line with the legal authority of each professional group.

Implementation was carried out through support to the Saiful Anwar hospital, a province-level facility located in Kota Malang, which serves as a higher level referral and regional teaching hospital for a catchment area that includes both Kabupaten Malang and Kabupaten Pasuruan. In Malang, activities were implemented at the Kanjuruhan General Hospital and in Pasuruan at the Bangil Hospital. Standards for emergency care at Saiful Anwar were assessed to be reasonably high, with the main area of deficit in Continuous Quality Improvement Systems. To this end, materials, protocols and competency-based training for handling maternal and neonatal emergencies by non-specialist medical staff were introduced to Saiful Anwar. Given the role of Saiful Anwar as a regional teaching and referral center, investments at this level were done in order that Saiful Anwar would lead the training of the two district hospitals and future replication efforts. Strong program leadership from the Saiful Anwar hospital saw the initial training of the hospitals completed, and HSP therefore agreed to support training and follow-up supervision on MNERC and KMC for an additional seven district hospitals, completing replication throughout the entire catchment area. In this way the activity serves as a model for improving maternal and neonatal emergency care and an approach to continuous quality improvement; this model could also be replicated to regional teaching hospitals nationally.

Table 9. Overview of Achievements in Hospital-Based Activities

Indicator	2010
# of people trained in MNERC	383
# of people participated in MNERC OJT	465
# of people trained in PONEK (2006-2010)	520
# of people participated in KMC OJT	70
# of hospitals implementing KMC for under/low-birthweight babies and with written KMC policy	10
% of low-birthweight infants that received KMC during program implementation	20%

Photos this page: PONEK modules helped standardize the neonatal care package in hospitals

Improving the Quality of Maternal and Neonatal Emergency Room Care (MNERC)

Despite significant progress in recent years, maternal and neonatal mortality rates in Indonesia remain unacceptably high. This is true even at the hospital level, due not only to delays in critical cases reaching the hospital, but also to poor initial management of such cases once they arrive. At many district hospitals, emergency rooms are not properly equipped or trained to handle obstetric and newborn emergencies, and front-line providers are often not authorized to provide emergency care without an obstetrician or neonatologist present. Often, such cases are not even assessed before they are sent up to the obstetric or neonatal ward, and poor coordination between wards often leads to further delays in receiving life-saving care. HSP-supported assessments in several district hospitals in 2010 revealed that obstetric or neonatal doctors were not always available, and ward staff in charge had little expertise in or access to adequate resuscitation equipment, and no standing orders to provide emergency care.

MNERC activities supported by HSP made important strides – in complement to the PONEK and PONED training programs updated and revised with HSP assistance – toward beginning to change the culture of emergency care in district hospitals, and ensure mothers and children can access prompt, life-saving care, day or night. After reviewing and clarifying national protocols with respect to management of obstetric and neonatal emergencies by non-specialists, some 429 hospital staff from 22 districts were trained in MNERC protocols. The protocols were then used to develop a full emergency room improvement package – 17 trainers were trained followed by two additional trainings for 28 participants with HSP assistance – and implement it with Saiful Anwar serving as a regional training center. The process includes technical assistance to participating hospitals to conduct an initial clinical and managerial assessment, develop a facility self-improvement plan, and establish ongoing training, feedback, and reporting systems through the regional training center.

In response to this, HSP worked with the Indonesia Society for Perinatology (Perinasia) to review the protocols, standards and standing orders that would be required for emergency room personnel to deliver obstetric and neonatal care and with the Saiful Anwar Provincial Hospital to build a regional model for training and supervision. This approach strengthens the existing system as regional referral hospitals have the duty to train and supervise staff from other district hospitals in the region: the Saiful Anwar hospital supervises nine district hospitals. The approach is a competency model, which includes measuring success against self-improvement plans from baseline assessments.

Initial results of on-the-job training conducted between July and September 2010 in the nine district hospitals show a marked improvement in adherence to standards for emergency care of maternal and neonatal cases.

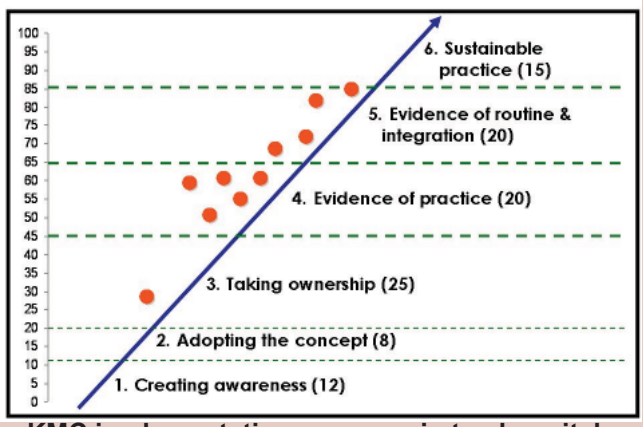
HSP also supported the implementation and scale-up of **Kangaroo Mother Care** (KMC), a low-cost and low-resource approach for caring for premature and low-birthweight newborns. In May 2008, HSP supported a team of delegates from three teaching hospitals and the MOH to attend a study tour to Cape Town and Pretoria, South Africa. The program then built on this capacity in 2010 by expanding to an additional eight hospitals in East Java, West Java, and Jakarta. The KMC program model utilized two of the teaching hospitals, Dr. Soetomo in Surabaya and Cipto Mangunkusumo in Jakarta, which participated in the study tour as centers of excellence. These institutions served as the training centers and provided supervision for the eight expansion hospitals. The program consisted of a baseline assessment; training of key health professionals; two on-site supervisory visits to each hospital; and an end-line assessment.

Mothers practice Kangaroo Mother Care with their underweight newborns

Kangaroo Mother Care: Growing by Leaps and Bounds

After supporting the initial introduction of KMC in Indonesia, HSP worked with Perinasia to support and document further scale-up of KMC in 2009-2010 in 10 hospitals across Java, with technical assistance from international KMC experts. Baseline and endline assessments allowed for scoring the progress of implementation of KMC in each hospital.

An analysis of these assessments found that nine out of the ten hospitals trained were successfully implementing KMC by the end of the project, including four facilities (two of which were training centers) that were approaching integration and sustainable practice. Findings showed that KMC was well-accepted and supported in most settings by hospital staff and patients. Better integration of services between different health authorities, and both between and within health facilities, is still needed however to overcome general weaknesses in the health system that result in poor continuity of care, especially for post-discharge follow-up of low birth-weight babies.



KMC implementation progress in ten hospitals

To support future scale-up of KMC in Indonesia and maximize the impact of the approach, the study recommended to strengthen the existing hospitals implementing KMC before larger scale-up initiatives or the introduction of KMC at the community-level. In addition, it was recommended to develop a model for the scale-up of KMC that builds on the existing health system. The model would include a provincial teaching hospital that serves as a center of excellence for future training and supervision of district hospitals and that is also used as referral points for step-down facilities such as the *puskesmas*, *polindes*, and *posyandu*.

Baseline assessment of hospital emergency equipment

Documenting Quality and Access to Perinatal Emergency Care (QUAPEC)

While Indonesia has made significant gains in reducing maternal and neonatal mortality over the past three decades, largely thanks to expansions in community-level services, progress has slowed in recent years. There is now a broad consensus that achieving further reductions in mortality will be difficult without increased attention to the provision of hospital-level care for complications. Prior to QUAPEC, however, there was little information available on the quality of hospital care provided to women and children, or about the characteristics of hospital users. QUAPEC not only provided valuable evidence on the importance of improving hospital emergency care for mothers and newborns, but suggested possible entry points for doing so as part of an integrated district approach.

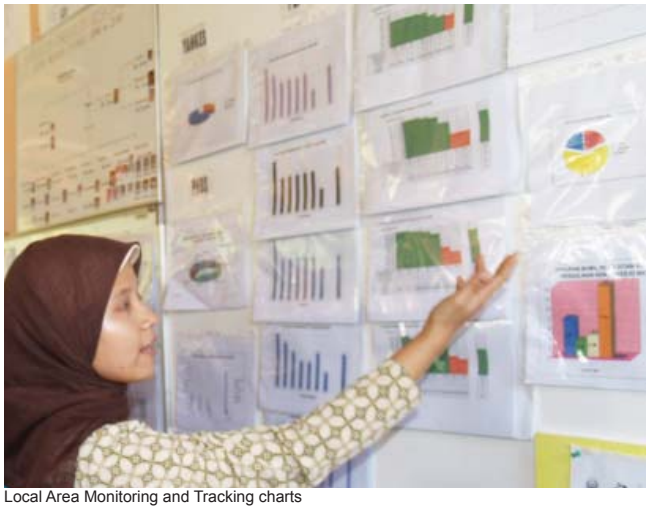
HSP-supported researchers assess the quality of patient care at the Cipto Mangunkusumo Hospital, Jakarta

HSP also worked with the University of Indonesia on QUAPEC, or Quality and Access to Perinatal Emergency Care at the district level, an in-depth observational study on the quality of care provided to pregnant women and newborns in two district public hospitals. The study included detailed analysis of medical records covering all obstetric and neonatal admissions over a 12-month period, and direct observation of care provided for obstetric and neonatal cases in both routine births and for key complications. It also included information on the characteristics of public hospital users including method of payment, and is expected to make a significant contribution to the knowledge base on hospital care in Indonesia by directly linking the care of the mother to the care and outcomes of the infant. In all, QUAPEC documented the experiences of 2,498 maternal patients and 699 newborns in the two hospitals over a one-year period, providing valuable information on the quality of perinatal hospital care in Indonesia, as well as on barriers and opportunities for lowering hospital-based mortality.

Local Area Monitoring and Tracking (LAMAT)

As an overarching component of the integrated MNCH health systems approach, HSP worked during the extension phase to strengthen the health information system in Malang and Pasuruan across all levels of the health system. The MOH's Local Area Monitoring and Tracking (LAMAT) system, previously developed with UNICEF support, was introduced to both Malang and Pasuruan districts. The LAMAT system builds on the already existing Local Area Monitoring (LAM) information system and introduces an element of data analysis, use, and active surveillance. In Malang these improvements were made to the paper-based system whereas in Pasuruan computer software was introduced. The rationale for this was based partly on an assessment that determined that Malang was not yet ready to change to a computerized system. This outcome, however, also proved to be an opportunity to show that the fundamentals of the system could be implemented without the need for computers, demonstrating how the manual system could also be improved by the addition of tracking activities: an important point for low-resource settings and one that provides valuable lessons for remote areas of Indonesia.

Local area monitoring and tracking improves the coverage of maternal care at the community level


Local Area Monitoring and Tracking charts

How MNCH Active Surveillance works

The LAMAT methodology encourages village midwives and kader to actively identify and monitor women, newborns and children in the village, and cross-check their information to identify new pregnant women or those who fail to appear for a scheduled check-up or similar meeting (known as "drop-outs"). Midwives and kader then work together with community leaders, traditional birth attendants, religious leaders or other relevant members of the community to follow up, including by providing outreach to the household if required. This basic problem analysis is undertaken on-site, ensuring a timely response. In this way, a strengthened HIS becomes part of a direct intervention for saving the lives of women, newborns and children at the village level.

LAMAT was rolled out by using existing elements of the system: through monthly supportive supervision meetings and by updating checklists to include data compliance elements. At the sub-district level, HSP supported the DHO to introduce the LAMAT approach to all *puskesmas* in Malang (39) and Pasuruan (33). In order to ensure that the system was understood in some detail by counterparts, 13 'focus' *puskesmas* received intensive technical assistance from DHO and project staff to strengthen the completeness and accuracy of MNCH record keeping, to conduct analysis of data, provide feedback to village level midwives, and to formulate follow-up plans based on the analysis. These activities were supported through monthly meetings of the village midwife with the *puskesmas* staff, through supportive supervision from the *puskesmas* to the *polindes* and *posyandu*, supportive supervision from the DHO to the *puskesmas*. Additionally, HSP supported peer-to-peer exchanges with another district that was one of UNICEF's original LAMAT sites. By the final months of HSP support, the LAMAT focus *puskesmas* were able to provide additional peer-to-peer support to non-focus *puskesmas*, thus ensuring program quality as part of the scale-up.

At the village level, HSP supported training for the village midwife, *posyandu kader*, and traditional birth attendants to upgrade their skills and strengthen the completeness and accuracy of MNCH record keeping, to do basic analysis on-site using the information at hand, and to formulate follow-up plans based on that analysis. These activities are reinforced through monthly meetings of the village midwife with the *puskesmas* coordinating midwife and through supportive supervision from the *puskesmas* to the *polindes* and *posyandu*. While general trainings were given as broadly as possible, a system of focus villages was supported to ensure detailed understanding at selected sites. Peer-to-peer replication was also supported at the village level, and was underway in both districts by the time of HSP closure.

Table 10. Overview of Achievements in LAMAT 2010

Indicator	2010
# of people trained in LAMAT	2,838
# of trainers trained in LAMAT	60
# of LAMAT focus puskesmas	13
# of LAMAT focus villages	59
# of LAMAT expansion *puskesmas* (including focus *puskesmas*)	72
# of LAMAT expansion villages (including focus villages)	489
# of peer-to-peer exchanges with Wonosobo (UNICEF LAMAT district)	4
# of participants LAMAT data operator training	13

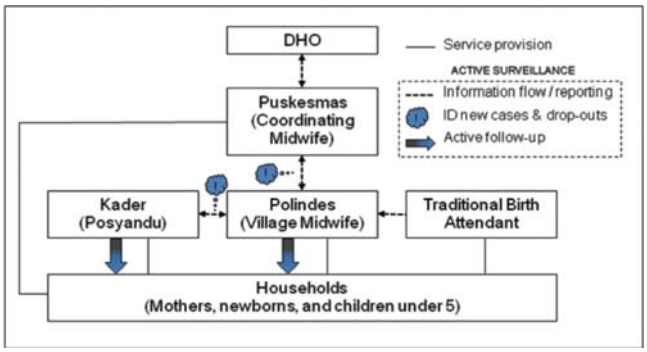
Using Active Surveillance to Increase Coverage of MNCH Services

The implementation of LAMAT in Malang and Pasuruan extended a tradition long-tested in the area of infectious disease surveillance and immunization. Active surveillance and follow-up with target populations, along with reinforcing the existing role of *kader* and village midwives in monitoring, ensure women and newborns receive essential MNCH services. A 2010 HSP case study of LAMAT in the two districts surveyed six *puskesmas* and six villages at baseline and follow-up as well as interviewed the DHO, PKK, and the village community. The study highlighted the value of this approach in encouraging better and more accurate data collection, as well as the use of data to focus the efforts of community health workers on priority problems. Following HSP-supported monthly technical assistance visits led by the DHO and *puskesmas,* village-level midwives conducted more detailed data collection, processing and analysis, and more actively prepared action plans to follow up with "drop-outs" in the village (mothers and newborns not receiving services). *Kader*, as well as traditional birth attendants in three of the four villages surveyed, reportedly made meaningful contributions to these efforts, sharing information with the village midwife and helping to identify and follow-up with those not being reached by key services. In addition, data was used as an input to developing village action plans which fed into *musrenbang*, as well as in planning at the district and sub-district.

While both districts continue to face challenges from overlap and duplication in reporting, a lack of clearly defined roles and responsibilities, challenges in data quality checking and analysis, and a lack of support and feedback within the system, LAMAT implementation led to clear improvements in a relatively short implementation period. Improvements were seen regardless of whether implementation was done through the manual system or the computerized system, although computerization at the *puskesmas* level reportedly facilitated data analysis. More than 70% of key system indicators in each district improved between baseline and follow-up, across the five key dimensions examined — clarity in roles and responsibilities, data collection, analysis and use, and feedback & supervision — and at all levels from village to sub-district to district.

Village midwives are the front line providers who collect data for LAMAT

Figure 9: Active surveillance and follow-up under LAMAT



Maternal Perinatal Audit (MPA)

Maternal Perinatal Audit (MPA) is an activity for tracing back the causes of maternal and perinatal morbidity and mortality to prevent future cases. This activity helps health personnel to determine the conditions that resulted in the mortality/ morbidity. The MPA can also function as a tool for monitoring and evaluation of the referral system. It is national policy in Indonesia to do a verbal autopsy of every maternal and perinatal death. HSP supported the district governments of Malang and Pasuruan to facilitate this process, including by supporting the establishment of MPA team at district and sub-district levels. For deaths that occur in the community, verbal autopsies are done at the health center or *puskesmas* by sub-district and district levels health officials. For deaths that occur at the hospital, district level health officials complete the verbal autopsy using hospital records. The district then does a periodic review (approximately twice a year) of a selection of cases. The MPA data should be analyzed by district and sub-district MNCH teams, to identify causes of and corrective actions for avoidable factors, within the scope of authority of each administrative level. With HSP assistance, the DHO has developed an adaptation of the national guidelines for implementing verbal autopsies and for conducting the reviews. HSP helped the DHO orient *puskesmas* and district level staff on these guidelines and has assisted with cost-sharing in the implementation of verbal autopsies and reviews.

During the implementation period in FY 2010 there were 32 maternal deaths and 193 neonatal deaths in the districts of Malang and Pasuruan. Verbal autopsies were completed for all of these deaths and reviews were conducted for 14 maternal and 18 neonatal cases.

Of the 32 maternal deaths that occurred between January and May 2010 in Malang and Pasuruan, around 60% were in women under 30 years of age, with around half having an education level of primary school or lower. Almost all of the deaths occurred at the hospital or in transit (71% hospital, 23% in transit) and the top two killers of women in Indonesia, post-partum hemorrhage and eclampsia, accounted for 67%. Twenty-eight patients sought a referral and of those, 56% went to two or more locations with 41% seeking care at three locations. The average time between seeking care at the first location and receiving care at the final location was 8.9 hours.

Regarding 193 neonatal deaths in Malang and Pasuruan between January and May 2010, around 95% of the mothers were below 30 years and 89% were below 25. Around half of the mothers had primary school or lower and only 18% had completed high school or a higher level of education. 57% of the infants who died were male and most of these died within the first seven days (49%) or were stillborn (37%). The most common places of death were the hospital (58%) and at home (28%) and low-birth weight and asphyxia, the top two killers, accounted for around half of the deaths. There were 147 infants with a referral and of these 57% sought care at two or more locations. The average time between seeking care at the first location and receiving care at the final location was 6.8 hours.

Presentation of maternal and perinatal deaths audit results

Table 11. Overview of Achievements in MPA

Indicator	2010
# of MPA teams established in district and subdistrict level	62
# of people trained on MPA in hospital and district	255
% of reported deaths reviewed by MPA team (verbal autopsy)	100%

Supportive Supervision

HSP support for *puskesmas* service strengthening was provided not only through training for the clinical skills of APN and PONED, but also through technical assistance for improving the supervisory function of midwife coordinators and staff at *puskesmas* and *polindes*. Prior to HSP assistance in tools development and implementation, 'supervision' although technically already a part of the district system, was poorly implemented, with few supervisors appropriately trained.

Training on Supportive Supervision

Supportive supervision has built on the existing approach and is one of the most important activities for improving health service quality, through on-the-job training with respect to specific clinical and non-clinical procedures as well as general management and supply issues. In this way, supportive supervision can ensure that birth attendants are skilled and actually perform to standards. Supportive supervision has also provided the necessary on-the-job follow up to ensure sound implementation of new interventions, including APN, IMCI, nutrition/breastfeeding and LAMAT. This is an example of the systems approach supported by HSP.

Supportive supervision by midwife coordinators and health center doctors focuses on supervision of lower-level health workers and activities, particularly the village midwife, and has now been expanded to cover supervision of the data collection system. Regular meetings held at the *puskesmas* discuss the performance of health care providers. In particular, supportive supervision checklists are used to identify gaps in performance at the *puskesmas* and *pustu* and to determine corrective actions for improving the quality of services. HSP supported the development of a self-assessment checklist that midwives use to assess their own clinical skills and management capacity, as well as the readiness of their facilities to deliver quality care. The checklist covers such areas as documenting patient history, examining the placenta for completeness during the third stage of labor and ensuring the availability of oral rehydration therapy and baby thermometers. The results of self-assessments are reviewed and verified by midwife coordinators, and a performance improvement plan is agreed upon to structure the course of improvements. Progress is assessed through monthly meetings and quarterly review of data, with supervisors ensuring each midwife gets the support she needs to improve.

HSP assisted the MOH to develop a supportive supervision package consisting of eight books: the Coordinator Midwife Guidelines; the Supportive Supervision Training packages (including Reference book, Trainer's book and Trainee's book); Checklists for MNCH and Basic Obstetric Services; and the Guidelines for the Management Information System of MNCH Services (including checklist software). Two CDs are also available as part of the packages: the first includes all relevant materials while the second contains a Microsoft Access-based interactive checklist program. 2,000 packages were distributed to all provinces, selected districts, clinical training center networks, and NGOs. From January 2006 to September 2008, HSP helped train 730 health staff from 165 *puskesmas* across 26 districts to use the new tools. Among the trainees were 150 facilitators from six HSP project areas, with an additional 29 trainers funded by UNICEF. Trainings were conducted using illustrated lectures, role-playing, group discussions and competency-based and adult learning methods. In preparation for these trainings, trainers were taught to use the Management Information System for MNCH Services, which produces verification checklists and compliance rates.

A National Workshop on Supportive Supervision in Jakarta was held on December 18, 2008 and attended by MOH, professional organization and NGOs to share best practices and lessons learned on the implementation of supportive supervision for program sustainability. The meeting made recommendations for program replication and scale-up.

Implementation of supportive supervision resulted in improvements in basic obstetric and neonatal services and in maternal and child health services both in *polindes* and *puskesmas*. Two cycles of the supportive supervision system were implemented in 31 districts in total 18 HSP project districts and 11 additional replication districts across six provinces including at 92 *puskesmas* and 276 *polindes*, some of which comprised private midwife practices. The compliance rate for basic obstetric and neonatal services in *polindes* in East Java increased from 70.96% (in the first cycle) to 77.82% (in the second), while in North Sumatra it rose from 63.61% to 72.60%. The approach also saw measurable improvement when used as part of LAMAT implementation: in Malang, data compliance at puskesmas increased from 82.37% to 93.65% between January and May, 2010. These and other supportive supervision results have been used to inform the sub-district *Musrenbang* and SKPD Forum, as input for district health plans.

Bidan Delima

While the presence of skilled birth attendants at home deliveries has expanded greatly among Indonesia's middle-class, only a third of home births in poor households were attended by a health provider. By contrast, institutional deliveries have become increasingly common, across all income groups, the majority of them relying on the services of private midwives. As the role of private midwives expands, greater engagement with and oversight of private midwifery services will be essential to address Indonesia's maternal health needs. Like its work in public-private partnerships, and to complement its work with midwives in public *polindes* and *puskesmas*, HSP also sought to harness the resources and energy of the private midwifery sector.

To that end, a quality recognition program was created to help identify, validate, and promote the use of private-sector midwives who operate at national technical standards. Known as Bidan Delima, the certification program is managed through a network of offices at the central, provincial and district levels by the long-

established Indonesia Midwives Association (IBI), to which most Indonesian midwives belong. Since its inception in 2003, Bidan Delima has expanded from 50 districts in six provinces to 204 districts in 15 provinces. Membership has increased from 4,645 to 8,443 members, with as many as 1,700 midwives working as Bidan Delima facilitators authorized to validate new members. In districts where the program is available, about one-third of private sector midwives are already validated as Bidan Delima.

HSP also assisted IBI with updating quality assurance instruments to meet national standards for Basic Delivery Care (APN), and ensuring their consistency with the APN and supportive supervision quality checklists. Developed with technical assistance from JNPK, the instruments cover newborn care, early initiation of breastfeeding, active management of the third stage of labor, and manual removal of the placenta. With these updates, membership in Bidan Delima means that enrolled private midwives received the latest training on preventing maternal and newborn deaths.

USAID has long supported Bidan Delima and investments in the IBI as part of its support to MNCH as well as family planning programs. Despite its impressive history and achievements and this long support, the organization was founded on voluntary inputs from retired and semi-retired midwives; HSP assisted IBI with institutional capacity building. To ensure the stability of the Bidan Delima program, HSP assisted IBI with developing management guidelines consisting of four books that cover the concept of Bidan Delima, the structure and organization of IBI, management of logistics and financing, management information system, monitoring system, and advocating for and marketing the program. HSP supported the Bidan Delima program through subgrants for program management and information systems improvements as well as technical assistance on quality assurance aspects. During the extension phase, HSP supported management consultant services to work with IBI and assist them to undertake a review of the Bidan Delima program and to chart a course for the future of the program. This resulted in the Bidan Delima program being restructured and separated from the overall IBI Board Structure, as an independent management unit. Since then, HSP supported the operation of Bidan Delima in *Kabupaten* Malang and Pasuruan to demonstrate a system for quality assurance at the local level.

Becoming a Bidan Delima

- Midwives are recruited through outreach activities and promotional materials. Individuals register to become a Bidan Delima at their local IBI chapter, paying a registration fee of Rp. 50,000 (US$ 6).
- A Bidan Delima facilitator helps each candidate conduct a self-assessment of her readiness for accreditation, providing support in specific areas so that she can meet facility standards and required skills competencies.
- The facilitator makes an on-site visit to validate the candidate's qualifications for Bidan Delima membership. The midwife pays a Rp. 350,000 (US$ 39) membership fee, and receives a Bidan Delima kit that includes clinic signage and other materials that help establish market recognition.
- Bidan Delima members also receive reference materials on clinical service delivery standards and are routinely supervised by a facilitator. Membership in the program requires an annual fee of Rp. 250,000 (US$ 28).

Profile of a Bidan Delima

Tuti Kumara has been a midwife for so many years, she can hardly remember how long. Delivering around 20 babies a month, she tirelessly serves the 5,000 residents of Cikalongkulon village in West Java. "My siblings and I were delivered by traditional birth attendants. I wanted to become a midwife so mothers can deliver with trained professionals," she says.

Visit to Bidan Delima's clinic

Stepping into Bidan Tuti's clinic, one immediately takes notice of the colorful posters that adorn the walls and alert the viewer to the importance of handwashing with soap, breastfeeding, family planning, diarrhea and avian flu. All in all, clients have a lot to learn as they wait to see the busy midwife in her bright and clean waiting room. When asked whether clients need an appointment, Bidan Tuti laughed and said, "No, definitely not. Anyone is welcome to come by at any time. The community feels comfortable with me."

Recalling the days when she first enrolled in the program, Tuti says the greatest challenge was explaining to the community just what her new title meant. "I wanted the community to know that I am a midwife with skills!" she says. The most common complication she sees is a retained placenta, which she learned how to stabilize through her training in Basic Delivery Care, she explained. If Tuti cannot handle a complication, she refers patients to a hospital in nearby Cianjur city, about a half hour away. For families with no available transportation, she'll call upon local transportation volunteers arranged by the HSP-supported P4K program or the local *puskesmas* vehicle. Tuti has even used her own car to get pregnant women to the emergency services they need. "I never ask them for money," she explains, "because oftentimes these women are poor."

Bidan Tuti is just one of more than 8,400 Bidan Delima in Indonesia working every day to make a difference in the lives of mothers and babies.

Community involvement in improving MNCH

HSP supported communities to ensure their ownership of and involvement in the protection of mothers and children. Through the creation of neighborhood-managed, self-sustainable programs, including routine registration of pregnant women, emergency birth plans, and data collection for local heath needs assessment, HSP supported programs and partners that had the aim of helping communities to empower themselves to become part of the solution to reducing maternal and child mortality. HSP work in behavior change had as its aim to build the capacity of district partners to promote MNCH through an effective behavior change communications strategy and community mobilization efforts.

In order to improve sustainability of community based activities, during the extension phase HSP shifted focus from working with local NGOs to work in close partnership with the *Pemberdayaan Kesejahteraan Keluarga* (PKK or Family Welfare Movement). This was seen as more consistent with the overall systems approach and was also a means to expand coverage. The PKK is a long-established institution with presence throughout the nation, and a mandate to work in family health and wellbeing.

Women provided inputs for the drafting of the village regulation on MNCH

Mobilizing communities

At the community level, HSP has supported the establishment or strengthening of Community Health Committees (CHCs) to perform key health activities. These groups comprise volunteers who have long been responsible for managing many of the child health services offered by *posyandu* and more recently for implementing the Ministry of Health's *Desa Siaga* (Alert Village) program with its Birth Preparedness and Complication Readiness (P4K) initiative. A key counterpart in the village remains the village midwife or bidan, who is generally the most accessible health provider for pregnant women and children.

The *Desa Siaga* name was originally used for the P4K program, but later taken as the name of the broader village-based health promotion campaign; the change to P4K took place in 2007. As HSP had been so involved in national capacity-building programs for birth preparedness, the Ministry requested HSP support to launch the P4K program for national roll-out. The inauguration took place in a "model village" where the Community Health Committee received support from HSP. Around 50 pregnant couples from Bunar village, in the Tangerang district of Banten, turned out to tell the Minister of Health about their birthing plan, and district officials were on hand to showcase progress the district is making on maternal and child health.

This event introduced the first use of stickers on the home of pregnant women to facilitate them when any emergency or complications developed. The sticker contains details including the name of the woman, her due date, the name of midwife who will attend the delivery, transportation and support person.

In 2007, HSP supported the inauguration of *Desa Siaga* in Sukapura, Bandung District, in West Java. The community was enthusiastic about the *Desa Siaga* activities from the beginning. On the first day, 160 people came to get their blood tested. On day two, 200 *kader* took a 5 KM healthy walk – which participants said was tiring but fun, with kader singing along the road. Commented one participant, "We are happy with this healthy walk. It was not only for our own health, but also a chance for us to get to know each other." After finishing the healthy walk, around 100 pregnant women and their husbands joined in on exercises for pregnant women and received maternal and neonatal health counseling. Says 31-year old Ibu Sumiyem, 3-months pregnant with her third child, "Before I didn't have enough knowledge about maternal and neonatal health, so I'm grateful for these events. I hope all pregnant women in my village can gain this knowledge, so if they face difficulties during their pregnancy they will know what to do."

To support effective community mobilization, HSP worked primarily within the health system, building the capacity of district- and *puskesmas*-level partners to facilitate community-based responses to key health concerns, including revitalization of the *posyandu*. In the final year of the program, this systems approach was also extended to the PKK, with support for facilitator training of sub-district level *kader*. As part of this approach, HSP district-level staff worked with village counterparts to identify key community leaders for training and support. The key tasks and skills addressed with HSP assistance included community involvement, participatory community health assessments and planning. Across HSP program areas, 651 CHCs were established, with providers, midwives, and community members trained on interventions designed to reduce maternal and child mortality. By the close of the program, 2,354 CHCs were operational through program support or by replication using HSP's tools.

HSP has also worked with district counterparts to strengthen the implementation of P4K, including aspects such as linking the pregnant women to service delivery through LAMAT and providing *kader* with basic understanding of evidence-based interventions, recognition of danger signs and other key information. CHC regularly collect important community data, including registering the number of pregnant women in the area through health posts and recording the due dates, blood type,

and provider names of pregnant women both in community logs and on stickers placed on the homes of pregnant women. This information is then used to draw up emergency birth plans, including a roster of emergency transportation volunteers who are on call in case of a problem. Family members sign off on their commitment to this plan. Equipped with a picture of how many pregnant women there are in the community at any one time, CHC volunteers also routinely collect donations used to start delivery funds for mothers-to-be, logging the amounts collected and disbursed.

To facilitate understanding of and support for community mobilization activities, HSP developed a series of tools used to train over 950 partners and community members. In its first year, HSP worked with the MOH Directorate of Maternal Health to package its P4K birth preparedness and complication readiness approaches, producing 1,300 village kits, which were distributed nation-wide. That same year, 92 government trainers from 33 provinces were trained to utilize these materials, as a result of which birth preparedness and complication readiness programs were implemented in the 363 villages at that time supported by HSP interventions. Hand washing with soap modules were based on materials designed by Studio Driya Media for Save the Children's food security and nutrition program, also funded by USAID. For its immediate breastfeeding module, HSP supported the MOH Directorate of Nutrition. By the end of 2008, 156 villages had implemented hand washing activities and 182 villages had promoted early and exclusive breastfeeding using HSP modules and tools.

At the national and provincial levels, 246 trainers were trained in the P4K approach, 69 in handwashing with soap and 31 in early and exclusive breastfeeding. At the district level, 2,328 trainers were trained in P4K, 354 in handwashing, and 396 in community approaches to promoting early and exclusive breastfeeding. This network of trainers was the backbone of efforts to expand effective community approaches to improve maternal and child health.

HSP supported the passage of village level regulations, *Peraturan Desa* (or *perdes*). The ultimate aim of *perdes* is to institutionalize MNCH at the local level and ensure higher likelihood of sustainability. This was done in several ways; by institutionalizing the role and function of the CHC in village decision making (see section on the *musrenbang* process), by committing the village to ensuring eligible villagers have the necessary documents for social health insurance (*JamKesMas*) and by obtaining a commitment for local funds for practical MNCH needs (e.g. transportation in emergencies and active surveillance). HSP supported guidelines, a template and presentation materials for use in district *perdes* development workshops. This was achieved in cooperation with *Bagian Hukum Pemda* or district legal bureau, which proved essential to ensure that the *perdes* were in line with local regulations, while participation of DHO and *puskesmas* has ensured technical input on MNCH. Orientation and preparation workshops were completed at district and sub-district levels. *Perdes* development has been well received at village level and the template has proved a useful tool.

US Secretary of State, Hillary Clinton's visit to village-level community mobilization activity

Table 12.
Community Mobilization Activities, 2006-2010

Indicator	2006 - 2010
Number of villages with community health committees	2,354
Number of *Perdes* passed	571
Number of NATIONAL TRAINERS trained in *Desa Siaga* (P4K)	92
Number of REGIONAL TRAINERS trained in P4K	354
Number of people trained in community moblilization (includes P4K)	2,328
Number of villages replicating *Desa Siaga* (P4K)	911

Institutionalizing MNCH at the Village Level through *Peraturan Desa* (*Perdes*)

In Malang and Pasuruan, East Java, the passage of village-level *perdes* played an important role in the integrated MNCH program supported by HSP. The perdes not only supported implementation of the district MNCH *perda* and but also helped to institutionalize community-based MNCH promotion. A 2010 HSP case study, which reviewed the *perdes* development process in eight villages, found that the perdes aimed to to clarify roles and responsibilties at the village level regarding village-led MNCH activities, as well as the role of *kader* and midwives in village planning. *Perdes* connected village efforts to larger district initiatives by explicitly referring to the MNCH *perda,* clarified that village and other local fund sources should be made available to support MNCH programs, and affirmed the commitment of the village government to support activities such as *posyandu* revitalization. The *perdes* model was also proved to be adaptable to local preferences - a majority (69%) of village respondents (n=48) reported making changes to the sample *perdes* provided during training in line with village needs, such as by adding content related to community contributions or the use of village budget funds.

The *perdes* development process involved more active roles for village government officials in MNCH promotion activities normally left more to health personal – overall, most village respondents reported that the village parliament (88%) or village head (85%) had been involved in preparing the *perdes*, In Pasuruan, 42% of respondents reported that the TBA was actively involved, indicating the *perdes* development process can also provide an opportunity for improved coordination and cooperation among stakeholders in the village.

While future implementation will undoubtedly depend on the level of continuing stakeholder commitment within each village, respondents were already optimistic about the impact of *perdes*. When villages were asked open-ended questions about the benefits of *perdes*, 12 cited improved attention to health, 10 cited improved access to services, another 10 cited improvements in community MNCH activities, five cited improved community MNCH activities, and four noted that *perdes* provided a legal basis for health activities. The majority of respondents also felt that *perdes* would require both the CHC and village government to undertake activities not previously undertaken.

Promoting healthy behaviors

Since promoting healthy behaviors begins and ends with the community, the HSP behavior change communication (BCC) strategy was solidly based on an understanding of its target audience. HSP supported development of messages for BCC at the local level in each of its focus areas, based on an understanding of the cultural norms, beliefs, and peer and family influences that shape healthy behaviors. Community representatives in each province used situational analysis to identify particular maternal and child health problems and the behaviors associated with those problems. HSP assistance focused on (but was not restricted to) three key behaviors: skilled birth attendance, early initiation of breastfeeding, and hand washing with soap. Messages were targeted to the local context, with each area producing its own messages, posters and printed materials to support BCC. In the campaign to promote breastfeeding alone, in several districts separate messages were designed for pregnant women, husbands, midwives, and clinic managers.

During the first four years of the program, 247 people were trained in BCC techniques, including 10 at the national level, 34 at the provincial level and 203 at the district level. Operational BCC campaigns were launched in across 15 districts and included radio spots, interpersonal messages delivered by service providers, community-level activities, and printed materials such as posters and fliers. Community leaders and advocates also reached mothers, husbands and families through large-scale events that were as fun as they were informative.

Creating Messages That Work: Just Do It!

When the West Jakarta BCC Team started designing messages to promote breastfeeding, they first came up with slogans using proper Indonesian, such as "Inisiasi Menyusu Dini" ("Early initiation of breastfeeding"). But as this group of energetic women worked with HSP-supported facilitators, they started to get creative using Indonesian slang. While slang is not often used in government health promotion, it predominates in everyday conversation and, in a city like Jakarta, is ever-changing.

When the facilitators sat down with mothers to discuss breastfeeding, they jumped right into a discussion of what words most clearly communicated the concept of "breastfeeding within one hour after delivery." The mothers present said they felt most comfortable with less formal terms. And so, by the end of the session they were laughing and agreeing that the slogan, "ASI Langsung, Langsung Aja…Gitu Lho!" (Breastfeed immediately, Just Do It…That's The Way!) was the most clear and attention-grabbing. The focus group also helped the BCC team identify the barriers they must address in order for mothers to change their breastfeeding behaviors. Most women had not heard of immediate breastfeeding from the sources they considered credible: their mothers, midwives and friends. The majority also believed that the difficulties of recovering from the delivery wouldn't allow them to breastfeed their newborn within an hour. Most simply thought they wouldn't have breastmilk in such a short amount of time. "How can we breastfeed," asked one mother, "when there's no breastmilk?" "When your baby is hungry in the first few days, it needs formula milk because the mother's breastmilk hasn't come in yet," said another. After completing the formative research, the BCC team concluded that they needed a "big moment" to kick-start the practice of immediate breastfeeding in West Jakarta. In addition to billboards, radio spots and training midwives to promote immediate breastfeeding, the team also got involved in registering the 1,001 pregnant women who pledged their commitment to breastfeed.

Behavior change messages on HSP-supported posters

Commitment to breastfeeding

During a ceremony held on January 23, 2008 in Jakarta, 1,001 pregnant women and 200 midwives gathered to publicly declare their commitment to immediate and exclusive breastfeeding. Presided over by Jakarta Governor and his wife, the pledge ceremony included a noted breastfeeding advocate, and the USAID Indonesia Deputy Mission Director. Prior to the event, the "Declaration of 1,001 Pregnant Women on the Early Initiation of Breastfeeding", HSP laid the groundwork for media exposure by hosting a one-day workshop for journalists. The event itself, held at the Jakarta Convention Center, was attended by journalists from media outlets from a variety of print, television and online sources, resulting in wide coverage of the event and information on early initiation of breastfeeding. During the ceremony, informed consent forms from 10,000 pregnant women who pledged their commitment to immediate breastfeeding were submitted to the Governor and recorded in the *Museum Rekor Indonesia*, the Indonesian equivalent of the Guinness Book of World Records. The Governor's wife was inspired by the event and asked the Provincial Health Office to work with her to launch immediate breastfeeding campaigns through the women's group PKK, Indonesia's largest mass-based women's movement. HSP supported the planning of follow-on events, providing support for speakers, communications materials and corporate sponsors.

The first of the follow-on events took place on March 31, 2008, with over 600 PKK members from South Jakarta attending and declaring their support to promote breastfeeding in their respective neighborhoods. The second was in Aceh on April 20, 2008, with an additional 1,001 pregnant women. This was followed by an event in Deli Serdang (North Sumatra) on May 28, with 2,010 pregnant women from 22 districts. Tangerang district of Banten province also got in on the act with 2,000 pregnant women committing to early initiation of breastfeeding in April 2008. Finally, the *Suami Sigap* event in August 24, 2008 received enormous public support from the Surabaya community, as evidenced by 1,128 couples or more than 2,010 people who participated, and during which the Mayor of Surabaya spoke of the need for husbands to take an active role in supporting their wives' pregnancy, part of which is ensuring immediate breastfeeding. Each event was supported by the presence of midwives and health care providers, government and health officials, and was funded by a variety of local private sector sponsors. In addition, a variety of NGOs were involved in mobilizing community support for the events, including IBI, PKK, Aisiyah and Fatayat NU.

Breastfeeding continues until baby is six months of age

Hand washing with soap

Hand washing is perhaps the single most important means of preventing the spread of childhood disease, and hand washing habits are established early in life. Hand washing with soap has the potential to save the lives of 40,000 children a year who would otherwise die of diarrhea-related causes. HSP supported several large hand washing campaigns, including one in Aceh that targeted 65 schools and more than 6,000 children and one in Turen sub-district, Malang that involved 70 schools, over 1,000 students and some 500 teachers. In addition, over 350 CHC members from 156 villages were trained on promotion of hand washing. HSP-supported CHCs designed creative and interactive projects to get the hand washing message across. In East Java, one CHC used traditional *wayang* shadow puppets to promote hand washing, while in North Sumatra communities organized quiz nights to encourage good health and hygiene.

This work involved an array of partners, the Ministry of Health, district governments, NGOs, professional associations, health providers, the private commercial sector and community members. At each level, HSP provided technical assistance that strengthened the ability of the health system and providers to promote hand washing and prevent and treat childhood diarrhea. Starting at the community level, HSP supported the CHCs, which provided a platform for the Ministry of Health's *Desa Siaga* initiative that emphasizes sanitation, safe water and hand washing. HSP also had a key counterpart in the village midwife. In addition to training, HSP also supported infection prevention initiatives in midwifery clinics, with a focus on clean water and hand washing.

At the sub-district level HSP worked to strengthen puskesmas service provision through clinical training in breastfeeding, infection prevention, and case management of diarrheal disease. The program also provided support in the area of planning and support to *posyandu*, and accreditation of lower-level health facilities. The program offered support in overall health promotion, including providing hand washing with soap trainings for DHO staff and supporting district-wide hand washing activities.

A consortium of USAID partners – including HSP, the Environmental Services Program (ESP) and the Safe Water Systems (SWS) program – launched a province-wide hand washing with soap campaign in partnership with the Aceh Provincial Health Office in May 2006. Other organizations – CARE, UNFPA, People's Hope Japan Foundation, WSLIC-2 (a World Bank-funded water and sanitation project) and CWHSP (an Asian Development Bank water services project) – were also partners in this work.

In May 2007, a national hand-washing campaign launched at the National Monument in Jakarta, encouraged people to regularly wash their hands with soap. The Coordinating Minister for

People's Welfare welcomed the crowds by demonstrating how to hand wash with soap and releasing balloons. 2,700 mothers and children from 25 elementary schools in Jakarta and Bekasi participated in the campaign.

HSP support for these activities was in line with the national Healthy and Clean Life Behaviors Program (*Perilaku Hidup Bersih dan Sehat* or PHBS) which targets behaviors around hand washing, clean water and sanitation at the community and household levels. In 2009, HSP assisted the Center for Health Promotion with scaling up PHBS in HSP areas. As a result of these efforts, more than 26,000 people were trained on the importance of hand washing with soap, ranging from national facilitators, to local advocates and village leaders to school children. The MOH went on to replicate these activities in over 12,000 villages nationally.

Table 13. Breastfeeding and Hand Washing Activities, 2006-2008

Indicator	2006 - 2008
Number of REGIONAL TRAINERS trained in immediate breastfeeding	31
Number of REGIONAL TRAINERS trained in hand washing with soap	134
Number of CHC members in HSP villages trained in immediate breastfeeding	388
Number of CHC members in HSP villages trained in hand washing with soap	354

Prioritizing MNCH from the Bottom-Up

The approach of helping districts to better utilize the *musrenbang* process to leverage resources for MNCH evolved to become a key component of HSP support to integrated MNCH programming in Malang and Pasuruan, East Java, in 2009-2010. In addition to village-level planning using LAMAT data to prepare proposals for *musrenbang*, *puskesmas* were encouraged to take village planning into consideration during *puskesmas* planning as well as provide input to sub-district *musrenbang* to further reinforce MNCH as a priority.

The result, according to a 2010 HSP case study of the district planning process – which included observations of actual *musrenbang* as well as interviews with village, sub-district, and district officials – was broad participation of the health sector in *musrenbang* at the community level, and signs of better integration of *musrenbang* and health sector planning processes. Whereas in previous years MNCH-related proposals reportedly were not broadly discussed, in 2010 they were discussed in the vast majority of *musrenbang* meetings observed. At the village level, most villages observed accepted at least one MNCH proposal for inclusion in *musrenbang* requests to the next level (83%) or for funding from local sources (47%). As shown in Table 14, many of the activities proposed were in line with MOH priorities for community-based MNCH programming, such as operation of the *posyandu*, community training or education, and birth preparedness activities. In Pasuruan, where *musrenbang* was observed up to the district level, MNCH was also broadly discussed as a district priority, which one DHO official said would likely lead to stronger political support for increased funding in 2011.

Handwashing habit starts early

The *Musrenbang* Process

Musrenbang is the central component of the national 'bottom-up' planning system, consisting of consultative forums held at the village, sub-district, and district level for the purposes of soliciting public input for annual district planning. HSP activities support the prioritization of MNCH within the *musrenbang* process, complementing other activities (such as PTP, DTPS and advocacy) that target the district government planning process directly. While *musrenbang* is intended to provide input for district planning, the process engages decision-makers at the village and sub-district levels, creating the possibility of influencing the allocation of other fund sources outside of DHO control (e.g. village funds, whether from the regular Village Allocation Fund or from sources such as the National Community Empowerment Program – PNPM – which can allocate funding at the village level for health-related activities). In addition, *musrenbang* meetings at each level provide opportunities for communication and cooperation between civil society, health providers, and the DHO, which can increase public accountability for providing MNCH services.

The first bottom-up planning activity in the process is the village *musrenbang*, in which villages determine their priorities and budget plan, including priorities to be passed up to the sub-district level. At the village level, HSP provided technical assistance by training CHCs and village midwives to develop and advocate MNCH priorities during the *musrenbang*. Priorities and requests for MNCH activities that cannot be accommodated in the village budget are brought to the sub-district *musrenbang,* where villages can come together and agree on priorities to be passed up to the district level. LAMAT data is a key element of this planning.

Table 14. Percent villages/sub-districts that discussed specific MNCH Proposals in *musrenbang* (2010), by type of activity

Activity Type	Malang		Pasuruan		Overall	
	Villages (n= 33)	Sub-districts (n=19)	Villages (n= 38)	Sub-districts (n=7)	Villages (n= 71)	Sub-districts (n=26)
Supplemental feeding	64%	68%	63%	71%	63%	69%
Community training / education	67%	79%	47%	43%	56%	69%
Other health activities (non-MNCH)	21%	53%	42%	43%	32%	50%
Operational funds for *posyandu* (i.e. stipends or transport funds for *kaders*)	36%	32%	26%	43%	31%	35%
Infrastructure, drugs, or equipment (including maintenance)	39%	74%	21%	86%	30%	77%
Other birth planning / preparedness activities (including village ambulance system, identification of blood donors)	21%	37%	24%	0%	23%	27%
Establish a community birth fund	6%	11%	32%	14%	20%	12%
Other MNCH-related activities	18%	21%	16%	43%	17%	27%
Monitoring and/or tracking of pregnant women & newborns	15%	26%	13%	14%	14%	23%
Health worker training	3%	37%	3%	14%	3%	31%

listed above excludes villages and sub-districts where specific proposals were not recorded by the observer.

Emergency response (flooding in Jakarta, earthquake in Yogyakarta)

In February 2007, three days of torrential rain caused massive flooding throughout Jakarta and over 350,000 people were left homeless. As the city went on high alert, USAID and HSP determined that some 75,000 residents West Jakarta (an HSP target area) had been displaced or were living in flooded houses. HSP immediately allocated US$ 5,000 to flood relief efforts and assisted the local Health Office with mobilizing 200 person-days of maternal and child health services that reached over 19,000 people. The program also channeled a US$ 5,000 contribution from the US Embassy Office of Defense Cooperation (ODC) to distribute cleaning supplies and mosquito-control products in an effort to curb the spread of dengue and malaria.

HSP also supported the District Health Office to secure over US$ 320,000 in corporate donations that helped the city meet its emergency health service needs. In a showcase effort, HSP and HSBC assisted the reconstruction and re-equipping of the Rawa Buaya *Puskesmas* clinic. "HSBC's assistance allowed the badly damaged clinic to resume services to approximately 70 patients per day who receive antenatal, family planning, child health, nutrition and dental services," explained the Director of the West Jakarta Health Office.

In the aftermath of the May 27th earthquake in Yogyakarta and Central Java, USAID asked HSP to support a 45-member medical team to provide mobile health services to one of the most stricken areas of Klaten, Central Java.

Medical volunteers from the Associations of Pediatricians (IDAI), Midwives (IBI), and Nurses (PPNI), and the Public Health Association (IAKMI) worked alongside *Puskesmas* Jogonalan staff to provide services to 14 villages. The focus was on immunizing against measles and tetanus, and providing care for common illnesses in the post-emergency environment such as respiratory infections, diarrhea, and skin ailments. The HSP-supported team provided services to 13,000 people, including 10,335 tetanus toxoid immunizations, 1,635 measles immunizations with Vitamin A, and 1,050 medical consultations.

Relief effort in Yogyakarta (above) and Jakarta (below)

Support to Nanggroe Aceh Darussalam, 2005-2008

HSP was allocated an additional US$ 5.65 million on top of its original funding from USAID/Indonesia subsequent to the Indian Ocean tsunami of December 26, 2004, in order to strengthen the health system's response to maternal and child health issues, and for the psychosocial protection of women and children in Aceh.

HSP worked closely with the Ministry of Health to provide technical assistance for district planning and budgeting, advocacy, community mobilization, behavior change communication, supportive supervision and improving quality of and access to midwife services. In addition:

- HSP supported the renovation of 11 community midwife clinics (*polindes*), including improvements to water and sanitation facilities. Renovations either brought the centers to national standards, or provided replacement equipment of a higher quality.
- In collaboration with AmeriCares, 22 health facilities were provided with new clinical equipment and furniture.
- A Children's Parliament was held on June 2008 and organized by the Aceh Cultural Institute (ACI), with the support of HSP. The Parliament was designed to provide a democratic forum for children to participate in civil society, to facilitate children's views being delivered to government, and to introduce children to notions of democratic decision-making.
- A workshop to "Save Pregnant Women", held in June, 2008, was supported by HSP and attended by the Governor of Nanggroe Aceh Darussalam.
- HSP supported the establishment of a clinical training center (P2KP) in Meulaboh district hospital, West Aceh, with 10 midwife clinical trainers.
- Six private midwife clinics were upgraded and accredited as clinical training sites for the Aceh Besar clinical training center (P2KP), which enables midwives from the west coast of Aceh to access training locally.
- The Bidan Delima program was launched with HSP support in Aceh in the presence of the Governor. At least 88 Bidan Delima midwives had been accredited by the end of the program.
- Midwives assisted in the promotion of Early Initiation of Breastfeeding event called "1,001 pregnant women". 1,250 pregnant women gathered to affirm their commitment to immediate breastfeeding. The number of attendees topped the event in Jakarta. The Banda Aceh mayor and his wife, midwives, health care providers and officials from USAID provided their support to this awareness-raising and advocacy event.
- Aceh communities were mobilized in support of the *Gampong* (or *Desa*) *Siaga* initiative to promote community birth preparedness. This entailed formation of Community Health Committees (CHC) in each village.
- Promotion of immediate and exclusive breastfeeding, including through midwives and behavior change communication campaign.
- A handwashing promotion program in Aceh's schools reached more than 6,000 children.

The women and children of Aceh suffered the dual tragedies of the Indian Ocean tsunami disaster of December 2004 and the long-standing (around 20 years) conflict between separatists and government forces, with the associated human rights abuses. Psychosocial and mental health promotion activities supported by HSP included:

- Training for two mental health nurses per 30,000 population, in 12 *puskesmas*.
- Training for village level psychosocial volunteers in 49 villages.
- Renovation and equipment of a 10-bed acute-care psychiatric unit to high standards within the Jantho district hospital.
- Integration of the psychosocial and mental health approach into the mainstream of the Aceh public health system.
- Partnership with PULIH to provide psychosocial support systems for women and children in communities affected by disaster and conflict. This included support for parents through caregivers groups.
- In-service training of 21 PULIH staff (over a six-month period) and volunteers on protection and psychosocial support for affected and vulnerable children. Materials were used to replicate the training to Muhammadiyah-organization supported child centers in Aceh, with HSP funds.

The Nanggroe Aceh Darussalam Provincial Health Office hosted a conference for all 23 of its districts to learn about best practices in maternal and child health programming. Sponsored by the USAID Health Services Program (HSP) as part of Aceh program phase out, over 300 stakeholders attended the conference including DHO staff, parliamentarians, NGO activists, professional associations and health providers. Participants joined skills-building sessions on a range of issues: planning and budgeting for health, advocacy, quality assurance, service provision, community mobilization, behavior change communications, and partnerships with the private sector. The conference was designed to allow participants to "track" courses in their specialty areas, with nationally-known resource people.

Children parliament: voice for the future


Launching of Bidan Delima Program in Nanggroe Aceh Darussalam

Millennium Development Goals (MDGs) Activities

Indonesia has an ongoing commitment to achieving the Millennium Development Goals, with national development plans, policies and programs consistent with these targets. Similarly, HSP had always been framed in terms of a commitment towards the MDGs, in particular Goals 4 and 5 for child and maternal health, and – with the HSP mandate to focus on health for the poor – Goal 1 for reducing poverty. HSP was therefore well-placed to provide technical assistance to key Indonesian partners in determining how they could mobilize existing resources; programmatic, human and financial, towards achieving the MDGs.

With 2015 as the final MDG target date, 2010 is an important milestone along that road. As this was also the final year for the program, HSP used the opportunity to assist GOI and other Indonesian partners to develop plans for reaching 2015. At a series of events, partners drew up detailed implementation plans, drawing on Indonesian resources and on the tools and approaches that HSP and partners had worked together to develop over the life of the program.

In February 2010, the MOH and HSP sought to utilize the strengths of professional organizations, such as IBI, IDI, POGI, IAKMI, IDAI, PPNI, and Perinasia in reaching the MDGs. At a series of HSP sponsored events, 138 members of these organizations reviewed their existing goals and mandates and considered how the MDGs could fit into their programs and activities. As well as examining the role of individual organizations, they reflected on what could be achieved collectively.

The *Kemenko Kesra* National Coordination Meeting on the Strengthening of Health, Population and Family Planning Systems to Achieve the MDGs in March 2010 was sponsored by HSP and attended by 185 people, including officials from all relevant ministries and agencies and selected Governors and Bupatis. Recommendations from the event were handed to *Kemenko Kesra* and were later taken into consideration in the April Cabinet meeting, which culminated in the Presidential Instruction 3, 2010 on Accelerating Implementation of National Development Priorities, including improving performance against the MDGs.

The Indonesian Women's Congress (Kowani) is a federation of 84 nationally based voluntary women's organizations established in 1928. In October 2009, President Yudhoyono called on Kowani to help lead the nation in achieving MNCH-related MDGs. In response, Kowani ran a campaign in May, 2010 on "Shared Responsibility for Reducing Maternal and Infant Mortality", launched with a community walk and information seminar attended by Minister of Health, Dr. Endang Sedyaningsih and State Minister for the Role of Women, Linda Amalia Sari; HSP provided partial support.

The campaign continued with the HSP-supported national meeting for "Revitalizing Kowani's Role to Support the Achievement of the Millennium Development Goals on Gender and Health". Member organizations reviewed their existing roles and missions and how the achievement of the relevant MDGs could be advanced as part of existing organizational mandates. A list of recommendations was given by Kowani Chairwoman Dr. Dewi Motik to Indonesian Vice President Boediono the next day, highlighting the strong link Kowani has with Indonesia's decision-makers.

Following the National Meetings, HSP supported three regional meetings in July 2010, covering western, central and eastern Indonesia. Hosted by the MOH in partnership with Bappenas, decision-makers and health providers made commitments to MNCH and made plans against regional roadmaps. Representative from all 33 provinces took part and representatives from the almost 500 districts of Indonesia were invited. It was the first time this approach had been taken with this range of stakeholders.

The overall aim was to link the existing bottom-up planning process with new injections of top-down 'deconcentration' and BOK funds to develop a coherent plan and budget for each region. This is the first step toward creating a comprehensive regional action roadmap for each and every province and district in Indonesia, and sets the stage for how the GOI will further develop and sustain its plans for achieving the MDGs.

Districts have the best knowledge to draw local action plans to help accelerate achievement of the MDGs

Women and children are the primary target for MDGs achievement

Major Products

Table 15. Tools revised and/or developed with HSP assistance

Tool	Responsible agencies and partners
DTPS-MNCH: Planning	MOH Directorates of Maternal Health, Child Health, Nutrition, and Pharmacy; UI; Penala Hati
DTPS-MNCH: Advocacy	WRI; MOH Directorates of Maternal Health, Child Health, and Health Promotion; ADB, WHO; UNICEF
Integrated Management of Childhood Illness (IMCI)	IDAI, MOH Directorates of Child Health, Surveillance, Nutrition, Infectious Disease; WHO; Save the Children; GTZ; JICA; UNICEF
Normal Delivery Care (APN 2008)	JNPK; IDAI; IBI; MOH Directorates of Maternal Health, Child Health, Nutrition; WHO, UNICEF; Save the Children
APN Qualification & Accreditation tool	JNPK; MOH Directorate of Maternal Health
Basic Obstetric and Neonatal Care (PONED 2008)	JNPK; MOH Directorates of Maternal Health, Child Health
Comprehensive Obstetric and Neonatal Care (PONEK 2008)	JNPK; IDAI; MOH Directorates of Medical Services, Maternal Health, Child Health
Supportive Supervision	MOH Directorates of Child Health, Surveillance, Nutrition, Infectious Disease, Medical Services; JNPK; IBI; UNICEF; WHO
Behavior Change Communications	MOH Directorates of Maternal Health, Health Promotion
Birth Peparedness and Complication Readiness (P4K)	MOH Directorates of Maternal Health, Health Promotion
Breastfeeding – KADARZI community modules	MOH Directorate of Nutrition; Studio Driya Media; IBI
Bidan Delima guidelines and tools	IBI, DHO

Studies and reports developed by HSP

- Integrated MNCH Approach Technical Report
- Case Study: Data into action: active surveillance & planning of village health activities
- Case Study: Planning & budgeting under decentralization: focusing district health resources on evidence based interventions
- Endline Report: Household Survey of Maternal, Neonatal, and Child Health in 22 Districts of Five Provinces in Indonesia, 2009
- Implementation and Evaluation of Kangaroo Mother Care in Ten Hospitals in Indonesia
- QUAPEC Report: Quality and Access to PErinatal Hospital Care at the District Level
- Maternal Neonatal Emergency Room Care (MNERC) Activity Report

Handover of tools and modules revised and developed with HSP support from USAID to the Government of Indonesia

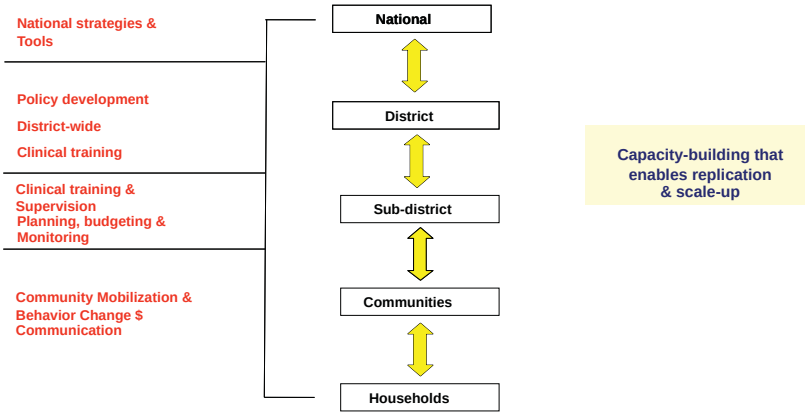
Sharing of experience during the extension period allowed scale-up of integrated model

Health System Approach for the Development and Revision of Tools, Protocols, and Modules

The HSP took the approach of strengthening the Indonesian system for MNCH, using the existing components of that system, both clinical and governmental. Support was also given to the MOH to revise and update a number of the key guidelines and tools or to develop new ones in places where gaps had been identified. In supporting these revisions, HSP played a catalytic role by bringing together diverse actors, led by the relevant health professional organizations and the MOH, with the result that Indonesian technical health policy was revised as needed in accordance with international evidence-based best practices.

This approach represents a process of health system change within the environment of overall changes taking place as a part of the decentralization process. Chart 1 presents an overview of the different levels of the system.

Chart 1: IMNCH Model Health System Approach



The main counterpart for HSP has been the Ministry of Health (see Chart 2 for the organizational chart with MOH counterparts). Other partners have included district governments, NGOs, professional associations, health providers, the private commercial sector and community members. At each level, HSP has provided technical assistance that strengthened the ability of the health system and providers to improve the quality of and access to services to prevent and treat maternal, newborn and child health problems. During the first phase of HSP, an agreement was reached with the National Ministry of Health for the review and revision of national tools and policies related to MNCH and the Making Pregnancy Safer/Child Survival Strategy.

The tools and modules developed (see Appendix 2) in partnership with the Ministry of Health were symbolically (because all tools were already apart of the system) handed over to the Ministry at a series of events in March 2009 and June 2010. As part of these events, the MOH announced a commitment to continue to use these revised and new tools as a part of the national program scale-up and replication.

Chart 2: National Level

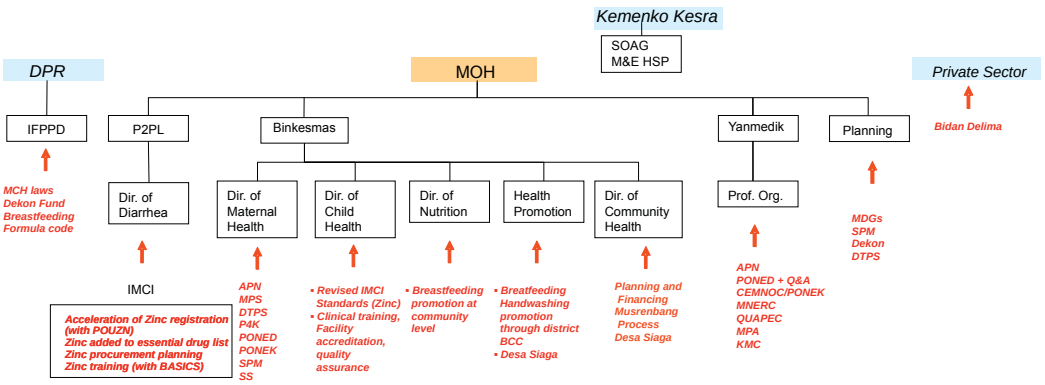
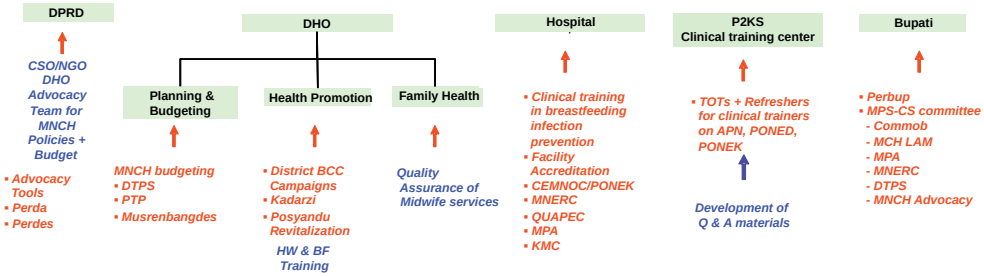


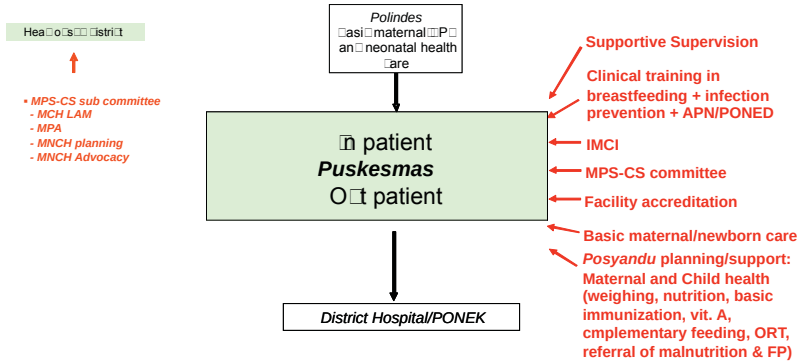
Chart 3: District Level (DHO)



At the district level, the main HSP counterpart was the District Health Office (DHO), although this has expanded to include key cross-sectoral partners including the District Hospital, the District Development Planning Board (Bappeda) and the district offices of the Family Empowerment Movement (*Pemberdayaan Kesejaheraan Keluarga* or PKK) (see Chart 3 for areas of assistance). As a part of the handover and close-out of HSP activities the DHOs made a commitment to continue to use these tools as a part of District level scale -up and replication of MNCH activities.

At the sub-district level HSP worked to strengthen the service provision of the Puskesmas clinic, which typically covers around 40 villages. The HSP provided support in the area related to puskesmas planning, supervision and management, IMCI and other clinical activities (see Chart 4 for areas of assistance). These activities include support to the *Polindes*, Posyandu, and accreditation of lower-level health facilities, and improved use of data.

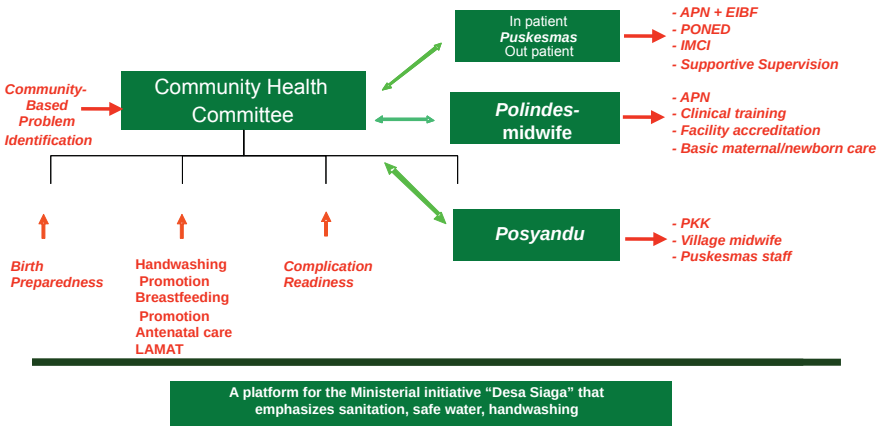
Chart 4: Subdistrict Level



At the community level (see Chart 4), HSP supported the establishment or strengthening of groups to perform key health activities; here referred to as Community Health Committees (CHCs). These groups are comprised of volunteers who have long been responsible for managing many of the maternal and child health services offered by *Posyandu* and more recently for implementing the Ministry of Health's *Desa Siaga* (Alert Village) program with its Birth Preparedness and Complication Readiness (P4K) initiative. HSP has particularly worked to improve implementation of P4K, including aspects such as linking the pregnant women and newborn to service delivery through LAMAT and providing kader with basic understanding of evidence-based interventions, recognition of danger signs and other key information.

A key counterpart in the village remains the village midwife who is generally the most accessible health provider for pregnant women and children.

Chart 5: Community + Household Level



Photos this spread□communities bene□t from community mobili□ation activities

RESULTS AND FINDINGS

Performance Monitoring

Through monitoring and evaluation (M&E) the project has measured, recorded, analyzed, and reported on activities, outcomes of activity implementation, progress, and the achievement of results. HSP's M&E objectives were to determine whether program activities were carried out as planned, to identify program constraints and barriers, assess program success against objectives, measure program impact, and draw lessons learnt for continuous program improvements. The M&E team also worked on a broader scale and provided M&E technical assistance to partners at the district, provincial, and national level.

HSP tracked project indicators and performance through three main reporting mechanisms, the Performance Monitoring Plan (PMP), the Operational Plan (OP), and routine project output indicators tracked through the HSP Management Information System (MIS).

USAID's PMP Indicators

HSP's PMP was designed to reconcile with the 2006 USAID PMP, both to ensure consistency and to facilitate USAID data acquisition for annual reporting purposes. Historically in the project, USAID/ Indonesia had twenty-two PMP indicators, related to progress against its broader Basic Human Services (BHS) portfolio. The various contracting partners for BHS provided much of the data associated with these indicators; accordingly, HSP was responsible for nine indicators.

In 2008, HSP reported on 20 indicators that were agreed on with USAID, in 2009 HSP reported on 15 PMP indicators, and in 2010 HSP reported on 9 PMP indicators.

Table 16. HSP BHS PMP Indicators 2006-2010

Outcome Indicator	Baseline 2006	Achieved 2007	Achieved 2008	Achieved 2009	Achieved 2010
% of birth/deliveries attended by skilled health personnel	69.5%	66.5%	76.0%	73.2%	93.4%
Modern contraceptive prevalence rate	75.8%	74.5%	79.5%	77.3%	71.7%
Early initiation of breastfeeding	9.3%	20.7%	27.2%	37.7%	26.9%
Percent of children <36 months with diarrhea in last two weeks	NA**	25.8%	21.5%	22.7%	NA***
Number of national, provincial or district-led advocacy initiatives in support of improved basic human services/ maintained healthy ecosystems	16	49	37	43	NA***
Number of districts with increased financial resources accessed from existing government or other sources to deliver basic human services	NA	22	13	NA	NA***
Number of districts with plans and budgets to improve service delivery	10	24	31	4	3
Percent of trained providers who perform to established standards	82%	99%	63%	99%	NA***
Percent of caretakers washing hands with soap at critical times	NA**	11.9%	7.4%	14%	NA***

*** No target was set in FY 2010 since the HSP program does not influence this indicator**
**** Not collected in 2006 given minimal HSP interventions**
***** Did not report in FY 2010 as per Annual Plan**

USAID Operational Plans

Through inputs made to USAID, HSP contributed to the development of the FY2007 Indonesia OP. HSP activities contributed to two program elements under the Health Program Area of the Investing in People objective. These include Element 1.6 (Maternal and Child Health) and Element 1.7 (Family Planning and Reproductive Health), as defined in the FY2007 Operational Plan Guidance issued by the Office of the Director of US Foreign Assistance in October 2006. The complete list of Program and Sub-Element indicators is as follows:

Program Element 1.6: Maternal and Child Health

- Sub-Element 1.6.1: Birth Preparedness and Maternity Services
- Sub-Element 1.6.2: Treatment of Obstetric Complications and Disabilities
- Sub-Element 1.6.3: Newborn Care and Treatment
- Sub-Element 1.6.4: Immunization, Including Polio
- Sub-Element 1.6.5: Maternal and Young Child Nutrition, Including Micronutrients
- Sub-Element 1.6.6: Treatment of Child Illness
- Sub-Element 1.6.7: Household-level Water, Sanitation, Hygiene and Environment
- Sub-Element 1.6.8: Health Governance and Finance (MCH)
- Sub-Element 1.6.10: Host Country Strategic Information Capacity
- Program Sub-Element 1.6.11: Program Design and Learning

Program Element 1.7: Family Planning and Reproductive Health

- Sub-Element 1.7.3: Policy Analysis and System Strengthening

HSP in consultation with USAID/Indonesia agreed that the program would report on achievements against 15 OP indicators in FY09 and 10 OP indicators in FY10.

Table 17. HSP 2009-2010 OP Report to USAID

Standard Indicator	FY 2009 Target	FY 2009 Achieved	FY2010 Target	FY2010 Achieved
# of people trained in maternal /newborn health through USG-supported programs Male Female	1,000 250 750	5,494 2,324 3,170	500 125 375	3,077 753 2,324
# of people trained in child health and nutrition through USG-supported programs Male Female	500 125 375	5,902 2,143 3,759	Indicator dropped in FY10	Not reported Not reported Not reported
No. of baseline or feasibility studies prepared by the USG	0	2	Indicator dropped in FY10	Not reported
Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	5,945,025	6,122,013	4,832,118	5,291,295
No. of cases of child diarrhea treated in USAID assisted programs	1,206,367	1,360,720	222,076	581,514
No. of children reached by USG supported nutrition program	457,554	515,202	Indicator dropped in FY10	Not reported
No. of deliveries with a skilled birth attendant in USG assisted programs	627,885	623,575	541,280	591,438
No. of evaluations conducted by USG	1	3	Indicator dropped in FY10	Not reported
No. of monitoring plans prepared by USG	0	0	Indicator dropped in FY10	Not reported
No. of policies passed with USG support	10	41	Indicator dropped in FY10. Replaced with "No. of improvements to laws…"	Not reported
No. of improvements to laws, policies, regulations, or guidelines	Indicator added in FY10	Indicator added in FY10	145	330
No. of newborns receiving essential newborn care through USG supported programs	417,588	483,290	417,917	416,392
Number of children age <12 months of age who received DPT3 from USG-supported programs	56,510	64,103	9,716	44,343
Number of children under 5 years of age who received Vitamin A from USG-supported program	452,939	575,602	101,946	217,650
No. of post partum/newborn visits within 3 days of birth in USG assisted programs	512,125	525,993	413,864	530,160
No. of women receiving AMTSL through USG supported programs	545,538	538,455	471,812	535,248

Monitoring and Evaluation Reporting

HSP had three types of reporting: monthly, quarterly, and annual. Program implementation activities were monitored monthly, and program achievements and progress were monitored and reported on a quarterly and annual basis, depending on the indicator.

Monthly Reporting. Monthly reporting included updating progress in the HSP MIS against project plans, program outputs, training database, and community mobilization data reporting.

Quarterly Reporting. The quarterly reporting process focuses on the collection of information against the workplan and PMP/OP indicators.

Annual Report. The HSP Annual Report reviews the program's yearly progress and highlights achievements, summarizing the information already captured in the year's quarterlies. Lesson learned and best practices are also an important aspect of the annual report. The Annual Report also reports on the required PMP and OP indicators, including results from the household survey.

Interviews during the household survey

Village midwives are involved in the health monitoring of women, babies and children

Summary of Data Sources

There are a number of sources HSP employed for gathering data, as follows:

- **HSP Management Information System (MIS).** This internal monitoring and tracking system tracked implementation, captured program documentation, and provided selected options for disaggregation.

- **Baseline. A BHS-wide Baseline Survey** – covering HSP scope as well as that of the Environmental Services Program (ESP) and the Aman Tirta (AT – safe water program) – was completed in February 2006. The objective of the joint BHS Baseline survey was to establish a reference point for evaluating program impact at the household level over the life of the program. Changes over time and between the intervention and comparison groups (without HSP/BHS interventions) of households were measured for key indicators.

  The survey population was limited to households with at least one woman with a living child under three years of age in 30 selected

Posyandu offers maternal, neonatal and child health services

districts of 6 provinces. Of these 30 districts, 24 were intervention districts while six were control sites (one control district in each province). The survey sampled 240 eligible households per district. In each selected neighborhood, a household census was conducted to identify eligibility and ensure a simple random selection of four eligible households per neighborhood. Household data, including those on health knowledge and behaviors, seeking treatment, and access to health services were collected through interviews with women using a structured questionnaire.

- **Rapid Surveys.** To track yearly indicators at the population level, and to collect data for reporting against the OP, HSP carried out a rapid survey at the end of FY07, FY08, and FY10. The rapid surveys used the same methodology as the baseline survey but only collected data related to HSP result indicators.

The FY 2007 rapid survey included households in 11 selected districts in six HSP provinces: Nanggroe Aceh Darussalam (NAD), North Sumatra, Banten, Jakarta, West Java, and East Java.

The FY 2008 rapid survey was implemented in 12 districts in six provinces; Nanggroe Aceh Darussalam, North Sumatera, Banten, DKI Jakarta, West Java, and East Java.

The FY 2010 rapid survey was implemented in two districts (Malang and Pasuruan) in East Java province. Results from the 2009 endline survey in Jombang district were used as a control district.

- **Endline Survey 2009.** In 2009, HSP conducted an endline survey with the objectives to document changes of key MNCH indicators at the community level in 2009 as compared to the 2005 baseline survey, to assess to what extent the HSP has contributed to changes of key MNCH indicators, and to assess the socio-economic differentials of key MNCH indicator as compared to the 2005 baseline survey. The project undertook the endline survey at this point since this time period marked the ending of activities in most project area. In its implementation, the endline survey 2009 adopted similar methodology to the 2005 baseline survey to ensure comparability.

  The survey covered five provinces with HSP intervention districts, and did not include Aceh since HSP interventions in this province had finished in 2008. The study was conducted in 17 HSP intervention districts and five control districts. Table 18 shows the program's achievements as measured by 11 indicators.

In 2009, eight of the 11 indicators showed a statistically significant improvement compared to baseline figures. Three indicators showed no significant difference or showed a decline. They are: use of modern contraceptive, coverage of vitamin A and contact with *posyandu*. Of these, the first two had no specific intervention by HSP but were collected on request of USAID. The third indicator was partially influenced by HSP support, however monthly attendance at *posyandu* is not always an accurate indicator of actual coverage.

Table 18. HSP survey results by main indicators 2005-2009

Indicators	2005	2007	2008	2009
Delivery by health provider	67.5	66.5	76.0	73.5
Early initiation of breastfeeding within one hour	10.0	20.7	27.2	37.1
Neonatal contact in first seven days	49.6	70.4	76.2	67.0
Children under 3 years who had diarrhea in the last two weeks	28.9	25.8	21.5	22.4
Children under 3 years who had diarrhea in the last two weeks and took ORT or sought treatment	51.4	6.1	64.6	66.9
Reported washing hands with soap at least three of five critical times	7.1	11.9	7.4	13.9
Average number of antenatal care visits	8.5	-	9.2	9.3
Children aged 12-36 months who have KMS/child immunization card and showed three DPT vaccines before 1st birthday	50.8	-	62.0	64.0
Use modern contraceptive	76.5	74.5	79.5	77.3
Contact with *posyandu* (health post) in the last month	68.0	61.0	60.0	64.7
Children aged 12-36 months who took vitamin A in last 6 months	67.9	-	52.2	68.2

RECOMMENDATIONS AND LESSONS LEARNED

General Recommendations

1. Continue to support the focus on maternal and neonatal mortality reduction and efforts to achieve MDGs, especially goals four and five: Provide technical assistance to build on the previous investment by HSP in providing support for the national and local roll out to all levels of a road map and plans to reach MDGs, especially four and five.
   The reduction of maternal mortality has been the most challenging for Indonesia to change. While there are some indications of progress in results from the most recent IDHS, at current rates, Indonesia will have a difficult time reaching its MDG of 102/100,000 by 2015. It would have to cut its current rate in half. Four successive IDHS surveys (1993, 1997, 2002, and 2007/08) have indicated that mortality (rates per 1,000) for women aged between 15 and 49 declined by 11% (from 2.19 to 1.95) over the past fifteen years, and the MMR has dropped significantly (from 390 to 228). In a similar time period, the percentage of adult female deaths due to maternal causes has fallen from 19% to 10%.[5] Maternal morbidity is high in Indonesia, as well; a 1998 study found that for every maternal mortality, 908 women sustained life-threatening or serious morbidities.[9] It is estimated that 85% of the maternal deaths have one or more avoidable factors.

   While there is more progress on child mortality rates, there has been less progress on reducing neonatal mortality. Two-thirds of the under-five deaths occur during the first year of life and about two-thirds of the infant deaths took place during the neonatal period (first month) and about two-thirds of the neonatal period happened during the perinatal period (0-1 week). By focusing on neonatal deaths, which are 90% preventable, would contribute in large measure to the acceleration in the reduction of overall child mortality.

2. Prioritize actions that increase access to and availability of quality 24 hours 7 days a week BEONC and CEONC in districts. Currently, nationwide, 59% of births in Indonesia take place at home, of which approximately half are as sisted by skilled providers, who may or may not be linked to higher levels of care, increased access to care will increase the chance of a woman and her baby receiving timely and adequate care in the event of a serious complication.

   Therefore, a priority focus should be on helping district health officials to identify and remedy weaknesses in the referral and supervision systems. It is also necessary to ensure adequate availability of quality 24- hour BEONC and CEONC seven days a week. In some districts, there is also the need to upgrade facilities, improve the capacity of healthcare providers, and rationalize the distribution of human resources. It is important that district-level planning and information systems address these weaknesses in a way that ensure the availability and quality of care.

3. Prioritize the strengthening of information systems and data management in communities, *posyandu*, *puskesmas*, and hospitals. At the community and *posyandu* levels, engage local health committees and *kaders* to practice active surveillance by linking the identification and registration of pregnant women and newborns to service delivery and the collection and analysis of information on maternal and neonatal outcomes. At hospitals and *puskesmas* activate and strengthen MOH mandated maternal and perinatal audit systems that are currently not fully operational or effective.

   The audit systems should also cover private providers and maternal and neonatal healthcare facilities in order to hold them equally accountable for outcomes. It is also recommended that the new program develop a district-wide surveillance and response system with oversight from safe motherhood committees established at different levels of the district health system, and with ultimate accountability residing with the DHO, PHO, and civil society monitoring groups.

4. Ensure that the private health sector, NGOs and Religious Organizations are integrated into district models for reducing maternal and neonatal mortality: Private providers, NGOs and Religious Organizations are an important source of maternal and newborn care. Since many public sector providers also work in the private sector and with NGOs/ Religious Organizations, distinctions between sectors becomes blurred.

   Private and NGO hospitals and clinics are prevalent in urban and peri-urban areas but even in more rural areas, many of the midwives employed by the public sector in *puskesmas* or as *bidan di desa* also maintain private practices. It is recommended that the new program pilot a variety of public-private provider partnerships to improve quality and increase accessibility of MNH services. To more fully engage private sector providers in improving maternal and newborn health outcomes, more information will be needed to assess the regulatory and reporting processes, whether they are

adequate and how to improve implementation at the national and district levels. Provide technical assistance at the central and district level to strengthen systems for supervision and licensing of private providers. Also, any demand side financing initiatives could include the private sector using this financial incentive as a way to enforce quality standards among providers and offer choice and access to communities.

5. Support learning from experiences on reducing maternal and neonatal mortality across Indonesia: Knowledge management should be a strong component of the efforts to reduce mortality and morbidity. It is, therefore, important to broadly disseminate lessons learned and evidenced based best practices that emerge from working in a comprehensive manner at the district level.

   It is this knowledge management activity that will be pivotal in enabling the achievements of a few districts to benefit many more districts that can learn from and adapt program successes to their own contexts.

Specific Recommendations

Health Governance

1. Support for integrated programming as part of the decentralized health system should continue.

The primary challenges toward reaching MDGs 4 and 5 in Indonesia have less to do with finding the right interventions than how to implement proven solutions within the system. There is broad consensus about the evidence-based best practices programs and approaches needed to reduce maternal, neonatal and child mortality, and the MOH has a wide variety of tools available. In the Indonesian context, however, the existence of a tool or program does not necessarily lead to implementation at the district level; challenges such as unclear authorities for health policy development, lack of capacity and resources, and lack of local political will at the local level present formidable obstacles. Yet in change there is opportunity, and evolving local autonomy also opens new potential for developing capacity and new approaches for health system development.

There is no "magic bullet" for strengthening district health systems, but a technical assistance model focused on the district health system can make a significant contribution. Under decentralization, districts play a central role in managing, funding, and delivering health services. They exercise significant autonomy in deciding resource allocations and determining priorities in implementing national health policy, particularly at the community level.

Technical assistance must be tailored to local institutional realities and build on local leadership and lines of authority. Districts can vary widely in terms of the strength of local institutions, political will, and health system capacity and they need support in a variety of areas including management, supervision, planning, health information systems, clinical training, and community mobilization. The integrated approach supported by HSP provides a flexible framework that emphasizes the connection between interventions, but allows for individual approaches to be adapted to address gaps in specific district settings.

2. Donor assistance can play an important role in ensuring collaboration and consistency across MOH directorates.

HSP has played a critical role in helping central-level directorates coordinate and ensure the consistency of their approaches. A key area of support, for instance, has been the expansion of the Making Pregnancy Safer guidelines to address a broader spectrum of MNCH issues at the district level. HSP has also involved for the first time the child health and pharmaceutical directorates in the revision of the DTPS planning and budgeting tool. Another example is HSP's work to ensure that the clinical protocols for newborn care are the same across training manuals for delivery care and IMCI. HSP's technical review teams often include directorates and professional associations that may not otherwise have worked so closely together.

3. Donor support should be focused on providing the kinds of technical assistance needed to help district stakeholders unlock local sources of funding

Diverse sources of funding are available, both public and private, that can be more broadly tapped and more effectively utilized to support MNCH. Decentralization has resulted in local control over funding allocations that can support health service provision. Districts control a significant share of funding through central block grants and district own-revenues, and in some districts, user fees from health services are bringing in increased revenues controlled to varying degrees by implementing agencies. Allocations can also be influenced towards health at the village level. The emphasis on decentralization means that there is a window of opportunity to convince and enable decision-makers to use evidence-based and bottom-up planning processes.

At the same time additional resources are planned from the central level via the national budget (APBN, used mostly to cover salaries) and national deconcentrated funds (DECON) which is earmarked and administered through the centralized process from the MOF to MOH to Provincial Health Office then District level. Special funding blocks aimed at facilitating reaching the MDGs, especially 4 and 5, such as free deliveries and treatment of obstetric complications, special grants to selected *Puskesmas*, BOK, etc can be integrated into the planning process with all levels. This was accomplished as a part of the roll out of the MDGs planning to all PHOs and Heads of Health Offices. A "Road Map" was developed to integrate planning for 2011-2014 down to the district level. Continued follow up and monitoring of indicators is planned by the MOH and where needed additional support should be given to this activity by donors.

Despite the many opportunities, in practice local governments need a tremendous amount of support to program their funds effectively. The ambiguity of budgetary classifications makes it difficult for planners to assess and evaluate their expenditures.

Budget performance is often weak, with actual expenditures deviating greatly from plans. This is in large part due to the lateness of national transfers to the regions, and the rigidities of reallocating resources between weak and better-performing activities. Turn-over and transfers in DHO staffing – particularly in planning departments – means there is a recurring need to train planned in the DTPS-MNCH tool. Also, there is fragmentation in MNCH planning due to the structure of the MOH, and an integrated approach for improving MNCH across Directorates does not exist. Finally, because planning and budgeting is a political process, not just a technocratic one, sub-optimal policies and budget allocations often emerge despite using a DTPS approach. Programs must both recognize the opportunities and the reality of the state budgeting and spending process in Indonesia.

4. Continued support for local advocates will be needed to see the impact of evidence-based planning interventions on local budget allocations; longer time horizons are needed to allow for the major shifts needed to cement these approaches in local planning practice.

HSP budget analyses have shown that while many districts succeeded in pressing for increased funding for MNCH, there is a broad range of factors, including political considerations, that influence district health budgets. Shifting the mindsets and practices of key decision-makers in the district and *puskesmas* planning process to prioritize evidence-based, rather than historically or politically expedient, activities is undoubtedly a longer-term effort. There are an increasing number of district-level civil society organizations engaged in pro-poor and gender budgeting, which naturally includes support for increased allocations for health, and there is continued need to support these organizations technically – and financially – to ensure that advocacy efforts are maximized. In many districts, media representatives trained by the program also became champions for the cause, and promoted understanding of MNCH issues among the broader public, building demand for expanded and improved services. Encouragingly, the program saw more collaboration between "visionary" members of Offices of Health, and Parliamentarians, with civil society advocates for change. The tone of advocacy in Indonesia is changing, from a stand-off between NGOs and government, to one of a shared vision of working towards the same goals. Future programs can capitalize on this.

HSP-supported tools including DTPS & advocacy modules, and PTP, provide guidance for planners and ultimately help to increase funding for MNCH programs. Continued support for advocacy as a key component of the DTPS approach, with a focus on building relationships and buy-in among key decision-makers, should assist with moving to more evidence-based best practices planning approaches. Expanded use of the enhanced PTP method — based on DTPS — to improve *puskesmas* planning capacity will help *puskesmas* managers implement changes in accordance with priorities identified as well as linkage with the *Musrenbang* P4K and PKK village level plans and integration with the *Posyandu* activities

5. The passage of district and village-level regulations on MNCH programming provides a strong basis for sustainability.

Regulations such as district *perda* and village *perdes* lock in long-term commitments from local officials to support MNCH programs. HSP experience indicates that these legal instruments are providing decision-makers with a reference to justify and support changes in MNCH programming, including increased funding. In the decentralized health system, the passage of such regulations has been seen as an effective tool for institutionalizing a commitment to MNCH in district government policy. That said, plenty of follow-on support is needed to hold lawmakers accountable to their own regulations once they are passed.

Sustainability is also supported through the integration of the various district planning cycles to help ensure ongoing support for MNCH planning and budgeting. This can be achieved by ensuring that DTPS plans form part of the broader health plan or strengthening the linkages between technocratic planning processes and the bottom-up *musrenbang* planning system as a component of planning interventions.

Future options could include expanding the DTPS approach beyond MNCH to all health planning; feedback from many district health planners suggests this would be the logical next step for improved evidence-based planning across the sector. Future support should also assist districts to expand the time horizon of evidence-based planning to a medium-term plan (five years) in order to improve sustainability and a focus on health outcomes.

6. Strengthening both the availability and use of health data within the district health information system should be a key priority for improving evidence-based planning.

Data and information are important as the basis for performance-based budgeting, but there are significant reasons for concern about the quality of data from the district HIS. DHOs are often registering only a small portion of maternal deaths which other sources have shown are occurring. The MPA system is not functioning in many areas, and even where it is conducted, it may not necessarily be linked to problem identification and corrective actions. HSP experience has shown that technical assistance can improve the tracking of maternal and neonatal deaths through MPA and stronger routine surveillance data through LAMAT and community

PERATURAN DAERAH KABUPATEN PASURUAN

NOMOR 2 TAHUN 2009

TENTANG

KESEHATAN IBU, BAYI BARU LAHIR DAN ANAK (KIBBLA)
DI KABUPATEN PASURUAN

District regulation on Maternal, Neonatal and Child Health in Pasuruan district

active surveillance. By focusing on use of data, whether through DTPS, *puskesmas* planning or active surveillance at the community level, the importance of data is made real to stakeholders. These interventions encourage real-time use and analysis of data not just for district planning, but for active management of MNCH programs by providers at the village, sub-district, and district level.

7. Country information on where women and newborns die remains scarce, yet is badly needed to ensure efficient and effective use of resources.

There has still yet to be a national maternal or perinatal mortality study in Indonesia, so data on where women and newborn die is lacking. At this stage in reducing maternal and child mortality, when the "easier" solutions have already been implemented, it will be increasingly important to have this kind of information in order to assist the MOH to sharpen its strategies to improve MNCH. Currently, the MPS strategy is based on international best practice, which is commendable. But without more detailed information about how, why and where women and babies are dying, it will be difficult to effectively target GOI and donor resources to make the greatest impact.

8. The implementation of MNCH regulations should be the framework for donor support at sub-national levels.

MNCH regulations provide guidance to donors and other possible supporters (including from within the Indonesian health system) as to local needs and priorities in achieving better health for women, babies and children. By structuring support in this way, the political commitment needed to tackle some of the more challenging aspects is ready. Also, the regulatory framework covers multiple aspects of the health system at district level and below; this provides an opportunity for supporting that system, rather than isolated clinical or governance interventions.

9. A holistic approach – supporting the health system from both a demand and a supply side – creates synergies that deepen investments.

The HSP case studies found that a combined approach benefits from synergies between each individual area of health system strengthening. Appropriate planning and budgeting for MNCH services cannot be undertaken without accurate and timely local MNCH information. By both strengthening capacities in LAMAT implementation and providing complementary planning assistance to implement DTPS and PTP, HSP was able to support districts in closing gaps between the local HIS and planning and budgeting from the village level (through village midwife/*kader* participation in local *musrenbang* fora) upwards (such as the review of LAMAT data by DTPS teams to determine district-level MNCH priorities and budgets need to address them). Similarly, evidence-based budget requests are not likely to be accepted by decision-makers for funding unless there is high-level commitment to addressing MNCH. By institutionalizing a focus on MNCH through local-level regulations, districts were able to garner such interest and priority-setting support.

10. Support to national and provincial levels should focus on the role of these levels in stewardship, technical support and oversight of district implementation.

Technical ministries have an important role in setting technical direction, providing tools and guidance, and implementing targeted vertical programs, but they have limited authority over district governments. Yet, with the concurrent recentralization process as a part of the DECON funds, special programs such as free deliveries and treatment of obstetric complications for the poor, special (BOK) funding to *Puskesmas* and the fact that there are still 14 centrally funded vertical health programs, there is a need for greater coordination and integration at all levels. The MOH has signaled that issues of accreditation and regulation will be increasingly important within the term of the current government. Donor support could assist officials at all levels to clarify roles for oversight and support to ensure districts, while setting priorities within the limits of their authority, are also delivering health services according to the Minimum Service Standards (SPM).

11. Geographical disparities may call for a more diverse approach to improving MNCH.

The MOH and districts have programs for lagging and remote areas and pro-poor assistance which should be strengthened.

12. The Corporate Social Responsibility (CSR) law requires that the private sector contribute to social development; this opportunity should continue to be supported by future programs.

There is great interest in garnering private support for health programs. Efforts to strengthen problem analysis and planning at all levels can be extended to assist partners to propose support for activities to appropriate local partners. This can happen from the national right down to the village level. Capacity needs to be built within the health system to understand the interests of the private sector and how the needs of the community might intersect with these.

13. Good governance efforts by other donors can be leveraged for improvements in health.

A number of donors' efforts – including other programs funded by USAID thorough democracy and governance programming – are working to strengthen participation, transparency and accountability. These programs – such as the LGSP and DSRP programs – are building blocks for good governance that provide opportunities for sectoral programs like HSP. In the next generation of good governance programs, funded by USAID and other bilateral and multilateral donors – the focus on making good governance deliver is a priority. An example is the World Bank's PNPM program, which has been adopted by the Government of Indonesia, which has a special fund to focus on achieving health and education MDGs. Many times good governance programs lack technical depth in public health, and a follow-on program to HSP could easily leverage these other program resources by bringing the evidence-based approach to MNCH to their work.

CLINICAL QUALITY

14. While the Ministry of Health has adopted best practice policies in many key interventions areas, some practices need additional reinforcement before they will become part of the mainstream program at the district level.

More work is needed to convince districts on the effectiveness of a number of key MNCH interventions as they are not yet routinely incorporated into plans. Support for Active Management of the Third Stage of Labor, Early Intiation of and Exclusive Breastfeeding and the new MOH protocols for newborn care are critical examples. New tools or policies are not required; efforts should be made to ensure that sufficient funding is available in district budgets for upgrading midwifery skills where required.

The most effective approach to improving clinical practice under a health systems strengthening approach is via supportive supervision, both as a means of introducing new practices and of reinforcing them. Implementation of supportive supervision at all levels and peer to peer support and replication also increases the performance of the institutions and encourages effective communication and better partnerships between *puskesmas* staff, *bidan desa* and *kader* for *posyandu* activities. Donor support for improved clinical approaches should also support implementation through this modality.

15. There are continuing challenges with expanding access to midwifery services.

In aggregate terms, Indonesia has a large number of midwives, and the MOH and district governments remain committed to ensuring universal access to midwifery services. However, distributional problems continue, and coverage of skilled birth attendance is only increasing at a rate of 1.5% - 2% per year. Overall, the inefficiencies and poor quality of services have resulted in low utilization rates in public facilities. In many districts, while there are sufficient numbers of village midwives, they are not living at their post – and high costs of transportation are a major barrier to utilization. Dual practice adds to the relatively low figures of health staff in rural areas, given that public sector providers prefer to live in areas where there is a large and well-off enough population for them to establish a private practice. Midwives who are assigned to remote areas tend to be less experienced and manage fewer deliveries, making it harder for them to maintain/develop their skills. While *Askeskin* is providing the poor with better healthcare access, and delivery services are covered through this scheme, the program needs to be better targeted, as richer quintiles are also benefiting from it.

16. Partnerships with professional associations should be encouraged as these groups play a key role in strengthening quality and adherence to standards in training and care.

Professional organizations can lead acceptance of methods to improve the quality of care, both in the private and public sectors, but need further support to play that role. Professional associations such as Perinasia, IDI, POGI, IDAI, PPNI, IAKMI and, especially, IBI, played a central role in HSP-supported clinical training and assessment activities, both at the hospital and community level. They have significant clout with the MOH and also wield great influence over providers through control of membership and a role in licensure. As a national training network center, JNPK plays a role in national training and certification programs. Indonesia's professional associations are not yet systematically using that influence to reinforce development of, and adherence to, national standards, but could be leveraged to play such a role.

Future programs should continue to strengthen the role of IBI. Midwives are a major provider of MNH services especially at the community level and in private practices. IBI is an association of over 70,000 public and private midwives and thus are a potential force for improving maternal and newborn survival. It is recommended that IBI continue to receive support to professionalize the association and strengthen its ability to advocate for MNH services and better support its members to deliver quality care.

17. Better regulation, accreditation, licensure, quality assurance, and certification are needed for both the public and the private sector.

While the private sector is growing as a provider of MNCH care, the public sector still provides treatment for a significant number of poor patients, and is particularly important as a provider of community and public health programming. However, adherence to standards of practice within the public sector is variable at best, and little is known about quality in the private sector. Licensing requirements are largely check-list based and do not evaluate the quality of care. District governments need support to build their capacity to ensure effective regulation and quality assurance. Due to dual practice amongst midwives, there are significant externalities to building capacity within the public sector as an entry point, while taking complementary steps – such as working with national professional associations – to improve private sector care.

Similarly, for the hospital sector, greater efforts are required for regulation, quality assurance and certification. Ongoing supervision of clinical standards, including by use of clinical checklists, shows promise in a number of areas.

18. Working with initiatives engaged in civil service reform to address dual practice could bring important benefits.

The World Bank's Health Public Expenditure Review provides an important analysis of health financing, and documents a number of problems with the current civil service policy as related to the delivery of health services. First, it is well-understood that salaries for civil servants utilize the majority of the state budget, and that bureaucratic reform is needed to control costs and hold civil servants more accountable. In the health sector, the policy of dual practice – where civil servants are paid to work in the *Puskesmas* during the morning, and a private practice in the afternoon, is causing multiple problems with health service delivery. First, absenteeism is high, given that so many practitioners prioritize their private practice over their work hours in the public sector. Second, the private practice is a pull factor of paying clients away from the public sectors – as for many better-off Indonesians, private sector services are seen as more convenient and higher quality. Other donors such as the World Bank and AusAID are set to address these issues in the coming 5-10 years, and follow-on programs funded by USAID would do well to engage with and inform these initiatives.

19. While the private sector is growing in importance as a provider of MNCH care, entry points for donor assistance are not always apparent. Any direct support should have a clear strategy for investment including realistic outcomes and a plan for exit.

As noted above, little is known about standards of care in the private sector facilities, including private hospitals. Clarifying roles and responsibilities of government, professional organizations and providers (for example faith-based organizations) in regulating the quality of clinical care would be one possible approach for donor assistance.

While many more women are reporting delivering with private midwives, the reality is that the vast majority of midwives in Indonesia conduct dual practice. Efforts to improve the clinical practice of public midwives should improve private practice and vice versa.

In an effort to improve private midwifery practice, USAID has invested in IBI's Bidan Delima program over the past decade. The hope was that the Bidan Delima would become a self-sustaining franchise, and be managed autonomously from the professional organization. While the split of management was achieved under HSP support, the review of Bidan Delima as an organization showed that IBI did not see the program in the same terms as the donor. While both parties wish to emphasize the program as a mark of quality assurance, IBI sees the program as a 'moral movement' rather than a franchise business. There is also little evidence that the poor are patients of these private practices. Should USAID wish to continue to support the development of this program, a strategy that starts from IBI's conceptualization of Bidan Delima is required. With little hope for financial sustainability under current fee and service structures, USAID must be clear on the nature of investment and on an exit strategy before further investments are made. Given that the service does not address the needs of the poor, it is recommended that any future support be separately procured from a broader MNCH program.

20. There should be increased focus on newborn care because newborn mortality remains a concern, and slows overall progress in child health.

Up to 50% of child deaths occur within the first 24 hours of life, with 20 newborns dying for every 1,000 live births. Of newborn deaths, 75% take place in the first week of life. Low birth weight underlies much of neonatal and infant mortality, and is associated with around 35% of neonatal death in Indonesia. While postnatal care of mothers and newborns is highly cost-effective, it remains a weak link in the continuum of care.

21. Future donor support should strengthen the role of hospitals in providing maternal and newborn care, particularly in cases of obstetric and neonatal emergency.

There are simply not enough obstetricians or neonatalogists to cover the Indonesian population. The HSP supported QUAPEC study showed that the majority of hospital deliveries in rural areas are for emergency cases. The HSP-supported training of general emergency room personnel in dealing with emergency obstetric and neonatal cases shows a promising route to providing care in the face of this specialist shortfall. Training for this group should not be comprehensive but instead focus on the major maternal and neonatal diagnoses. This approach should be scaled-up nationally using regional training hospitals as the vehicle for both training and ongoing supervision.

As part of this approach, efforts should be made to improve both the physical capacity and overall management to address major deficiencies in the hospital environment.

22. Kangaroo Mother Care (KMC) should continue to be supported under any new programming, however considerations of a staged approach to implementation and scale-up are needed.

KMC is an effective and low-cost approach that could help to significantly reduce the large percentage of neonatal deaths attributable to low birth-weight in Indonesia. Future donor support should seek to strengthen activities in the hospitals that have begun to work with the KMC approach to ensure there is a functional model before considering a scale-up to other hospitals.

Hospital-based implementation should also be functioning before introducing community-based KMC. For KMC to work in the community, a continuum of care up to the hospital must be in place. Implementing hospitals should also have a supervisory role over outpatient care, even if undertaken at the *puskesmas* or by a village midwife.

It is recommended not to continue a model of rapid scale-up across hospitals unless it is under the guidance of the MOH Medical Services Directorate with support from professional groups. More consideration is needed to determine the most appropriate method for ensuring that implementation of the approach meets standards for quality of care. These considerations should also determine how to incorporate costs associated with KMC into routine health system budgets so that the introduction of KMC is not considered an impost by hospital administrators.

Support should also be given to advocating for a new protocol for promoting the skin to skin position for transporting all newborns from home to health care facility and between health facilities. This should apply to all newborn and not just low birth-weight babies. Given the large numbers of trips undertaken by motorcycle, particularly in rural areas, the promotion of this protocol has the ability to save the lives of many newborns.

23. Low rates of immediate breastfeeding contribute to high newborn mortality rates.

Less than 30% of Indonesian babies are breastfed within one hour of birth, with immediate breastfeeding rates even lower among poorer mothers. Sixty percent of newborns receive pre-lacteal foods during the first three days of life, and only 9% of urban infants and 20% of rural infants are exclusively breastfed until six months of age. The median duration for exclusive breastfeeding in Indonesia is only 1.6 months. Early substitution of breast milk with infant formula or other foods is a serious issue. The marketing of breast milk substitutes is

not controlled, with health providers commonly promoting the use of infant formula. HSP's program found that simple training programs for midwives about integrating AMTSL with immediate breastfeeding practices brought immediate benefits, and substantially increased immediate breastfeeding rates in short period of time.

COMMUNITY

24. While international consensus is that community interventions have been overemphasized at the expense of clinical improvement, HSP experience shows that there is still a need to support community mobilization efforts in Indonesia. The focus of this support should be targeted to specific messages, should target vulnerable groups, should strengthen existing community structures and should draw on locally available resources and funding.

25. Support should target specific messages and approaches.

Community mobilization efforts should not attempt to replace essential health services, but instead focus on key interventions that are within the purview of *kader* and other community stakeholders. The core of the effort is to work with *kader, bidan di desa* and traditional birth attendants to increase the number of deliveries by skilled birth attendants and the number of facility-based deliveries. As a part of this more work is needed on referral; the HSP-supported QUAPEC study showed that recognition of danger signs for obstetric and neonatal complications, and the appropriate pathways for referral, are low amongst the community. HSP supported additional training on this issue for communities, but future assistance should ensure that this is more carefully covered as part of the P4K package.

Kader were already familiar with active surveillance from immunization drives, but were introduced to an expansion of this approach to cover MNCH with HSP support. While the concepts were understood, ensuring routine application will require more time than was available under the HSP extension and good follow up and support by *bidan di desa* and *puskesmas* staff.

Wherever possible, these activities should be introduced as strengthening of existing mechanisms rather than new activities, and should draw on existing skills and experience gained from other community level activities.

26. While community activities can be taken to scale, a focus on the poor must be maintained.

The GOI has a special focus on poor, remote and lagging regions, and many districts mirror this on a local scale. Support for this policy can help to reach the poorest communities, however Donor support can help districts to reach the most vulnerable, as community systems tend to be weakest in poor areas.
As well as targeting poor communities, reaching out to the most vulnerable within communities could show significant results. The HSP-supported QUAPEC study showed that the majority of emergency cases presenting at district hospitals were from poor, rural households and were the first pregnancy for the woman. There is global evidence of the efficacy of pre-marriage counseling programs for improving reproductive as well as maternal, neonatal and child health. Future assistance should seek to strengthen existing community level programs to reach these most vulnerable groups.

27. Competing "single issue" approaches to community mobilization and the lack of meaningful participation in most community mobilization approaches remain challenges

Community mobilization has a long history in Indonesia, emerging from the context of community organizing being used as a form of social control. Within the health sector, almost every directorate has some community mobilization scheme – ranging from the *Posyandu* and P4K to nutrition (*Kadarzi*) and "the alert village" (*Desa Siaga*). These efforts are not well-coordinated, and therefore often replicate or even compete with one another. At the community level, community participation efforts supported by government are even larger in number – addressing water and sanitation, the environment, livelihoods, infrastructure, and education. Most of the MOH's community mobilization approaches do not adequately budget for the skills-building and activities that make community participation meaningful. While HSP has tried to get its "mobilization methodology" down to an approach that is feasible with government resources, there is often so much pressure to rapidly scale up these approaches that district government is not able to spend the resources needed to make them sustainable and effective. The over-simplification of community mobilization approaches remains a challenge, as mobilization is often viewed by government as a "silver bullet" that in practice is not sustainable or effective without sufficient attention, resources and support.

28. Existing community organizations and campaigns should be mobilized to lead community level activities.

Earlier phases of HSP worked to establish community health committees, however the problem of sustainability presented itself. NGOs and religious organizations, who had been HSP partners in working at the village level were seeking ongoing funding in order to continue their support. In the final phases of HSP, agreements were made to partner with the PKK for support of P4K, active surveillance and *posyandu* activities. Not only does the PKK carry political clout – based on an assumption of male political power, the wife of the local official (for example, *Bupati*) is the *ex officio* head of the PKK at each level of the system – but funds are also allocated through district budgets. In conjunction with this approach, HSP also supported existing district health campaigns, or the MNCH elements thereof. In doing so, the support of the District Health Office and other district stakeholders is also brought into play. It is recommended that any future assistance similarly support existing local campaigns wherever possible.

HSP support focused on ensuring good collaboration between the PKK and any other existing groups undertaking health activities at the community level, encouraging a model of cooperation rather than duplication of activities, as was often the case. Involvement of the village midwife is critical. Part of the support was helping the

PKK to prioritize the activities of the Pokja IV (the working group on health) within the PKK. HSP also supported training of nominated PKK members at the sub-district level to act as facilitators of village committees. These facilitators can not only assist communities to sustain activities revitalized with HSP support, but can continue to facilitate groups in other villages in an effort to reach full district coverage of activities.

29. Efforts to garner local funding sources should be supported.

Through *musrenbang*, villages can press for allocation of village funding to support community health programs, and for prioritization of health and MNCH in the district budget. Other sources of funding exist at the community level which can be leveraged through local planning, such as PNPM, a national participatory planning program which provides block grants for village development projects, some of which include a focus on MNCH. Donor support should focus on providing counterparts and beneficiaries with the skills to leverage these sources over providing direct funding.

30. Further investments should be made in the development of tools for guiding community level evidence-based planning.

HSP supported the development of tools to help communities to undertake evidence-based problem analysis and planning. These tools gave participants the means to conduct basic analysis of data generated in that village. Due to time constraints, these tools did not undergo rigorous testing and were not adopted by the GOI. Feedback from HSP field staff and counterparts however, reported that these simple picture based guides were very helpful to community members with low literacy in conceptualizing health problems and linking the identification of problems with evidence-based solutions appropriate to community-level capacities.

With increasing funds available at the village level through sources such as the National Community Empowerment Program (PNPM) as well as other village block grants, guidance is increasingly important. It is not realistic to expect non-specialists to know what interventions will have the desired community health outcomes; these tools provide guidance on solutions while allowing communities to analyze their own situations and make their own priorities. The tools also functioned as an educational tool for communities for increasing understanding on MNCH

31. Sustainability of community level activities can be enhanced through the passage of MNCH *perdes*.

Village regulations give rise to a greater likelihood of sustainability in that they institutionalize a number of key provisions into local law. Typical aspects of the regulations included commitments to fund village-level MNCH activities (although envelopes were rarely stipulated). Also important was that many regulations established the role of the community health committee (or similar) in relevant aspects of village decision making, including participating in village planning sessions including *musrenbang*. The process of passing a perdes also meant that a wider cross-section of stakeholders became involved in considering MNCH issues, which has proved useful when CHCs come to advocate for funding.

While HSP supported the development of a template for MNCH *perdes*, the template was suitably generic. Villages felt free to adapt the template to suit their own political priorities, while still following the general guidance on supporting MNCH.

Although villages are considered politically autonomous at the level of their authority, sub-districts and districts can still play a role in monitoring the implementation of perdes. HSP support encouraged complementarity between regulations, with each level defining the role of stakeholders within that sphere of influence.

32. Support for community-level planning should also provide CHCs with the relevant knowledge and skills to leverage funds from other sources, including the private sector and other GOI programs.

The tools and approaches that HSP supported to conduct analysis and planning for village level *musrenbang* proposals can assist communities to determine their own development agendas and to use available sources of funding to fill various gaps. The planning process is expected to assist with Ministry of Home Affairs calls for medium-term village development plans. The approaches are equally applicable for use in PNPM planning, to the development of CSR proposals, and could also help communities to better dictate the terms of NGO support.

In the final stages of HSP, field staff facilitated meetings between the PKK Community Facilitators and Facilitators from the National Community Empowerment Program (PNPM). The potential for leverage is enormous. Eight of the 12 indicators for the Generasi sub-program are related to health outcomes. Other PNPM sub-programs are also relevant; one provides conditional cash transfers to poor families on the proviso of meeting selected health and education seeking behaviors, including child immunization; another provides general development funding that could be used for health if identified as a community priority.

APPENDICES

Appendix 1. National, provincial or district-led advocacy initiatives in support of basic human services assisted by HSP in 2005-2010

No.	Activity	Date	Achievements
1.	National Call to Action for Health in Jakarta	November 2005	The meeting was opened by the Vice President and attended by six Ministers, 33 Governors, and Bupati from 63 of Indonesia's 440 districts. The United States Ambassador attended, pledging US government support.
2.	HSP National Program Launching at National Level in Jakarta	May 10-11, 2006	HSP Program Launched in National level by Ministry of Health for implementation in six provinces in 2005 - 2009. The meeting was attended by MOH, professional organization and NGOs. The event was covered by newspapers.
3.	National Parliamentarians' Conference on MNCH in Jakarta	February 2006	At the meeting, all 33 governors committed to ensuring that their provinces will provide adequate budget to ensure improvements in maternal, newborn and child health, laying the groundwork for HSP's advocacy strategy. This was followed by a series of advocacy meetings targeting provincial and district Parliamentarians. Advocacy efforts reiterated the low status of maternal, newborn and child health, and highlighted the opportunity to make significant progress given the large increase in central-level funding for MNCH in 2006.
4.	Commission IX Hearing Brings Progress in Enhancing Maternal and Child Health Policy	March 2006	HSP provided technical assistance to Commission IX and IFPPD to host a public hearing on the gaps in the pending Health Law amendment in the area of maternal, newborn and child health. HSP supported an analysis of the amendment alongside expert health scholars and practitioners, helping Commission members to recognize that pressing issues related to MNCH were barely addressed in the amendment. Professor Ascobat Gani, DR, PH of the University of Indonesia Department of Public Health suggested that parliament should more thoroughly address nutrition in the pending health bill. Dr. Sukman Tulus Putera of the Indonesian Pediatric Society also requested that nutrition be addressed in the bill, specifically promotion of exclusive breastfeeding for an infant's first six months of life and nutrition supplementation during childhood. Dr. Putera also noted that specific policy does not yet exist to support children's basic rights regarding universal access to primary health care, complete immunizations, and medications. Harni Kusno represented the Indonesian Midwifery Association at the hearing. She expressed her support for a mandate that will specifically address the needs of pregnant mothers, supporting health infrastructure and the provision of maternity services. After a thorough briefing by experts at the hearing, Dr. Imam Supardi of the Budger Commission IX Committee has a better

No.	Activity	Date	Achievements
			understanding of pressing maternal and child health issues, and is supportive of developing specific policies to improve the health of women, infants and children. Commission IX members noted that the session was one of the most substantive they had held on the health amendment, helping the move towards addressing issues that make a real difference in the health and welfare of women and children.
5.	HSP Program Launching at Regional Level	April—May 2006	Launching meeting has been conducted in each province: • NAD: April 6, 2006 • Banten : April 6-8, 2006 • North Sumatera: April 26, 2006 • East Java : April 2006 • West Java: April 2006 • DKI Jakarta : May 10-11, 2006
6.	Handwashing campaign launched in Aceh	May 2006	A consortium of USAID partners – including HSP, the Environmental Services Program (ESP) and the Safe Water Systems (SWS) program – launched a province-wide handwashing with soap campaign in partnership with the Aceh Provincial Health Office. Other organizations – CARE, UNFPA, People's Hope Japan Foundation, WSLIC-2 (a World Bank-funded water and sanitation project) and CWHSP (an Asian Development Bank water services project) – partnered with USAID to launch the campaign in May 2006.
7.	Advocacy to Parliament on the International Code on Marketing of Breast Milk Substitutes in Jakarta	August 2006	As a result of the meeting, Indonesian legislators requested that they be provided with "model language" to ensure that any further revisions to the Health Law Amendment reflect international standards. This will lay the ground for HSP to support breastfeeding counseling training, starting in FY07.
8.	HSP, USAID and the White Ribbon Alliance at a national advocacy meeting in Jakarta	September 2006	150 APPI members met to review their advocacy achievements and to set advocacy goals for 2007. The network also launched the expansion of their mandate to address newborn and child health. The workshop was opened by the Director General for Community Health, Dr. Sri Astuty S. Soeparmanto, who noted the importance of NGO-government collaboration. Dr. Astuty expressed appreciation for APPI's network of constituents, which includes members such as 'Aisyiyah, Fathayat, Muslimat, Wanita Katolik, PWKI, IAKMI, IDI, PKBI, POGI, IBI and the Scouts. She noted that improvements in MNCH would require a broad coalition of stakeholders, and laid out the plans of the MOH.
9.	MPS-CS Workshop: Turning Policy into Practice: Ministry of Health Launches District Guidance to Accelerate Improvements in Maternal, Newborn and Child Health	November 15-16, 2006 in Hotel Makassar	The Ministry introduced draft implementing guidelines for the MPS Strategy. Developed with technical assistance from the USAID Health Services Program, the guidelines are an effective tool for turning policy into practice at the district level. Attended by the Directors of 12 Provincial Health Offices, the workshop was designed to help districts to obtain the funding and technical support they need to turn the MPS policy into practice. USAID will continue its support to the MOH as it develops and documents a district model for a high impact and evidence-based package of maternal, neonatal and child interventions. Progress cannot be made without an increase in resources. To support the pilot testing of the draft guidelines, the Minister of Health committed to providing Rp. 4 billion ($444,000) for Eastern Indonesia to replicate a basic obstetric and neonatal emergency training program that was developed with USAID support.

No.	Activity	Date	Achievements
10.	Revision of the Minimum Service Standards (SPM) Guidelines	2007	The MOH is revising its minimal service standards so that they have a stronger legal basis, so that local officials can be held accountable for meeting national standards.
11.	Developed *Dekonsentrasi* Guideline	2007	HSP has a unique opportunity to assist the national government in determining how federal de-concentration (*Dekon*) funds will be used to improve the health of women, infants, and children in Indonesia's provinces and districts. HSP staff members have been working with the Ministry of Health to determine guidelines for de-concentration funds spending and processes for disseminating information to the province and district levels. Once the Minister of Health formally approves the guidelines, HSP will join representatives from the Ministry of Health to meet with stakeholders, Provincial Health Officers, and the Bureaus of Provincial Planning to facilitate the processes of implementing the guidelines and creating spending plans.
12.	Launching P4K Stiker in Tangerang, Banten	2007	In 2007, the Ministry of Health officially changed the name of its community-based birth preparedness and complication readiness program from *Desa Siap Antar Jaga* to P4K. HSP has been so involved in national capacity-building programs for birth preparedness, the Ministry requested HSP's support to launch the P4K program. The inauguration took place in a "model village" where the Community Health Committee receives support from HSP: Bunar village, in the Tangerang district of Banten. Around 50 pregnant couples turned out to tell the Minister of Health about their birthing plan, and district officials were on hand to showcase progress the district is making on maternal and child health.
13.	MPS-CS Workshop	2007	The MOH and HSP held workshops in six of HSP's target districts to solicit input from District Health Office (DHO) program staff on the structure and functionality of MPS-SIG. District teams used the Guidelines to review their workplans, as a way to monitor and assess district progress on implementing MPS, and progress in achieving the targets set forth in Healthy Indonesia 2010 and the 2015 Millennium Development Goals. Now under final revision, the Guidelines will be integrated into district planning.
14.	White Ribbon Alliance Meets with Indonesia's First Lady	February 14, 2007	The Indonesia White Ribbon Alliance (APPI) has made sure that Indonesia's First Lady Ani Yudhoyono is aware that every hour, two Indonesian women die due to complications with pregnancy and childbirth. Advocates from APPI, the Ministry of Health and the National Family Planning Board (BKKBN) asked the First Lady to support their campaign to promote safe motherhood in commemoration of the upcoming Indonesian National Holiday, Kartini Day. R.A. Kartini was a pioneer in the area of women's rights who died at the age of 25 from complications due to postpartum hemorrhage after the delivery of her first son. During the meeting, First Lady Yudhoyono agreed to be a patron of the White Ribbon Alliance and safe motherhood in Indonesia.
15.	Inauguration of Desa SiAGa in Sukapura, Bandung District, in West Java	April 2007	The community was enthusiastic about the *Desa SiAGa* activities from the beginning - on the first day, 160 people came from 15 RWs to get their blood tested. On day two, 200 cadres participated in a 5 KM healthy walk – which participants said was tiring but fun, with cadres singing along the road. Commented one participant, "We are happy with this healthy

No.	Activity	Date	Achievements
			walk. It was not only for our own health, but also a chance for us to get to know each other." After finishing the healthy walk, around 100 pregnant women and their husbands joined in on exercises for pregnant women and received maternal and neonatal health counseling. Says 31-year old Ibu Sumiyem, 3-months pregnant with her third child, "Before I didn't have enough knowledge about maternal and neonatal health, so I'm grateful for these events. I hope all pregnant women in my village can gain this knowledge, so if they face difficulties during their pregnancy they will know what to do."
16.	National Handwashing Campaign Launched in Jakarta	May 6 2007 At the National Monument in Jakarta	On Sunday, May 6 2007, a national hand-washing campaign launched at the National Monument in Jakarta, to encourage people to regularly wash their hands with soap. The Coordinating Minister for People's Welfare, Aburizal Bakri, welcomed the crowds by demonstrating how to hand wash with soap and releasing balloons. 2,700 mothers and children from 25 elementary schools in Jakarta and Bekasi participated in the campaign.
17.	Bidan Delima launched in Aceh	February 5, 2008	With HSP's support, the Bidan Delima program is now operational in Nanggroe Aceh Darussalam (NAD). IBI launched Bidan Delima in the presence of the Governor of Aceh, Irwandi Yusuf, who expressed his strong support for the program. Eighty-five new Bidan Delima members were inaugurated, with the Governor noting that the province's 6,420 midwives play an important role in serving the health care needs of families across its 6,388 villages.
18.	The "1,250 Pregnant Women" event in Aceh	April 2008	Banda Aceh topped Jakarta with an event attended by 1,250 pregnant women.
19.	The "2,000 Pregnant Women" event in Tangerang	April 2008	2,000 women in Tangerang total has commitment to have immediate breastfeeding.
20.	The "2,000 Pregnant Women" event in Deli Serdang	April 2008	2,000 women in Deli Serdang total has commitment to have immediate breastfeeding.
21.	*Suami Sigap* event in Surabaya	May 2008	Surabaya mobilized 1,000 pregnant couples – 2,000 men and women total has commitment to have immediate breastfeeding.
22.	The "1,001 Pregnant Women" event in Jakarta	May 2008	The newly elected governor of DKI Jakarta, Fauzi Bowo, committed to securing a pledge from 10,000 pregnant women to initiate early breastfeeding by his hundredth day in office. The Governor reached his goal, and with HSP's support hosted the "1,001 Pregnant Women" event at the Jakarta Convention Center. News coverage broadcast by more than 45 media outlets garnered national attention, which was followed by a series of smaller events at which the Governor's wife reached over 3,500 pregnant women in her role as the Head of the Jakarta PKK.
23.	Children's Parliament: Children's Inspiration for Health Development in Aceh	June 2008	The Children's Parliament was organized by the Aceh Cultural Institute (ACI), with the support of the Health Services Program. Founded by the former Minister for Human Rights, Dr. Hasballah Saad, ACI aims to provide participatory channels for children to express their own views, concerns and to reflect on t their perspectives. The Parliament was designed to provide a democratic forum for children to participate in civil society,

No.	Activity	Date	Achievements
			and to facilitate children's views being delivered to government. Dr. Hasballah noted the importance of children being able to experience truly participatory and democratic forums from a young age, so that when as adults they hold leadership positions, acting democratically will come naturally to them. The event was attended by Mr. Walter North, USAID/Indonesia Mission Director, who reminded the audience that former American President Bill Clinton got his start in politics when he participated as a student in Model Parliament activities in his home state of Arkansas. "I have every hope that sitting here today, there is a future leader who will be as successful as Bill Clinton was in politics," said Mr. North in his address.
24.	Workshop on Best Practices in Maternal and Child Health (MCH) Programming in NAD.	June 18—19, 2008 in NAD	The Nanggroe Aceh Darussalam Provincial Health Office hosted a conference for all 23 of its districts to learn about best practices in maternal and child health programming. Sponsored by the USAID Health Services Program (HSP), over 300 participants attended the conference and were able to participate in skills-building sessions on a range of issues: planning and budgeting for health, advocacy, quality ssurance, service provision, community mobilization, behavior change communications, and partnerships with the private sector. The conference was designed to allow participants to "track" courses in their specialty areas, with nationally-known resource people. DRPD members, health office staff, midwives, and NGO activists were in attendance.
25.	Journalists Workshop: A cost effective way for healthy life: Handwashing With Soap	October 15, 2008	Just in time for World Hand Washing Day, HSP partnered with the Ministry of Health (MOH), the World Bank's Water Sanitation Program (WSP), and Reckitt-Benckiser, the manufacturer of Dettol soap, to host a workshop aimed at encouraging journalists to report on the importance of hand washing with soap (HWWS) as an effective preventative measure against infectious disease, including diarrhea. Thirty-one journalists from a variety of media outlets - including one television station, three radio outlets, eight magazines and 11 newspapers - attended the halfday event. Guest speakers included Dr. Wan Alkadri from the MOH's Directorate of Environmental Health; Irwan Julianto, senior editor at Kompas newspaper; Dr. Nyoman Kandun, Director General for Communicable Diseases at MOH, and Professor Ascobat Gani, a noted health economist at the University of Indonesia
26.	National Workshop on Supportive Supervision in Jakarta	December 18, 2008 Hotel Bidakara, Jakarta	Attended by MOH, professional organization and NGOs to share best practices and lesson learned on implementation of supportive supervision for program sustainability. The result of meeting is to derive a set of recommendations for program replication and scale-up.
27.	Local Regulations passed	2008—2009	*Perda* (*Peraturan Daerah*) and *Perbub* (*Peraturan Bupati*) / passed:

No.	District/City	Date passed
1.	Kab. Sumedang	2 June 2008
2.	Kab. Malang	25 September 2008
3.	Kab. Madiun	17 November 2008
4.	Kab. Serang	20 November 2008
5.	Kab. Pasuruan	13 January 2009
6.	Kota Medan	20 January 2009
7.	Kab. Deli Serdang	16 February 2009
8.	Kab. Serdang Bedagai	February 2009

No.	Activity	Date	Achievements
			No. / District/City / Date passed 9. Kab. Purwakarta — 10 March 2009 10. Kota Sibolga — 13 March 2009 11. Kab. Bandung — 17 March 2009 12. Kab. Cirebon — 31 March 2009 13. Kab. Bogor (*Perbup*) — 26 May 2008
28.	Village Regulations passed	2008-2010	The village regulations (*Peraturan Daerah*) on MNCH passed in: • Deli Serdang : 8 • Malang : 221 (and additional 1 SK) • Pasuruan: 94 The village regulations (*Peraturan Daerah*) on *Musrenbang* passed in: • Deli Serdang : 1 • Kediri : 4 • Sumedang : 4
29.	The advocacy national meeting to share lessons learned and best practices in Jakarta	March 25, 2009 Hotel Bidakara, Jakarta	Attended by 114 out of 120 people we invited. They came from 23 HSP intervention districts incorporating MOH, districts, other departments and NGOs at national level. Participants from the districts comprised DPRD members, DHO (District Health Offices), local NGOs and Advocacy Team members. The event presented the following topics: "Health and Human Rights," "Experience in producing MNCH *Perda* through executive and legislative initiatives," "Working with Media for Advocacy Success," "The Result of MNCH Budget Analysis" and "Framework to produce *perda*." The session of sharing best practices and lesson learned from districts was very interesting. Four topics were presented: Lesson learned from Kota Medan in producing MNCH *Perda*, from Serang District that produced SKK (*Sistem Kesehatan Kabupaten* or District Health System), from Malang District and lesson learned from West Java about working with media for advocacy success. The moderator was Ridho from Legal Bureau of MOH.
30.	National Meeting on MNCH Program	March 2, 2009	A meeting as the preparation of National Dissemination of MNCH program at national level has been conducted. Meeting with MOH to discuss the best practices and lessons learned on program implementation of DTPS, advocacy, PPP, clinical training, IMCI, supportive supervision, Bidan Delima, BCC and Community Mobilization.
31.	Dissemination of MNCH Program at National Level	March 2, 2009	At a ceremony, over 200 people witnessed Indonesia's Ministry of Health (MOH) officially endorse a set of tools and modules created with technical assistance from USAID's maternal, neonatal and child health program. Commencing with the Director of Maternal Health, Dr. Sri Hermayanti, who thanked USAID and the Health Services Program (HSP) for their initiative and support, the event was not only an occasion to hand over MNCH tools to district health offices for national scale-up, but also an opportunity to reflect on lessons learned and insights gleaned from four years of collaboration. A symbolic gesture of the actual endorsement of program activities then took place as Lisa Baldwin presented

No.	Activity	Date	Achievements
			Dr. Budihardja with a board of icons representing the 17 MNCH programs on which HSP has assisted the MOH – including the DTPS guidelines, IMCI modules, Supportive Supervision books, and PONEK training packages. Widening the circle of stewardship in accordance with Indonesia's decentralized health system, Dr. Budihardja, in turn, handed the board over to a representative of the nation's 33 provincial health offices.
32.	Dissemination of MNCH Program at Regional Level	March 2009	Meeting with DHO and PHO to discuss the best practices and lessons learned on program implementation. A symbolic gesture of the actual endorsement of program activities then took place with a board of icons representing the 17 MNCH programs on which HSP has assisted the MOH – including the DTPS guidelines, IMCI modules, Supportive Supervision books, and PONEK training packages. In each places, the workshop held on: • Banten : March 4, 2009 in Serang • North Sumatera: March 10, 2009 in Medan • East Java : March 23, 2009 in Surabaya • West Java : March 30, 2009 in Bandung
33.	Seminar on Sharing Best Practices: Result of Grant and Allowance Project in MCH Program (Conducted by the Indonesia National Planning Board)	26 May 2009 Hotel Arya Duta Jakarta	Donors and NGOs working on MCH program including JICA, AusAID, DHS1-ADB, DH2-ADB, HSP-USAID, JTZ, UNICEF participated in this meeting. HSP's participation in the seminar to share the best practices and lessons learned of MCH program. A local parliament of Deli Serdang district was presented as best practice on advocacy activities and shared a lesson learned on MCH *Perda* in support the increasing of local budget.
34.	PERINASIA National Congress: Initiative to Improve Quality of Life of the Low Birth Weight	November 5-7, 2009 in Balikpapan	The three-day meetings with the main topic of the symposium is closely related with the quality of life of Indonesian children. Speakers were experts from bureaucrats, professionals and practitioners from referral or local teaching institutions in Indonesia or overseas.
35.	GSI Launching in Malang	December 2009	In conjunction with the celebration of Indonesia's 81st Mother's Day, the Regency of Malang launched a revitalization of the *Gerakan Sayang Ibu* (Mother Friendly Movement) as part of the Regency's efforts to reduce maternal and child mortality. Over 750 participants, mostly women involved in volunteer efforts at sub-district and village levels, formed the audience for a talk show style event with the theme: "Utilizing the strength, dignity, high-standing, role and position of women in Malang Regency, we can improve our maternal and child health status for a better quality of life."
36.	Series of meetings of the health professional associations on MDG	February 16-17, 2010. Hotel Crown, Jakarta	• IBI 8 Feb 49 participants (2 men, 47 women) • IAKMI 8 Feb 39 participants (21 men, 18 women) • PPNI 10 Feb 33 participants (15 men, 18 women) • IDI 11 Feb 17 participants (12 men, 5 women)
37.	Coordinating Ministry for People's Welfare (*Kemenko Kesra*) - National Workshop on MDGs: Achievement MDG 4 & 5 and Role of Professional Health Organizations	March 30-31, 2010 Hotel Grand Sahid Jaya, Jakarta	The "National Meeting on Strengthening the Health, Population and Family Planning Systems for the Achievement of MDGs 1, 4 and 5", was a major meeting of all national ministries and agencies with responsibilities for health-related goals, along with selected Governors

No.	Activity	Date	Achievements
			and *Bupati*s. Held with HSP support on 30-31 March, it was attended by 185 participants (152 men, 33 women). A series of concrete recommendations was made, which provide direction to both national Ministries and sub-national governments of the actions to be taken at each level. This guidance is important, as on April 18, 2010, the President of Indonesia, Dr. Susilo Bambang Yudhoyono issued a Presidential Instruction (*Inpres*) on Accelerating the Implementation of National Development Priorities. This instruction includes a series of commitments in line with improving performance against the MDGs, and all levels of government are expected to perform. Total participants 172 persons.
38.	Kowani meeting	May 2010	The Indonesian Women's Congress (Kowani) is the peak body representing over 80 women's organizations in Indonesia. HSP provided some support to a meeting on May 10 which had the theme, "Safe Motherhood Awareness Campaign"; the Minister of Health and Minister of Women's Empowerment both attended this event. On the 19-20 May, HSP hosted a major meeting of 280 participants (all women), representing 80 organizations, that looked at accelerating achievement of the MDGs by drawing on the potential resources implied in the existing mandates and missions of member organizations. As a follow up to this meeting, the Kowani Chairwoman took the recommendations, which related to MDGs 3,4,5 and 6, directly to the Vice-President of the Republic of Indonesia. Kowani also intends to present their recommendations to the Indonesian Chamber of Commerce, Kadin, in the hope of securing Corporate Social Responsibility funds.

Enhanced skills in delivery attendance improves health outcomes

Mothers and newborns benefit from HSP's intervention

Appendix 2: Complete List of Tools, Protocols and Modules Revised and Developed by HSP

Human Resource Training Manuals for the Implementation of the MNCH Program

Training Manuals for Maternal and Neonatal Health Program	
APN Training Manual	APN standardization training manual for health provider attending normal deliveries in different levels of health facility.
PPGDON Guidelines	Training manual for standardization and implementation of First Aid to Obstetric and Neonatal Emergency for health providers
PONED Training Manual	Training manual for standardization and implementation of Basic Obstetric and Neonatal Emergency Services for health providers
PONEK Training Manual	Training manual for standardization and implementation of Comprehensive Obstetric and Neonatal Emergency Services
Practical Guide to Family Planning Services/CTU	This guide provides practices guidelines to provide FP services.
Practical Guide to Maternal and Neonatal Services	This guide provides practices guidelines to provide maternal and neonatal services.
Practical Guide to Infection Prevention	This guide provides practices guidelines to apply infection prevention.
Training Manuals for Maternal, Neonatal and Under-Five Health Program	
Neonatal Asphyxia Management (included in APN)	Training manual for standardization and implementation of asphyxia management on low birth weight infants for midwives
LBW Management	Training manual for standardization and implementation of LBW management for village midwives
MCI	This book provides guidelines to assess a sick younger-than-2-month-old baby and how to manage it.
Training Package on Integrated Management of Childhood Illness (IMCI) (Ministry of Health, Republic of Indonesia, 2008)	This package consists of several books: 1. Facilitator's guide to the IMCI Module 2. Module 1 Introduction 3. Module 2 Evaluation and Classification of sick children age 2 months to 5 years 4. Module 3 Determine Action and Administration of Medication 5. Module 4 Counseling for Women 6. Module 5 Integrated Management of Newborn younger than 2 months old 7. Module 6 Follow up 8. Book on Photo Collection 9. Book on Charts of the Integrated Management of Childhood Illness 10. Recording Forms This package is for the IMCI training and implementation
Relevant Training Manuals	
Behavior Change Communication Manual	Training manual for District Health Office staff to improve their capacity in Behavior Change Communication.
IPC-C Training Manual	Guidelines on inter-personal communication and counseling for health providers.
Guide to the DTPS MNCH – MNCH Program Planning Process (Ministry of Health, 2008)	Training manual on planning and advocacy for the District Advocacy Team
Training Package on Supervision Supportive for Maternal and Child Health Program (Ministry of Health, Republic of Indonesia, 2008)	This package is a reference to conduct training on and implementation of supportive supervision for MCH Program manager and Midwife Coordinator at the district level, the head of Puskesmas, MCH Program manager and Midwife Coordinator at the Puskesmas. Supportive supervision applies to midwives in Pustu, village midwives, midwives in Puskesmas Kelurahan, and private practice midwives. The package consists of:

Training Manuals for Maternal and Neonatal Health Program	
	1. Reference for Maternal and Child Health Program Supportive Supervision 2. Handbook for participants of the MCH Program Supportive Supervision 3. Handbook for Trainers of the MCH Program Supportive Supervision 4. Reference for Management Information System (Software to process the MCH Data) 5. Checklist for Puskesmas with in-patient care, Supportive Supervision for MCH, FP, and Delivery Care Services 6. Checklist for Puskesmas, Supportive Supervision for MCH and FP Services 7. Checklist for Polindes, Supportive Supervision for MCH, FP, and Delivery Care Services
Manual on Community Mobilization for Participatory Development Planning (HSP and Yayasan Satu Indonesia, 2008)	Training Manual for the Village Health Committee to increase community participation in health program planning, especially MNCH
Training Module on Community Mobilization for Maternal and Child Health Program (HSP, 2007)	This training module is developed for village facilitator to conduct need assessment and long-term planning together with the community. The book discusses the content of each session in the training (1) The basics in community mobilization, (2) The phases of community mobilization, (3) The skills and tasks of community mobilization officers, (4) The relationships between community leaders – Village Health Committee –Village midwife – *Puskesmas* staff, (5) Community need assessment, (6) Long term planning, (7) P4K. Components

Quality Assurance Guide to the Maternal and Child Health Program Implementation and Services	
Guide to Maternal and Neonatal Health Program Implementation and Services	
FP Program Management	This book provides guidelines on FP Program Management.
Guidelines on Birth Preparedness and Complication Readiness with Sticker (Ministry of Health, Republic of Indonesia, 2009)	This book contains guidelines to implement the steps on P4K. It explains (1) the background, objectives, benefits, target population, definition and legal foundation of the P4K with Sticker; (2) implementation of the P4K with Sticker including program indicators, outputs of the P4K with Sticker, components of the P4K with Sticker, activity phases, the role of Puskesmas, midwife, TBA and MCH support group, and MCH support group workplan; and (3) way to monitor and evaluate P4K.
ANC Guide	A reference for the provision of antenatal care for pregnant women
MCH Book	The MCH book contains record of maternal health (pregnancy, childbirth, postpartum) and child (newborns, infants and under-five) health (growth and development). It also contains information on maternal and child health and how to maintain it.
Management guide to women's class	A guide to conduct women's class program. The activity is intended to give important knowledge to pregnant women so that they will have a clean and safe pregnancy and delivery.

Quality Assurance Guide to the Maternal and Child Health Program Implementation and Services	
Guide to Maternal and Neonatal Health Program Implementation and Services	
Guidelines to Basic Midwifery Services based on Human Rights and Gender Fairness (Ministry of Health, Republic of Indonesia, Directorate General of Public Health, Directorate of Family Health, 2004)	This book is intended for midwives in providing antenatal services, delivery and postpartum care integrated under innovative approach by raising awareness of human rights and gender. It is revised to reflect the updated services standards. The book was developed based on the guidelines for Basic Midwifery Services adapted from the Healthy Mother and Healthy Newborn Care book of 1997 and 1998. The followings are explained in the book (1) Midwifery services based on human rights and gender; (2) Midwife's leadership in the community containing leadership around reproductive health and rights, characteristics of effective leadership, and how to build midwife's leadership capacity; (3) communication skill in counseling; (4) antenatal services (equipment, history taking, physical examination, need-based services, recording of antenatal service results); (5) infection prevention covering objectives, definition and principles, infection prevention procedure, hand washing and use of gloves, application of aseptic techniques, and infection prevention outside an institution; (6) Delivery care covering the stages of the delivery process, maternal care during delivery, 1st, 2nd, and 3rd stage of labor, and childbirth services; and (7) Postpartum care (changes to woman and baby and postpartum services)
Midwifery Service Standards	This book contains information on standards in midwifery service provision.
Guidelines to STI Services in Integrated Reproductive Health	This book provides guidance on how to manage sexually transmitted infection in women
Guidelines on Malaria Prevention and Management	This book provides guidance on how to manage malaria in pregnant women
Guidelines on PMTCT	This book provides guidance on how to maintain and manage the health of pregnant woman who has HIV infection to prevent transmission to her baby.
Technical guidelines on Injection of Prophylactic Vitamin K1 for newborn	Guidelines to inject vitamin K1 prophylaxis to newborn for health providers.
Guidelines on MPA	Guidelines to trace causes of maternal and neonatal morbidity and mortality. This tracking is important to avoid recurrence.
Guidelines to Develop Basic Emergency Obstetric – Neonatal Services (PONED) (Ministry of Health, Republic of Indonesia, 2004)	This book is used to develop and implement PONED in the district. This guidelines explain (1) Policy on program development covering definition and criteria, person in charge, support from relevant parties, PONED distribution, and collaboration in provision of PONED services; (2) Steps to develop a PONED *Puskesmas* including preparation, implementation, recording and reporting, and monitoring and evaluation; and (3) program supervision covering aspects of supervision, organization, role of supervisor and supervision activities.
Guidelines on Maternal and Neonatal Referral System at the District Level (Ministry of Health, Republic of Indonesia, 2007)	This book is intended for health providers who manage and provide maternal neonatal health services. It explains the following (1) Definition of MPS as the strategies to accelerate reduction of MMR and NMR; (2) Maternal and Neonatal Referral System, covering maternal and neonatal referral problems, benefit and definition of the maternal and neonatal referral system, development of pre-hospital, referral path of emergency obstetric and neonatal services, development of 24-hour PONEK hospital, recording and reporting, monitoring and evaluation, quality assurance program, indicators, and community participation in maternal and neonatal referral system; (3) development of maternal and neonatal referral system components including PONEK at the district hospital, PONED in *Puskesmas* and *Puskesmas* with in-patient, PONED at village health facilities; and (4) Evaluation of performance including principles to measure performance, measurement of 24-hour emergency unit performance, and obstetric and neonatal emergency services for patients.

Guide to Neonatal, Infant and Under-Five Health Program Implementation and Services	
Buku KIA (the Maternal and Child Health book)	The MCH book contains record of maternal health (pregnancy, childbirth, postpartum) and child (newborns, infants and under-five) health (growth and development). It also contains information on maternal and child health and how to maintain it.
Management guide to the class of women with under-five	This book provides guidance to manage a class for women with under-five. This activity is intended to provide the best information that women with under-five should know to be able to maintain and monitor her child's growth and development.
Training Package for Integrated Management of Childhood Illness (IMCI) (Ministry of Health, Republic of Indonesia, 2008)	IMCI is a management approach for sick under-five who come to a health facility. IMCI provides guidance for health provider to conduct comprehensive assessment of sick under-five to avoid mistakes in diagnosis and/or undiagnosed health problems. IMCI provides guidance on management of under-five for health problems based on assessment findings. The reference for IMCI is the book on Integrated Management of Childhood Illness charts and recording forms that is a part of the Training Package for Integrated Management of Childhood Illness.
Other Relevant Implementation Guidelines	
Guide on MCH LAM	A guide for the MCH program management to continually monitor coverage of the MCH services in an area for fast and appropriate follow up in areas with low MCH service coverage.
Guide on Bidan Delima	A guide for management and technical guidelines for implementing Bidan Delima Program in conjunction with the Pre-qualification tool, self-assessment, validation and facilitator's guide.
Implementation Guide for Deconcentration fund	A guide for the implementation of the MCH Program at the district using the Deconcentration fund

Reference for Monitoring, Supervision and Evaluation of the MNCH Program and Services

Reference for Supervision of the MNCH Program and Services	
Supportive Supervision of the Family Planning Services (Ministry of Health, Republic Indonesia, Directorate General of Public Health, Directorate of Maternal Health, 2006)	This manual explains the way to conduct supportive supervision on the FP services. It explains (1) integration of FP services into the health system, covering planning of the FP services and Recording and Reporting System for the FP services; (2) the main topics in supportive supervision that include definition, supportive supervisor, and connection between supervision supportive and quality assurance; (3) implementation of supportive supervision in FP services and (4) guide on how to fill in supportive supervision tool for FP services. This manual is intended for health providers who supervise FP services at the district and *Puskesmas*.
Manual for Medical Audit of the Family Planning Services (Ministry of Health, Republic of Indonesia, 2004)	This manual explains the objectives and methods for Medical Audit of FP Services (MPA-FP). The book explains (1) the objectives, target, operational definition, scope, influencing factors and strategies to implement the MPA-FP; (2) MPA –FP mechanism that includes principles and procedure of the MPA -FP; (3) steps to do the MPA –FP that include preparation, implementation, and monitoring and evaluation; and (4) Reporting and indicators. This book serves as a reference for FP providers at the district level, district hospital, *Puskesmas*, and village midwife.
Situation Analysis and Technical Guidance on FP Management Services (Ministry of Health, Republic Indonesia, Directorate General of Public Health, Directorate of Maternal Health, 2007)	This book simply discusses data on FP services to analyze technical guidance for FP service outlets in provincial and district levels. The book was developed for the FP service manager at the provincial and district levels to supervise quality of FP services at basic health services level. This book explains (1) type of FP service data and (2) technical guidance for data analysis that include analysis of data on performance and quality of FP services, analysis of supporting data, source of data, and activities to improve quality of FP services.
Package-I Self Assessment Tool: Tool to Measure Facility Performance (Directorate General of Public Health, Ministry of Health, Republic Indonesia, 2005)	This book contains guidance to use the self-assessment tool on (1) HR and physical structure, (2) facility management, (3) implementation of client-oriented principles, and (4) infection prevention efforts.
Package-II Self Assessment Tool: Tool to Measure Facility Performance (Directorate General of Public Health, Ministry of Health, Republic Indonesia, 2005)	This book contains instructions on how to use the self-assessment tool on (1) new FP client, (2) new FP pill user, (3) new FP injection user, (4) new IUD user, (5) new implant user, (6) combined oral continuing user, (7) progestin-only pill continuing user, and (8) follow-up visit of IUD user.
Maternal and Child Health Program Supportive Supervision Training Package (Ministry of Health, Republic Indonesia, 2008)	This book is not only intended for supportive supervision training, but also guidelines for conducting supportive supervision. Supportive supervision activities are carried out by the MCH program manager and midwife coordinator at the district level, head of the *Puskesmas*, and MCH program manager and midwife coordinator at the *Puskesmas*. Supportive supervision applies to midwives in *Pustu*, village midwives, Puskesmas *Kelurahan* midwives, and private practice midwives.
Guidelines on Birth Preparedness and Complication Readiness with Sticker (Ministry of Health, Republic Indonesia, 2009)	This book contains guidelines to implement the steps on P4K. Chapter III explains the steps to monitor and evaluate P4K.
Guidelines to Develop Basic Emergency Obstetric – Neonatal Services (PONED) (Ministry of Health, Republic Indonesia, 2004)	This book explains the steps to develop PONED in the district. Chapter IIIC explains the reporting and recording and chapter IIID explains the steps on monitoring and evaluation that include monitoring, supervision and evaluation activities. And chapter IV explains the supervision for PONED that include organization, role of supervisor and supervision activities.

Reference for Supervision of the MNCH Program and Services	
Guidelines for Monitoring, Supervision and Evaluation of Neonatal, Infant and Under-Five Health Program and Services	
Guidelines for Monitoring, Evaluating and Mapping of Integrated Management of Childhood Illness (IMCI) Application at the District and Province (Ministry of Health, Republic Indonesia, 2007)	The guidelines contain (1) background and objectives of training, post training monitoring, routine supervision, evaluation and mapping of IMCI application and (2) how to monitor, evaluate and map IMCI mapping that includes definition, objectives and target population, monitoring and evaluation tool and its use, and analysis of monitoring and evaluation results.
Other Relevant Monitoring and Supervision Guidelines	
Guide on MCH LAM	A guide for the MCH program management to continually monitor coverage of the MCH services in an area for fast and appropriate follow up in areas with low MCH service coverage.
Implementation Guide for Deconcentration fund	A guide for the implementation of the MCH Program at the district using the Deconcentration fund

Appendix 3. Pathway to Care and Survival – Diagnostic and Implementation Process

	Issues	Life-Saving Initiative	Objectives	Activities and Interventions	Coordination and Partnership	Monitoring and Evaluation Indicators	Extension Program Indicators
Household and Community	**Maternal health** - MMR 307/100,000 live births (2002) - Hemorrhage, Sepsis, Eclampsia - Unsafe Abortion - Shortage of service from skilled providers - 59% deliveries take place at home - 34% home delivery attended by skilled providers - Socio-cultural discrimination against women - MCH- related infectious diseases	**Step 1. Recognition of Problem** - Women and their families don't recognize dangerous complications - Knowledge awareness - Effect/ vulnerability **Step 2. Decision to Seek Care** - Women and their families delay deciding to seek care - Behavior - Motivation to seek care - Barriers **Step 3. Access to Care** (Logistics to reach) - Women don't receive prompt care at health facilities - Transportation - Cost	- Increase knowledge and improve health behavior of households and community - Raise awareness about signs of life-threatening complications, birth preparedness/ antenatal care, safe clean delivery, post partum care, P4K/ *Desa Siaga* - Provide education to men and women about when and where to seek care. - Develop community MCH Plans based on needs assessments. - Create emergency transportation plan. - Upgrade transportation systems. - Enhance referral systems	- Trained skilled attendant at delivery - Basic obstetric and neonatal care (APN) - Standard precautions and prevention of Infection (hand washing) - Birth Preparation and Complication Readiness (P4K-*Desa Siaga*) - Comprehensive Emergency Obstetric Neonatal Care (CEMONC – PONED + PONEK) - Prevention and treatment of intrapartum & postpartum hemorrhage and complications - Quality improvement – Supportive Supervision - Improve MPA + LAMAT Systems	Ministry of Health, BKKBN, UNFPA, UNICEF, USAID, WB, ADB, GTZ, CIDA, UNDP, AusAID, APPI, Care, Save the Children, YLKI, Professional Organizations (POGI, IDAI, IBI, PPNI, IAKMI), WHO	MMR % skilled birth attendance % ANC (K1,4) % postpartum visit Contraceptive prevalence	**Area 1:** Integrated Model - Skilled birth attendance - Early initiation of breastfeeding **Area 4: I**BI and Bidan Delima - No. of Bidan Delima
	Neonatal Health 32/1000 live births Major causes of death: asphyxia, sepsis, hypothermia, LBW/ prematurity, diarrhea **Infant Health** 25/1,000 live births Major causes of death: pneumonia, diarrhea, malnutrition Only 16% of infants (0-3 months) are exclusively breastfed		- Increase knowledge and improve health behavior of households - Develop action plans for neonatal emergencies - Raise women's status. - Educate community members about the importance of seeking care swiftly - Raise awareness about signs of life-threatening newborn complications, birth preparedness/ antenatal care, safe clean delivery, post partum care, family planning - Provide education to men and women about when and where to seek care fop newborns - Develop community MCH - Plans based on needs assessments	- Improving nutrition and health of women during pregnancy, labor and postpartum - Tetanus Toxoid - Immunization for pregnant women - Birth and emergency preparedness (P4K/*Desa Siaga*) - Early detection of pregnancy related problems affecting infant health - Prevention of Mother-Child Transmission of HIV - Clean and safe deliveries (APN) - Cord, eye and skin care - Education on introduction and assistance for low birth weight or "too" infants & essential nutrition - Prevention & management of hypothermia (skin-to-skin/kangaroo method) - Introduction to and management of asphyxia - Early initiation of and exclusive breastfeeding - Recognize and refer infection case - Neonatal and infant immunization - Information and counseling on home care, danger signs, and area for infant and neonatal management APN, PONED, PONEK, IMCI	Ministry of Health UNICEF, WB, ADB, GTZ, CIDA, UNDP, USAID, AusAID, IDI, IDAI, POGI, IBI, PPNI, IAKMI, Care, Plan Int., Save the Children, WHO	NMR & MMR % mother & family seek care % early initiation of breastfeeding % exclusive breastfeeding Neonatal visit % of families utilizing referral facility % of families using skin-to-skin/kangaroo care % of families able to provide neonatal home care % of Asphyxia management	**Area 1:** Integrated Model - Early initiation of breastfeeding - Proportion of newborns receiving post-partum care visit **Area 3:** PONEK - % of hospital obstetric unit staff performing to standard - % of hospital neonatal unit staff performing to standard

	Under-five Health U5MR 103/1000 Major causes of death: - infection, high fever/ DHF, diarrhea and ARI/ Pneumonia - 26% malnourished or low body weight (medium to severe) - Low coverage of immunization on preventable diseases - Only 16% of infants (0-3 months) are exclusively breastfed		Increase knowledge and improve health behavior of households: - Raise awareness about prevention and signs of life-threatening child health problems - Provide education to men and women about preventive behaviors, immunization, handwashing with soap, household sanitation, use of clean water, when and where to seek care - Develop community MCH plans based on need assessment	- Nutritional improvement for lactating women - Education on complementary feeding and rich in nutrition (and micronutrient such as Vit. A, Fe, Iodine) for under-five - Stimulation, Detection, Intervention on Infant Growth and Development - Access to and nutritional improvement and complementary nutrition supply for under-five - Prevention and treatment of diarrhea, ARI, nutritional problem (IMCI) - Clean water supply and household/ neighborhood sanitation improvement - Full immunization - Improvement on referral system for under-five health problem - Verbal autopsy for every under-five death and improvement of under-five health initiative based on autopsy findings	Ministry of Health. UNICEF, WB, ADB, GTZ, CIDA, UNDP, USAID, AusAID, IDI, IDAI, POGI, IBI, PPNI, IAKMI, Care, Plan Int., ESP, SWS, ID, Save the Children WHO	Under-5 mortality ratio % of exclusive breastfeeding/6 months % of micronutrient coverage % of full immunization coverage % of well-nourished under-five % use of clean water and hand washing % responsive to under-five danger/ emergency health problem % utilization of referral facility	
Health Providers and Facilities	**Providers and Facilities** - Public health facilities reach only about a third of the country's population - Limited services available in public facilities - Poor community participation - Low availability of adequately trained and skilled health providers at facilities - Low community knowledge and interest on health services - Decentralization process not uniformly applied or adequately budgeted for minimum service standards for basic integrated package of services - Private sector - Financial barriers - Social barriers (Discrimination against the poor)	**Step 4. Quality Care** - Women, newborns/infants and under-five don't receive prompt care at health facilities - Knowledge, skills, attitudes, behaviors should be - improved to provide quality services - Technical competency: training & experience will lead to effective and safe services - Ability to provide sufficient supplies, equipment, drugs - Continuity of care - Strengthening district health management, planning, budgeting, implementation and monitoring of health programs	- Improve access & quality of essential MNCH services - Strengthen district capability to provide essential MNCH services - Sustain established child survival programs - 24 hours obstetric/neonatal care - Upgrade the quality of care at health facilities. - Increase compliance to national protocols to treat obstetric complications (CEMONC – APN, PONED, PONEK, IMCI) - Ensure adequate stocks of medical, drugs supplies and blood. - Enhance referral systems between communities and health facilities - Develop district health plans based on community needs for integrated service package	- Improve collaboration with other facilities - Implement national service standards for obstetric and neonatal care with APN, PONED, PONEK, IMCI, Supportive Supervision - Improve planning skill with DTPS - Competency-based training and qualification assurance for providers - Assist MOH to improve implementation of the integrated package of MNCH services (district level) - Assist IBI to improve management of the Bidan Delima Program - Develop and test effectiveness of revised maternal, neonatal, infant and under-five referral system - Improve performance of private providers and facilities in essential obstetric and neonatal management (Bidan Delima) - Training for health managers to develop plan based on performance, funding availability and effective MNCH improvement initiative (DTPS Advocacy)	MOH Maternal health, Child Health, Dir. Of Med. Services. Dir. Of Health Communicatio, Nutrition, Pusdiklat, Min. of Women Empowerment, Min. of Education, Min. of Religious Affairs, MoHA, Bapenas/Bapeda, WHO, PHO, DHO, DPR/DPRD, JNPK, Univ.Med. Faculty, Midwifery/nursing academy, UNFPA, Care UNICEF, Plan Int., BKKBN, USAID, Parliamentarians Forum, WB, ADB, GTZ, CIDA, UNDP, AusAID, APPI, YLKI, POGI, IDAI, IBI, PPNI, IAKMI, P2KT, P2KS, P2KP, Save the Children	MMR, IMR, U5MR % of full time and quality services % of district performance based planning using budgeting tools % of community empowerment body at the district level % of districts meeting MOH performance standards % of community who are satisfied with provider's services Number of advocacy initiatives Number of districts reporting and increased share for MNCH services within the total district budget Number/percent of trained providers who perform to established standards	**Area 1:** Integrated Model - Increase in district budget allocation to health - Districts with MPS committee - Use of DTPS for MNCH planning **Area 2:** Replication - Proportion of budget allocated to MNCH **Area 3:** PONEK - % of hospital obstetric unit staff performing to standard - % of hospital neonatal unit staff performing to standard **Area 4:** IBI and Bidan Delima - No. of Bidan Delima

APPENDIX 4. EVIDENCE BASED INTERVENTIONS

CAUSES OF DEATH (and disability)	% DEATH INDONESIA	% MORTALITY REDUCTION	EVIDENCE-BASED INTERVENTIONS (bold font indicates interventions pre-delivery)
MATERNAL In Indonesia, approximately 20,650 women and girls die each year from pregnancy-related complications, and another 413,000 to 619,000 suffer from pregnancy-related morbidities (BASICS). Estimated mortality during pregnancy is 10%, during delivery 14% and postpartum 3.3%, with wide provincial variations. (1995 HHS). Indonesia is working towards the MDG target of reducing by three-quarters, between 1990 and 2015, the maternal mortality ratio. **MOH 2009 Target for MMR is to reduce it from 307/100,000 to 226/100,000.**			
Hemorrhage	28%	60%	AMTSL (use of uterotonic agents; controlled cord traction; fundal massage) (Fe Supplementation)
Eclampsia	24%	7%	Management of convulsions; magnesium sulphate; stabilization; referral for prompt delivery (detect in pregnancy; Fe supplementation)
Infection	11%	13%	Clean delivery; antibiotics if infection arises; shock management including blood transfusion, remove retained placenta, fluids, antibiotic treatment of infection/TT2
Obstructed Labor	5%	10%	Detect in time; refer for operative delivery; partograph; assisted extraction
NEONATAL In Indonesia, 1 in 3 births have an elevated mortality risk that is avoidable. Deaths in the newborn period count for 56% of all deaths during the first year of life. Global evidence shows two-thirds of infant deaths occur within the first month of life; among those, two-thirds die in the first 24 hours. 70% of neonatal deaths occur at home without a SBA. (IDHS, BASICS). **MOH 2009 Target for NMR is to reduce it from 20/1000 to 15/1,000; IMR is to reduce it from 35/1000 to 26/1000.**			
Complications of Prematurity/LBW (contributing factor)	35%	20-40%	Skin-to-skin; drying and warming; early and exclusive breastfeeding; antibiotics (mother: birth spacing, nutrition, malaria control). Immediate breastfeeding alone could reduce mortality by 17-22%.
Birth Asphyxia and Injury	27%	5-30%	Skilled birth attendance at birth; stimulation and resuscitation
Neonatal Infections	15%	10-30%	Clean safe delivery, tetanus immunization during pregnancy, cord care, eye care, early and exclusive breastfeeding
Tetanus	10%	10-20%	Antenatal care; physical examination; TT2
CHILD under 5 years of age. In Indonesia, childhood mortality continues to decline. Coverage of childhood immunizations against the six major diseases rise from 52% in 2002/03 to 59% in 2007/08 (IDHS). Indonesia is working towards the MDG target of reducing by two-thirds, between 1990 and 2015, the under-five mortality rate. **MOH 2009 Target for reducing CMR is to reduce it from 46/1000 to 33/1000.**			
Malnutrition (contributing factor)	54%	30-50%	Essential nutrition interventions (iodine, exclusive and complementary breastfeeding, care of sick and malnourished children, vitamin A, Fe). Exclusive breastfeeding alone could reduce mortality by 10-13%
Acute Respiratory Infections (ARI)	25%	30-60%	Antibiotics; breastfeeding (immediate, 6-months, up to 2 years); complementary feeding
Diarrhea	12%	40-50%	Feeding practices; ORS; zinc, breastfeeding and increased fluids for sick children; handwashing with soap; safe drinking water
Measles	7%	30-86%	Immunization; vitamin A
Malaria	5%	40%	Antimalarial treatments; C-IMCI

Reproductive Health practices (antenatal care, delay first pregnancy, birth spacing, family size); **Infant and Child Feeding** practices (breastfeeding, complementary feeding); **Immunization** practices (full course for infants, sick infant immunizations, TT2 for mothers); **Home Health** practices and treatment (insecticide-treated bednets, handwashing, drinking water, fecal matter disposal, vitamin A, iodized salt, care during illness, ORT, medicine appropriateness); **Care-Seeking** practices (recognizing illness, seeking appropriate care)

Sources: a. UNFPA/Indonesia; b. USAID/CORE Maternal and Newborn Standards and Indicators Compendium; c. Susenas 1998; Indonesia Demographic and Health Survey 2002/2003; d. Surkesnas 2001; e. CAH-WHO 1995, 1999, 2004; f. Lancet 2005. Other resources include Basics II Newborn Health in Indonesia Situation Analysis 2004, Healthy Indonesia 2010 and the Millennium Development Goals

Abbreviations and Indonesian Terms

AMTSL : Active Management of the Third Stage of Labor
APBD : *Anggaran Pendapatan dan Belanja Daerah*; Government funds available from provincial and district income
APN : *Asuhan Persalinan Normal*; Basic delivery care training for midwives
Askeskin : *Asuransi Kesehatan Miskin*; Health Insurance for the Poor
AT : *Aman Tirta*; USAID's project
Bappeda : *Badan Perencanaan dan Pembangunan Daerah;* Regional Planning Board
Bappenas: *Badan Perencanaan dan Pembangunan Nasional;* National Planning Board
BCC : Behavior Change Communication
BOK : *Bantuan Operasional Kesehatan*; Operational fund for *Puskesmas*
BKKBN : B*adan Koordinasi Keluarga Berencana Nasional;* National Family Planning Coordination Board
BP : British Petroleum
CHC : community health committee
Commob : community mobilization
CS : Child Survival
CSR : Corporate Social Responsibility
Desa Siaga : *Siap Antar Jaga* (literally, a village prepared to assist and protect; a national birth preparedness and complication readiness program)
DHO : District Health Office
DPRD : *Dewan Perwakilan Rakyat Daerah*; District legislature
DTPS : District Team Problem Solving; WHO-originated budgeting and planning tool
ESP : Environmental Services Program; USAID's program
FP : Family Planning
FY : Fiscal Year
GOI : Government of Indonesia
GSI : *Gerakan Sayang Ibu*; Mother-Friendly Movement
HIS : Health Information System
HIV : Human Immunodeficiency Virus
HSP : Health Services Program; a USAID's project
IAKMI : *Ikatan Ahli Kesehatan Masyarakat Indonesia*; Indonesia Public Health Association
IBI : *Ikatan Bidan Indonesia;* Indonesian Midwives Association
IDAI : *Ikatan Dokter Anak Indonesia*; Indonesian Pediatric Association
IDI : *Ikatan Dokter Indonesia*; Indonesian Medical Doctor Association
IEC : Information, Education and Counseling
IMCI : Integrated Management of Childhood Illness
IPI : Integrated Package of Interventions
JNPK : *Jaringan Nasional Pelatihan Klinis*; National Clinical Training Network
KADARZI : *Keluarga Sadar Gizi*; Family aware of nutition
KMC : Kangaroo Mother Care
LAM : Local Area Monitoring
LAMAT : Local Area Monitoring and Tracking
LGSP : Local Governance Support Program; a USAID's project
MCH : Maternal and Child Health
MCHIP : Maternal and Child Health Integrated Program; a USAID's project
MDGs : Millennium Development Goals
MMR : Maternal Mortality Ratio
MNCH : Maternal, Neonatal and Child Health
MNERC : Maternal and Neonatal Emergency Room Care
MOH : Ministry of Health
MPA : Maternal Perinatal Audit
MPS : Making Pregnancy Safer (MOH strategy)
Kemenko Kesra : *Kementerian Koordinasi Kesejahteraan Rakyat*; Coordinating Ministry for People's Welfare
Musrenbang : *Musyawarah Perencanaan Pembangunan*; Development Planning Meeting
NGO : non-governmental organization
ORT : Oral Rehydration Therapy
P4K : *Program Perencanaan Persalinan dan Pencegahan Komplikasi*; MOH's Birth Preparedness and Complication Readiness program
Perda : *Peraturan Daerah*; district regulation
Perdes : *Peraturan Desa*; village regulation
Perinasia: *Perkumpulan Perinatologi Indonesia*; Indonesian Perinatology Association
PHBS : *Perilaku Hidup Bersih dan Sehat*; Clean and Healthy Life Behaviors
PHO : Provincial Health Office
PKK : *Pemberdayaan Kesejahteraan Keluarga*; Family Welfare Movement
PNPM : *Program Nasional Pemberdayaan Masyarakat*; National Community Empowerment Program
POGI : *Perkumpulan Obstretri dan Ginekolog Indonesia*; Indonesian Obstetric Association
Polindes : *Pos Bersalin Desa*; Village Birthing Clinic
PONED : *Pelayanan Obstetri Neonatal Emergensi Dasar*; Basic Emergency Neonatal Obstetric Care
PONEK : *Pelayanan Obstetri Neonatal Emergensi Komprehensif;* Comprehensive Neonatal Obstetric Emergency Care
Posyandu : *Pos Pelayanan Terpadu*; Integrated Health Post
POPPHI : Prevention of Postpartum Hemorrhage initiative
PPNI : *Persatuan Perawat Nasional Indonesia*; Indonesian National Nurses Association
PPP : Public Private Partnership
PTP : *Perencanaan Tingkat Puskesmas*; Puskesmas Planning
Puskesmas : *Pusat Kesehatan Masyarakat*; sub-district health facility
Pustu : *Puskesmas Pembantu*; satellite health clinic
Q+A : Qualification and Accreditation
QUAPEC: QUality and Access to PErinatal Hospital Care
SDIDTK : Neonatal and Child Growth and Development Monitoring
SS : Supportive supervision
TT2 : 2nd Tetanus Toxoid immunization
UNICEF : United Nations Children's Fund
USAID : United States Agency for International Development
WSP : World Bank's Water and Sanitation Program
WHO : World Health Organization

References

1. Adapted from Helen de Pinho presentation at the Wilson Center in the symposium on Maternal and Newborn Health as a Priority for Strengthening Health Systems, March 8, 2010.

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HSP Implementing Partners

JSI John Snow Incorporated is a leader in improving health of individuals and communities worldwide. JSI has implemented projects in maternal health, reproductive health, child health, HIV/AIDS, and commodity security in 84 countries. JSI and its partner sub-contractors supported the Health Services Program (HSP) to build local capacity to address critical health problems based on expertise and evidence-based experience.

Abt Associates Abt had primary responsibility for coordinating the district decentralization support work, and developing a coordinated approach to BCI, advocacy and community mobilization. Abt focused on improving management capacity at the district level and harnessing the private commercial and NGO sector to improve MNCH as well as building the capacity of the Bidan Delima program with IBI.

Mercy Corps Mercy Corps is a community facilitating organization and provided assistance for the community mobilization activities.

The Manoff Group Manoff provided behavior-centered programming for nutrition and behavioral change communication. Internal and external factors influence behavioral change. Therefore, it is important to understand underlying behavior and use it to design strategies for behavioral change. Behavioral science and communication is brought in to build capacity in strategic communications and community decision-making, and also to monitor and evaluate practice improvements.

University of Indonesia The Center for Family Welfare is a research institution within the University of Indonesia. It has a large number of experts with different disciplines and a large amount of experience from previous projects. UI's major areas which provided assistance are as follows: Monitoring and Evaluation of the Program; Strengthening MOH Supportive Supervision System; Baseline and End-assessment and Surveys of the Program; Advocacy to Government, NGOs and Private Sectors; and Drugs and Commodity Management (DCM); QUAPEC Study.

HEALTH SERVICES PROGRAM

Maternal, Newborn, and Child Health Program
Program Kesehatan Ibu, Bayi Baru Lahir, dan Anak