

**Technical Review**  
**Recommendations for Future Directions for**  
**Safe Motherhood and Neonatal Health**  
**USAID Indonesia**

A Report Prepared for USAID

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## **Acronyms**

ADB	Asian Development Bank
AKBID	Midwifery Pre-service training academy (Akademi Kebidan)
PAC - APK	Post abortion care (Asuhan Persalinan K
BDC - APN	Basic Delivery Care Training Package (Asuhan Persalinan Normal)
ASUH	Healthy Start for a Healthy Life
AusAID	Australian Agency for International Development
BCI	Behavior Change Interventions
BDD	Bidan di Desa (village midwife)
BPCR	Birth Preparedness and Complication Readiness
CCU	Curriculum Content Units (Diploma Education of Bidan)
Desa SIAGA	Alert Village (Desa - village; SIAGA – Siap Antar jaGA)
DPRD	District Parliament
FGD	Focus Group Discussion
GoI	Government of Indonesia
GSI	Gerakan Sayang Ibu (Indonesian Mother Friendly Movement)
IBI	Indonesian Midwives Association (Ikatan Bidan Indonesia)
IPC/C	Interpersonal Communication and Counseling
KuIS	Coalition for Healthy Indonesia – Koalisi Indonesia Sehat
MEOR	Monitoring, Evaluation and Operations Research
MNHI Program	Maternal and Neonatal Health Indonesia Pogram
MPS	Making Pregnancy Safer (WHO global initiative)
MoH/DepKes	Ministry of Health/Departmen Kesehatan (Department of Health)
NCTN - JNPK	National Clinical Training Network – Jaringan Nasional Pelatihan Klinik
NGO	Non-government organization
PKBI	Indonesian Planned Parenthood Association (Perhimpunan Keluarga Berencana Indonesia)
PKK	Family Welfare Program (Program Kesejahteraan Keluarga)
PPH	Post partum haemorrhage
PQI	Performance and Quality Improvement
SNL	Saving Newborn Lives
STARH	Sustaining Technical Achievements in Reproductive Health
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WRA - APPI	White Ribbon Alliance (Alliansi Pita Putih Indonesia)

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## Executive Summary

### *Introduction:*

The Maternal and Neonatal Health Indonesia (MNHI) Program Review (11 August – 5 September 2003) had the overall purpose of:

- Identifying the key accomplishments of the MNHI Program and making technical and programmatic recommendations to focus and consolidate the United States Agency for International Development's (USAID) future directions in safe motherhood and neonatal health.
- Engaging key stakeholders from Ministry of Health/Departemen Kesehatan (MoH/DepKes), professional and Islamic associations, Non-government Organizations (NGOs), women's associations, district teams, community groups and key donors to recommend future technical and programmatic directions.
- Examining and identifying strategies and approaches to scale up successful interventions and approaches.

The results of the review process will be utilized by USAID/Indonesia to assist in refocusing and guiding future directions to support safe motherhood and neonatal health programming.

### *Process:*

The Review process sought to consult with a broad stakeholder group. Through Focus Group Discussions (FGDs) and Key Informant interviews over 100 people from the Government of Indonesia (GoI), donors, NGOs and other stakeholders were able to express views on the future directions for safe motherhood and neonatal health, skills development, quality improvement, referral systems and sustainability. A wealth of information was presented during this process and was supportive in the development of the new strategic directions proposed by the team. During the course of the review the team also had the opportunity to have intensive conversations with the Technical Assistance teams from the MNHI and Health Start for a Healthy Life (ASUH) Programs.

### *Results of the Review*

#### *Key Accomplishments of the MNHI Program:*

The MNHI Program Team wrote background papers that summarized the key accomplishments of the last four years from each component. The ASUH Program is currently completing its documentation process and will share the final results at the end of the second week of September. Much has been achieved in maternal and newborn health through the implementation of these two programs; their accomplishments will serve as the building blocks and platform for changes in practice and behavior in the future. Capacity building in training systems (in-service and pre-service) for the future

development of skilled birth attendants and creation of community demand has been significant.

The Program has provided support to the development of key strategic directions such as the Making Pregnancy Safer (MPS) strategy that is the basis for district level interventions in the decentralizing environment.

The Program has also facilitated the development of key relationships with and between all levels of government, NGOs reached through the White Ribbon Alliance - Aliansi Pita Putih Indonesia (WRA - APPI), professional organizations and communities where intensive interventions have occurred.

These achievements and the inputs from the broad range of stakeholders have been important factors in the development and enabling of a new focus. There were many interventions implemented during the MNHI Program that are in a position to be handed over directly to partners (for example radio vignettes to build midwifery capacity). Others will benefit from active integration into the proposed district wide approach (for example Post Abortion Care (PAC-APK)) and others will be actively developed and scaled up in partnership with NGOs and District Government (for example social mobilization).

*An Overview of the Strategy – the Web of Action:*

The recommended strategic direction recognises the elements of safe motherhood and neonatal health. The strategy will address the completion of a “web of action” based around several critical relationships. These are the relationship between:

- The bidan (midwife) and the mother, family and community to strengthen the latter’s capacity to prepare for birth and to respond to emergencies.
- NGOs, communities and government to create the environment for community action.
- The woman and family, bidan and services to enable the woman to seek and find appropriate levels of services to meet her needs.
- Bidan, other service providers and government to work together to improve the quality and responsiveness of services through better planning and quality improvement.

Consolidation of effort will occur through a district wide approach linking the past inputs as building blocks to the future. The approach should include capacity building within existing systems and future programmatic interventions should be focused on building capacity in government and NGOs to achieve scaling-up and sustainability.

Community level interventions will continue through NGOs and will be based on the core elements of behavior change. These are community participation, collective responsibility, action-oriented messages, midwife empowerment through capacity building approaches (currently through Radio Vignettes and reflective discussion), and

change agents for the village level. This will provide the supporting mechanism for positive changes in behavior at the village and community level.

NGOs and government will form partnerships to plan, implement and monitor district wide approaches. This partnership will be one of the key advocacy approaches. The District Health Office will become increasingly active in seeking the community voice and supporting communities and NGOs to advocate for changes in areas such as policy and funding.

Service Delivery Systems complete the “web of action”. The implementation of an agreed essential package of services at each level will enable service responsiveness for Safe Motherhood and Neonatal Health. This part of the strategy will include supportive development of quality improvement within the existing systems and practices.

*Expected Results:*

The expected results from the Strategic Direction are:

- Use of skilled attendance during pregnancy, at birth and in the postnatal period.
- All maternal and newborn complications cared for at appropriate level.
- Postnatal visiting including newborn care.
- Core elements of “Desa SIAGA” replicated with community action.
- Compliance with standards.
- Strengthening district level capacity to plan and manage maternal and newborn health services.

*The Recommendations:*

The recommendations cover each of the areas of the “web of action”. These are:

- **Women, family and community.** These recommendations focus on community action for Safe Motherhood and Neonatal Health. The core elements of the “Desa SIAGA” (Alert Villages) approach will be the basis of scaling-up within communities and across districts. It is recommended that this be facilitated through key partnerships between communities (being inclusive of the women and family), NGOs and in some circumstances, government.
- **Service Delivery and Skilled Provider at the Community Level.** The recommendations in this area are designed to create a district wide quality improvement model to establish and maintain responsive services for mothers and newborn. This will require strengthening of existing quality improvement systems and practices. The basis for quality improvement and service delivery will be the implementation of an agreed package of essential services to improve the organization and management of care. The need for developing quality providers into the future is recommended through targeted support of the three year pre-service Diploma Level Education for midwives (DIII). National level support should be provided to facilitate agreement on essential services for maternal and newborn care and the development of the newborn strategy.

- **District Government and NGOs:** The recommendations for this part of the “web of action” are based on mutually supportive partnerships working within existing systems with a strong emphasis on capacity building. Creating capacity within government to respond to the voice of the community (including the NGO sector) will be important in defining the future and the responsiveness of government. Sharing of outcomes will also be enhanced through linking capacity building in the analysis of data and the prioritization of future planning and implementation within districts.

The team recognized the critical role of linkages to national and provincial level structures to support the development and implementation of an integrated maternal and newborn strategy (through the MPS). The provincial structure is important in creating opportunities for dialogue, information sharing and socialization across provinces of approaches from the central level.

In addition, recommendations were made based on the guiding principles for the strategic direction. These were agreed to and include:

- Mechanisms for scaling-up be identified and included in development of the strategic direction.
- Sustainability readiness at the outset of programmatic interventions. This will be facilitated through capacity building and shared responsibility.
- Government and NGO partnership is recommended as one of the key partnerships for sustainability. The capacity for each of the partners to support progress through leveraging funding to support activities and sharing common goals is in the view of the team a means of enhancing sustainability.
- Quality improvement systems and practices across all stakeholder groups will be fundamental to the management of barriers.
- Advocacy is inherent in creating positive change. Previous experience has demonstrated scaling-up effects through district-wide ownership.
- The birth preparedness and complication readiness (BPCR) matrix is an integrated framework that could be used for participatory planning at all levels from government to village level.
- The recognition of the mother baby dyad in services and within the community should be integrated into all interventions.

*In Summary:*

The Review Team believes that USAID can achieve significant results by continuing to invest in future programs for safe motherhood and neonatal health. The Review Team has suggested a strategic direction for the future based on extensive information from the MNHI and ASUH Programs. The core of the strategy is a series of partnerships that link to facilitate the relationship between the mother and family with the first level of skilled attendant. Usually this is the village midwife or Bidan di Desa (BDD) located in the village. The partnerships will support the priority interventions. These are social mobilization, service delivery processes and systems and quality improvement systems and mechanisms.

# **1 Introduction**

## **1.1 Background to the Program**

In 1998, the basis for planning for the MNH Program in Indonesia was the analysis that the then severe economic crisis was resulting in a significant decline in health care spending, shifting care seeking from public health facilities to traditional healers. This trend was expected to reverse health gains made over the last 10 years. Although there was an increased desire to avoid pregnancy because of economic burdens, at the same time this was accompanied by an increase in unsafe abortion, increasing proportions of mothers and infants nutritionally compromised and stagnant or rising neonatal and maternal mortality.

The Maternal and Neonatal Health Program is a global USAID program. USAID Indonesia provided funds to the Program starting in 1999. Activities in Indonesia began with a maternal health review and set of recommendations to the government on the future needs of a comprehensive maternal health program in Indonesia. Building on the lessons learned from two previous USAID projects (MotherCare and the Maternal Health Training Project), and in accordance with the initial review, the MNHI program began implementing activities in West Java in March 2000 with a preliminary planning workshop for the districts.

The Program has implemented a dual approach. The supply side approach was based on improving maternal health service centers for referral and training to address the significant problem of a skills deficit to deal with post partum hemorrhage (PPH) (estimated to contribute to up to 46% of maternal mortality). While the demand side approach for services was focused on community mobilization responses to address the problems of late referral for care, lack of preparation (blood, finances and transportation) for mitigating delivery complications and a delay in seeking assistance. In its second year of implementation, the Program added a post abortion care component and a research project on the safety and efficacy of using Misoprostyl<sup>1</sup> in low resource settings. In the last 18 months of implementation, programming in support of newborn health increased significantly.

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<sup>1</sup> Misoprostyl is a prostaglandin drug that has been tested throughout the world and is known to be effective for decreasing PPH.

The GoI's concerted actions together with increased donor and bilateral USAID support to safer motherhood programs have made inroads into overcoming the scenario described in 1998 as evidenced by the following:

*Table One: Changes in Key Indicators*

	1997	2003	Percent Change
<b>Delivery by a Health Professional</b>			
Indonesia	43%	66.2%	54% (increase)
West Java	30.5%	48.6%	59% (increase)
<b>Delivery at Home</b>			
Indonesia	79.3%	60.2%	24% (decline)
West Java	89.7%	71.4%	20% (decline)
<b>Delivery in a Health Facility</b>			
Indonesia	18.3%	39.8%	117% (increase)
West Java	10.1%	28.6%	186% (increase)

The proportion of births in Maternal and Neonatal Health Indonesia (MNHI) Program areas in West Java attended by a skilled birth attendant has risen from 66% (1999) to 72.2% (2003), now higher than the national average.

## 1.2 Review Process

The MNHI Program is now entering the transition phase. The Review was undertaken to document the key accomplishments of the Program and to make recommendations to USAID' on future strategic directions for Safe Motherhood and Neonatal Health (2004-2007). The Scope of Work for the review is in Attachment One.

The review was based on a participatory approach with many avenues for input from stakeholders during the review process. Inputs were received in FGDs (11 – 22 August) and discussions with key informants. Over 100 people participated in this process. Participants in FGDs are listed in Annex One to Attachment Two (Short Report Focus Group Discussions). A list of key informant discussions is found in Annex Two Attachment Two.

Between 25 August to 5 September the MNHI Program and ASUH Program teams presented information about achievements and actively participated in discussions. At least one member of the DepKes Team who had been closely involved with the Programs (MNHI and ASUH) participated in discussions on each day. This facilitated dialogue and enabled many perspectives on issues to be presented. Presentations from the MNHI program covered policy and advocacy, performance and quality improvement, behavior change and social mobilization and research, monitoring and evaluation components and the ASUH team made one presentation of its program. The Review Schedule is in Attachment Three.

The Review Team then discussed the presentations, examined other known approaches and developed draft recommendations. These recommendations were presented to the

MNH and ASUH programs as well as other interested stakeholders and then discussed with MoH/DepKes. The final recommendations have taken into considerations the iterative inputs from all of these stakeholders.

### **1.3 The Environment**

#### **Safe Motherhood and Neonatal Health**

The Indonesian government has demonstrated significant political support and interest in safe motherhood for the last two decades. They have been a signatory to all global initiatives and independently began the Mother Friendly Movement (GSI) in the early 1990's as a way to improve services for maternal health. Despite this political commitment, ratios of maternal deaths continue to be among the highest in the region. Estimates<sup>2</sup> of the maternal mortality ratio range from 198/100,000 in Bali to over 1000/100,000 in Papua. The official maternal mortality ratio (MMR) is 334/100,000<sup>3</sup>. A significant proportion of maternal death (up to 46%) is caused by PPH. Among neonates, 80% of the deaths occur in the first week of life and those deaths are attributed primarily to low birth weight (below 2500 grams) and asphyxia and infections. It is believed that one newborn dies every five minutes in Indonesia<sup>4</sup>.

In 2001, Indonesia became a focus country for the World Health Organization (WHO) MPS strategy. Over the course of a year a national taskforce, which included MNHI Program staff, created the framework within which all safe motherhood programs were to be implemented. Although the framework reflects global standards and the best practices to address maternal mortality, it has been difficult to operationalize. To date, few of the districts are using the framework as a blueprint for maternal health programming.

#### **Decentralization**

Decentralization was also implemented in January 2001 following the passing of National Law 22 in 1999. This law provides for greater regional autonomy and for decision-making authority to lie with district level politicians. Although authorities have passed additional laws, decentralization is still in its nascent stages and continues to contribute to programmatic delays. Maternal health will remain one of the mandated six key programs and a minimum package of interventions and standards is being developed. However, district planning boards are free to allocate fiscal resources as they deem appropriate and this has resulted in funding inequalities between districts in the same province.

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<sup>2</sup> The validity of the Maternal Mortality Ratio (MMR) in Indonesia suffers from a lack of adequate data collection systems. Most professional organizations believe that maternal deaths are severely under-reported and thus national figures do not reflect the true level of the problem.

<sup>3</sup> Figures quoted in the Making Pregnancy Safer (MPS) strategy (2001).

<sup>4</sup> ASUH Program statistics presented to the Review Team (29 August 2003).

## Critical Success Factors

During the review process the Review Team utilized information presented to establish a set of critical success factors for on-going programming. This information was summarized from the MNHI Program documentation and the stakeholder discussions.

The establishment and continuity of partnerships across the MNHI Program and within the intervention strategies has been critical in ensuring successful interventions. Significant effort has been allocated to this. However, implementation of other critical success factors for sustainability and scaling up have been mixed and will require on-going support:

- **Government support at the province and district level.** It was noted during the review of the documentation that support for the whole Program is patchy with very high levels of commitment and facilitation in some areas while in others there is little or none. Financial support from the GoI for MNHI Program related activities only occur at the District level.
- **Translation of strategic commitment into integrated interventions.** In general, the Program has not had the opportunity to integrate interventions. For example, in the implementation of the post abortion care strategy, community mobilization processes have not yet been integrated. This is important to ensure utilization of services.
- **Linkage between supply and demand.** It is thought that demand generation will lose momentum if the health system cannot respond appropriately to community need. The GoI has not addressed the deficits in capacity in the supply side even though strong commitment to this was indicated in the MPS strategy. The development of service delivery systems will be critical in the future to manage a reduction in maternal and neonatal mortality.
- **Quality improvement.** Gains in quality improvement in the current Program have been seen in a limited sense. Maternal service delivery centers that have been targeted for improvement as training and service delivery sites have made steps towards quality improvement as part of the site preparations. The implementation of the Radio Vignettes where a process of case studies and quality improvement have been linked have also been seen to have had an impact on the quality of services provided by the BDD (anecdotal evidence). Professional organizations and GoI quality improvement approaches have been supported by the MNHI Program however little spontaneous activity has been seen to support quality improvement in the Program areas.
- **Implementing standards of practice to support quality improvement.** It was emphasized during the FGDs that the standards of practice are available however, there is a significant need for these to be enforced. This will contribute to improvements in the quality of services and should be a focus of service delivery systems development.
- **Communication with other programs and processes.** This is important in ensuring that lessons learned and tools developed can be used in other environments. This has occurred in the implementation phase of the MNHI

Program. However responsibility and accountability of partners for assuring that tools are flexible enough to respond to multiple environments and that scaling-up continues has not been addressed at this stage.

- **District level advocacy is effective due to decentralization.** This increases the likelihood of budget allocation and government direction in the implementation as was seen in the MNHI program.
- **Civil society.** Elements of a civil society, including a free press, consumer rights, gender equity and rule of law are important in realizing changes to maternal health. The community voice is of equal importance in creating long term changes in government and community attitudes and approaches that support better maternal health outcomes.

## **2 Key Accomplishments of the MNHI Program**

### **2.1 Achievements in Policy, Advocacy, Monitoring and Evaluation**

Indonesia already had a supportive political environment for maternal health at the onset of the MNHI Program. However, with the advent of decentralization, and the adoption of the MPS strategy, the policy environment became more labile, necessitating different approaches. MNHI Program was able to embrace the changes and accomplish the following policy results:

- Promoted international evidence based standards for service delivery and pre- and in-service training. This included promoting coherence between existing standards, significantly reducing exposure to materials that were not evidence-based and developing political commitment from the medical professional organizations to implement the standards. In the districts where hospitals actively promoted these standards, clinical care improved.
- Participated in the development of the MPS strategy, the primary policy instrument for guiding maternal health interventions throughout Indonesia. The MNHI Program participation resulted in the framework being evidence-based, comprehensive and inclusive of global best practices for reducing maternal mortality.
- The MNHI Program supported studies to inform the policy debate for district level decision-makers in relation to sustaining the BDD Program. These were:
  - Economic support for the BDD. This study provided costing information to the district government. This allowed them to determine the true cost of supporting bidans in the district and provided better data for district programming.
  - A literature review of all the existing literature on the BDD Program in Indonesia. Reviewing this material led to a summary of the political, financial, social and cultural constraints to the BDD Program. This work helped inform the government's decision to loosen regulations for

the renewal of BDD contracts and served as a basic reference for a national task force. As a result of this study a thorough impact evaluation of the BDD Program is to be undertaken to determine whether the government investment over a seven-year period has yielded the intended impact on maternal health. The Department of Community Health will conduct the study in 2004.

- A study of district budget allocations determined that the largest allocation of funds went to support staff salaries and that very little funding was available for maternal and neonatal health program activities. This study provided information to the MNHI Program counterparts so they could mount an active lobbying campaign to increase government funding. As an outcome of MNHI Program advocacy efforts, Cirebon City exceeded the government target of a 15% allocation of its budget for maternal health; making it one of only five districts out of 341 districts<sup>5</sup> in Indonesia to exceed or meet this goal.

During year three of the program, the government began to pursue the development of a national strategy for neonatal health. The MNHI program provided representation to this effort. This is ongoing and will be continued.

The Monitoring, Evaluation and Operations Research (MEOR) component of the present MNHI Program has been very responsive to the needs of the Program. Supportive studies have been carried out across the Program and the results of the studies are presented throughout this section of the report. The MEOR team members were allocated to other components to support documentation of studies and recording results of activities.

## **2.2 Achievements in Supply of Quality Services**

The cornerstone of the Performance and Quality Improvement (PQI) strategy was development of comprehensive maternal health service centers as referral and training centers. These centers provided capacity for in-service training as well as expansion of Basic Delivery Care – Asuhan Persalinan Normal (BDC - APN) through in-service training (in collaboration with the National Clinical Training Network – Jaringan Nasional Pelatihan Klinik (NCTN-JNPK)) and pre-service education (with midwifery schools – Akademi Kebidan (AKBID)). Clinical knowledge and skills of midwifery staff, obstetric residents and specialists have been upgraded and standardized at hospitals and clinics used for in-service training and precepting pre-service students.

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<sup>5</sup> There were 341 districts in Indonesia in 2002. There are now over 400.

The PQI component of MNHI Program developed the following processes, systems and resources that are being used to scale up efforts in improving maternal and newborn survival:

- **National evidence based standards have been developed adopted and disseminated.** The Buku Panduan developed from Management of Complications in Pregnancy and Childbirth (Integrated Management of Pregnancy and Childbirth – IMPAC) and newborn care standards are evidence-based guidelines adapted from global guidelines, and these are now widely available. In addition, global infection prevention guidelines have been translated for use in Indonesia and are being used across the country to enhance the quality of care.
- **Standardized competency based training materials are ready and have been tested countrywide.** Standardized training materials for BDC-APN, PAC-APK, newborn care, breastfeeding, antenatal care, emergency obstetric care, family planning, interpersonal communication and counseling, quality improvement, supervision, and infection prevention have already been used in many training activities across Indonesia.
- **Core group of training sites and trainers available in West Java.** Through the national clinical training network and pre-service midwifery academies (AKBID), there are now a core group of trainers who have the capacity to train others in critical skills for normal delivery and management of the third stage of labor. Service delivery sites that model the correct behaviors and perform according to standard have been created and serve as ideal sites for pre-service and in-service training.
- **A critical mass of experts in maternal and newborn health have been developed.** These experts (innovators and change agents)<sup>6</sup> have the skills to critically evaluate the evidence basis for changes in practice, are “standardized” and are proficient in key skills, can transfer skills to their workplace and to others, and are advocates and change agents for new approaches. These change agents are prepared to provide increasing support to new programs.
- **Training systems have been developed and service delivery and quality of care improved at training hospitals and clinics.** Twelve service delivery sites have been strengthened to model correct behaviors and serve as pre-service training sites for childbirth care. Four have been strengthened for training in PAC-APK.
- **Evidence based practices have been adopted.** Active management of the third stage of labor was performed for 99.7% of births at two hospitals in West Java between 2001 and 2003, resulting in an incidence of postpartum hemorrhage of only 1.7% compared to an incidence of 18% in a previous reporting period. Trained midwives in East and Central Java used active management of the third stage of labor in 97% of 2708 home births, resulting in a 4.6% incidence of PPH, compared with a 20.5% incidence of PPH in births not receiving active management.
- **Wasteful and unnecessary medical interventions have been restricted.** In 2002, of the 79% of the births recorded at Astanya Anyar Hospital and 59% at Ujung Burung Hospital documented with partographs (a tool to promote better management

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<sup>6</sup> Drawn from a pool of midwives and obstetricians and gynaecologists who have demonstrated a keen interest in performing to the highest standard and sharing this knowledge.

of labor) only 9% of these women had episiotomies, where previously episiotomies were performed on a routine basis.

- **Innovative approaches have been evaluated.** To reduce PPH in areas where a large proportion of births are not attended by skilled providers, the MNHI Program has demonstrated the Safety, Acceptability, Feasibility and Program Effectiveness (SAFE) of community based counseling and distribution of PPH prevention medication (Misoprostol) by an existing network of volunteers. This approach increased coverage of PPH prevention medications to 93 % of all pregnant women in the study area and resulted in 45% reduction in need for emergency referral for PPH. The national steering committee and MoH/DepKes reviewing and evaluating this intervention have decided that an expansion of this program nationally.

### 2.3 Achievements in Demand and Utilization of Services

The MNHI Program has breathed life into the BPCR matrix developed as part of the MNH global Program. This matrix provides a tool for prioritization, planning and monitoring for communities. The messages developed during this process are the core elements of the behavior change interventions and are disseminated through various channels. These channels were mass media campaigns, community mobilization, and midwife empowerment. The key achievements include:

**SIAGA Campaign:** Community action and collective responsibility are the hallmark of the MNHI Program's behavior change interventions. The campaign builds on the traditional Indonesian concept of *gotong royong* or mutual help that is a participatory, grassroots community action towards a common objective. The MNHI Program's *Desa SIAGA* (alert village) model has reinvigorated *gotong royong* to build community awareness and responsiveness to birth preparedness and emergencies with the objective of reducing delay in seeking and reaching care. The campaign identified four key messages for collective action – (1) notification of pregnancies, (2) blood donation for emergencies, (3) saving funds for delivery, and (4) transportation for emergencies. Key achievements were:

- Use of skilled birth attendants increased from 66 percent (1999) to 72 percent (2003).
- All 24 districts of West Java have adopted and are using the BPCR matrix.
- Establishment of functioning *Desa SIAGA* systems increased from 36 percent (2002) to 70 percent of villages or hamlets (2003).
- Pregnancy notification by the community increased from 62 percent (2001) to 98 percent (2003).
- Spontaneous replication, inspired by the program's community facilitators, occurred in 59 non-intervention villages.

**Midwife Empowerment:** The program provided interpersonal communication and counseling (IPC/C) skills training to midwives and then followed up the training with long-distance continuing education through Radio Vignettes and group discussions.

Key achievements were:

- A very high proportion of participating midwives listened to every episode (92%) and thought the topics were relevant (96%).
- Most midwives (88%) attended the discussion groups as part of regular discussions organized by Indonesian Midwives Association (Ikatan Bidan di Indonesia – IBI) and the government.
- Communication and counseling skills of midwives improved immediately after the IPC/C training but these gains were not maintained three months later.

**Advocacy through NGO alliance:** The White Ribbon Alliance – Alliansi Pita Putih (WRA - APPI) brought together a network of over 300 NGOs from 15 districts of nine provinces to advocate for improved policies and increased budget allocations.

Key achievements were:

- Policy. Through linkages to the Working Group for the Mother Friendly Movement (GSI) WRA-APPI has provided input on a national draft health law to support safe motherhood and neonatal health. In West Java the administration has issued a decree called “Raksa Desa Program”, a program aimed at increasing responsiveness of 5776 villages in West Java to emergencies. This is due to the involvement of the vice governor who has become a strong supporter of WRA-APPI. In Cirebon City advocacy to the district has led to the formulation of a policy specific to maternal and newborn health.
- Budget. WRA-APPI leveraged nine times more funds from NGOs to support of WRA-APPI activities. Advocacy increased budget allocations by district administrators to maternal and neonatal health activities in the MNHI Program districts.

## 2.4 Building Blocks for the Future

Due to the achievements of the current MNHI Program there are several interventions ready for hand-over to partners.

### *Policy, Advocacy, Monitoring and Evaluation*

Policy and advocacy are integral to the support for programming. The important role played in overcoming barriers and creating supportive environments are the framework within which policy and advocacy reside. It is anticipated that the level and scope of input will change in the future. This is discussed further in section 3.3 (Government and NGOs for Community Mobilization) of this document.

The operations research element of the MEOR component is ready for handover to local universities and other organizations. The Review Team sees an important role in capacity building for monitoring and evaluation within NGOs and government in the new strategic direction. This is elucidated further in section 3.3 (Government and NGOs for Community Mobilization).

### *Performance and Quality Improvement*

For the existing PQI interventions there are significant opportunities for handover. These are:

- In-service training systems and processes. There has been a great deal of capacity built within IBI to enable the management and development of training systems and practices. Some additional technical input is required to include the management of asphyxia and newborn complications in the BDC-APN training however there are additional inputs proposed in the Saving Newborn Lives (SNL) program to support this in the near future.
- Pre-service training. The curriculum content units for maternal and neonatal health have been disseminated to all government run AKBID. These are being integrated into the curriculum along with the supportive training network of preceptors in West Java. The AKBID that have implemented the curriculum content units (CCUs) are ready to serve as models for future development. Additional inputs will be required to support the integration of newborn care.
- Regional Expertise. The regional experts developed during the MNHI Program are ready to provide support across Indonesia.

### *Behavior Change Initiatives*

There are several behavior change initiatives ready for handover. These include:

- Mass media campaigns. These are recognized as important supportive activities for Maternal and Neonatal Health however there are several opportunities for these to be continued through other advocacy and communications programs such as the Coalition for Healthy Indonesia - Koalisi Indonesia Sehat (KuIS).
- Radio vignettes. The radio vignettes have provided many opportunities to enable midwives to explore new areas of practice. They have been enthusiastically accepted. IBI has committed to work to disseminate the information and current content across Indonesia. The development of new content provides an opportunity for further technical assistance.
- Interpersonal Communication and Counseling. This content is being incorporated into pre-service training for midwives.

## **2.5 Linkages and Leverage: Achievements and Building Blocks**

The MNHI Program has worked extensively to create opportunities for linkages between the Program and other donor activities. The Program has developed critical relationships across the health system including with NGOs that have a key role to play in the future improvements to maternal and neonatal health.

Successes within this group of activities include the dissemination of guidelines and standards for practice to midwives and hospitals across Indonesia; the provision of technical assistance to Banda Aceh and East Timor for the dissemination of training packages; the development of APK services and training systems in nine provinces with the support of Asian Development Bank (ADB) funding; and, the sharing of tools, training packages and the Desa SIAGA approach in East Nusa Tenggara and West Nusa Tenggara through the Australian Government Agency for International Development (AusAID) Women's Health and Family Welfare Project.

As discussed above the readiness and preparedness of the NCTN-JNPK, IBI and the WRA - APPI to leverage funding will provide many sustainable opportunities in the future.

Opportunities for linkages to other Programs in the future include:

- Government Programs for Public Health (such as immunization programs and vaccinations in early infancy such as Hepatitis B and BCG).
- Other USAID Programs such as ASUH, Strategic Technical Assistance in Reproductive Health (STARH), the Decentralization Program and Coalition for Healthy Indonesia (KuIS).
- Saving Newborn Lives (SNL).
- WHO in the area of pre-service training, use of guidelines in practice and quality assurance.
- With AusAID to support maternal and child health and social mobilization.
- Synergies with local NGOs to provide capacity building and skill transfer for training, clinical services, social mobilization and advocacy.
- Opportunities to provide technical assistance to small grants processes such as those being offered by the World Bank (WB).

## **3 The Strategic Direction**

### **3.1 A View of the Future**

During key informant discussions common themes were apparent in relation to the future. These were:

- While there has been a steady increase in the percentage of births in facilities (18% in 1997 to 40% in 2002-2003), it is likely that the majority of births will continue to occur at home particularly in rural areas where institutional deliveries accounted for only 22 percent in 2002-2003<sup>7</sup>.
- The majority of birthing services will be provided in the community by the BDD however it is likely that there will be limited coverage unless BDD are encouraged to cover more than one village. Incentive systems will need to be developed to ensure that access is maintained in remote rural areas.
- The dukun bayi (traditional birth attendant) will maintain their spiritual and cultural support role in rural communities however it is likely that there will be partnerships formed and community based antenatal care, delivery and clinical components of postnatal care will be provided increasingly by the BDD.
- All midwives are required to have a minimum of a three-year diploma program by 2010 to enable them to practice. It is very likely that only a small proportion of these midwives will work at the village level with the majority working in private practice in urban and semi-urban areas. This presents opportunities for bidan working in community primary health care centers (Puskesmas) to provide home based delivery services.
- Communities will become increasingly knowledgeable and involved in advocacy for improvements in health service delivery.
- Services will develop in-line with the MPS Strategy. This will involve development of the Puskesmas and the District Level Hospital.
- Slow improvements in service delivery will occur but will require active intervention.
- District level governments have a significant role in the allocation of budgets and will become increasingly knowledgeable due to advocacy activities about the benefits of allocating budgets to public health initiatives.
- A skills deficit in midwives and clinicians will continue until improvements in processes and training systems occurs across the country.

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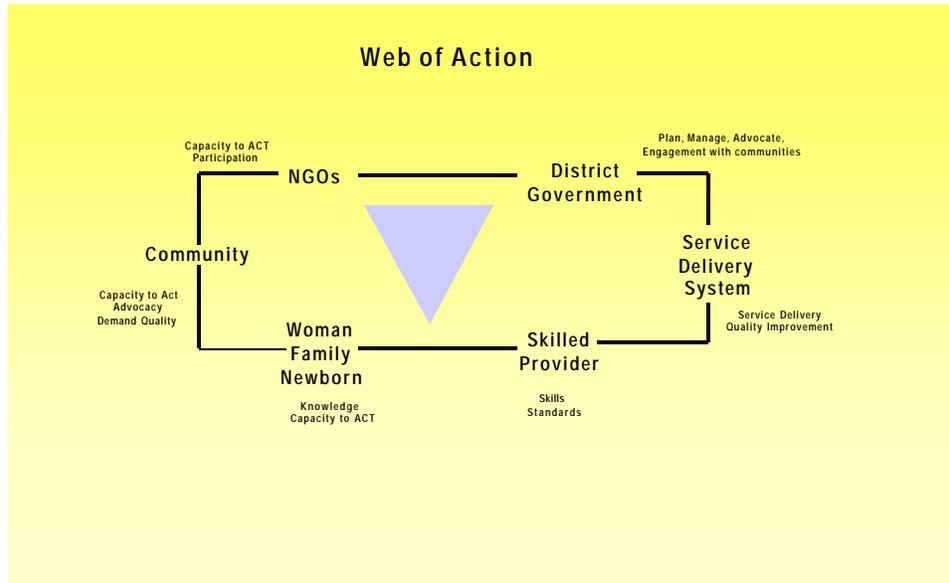
<sup>7</sup> District Health Survey 1997 and DHS 2002/2003(in draft)

### 3.2 An Overview of the Strategic Direction

At the heart of the recommended strategic direction is the provision of quality services for the mother-baby dyad through a “web of action” that is based on several critical relationships. These relationships are between:

- The bidan (midwife) and the mother, family and community to strengthen the latter’s capacity to prepare for birth and to respond to emergencies.
- NGOs, communities and government to create an enabling environment for community action.
- The woman and family, bidan and services to enable the woman to seek and find appropriate levels of services to meet her needs.
- Service providers and government to work together to improve the quality and responsiveness of services through better planning and quality improvement.

Diagram One: The Web of Action



Consolidation of effort will occur through a district wide approach linking the past inputs as building blocks to the future. The approach should include capacity building within existing systems and future programmatic interventions should focus on building capacity in government and NGO to achieve scaling-up and sustainability.

Community level interventions will continue through NGOs and will be based on the core elements of behavior change. These are community participation, collective responsibility, action-oriented messages, midwife empowerment through capacity building approaches (currently through Radio Vignettes and group discussion), and change agents at the village level. This will provide the supporting mechanism for positive changes in individual behavior and social norms at the community level.

NGOs and government will form partnerships to plan, implement and monitor district wide approaches. This partnership will be one of the key advocacy approaches. The District Health Office will become increasingly active in seeking the community voice and supporting communities and NGOs to advocate for changes in areas such as policy and funding.

Strengthening service delivery systems complete the “web of action”. The implementation of an agreed essential package of services at each level will enable service responsiveness and a continuum of care for safe motherhood and neonatal health. This part of the strategy will include supportive development if quality improvement within existing systems and practices.

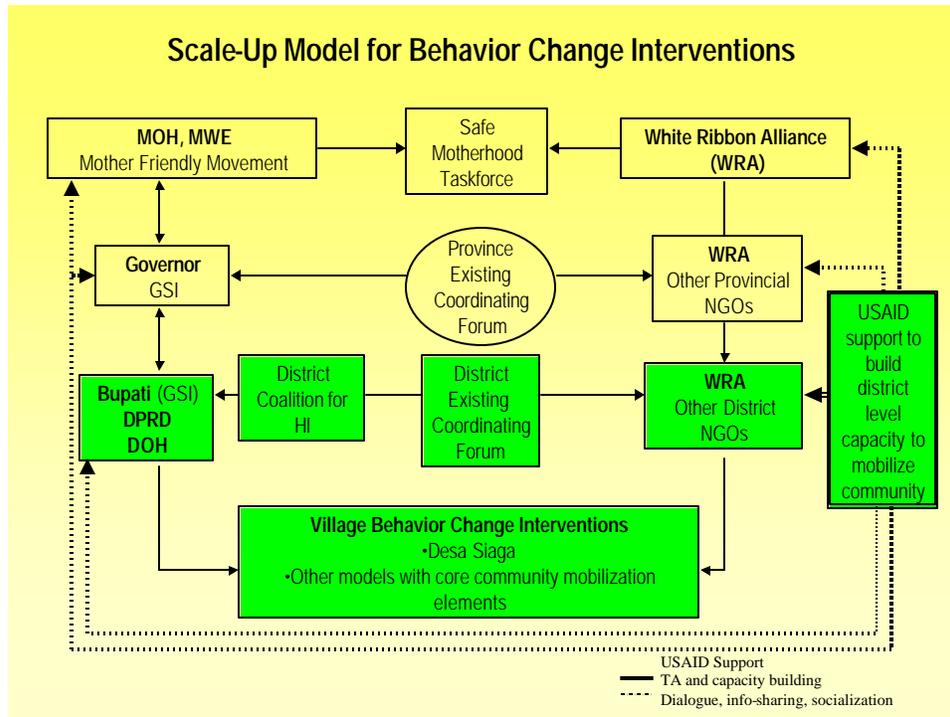
In summary, the main focus of a future safe motherhood and newborn health program will be strengthening existing service delivery systems and generating community demand and utilization of quality care. The fundamental principles for achieving successful district wide programs are to build on the strength of current GoI and donor supported programs. The new focus will require moving from developing guidelines, training systems and processes, and testing community approaches to implementing them at the district level. Emphasis in service delivery will be placed on the provision of a basic package of essential services in districts; this will be complemented by behavior change communications and community mobilization interventions aimed at increasing the utilization of such services.

### **3.3 Implementing the Web of Action**

As described above, two core interventions are proposed: strengthening service delivery systems and community mobilization approaches. Key partnerships between government, NGOs, and communities; training systems and processes; and community mobilization models tested by MNHI and ASUH will be the building blocks for the future. Capacity building, implementation of sustainable interventions, and scaling up will be the common themes that will cut across the future program.

## Government and NGOs for Community Mobilization

Figure Two: Community Systems



NGOs will be the key vehicle through which the future program will scale up community mobilization activities. The WRA-APPI with its network of 100 member NGOs with a common ideology, provides a mechanism for national, province and district level knowledge and information sharing. In the future, the national WRA-APPI network will serve as a mechanism for dissemination and implementation of tools and guidelines nationally.

This model for scaling-up of the community mobilization interventions is designed to be sustainable in various ways. It will develop partnerships between NGOs well entrenched in their communities, that have a history of mobilizing their own resources for community development, and that will continue working in those communities regardless of the source of support. The strategy will link with the district KuIS that fosters corporate social responsibility among large private sector companies.

Existing coordination forums will be inclusive of NGOs and the district legislature. This will facilitate advocacy for increased budget allocations and increasingly supportive policies (as was experienced in the current MNHI Program). The partnerships between NGOs and local government will maximize their respective complementary strengths and be based on shared responsibility.

Diagram Two above identifies partnerships at all levels with USAID support focusing primarily at the district level. Government and NGOs will be responsible for measuring

and monitoring progress. NGOs will develop champions at all levels to support advocacy and community action while the government will be responsible for ensuring that services are responsive to community demand (linking to the government's role in improving service delivery systems).

The core elements of the Desa SIAGA will be implemented in communities by the NGO networks. Selection of key action messages and approaches will mobilize communities to take collective action and responsibility, and change social norms and individual behavior.

The government also has a role in creating an enabling environment. The strategic direction supports the development of capacity to identify and overcome policy and financial barriers for achieving incremental improvements in maternal and neonatal health.

### Strengthening Service Delivery Systems

Figure Three: Service Delivery

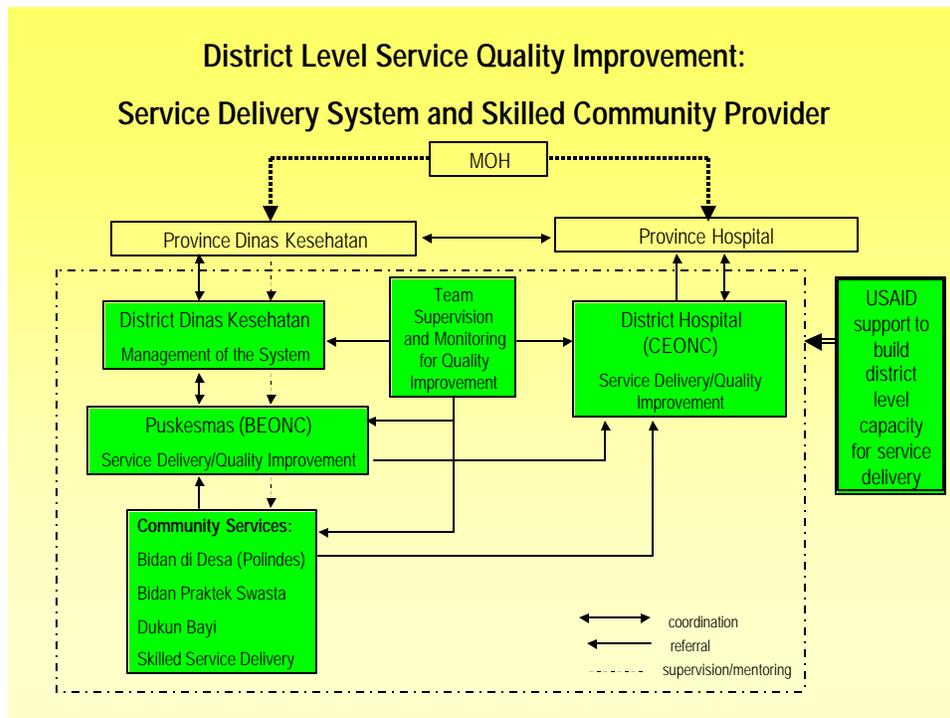


Diagram Three describes the current basis of service provision and linkages within the system. Basic services are provided at the community level by private midwives, BDD, and traditional birth attendants (dukun bayi); basic emergency obstetric and neonatal care services are provided at the health center (Puskesmas) and comprehensive emergency obstetric and neonatal care services at the district hospital. The strategic direction focuses on building capacity and strengthening systems for an essential package of services appropriate to all three levels to ensure a continuum of care for the mother-baby

dyad. The essential services will be based on an agreed list appropriate to each level. A suggested list is included in Attachment Four.

Quality improvement approaches will be enhanced through various interventions including strengthening of supportive supervision and mentoring, compliance with standards, and use of data to track performance. Effort should be allocated to setting and implementing performance parameters for essential services. It is important that the standards and materials that have already been developed and the expertise of trainers and change agents that were developed during the current MNHI Program should be utilized to enable change and scaling-up. Linkages to community level interventions will be imperative in the implementation of this strategic direction.

### **3.4 Technical Assistance for the New Strategy**

There are opportunities for technical assistance within the new strategy. These can be summarized as:

- Performance (service) improvement.
- Capacity building for monitoring and evaluation.
- Participatory approaches at and within critical partnerships (web of action).
- Capacity building to strengthen service delivery systems, improve quality, and performance.
- Capacity building for the delivery of an essential maternal and newborn care package that is consistent with the minimal package of services defined by the government.
- Capacity building of NGOs for designing and implementing community mobilization, identification of key action-messages, advocacy, and other behavior change interventions.
- Prioritization, planning and management at the district and community level.

### **3.5 Key Result Areas for Safe Motherhood and Neonatal Health**

The expected results for the Strategic Direction are:

- Use of skilled attendance during pregnancy, at birth and in the postnatal period.
- All maternal and newborn complications cared for at appropriate level.
- Postnatal visiting including newborn care.
- Core elements of “Desa SIAGA” replicated with community action.
- Compliance with standards.
- Strengthening district level capacity to plan and manage maternal and newborn health services.

## 4 Recommendations

### 4.1 Introduction

There are two levels of recommendations made. These are general recommendations that will be critical success factors for the strategic direction. There are also specific recommendations presented to guide the articulation of the strategy into design and programming. Recommendations made in this document are to facilitate strategic investment for USAID in Safe Motherhood and Neonatal Health.

### 4.2 The Guiding Principles

The guiding principles were defined during the process of the review. These were:

- Mechanisms for scaling-up be identified and developed as part of the implementation process.
- Sustainability readiness at the outset of programmatic interventions. This will be facilitated through capacity building and shared responsibility.
- Government and NGO partnership is recommended as one of the key partnerships for sustainability. The capacity for each of the partners to support progress through leveraging funding to support activities and sharing common goals is in the view of the team a means of enhancing sustainability.
- Quality improvement systems and practices across all stakeholder groups will be fundamental to the management of barriers.
- Advocacy is inherent in creating positive change. Previous experience has demonstrated scaling-up effects through district-wide ownership.
- The birth preparedness and complication readiness (BPCR) matrix is an integrated framework that could be used for participatory planning at all levels from government to village level.
- The recognition of the mother baby dyad in services and within the community should be integrated into all interventions.

### 4.3 Recommendations and Key Themes

#### Recommendations based on the Guiding Principles

*Theme: Scaling Up through selected districts with Province-wide impact*

It is recommended that the programming arising from this strategic direction include a district wide focus with intensive interventions across a province. The role of the province is important for information sharing and dissemination. When choosing districts criteria should include those with large populations, existence of infrastructure to support maternal and newborn health, existing skilled providers, the presence of other programs, and, importantly, existing district support for health sector interventions.

*Theme: Capacity Building and Participation as a Key Approach to Decentralization and Sustainability Readiness*

It is recommended that capacity building and participation be the primary approaches for the development of safe motherhood and neonatal health interventions. The focus of this effort should be in encouraging and supporting dialogue between community representatives and local government at the district and village level to enable joint planning and supportive management and monitoring. It is important to ensure that resulting interventions be “sustainability-ready” from the beginning of the design and implementation. Systems and services based interventions are more likely to succeed if linked to alternative sources of funding.

*Theme: Government and NGO Partnerships*

These partnerships will be based on linking government systems with NGOs working in safe motherhood and neonatal health. This will build on a critical mass of champions (service, government and civil society) at each level. Government systems will provide policy, regulation and funding processes for sustainable interventions. NGOs will facilitate advocacy, quality improvement systems and practices, participatory approaches to community demand generation and networks into villages. NGOs working at any of four levels should be considered for this partnership. There are those that are semi-autonomous but linked to government services (such as Family Welfare Program (PKK) and Indonesia Planned Parenthood Association (PKBI)), NGOs that are WRA-APPI members, NGOs that are specific to certain districts and that implement local level initiatives and those international NGOs providing local level support.

It is recommended that there be clear articulation of shared responsibility at all levels and in each technical area. Memoranda of Understanding (MoUs) should be agreed for interventions and include outlines of expectations and capacity building indicators. In addition the MoUs should be based on ownership and accountability for issues and management strategies.

*Theme: Quality Improvement*

It is recommended that a comprehensive quality assurance approach be undertaken to improve the quality of services. This should include processes such as performance improvement, use of data for assessment and problem-solving, compliance with standards, and use of the BPCR as a tool for developing quality improvement indicators for monitoring and evaluation. In addition these indicators should be linked to regular monitoring by District Government and NGOs.

*Theme: Advocacy*

Advocacy is an integrated activity across the current program. It is recommended that the key areas for advocacy be:

- Licensing, accreditation and quality at national, provincial and district level.
- Key community interventions/messages.
- Budget allocation focused at district level for maternal and neonatal health including training initiatives and bidan deployment.
- To support the development of community input and representation in health services and systems planning and management.
- Reducing barriers to care.

*Theme: Birth Preparedness and Complication Readiness*

The BPCR matrix is a powerful and easily implemented tool for planning, implementation and evaluation. It is recommended that this be used to establish a common framework for programming and to support MPS implementation. It is also recommended that the matrix be reviewed to incorporate interventions for the newborn and neonate.

*Theme: The Mother Baby Dyad*

All interventions should link to the support of the mother and baby dyad. This includes mother and baby friendly services and communities.

**District Government and NGOs**

*Theme: Participation in national level strategy development and co-ordination activities.*

It is recommended that there be continued investment in technical assistance for the development of the neonatal health strategy. Mechanisms include:

- Participation in the newly formed national task force to ensure that clinical and community best practices are integrated into the framework
- Linkage between the neonatal health strategy and MPS
- Leadership within the committee to support the development of operational plans for improving newborn care.

*Theme: Overcoming end user fees barriers is inherent in the Strategy.*

There is significant development funding for programming an operational system for health care financing (for example, Asian Development Bank (ADB) and World Bank (WB) funding). Opportunities to link to these programs should be sought.

It is recommended that programming arising from this strategy enable the community to overcome barriers to the costs of health care. This should include interventions such as enhancing transparency in relation to end-user costs for services through advocacy and information for communities and community savings schemes as part of community preparedness. In addition villages should be prepared to support BPCR.

It is also recommended that current policies on emergency care should be reviewed and enforcement strategies should be identified. In the event that cost recovery needs and financial allocations from the District Parliament (DPRD) are contributing factors, this too should be examined.

*Theme: Support for policy implementation and enforcement at the district level.*

It is recommended that there be targeted effort to support capacity building in district branches of IBI, the local health office and the local health council to implement policies for accreditation in the district and adherence to standards of care. Another critical area is that AKBID comply with policy and enable districts to develop enforcement strategies.

*Theme: Measuring, monitoring and evaluating.*

It is recommended that a refocusing of monitoring and evaluation be undertaken. This should include a close linkage with the indicators for shared responsibility between District Government and NGOs. For example government would monitor and evaluate access to appropriate level of service while NGOs would monitor and measure community action (section 3.5). The functional relationships for monitoring and evaluation should be directly with the District Government and NGOs involved in partnerships. This will enable capacity building, joint monitoring and evaluation. Opportunities for use of data collected through other mechanisms should be actively pursued.

## **Woman, Family and Communities**

*Theme: Core elements for community mobilization*

Community mobilization will continue to be a critical means of empowering the community. It is recommended that the core elements of community mobilization be replicated to scale up community action for maternal and newborn health. These are:

- Community Participation.
- Collective Responsibility.
- Action oriented messages based on key actions.
- Bidan Empowerment through Radio Vignettes.
- Change Agents (for example, WRA – APPI representative, NGO representative, BDD, or community facilitator).
- The BPCR matrix should provide the framework for the implementation of these elements.

*Theme: Building capacity in civil society as the mechanism for social mobilization*

It is recommended that community mobilization be facilitated through building capacity within civil society. This will result in NGOs being actively involved in the expansion of community mobilization activities and supporting/acting as change agents as determined by the communities involved. Specifically NGO capacity will be built for working in a participatory manner with communities to plan, design, and monitor the implementation of community mobilization activities.

*Theme: Messages for action and behavior change*

It is recommended that the behavior change messages will mirror the essential package of services to be implemented. The four action messages for maternal health are pregnancy notification, emergency transportation, funds for skilled delivery and walking blood donor. The messages for newborn care are pregnancy notification, emergency transportation, and funds for skilled delivery, clean cord care, tetanus immunization, thermal protection, and early and exclusive breastfeeding.

**Clinical Network and Skilled Provider at Community Level**

*National Level Recommendations:*

*Theme: Essential package of maternal and newborn care services*

Along with a newborn strategy the development of a package of obligatory and minimal services is critical for district planning. The process of development and adoption should be supported at the national level but with the full involvement of district Stakeholders. Collaboration with decentralization processes and development partners working in this area will be crucial.

*Theme: Support to Pre-service DIII Programs*

A steady supply of skilled midwives is needed to cope with expected increased demand over time. It is also imperative that the pre-service curriculum continues to be developed to enable service delivery. It is recommended that support be given to supporting the development of pre-service education. The role of future support should be in developing additional technical components that link to the newborn strategy.

*District Level Recommendations:*

*Theme: District wide performance improvement model*

Establish and support an appropriate district wide performance and quality improvement model. Such a model would combine several essential elements including but not limited to:

- Strengthening the capacity of the district health system to provide supervision
- Developing means of implementing and maintaining standards including rewards and sanctions
- Developing appropriate regular internal monitoring and criterion based audits.

*Theme: Strengthen organization and management of care*

Examine and strengthen the organization and management of care at home, at village level health centers (Polindes), Puskesmas and hospitals, so that efficiencies can be achieved, multiple services integrated, missed opportunities for key interventions minimized and effective care made available as proximate to need as possible.

*Theme: Skills development*

Agreements for the support of skills development should be based on needs at the district level. It is likely that there will be extensive skills deficits particularly in relation to emergency obstetric care and newborn services. It is recommended that strategies for skills development be agreed and implemented as part of the district approaches and aligned to agreed outcomes. Key areas should be selected as the basis for skills development and trainees linked to existing training systems and on-the-job training.

*Theme: Introduce best practices and new evidence based interventions*

Building on the experience of current programs it is recommended that new evidence-based interventions be introduced such as community prevention of PPH and home visits for newborn care that serve to increase survival for populations that are most vulnerable.

## **5 Conclusions**

In conclusion the current MNHI Program and the ASUH Programs have provided a great deal of information to the Technical Review Team in relation to the achievements and lessons learned during the implementation phases. Significant and valuable work has been undertaken and can be used to build on in the future. The Review Team believes that USAID can achieve significant results by continuing to invest in future programs for safe motherhood and neonatal health.

The Review Team has suggested a strategic direction for the future based on extensive information from the MNHI and ASUH Programs. The core of the strategy is a series of partnerships that link to facilitate the relationship between the mother and family with the first level of skilled attendant. Usually this is the BDD located in the village. The mutual relationships can assist in the development of capacity and increased funding into district wide systems to support improvements in maternal and neonatal health. The relationships will support the priority interventions. These are social mobilization, service delivery processes and systems and quality improvement systems and mechanisms.

The Review Team has formulated several key recommendations to USAID to sharpen the focus for future investments. There was a strong consensus within the team, DepKes/MoH and stakeholders to shift the focus from training and policy development to a large-scale district wide service delivery and social mobilization approach using the materials and tools developed during the MNHI and ASUH Programs.

Future programming should have a sustainability ready prerequisite. Other elements of the guiding principles include shared responsibility and consistent commitment to the implementation of district wide programs. Critical relationships are also at the center of the strategy and these focus on strengthening capacity and responsiveness. The strategic direction is focused and consolidates interventions in similar geographic locations. Service delivery, quality improvement, social mobilization and community demand are at the center of the strategy.

It is expected that the strategy will also enhance sustainability and scaling-up, as it will be community, NGO, government and service delivery driven. Technical inputs support the processes of decision-making, planning and management.

## **6 References**

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Ministry of Health, Republic of Indonesia (2001). National Strategy Making Pregnancy Safer in Indonesia 2001-2010

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**Attachment One: Scope of Work for the MNHI Review**

**TECHNICAL REVIEW  
RECOMMENDATIONS FOR FUTURE DIRECTIONS  
Maternal and Neonatal Health Program  
USAID/Indonesia**

*Cooperative Agreement No. HRN-A-00-98-00043-00*

**Overview**

Indonesia lags far behind its neighbors, with one of the highest maternal mortality ratios (334 per 100,000) in the Southeast Asian region. While the country has experienced a decline in infant mortality, neonatal mortality has not witnessed a rapid decline (25 per 1000 live births). In response to the high maternal and neonatal mortality and morbidity, USAID/Indonesia began to provide technical assistance and funding to the Maternal and Neonatal Health (MNHI) Program in 2000.

The MNHI Program is a USAID/Bureau for Global Health flagship initiative to reduce maternal and newborn deaths in the developing world. The MNHI Program Cooperative Agreement will end on September 30, 2004 and the Bureau for Global Health has requested that all field activities begin to phase down in April 2004.

Given high maternal and neonatal mortality, the MOH/DepKes and USAID/Indonesia remain very committed to continuing to work and invest in this area. USAID's Strategic Objective Agreement Grant (SOAG) with the Government continues through September 30, 2005. The goal of the SOAG is to protect the health of the most vulnerable women and children through maternal and child health, reproductive health, HIV/AIDS and decentralization activities. Improving maternal and neonatal health is a critical component of the SOAG program.

Due to the close out of the MNH Program Global Cooperative Agreement, USAID/Indonesia and in-country partners endorse a participatory technical review to document key accomplishments and identify recommendations for future work (2004-2007) in the area of safe motherhood and neonatal health. The review will take place from mid-August to early September 2003. The major technical components in the Indonesia MNH Program will be reviewed to: identify key accomplishments to date; provide critical recommendations to focus and consolidate future activities and identify potential results; and involve in-country stakeholders and donors to examine ways to leverage and scale up successful results. The results of this review will provide USAID with the identification of the priority technical and programmatic areas for future focus and describe potential results to be achieved in the future.

## **Background**

Data in Indonesia indicate that 42% of maternal deaths are due to postpartum hemorrhage. Therefore, the MNHI Program focus is to prevent and treat complications of pregnancy, primarily through the active management of the third stage of labor to reduce postpartum hemorrhage for maternal mortality reduction. The Indonesian program is also designed to address newborn survival with a focus on prevention of hypothermia, infection and asphyxia. The program uses evidence based data and technical leadership to save lives and develop effective interventions at the national and district level.

The MNHI Program's Strategic Objective is:

### **SO: Health of Indonesian women and children improved**

The program has three intermediate results:

- IR 1:** Policy environment for reproductive and child health improved;
- IR 2:** Health service systems strengthened to improve access, quality and sustainability;  
and
- IR 3:** Women, families and communities empowered to take responsibility for improving health.

The MNHI Program is designed to achieve sustainable results at both the national and district impact. National interventions include improving the policy environment and developing behavior change interventions using mass media. A critical component of the program is focused on developing effective training and service delivery models to increase access and improve quality of maternal and neonatal health services. The program also provides technical assistance to promote community interventions, actions, and advocacy to save lives and mobilize community resources. Given the limited USAID resources and the magnitude of the problems, the MNHI Program is also expected to develop successful models that can be replicated by the GOI, local districts, other donors and the private sector.

## **Methodology for the Review**

The Mission embraces active participation of key stakeholders from the MOH/DepKes, professional associations, advocacy organizations, NGOs, donors and both field and knowledgeable headquarters staff. USAID will recommend 2 representatives from DepKes participate in the review and recommendations process.

## **Purpose of the Technical Review**

The overall purpose of this technical review is:

1. To identify the key accomplishments to date and make technical and programmatic recommendations to focus and consolidate USAID's future directions in safe motherhood and neonatal health;
2. To engage key stakeholders from MOH/DepKes, professional and Islamic associations, NGOs, women's associations, district teams, community groups and key donors to recommend future technical and programmatic directions.
3. To examine and identify strategies and approaches to scale up successful interventions and approaches.

The recommendation from this report will be utilized by USAID/Indonesia to assist in refocusing and guiding future directions to support safe motherhood and neonatal health programming.

Specifically, the key questions that the Team should address are:

1. To summarize the major accomplishments and results of the MNHI program:
  - Policy Issues
  - Clinical Training and Performance & Quality Improvement
  - Behavior Change Interventions including Social Mobilization
  - Evaluation and Operations Research
  - Misoprostol/PPH Dissemination and rollout
2. To engage key stakeholders in a participatory process (interviews and focus groups) to receive their feedback and recommendations on USAID's future role in maternal and neonatal health. Given decentralization of health services, what are the most critical priorities? What recommendations can be made that align with USAID's comparative advantage to provide technical leadership?
3. To make recommendations that will assist USAID to focus and consolidate future investments in safe motherhood and neonatal health on priority interventions that will lead to results. For each component, specific recommendations should be made to address the following:
  - a. Should USAID continue investments in this component/technical area?
  - b. What results can be achieved over a 3 year time period?
  - c. What are the priority interventions needed to achieve results?

### **A. Policy:**

Specific areas that should be addressed include:

- Sustainability of the Bidan Di Desa
- Dissemination of MNHI Service Delivery Guidelines
- Development of Newborn Strategy

B. Clinical and Performance Quality Improvement:

Specific programmatic and technical areas that need to be addressed include:

- APN (Normal Delivery) Training and Follow-up
- Post abortion care PAC - APK training and follow-up
- Newborn Care
- Performance and quality improvement approaches
- Role of in-service and pre-service training
- Role of EOC? District hospital Referrals?

C. Behavior Change Interventions including Social Mobilization

Specific programmatic and technical areas that need to be addressed include:

- SIAGA Campaign-national and district level
- White Ribbon Alliance-national and district level
- Birth Preparedness and Complication Readiness
- Newborn messages

D. Monitoring and Evaluation

Specific programmatic and technical areas to be addressed include:

- Misoprostol Dissemination and Roll out
- Special Studies and Operation Research Issues

E. District Strategy

In the future, should USAID's investments continue in the same geographical areas and districts? What should be the criteria for continued investment at the district level?

F. Other Technical Areas to Be Considered

What other areas should USAID consider to invest in that can impact upon reducing mortality and morbidity in maternal and neonatal health.

4. The ASUH (Healthy Start for a Healthy Life) Program has developed an integrated package of capacity building interventions for village midwives, communities and district health officers to improve the health of newborns. What lessons learned and best practices should be incorporated into the future USAID safe motherhood and newborn care program?
5. Given the lessons learned in leveraging during the current program, what recommendations can be proposed to maximize opportunities to leverage resources from the public sector, private sector, NGOs and donors to scale up successful interventions?
6. Provide recommendations on strengthening partnerships with key institutions:
  - MOH/DepKes & the Activity Coordination Unit
  - Saving Newborn Lives
  - Professional Associations and local NGOs:

- IBI
- POGI
- JNPK, etc.
- Donors including:
  - UNICEF
  - UNFPA
  - WHO
  - AusAID
  - World Bank
  - ADB

Provide recommendations on strengthening linkages and partnerships with other implementing partners for example: MSH/M&L, STARH, HKI, and Coalition for Healthy Indonesia, etc.

### **Final Report**

This report will be used as an internal document by HPN. It should be user friendly and it should clearly summarize key achievements and make specific recommendations for future USAID technical and programmatic focus.

### **Team Composition**

The mission is proposing the following positions for the Technical Review Team. Below each position is a summary of the qualifications and expertise needed for the position:

- Team Leader: ***Kim Wheeler***  
In-depth understanding of maternal and neonatal health issues in the Indonesia context and a very good understanding of USAID are essential. Demonstrated track record as a Team Leader and able to complete assignments in a timely fashion. Excellent writing skills required developing the final report. Strong facilitation skills are required that can allow for constructive dialogue between team members and consensus building.

The team leader is responsible for organizing and delivering the final Technical Report, Executive Summary and PowerPoint Presentation that summarizes findings and recommendations.

- In-Country Facilitator of Stakeholder and Donor Meetings: ***Lucy Mize and Dr. Djoko Soetikno***  
Excellent knowledge of the Indonesia setting and context; in-depth understanding of the Indonesia Safe Motherhood Program; ability to communicate well in both English and Bahasa Indonesian. Capable of conducting interviews and focus group discussions, analyzing the data and assisting the team to think about how to consolidate and refocus the program given input from key stakeholders.

- Technical Expert in Clinical Training and PQI: **Harshad Sanghvi** (full time) and **Nancy Caiola** (part-time participant)  
Clinical expertise in maternal and neonatal health and postabortion care. Extensive knowledge of the Safe Motherhood Programs and neonatal health in Indonesia, in-depth understanding of national service delivery guidelines, performance quality improvements, capacity building, and training system development. If possible, we would like to invite Nancy Caiola/STARH to participate part time to provide TA to strengthen PQI approaches.
- Behavior Change Communication/Social Mobilization Specialist: **Lily Kak**  
USAID/Washington  
Excellent knowledge of BCC and Social Mobilization approaches to empower clients and communities to take action to reduce maternal and neonatal deaths. Good understanding of collective responsibility and the use of the BP/CR and the White Ribbon Alliance.
- MOH/DepKes Representatives  
We propose working with 2 technical experts from the MOH/DepKes that can actively participate as key informants and serve as sounding boards in the review process. These individuals must have a very good understanding of the MNHI program and will play an important role in helping the team make recommendations for both maternal and neonatal health. They will actively participate in discussions about the future role and strategic directions of the project. S/he will provide the team with feedback, ideas, and information from MOH/DepKes' perspective and assist the team to make linkages with other key donors and organizations. These individuals are not expected to do extensive writing.
- USAID Technical Expert: **Monica Kerrigan**  
USAID has identified the MNHI Program CTO to actively participate on this team. Her role will be to participate in the key stakeholder meetings in August and play an active role in working with each team to focus program elements and identify key results.

### **Proposed Timeline:**

The Mission proposes that the in-country SOW for the team be done in four phases:

- Documentation of Results MNHI Program Staff Summarize Results: June-August
- All MNHI technical teams should summarize the major accomplishments of their component prior to August 8, 2003. These summaries should articulate the major accomplishments and significant results with data and evidence to support measurable progress.
- MNHI should put all key technical and programmatic reports and accomplishments on CD Rom prior to the arrival of the technical team.
- Develop in-country schedule and tools: July-August
- The MNHI staff and USAID CTO will work together at the beginning of July to outline an agenda and timeline for the stakeholder meetings and schedule for the Technical Team Review (August 25-September 5).
- Carry out Stakeholders Meeting in August 11-22

The Team Leader, in country facilitator, and USAID will work together to carry out key interviews and focus groups of MOH/Depkes, professional associations, local NGOs, advocacy groups, key districts, etc. The results of the interview will be written up and shared with the technical review team in early September.

**Technical Review Team, In-country: August 25-September 5**

Propose the following:

*August 25:* Team Preparation and Planning Meeting-Review SOW discuss the proposed schedule, agenda, discuss tasks and assignments/roles and responsibilities and logistics. Begin technical review process.

*August 25-September 3:* Technical Team reviews of MNHI and ASUH program and discuss the stakeholders' analysis to develop a consensus and recommendation for the future.

*September 3 & 4:* Team will develop PowerPoint Presentations and finalize writing sections to provide to the Team Leader.

*September 5:* Debriefing at USAID and MOH/DepKes *September 6-12:* Team Leader stays to pull together the recommendations and draft report is submitted to USAID on September 12, 2003.

**Deliverables**

At the end of the SOW the mission requests the following:

1. Submission of the Final Report with Executive Summary by September 19, 2003. The report should NOT be a lengthy document, but user friendly in order for USAID to use the recommendations for future MNHI programming.
2. PowerPoint presentation used to summarize the findings and recommendations of the consultation. The Team Leader and team members should conduct the PowerPoint presentation and discussion for USAID and MOH DepKes in country.

## **Attachment Two: Summary of Focus Groups and Key Informant Interviews (August 11-20, 2003)**

### **Executive Summary**

Focus group discussions, which included over 100 people and 25 hours of conversation, were used as the primary method to obtain stakeholder opinions, concerns and hopes for the future of maternal health in Indonesia. The informants included two groups of pregnant women who are the intended beneficiary of program interventions, village midwives and central level decision makers. Despite the differences in position and experiences within the groups, consistent themes arose. These themes were:

- Decentralization and its impact on health resources and services, elements of civil society
- The role of the BDD and the role of the traditional birth attendant (dukun bayi)
- Linkages and Leverage, the Public-Private Shift
- Quality of interventions, including pre-service institutions, training approaches and maintenance of standards
- Identified trends and changes that would impact on the future of maternal health, including adolescent care, access to family planning and the operationalization of the Making Pregnancy Safer National Initiative.

Decentralization, while a political fact of life<sup>8</sup>, has not yet evolved into a significant opportunity to garner more resources in support of maternal and neonatal health. Lines of authority are still evolving and the central level has not yet ceded its perceived power of delimiting program goals although they no longer control resources to support program goals. Recent decisions, such as the one to allow BDD to extend their contracts for a third and fourth cycle, are not perceived as beneficial to the districts because the fiscal resources needed to subsidize those contracts have not been allocated. There was agreement however that ultimately, within a decade timeframe, localized decision making would result in programs better suited to meet the defined health needs of the district community.

Village midwives are still considered by almost all sources as the primary caregiver for maternal health for both the short and long term future. However, the system within which they function is viewed as changing. IBI continues to press for better credentialing and pre-service training of midwives; thus the 65,000 currently in the field<sup>9</sup> could find themselves insufficiently prepared to meet more stringent professional criteria, such as mandatory D-3 level education. Traditional birth attendants are considered to be members of a declining population. Those that remain in the field will have a changed

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<sup>8</sup> See the June, 2003 World Bank Report entitled: Decentralizing Indonesia: A Regional Public Expenditure Review Overview Report (No. 26191-IND) for a summary of the current status of decentralization in Indonesia.

<sup>9</sup> A recent newspaper article on September 2 stated that over 21,000 of these midwives have already left their post and are unavailable to serve clients. Clearly, the deployment of midwives will remain a significant factor in the future.

cultural role and will minister to the social and religious aspects of the birth process, rather than the clinical support.

Linkages between key elements of the health system are insufficiently developed. Elements that are under review include the role of the general practitioner in being able to provide emergency obstetric care, and the devolution of basic and advanced emergency care to the Puskesmas level, which would be reorganized so that physicians no longer serve as administrators. The referral hospital status is also under review as service providers grapple with legal and administrative barriers that contribute to fallible hospital systems that do not deliver emergency care as it is needed and which continue to contribute significantly to maternal death. All of the stakeholders agreed that Indonesia would not make the full transition to facility based deliveries within the next ten to twenty years so it is important to make sure that the linkages in the system between individual practitioner at the village level, the community health center and the referral hospital be strengthened. Leveraging of resources in support of maternal health is also just beginning, there needs to be better use of other program resources, existing inputs and the private sector as a role model for better quality care.

Quality of care was the overarching theme that covered issues such as training interventions and the institutionalization of standards. Training was still deemed to be an appropriate intervention for all cadres of service providers except traditional birth attendants; the National Clinical Training Network (NCTN) was identified as a resource but there are doubts about its institutional capacity to respond to the need. There was explicit acknowledgement that pre-service education needed more investment in order to have long term impact, yet at the same time the unchecked growth of new midwifery academies and the inconsistent standards to which graduates were held were acknowledged as problematic. Incentives and or penalties were deemed appropriate as a way to institutionalize standards and create better adherence to the known quality factors. All the informants believe that Indonesia has advanced through the development of standards phase and now must concentrate on consistent implementation.

Other salient points that came up in the majority of the discussions include the future of adolescent services; the potential impact on maternal health from the uncertain supply of contraceptives after 2004 (and decreased district budget allocations to buy the contraceptives); and the impact of changes to the current policy regarding abortions. Many of the informants also referred to elements of civil society (free press, increasing consumer demands, expanded basic education, rule of law, etc) as important in creating a better environment for maternal survival. One other notable point is as of yet, the Making Pregnancy Safer Initiative has not yet moved the Safe Motherhood agenda forward nor created a workable framework for districts to develop maternal health plans. This was raised as a very important lesson learned and one that should not be repeated as the government finalizes the new national newborn strategy.

## **Introduction**

### *Background, Key Questions and Themes, Process*

The MNH program sought the widest range of stakeholder comments and used extensive focus group discussions, small meetings and key informant interviews as methods for eliciting input. Among the groups and individuals consulted were:

- Facilitators developed and used under the existing MNH program
- Bidan di Desa
- Puskesmas staff
- District level health officers
- Provincial level health officers
- Central level government officials from the Ministry of Health, BKKBN and Women's Empowerment
- Dr. Adik Wibowo, Dr. Ardi Kaptiningsih, Dr. Alisjahbana, Dr. Joedo Prihartono
- Professional Organizations
- NGO's
- Donors and other USAID Collaborating Agencies (STARH, KuIS, PATH, MSH)
- Training Organization and Training Providers.

To provide a framework for discussion, five questions on the view of the future, human resource development, quality of care, health system linkages and decentralization were developed by a small committee. The five questions were:

1. In the last decade, the Indonesian government commitment, donor funding, public awareness campaigns as interventions for safe motherhood but progress in decreasing maternal mortality has been very slow. What would you propose as the five most crucial interventions over the next decade in order to get the maternal mortality ratio to decrease significantly?
2. The Indonesian government and the donor community have invested heavily in training as a key intervention to improving quality of services and in making services more available. Over the next decade, do you think the level of training resources should stay the same, increase or decrease? To what extent do you think resources should be used for pre-service education vs. in-service education? Do you think there are groups of providers who have not yet been trained who should be?
3. Indonesia acted quickly to embrace the notion of quality of care and there are national standards and clinical guidelines already developed and disseminated to support quality improvement. Despite this, supervision and field assessments routinely find that adherence to standards is poor and that existing quality guidelines are not being implemented. What do you think is the reason that it is so difficult to institutionalize good quality services? What should be done in the coming decade to ensure that standards of care are adhered to and that the quality improvement programs are implemented?

4. In previous program interventions, the referral system and timely referral were both identified as significant barriers to care and probable contributing factors to maternal death. Since then, the referral system has improved and complicated cases are being referred in a more timely manner. However, there still appear to be problems in the fact that maternal deaths are now occurring at hospitals. What are the factors that are contributing to these facility based deaths and how can the overall referral system still be improved?
5. This review will address themes such as sustainability of programs, maternal health care in a decentralized health system, and future policy needs. It will also address the concept of maternal health as a human right. Are there other themes that you think should be considered in order for this review to be sufficiently comprehensive? Are there factors in the already identified themes that are of particular concern?

These questions served as prompts and discussion guides and ensured that there was uniformity between groups. During the course of the interviews and discussions, when consistent themes were uncovered, they were raised with subsequent groups to ensure as wide an input as possible. All the groups were held in Indonesian, with the exception of the donor group, and Dr. Djoko and Lucy Mize served as moderators. The team leader, Dr. Wheeler, attended as many groups as possible and Dr. Siregar, the MNH evaluation expert, co-facilitated some of the groups in Jakarta. Each group was between one and a half to two hours in length.

There are a few caveats to the process that must be identified. We had stipulated individuals to join the groups in order to draw in the most experienced thinkers but at times, junior staff were substituted who were not quite as familiar with the issues. The donor group had limited participation and did not have members from the World Bank, WHO and the Ford Foundation because of scheduling conflicts; efforts were made to interview those donors separately after the group to try and expand the breadth of informants. Last, although the intent of the groups was to look to the future and envision what needed to be done over a ten to twenty year time span to change maternal and neonatal health outcomes, many of the informants persisted in discussing the present and the problems, hurdles and issues of the current program. Although this was valuable, it sometimes resulted in discussions held at too detailed a level instead of at the strategic thinking level that we had envisioned. Nonetheless after two weeks of interviews and groups, a wealth of information was generated. This information is discussed in greater detail in the following pages.

## ***Discussion of Findings***

The following pages summarize the conversations with each specific group and link their comments to the themes outlined in the executive summary. The recommendations in the main body of the report also reflect input from these focus groups and can also be identified through the themes.

### **Central Level Government**

#### *Decentralization*

The national maternal health program should develop one simple package and cost structure. This will prevent fragmentation and enhance replication. Now, for example, each donor develops specific interventions in a certain area, but they cannot be implemented in other areas because of complicated activity and project structure and high cost (true costs are often not known because of donor subsidy.) There is a need to develop a task force for MNH, which has the authority to develop integrated interventions, and screen new ideas as to whether they are appropriate to the current situation and national implementation. In the future, the program for neonatal health care should get same attention as the maternal health interventions. Training in advocacy skills is important for the District to get commitment from Bupati/Walikota (local governance structure); under decentralization, their commitments are more vital and are needed to strengthen decentralization.

#### *Linkages and Leverage/Role of the Midwife*

Models for social mobilization, which have been developed, should link with the hospital and providers, especially midwives. All midwives, including at the hospital level, should be trained in the basic delivery care module (BDC-APN). If the community is socialized to expect better care from the overall system but only village midwives receive the BDC-APN training while the attitude and procedures in the Puskesmas and hospital are not developed commensurate with community expectations, then the community will become frustrated, and the program will fail. Doctors in hospitals should also be well informed on clinical changes, and the SOP in hospitals must be updated regularly to reflect the approved clinical practices. One of the service problems is hospital GPs are not yet well trained for emergency obstetric care, and some hospitals have not yet developed standard operational procedures for emergency complications, which can be followed by GPs or other providers in the emergency ward.

Relationships between the community health-center Bidan, the BDD and the hospital-based midwives need to improve. Hospital midwives need to be involved in any BDD improvement activities, such as interpersonal counseling training and radio vignettes long distance learning. This commonality will provide a link between efforts for providers in the field with providers in the hospital. In addition, the commitment from the Puskesmas to supervise and support bidans is very important and is a gap in the current system. The concept of the mother and baby friendly hospital, while still valid, is no longer getting adequately implemented.

### *Quality of Interventions*

Reporting and recording at the hospital level do not sufficiently capture maternal health data and the current system of maternal and neonatal audits is also not working as well. It appears that during the first two years of decentralization, there are less data captured on maternal health at the district level and less reporting of data to the center. There is the need for the development of a simple reporting system with maternal and neonatal health data.

There are many missed opportunities for improving maternal health through linkages with Communicable Disease programs on Malaria, TB and HIV/AIDS. Bidans have less understanding on Communicable diseases, although the impact on women from communicable diseases during pregnancy is higher compared to non-pregnant women or men. There is an issue on the gender “discrimination” in the treatment for Communicable Diseases, for example 65 % of males get TB treatment and visit health services but only 35 % women get the same treatment.

### **Donor Organizations**

#### *Decentralization*

Adequate funding levels for health will continue to be problematic and advocacy to the DPRD is considered a long- term successful strategy, as long as the central level Commission Seven is also included in these efforts so they can assert lateral pressure on the DPRD. To prevent the fragmentation of health services and each vertical program doing their own lobbying, there should be a more holistic approach that combines family planning, safe motherhood, nutrition and adolescence, integrated district planning was seen as important for securing funds for this holistic approach. Many of the donors agreed that orienting health programs as the way to protect the future of Indonesia’s youth would be a successful hook to obtain investment funds. It is a real concern to UNFPA that in their own district assessment, 30-40% of the districts have not allocated funds for the purchase of contraceptives. This is considered catastrophic and there is the belief that the absence of contraceptives could undermine the entire safe motherhood program, resulting in an increase of unwanted pregnancy and unsafe abortion.

#### *Linkages and Leverage/Role of the Community Midwife*

For community mobilization efforts to be sustainable and truly embedded in the community, they need to be more integrated. Approaches should include the schools and an effort to increase the overall level of education of the marginalized groups, plus an effort to address the continuing social inequities. The donors agreed on bidans continuing to play a key role in service delivery. An interesting point raised by UNICEF was whether the extension of the misoprostol trial would raise the credibility of traditional birth attendants and resurrect a professional role for them. The donors agreed that there should be no further training of traditional birth attendants as it would muddy the waters and again give them credibility when they were reducing slowly in numbers through natural attrition and changes in community birthing practices.

### *Quality of Interventions*

The rigidity of the health systems is still a factor in maternal death, and within the hospitals, there are significant issues of access. Hospitals routinely don't have enough staff to cover weekend needs, in the World Bank areas, they have documented a trend of increased deaths on the weekend because of the absence of specialists. This absence of specialists is notable in the Eastern regions of Indonesia; there have been proposals seeking to provide general physicians with the skills necessary to cope with emergency obstetrical needs. Some areas have implemented these proposals despite the fact there is some resistance from the Indonesian Association of Obstetricians and Gynecologists (POGI) and debate on the exact nature of training is still ongoing. Other problems associated with hospitals include inadequate supplies of blood products coupled with poor practices and institutionalized discrimination against poor people. However, there is some evidence to show that owning a Kartu Sehat (KS) allows the poor to access Class 3 services and that providers will serve these patients because they make up in volume what they lose in per patient reimbursement structures.

### *Identified Trends*

The difficult issues associated with maternal survival as a human right was seen to be reached through a refocusing of the issue to child survival. It was generally agreed that the woman's right to survive could be linked closely with advocacy for the child.

### **Professional Organizations - Decentralization/Civil Society**

Maternal health is viewed as a key development factor in the healthy development of future generations of the Indonesian nation. Given this, maternal health should remain a responsibility of the central government. Funds from the DAK account (Dana Alokasi Kursus or special fund allocation), should be used to support an integrated Women, Infant and Child (WIC) program, involving sectors such as education and religious affairs. This should become the primary government policy on sustainable economic development in the health sector, and should examine the role of the private sector in supporting national health goals and generating income for the government. Without developing more equitable financing, there will be a negative impact on service; poor families who can't pay fees for Bidans will be forced to use traditional birth attendants, high-risk mother referred to hospitals will either be rejected out of hand or suffer unacceptable delays in service and possibly suffer adverse consequences.

### *Quality of Interventions*

The management of health services should be removed from the Ministry of Health and instead should become a responsibility of the Central Planning Commission (Bappenas), who could tap resources from other sectors and develop an integrated national policy for women and children. This would also cover planning for health services and providing skilled manpower. GPs in remote areas should be trained on emergency obstetric care

including c-sections, because of the limited number of obstetricians and gynecologists and their unequal distribution.

## **Non-Governmental Organizations**

### *Decentralization*

They acknowledge that there has been some confusion at the grass roots level over the plethora of mobilization approaches, such as the White Ribbon Alliance and GSI. However they feel these approaches support each other and think that future efforts or campaigns should build on existing strengths. They consider the PEMDA as an ally and feel that using their board of directors to capitalize on the hierarchical nature of Indonesian political intervention is a legitimate approach, even though using governors to instruct the DPRD in support of the White Ribbon is a top-down approach

### *Linkages and Leverage*

Given the breadth of membership that belongs to NGOs, the NGO's think that they can be successful at making positive cultural and social changes in the status of women that would contribute to the reduction of maternal mortality. They believe their future mandate is to include private service delivery, family planning, gender equity programs, right to basic education expansion, and treatment of STDs. They think their efforts can cause a shift from "sumbur, dapur, kasur- or washing, cooking and sex" to better equality and joint decision making on health needs. They think the institutions they support (such as midwifery academies and clinics) can become alternate service delivery sites that contribute to improved maternal health, however they view themselves as complementary to the government and not as replacement services. For example, they are reluctant to embrace the government mandate that NGO's deal with adolescent health services as it is too "sensitive" for the government.

## **Training Organizations/Training Site Managers -**

### *Quality of Interventions*

Quality of pre-service is low, in part because the number of academic institutions is high, but faculty members and mentors are few, and there is no institutionalized competency standard for midwives in Indonesia. Midwifery education is not yet ready to follow competency base training, and there is insufficient educational material and equipment available for the students in the system. There is a need to have a standard essential care or core competency for bidans as the basis for education, this can then be added to if they choose to have an extended clinical role, or depending on the job needs of the "users". Currently, there is also no system to maintain clinical skills of bidans after graduating. There should be improvement in the role of provincial and district in-service training centers not only as a training organization but also as clinical supervisors to assure quality post-training. There should be good coordination among AKBID, provincial and district training centers, for follow-up post training and for continuing education.

The cost for midwifery education will possibly increase because as hospital training sites become private hospitals, they will be able to charge for students to have opportunities for clinical practice, this will be one of the income generating centers for the hospital.

There remain policy needs regarding clarification of different Ministry instructions for implementing accepted standards. The Ministry of Health letter of decision, (SK Menkes no 900/2002) gives authority to midwives to practice differently than prescribed in the BDC-APN training.

### *Identified Trends*

One suggestion was to create within hospitals, specialized obstetric emergency wards, to treat clients who have had unsafe abortions or who are experiencing complications. From a study on abortion practices, with 1500 respondents, providers found that most are women with three children, and they terminated the pregnancy for several reasons, such as economic hardships, unwanted pregnancy and contraceptive failure. Their terminations were done using unsafe abortion practices.

### **Provincial Stakeholders -**

#### *Decentralization*

Discussions at this level focused on systems and access. There was concern over the deployment of staff and who controlled this deployment, with a particular concern over the future funding of contract BDD. As a result of decentralization, they felt there was competition among sectors to get general resources funds for training. They also acknowledged that the next few years were a time of transition as they moved their role from “rowing” to “steering”.

#### *Quality of Interventions*

They agreed that health personnel as a whole are not meeting competency standards when they graduate because there is a lack of preceptors, inadequately prepared Degree level and Diploma level instructors, insufficient real client practice prior to graduation and poor supervision practices to support newly graduated practitioners. There was discussion of creating a “health council” as a board that could support standards and quality, including certification of practitioners and this would institutionalize standards. There is still the perception that in the near future (five year time frame) work will need to be done to synchronize all the manuals and standards that are in use, gave the example of how different books provide different instructions for filling out the partograph. They are concerned the training sites currently in use will not be sustainable without ongoing donor support, although training interventions remain a key element to the maternal health program.

### *Identified Trends*

The group thought that a very real threat to maternal health in the coming years will be the shortage of contraceptives, with an attendant rise in pregnancy at short intervals and unwanted pregnancy. This in turn will give rise to an increase in unsafe abortion. Dr. Herman advocated for a change in national policy to allow for legal and safe abortion on demand below 12 weeks. In relation to social and cultural factors that influence health outcomes, absolute poverty and decreased levels of basic education put women at greater risk for dying, at least in the urban West Java experience. Solutions to this would be to focus on educating the men about the increased risks for their wives. Programs on domestic violence and pitfalls of early marriage should also be focused directly on men as they continue to make most of the household decisions.

### **District Stakeholders/Heads of Puskesmas**

#### *Decentralization/Role of the Bidan*

There was conflicting input on the future of BDD. One side argued that decentralization and flat revenue streams would force bidans out of the public sector since district governments could no longer afford minimal salaries, others thought that the village bidan would continue to exist but there would be a reorganization of their relationship to the Puskesmas. None of the respondents were able to answer questions pertaining to how the MPS strategy had served to improve care, most dismissed it as a central level effort that did not fit the reality of services at the district level. At a minimum, they thought that 18% of the district budget must be allocated to maternal health services and this figure needs to include funds for supervision and training of supervisors.

#### *Quality of Interventions*

Funds also need to be used to change the climate of care within hospitals, referrals are not treated in a timely manner and staff are not proactive in trying to make systems work for a woman experiencing delivery complications. This is where there is still a role for the community facilitators that have been trained by MNH, they can become patient advocates within the hospital setting and make the system work for their clients. However, others thought if bidans were trained in BDC-APN and developed a better client oriented/service perspective, then the role of facilitator was not so important in the future. All agreed that better skills were needed, particularly for the treatment of complications. However, the reality facing Kuningan district is that with 44 Puskesmas and the ability to train the staff in emergency care of only two centers each year, they still would not be done this kind of training within a ten year time horizon.

### *Identified Trends*

Cultural practices in rural villages in West Java continue to pose barriers to maternal health as many of the providers knew of ten-year old girls giving birth. They also stated that overall low levels of basic education among both men and women hampered community mobilization efforts and the penetration of birth preparedness messages.

## **Bidan Di Desa**

### *Decentralization/Role of Bidan*

Bidans think that in then years there will be very few dukun to challenge their supremacy as the skilled provider of choice for women. However they acknowledge that right now it is hard to motivate women to use them because of economic barriers and also low education barriers. Most of the bidans voiced unhappiness with their deployment and their contract status, they all wanted to become government employees and they wanted ancillary workers to help them meet the health needs of the community. They valued the role of the facilitators, viewing them as advocates of evidence-based information they could share with clients.

### *Quality of Interventions*

Many of the bidans had real difficulty with the referral system as they had all experienced maternal deaths when clients were turned away from hospitals. A hospital was cited for discriminatory practices against those clients who used the health card system. Because of lack of quick response by the specialists, it is considered as a particularly vulnerable point in the referral chain. The bidan found that this hospital did not use the Maternal Audit system, which they think would be very useful for pointing out flaws in the referral system and for developing solutions. As there were midwives from both districts, they pointed out that in Kuningan, only 25% of the costs are covered for care but Cirebon covers 100% of the costs for poor families and as a result, poor women are at greater risk.

## **Kuningan and Cirebon Facilitators**

### *Decentralization*

Since decentralization has been implemented, getting the community involved in health development has become more important. The facilitator can play the role of planning and allocating budget resources for community activities in maternal health as long as they serve in a communication forum with Dinas Kesehatan. They can play a role as an advocacy group to the legislative assembly and provide a more concerted community voice. They believe one of their roles is to maximize the resources of the government because government fiscal resources are limited. They do this by serving as bridge between the community and the health systems and also by aiding the BDD. They feel they could expand their current role to cover many other facets of public health, such as vaccination coverage and clean water. However, they view themselves as independent and if the government wanted them to socialize programs that they were not in favor of (such as one child family or abortion on demand below 12 weeks) they would have to evaluate whether those measures were congruent with Islam and the needs of the community.

### *Quality of the Interventions*

Behavior of health personnel in the hospital needs to improve, especially in the response to emergency cases. The quality of services in health care facilities also needs to

improve, and become more client oriented rather than profit oriented. They stated they would continue to have a future role in making sure that hospitals were complying with regulations to treat women regardless of their resources and they felt they could have a significant impact on delivery outcomes if they served as an advocate for the woman once she was referred because of complications.

### *Identified Trends*

The current MNH program should become broader by including adolescents as a special target group. Educating adolescents on reproductive health is a key intervention. The group felt that with so much information available through global resources such as the Internet, there was a need to counteract inappropriate information that would stimulate Indonesian youth to have the wrong perceptions of reproductive health matters. They also see their role as a catalyst for the community to develop overall better practices and learn to care for women

### **Kuningan and Cirebon Pregnant Women**

#### *Role of the Bidan*

Among the informants, most were planning to deliver at home and with a midwife although one client planned a hospital birth with an obstetrician/gynecologist as she had experienced complications during her first birth. The group thought this practice of home delivery would continue over both a ten year and twenty year time horizon (they said they thought their daughters would also deliver at home). The presence of the BDD and the village facilitator makes mothers and family members feel more secure, as compared to staff such as posyandu members, kader, or dukun bayi. This is because the BDD and facilitator can actively support the mother in cases of emergency. BDD and the facilitator can accompany mothers to the hospital, and negotiate with hospital so it will pay more attention to the client's care. The role of the dukun bayi now is to take care of the baby until it is 6-10 days old; and the mothers believe that some day there will be no more dukun bayi. The group stated that only the really poor people used dukun now for delivery but that most women in their villages still used them for the seven-month ceremony, for care of the newborn and for massage and also for comfort during the labor process. Another stated reason for accessing dukun was if a woman felt ashamed about the number of births she had had, dukun bayi were viewed to less censorious because they were seen as operating on the side of the organized health system and thus less concerned with client adherence to government efforts to limit births.

#### *Quality of the Interventions*

None of the participants knew whether their bidans had been trained in BDC-APN. During probing on practices of the bidans, a few commented that bidans didn't use gloves to examine them. The primary criteria for bidan selection appeared to be the client perception that the bidan was patient and shared information with them and also if other women in the community trusted her. The respondents did not know if they would be brave enough to tell a bidan if they did not like certain things she was doing and they all

said they would never challenge a doctor. None of them wanted to be referred to the hospital because of known cases of discrimination and rude and insulting behavior to women who arrived without sufficient fiscal resources. They all had anecdotes of friends and neighbors who had suffered; one informant reported a woman who had curettage for a miscarriage without the use of any anesthetic because she was poor, while the informant had had the same procedure for the same reason at the same hospital with anesthesia because her husband could pay the fees.

### *Identified Trends*

Questions concerning equity did not provoke any strong responses, they all said having a child was a mutual decision and that it was only polite to ask their husband's permission before using family resources for their personal health needs. They felt they could speak up and ask their husbands to reduce smoking and use the money for milk for children or their own antenatal care. The mother's group requested greater involvement of their husbands in learning about maternal health instead of only women. This would allow men to better understand and make better decisions in support of women's needs during complications or routine health care

### **Summary of Key Informant Interviews**

In planning for the review, the team wished to access Indonesian experts who had been involved in the safe motherhood and neonatal health program for an extensive period of time. The team was fortunate enough to be able to interview four experts; they were Dr. Joedo Prihartono, the national consultant to the Ministry of Health for the Making Pregnancy Safer Initiative and the medical director of a private health care foundation; Dr. Adik Wibowo, who currently serves in the WHO South-East Asia office as the head of research and evaluation and who formerly taught at the University of Indonesia, had a private obstetrics practice and served as a consultant to MotherCare; Dr. Ardi Kaptiningsih, who was the head of the maternal health division in the Ministry of Health and who is now on a limited time appointment to WHO SEARO and Dr. Anna Alisjahbana, who is the current director of the WHO Collaborating Center in Bandung and is also the project director for an early childhood development program.

Analysis of their comments led to themes that echoed those already heard from the focus groups, namely:

- Civil Society, Decentralization and Economics.
- Overall Health Care Delivery System and the Role of the Midwife.
- Linkages between Sectors.
- Cultural Factors.

### *Civil Society, Decentralization, and Economics*

The framework of civil society is crucial to create an enabling environment that promotes maternal survival. Elements of civil society that are key include passing legislation that affords service delivery providers legal protection when they try to assist during complications and a more transparent selection process for posts so that candidates don't have to pay bribes in order to get a post. Other elements include using the press to argue for needed changes, training policy makers to become champions for health and using Non-Governmental Organizations as the avenue to elicit community health changes.

Decentralization is acknowledged as a political construct that will continue to evolve over time, however the informants thought there was no going back to a more centralized system. They felt that districts which had already demonstrated their commitment to health and better governance should be rewarded by program support as this would contribute to the success of the endeavor, as would working closely with bupati, since their role had expanded under decentralization. One cautionary note was that as of yet, there had been insufficient assessment of how politicians perceive health. In order to obtain more information, questions such as "How do politicians perceive the importance of maternal health?", "How are decisions on health financing made?", "How often do parliament members debate health subjects and what degree of support are sitting house members giving to health programs?" will need to be answered.

The economics of health care, from supply and demand sides, was considered a prominent factor impeding change. From the consumer side, within the poorest segments, there are groups that are so marginalized they will never be able to access emergency services and they have very few options other than community based care for improving health outcomes. In order to plan how to reach these groups, the government needs to do a better job of defining "poor and needy" so that this population is not arbitrarily disenfranchised from accessing programs. From the supply side, there will continue to be disincentives for providers to practice in the public sector, if the government doesn't take measures to increase salaries, equalize earnings disparities between the public and private sector, and continue subsidies for medical education.

### *Overall Health Delivery System and Community Midwives*

Community midwives were acknowledged to be the backbone of the system and to have the primary capacity to do deliveries. Their relationship and partnership with traditional birth attendants and other community members such as kaders was viewed as integral to the delivery of good quality services. However they are not alone within the system and unless better support comes from the community health center and the district hospital, they will not be able to adequately function. Overall functioning of the existing health systems was thought to be weak, due to the continued staff turnover at the community health center, the poor distribution of providers, the inability of GPs to perform emergency obstetric care and barriers to access because of the lack of social insurance.

### *Linkages*

Linkages between different parts of the health care system and also other social sectors are very important. Medical interventions alone will not have an impact on maternal health, there needs to be an increase in basic education and also a mix of social and economic relationships for impact. In addition, within the health sector, training must be accompanied by follow-up and supervision if it is to have sufficient impact as training alone is just one intervention with the wider framework of actions needed to promote maternal survival. The messages of birth preparedness are still valid and provide an ideal opportunity for linkage, while the MPS strategy has been insufficiently operationalized to have had an impact on safe motherhood and has not yet created the vital links that will reduce maternal mortality.

### *Cultural Factors*

As stated above, medical interventions alone will not have an impact on maternal health, cultural practices will need to be addressed too. Currently, women are still viewed as disposable in Indonesia. Men need to be involved so that society understands that each maternal death is a significant loss. Citing the example of how immunization rates for children improved considerably once men were part of the process, the informants thought there could be the same shift in maternal mortality if men become a more significant part of the solution.

Given the culture of shame and its contribution toward maternal death, adolescent girls, very young mothers and women with large number of children need to be targeted for birth preparedness messages. Otherwise, shame over their condition and its perceived drift from the societal norm, could prevent them from seeking care.

## **Attachment Two; Annex One: List of Participants in the Stakeholder Discussions**

### **Focus Group Discussion with Government Organizations**

Day/Date: Monday, 11 August 2003

Venue: MNH Jakarta Office

1. Lely E. Hadjar, BKKBN
2. Lenggang Kentjana, MenegPP
3. Carmelia Basri, Ditjen PPM PPL, MoH
4. Siti Nadia, MoH
5. Harni, Keperawatan, MoH
6. Asih Widowati, Yanmed, MoH
7. Martini, Gizi Masyarakat
8. Koesminarti, Promosi Kesehatan, MoH
9. Gita Maya, Ditkesga, MoH
10. Lukman, Ditkesga, MoH

### **Focus Group Discussion with International Organizations**

Day/Date: Monday, 11 August 2003

Venue: MNH Jakarta Office

1. Mela Hidayat, UNFPA
2. Endang Achadi, IMMPACT
3. Nina Yulianti, AUSAID
4. Frances Bauns, AUSAID
5. Ingrid Hilman, UNICEF
6. Budi Subianto, UNICEF

### **Focus Group Discussion with Non Government Organizations**

Day/Date: Tuesday, 12 August 2003

Venue: MNH Jakarta Office

1. Dr. Malichah MS, Aisyah
2. Dra. Ny. Hadi Santoso, KOWANI
3. Farida S. Wahid, Muslimat NU
4. Mien Dahlan, PKBI

### **Focus Group Discussion with Professional Organizations**

Day/Date: Tuesday, 12 August 2003

Venue: MNH Jakarta Office

1. Rulina Suradi, Perinasia/IDAI
2. Syafri Guricci, IAKMI
3. Suryono, POGI
4. Wastidar, IBI

**Focus Group Discussion with Training Organizations**

Day/Date: Wednesday, 13 August 2003

Venue: MNH Jakarta Office

1. Emi Nurjasmi, Pusdiknakes
2. Yati Suhartati, PPNI
3. Suratin, Pusdiklat
4. Budi Iman S, P2KS DKI Jakarta
5. Imran Chair, Perinasia
6. Omo A. Madjid, P2KT Jakarta

**Focus Group Discussion with Training Sites**

Day/Date: Friday, 15 August 2003

Venue: Dinas Kesehatan Propinsi Jawa Barat

1. Suhayati, P2KS Jawa Barat
2. Nani Kusnaeni, P2KS Jawa Barat
3. Ai Dewi H, Puskesmas Puter
4. Siti Jamah, Prodi Kebidanan Cirebon
5. Ilah, P2KP Cirebon
6. Pung Purnama, RSUD Ujung Berung
7. Herman Sunarto, RS. Astana Anyar
8. Tati Rostati, Prodi Kebidanan Bandung

**Focus Group Discussion with Provincial Stakeholders**

Day/Date: Friday, 15 August 2003

Venue: Dinas Kesehatan Jawa Barat

1. Dra. Nani Mukaromah, White Ribbon Alliance
2. Nining Supari ST, White Ribbon Alliance
3. Ipit R, BKKBN
4. ETTY Y, BKKBN
5. Dr. Fita, Dinas Kesehatan Jawa Barat
6. Dr. Ilsa, Dinas Kesehatan Jawa Barat
7. Dr. Nida, Dinas Kesehatan Jawa Barat
8. Yayu, Dinas Kesehatan Jawa Barat

**Focus Group Discussion with District Stakeholders**

Day/Date: Tuesday, 19 August 2003

Venue: Dinas Kesehatan Kabupaten Cirebon

1. Triyani, Dinas Kesehatan Kabupaten Cirebon
2. Mudjilah, BKKBN Kota Cirebon
3. Anang Yuwana, White Ribbon Alliance
4. Soleh Bastaman, Dinas Kesehatan Kabupaten Cirebon

5. Lilis H, Dinas Kesehatan Kabupaten Kuningan
6. Kaptiningsih, Dinas Kesehatan Kota Cirebon
7. Prihadi, Kepala Dinas Kesehatan Kabupaten Cirebon
8. Drs. Kamil, Sekretaris Daerah Kuningan
9. Drs. H. Syarif MA, Kepala DPM Kabupaten Kuningan
10. Tini Kartini, DPM Kabupaten Kuningan
11. Eni Rusnaeni, DPM Kabupaten Kuningan
12. Iis A, DPM Kabupaten Kuningan

**Focus Group Discussion with Head of Puskesmas**

Day/Date: Tuesday, 19 August 2003

1. Hj. Erah S, Puskesmas Maleber, Kuningan
2. Hj. Yeti Mulyatini, Puskesmas Wosengkahan, Kuningan
3. Hj. Siti Masroch, Puskesmas Cihaur, Kuningan
4. Dr. Ida Aida AZ, Puskesmas Sitopeng, Cirebon
5. Juju Juniati, Dinas Kesehatan Kabupaten Kuningan
6. Drg. Nila Sofyan, Puskesmas Beber, Kabupaten Cirebon
7. Hj. Nani S, Puskesmas Plumbon, Kabupaten Cirebon
8. Drg. Selly P, Puskesmas Mundu, Kabupaten Cirebon

**Focus Group Discussion with Bidan Sub-Coordinator**

Day/Date: Tuesday, 19 August 2003

1. Endang S, Dinas Kesehatan Kabupaten Cirebon
2. Ismiyati, Puskesmas Mundu, Kabupaten Cirebon
3. Hj. Nani Iryani, Dinas Kesehatan Kabupaten Kuningan
4. Sumiati, Puskesmas Japara, Kuningan
5. Hj. Tuti Nursari, Puskesmas Kalimanggis, Kuningan
6. Hj. Nani R, Puskesmas Kesunean, Kota Cirebon

**Focus Group Discussion with Bidan Desa**

Day/Date: Tuesday, 19 August 2003

1. Gusti Slamet, Puskesmas Cangkol, Kota Cirebon
2. Retno Bariah, Puskesmas Kembang, Kota Cirebon
3. Hj. Nani R, Puskesmas Kesunean, Kota Cirebon
4. Yati R, Puskesmas Beber, Kabupaten Cirebon
5. Endang Ikhwati, Puskesmas Mundu, Kabupaten Cirebon
6. Aat Sutihat, Puskesmas Luragung, Kabupaten Kuningan
7. Iti, Puskesmas Maleber, Kabupaten Kuningan
8. Nining Suhartini, Puskesmas Cidahu, Kabupaten Kuningan

**Focus Group Discussion with Mothers**

Day/Date: Wednesday, 20 August 2003

1. Djohan E, Desa Perbutulan
2. Beida, Desa Sukapura
3. Farihin, Desa Haryamukti
4. M. Kampel, Desa Sidawang
5. Nunu Sabari, Desa Pangusapan
6. Entin Fudah, Desa Jati Pancur
7. Sy. Badar
8. Ewo Suhasa
9. Ade Fitry, Desa Lemah Wungkuk
10. Sri Mulyati, Desa Sukapura
11. Dessy Susanty, Desa Pangrango
12. Jaemah, Desa Jagasatra
13. Mamah Sanimah, Desa Jatipancur
14. Oom Qomariah, Desa Kedungsana
15. Nur Hasanah, Desa Sidawangi
16. Entin Faridah, Desa Jati Pancur

**Focus Group Discussions with Facilitators**

Day/Date: Wednesday, 20 August 2003

1. Sumardi HS
2. Ing Nurohim
3. Siti Musrifah
4. Jojo Sudarjo
5. Uki, Desa Cibinuang
6. Titi, Desa Kalimanggis Wetan
7. Sri Mulyati, Desa Cicukih
8. Nh. Herman, Desa Cirahayu
9. Sulistiwati, Dinas Kesehatan Kabupaten Kuningan

**Attachment Two; Annex Two: Key Informant Discussions**

<b>Meeting Date</b>	<b>Organization</b>	<b>Key Discussions</b>
21 July – 25 July	MNHI Team Meetings	Discussion of the SoW for the Review Preparation for presentations Review of the documentation
28 July	USAID	Comparative advantage Future directions – neonatal health, the role of pre-service training
29 July	Meneg PP (Ministry for Women's Empowerment)	Technical Review Mother Friendly Movement
31 July	STARH Program	Areas of overlap Sustainability of interventions – program focus
1 August	ASUH	Discussions about review and the involvement of the ASUH program
4 August	WHO	WHO QI program linked to the Puskesmas Future directions – need to improve medical services (major constraints here); consumer groups need to grow and develop; better standards for pre-service training is very important
7 August	USAID – HPN discussion	Reviewed scope of work and review schedule Suggested links to other organizations and programs for additional information Discussion of the relatively different approaches between ASUH (used existing systems) and MNHI (focused directly on the BDD and service providers)
11 August – 13 August	FGDs – central level	
14 August	AusAID	Look to an area focused approach in the next strategic plan Include a civil society development component Institutionalization of training
14 August	CIDA (Canadian International Development Agency)	Discussed the implementation of the ALARM training package – indicated some overlap with the MNHI interventions Future directions will be focused in communicable diseases – lots of scope

Meeting Date	Organization	Key Discussions
		for opportunistic healthcare
14 August	MNHI Team	<p>A view of the future:</p> <ul style="list-style-type: none"> <li>▪ Delivery costs free to the end user</li> <li>▪ Access to health services for all</li> <li>▪ Mothers trusting bidans</li> <li>▪ Standardized quality of care across Indonesia</li> <li>▪ Safe mother and newborn</li> <li>▪ Safe Motherhood on the political agenda</li> <li>▪ Community empowered and closely linked to the delivery of health services</li> <li>▪ Consistent access to maternal health services</li> <li>▪ Mother and baby friendly</li> <li>▪ Safe Motherhood includes reproductive health and family planning</li> <li>▪ Safe Motherhood interventions are evidence based</li> </ul>
15 August	FGDs Bandung	
15 August	WHO Collaborating Centre – Bandung	Child health information package developed – has been implemented in several provinces – provides for linkages between the BDD and Dukun Bayi
19-20 August	FGDs – Kuningan and Cirebon District	
21-22 August	Visits to PAC - APK sites – North Sumatra	<p>Visited 2 Puskesmas and 3 hospitals (2 private, 1 government)</p> <p><i>General impressions:</i></p> <p>Variable results of input</p> <p>Success very dependent on the system within which the organization functioned – still room for quality improvement</p> <p>Sustainability of the system possible but will require income generation</p>

**Attachment Three: The Review Schedule**

Date	Time	Content	Session Facilitator/s
<i>Introductions</i>			
25 August - Facilitator for the day – Kim	9.00 – 9.30	Opening Discussions: Introductions – discussion of schedule The review	Kim
	9.30-10.00	National directions/strategies – presentation and discussion	DepKes
	10.00 – 10.30	Comparative Advantage – meaning, rationale – general discussion Documentation:	Monica
	10.30 – 11.00	Key results from MNHI program	Pak Cholil/Pak Kemal
	11.00 – 11.40	Overview of documentation to date – process, key content (4 teams - 10 mins each)	MNHI team leaders
	11.40 – 12.00	FGDs to date – discussion of process and key findings	Djoko and Lucy
	12.00 – 12.30	Lunch	
	12.30 – 1.00	Team roles and responsibilities Expectations and SOW – roles and commitment, report writing, key questions – written statement documented for all Overview of approach to be taken, recommendations each day, key achievements - documentation	Kim/Monica
	1.00 - 2.00	Recommendations: Development of criteria for recommendations in relation to approaches, general direction Recommendations arising in relation to overview	Kim/Monica
	3.15 –	Key Accomplishments <i>Component Team Discussions</i> Team members to work with each group to address queries from documentation: PQI/TK/MEOR – Harshad/Djoko/Monica BCI/MEOR – Lily/Lucy	Team members working with component teams

Date	Time	Content	Session Facilitator/s
		Policy/Advocacy/Management – Kim/DepKes	
<i>Component Interventions</i>			
26 August - BCI Facilitator for the day Lily	9.00 – 9.15	Overview of previous day – key findings	Kim BCI team
	9.15 – 10.00	BCI team presentation: Key foci Successes Issues Future – linkages to supply (mechanisms and processes) Opportunities Discussion of presentation – other models?	
	10.15 – 11.00	Review of findings from FGDs facilitator/cadre, NGOs	Lily
	11.00 – 12.00		Lucy/Pak Djoko
	12.00 – 1.00	<i>Lunch</i>	
	1.00 - 5.00	Recommendations and Key Accomplishments	Kim/Monica
	5.00 – 6.00	Wrap up of findings for the day	
27 August – PQI/TK Facilitator for the day - Harshad	9.00 – 9.15	Overview of previous day – key findings	Lily PQI/TK team
	9.15 – 10.00	PQI/TK team presentation: Key foci Successes Issues Future – linkages to demand (mechanisms and processes) Opportunities Discussion of presentation – linking to existing system	
	10.15 – 11.00	Review of findings from FGDs – professional groups, NGOs, training organizations, training sites, BDs	Harshad Lucy/Pak Djoko
	11.00 – 12.00	Other models – who does what where – successful?	Harshad
	12.00 – 1.00	<i>Lunch</i>	
	1.00 - 5.00	Recommendations and Key Accomplishments	Harshad
	5.00 – 6.00	Wrap up of findings for the day	

<b>Date</b>	<b>Time</b>	<b>Content</b>	<b>Facilitator/s</b>
28 August – Policy and MEOR <b>Facilitator for the Day – Pak Lukman</b>	9.00-9.15	Overview of the previous day – key findings	Harshad Pak Cholil  Pak Lukman Lucy/Djoko Pak Lukman  Kim/Monica
	9.15 – 10.00	Policy interventions: Key foci – approach to policy Successes Issues Future – linkages to demand (mechanisms and processes)	
	10.00 – 10.30	Discussion of presentation	
	10.30 –11.00	Review of findings of FGDs – province	
	11.00 – 11.30	Identification of other successful models – who does what where?	
	11.30-12.00	Recommendations – (more discussion time in afternoon)	
	12.00 – 1.00	<i>Lunch</i>	
	1.00 – 1.45	MEOR interventions: Achievements Issues Opportunities	Pak Kemal
	1.45 – 2.30	Discussion of presentation	Pak Lukman
	2.30 – 3.00	Suggestions from FGDs	Lucy/Djoko
	3.15 – 5.00	Recommendations (Policy recommendations too)	Kim/Monica
	5.00 -	<i>Wrap up of findings for the day</i>	

<b>Date</b>	<b>Time</b>	<b>Content</b>	<b>Facilitator/s</b>
29 August – Linkages – <b>Facilitator for the day – Ibu Ina</b>	9.00 – 9.15 9.15 – 10.00 10.15 – 11.00 11.00 – 11.30	Overview of the previous day – key findings ASUH Program Presentation Key findings Discussion of Presentation Discussions of approaches to links between: Supply and demand OPM	Pak Lukman Anne Palmer/ASUH team Ibu Ina Team discussion
	<i>11.30 – 12.30</i>	<i>Lunch</i>	
	12.30 – 2.30 (12.30 – 1.00) (1.00 – 1.15) (1.15 – 1.30) 1.30 – 2.00 2.00 – 4.00 4.00	Management strategies for future programming (“integrated infrastructure”): FGDs – international organizations, national and district government Approaches to TA Capacity development – closer counterpart relationships – issues and mechanisms? Defining approaches for better linkages– general directions - recommendations Review of key directions arising through the week, key achievements, recommendations Overview of the reporting format Next week – expectations	Kim/Monica  Djoko/Lucy  Monica Monica  Ibu Ina  Ibu Ina Team Discussion Kim/Monica Kim
30 August	Weekend – write up		
31 August			

<b>Date</b>	<b>Time</b>	<b>Content</b>	<b>Facilitator/s</b>
<b>Recommendations and Documentation</b>			
1 September – <b>Facilitator for the day - Kim</b>	9.00 – 10.00 10.00 – 11.00 11.00 – 12.00 1.00 – 2.00 2.00 – 3.00 3.00 – 6.00	USAID directions and strategies Review of documents prepared by team members over weekend Key recommendations – PQI Key recommendations continued –BCI Key Recommendations – MEOR/AP/Linkages Key Recommendations continued - discussions	Monica Team members Harshad Lily DepKes All
2 September <b>Facilitator for the day - Monica</b>	9.00 – 12.00  1.00 – 6.00	Key recommendations – finalization Key Recommendations – Policy, linkage and infrastructure (Pak Cholil)  Presentation preparation – Team Documentation and presentation finalized - Team	DepKes team  All
3 September - <b>Facilitator for the day - Kim</b>	9.00 – 10.00 10.00 – 12.00 1.00 – 3.00 3.00 – 6.00	Presentation – key recommendations to MNHI/ASUH team Discussion of presentation content Discussion as required Documentation finalization (background materials for presentations): Executive Summary Recommendations Presentation	Team Kim/Monica
4 September	TBA (morning?) TBA (4.00 – 6.00?)	Presentation to USAID Mission Director Presentation to DepKes	Team Team
5 September	9.30 – 11.30	Debriefing USAID Presentation and Discussion	Team
6-11		Finalization of report	Kim

<b>Date</b>	<b>Time</b>	<b>Content</b>	<b>Facilitator/s</b>
September			
12 September		Draft Report submitted	Kim
19 September		Final Report submitted	Kim

## **Attachment Four: Suggested Essential Package of Services**

### **At Community and Puskesmas level:**

Through Desa SIAGA promote:

*Four Key Messages* (transport, blood donation, savings, notification of pregnancy)

- Clean cord care
- Exclusive breastfeeding,
- Ensuring keeping babies warmth
- Ensuring continuum of skilled care for pregnancy, childbirth and newborn
- In addition to current 4 messages

### *Services and Networks:*

- Early detection of newborn problems through the postpartum visit
- Focused antenatal care
- Micronutrient and nutrition interventions
- Basic childbirth and postpartum care
- Essential Basic newborn care, and immunization
- Breastfeeding support, Kangaroo mother care
- Stabilization and timely management of complications including management of newborn asphyxia and infections
- Effective and safe referral

### *Mechanisms:*

- Post partum visits for the newborn
- Utilization of skilled attendance
- Examine opportunity for revitalizing village level health centers (Posyandu) where appropriate
- Bidan/Dukun /kader (community group) partnerships

### **At First referral level (Puskesmas PONED)**

#### *Basic Emergency care services including:*

- Treatment of shock, PPH, eclampsia, fever
- Postabortion care and vacuum extraction
- Newborn asphyxia, infections, Kangaroo Mother care

### *Mechanisms:*

- On the job training
- Criterion based audits
- Puskesmas/community health partnerships

**At Second referral level (District Hospital)**

*Comprehensive Emergency care services including:*

- Treatment of shock, PPH, eclampsia, fever
- Blood transfusion and surgery
- Obstructed labor, caesarean section, vacuum extraction
- Postabortion care
- Newborn asphyxia, infections, jaundice

*Mechanisms:*

- On the job training
- Criterion based audits
- District hospital /community health partnerships.