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# Final Quarterly Progress Report No.6 Quarter Two, FY 2012 January—March 2012

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**MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM**

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## MCHIP OVERVIEW

### Background

The Maternal and Child Health Integrated Program (MCHIP) in Indonesia is a USAID-funded, three year program from January 2010 to December 2012, with a budget level of USD 9.8 million. This program is being implemented by Jhpiego, in collaboration with Save the Children (SC) and John Snow Inc. (JSI). In support of the MOH Road Map to the 2015 MDGs, MCHIP/Indonesia is being implemented in three districts that are classified as “Health Problem Areas”: Serang District in Banten Province; Kutai Timur District in East Kalimantan Province; and Bireuen District in Aceh Province. All districts have areas that are considered “remote”.

In April 2011, the program work plan was revised to accommodate scaling up of life-saving interventions throughout the 3 target provinces. This quarterly report reflects the addition of a sub-objective aimed at taking interventions to scale at the provincial level.

The overall objective of the program is to catalyze implementation of existing policies that promote key **evidence based life- saving interventions at scale** in remote areas. To achieve the program goals, MCHIP inputs are contributing to four sub-objectives:

1. Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.
2. Improve maternal and newborn care in the community
3. Improve quality of clinical services at all levels of care
4. Improve management of district health system

#### Sub Objective 1(cross cutting): Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces

##### Results:

- District teams in three remote areas scaling up high impact interventions district-wide
- Provincial teams in three remote areas implementing plans to scale up high impact interventions in other districts, using technical assistance from core districts.

#### Sub Objective 2: Improve Maternal and Newborn Care Practices at the Community Level

##### Results:

- Expanded use of life saving approaches (postnatal care, KMC, C-IMCI) by village midwives and kaders
- Increased knowledge, skills and practices of healthy maternal and neonatal behaviors in the home
- Communities mobilized for action and advocacy

#### Sub Objective 3: Improve Quality of Clinical Services at all Levels of Care

##### Results:

- Improved competencies of health care providers for pregnancy, childbirth and postnatal care, including AMTSL, PE/E, newborn resuscitation, and KMC
- Improved systems for assuring quality of care, including the use of performance standards and maternal-perinatal audit

#### Sub Objective 4: Improve Management of the District Health System

##### Results:

- Increased use of evidence-based planning at all levels of the health system
- Improved use of LAMAT and MPA to monitor district programs and achievements
- Institutionalized support and resources for maternal, neonatal and child health

## I. Major accomplishments

1. MCHIP has implemented *kelas ibu* in all of the target sites as well as expanded beyond the target sites in MCHIP and non-MCHIP coverage areas.
2. In Padarincang subdistrict of Serang the percentage of delivery by attendance for June through December 2011 showed that births due to bidan and TBA together, as a part of the partnership was 62.73% of all births, higher than that of the TBAs or bidans alone. Successful implementation of Midwifery TBA partnership program has contributed to these numbers.
3. The process and components for C-IMCI for newborn and under five is complete in Kutai Timur and Bireuen. In the remaining months, the districts will focus on strengthening supportive supervision and data.
4. For IPNC at the national level, in collaboration with the MoH, MCHIP adapted the global combined job aid for ANC, delivery, and PNC for Indonesia. The job aid is for the use of midwives at all levels.
5. For IPNC, MCHIP in collaboration with the MoH adapted the IPNC guideline for Indonesia for use of midwives, supervisors, and the puskesmas. The guideline addresses a) the importance of IPNC; b) tasks to perform during an IPNC visit; c) How to perform an IPNC visit; d) timeline for IPNC; and e) form for recording and reporting IPNC visits adapted from the PWS KIA.
6. All components for facility based KMC has been established in all three districts. MCHIP with Perinasia developed a “how to” manual for establishing facility based KMC. This manual addresses all the essential components – leadership, management, personnel, and resources for establishing facility based KMC. Perinasia will use this guideline for establishing facility KMC in other sites.
7. The second round of AMTSL assessment was conducted from February to March in all three districts. A total of 376 midwives were assessed in AMTSL competency in 3 districts and 304 (81%) midwives were found competent in all three steps of AMTSL- a significant increase from Aug 2011 of 35% competent midwives.
8. As reported in the LAMAT data from the three districts, the management of births occurring at facilities ranged from 20 to 50 percent of all deliveries with skilled birth attendant for this quarter. In the previous quarter only 10 to 20 percent of all deliveries with SBA was occurring at the facilities. Increase in skills of the health workers as well as increase in quality of the sites may have contributed to some of this increase.
9. In 2011, MCHIP facilitated the completion of the DTSP process in all districts; the result was a significant increase in budget allocation for MNCH for 2012 for all three districts.
10. For maternal perinatal audit, In Jan 2011, all districts started with low number of audits, 32% in Serang and 0% in Bireuen and Kutai Timur. By mid 2011 increased to 47% (n= 60 ) in Serang, 78% (n= 27 ) in Kutai Timur and 100% (n= 15 ) in Bireuen. At the end of 2011 (October- December) all sites achieved and continue to maintain verbal autopsy for 100% (n=49 ) of all maternal and neonatal deaths reported.

## II. Narrative description

### Sub-objective 1: Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.

#### a. MDG Road map

The GoI in 2010 through a presidential decree, required all provinces and districts to accelerate the achievement toward the MDGs during the next five years. As a part of this initiative “MDG Roadmap” a strategy document at the national level was developed and distributed throughout Indonesia for replication at the provincial and the district level. The “MDG Roadmap” outlines goals, activities, timeline, indicators, and targets to measure progress toward the MDGs. MCHIP in this quarter continued to facilitate the finalization and approval of the MDG Roadmaps for the three districts for health specifically MDGs 4 & 5 for submission to the Provincial Bappeda. The finalization and approval of the MDG Roadmaps for the district is anticipated by October 2012.

Challenges MCHIP addressed in facilitation of this process are a) limited understanding of the national strategy and the need for MDG roadmap at the district level; b) Delays in the development and review of the MDG roadmaps- the original timeline required all districts to finalize and approve the Roadmaps by the end of 2011; c) Limited monitoring from the national level on the status of these roadmaps; d) Frequent personnel transitions at the provincial and the district level. The completion of the MDG roadmap requires completion of all MDGs not just MNH, this may cause further delay in completion of the MDG Roadmaps.

#### b. Mini-university Preparation.

MCHIP will conduct mini university to disseminate the guidelines and lessons learnt in each of the MCHIP Provinces (Fig 1). The attendees for the Mini University are representatives from all districts in the MCHIP province. The district team includes head of the district, head of the District hospital, Bappeda staff, head of the district health office, and head of the family welfare department of the district health office. Representative from the ministry of health, USAID, as well as the MCHIP target district will also attend. *Penala Hati*, a consulting agency with expertise in facilitation, assisted MCHIP to plan for and in facilitation of the sessions.

Fig 1. Planning and Preparation for the Mini -University

DESCRIPTION	SERANG	BIREUEN	KUTAI TIMUR
Time/date	30 Apr-2 May	5-7 June	24-26 May
Venue	Hotel Horizon	Hotel Hermes	Hotel Mesra

City	Bekasi	Banda Aceh	Samarinda
<b>Participants and Facilitators</b>	196	150	200
<b>Class Facilitator</b>	PHO, DHO, District Hospital Puskesmas, kader and community from MCHIP areas	DHO, District Hospital, Puskesmas, kader and community from MCHIP areas	DHO, District Hospital, Puskesmas, kader and community from MCHIP areas
<b>Topics</b>	<ol style="list-style-type: none"> <li>1. Mother Support Group</li> <li>2. Partnership Midw-TBA</li> <li>3. Referral Strengthening of CEONC and BEONC</li> <li>4. SBMR-IP</li> <li>5. LAMAT and MPA</li> <li>6. Planning &amp; Budgeting</li> </ol>	<ol style="list-style-type: none"> <li>1. Mother Support Group</li> <li>2. POMA and <i>Perbub</i></li> <li>3. C-IMCI and KMC</li> <li>4. SBM-R and IP</li> <li>5. AMP</li> <li>6. DTPS</li> </ol>	<ol style="list-style-type: none"> <li>1. Mother Support Group</li> <li>2. Partnership Midw-TBA</li> <li>3. Desa Siaga</li> <li>4. C-IMCI</li> <li>5. KMC – Hospital</li> <li>6. SBM-R</li> <li>7. AMP</li> <li>8. DTPS</li> <li>9. Perda KIBBLA</li> </ol>

Preparation for the Mini-University was continued this quarter in all three districts with following key strategies in mind:

- **Positioning the provincial health office at the center of the Mini University planning.** In the decentralized setting of Indonesian health system, planning with the provincial health office helped build capacity of the provincial team. The province on their part have actively participated in socializing the concept of Mini University to the districts as well as getting buy in from the districts. The provinces will also play a key role in district selection to receive technical assistance from MCHIP.
- **Promoting district ownership of the Mini University.** MCHIP is positioning the Mini University as an opportunity for the MCHIP district to showcase their achievements. The selected hospital, Puskesmas, and community counterparts will present their program interventions and results facilitated by MCHIP. The DHO and PHO staff will also be filling in subordinating roles such as that of the note-taker at the meeting. The Mini-university will also serve as a handover of MCHIP lessons learned from the MCHIP team to the district and the provincial counterpart.
- **Preparing participating districts to maximize the experience of Mini University.** MCHIP's intention is to have all participating districts attend the Mini-University with predetermined areas of interest based upon their needs and budget availability. MCHIP is socializing this intent through the preparation meeting with the Provincial and the district teams. To further ensure this, in Serang MCHIP will be using selection criteria to identify the first six districts that will receive Technical assistance from MCHIP along with funding support for a small workshop or training. Similarly in Bireuen, a general open mini university for all districts will be followed by specific site visits for selected districts only.

## Mini University Documentation

- **Program implementation guideline** including cost analysis to guide the participating districts in their implementation plan and also serve as a national level documentation.
- **Short videos** on the program interventions (Serang) will be shown prior to the relevant session to engage the participants and to provide a general overview
- **Report on the Mini University** will include the strategies undertaken to prepare the province for the Mini University and a detailed document on the proceedings, information shared, and discussions in the meeting.

## Sub-objective 2: Improve Maternal and Newborn Care Practices in the Community

### a. *Mother's classes (Kelas Ibu).*



*Kelas Ibu* is Mother's classes at the village level where pregnant women and mothers are given key messages on maternal and newborn areas including nutrition/ anemia, exclusive breastfeeding, immunization, skilled birth attendant, newborn and maternal danger signs, hand washing, and family planning. MCHIP in this quarter conducted refresher training for the *kelas ibu* facilitators in all three districts to strengthen their facilitation skills for the topics that will be delivered in the upcoming months. In Serang, MCHIP

printed 130 *kelas ibu* flipcharts and distributed to 65 new *kelas ibu* groups.

MCHIP has met its target for *kelas ibu*. The popularity and the enthusiasm for *kelas ibu* has caught on beyond the MCHIP sites. Upon request from these districts, MCHIP has facilitated the replication of *kelas ibu* in 12 non-MCHIP puskesmas coverage area in Bireuen and 12 in Kutai (Fig 2). MCHIP also facilitated the discussion with the DHO to utilize the health operation budget (*BOK- Bantuan Operasional Kesehatan*) to implement the *kelas ibu* in these 12 non- MCHIP Puskesmas. Serang in March also facilitated the replication of 65 *kelas ibu* within MCHIP target villages.

Fig 2: Number of *kelas ibu* in the target and replication sites.

	Bireuen	Kutim	Serang	Total
Number of <i>Kelas ibu</i>	62	42	67	169
Number of target Villages	62	42	66	170
Replication beyond the target	12 <i>puskesmas</i> training and facilitation completed in 12 non-MCHIP subdistricts.	12 <i>puskesmas</i> training and facilitation completed in 12 non-MCHIP subdistricts	65 additional <i>kelas ibu</i> in MCHIP target villages	

**At the national level:** Prior to MCHIP, the MoH was offering *kelas ibu* to pregnant women only. MCHIP expanded the *kelas ibu* to the postpartum women. *Kelas ibu* has become one of the popular and sought after MCHIP programs. MCHIP shared the popularity and enthusiasm for *kelas ibu* with the MoH – learning from MCHIP experience, the MoH with MCHIP support is now updating their guidelines to include a) content for postpartum women; b) *kaders* as facilitators b) self-tests for knowledge assessment before and after the courses for the participants; and c) larger and clearer illustrationsc) flip chart for easy facilitation . MCHIP plans to pilot test these flipcharts in Jhpiego and MCHIP sites. Once the pilot tests are complete the MoH plans to



### *Challenges and lesson learnt*

- a) Mothers coming to *Kelas ibu* who bring their babies with them are often distracted. The facilitators recommend that the mothers bring company to take care of the babies or have volunteers or *kaders* available to care for the babies to allow mothers to focus on the class.
- b) Given the growing number of participants for *kelas ibu* villages are now holding more than one series of sessions at one time. There is a need to scale up *kelas ibu* at the village level itself.
- c) Some participants do not like being questioned in group, when asked about experience; the facilitators will need to approach participants in a less intimidating manner.

- d) In some villages, where there are no village midwives, the *kaders* were trained to facilitate, but they were not confident in facilitating the sessions on their own and the participants did not feel comfortable without a midwife present. Village midwives are essential for the functioning of *kelas ibu*.

### **Stories from the field- Now I know.**

Like the previous months, the *kelas ibu* in *Posyandu* Melati was always crowded with women



both pregnant and those who had babies. This activity seemed to be a favorite in this *Posyandu*. It was not surprising that participants in the *kelas ibu* always exceeded capacity and had to be divided into two, and even then it was still too large for the ideal class size (12-15 people). The monthly report showed that participants reached 42 women.

Of the many participants, one participant attracted my attention. She came with her 40-day old baby. It seemed she was a frequent visitor. She was Mrs. Sanah, 42, wife of a driver who transported vegetables. She lived in Wadas Cikiray, Sindangsari village. Her house was approximately 2 km from the place where the class was held. "She was one of participants who diligently attended *kelas ibu*. She joined the class since she was pregnant with her third child," said the village midwife.

While waiting for the other participants to come, I approached and talked with Mrs. Sanah to know more about her and her motivation to attend the class. Mrs. Sanah told me her experience of *kelas ibu*. According to her, she learned about *kelas ibu* when she had her antenatal care visit at the *Posyandu* seven months ago. At first, it crossed her mind that the activity would be the same as the education package she once completed to get a high school diploma. She asked a *kader*, who explained to her that it was not like school. *Kelas ibu* turned out to be fun.

"I become more curious, sir. Sure enough, it was a very fun class, not only for me but all women were happy. Other than learning a lot about pregnancy and baby care, I also learned about exclusive breastfeeding and handwashing with soap. Now I know why the nipples of lactating women are often sore; it's because the way she nurses is wrong," she recounted from her learning in the class.

She admitted that her knowledge from the class was applied during her last pregnancy. Mrs. Sanah tried to do what she learned, including the exclusive breastfeeding, when her third child was born. For her, the pregnant women's class was a blessing. "Through this activity I now know all about how to be a good mother, and I became an active family planning user. It is very useful, not only for me but also for my family," she said. Now she was not only an active participant in the pregnant women's class, but she also did not hesitate to invite other women she knew to join. "Come on ladies, join the class. You will get many benefits," said Mrs. Sanah when she invited other women to come along with her to the class. *Reported by Field officer Abdul Jabbar*

**b. Midwife-TBA partnerships**



To increase skilled attendance and facility-based births, one of the approaches the government is pursuing is to promote partnerships between midwives and TBAs by clarifying roles, agreeing on mutual financial compensation, and providing recognition of strong partnerships. MCHIP's role in the district is to build capacity of the puskesmas to facilitate the relationship between TBAs and

midwives. Some of the factors essential for the successful implementation of this partnership are commitment between midwives and TBAs; support from stakeholders; public awareness of the partnership; and effective administration of the partnership. Where applicable, there needs to be consistent and periodic effort to revitalize and tend to this partnership.

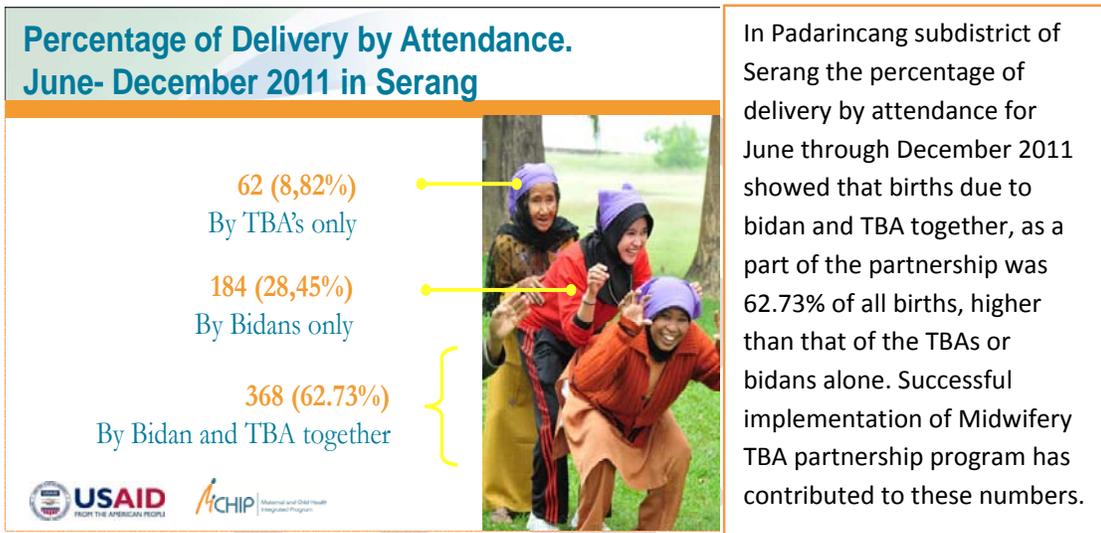
To date MCHIP has facilitated the development of Memorandum of Understanding (MoU) formalizing the midwife- TBA partnership and continued monitoring visits in all three districts by the DHO. Given the large coverage population for Serang and budget limitation, MCHIP decided to pilot this in only Padarincang subdistrict. Across 14 villages in Padarincang 14 village midwives and 102 TBAs are present- 83% of these TBAs are in the partnership. In Kutai Timur the partnership is implemented in 3 subdistricts only- Kaubun, Teluk Pandan, and Rantau Pulung. There are 16 village midwives, and 65 TBAs- 89% of whom are in the partnership (Fig 3)

Fig 3: Percentage of midwives in Serang and Kutai Timur by partnership.

	Percentage of midwife in partnership	Percentage of TBAs in partnership
Serang ( <i>Padarincang</i> )	100%	83%
Kutai Timur ( <i>Kaubun, Teluk Pandan, Rantau Pulung</i> )	100%	89%

In this quarter, MCHIP in Kutai Timur facilitated partnership monitoring at the Teluk Pandan, Rantau Pulung, and Kauban sub-district. This activity was attended by 70 participants (TBA 39, village midwife 19 and kader of KIBBLA 12). Consistent monitoring and team building is essential to maintain the partnership. In this quarter MCHIP in Serang expanded the midwifery- TBA partnership program from the original Padarincang subdistrict to the

remaining four MCHIP puskesmas coverage areas- Tirtayasa, Pamarayan, Petir, and Kramat Waktu. Initial team building activities for these target sites for 172 participants was facilitated in this quarter by representative from the DHO, sub-district, and Indonesia Muslim association. In Serang monitoring of midwife TBA partnership in Padarincang subdistrict found an increase in deliveries being conducted by TBA due to the lack of monitoring from puskesmas and the local government. Continued Monitoring and support is key in maintaining the quality of the program. In Serang a series of meetings were held to revise the existing MOU to refer to the *Perda*, MNCH *Perbup*, Making pregnancy Safer, and district health strategy. Referring to these laws will contribute to the sustainability of the MOU and thus the partnership.



For the three subdistricts in Kutai Timur (Kauban, Telukpandan, and Rantau Pulung) for June through December 2011 delivery with SBA is 72% (n=300) , with TBA only 25%, and in partnership 3% . In Kutai Timur, the number of village midwives is comparatively lesser than Brieuen or Serang; most of the midwives are at the puskesmas. The percentage of SBA in the three sites is relatively higher at 72%; however the births with TBA at 25% can further be reduced through the partnership. While the MoU between the midwife and TBA was signed by the majority of TBAs and midwives, the relatively smaller number of births in partnership may be due to lag in consistent and regular monitoring.

*Challenges and Lessons learned*

- a) It is essential that both TBA and midwife adhere to the terms of the partnership. Derailment by even one of the members can encourage similar behavior in others. For instance, midwives who are part of the partnership delivered alone, causing the TBAs to engage to attend births by themselves.
- b) Regular and consistent supervision and monitoring by the Puskesmas and the subdistrict is essential to maintain the relationship as well as to resolve any conflicts.
- c) Reward and punishment mechanism for good and bad performance or derailing from the partnership is being discussed with the intention that this will increase the adherence to the partnership.

c. **C-IMCI and community KMC (C-KMC)**

Community Integrated Management of Childhood Illness (C-IMCI) is a strategy to deliver life-saving curative interventions for common serious newborn and childhood infections (newborn sepsis, pneumonia, diarrhea and malaria) for children under 5 in communities with limited access to facility-based care. Kangaroo Mother Care (KMC) in Indonesia is primarily a facility based intervention to manage Low Birth Weight babies. MCHIP in Indonesia is piloting C-IMCI for newborn sepsis, pneumonia, and diarrhea and KMC. Indonesia currently does not have a national policy on C-IMCI; findings from the C-IMCI pilot will inform the national level policy. The C-IMCI newborn package was updated with the C-IMCI for under five for diarrhea, pneumonia, and malaria at the MCHIP target sites and providers were trained accordingly. At the national level, no major activities was undertaken this quarter. The development of the national guideline for C-IMCI is planned of June/July as a part of the Multi Agency Working Group.

In Bireuen, midwives are trained to provide C-IMCI/C-KMC. In Kutai Timur given the shortage of midwives, *Kaders* are trained to provide C-IMCI /C-KMC when midwives are not available. The C-IMCI/C-KMC providers are supervised by the midwife coordinator or Puskesmas doctor. In Kutai Timur 41 villages and in Bireuen 72 villages that are currently implementing C-IMCI.

i. **Training**

In Bireuen, given the interest from the puskesmas to expand C-IMCI services in their



coverage areas particularly for those located more than 5km from puskesmas and with a large population, C-IMCI/ C-KMC was expanded to these sites. To date C-IMCI/C-KMC has been implemented in 72 villages across Bireuen District. The training for the village midwives for C-IMCI for newborn and under five and C-KMC for the new sites was conducted together with the refresher training for those from the existing sites.

In Bireuen, another set of refresher training for village midwives and their supervisors (*bidan* coordinator, and doctor puskesmas) was conducted in January for 24 midwives from 2 puskesmas coverage area. The refresher training was facilitated by the C-IMCI facilitators (*kaders* and *bidan di desa*) at the sub-district level. The facilitators educated the C-IMCI workers on any updates in the content of the C-IMCI module. Challenges on C-IMCI treatment and referral that the village midwives faced daily was also discussed.

In Bireuen, MCHIP and DHO completed three batches of training for C-IMCI under five. C-IMCI under five is the intervention for 2-59 months for the identification and treatment of pneumonia and diarrhea. C-IMCI under five training was completed in 3 out of 6 puskesmas attended by 39 village midwives. The C-IMCI under five was a three day training. The C-IMCI under five and the C-IMCI for newborn now completes the C-IMCI package in Bireuen.

Fig 4. C-IMCI puskesmas, area/villages and trained midwife in Bireuen

No	Puskesmas	C-IMCI Area/village (target)	Additional C-IMCI Area/villages	Trained-midwife
1	Gandapura	10	2	12
2	Makmur	10	3	10
3	Peusangan Selatan	10	2	12
4	Juli	10	0	10
5	Jeumpa	10	0	8
6	Peudada	12	3	14
	<b>Total</b>	<b>72</b>	<b>10</b>	<b>66</b>

In Kutai Timur, three days training for the facilitators, supervisors, and workers on under five C-IMCI was conducted in January. The training was attended by 22 village midwives and 20 *kaders* who are now able to provide C-IMCI under five services.

Fig 5 C-IMCI puskesmas, C-IMCI area/ villages, and trained health worker in Kutim

No	Puskesmas	C-IMCI Area/village (target)	Additional C-IMCI Area/villages	Trained-Health Worker ()
1	Bengalon	6	-	5
2	Kaubun	8	-	8
3	Kaliorang	7	-	7
4	Sangkulirang	6	-	6
5	Teluk Pandan	6	-	8
6	Rantau Pulung	8	-	8
	<b>Total</b>	<b>41</b>	<b>-</b>	<b>42</b>

#### ii. Competency Assessment and deployment

Trainees must score 80% and above in each topic before they are deployed. The trainees who are now C-IMCI workers are deployed using C-IMCI Kits and tools. C-IMCI and CKMC kit includes ARI Timer, thermometer, weighing scale, module, tools and facilitation tools In



Bireuen out of 66 village midwives trained, DHO has deployed 39 C-IMCI workers (village midwives) as of March 2012. In Kutai Timur, competency assessment of the C-IMCI midwives and *kaders* was conducted this quarter. All 42, 22 village midwives and 20 *kaders*, passed the competency assessment and were deployed.

#### Supervision

Bireuen and Kutim continued to supervise and monitor the implementation of C-IMCI. Supervision of the supervisors was conducted through the supervisory visits to the puskesmas by the MCHIP team and supervisors from the DHO using the C-IMCI

supervisory checklist to score the C-IMCI supervisors. Supervision of the supervisors found that the supervisors were able to verify the availability, process, case finding, and correct

treatment, using the C-IMCI supervisory checklist. Supervision of the C-IMCI workers for newborn was conducted through individual supervision (in village) and group supervision in the puskesmas. Supervision was conducted through observation and case scenario. The suggested periodicity of supervision is monthly at the health facility and 3 monthly on-site.

*iii. C-IMCI integration with Kelas ibu*

Bireuen integrated taking care of the LBW babies using KMC in selected *kelas ibu* facilitated by the *kaders* and supported by the TBAs and village midwives. A series of training was held in January for 103 *kaders* and the TBAs to build their competencies in caring for the LBW babies using KMC in all of the MCHIP coverage area. These training were conducted at the target puskesmas by the C-IMCI facilitators using the C-IMCI module. Building Kader and TBA competencies to care for and counsel on supporting LBWs is important to improve case finding and LBW management in the community. All *kaders* and TBAs in the MCHIP coverage area in Bireuen have now been trained in CKMC and infection identification in the newborn.

*iv. Case findings*

Cases were identified for under 5 and all identified cases received treatment (Fig 6) in both districts.

Fig 6: Case findings for under 5 in January, February, and March 2012

	Pneumonia	Diarrhea	Dysentery	Fever	Total cases identified	Total treatment received
Kutai Timur Jan and Feb	8	12	0	5	25	25
Bireuen March only	9	17	3	12	29	29

Fig 7: Case findings and treatments for Bireuen for newborn for Jan- March 2012

	Low Birth Weight	Possibility of Severe Bacterial infection	Bacterial local infection	Total
Live births	N/A	N/A	N/A	196
Cases identified	10	8	17	35
Cases referred	1	3	-	4
Cases treated	-	-	-	35 (100%)
Cases recovered during this period	5	1	12	18 (51%)

Cases were identified for newborn for Bireuen- all 35 cases identified for newborn was treated. Of the cases identified 51% recovered during this period. The data for Kutai Timur is for the newborn is in process. The village midwives have completed the recording; the supervisors are currently verifying the data. This data will be presented in the next quarter.

*v. STTA*

In February, Dr. Salim Saddrudin, technical advisor for C-IMCI visited Bireuen and Kutim to review the program implementation. Dr. Salim identified challenges and provided recommendations specifically regarding monitoring and supervision and recording and reporting. MCHIP staff together with the DHO is acting on the program recommendations. Some of the challenges identified by Dr. Salim are included in the section below.

*Challenges and lessons learned*

- a) Supervision from the Puskesmas and the DHO is important to maintain the knowledge and skills of C-IMCI workers. Gaps in supervision is attributed to the distance and limited budget for transportation to conduct the supervision visit and issues of accessibility during rainy season. In Kutai Timur according to the DHO budgets have been allocated for supervisory visit, in this case reminders and skills reinforcement of the supervisors is needed. Strengthening the supervision and monitoring will be prioritized in the upcoming quarter through training and mentoring and consistent follow up by the MCHIP staff in collaboration with the DHO.
- b) Recording and reporting for C-IMCI on the birth, postnatal visit, case findings and treatment is incomplete. Clarification when needed through supervisors on the forms to be completed and definitions will be stressed in the next quarter. Additionally C-IMCI has a separate reporting and recording process, MCHIP will coordinate through the MAWG on streamlining data collection, aggregation, reporting and feedback mechanism
- c) In some of the MCHIP sites, the IMCI program is not yet introduced, but we are introducing the C-IMCI, training of the doctors and the puskesmas staff on IMCI is recommended before C-IMCI.
- d) The Bidans reported that they had stock-outs of gentamicin and cotrimoxazole in the community. The DHO reported that they have not received any orders for medications from the district pharmacy. This may be due to lack of supervision by the Puskesmas staff as no information was coming to the Puskesmas on shortages at community level, and in turn there was no request made to the DHO pharmacy. Strengthening of supervision from the puskesmas to the village can address this gap.
- e) Supplies provided initially as a part of the C-IMCI Kit is not functioning properly. DHO is planning to replace these but has not been completed.

## ***Stories from the Field: Kader and puskesmas collaborate to care for Low birth weight babies in Kutai Timur.***

"Your baby now weighs 2.2 kg, continue breastfeeding, and please return later for follow up" midwife Maya explained to Sri Astuti, the C-IMCI cadre from Kebun Agung, Rantau Pulung sub district and gave a small piece of paper for follow up.

That morning Sri Astuti accompanied Lailatus Saadah and Joni Pranata to go to Puskesmas Rantau Pulung to have their baby checked. The baby was born premature at seven month gestation with birth weight of 1.9 kg at Puskesmas Rantau Pulung on January 8, 2012. After 3 days, the condition of Lailatus Saadah's baby was worse so the mother and family decided to contact Sri Astuti, a cadre. Sri Astuti who just returned from C-IMCI training immediately came over, and brought the baby and his parents to Puskesmas Rantau Pulung. After a thorough examination, the Puskesmas provider decided to refer the baby to RSUD Sangatta. Arriving at RSUD Sangatta, the baby was weighed at 1.4 kg. The decision was to hospitalize him in the hospital.

"One week before we left, Tini, the hospital nurse, taught us KMC, but only the baby's mom and grandmother did the KMC. As for me, I am afraid, I don't have any courage!" Joni the father said with a smile. On 11 February Lailatus Saadah's baby was brought home. "And I took turn with her grandmother to continue KMC at home" continued Lailatus.

Puskesmas Rantau Pulung policy requires each delivery in the sub district to be attended in the Puskesmas, not at home. As stated by the Head of Puskesmas Rantau Pulung, Dr. John, delivery in a Puskesmas was expected to be more secure because the facility was better equipped, clean and managed by a team of 4 midwives. All midwives worked together to attend deliveries. With the midwife-TBA partnership program in existence, a TBA should no longer attend deliveries. Sri Astuti said that when a woman was about to give birth, the TBA brought the woman to the Puskesmas, and the cadre's role was to visit the woman's house. Before receiving C-IMCI training, Sri Astuti said she was not providing care for sick babies, but after the training she visits newborn or under-five children in her village.

That morning, Sri Astuti, Lailatus Saadah and Joni Pranata said good bye with cheerful smiles. In addition to having good services, the baby got a pretty hat as a souvenir from the midwife provided by MCHIP.

### ***d. Handwashing for newborn survival***

In Bireuen, during February 11 – 24, 2012, a total of 475 people adhered to the Hand Washing with Soap (HWWS) promotion activities conducted at Peudada Sub-district and facilitated by Puskesmas Peudada staff in order to share the knowledge regarding the importance of HWWS prior to taking care the newborn due to its benefit to prevent the baby from infection of major killer on newborn sepsis. This was completed as a part of the *kelas ibu* in Bireuen. No Activities was held this quarter in Kutai Timur or Serang.

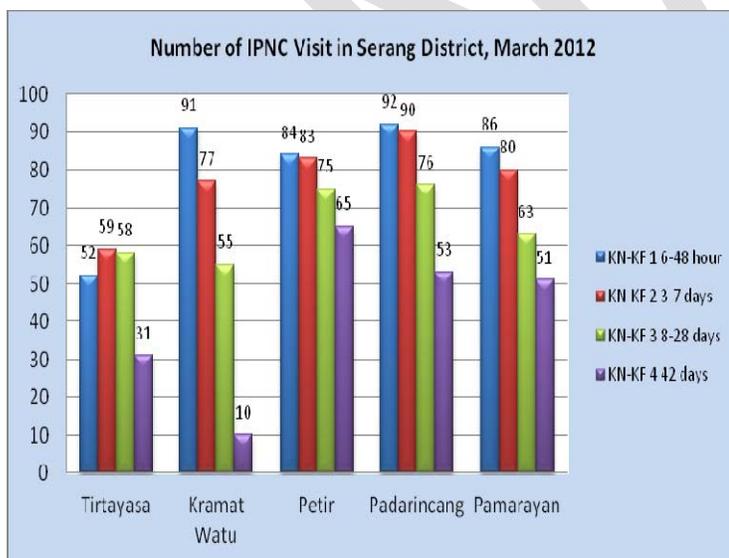
**e. Integrated Postnatalcare**

MCHIP in Indonesia is developing an integrated model for Post natal care (PNC) to be scaled up at the national level. The current PNC schedule for skilled care differs for the mother and the newborn, and few postnatal visits are happening at all. The period during which mothers and newborns are most at risk, 24 to 48 hours after birth, is often missed, as this early visit is not integrated into community health services. The three MCHIP target districts have agreed to allow midwives to conduct integrated PNC visits for mothers and newborns. The guideline for the four recommended integrated postpartum visits are 6-48 hours, 3-7 days, 8-28 days, and 36-42 days. After the socialization of IPNC in the previous quarter, MCHIP is supporting village midwives to conduct home visit and use the IPNC forms for recording and reporting.

In the three districts IPNC in the form of both facility as well as home visits was continued. In Serang MCHIP supported 65 village midwives to conduct home visit for neonatal and postpartum mother (KN and KF) by providing transportation costs. On the job mentoring for IPNC was also conducted in all three MCHIP districts. The sessions were facilitated by P2KS trainer with facilitation from MCHIP. This is the second on the job mentoring session for IPNC. The session was attended by village and puskesmas midwives.

Data from all three districts show that IPNC visits are happening. A general declining pattern for all sites from the first to the fourth visit is observed (Fig 8).

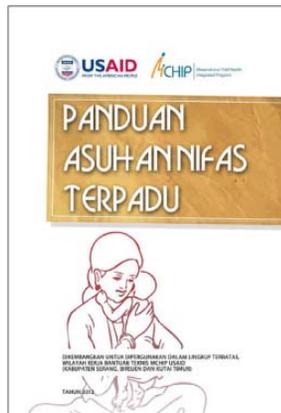
Fig 8: Number of IPNC visit in Serang district in March 2012



**At the national level**, in collaboration with the MoH, MCHIP adapted the global combined job aid for ANC, delivery, and PNC for Indonesia. The job aid is for the use of midwives at all levels- it consist of a checklist of tasks according to standard that should be performed at each stage. The job aid serves as reminder as well a tool to assist compliance to the evidence based standards. As a next step, MCHIP will field test the job aid in MCHIP or other jhpiego sites.



The immediate postnatal period is where the majority of the deaths takes place, however PNC in Indonesia is not regular and are separate for mothers and newborns. To streamline and strengthen the IPNC visits, MCHIP in collaboration with the MoH adapted the IPNC guideline for Indonesia for use of midwives, supervisors, and the puskesmas. The guideline addresses a) the importance of IPNC; b) tasks to perform during an IPNC visit; c) How to perform an IPNC visit; d) timeline for IPNC; and e) form for recording and reporting IPNC visits adapted from the PWS KIA. The draft for the INPC guideline has been approved by the MoH and as a next step will be tested in MCHIP or other jhpiego sites.



**Challenges:**

- a) While the first visit KN1 and KF1 is high, there is a universal decline toward KN1 and KF1. This pattern is similar not only to postpartum and postnatal visit but also to Antenatal visits. One of the perceived advantages of IPNC is an increase in the number of and compliance to all four visits, given that the integration can reduce the duplications and overall number of visits required. The MCHIP data for this quarter on number of postpartum and postnatal visit received in the first week of life, if continues at this trend, will be able to meet the national target of 80%.
- b) Recording and reporting of IPNC is a challenge. The revised PWS/KIA has three separate visits for mothers and three for newborns. MCHIP developed an integrated

form to report four integrated visits. Midwives are only completing the PWS/KIA form but the MCHIP form is not being completed, thus the fourth visit is low

### ***Sub-objective 3: Improve quality of clinical services at all levels of care***

#### ***a. Kangaroo Mother Care (KMC)***

MCHIP is expanding facility based KMC in three MCHIP target hospitals in the three districts. *Perinasia* (Indonesian Perinatologist Association) that had been leading the effort of establishing facility based KMC in Indonesia is providing technical assistance to MCHIP for KMC expansion.

In this quarter KMC teams from Bireuen and Kutai visited the Rumah Sakit Cipto Mangunkusumo (RSCM) - one of the best KMC hospitals in Indonesia. Following the visit, the Bireuen team shared the findings from the RSCM visits to the larger KMC team within the hospital, attended by 25 participants. This activity completes the majority of facility KMC activity for MCHIP.

Facility based KMC has been established in all three district hospitals through the following components:

- Providers received comprehensive training for KMC including topics on learning organization (how to prepare hospital staff to adopt a new approach), Breastfeeding, and KMC.
- KMC team at the hospital established and responsible for advocating, planning, and budgeting for KMC
- Standard operational procedure for KMC in place
- Recording and reporting for KMC established
- Provision of IEC materials and KMC kits
- Official decree from the head of hospital with commitment and allocating resources for KMC



As a next step, MCHIP in all three sites will coordinate with the District health office to establish a link between facility and community KMC so that when patients are discharged from the hospital the midwives in the puskesmas coverage areas are encouraging and monitoring KMC for these patients. In Bireuen and Kutai Timur, when the hospital was trained for KMC, doctor and bidan coordination for puskesmas also attended the training. The C-IMCI component also includes the C-KMC component. In this quarter in Kutai Timur, 4 puskesmas attended the workshop on KMC conducted by the RSUD Sangatta with support from MCHIP. These sites were selected based on the frequency of the LBW cases. In Serang the DHO is already implementing KMC at the puskesmas. MCHIP will continue to monitor the KMC at the hospitals.

MCHIP with *Perinasia* developed a “**how to**” manual for establishing facility based KMC. This manual addresses all the essential components – leadership, management, personnel, and resources for establishing facility based KMC. *Perinasia* will use this guideline for establishing facility KMC in other sites.

### Challenges and Lessons learned

- a) MCHIP’s goal in these three hospitals is to prepare the hospital to implement KMC. What is currently being implemented is ‘intermittent KMC’ with counseling for the patients to continue KMC at their home. All three hospitals are currently using incubators to manage LBW; a shift to the continued KMC will take time.
- b) Another challenge that was identified in all sites was the separation of mothers and newborns after birth. While newborns often stay in hospitals for a few days, mothers often leave early. To address this gap, KMC rooms for mothers are now available in Kutai Timur and under construction in Serang. Bireuen does not have any plans to build KMC room immediately; a new building for the district hospital in Bireuen is currently under discussion. However cost implications as well as household responsibilities will allow the mothers to stay only a few days at the hospital- a constraint for continued KMC practice.

### b. Clinical Mentoring and Training.

During this quarter, MCHIP continued providing on-the-job mentoring at all 17 puskesmas and 3 hospitals. Basic supplies and equipment were provided for infection prevention, and minor renovations were completed at the puskesmas. Intervention to date in 3 districts include standards to improve and monitor quality, onsite training on infection prevention, onsite training on KMC, ER, AMTSL, IPNC, MgSO4 for staff, and, clinical on the job mentoring.



i. Active Management Third Stage Labor (AMTSL)

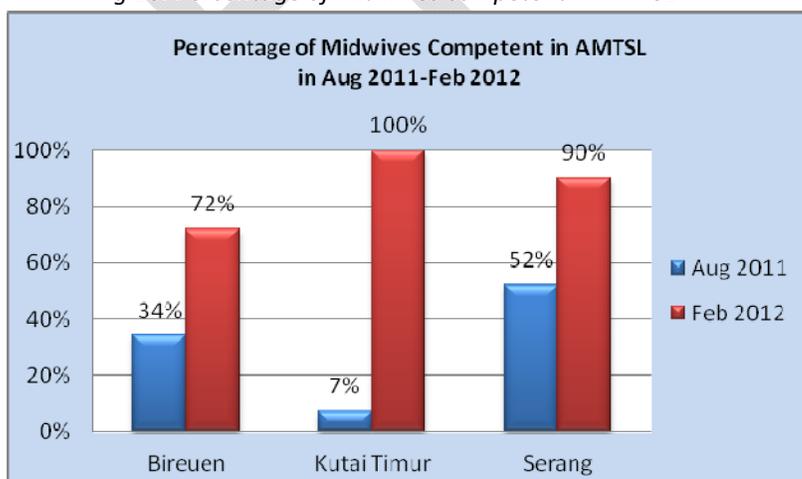
Kabupaten	Survey	# of total midwives	# of midwives assessed	# of midwives competent
Bireuen	Aug 2011	235	235	80 (34%)
	Feb 2012	273	226	163 (72%)
Kutai Timur	Aug 2011	67	53	4 (7%)
	Feb 2012	80	57	57 (100%)
Serang	Aug 2011	100	94	49 (52%)
	Feb 2012	97	93	84 (90%)
Total	Aug 2011	402	382	133 (35%)
	Feb 2012	450	376	304 (81%)

The second round of AMTSL assessment was conducted from February to March in all three districts. A total of 376 midwives were assessed in AMTSL competency in 3 districts and 304 (81%) midwives were found competent in all three steps of AMTSL—a significant increase from Aug 2011 of 35% competent midwives (see fig 9 & 10).

Fig 9: Midwives competent in AMTSL in August 2011 and Feb 2012

In Bireuen, 226 midwives were assessed and 72% were found competent. Puskesmas Peudada had the highest percentage (86%) and Puskesmas Jeumpa had the lowest percentage (47%). In Kutai Timur, 57 midwives were assessed and 100% were found competent. In Kutai Timur, there were 'try-out' sessions prior to the AMTSL survey in February. In Serang, 93 midwives were assessed and 91% were found competent. Puskesmas Tirtayasa, Petir and Kramat Watu had 95% of midwives competent in AMTSL and Puskesmas Padarincang had only 75% midwives competent. The increase in AMTSL scores can be attributed to consistent on the job mentoring from the P2KS with facilitation from MCHIP.

Fig 10: Percentage of midwives competent in AMTSL



On the job mentoring for treatment of Pre-eclampsia/ Eclampsia using Magnesium sulphate was conducted in all three districts. This is second on the job mentoring session for Magnesium sulphate. The mentoring was conducted by the P2KS trainers with facilitation from MCHIP. Village puskesmas midwives attended the on the job training. On the job training for infection prevention was also a part of this session.

On the job mentoring for APN and ANC was also conducted for all three districts. This is done routinely every two or three months in the target districts. The mentoring was conducted by P2KS trainers with facilitation from MCHIP. Village and puskesmas midwives attended this on the job mentoring session.

The midwives in MCHIP area in Serang were provided training on Postpartum Family planning insertion facilitation by the District health office. However, counseling was not part of the training. MCHIP, to address this gap, conducted postpartum family planning counseling training for 70 village midwives from the five puskesmas coverage area. In Kutai Timur and Bireuen, the skill as well as counseling training was conducted by the local government.

Minor renovation of 4 puskesmas was started in Serang: Petir, Padarincang, Tirtayasa, and Pamarayan. This activity was previously planned for the quarter before, but was not implemented because of administrative challenges. These renovations focus on minor supplies and renovations for infection in the delivery room.

#### *ii. PONED Assessment*

Assessment for the implementation of PONED was conducted jointly by the DHO, District hospital, and P2KS and facilitated by MCHIP in three Puskesmas in Bireuen and four Puskesmas in Kutai Timur. All Puskesmas are currently providing PONE services. The team assessed the availability of resources, identified challenges, and proposed solutions in the implementation of PONED. Some of the challenges identified were:

- Limited skills and confidence amongst the puskesmas staff
- Lack of supplies, equipment, and ambulance either not available or in a bad condition hampering referral
- Cases of obstetric complications rare
- Process of referral to the RSUD delayed due to bad road, rain etc.

#### *Challenges and Lessons Learned*

- a. Limited number of Ob/Gyns and Pediatrician in each district. To address the gap, MCHIP is strengthening the skills in handling emergency cases of the General practitioners and senior midwives through on the job training, mentoring, supervision, and internship in RSUD. MCHIP advocated through PTP and DTSP for the provision of budget for these internship.
- b. Using P2KS for training and clinical mentoring is cost effective and in line with recommended guideline, however, there have been several cases where the verification from P2KS has been biased due to a personal relationship with the participants. Using P2KS from other districts for verification is an option; however, this would reduce the opportunity to develop the capacity of P2KS from the district for monitoring.
- c. Training models such as the resuscitation and pelvic models are currently either available at the P2KS or through MCHIP, puskesmas do not have the budget to

purchase these models that cost around 1000 USD. Easy access to these models would increase the capacity of the puskesmas to conduct on the job training for the puskesmas staff as well as the desa staff independently.

- d. Conflicts and differences in opinion between and within the primary stakeholders, DHO, P2KS, district hospital, and puskesmas can lead to challenges in program start up and effective coordination and implementation. Relationship between these sites for example between puskesmas and district hospital are at times improved when the puskesmas is able to stabilize and refer clients in a better condition.

c. **Improved systems for quality assurance.**

Standards-Based Management and Recognition (SBM-R) is a practical approach to improving the quality of health care and the performance of service delivery systems. With technical assistance from Jhpiego, the approach has been implemented in over 20 programs in developing countries and across several health areas, including maternal child health, reproductive health, HIV/AIDS, and malaria. Under MCHIP program, SBM-R has been implemented in three districts in the three Indonesia; Bireuen, Serang and Kutai Timur.



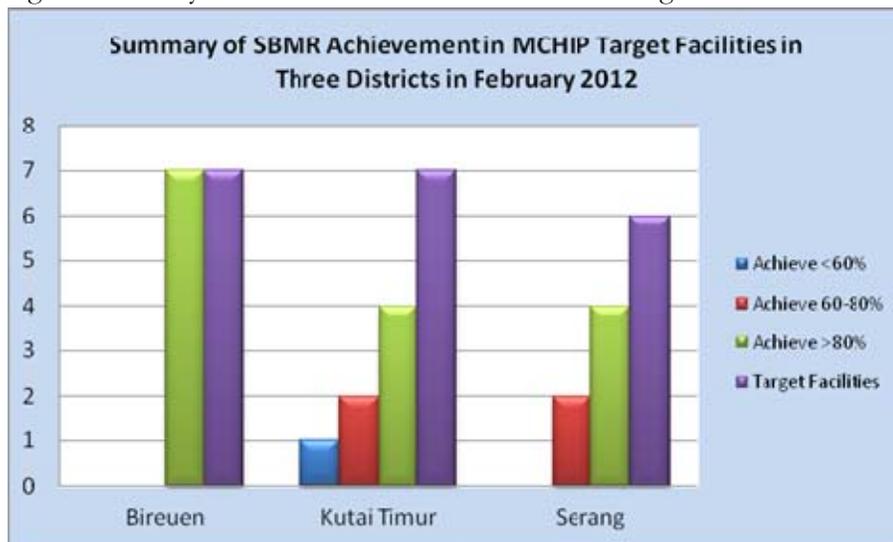
Target hospitals, facilities, midwives in all three districts continued to monitor and recognize their progress using the SBM-R performance standards. At each level the assessments are conducted using the checklist that covers performance standard indicators for areas shown in Table 1 below. The standards focus on proven high impact interventions such as the AMTSL, use of Magnesium sulphate for management of PE/E, iron supplementation for prevention of maternal anemia, emergency obstetrics and newborn care, newborn resuscitation for management of newborn asphyxia, and essential newborn care.

Figure 11: SBM-R Performance Standard at All Levels

Midwife Level	Puskesmas Level	Hospital Level
Tool 1. Pregnant women care	Tool 1. Physical Facility	Tool 1. Infection Prevention
Tool 2. Normal delivery and newborn care	Tool 2. Antenatal Care	Tool 2. Pregnancy Complication
Tool 3. Mother and newborn postpartum care	Tool 3. Pregnancy Complication	Tool 3. Normal delivery, delivery, postpartum and newborn care
Tool 4. Delivery complication	Tool 4. Normal delivery and postpartum care	Tool 4. Delivery complication
Tool 5. Contraceptive methods	Tool 5. Management of delivery complication	Tool 5. Antenatal and postpartum care
Tool 6. Family Planning – Oral contraceptive and injection	Tool 6. Postnatal complication	Tool 6. Family planning service in hospital
Tool 7. Child immunization	Tool 7. Postpartum care	
Tool 8. Under five children care	Tool 8. IMCI for newborn <2 months	
Tool Infection Prevention	Tool 9. IMCI for 2 month to 5 years child	
	Tool 10. Child Immunization	
	Tool 11. Contraceptive methods	
	Tool 12. Infection Prevention	

During this quarter, facilities and midwives in all three districts continued to monitor and recognize their progress using the SBM-R performance standards. In general, the 3 districts have conducted the 4<sup>th</sup> or 5<sup>th</sup> cycles of SBM-R monitoring and data collection. Figure 12 below summarizes the SBM-R achievement for all MCHIP sites to date. Bireuen is leading with all sites complying with more than 80% of the standards. Serang is close with all sites complying with more than 60% of the standards. Kutai Timur has one site, puskesmas Sangkulirang performing under 60% with lower performance in infection prevention and IMCI (fig 11)

Fig 12: Summary of SBM-R achievements in MCHIP target facilities in three districts



#### *Comparative Analysis*

In this quarter, MCHIP also hired a consultant to do a comparative review of the three quality improvement tools that are currently being implemented in Indonesia for Maternal and newborn health. These are a) Supportive supervision, b) Bidan delima, and c) SBM-R. Each component of the three Quality improvement approach was compared. Details of the findings will be presented in the next quarter. A summary of the findings as well as recommendations are as follows:

1. All three approaches have the same goal- improving performance and the quality of MNCH services.
2. Supportive Supervision and Bidan Delima are national tools, while SBM-R is being implemented in some sites.
3. SBM-R is targeted for the use of providers at the private midwifery practice, posyandu, poskesdes, Puskesmas, and the district hospital. Supportive supervision is targeted for the use of supervisors to manage performance at the level of Puskesmas and below.

4. Organizations that are and should be promoting and using quality improvement approaches are District health office, JNPK, private and donor based institutions.
5. SBM-R standards are the most detailed and specific- it not only includes “what to” but also “how to”. The standards for Supportive supervision only address what needs to be done.
6. In Bidan Delima clients are a part of the verification process. In SBM-R and Supportive supervision, the validation is conducted by the supervisor internally or externally, and can be observed with or without patient.
7. In SBM-R and Bidan Delima, compliance to the standards is increased through on the job training and mentoring.
8. Recognition for increase in performance is important for motivation and incentive purposes. SBM-R and Bidan Delima includes recognition.
9. In all three approaches community involvement in a systematic manner is lacking.
10. Budget for supportive supervision is essential for all three models. However, SBM-R is based on self-assessment and self-verification, if implemented well, SBM-R can be independently run by the Facility itself with limited need for external supervision.

#### Recommendations

1. Directorate to explore the integration of the existing quality improvement approaches based on best practices and perceived advantages of all.
2. Strengthen the capacity of the District Health office, Team MNCH, and professional organization such as JNPK to promote and supervise the implementation of quality improvement approach.
3. Include patient and community in the verification process. Customer satisfaction survey can be one of the methods to do so.
4. Emphasize “Recognition” component of the quality improvement approach- linking this with the CSR effort in the community should be explored.
5. Maxmization of the existing monthly meetings to promote, discuss, and disseminate the quality improvement approaches and allocation of resources for supervision is essential.

The findings intially was disseminated amongst MCHIP, EMAS teams as well as the representatives from the Ministry of health. As a follow up the Ministry of health intends to explore the integration of positive findings and aspects from the comparative study into the supportive supervision system in Indonesia.

#### *Challenge and lessons learned*

- a) SBM-R and supportive supervision, both quality improvement tools, overlap in some sites, creating confusion and duplication of resources. An integrated national tool including positive aspects from both SBM-R and supprotive supervion is necessary.
- b) The Recognition part of SBM-R where the sites or individuals are recognized for their performance needs to be strengthened. The sites and individuals are currently being rewarded with certificates, more substaintial recognition mechanisms that are

systematic, such career pathing for individuals, and superior accreditation for sites needs to be explored.

- c) The gaps identified during the SBM-R process at times require renovations or procurement of supplies and materials, the puskesmas often has to wait to include this in their annual budget- as they don't have separate funds to purchase or implement these immediately.

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### **Stories from the field –Now I am more Professional**

"When I started as a village midwife, providing care to the patient, it was just to do it and far below standard." That was the honest confession of Hajjah Siti, S.ST. (28), a midwife at Sujung village, Tirtayasa sub district Serang District, when she talked about her experience in providing services to the community. In addition, according to the Midwifery Academy alumnus of Poltekes Bandung of Rangkasbitung Branch who graduated in 2005. The equipment for examination and care were also incomplete and of poor quality. At that time, she thought that the important thing was to provide the service, whether the patients were satisfied or not was not a priority. "First, I do not have any target to achieve and was not motivated to improve quality." Said the midwife who had been working as a village midwife for 6 years.

But that was history. Now, Siti Hajjah has good performance in *Puskesmas* Tirtayasa and made many changes in the puskesmas to comply with the standards; she also did the same in her residence where she opened her practice. All her colleague midwives in the village and *Puskesmas* applied these changes as well after knowing and using the SBM-R.



The SBM-R is an instrument to measure providers' compliance particularly village and *Puskesmas* midwives, BPS (private practice midwife) as well as hospital as the institution providing quality services following the standards of the Ministry of Health of the Republic Indonesia and professional organizations. Quality of health care is largely determined by providers' competency or compliance rate; it is one practical way to improve quality of care by improving performance including completeness of equipment. SBM-R determines individual or team gap in the standards. SBM-R, therefore, is very useful to improve the quality of maternal, infant and children health care practices. In addition SBM-R also serves as an assessment tool, job aids, training / orientation as well as monitoring, supervision and evaluation tool for the performance of health providers / health care facilities.

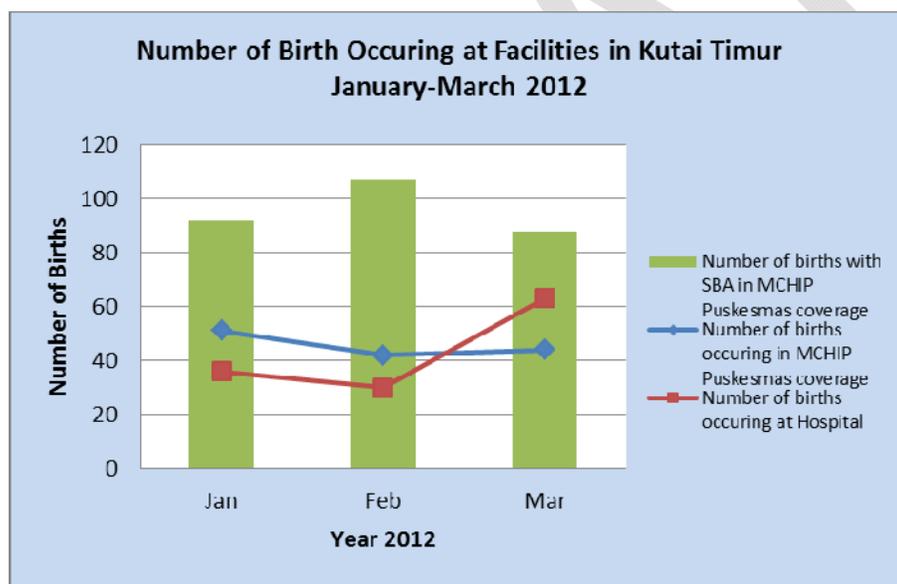
According to the Head of *Puskesmas* and Bikor (midwife coordinator), after using SBM-R for one year, midwives' performance and compliance to quality service standards slowly increased. Siti Hajjah admitted that after using SBM-R, she was more thorough in examining pregnant patient. Complications were detected early and easily to decide treatment.

*Reported by Solihin Abbas Field officer*

### **Birth at Facilities**

As reported in the PWS/KIA data from the three districts, the management of births occurring at facilities ranged from 20 to 50 percent of all deliveries with skilled birth attendant for this quarter. In the previous quarter only 10 to 20 percent of all deliveries with SBA was occurring at the facilities. Increase in skills of the health workers as well as increase in quality of the sites may have contributed to some of this increase.

*Figure 13: Number of Births occurring at facilities in Bireuen*



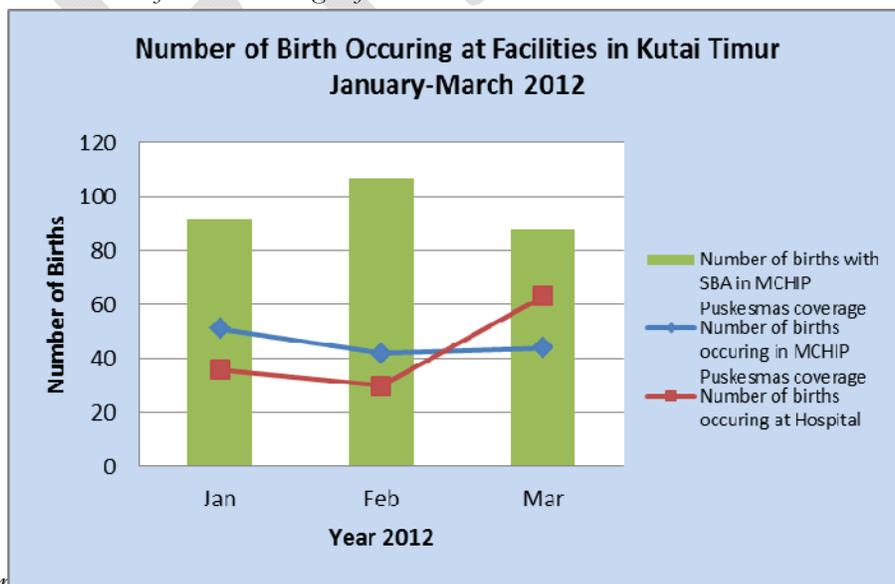
In Bireuen in the six MCHIP *puskesmas* coverage areas/ subdistricts, the number of births with SBA has remained somewhat consistent at an average of 175 births per month; this is equivalent to an approximate 79% of all births in the MCHIP *puskesmas* coverage area. The percentage of births occurring at the *puskesmas* in Bireuen is low. This may be due to the relative proximity of the population to the hospital. Additionally after the initiation of *Jampersal*, women are delivering directly at the hospital. While *Puskesmas* also accept *Jampersal*, the perception is that it is comparatively safer to deliver at the hospital given the availability of comprehensive services and expertise. The MCHIP district hospital in Bireuen is also attending to clients from other sites- one of the districts closer to Brieuen does not have a hospital, so the clients come to the Bireuen district hospital for services. Village midwives, that are not part of the graph, also attend births, but the numbers vary significantly depending upon the distance from the nearest facility.

Figure 14: Number of Births occurring at facilities in Serang



In Serang in the five MCHIP Puskesmas coverage areas, the number of births with SBA for January through March is an average of 400 births per month; this is equivalent to 90% of all births in the MCHIP Puskesmas coverage area. The number of births occurring at the Puskesmas is low and consistent at an average of 100 births per month or 22% of all births due to SBA. The district hospital data shown above also includes the population outside of the MCHIP coverage area. Village and private facilities also provide SBA services in Serang, offering more choices to women and their families.

Figure 15: Number of births occurring at facilities in Kutai



Timur

## Factors Affecting Delivery Locations in Indonesia

MCHIP in this quarter finalized the report for “Factor affecting delivery in Indonesia”- cross-sectional study analyzes the reasons why women choose home or facility-based delivery. 300 respondents (93 pregnant women, 91 postpartum women with non-facility deliveries, and 116 postpartum women with facility deliveries) were interviewed in Minas, Karawang, Bojonegoro and Serang districts.

34% of postpartum respondents had home deliveries, and only 37% of pregnant respondents planned facility delivery. For women with facility deliveries, quality of service (73%), physical access (44%), and knowledge (42%) were their top influencing factors. For postpartum women with non-facility deliveries, cost (46%), convenience (45%), and physical access (43%) were their top influencing factors.

The study found that all respondents with non-facility deliveries paid TBAs for delivery services, but 8 respondents who gave birth with midwives paid nothing, because of *jampersal*. Of respondents with non-facility deliveries, 52% said the nearest health facility is less than 15 minutes from their home, 97% have access to transportation, and 67% said that transportation to the nearest health facility costs less than 10,000 rupiah (\$ 1.15).

For women with non-facility deliveries, cost and physical access were their main barriers. *Jampersal* can solve the cost problem, but it has only been fully implemented in two of the four districts. Outreach efforts are needed to educate pregnant women that costs for facility deliveries can be less or equal to costs of non-facility deliveries. Distance and transportation costs are not necessarily barriers, though road conditions and unavailability of transportation can be problematic. A low percentage of respondents cited that nothing would persuade them to choose facility-based delivery. However, this study shows if costs were reduced, quality of services increased, and transportation barriers removed, women who chose non-facility deliveries would be more likely to choose facility deliveries.

## Sub-objective 4: Improve Management of the District Health System

### a. Evidence-based Local Planning.

Evidence-based local planning involves a series of processes toward ensuring evidence based planning and budgeting for district level programs for all sectors. MCHIP is facilitating the evidence based planning process for MNCH for the target districts. The evidence based



planning is completed on an annual basis and is bottom up from the community level to the district level. The village or the community level planning or *pra-musrenbangdes* is followed by the sub-district level planning at the puskesmas called the *Perencanaan Tingkat Puskesmas* or PTP that feeds into the District Team problem solving (DTIPS) at the district level.

In 2011, MCHIP facilitated the completion of the process in all districts; the result was a significant increase in budget allocation for MNCH for 2012.

Fig 16: Budget allocation for MNCH for all three districts for 2011 and 2012

	Budget 2011	Budget 2012	Percentage increase
Serang	54.000.000 Rp (~5,871 USD)	270.000.000 Rp (~29,375 USD)	400%
Kutai Timur	800.000.000 Rp (~87,000 USD)	1.200.000.000 Rp (~130,000 USD)	50%
Bireuen	0 Rp	500.000.000 Rp (~54,000 USD)	-

The planning for the 2013 allocations began with the *pra-musrenbangdes* in all three districts in the previous quarter. This was followed by the PTP in all three districts for all of the target subdistricts. The PTP has three steps a) Orientation, b) workshop, and c) advocacy. The workshop to review the performance of the puskesmas, identify gaps, and propose workplan to address the gap and request the budget accordingly was conducted by all puskesmas in this quarter. The advocacy at the sub-district level on the results from the PTP was also conducted in this quarter. The PTP in Kutai Timur in January was attended by 36 participants, and Bireuen in February was attended by 33 participants.

A summary of the PTP from six sub-districts in Kutai Timur showed bleeding as the major cause of maternal death; LBW and asphyxia as the major cause of newborn death; and diarrhea as the major cause of child under five death. The strategies in the proposed workplan to address these major causes of deaths included training, additional human resources, procurement, initiation or revitalization of community based interventions, and strengthening quality of care.

Following the PTP the DTSPS workshop was conducted in all three districts attended by various stakeholders. The goal of the workshop in general was 1) Develop workplan and budget allocation for MNH activities for FY 2013- evidence based planning 2) Review and discuss PTP, LAMAT coverage 2011 and 2012 3) Identify best practices and prioritize activities 4) Get buy in from stakeholders for final approval 5) Alignment of the workplan with the planning rules and regulation.

#### *Challenges and lessons learned*

- a) While MCHIP supported the evidence based planning for the MCHIP target sub-districts, at the district level, the request for the non-MCHIP sub-districts may not be evidence based; at times these may be copy pasted versions from the year before. Inconsistency amongst the subdistricts, in the end, leads to a district plan that is not completely sound.
- b) The DTSPS pulls in from various other district level strategies and goals such as the MPS, MDG roadmap, and *Restra bidang Kesehatan* or strategic planning for health sector. While MCHIP is assisting with the MDG roadmap and DTSPS, strategic planning for health sector is not a part of MCHIP's scope of work. In Bireuen, the DTSPS process was hampered by the lag in the development of the strategic planning for health sector.
- c) Beyond the completion of DTSPS advocacy at the district level for MNCH is essential because there are several sectors competing for the funds allocation for the district level planning other than the MNCH.

#### **b. *Improved process for conducting maternal-perinatal audits.***

Effective maternal and perinatal audits are associated with improved quality of care and reduction of severe adverse outcomes<sup>1</sup>. Maternal Perinatal Audit (MPA) is for tracking the causes of maternal and perinatal morbidity and mortality to prevent future cases. MPA helps health personnel determine the conditions that resulted in the mortality/morbidity of mothers and newborns. The MPA can also function as a tool for monitoring and evaluation of the referral system. Indonesia's national policy is to conduct a verbal autopsy of every maternal and perinatal death. The MPAs are done through a collaborative team from the DHO and the district hospital. Additionally the MOH has recently revised the MPA forms and process and all districts are expected to implement this process. However, in many districts, the process is

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<sup>1</sup>Pattinson RC, Say L, Makin JD, Bastos MH: Critical incident audit and feedback to improve perinatal and maternal mortality and morbidity. *Cochrane Database Syst Rev* 2005, (4):CD002961.

only partially implemented, if at all. The revisions pertain to the “no name, no blame, and no shame” policy, the audits are to be conducted in a confidential and blame free environment.

MCHIP in all three sites in collaboration with the DHO is introducing the revised MPA forms and strengthening of the MPA process. MPA teams in each district were mobilized to form the MPA implementing structure. For deaths that occur in the community, verbal autopsies are done at the health center or the puskesmas, by sub-district and district level health official. For deaths that occur in the hospital, district level health officials conduct the verbal autopsy. Selected cases from the district on a periodic basis is then reviewed by the MPA team at the district level that includes a body of experts on MNH, representative from DHO, private and district hospital, professional organizations etc. MCHIP assisted the DHO in orienting the village midwives, puskesmas, and hospital on the new MPA forms. MCHIP also assisted the DHO in the development of MPA team at all levels.

In Bireuen and Serang the strengthening of MPA system was completed in the previous quarter. In Kutai Timur, MPA Training was completed for the two remaining puskesmas of the six target puskesmas. In these two puskesmas, prior to the MPA training, the old MPA form was being partially completed. A multistakeholder MPA team consisting of the DHO, district hospital, PKK, puskesmas, P2KS, IBI and PPNI was established. In Serang, MPA implemented was during January with verbal autopsy for maternal and neonatal deaths in MCHIP subdistricts. The MPA team at the district level continued selected 9 out of 21 maternal and neonatal deaths for review. In Bireuen, MPA implementation meeting review was conducted on March 19, attended by 55 participants from 18 Puskesmas. This meeting reviewed selected 8 perinatal and 5 maternal deaths from the deaths that occurred from October through December 2011 throughout the Serang district and provided recommendations.

Two maternal deaths were reviewed, causes of death identified as postpartum hemorrhage and Pre-eclampsia/eclampsia. Recommendations made by the review team were as follows.

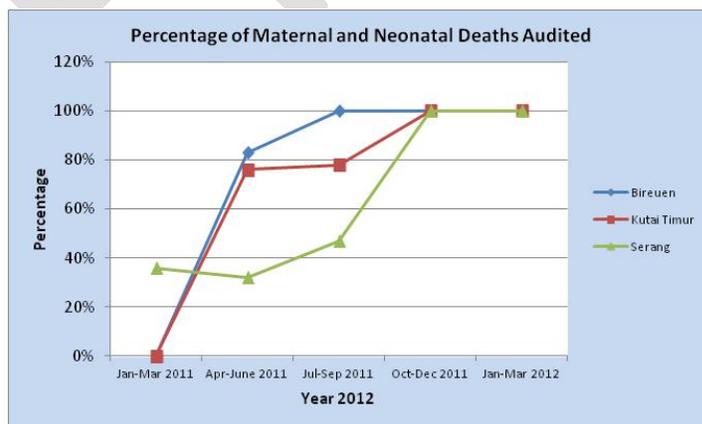
*Fig 17: Summary of review of selected maternal deaths by the MPA committee in Serang.*

Maternal deaths	Recommendations	MCHIP interventions
Case I (PPH)	1. Increase the capacity of the bidans and doctors to handle emergency obsetetric cases.	1. MCHIP is strengthening Puskesmas PONED and capacity of bidans on AMTSL and case stabilization through SBM-R
	2. Develop standard operating procedure for management of emergency obstetric in puskesmas and BPS for bidans and doctors simple and easy to understand.	2. MCHIP has made available and encouraged the use of standard operating procedure of emergency obstetrics in the puskesmas.
	3. Provisions of transfusion sets and uterotonics in the puskesmas.	3. MCHIP advocates for the provision of uterotonics to the DHO on behalf of the puskesmas
	4. Socialization and inventory of blood in all sites where bidan is working.	4. MCHIP through the Desa Siaga/ P4K is supporting the blood donation events and inventory of blood in all sites

Case II (PE/E)	1. Develop standard operating procedure for PE/E stabilization and management for midwives and doctors at the puskesmas level that is simple and easy to understand.	2. MCHIP has made available and encouraged the use of standards operating procedure for PE/E and use of magnesium sulphate at the puskesmas as well as the desa through SBM-R
	3. Provision of MgSO4 in Puskesmas/BPS, and nifedipin and/or metildopa for hypertensive cases.	4. MCHIP advocates for the provision MgSO4 to the DHO on behalf of the puskesmas.
	5. Provision of Proteinuria test at the puskesmas/ BPS for detection of PE/E	-
	6. Socialization of standard operating procedure, P4K and active supervision	7. MCHIP is strengthening supportive supervision for all interventions including PE/E as well as the identification of danger signs through community interventions such as Kelas ibu

In Jan 2011, all districts started with low number of audits, 32% in Serang and 0% in Bireuen and Kutai Timur. By mid 2011 increased to 47% (n=60) in Serang, 78% (n=27) in Kutai Timur and 100% (n=15) in Bireuen. At the end of 2011 all sites achieved and continue to maintain verbal autopsy for 100% (n=49) of all maternal and neonatal deaths reported.

Fig 18: Percentage of Maternal and Neonatal deaths Audited in three MCHIP districts.



### Challenges and Lessons Learned

As MPA is being ramped up in all three districts, more cases of maternal and newborn deaths are being identified and recording, this may seem like the cases are increasing despite MCHIP support in the target districts.

c. *Data management.*

Data reporting and recording is one of the major challenges of the Indonesian health system. PWS KIA is the basic form of reporting at the community and the puskesmas level. Midwives are responsible for completing the PWS KIA forms. In 2011, MCHIP has completed PWS KIA training for district and Puskesmas MCH staff. This quarter, the three district continue to monitor the implementation of PWS KIA. The PWS KIA is not completely implemented at all levels. In Kutai Timur, one Puskesmas was using incorrect form and puskesmas forms

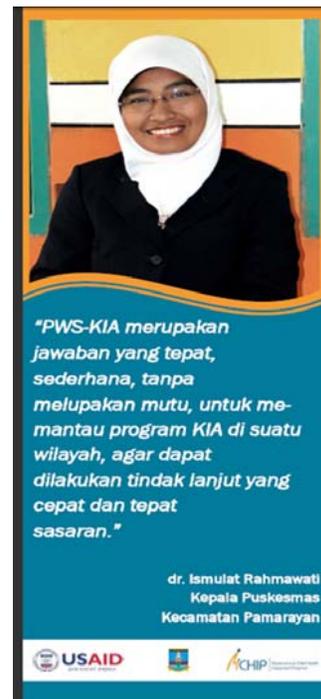


instead of the community forms are being used by village midwives, and vice versa. Some Puskesmas are implementing the community level PWS KIA but these are not being captured at the puskesmas level. In general, the key personnel implementing PWS KIA at the puskesmas and the village midwives are not aware of the PWS KIA guideline. Limited understanding of the indicators (the definitions, and how to interpret) amongst the midwives and an ingrained attitude that as a clinician, the role of bidan is to provide clinical services- and not so much to record and report data and limited understanding of “how data will be helpful to them” and seen as a burden

are also some of the major constraints.

MCHIP has conducted the PWS KIA socialization and training at the puskesmas level with the intent of initiating a cascade effect to the village midwives through the Puskesmas or the bidan coordinator. However, during site visits MCHIP learned that the knowledge and skills are not being transmitted to the village midwives. To strengthen both village midwives and the puskesmas on PWS KIA, MCHIP is reinforcing the PWS KIA reporting and recording at the regular monthly puskesmas meeting.

In Kutai Timur, quarterly review of the MNCH data focused on Geographic Information System (GIS) strengthening for all puskesmas in Kutai Timur. The GIS allows viewing of the coverage data in the form of a map. The training was conducted by the Kutai Timur DHO with support from the Kutai Timur PHO. The puskesmas team learned how to develop a map and analyze the PWS/KIA data using the map. The team also discussed the coverage data of over 100% in some cases; this may be due to a lower estimation of the population data, or serving clients outside of the coverage area. The proposed solution was to add an additional step to remove clients that are not of the coverage area from the database and also follow up with the DHO



*"PWS-KIA merupakan jawaban yang tepat, sederhana, tanpa melupakan mutu, untuk memantau program KIA di suatu wilayah, agar dapat dilakukan tindak lanjut yang cepat dan tepat sasaran."*

dr. Ismulat Rahmawati  
Kepala Puskesmas  
Kecamatan Pamarayan



and PHO for a realistic population estimate for the next year. MCHIP will prioritize the strengthening of PWS/KIA in the upcoming quarter.

**d. Institutionalized commitment for MNCH.**



In the past quarter, several laws on MNCH was drafted and finalized. In Bireuen at the district level Qanun KIBBLA, and POMA regulation (Obstetric Maternal and Perinatal Program) was finalized and disseminated. In Kutai Timur, local government has completed a draft of the Qanun KIBBLA draft and it is in the process of signatory approval.

At the village level, *Perdes* (Peraturan Desa – Village regulation) for MNCH program institutionalizes commitment. In Bireuen, a coordination meeting with local government and stakeholders was conducted to move the *perdes* is ongoing. A draft of the *Perdes* for Gandapura and Makmur villages was developed. In Kutai Timur *perdes*. To date, 45 *Perdes* have been developed and approved in Serang, more than the targeted 10. No major activities under this category were conducted in the quarter.

### III. MANAGEMENT

#### ***MCHIP Audit***

Conducted by: Office of Inspector General in Philippines

Scope or work: “Is USAID/Indonesia’s Maternal and Child Health Integrated Program (MCHIP) achieving its main goal of improving maternal, newborn, and child health care services?” The OIG’s interest is to audit the USAID mission’s management and supervision and MCHIP was chosen out of the list of the existing mission portfolio. The focus of the audit was on Monitoring and evaluation specifically – their questions can be grouped under the following category:

- Do the indicators fit the program scope
- How are the indicators being calculated
- How are the indicators being recorded, collected, and reported by MCHIP
- The synchrony between what MCHIP Jakarta is reporting and if this matches with the district level documentation
- Verify district level data by speaking with beneficiaries and stakeholders
- The linkage between global MCHIP Indicators and local (Indonesia) indicators and how they were selected

Dates: 5<sup>th</sup>- 30<sup>th</sup> March

Schedule: Initial and debrief meetings in Jakarta with site visits to all three districts

Preparation:

- Submitted all key program documents including scope of work, Workplan, Report, and PMP.
- Submitted documentation on M&E specifically M&E system, internal data quality assessment, timeline and changes on PMP to date, data files as requested.
- Reviewed and revised the PMP upon request from and in coordination with USAID
- Provided guidance to the field on “how to prepare” for the audit through email, and meetings (Bireuen, and Kutim) as a part of onsite visit.
- Anticipated questions based upon interview with the Jakarta team were sent out to the field to prepare specifically on M&E.
- Shared reports between districts on the trips- on questions asked, sites visited, etc.
- Field visits were accompanied by key technical leader from Jakarta for each district

Lessons learned:

- ‘Document, Document, Document’- All major exchanges with the mission, esp. those pertaining to the changes in workplan, PMP, and reporting requirements needs to be submitted for approval to the mission. While changes in the PMP and indicators that MCHIP Indonesia will report out on a quarterly basis, was discussed within the team and in consultation with the mission, there is no documentation of approval from the mission to move forward with the changes.
- Ensure that central team as well as the district team has the same understanding of the program targets for their district. While the program goals and targets have been disseminated during retreats, the district teams in some cases were not aware of the program targets. Staff transitions may have contributed to some of this. MCHIP moving forward plans to:
  - Disseminate the new M&E framework – not just by email – but also follow up with a meeting with the district teams to discuss the changes. The Key Technical advisors when traveling to the field will walk the team through the M&E framework and quiz them if needed on their understanding of the targets.
  - Add an extra step in the development and submission of quarterly reports. The quarterly reports before submission to the USAID will be sent out to the districts and requested feedback, as well as meeting to discuss the data

presented on their target and how they are measuring up to the target. The MCHIP team at the central level was receiving data and submitting to the mission after analysis, but the data submitted was not being sufficiently explained to the district staff. In other words, the information (data) was flowing up, but the information on 'what was presented and why' was not flowing down to the district level.

- Internal data quality Assessments should be a regular part of the program workplan. Staff or consultants as a part of their visit should plan to check the quality of data that is being recorded at the district level and if these data correspond to what is flowing up and being reported by the central level. One time retreat or dissemination of information is not sufficient, periodic check up on the data quality that is being reported is essential.
- Program Monitoring and evaluation is not just the responsibility of the M&E team but also the technical and the program team. The technical and the program staff at the central as well as the district level should take equal responsibility for indicators and progress toward target and presentation for their technical area.

### ***M&E framework***

MCHIP in this quarter also revised and finalized the monitoring and evaluation framework. The framework was revised for the following reason a) To best reflect the MCHIP work to date and moving forward; b) What is feasible and realistic given our experience collecting data to date; and c) Clarify definitions and refine target. Moving forward MCHIP will be reporting on the revised indicators.

### ***Staff changes***

As MCHIP is nearing the end, there have been a few staff transitions at the field offices. When possible MCHIP will look at maximizing existing resources to hire new staff, but positions that are critical for the successful completion of the program will be rehired.

### **Summary of action plan and next steps**

- Conduct Mini- University in all three districts
- Facilitate scale up at the provincial and district level after the mini university
- Ongoing monitoring and supportive supervision for majority of interventions
- Complete the pilot testing for C-IMCI and strengthen supervision and recording and reporting
- Support national guideline development for C-IMCI
- On the job mentoring for PONEK and PONEK for Bireuen and Kutai Timur
- Evaluation of the SBM-R interventions on the MCHIP sites
- Facilitate the completion of the DTSP process for the 2013 allocation

## Annex 1. MCHIP Tracking Indicator

No	INDICATOR	Project Target	Jan-Mar 2012			
			Bireun	Kutim	Serang	TOTAL
<b>Program Objective/Strategic Objective:</b> Increased utilization of quality district-based integrated MNCH services, and practice of healthy maternal and neonatal behaviors in the home?						
<b>GENERAL MNCH INDICATORS</b>						
1	Proportion of women who receive at least 4 antenatal visits *	95%	21%	13%	16%	17%
2	Proportion of deliveries with a skilled birth attendant in MCHIP program areas*	90%	20%	12%	22%	18%
3	Proportion of newborns who receive postnatal visits during the first week of life*	80%	21%	13%	23%	19%
4	Proportion of women who receive postnatal visits during the first week of life*	80%	21%	13%	23%	18%
5	Percentage of births occurring at facilities*	10%	4%	6%	6%	5%
6	Number of people trained in maternal/newborn care through USG supported programs	1,500	1,742	1,783	2,360	5,885
<b>Sub Objective 1: Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces</b>						
7	Number of subdistricts in MCHIP target districts that receive technical assistance from MCHIP for scale up**	17	0	0	0	0
8	Number of districts in MCHIP provinces that receive technical assistance from MCHIP for scale up **	23	0	0	0	0
<b>Sub Objective 2: Improved Maternal and Newborn Care Services and Practices at the Community Level</b>						
9	Number of districts where C-IMCI established	2	1	1	NA	2
10	Number of districts where Community KMC established	2	1	1	NA	2
11	Number of national policies drafted with USG support	1	NA	NA	NA	1
12	Number of Perdes established	36	0	21	35	56
13	Number of National level public-private partnerships	1 ppp	NA	NA	NA	3
<b>Sub Objective 3: Improved Quality of Clinical Services at all Levels of Care</b>						
14	Number of health facility implementing QA/QI approaches	20	7	7	6	20
15	Percentage of village midwives in MCHIP supported areas are competent in AMTSL	100%	72%	100%	90%	87%
16	Percentage of target facilities achieving at least 60% of performance standards	100%	100%	86%	100%	95%
17	Number of women who come to target Puskesmas and hospital treated with MgSO4	200	4	3	158	165
18	Number of puskesmas PONED treating complications	6	3	6	5	14
19	Number of district hospitals with KMC established	3	1	1	1	3
<b>Sub Objective 4: Improved Management of the District Health System</b>						
20	Number of MNCH teams established at district and subdistrict level that meet regularly	15	1	7	6	14
21	Number of people trained in DTPS and PTP workshop	95	50	50	69	169
22	Number of districts with MNCH plans and budgets linked to DTPS	3	1	1	1	3
23	% of reported maternal or neonatal deaths audited	100%	100%	100%	100%	100%
24	Number of local regulations and laws adopted	50	2	12	45	59

\*Reported achievement for Jan-Mar 2012 quarter only to track progress toward national target. The rest are cumulative for program to date.

\*\*These numbers will be implemented after the Mini University activity planned for Apr-June 2012 quarter

FINAL

Training Database Jun 2010 to  
March 2012

No	Training	Bireun			Kutai Timur			Serang			All Districts		
		Total	M	F	Total	M	F	Total	M	F	Total	M	F
<b>SO 2: Improved Maternal and Newborn Care Services and Practices at the Community Level</b>													
2.1	Kader Training for MSG	44	0	44	23	7	16	NA	NA	NA	67	7	60
2.2	KMC Socialization for Cadre	29	0	29	41	6	35	NA	NA	NA	29	0	29
2.3	TOT CCM Facilitator	15	0	15	18	2	16	NA	NA	NA	33	2	31
2.4	CCM Training for Health Worker	111	0	111	153	15	138	NA	NA	NA	264	15	249
2.5	CCM Training for Kader	129	0	129	18	3	15	NA	NA	NA	18	3	15
2.6	CCM Supervisor Training	23	5	18	15	3	12	NA	NA	NA	38	8	30
2.7	TOT CCM Training for U5 Package	38	5	33	50	4	46	NA	NA	NA	50	4	46
2.8	CCM Training Under Five Package for Health Worker and Kader	21	1	20	42	5	37	NA	NA	NA	63	6	57
2.9	C-KMC Training for Village Midwives	131	0	131	22	0	22	NA	NA	NA	131	0	131
2.10	CCM Training (National level)	NA	NA	NA	NA	NA	NA	NA	NA	NA	8	3	5
2.11	Kader Training for CHC/Desa Siaga	NA	NA	NA	48	25	23	201	5	196	249	30	219
2.12	MSG Facilitator Training District Level	7	0	7	23	2	21	7	1	6	37	3	34
2.13	MSG Facilitator Training Puskesmas Level	42	1	41	17	5	12	15	2	13	74	8	66
2.14	MSG Facilitator Training Village Level	146	0	146	140	12	128	197	2	195	483	14	469
2.15	MSG Facilitator Refresh Training	167	0	167	209	4	205	831	4	827	1207	8	1199
2.16	P4K Training Refreshing	156	4	152	255	127	128	193	30	163	349	34	315
<b>TOTAL</b>		<b>1059</b>	<b>16</b>	<b>1043</b>	<b>1074</b>	<b>220</b>	<b>854</b>	<b>1444</b>	<b>44</b>	<b>1400</b>	<b>3100</b>	<b>145</b>	<b>2955</b>
<b>SO 3: Improved Quality of Clinical Services at all Levels of Care</b>													
3.1	SBMR Workshop	98	8	90	49	10	39	50	8	42	50	8	42
3.2	APN Training	36	0	36	1	0	1	NA	NA	NA	37	0	37
3.3	IP Training	145	26	119	143	33	110	138	24	114	426	83	343
3.4	KMC Training	48	7	41	26	3	23	34	2	32	108	12	96

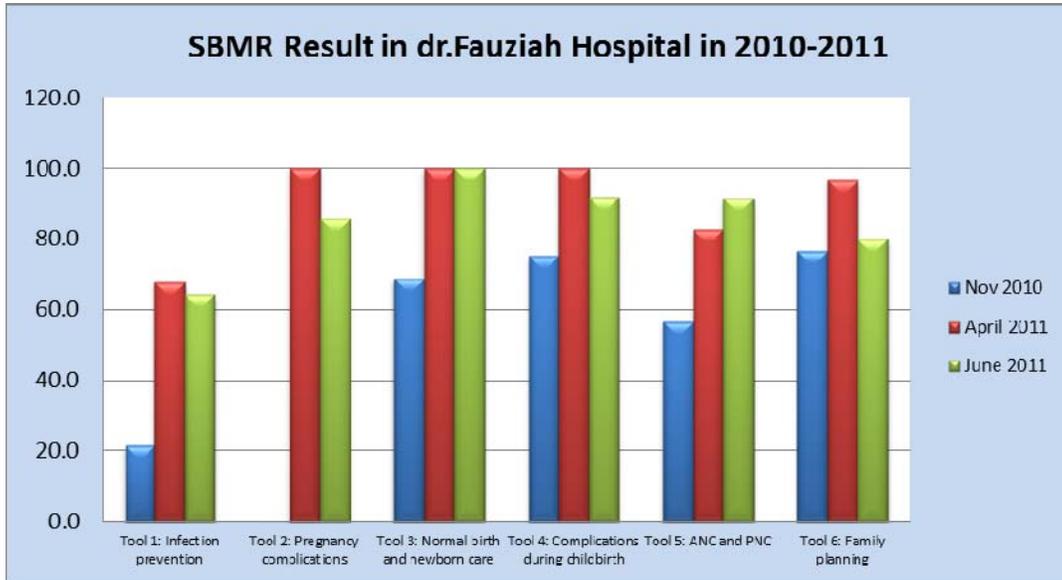
3.5	Lactation Management Training	30	2	28	24	1	23	30	3	27	84	6	78
3.6	Learning Organization Training	24	3	21	15	4	11	22	3	19	61	10	51
3.7	PONED Training	-	-	-	3	1	2	28	0	28	35	1	34
3.8	PONEK Training	4	1	3	4	0	4	4	1	3	4	1	3
3.9	Clinical OJM for health provider	312	0	312	654	64	590	203	1	202	203	1	202
3.10	MNERC Training	NA	NA	NA	NA	NA	NA	10	3	7	10	3	7
3.11	TOT MPA	5	2	3	5	3	2	5	3	2	5	3	2
3.12	MPA Training	15	0	15	67	3	64	119	1	118	201	4	197
3.13	Counseling FP Postpartum	NA	NA	NA	NA	NA	NA	70	0	70	70	0	70
3.14	Emergency drill (OJM)	98	4	94	29	6	23	-	-	-	52	9	43
<b>TOTAL</b>		<b>815</b>	<b>53</b>	<b>762</b>	<b>1020</b>	<b>128</b>	<b>892</b>	<b>713</b>	<b>49</b>	<b>664</b>	<b>1346</b>	<b>141</b>	<b>1205</b>
<b>SO 4: Improved Management of the District Health System</b>													
4.1	TOT Pramusrenbangdes	28	10	18	18	10	8	24	14	10	70	34	36
4.2	TOT DTSP	36	5	31	17	9	8	NA	NA	NA	36	5	31
4.3	PTP Workshop	64	23	41	87	46	41	110	33	77	296	118	178
4.4	DTSP Workshop	26	12	14	26	16	10	45	14	31	97	42	55
4.5	PWS-KIA Orientation	NA	NA	NA	178	40	138	NA	NA	NA	178	40	138
4.6	PWS-KIA Training	100	0	100	126	6	120	40	2	38	251	3	248
4.7	Advocacy Training DTSP-KIBBLA	13	4	9	NA	NA	NA	NA	NA	NA	13	4	9
<b>TOTAL</b>		<b>267</b>	<b>54</b>	<b>213</b>	<b>452</b>	<b>127</b>	<b>325</b>	<b>219</b>	<b>63</b>	<b>156</b>	<b>941</b>	<b>246</b>	<b>695</b>
<b>TOTAL</b>		<b>2,141</b>	<b>123</b>	<b>2,018</b>	<b>2,546</b>	<b>475</b>	<b>2,071</b>	<b>2,376</b>	<b>156</b>	<b>2,220</b>	<b>5,387</b>	<b>532</b>	<b>4,855</b>

'NA'= not part of the workplan

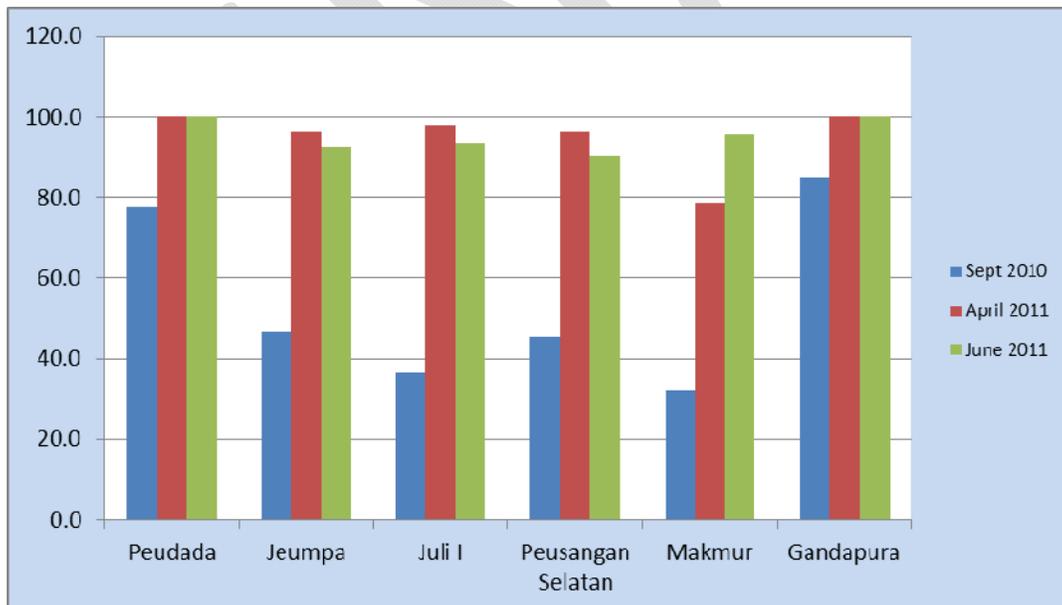
'-' = To be conducted in the upcoming quarters

### Annex 3. SBM-R Result in MCHIP Target Facilities

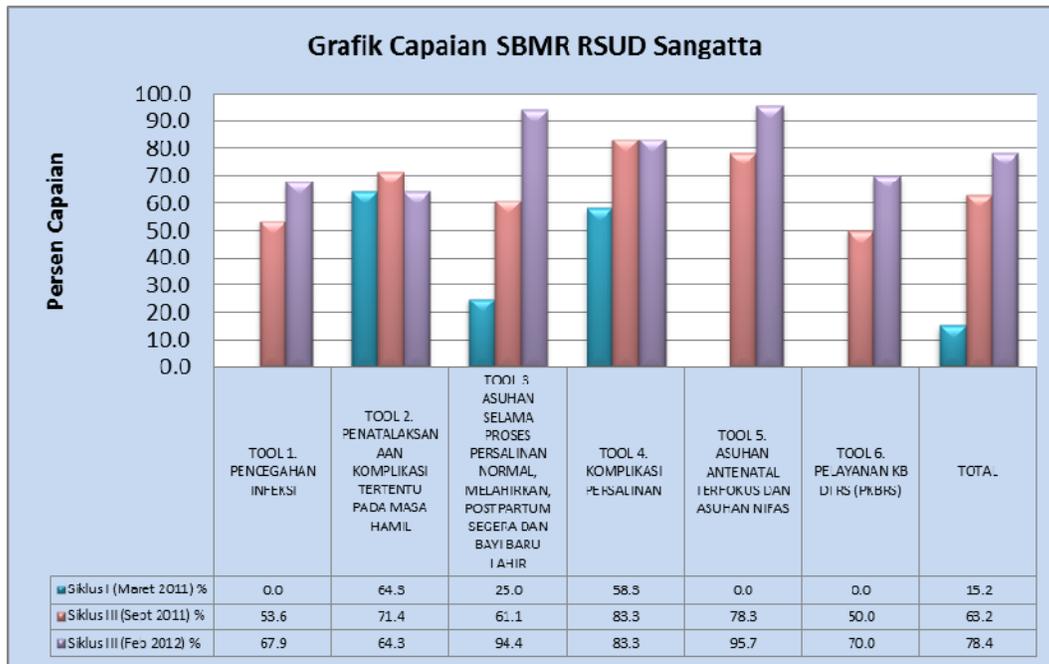
#### 3.1 SBM-R Result in dr. Fauziah Hospital, Bireuen



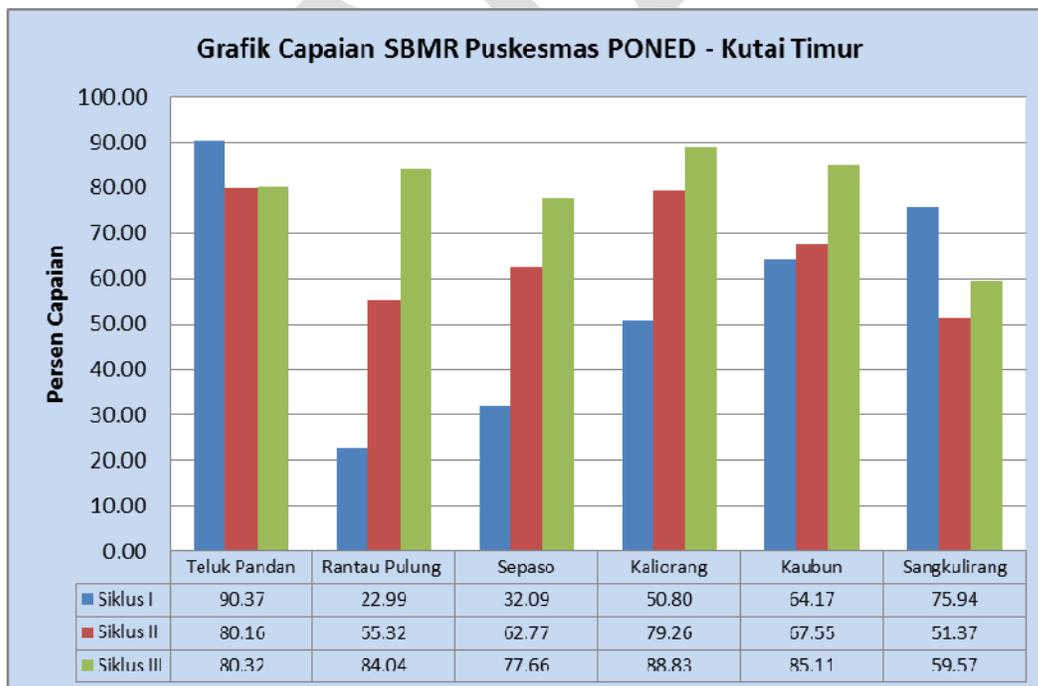
#### 3.2 SBM-R Result in Puskesmas Bireuen



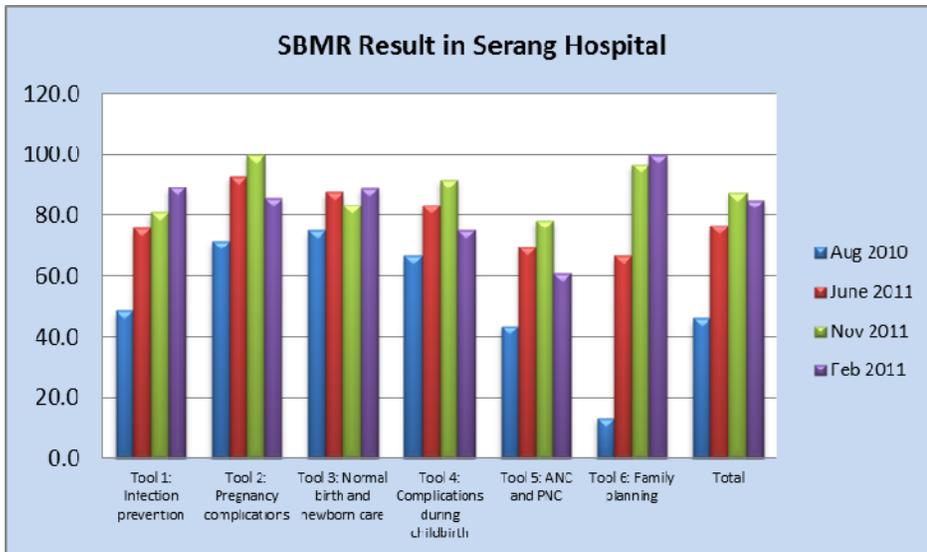
### 3.3. SBM-R Result in Sangatta Hospital



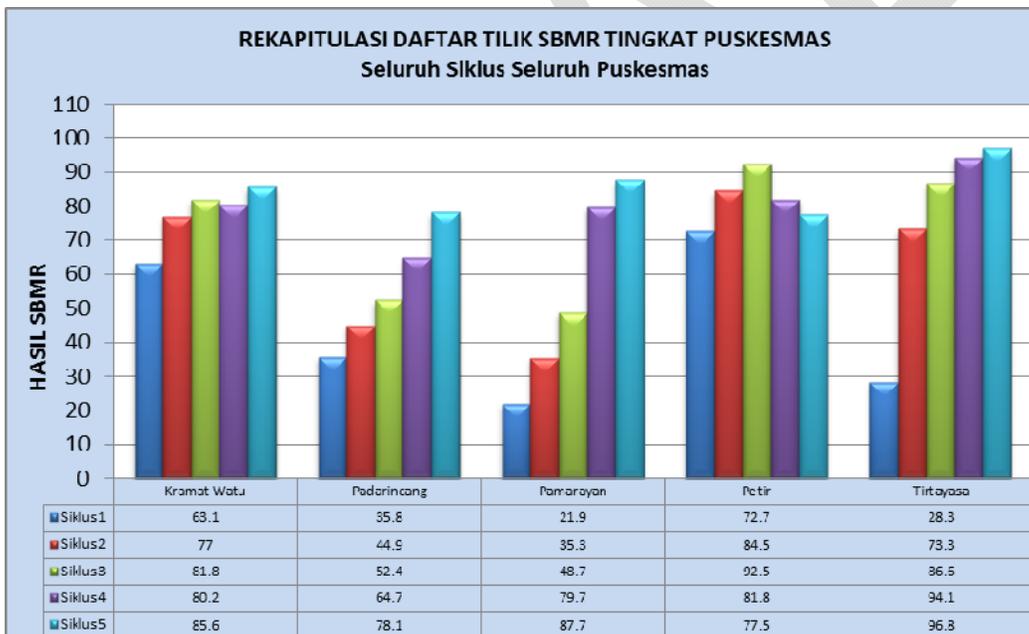
### 3.4 SBM-R Result in Puskesmas Kutai Timur



### 3.5 SBM-R Result in Serang Hospital



### 3.6 SBM-R Result in Serang Puskesmas



### Annex 4. Newsletter Article



