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Table of Content

Table of Content	i
List of abbreviation	ii
List of Figure	iii
List of Annex	iv
MCHIP OVERVIEW	1
I. Major Accomplishments	2
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 province	
a. MDG Road Map	3
b. Mini University	3
c. Resources for replication post-Mini University	7
d. Replication post Mini University	8
Sub-objective 2: Improve Maternal and Newborn Care Practices in the Community. 10	
a. Mother’s classes (Kelas Ibu).....	9
b. Midwife-TBA partnerships	12
c. C-IMCI and community KMC (C-KMC)	14
d. Handwashing for newborn survival	17
e. Integrated Postnatalcare	17
Sub-objective 3: Improve quality of clinical services at all levels of care	
a. Kangaroo Mother Care (KMC)	21
b. Clinical Mentoring and Training	22
c. Improved system for quality assurance	25
Sub-objective 4: Improve Management of the District Health System	
a. Evidence –based Local Planning	29
b. Improved process for conducting maternal-perinatal audits	31
c. Data Management	32
d. Institutionalized commitment for MNCH	33
III. Progress Toward MCHIP Indicators	34
IV. Management	35
ANNEX.	
Annex 1. MCHIP Tracking Indicator	
Annex 2. Training Database Jun 2010 to March 2012	
Annex 3. Electronic Media Publication on MCHIP activities	
Annex 4. Newspaper Publication on MCHIP activities	
Annex 5. SBM-R Result in Serang District	

List of Abbreviation

ADD	: <i>Anggaran Dana Daerah</i>
AMTSL	: Active Management Third Stage Labor
ANC	: Ante Natal Care
APBK	: <i>Anggaran Pendapatan dan Belanja Kota</i>
Bappeda	: <i>Badan Perencanaan Pembangunan Daerah</i>
BEONC	: Basic Emergency Obstetric and Neonatal Care
BKPG	: <i>Bantuan Keuangan Peumakmu Gampong</i>
BOK	: <i>Bantuan Operasional Kesehatan</i>
CCM	: Community Case Management
CEONC	: Comprehensive Emergency Obstetric and Neonatal Care
C-IMCI	: Community Integrated Management of Childhood Illness
CKMC	: Community Kangaroo Mother Care
DHO	: District Health Office
Dirjen	: <i>Direktur Jenderal</i>
Ditjen	: <i>Direktorat Jenderal</i>
DTPS	: District Team Problem Solving
ER	: Emergency Room
FY	: Fiscal Year
GoI	: Government of Indonesia
HIV/AIDS	: Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HWWS	: Hand Washing With Soap
IBI	: <i>Ikatan Bidan Indonesia</i>
IMCI	: Integrated Management of Childhood Illness
IP	: Infection Prevention
IPNC	: Integrated Post Natal Care
JHPIEGO	: John Hopkins Program for International Education in Gynecology and Obstetrics
JNPK	: <i>Jaringan Nasional Pelatihan Klinik</i>
JSI	: John Snow Inc.
KF	: <i>Kunjungan Nifas</i> (Postpartum Visit)
KIA	: <i>Kesehatan Ibu dan Anak</i>
KIBBLA	: <i>Kesehatan Ibu Bayi Baru Labir dan Anak Balita</i>
KMC	: Kangaroo Mother Care
KN	: <i>Kunjungan Neonatal</i> (Neonatal Visit)
LAMAT	: Local Area Monitoring and Trace
LBW	: Low Birth Weight
M&E	: Monitoring and Evaluation
MAWG	: Multi Agency Working Group
MCH-LAM	: Maternal Neonatal Care-Local Area Monitoring
MDGs	: Millennium Development Goals
MgSO ₄	: Magnesium Sulfate
MNCH	: Maternal Neonatal Child Health
MNH	: Maternal and Neonatal Health
MoH	: Ministry of Health
MoU	: Memorandum of Understanding
MPA	: Maternal Perinatal Audit
MPS	: Making Pregnancy Saver
MSG	: Mother Support Group
MSS	: Minimum Services Standard

MU	: Mini University
OJM	: On the Job Mentoring
P2KS	: <i>Pusat Pelatihan Klinik Sekunder</i>
P2PL	: <i>Pencegahan Penyakit dan Penyehatan Lingkungan</i>
P4K	: <i>Program Perencanaan Persalinan dan Pencegahan Komplikasi</i>
PE/E	: Pre-Eclampsia/ Eclampsia
Perbup	: <i>Peraturan Bupati</i>
Perda	: <i>Peraturan Daerah</i>
PHO	: Provincial Health Office
PNC	: Peri Natal Care
PoA	: Plan of Action
Polindes	: <i>Pos Persalinan Desa</i>
POMA	: <i>Pelayanan Obstetri Maternal dan Perinatal</i>
PONED	: <i>Pelayanan Obstetri Neonatal Emergensi Dasar</i>
PONEK	: <i>Pelayanan Obstetri Neonatal Emergensi Komprehensif</i>
Posyandu	: <i>Pos Pelayanan Terpadu</i>
PPNI	: <i>Persatuan Perawat Nasional Indonesia</i>
PTP	: <i>Perencanaan Tingkat Puskesmas</i>
Puskesmas	: <i>Pusat Kesehatan Masyarakat</i>
PWS-KIA	: <i>Pemantauan Wilayah Setempat- Kesehatan Ibu dan Anak</i>
QA/QI	: Quality Assurance/ Quality Improvement
RS	: <i>Rumah Sakit</i>
RSUD	: <i>Rumah Sakit Umum Daerah</i>
SBA	: Skilled Birth Attendant
SBM-R	: Standard Based Management and Recognition
SC	: Save the Children
STIKES	: <i>Sekolah Tinggi Ilmu Kesehatan</i>
TBA	: Traditional Birth Attendant
TOT	: Training of Trainer
USAID	: United States Agency for International Development
USG	: Ultrasonography
VHC	: Village Health Community

List of Figure

Fig 1. Mini-University at a glimpse	4
Fig 2. First Priority Program Selected for Replication in 3 Provinces	5
Fig 3. Priority Program Selected in Aceh Province	5
Fig 4. Priority Program Selected in Kalimantan Timur Province	6
Fig 5: Priority Program Selected in Banten Province	6
Fig 6. Ratu Nur'aini, a facilitator from PHO banten facilitating MPA and MCH-LAM Class in Banten Mini University.....	8
Fig 7. Replication Planning for 3 Province	9
Fig 8: Number of <i>Kelas Ibu</i> in the target and replication sites	10
Fig 9. Pre and Post Test Result for <i>Kelas Ibu</i> in Bireuen, 2011-2012	11
Fig 10. Number of TBA in partnership and Delivery Assistance in 5 Puskesmas, Serang in January-May 2012.....	12
Fig 11. % Delivery by attendance in Serang, January-June 20121	13
Fig 12. % Delivery by attendance in Kutai Timur, January-June 20121	13
Fig 13. C-IMCI Puskesmas, area/ villages and trained midwived in Bireuen for newborn and under five	14
Fig 14. C-IMCI Puskesmas, area/ villages and trained midwived in Kutai Timur for newborn and under five	15
Fig 15. Case findings and treatment for Children under 5 for January-May 2012 in Bireuen and Kutai Timur Districts	16
Fig 16. Case findings and treatments for Newborn for Jan- May 2012 in Bireuen and Kutai Timur Districts	16
Fig 17. Disparity KN2 and KF2 in Bireuen, 2011-2012	18
Fig 18. Disparity KN2 and KF2 in Bireuen, 2011-2012	18
Fig 19. IPNC trend in Serang Sep 11 to May 12	19
Fig 20. Type of partnership With Stakeholders and Partner	20
Fig 21. Midwives competent in AMTSL in August 2011 and Feb 2012	22
Fig 22. SBMR Score and MgSO4 in 5 Puskesmas in Serang District, 2010-2012	23
Fig. 23. MgSO4 Treatment for Severe PE/E in MCHIP Puskesmas in Kutai Timur, March—May 2012	23
Fig. 24: SBM-R Performance Standard at All Levels	26
Fig 25. SBM-R Result at Village Level in Peudada Sub-district, Bireuen District, 2010-2012	26
Fig 26. SBM-R Result in 5 Puskesmas in Serang District, 2010-2012.....	27
Fig 27. Summary of SBM-R achievements in MCHIP target facilities in three districts	27
Fig 28. Number of Births occurring at facilities in Bireuen	28
Fig 29. Number of Births occurring at facilities in Serang	28
Fig 30. Number of births occurring at facilities in Kutai Timur	29
Fig 31. Increasing in Budget allocation for MNCH for all three districts for 2009-2012... ..	30
Fig 32. Percentage of MPA in Three Districs.....	32
Fig. 33. MCHIP Activities July-December 2012	36

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

MAJOR ACCOMPLISHMENTS

1. MDG Roadmap for Serang and Bireuen the MDG roadmap was finalized and submitted to MDG's task force at province level this quarter. For Kutai Timur, the finalization is scheduled for September 2012 by the Provincial Bappeda.
2. MCHIP successfully conducted the Mini University in all three provinces. The districts showed enthusiasm and ownership- and the provinces played an important role in planning for the Mini University. The participants were a total of 657 from 42 districts across three provinces.
3. The goal of the Mini-University was to disseminate the accomplishments of the MCHIP districts and get other districts interested in implementing similar interventions. The Mini-University goals were met- all participating districts selected and prioritized interventions for replication.
4. MCHIP developed resource for replication for the use of facilitators that includes a. guidelines on program implementation; b. facilitators to support implementation; c. becoming a facilitator; and d. conducting a mini-university.
5. All 62 *kelas ibu* in Bireuen, and a large number of *kelas ibu* in Kutai Timur and Serang are now receiving funding from the community fund (ADD and others) for the continuation beyond MCHIP.
6. One of the objectives of *kelas ibu* is to increase the percentage of deliveries occurring at facility, in Bireuen District, the percentage of deliveries at the facility during this period compared with the same period on 2011 increased from 3% (n=1,346) to 19% (n=2,692) and in Serang from 4% (n=3,133) to 15% (5,588).
7. In Serang the TBA midwifery partnership program was expanded from one MCHIP subdistrict to all five subdistricts and from January through May 2012- 88% of the TBAs is now part of the partnership and 34% of the births are being done in the partnership. In Kutai Timur, the percentage of births in the partnership increase from 3% to 19% of all births and decrease in that of births by TBAs only from 25% to 21%.
8. Facility data from 3 districts shows an increase in capacity of the *puskesmas* and hospital to manage severe pre-eclampsia cases by administering magnesium sulphate, the percentage of cases managed in Bireuen and Serang remain 100% this quarter (Serang: 158 in last quarter and 428 up to this quarter; Bireuen: 4 in last quarter and 112 up to this quarter), and increased in Kutai Timur from 50% (n=6) to 77% (n=13) in April to June 2012.

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 facilitated the finalization of the MDG Roadmaps for the three districts for health specifically MDGs 4 & 5 for submission to the Provincial Bappeda. The finalization of the MDG Roadmap for Kutai Timur is scheduled for September 2012 by the Provincial Bappeda. For Serang and Bireuen the MDG roadmap was finalized and submitted to MDG’s task force this quarter.

Meanwhile MCHIP mainly supports MDGs 4 & 5, the finalization other MDGs targets by other sectors before it can be approved by province level become the challenges to finalize MDG’s Road Map.

b. Mini-university .



During April and May, three districts continued with Mini-University preparation. Series meeting with PHO, DHO and stakeholders conducted at province and district levels. MoH also was involved in the preparation to provide direction and input on program implementation and prepared national policy to be presented in panel discussion.

MCHIP conducted mini university to disseminate the guidelines and lessons learnt in each of the MCHIP Provinces (Fig 1). The attendees for the Mini

University were representatives from all districts in the MCHIP provinces. The district team included 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 attended the Mini-University. *Penala Hati*, a consulting agency with expertise in facilitation, assisted MCHIP to plan for and in facilitation of the process.

Fig 1. Mini-University at a glimpse

DESCRIPTION	SERANG	BIREUEN	KUTAI TIMUR
Time/date	30 Apr-2 May	5-7 June	24-26 May
Venue	Hotel Horizon, Bekasi	Hotel Hermes, Banda Aceh	Hotel Mesra, Samarinda
Participants and Facilitators	195	276	186
Districts	7	22	14
Class Facilitator	PHO, DHO, District Hospital Puskesmas, kader and community from MCHIP areas		
Topics	<ol style="list-style-type: none"> 1. MSG 2. TBA-Midwifery Partnership 3. SBM-R and IP 4. MPA and MCH-LAM 5. DTIPS 6. BEONC/CEONC 	<ol style="list-style-type: none"> 1. MSG 2. "POMA" and "Perbup" 3. C-IMCI 4. SBM-R and IP 5. MPA 6. DTIPS 7. KMC 	<ol style="list-style-type: none"> 1. Desa Siaga (including TBA-Midwifery Partnership and MSG) 2. C-IMCI 3. SBM-R and IP 4. MPA 5. DTIPS 6. KMC

Mini University report from three provinces will be provided in separate reports. Highlights from the Mini-University :

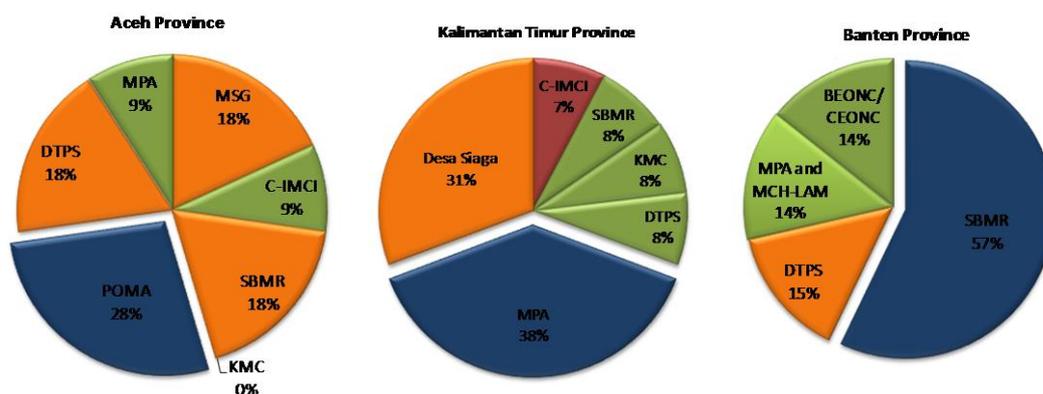
- **The Provinces played an important role in the planning and implementation of the Mini University.** MCHIP's goal was to position the mini-university as a Provincial health office activity. All provinces showed good enthusiasm and support, and have the level of ownership and the role played.
 - Invitation letters and socialization of Mini University amongst districts
Provided input on the development of agenda, invitees list, assigned participants by class
 - Socialization of mini-university to the governor and the secretary
 - Socialization and invitation of mini-university to the other districts
 - Provided cost share for the participants
 - Formal opening and closing of the Mini University
 - Attended and participated in the sessions, in some as co-facilitators.
 - Leadership and coordination in the Mini University committee

- **The district ownership was strong and clearly visible in all three districts.** The district teams were proud and confident when presenting their work. The teams of facilitators selected from the District health office, hospital, puskesmas, and community in each class handled the questions and discussions very skillfully and with diplomacy. The Mini-University was truly a showcase of the district's achievements and efforts and the districts tirelessly advocated for adoption of the programs. The DHO and PHO staff also filled in subordinating roles such as that of the note-taker, session coordinator, etc.

- **Strong Participation from the non-MCHIP districts.** The districts attended the mini-university in large numbers – all districts had representation at the Mini University. The districts were excited to hear about and learn from the MCHIP model district- the district asked questions, expressed enthusiasm and commitment, and in some cases held strong discussions and shared their own experience on why or why not the MCHIP model could be replicated in their area. For example in East Kalimantan, all participants invited attended, no one dropped out, and participants attended all six classes. Figure 2 below shows the priority of the districts for replication. SBM-R in Banten, POMA in Aceh, and MPA in East Kalimantan

are the most requested. The ranking on the program selected is a reflection of the strength of the MCHIP district, as well as the perceived need from other districts. For example, in East Kalimantan, the strength of the community class such as *desa siaga*, influenced by several years of strong community participation and performance in that area culminated in a strong *desa siaga* class at the mini-university. In Aceh, the home grown model of POMA, perceived as an innovative by the team of Bireuen, was accepted as their own by the Acehese. In Banten, the classes that represented strengthening clinical skills and performance, such as the SBMR, BEONC/CEONC came out as the leading choice. In general the ranking of the topics were based on the 1) need of the district; 2) Human resources available; and 3) the budget available. The districts felt that if the program was deemed necessary, funds could be requested for the implementation of the program in the next cycle.

Fig 2. First Priority Program Selected for Replication in 3 Provinces



Below tables shows the complete buy-in programs in three Mini University events selected by other districts. To prepare Training of Facilitator or Training of Trainer, each program is highlighted the first or second priority to be replicated at the first stage due to limited time and resources from MCHIP and replicant.

Fig 3. Priority Program Selected in Aceh Province

No	Kabupaten / Kota	Kelas Ibu	Program					
			MTBS-M	SBMR	POMA	AMP	PMK / PAD	DTPS
1	Aceh Tamiang	1	3	5	7	2	6	4
2	Aceh Tenggara	4		1	2	3	6	5
3	Sabang	2	5	4	1	3	6	7
4	Pidie Jaya	2	3		4	1		
5	Nagan Raya	1	2	3				
6	Langsa	6	5	1	4	2	7	3
7	Pidie	5	3	1	6	4	7	2
8	Aceh Timur	4		2	3			1
9	Aceh Singkil	3		1	2			
10	Banda Aceh	1		2	3	4	5	
11	Simeulue	2	3	6	1	5	7	4
12	Aceh Utara	5	4	2	3	7	6	1
13	Aceh Jaya	4		2	1	5	6	3
14	Aceh Selatan	4	6	5	2	3		1
15	Bener Meriah	5	1	3			2	4
16	Aceh Tengah	2	1			4	3	

17	Lhokseumawe		4	5	3	1		2
18	Aceh Barat	4	3		1	5		2
19	Aceh Barat Daya	3	5	4	1	2		
20	Aceh Besar	6		4	5	2	3	1
21	Subussalam	2		4	1	3	5	
22	Gayo Lues	1			3	2		
Total prioritas 1+2		4+5	2+1	4+4	6+3	2+5	0+1	4+3
		9	3	8	9	7	1	7

Fig 4. Priority Program Selected in Kalimantan Timur Province

No.	Kabupaten/Kota	Desa Siaga	Program				
			MTBS-M	SBMR	PMK	AMP	DTPS
1	Balikpapan	3	5	4	6	2	1
2	Bulungan	1	4	5	6	3	2
3	Berau		1	3			2
4	Tana Tidung	4	1	3	2		
5	Kutai Barat	1	3	4	6	5	2
6	Kutai Kartanegara			3	2	1	
7	Nunukan	1	4	2	5	3	6
8	Penajam	2		1	4	3	
9	Samarinda	2	4	5	6	1	3
10	Malinau	4	3	6	2	1	5
11	Tarakan	1	2				
12	Bontang	2			3	1	
13	Paser	3	4	6	2	1	5
14	Kutai Timur	√	√	√	√	√	√
Total prioritas 1& 2		4+3	2+1	1+1	0+4	5+1	1+3
		7	3	2	4	6	4

Fig 5. Priority Program Selected in Banten Province

No	Kabupaten/Kota	Kelas Ibu	Kemitraan Bidan-Dukun	Program			
				PONED-PONEK	SBM-R dan PI	PWS-KIA dan AMP	Perencanaan dan Anggaran
1	Kab.Tangerang	5	6	2	1	4	3
2	Kab.Lebak			2	1	3	
3	Kab.Pandeglang	6	5	1	2	4	3
4	Kota Tangerang	5	6	2	1	3	4
5	Kota Serang	5	6	4	3	1	2
6	Kota Cilegon	6	5	3	2	4	1
7	Kota Tangsel	5	6	2	1	4	3
Total prioritas 1+2		0+0	0+0	1+4	4+2	1+0	1+2
		0	0	5	6	1	3

Note:  Program prioritas 1

 Program prioritas 2

General Mini University Proceedings

All districts followed a similar structure for the Mini University Processing. Opening and panel discussion on the first day, parallel program sessions on the second day, and 'shopping', and closing on the last day. A Keynote speaker was invited to deliver a compelling and motivating speech,

In Aceh, Moderator: Dr. M.Yadi Mkes, PKK (Head of PHO Aceh); Keynote speaker: Dr. Nila F. Moeloek (President's delegation for MDGs)

In Banten, Moderator: Ratu Nuraini, SKM (Family Health Department, PHO Banten); Keynote Speaker: Dr. Kartono Mohammad (expert in MNCH).

In East Kalimantan, Moderator: Masyitah (PHO Kalimantan Timur); Keynote speaker: Dr. Ema Mulati (MOH).

The classes were held in parallel sessions and participants were pre-assigned to each class. The classes, two hours each, were filled with group activities, motivating video and songs, presentations, compelling testimonial, and discussions. The closing day, the participating districts were invited for a 'shopping' session, where they ranked the programs of their interest for replication.

c. Resources for Replication post-Mini University

In the remaining quarters, MCHIP in addition to completing its' core program activities; will assist in the replication of the programs in the participating districts. MCHIP has developed the following resources and support for program replication:

- **How to implement a program?** Based on the experience of the program implementation, MCHIP has developed a program guideline that lays out the 'how to' of the program implementation and the unit cost for the program. These guidelines were provided to all participants.
- **Who will be the technical experts?** Team of facilitators or champions, handpicked from the district health office, hospital, puskesmas, and the community, and represented the best performing and motivated individuals and program team. The facilitators conducted the classes at the mini-university and shared their program experiences and lessons learned with the districts. The facilitators will be serving as the resources for replication for the other districts- conducting orientation, supporting implementation, monitoring and follow-up.



Fig 6. Ratu Nur'aini, a facilitator from PHO Banten facilitating MPA and MCH-LAM Class in Banten Mini University



- MCHIP districts- from implementer to mentor?** The MCHIP districts have established themselves as the model district. After the Mini-university, and with other districts now looking at the MCHIP district to seek guidance for replication, the MCHIP districts are now finding themselves in the role of a mentor. As MCHIP has limited staff, time, and budget remaining, MCHIP plans to improve the mentoring capacity of the district and one such method is the development of and orientation to the facilitators guideline or how to become a facilitator. MCHIP and PHO/DHO also plans to refresh and add some more facilitators from District and province level. The guideline includes 4 components for benchmarking Integrated MNCH or *KBBLA Terpadu*: (1) What is Integrated MNCH?; (2) How Integrated MNCH can work? ; (3)How Integrated MNCH should be implemented through systematic stages? (4)How to maintain and sustain the Integrated MNCH to be continued by local government?
- How to plan and conduct a Mini-university?** All materials developed for the Mini-University and replication will be housed in a website to allow the districts and provinces to access these when necessary. MCHIP will also track the number of visitors to the site to assess the usefulness of the site.

d. Replication post Mini University

To replicate the program, criteria to be met by the interested districts are: support from Province Health Office, availability of budget for replication, availability of human resources such as the facilitator to be trained by MCHIP districts for each selected program. Figure 4 below outlines the skeleton for replication process for all districts. MCHIP will support the “kick-off” training for each topic only and the continuing activities will be funded by the local budget from the districts. MCHIP will provide technical assistance, monitoring and supervision until the closing-out of the district offices in October 2012.

MCHIP conducted the Mini University and the replication activities in coordination with the MoH. MCHIP counterpart at MoH provided input the Mini University design and attended

the Mini University. The MoH was invited by MCHIP for all the replication sessions- and will further coordinate with the MoH to disseminate the lessons learned and recommendations during the program learning events planned.

Fig 7. Replication Planning for 3 Provinces

No	Activity	Participants	Trainer	Budget	
				MCHIP	DHO/PHO
1	Orientation on MNCH Integrated Program at province level	Facilitators from target districts and provinces	PHO, MCHIP	✓	
2	Training of Facilitator for selected program at province level	Facilitators from replication districts in 3 provinces	Facilitators received Orientation	✓	✓
3	Training for Puskesmas and village facilitator at district level	Facilitators from Puskesmas and Village level	Facilitators from each replication district that received training of facilitator.	✓	✓
4	Program implementation	Non-MCHIP Districts	PHO, DHO		✓
5	Monitoring and evaluation at district level	PHO and DHO MCHIP area visit replication district	PHO, DHO	✓	✓

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 has met its' target for *kelas ibu* and beyond. For the remaining time period MCHIP will provide refresher training for facilitators and advocate for the sustainability of *kelas ibu* utilizing the health operation budget (*BOK- Bantuan Operasional Kesehatan*) to implement the *kelas ibu*. As shown in figure 5, large percentage of *kelas ibu* in all districts are now supported through the community fund (ADD and others) and MCHIP is only providing minimal support. *Kelas ibu* is also in the process of replication within and outside the district. About 10-20USD per month is allocated by the ADD or community funds to support *Kelas ibu* in the village and the cost is food, door prizes, and supplies and sometime refresher training/ training for *kelas ibu* facilitators, and these fundings are sometimes allocated as funding for *Kelas ibu* or also through *desa siaga*. *BOK* funds provide transportation cost for the midwives and the facilitators to attend and supervisor *kelas ibu*.

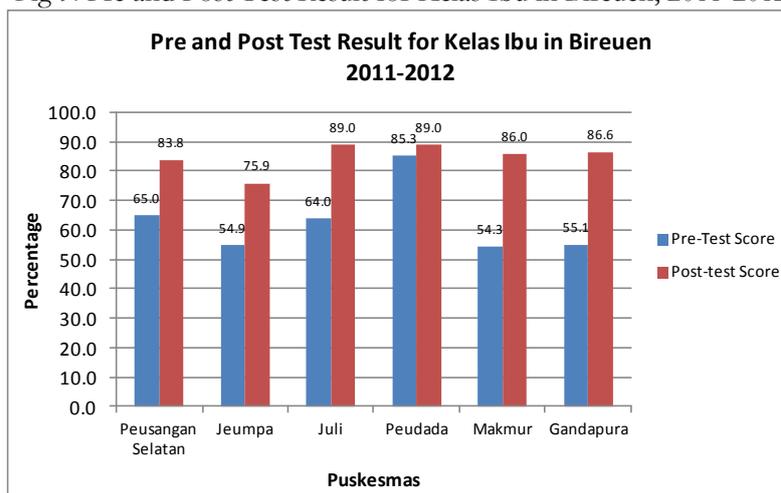
Fig 8. Number of *kelas ibu* in the target and replication sites.

	Bireuen	Kutai Timur	Serang	Total
Number of <i>Kelas ibu</i>	62	42	67	171
Number of target Villages	62	42	66	170
Number of <i>kelas ibu</i> that will receive funding from village and Puskesmas after MCHIP	62 <i>kelas ibu</i> funded by community (not ADD) (MCHIP only supports for stationeries)	31 <i>kelas ibu</i> funded by village (ADD) 11 <i>kelas ibu</i> funded by community (MCHIP no longer support <i>kelas ibu</i>)	(82 new MSG in 7 sub district replication will be funded by BOK budget)	73
Replication within MCHIP district	12 <i>puskesmas</i> (training)	12 <i>puskesmas</i> (training)	65 <i>kelas ibu</i> within 65 target villages Selected by 7 sub-districts in Serang	89
Replication in other districts	Selected by 4 districts (Banda Aceh, Nagan Raya, Gayo Lues, Aceh Tamiang)	Selected by 4 districts (Bulungan, Kutai Barat, Nunukan, Tarakan)	-	

Specific activities in this quarter included:

- In Serang, a refreshing training for *kelas ibu* facilitator was conducted for 166 participants on topic 3 and 4 (Handwashing with soap and maternal danger sign) to be delivered in the coming months.
- For sustainability of the *kelas ibu*, MCHIP Serang facilitated advocacy to BOK budget for impelmentation. In Padarincang subdistrict, there are 3 groups of which 2 are supported by the BOK budget since February 2012, while 1 group is still supported by MCHIP.
- In Bireuen, MSG continued implemented in 62 villages with around 450 participants in total, of which most of the participants are mother with baby (60%) and some pregnant women (40%).
- In Kutai Timur, *Kelas ibu* continue to be implemented in the community, all groups have independent implementation without budget support from MCHIP. From 42 total groups, 31 groups funded by ADD and 11 groups funded by community money. MCHIP continues to monitor by phone the *Kelas Ibu* implementation.
- In Bireuen, refresher training was conducted in April for 164 participants (47 village midwives, 117 kaders) for 6 *Puskesmas*.
- A total of 62 classes in 62 villages in Bireuen completed a series (8 topics) of *kelas ibu*. Results from the series show an increase in participant's knowledge on the topics of *kelas ibu*.

Fig 9. Pre and Post Test Result for Kelas Ibu in Bireuen, 2011-2012



- In Bireuen, a fundraising meeting with DHO and Village Health Committee (VHC) was conducted on May 1. One of the purposes of the meeting was to discuss and identify follow up items to maintain sustainability of community programs such as *kelas ibu*, *Desa Siaga*, and *posyandu* activities. The VHC will continue to lobby with the BKPG (*Bantuan Keuangan Peumakmu Gampong*) team for the village funds and to assign budget for *Posyandu* and *kelas ibu* activities through *Musrenbang* process. BKPG is a program for supporting the village with fund for income generation, health (10%), etc. based on proposal by the community.
- One of the objectives of *kelas ibu* is to increase the percentage of deliveries occurring at facility, in Bireuen District, the percentage of deliveries at the facility during this period compared with the same period on 2011 increased from 3% (n=1,346) to 19% (n=2,692) and in Serang from 4% (n=3,133) to 15% (5,588). While decreasing in Kutai Timur from 33% (n=715) to 15% (n=2,385) since deliveries currently happening in Polindes instead of Puskesmas due to the increasing quality of village midwives.

At the national level: Continue from last quarter in developing MSG flipchart with MoH, MCHIP plans to pilot test these flipcharts in Jhpiego and each of the MCHIP districts in July. In this quarter, MCHIP developed a methodology and checklist for the pilot testing of the flipcharts. Once the pilot tests are complete the MoH plans to distribute the revised flipcharts nationwide.



Challenges and lesson learnt

Besides previous challenges and lesson learnt in last quarter, it is found that:

- There are differences in commitment among *Puskesmas* to allocate budget for *Kelas Ibu* implementation using BOK budget.
- The capacity of *Kaders* in facilitating *Kelas Ibu* is different among the villages and unique between one *Kader* to other.
- There is an emphasis from MOH that Village Midwife is responsible for *Kelas Ibu* implementation with limited *Kader* involvement, while *Kelas Ibu* support by MCHIP uses *Kader* as facilitator.
- The success of *Kelas Ibu* depends on facilitator (*Kader*), support from *Puskesmas* and village leaders, as well as timing and place of activity.
- The 'opening' class which allows the new participants to join in the middle of cycle, needs more attention from facilitators on how to measure participants' knowledge through pre-post test.

b. Midwife-TBA partnerships

To date MCHIP continue strengthened the midwife- TBA partnership and monitoring visits. In Serang, implementation of TBA-midwife partnership in this quarter implemented in additional 4 sub-districts, after Padarincang subdistrict. The monitoring result shows that 88% (n=253) midwife and 12% (n=33) in partnership. Number of delivery mostly assisted by midwife rather than with TBA alone (11%) and in partnership (34%).

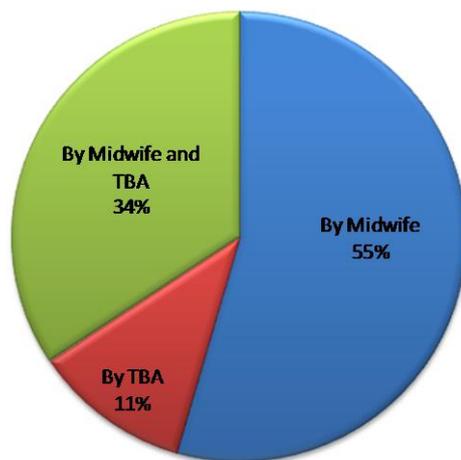
Fig 10. Number of TBA in partnership and Delivery Assistance in 5 Puskesmas, Serang in January-May 2012

#	District	Number of TBA				Number of Delivery					
		In Partnership		NOT in Partnership		By Midwife		By TBA		By Midwife-TBA	
		#	%	#	%	#	%	#	%	#	%
1	Padarincang	84	83%	17	17%	131	25%	92	18%	301	57%
2	Pamarayan	44	100%	0	0%	201	61%	37	11%	94	28%
3	Petir	61	97%	2	3%	268	58%	55	12%	143	31%
4	Kramatwatu	41	79%	11	21%	231	79%	28	10%	35	12%
5	Tirtayasa	23	88%	3	12%	244	68%	9	3%	104	29%
TOTAL		253	88%	33	12%	1075	54%	221	11%	677	34%

- Additionally in Serang, midwife-TBA partnership program is being replicated in non-MCHIP EMAS Puskesmas coverage area (Anyer, Bojonegara, Cikeusal, keragilan, Pontang, Ciomas, Cikande). All 7 Puskesmas have conducted workshop to revise the MoU of the partnership. This is the start of the partnership replication.
- In Bireuen, the TBA Midwife partnership program is replaced by the POMA (Paket pelayanan obstetri maternal perinatal) decree. MCHIP facilitated the development and implementation of POMA in Bireuen. POMA is a new program and not part of the national Program. POMA is a signed contract between the pregnant woman, midwife, and head of the puskesmas. POMA outlines the responsibilities of the service provider (midwife) toward mother and newborn to provide ANC, delivery, and PNC services. The client is responsible for accepting referral to facilities if necessary, and reading and keeping a copy of the POMA services on hand. In this quarter, a team building activity attended by 56 midwives and TBAs. Following messages were reinforced:

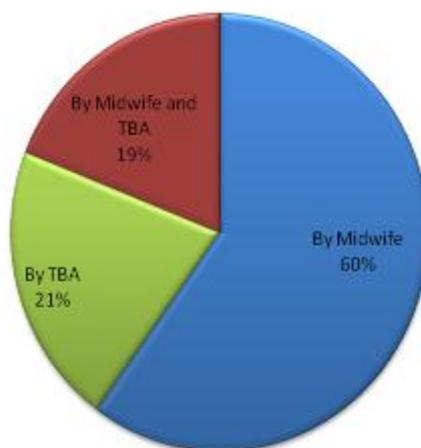
- Referral procedure was from village midwives to higher level health facility such as Puskesmas or Hospital (not to private clinics)
- Village Midwives have to implement the contract with pregnant mothers and fulfill the contents as stated in POMA
- Private Midwives have to report prenatal care for their clients to responsible *Puskesmas* (not to Village midwives) from the first visit up to the post natal care completion- each head of Puskesmas reports to the District Health office for their catchment area.
- Village Midwives & Private midwives have to work together in implementing POMA
- Village Midwives & Private midwives are prohibited from delivering at patients home
- Punishment for violating the rules were warning letter, rejection for insurance claim, and repealing of license.

Fig.11. % Delivery by Attendance in Serang, January-June 2012



After the implementation of the midwife-TBA partnership in five sub-districts, the total in Serang the percentage of delivery by attendance for January through May 2012 showed that births due to bidan and TBA together, as a part of the partnership was 34%, higher than that by TBA, alone (11%). Successful implementation of Midwifery TBA partnership program has contributed to these numbers.

Fig 12. % Delivery by Attendance in Kutai Timur, January-May 2012



From January to May 2012, in the three Sub-districts in Kutai Timur, It was reported that out of 282 total deliveries, 21% (n=282) were assisted by TBA only, 19% were in partnership and 60% were assisted by Midwife only, more than 80% deliveries were assisted by skilled birth attendant. This is an increase from the previous quarter of 72% of SBA, with only 3% in partnership and decrease from the 25% by TBAs only

Challenges and Lessons learned

Besides previous challenges and lesson learnt in last quarter, it is found that:

- The roles of subdistrict and village leaders are important in achieving the partnership and compliance by both midwife and TBA.
- The succesful of partnership is not really depend on the compliance of TBA only, but more on the compliance of midwife in sharing role with TBA.

- c) Village midwife, Puskesmas and DHO still do double reporting on Postpartum care for mother and neonatal, one form is the IPNC form from MCHIP, and the other form is Neonatal Visit (KN) form and Postpartum Visit (KF) form from MoH. Currently, up to national level Postpartum data still reported in MoH form which is separate between Neonatal and Postpartum.
- d) Challenge to convince that IPNC is not the new program but it is the integrated program between Neonatal and Postpartum Visit, the activity that already implement currently by midwife, to increase effectiveness of Neonatal and Postpartum care from health provider.

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, MCHIP provided input toward the national C-IMCI guideline through the Multi-Agency working group. The national C-IMCI guideline will be tested in Berau East Kalimantan in July.

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.

In this quarter, in Bireuen, training for C-IMCI/CKMC was conducted for village midwives in 12 Puskesmas. This training is aimed to scale up the C-IMCI/CKMC program to other subdistrict in Bireuen District. The training was conducted for 4 days (2 days for CCM Underfive and 2 days for CCM Newborn) and the participants were trained by district facilitators from Bireuen DHO. The participants are the midwives Coordinator or IMCI staff- previously trained on IMCI. The participants were trained to be the facilitators and supervisors of C-IMCI so that they can expand the program in their Puskesmas coverage area. The number of trained midwives who can provide C-IMCI in Bireuen district is the same as previous quarter 66 midwives representing 72 villages.

Fig 13. C-IMCI puskesmas, area/villages and trained midwife in Bireuen for newborn and under five.

No	Puskesmas	C-IMCI Area/village (target)	Additional C-IMCI Area/villages	Trained-midwife	Supervisors
1	Gandapura	10	2	12	4
2	Makmur	10	3	10	3
3	Peusangan Selatan	10	2	12	3
4	Juli	10	0	10	3
5	Jeumpa	10	0	8	3
6	Peudada	12	3	14	2
	Total	62	10	66	18

In Kutai Timur, after the under 5 training in January, a C-IMCI Refresher Training was completed for health workers from all 6 sub-districts for Newborn (March) and Under 5 (April). The training was held for 1 day that included updates, simulation and discussion. A pre-test and post-test was performed, and majority of participants scored higher in the post test demonstrating and increase in knowledge.

Fig 14. C-IMCI puskesmas, C-IMCI area/ villages, and trained health worker in Kutai Timur for newborn and under five

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

ii. Supervision

Bireuen and Kutai Timur 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.

These gaps in supervision identified by the STTA in his visit in the previous quarter and has been improved in Bireuen as follows:

- MCHIP is ensuring that birth and postnatal visit data are recorded in the treatment register and monthly summary
- Each *Puskesmas* has a folder for individual village midwives that contain the midwives' monthly report, the completed supervision checklist and the completed mentoring checklist.
- DHO have put funds of CCM-CKMC supervision in BOK (Bantuan Operasional Kesehatan). The suggested periodicity of supervision is monthly at the health facility and 3 monthly on-site. This is the minimum, individual districts and Puskesmas can increase the frequency, if required.
- MCHIP team is ensuring that all *Puskemas* supervisors, Bidans/nurses/*kaders* have all the required registers and checklists.

iii. Case findings

In Bireuen and Kutai Timur, C-IMCI workers (village midwives) will report any case finding of newborn sepsis and LBW into register. At the end of each month, register will be submitted to supervisors at the *Puskesmas* level. The supervisors will compile the case findings into monthly summary. The case that is not managed at village by C-IMCI workers will be referred to the *Puskesmas*.

C-IMCI workers will prepare the referral slip and report it to the supervisor. Currently, MCHIP and DHO are working to improve the data recording at *Puskesmas* level. Challenges identified from supervision for the data recording at the *Puskesmas* level are:

- Quality of data in the treatment register and monthly summary was incorrect
- Some of village midwives submitted the treatment registers beyond the schedule
- The low number of case finding in some village particularly in area where the village midwives do not stay in the village

In Bireuen since July 2011 to May 2012, 44 cases of LBWs were identified in the community and 7 of them were referred to the health facility. The LBWs were delivered at home and at the health facility. Majority of these LBWs were provided with immediate breastfeeding and KMC, as a result most of them gained weight.

Fig 15. Case findings and treatment for Children under 5 for January-May 2012 in Bireuen and Kutai Timur Districts

	Pneumonia	Diarrhea	Dysentery	Fever	Total Cases Identified	Total Treatment Received
Bireuen	28	66	8	44	146	146
Kutai Timur	50	83	5	3	141	141

Fig 16. Case findings and treatments for Newborn for Jan- May 2012 in Bireuen and Kutai Timur Districts

Bireuen District					Kutai Timur District				
	Low Birth Weight	Possibility of Severe Bacterial Infection	Local Bacterial Infection	Total		Low Birth Weight	Possibility of Severe Bacterial Infection	Local Bacterial Infection	Total
Live births				326	Live births				192
Cases identified	17	6	29	52	Cases identified	10	3	29	42
Cases referred	3	6	0	9 (17%)	Cases referred	1	3	0	4 (10%)
Cases treated	15	6	29	50 (96%)	Cases treated	10	3	29	42 (100%)
Cases recovered during this period	15	3	29	47 (94%)	Cases recovered during this period	10	3	29	42 (100%)

Cases were identified for newborn for Bireuen- all 52 cases identified for newborn were treated. Of the cases identified 94% recovered during this period. Cases were identified for newborn for Kutai Timur- all 42 cases identified for newborn was treated. Of the cases identified 100% recovered during this period.

Challenges and lessons learned

- a) 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 still need to be continued as a priority.

- b) Since C-IMCI has a separate reporting and recording system, data on C-IMCI on the birth, postnatal visit, case findings and treatment still difficult to obtain. MCHIP will continue to coordinate through the MAWG on streamlining data collection.
- c) Eventhough IMCI in some of the MCHIP sites has been introduced, but it still need to streghthen to be well function. So that the continuation of referral cases, logistic, drugs and record of C-IMCI program has slowly progress.

d. Handwashing for newborn survival

MCHIP Continue support the HWWS activities at national and district level. On May 5, 2012, MCHIP attended a meeting on Preparation of National Hand Washing With Soap (HWWS) Day Event at Ditjen P2&PL. A few conclusions were (1) National HWWS Day event will take place in Surabaya on October 15, 2012. The event will not only held at Schools but also at Public places, such as: Traditional Markets, Hospitals and other Health facilities, (2) It shall more focus at community level specific to Mother and Child Health which is accordance to RPJMN

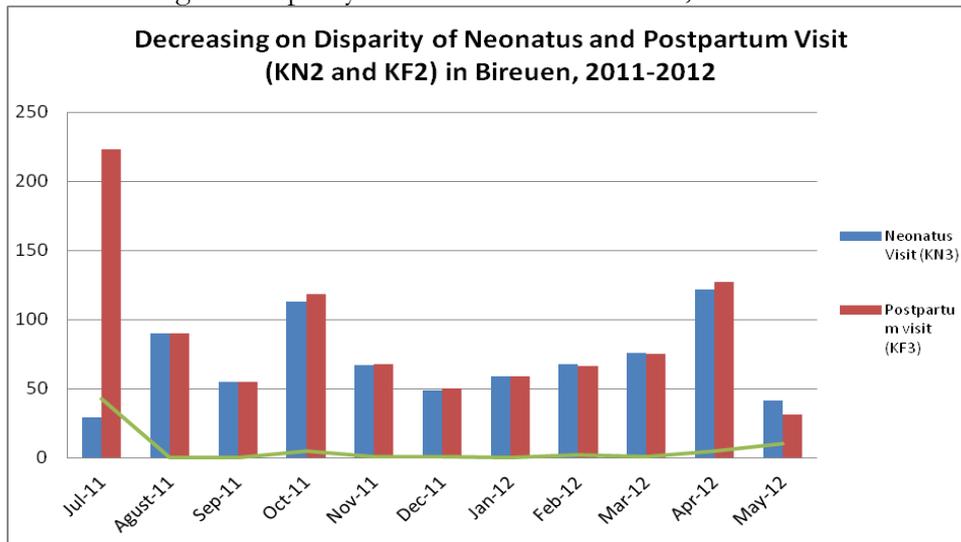
At district level, as part of increasing best health practices of maternal and neonatal at home, MCHIP is continuing to promote Hand Washing with Soap through many activities, for examples, at Kelas Ibu, Posyandu and C-IMCI home visits by teaching care givers on HWWS to prevent neonatal infection

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. The MCHIP developed IPNC form is currently only being used and reported in three districts in addition to the PWS KIA. In Serang IPNC form is used and reported by village, Puskesmas and district level. While in Bireuen and Kutai Timur, IPNC form is used by village midwife for reporting to Puskesmas, but Puskesmas report IPNC to DHO using MCH-LAM form.

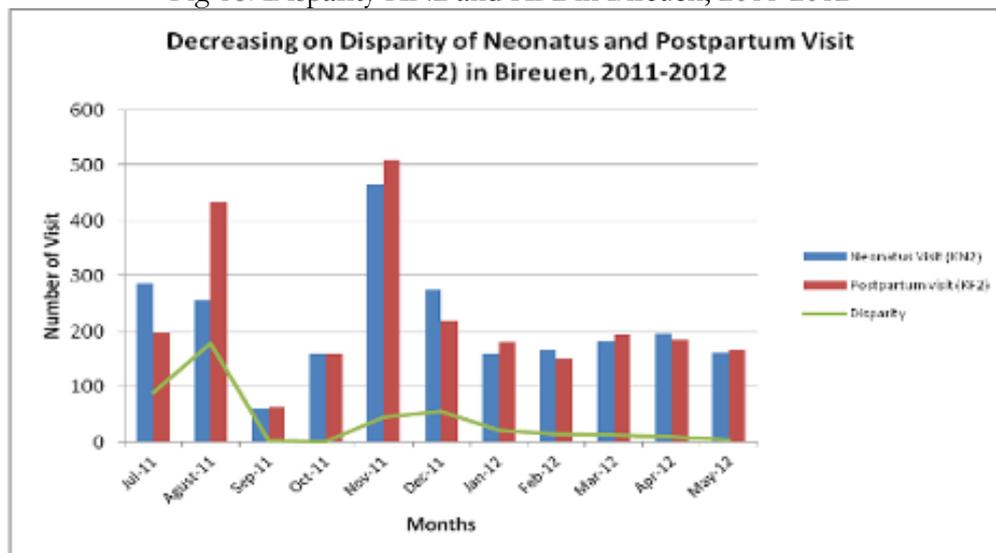
Based on MCH-LAM data in Kutai Timur, there is a decreasing disparity of the neonates and the postpartum visit.- in 2011, disparity between KN3 and KF 3 is 8 visits in average, while in 2012 the disparity has decreased to 3 visit in average. The decrease indicates that larger numbers of visits are happening in an integrated manner.

Fig 17. Disparity KN2 and KF2 in Bireuen, 2011-2012



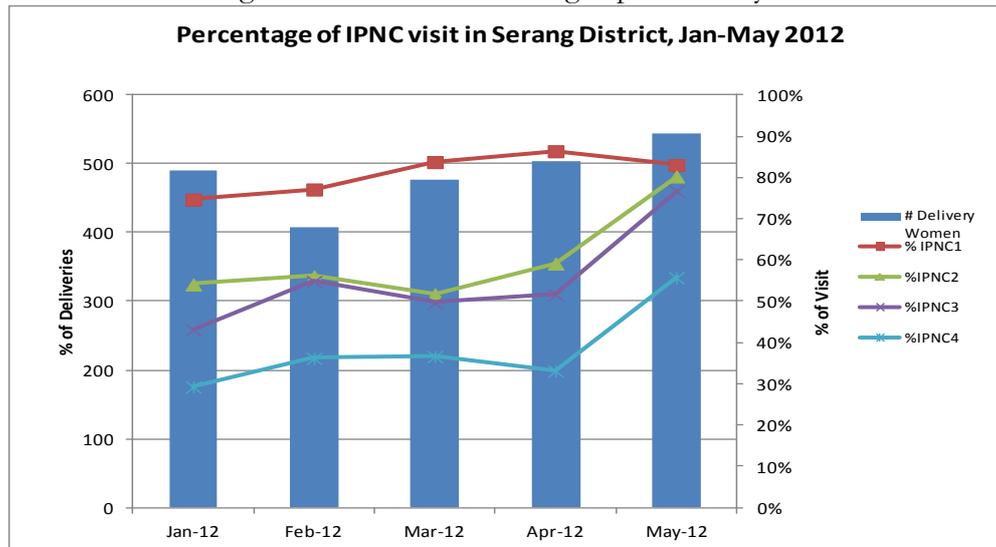
while in Bireuen, there is a decreasing disparity of the neonates and the postpartum visit.- in 2011, disparity between KN2 and KF 2 is 62 visits in average, while in 2012 the disparity has decreased to 12 visit in average. The decrease indicates that larger numbers of visits are happening in an integrated manner.

Fig 18. Disparity KN2 and KF2 in Bireuen, 2011-2012



In Serang MCHIP continued to supported 65 village midwives to conduct home visit for neonatal and postpartum mother (KN and KF) by providing transportation costs. Data from Serang shows an increase in the percentage of IPNC1 from Sep 2011 to May 2012.

Fig 19. IPNC trend in Serang Sep 11 to May 12



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 separately recorded in LAM-MCH. Based on the Minimum Service Standard (MSS) following the new Ministry decree, the quality of PNC should cover the newborn care simultaneously, so that only PNC is the main indicator in MSS. 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 IPNC should have at least 4 visits to cover both post natal and neonatal essential health services. Next quarter, MCHIP developed plan to pilot test the IPNC materials at the midwifery school in Jakarta. The findings from the pilot test will be reported in the next quarter

Challenges and Lesson Learned:

- a) 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 reached 80%, while IPNC 2 and IPNC 3 almost reached the target, but IPNC 4 is still far less than 60%.
- b) Village midwife, Puskesmas and DHO still do double reporting on Postpartum care for mother and neonatal, one form is the IPNC form from MCHIP, and the other form is Neonatal Visit (KN) form and Postpartum Visit (KF) form from MoH. Currently, up to

national level Postpartum data still reported in MoH form which is separate between Neonatal and Postpartum.

- c) Challenge to convince that IPNC is not the new program but it is the integrated program between Neonatal and Postpartum Visit, the activity that already implemented currently by midwife, to increase effectiveness of Neonatal and Postpartum care from health provider.

Community Activities at National Level

MCHIP conducted coordination and cooperation with many different stakeholders and Partners throughout the period of the program, using various methods of workshops, trainings and series of meeting, such as refresher training for health worker and informal discussions at the village, sub district and district level with beneficiaries, local government officials and partners. Below is a table outlining the types of partnerships the program maintained and the activities conducted in cooperation.

Fig 20. Type of partnership With Stakeholders and Partners

Organization	Partnership	Completed activities
Government of Indonesia		
National Government		
MOH Dirjen. Bina Gizi dan KIA	<ul style="list-style-type: none"> ▪ Finalization of IPNC guidelines and job aid for midwife ▪ Finalization of National <i>Kelas Ibu</i> Flipchart 	<ul style="list-style-type: none"> • Conducted series of meeting to finalize IPNC guideline and job Aid and <i>Kelas Ibu</i> topics (I-V) • Procurement process to prepare dummy of IPNC and <i>Kelas Ibu</i> flipchart that would be pilot tested • Conducted pilot testing: <ol style="list-style-type: none"> a) At STIKES Mitra Ria Husada Program Studi Kebidanan for IPNC guideline and Job Aid b) At three MCHIP Districts for National <i>Kelas Ibu</i> Flipchart ▪ Attend meeting on preparation of National HWWS Day ▪ Support on producing IEC materials
Ditjen P2PL	<ul style="list-style-type: none"> ▪ National Hand Washing With Soap Day 	
Local Government		
DHO	<ul style="list-style-type: none"> ▪ Providing support and coordination for all implementation of activities 	<ul style="list-style-type: none"> ▪ As the lead implementer and partner conducted training for health providers (Mother Support Group, C-IMCI/CKMC)
Parliament	<ul style="list-style-type: none"> ▪ Drafting Local Regulation of MNCH (Rancangan PERDA/Qanun KIBBLA) 	<ul style="list-style-type: none"> ▪ Review, public hearing and signing the PERDA
Sub-district and Village	<ul style="list-style-type: none"> ▪ Drafting and Socializing of Perdes (village regulation) 	<ul style="list-style-type: none"> ▪ A total of 56 Perdes have been signed (21 in Kutai Timur and 35 in Serang) ▪ In Bireuen, 62 Perdes on MNCH were drafted and would be signed after the Qanun KIBBLA was signed. Socializations were conducted at Village Community

	Meeting, presented by Head of Sub-district. At the last session, formed of the Alert System to fulfill the P4K program and Perdes mandatory	
Coordination with other players in the sector		
Multi-Agency Working Group	<ul style="list-style-type: none"> ▪ Drafting National guidelines of C-IMCI 	<ul style="list-style-type: none"> ▪ Finalized National C-IMCI guidelines ▪ National C-IMCI guideline would be pilot testing in Berau, Kalimantan Timur (District which is interested to replicate C-IMCI)
Lifebuoy (Unilever)	<ul style="list-style-type: none"> ▪ Reviewing and discussing the hand washing and neonatal infection materials from Unilever on how to proceed and utilize in Indonesia 	<ul style="list-style-type: none"> • Conducted meeting on neonatal materials and program with Lifebuoy that would be used in MCHIP districts

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.

To date, 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

The Serang maternal and newborn ward has moved to the new building – a room for KMC has been identified in the building and is currently being furnished. KMC rooms for mothers are now available in Kutai Timur and under construction in Serang. In Bireuen, budget allocation for additional room to have KMC services available from local government (*APBD* budget). The three districts are using KMC guideline developed by *Perinasia* to implement KMC at facility.

MCHIP in all three sites has ongoing coordination with the District health office to establish link between facility and community KMC so that when patients are discharged from the hospital the midwives in the *puskemas* coverage areas are encouraging and monitoring KMC for these patients. MCHIP will continue to monitor the KMC at the hospitals in coordination with DHO using

monitoring checklist based on KMC guideline. The monitoring checklist encourage link between community and facility in impelmenting KMC program.

In Kutai Timur from January through June 2012, a total of 46 LBW cases were identified at the hospital, of these 19 received KMC at the hospital and all 18 showed an increase in their weight.

Challenges and Lessons learned

- a) 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. 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) 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. 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 for infection prevention, and minor renovations were not longer provided, except in Serang. 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)

Fig 21. Midwives competent in AMTSL in August 2011 and Feb 2012

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%)

In this quarter, AMTSL assesment is still in the second round that conducted in March, while the first assesment was in February. The third assesment will be conducted in September 2012 in all three districts.

ii. Magnesium Sulphate administration

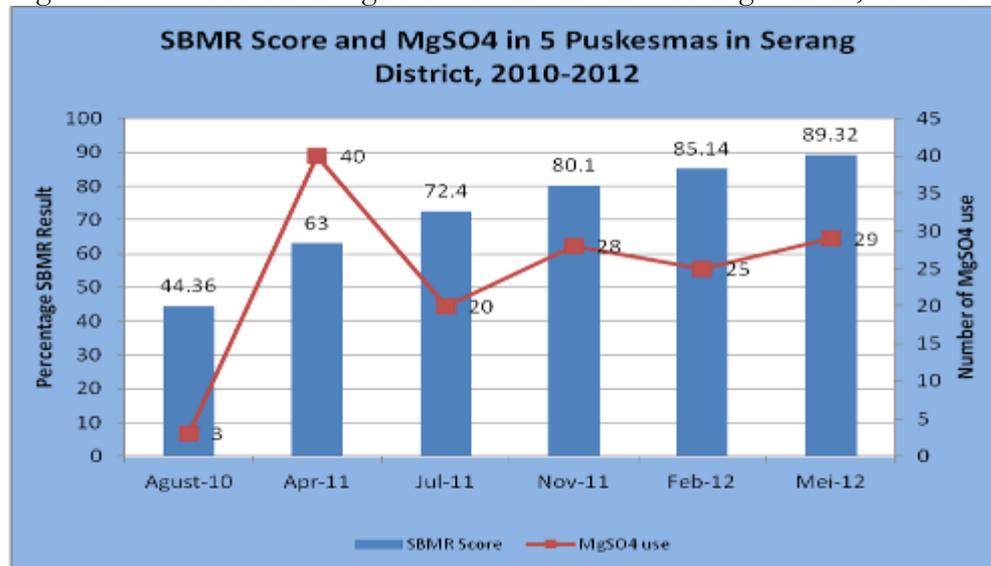
Magnesium sulphate administration to several pre-eclampsia is being supported by MCHIP through the on the job training and mentoring as the part of SBM-R. While there has been an increase in use of magnesium sulphate at the community level esp. in Serang, administration of magnesium sulphate needs to be strengthened. Lack of confidence is cited by midwives and limited cases as deterrent to use of magnesium sulphate.

Facility data from 3 districts shows an increase in capacity of the *puskesmas* and hospital to manage severe pre-eclampsia cases by administering magnesium sulphate, the percentage of cases managed in

Bireuen (Jan-Mar=4 and Apr-Jun=12) and Serang (Jan-Mar=158 and Apr-Jun=270) remain 100% this quarter, and increased in Kutai Timur from 50% (n=6) to 77% (n=13) in April to June 2012.

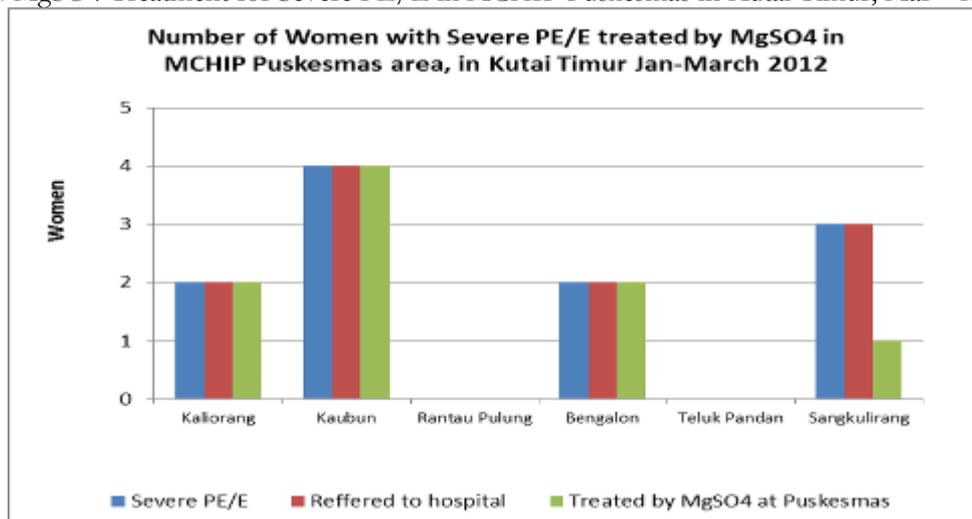
Data from Serang below shows an increase in the use of Magnesium sulphate for severe pre-eclampsia- these include cases that were administered Magnesium sulphate for delivery at the puskesmas as well as prior to referral to the hospital. In general the 5 puskesmas has increased their SBM-R score, as well as the average number of cases per month that receive Magnesium sulphate.

Fig 22. SBM-R Score and MgSO4 in 5 Puskesmas in Serang District, 2010-2012



Data from the six puskesmas in Kutai Timur shows between 0-5 cases of severe PE/E administered before referral to the hospital on a monthly basis starting January 2011. The data from Jan-Mar 2012 for Kutai Timur shows on average 11 cases of severe PE/E at the four puskesmas, most of them received Magnesium sulphate before referred to the hospital. The two puskesmas for Rantau Pulung and Teluk Pandan did not report any cases of severe PE/E.

Fig. 23. MgSO4 Treatment for Severe PE/E in MCHIP Puskesmas in Kutai Timur, Mar—May 2012



In Bireuen, Pre-eclampsia / eclampsia training was conducted for 224 midwives in the six puskesmas coverage areas in May. The midwives at the puskesmas were trained on MgSO4 administration for stabilization and referral.

For Bireuen, MCHIP collected the data from Puskesmas as well as *Polindes* including cases that were referred after being given MgSO₄. The updated data from January to March 2012 included 3 PE/E cases with one being given MgSO₄ and April to June 2012 reported 4 PE/E cases with one being given MgSO₄. The number of cases when compared to the hospital in the same quarter, 2 cases Jan-March and 12 cases April through June 2012..

Other clinical mentoring

- In Serang, midwives of P2KS Cirebon, P2KS Jakarta and P2KS Banten conducted on the job training at 5 Puskesmas. The OJM was conducted for 3 days, with the agenda strengthening Infection Prevention, Delivery and ANC care in day 1; visit Polindes in day 2; follow by partograph, discussion and develop action plan in day 3.
- In Serang, 60 health care providers, include village midwives, Puskesmas midwives, and coordinator midwife participated in strengthening clinical skills on APN, breastfeeding, and AMTSL. 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.
- In Kutai Timur, routine on the job mentoring carried out in MCHIP Puskesmas area for clinical topics include MgSO₄, AMTSL, Infection prevention and also recording and reporting. The mentoring is aimed to increased the capacity of health provider to treat complication.
- On the job mentoring for treatment of Pre-eclampsia/ Eclampsia using Magnesium sulphate was conducted in all three districts. This is third 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. In Bireuen, this was conducted on 17 -18 April which was attended by 65 participants from 18 Puskesmas in Bireuen. On May, A total of 224 midwives & village midwives also received socialization of MgSO₄ through OJM in each of the 6 Puskesmas in Bireuen
- Minor renovation of 4 puskesmas is ongoing 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.

iii. PONED

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, it was planned to join P2KS training in Medan for Bireuen team and in Surabaya for Serang team. All Puskesmas are currently providing PONED 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.

In Kutai Timur and Bireuen, the follow on activity from PONED assessment was held in July and will be reported in the next quarter. In Serang, in this quarter follow up post training PONED conducted for 5 MCHIP puskesmas. On the job mentoring by P2KS conducted for 10 participants in each Puskesmas to improve knowledge and performance of the PONED team.

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 DTPS 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.

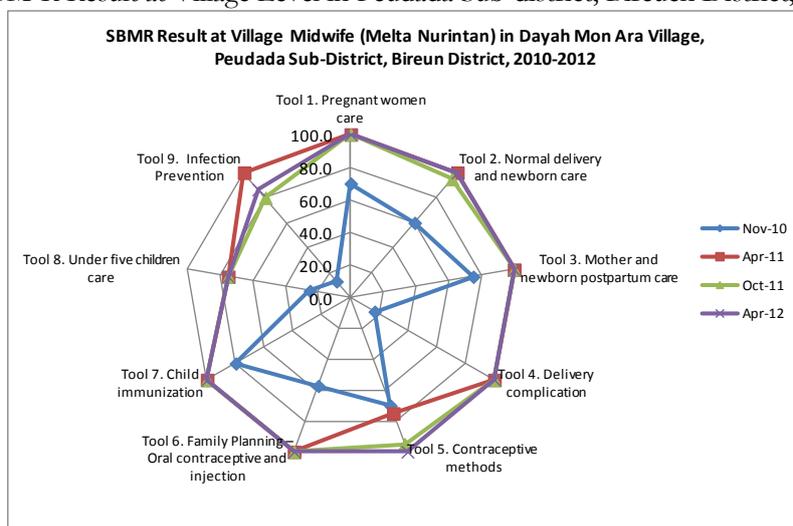
Target hospitals, facilities, midwives in all three districts continued to monitor and recognize their progress using the SBM-R performance standards. At each level the assessments are conducted using the checklist that covers performance standard indicators for areas shown in Table below. The standards 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 24. 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 9. 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 4th to 6th cycles of SBM-R monitoring and data collection. In Bireuen, SBM-R for village midwives has been implemented for the 4th cycles in April 2012. Mostly all tools has reached 100%, except U-5 Children Care and Infection Prevention. It is interesting than IMCI to 75% (Tool 8) but can not be improved until the next round due to unavailable of growth stimulation devises for under five since it need collaboration with Family Planning Board and Education Ministry to provide the devises. Figure below show result of one of midwife in Bireuen for four cycles.

Fig 25. SBM-R Result at Village Level in Peudada Sub-district, Bireun District, 2010-2012



SBM-R has been conducted upto 6 cycles in Serang with a general increase in the achievement in each cycle. In 4 Puskesmas, the result constantly increased, but in Petir Puskesmas the achievement decreased in 4th and 5th cycles due to run out of some logistic and IEC materials, broken equipments, and lack of antibiotics.

Fig 26. SBM-R Result in 5 Puskesmas in Serang District, 2010-2012

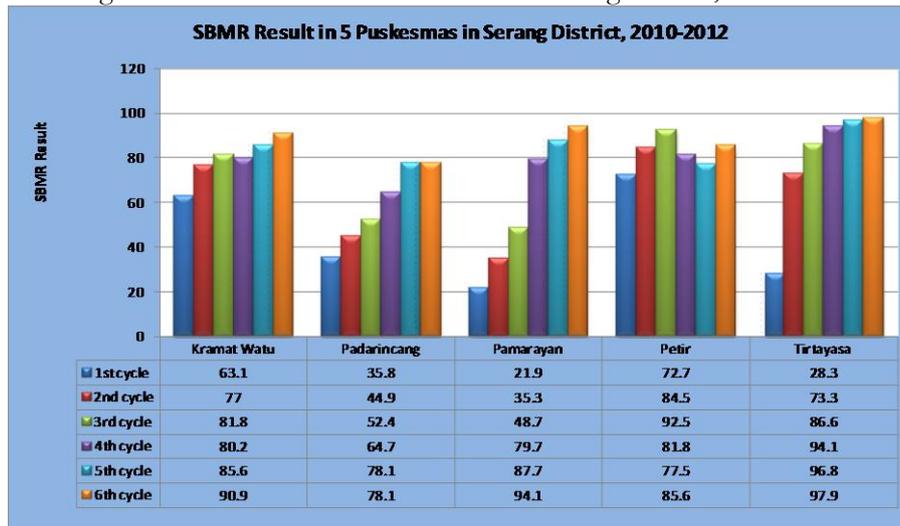
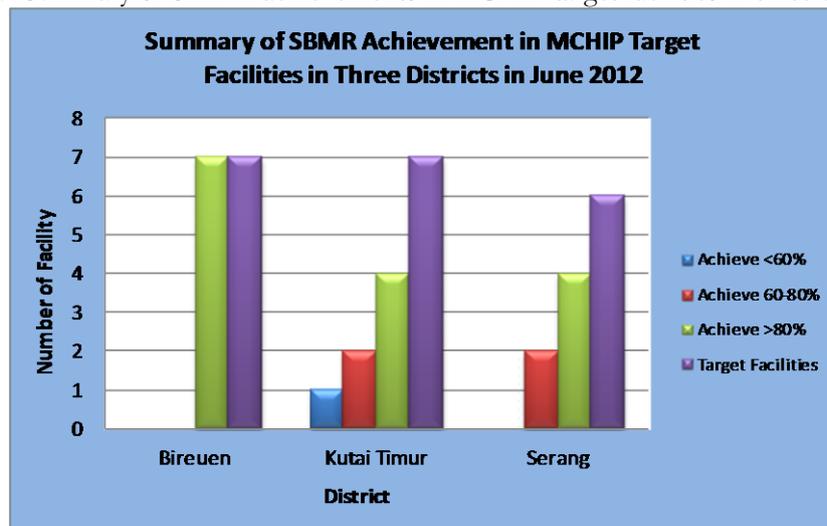


Figure below summarizes the SBM-R achievement for all MCHIP sites to date. Bireuen is leading with all sites complying with more than 80% of the standards. Serang is close with all sites complying with more than 60% of the standards. Kutai Timur has one site, puskesmas Sangkulirang performing under 60% with lower performance in infection prevention and IMCI.

Fig 27. Summary of SBM-R achievements in MCHIP target facilities in three districts



Challenge and lessons learned

- It was understood that SBM-R and supportive supervision, both quality improvement tools, can be implemented in synergy.
- 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 substantial recognition mechanisms that are systematic, such as career pathing for individuals, and superior accreditation for sites needs to be explored.
- 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.

Birth at Facilities

As reported in the PWS/KIA data from the three districts, the management of births occurring at facilities achieved more than 40 percent of all deliveries with skilled birth attendant (89% in Bireuen, 45% in Kutai Timur, 48% Serang) for this quarter. In the previous quarter only 20 to 50 percent of all deliveries with SBA were 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.

Fig 28. 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 187 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 a higher number of births at occurring at the *polindes* that are closer to the population. On a site

visit to two Puskesmas in Bireuen, the Puskesmas felt that delivering at the *polindes* in their catchment area is satisfactory- since the midwives have received similar training and are supervised by the Puskesmas midwife, and have access to the Puskesmas when needed (availability of a transport mechanism and system). For some clients delivery at the hospital has been made more accessible due the availability of the *Jampersal*, 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, thus also keeping the delivery at the Puskesmas relatively low. The MCHIP district hospital in Bireuen is also attending to clients from other sites- one of the districts closer to Bireuen does not have a hospital, so the clients come to the Bireuen district hospital for services.

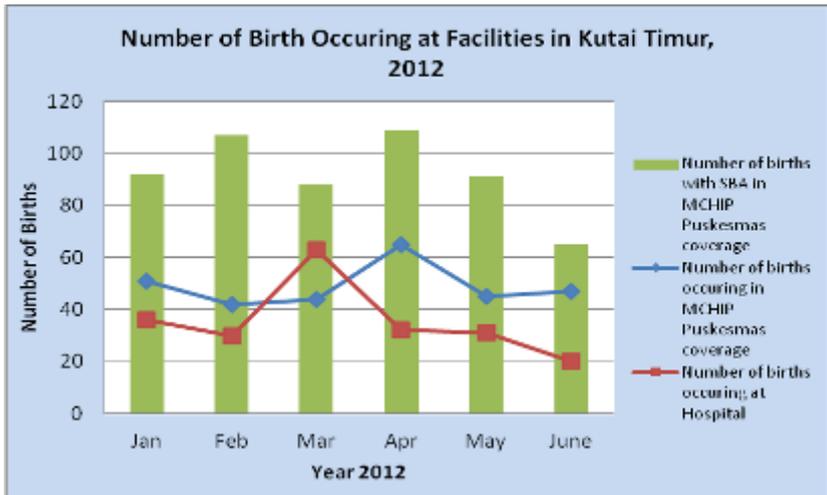
Fig 29. Number of Births occurring at facilities in Serang



In Serang in the five MCHIP Puskesmas coverage areas, the number of births with SBA for January through March is an average of 450 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.

Fig 30. Number of births occurring at facilities in Kutai Timur



In the six MCHIP coverage areas for Kutai Timur, on average 92 births a month is being assisted by the skilled birth attendants, this is equivalent to 55% of all birth in the area. On average 54% of the births assisted by SBA is happening at the puskesmas, this is higher than other MCHIP sites. Unlike Bireuen and Serang, Kutai Timur has limited choices for delivery, the number of private facilities and village midwives are

limited. In Kutai Timur delivery at the hospital is low; referrals from the MCHIP site are also being made to the district hospital in Bontang.

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-level planning at the puskesmas the *Perencanaan Tingkat Puskesmas* or that feeds into the District Team problem solving (DTPS) at the level.

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



district called PTP

district

MNCH

Fig 31. Increasing in Budget allocation for MNCH for all three districts for 2009-2012

Anggaran	2009	2010	2011	2012
BIREUEN				
APBK Kesehatan	18,247,294,630	8,624,443,833	6,366,427,850	12,123,430,900
KIBBLA	86,394,000	52,740,500	0	439,952,000
KUTAI TIMUR				
APBK Kesehatan	37,216,389,468	67,885,271,625	66,387,466,500	67,845,000,000
KIBBLA	1,799,518,760	2,701.955,556	3,600,214,400	4,073,094,450
SERANG				
APBK Kesehatan	69,917,125,762	62,592,023,472	81,854,668,797	67,424,852,607
KIBBLA	8,347,626,000	6,509,138,250	8,185,466,880	7,416,733,787

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 deaths. 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. In this quarter in Serang, DTSPS finalization conducted to finalize the DTSPS document to support local planning at district level (Musrenbang Kabupaten) In Bireuen, advocacy activities carried on for MNCH budget allocation at district level. The budget allocation increased within the last 2 years.

Challenges and lessons learned

- a) Looking at the increasing budget during 2011 and 2012, it is become important to ensure advocacy process for 2013 budget to maintain or increase allocation for MNCH activities. The advocacy will include guide activities for MNCH budget that currently submitted to Parliament to be discussed for priority of the activity and budget ceiling for sectors.
- b) 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.
- 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 outcomes¹. 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 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 early this year. Verbal autopsies are now being conducted and monitored on a quarterly basis. In Serang, MPA was implemented in January with verbal autopsy for maternal and neonatal deaths in MCHIP subdistricts. In this quarter, verbal autopsy for 33 maternal and neonatal death cases was completed by the village midwives and reported to the DHO. These constitute 100% of the maternal and neonatal death cases.

In Bireuen during April to June 2012, there are 8 maternal and neonatal deaths and 17 - all 25 deaths had autopsy verbal. Total cases reviewed by MPA team were 3 maternal deaths and 5 neonatal deaths. One meeting to review maternal and neonatal deaths was conducted in June- series of recommendation developed. Recommendation socialized to 18 Puskesmas as follow up of MPA result- including strengthening of the MgSo4 administration for midwives. In response, MCHIP facilitated a district wide MgSO4 administration strengthening socialization and workshop.

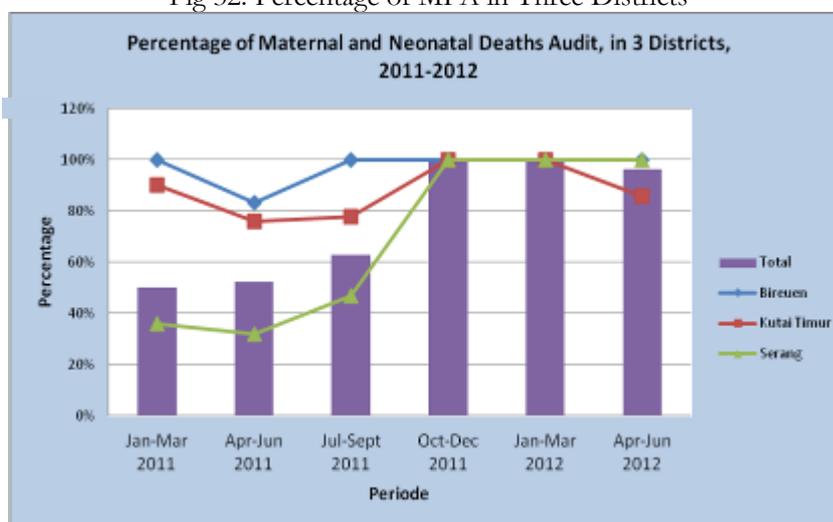
In Kutai Timur, in the previous quarter, MPA Training was completed for the two remaining puskesmas of the six target puskesmas. In these two puskesmas, prior to the MPA training, the old MPA form was being partially completed. A multistakeholder MPA team consisting of the DHO, district hospital, PKK, puskesmas, P2KS, IBI and PPNI was established. In this quarter, Kutai Timur conducted autopsy verbal for 12 (out of 14) neonatal deaths during April- June 2012, no maternal deaths were reported. In Kutai Timur, scaling-up activities for MPA Audits was started in June 2012 with implementtaion of MPA TOT. The training aimed to socialize new MPA approach to health worker, program officer, and other stakeholder in Bontang and Kutai Kartanegara. The two district were using the old version of MPA. Asisted by MCHIP, the two district will implement the MPA revision starting July 2012. In Kutai Timur, series of meeting with MPA team was conducted to

¹Pattinson 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.

develop SK Bupati for the legitimization of the MPA team- the draft was completed and is in process of receiving the approval from the Bupati.

In this quarter, total deaths with autopsy verbal are on average 96% (n=54) for three districts (100% Bireuen, 86% Kutai Timur, 100% Serang). The Autopsy verbal was not conducted for the two deaths in Kaliorang Puskesmas as the team there was engaged in facilitation of the Mini University.

Fig 32. Percentage of MPA in Three 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 recorded, this may seem like the cases are increasing despite MCHIP support in the target districts.
- Verbal autopsies are being conducted along with review of the selected cases, however responsibility for implementing and monitoring the recommended actions is unclear.
- Some recommendation derives from the team can not be fulfilled in the short tem period, but need to be linked with the district annual planning process.

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 implmentation 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 vise 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 imited 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 the 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 Bireuen, a total of 36 participants consisting of Midwife coordinators & MNCH Coordinators from 18 Puskesmas participated on Workshop PWS/KIA & Indicator Analysis that conducted was on May 10 – 11, 2012. Facilitator for the workshop was Andi Yussianto from MOH.

Challenges and Lessons Learned

- a) The recording and reporting system to cover MCHIP program require strong recording and reporting system at district using revised MCH-LAM 2010. The three districts still in the process to adapt the new system at village midwife, Puskesmas and district level, especially at IMCI part.
- b) There are still challenges to integrate target beneficiaries among cross programs (Communicable Disease, MCH, Nutrition, Family Planning, etc.) create confusion in calculate target and achievement among programs.

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. To date, 45 *Perdes* have been developed and signed in Serang, more than the targeted 10. No major activities under this category were conducted in the quarter.

Challenges and Lessons Learned

- a) The changing of leadership will create different approach to do continuing advocacy. For example in Bireuen, new *Bupati* needs to be informed about Integrated MNCH as soon as possible since the last *Bupati*'s involvement was so intence, it would take a long time to reach the same understanding and support from the new *Bupati*.
- b) The socialization of village heads' authority to approve *Perdes* is not maximal so that the head of vilages are too cautious in approving *Perdes*. It need coordination with Legal Bereau at district level for the solution.

Progress toward MCHIP Indicators (See Annex 1)

General MNCH indicators

MCHIP is tracking the progress of four general indicators namely 1) Proportion of women who receive at least 4 ANC visits; 2) Proportion of deliveries with SBA in MCHIP area; 3) Proportion of newborns who receive postnatal visits during the first week of life; and 4) Proportion of women who receive postnatal visits during the first week of life. The MCHIP districts follow a similar pattern for all four indicators with Bireuen leading followed by Serang, both districts either slightly below or exceeding the targets, followed by Kutai Timur performing well below the target. Kutai Timur from the beginning has been the weakest of the three districts due to several factors including but not limited to access to sites resulting from distance, road condition, and availability of fund for transport; weak district health office; lacking midwives in the villages; challenges in data collection and reporting. These challenges still persist- but with MCHIP districts performing at a higher level compared to the non-MCHIP districts (see Annex 2). The specific challenges documented by MCHIP in relation to each of the indicators are as follows:

- All four ANC visits in Kutai Timur - In addition to the challenges mentioned above, the population of Kutai Timur largely consists of labor migration, and the women prefer to return to their mother's house for delivery, which may be in a different district.
- The % of skilled birth attendant is largely influenced by the access issues and the limited availability of midwives in the village. Women prefer to use dukuns for delivery and go to the puskesmas or seek a midwife only in cases of complication.
- The low number of postnatal visits is largely related to access issues and limited availability of midwives in villages.

All districts have met and exceeded the target of 10% of facility births that includes both puskesmas and hospital births. In addition to MCHIP efforts, the socialization and use of Jampersal has contributed toward the increase in facility births.

MCHIP has exceeded the target (by less than 25%) for training with cumulative 7,126 people trained up to this quarter. MCHIP does not anticipate significant increase in this number in the next quarter, as replication processes are underway and most of the core activities are complete.

Subobjective One

Indicator 7) number of subdistricts in MCHIP target districts that receive TA from MCHIP to scale up interventions, MCHIP has exceeded the combined target between Bireuen and Serang. The replication for the subdistricts for Kutai Timur will be initiated in the next quarter. An uptake on the indicator 8) number of districts in MCHIP target districts that receive TA from MCHIP to scale up interventions will be showing an increase in next quarter after the completion of the Mini University this quarter.

Subobjective Two

Under the subobjective two indicator 12) Number of *perdes* established – this number is zero for Bireuen because the approval of the *perdes* hinges on the approval of the Qanun KIBBLA. The Qanun KIBBLA is signed by the Bupati, and in Bireuen with the recent election and change in Bupati, MCHIP recognized the potential of using the Qanun KIBBLA as a vehicle to get the new Bupati aware of and involved in MCHIP. The new Bupati in Bireuen recently signed the Qanun KIBBLA and will be presented in the next quarter.

Subobjective three

For indicator 19) number of district hospitals with Kangaroo mother care established was zero for Serang because the hospital moved recently and the KMC room is yet to be set up.

Subobjective four

For indicator 20) Number of MNCH teams established at district and subdistrict level that meet regularly, there is only one team established at the district level for Bireuen while for other districts there are teams at district and sub-district level. Once the Qanun KIBBLA for Bireuen is approved, the MNCH teams will also be functional at the subdistrict level.

For indicator 24) Local level laws adopted there are only 9 for Bireuen, this is linked to Qanun KIBBLA, as mentioned above once this is approved, the local laws will also be approved and adopted.

MANAGEMENT

MCHIP Audit

MCHIP responded to questions from the auditors this quarter in liaison with USAID. No report has yet been received from the auditors

M&E framework

In the previous quarter MCHIP revised 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. MCHIP has reported on the indicators from the revised M&E framework this quarter.

In addition to summary of M&E indicators, MCHIP is also providing 'Monitoring and tracking tool' that lays out in details progress toward each indicator by quarter, target by quarter, and activities completed in the quarter to contribute toward the indicator. This is a new tool.

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

- Replication post Mini University
- Documentation post Mini University
- Ongoing monitoring and supportive supervision for majority of interventions
- Complete the pilot testing 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 D'TPS process for the 2013 allocation

Fig 33. MCHIP Activities July—December 2012

No	Activity	Bireuen	Kutai Timur	Serang
A. Replication Activities				
1	Orientation on KIBBLA terpadu	Jun	Jun	Jun
2	Training of facilitator for all programs	Jul-Agt	Jul-Agt	Jun-Sept
3	Program implementation	Jul-Sept	Jul-Sept	Agt-Sept
4	Monitoring and supervision	Sept	Sept	Sept
B. Community Activities				
1	Continue MSG implementation	Jul-Sept	Jul-Sept	Jul-Sept
2	MSG supervision and monitoring	Jul-Sept	Jul-Sept	Jul-Sept
3	HWWS Event	-	Oct	-
4	Draft endorse Perdes	Agt	-	Jul-Agt
5	Perdes socialization	Agt-Sept	-	Agt
6	Monitoring midwife-TBA partnership	Sept	Sept	Sept
7	Support IPNC visit in each subdistrict	Jul-Sept	Jul-Sept	Jul-Sept
8	Continue C-IMCI implementation	Jul	Jul-Sept	NA
9	C-IMCI supervision and monitoring	Jul	Jul-Sept	NA
C. Clinical Activities				
1	SBM-R data collection	Agt-Sept	Agt-Sept	Sept
2	PONED strengthening/ training	Agt-Sept	-	-
3	Follow up after PONED training	-	Jul-Agt	-
4	Invite RS Wahidin to RS Sangatta to learn MgSO ₄	-	Sept	-
5	PONEK strengthening/ training	Agt-Sept		
6	AMTSL Assesment	Agt	Agt	Agt
7	Minor renovation and provide basic supplies and equipments	-	-	Jul-Sept
D. Health Management Activities				
1	Continue MPA implementation	Jul-Sept	Jul-Sept	Jul-Sept
2	MPA monitoring and evaluation	Agt	Agt	Agt
3	Review MNCH data	Agt, Sept	Jul-Sept	Jul-Sept
4	Support legal drafting	Agt	Sept	Oct
E. Handover				
	Handover activity in each district	Oct	Oct	Oct

Annex 1. MCHIP Tracking Indicator

No	INDICATOR	Project Target	Apr-Jun 2012			
			Bireue n	Kutai Timur	Serang	TOTAL
Program Objective/Strategic Objective: Increased utilization of quality district-based integrated MNCH services, and practice of healthy maternal and neonatal behaviors in the home?						
GENERAL MNCH INDICATORS						
1	Proportion of women who receive at least 4 antenatal visits*	95%	45%	23%	34%	35%
2	Proportion of deliveries with a skilled birth attendant in MCHIP program areas*	90%	41%	26%	48%	42%
3	Proportion of newborns who receive postnatal visits during the first week of life*	80%	42%	24%	52%	44%
4	Proportion of women who receive postnatal visits during the first week of life*	80%	40%	23%	49%	42%
5	Percentage of births occurring at facilities*	10%	19%	15%	15%	16%
6	Number of people trained in maternal/newborn care through USG supported programs	6,500	2,330	1,878	2,918	7,126
Sub Objective 1: Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces						
7	Number of subdistricts in MCHIP target districts that receive technical assistance from MCHIP for scale up**	17	11	0	7	18
8	Number of districts in MCHIP provinces that receive technical assistance from MCHIP for scale up **	23	0	2	0	14
Sub Objective 2: Improved Maternal and Newborn Care Services and Practices at the Community Level						
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	80	0	48	35	83
13	Number of National level public-private partnerships	1 ppp	NA	NA	NA	3
Sub Objective 3: Improved Quality of Clinical Services at all Levels of Care						
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	Percentage of women who come to target Puskesmas and hospital treated with MgSO4	100%	100%	77%	100%	99%
18	Number of puskesmas PONED treating complications	6	3	6	5	142
19	Number of district hospitals with KMC established	3	1	1	0	2
Sub Objective 4: Improved Management of the District Health System						
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 DTSP and PTP workshop	420	50	50	69	169
22	Number of districts with MNCH plans and budgets linked to DTSP	3	1	1	1	3
23	% of reported maternal or neonatal deaths audited	100%	100% (7 of 7)	86% (12 of 14)	100% (33 of 33)	96% (52 of 54)
24	Number of local regulations and laws adopted	50	9	29	45	83

*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

Annex 2: PWS/KIA data on four general indicators for MCHIP and non-MCHIP districts

Indikator	Project Target	Quarter Jan-Jun	MCHIP / Non MCHIP	Numerator / Denominator	Bireuen	Kutai Timur	Serang	TOTAL	Bireuen	Kutai Timur	Serang	TOTAL		
					Berdasarkan data PWS-KIA				Berdasarkan data laporan bulanan Puskesmas					
Proportion of women who receive at least 4 antenatal visits	95%	48%	MCHIP	Number of women who received four antenatal visits	1320	514	2015	3794	1277	511	2006	3794		
				All pregnant women in MCHIP supported areas (yearly)	2821	2186	5854	10861	2821	2186	5854	10861		
				Percentage	47%	24%	34%	35%	45%	23%	34%	35%		
			Non MCHIP	Number of women who received four antenatal visits	2879	1209	7563	3794						
				All pregnant women in MCHIP supported areas	6600	6487	22878	10861						
				Percentage	44%	19%	33%	35%						
DISTRICT COVERAGE					44.6%	19.9%	33.3%							
Proportion of deliveries with a skilled birth attendant in MCHIP program areas	90%	45%	MCHIP	Number of women who deliver with a skilled birth attendant	1084	510	2665	4360	1103	552	2705	4360		
				All births in MCHIP supported areas	2692	2086	5588	10358	2692	2086	5588	10366		
				Percentage	40%	24%	48%	42%	41%	26%	48%	42%		
			Non MCHIP	Number of women who deliver with a skilled birth attendant	2663	1422	9788	3794						
				All births in MCHIP supported areas	6301	6192	21572	10861						
				Percentage	42%	23%	45%	35%						
DISTRICT COVERAGE					41.7%	23.3%	45.4%							
Proportion of newborns who receive postnatal visits during the first week of life	80%	40%	MCHIP	Number of newborn who received at least two postnatal visits	1092	584	2781	4324	1071	480	2773	4324		
				Number of live births in MCHIP supported area	2564	1987	5322	9296	2564	1987	5322	9873		
				Percentage	43%	29%	52%	47%	42%	24%	52%	44%		
			Non MCHIP	Number of newborn who received at least two postnatal visits	2519	1489	10066	3794						
				Number of live births in MCHIP supported area	6001	5897	20798	10861						
				Percentage	42%	25%	48%	35%						
DISTRICT COVERAGE					42%	19.6%	46.3%							
Proportion of women who receive postnatal visits during the first week of life	80%	40%	MCHIP	Number of women who received at least two postnatal visit at community or facility level	1108	583	2381	4314	1077	487	2750	4314		
				Number of all births in MCHIP supported area	2692	2086	5588	10665	2692	2086	5588	10366		
				Percentage	41%	28%	43%	40%	40%	23%	49%	42%		
			Non MCHIP	Number of women who received at least two postnatal visit at community or facility level	2552	1182	10170	3794						
				Number of all births in MCHIP supported area	6301	6192	21572	10861						
				Percentage	41%	19%	47%	35%						
DISTRICT COVERAGE					36%	19%	46%							

Annex 3. Electronic Media Publication on MCHIP activities

<http://www.tribunnews.com/2012/04/30/usaid-telah-kucurkan-bantuan-sebesar-rp-82-m-untuk-mchip>



<http://www.thejakartapost.com/news/2012/05/01/banten-officials-meet-with-usaid.html>



<http://mediabanten.com/content/usaid-soroti-kesehatan-ibu-dan-anak-banten>



<http://suaramerdeka.com/v1/index.php/read/news/2012/04/30/117013>



Kualitas SDM Tentukan Keberhasilan Penurunan AKI dan AKB

SAMARINDA - Masalah kesehatan ibu hamil dan bayi, terutama yang terkait soal jumlah bayi lahir meninggal dan kematian bayi setelah tujuh hari pertama kelahiran (postnatal) dan kematian wanita ketika hamil, melahirkan atau 42 hari setelah melahirkan (maternal) terus mendapat prioritas utama dalam pembangunan kesehatan kabupaten/kota di Kaltim.

Kualitas sumber daya manusia (SDM) sangat ditentukan oleh keberhasilan pemerintah meningkatkan akses dan kualitas pelayanan khususnya kepada kelompok rentan yaitu ibu, bayi baru lahir dan balita, melalui program Kesehatan Ibu, Bayi Baru Lahir dan Anak (KIBBLA).

"Tingginya Angka Kematian Ibu (AKI) dan Angka Kematian Bayi (AKB), serta lambatnya penurunan kedua angka tersebut menunjukkan bahwa pelayanan kesehatan ibu dan anak (KIA) sangat menciak untuk ditingkatkan lebih akses maupun kualitas pelayanan."

Ujare pengkaltan pelayanan KIA perlu dilakukan bagi para petalokana pelayanan di tingkat

AGENDA PEMPROV KALTIM

- 07.00 Dukung Publik Hari Pendidikan Gedung Fakultas Teknik
- 08.00 Mini University Program Kesehatan Ibu dan Anak (KIBBLA) Prip Kaltim/Kaltimless
- 08.30 Workshop Seram-Ceria GOR Segiri
- 09.30 Pertemuan Komisi DPRD Prov. Jawa Tengah Dengan Pemprov Kaltim Ruang Tegalar
- 10.00 Puncak Peringatan Bulan Gotong Royong Masyarakat IX dan HMG PKK ke-40 oleh Presiden RI Sidiqo (Jatim)
- 14.00 Konvensi an Pameran Tahunan Indonesia Petroleum Association Jakarta
- 19.30 Ganeha Initiative "Peningkatan Pusat Daerah dalam Kerukuh Polis KBMM Alumni ITS Jakarta Selatan

dasar dan rujukan," kata Kabid Kesehatan Masyarakat, Dinas Kesehatan Kaltim, Sum Cahyono, Rabu (23/5).

Dia mengatakan, berbagai upaya untuk menekan AKI dan AKB telah banyak dilakukan menuju pencapaian target Millennium Development Goals (MDG) 2015. Rencana Aksi Nasional (RAN) sebagai acuan dalam penyusunan Rencana Aksi Daerah (RAD) juga telah disusun untuk mempercepat pencapaian target tersebut.

Namun demikian, hasil yang

dicapai belum sesuai harapan, diperlukan upaya ekstra yang lebih terarah, terfokus dan terintegrasi mengingat waktu yang tersisa sudah semakin dekat. Sehubungan dengan itu, Dinas Kesehatan Kaltim bekerjasama dengan United States Agency for International Development (USAID) melalui Maternal and Child Health Integrated Program (MCHIP). Hal ini (Kamis 24/5) akan menyelenggarakan "Mini University" mengenai KIBBLA.

Mini University tersebut merupakan media untuk berbagi

pengetahuan dan pengalaman kader, bidan desa, petugas puskesmas, petugas RS dan Dinas Kesehatan serta stakeholder lain kepada seluruh peserta dan Dinas Kesehatan kabupaten/kota di Kaltim.

"Kegiatan ini merupakan bagian dari Strategi agar kegiatan yang sudah dilaksanakan USAID melalui program MCHIP periode 2010-2012 dapat berlanjut," katanya.

Sementara itu, tujuan utama mini university yaitu landasempunya hasil kegiatan pengembangan model, intervensi dan pembelajaran dari berbagai program bantuan teknis MCHIP. Sedangkan tujuan khusus yaitu diembulkannya informasi hasil kegiatan pengembangan model dalam peningkatan pemroses, peran dan pemberdayaan masyarakat menunjang program KIBBLA.

Narasumber yang akan hadir, diantaranya dan Kementerian Kesehatan, Bappeda Kaltim, USAID, Prof Nita Mobeek, Dirkes Kaltim, Dirkes Kutai Timur dan lain-lain. (Inal/ed)

Gelar Mini University Empat Hari

● Dinkes Kaltim Tawarkan Program Kesehatan Terpadu

SANGATTA, TRIBUN- Selama empat hari dari tanggal 23 sampai 27 Mei 2012, Dinas Kesehatan Kutai Timur bekerjasama dengan program Maternal Child Health Integrated Program (MCHIP) dari United States Agency for International Development (USAID) menggelar kegiatan Mini University program Kesehatan Ibu dan Bayi Baru Lahir dan Anak (KIBBLA). Kegiatan digelar di Hotel Mera International Samarinda.

"Kegiatan ini akan diikuti oleh perwakilan 14 kabupaten/kota di Kaltim, khususnya Dinas Kesehatan dan SKPD terkait lainnya," kata Kepala Dinas Kesehatan Kaltim, dr. Marten Luthar, Rabu (23/5) kemarin.

Lebih lanjut ia mengatakan kegiatan Mini University merupakan sosialisasi program KIBBLA yang telah dilaksanakan di semua kecamatan di Kaltim dalam

kurun waktu 2 tahun pelaksanaan program. "Terapan keenam, dengan ekspose program kesehatan terintegrasi di Kutim yang telah merolek menerapkannya di enam kabupaten/kota lain di Kaltim. Terutama dengan penyediaan di masing-masing daerah," jelas Marthen kepada sejumlah wartawan.

Sejarah program yang akan ditampilkan di antaranya program dua sias, yaitu ibu, kemiskinan dan haid, MTRM, SBML, AMP Audit Maternal Perinatal, juga DTPS. "Rencana program tersebut sudah kita lakukan di semua kabupaten selama 2 tahun. Nah, selama 2 hari ini akan kita presentasikan kepada peserta," paparnya.

KIBBLA, lanjut Marthen adalah strategi untuk

penyediaan program MCHIEV Development Goal (MDG 5) untuk poin 4 dan 5 yang juga sejalan dengan visi dan misi Dinas Kesehatan Kaltim. Yaitu terwujudnya masyarakat Kutai Timur yang mandiri untuk hidup sehat.

"Kesehatan harus diawali dengan adanya ibu dan keselamatan bayi dan anak," katanya. Marthen berharap kegiatan yang akan di buka oleh Asisten III Setprov Kaltim ini akan bisa diwujudkan oleh kabupaten/kota lain di Kaltim.

"Harapannya semua kabupaten/kota akan mengambil program ini. Itu yang saya dengar, MCHIP ini akan akan menjadi terdapat sistem untuk kabupaten/kota yang memprogram salah satu dari enam program yang ditawarkan," kata Marthen. (ed)

Pemprov Tekan Angka Kematian Ibu dan Bayi

SAMARINDA - Program Kalimantan sebagai menekan Angka Kematian Ibu (AKI) dan Angka Kematian Bayi (AKB) akan menggelar target Millennium Development Goals (MDG) Tahun 2015 dengan menargetkan penurunan lima persen (5%) dari angka kematian ibu dan anak. Hal ini akan diwujudkan melalui upaya kepada seluruh peserta dan Dinas Kesehatan kabupaten/kota di Kaltim.

"Kualitas SDM khususnya personal masa dengan dibekali keterampilan yang akan meningkatkan akses dan kualitas pelayanan di wilayah kabupaten/kota yaitu ibu, bayi baru lahir dan balita dengan meningkatkan pelayanan kesehatan ibu dan anak secara terpadu serta dan berkesinambungan bagi semua petalokana pelayanan kesehatan di Kaltim hingga tingkat pelayanan rujukan," kata Gubernur Kaltim dr. H. Marthen Luthar yang akan membuka kegiatan Mini University Program Kesehatan Ibu dan Bayi Baru Lahir dan Anak (KIBBLA) di Kabupaten Kutai Timur di Samarinda, Kamis (24/5).

Gubernur mengatakan, masalah kesehatan ibu dan anak dan bayi adalah masalah yang paling mendasar yang dihadapi oleh masyarakat. Oleh karena itu, pemerintah akan melakukan upaya untuk meningkatkan kualitas sumber daya manusia (SDM) melalui program kesehatan ibu dan anak.

Martheny, berbagai upaya untuk menekan AKI dan AKB telah dilakukan, mulai dari upaya pencegahan target MDG Tahun 2015. Rencana Aksi Nasional (RAN) yang akan dilaksanakan sebagai acuan dalam penyusunan Rencana Aksi Daerah (RAD) juga telah disusun untuk mempercepat pencapaian target tersebut.

Namun demikian, hasil yang dicapai belum sesuai harapan. Diperlukan upaya ekstra yang lebih terarah, terfokus dan terintegrasi mengingat waktu yang tersisa sudah semakin dekat. Sehubungan dengan itu, Dinas Kesehatan Kaltim bekerjasama dengan United States Agency for International Development (USAID) melalui Maternal and Child Health Integrated Program (MCHIP).

Hal ini merupakan media untuk berbagi pengetahuan dan pengalaman kader, bidan desa, petugas puskesmas, petugas RS dan Dinas Kesehatan serta stakeholder lain kepada seluruh peserta dan Dinas Kesehatan kabupaten/kota di Kaltim.

"Kegiatan ini merupakan bagian dari Strategi agar kegiatan yang sudah dilaksanakan USAID melalui program MCHIP periode 2010-2012 dapat berlanjut," katanya.

Sementara itu, tujuan utama mini university yaitu landasempunya hasil kegiatan pengembangan model, intervensi dan pembelajaran dari berbagai program bantuan teknis MCHIP. Sedangkan tujuan khusus yaitu diembulkannya informasi hasil kegiatan pengembangan model dalam peningkatan pemroses, peran dan pemberdayaan masyarakat menunjang program KIBBLA.

Narasumber yang akan hadir, diantaranya dan Kementerian Kesehatan, Bappeda Kaltim, USAID, Prof Nita Mobeek, Dirkes Kaltim, Dirkes Kutai Timur dan lain-lain. (Inal/ed)

Mini University adalah 100 peserta terdiri dari kabupaten/kota yang terdiri dari Dinas Kesehatan, Bappeda, dan RSUD, PNI Pro, Dinas Kesehatan Masyarakat, Perkesmas, dan Persegi Program IA. Dengan koordinasi dan koordinasi di tingkat Kabupaten, Kota, Kecamatan, Puskesmas, dan Dinas Kesehatan Kabupaten/kota. (Inal/ed)

USAID Gelontorkan 9 Juta Dolar AS

● MCHIP Dorong Penurunan Angka Kematian Ibu dan Bayi

SAMARINDA, TRIBUN- The United States Agency for International Development (USAID) dan Dinas Kesehatan Kutai Timur menggelar seminar di Ruang Pertemuan Mera International Samarinda, Kamis (24/5). Dalam seminar "Mini University" ini, menghadirkan program Kesehatan Ibu dan Anak (KIBBLA) oleh USAID dan MCHIP (Maternal Child Health Integrated Program).

Selama 2011, program USAID MCHIP telah membantu lebih dari 45 ribu ibu hamil dan bayi baru lahir di 177 desa di Provinsi Aceh, Banten, dan Kaltim. Rencananya akan dilakukan ekspansi program ini ke seluruh Kalimantan. Untuk itu, akan digelar Mini University program kesehatan ibu dan anak yang akan berlangsung selama dua hari di Samarinda.

Anna Hiron, selaku Country Director BIRN/USAID dan Kepala Dinas Kesehatan Kutai Timur mengatakan, USAID sangat bangga bermitra dengan pemerintah provinsi dan daerah untuk mengurangi beban pembangunan melalui

dukungan program kesehatan ibu dan anak tahun 2011.

"Kualitas kesehatan ibu dan anak sangat penting untuk memastikan bahwa generasi mendatang akan tumbuh dengan sehat dan kuat," kata Anna Hiron, Kepala Dinas Kesehatan Kutai Timur dan Koordinator Program MCHIP.

USAID dan MCHIP telah membantu lebih dari 45 ribu ibu hamil dan bayi baru lahir di 177 desa di Provinsi Aceh, Banten, dan Kaltim. Rencananya akan dilakukan ekspansi program ini ke seluruh Kalimantan. Untuk itu, akan digelar Mini University program kesehatan ibu dan anak yang akan berlangsung selama dua hari di Samarinda.

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Hal ini merupakan media untuk berbagi pengetahuan dan pengalaman kader, bidan desa, petugas puskesmas, petugas RS dan Dinas Kesehatan serta stakeholder lain kepada seluruh peserta dan Dinas Kesehatan kabupaten/kota di Kaltim.

"Kegiatan ini merupakan bagian dari Strategi agar kegiatan yang sudah dilaksanakan USAID melalui program MCHIP periode 2010-2012 dapat berlanjut," katanya.

Sementara itu, tujuan utama mini university yaitu landasempunya hasil kegiatan pengembangan model, intervensi dan pembelajaran dari berbagai program bantuan teknis MCHIP. Sedangkan tujuan khusus yaitu diembulkannya informasi hasil kegiatan pengembangan model dalam peningkatan pemroses, peran dan pemberdayaan masyarakat menunjang program KIBBLA.

Narasumber yang akan hadir, diantaranya dan Kementerian Kesehatan, Bappeda Kaltim, USAID, Prof Nita Mobeek, Dirkes Kaltim, Dirkes Kutai Timur dan lain-lain. (Inal/ed)

Annex 5. SBMR Result in Serang District

