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Final Program Report

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Maternal and Child Health Integrated Program (MCHIP)/Indonesia

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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Abbreviations and Acronyms

ADD	<i>Anggaran Dana Daerah</i>
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
APBK	<i>Anggaran Pendapatan dan Belanja Kota</i>
Bappeda	<i>Badan Perencanaan Pembangunan Daerah</i>
BEmONC	Basic emergency obstetric and neonatal care
BKPG	<i>Bantuan Keuangan Peumakmu Gampong</i>
BOK	<i>Bantuan Operasional Kesehatan</i>
CCM	Community case management
CEmONC	Comprehensive emergency obstetric and neonatal care
C-IMCI	Community integrated management of childhood illness
C-KMC	Community kangaroo mother care
DHO	District health office
DHS	Demographic and health survey
Dirjen	<i>Direktur Jenderal</i>
Ditjen	<i>Direktorat Jenderal</i>
DTPS	District team problem-solving
ER	Emergency room
FY	Fiscal year
Gol	Government of Indonesia
HHS	Household Health Survey
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health management information system
HWWS	Handwashing with soap
IBI	<i>Ikatan Bidan Indonesia</i>
IMCI	Integrated management of childhood illness
IDHS	Indonesia Demographic and Health Survey
IP	Infection prevention
IPNC	Integrated postnatal care
JNPK	<i>Jaringan Nasional Pelatihan Klinik</i>
JSI	John Snow, Inc.
KF	<i>Kunjungan Nifas (postpartum visit)</i>

KIA	<i>Kesehatan Ibu dan Anak</i>
KIBBLA	<i>Kesehatan Ibu Bayi Baru Lahir 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
MgSO₄	Magnesium sulfate
MNCH	Maternal, neonatal, and child Health
MNH	Maternal and neonatal health
MoH	Ministry of Health
MoU	Memorandum of understanding
MPA	Maternal perinatal audit
MPS	Making pregnancy safer
MSG	Mother support group
MSS	Minimum services standard
MU	Mini-University
Ob/gyn	Obstetrician/gynecologist
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	Perinatal care
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	Quality assurance
QI	Quality improvement
RS	<i>Rumah Sakit</i>
RSUD	<i>Rumah Sakit Umum Daerah</i>
SBA	Skilled birth attendant
SBM-R	Standards-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

Executive Summary

The main goal of the Maternal and Child Health Integrated Program (MCHIP) in Indonesia was to facilitate the uptake of evidence-based and integrated maternal, newborn, and child health (MNCH) programs and policies at the district level. The United States Agency for International Development (USAID) awarded the global flagship maternal, newborn, and child health program, or MCHIP, to Jhpiego and partners in 2009. The USAID mission in Indonesia bought into the global MCHIP mechanism in 2010, as a two-year program for USD 4.8 million that was later extended to three years for a total of USD 9.8 million. In Indonesia, Jhpiego—with implementing partners Save the Children (SC) and John Snow, Inc., and a host of local institutions—collaborated with the Ministry of Health (MoH) and district health offices (DHOs) to design and implement a dynamic and innovative approach to providing technical assistance to the MNCH program in three selected program districts. Officially launched in June 2010, MCHIP served as the bridge between the two USAID MNCH bilaterals—Health Services Program (HSP) and Expanding Maternal and Neonatal Survival (EMAS)—as the former ended in 2010 and the latter was initiated in 2011. This report presents the design, rationale, results, challenges, and lessons learned as a part of the technical assistance provided to the MoH and DHOs.

There are several observations regarding reasons why Indonesia still has one of the highest maternal and newborn mortality rates in Southeast Asia, despite significant development success. One of the observations is that, at the central level, Indonesia has several evidence-based policies, materials, tools, and high-impact approaches that have been developed, introduced, and endorsed by the MoH over the past decade. Yet, few remote districts have succeeded in implementing these policies. To address this gap, MCHIP was tasked with demonstrating how integrated, high-impact MNCH approaches can be scaled up throughout the remote districts. The MoH and MCHIP selected three districts that ranked low in the MoH composite index for development and community health—classified as “Health Problem Areas.”

MCHIP facilitated the implementation of MoH-approved, community-based programs—such as *Kelas Ibu* (health information classes for pregnant women and mothers) the Traditional Birth Attendant (TBA)-Midwife Partnership, and Handwashing with Soap (HHWS)—in 17 sub-districts across the three districts with an estimated population of 507,000, which included 11,000 pregnant women and 10,000 newborns in 2010.¹ In addition to these MoH-approved programs, MCHIP also modeled new programs such as Community Case Management (CCM) and Integrated Postnatal Care (IPNC). These community-based programs were designed to increase the demand for and awareness of key MNCH messages and services. Lessons learned from these community health programs were funneled up to the national level to enhance the national guidelines, policies, and job aids. For example, *kelas ibu* materials and job aids were updated based on MCHIP experiences of *kelas ibu* implementation; and national guidelines for IPNC and CCM were adapted to the Indonesian context.

To meet the demand for MNCH services, MCHIP facilitated the strengthening of three district hospitals, 17 *puskesmas* (community health centers), and 185 midwifery practices using a quality improvement approach called Standards-Based Management and Recognition® (SBM-R). All facilities and midwifery practices complied with 80% or more of the evidence-based MNCH standards. For the midwives who are frontline health care providers, lifesaving skills such as active management of the third stage of labor (AMTSL), management of pre-eclampsia/eclampsia, and essential newborn care were reinforced through on-the-job training and supportive supervision. As a result, 100% (400) of the midwives observed showed

¹ Indonesia 2010 Population Census; District Health Profile 2009/2010

compliance with standards in all three steps of AMTSL; the majority of women with severe pre-eclampsia and eclampsia cases at the *puskesmas* received magnesium sulfate before referral; and at the three district hospitals, approximately 46% (302) of low birth-weight (LBW) babies received kangaroo mother care (KMC)—with 66% (199) of the LBWs that received KMC showing an increase in weight.

MCHIP also facilitated strengthening of the district health management system. After political decentralization in 2001, the districts were provided the autonomy to lead and manage their health programs. However, districts are lacking in the technical resources and management capacity to do so. MCHIP facilitated the rollout of the District Team Problem-Solving (DTPS) process to ensure evidence-based planning and budgeting for district-level programs. As a result, the districts saw an increase in the percentage of allocation in the total district budget toward MNCH. Maternal and perinatal audits to conduct verbal autopsies of 100% of all the maternal and newborn deaths and review of selected cases, ranging from the community to the district level, were facilitated by MCHIP in all three districts. And finally, to ensure that the MNCH programs are sustained over time, MCHIP facilitated the development and adoption of 148 MNCH local laws and regulations called *perda*, *perdes*, and *qanun*.

To disseminate accomplishments of and lessons learned from the MCHIP districts in adopting the national MNCH programs, as well as to generate interest of other districts and provinces, MCHIP facilitated a Mini-University² in each of the three districts. The provincial government and provincial health offices were linked in to the effort. As a result of the dissemination, all 42 participating districts (100% of the districts in the three MCHIP provinces) showed interest in replication, 34 of these districts participated in a training-of-facilitators event for their requested program, and 20 of the 34 districts requested and received technical assistance from the MCHIP districts to establish or revitalize their MNH programs.

The program approach, deliverables, and resources described in this report serve as a roadmap for the districts and provinces to replicate the integrated MNCH programs nationwide.

² The Mini-University is a showcase of MNCH programs implemented by MCHIP districts, imparted in a classroom-type setting. The participating districts learn from the MCHIP districts' program implementation experience and commit toward implementation of similar programs in their districts.

Major Achievements

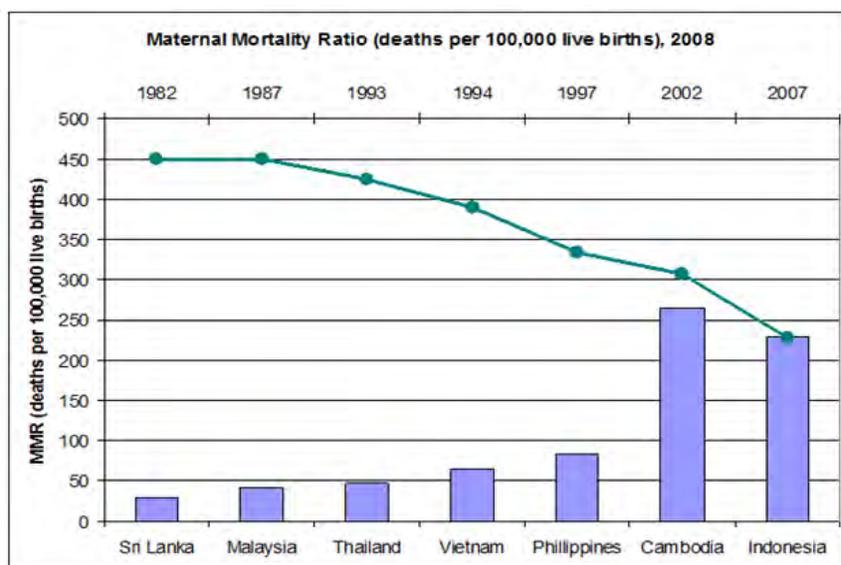
- Increased the actual number of deliveries assisted by skilled birth attendants by 28% and facility-based deliveries by 20% in MCHIP-assisted sites.
- Increased the proportion of newborns who receive postnatal visits during the first week of life by 6% and mothers who receive postnatal visits during the first week postpartum by 10%.
- Decreased the proportion of births attended by TBA by 5% and increased the number of births attended by TBA-midwife partnerships by 14% in two of the three MCHIP-assisted sites.
- At the MCHIP-assisted hospital in Serang, increased the proportion of maternal and newborn cases successfully managed in the emergency room by 7% and 10%, respectively.
- Contributed to reaching an estimated 12,025 mothers and pregnant women through the mother support group, or *kelas ibu*, platform with maternal and newborn health messages.
- Provided on-the-job mentoring and/or training to a total of 5,335 providers and community health workers on various clinical and non-clinical skills related to maternal, newborn, and child health.
- A total of 46% (302) of the low birth-weight babies born reportedly received kangaroo mother care, and 66% (199) of those who received KMC showed an increase in weight in the MCHIP-assisted sites.
- Assisted all three MCHIP districts in submitting an allocation request for MNCH funding based on real need. In two of the three districts, allocation for MNCH, as a part of the MoH budget, increased by 12%.
- Tested a new community case management model for children 2 to 59 months of age (pneumonia and diarrhea) and infants less than 2 months of age (newborn sepsis) delivered by community midwives.
- Assisted the passage of *perda* in two MCHIP districts, *perbub* in one MCHIP district, and *perdes* in 85% of the MCHIP villages. These are laws that represent commitment of the local government to MNCH and may lead to sustained allocation of resources over time.
- Conducted dissemination of the program findings and experiences in the form of mini-universities in three provinces and Jakarta. The dissemination events were attended by 657 personnel, including: health officials at the provincial, district, and central levels; stakeholders such as *Bappeda* (National Planning Board); several departments from the MDGs Special Envoy Office and MoH; local and international NGOs; and representatives from UN agencies.
- As a result of the dissemination, all 42 participating districts (100% of the districts in the three MCHIP provinces) showed interest in replication, 34 of these districts participated in training-of-facilitators events for their requested program, and 20 of the 34 districts requested and received technical assistance from the MCHIP districts to establish or revitalize their MNH programs.

Introduction

There has been a steady decline in maternal mortality in Indonesia over the last decade; however, Indonesian women continue to die during childbirth at an unacceptably high rate. Based on the most recent data from the demographic and health survey (DHS) for 2007, the maternal mortality ratio (MMR) is 228 deaths for every 100,000 live births—the highest rate among countries in the region (Figure 1). Using the direct sisterhood method,³ the Government of Indonesia (GoI) estimates that the MMR will be 195 in 2015; other measurement methods—such as PMDF (proportion of maternal deaths in females of reproductive age)—indicate that the MMR could be between 264 and 285 by 2015.⁴ The United Nations Children’s Fund (UNICEF), World Health Organization (WHO), United Nations Population Fund (UNFPA), and World Bank’s most recent estimates put the MMR in Indonesia at 420 by 2015.

With the MMR at 228, Indonesia is not on track to meet the Millennium Development Goal (MDG) 5, reduction of the MMR to 102 per 100,000 live births, by 2015. Over the last 14 years, the causes of maternal deaths have changed in Indonesia—with declining rates of postpartum hemorrhage (PPH). In the 1995 Household Health Survey (HHS), 43% of deaths were attributable to PPH, while the 2002 HHS attributed 30% of deaths to this cause. However, national figures do not reveal individual provincial differences, ranging from 54% of deaths in South Kalimantan and 34% of deaths in West Sumatra.⁴ Eclampsia, abortion complications, sepsis, prolonged labor, and anemia are the other main causes of maternal mortality over time in Indonesia.

Figure 1: MMR in Southeast Asian Countries



Despite its growing economy, Indonesia has one of the highest MMR among Southeast Asian countries.

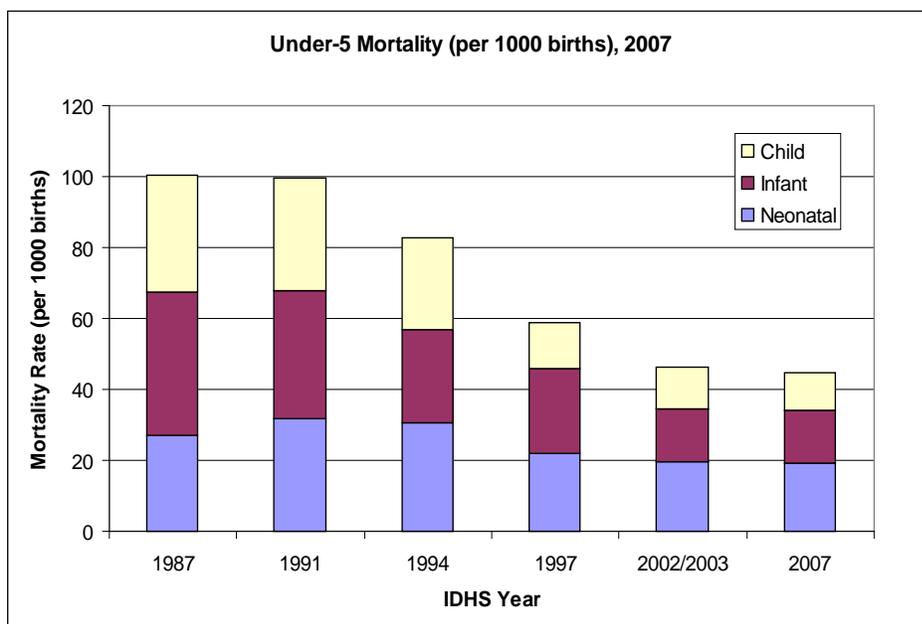
Source: Hogan et al. 2010. Maternal mortality for 181 countries, 1980-2008: A systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 6736(10):60518-1; IDHS Data 1994, 1997, 2002, 2007; Summary Report – Millennium Development Goals. 2007.

³ The sisterhood method is an indirect measurement technique of the kind frequently used for a variety of demographic parameters which has been adapted to maternal mortality. It reduces sample size requirements because it obtains information by interviewing respondents about the survival of all their adult sisters. These guidance notes are intended for health policy-makers and planners who wish to estimate levels of maternal mortality, but who may not be familiar with the different approaches available and the strengths and weaknesses of each. They are not intended to provide detailed technical guidance on how to carry out sisterhood studies.

⁴ Indonesia National Planning Board 2007

Although Indonesia has made significant progress toward reducing overall child (under five years of age) mortality, newborn mortality rates have remained stagnant and are responsible for the majority of all child deaths (Figure 2). Unless the newborn mortality rate is reduced further, Indonesia will not meet its MDG for reducing child mortality by two-thirds by the year 2015.

Figure 2: Under-Five Mortality over Time



Despite these gloomy predictions, the GoI and the Ministry of Health (MoH) are committed to accelerating the progress toward MDGs 4 and 5. The Indonesian health system has a tiered approach, representing a continuum of care from village and sub-district level health facilities, up to district and provincial public hospitals. At the sub-district level, 8,000 primary health centers (*puskesmas*) are nominally equipped to provide services, each covering around 30,000 people. *Puskesmas* are supported by over 20,000 satellite health centers (*pustu*), village-based maternity centers (*polindes*), and community health posts (*posyandu*). While this provides a system that should routinely collect health data, the reporting and publishing of routine health data dropped off after the decentralization in 2001.

Indonesia's frontline health provider for MNH services is the village midwife or *bidan di desa*. The GoI initiated the village midwives program in 1989 to increase community access to skilled birth attendants (SBAs). There are 80,000 midwives in Indonesia (World Bank 2009). Not all villages have midwives and the concentration varies, as many prefer to live in or near urban areas. The skills of midwives have also declined, with some having no hands-on experience delivering babies, due to the unregulated proliferation of midwifery schools. Midwives at the community level are supported by *kaders*, or community health workers, who could be men or women (with limited or no education) from the community. In communities where there are no midwives, *kaders* may play a larger role in providing maternal, newborn, and child health (MNCH) services. Obstetrics and gynecology (ob/gyn) specialists are in short supply in Indonesia: 10 of the 33 provinces have fewer than seven ob/gyn specialists each, and one province has only one registered ob/gyn specialist. The majority of deliveries in Indonesia are conducted by the midwives, with ob/gyn specialists handling less than 10% of the births.⁵

⁵ IDHS 2007

There are several observations regarding the reasons why the maternal and infant mortality rates have not decreased as anticipated despite decades of intervention. One of the observations is that, at the central level, Indonesia has several evidence-based policies, materials, tools, and high-impact approaches that have been developed, introduced, and endorsed by the MoH over the past decade. Yet, few remote districts have succeeded in implementing these policies. Several factors contribute to this problem, including decentralization, lack of skilled providers, lack of infrastructure, limited capacity of the central MoH to provide guidance and monitoring of the programs—among others. USAID/Indonesia and the Director General for Community Health invited the Maternal and Child Health Integrated Program (MCHIP) to join the MoH in its efforts to demonstrate how integrated, high-impact MNCH approaches could be scaled up throughout remote districts (of which the MoH maintains a list). Expansion of the national MNCH programs into these remote areas became MCHIP’s mandate.

MCHIP/Indonesia was a USAID- funded, three-year program from January 2010 to December 2012, with a budget of USD 9.8 million. This program was implemented by Jhpiego, in collaboration with Save the Children and John Snow, Inc. (JSI). In support of the MoH Roadmap to the 2015 MDGs, MCHIP/Indonesia was implemented in three districts that rank low in the MoH composite index of development and community health and are classified as “Health Problem Areas”: Serang District in the Banten Province; Kutai Timur District in the East Kalimantan Province; and Bireuen District in the Aceh Province.

PROGRAM GOALS AND OBJECTIVES

The overall objective of the program was to catalyze implementation of existing policies that promote key **evidence-based, lifesaving interventions at scale** in remote areas. To achieve the program goals, MCHIP inputs contributed to four sub-objectives (see Figure 3 for a graphic representation of the “Results Framework”):

1. Effective implementation of MDG Roadmap for scaling up lifesaving 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 the district health system

Sub-Objective 1 was added in April 2011, to accommodate scaling up of lifesaving interventions throughout the three target provinces. (Accordingly, Sub-Objective 1 is covered last in the report, following Sub-Objectives 2 through 4.)

Figure 3: MCHIP Results Framework

Sub-Objective 1 (Cross-Cutting): Effective Implementation of MDG Roadmap for Scaling up Lifesaving Interventions to Achieve MNCH Impact at Scale within Three Remote Provinces.		
Results: <ul style="list-style-type: none"> • 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	Sub-Objective 3: Improve Quality of Clinical Services at All Levels of Care	Sub-Objective 4: Improve Management of the District Health System
Results: <ul style="list-style-type: none"> • Expanded use of lifesaving 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 	Results: <ul style="list-style-type: none"> • 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 	Results: <ul style="list-style-type: none"> • 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

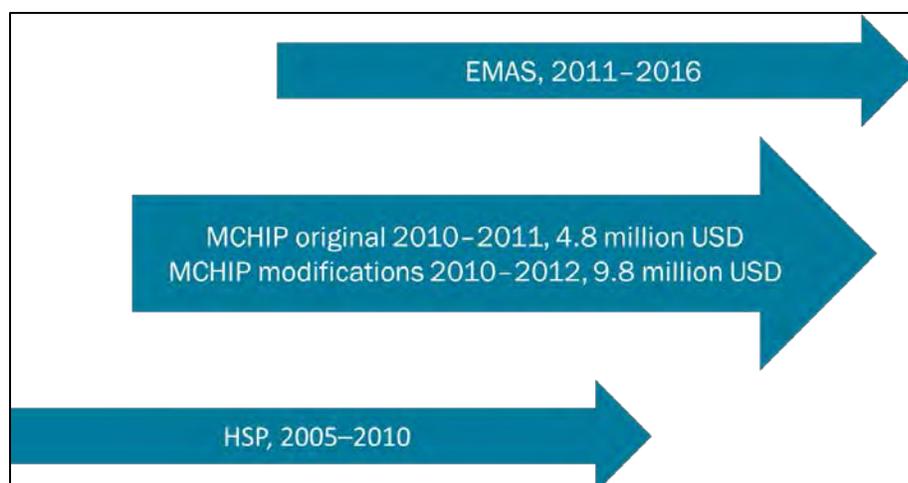
PROGRAM DESCRIPTION

Program History

The original program description, entitled “Strengthening Maternal and Newborn Health in Indonesia,” was issued by USAID/Indonesia to MCHIP for a period of two years, November 2009–September 2011, and for a total amount of USD 4.8 million. MCHIP was intended to be the bridge between the existing MNCH bilateral, the Health Services Program (HSP) slated to end in September 2010, and the new bilateral, Expanding Maternal and Neonatal Survival (EMAS)—planned for late 2010. This program description for MCHIP included selected high-impact interventions for MNCH and cross-cutting areas.

In June 2010, program implementation commenced in the three districts; shortly thereafter (end of 2010), USAID informed the MCHIP team of the availability of additional funding, bringing the program total to USD 9.8 million, and an additional year of implementation through December 2012 (Figure 4). In response to these changes: 1) the geographic scope was expanded from nine to 17 sub-districts across the three target districts, and 2) a cross-cutting objective on scale-up and expansion was added as Sub-Objective 1.

Figure 4: Program Continuum and Timeline



During MCHIP/Indonesia's lifetime, the MoH underwent a structural change: the Directorate General for Public Health was refocused to become the Directorate General for Nutrition and Maternal, Newborn, and Child health. The change reflected the MoH's efforts to meet the MDGs, with the intent of becoming a more dynamic and responsive organization and addressing the gaps in MNCH and nutrition. Although the changes created some initial confusion, MCHIP benefitted overall from the interest and attention generated by the refocused directorate.

District Selection and District Profile

Given the priorities identified by the MoH and USAID, and the extent of the national level policy work already completed by the previous programs, the design team concluded that MCHIP could contribute the most by focusing on implementing an integrated MNCH model for replication in three or four districts that rank low (due to poor health indicators) in the MoH composite development and community health index. Based on the findings from the visit, the criteria for district selection were identified as follows:

- Districts that fall in the mid-range of the MoH composite index
- Existing presence of MCHIP partners (to allow for quick start-up)
- Evidence of local commitment or reform-minded district leadership
- Existence of a *Bupati* (head of the district) decree prioritizing maternal and child health
- History of public-private partnership for leveraging support

Based on these criteria, seven districts were short-listed, out of which three were selected: Kutai Timur in East Kalimantan, Bireuen in Aceh, and Banten in Serang.

Kutai Timur in East Kalimantan

With a population of 255,637, the Kutai Timur district, located in the East Kalimantan province, is made up of 18 sub-districts, including 135 villages (Figures 5 and 8). There are 19 *puskesmas* spread throughout the 18 sub-districts, with two district-level general hospitals that serve as referral points for the community health centers.⁶ For MNH services in particular, there are 82 midwives and two ob/gyn specialists in Kutai Timur.⁷ The majority of the midwives work in Sangatta city, with only 17–24% placed in villages in the sub-districts; as such, a safe

⁶ Kutai Timur Regency website: <http://regionalinvestment.com/sipid/en/area.php?ia=6404>

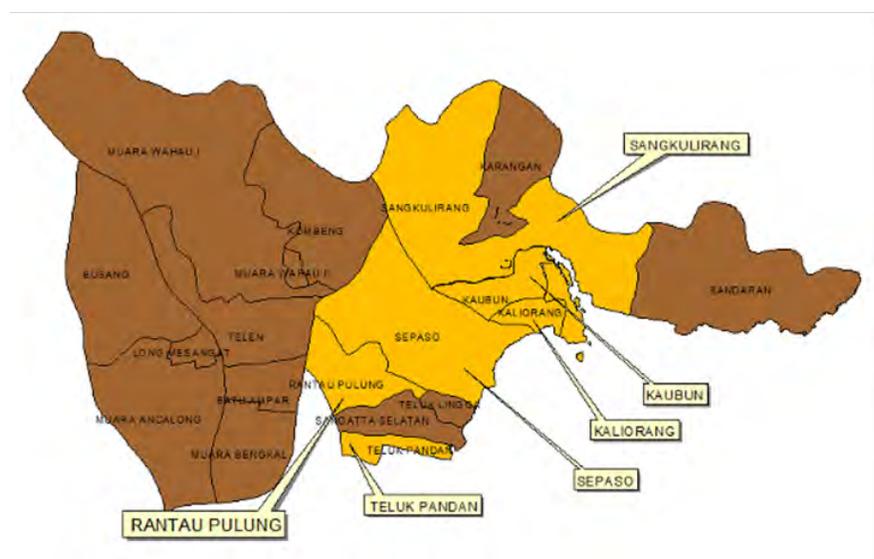
⁷ Indonesian Midwives Association, East Kalimantan Chapter

and clean delivery is still difficult for many women who cannot make it to a nearby health care facility. When complications arise, difficulties with transportation and inaccessible roads, especially during rainy season, make childbirth without a midwife particularly risky.

Kutai Timur (Figure 5) was selected as an MCHIP focus district for the following reasons:

- In comparison to districts in Java, Kutai Timur is quite remote, requiring a two-hour flight to Balikpapan from Jakarta (the business center of East Kalimantan province), followed by an eight-hour journey by road to Sangatta (the district capital of Kutai Timur). The generally poor condition of roads throughout the district further complicates the population’s access to services and markets.
- Comparatively weak human development indicators and a below-average ranking in the MoH composite community health development index place the district at a ranking of 196 among approximately 440 Indonesian districts.
- Jhpiego had a previous two-year experience in the district, implementing an MNH program with the financial support of British Petroleum and Rio Tinto Indonesia. The program had already established a sound collaboration with the district government, the district health office (DHO), local hospitals, and the local chapter of Indonesian Midwifery Association (IBI) in Kutai Timur. With these existing partnerships to build upon, MCHIP would be well-positioned to address a more comprehensive and integrated approach to MNCH.
- Private sector companies, such as British Petroleum and Rio Tinto, are operational in this area; they are ready to demonstrate effective public–private partnership models for improving and sustaining the health and well-being of families living in remote regions of Indonesia.

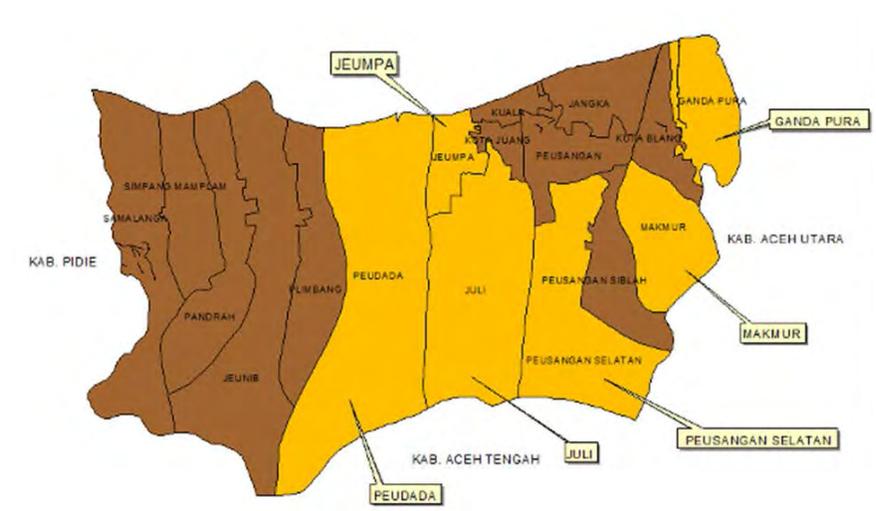
Figure 5: Kutai Timur – Five MCHIP Target Sub-Districts



Bireuen in Aceh

Bireuen, located in the Aceh province, with a population 389,288, encompasses 17 sub-districts and 608 villages (Figures 6 and 8). A total of 17 *puskesmas* are spread across the 17 sub-districts, with one district hospital that serves as the referral point for the district. In relation to MNH, the population is served by three ob/gyn specialists, two pediatricians, and 561 midwives including 228 *bidan di desas* (village midwives)—64% of whom live in the villages they serve. The district also has a strong foundation of community volunteers: a total of 3,125 *kaders* across 625 *posyandu*.

Figure 6: Bireuen – Six MCHIP Target Sub-Districts



Bireuen was selected as an MCHIP focus district for the following reasons:

- The district ranks low in human development indicators and has a below-average ranking in the MoH composite index due to poor health indicators.
- Some of the gaps identified are: poor household-level practices in exclusive breastfeeding, handwashing, and nutrition; poor quality of care at district hospitals; poor quality of community-based kangaroo mother care (KMC); lack of facility-based KMC; and need for continued capacity-building for community workers.
- MCHIP partners Save the Children and Jhpiego, the International Organization for Migration (IOM), and UNICEF were all active in the district of Bireuen at the time. Save the Children’s work in Bireuen was built on a foundation of community mobilization and empowerment to support communities to find sustainable solutions to health and livelihood issues. Also, Save the Children had strong ties to both the people and the district and provincial governments.
- The local government and DHO had an established commitment to improving MNCH programs and working in cooperation with international organizations.
- A foundation had been established for key health practices such as immunization, breastfeeding, good nutrition, antenatal care (ANC), postnatal care (PNC), and community case management (CCM) of pneumonia and diarrhea. A *kader* or community health worker federation and clinical training network exist that focus on PPH and birth asphyxia.
- SC had existing public–private partnerships with Starbucks and Green Mountain Coffee.

Serang in Banten

Serang, located in the Banten province, has a population of 1,402,818 and encompasses 28 sub-districts and 308 villages (Figures 7 and 8)—140 of which are now functioning as *Desa SIAGA*⁸ communities. For MNH indicators in particular, there is one hospital that serves as a referral point for 28 *puskesmas* and several community health centers. A total of 422 midwives, 572 nurses, and 129 medical staff serve a target population including 31,634 pregnant women,

⁸ “Desa SIAGA” (or “ALERT village”) is a community-mobilization strategy developed by Jhpiego’s MNH Program funded by USAID. Currently being scaled up nationwide by a variety of donors and partners, this strategy promotes community readiness for childbirth: 1) pregnancy notification and referral to a midwife; 2) organization of transport; 3) organization of blood donors; and 4) family and village savings for birth emergencies.

Figure 8: Program Target Population⁹

District/Sub-District	Total Population	Total Number of Newborns	Total Number of Deliveries	Total Number of Pregnant Women	High-Risk Pregnant Women	High-Risk Newborns
Bireuen	389,288	7,708	8,093	8,479	1,696	1,156
Jeumpa	32,413	642	674	706	141	96
Peudada	25,056	496	521	546	109	74
Juli	30,764	609	640	670	134	91
Gandapura	22,156	439	461	483	97	66
Makmur	14,954	296	311	326	65	44
Peusangat Selatan	13,509	267	281	294	59	40
Serang	1,402,818	28,758	30,196	31,634	6,327	4,314
Kramat Watu	86,599	1,775	1,864	1,953	391	266
Padarincang	61,797	1,267	1,330	1,394	279	190
Pamarayan	51,431	1,054	1,107	1,160	232	158
Petir	50,968	1,045	1,097	1,149	230	157
Tirtayasa	41,382	848	891	933	187	127
Kutai Timur	255,637	4,678	4,912	5,146	1,029	702
Bengalon	24,942	456	479	502	100	68
Teluk Pandan	12,507	229	240	252	50	34
Rantau Pulung	7,249	133	139	146	29	20
Sangkulirang	15,731	288	302	317	63	43
Kaliorang	8,377	153	161	169	34	23
Kaubun	7,365	135	142	148	30	20
District	2,047,743	41,144	43,201	45,258	9,052	6,172
Target Sub-Districts	507,200	10,133	10,639	11,146	2,229	1,520

Collaboration with the Government of Indonesia

The MCHIP implementation strategy was built around demonstrating “how to” implement national programs at the district level, with a particular focus on more remote districts. MCHIP initially focused at the district level, then worked more closely with provincial-level authorities during the replication phase of the program.

- Ministry of Health.** The MoH has been a key partner. The initial program design and planning were completed in coordination with the MoH to help ensure that efforts fit the needs initially outlined by the MoH. MCHIP was in regular contact with the major sub-directorates within the general directorate for MNCH and nutrition. In addition, the MoH participated in some site visits and incorporated lessons learned from MCHIP into national materials, such as updating the *kelas ibu* based on MCHIP experiences. Feedback to the MoH, including to its different directorates, was provided through the mini-university forum, whereby the districts led discussions and presented on their program uptake in front of the MoH and other national stakeholders.

⁹ Indonesia 2010 Population Census; District Health Profile 2009/2010

- **District health offices.** Working hand-in-hand with the DHO of the target districts was the central strategy of the program implementation. The program had one specific component dedicated to increasing the management capacity of the district. However, the level of involvement and leadership from the DHO varied by district, with the DHO as well as the *Bupati* in Bireuen being the most actively involved in MCHIP. All activities were done in collaboration with the DHO, and a point person at the DHO was available for all components and major activities.
- **Other local institutions.** For all training, MCHIP used local training institutes such as the P2KP and the P2KS. When needed, the internships for *PONED* (in basic emergency obstetric and newborn care [BEmONC]) were conducted at the district hospitals, thus increasing the capacity of both institutions and enhancing communication between the *puskesmas* and the hospital.

Program Objectives, Activities, and Results

The monitoring and evaluation (M&E) team worked with the program and technical teams to collect data on community, clinical, and management components. Data were reported from the province to the Jakarta office on a quarterly basis. Key data sources used were: the Maternal and Child Health/Local Area Monitoring (MCH-LAM, or PWS/KIA) surveillance system, hospital databases, Standards-Based Management and Recognition® (SBM-R) assessments, and program reports.

The PWS/KIA is an active surveillance system that is part of the National Health Management Information System (HMIS) for pregnant, newly delivered, and/or lactating women, and for neonates. This system includes a database that houses information collected at the household level by midwives and community volunteers. The system is intended to assist the DHO, health center, and village midwives in: 1) monitoring antenatal, delivery, and postnatal service coverage; and 2) identifying and addressing problems among mothers and neonates at the household level. This system is also intended to improve the quality of the monthly meetings at the health center and to help in the development of health center microplans to improve MNH services.

The quality of data collected through the PWS/KIA is generally lagging. Several challenges exist, such as limited capacity within the DHO and the *puskesmas* to monitor the data quality, as well as confusion on the part of the midwives regarding the definition of the indicators and the appropriate data required. MCHIP used data from the PWS/KIA to monitor the coverage of MNH services in the target sites on ANC, skilled birth attendance, and postpartum and neonatal visits.

In the target districts, MCHIP implemented the following activities to support the strengthening of PWS/KIA (Figure 9):

- Held orientation meeting for the socialization¹⁰ of *PWS/KIA Guideline 2009/2010*, published by the MoH. The meeting was conducted for the midwife coordinators and village midwives to introduce the revised PWS/KIA and provide guidance on how to complete the PWS/KIA. Although the MoH had issued guidelines on PWS/KIA, midwives reported and displayed limited or no awareness of the guidelines and had not received any orientation to PWS/KIA.
- Strengthened the monthly data collection, analysis, and follow-up process at the *puskesmas* level through monthly meetings at the *puskesmas*. At these meetings, MCHIP facilitated a review of the process.

¹⁰ Socialization is a commonly used term in Indonesia meaning to introduce a new idea/program/concept; it includes a series of meetings and workshops at various levels such as the central level MoH, provincial, district, and the village level.

- Institutionalized the PWS/KIA. Regular meetings are scheduled at the *puskesmas* level, but the data collected were not discussed in these meetings. MCHIP initiated the discussion of data during these meetings to guide program implementation at the *puskesmas* level.

Figure 9: PWS/KIA Strengthening Activities Facilitated in the Three Districts

District	PWS/KIA Orientation Meeting	Data Collection and Processing	Data Analysis and Follow- Up	Institutionalization of PWS/KIA
Serang	One time	Conducted monthly	Conducted monthly at puskesmas	PWS/KIA data are discussed in quarterly meeting at puskesmas and at MNCH Team meeting at sub-district level.
Kutai Timur	One time	Conducted monthly	Conducted quarterly at puskesmas	PWS/KIA data are discussed in monthly meeting at puskesmas.
Bireuen	One time	Conducted monthly	Conducted monthly at puskesmas	PWS/KIA data are discussed in quarterly meeting at puskesmas.

In addition to PWS/KIA, MCHIP pulled data from the following sources:

- **Hospital database.** MCHIP collected data from the target hospitals on the number of deliveries, magnesium sulfate (MgSO₄) use, and KMC program implementation.
- **SBM-R assessments.** SBM-R assessments were conducted on a quarterly basis, and data from these assessments were used for both facility-based decision-making and program reporting. These assessments have enabled the facility, DHO, and MCHIP to determine whether high-impact, lifesaving interventions are being performed according to standard.
- **Activity report.** The report was used to populate some of the process and output indicators, such as the such as number of laws established, number of people trained, and number of guidelines approved by the MoH.

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

2.1 KELAS IBU

Activities and Accomplishments

Kelas ibu are classes at the village level in which pregnant women and mothers are given key messages on eight areas of maternal and newborn care, including: 1) ANC, 2) exclusive breastfeeding, 3) skilled birth attendance and birth at a facility, 4) handwashing with soap, 5) danger signs for mother and newborn, 6) immunization, 7) family planning, and 8) nutrition/anemia. Although a national *kelas ibu* program was approved by the MoH, classes were not taking place at the village level.

The process for the development of *kelas ibu* started with capacity building at the district level. Facilitators for *kelas ibu* at the district level were trained through a training-of-trainers event

followed by socialization of the *kelas ibu* at the community level, such as through religious platforms. Once the *kelas ibu* is up and running, a process for monitoring and reporting of the classes within the existing system is coordinated with the *puskesmas* and the DHO staff. Major achievements for the *kelas ibu* are as follows:

- MCHIP facilitated 238 *kelas ibu* across 139 villages in the three districts (Figure 10).
- All 238 *kelas ibu* eventually received resource allocation from the *puskesmas* and the village for continuation.
- MCHIP facilitated a “how to” guideline for *kelas ibu* that can be used by other districts for replication. The guideline covers the process for development of *kelas ibu*, standard costs, potential challenges, and solutions.
- MCHIP developed 33 *kelas ibu* facilitators at the district level, 86 facilitators at the sub-district level, and 466 facilitators at the village level to serve as champions in their communities and as resources for replication (Figure 11).

At the national level, before MCHIP, the MoH was offering *kelas ibu* to pregnant women only. MCHIP expanded the *kelas ibu* to postpartum women as well. *Kelas ibu* has become one of the most popular and sought-after programs. MCHIP shared the popularity and enthusiasm for *kelas ibu* with the MoH— learning from MCHIP experience, the MoH with MCHIP support updated their guidelines to include: a) content for postpartum women; b) use of *kaders* as facilitators; b) self-tests for knowledge assessment before and after the courses for the participants; c) larger and clearer illustrations; and d) flip charts for easy facilitation. MCHIP pilot-tested these flip charts in Jhpiego and MCHIP sites, then revised and distributed them. The MoH is now promoting the revised guideline as the new national guideline.



Challenges and Lessons Learned

- Community members in general preferred that *bidans* (midwives) facilitate classes, rather than *kaders*, as *bidans* were more of a trusted entity in the community. However, MCHIP initiated a model in which *kaders acted* as facilitators of the sessions and *bidans acted* as supervisors, a model that was also accepted by the community. This model allowed *bidans* flexibility with their time and provided an opportunity for the *kaders* to be engaged in improving maternal and newborn health.
- Because some of the *kaders* had only completed elementary school, training them to become facilitators took longer than anticipated. Not all *kaders* who were trained as facilitators were skilled at and comfortable with public speaking. Fewer *kaders* than *bidans* came back for refresher training. For these reasons, selection of *kaders* should be well thought out; “weak” *kaders* can be “supplemented” by *bidans* who have strong supervision skills and are energetic and dynamic.
- Both monitoring and supervision from the *puskesmas* of the *bidans* and the *kaders* are essential for optimal implementation of *kelas ibu*.

Figure 10: Kelas Ibu in MCHIP Target Areas

Districts	Target Villages	Number of Villages with Kelas Ibu	Population of Pregnant Women	Number of Deliveries	Total Kelas Ibu	Total <i>Kelas Ibu</i> now funded by the local government
Serang	65	65	6,769	6,461	134	100%
Kutai Timur	48	42	1,915	1,857	42	100%
Bireuen	62	62	3,341	3,189	62	100%

Source: MCHIP

Figure 11: Facilitators for Kelas Ibu

Availability of Facilitators at Each Level			
	Districts	Sub-Districts	Villages
Serang	20	15	195
Kutai Timur	6	35	144
Bireuen	7	36	124

Source: MCHIP

Mrs. Sanah, 42, a regular attendee of kelas ibu at the Posyandu Melati in Serang, started coming to kelas ibu when she was pregnant with her third child. Since joining kelas ibu, Mrs. Sanah has practiced exclusive breastfeeding and became an active family planning user. She now invites women from her community to attend kelas ibu.



2.2 TBA-MIDWIFE PARTNERSHIP

Activities and Accomplishments

To increase skilled attendance and facility-based births, one of the approaches the government is pursuing is to promote partnerships between midwives and traditional birth attendants (TBAs), by clarifying roles, agreeing on mutual financial compensation, and recognizing strong partnerships. According to the WHO, TBAs—whether trained or not—are not considered skilled birth attendants (SBAs) at delivery. MCHIP facilitated the initiation and/or revitalization of the TBA–Midwife Partnership program in two of the three MCHIP districts: Serang and Kutai Timur. In Kutai Timur, only three of the six sub-districts implemented the partnership program. Bireuen implemented a POMA program (described under Sub-Objective 3) with similar goals in lieu of the TBA–Midwife Partnership.

To familiarize the people with the concept of the TBA–Midwife Partnership and to generate political will and support for it, socialization of the partnership was held. The *puskesmas* head and the midwife coordinator received an orientation to the partnership concept. Facilitation of the partnership happened through teambuilding activities between midwives and TBAs held on a periodic basis, and through the development of a memorandum of understanding (MoU), which outlined respective roles and responsibilities for the midwives and TBAs. Once the

partnership was in place, an M&E process was developed in collaboration with the DHO and *puskesmas* staff.

Achievements in the area of the TBA–Midwife Partnership are as follows:

- The data from January through September 2012 for the two districts show an increase in the percentage of births attended in partnership from 8% to 22%, and a decline in births attended by TBAs only from 17% to 12% (Figure 12).
- A total of 88% (n = 355) of TBAs in the two districts became part of the partnership by September 2012. The percentage of births by TBAs was 13% and in partnership was 23% from January through September 2012 (Figure 13).
- MCHIP facilitated a “how to” guideline for the TBA–Midwife Partnership that can be used by other districts for replication. The guideline covers the process for development of the partnership, standard costs, potential challenges, and solutions.

Figure 12: Deliveries Assisted by Midwives, TBAs, or in Partnership in Serang and Kutai Timur, January–September 2012

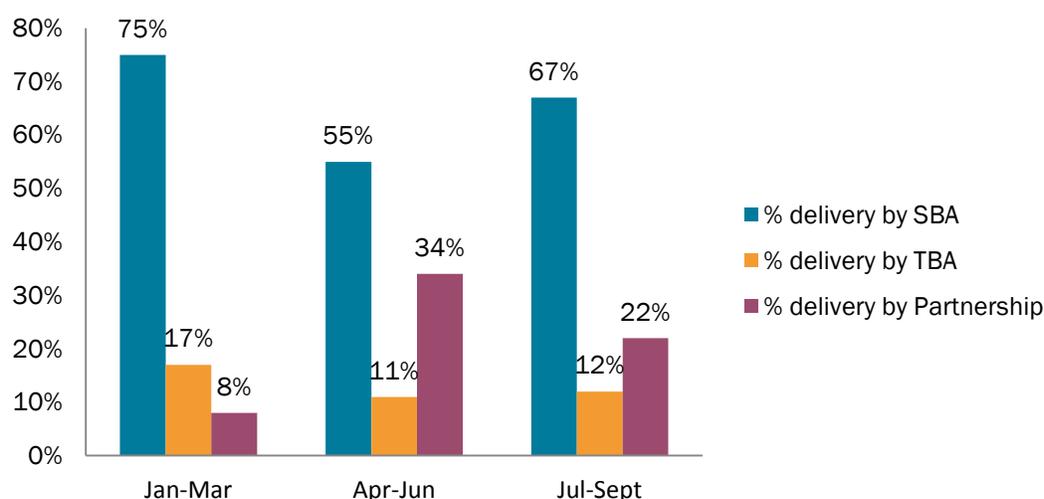


Figure 13: TBA and Midwife Births and Partnerships in September 2012

District	TBA in Partnership		By Bidan		By TBA		TBA-Midwife Partnership	
	#	% of total TBAs	#	% of total births	#	% of total births	#	% of total births
Kutai Timur	58	85%	298	64%	77	16%	90	19%
Serang	256	89%	2,940	63%	455	10%	1,267	27%

Mba Rondo, a traditional birth attendant, in the village of Kadungan Jaya in Kutai Timur has assisted roughly 408 births since she moved here 15 years ago. Before, her village did not have a midwife, so she started providing TBA services to the pregnant women in her village. Now the DHO has appointed a midwife in her village, and Mba Rondo participates in the Midwife-TBA Partnership. In her new role, she has referred four births to the village midwife and assisted the midwife—she; Mba Rondo receives Rp 50.000 (~\$5) for every birth she assists the midwife with. Mba Rondo is happy in her new role: “as I have grown old, I am no longer bold to assist births, I am afraid that the doctor will be summoned, and I may be sent to prison if anything goes wrong.”



Challenges and Lessons Learned

- The records of birth by TBAs are incomplete at the *pustu* or the *puskesmas* level—some of the births are not reported by the TBAs. This is just one example of the “disconnect” between TBAs and the health system. The TBA–Midwife Partnership allows the TBAs and health system to interact—not alienating one from the other—and represents a step toward creating a dialogue between the two parties.
- For the TBAs, attending births is a large part of their livelihood; the TBA–Midwife Partnership limits the role of TBAs to being a provider of nonmedical services to the pregnant woman or new mother (e.g., cleaning, massaging, cooking), as an important part of the birthing process. A short-term measure that is less drastic is to engage the TBA in serving as *kader* or community health worker in the community; in the long-term, a dialogue with other sectors is necessary to find alternative sources of livelihood for the TBAs.

2.3 COMMUNITY CASE MANAGEMENT

Activities and Accomplishments

Community Case Management (CCM) is a strategy for delivering lifesaving curative interventions for common serious childhood infections (pneumonia, diarrhea, and malaria for children under 5) in communities with limited access to facility-based care. UNICEF and WHO’s joint statement on CCM (2011) advocates for its immediate scale-up. These interventions include: antibiotics for pneumonia, antimalarial for malaria, and oral rehydration solution and zinc for diarrhea. Typically, community health workers are trained to assess, classify, and treat children with signs of illness; families are trained to recognize and seek care for signs that indicate serious disease. Countries in Asia, Africa, and Latin America have adopted this strategy to provide curative services to remote and inaccessible communities. In addition to CCM for pneumonia and diarrhea for under-five children, MCHIP/Indonesia introduced CCM for newborn sepsis in the two districts of Bireuen and Kutai Timur.



The objectives behind introducing CCM were as follows:

- Accelerate achievement toward MDG 4—newborn mortality is still high
- Provide coverage in areas with low access to facilities
- Actively promote case findings in the community
- Increase the demand for Integrated Management of Childhood Illness (IMCI) services at the facility (IMCI was introduced in Indonesia in 1995 with mixed success¹¹)
- Trigger the development of IMCI programs in places where IMCI does not exist
- Contribute toward the development of a community–IMCI strategy as a part of the Multi-Agency Working Group (MAWG)¹² at the national level

To establish CCM, MCHIP—in collaboration with the MAWG—undertook a process in the two districts and at the national level that included the following activities:

- Established a national working group
- Conducted assessment/formative research of the identified area
- Developed a program strategy and implementation plan addressing drug supply, law/policy, training, monitoring, and supervision
- Developed training modules for CCM for both newborn and child
- Conducted training of facilitators, supervisors, and health workers
- Initiated CCM services by the health workers
- Initiated regular monitoring and supportive supervision
- Conducted refresher trainings and regular meetings with supervisors

MCHIP facilitated the introduction and implementation of CCM in Bireuen and Kutai Timur, taking into consideration the geography, services, and availability of resources in the two districts. In Kutai Timur, the population is unevenly spread over a wide geographic area with limited access to facilities and providers; midwives prefer to be based in the *puskesmas*, with only a few actually living and practicing in the villages. For this type of setting, CCM was intended to serve as an alternative resource, which was closer to the community. In Bireuen, midwives are more or less available and spread evenly in the villages, but the relatively low knowledge/awareness of newborn and child health issues in the community was a primary consideration for the CCM roll-out.

In Bireuen, 72 of 202 villages were selected in two phases. In the first phase, villages were selected within 5–10 km of the *puskesmas*—hard to reach but still able to be supervised. In the second phase, villages beyond 10 km were included. In Kutai Timur, 41 out of 48 villages were selected, all within 5–10 km of the *puskesmas*. Implementation of CCM in both sites was intended to contribute toward better health and survival for the newborn and child as follows:

- Keeping the newborn warm
- KMC for low birth-weight (LBW) babies

¹¹ Widyastuti, Soerojo. WHO. 2004. Documentation of IMCI activities in Indonesia 1995-2003.

¹² In 2010, the MoH initiated a MAWG at the national level. The goal of the MAWG was to advocate for and facilitate the development of a C-IMCI strategy and implementation guideline for Indonesia. Organizations in the MAWG include UNICEF, MCHIP, WHO, Child Fund, World Vision, and Mercy Corps.

- Proper care of the umbilical cord for the newborn
- Antibiotics for neonates
- Oral rehydration solution and zinc for diarrhea
- Cotrimoxazole for pneumonia
- Artemisinin-combination therapies (ACT) for malaria

Achievements for CCM in Bireuen and Kutai Timur are as follows:

- A training module package for newborn and child for CCM was developed. The guidelines were adapted from the existing global package on CCM (Figure 14).
- In Bireuen, 66 village midwives were trained and supervised by 17 supervisors to provide CCM services for newborns and children across 72 (out of 202) villages. In Kutai Timur, 42 village midwives and 41 community health workers across 41 (out of 48) villages were trained to provide CCM services for newborns in coordination with 12 supervisors (Figure 15).
- In Bireuen and Kutai Timur, from July 2011 through September 2012, all instances of newborn infection and LBW recorded were reported as recovered, with the majority treated in the community and few referrals (Figure 16).
- In Bireuen and Kutai Timur, January 2012 through September 2012, the number of cases identified and treated for children is shown in Figure 17.

Figure 14: Training Package for Midwives and Community Health Workers for CCM

The training for the midwives and community health volunteers covers:	
C-IMCI Package for the Newborn (0–2 months)	
1	Essential newborn care
2	Introduction to danger signs and preparation for referral
3	Management of low birth-weight babies
4	Management of newborn infection
C-IMCI Package for the Child (2 months–5 years)	
1	Introduction to danger signs and preparation for referral
2	Management of pneumonia
3	Management of diarrhea
4	Management of fever

Figure 15: Health Personnel Trained in CCM

Districts	Villages	Health Personnel Trained on CMC for Newborn (Village Midwives)	Health Personnel Trained on CMC for Child (Village Midwives)	Community Health Workers Trained for CMC Newborn (<i>Kaders</i>)	Community Health Workers Trained for CMC Child (<i>Kaders</i>)	Supervisors
Bireuen	72	66	66	0	0	17
Kutai Timur	41	40	42	41	39	12

Figure 16: Newborn Infections Identified, Referred, and Treated

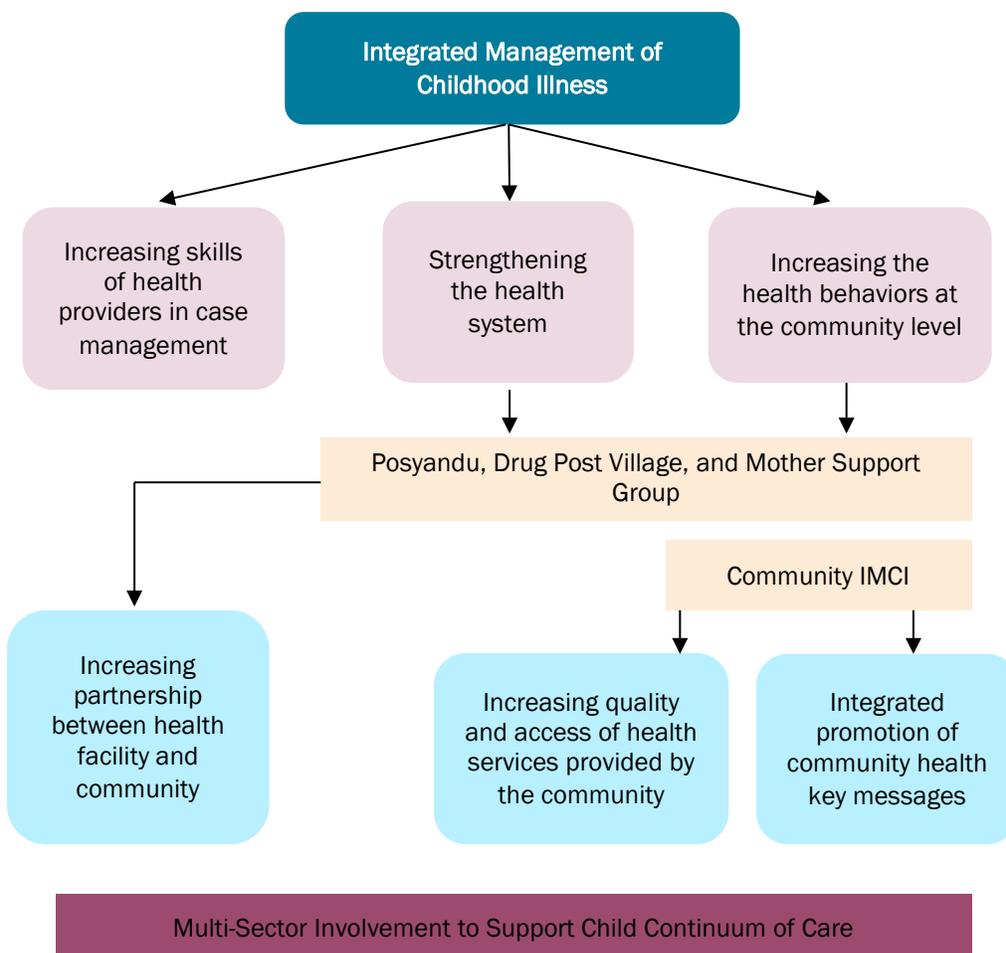
Bireuen				
	Total	Referred	Treated in the Community	Recovered
Live Births	979			
Possible Severe Bacterial Infection	12	6	6	12
Local Bacterial Infections	114	0	114	114
Total LBW Cases	185 (19%)	13 (7%)	172 (93%)	185 (100%)
Kutai Timur				
Live Births	384			
Possible Severe Bacterial Infection	7	3	4	7
Local Bacterial Infection	19	0	19	19
Total LBW Cases	42 (11%)	3 (7%)	39 (93%)	42 (100%)

Figure 17: Child Cases Identified and Treated

	Pneumonia	Diarrhea	Dysentery	Fever	Total Identified Cases	Total Cases Treated
Bireuen	50	129	15	91	285	285
Kutai Timur	78	151	17	3	249	249

- In Bireuen and Kutai Timur, with training and support, the midwives were able to provide CCM services (identify, refer, and treat cases) in their communities. In places where midwives are limited, community health volunteers can be recruited and trained to assist midwives in identifying and referring cases.
- MCHIP facilitated a “how to” guideline for CCM that can be used by other districts for replication. The guideline includes process for development of CCM, standard costs, potential challenges, and solutions.
- At the national level, through the MAWG, MCHIP contributed toward the development of a community-IMCI strategy and guideline (Figure 18).

Figure 18: National Integrated Management of Childhood Illness Strategy



Challenges and Lessons Learned

- Based on two program recommendations for supervision: 1) The midwife coordinator or a *puskesmas* midwife would supervise the village midwives and the *kaders* on monthly visits to the health facility and one visit every three months to the program site. The DHO in Bireuen and Kutai Timur allocated a budget for four mentoring visits in a year. 2) The DOH staff, in conjunction with MCHIP, would supervise the midwife coordinator or the *puskesmas* midwife. However, during the site visits, it was observed that in some sites, supervision was poor. Initially, lack of budget for supervision (e.g., to cover transport to the sites) was reported by supervisors as a barrier. The DHO later reported that it has made necessary funds available, so this should no longer be a barrier.



- In some cases, supervisors reported that they have not conducted field visits because the *bidans* have not identified any possible severe bacterial infections (PSBIs) or LBW infants. This was verified in areas where program population is small, which meant *bidans* were not getting enough cases to retain their skills. For example, in Kutai Timur, three deliveries on average are conducted per month in the *puskesmas* and they have not seen a case of newborn sepsis in the last 6 months. In such situations, the supervisors are then responsible for maintaining the skills of these *bidans*; however, it was observed during site visits that regular maintenance of skills was not taking place.
- MCHIP reinforced the supportive supervision skills of the supervisors through on-the-job training and mentoring. During subsequent site visits, the supervision rate was reported as good, with frequent contacts; however, the quality of the supervision visits was still found lacking.
- MCHIP provided checklists and registers to collect data on CCM. These tools went through a few rounds of revisions to ensure that they would facilitate all needed data collection. During the site assessment visits, the *bidans* were observed not completing the registers; cases identified and treatment data for pneumonia, diarrhea, newborn sepsis, and LBW were found to be inaccurate. One of the reasons found for the poor quality of data was that reporting CCM data was not required at the *puskesmas*. To address this situation, MCHIP facilitated a revision of the required indicators at the *puskesmas* level so that it included CCM. In addition, on-the-job mentoring for village midwives, as the part of the supervision visits, was increased.

2.4 HANDWASHING WITH SOAP

Activities and Accomplishments

Every year, an estimated 4 million newborns die in the first months of life. Of these deaths, 86% are due to a combination of infections, prematurity, and complications during labor. However, simple, low-cost health interventions could reduce this figure by up to 70%. One such intervention is handwashing with soap (HWWS). A community study in Nepal concluded that HWWS can reduce newborn deaths by up to 44%. For countries where newborn mortality is high, adopting HWWS as a standard practice before delivery and while handling newborns is not only important—it saves lives.

For National Handwashing Day in 2011 and 2012, MCHIP worked with the National Handwashing Alliance in Indonesia to focus on HWWS for newborn survival. The theme for 2012 was “healthy child starts with healthy hand.”

MCHIP, in collaboration with the Hygiene Center of the London School of Tropical Medicine (LSHTM) and Unilever, conducted a study in Serang to identify HWWS opportunities for mothers and newborns (Box, below). Together, MCHIP and Unilever facilitated the adaptation of global handwashing promotional materials to the Indonesian context. The package includes flip charts and posters, as well as name plates to recognize families that are practicing HWWS—to be used by providers and community health workers.

In December 2012, MCHIP collaborated with the MoH to conduct a socialization of these handwashing materials to selected district health officers, village midwives, and community health workers from the three MCHIP target districts. Through several interactive sessions, 36 participants learned the importance of handwashing, as well as how to use the flip chart to increase knowledge and adoption of HWWS practices in the community. Participants will serve as the facilitators and resource persons on handwashing in the districts and provinces.

The National Handwashing Alliance in Indonesia declared “handwashing for newborn survival” as the theme for the Global Handwashing Day in 2011 and 2012. Activities were held in all of the districts that MCHIP is working in and more. Before the event, radio jingles and a 90-minute talk show (with district health staff, MCHIP, and the perinatal professional association) about handwashing and newborn health were conducted on October 14th. In the city of Bandung, the Governor of West Java Province spent the day with school children, teaching them how to properly wash their hands. In Aceh, the Governor of the district led a large event, which included leading a song on stage about handwashing! Midwifery students, the next generation of health care providers, conducted handwashing demonstrations and activities with mothers and babies and provided educational materials on the importance of washing one’s hands. Bars of soap were distributed to the community for their own use at home.



Identifying Opportunities for Handwashing for Mothers and Newborns Led by LSHTM, Supported by MCHIP

Context: Almost four million newborns die each year in low- and middle-income countries. A third of these deaths are attributed to infection. The USAID-MCHIP and Unilever-Lifebuoy partnerships have the common goal of reducing neonatal mortality by increasing the practice of handwashing with soap (HWWS) among new mothers, health care workers, and caretakers. Indonesia is one of three countries in which an intervention will be piloted before it is rolled out at a large scale. Conducting formative research in Indonesia informs decision-making for the intervention design.

Objectives: This study aimed to answer questions around the context and practices of handwashing among those who come into contact with newborns in Indonesia, with the objective of learning how to introduce and strengthen the practice of handwashing among new mothers, caregivers, and birth attendants.

Methods: Twenty-seven mothers participated in the formative research study, 15 living in urban Serang and 12 from rural areas in Serang District. Qualitative data were collected from participants using three methods: mothers were videoed going about their daily activities, and while demonstrating events that occur inside bathrooms (which can't otherwise be seen); in-depth interviews were conducted that inquired into opinions about birth attendants, knowledge about the risks their newborns face, handwashing practices, and ways in which their lives has changed since giving birth (using a process called "script elicitation"). In addition, focus group discussions were conducted among midwives and traditional birth attendants. Data analysis involved parsing videos to identify sequences of activities. This information was used to: 1) document when HWWS occurred with respect to critical handwashing occasions (after defecation and before eating and serving food), and 2) track other occasions in which handwashing with soap occurred. Thematic analysis of interview transcripts and focus group discussions were also carried out.

Results: Women's lives are drastically changed by giving birth: they spend more time at home (often not leaving at all) and usually spend long periods alone with their babies, doing childcare instead of household work or jobs outside the home. Their daily activities are therefore considerably different, and less routine, as they must respond to the constantly changing needs of their new charges. Women often change their diet in accordance with a variety of cultural beliefs about protecting their own health and that of their child. Women believe that by solely breastfeeding they can keep their baby healthy. Women do not associate handwashing with illness. HWWS was observed to occur on at least one occasion in half of the households under study, and was seen to occur after sweeping, doing laundry, and returning home (in urban areas). HWWS was rare before meals and occasional after meals. HWWS after changing the baby's napkin was observed in some households. Water and soap availability was not a barrier to handwashing. HWWS was most frequent in households in urban areas, and among better educated and more affluent women. Women trust midwives more than traditional birth attendants, although both types of birth attendants have important roles and influence over new mothers.

Conclusions and recommendations: A foundation of practice for HWWS exists in this community, on which a handwashing promotional campaign can be built. Women are already experiencing a wide range of changes in their life at this time and would probably accept changes to handwashing practices, too, if they are convinced it is important. Many different messages are currently delivered to mothers before and after the birth of their children—by those in the health services and by family members. We suggest that messages about handwashing be delivered shortly before and after the birth. They should also be targeted to first-time mothers because they are particularly concerned about the welfare of their child and most likely to be receptive to advice. To help mothers develop the habit of handwashing after the baby defecates, the intervention could combine handwashing messages with information on how to dispose of/wash napkins after the baby defecates. It is suggested that midwives have the opportunity and skill to take a leading role in delivering the intervention once developed.

Sub-Objective 3: Improve the Quality of Clinical Services

3.1 INTEGRATED POSTNATAL CARE

Activities and Accomplishments

In Indonesia, the current PNC schedule for skilled care differs for the mother and the newborn, and few postnatal visits are taking place 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 with community health services. The guideline for the four recommended integrated postpartum (IPNC) visits is one each at 6–48 hours, 3–7 days, 8–28 days, and 36–42 days.

IPNC-related program highlights and achievements are as follows:

- For the initial 6 months of the program, MCHIP made efforts to achieve consensus on a single schedule for integrated postnatal visits. Although the Child Health Directorate was supportive, the Maternal Health Directorate did not initially agree to a schedule that includes two postnatal visits in the first week of life.
- Once both directorates agreed on a common schedule, MCHIP facilitated the initiation of IPNC in the three districts. MCHIP facilitated the adoption of a global IPNC guideline to the Indonesian context. The guideline and job aid are intended for use by 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) the timeline for IPNC; and e) recording and reporting IPNC visits (using an included form, adapted from the PWS/KIA). The IPNC guideline was field-tested and has been approved by the MoH for distribution.
- MCHIP adapted the global combined job aid for ANC, delivery, and PNC for Indonesia. The job aid, intended for use by midwives at all levels, consists of a checklist of tasks (based on a performance standard) for care to be given at each stage. The job aid for IPNC serves as reminder, as well a tool, to assist in compliance with the evidence-based standards in each visit. The job aid was field-tested and approved for distribution by the MoH. The guideline and the job aid were combined into one package for distribution.
- The IPNC model was rolled out in the three districts through socialization of the IPNC concept at the district and sub-district levels, followed by training of midwives in conducting IPNC home visits using the integrated IPNC checklist.
- Serang reported on its IPNC visits using the MCHIP-developed reporting format (the PWS/KIA is only equipped to report three separate visits for mothers and newborns). The IPNC data for January through September 2012, by month, show that the majority of births are receiving IPNC visits 1 and 2, with a decline in IPNC visits 3 and 4 (Figure 19).

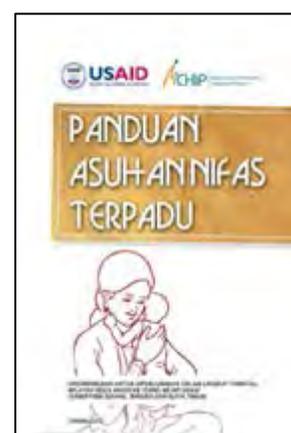


Figure 19: IPNC Visits for Five *Puskesmas* Coverage Area in Serang



Challenges and Lessons Learned

- The uptake of IPNC was relatively successful in Serang compared to Kutai Timur and Bireuen. In Serang, MCHIP cost-shared transportation expenses for midwives' home visits, which contributed toward the uptake of IPNC. In Kutai Timur and Bireuen, IPNC uptake was not as successful because of challenges in the rollout, including resistance from the local government.
- The currently required PWS/KIA forms show three visits for mothers and three separate visits for newborns, in line with current practices nationwide. Midwives were completing the PWS/KIA form and not regularly report on the MCHIP-facilitated model of four integrated visits for mother and newborn. Serang was recording and reporting the visits using the MCHIP-provided IPNC forms, which Bireuen and Kutai Timur did not agree to use. MCHIP extrapolated the IPNC information from the PWS/KIA report for the two districts.

3.2 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 more than 20 programs in developing countries and across several health areas, including maternal and child health, reproductive health, HIV/AIDS, and malaria. MCHIP implemented the SBM-R at the midwife, *puskesmas*, and hospital levels; the tools used are shown in Figure 20.

SBM-R-related program highlights and achievements are as follows:

- MCHIP adapted the global SBM-R standards for the Indonesian context for use at the hospital, *puskesmas*, and the village midwife levels.
- MCHIP facilitated the implementation of SBM-R in three hospitals, 17 *puskesmas*, and 185 midwifery practices in Bireuen, Kutai Timur, and Serang (Figure 21).

- All three hospitals, 17 *puskesmas*, and 185 midwifery practices achieved compliance on more than 80% of the standards. An example of change over time: Kutai Timur Hospital, during the first round of assessment, complied with none (0) of the standards for Tool 1: Infection Prevention, Tool 5: ANC and Postpartum Care, and Tool 6: Family Planning. Bireuen Hospital complied with none (0) of the standards for Tool 2: Pregnancy Complications. Over the course of the program, both hospitals managed to comply with and maintain an average of 80% of the standards in these tools. Results of the last round of SBM-R assessments for the sites are shown in Figure 22.
- MCHIP facilitated the development of a “how to” guideline for SBM-R that can be used by other districts for replication. The guideline covers the process for development of SBM-R, standard costs, potential challenges, and solutions.
- MCHIP demonstrated compliance to all three steps of AMTSL, with an increase from 35% to 100% for 400 midwives. This improvement can be attributed to intense on-the-job mentoring and supportive supervision provided by the midwife coordinators. The assessment was conducted three times over a period of one year, using models or clients when available.

Figure 20: SBM-R Tools at the Midwife, *Puskesmas*, and Hospital Level

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

Figure 21: SBM-R Sites

SBM-R Level	Bireuen	Kutai Timur	Serang
Hospital	1	1	1
Puskesmas	6	6	5
Midwife	30	84	71
Total	37	91	77

Figure 22: Total SBM-R Result in the Last Round of Assessment

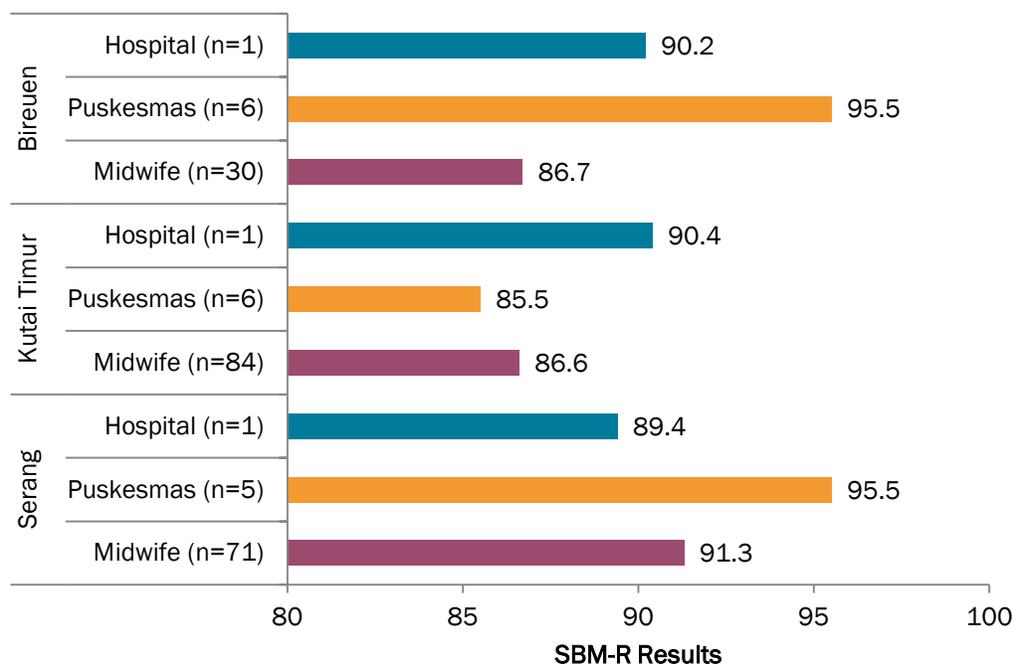
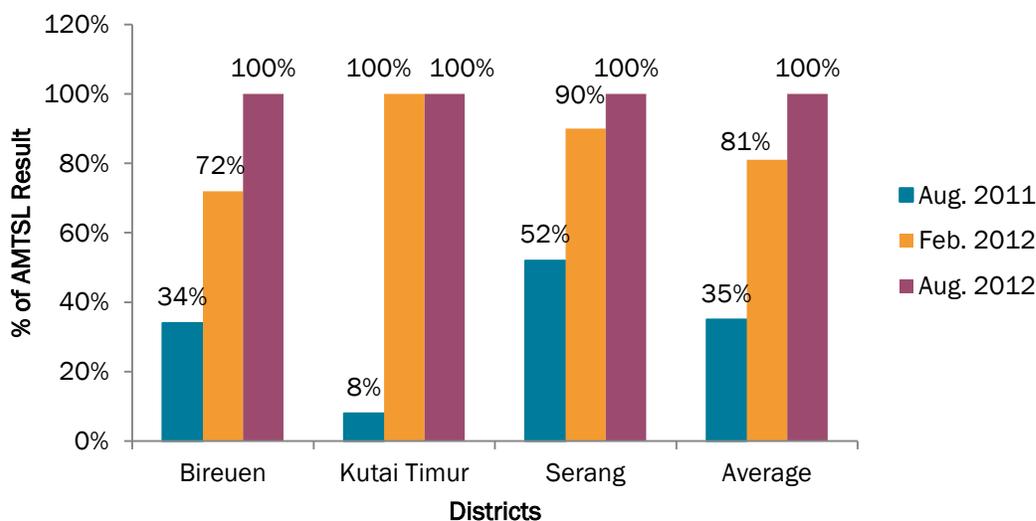


Figure 23: AMTSL Survey Results 2011–2012



- To initiate a discussion about standardization of quality improvement (QI) tools, MCHIP facilitated a comparative analysis of existing tools in terms of: a) supportive supervision; b) SBM-R; and c) *bidan delima*. Such efforts were important because Indonesia does not have a national recommendation for QI tools for facility-based services; as a result, QI processes initiatives often overlap, causing confusion at the sites. Initially, findings of MCHIP's analysis were disseminated among MCHIP and EMAS teams, as well as representatives from the MoH. Recommendations were made to the MoH based on study findings, with the intent of creating momentum for a national QI tool. A detailed report of the findings is available in Bahasa Indonesia (for a report summary, see Figure 24).

- MCHIP facilitated a process evaluation of SBM-R to assess: ownership of the tools and the process; development and validation of standards; internal and external assessment processes; analysis of gaps and finding solutions and resources; recognition; supervision; and perception of the community. The assessment was conducted by a team from the University of Indonesia. A summary of the findings is shown in Figure 25; a detailed report is available upon request.

Figure 24: Summary of the Comparative Analysis of the QI Approaches: SBM-R, Supportive Supervision, and *Bidan Delima*

Findings: All three QI approaches have the same goal—improving performance and the quality of MNCH services. Supportive supervision and *Bidan Delima* are national tools, whereas SBM-R is being implemented in some sites. SBM-R is targeted for the use of providers at the private midwifery practice, *posyandu*, *poskesdes*, *puskesmas*, and district hospital. Supportive supervision is targeted for the use of supervisors to manage performance at the level of *puskesmas* and lower. Organizations that are and should be promoting and using QI approaches are the DHO, JNPK, and private and donor-based institutions. SBM-R standards are the most detailed and specific of the three, including not only the “what to do” but also the “how to do it.” The standards for supportive supervision only address what needs to be done. In *Bidan Delima*, clients are a part of the verification process. In SBM-R and supportive supervision, the validation is conducted by the supervisor internally or externally, and can be observed with or without a patient. In SBM-R and *Bidan Delima*, compliance to the standards is increased through on-the-job training and mentoring. Recognition for increase in performance is important for motivation and incentive purposes. SBM-R and *Bidan Delima* include a recognition component. In all three approaches, community involvement in a systematic manner is lacking. Budget for supportive supervision is essential for all three models. However, SBM-R is based on self-assessment and self-verification; if implemented well, SBM-R can be independently run by the facility itself with limited need for external supervision.

Recommendations: The MoH should explore the integration of the exist QI approaches based on best practices and perceived advantages of all. The capacity of the DHO, MNCH Team, and professional organization such as JNPK to promote and supervise the implementation of QI approach needs to be strengthened. Patients/clients and the community should be included in the verification process. Customer satisfaction surveys can be one of the methods to do so. The “recognition” component of the QI approach should be emphasized—linkages with the Corporate Social Responsibility effort in the community should be explored. Maximization of the existing monthly meetings to promote, discuss, and disseminate the QI approaches and allocation of resources for supervisors is essential.

Figure 25: Major Findings from the SBM-R Process Analysis

Ownership. Recognizing the importance of SBM-R, the DHO has expanded its implementation to other puskesmas in Bireuen; in Serang, there is intent to do so. SBM-R has increased knowledge of health providers (e.g., in use of personal protective equipment for infection prevention), and village midwives are willing to use personal funds when necessary. The puskesmas provides a budget, from its operational costs, for buying consumables and maintaining equipment. Replication has been undertaken by the puskesmas in their coverage villages, but differences in perception of responsibility of health center versus MCHIP are apparent. The village midwives and the coordinator midwife did not keep copies of the evaluation result. The hospital acknowledged SBM-R as a “need” to provide the best care to patients, but dependency on MCHIP is apparent.

Performance standards development and validation. External assessment in general was found to be similar in Bireuen and Serang. Initially, in Bireuen, the DHO was not part of the assessment—primarily because the DHO cited that it did not have the competencies needed for the assessment. Differences in perception exist regarding the responsibility of MCHIP versus the health center for conducting supervision. The assessment period is usually every three months; however, completion of tools and evaluation meetings generally follow MCHIP schedule.

Analyzing performance gaps and mobilizing resources. The facilities analyze their performance gaps; however, data processing is still mostly done with MCHIP assistance. Action planning and prioritization are done in evaluation meetings. The resources options ranged from BoK (operations fund), insurance funds, APBD (local funds), health center planning (PTP), MCHIP, and other donors; sometimes staff cited using their personal funds. At the village level, midwives have shown innovation in filling in the gaps by using or creating homegrown substitutes

Role of district supervisors. The DHO serves as district supervisor at both the health center and village level. The supervision is conducted in several ways (i.e., through specific SBM-R supervision with MCHIP), integrated with existing supervision mechanism (e.g., regular meeting of coordinator midwives, Regional Supervision/Bina Wilayah, Technical Assistance/Pembinaan Teknis). The initiative for supervision with MCHIP mainly comes from MCHIP. During supervision, the completed tools are checked, along with the midwives’ skills and facility completeness. Feedback is delivered directly during supervision. At the hospital level, the external assessment is only conducted by MCHIP, with internal supervision from the ward chief and management-level personnel.

Recognition. Recognition is mainly supported by MCHIP, such as rewards for the health center or village midwife that achieved the highest score. Health centers do not have budget allocation to provide rewards for the staff. The types of recognition vary, including both material and non-material rewards such as congratulation and applause during the evaluation meeting. Staff reported recognition as improving motivation and competitive spirit among health centers and midwives.

Community perception. In general, midwives are nice, friendly, and patient, and midwives provide counseling in each examination/visit. Information explained by the midwives is not limited to reproductive health, but also includes health in general (e.g., personal hygiene, nutritious food, etc.). Midwives also discussed preparation for delivery. Midwives are not always available due to other activities at the puskesmas or the DHO.

Input on the SBM-R method and tools. Tools reflected a discrepancy in the existing standard operation procedure at the facility. A “not applicable” column was suggested for insertion in the tool. Evaluation or periodic assessment was not comprehensive in all areas; in addition to reviewing the completed SBM-R tools, the external verification should also observe clinical skills provision when possible. Ensure that health care providers keep records of findings from the external evaluation and scores from assessment cycle for monitoring.

Hajjah Siti, S.ST. (28), a midwife at Sujung village, Tirtayasa sub-district in Serang, says, "When I started as a village midwife, providing care to the patient, it was just to do it and far below standard ... I did not have any target to achieve and was not motivated to improve quality." Now, Siti Hajjah uses SBM-R in Puskesmas Tirtayasa and has made many changes to comply with the standards; she also did the same in her residence, where she opened a practice. Siti Hajjah explains that after using SBM-R, she was more thorough in examining pregnant patient. Complications were detected early and treatment was more easily decided.



3.3 BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE

Activities and Accomplishments

Access to basic emergency obstetric and newborn care (BEmONC) is an important factor in reducing maternal and newborn mortality and morbidity. In Indonesia in 1997, selected *puskesmas* in the district were strengthened to provide BEmONC services and are now categorized as the “BEmONC *puskesmas*.” The reality, however, is that the *puskesmas* are either incapable of providing BEmONC services or the quality is lagging. As a result, the BEmONC *puskesmas* were referring cases to the hospital, with little or no intervention on their part, and the village midwives were bypassing *puskesmas* and also referring cases directly to the hospital. The MoH-approved training module for the BEmONC *puskesmas* is shown in Figure 26.

Figure 26: BEmONC Training Module

Maternal Component	Neonatal Component
<ul style="list-style-type: none"> • Partograph • Bleeding in Early Pregnancy (Perdarahan pada kehamilan muda (abortus)) • Postpartum Hemorrhage • Pre-Eclampsia and Eclampsia • Obstructed Labor • Postpartum Infection 	<ul style="list-style-type: none"> • Low Birth-Weight Management • Newborn Asphyxia • Difficulty in Breathing of the Newborn • Neonatal Convulsions • Neonatal Infection • Newborn Referral
Emergency Obstetric and Neonatal Care (Penatalaksanaan kegawatdaruratan medic)	
General Preparation before Providing EmONC (Persiapan umum sebelum tindakan kegawatdaruratan obstetric dan neonatal)	

Source: Training Module BEmONC, JNPK-Depkes 2008

In targeted BEmONC *puskesmas*, MCHIP conducted a needs assessment of the existing BEmONC facilities, followed by the socialization of the results and action-planning with the *puskesmas*, DHO, P2KS (training institution), and hospital. Internships for the BEmONC *puskesmas* team were organized at the hospital, followed by post-internship emergency drills at the *puskesmas* to maintain the BEmONC team’s knowledge and skills in emergency management. Performance of the *puskesmas* in BEmONC was measured and monitored using the SBM-R tools for the *puskesmas* (Figure 27).

BEmONC-related program highlights and achievements are as follows:

- In Serang, MCHIP facilitated BEmONC strengthening in three *puskesmas*; on-the-job mentoring was provided to 17 providers. The internship at the hospital in Serang—for a team including a doctor, midwife, and nurse from the *puskesmas*—focused on cases comparable to those often received in the *puskesmas*. Internship components are outlined in Figure 28.

Figure 27: Puskesmas BEmONC in the Three Districts

District	Total BEmONC Puskesmas	BEmONC Puskesmas in MCHIP Area		
		Total BEmONC Puskesmas	Initial Score Using SBM-R Tools*	Final Score Using SBM-R Tools*
Serang	15 (2001) 6 active (2011)	3	44%	92%
Kutai Timur	11 (2011) 15 (2012)	5 (2011) 6 (2012)	46%	94%
Bireuen	5 (2012)	2 (2012)	53%	96%

* Using tools 1, 3, 5, 6, 12 of Puskesmas

Figure 28: Internship Components for BEmONC

Maternal Component	Newborn Component
Management of PE/E	Low birth weight
Vacuum extraction	Asphyxia
Postpartum hemorrhage	Immediate breastfeeding and rooming-in
Curretage/MVA (manual vacuum aspiration)	-
Use of partogram	-

- In Kutai Timur, in 2010 and 2011, the DHO and Jhpiego (through corporate support) had facilitated training for the BEmONC team at the *puskesmas*. In 2012, MCHIP facilitated strengthening of the BEmONC team (15 providers) at the Sangatta Hospital through on-the-job training and a site visit to the Malang Hospital, which is considered the regional model in emergency newborn and obstetric and newborn care.
- An increased capacity to administer MgSO₄ over time was observed in the three districts. The majority of women with pre-eclampsia/eclampsia (PE/E) received MgSO₄ before referral (Figure 29). In Serang, an increase in the score for SBM-R Tool 3: Pregnancy Complications aligned with an increase in the use of MgSO₄ for PE/E cases (Figure 30).

Figure 29: SBM-R Score (Tool) MgSO₄ Use for Severe PE/E Cases

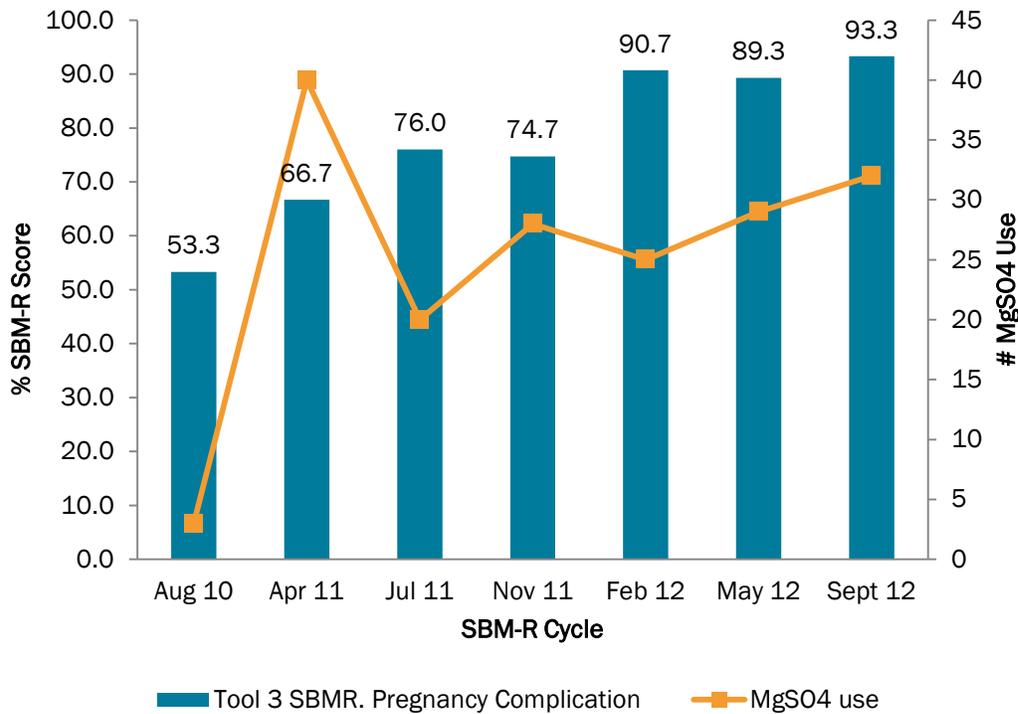
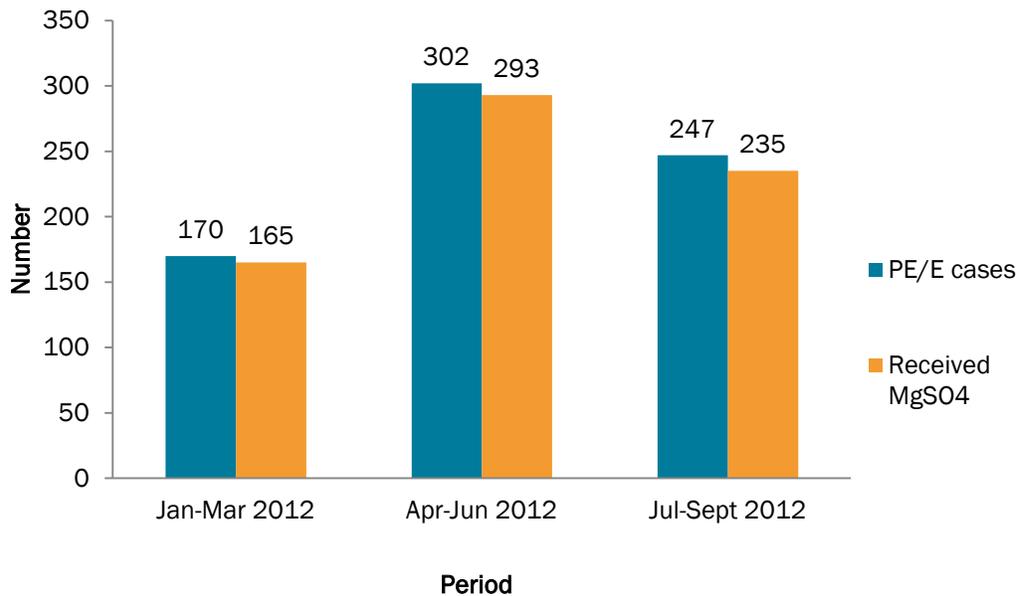


Figure 30: MgSO₄ Use for Severe PE/E Cases in Three Districts, 2012



Midwife Sri Wahyuni Is Able to Manage Pre-Eclampsia Cases

Ayu, 20 years old, was pregnant with her first child. On the 28th of April, 2012, at 21.10, she was brought by her family and a neighbor to the *puskesmas* Bengalon after experiencing convulsions at home. At the *puskesmas*, the midwife Sri Wahyuni quickly checked her condition: BP 220/120 mmHg, gestation 32–34 weeks, fetal heart rate 140 beats per minute, and rare contractions. Ayu was diagnosed with severe pre-eclampsia.



Eclampsia is one of the major killers of women during childbirth in Indonesia and globally. Each year in Indonesia, approximately 10,000 women die during childbirth, and 13% of these deaths are due to eclampsia. Magnesium sulfate is commonly used for the prevention and treatment of eclampsia and pre-eclampsia. In Indonesia, the capacity of village midwives to administer magnesium sulfate is weak. In the three target districts, MCHIP increased the capacity of midwives to administer magnesium sulphate prior to referral—through on-the-job mentoring.

Sri Wahyuni called the doctor at the *puskesmas* and reported Ayu's condition and the need for the immediate referral to the hospital. Also, Sri Wahyuni successfully administered magnesium sulfate to Ayu and inserted Foley catheter before the referral.

The nearest hospital was two hours' drive from the *puskesmas*, and Sri Wahyuni accompanied her patient; no convulsions occurred on the way to Hospital. Sri Wahyuni also sent an SMS message to the hospital ob/gyn, explaining that she is coming with a patient and describing the patient's condition. When they arrived at the hospital, the ob/gyn and the operation theater were ready for them. Ayu had a cesarean section at 23.15, and a baby boy (1,800 gm) arrived—crying and healthy.

Challenges and Lessons Learned

- Providers trained on BEmONC were frequently transferring patients to other facilities, which was affecting the quality of services. When the doctor leaves the *puskesmas*, the likelihood that the *puskesmas* can continue functioning as a BEmONC site is greatly reduced.
 - Internship experience for the BEmONC team at the hospital, which allowed frequent exposure to case types frequently seen at the *puskesmas*, constitutes a good approach to strengthening BEmONC at the *puskesmas*. It also helps in improving the relationship between the hospital and the *puskesmas*, making it easier for the *puskesmas* staff to facilitate referral or access hospital staff when needed.

3.4 COMPREHENSIVE EMERGENCY OBSTETRIC AND NEONATAL CARE

Approximately 44% of all maternal deaths in Indonesia occur at the hospital, due not only to delays in critical cases reaching the hospital, but also to poor initial management of such cases once they do arrive.¹³ At many district hospitals, emergency rooms are not properly equipped or staff are not trained to handle obstetric and newborn emergencies (comprehensive emergency obstetric and neonatal care, CEmONC). In addition, frontline providers are often not authorized to provide emergency care without an obstetrician or pediatrician present. Often, such cases are not even assessed before they are sent to the obstetric or neonatal ward, and poor coordination between the emergency rooms and wards leads to further delay in patients receiving lifesaving care.

¹³ DHS Indonesia; HHS 2001; Lancet 2007

The three district hospitals in which MCHIP worked may be characterized as follows:

- The **Serang Hospital** is a Type B hospital (average 650 beds, several specialty departments) and is certified as a CEmONC hospital. This facility had received technical assistance through the previous USAID program HSP, as well as several supervision visits from the central MoH and training institution (JNPK). Despite the support, the Serang Hospital still handled all of its emergency maternal and neonatal cases in its maternal and neonatal ward, as the emergency room was not equipped to handle these particular emergency cases. The hospital complied with only 43% of the SBM-R standards during the initial round of assessment. For example, mothers and newborns were separated after birth (no rooming-in services) and there were no facilities or support for kangaroo mother care (KMC).
- The **Sanggata Hospital in Kutai Timur** is a Type C hospital (average 190 beds, specialty hospitals) that had not received any training or supportive supervision to date and was not certified in CEmONC. The initial round of SBM-R data showed a low compliance rate of 15.2%. For example, magnesium sulfate was not given for management of PE/E cases and not part of the standard operating procedure for PE/E case management; facilities and support for KMC were lacking.
- The **Dr. Fauzia Hospital in Bireuen** is also a Type C hospital (average 190 beds, specialty hospitals) that had not received any training or supportive supervision to date. The initial round of SBM-R data showed a low compliance rate of 46.96%. For example, magnesium sulfate was not yet part of the standard operating procedure at the hospital (although it was administered for PE/E case management); rooming-in services were not yet implemented; support for KMC was lacking.

MCHIP-facilitated interventions and achievements include the following:

- In the three districts, the clinical skills of emergency room staff were improved. A total of 54 doctors, midwives, and nurses across the three districts, as well as three staff from the MoH, attended an orientation on the management of emergency maternal and newborn care (MNERC). A total of 55 providers (doctors, nurses, and midwives) received training on MNERC at the Saiful Anwar Hospital in Malang (RSSA), which is considered the regional model for MNERC (Figure 31). This was followed by on-the-job training by a team of experts from RSSA. Although all three hospitals completed a baseline assessment on the emergency room standards, only Serang Hospital continued with on-the-job training to address gaps identified in the assessment.
- Serang Hospital showed an increase in compliance to the MNERC tools data from the emergency room (Figure 32), as well as a decline in the number of maternal (85 to 10) and neonatal (31 to 1) deaths, and an increase in the number of maternal (1085 to 1511) and neonatal (233 to 543) cases treated during the same period (Figure 33).

Figure 31: Training on Emergency Maternal and Neonatal Emergency Room Services

District	Orientation for Doctor and Management	Training on Emergency Maternal and Neonatal – Emergency Room		
		Doctor	Nurse	Midwife
Serang	15	7	7	8
Kutai Timur	20	7	3	7
Bireuen	16	7	3	6
Kemkes	3	-	-	-

Source: Activity report

Figure 32: Compliance to the MNERC Tools for the Serang Hospital

Total Number of Indicators Measured	Baseline Data	Assessment I	Assessment II
5	48%	62%	83%

Source: Hospital data

Figure 33: Emergency Room Patients—Maternal and Neonatal

Years	Emergency Room Patients: Maternal and Neonatal					
	Maternal			Neonatal		
	Total	Managed	Deaths	Total	Managed	Deaths
2010–2011	1170	1085	85	264	233	31
2011–2012	1521	1511	10	544	543	1

Source: Serang hospital emergency room registers

3.5 KANGAROO MOTHER CARE

Kangaroo mother care (KMC) is a simple, low-cost intervention in which mothers serve as human incubators for their newborns. According a recent meta-analysis¹⁴ of KMC, this practice is one of the most effective ways to save the lives of preterm babies. KMC has three main components, including: a) thermal care through continuous skin-to-skin contact; b) support for exclusive breastfeeding or other appropriate feeding; and c) early recognition and response to complications.

In Indonesia, *Perinasia* (Indonesian Perinatologist Association) has been leading the effort of establishing facility-based KMC. MCHIP, in collaboration with *Perinasia*, established the following components of KMC in all three district hospitals:

- Providers received comprehensive training for KMC including topics on “learning organization” (how to prepare hospital staff to adopt a new approach), breastfeeding, and KMC practices (Figure 34).
- A KMC team was established at the hospital and is responsible for advocating, planning, and budgeting for KMC.
- A standard operational procedure for KMC was put into place.
- Recording and reporting for KMC were established.

¹⁴ Lawn et al. 2010. Kangaroo mother care to prevent neonatal deaths due to preterm birth complications. *International Journal of Epidemiology* 39:i144–i154.

- Information, education, and communication (IEC) materials and KMC kits were provided.
- An official decree was issued from the head of the hospital, with commitment and allocation of resources for KMC.
- A KMC network among the hospital, DHO, and *puskemas* was developed.

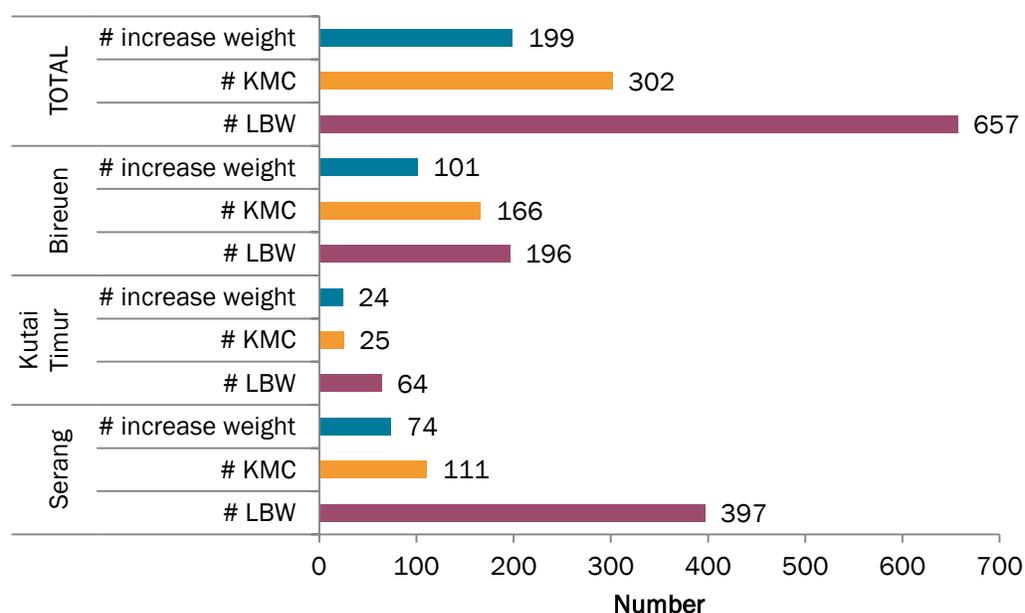
The three district hospitals are now implementing intermittent KMC. In all three districts, approximately 46% (302) of LBW babies received KMC and 66% (199) of them showed an increase in weight (Figure 35). A detailed report on the KMC implementation is available in Bahasa Indonesia upon request. MCHIP and *Perinasia* developed a “how to” manual for establishing facility-based KMC, which addresses all of the essential components: leadership, management, personnel, and resources.

Figure 34: Training and Orientation for KMC in the Three Districts

Districts	Participants from the Puskesmas	District Hospital			
		Orientation and Low Birth-Weight Management	Training KMC		
			Doctor	Nurse	Midwife
Serang	12	22	2	6	2
Kutai Timur	5	13	2	7	7
Bireuen	17	16	2	3	7

Source: Activity report

Figure 35: Total KMC Implementation in Three Districts, January–September 2012



Source: Hospital data

3.6 CLINICAL GOVERNANCE

In Indonesia, hospitals are not functioning optimally, despite having most of the resources needed. This lack is often attributed to lack of “clinical governance.”¹⁵ At the three district hospitals, MCHIP facilitated several activities to increase understanding and awareness of this important aspect of quality care. One method used was to work through *Budi Kemuliaan*. *Budi Kemuliaan Hospital* in Jakarta is considered the gold standard in clinical governance and accountability. MCHIP facilitated an orientation to clinical governance for 15 district hospital and five DHO staff, as well as an internship and on-the-job training. The CEmONC team (doctor [ob/gyn], child doctor, nurses, and midwives) at the district hospital participated in the internship at *Budi Kemuliaan Hospital*, which focused on how to develop and nurture a system of clinical governance. In addition, on-the-job training and an emergency drill were led by the *Budi Kemuliaan* team to reinforce the systems for clinical governance; these activities were conducted for 12 CEmONC team members at the hospital, three DHO staff, and 90 staff and providers from the *puskesmas*.

Sub-Objective 4: Improve the District Health Management System

Under decentralization, local governments in Indonesia have been granted greater autonomy to manage service delivery at the provincial and district levels. As a result, district governments have taken on vastly expanded roles and responsibilities for planning and managing public health programs and funding in response to local problems. To better assist the three MCHIP target districts to fulfill these essential functions in the area of maternal and child health, MCHIP facilitated the series of interventions described below.

4.1 MATERNAL AND PERINATAL AUDIT

Activities and Accomplishments

Effective maternal and perinatal audits are associated with improved quality of care and reduction of severe adverse outcomes.¹⁶ The Maternal Perinatal Audit (MPA) is done to track the causes of maternal and perinatal morbidity and mortality in order to prevent future cases. The MPA can also function as a tool for the monitoring and evaluation of the referral system. Indonesia’s national policy is to conduct a verbal autopsy of every maternal and perinatal death. For deaths that occur in the community, verbal autopsies are to be done at the health center or the *puskesmas*, by sub-district and district-level health officials. For deaths that occur in the hospital, district-level health officials are to conduct the verbal autopsy. Selected cases from the district, on a periodic basis, are to be reviewed by the MPA team at the district level. This team includes a body of experts on MNH—for example, representatives from the DHO, private and district hospitals, and professional organizations.

In 2010, the MoH revised the MPA forms and process based on a “no name, no blame, and no shame” policy. This means that the audits are to be conducted in a confidential and blame-free environment. However, in many districts, the process is only partially implemented, if at all. The three MCHIP districts were still using the old (non-confidential) MPA version and there was no MPA team. In the three districts:

¹⁵ Clinical governance is a systematic approach to maintaining and improving the quality of patient care within a health system.

¹⁶ Pattinson et al. 2005. Critical incident audit and feedback to improve perinatal and maternal mortality and morbidity. *Cochrane Database Syst Rev* 4:CD002961.

- MCHIP facilitated the development of the MPA system and, with 16 MPA facilitators, trained 170 providers on how to complete MPA forms—as well as organized over 100 orientation and socialization events on MPA (Figure 36).
- For maternal deaths (n = 83), 33 verbal autopsies were completed and 23 cases were reviewed from January 2011 through December 2012. For neonatal deaths (n = 561), 142 verbal autopsies were completed and 26 cases were reviewed from January 2011 through December 2011. In Kutai Timur, by the time the project ended, reviews had not been completed. Starting in January 2012, almost 100% of the deaths received a verbal autopsy, once most of the process was complete (Figure 37).

Figure 36: Training, Refreshers, and Socialization of the New MPA in the Three Districts

Districts	Refresher for the MPA Facilitator	Training to Complete MPA forms (Midwives, Midwife Coordinator)	AMP Socialization with the DHO, Puskesmas, and Hospital
Serang	6	39	22
Kutai Timur	5	67	22
Bireuen	5	64	62

Source: Activity report

Figure 37: Maternal and Perinatal Deaths with MPA at the Districts—Focus on Puskesmas that Received MCHIP TA (2011–2012)

Districts	Maternal			Perinatal		
	Total Deaths	Verbal Autopsy Completed	Cases Reviewed	Total Deaths	Verbal Autopsy Completed	Cases Reviewed
Serang	41	19	15	431	98	15
Kutai timur	20	3	0	53	9	0
Bireuen	22	14	8	77	35	11

Source: Activity report

Challenges and Lessons Learned

- The new MPA forms are longer and require more time to complete, and the limited availability of the specialist doctor from the hospital delays the recommended review of selected cases.
- MCHIP facilitated the completion of verbal autopsies for 100% of cases along with review of the selected cases; however, the responsibility for implementing and monitoring the recommended actions was unclear.
- A clear linkage between the MPA and the district planning process is essential, allowing gaps identified through the MPA to be verified and included in district team problem-solving for resource allocation. Quality improvement and supportive supervision tools—such as SBM-R, supportive supervision, and others—can also be revised to address the gaps identified.
- Regular supervision from the DHO is essential to ensure that all maternal deaths receive a verbal autopsy. The recommendation is to integrate this activity with the regular DHO supervision visits. The MPA team should receive resources to support assessment visits and review associated activities. Flexible policies that will allow the use of existing budget sources (e.g., the BOK, *puskesmas* budget, and others) for MPA activities should be implemented.

4.2 DISTRICT TEAM PROBLEM-SOLVING

Activities and Accomplishments

Evidence-based local planning involves a series of processes aimed at ensuring evidence-based planning and budgeting for district-level programs for all sectors. MCHIP facilitated the evidence-based planning process for MNCH for the target districts. This planning is completed on an annual basis and in a bottom-up manner, from the community level to the district level. The village or the community level planning, or *pra-musrenbangdes*, is followed by sub-district level planning at the *puskesmas* called the *Perencanaan Tingkat Puskesmas*, or *PTP*, which feeds into district team problem-solving (DTPS) at the district level.

Below are the major achievements related to DTPS:

- Facilitated the process of DTPS in 2011 to influence allocation for 2012, and in 2012 to influence allocation for 2013. In the three districts, 58 personnel—including doctors, midwives, and representatives from the provincial health office (PHO), DHO, *PKK*, *IBI*, *Bappeda*, *BKKBN*, hospital, and others—were trained to serve as the facilitators for DTPS. Orientations and workshops on DTPS were held at the district level in all three districts. An advocacy team was developed in all three districts.
- Helped establish an increase in the percentage of the DHO budget allocated for MNH in Bireuen and Kutai Timur. Although the percentage increase is small, it is significant is that the allocation is based on the actual need and was not “*copy pasted*” from the year before—as is usually done (Figure 38).

Figure 38: Allocation of Budget for MNCH from the Total DHO Budget

Districts	Year 2011 (Pre-MCHIP, assigned in 2010)		Year 2012		Year 2013	
	DHO Budget (Rp)	Budget for MNCH from the DHO Budget (Rp)	DHO Budget (Rp)	Budget for MNCH from the DHO Budget (Rp)	DHO Budget (Rp)	Budget for MNCH from the DHO Budget (Rp)
Serang	81.854.668.797	10%	67.242.852.607	0.7%	TBD	-
Bireuen	6.366.427.850	0%	12.123.430.900	3.6%	20.462.256.822	3.1%
Kutai Timur	40.572.466.501	8.8%	46.000.000.000	3.4%	49.000.000.000	18%

Dr. Robiatun Adawiah: Section Head of KIA DHO Serang, on Her Experience as DTPS Facilitator

MCHIP: What has changed in Serang since the implementation of DTPS?

Dr. Robiatun Adawiah: We are grateful to Allah that we received assistance from MCHIP; the DTPS process in Serang was completed. We started with multi-stakeholder orientation, planning, followed by advocacy. As a result, we were able to receive a large budget allocation for maternal and newborn health for Serang. The understanding of maternal and newborn health elements amongst non-health stakeholders has also increased.



Challenges and Lessons Learned

- Participants invited to attend the DTSP orientation were often represented by a junior-level representative with limited understanding of MDGs and public health programs. A cross-sectoral and cross-programmatic orientation on the MDGs should be prioritized by the district. Active participation in health programs from representatives of other sectors has garnered them pride and respect from their community.
- Data are essential for the planning process; however, data from some of the *puskesmas* were incomplete. Planning needs to be synchronized with other programs and sectors, but the identification and consensus on the process were lacking. Before program planning, the required data should be updated and complete; the *puskesmas* staff should be involved as a part of the planning process. The planning process at the village level should be guided by a health staff from the DHO. With DTSP, the program/budget planning for MNCH is systematic and starts from the bottom up, enabling the real programmatic needs of the community to be prioritized.
- Once the planning is complete, advocacy and development of *perda* should be prioritized. This is often challenged by the limited availability of local funds to finance advocacy and *perda* development. Advocacy to ensure proper allocation is intensive and essential at every step in the planning process; the time needed to develop a *perda* that remains consistent, despite the changes in the senate, is longer than the 1–2 year program limit. A “public figure” with access to executive and legislative teams should be nurtured as a representative for MNCH program advocacy.
- While MCHIP supported the evidence-based planning for the targeted sub-districts at the district level, the requests from other sub-districts may not be evidence-based. At times, their requests may be duplicates (“copy-pasted”) from the year before. Inconsistency among the sub-districts, in the end, leads to a district plan that is not completely sound. Through the mini-university approach, MCHIP facilitated the district-wide distribution of the experience of adopting DTSP in the MCHIP target sub-districts.

4.3 INSTITUTIONALIZATION OF MNCH

Activities and Accomplishments

Under decentralization, local regulations provide district-specific guidelines for policymakers to prioritize budgeting for health and to implement health programs—including for MNCH. They also provide an avenue by which advocacy efforts become institutionalized, representing long-term commitments from the local officials to support the MNCH program. Building on the HSP, MCHIP worked with DHOs, NGOs, parliamentarians, religious organizations, and other stakeholders to create alliances around MNCH issues at the district level—with the aim of passing local MNCH laws. These laws and regulations primarily fall under three categories: 1) *perdes* or regulations at the village level; 2) *perda/qanun* or regulations at the district level; and 3) others that can be authorizations from the Bupati (district head), called the SK (e.g., SK Team AMP, SK Team KMC) or others at the service delivery level (e.g., POMA).

Below are the major MCHIP achievements related to institutionalization:

- MCHIP facilitated the passing of MNCH *perda* in Kutai Timur and Bireuen in 2012, initiated by the development of a multi-sectoral alliance around MNCH issues that was later formalized as an advocacy group. To operationalize the *perda*, a further decree from the district head “*Perturuan Bupati*,” or *perbup*, is necessary. However, because of timing constraints, MCHIP was not able to facilitate the approval of *perbup* in Kutai Timur and Bireuen. In Serang, HSP facilitated the passage of MNCH *perda* in 2008; as a follow-on, MCHIP facilitated the *perbup* passage in Serang in 2011. Figure 39 shows the progression of *perda* and *perbup* in the districts.

- The operationalization of the *perda* at the village level happens through *perdes* that clarifies roles and regulations to a greater degree than *perda*, as well as provides operational instructions to implementers and partners. *Perdes* also helps to give formal recognition and an institutional foundation within the village for community-based MNCH activities. MCHIP facilitated the passage of *perdes* in all MCHIP target villages in Kutai Timur (48) and Bireuen (62) and in 54% of the villages in Serang (35) (Figure 40).

Figure 39: Progression of Perda and Perbub MNCH in Serang, Kutai Timur, and Bireuen

Districts	Advocacy Team	Draft Perda	Year Perda Was Passed	Perturan Tambahan (Perbub) Passage
Serang	2007	2007	2008	2011
Kutai Timur	2011	2011	2012	Not yet
Bireuen	2011	2011	2012	Not yet

Source: MCHIP 2012

Figure 40: Total Villages with Perdes in Kabupaten Serang, Kutai Timur, and Bireuen

District	Total Villages	Total Villages that Received MCHIP TA	Total Villages with Perdes	% Villages with Perdes
Serang	65	65	35	54%
Kutai timur	135	48	48	100%
Bireuen	609	62	62	100%

Source: MCHIP 2012

- MCHIP facilitated the development and implementation of the *POMA* (Paket pelayanan obstetri maternal perinatal) decree in Bireuen. *POMA* is unique to Bireuen and initiated with the DHO leadership. *POMA* is a signed contract among the pregnant woman, midwife, and head of the *puskesmas*, outlining the responsibilities of the service provider (midwife) toward the mother and newborn to provide ANC, delivery, and PNC services. The client is responsible for accepting referral to facilities, if necessary, and for reading and keeping a copy of the *POMA* services on hand. If any one of the parties fails to follow the items outlined in the contract, sanctions in the form of inability to receive the insurance claim and birth certificates could be enacted (these sanctions are also outlined in the contract). In Bireuen, *POMA* was institutionalized through the *Peraturan Bupati* to be implemented in all sub-districts.

Challenges and Lessons Learned

- Response and participation of the leadership and other programs and sectors in the three districts varied. To address these variations, different approaches were required at times to convince the legislative, executive, and non-health personnel to invest in MNCH. For example, in Bireuen, a new *Bupati* came on board toward the end of 2012; to increase the involvement and pique the interest of the new *Bupati* toward MNCH, MCHIP facilitated the signing of the *perda* by the new *Bupati* (instead of the outgoing one), keeping him in the forefront of the community as a supporter of MNCH.

- The process and time required to initiate, develop, and pass a regulation are different in all three districts. The navigation of the regulation through the legislative body in all three districts was complicated, delaying the *perda* passage. MCHIP recommends a DTPS workshop as an orientation to MNCH for all parties before initiating the regulation process. Commitment and involvement from other sectors are stronger when tasked with a specific deliverable.

Figure 41. Teams Formed for Effective Technical Assistance

Districts	Team Formed	Program	Issued by
Serang	<ol style="list-style-type: none"> 1. Team MNCH District 2. Team MPA District 3. Forum Desa Siaga Tk. Kec. 4. Team MNCH Village 5. Team Handwashing 	<ol style="list-style-type: none"> 1. DTPS, Regulations 2. MPA Revised (Kemkes 2010) 3. MNCH in District 4. MNCH in Village 5. Handwashing promotion 	<ol style="list-style-type: none"> 1. District Head 2. District Head 3. Subdistrict Head 4. Village Head 5. Bupati
Kutai Timur	<ol style="list-style-type: none"> 1. Team Advocacy MNCH 2. Team MPA District 3. Team DTPS 4. Forum Warga Siaga 5. Team MDGs 	<ol style="list-style-type: none"> 1. Perda MNCH 2. MPA Revised (Kemkes 2010) 3. DTPS 4. Perda MNCH 5. MDG Roadmap 2012 	<ol style="list-style-type: none"> 1. District Head 2. District Head 3. District Head 4. District Head, Subdistrict Head, Village Head 5. District Head
Bireuen	<ol style="list-style-type: none"> 1. Team Advocacy MNCH 2. Team MPA District 3. Team MNCH District 4. Team DTPS 5. Team SBM-R Puskesmas 	<ol style="list-style-type: none"> 1. DTPS, Perda KIBBLA 2. MPA Revised (Kemkes 2010) 3. MNCH Integration 4. DTPS 5. SBM-R 	<ol style="list-style-type: none"> 1. District Head 2. District Head 3. District Head 4. District Head 5. Puskesmas Head

Sub-Objective 1: Effective Implementation of MDG Roadmap for Scaling Up Lifesaving Interventions to Achieve MNCH Impact at Scale within Three Remote Provinces

1.1 MDG ROADMAP

In 2010, through a presidential decree, the GoI required all provinces and districts to accelerate achievement toward the MDGs during the next five years. As a part of this initiative, the “MDG Roadmap,” a strategy document at the national level, was developed and distributed throughout Indonesia for replication at the provincial and district levels. The MDG Roadmap outlines goals, activities, timeline, indicators, and targets to measure progress toward the MDGs. MCHIP facilitated the finalization and approval of the MDG Roadmaps for the three districts, specifically for MDGs 4 and 5, for submission to the provincial *Bappeda* through the MDG task force. The MDG Roadmap finalization was navigated through the DHO, district planning board, and multiple stakeholders in the form of advocacy meetings.

The challenges MCHIP addressed in facilitation of this process were: a) limited understanding of the national strategy and the need for MDG Roadmap at the district level; b) delays in the development and review of the MDG Roadmaps (the original timeline required all districts to finalize and approve the roadmaps by the end of 2011); c) limited monitoring at the national level on the status of the roadmaps; d) frequent personnel transitions at the provincial and

district levels; and e) the fact that completion of the MDG Roadmap requires completion of all MDGs, not just MNH, which may cause further delays.

1.2 PROGRAM REPLICATION

MCHIP defines replication as the development of resources and experts for the facilitation of technical assistance, from the MCHIP districts to the other districts and sub-districts in the province, to enable adoption of the national MNH programs. The replication process was initiated through the Mini-University setting through with the dissemination of achievements/lessons learned from the MCHIP districts. The Mini-University sessions were hugely successful and well-attended. Afterward, the Mini-University became popular among the DHO and the MoH counterparts at their own meetings and dissemination events.

Planning for the Mini-University

MCHIP conducted a Mini-University to disseminate the guidelines and lessons learned in each of the MCHIP provinces (Figure 41). The attendees were representatives from all districts in the MCHIP province. The district team included the head of the district, head of the district hospital, *Bappeda* staff, head of the DHO, and head of the Family Welfare Department of the DHO. Representatives from the MoH, USAID, and MCHIP target districts also attended. *Penala Hati*, a consulting agency with expertise in facilitation, assisted MCHIP in planning for and facilitating the sessions. Preparation for the Mini-University began as early as mid-2011 through socialization to the stakeholders.

Planning involved the following key strategies:

- ***Positioning the PHO at the center of the Mini-University planning.*** In the decentralized setting of the Indonesian health system, planning with the PHO helped build the capacity of the provincial team. The province, on its part, actively participated in socializing the concept of the Mini-University to the districts, as well as in getting buy-in from the districts. The provinces also played a key role in district selection to receive technical assistance from MCHIP.
- ***Promoting district ownership of the Mini-University.*** MCHIP positioned the Mini-University as an opportunity for the MCHIP districts to showcase their achievements. The selected hospitals, *puskesmas*, and community counterparts presented their program interventions and results, facilitated by MCHIP. The DHO and PHO staff filled subordinating roles such as that of the note-taker at the meeting. The Mini-University also served as a handover of MCHIP lessons learned from the MCHIP team to the district and provincial counterparts.
- ***Preparing participating districts to maximize the experience of Mini-University.*** MCHIP's intention was to have all participating districts attend the Mini-University with predetermined areas of interest based upon their needs and budget availability. MCHIP socialized this intent through the preparation meeting with the provincial and the district teams. In Serang, MCHIP used selection criteria to identify the first six districts to receive technical assistance from MCHIP, as well as funding support for a small workshop or training. Similarly, in Bireuen, a general "open" Mini-University for all districts was followed by specific site visits for selected districts only.

Figure 42. Mini-University Sessions

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-Midwife Partnership 3. SBM-R and IP 4. MPA and MCH-LAM 5. DTSP 6. BEmONC/CEmONC 	<ol style="list-style-type: none"> 1. MSG 2. “POMA” and “Perbup” 3. C-IMCI 4. SBM-R and IP 5. MPA 6. DTSP 7. KMC 	<ol style="list-style-type: none"> 1. Desa Siaga (including TBA-Midwife Partnership and MSG) 2. C-IMCI 3. SBM-R and IP 4. MPA 5. DTSP 6. KMC

Highlights from the Mini-University

The enthusiasm, energy, and dedication that preceded and were so strongly visible at the Mini-University in all three districts are difficult to translate in this report—some highlights are described below:

- ***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 PHO activity. All provinces showed enthusiasm, support, and a level of ownership through fulfilling the following roles:
 - Sent invitation letters and led socialization of Mini-University among districts
 - Provided input on the development of the agenda and invitees list, as well as assigned participants by class
 - Socialized Mini-University to the governor and the secretary
 - Provided cost-share for the participants
 - Led formal opening and closing of the Mini-University
 - Attended and participated in the sessions, including as co-facilitators.
 - Provided 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 in each class—selected from the DHO, hospital, *puskesmas*, and community—handled the questions and discussions very skillfully and with diplomacy. The Mini-University was truly a showcase of the district’s achievements and efforts, with districts tirelessly advocating for adoption of the programs. The DHO and PHO staff also filled subordinating roles such as that of the note-taker or session coordinator.

- **Strong participation was evident from non-MCHIP districts.** The districts attended the Mini-University in large numbers, with all having representation there. The districts were excited to hear about and learn from the MCHIP model district. They asked questions, expressed enthusiasm and commitment, and in some cases held strong discussions—sharing their own experiences related to why or why not the MCHIP model could be replicated in their area. For example, in East Kalimantan, all participants who were invited attended, no one dropped out, and they attended all six classes. Figure 42 below shows the priority of the districts for replication, with the most requested classes being SBM-R in Banten, *POMA* in Aceh, and MPA in East Kalimantan. The ranking of programs 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 on *Desa SIAGA*, which was 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 innovative by the team of Bireuen, was accepted as “their own” by the Acehnese. In Banten, classes that represented strengthening clinical skills and performance, such as the SBM-R and BEmONC/CEmONC classes, came out as leading choices. In general, the ranking of the topics was based on: a) needs of the district; b) human resources available; and c) 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.

Resources for Replication Post-Mini-University

MCHIP developed the following resources in support of the program replication:

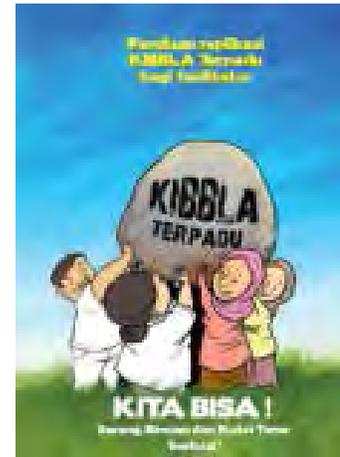
- **How is the program implemented?** Based on the experience of the program implementation, MCHIP has developed a program guideline that lays out the “how to” of the program implementation and unit cost for the program. These guidelines were provided at the Mini-University.
- **Who will act as technical experts?** A team of facilitators or champions—handpicked from the DHO, hospital, *puskesmas*, and the community—represented the best-performing and most motivated individuals. The facilitators conducted the classes at the Mini-University and shared their program experiences and lessons learned with the districts. The facilitators will serve as the resources for replication for the other districts—conducting orientation, supporting implementation, monitoring, and follow-up.
- **MCHIP districts—from implementer to mentor?** The MCHIP districts have established themselves as model districts. After the Mini-University, and with other districts now looking to them for guidance on replication, the MCHIP districts find themselves in the role of mentor. As MCHIP had limited staff, time, and budget remaining, MCHIP planned to improve the mentoring capacity of the districts; one such method was the development of and orientation to the facilitator’s guideline on how to become a facilitator. MCHIP and the PHO/DHO also planned to refresh and add some more facilitators from district and



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

province levels. The guideline includes four components for benchmarking integrated MNCH or *KIBBLA Terpadu*:

- **What is “KIBBLA Terpadu”?** MCHIP defines *KIBBLA Terpadu* as an integrated community, clinical, and management system to support continuum of care. Planning, implementation, problem-solving, and evaluation for all MNCH programs should be synergized to represent integrated MNCH programs.
- **How does *KIBBLA Terpadu* work?** First, a *shared vision* helps everyone understand why *KIBBLA Terpadu* is important in their area of work. Second, *leaders* are identified to champion *KIBBLA*. Third, *collaboration* among all stakeholders at all levels must occur.
- **How is *KIBBLA Terpadu* implemented?** First, *orientation* for stakeholders is conducted, where shared vision is highlighted and awareness of MNCH issues is raised. Second, *technical guidance* is provided for program implementation and monitoring and evaluation. Third, *consistent advocacy* to the stakeholders and the decision-makers carried out.



Cover of Integrated MNCH Program guide

- **How is *KIBBLA Terpadu* maintained and sustained?** In the short-term, *advocacy and coordination* with the National Planning Board or *Bappeda* is essential. In the long-term, *perbup* or *perda* should be advocated to the executive and legislative stakeholders. MCHIP also developed a website for *KIBBLA Terpadu* (www.kibblaterpadu.net). All materials from the Mini-Universities in the three provinces were uploaded to this website, and a discussion forum is available to all districts for replication of the *KIBBLA Terpadu*. Participants of the Mini-University are able to access *KIBBLA Terpadu* information from this website. Socialization of the *KIBBLA Terpadu* was conducted in July 2012 in three Provinces for the DHO, *puskesmas*, and hospital staff.



Cover of 3-in-4 MNCH Integrated Program Implementation guide

- **How is a Mini-University planned and conducted?** All materials developed for the Mini-University and its replication are available online, allowing the districts and provinces access whenever needed. The MNCH department is planning to house these materials on its website.

Replication Criteria and Resources (Post-Mini-University)

For program replication, the criteria set for interested districts were: support from the PHO, availability of budget for replication, and availability of human resources such as the facilitator to be trained by MCHIP districts for each selected program. The general process for replication is shown in Figure 42 and includes cost-share from the DHO/PHO. MCHIP supported the “kick-off” training only for each topic; the continuing activities were funded by the local budget from the districts. MCHIP provided technical assistance, monitoring, and supervision until the closing-out of the district offices in October 2012. The replication steps and progress toward each are described in the next section.

One of the goals of the Mini-University was to help establish commitment from the participating districts to implement similar MNCH programs in their districts. The participating districts selected the MNCH programs they intend to implement using the following criteria: a) district need; b) availability of budget; and c) availability of human

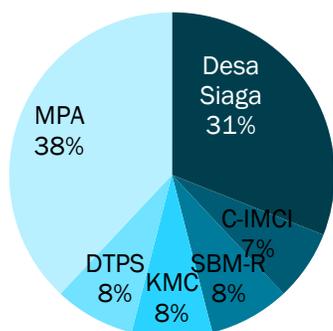
resources. The districts also felt that if the program was deemed necessary, funds could be requested for implementation in the district’s planning and budget cycle. *POMA* was selected as the first priority program for replication in Aceh, MPA in Kalimantan Timur, and SBM-R in Banten. (See Figure 44.)

Figure 43: Replication Process for the Three Provinces

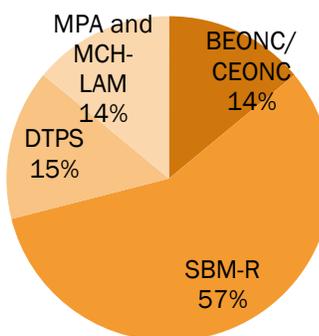
No	Activity	Participants	Trainer/ Conducted by	Budget	
				MCHIP	DHO/PHO
Step 1	Orientation on MNCH integrated Program	Facilitators from MCHIP districts	PHO, MCHIP	✓	
Step 2	Training-of-facilitator for selected program at province level	Facilitators from replication districts in three provinces	Facilitators received orientation	✓	✓
Step 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.	✓	✓
Step 4	Program implementation	N/A	Implementing district		
Step 5	Monitoring and evaluation at district level	N/A	PHO, DHO, & MCHIP (time permitting)	✓	✓

Figure 44: First Priority Program Selected for Replication in the Three Provinces

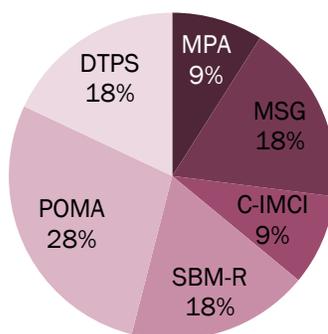
Kalimantan Timur Province



Banten Province



Aceh Province



MCHIP developed the following resources to support replication, to be socialized to the MoH during the close-out meetings:

- Detailed program and cost guidelines
- Detailed guidelines to develop an integrated MNCH program
- Facilitators and champions for replication of integrated MNCH program at the provincial, district, and village levels

Process of Replication (Post-Mini-University)

Figure 45 below describes the design for replication, as well as the participant and funding source for each step. The budget is being cost-shared, primarily coming from the DHO/PHO, which reflects ownership and support for the program. The steps involved in replication are as follows.

Step 1 – Orientation. The purpose was to build the capacity of the facilitators from the MCHIP districts and the province to develop an integrated MNCH program. The orientation was conducted by MCHIP and PHO; it addressed the development, implementation, and sustainability of an integrated MNCH program (*KIBBLA Terpadu*).

Step 2 – Training of Facilitators. After completion of the Mini-University, a letter from the PHO, the Mini-University implementation summary report, and a list of programs that were selected for replication by the district were sent to the participating districts. The letter informed the districts to re-register for a training-of-facilitator event with mandatory cost-share for the participants' cost.

The training-of-facilitator event was conducted at the provincial and district levels. Not all of the districts that had signed up for replication at the Mini-University attended the training-of-facilitators event, the primary reason cited being budget limitations at the district level.

In Banten, all of the districts that selected programs for replication continued with the training-of-facilitator event for at least one program; 12 of 13 in Kalimantan Timur and 15 of 20 in Bireuen continued with the training-of-facilitator event. Each district sent two to five participants on average—from the DHO, *Bappeda*, hospital, and related stakeholders—depending on the training topic. In Kalimantan Timur, districts' cost-share from private sector Corporate Social Responsibility (CSR) funded some of the participants.

The training-of-facilitator event in each province was led by the team of facilitators from the MCHIP districts who also presented at the Mini-University. The new facilitators were from the DHO, *puskesmas*, and the hospital; they will serve as resources for continuation and expansion of integrated MNCH programs in the province. Figure 45 shows the numbers of facilitators.



Dr. Atahillah SpOG, a facilitator from Dr. Fauziah Hospital, facilitating MPA Training of Facilitator in Aceh Province.

Figure 45: Numbers of Mini-University Facilitators in the Three Provinces

Aceh Province	Kalimantan Timur Province	Banten Province
<ul style="list-style-type: none"> • DTPS: 8 facilitators • SBM-R: 7 facilitators • Kelas Ibu: 4 facilitators • MTBS-M: 5 facilitators • POMA: 4 facilitators • AMP: 5 facilitators 	<ul style="list-style-type: none"> • AMP: 6 facilitators • DTPS: 7 facilitators • Desa Siaga: 16 facilitators • SBM-R: 3 facilitators • IP: 2 facilitators • C-IMCI: 10 facilitators 	<ul style="list-style-type: none"> • PONEK: 8 facilitators • SBM-R: 4 facilitators • Kelas Ibu: 5 facilitators • PWS-KIA & AMP : 6 facilitators • DTPS: 4 facilitators • MNERC: 12 facilitators • PONEK: 5 facilitators

Following the training-of-facilitator event, the DHO sent letters to the participating districts summarizing the report from the event, along with a plan of action for each program to be implemented. The DHO also offered technical assistance to districts from July through September.

Step 3 – Technical Assistance for Replication. After the training-of-facilitator event at the provincial level, some districts requested technical assistance from the MCHIP districts for program implementation in their area (Figure 46).

In Aceh, the DHO from Pidie requested technical assistance for the implementation of the SBM-R; three local facilitators from Bireuen conducted an SBM-R workshop in the district. The budget for this activity came from the implementing districts and PHO. The workshop participants were from six *puskesmas*, two districts hospital, and the Pidie DHO. As a follow-on, the participants from each *puskesmas* and hospital drafted their action plan for SBM-R in their work place.

In addition to SBM-R, the Aceh facilitator also provided technical assistance for other programs including:

- DTPS for Aceh Tamiang district
- POMA program for Aceh Barat dan Aceh Jaya
- Kelas ibu and *MTBS-M* for Aceh Tengah

In Kalimantan Timur, the facilitators from the province provided technical assistance for the MPA program to Kutai Kartanegara (on June 23–24, with 61 participants) and Bontang (June 27, with 34 participants). This activity was funded by the implementing districts and CSR from the private companies; a plan of action was generated to implement MPA at the district level. Other districts that requested technical assistance were:

- Bulungan, Tarakan, and Nunukan district for *kader Desa Siaga* workshop
- Balikpapan district for DTPS
- Penajam district for SBM-R
- Tana Tidung and Balikpapan for MPA

In Banten, technical assistance was provided to all seven districts on topics including SBM-R, infection prevention, PWS/KIA, MPA, and BEmONC/CEmONC. The technical assistance in Banten was immediately followed by the training-of-facilitator event. The budget for this activity was from the implementing districts and MCHIP.

Figure 46: Further Technical Assistance for Districts

No	Technical Assistance	Districts
Aceh Province		
1	SBM-R	Pidie and Langsa
2	MTBS-M	Aceh Tengah
3	Kelas Ibu	Sabang, Gayo Luwes, Aceh Tengah
4	POMA	Aceh Barat and Aceh Jaya
5	DTPS	Aceh Tamiang
Kalimantan Timur Province		
1	Desa Siaga	Bulungan, Tarakan, Nunukan
2	DTPS	Balikpapan
3	SBM-R	Penajam Paser Utara
4	MPA	Tana Tidung, Balikpapan
Banten Province		
1	SBM-R	7 districts in Banten Province
2	PWS-KIA	7 districts in Banten Province
3	MPA	7 districts in Banten Province
4	BEmONC/CEmONC	7 districts in Banten Province

As shown in Figure 46, technical assistance in Banten has been provided to all districts—facilitated by easy access among districts, low costs, the small number of districts, and the readiness of facilitators. In the other two districts, distance, access, large number of districts, budget, and limited sensitization of the facilitators and providers were some constraints. For example, *P2KP* (or the institution for clinical training) is not active in Bireuen and Kutai Timur, so clinical trainers were invited from the Sigli, the closest district, and Samarinda.

The replication progress to date is summarized in Figure 47. Key points are as follows:

- All 42 participating districts selected programs for replication after the Mini-University.
- A total of 34 (of 42) districts participated in the training-of-facilitator event for at least one program intervention. The primary reason cited for not participating was the lack of budget in the district.
- MPA and DTPS were the most requested interventions for replication. These choices were driven by the need to understand why and where the maternal and newborn deaths were happening and to influence the allocation of appropriate resources.
- Of the 34 districts that participated in the training-of-facilitator events, 20 requested and received further technical assistance from the MCHIP districts to implement at least one of the programs.

Figure 47: Summary of Replication Achievement in Three Provinces

No	Variable	Aceh	Kalimantan Timur	Banten
1	Total districts in province (not including MCHIP district)	22	13	7
2	Number of districts that signed up for replication	22	13	7
3	Number of districts that participated in the orientation	22	13	7
4	Number of districts that completed training-of-facilitator	68% 15 out of 22 districts	92% 12 out of 13 districts	100% 7 out of 7 districts
5	Number of districts that requested and received TA from MCHIP district for replication	30% 5 out of 15 that completed step 4	66% 8 out of 12 that completed step 4	100% 7 out of 7 that completed step 4
5	Districts that received the highest number of technical assistance inputs for replication	Pidie MTBS-M, SBM-R, POMA, DTPS	Balikpapan AMP, DTPS Penajam Paser Utara Desa Siaga, SBM-R	Tangerang, Lebak, Pandeglang, Kota Tangerang, Kota Serang, Kota Tangsel 2 programs each
6	Number of districts planning to replicate their first priority program selected at the Mini-University	68% 15 out of 22 selected as first priority	85% 11 out of 13 selected as first priority	100% 7 out of 7 selected first priority
8	Elements most in the process of being replicated	MPA Selected by 6 districts	MPA Selected by 7 districts	DTPS Selected by 7 districts
9	Total subdistricts and puskesmas in MCHIP district	12 Subdistrict (total 18 Puskesmas)	13 Subdistrict (19 Puskesmas)	25 Subdistrict (30 Puskesmas)
10	Sub-districts that received technical assistance from MCHIP for replication	100% 12 out of 12 Puskesmas replicate IPNC, Kelas Ibu, LAMAT, C-IMCI, SBM-R, MPA	100 % 13 out of 13 subdistricts replicate Kelas Ibu (13 Puskesmas in Aug 2012) And 2 subdistricts Desa Siaga & Midwife-TBA partnership (Muara Ancalong and Muara Bengkal replicate after Mini University)	100% 30 out of 30 Puskesmas replicate SBM-R 7 out of 7 subdistricts replicate Kelas Ibu and Midwife-TBA partnership

Replication at the Sub-District Level within MCHIP Districts

MCHIP facilitated the strengthening of the existing programs in all of the non-MCHIP sub-districts within the three districts. In Bireuen, 12 of 12 non-MCHIP *puskesmas* received support for IPNC, *kelas ibu*, PWS/KIA, C-IMCI, SBM-R, and MPA. Some were provided before Mini-University, showing the enthusiasm of DHO to implement the program by requesting technical assistance from MCHIP. In Kutai Timur, MCHIP facilitated *kelas Ibu* in 12 of 12 non-MCHIP sub-districts in August 2011. Additional technical assistance to the Muara Ancalong and Muara Bengkal sub-districts for *Desa SIAGA* and the Midwife-TBA Partnership was conducted in September 2012. In Serang, 25 of 25 non-MCHIP *puskesmas* received technical assistance for the SBM-R program after the Mini-University.

Feedback to the MoH

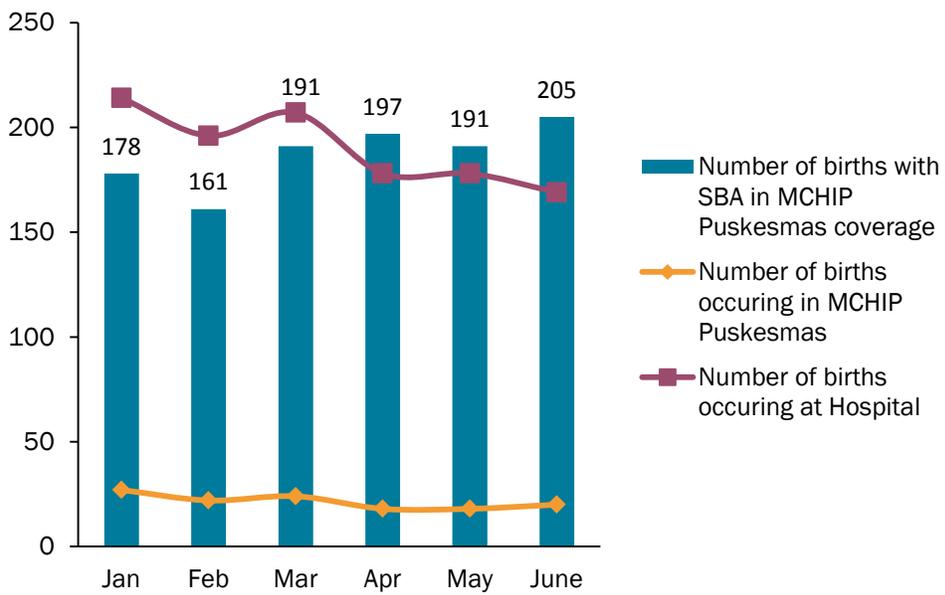
Linking back to the MoH's original request to USAID and MCHIP to roll out MNH programs in remote areas and to provide lessons learned was completed. Feedback to the MoH was provided by engaging MoH officials in the program roll-out in MCHIP target districts. In addition, a one-day culmination event was held in the form of a dissemination activity in Jakarta in December 2012. At the event, MCHIP target districts presented and facilitated sessions on their program implementation experience—including successes, lessons learned, and challenges. Highlights from the information shared and dialogue that followed are presented as a part of the program implementation section. Program implementation guidelines were provided, summarizing the findings. Follow-up actions were identified and personnel responsible were assigned to complete each action. (See Mini-University Report for Jakarta).

Annex 1: Program Results Based on Program Monitoring Plan

PMP results: MCHIP and USAID agreed upon 24 indicators to measure program progress. Data sources used were PWS/KIA, the SBM-R assessment report, hospital data, and MCHIP activity reports. The progression, through years and by indicators, is described below:

1. *Proportion of women who receive at least four antenatal visits.* The data source is the PWS/KIA records received from the districts. **The national annual target is 95% by 2015. In 2012 Bireuen exceeded the target at 97%, Kutai Timur was at 51%, and Serang at 68%. Comparison from 2010 to 2012 showed: in Bireuen, increase from 84% to 97%; in Kutai Timur, decrease from 54% to 51%; and in Serang increase from 63% to 68%.**
2. *Proportion of deliveries with a Skilled Birth Attendant.* The data source is the PWS/KIA records received from the districts. **The national annual target is 90% by 2015. In 2012 Bireuen and Serang exceeded the target at 96% and 91% , and Kutai Timur was at 56%. Comparison from 2010 to 2012 showed progress: in Bireuen, 37% to 96%; Kutai Timur, 43% to 56%; and Serang, 77% to 91%.**
3. *Proportion of newborns who receive postnatal visits during the first week of life:* The data source is the PWS/KIA records received from the districts. **The national target is an annual target of 80% by 2015. In 2012, Bireuen and Serang met and exceeded the target at 98%, and Kutai Timur was at 65%. Comparison from 2010 to 2012 showed: in Bireuen, increase from 85% to 98%; in Serang, increase from 77% to 98%; and in Kutai Timur, increase from 55% to 65%.**
4. *Proportion of women who receive postnatal visits during the first week of life.* The data source is the PWS/KIA records received from the districts. **The national target is an annual target of 80% by 2015. In 2012, Bireuen and Serang met and exceeded the target at 94%, and Kutai Timur was at 48%. Comparison from 2010 to 2012 showed: in Bireuen, increase from 81 to 94%; in Serang, increase from 64% to 94%; and in Kutai Timur, decrease from 51% to 48%.**
5. *Percentage of births occurring at facilities (Puskesmas, hospitals).* These data were collected by MCHIP and are not part of PWS/KIA. **The MCHIP target is 10% of all annual births for the MCHIP coverage area at the *puskesmas*; no targets were set for the hospital because the coverage areas are beyond MCHIP sites. This indicator was modified to become an indicator with annual target in 2012 only. All three districts reached the 10% facility birth target.**

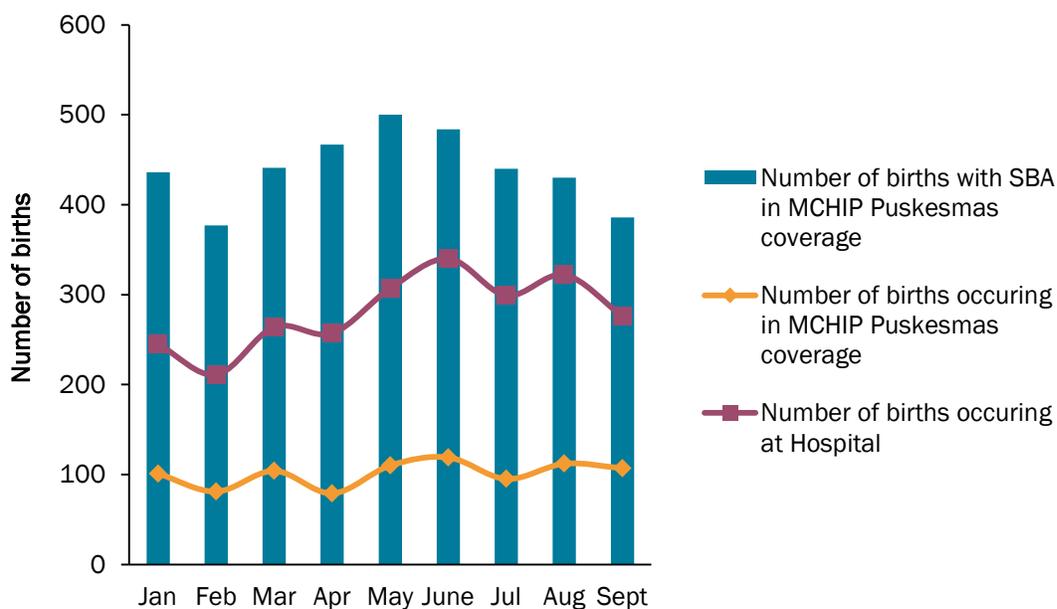
Number of Birth Occurring at Facilities in Bireuen, 2012



Number of Birth Occurring at Facilities in Kutai Timur, January–September 2012



Number of Birth Occurring at Facilities in Serang, January–September 2012



6. *Number of People trained in maternal/newborn care through USG-supported indicators.* This is a cumulative indicator for the life of project. The data source was monthly activity reports. **The program target is 6,500 personnel, and the final number at the end of program was 7,363.** MCHIP has exceeded the target (by approximately 25%) due to the more-than-anticipated number of requests for technical assistance from the districts and sub-districts for replication.

7. *Number of sub-districts in MCHIP target districts that received technical Assistance from MCHIP to scale-up interventions.* This indicator was defined as the number of sub-districts that have received TA from MCHIP sub-districts in at least one of MNCH interventions or programs. This intervention became active after the Mini-University, and data were collected through the MCHIP activity reports. **The final number of sub-districts was 34 (15 Bireuen, 12 Kutai Timur, and 7 Serang) against a target of 23.** The final number is higher than the target because of the large number of TA requests from the other sub-districts.
8. *Number of districts in MCHIP provinces received TA from MCHIP for scale-up.* This indicator was defined as the number of districts that have received TA from MCHIP sub-districts in at least one of the MNCH interventions or programs. This intervention became active after the Mini-University, and data were collected through the MCHIP activity reports. **The final number of districts was 50 (12 Bireuen, 13 Kutai Timur, and 25 Serang) against a target of 23.** The final number is higher than the target because of the large number of TA requests from the other districts.
9. *Number of districts where CCM established.* This is defined as a district where all of the following criteria have been met: a) guideline for CCM developed and available; b) trainers for CCM developed; c) *bidan di desa* and *kaders* able to identify and treat newborn sepsis, diarrhea, and pneumonia; d) supportive supervision for *bidan di desa* and *kader* in place; and e) tools for recording and reporting CCM available. **CCM was established in Bireuen and Kutai Timur, as targeted.**
10. *Number of districts where community KMC was established.* This is defined as a district where all of the following criteria have been met: a) community KMC guideline adapted and integrated with CCM guideline; b) trainers for Community KMC developed; c) *bidans* and *kaders* able to counsel on KMC; and d) supportive supervision in place for *bidans* and *kaders* on KMC. **Community KMC was established in Bireuen and Kutai Timur as targeted and was rolled out as a part of the CCM package.**
11. *Number of national policies drafted with USG support.* **One guideline for Integrated Postnatal Care was developed against the target of one.** See Sub-Objective 3 for more details.
12. *Number of Perdes established.* This is defined as the number of village policies drafted and signed. A monthly program report was used as the data source for this indicator and is reported as a cumulative indicator. **The identified target was 80 for the life of the project, which is 80% of all MCHIP target villages. At the end of the project, 145 perdes were established (62 Bireuen, 48 Kutai Timur, and 35 Serang).** The number of perdes established exceeded the target because in Bireuen, the *Bupati* signed the *Qanun*—automatically approving all the *perdes*.
13. *Number of national-level public-private partnerships.* This is defined as a partnership with the corporate sector to support maternal and newborn health programs. **MCHIP reported three partnerships against a target of one: a) Unilever on HWWS; b) Exxon Mobil in Bojonegoro and Tuban; and c) Chevron in Penajam and Riau provinces.**
14. *Number of health facilities implementing QA/QI approaches.* This is defined as the facilities that display and demonstrate: a) availability of SBM-R tools; b) staff able to define SBM-R; and c) staff able to demonstrate at least three criteria from each tool. **All MCHIP puskesmas and facilities, or 20 health facilities, implemented QA and QI approaches.**
15. *Percentage of midwives competent in AMTSL in MCHIP-supported areas:* These data were collected through a periodic survey/skills assessment of the midwives on models or clients when available. **The target of 100% was achieved by the end of the project.** (See Sub-Objective 3 for more details.)

16. *Percentage of target facilities achieving at least 60% of performance standards:* These data were collected through the SBM-R report. **The target was 100% of the facilities and was met by the end of the project.**
17. *Percentage of women diagnosed with severe PE/E who were treated with MgSO₄ before referral:* This indicator was added in 2012. These data were extracted manually by the MCHIP staff from the labor and delivery register. **The target is 100% and is reported by quarter. For the year 2012, 95% was reported** (Bireuen 93% [28/30]; Kutai Timur 56% [20/36]; and Serang 100% [644/644]).
18. *Number of puskesmas PONED treating complications. This is defined as Puskesmas having the capacity to manage basic emergency obstetric cases based on the following criteria: a) one doctor, one bidan, and one nurse trained in PONED; b) equipment and supplies available for PONED; and c) management of at least one PONED case per quarter. This was verified on a quarterly basis by MCHIP staff.* **The target was six puskesmas and at the end of 2012, 5 puskesmas were practicing PONED, 1 puskesmas in Bireuen did not meet the criteria because of transfer of the doctor to a different site in the July-September 2012 quarter.**
19. *Number of districts hospitals with KMC established.* Readiness for KMC implementation is defined as: a) the hospital releases an official decree prioritizing KMC; b) providers are trained on KMC; and c) guideline for KMC implementation is developed and available at the hospitals; and d) a KMC room is available at hospital. **This was completed in the three hospitals as targeted.**
20. *Number of MNCH teams established at the district and sub-district levels that meet regularly.* These data were reported/extracted from the activity report. The target was 15 teams, which is 70% of the total coverage area of three districts and 17 sub-districts. **The total reported at the end of the project 14 teams, including those at the district and sub-district level. Bireuen had only one team formed at the district level, the authorization of the district law (Qannun KIBBLA) was delayed in Bireuen because of the change in the Bupati, that resulted in time constraint in formation of sub-district teams.**
21. *Number of people trained in DTPS and PTP workshop.* These data were reported/extracted from the activity report and are presented as cumulative data from the beginning of the program. **At the end of the project, 394 were reported against a target of 420.** The number of participants for DTPS and PTP is low because the plans for the PTP were downsized to one session in each district, instead of one in each puskesmas, and the session was attended by fewer participants. This was done to accommodate the timing constraint and the closing of the field offices.
22. *Number of districts with MNCH plans and budgets linked to DTPS.* These data were extracted from the activity report. **At the end of the program, all three target districts had their MNCH plans and budgets linked to DTPS.**
23. *Percentage of reported maternal or neonatal deaths audited.* These data were extracted from the submitted verbal autopsy reports and PWS/KIA. **The target was 100%, an annual target presented on an annual basis. At the end of 2012, 100% was reported.**
24. *Number of local levels law adopted.* This is defined as perda and perdes, local laws at district and village levels. These are cumulative data from the beginning of the program. **The project target was 50; at the end of the project, 148 were reported.** The number of local regulations and laws adopted exceeded the target because a large number of villages in the MCHIP district continued to adopt regulations related to MNCH.

No	INDICATOR	Project Target	Jan-Dec 2012			
			Bireuen	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%	97%	51%	68%	72%
2	Proportion of deliveries with a skilled birth attendant in MCHIP program areas*	90%	96%	56%	91%	85%
3	Proportion of newborns who receive postnatal visits during the first week of life*	80%	98%	65%	98%	91%
4	Proportion of women who receive postnatal visits during the first week of life*	80%	94%	48%	94%	85%
5	Percentage of births occurring at facilities*	10%	28%	24%	23%	25%
6	Number of people trained in maternal/newborn care through USG supported programs	6,500	2,330	2,115	2,918	7,363
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	15 (68%)	13 (92%)	7 (100%)	35
8	Number of districts in MCHIP provinces that receive technical assistance from MCHIP for scale up **	23	12 (100%)	13 (100%)	25 (100%)	50
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	2
12	Number of Perdes established	80	62	48	35	145
13	Number of National level public-private partnerships	1	NA	NA	NA	4
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%	100%	100%	100%	100%
16	Percentage of target facilities achieving at least 60% of performance standards	100%	100%	100%	100%	100%

No	INDICATOR	Project Target	Jan-Dec 2012			
			Bireuen	Kutai Timur	Serang	TOTAL
17	Percentage of women who come to target Puskesmas and hospital treated with MgSO4 prior to referral	100%	93%	56%	100%	97%
18	Number of puskesmas PONED treating complications	6	1	2	2	5
19	Number of district hospitals with KMC established	3	1	1	1	3
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 DTPS and PTP workshop	420	139	113	155	407
22	Number of districts with MNCH plans and budgets linked to DTPS	3	1	1	1	3
23	% of reported maternal or neonatal deaths audited	100%	100% (15 of 15)	100% (18 of 18)	100% (28 of 28)	100% (61 of 61)
24	Number of local regulations and laws adopted	50	71	30	47	148

Miscellaneous Activities Supported by MCHIP

- **MDGs Special Envoy Office.** The President of Indonesia appointed a special envoy to promote MDG achievement in Indonesia. Upon request from USAID, MCHIP procured computers for the MDGs Special Envoy Office.
- **Bumi Sehat.** Upon request from USAID, MCHIP provided special assistance to Bumi Sehat, an organization established by Robin Lim, who received the CNN Hero of the Year award. This assistance included facilitating and supporting a consultant tasked with development of a business plan for Bumi Sehat. A draft business plan was provided to the board of directors for Bumi Sehat.

Annex 2: Major MCHIP Documents¹⁷

NO	ITEMS	DESCRIPTION	REMARKS
1	Reports	Quarterly Reports Final Report	MCHIP MCHIP
2	Work plan		MCHIP
3	Tools/Module/ Guideline	Kelas IBU Flipchart Pregnancy Wheel IPNC Guideline & Job Aids Perinasia Manual ICMC Perinasia KMC Reports & PowerPoint C-IMCI Tools Final (PPK, Hospital & Midwives)	MOH & MCHIP MCHIP MOH & MCHIP Perinasia Perinasia MCHIP
4	SBM-R Guideline	Puskesmas (Bahasa Only) Hospital (Bahasa Only) Midwives (Bahasa Only)	MCHIP MCHIP MCHIP
5	Consultant Report	Comparative Analysis on Supportive Supervision (Bahasa Only) Final Report of the SBM-R Process Analysis (Summary in English and Full Report in Bahasa Only)	Syahrizal Syarif Puska UI
6	Survey/Research	HWWS Facility Based Delivery Comparative Analysis Supportive Supervision Survey SBM-R Process at Field	The London, Unilever & MCHIP Kathleen Higgins Syahrizal Syarif Puska UI
7	Book	Kibbla <i>Terpadu</i> Book Kibbla Replication Book	MCHIP MCHIP
8	Selected Photos		MCHIP
9	Selected Video		MCHIP
10	Mini University (National, Kutai Timur, Bireuen & Serang)	PowerPoint Presentations	MCHIP

¹⁷ Soft copies will be delivered separately.