Report of the Mid-Term Evaluation -

Expanding Maternal and Newborn Survival (EMAS) Program

USAID/Indonesia

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Dr. Broto Wasisto

Dr. Meiwita Budiharsana

Dr. Marjorie Koblinsky

Dr. Alfred Bartlett

Executive Summary

During April-May, 2014, an independent evaluation team commissioned by USAID/Jakarta carried out a mid-term evaluation of the Expanding Maternal and Newborn Survival (EMAS) Program. The USAID-supported EMAS program is a five-year cooperative agreement with JHPIEGO aimed at contributing to the reduction of maternal and newborn (MN) deaths in Indonesia. Maternal mortality in Indonesia remains substantially higher than expected in comparison with other south Asian countries having similar economies and states of development. Also, despite progress in reducing mortality among older infants and children, during the past decade Indonesia has not substantially reduced mortality among newborns (the first month of life). As a result, the country is losing momentum in its in child survival.

The EMAS program builds upon analysis of previous Indonesian maternal-child health programming approaches and USAID's experience in supporting those approaches. In the 1990's, Indonesia and USAID's support focused on training and deployment of large numbers of community midwives. More recently, this approach expanded to improve management of routine deliveries. During 2005-2010, with decentralization of the Indonesian health system, USAID supported strengthening of decentralized MN health services and engaging local government, which has budget and management authority over local health services. During 2010-2011, USAID supported development of approaches to improve quality and access to MN care through increasing use of evidence-based life-saving interventions, improving the referral system, and promoting district level problem solving.

These experiences led to recognition of the need to improve effective management of the illnesses and complications that result in maternal and newborn death. Therefore, USAID and the Government of Indonesia agreed that the EMAS program should focus on:

- Improving detection and management of complications at the *puskesmas* (primary health care center), where complicated MN cases are expected to enter the health system;
- Strengthening the effectiveness and timeliness of referral of complicated cases from Puskesmas to the hospital level where definitive management is supposed to be available; and,
- Improving quality of care and organization of services for complicated MN cases at referral hospitals - Emergency Department, Maternity Unit, Operating Room, and Neonatal Unit.

Within this focus, EMAS has several over-arching objectives:

- Contributing to 25 per cent national reductions in maternal and newborn mortality;
- Improving quality of emergency MN care in at least 150 hospitals; and,
- Improving life-saving clinical interventions and effectiveness of referrals in at least 300 *puskesmas*.

The EMAS agreement was awarded in September 2011; program implementation effectively started in 2012, meaning that the program has been carrying out its program approaches for just under 2 years, with roughly 2.5 years remaining. The EMAS approach has three main components, each with a set of specific activities:

- Improving quality of emergency MN care at *puskesmas* and referral hospital levels;
- Improving effectiveness of MN emergency referrals; and,
- Generating political and civil society demand and support for improved MN services and improved outcomes of MN complications.

Use of information/communication technology in support of these approaches is a cross-cutting element of EMAS's approach.

EMAS operates in 6 provinces (all are among the 9 provinces identified by the Ministry of Health as high-burden MN priority provinces). By end of agreement, it is currently planned that EMAS will have operated in 30 districts (of which 28 are among the 64 identified by the MOH as high-burden MN priority districts).

EMAS proposed a 3 Phase strategy. In Phase 1, EMAS implementing partners play a strong role in introducing the components listed above through a multi-stage mentoring approach. The facilities, Pokjas (oversight committees), and "Civic Forums" receiving this Phase 1 support are designated as "Vanguard" organizations when they reach a high level of compliance with the key components of the approach. These Vanguard facilities and organizations are to be the source of mentoring support to Phase 2 facilities and organizations. However, organization-wide improvement has not been uniform, although individual units and individual staff have reached the level of capability required for mentoring. For this reason, EMAS has begun Phase 2 by using a combination of its own implementing partners and selected mentors from Phase 1 facilities. EMAS has also begun developing experts from provincial and state-run teaching ("vertical") hospitals as additional mentors, consistent with the role of these high level facilities.

In Phase 1 (May 2012-September 2013), EMAS provided mentoring and assistance to 23 hospitals, 93 *puskesmas*, and associated stakeholder organizations in 10 districts. In Phase 2 (through September 2014), the program intends to reach 69 additional hospitals and 116 *puskesmas* in 13 additional districts and 6 cities. Phase 3 (through September 2016) proposes to reach additional services and organizations in an additional 7 districts.

The purposes of the mid-term evaluation were to:

- Assess EMAS progress in achieving the goal, objectives and planned outputs as stated in the agreement's project description and in approved workplans;
- Provide recommendations to improve EMAS program effectiveness over the remaining 2+ year life of project; and,
- Provide recommendations for USAID to consider in the design of future projects aimed at improving maternal and neonatal health in Indonesia.

The evaluation was carried out by a team of two senior Indonesian health experts and two US-based experts, all with substantial experience in maternal, child, and reproductive health and health systems. The evaluation included review of USAID and EMAS program-related documents as well as a substantial number of documents related to MN health and health policy and systems in Indonesia; review and analysis of program reports, tools, frameworks, data, assessments, clinical standards and guidelines, and monitoring/reporting instruments; meetings in Jakarta with USAID, EMAS, Ministry of Health and other government officials, representatives of professional associations, multilateral organizations, academics, and other stakeholders; and travel to field sites in 4 districts across 3 provinces, including meetings with local government and health authorities, directors, clinicians, and clinical staff in *puskesmas* and (public and private) hospitals, members of local non-government organizations and health advocacy groups, and patients. During the course of the evaluation, the team interviewed a total of over 200 informants (Appendix 4).

Major findings of the evaluation in terms of **Relationships with Government of Indonesia and GOI MNH strategies and programs** include:

- The EMAS approach is in line with GOI strategies and program approaches.

- At provincial and district level, political engagement by EMAS is high, contributing to increased awareness of maternal and newborn mortality and to uptake, support, and expansion of EMAS approaches.
- At central GOI level, both USAID and EMAS do not have adequate engagement and communication with the political level, with the result that EMAS's work and learning are not currently perceived as connected with national strategies and program approaches.

In terms of **Results of EMAS implementation**, key findings include:
- EMAS content is not new – however, the approach through which this content is supported by EMAS appears to encourage uptake and practice improvement.
- At provincial, district, and facility levels, EMAS appears to be contributing to positive changes in quality, organization, and management of MNH services.
- One of EMAS's most important results has been turning a fragmented non-system for referral into a functional network, and the development of relationships, connection, and communication within that network.
- In the past year, EMAS has undertaken a strategic approach to improvement of data availability, quality, and use, and has instituted some solid and potentially useful approaches.
- Overall, EMAS has generated some important and innovative engagement of private sector partners in organization and quality improvement of MNH services; however, this is limited.

In relation to **Achieving impact and sustainability at scale**, evaluation findings include:
- A major issue is that data available from EMAS and from health services where it is working do not allow connection of the observed and reported changes in processes with changes in health worker or system performance, nor with MN mortality.
- Because of this lack of certainty about performance and mortality, one of the most important things to determine is the actual operational and clinical causes of continuing maternal and newborn deaths.
- The limitations of EMAS capacity to directly engage in expansion may limit achievement of implementation at scale.
- Overall, EMAS has elements that can potentially be implemented at scale, but does not actually have a strategy for leveraging such implementation at scale.
- A key element of being an effective thinking, learning, and communicating organization – and of contributing to impact at scale – is to systematically generate and share learning from EMAS's engagement at the operational level.
- The MTE provides an opportunity for reconsideration and discussion of the quantitative targets that have been set for EMAS, in the light of both political reality and reality on the ground.
- There are important changes happening in Indonesia that could override efforts (including, but not limited to EMAS's) to increase effectiveness of MN services.

In terms of EMAS's own **Management**, the evaluation team found that:
- Some important management issues, including acting upon remaining findings and recommendations of the recent Management Assessment, need to be acted upon.

Based on these findings, the evaluation team concludes that the approaches developed and implemented by EMAS have important potential to improve the performance of Indonesia's health services in managing the complications that are the major causes of maternal and newborn morbidity and mortality. **To realize this potential at scale, however, EMAS needs to address critical challenges.** One is to identify the connection between the process changes that EMAS has succeeded in generating

with improvement in patient outcomes. Equally important is strengthening communication and connection with the GOI – especially the MOH – at the central level. EMAS also needs to work with USAID, the GOI, and other stakeholders to develop a strategy for implementation at scale that goes beyond its direct engagement, to link its results with national-scale initiatives and programs. Internally, EMAS needs to deal with management and organization issues identified by the earlier Management Assessment and the evaluation itself. More broadly, key areas in which EMAS is a stakeholder (but not the lead player) include in-depth study of the clinical and operational causes of high mortality in Indonesia, as well as examination of the effects of transition to the new JKN insurance program on effective management of MN complications.

Based on these findings and conclusions, the evaluation team makes several key recommendations, including:

For EMAS –

- Draw upon their Provincial Team Leaders as part of regular communication and experience sharing with the central MOH.
- Document and share the process by which this political engagement is generated, and the results of this engagement.
- Urgently seek to engage in systematic, regular, close and ongoing strategic technical and policy-level communication and consultation on MN policy and program direction to "build a bridge" with senior decision-makers in the central MOH.
- Within the next 2-3 months, complete EMAS's Learning Agenda through a collaborative process, engaging central and operational level partners.
- Systematically document the development of referral networks and the improved communication within them that occurs as a result, and bring this documentation to partners and stakeholders as soon as possible.
- Continue and increase its efforts to connect its data generation and indicators with facility management, referral system strengthening, and service delivery improvement with local government and advocates to inform decision-making, and with other ongoing or potential approaches to improve data availability and use by facilities and by health authorities.
- Define and monitor the connection of the program's inputs with intended changes in process and intermediate outcomes, and of those with reduction of MN mortality.
- Relate changes associated with EMAS's district-level work to the broader district context – *i.e.*, numbers of annual births in the district, MN coverage at facility level (whether EMAS supported or not), and district-wide MN mortality.
- Define and share with USAID and partners the approach by which it will monitor and evaluate the effectiveness of Phase 1 facilities and organizations in transferring the EMAS approaches they themselves have taken on.
- Engage the central and operational levels of professional associations as much and as effectively as possible to enlist them in the mentoring approach.
- Be aware of the JKN parameters and ensure facilities at all levels provide rapid receptivity to women in labor (whether referred or not), and work with provincial and district level staff of EMAS and the MOH to socialize the JKN requirements, review the referral options for women, and ensure that women have the paperwork necessary to be admitted to facilities for themselves and /or their newborns.
- Carefully document and bring to the central level the effects they encounter of JKN implementation on care and referral received by women and newborns in the districts where EMAS is working.

- Implement the recommendations of the recent Management Assessment, including hiring a seasoned Deputy Director with substantial management and program experience, and organizing HQ staff, relations, and communication clearly and effectively.
- Make all possible efforts to fill staff vacancies at province and district team levels, since these vacancies are affecting aspects of program support and the back-up capacity at the next level is limited.

For USAID and EMAS -

- Communicate clearly how EMAS's focus of work aligns and connects with the broader context of and system requirements for MN mortality reduction, and with national and subnational strategies for MNH.
- Develop and support a study to define the probable clinical and/or operational causes of such deaths, in EMAS areas/facilities and more broadly in EMAS districts.
- Advocate with the GOI to make funds available for mentoring activities by provincial and vertical hospitals, to support their participation in mentoring.
- Develop a plan for achieving effect and impact at scale by connecting key lessons and components of EMAS's approach with other forces and initiatives that can bring these into the mainstream of MN health policy and programs in Indonesia.
- Use this mid-point evaluation to discuss among themselves, and with GOI and other stakeholders, the most relevant impact goal and district/facility targets to maximize EMAS's effective contribution and learning.

For USAID –

- Request and encourage MOH leadership to participate in experience-sharing activities with provincial and district representatives and EMAS staff.
- Engage in systematic, regular, close and ongoing technical and policy-level communication and consultation on MN policy and program direction with senior decision-makers in the central MOH by drawing on its senior level health experts.
- Consider funding a study regarding the implications of the fertility and family planning plateau and its impact on maternal mortality, to inform discussions of how to ensure healthy fertility rates.
- ***IF*** – ***AND ONLY IF*** - USAID determines that EMAS has developed the capacity and taken the actions required to respond to the recommendations of this evaluation, ***THEN*** USAID should consider identifying additional funds and a mechanism to extend EMAS's work by two additional years, without waiting until year 4 or 5; extending the program's work will substantially increase the probability of having the important investment USAID is making through EMAS achieve scalable and sustainable results.

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[IN USAID VERSION ONLY]

APPENDICES

Abbreviations

Bappenas	Badan Perencanaan Pembangunan Nasional
BEmONC	Basic Emergency Obstetric and Newborn Care
BPJS	Badan Penyelenggara Jaminan Sosial
BPS	Badan Pusat Statistik
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CPAP	Continuous Positive Airway Pressure (breathing support)
DHO	District Health Office
GoI	Government of Indonesia
IBI	Ikatan Bidan Indonesia
IDAI	Ikatan Dokter Anak Indonesia
IDI	Ikatan Dokter Indonesia
Jamkesda	Jaminan Kesehatan Daerah (Local Government Health Insurance)
Jamkesmas	Jaminan Kesehatan Masyarakat (Community Health Insurance)
Jampersal	Jaminan Persalinan (Community insurance for antenatal, childbirth, and postnatal care)
JNPK	Jaringan Nasional Pelatihan Klinis (National Clinical Training Network)
JPKM	Jaminan Pemeliharaan Kesehatan Masyarakat (Public Health Care Insurance; managed-care model)
JKN	Jaminan Kesehatan Nasional
JNPK	Jaringan Nasional Pelatihan Klinis
LKBK	Lembaga Kesehatan Budi Kemuliaan
MDGs	Millennium Development Goals
MenKoKesra	Ministry of People's Welfare
MN	Maternal and Newborn
MoH	Ministry of Health
MOU	Memorandum of Understanding
MTE	Mid-Term Evaluation
PE/E	Pre-Eclampsia/Eclampsia
PerDa	Peraturan Daerah (District/municipality regulation)
PKK	Pemberdayaan dan Kesejahteraan Keluarga
POGI	*Perkumpulan Obstetri Ginekologi Indonesia*
Polindes	Pondok Bersalin Desa (Village Maternity Hut)
Posyandu	Pos Pelayanan Terpadu (Integrated Health Post)
PUSDATIN	Pusat Data Indonesia (Center for Data, MoH Indonesia)
PWS KIA	Pemantauan Wilayah Setempat Kesehatan Ibu dan Anak (Local Area Monitoring for Maternity and Child Health)
Puskesmas	Pusat Kesehatan Masyarakat (Community Health Center)
Risfaskes	Riset Fasilitas Kesehatan
Riskesdas	Riset Kesehatan Dasar
SOP	Standard Operating Procedures
TN2PK	Tim Nasional Percepatan Penanggulangan Kemiskinan (National Team for Accelerating Poverty Reduction)

Introduction – Maternal-Newborn health context in Indonesia (4,610,000 births expected in 2015) and USAID's response

Indonesia, the fourth most-populous country in the world, continues to face major health care challenges since the economic collapse of 1997 that resulted in a sharp increase in the population in and near poverty. In response, the government moved quickly to reduce socioeconomic inequity in health care access through a series of health insurance plans, resulting recently in the 2014 launch of universal health coverage by 2019 through Jaminan Kesehatan Nasional (JKN). In 2001, decentralization and devolution of authority to districts was initiated to increase responsiveness to local conditions. ***Even so, the health status of the country continues to lag behind neighboring countries, especially in maternal and newborn health.*** This is especially prominent in Indonesias's maternal mortality ratio, which is substantially higher than that of other south Asian countries having similar levels of economic development. While it has made substantial progress in reducing mortality rates among older infants and children under age five, Indonesia has failed to make progress in reducing the rate of newborn mortality, which has been stagnant for the past decade. Contributing to this lack of progress is overall low government spending on health. And although Indonesian women's status improved between 1990 and 2010, with gender parity in education at the primary, secondary and tertiary levels (World Bank 2012), better women's rights (Satriyo HA. 2008), more participation in government (Bachelet M. 2012), and progress in women's participation in decision making at household level, the important exception is women's decision making for their own health care (IDHS 2003, 2013).

Outcomes

Reducing maternal mortality is now and has been a national priority in Indonesia since the Safe Motherhood Initiative was launched globally in 1987 (AbouZahr 2003). While estimates of the absolute numbers of maternal deaths have decreased by nearly two thirds between 1990 and 2010 to less than 10,000, reduction of the maternal mortality ratio (MMR) appears slow and with variable progress depending on the estimation method used (IDHS et al 2013; IDHS2003; NAS and AIPI 2013). The 2013 estimate for the MMR is 190/100,000 live births, according to WHO (2013). Inequities remain: mothers who die are typically between 20-34 years old, rural, and poorly educated (NAS and AIPA 2013). For neonatal mortality, the poorest experience three times more deaths than the richest (IDHS et al 2013; IDHS et al 1991).

Facility birthing has tripled, from 21% to 63% between 1991 and 2012 (IDHS et al 2013; IDHS 1991), with the poorest making the smallest gains: 30% facility birthing versus 88% in the richest quintile (2012) (IDHS 2013). Progress in "facility birthing" needs to be qualified: of the 46% women who were using "health facilities" in the mid-2000s, only one of four gave birth in a hospital (IDHS 2008). 65% of "facility births" were in private midwifery clinics and village birthing posts - often the home of a village midwife - where, for example, 90% lacked a sterilizer or resuscitation equipment and 80% lacked magnesium sulphate (AIPMNH-NTT 2008). A further 6% of women gave birth in health centers, *puskesmas*. Only 15% of the public *puskesmas* are functioning as PONED centers (have staff trained in BEmONC) (World Bank 2014).

Caesarean section rates have increased from 0.8% (1986-91) to 12.3% (2007-2011) (IDHS 2013; IDHS 1992). Although women with severe obstetric complications typically rely on public hospitals, most caesarean sections are provided in private facilities, with a large gap between the poor and rich: only 3.7% among those in the poorest quintile had a caesarean for birth versus 23% among the richest in 2012 (IDHS 2013).

Access to services and quality of care
When the Government of Indonesia (GoI) launched their Safe Motherhood Initiative in the late 1980s, the main focus was on a rapid scale-up of access to professional care, the centerpiece of which was the *Bidan di desa*, the village midwife program. By 1997, over 54,000 midwives had been deployed, and by 2012, the number of midwives had risen to over 200,000 (NAS and AIPA 2013). Even so only 40% of the villages are reported covered, with many midwives moving to urban areas to increase their patient load.

Between 1991 and 2012 midwife-assisted births increased by 53 percentage points, from 31% to 84% (IDHS 2013; IDHS 1991), but persistent poor quality of care has been well documented (World Bank 2010; Ensor et al 2008; Rokx et al 2010). Confidential inquiries in western Java found village midwives' emergency diagnostic skills to be accurate, but clinical management of complications wanting (D'Ambruoso L et al 2009).

Reasons behind the poor performance of midwives are partly related to deficiencies in the basic training consequent to the pace of scale up, and partly to the deployment strategy. Midwifery academies have proliferated over this past decade and with over 750 now existing, midwifery students do not have enough clients during training to become proficient. When posted, a midwife may be a sole provider at village level, working under different employment means (civil servant, short-term contract staff, or private practitioners) with varying levels of supervision and referral support. The low volume of work per midwife compounds the lack of training and experience with obstetric emergencies and referral possibilities for many midwives: village midwives may average 30 births or lower per year (IBI 2014 pers comm). And while the issue of individual capacities and preparation of midwives led to a three-year training program by the mid-1990s, and certification of graduates is currently in development, performance problems have been exacerbated by poor communication between midwives and referral support. Sub-optimal support from referral sites, including the lack of 24 hour accessibility, the lack of communication between the levels of care, and the unintended consequences of incentives/disincentives in the system, have continued to hinder quality improvement.

The lack of coordination between midwives and their referral system has been known for some time—but little effort has been made to overcome the problems. For example, deployment of midwives was poorly coordinated with the parallel expansion of the hospital network (a 22% increase in the number of hospitals between 1998 and 2008, with most of the increase in larger size hospitals [Hort et al 2011]) and continued expansion of the *puskesmas* since the 1980s. Equipment and supply systems for maternal and newborn care also lagged behind. In 2011, a national facility survey showed that of the nearly 9000 health centers only 45% met the personnel requirement to provide BEmONC, 12% had the required equipment, and 28% could provide 24 hour services (Riskfaskes 2011). While 83% of public hospitals had at least one obstetrician (not necessarily full-time), only 21% met the nine CEmONC criteria, including a 24 hour operating room, blood, laboratory and radiology services, and a team available 24 hours a day. Less than half could provide comprehensive maternity services due to lack of qualified human resources, equipment and blood. There is also regional and geographic imbalance in health care delivery - given the 15,000 islands of Indonesia, this is not surprising, but presents problems in terms of ensuring all have access to the care needed (NAS and AIPI 2013). The GoI has recently launched policies and regulations to improve hospital and health center services including appropriate recruitment and distribution of human resources, accreditation of hospitals and *puskesmas*, introduction of quality improvement cycles, maternal and perinatal audits, and increased financial support from central as well as local government to address the gaps in infrastructure, equipment and supplies.

Poor quality of care at both midwifery and hospital levels has influenced the way families recognise problems and make decisions to move women to care. This has been compounded by very substantial transport and inpatient costs: typically US$111 for a normal birth and US$423 for a Caesarean section (Pujiyanto. 2009). A 2005 financial safety net for health has since evolved into national and district-level insurance programs for the poor and near poor, with the ambitious goal of universal coverage by 2019 (World Bank 2010). These insurance programs have reduced the equity gap in accessing services, but not yet eliminated it. They also cover transport costs, but only partially and not to the first level of care, costs of which are borne by families.

Steering and governance support

Given the size and complexity of the country, with over 500 districts and municipalities, and the heavy reliance on a private sector that represents a challenge as well as an asset, effective governance and integration of the health care delivery system has been a persistent problem. In 1999, Indonesia decentralized health policy and program management to district level with the intention of improving access and quality of health services. Given the variable capacity to design policies and to fund and manage programs across the districts and municipalities, the results have been uneven. Persistent lack of coordination of the different levels of government institutions, especially at district level, has resulted in uneven progress and achievement among districts, a multiplication of approaches and organizational set-ups, with little capitalization on lessons learned. Midwifery care at primary health facilities and hospital care for emergencies have been managed and funded separately, with resulting communication and accountability problems (Heywood, and Harahap 2009). The absence of integration and continuity in the system has severely constrained the effectiveness of the maternal and newborn programs.

National regulations set minimum standards for districts for 18 health indicators in 2008; five of these health indicators relate to maternal, newborn and child health. Absence of a reliable health information system to enable efficient and effective management of health and insurance programs is well recognized; however, effective solutions have remained at the planning stage.

The GoI is committed to identifying and addressing ongoing challenges as they arise: for example, the GoI recently included private sector providers in the National Insurance Program, the JKN. Much hope has been put in the flexibility decentralization would allow. The lesson learned, however, is that decentralization does not always lead to improved maternal and newborn services. The issues of equity and quality of care also require attention. Decentralization and devolution of authority to districts gives the mayor of each district the authority to select programmatic direction for the district. The political commitment shown at national Ministry level has not necessarily been taken up at district level.

USAID's response to the current situation of maternal and newborn health in Indonesia is its support for the Expanding Maternal and Newborn Survival (EMAS) program. EMAS builds upon analysis of previous Indonesian programming approaches and USAID's experience in supporting those approaches. As noted above, Indonesia and USAID have previously focused on increasing availability of and demand for "skilled" birth attendants through training and deployment of large numbers of community midwives, and on improved management of routine and emergency deliveries. During 2005-2010, in the face of decentralized management of health services, USAID supported the Health Services Program, which worked on strengthening decentralized MNH services and engagement of local government, as well as seeking approaches to improve quality and access to perinatal care. From 2010-2012, a "bridge program" implemented through USAID/Washington's Maternal Child Health Integrated Program (MCHIP) focused on increasing use of evidence-based life-saving interventions, improving the referral system, and district problem solving.

As illustrated below, from these experiences, and the emerging recognition that **improved maternal and newborn survival in Indonesia requires improved management of the illnesses and complications that result in maternal and newborn death**, USAID and the Government of Indonesia agreed that the EMAS program should focus on:

- Improving detection and management of complications at the *puskesmas*, where complicated maternal and newborn cases are expected to enter the health system;
- Strengthening the effectiveness and timeliness of referral of complicated cases to the hospital level where definitive management is supposed to be available; and,
- Improving quality of care and organization of services for complicated MN cases at referral hospitals (Emergency Department, Maternity Unit, Operating Room, and Neonatal Unit).

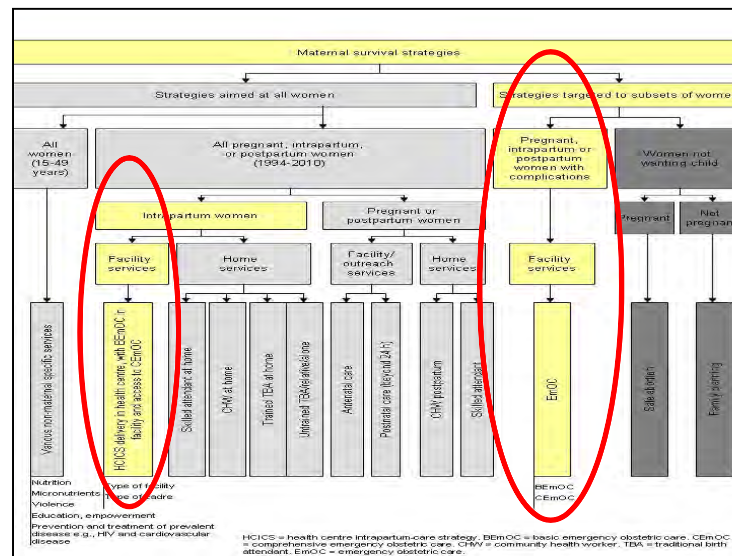


Figure 1 – Strategic framework for maternal health interventions, indicating areas (red circles) selected by USAID and GoI as focus of the EMAS program (based on *The Lancet*)

EMAS began in September 2011; actual program implementation effectively started in 2012, meaning that the program has been carrying out its program approaches for less than 2 years. The agreement has roughly 2.5 years remaining. At this point, in accordance with the timetable in the program design, USAID determined that an in-depth mid-term evaluation was appropriate.

I. The purpose of the evaluation

This mid-term evaluation is intended to:

- Assess EMAS progress in achieving the goal, objectives and planned outputs as stated in the agreement's project description and in approved workplans;
- Provide recommendations to improve EMAS program effectiveness over the remaining 2+ year life of project; and,
- Provide recommendations for USAID to consider in the design of future projects aimed at improving maternal and neonatal health in Indonesia.

Evaluation Questions

1. What are the major EMAS accomplishments to date? Identify key strengths in the EMAS program approach.
2. What evidence is there to validate the overall development hypotheses and programmatic approach? A complete response will address at a minimum:
   a. Effectiveness of technical content of EMAS.
   b. Strengths and weaknesses of the EMAS vanguard model, mentoring approach, engagement of partners through POKJAs, and engagement of provincial hospitals.
   c. Effectiveness of ICT and governance interventions, judged by contribution to achieving health objectives?
   d. What success has been achieved in engaging the private sector service providers? What opportunities, strengths and weaknesses can be identified to guide additional actions?
   e. Have there been any unanticipated changes in the host country or donor environment that suggest the need for changes in emphasis in the EMAS project to minimize implementation problems or unintended consequences and/or maximize impact in the remaining time available?
3. To what extent have monitoring information and lessons learned during project implementation been used to inform project management decisions? A complete response will address at a minimum:
   a. Whether systems for program monitoring are providing timely and relevant information to the appropriate individuals with responsibility and authority to act.
   b. Adjustments to program approaches that have been made based on such information.
   c. Whether such adjustments are likely to improve prospects for program impact, sustainability and scale-ability.
   d. Recommend specific new approaches and decision support tools to improve feedback for informed decision making.
4. What are the prospects for EMAS achieving impact at scale? A complete response will address at a minimum:
   a. The extent to which the approach to achieving sustainability and impact at scale are articulated in project documents.
   b. Whether EMAS approaches and materials are sufficiently in-line with existing standards and systems to be integrated into standard practice in systems operating at scale.
   c. The extent to which the EMAS learning agenda addresses main policy and program questions and evidence requirements to support sustainability and spread of EMAS innovations and approaches.
   d. The effect of partnerships with U.S. hospitals, commodity donation charities, or the private sector (Laerdal, GE, Chevron) on programmatic results or prospects for sustainability. What are the strengths, weaknesses, lessons learned, unintended outcomes, and cost effectiveness of these endeavors?
   e. Opportunities, strengths, and weaknesses of EMAS engagement of Indonesian partners both within the project and external – including government and private sector entities at the central, provincial and district levels, leadership of public and private facilities, professional associations, academics, and civil society.
5. Are all expected results likely to be achieved by the completion of the project and, if not, what changes in targeted results and/or implementation approaches should USAID/Indonesia consider?
   a. Are work plan milestones and results being achieved?
   b. Are EMAS project implementation priorities sufficiently focused for the best application of limited resources? Are there low yield (or likely low yield) project elements that should be

reduced or eliminated? Are there elements that should receive increased attention and resources?

c. Is the project reaching the desired beneficiaries? If not- why not?

[Note – Question 6 (financial management) is to be answered through a different mechanism, not by this Evaluation team]

II. **Brief description of the EMAS program**

The USAID-supported EMAS program is a five-year cooperative agreement with Jhpiego aimed at contributing to the reduction of maternal and newborn (MN) deaths in Indonesia. Sub-grantees include:

- the Budi Kemuliaan Health Institute (for mentoring to improve quality and management of facility-based MN care);
- Muhammadiyah (for MN service delivery improvement in its own and other private facilities, and for organization of civil society support for MN service improvement);
- Save the Children (for technical support in improving newborn care); and,
- Research Triangle Institute-RTI (for engagement of local government and development of information/communication technology approaches to help the program achieve its goals).

EMAS has several over-arching objectives. These include:

- Contributing to 25 per cent national reductions of maternal and newborn mortality;
- Improving quality of emergency MN care in at least 150 hospitals; and,
- Improving life-saving clinical interventions and effectiveness of referrals in at least 300 *puskesmas* (health centers).

USAID recognizes that improvement of care, even in this relatively ambitious number of facilities, cannot be the sole approach required to achieve the at-scale mortality reductions proposed under this agreement. These at-scale mortality reduction objectives are USAID's primary objective for EMAS.

The EMAS approach is now considered to have three main components, each with a set of specific activities. These are:

1. Improving quality of emergency MN care at *puskesmas* and referral hospital levels, by -

- Engaging facility leadership
- Modelling and mentoring from facilities with high quality services
- Carrying out shared assessment of facility capacity and services
- Establishing use of performance standards
- Introducing processes and tools to support improved provider practice (*e.g.*, emergency drills, organization of services, job aids and other decision support tools, assurance of stocked and accessible maternal and newborn "emergency trolleys")
- Establishing death and near-miss audits
- Establishing use of clinical "dashboard" for service monitoring
- Developing and promulgating "service charters" (agreements between facilities and stakeholders on services provided – operationalizing the 2009 Public Services Law)
- Improving feedback and communication within facilities
- Promoting rotations of *puskesmas* staff in referral hospitals
- Strengthening facility-based data recording and use for decision-making.

2. Improving effectiveness of MN emergency referrals, by –

- Engaging local government and health authorities, professional associations, hospitals (public and private), health centers , and other stakeholders in developing agreement on referral pathways

(MOUs); also in some cases, developing joint Standard Operating Procedures (SOPs) to define roles and responsibilities in the referral chain

- Introducing referral performance standards
- Establishing communication channels to support better information exchange during emergency MN referrals, including developing an sms-based system to facilitate referrals (SijariEMAS)
- Promoting Maternal-Perinatal Audits (MPAs)
- Promoting effective use of available insurance programs that support MN services
- Developing "citizen feedback mechanisms"

3. Generating political and civil society demand and support for improved MN services and improved outcomes of MN complications, by -

- Supporting formation of multi-stakeholder *Pokjas* (oversight committees, convened by Provincial and District Health Officers) to monitor and promote effectiveness of MN services, and establish legal and budgetary support for those services
- Supporting formation of groups of relevant civil society organizations in a "Civic Forum" to increase awareness of MN complications and appropriate preparation and care-seeking, channel community concerns to the political level, and participate in development of service charters.

Use of information/communication technology in support of these approaches is a cross-cutting element of EMAS's approach.

EMAS operates in 6 provinces (all of which are among the 9 provinces identified by the Ministry of Health as high-burden MN priority provinces). By end of agreement, EMAS intends to have operated in 30 districts (of which 28 are among the 64 identified by the Ministry of Health as high-burden MN priority districts). To implement its approaches, EMAS proposed a 3 Phase strategy. In Phase 1, EMAS implementing partners play a strong role in introducing the components listed above. This work is done through a systematic multi-stage mentoring approach, which differs from conventional training in being a side-by-side process of assessment, problem identification, problem-solving, and skill-building approach. This approach is intended to develop consciousness of the need for and value-added of the elements EMAS program in improving MN services.

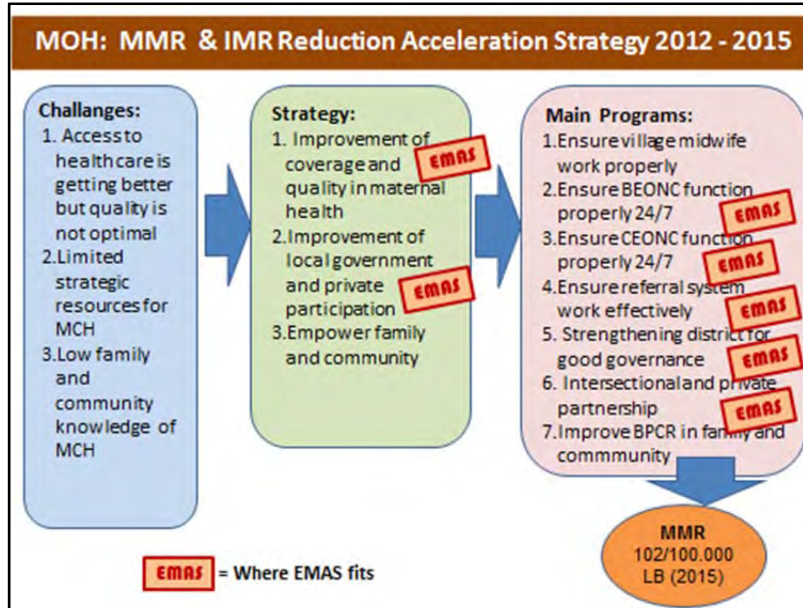
The facilities, *Pokjas*, and Civic Forums receiving this Phase 1 support are intended to become "Vanguard" organizations when they reach a high level of compliance with indicators of implementation of key components of the approach. These Vanguard organizations and facilities are intended to be the source of mentoring support to Phase 2 organizations and facilities. However, organization-wide improvement has not been uniform, although individual units and individuals have reached the level of capability required for mentoring. For this reason, EMAS has begun mentoring in Phase 2 by using a combination of its own implementing partners and selected mentors from Phase 1 facilities. EMAS has also begun developing experts from provincial and "vertical" hospitals as additional mentors, consistent with the role of these high level facilities.

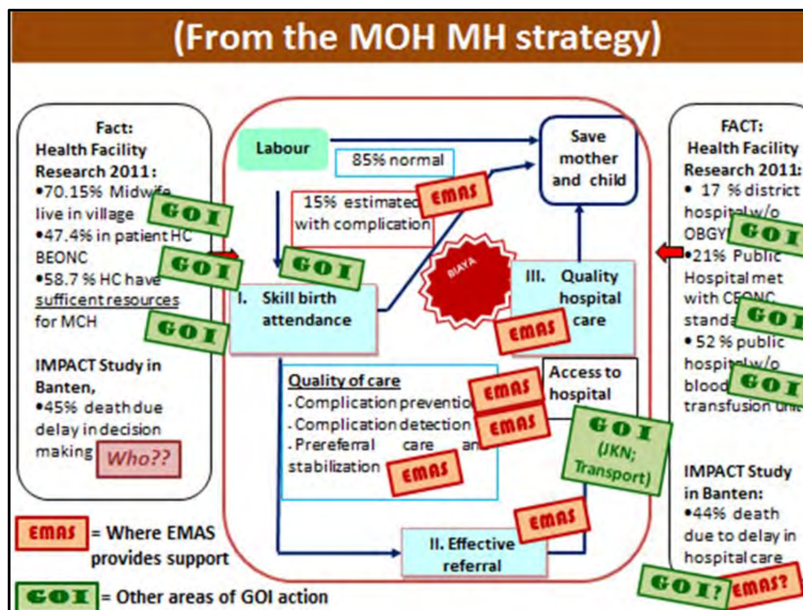
In Phase 1 (May 2012-September 2013), EMAS provided mentoring and assistance to 23 hospitals, 93 *puskesmas*, and associated stakeholder organizations in 10 districts. In Phase 2 (through September 2014), the program intends to reach 69 additional hospitals and 116 *puskesmas* in 13 additional districts and 6 cities; it will also provide limited support to an additional 474 low maternity volume *puskesmas* in those same districts/cities. Phase 3 (through September 2016) proposes to reach additional services and organizations in an additional 7 districts.

III. Major Findings and Recommendations

A. Relationships with Government of Indonesia and GOI MNH strategies and programs

- **The EMAS approach is in line with and aims to strengthen GOI strategies and program approaches such as PONED and PONEK.**
  - *EMAS addresses part (not all) of what Indonesia hopes to do to reduce MN mortality.*
  - *It works within and strengthens efforts in MOH priority provinces and districts.*
  - *It works with and strengthens the teaching/provincial hospitals of these areas to become mentors of district hospitals and puskesmas in these areas, and ensures coordinated referral.*





Figures 2a & 2b – Where EMAS fits within GoI strategies for maternal-newborn health

- *With minor exceptions (e.g., completing initial set-up of "emergency trolleys") EMAS works entirely within the resource envelope – budget, staff, facilities, equipment, drugs and commodities – of health services in the provinces and districts where it works.*
- *The tools EMAS has developed and promotes to improve performance and MN health service organization are based on and help implement national standards and guidelines.*
- *Therefore, if EMAS approaches are documented to improve effective implementation of national and local MN policies and services, scale-up and sustainability would not require extraordinary inputs by the health system itself.*

Recommendation (for USAID and EMAS) - EMAS and USAID need to communicate clearly how EMAS's focus of work aligns and connects with the broader context of and system requirements for MN mortality reduction, and with national and subnational strategies for MNH.

- **At provincial and district level, political engagement by EMAS is high, contributing to increased awareness of maternal and newborn mortality and to uptake, support, and expansion of EMAS approaches.**
  - *EMAS's Province-level Team Leaders are highly experienced, networked, credible, and politically effective; they are typically have held high positions in their geographic areas and are well connected.*
  - *EMAS engagement at Province and District levels has frequently led to engagement by and support from Bupatis, DHOs, and hospital/puskesmas leadership.*
  - *In some cases, Bupatis have issued decrees mandating implementation and even expansion of approaches initiated by EMAS (e.g., referral MOUs); in some cases, this political support has been matched by budget support for improvement of equipment and facilities and even for program expansion (e.g., Jombang District) or the promise of budget support in the coming financial cycle (e.g., Pinrang District).*
    - *Recent data from EMAS indicate a total of 31.5 billion rupiah of additional funds mobilized from Provincial, District, and Sub-District sources for local replication and expansion of EMAS's work.*
  - *This governance dimension is a critical component of EMAS's work in relation to achieving both scale and sustainability; it is separate from what EMAS calls "clinical governance" (which is really facility management).*
  - *In addition to direct liaison with local government to exert influence, there is room for strengthening advocacy (through Pokjas), more effective use of data (for both advocacy and planning), and identification and grooming of local champions to solidify local support.*
  - *The seniority and relationships with local government leaders of provincial and district team leaders are important complements to the operational support to governance activities (such as MOU, SOP, and Service Charter development) being carried out by EMAS's provincial governance specialists.*

Recommendations (for EMAS) – EMAS should draw upon their Provincial Team Leaders as part of regular communication and experience sharing with the central MoH – for example, having these Team Leaders come to Jakarta every quarter to meet with MoH stakeholders and the central *Pokja*.

- EMAS should document and share the process by which this political engagement is generated, and the results of this engagement – including where attempts to develop political

support did not work, why this appears to have happened, and whether and how they overcame those difficulties.

- EMAS should also identify additional approaches and efforts required to broaden and sustain political commitment to MN survival and health in the face of changes over time in individual elected officials and local champions.

Recommendation (for USAID and EMAS) – USAID and EMAS should review the progress and effects of work in the area of governance (that is, engaging local government, versus "clinical governance" of facilities) – including implementation of operational components such as development of referral MOUs or Service Charters, as well as the effect of provincial and district team leaders' personal efforts - to identify essential elements required for effecting change at scale.

Recommendation (for USAID) – USAID should request and encourage MoH leadership to participate in experience-sharing activities with provincial and district representatives and EMAS staff, since these activities represent the reality that MoH is trying to support, but MoH participation in such interaction in the past has been limited.

- ***At central GoI level, both USAID and EMAS do not have adequate engagement and communication with the political level, with the result that EMAS's work and learning are not currently perceived as connected with national strategies and program approaches and may not be accepted and supported for broader application.***
  - *Since MN mortality reduction is among USAID's and the GoI's highest health priorities, and since EMAS is a cooperative agreement – that is, a partnership between Jhpiego (and its sub-grantees) and USAID/Indonesia – both USAID and EMAS have important, but different and complementary, roles to play in engaging the GoI at senior levels.*
  - *USAID had substantive interaction and agreement with senior GoI (MoH) counterparts during program design, agreeing on the program focus, design, targets, and awardee selection, as well as during the first year of implementation.*
  - *However, during more recent EMAS implementation there has been turnover of senior leadership in most of the components of the central MoH with which EMAS needs to work.*
  - *At the same time, USAID's approach to senior level communication with the MoH also changed after year one, so that it now appears that USAID has not been as effectively engaged at the senior policy level.*
  - *The existing USAID-MoH liaison mechanism (funded through EMAS) appears to be useful for intermediate-level communication, but does not provide the technical and political seniority required to establish and maintain improved MOH support.*
  - *Similarly, while EMAS itself has ongoing technical interaction with MoH counterparts in several areas, it does not have adequate representation nor effective relationships at the policy leadership level.*
  - *In some cases, decisions or miscalculations by EMAS partners have contributed to misunderstanding with the central MoH.*
    - *The selection of and heavy reliance on LKBK as lead mentoring partner, rather than GOI facilities or other expert capacities, has led to some resentments.*
      - *The specific question was raised of why the formerly USAID-supported National Clinical Training Network (Jaringan Nasional Pelatihan Klinik, JNPK), in which the national and*

local chapters of the Indonesian Obstetrics and Gynecology Association (POGI) play a leading role, was not engaged.

        - *At the operational (district) level, the visionary and transformational approach taken by LKBK has <u>proven to be a key element</u> in the acceptance and uptake of EMAS's inputs.*
        - *However, at the central level, this approach and its representation have sometimes generated misunderstandings with some Echelon 2 officials of the MoH, with resulting difficulties in relationships and support.*
    - *The result of this apparent political isolation of USAID's program and EMAS's assistance from MoH senior leadership has in some cases led to the perception of EMAS as being parallel to or competitive with GOI strategies, and in some cases to misunderstanding of USAID's assistance (e.g., an apparent mistaken perception by some Indonesian government officials that the $55 million budget for USAID support of technical assistance through EMAS might represent an increase in the MoH's own MN budget and might therefore justify a reduction in the GoI's own MN funding).*
    - *There is positive support to build on, including the existence of the central Pokja (established by decree of the MoH and chaired by head of Child Health), the recent Ministerial Decree establishing continued MoH leadership for that Pokja, and the very recent designation the Director General of Nutrition & Maternal-Child Health as Chair of the central Pokja by the Secretary General of Health.*
    - *However, senior MoH managers at DG level who have positive perceptions of EMAS's approaches still report not seeing EMAS as being clearly connected to the MoH's own strategic approaches; they would like to see it be closely linked to the government's ongoing policy and program development.*
        - *The MoH Maternal Health department has stated that there needs to be better connection and communication of EMAS' work with the government's own MNH strategy.*
    - *In the absence of proactive establishment of better connection and relations at MoH leadership level, negative feelings and concerns about EMAS appear to be spreading.*
    - *While central MoH political support by itself cannot assure the achievement of scale and sustainability, lack of that support will certainly impede that achievement.*
    - *EMAS also believes that conditions required for achieving scale and sustainability will require engagement of <u>additional</u> elements of central government, including the Ministries of Home Affairs (decentralization) and Women's Empowerment as well as JNPK (National Training Network) and BPJS (managers of the JKN insurance program), and others outside government (e.g., the professional associations—IBI, POGI, IDAI, IDI).*

<u>Recommendations (for USAID)</u> – USAID should closely examine the history and status of their own policy-level relations with the central MoH, to identify where relations may have gone off track and what steps need to be taken to revitalize those relationships.

– Based on that analysis, USAID should engage in systematic, regular, close and ongoing technical and policy-level communication and consultation on MN policy and program direction with senior decision-makers in the central MOH by drawing on its senior level health experts, <u>specifically Dr. Bateman and Ms. Koek (and her successor)</u>; this senior level of communication cannot be achieved with less senior USAID staff.

<u>Recommendation (for EMAS)</u> – EMAS must urgently seek to engage in systematic, regular, close and ongoing strategic technical and policy-level communication and consultation on MN policy

and program direction to "build a bridge" with senior decision-makers in the central MoH and to repair relationships where misunderstandings exist and have not been dealt with effectively.

- *To do this, EMAS will need to add to its staff a highly experienced, well-regarded and politically savvy and connected, diplomatic senior policy advisor; the Evaluation Team strongly recommends that this be a new senior staff position, since we do not see this capability among existing EMAS Jakarta staff (the role and profile of such an advisor at central level would be similar to those of EMAS's Provincial Team Leaders).*

  NOTE: The Evaluation Team identifies this senior policy advisor position as distinct and separate from the "competent, well-seasoned Deputy Director from outside the EMAS structure to lead operations" identified in Recommendations of the recent EMAS Program Management Assessment. As noted in our Findings and Recommendations on program management (below), the Evaluation Team believes that this recommended Deputy Position post is also essential to EMSA functioning, and should also have in-depth understanding of the program and policy environment in which EMAS is operating at central and operational level, as well as the ability and credibility needed to establish and maintain excellent working relations with GoI counterparts.

B. Results of EMAS implementation

- **EMAS content is not new – however, the "*pendampingan*" approach through which this content is supported by EMAS appears to encourage uptake and practice improvement.**
  - *"Mentoring" & "Assisting," not "Training."*
  - *Health worker (including professionals) perceived self-improvement:*
    - *"Doing our jobs better;"*
    - *"Not being judged or talked at;"*
    - *"If we are going to mentor others, we need to be as good as possible ourselves;"*
    - *Practice, drills, self-criticism for improvement.*
  - *Referral coordination.*
    - *MOU development and endorsement, and collaboration in MOU development among care providers at the different levels of care.*
    - *Team development: Emergency teams at both levels that continue to practice drills as part of their job.*
    - *Referral standards that provide information on how to diagnose and stabilize patients prior to referral, and how to respond at the recipient end.*

Recommendation (for EMAS) – As the mentoring responsibility is spread among Phase 1 facilities and organizations, and among other trainers (*e.g.*, vertical and provincial hospital staff, professional associations) EMAS must ensure that this "*pendampingan*" dimension is understood and applied effectively by those additional "mentors," since it appears to be a key to effective change of practice.

- **At provincial, district, and facility levels, EMAS appears to be contributing to positive changes in quality, organization, and management of MNH services**.

  Observed changes include:
  - *Hospitals and puskesmas making renovations and changes in facilities for managing MN emergencies (e.g., establishing maternal and newborn emergency sub-areas in emergency*

rooms, relocating maternity or newborn care units to be more accessible, increasing privacy);
  - *Increasing and updating key equipment (CPAP, incubators);*
  - *Assuring availability and organization of emergency drugs and equipment through "emergency trolleys;"*
  - *Carrying out regular emergency drills to establish and maintain effective emergency care);*
  - *Organization of maternal and newborn emergency teams with defined roles for specific team members;*
  - *Posting emergency recognition and management guidelines in relevant units;*
  - *Using "dashboards" (though not uniformly) to track management indicators in MN units;*
  - *Stabilization of referral patients and timely referrals and response.*

- **One of EMAS's most important results has been turning a fragmented non-system for referral into a functional network, and the development of relationships, connection, and communication within that network.**
  - *Ensuring regulations from the Bupati or local parliament for the care system/ approach is an important first step in establishing the commitment and coordination of the providers at different levels.*
  - *The referral MOU development process not only specifies referral pathways, but also builds relationships: hospital bidan to puskemas bidan, bidans to specialists, etc.*
  - *SOP development, when combined with an MOU establishes a system in place of what is now fragmentation.*
  - *The SijariEMAS sms-based system for bidan, puskesmas, and hospital referral coordination has substantial acceptance and appears to be feasible for most districts and facilities.*
    - *SijariEMAS also has substantial appeal – it may actually turn out to be an important and effective driver of attention to improved referral.*
    - *SijariEMAS can also become an important source of data and analysis regarding referral processes (and for accountability).*
  - *By promoting team approaches, EMAS's assistance also fosters and supports leadership within facility staff.*
  - *The networking/team approach has engaged and established some degree of communication between public and private facilities in an innovative manner.*
  - *This is probably one of the most important products of EMAS's work to improve management of MN complications – however, EMAS itself does not yet seem to recognize it as such, and at central and field level does not talk about this successful forming of a network any more than it talks about other (probably less significant) pieces of what it does.*

Recommendations (for EMAS) - EMAS should systematically document (both narratively and with relevant indicators) the development of this referral network and the improved communication within it that occurs as a result, and bring this documentation to partners and stakeholders as soon as possible – ***this functional network result may turn out to be one of the program's most important contributions to improved management of MN complications in national and local health systems.***

- SijariEMAS appears to be the most effective application of EMAS's mandate to use communication technology to improve MN services. EMAS needs to consider the "marketing" as well as technical value of the SijariEMAS – its technological and physical aspects appear to capture the attention of facility staff and managers, as well as policy-level decision makers,

while presentation of the details of improved referral networks might be less effective in engaging those individuals. This attractiveness can be built upon as an entry point to develop understanding of and commitment to improved referral networks as a whole – not just the technology. However, to use SijariEMAS effectively as this "entry point" in selling the larger process required for improved referral, EMAS may require expertise in "marketing" to take full advantage of this attractive technology and use it to bring referral improvement to scale.

- **In the past year, EMAS has undertaken a strategic approach to improvement of data availability, quality, and use, and has instituted some solid and potentially useful approaches.**
  - *EMAS has developed systematic data collection approaches for both puskesmas and referral facilities, beginning with standardized registers at puskesmas and hospital level to gather required information on maternity cases.*
    - *These registers have been generally well accepted; they appear to be seen as a better and more useful way to collect patient-related information.*
    - *These registers allow patient data to be compiled for both facility management and for reporting to district level (and above).*
    - *However, so far these data are mostly being used internally by EMAS itself - data are not yet being aggregated by services, and are not being analyzed or used to manage or modify services, to identify and respond to clinical or system problem areas, or in advocacy.*
  - *EMAS has begun working with partner facilities to strengthen capacity for data generation and analysis, in ways that can improve both facility management and service delivery.*
  - *The data generated through these approaches can be linked with DHO and other district data collection and management processes, and potentially with PUSDATIN national data collection.*
  - *Data on district-wide maternity and newborn case management and mortality – not just in public facilities - is also needed.*

  <u>Recommendation (for EMAS)</u> – While acknowledging EMAS 's contention that it is not designed to be an HMIS development program, given the pervasive lack of data and the uncertainty about effective remedies that result, EMAS should continue and increase its effort to connect its data generation and indicators with facility management and service delivery improvement, with local government and advocates to inform decision-making, and with any other ongoing or potential approaches to improved data availability and use by facilities and local, provincial, and national health authorities. The efforts on building the awareness and capacity of improved data availability and use aimed at hospitals and *puskesmas* are good and should be continued.

- **Overall, EMAS has generated some important and innovative engagement of private sector partners in organization and quality improvement of MNH services; however, this is limited.**
  - *There is some involvement of true private sector (for-profit) hospitals in referral networks – this is innovative and promising, though not yet a major component.*
  - *Motivation of these hospitals is variable – some are oriented toward increasing patient and revenue numbers, assuming that quality of care is not their issue; others welcome quality improvement and service management assistance.*
  - *Muhammadiyah engagement in clinical services improvement has focused largely on Muhammadiyah facilities, which in itself is a substantial system.*
  - *Broader engagement by Muhammadiyah with other faith-based networks (Interfaith Alliance, NU) is beginning and is promising.*

- *Muhammadiyah is also engaged in civil society ("Civic Forum") organization (see note below on this).*
- *Private bidans (those who are not also working in the public sector) appear to be outside EMAS' reach; in some districts, they provide substantial coverage of maternal/newborn care - how can their capacities and patient coverage be captured?*

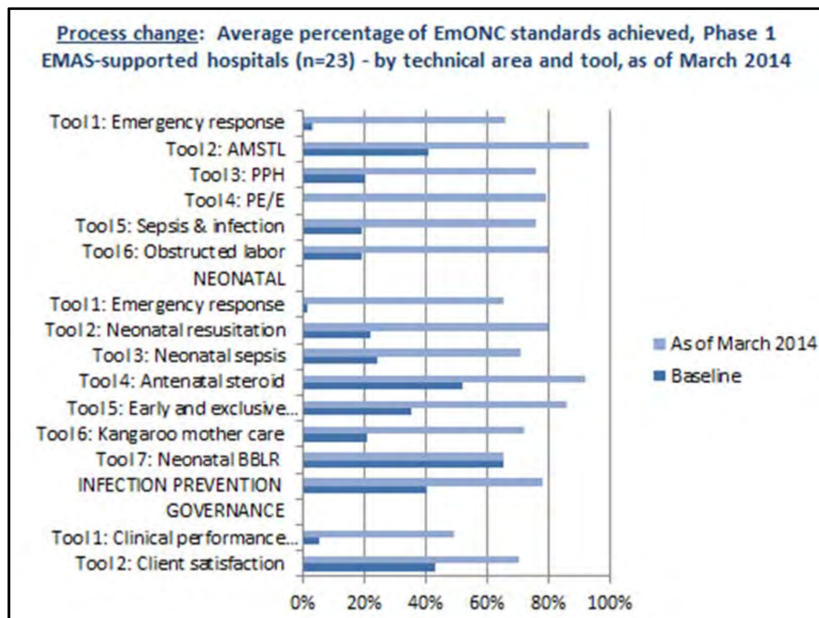
- **The core components of EMAS's work represent a systematic approach to engaging both health services and stakeholders to support strengthened management of MN complications; however, there may be too many pieces to the current approach to allow focus on success of the most important parts (and other key pieces that may need to be developed).**
  - *The basic components – hospitals, puskemas, referral, political support (Pokja), civil society involvement ("Civic Forum") are all valid, and they may be required for expansion and institutionalization.*
  - *However, they are not all equally strong*
    - *Pokjas are variable in their orientation and effectiveness, and in some cases are focusing more on getting support for their own functions than on progress in MN outcomes.*
    - *Civic Forums appear to include many enthusiastic – often young - people, but it appeared that they may not have a solid sense of how they and their organizations can meaningfully support improved MN services. In the limited interaction the MTE was able to have, many Civic Forum members seemed unclear about their roles as individuals versus as organizational representatives (in two instances, MTE members offered suggestions about how to strengthen the engagement of the individual members' own organizations).*
    - *Civic Forum members' knowledge of the subject generally appears low, and some voiced a request for more help. However, some members are well-connected and influential (e.g., PKK in Pinrang).*
  - *Some pieces of EMAS's work – for example, some of the client feedback mechanisms like SIGAPKU and "citizen report cards" – may not yield substantial pay-off and may dilute the limited capacity of EMAS, especially for implementing at scale.*
  - *On the other hand, governance at district level may not be pursued enough—e.g. data from the EMAS data system can be shared and become a means for the district statistical offices to be strengthened to provide needed data on MN coverage and death, as well as serving as input for more effective advocacy and planning.*
  - *While the field offices are aware of JKN and its potential impact on coverage and referral pathways, there is little to no obvious effort to influence JKN implementation and effects.*

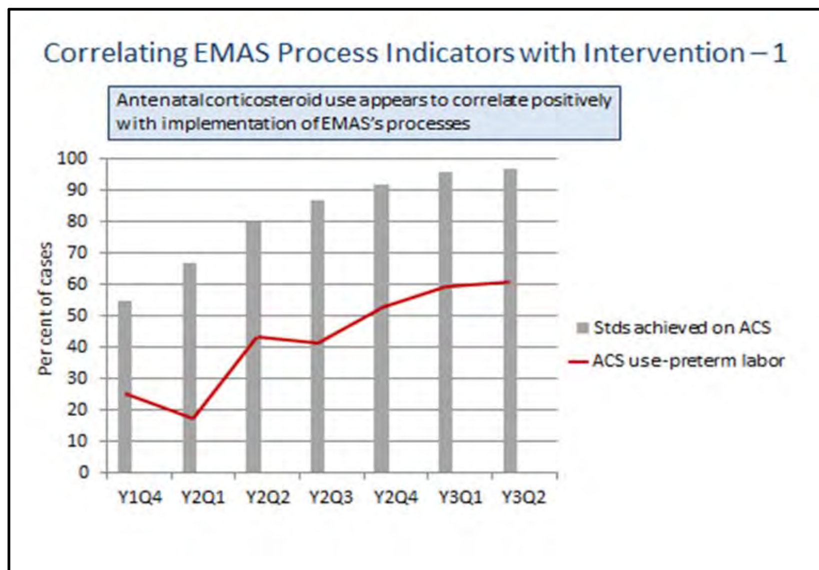
Recommendations (to EMAS) – EMAS should apply the "Theory of Change" causal pathway analysis to critically examine the many "moving parts" of the approach that it has developed, to identify those that are critical to support implementation and sustainability at scale and focus its energies and resources on making those work. Strong consideration should be given to dropping other components that are less critical or less effective.

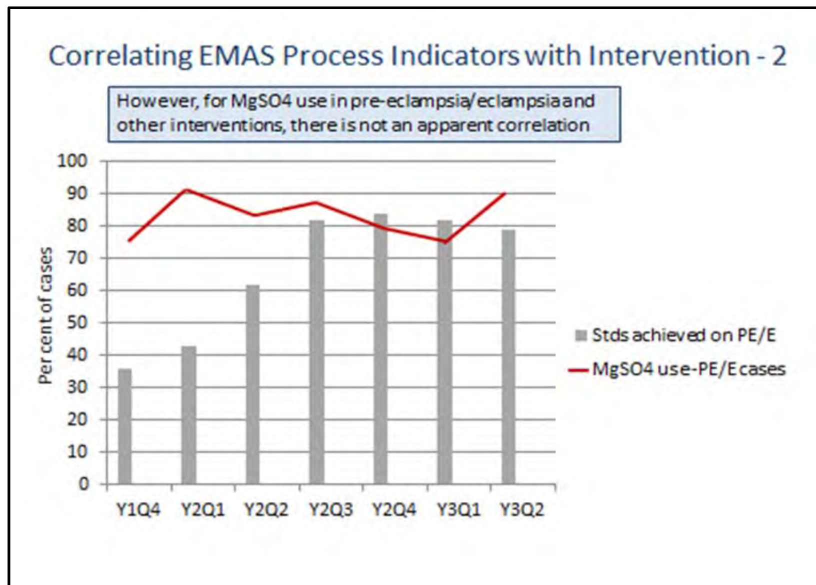
C. Achieving impact and sustainability at scale

- **A major issue is that data available from EMAS and from health services where it is working do not allow connection of the observed and reported changes in processes (e.g., adoption of standards and procedures) with changes in health worker or system performance, nor with MN mortality.**

- The majority of data reported regarding facilities working with EMAS are process data - achievement of standards, percentage of deaths/near miss reviewed.
- Many of these processes have shown substantial improvement during EMAS assistance.
- While intended to be standardized and based on the registers recently introduced by EMAS, the completeness of data on outcomes (e.g., per cent of PE/E cases treated with $MgSO_4$) and impact (MN deaths and case-fatality rates) remains uncertain.
- Virtually all data within the system are imperfect and do not allow inference of solid conclusions about patient management or mortality.
- Correlation of process improvements (e.g., achievement of standards) with the available data on use of key interventions is variable and inconclusive.







Mortality/Case Fatality Data from EMAS facilities

(Baseline versus early implementation)

	Baseline (Jan-Dec 2011)*			Year 2 (Oct 2012 - Sep 2013)**		
Obstetric Complication	Number of cases	Number of deaths	CFR	Number of cases	Number of deaths	CFR
PPH	682	18	2.6%	617	25	4.1%
PE/E	2804	36	1.3%	4491	53	1.2%
Sepsis	93	3	3.2%	110	7	6.4%
	3579	57	1.6%	5218	85	1.6%

Figures 3a, b, c, d – EMAS results: (a) Process indicators; (b,c) correlation of process changes with intervention delivery; (d) mortality/case fatality rates in EMAS facilities (*Baseline and Year 2 only, with different data collection methods*)

- Reported mortality rates and case fatality rates in EMAS facilities have not come down (but interpretation is limited by differences in data availability and collection methods at baseline and subsequently).
- Because of the incompleteness of district-wide birth and mortality data, even where EMAS is harvesting those district data its impact within the districts where it is working also remains unknown.
- There is reason to believe that the changes in facility and referral performance on which EMAS is focused are likely to be necessary – but not sufficient – to address MN mortality in

the complex Indonesian context (e.g., is there a timing issue—women arrive too late? Response is too slow or incomplete? Referrals are delayed? Or is something more needed re treatment as suggested in Souza et al, 2013).

- Thus far, EMAS appears to have focused more on implementation of the various components of its process improvement approaches, and have not focused on this disconnect of processes with improvements in outcome and impact as a priority issue.
- The "Theory of Change" pathways connecting processes with performance and outcomes, and careful monitoring of indicators along those pathways, may help understand the potential connection of EMAS's approach with MN outcomes.

Recommendation (for EMAS) - EMAS should first apply the "Theory of Change" causal pathway analysis approach to define the intended connection of the program's inputs with changes in process and intermediate outcomes, and of those with reduction of MN mortality. EMAS then needs to share this thinking with their field staff and MoH staff at all levels, carry out joint analysis of its individual intervention pathways, and institute a meaningful way to monitor the steps along the key pathways.

If a disconnect in the assumptions of the pathways is detected – e.g., actual health worker performance is documented to improve, but MN outcomes expected to be affected by that better performance do not improve – EMAS should work with partners to seek understanding of the forces that are negating the program's logic.

- EMAS should reflect the changes associated with their district-level work within the broader district context – *i.e.*, numbers of annual births in the district, coverage at facility level (by type of facility, and by whether EMAS supported or not). They should also relate the changes associated with EMAS's work with case management outcomes and mortality, again at district level. While even this exercise will not be perfect due to questionable data validity and in- and out-migration of women at the time of birth, it may help to determine the broader basis for EMAS's efforts to achieve impact at scale and for other needed interventions.

- **Therefore, one of the most important – and urgent – things to determine is the actual operational and clinical causes of continuing maternal and newborn deaths.**
  - *The incomplete nature of both facility and population-based data contribute to our inability to identify the key failures that need to be addressed.*
  - *However, even where data exist, they are not enough to distinguish operational or clinical causes of death.*
    - *For example, data on recent maternal deaths in EMAS facilities in Sulsel indicate that almost all those maternal deaths in Pinrang District occurred in the district hospital, the major cause was pre-eclampsia/eclampsia, the women were neither primagravidas nor uneducated, and they died within forty-eight hours of reaching facilities – however, these data do not allow us to determine whether these were failures of early entry into the system, failures of referral, failures of hospital emergency care, or manifestations of especially severe PE/E.*
    - *Similarly, consolidated January-March 2014 data indicate low (reported) rates of fresh stillbirths, along with low numbers of newborn deaths on day 1, but 3/4ths of deaths in the first week of life (40 per cent of which are in babies weighing over 2,000 grams).*
    - *We have incomplete information on births and deaths outside EMAS-assisted facilities.*

- o *These data findings indicate potentially important issues regarding clinical and operational causes of death - but they do not clearly define those issues.* ***We need to understand of what, and why, mothers and babies are dying.***
- o *Clinical record-keeping is generally of low quality and does not contain the information needed to answer these clinical and operational questions.*
- o *<u>Death</u> audits are generally not performed and when done are reportedly not in sufficient depth to answer these questions either; we need to look in detail at the potential system and clinical <u>failures</u> - mothers and babies who did NOT survive – to understand the things that need to be done to increase survival.*
  - *"Near-miss" audits can answer some important questions…especially to determine the timing of decision making and movement, plus response when in facilities; however, by definition they are studies of successes (or good fortune), i.e., mothers who survived.*

<u>Recommendation (for USAID and EMAS)</u> – USAID should seek partners (including the GoI), resources and a mechanism to support a study to permit systematic, expert examination of a large and representative sample of maternal and newborn deaths, with the objective of defining the probable clinical and/or operational causes of such deaths, both in EMAS areas/facilities and throughout EMAS districts. USAID should consider drawing upon existing experienced RMNH research organizations in Indonesia to develop and implement such a study.

– While development and execution of such a study is not expected to be within the existing capability of EMAS, EMAS must be a party to this process. EMAS's role should include promoting and generating local support for this investigation, as well as helping to best possible identify local data and informants. EMAS should also seek to develop approaches that increase the acceptability and actual implementation of maternal and newborn death audits in facilities, as they have begun to do for "maternal-perinatal death audits" by using standardized approaches and avoiding the tendency to assign blame. Success in doing this, if it can be shared more widely across the health system, would go a long way toward clarifying the clinical and operational failures that need to be overcome to improve MN survival.

- **The limitations of EMAS capacity to directly engage in expansion may limit achievement of effective implementation at scale.**
  - o *Phase 2 mentoring by Phase 1 facilities has not had sufficient time for its effectiveness to be evaluated (this is the "second hypothesis" of the EMAS design).*
  - o *The involvement of provincial and vertical hospitals and other resources (e.g., JNPK) is an important step in responding to the GOI's concern about EMAS's limited engagement of the government's own mandated resources in mentoring and improvement of MN services.*
    - *Engagement of these additional resources may help overcome the limitation of EMAS's own capacity.*
    - *Engagement of these additional resources (e.g., vertical hospitals) may also lessen the perceived negative attitude of the MOH to EMAS—and it should be used to do so.*
    - *There are GOI funds potentially available from the regular budgets of these facilities, their own revenue streams, and sources such as the provincial tobacco tax that could support this role by provincial and vertical hospitals.*
    - *However, these funds need to be mobilized.*
  - o *There are limitations in the number of specialists available at district and provincial levels to provide mentoring; for example, in Pinrang District and SulSel it is estimated that it may take*

as many as three more years to get a sufficient number of specialists for mentoring (according to an ObGyn at the provincial hospital [RSWS]).

- *Further engagement of professional societies (POGI, IDAI, IBI) may also expand the pool of effective mentors; this is happening to some degree at the operational level.*
- *However, there is always the danger that EMAS'S approach – based on "pendampingan," empowerment, network and relationship building, motivation – may get reduced to just "training" as the circle of "mentors" expands - appropriate selection and orientation of mentors for Phase 2 and beyond may mitigate this danger; however, this process needs to be monitored carefully in terms of quality and effectiveness as it proceeds.*

Recommendations (for EMAS) – EMAS should define and share with USAID and partners the approach by which it will monitor and evaluate this "second hypothesis" of the EMAS design – that is, the effectiveness of Phase 1 facilities and organizations in transferring the EMAS approaches they themselves have taken on.

– EMAS should engage the central and operational levels of professional associations as much and as effectively as possible to enlist them in this mentoring approach.

Recommendation (for EMAS and USAID) – EMAS and USAID should advocate with the GOI to make funds available for mentoring activities by provincial and vertical hospitals, to support their participation in mentoring.

- **Overall, EMAS has elements that can potentially be implemented at scale, but does not actually have a strategy for leveraging such implementation at scale.**
  - *Summing all the comments above, it is clear that EMAS has:*
    - *Had some success in affecting potentially important services within the Indonesian health system, working within the existing resource envelope (staff, budget, equipment, supplies);*
    - *Succeeded in helping services fill some gaps by mobilizing local resources (rather than providing those resources themselves);*
    - *Shown that the engagement of local political and health sector leadership can be mobilized, and that this is a crucial determinant of support for improved MN services;*
    - *Created an approach that goes beyond clinical services to include technical-political (Pokja) and civil society elements, which if successful are likely to be important contributors to sustaining and extending any improvements in MN services and awareness;*
    - *In some settings has raised important resources and developed influential champions;*
    - *At operational levels (Province and District) has involved critical components of the health system, including several provincial and vertical hospitals.*
  - *Despite having these elements in place, EMAS does not have an actual strategy to leverage implementation at scale.*
  - *Such a plan will need to include definition of the political, resource, advocacy, and operational components that will be needed; it will also require a scalable strategic approach to local governance, derived from the program's experience.*
  - *There are multiple initiatives in Indonesia that are likely to have effect at scale and offer the possibility of taking up EMAS's program approaches – including the MOH's new MNH strategy, the push to 2015 MDGs and the post-2015 agenda, the Indonesia Newborn Action Plan (and the new maternal mortality reduction goal), the JKN, possibly "regionalization."*
  - *The supportive and proactively positive positions taken by high-level GoI officials regarding connecting EMAS with such initiatives and with other government and political processes, in*

response to briefings on EMAS's work and the MTE findings, are indicative of how a strategic approach to connection at the policy and political levels can allow EMAS to contribute to impact at scale.

Recommendation (for USAID and EMAS) – USAID and EMAS should discuss and define the approach that EMAS should take, the stakeholders who need to be involved, and the potential assistance and analytic work that are required to develop an EMAS plan for achieving effect and impact at scale. This should be a structured plan for connecting EMAS's efforts with other forces and initiatives that can bring key lessons and components of EMAS's approach into the mainstream of MN health policy and programs in Indonesia. In this context, it should clearly define how EMAS will not just implement the components of its approach, but will also *function as a thinking, learning, and communicating organization* to bring its experiences and results into development streams that are likely to lead to scale.

- **A key element of being such a thinking, learning, and communicating organization – and of contributing to impact at scale – is to systematically generate and share learning from its engagement at the operational level.**
  - *EMAS enjoys a unique position by having operational connection to MN services and politics at the operational (facility and district) level, as well as having presence and engagement at provincial and central levels.*
  - *The contribution of EMAS to achievement of impact at scale will absolutely require the distillation and effective transfer of successful EMAS tools and approaches, and also key experience gained through its operational engagement.*
  - *The development of a Learning Agenda presents an major opportunity to work with central and local MoH and other stakeholders to identify and help answer critical questions about key determinants of MN health and services.*
  - *In this process, EMAS can review with stakeholders the most important components of its experience to date, and assure that the Learning Agenda reflects that experience.*
    - *In addition to providing quantitative analysis of program effects, one potentially useful way to package this experience would be the development of well-constructed case studies reflecting practice in key areas (e.g., examples of effective referral contributing to successful MN outcome, successful management of a complication resulting from improved organization for emergencies in a puskesmas or facility, use of data to improve MN service management, etc.).*
    - *EMAS's own experience as it finalizes and monitors movement along its "Theory of Change" causal pathways will also be instructive to the broader system, since such a systematic approach is often lacking in program and service implementation.*
  - *The present set of questions that EMAS has drafted do address important questions about policy and program issues related to reduction of MN mortality, including the relationship between EMAS's approach and the outcomes it hopes to affect.*
  - *However, this Agenda has so far been developed only internally – it is important to recognize that decision-makers who will be important in moving EMAS experience to scale may need to answer different questions than the ones EMAS itself might identify – for example, regarding human resource requirements.*
  - *Therefore, realizing the value and uptake of EMAS's learning in relation to achieving impact at scale requires opening development and implementation of this learning process to engagement with central and local MoH and other stakeholders.*

<u>Recommendation (for EMAS)</u> – Given the late stage of the program, EMAS needs to finish this Learning Agenda within the next 2-3 months, but must do so collaboratively. The draft Learning Agenda should now be taken to central and operational level partners for refinement and for partnership in design and implementation of a structured learning approach. Such a collaborative learning process is more likely to lead to program and policy changes by key decision-makers, and can also build partners' orientation and capacity to be learning organizations.

- **The MTE provides an opportunity for reconsideration and discussion of the quantitative <u>targets</u> that have been set for EMAS, in the light of both political reality and reality on the ground.**
  - *Substantial experience in design and management of USAID health sector programs indicates that having a specified impact level goal (i.e., per cent mortality reduction) to which its programs must contribute is essential to keep a focus on deliverables from displacing the focus on impact.*
  - *The "contributing to a national 25 per cent mortality reduction goal" was set in agreement with the GOI (which was at the time contemplating an even larger reduction).*
  - *The recent DHS Maternal Mortality Ratio estimate has caused confusion about rates of progress in maternal and newborn mortality reduction, and the appropriate target at this point.*
  - *In terms of numbers of districts (30) and facilities (150 hospitals/300 puskesmas) specified for EMAS to reach during life of program, this mid-point evaluation is an appropriate point for USAID and EMAS to reconsider what level of number of districts and facilities is most appropriate to maximize the effectiveness and learning from EMAS's work.*
    - *To ensure useful coordinated responsive referral, EMAS has found they need to expand their reach to include all puskesmas of the target districts, and all hospitals; this reality has already led to EMAS engagement with roughly 700 puskesmas and 70 hospitals in just Phase 2.*
    - *Each additional district requires setting up additional Pokjas and Civic Forums, as well as orienting and engaging with hospitals and providing some level of support (whether "Full Support" or "Limited Support" to all puskesmas in the catchment areas).*
  - *Several stakeholders, including within the MoH, have asked whether EMAS might not work across all facilities and in more depth in a smaller number of districts, to maximize effectiveness and learning (but not act as a "pilot").*

<u>Recommendation (for USAID and EMAS)</u> – USAID and EMAS should use this mid-point evaluation to discuss among themselves, and with GoI and other stakeholders, the most relevant impact goal and district/facility targets to maximize EMAS's effective contribution and learning in the context of experience to date, realities on the ground, and latest GOI strategic planning for MN health.

- **There are important changes happening in Indonesia that could override efforts (including, but not limited to EMAS's) to increase effectiveness of MN services.**
  - *JKN (universal health coverage) has recently been implemented (effective January 1, 2014); at the same time Jampersal, the health insurance that provided maternity coverage for all pregnant women, ended.*

    - *This shift to JKN comes with higher benefits for coverage of normal births at puskesmas/polindes/puskesdes levels and for complicated births at public hospital levels (for cesarean as well as for other complicated deliveries).*
    - *It however creates different incentives and changes the referral pathway (specifically stating that women must deliver at primary care level if normal, and proceed from Puskesmas to level C, B, and then A hospitals if complicated); this may affect the referral networks that EMAS has helped to develop.*
    - *Socialization of these policies - specifically for MNH - has been left to the MOH.*
    - *Those eligible for JKN funds are public facilities and private hospitals that sign a MOU; private bidans must work together with a doctor in order to submit claims.*
        - *Social insurance programs have already stimulated alliances that are unethical (e.g., bidans being paid by private hospitals to bring patients to them for caesarean section; or providing caesarean sections for non-medical reasons)*
    - *Women may go directly to any hospital if they have an emergency; whether women with risk factors (e.g., twins, anemia) can attend any hospital is not clear, and if the receiving facility does not agree that the situation is an emergency, the woman may be denied care.*
    - *Women must have complicated paperwork available when they attend any hospital (e.g., Jamkesmas card, ID card, SK from village head; and if referred, need referral papers from the primary level facility).*
    - *The relationship of JKN to Jamkesmas (locally funded health support for the poor) is unclear, evolving, and variable because Jamkesmas is a non-standardized local program.*
    - *To date no funds for JKN have been paid as there is no Presidential signature at this time*
- *A second major issue is that fertility has plateaued at 2.6 and contraceptive prevalence is essentially stagnant (in 2012, 58 per cent modern methods among currently married women of reproductive age).*
    - *These stagnating patterns of fertility and family planning may mean that women at higher risk (e.g. older women, higher parity; very young women; those with co-infections such as HIV and AIDS, TB or malaria; those living in remote areas, or with less education, and the poorest) are more likely to becoming pregnant, and also are more likely to suffer complications and to die.*

Recommendations (for EMAS) - EMAS should be aware of the JKN parameters and work to ensure that facilities at all levels provide rapid receptivity to women in labor (whether referred or not). In the localities where they are working, EMAS should also seek to clarify the relationship of JKN with local health insurance (Jamkesda). It would be useful for EMAS to work with its provincial and district level staff and the MoH to socialize the JKN requirements, review the referral options for women, and ensure that women have the paperwork necessary to be admitted to facilities for themselves and /or their newborns. District and provincial level pokjas and civic forums can potentially play important roles in monitoring the effects of JKN on care and referral of women and advocating to local government and health authorities to assure maintenance of efficient care and referral.

- As part of their strengthened communication and collaborative learning with the central MoH and GoI (including BPJS), EMAS should also carefully document and bring to the central level the effects they encounter of the transition to JKN and its implementation on care and referral received by women and newborns in the districts where EMAS is working. Early experience suggests that the MoH may have the ability to influence JKN implementation; EMAS might help

identify ways to apply this influence constructively for the benefit of women and newborns as the new insurance system rolls out.

D. Management

- **Some important management issues, including acting upon remaining findings and recommendations of the recent Management Assessment, need to be acted upon.**
  - In addition to points identified above regarding relationships with MoH, etc. -
    - There has been important staff turnover in province and district teams; some positions remain vacant despite those vacancies affecting program work (e.g., Quality Improvement Officer in Deli Serdang, ICT Officer in Surabaya).
    - Some EMAS field staff expressed frustration about communication and being in the loop: "None of our ideas have been accepted, we want to be heard" and "Where is follow up action after the Management Review?"
    - The Management Assessment recommendations about hiring a "well-seasoned" Deputy is important; this critical position will require substantial experience in both program management and MNCH programming, as well as the ability to form excellent working relations with counterparts (since this position will represent the program to the GoI when the Director is in the field or out of the country).
    - Recommendations for improving organization, reporting lines, and clear communication in the Jakarta office should also be operationalized.
      - The current organogram has 6 different program components reporting directly to the Director – such an arrangement is managerially ineffective.

Recommendations (to EMAS) - EMAS should continue implementing the recommendations of the recent Management Assessment, including hiring a seasoned Deputy Director with substantial management and program experience, and organizing HQ staff, relations, and communication clearly and effectively.

– EMAS should also make all possible efforts to fill staff vacancies at province and district team levels, since these vacancies are affecting aspects of program support and the back-up capacity at the next level is limited.

– EMAS should review with USAID the program's efforts and accomplishments in the extremely important governance area, since the MTE was unable to evaluate this area beyond the effects of MOUs and other outputs at operational level, and because interaction with local government appeared to be so strongly correlated with the influence of provincial and district team leaders themselves (the same dimension that needs strengthening at central level).

<u>Overall Recommendation to USAID</u> – EMAS is demonstrating potentially important changes in the way emergency MN care is provided in Indonesia. The process is slower than originally proposed, but may still prove to develop important contributions to MN mortality reduction in Indonesia. The Evaluation Team believes that closing the program after Year 5 may cut short the time required to fully develop a scalable and scaled approach and derive and institutionalize key components of what EMAS is learning to do. The entropy generated by ending one program and starting another will force the current program to have effectively just over one more year to respond to mid-term evaluation recommendations and also achieve expansion, scale, and learning. Experience with previous program transitions (e.g., the end of the USAID/Indonesia-supported Health Services

Project) teaches us that important experiences and progress are likely to be lost in such a transition after 5 years.

Therefore, the Evaluation Team ***strongly suggests*** that ***IF*** – ***AND ONLY IF*** - USAID determines that **EMAS has developed the capacity and taken the actions required to respond to the recommendations above** regarding:

- strengthening EMAS's policy level communication and relations with key stakeholders (including hiring an effective senior policy advisor to serve as "bridge-builder" with the MOH, other GoI agencies, and senior leadership of professional organizations and other stakeholders);
- Clearly defining the "Theory of Change" (causal pathway) connections between the process changes it promotes, health system performance in terms of delivering evidence-based interventions, and MN survival, and then systematically monitoring, evaluating, and documenting the progress (or lack therefof) in making those connections;
- implementing a collaborative and continuous approach to developing and carrying out a highly relevant Learning Agenda;
- responding to key Management Assessment recommendations, including hiring a seasoned Deputy Director with substantial management and program experience, and organizing HQ staff, relations, and communication clearly and effectively; and,
- appropriate development of a meaningful strategy to contribute to impact at scale;

THEN USAID should consider identifying additional funds and a mechanism to extend EMAS's work by two additional years, without waiting until year 4 or 5, since activities and key staff begin standing down in the end stages of a program.

Extending the program's work will substantially increase the probability of having the important investment USAID is making through EMAS achieve scalable and sustainable results. The conditionalities noted above link the award of an extension to meaningful compliance with MTE recommendations - actions necessary to support EMAS success and impact at scale.

IV. Additional Findings

Management related

- **Burn rates –** Limited financial reports made available to the MTE team indicate that as of February, 2014, the lead partner (Jhpiego) has expended 49% of planned available funds for its work in the program, while sub-agreement partners have expended considerably less (Save the Children – 37%; RTI – 30%; Muhammadiyah – 27%; LKBK – 20%). The explanation for these low expenditure rates by sub-grantees may be actual low burn rates, slow billing (with substantial accruals), or other funding pattern diversions – or a combination of these. EMAS and USAID program managers should track this closely as the program enters its second half.

- **Need for Advocacy/Public Relations capability –** In addition to urgently needing senior presence at the central level, as detailed extensively above, the MTE Team believes that EMAS has important stories to tell, both with the GOI and also to a wider policy and public audience. This will demand expertise in the public relations/advocacy area. That expertise can also help the struggling Civic Forums to identify appropriate and effective approaches to their work at the district level.

Technical

- **Pre-Eclampsia/Eclampsia – Need for a special focus (EMAS, MoH, USAID) -** PE/E has emerged as the leading cause of maternal deaths in areas that the MTE was able to look at. According to local specialists and limited data on actual numbers and outcomes of cases, this increased prominence of PE/E is NOT simply the result of the apparent increasing success in prevention and management of post-partum hemorrhage through appropriate (3rd stage of labor) use of uterotonics. Some specialists report a substantial increase in absolute numbers of PE/E cases, and also in their severity (with greater occurrence of organ damage and higher case fatality rates). Again, there are no good data to evaluate these reports. However, the importance of PE/E as a cause of maternal morbidity and mortality in Indonesia cannot be contested.

  One element that EMAS has not dealt with, because they are focused on management of complications, is the potential importance and feasibility of improving better early detection and expectant management of PE. However, data from both the MoH itself and the recent World Bank study on "Service Availability and Readiness" indicate that roughly half of *puskesmas* do NOT have urine dipsticks for identifying proteinuria. Thus, many cases of PE may be going undetected (or "under-managed").

  Against this background, the MTE identifies two possibilities for EMAS, the MoH, and possibly also USAID:
  - Through EMAS's engagement with district-level MN services, including at *puskesmas* level, EMAS could explore ways to improve the supplies, capability, and awareness of staff and associated community bidans regarding detection and expectant management of PE/E; and,
  - Drawing on best available data from EMAS's work, plus additional focused studies by public health researchers, partners could explore the incidence and operational factors associated with PE/E and associated mortality.

- **A similar need to learn more about prevalence and management of low birth weight/ prematurity –** Again, some anecdotal sources say this incidence is increasing. If so, this may be associated with the high rates of caesarean sections being performed in referral level facilities (*see below*). In any case, management of these small and preterm babies is uneven at best and in most facilities can benefit from improvement. Care during transport of these small/preterm babies during referral is an unknown. Some movement has been noted in introduction of antenatal corticosteroids for preterm labor and Kangaroo Mother Care – more work on these will be required. An additional area where input is needed is Continuous Positive Airway Pressure (CPAP) to support lung function in preterm infants. Many specialists in both public and private facilities express interest in and experience with use of CPAP – approaches range from very expensive CPAP equipment (>$10,000 US) to $10 "bubble CPAP" adaptations. There is much to learn from this experience, including the possibility of providing CPAP for small babies during transport. With the increased attention expected to be paid to newborn survival as a result of the Indonesia Newborn Action Plan, and the focus within that plan on the high proportion of neonatal deaths related to LBW/prematurity, EMAS might contribute meaningful learning and experience to management of these babies in the contexts where it is working. (This would be an excellent research topic for an MD/MPH candidate or other graduate student from a department with relevant expertise and supervision.) Save the Children/US is involved in evaluation of CPAP in low resource developing country settings through its Saving Newborn

Lives program – the existing connection of Save the Children neonatal experts with EMAS could transfer this experience to Indonesia and help EMAS support relevant action in this area.

- **Mortality below *puskesmas* – is there any EMAS role? -** The quality of bidan care is challenged by the increasing number of bidans and midwifery academies. EMAS itself is not designed to deal with bidans outside the *puskemas* level. However, some EMAS-assisted facilities and EMAS consortium partners *are* working to improve/sustain quality of care by bidan di desa and private bidans. EMAS may want to consider working with those *puskemas* and partners to provide simple tools that will help them in these efforts.

- **Infection control appears weak at best** – While EMAS does have process indicators on infection control, the MTE Team did not come away highly impressed by the realities of infection control in many facilities. In more than one case, we accompanied senior neonatologists who entered high risk nurseries without washing hands, and then – while not directly touching babies (while we were there) - touched objects that other staff would then later touch in providing care. Handwashing was not commonly observed, and in one facility the alcohol dispensers outside the neonatal unit were all empty. EMAS should look more closely at the realities of infection control, and effective interventions to strengthen it.

- **High rates of c-section and induction –** C-section rates in many of the referral facilities we visited were very high, even considering the fact that these are places receiving complicated cases and c-section is the necessary intervention in many cases. Rates reached as high as 90 per cent in one private facility. Insurance schemes and other financial incentives, possibly as well as demand, provide some perverse incentives for performing c-sections. There is a documented risk of complications associated with c-section for the mother and baby – including in many cases the fact that babies delivered by c-section are at least somewhat preterm. The questions for EMAS are, what is the appropriate level of c-sections in the facilities with which they are working, and what is EMAS's role if the present rate is clearly too high? EMAS should also seek ways to prevent effective referral from increasing inappropriate rates of delivery by cesarean section.

  In addition, the use of oxytocin to induce labor also seemed potentially excessive (in one RSUD hospital, almost half of deliveries). Oxytocin over-use can cause harm to the mother and especially the foetus, possibly increasing the danger of birth asphyxia. Again, what is EMAS's role in looking at these practices, and intervening if inappropriate practices are prevalent?

- **Value-added of expatriate specialist visits –** The team received limited feedback on this practice, but what it received was generally positive. According to one private facility, the practice improvement inputs provided by an outsider got much more attention than would the same inputs from an Indonesian expert. For private facilities, there also appeared to be a prestige factor. The MTE Team is unable to judge whether this value-added justifies this component of the program.

V. Summary of Conclusions and Recommendations

Based on the information it reviewed and received and its observations, the evaluation team concludes that the approaches developed and implemented by EMAS have important potential to improve the performance of Indonesia's health services in managing the complications that are the

major causes of maternal and newborn morbidity and mortality. Reportedly, when USAID was working with the GoI on design of EMAS, senior health officials stated that "We have good policies and guidelines; what we need help with now is *implementation*." Based on the changes in service delivery reported and observed, the MTE team believes that EMAS is providing that help, in ways that appear to be acceptable, feasible, and therefore scalable in the decentralized Indonesian health system. These changes in quality of MN care – and in the political and resource support that EMAS has also developed – would be expected to positively affect outcomes for mothers and newborns experiencing life-threatening complications.

However, to realize this potential at scale, EMAS needs to address critical challenges. One is to define and monitor the connection between the process changes that EMAS has succeeded in generating, with such improvement in patient outcomes and ultimately mortality. Equally important is strengthening policy and political level communication and connection with the GoI – especially the MoH – at the central level. Part of that improved communication will require EMAS becoming the "thinking, learning, and communicating organization" that its engagement across levels of the health system uniquely positions it to be. EMAS also urgently needs to work with USAID, the GoI, and other stakeholders to develop a strategy for leveraging impact at scale that goes beyond its direct engagement, to link its results and learning with national-scale initiatives and programs. Internally, EMAS needs to deal with management and organization issues identified by the earlier Management Assessment and the evaluation itself.

More broadly, the MTE has identified several key areas – identifying actual operational and/or clinical causes of ongoing mortality, identifying effects of the new JKN insurance program on management of maternal and newborn complications, a stronger focus on learning about and responding to high rates of PE/E and prematurity/low birthweight - in which both EMAS and USAID, along with other stakeholders, can potentially make important contributions.

Appendices [Attached separately]

Appendix 1

MIDTERM EVALUATION SOW

I. BACKGROUND OF PROGRAM

EMAS, USAID/Indonesia's flagship MCH program, aims to substantially contribute to a rapid reduction in maternal and new born mortality - by 25% over the next five years. With an investment of $55 million, EMAS is the largest bilateral agreement in the USAID Health office portfolio.

EMAS differs from prior USAID maternal and child health programs in its strong strategic focus on health facilities with the highest burden of mortality of mothers and newborns. EMAS works in six priority provinces in Indonesia: South Sulawesi, North Sumatra, East Java, Central Java, West Java, and Banten. Almost 70% of all maternal deaths and 75% of newborn deaths occur in Java and Sumatera alone, mostly from preventable causes.

In order to accelerate progress in reducing maternal and neonatal mortality, EMAS is focused on two main results:

1) Improve the quality of maternal and newborn health services at health facilities in the event of complications; and
2) Increase efficiency and effectiveness of referral systems for maternal and newborn health complications – to save the lives of mothers and babies by assuring that they get to the right place, at the right time, in order to receive the right services.

These are supported by major cross-cutting themes:

- Work in the province and district level to increase accountability and transparency in the health sector;
- Provide technical assistance on policy and decision-making related to maternal and newborn survival; and
- Use technology, such as cell phones and social media, to increase information flow between Ministry of Health, health facilities, and patients.

EMAS is implemented by a consortium led by JHPIEGO with Save the Children, RTI, Budi Kemuliaan Foundation and Muhammadiyah. It is coordinated with other assistance programs funded by USAID including UNICEF, WHO maternal assessment, AIPI/NAS Maternal Mortality Study, the WHO accreditation project, and the Indonesia DHS Survey.

A strategy to reach at least 150 hospitals and 300 health centers is aimed to be achieved through a "vanguard" referral network approach with influence on hospitals and districts outside of the facilities and districts where EMAS works. The "vanguard" network functions as a mentoring network. This mentoring network will be paired with additional referral networks over the life of the program to promote peer learning and reinforcement of best practices. Each referral network will typically include one public hospital, two to three private hospitals and approximately 10

health centers. In the first year and second year, the EMAS program provided EmONC technical support to 10 districts working with district hospitals and health centers as well as private hospitals and health centers. The initial strategy is to develop these 10 networks to function as mentoring hospitals to other district hospitals and classify them as "vanguard" networks. A network of hospital and health centers who are able to provide mentoring support to other districts. These 10 networks were expected to function as high performing district hospitals to support other district hospitals in the third year. Additional 29 districts and cities will receive technical support to improve the quality of EmONC services and improve referral network through the course of the project.

EMAS has completed its second year marking the first full year of implementation of EMAS. The second year annual report revealed steady progress across all program interventions. The "vanguard" network approach is focused on a staggered approach roll out series: Phase 1 (Program Years 1-2), Phase 2 (Program Year 3) and Phase 3 (Program Years 4-5)

Initially EMAS first year and second year approach included only district hospitals and relied heavily on their participation to roll out the activities to other district. The approach was revised in the middle of year 2 implementation to include hospitals in the cities and at the province level. Province level hospitals were defined to function as regional experts to provide technical support to district and city hospitals. In addition provincial hospitals were also assessed for their ability to function as the referral network umbrella to support the emergency referral network. This effort is in line with Ministry of Health's effort to improve the referral network at the central, province and district level.

USAID commissioned a management review of EMAS to begin in January to identify management gaps, constraints and opportunities in EMAS management and staffing. In addition to the management review initiated by USAID mission, JHPIEGO central office included in their 2014 workplan technical support to Chief of Party and the Deputy Provincial Officer to improve management systems and structure within EMAS. Lastly an assessment/ study on the use of Ante-natal corticosteroids is currently on going and being implemented together with MCHIP in EMAS selected district. The results of these reports will be available to the evaluation team.

II. PURPOSE AND UTILIZATION OF THE EVALUATION

The purpose of the evaluation is to:

1. Assess EMAS progress in achieving its goal, objectives and planned outputs as stated in the agreement's project description and in approved workplans;
2. Provide recommendations to improve EMAS program effectiveness over the remaining 2+ year life of project.
3. Provide recommendations for USAID to consider in the design of future projects aimed at improving maternal and neonatal health in Indonesia.

The timing of this evaluation is propitious for both making mid-term changes in EMAS implementation as well as for providing input toward future program design. Therefore the evaluation should produce two sets of recommendations for USAID. The first set should provide specific recommendations for mid-course corrections to the EMAS project. The second set of

recommendations should provide USAID with recommendations to take into consideration for future project design in maternal and neonatal health. There will be two versions of the final report – an internal USAID only version which contains the recommendations for future programs and an external version that is available to the public and does not contain this section.

III. EVALUATION QUESTIONS

The Evaluation Team will answer the following questions. Question 6 will be addressed by a USAID financial specialist and provided to the Evaluation Team for review and inclusion in the report as appropriate. The term "governance" when used here is the common term regarding such issues as local government policy and budget support, public participation in decision-making, public oversight of the quality of services, etc. This term does not include or refer to "clinical governance" which indicates aspects of leadership, management and administration of clinical services.

1. What are the major EMAS accomplishments to date? Identify key strengths in the EMAS program approach.

2. What evidence is there to validate the overall development hypotheses and programmatic approach? A complete response will address at a minimum:
   a. Effectiveness of technical content of EMAS.
   b. Strengths and weaknesses of the EMAS vanguard model, mentoring approach, engagement of partners through POKJAs, and engagement of provincial hospitals.
   c. Effectiveness of ICT and governance interventions, judged by contribution to achieving health objectives?
   d. What success has been achieved in engaging the private sector service providers? What opportunities, strengths and weaknesses can be identified to guide additional actions?
   e. Have there been any unanticipated changes in the host country or donor environment that suggest the need for changes in emphasis in the EMAS project to minimize implementation problems or unintended consequences and/or maximize impact in the remaining time available?

3. To what extent have monitoring information and lessons learned during project implementation been used to inform project management decisions? A complete response will address at a minimum:
   a. Whether systems for program monitoring are providing timely and relevant information to the appropriate individuals with responsibility and authority to act.
   b. Adjustments to program approaches that have been made based on such information.
   c. Whether such adjustments are likely to improve prospects for program impact, sustainability and scale-ability.
   d. Recommend specific new approaches and decision support tools to improve feedback for informed decision making.

4. What are the prospects for EMAS achieving impact at scale? A complete response will address at a minimum:

a. The extent to which the approach to achieving sustainability and impact at scale are articulated in project documents.
b. Whether EMAS approaches and materials are sufficiently in-line with existing standards and systems to be integrated into standard practice in systems operating at scale.
c. The extent to which the EMAS learning agenda addresses main policy and program questions and evidence requirements to support sustainability and spread of EMAS innovations and approaches.
d. The effect of partnerships with U.S. hospitals, commodity donation charities, or the private sector (Laerdal, GE, Chevron) on programmatic results or prospects for sustainability. What are the strengths, weaknesses, lessons learned, unintended outcomes, and cost effectiveness of these endeavors?
e. Opportunities, strengths, and weaknesses of EMAS engagement of Indonesian partners both within the project and external – including government and private sector entities at the central, provincial and district levels, leadership of public and private facilities, professional associations, academics, and civil society.

5. Are all expected results likely to be achieved by the completion of the project and, if not, what changes in targeted results and/or implementation approaches should USAID/Indonesia consider?
   a. Are work plan milestones and results being achieved?
   b. Are EMAS project implementation priorities sufficiently focused for the best application of limited resources? Are there low yield (or likely low yield) project elements that should be reduced or eliminated? Are there elements that should receive increased attention and resources?
   c. Is the project reaching the desired beneficiaries? If not- why not?

6. Is there a clear financial system of the prime and the sub-awardee that includes internal mechanism to ensure a clear financial reporting and cash flow?
   a. How effective has cash flow been managed in the project? Have there been any significant delays in cash flow either from the prime awardee to the major partners? What was the cause of the delays? What changes were made in managing cash flow?
   b. Have there been annual audits conducted for the prime as well as the sub-awardees? What have been the audit findings?
   c. Have there been problems with financial reporting from the sub-awardee to the prime and how are they resolved?
   d. How is the cost-share commitment being met?

IV. TASKS

1. Review background documents
2. Participate in a team planning meeting in Jakarta – review and refine SOW and evaluation framework, develop outline of report, finalize roles and responsibilities of team members, and develop detailed work plan with USAID and key stakeholders.
3. Review and further analyze further program information – PMP, Assessments, etc.
4. Conduct interview with stakeholders and key informants (list)
5. Conduct field visits to xx districts

6. Analyze information collected and draft main findings and recommendations
7. Conduct interim briefings with USAID, EMAS team, others as needed
8. Draft full report
9. Develop and present power point summary in exit briefing for . . .
10. Finalize report incorporating feedback from USAID and other reviewers (TBD)

V. COMPOSITION OF EVALUATION TEAM

The Evaluation Team shall consist of four professionals with 10+ years of experience in MCH programming in low-income countries. The team leader will be independent of USAID. The team shall also include a translator/interpreter.

The required areas of subject matter expertise that should be represented on the team correspond roughly to the technical foci and implementation context of the project being evaluated:

1) Maternal Health Expert
2) Neonatal Health Expert
3) MNH Policy and Health Systems Expert
4) MNH Evaluation Expert

All team members must be fluent in English, have proven ability to interact with people from many different social and economic backgrounds, and possess excellent writing and presentation skills. The team will have combined skills and experience in rapid appraisal methodologies (interviews, focus groups, etc.), institutional analysis, and strong knowledge of Indonesia's public sector functioning and Indonesian political processes. All team members must be willing and able to travel to remote zones.

The Team composition is suggested as follows:

1. **Team Leader** –

The Evaluation team leader will lead the evaluation team to carry out the SOW listed below. The team leader will be specifically responsible for ensuring evaluation questions are answered, the report is complete, and deliverables are met on time. S/he is the lead on clinical and global best practices for programming related to best practices in neonatal health, from both clinical and policy perspectives. As such the team leader will take the lead in developing all components related to neonatal health within the questionnaire, indicators and analyis. S/he will collaborate with the team to answer all the evaluation questions, analyze inputs to make conclusions, and provide written recommendations.

2. USAID/Washington Maternal Expertise:

The Maternal Health Senior Advisor will work with the other members of the evaluation team to carry out the SOW listed below. She is the lead on clinical and global best practices for programming related bto best practices in maternal mortality prevention and response, from a clincial and policy perspective. The Maternal Health Senior Advisor will take the lead in developing all components related to maternal health within the questionnaire, indicators and

analyis. She will collaborate with the team to answer all the evaluation questions, analyze inputs to make conclusions, and provide written recommendations.

3. Indonesian MNH Policy and Health System Advisor:

The Senior Maternal and Newborn Health Policy and Health System Advisor will work with the other members of the evaluation team to carry out the SOW listed below. The Senior Maternal and Newborn Health Policy and Health System Advisor will collaborate with the evaluation team lead to engage government stakeholders at the central, provincial and district offices. The MNH Policy and Health System Advisor will be the lead to ensure all relevant and updated standards and policies related Maternal and Newborn Health are gathered and included in the evaluation process and contribute to answering the evaluation questions, report, and expected results.

4. **Indonesian MNH Evaluation Specialist:**

The Maternal and Newborn Health Evaluation Specialist will work with the Evaluation Team Leader and other members of the evaluation team to carry out the SOW listed below. The MNH Evaluation Specialist will provide general support to the evaluation and will work closely with the team leader in supporting evaluation design, development of all evaluation documents and completion of deliverables. The MNH Evaluation Specialist will have specific responsibility for evaluation of EMAS M&E functions and products, and will contribute to evaluation of progress on the learning agenda. The MNH Evaluation Specialist will also take the lead to evaluate the contribution of the ICT and governance elements of the program to EMAS' main results.

VI. USAID MANAGEMENT OF EVALUATION

The USAID/Indonesia point of contact for the evaluation will be Ria Wardani. An Evaluation Committee comprised of the EMAS AOR, a representative of the Mission Program Office and MCH team members from the Health Office will be formed to respond to questions from the team, resolve administrative or logistical obstacles, and review Evaluation Team deliverables.

DRAFT: Logistics & Time Frame

The following provides a notional presentation of a prospective allocation of level of effort for the Evaluation assuming a six-day work week:

Estimated Start Date	Activity	Working Days	Location
April 1-2	Preparation – Selection of site visit locations and preliminary specification of planned interviews. Finalization of evaluation methodological approach(es) and field schedule. Document review. Development of questionnaires and/or other tools to be used in conducting surveys and fieldwork.	2 days	Anywhere
April 7-9	Team Planning Meeting and In-brief with USAID/Indonesia	3 days	Indonesia

	staff, EMAS implementing partners and stakeholders.		
April 10-23	Field Work and Data Analysis – Interviews, site visits, and analysis of comparative performance data. The team may split into two groups for interviews at different stages of field work.	12 days	Indonesia
April 24-29	Initial synthesis – In-country team work culminating in delivery of Detailed Evaluation Report Outline and draft PowerPoint presentation for review by Evaluation Committee. Additional meetings and interviews may also be scheduled to validate findings.	5 days	Indonesia
April 30 – May 5	Revision and refinement – In response to comments from Evaluation Committee, team will incorporate feedback and other input into finalized PowerPoint presentation and initial full report draft. Presentation to USAID/Indonesia and other stakeholders.	5 days	Indonesia
May 9	Final report production – Completion and delivery of final evaluation report based on Mission feedback.	3 days	Anywhere

Total:30 days

VII. DELIVERABLES

The Evaluation Team will be responsible for producing the following deliverables:

- Revised evaluation approach and draft schedule of field activities (prior to field work)
- Draft and final questionnaire(s) to be used during interviews/stakeholder meetings (prior to field work)
- Draft Report Outline (prior to field work)
- Detailed Evaluation Report Outline with bulleted response to evaluation questions and Draft PowerPoint Briefing (at the end of the synthesis phase)
- Finalized PowerPoint De-briefing and initial full report draft (before evaluation team departs Indonesia)
- Final Evaluation Report following standard reporting format and branding guidelines (within 2 weeks of receiving Mission comments on draft report).

An illustrative outline of the Evaluation Report is provided below:

Executive Summary

The Executive Summary will state the EMAS objectives; purpose of the evaluation; study method; findings; conclusions, lessons learned and recommendations for remaining EMAS implementation, future USAID programming priorities.

Table of Contents

Introduction

The context of what is evaluated including the relevant history demography socioeconomic and basic political arrangements.

Body of the Paper

1. The purpose and study questions of the evaluation. A brief description of the project.
2. Evidence, findings and analysis of the study questions.
3. Conclusions drawn from the analysis of findings stated succinctly.
4. Recommendations for EMAS mid-course corrections
5. Recommendations for USAID future directions

Appendices shall include:

1. Evaluation scope of work
2. List of relevant targets and results
3. List of documents consulted
4. List of individuals and agencies contacted
5. Schedule of activities in an Excel format
6. Evaluation Team composition
7. Details on evaluation methodology if necessary

All reports are to be submitted in English in both electronic and hard copies. The Team will provide 5 printed copies of the Draft and Final Evaluation Reports and 5 printed copies of the PowerPoint presentation.

The Final Evaluation Report should not exceed 30 pages in length in its body, not including title page; Table of Contents; List of Acronyms; usage of space for tables, graphs, charts, or pictures; and/ or any material deemed important and included as Annexes. The executive summary with brief evaluation findings, conclusions and recommendations will be translated into Bahasa Indonesia and included in the final report.

The Final Evaluation Report and PowerPoint addressing the Mission's comments should be submitted in both Word and PDF formats. Once the PDF format has been approved by the Mission, the Team will submit the Final Evaluation Report to the Development Experience Clearinghouse for archiving.

Appendix 2 - List of Relevant Target and Results

The EMAS "vanguard" network approach originally would be rolled out in three phases: Phase 1 (Program Years 1-2), Phase 2 (Program Year 3) and Phase 3 (Program Years 4-5). In Phase 1, activities covered 23hospitals and 93 *puskesmas* (health centers) in 10 districts out of the targeted 30 districts and cities in six provinces—North Sumatra, Banten, West Java, Central Java, East Java, and South Sulawesi. Between Phase 1 and the first quarter of Phase 2 (September 2011 and December 2013), the results of EMAS EmONC technical support showed that only one hospital (RS Margono in East Java) has achieved at least 80% of all four clinical performance standards at the end of Year 2. EMAS then changed its strategy to meet the mentoring demand as the program entered Phase 2 (Oct 2013 – Sep 2014). Phase 2 planned to cover an additional 55 hospitals and 100 more health centers in 13 districts and cities. Then in Phase 3, 7 more districts and cities will be included. EMAS included cities with the expectation to increase program impact by widening its geographic areas to cover major referral hospitals and vertical, provincial or influential Muhammadiyah

EMAS has to assign individual vanguard hospital/*puskesmas* to mentor on much narrower tasks, mentoring only the elements of Component 1 and 2 where they themselves had successfully achieved standards. But, this strategy has to deal with the fact that some health facilities (public or private hospitals and *puskesmas* or clinics) would not be able to send their staff to travel to Phase 2 districts to conduct mentoring. Despite being very supportive, the hospital directors in the visited Sidoardjo and Jombang hospitals) expressed their concerns on how their Ob-Gyns, midwives and Pediatricians will manage their time to Phase 2 districts to do mentoring while they must meet all their routine responsibility to the hospital including teaching and coaching the resident specialists, medical school interns, and students from midwifery and nursing academies (because most large district hospitals serve as teaching hospitals). Within this same period (2012/2013), the Ministry of Health issued a new policy on appointing a regional hospital at province that has specialists who are capable to provide technical support to district and city hospitals, and a regional district hospital that has specialists to accommodate and support *puskesmas* and private practice midwives (*Bidan Praktek Swasta or BPS*).

At the *puskesmas* level, the modified mentoring assignment received higher acceptance. During field visits to Puskesmas Talung Kenas in North Sumatra and Puskesmas Bareng in East Java, midwives and nurses confirmed that receiving the mentoring assignment has boosted their confident, discipline to learn more and become a good role model for the mentees. Also, they affirmed that mentoring approach "is feasible and does not require additional huge costs."

A desk review of EMAS accomplishments was done by comparing results of each EMAS indicators (Component 1 and Component 2) in Year 1 and 2 with the PMP targets of Year 3 end, and further linking with results from Quarter 1 of Year 3 (up to December 2013) to confirm achievements of Year 2. Achievements were ranked according to three categories: 'outstanding results' (target achieved fast and way beyond the PMP targets); 'slow progress'

(reached barely just the target) and 'fluctuated results' (not much progress recorded). The 'outstanding results' reflect not only the competence level but also which standard care has been enforced by the MOH (government) in the past. The 'slow progress' achievement indicate "new" habits and practices are in need to be monitored longer to become permanent behavior/practices. The 'fluctuating results' and 'no result' categories need more attention and actions coming directly from EMAS central level.

Component 1: Improved quality of EmONC in hospitals (private and public) and community health centers (puskesmas and BPS).
Successful or 'outstanding results' were seen in two clinical interventions: active management of the third stage of labor (AMTSL) or use of oxytocin (uterotonic agent) within one minute following the delivery of the baby (94%) and early initiation of breastfeeding (60%) [passing the year 3 end PMP targets of 90% and 50%]. This indicates that the MOH has enforced AMTSL as a feasible and inexpensive intervention to be practiced by all skilled attendants (including in home-based deliveries) because the 2002 to 2003 Demographic and Health Survey (IDHS) and a 2002 mortality study by the Indonesian National Institute of Health and Development (NIHRD) reported that 77 percent of maternal deaths were due to direct causes. Of these direct causes, the main causes were: postpartum hemorrhage (33 percent); pre-eclampsia (25 percent); infection (12 percent); unsafe abortion (5 percent); and prolonged labor (5 percent) (reported in POPPHI for USAID. *Management of the Third Stage of Labor: Data obtained from home deliveries in the Cirebon district, August – September 2006*).

Success in non-clinical interventions was seen in the introduction of near-miss audits that achieved 43%, way beyond the 15% target. In public hospitals, this audit increased significantly from 27% to 64%; while private hospitals which never had this before (0%) began to perform up to 25% after being supported by EMAS. However, the 43% achievements fell back to 26% in Quarter 1 of Year 3, indicating that behavioral and habitual change is still not permanently planted.

Another four outcome indicators achieved year 3 end targets by December 2013, although achievements at the end of Year 2 had not come close to the year 3-end targets. These are:

- Percentage of newborns whose mothers received antenatal steroids (PMP #6);
- Percentage of EMAS supported facilities that conduct death audits on all fresh stillbirths > 2000 grams (PMP #7); with public hospitals showed significant progress but no data from puskesmas because of the referrals to hospitals;
- Percentage of EMAS supported facilities that conduct death audits on all neonatal deaths > 2000 grams (PMP #8);
- Percentage of EMAS supported facilities that conduct death audits on all maternal deaths within 24 hours of occurrence (PMP #9); both private and public hospitals showed significant increases, but no data from puskesmas because of the referrals to hospitals.

Slow Progress Results: the following PMP outcome indicator was not achieved:

- Percentage of EMAS supported facilities that achieve 80% of EmONC performance standards (PMP #2), while this is the prerequisite for facilities readiness to function as District Vanguards (achieving 80-100% compliance in all four key categories of maternal, newborn, infection prevention and clinical governance). The overall achievement was 17% in September 2013 and only increased up to 51% by December 2013, despite promising average performance for maternal (65% in September 2013 and 84% in December 2013), newborn (65% in September 2013 and 84% in December 2013) and infection prevention (78% in September 2013 and 84% in December 2013). Only one hospital (RSUD Margono) passed the compliance with at least 80% of all four clinical performance standards at the end of Year 2. EMAS has to change its mentoring strategy because the original target was to have six Vanguard hospitals ready to begin mentoring in Phase 2.
  The *puskesmas* performance were actually unexpectedly good, because they were able to achieve 42% (n= 93), beyond the 40% Year 3-end target of achieving 80% of BEmONC standards. Puskesmas performance for infection prevention standards reached 61% (n= 87), also beyond the 40% Year 3 end target of Phase 1.

Because of the above low achievement, the readiness to function as Vanguard facilities was redefined to allow more than one Phase 1 hospital began mentoring in Phase 2. And six hospitals have been assigned to be EMAS mentor facilities: Asahan, Banyumas, Margono, Sidoardjo, Majalaya and Kanjuruhan Malang.

<u>'Fluctuating Result'</u> was seen in a very important clinical intervention: percentage of cases of severe pre-eclampsia/eclampsia managed with magnesium sulfate (MgSO4) according to global standards at EMAS facilities (PMP #3). Percentages fluctuated from high baseline data of over 80% to 92% in Year 1 back to 80% at the end of Year 2, and was still as low as 79% in Quarter 1 of Year 3 (December 2013) with private hospitals performed worse than public hospitals. Surprisingly, Puskesmas performance increased from no baseline to as high as 88% at the end of Year 2 (September 2013). The quarter 1 of Year 3 did not report on the hospital and *puskesmas* differences. An investigation is needed to obtain reasons of low year 2 achievements compared to year 1.

EMAS developed additional indicators to monitor clinical performance as part of the mentoring in hospitals in Quarter 1 of Year 3 (Sep. – December 2013), with the introduction of EMAS decision support tools (DST) – a set of tools to improve adherence to evidence-based protocols on major complications contributing to maternal and neonatal mortality. . The tools are supposed to be piloted in Muhammadiyah Cempaka Putih hospital in first quarter of Phase 2, together with introducing these tools in 8 facilities: Majalaya, Pare Pare, Lasinrang (Pinrang), Kardinah (Kota Tegal), Soesilo (Tegal), PKU Muhammadiyah Tegal, Deli Serdang and RSUP Banten hospitals. Mentoring has been provided by EMAS staff and US pediatricians. Five facilities have readily adopted these tools and instructed their nurses to use them, but three facilities have been less receptive (as pediatric specialists have not yet accepted the tools).

EMAS collects additional indicators that are not required in PMP (USAID) such as:

1. # of facilities (RSUD) using decision-support tools;
2. # of hospitals using dashboards w/ minimum set of indicators;
3. # of Phase 1 hospitals serving as mentors for Phase 2 hospitals;
4. # of facilities with signed service charters in place;
5. # of hospitals with citizen feedback mechanism in place;

with the first three achieved much lower than the Year 3-end target of 15 hospitals and the last two have met the Year 3-end target of 100%.

No results are found for three indicators: (not required in PMP):
- *Number of calls made from providers in EMAS supported facilities to an emergency obstetric and neonatal care hotline*;
- *Percentage of correct responses to SMS provider support quizzes sent to providers*;
- *Percentage of SMS recipients who respond to quizzes*.

Some field staff informed that where data were available, the validity was questionable.

Component 2: Increased Efficiency and Effectiveness of Referral Systems between Community Health Centers and Hospitals

<u>Successful or 'outstanding results'</u> were seen on two outcome indicators: Percentage of EMAS referral networks achieving 100% of referral performance standards (Vanguard Network Readiness Summary) (PMP #14) and Percentage of referral cases with a hospital response occurring within 10 minutes upon receipt of SijariEMAS notification (PMP #16).
Results showed that SijariEMAS referral have achieved its performance targets.

<u>Five other 'outstanding' input, process, output indicators</u> that have achieved results beyond year 3 end-targets are:

- *Percentage of EMAS target facilities that sign a service charter with community*. This indicator reached an overal of 100% (n= 116) with all 3 types of facilities (Private Hospital, Public Hospital, Puskemas) by September 2013;
- *Number of districts/cities where referral system standards are introduced* (Phase 1 and 2): 10 districts have achieved 100% of the target of 10 districts of Phase 1;
- *Number of districts using SijariEMAS to facilitate referrals* (Phase 1 and 2): 10 districts have achieved the target of 100% out of 10 districts of Phase 1;
- *Percentage of women with severe pre-eclampsia/eclampsia (PE/E) who are referred to EMAS hospitals from puskesmas/clinics and who receive at least one correct dose of magnesium sulfate (MgSO4) before referral*. While at the end of Year 2 this indicator was still far from the target of 40% before referral by the end of Quarter 1 of Year 3, this indicator has achieved 73%.
- *Percentage of newborns with suspected severe infection who are referred to EMAS hospitals from puskesmas/clinics and who receive at least one dose of antibiotics per national guidelines before referral.* Achievements among private hospitals are very high, more than doubled the 30% target of end of Year 3.

‘Slow Progress’results: Documenting results were difficult on *Number of obstetric or newborn cases referred to EMAS-supported hospital using SijariEMAS* (PMP #15) although the use of SijariEMAS has been highly accepted. Hospitals are reluctant to hire a special staff to record the number obstetric and newborn referal cases received using SijariEMAS. Also the Maternal Perinatal Audit (MPA) conducted by the district review team is an activity that needs not only district Pokja leadership but also health resource persons that is not there at the moment (PMP #19). More thoughts should be directed on whether data from these two indicators are worth to collect.

The following is an indicator with ‘no result’ but actually have a promising future if actions to solve the problems come directly from EMAS central level.
Referral standards (performance monitoring tools) developed with EMAS assistance are adopted by MOH. The MOH has not adopted any of EMAS referral monitoring tools. A discussion is on-going with Dr Diar Indriati – the Head of Sub-Directorate for Public Hospital (under Directorate of Health Referral) (11 April 2014), and positive response was given (by Dr Diar to the EMAS team of evaluators after the meeting) that her Sub-Directorate intended to adopt most of EMAS referral indicators. But she admitted that this needs to be endorsed by many upper layers in the Directorate of Health Referral. EMAS COP should approach MOH central to accelerate the process.

Additional Objective 3: Strengthened Accountability amongst Government, the community and health system has been added in Phase 2. And two out of the three outcomes indicators in PMP have been achieved:

- *Percentage of EMAS-supported districts with Vanguard Pokjas (Working Groups)* (PMP #21): Pokjas have been established in all 10 Phase I districts by the end of Year 2, and have been able to advocate for increased funding allocations for maternal and newborn activities (including for MPAs and mentoring activities within districts) in the 2014 revenue and spending budget. These Pokjas of Phase 1 (Malang, Sidoarjo, Bandung, Cirebon, Banyumas, Tegal, and Asahan) have all been helping to mentor and establish Pokjas of Phase 2;
- *Percentage of EMAS-supported districts with Vanguard Civic Forums* (PMP #22): Civic forums have been established in all Phase 1 districts (n=10). Civic Forum activities include collaboration with DHO, community groups and professional organizations to help monitor services, organize blood banks and help coordinate MCH Motivator activities.

Two indicators (SIGAPKU) and Citizen Feedback (*complaints/suggestions received through citizen feedback mechanisms, documented and resolved by local governments or public service delivery units)* are too soon to be evaluated. These mechanisms need to be reconsidered and discussed further in experts of the use of social media.

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Appendix 4 - List of Individuals and Agencies Contacted, 7 April – 14 May 2014

#	Name	Institution	Position/Title
	JAKARTA		
1	Dr. Oscar	Ministry of Health	Sub-Directorate Information and Communication Technology (PUSDATIN)
2	Dr. Amnur Kayo	Ministry of Health	Sub-Directorate Information and Communication Technology (PUSDATIN)
3	Dr Rudy	Ministry of Health	Sub-Directorate Information and Communication Technology (PUSDATIN)
4	Dr Boga	Ministry of Health	Head of Sub-Directorate Information and Communication Technology (PUSDATIN)
5	Dr. Deddy Tedjasukmana	Ministry of Health	Head of Sub-Directorate Support Services and Health Facility (BUK Penunjang)
6	Sodikin	Ministry of Health	Sub-Directorate Support Services and Health Facility (BUK Penunjang)
7	Dr. Anung Sugihantono	Ministry of Health	Directorate General of G/KIA
8	Dr. Gita Maya	Ministry of Health	Director of Maternal Health
9	Dr. Jane Supardi	Ministry of Health	Director of Child Health
10	Dr. Kartini Rustandi	Ministry of Health	Director Basic Health Services (BUK Dasar)
11	Dr. Rina SpA	IDAI	Ikatan Dokter Anak Indonesia (IDAI)
12	Dr. Nurdadi	POGI Jakarta	Perkumpulan Obsteri dan Ginekologi Indonesia
13	Dr. Muhamad Baharuddin SpOG MARS	Budi Kemuliaan	Director, LKBK
14	Dr. Retno	Budi Kemuliaan	Staff
15	Dr. Fatchiati	Budi Kemuliaan	Staff
16	Dr. Fahrul Arbi, SpA	Budi Kemuliaan	Staff
17	Dr. Dwirani Amelia, SpOG	Budi Kemuliaan	Team Leader, Quality Improvement, Maternal
18	Dr. Eka Nursiati, MARS	Budi Kemuliaan	Staff
19	Dr. Irma Sapriani, SpA	Budi Kemuliaan	Staff
20	Agus Rahmanto, SKM, MARS	Budi Kemuliaan	Staff
21	Dr. Cut Virollina	Budi Kemuliaan	Staff
22	Wildan Saleh, SE	Budi Kemuliaan	Staff

23	A Rahman Muttaqin	Muhammadiyah	Program Development Officer
24	Siti Masyitah Rahma	Muhammadiyah	Senior Program Manager
25	Dr. Sudibyo Markus	Muhammadiyah	Governance Advisor
26	Dwi Dwiyuliantina Sari	Muhammadiyah	Finance Officer
27	Anne Hyre	EMAS (Jakarta Office)	Chief of Party of EMAS
28	Kristina Grear	EMAS (Jakarta Office)	Senior Operations and Communications Advisor
29	Mia Pesik	EMAS (Jakarta Office)	Senior Program Manager
30	Dr. Evodia A. Iswandi	EMAS (Jakarta Office)	Senior Impact at Scale Strategic Advisor
31	Maya Tholandi	EMAS (Jakarta Office)	Senior Strategic Information Advisor
32	Ita Yusdarita	EMAS (Jakarta Office)	Program Manager
33	Hartono Rakiman	EMAS (Jakarta Office)	Communications Manager
34	Cindy Rakhmawati	EMAS (Jakarta Office)	Communications Officer
35	Cut Sofa Kumala	EMAS (Jakarta Office)	Program Coordinator
36	Dr. Trisnawati Gandawijaya	EMAS (Jakarta Office)	Team Leader – Referral quality
37	Ali Zazri	EMAS (Jakarta Office)	M&E Director
38	Dr. Wilson Wang	EMAS (Save the Children)	Team Leader, Quality Improvement, Newborn
39	Pancho Hekageri AK	EMAS (Save the Children)	Newborn Advisor
40	Bambang Wijayanto	RTI	ICT Advisor
41	Nuwirman	EMAS (Jakarta Office)	Government Advisor
42	Eko Prasetyo	Jhpiego	ICT4D officer
43	Dr. Massee Bateman	USAID	Health Unit
44	Irene Koek	USAID	Health Unit
45	Rachel Cintron	USAID	Health Unit
46	Mildred Pantouw (Millie)	USAID	Health Unit, AOTR
47	Ria Wardhani	USAID	Health Unit
48	Amelia Ginting	USAID	Health Unit
49	Dr. Ratna Kurniawati	USAID	Health Unit
50	Dr. Edie Rachmat	USAID	Health Unit
	EAST JAVA		
51	Dr. Wasis Nupikso SpOG	RSUD Sidoarjo	Head, Sie. Medical Services - Inpatient
52	Dr. Setyo Budi Pamungkas SpOG	RSUD Sidoarjo	Coordinator, Mentoring Team
53	Dr. Pramudyo Dwiputro	RSUD Sidoarjo	Head, Peristi RSUD

	SpOG		
54	Dr. Tjuput Purwastono SpOG	RSUD Sidoarjo	Head, PONEK RSUD
55	Eko Hari Widarto	RSUD Sidoarjo	Head, ER Nursing
56	Mamik Setyo Indrayani	RSUD Sidoarjo	Head, Birth Delivery Room
57	Siti Yunaria	RSUD Sidoarjo	Head, Perinatology
58	Umy Nurjayah	RSUD Sidoarjo	Midwife, MNE-Matenal&Neonatal Emergency
59	Vivin Auliawati	RS Siti Khodijah	Head, Birth Delivery Room
60	Sutik Winarsih	RS Siti Khodijah	Head, Perinatology
61	Dr. Hety Puspitaningrum	Puskesmas Taman	Doctor
62	Nurul Tri	Puskesmas Taman	Coordinator Midwife (Bidan Koordinator)
63	Endah Retno	DHO Kab. Sidoarjo	Staff, Family Health
64	Dr. Endang Damayanti	DHO Prov.Jatim	Sekretary, DHO
65	Dr. Herlin Ferliana, M. Kes	DHO Prov.Jatim	Head, Health Services
66	Dr. Nunik Dhamayanti	DHO Prov.Jatim	Head, Sie, Referral and Special
67	Avianto	DHO Prov.Jatim	Staff, Family Health
68	Dr. Sri Utami	DHO Prov.Jatim	Staff, Referral and Special
69	Dr. Hera Prasetia	RSUD Jombang	Head, Medical Services
70	Dr. Kuspardani	DHO Kab.Blitar	Head, DHO
71	Dr. Endah Woro	RSUD Ngudi Waluyo Blitar	Deputy Director, Health Services
72	Siti Afrida S.Kep, Ners	RSUD Kanjuruhan Malang	Head, Nursing
73	drg. Loembini Pedjati Lajoeng	DHO Kab. Pasuruan	Head, DHO
74	Dr. Arma Rosalina	RSUD Bangil Pasuruan	Head, Medical Services
75	Dr. Setyo Budi Pamungkas SpOG	RSUD Sidoarjo	Coordinator, Mentoring Team, Sidoarjo
76	Dr. Tjuput Purwastono SpOG	RSUD Sidoarjo	Head, PONEK RSUD Sidoarjo
77	Dr. Heri Wibowo, M.Kes	DHO Kab.Jombang	Head, DHO
78	Ida Nikmatul Ulfa	DHO Kab.Jombang	Head, Sie, Family Health
79	Dr. Iskandar	DHO Kab.Jombang	Head, PSDK
80	Luluk Nur Kholisah	DHO Kab.Jombang	Staff, MCH
81	Dr. Asnan	Puskesmas Cukir	Head, Puskesmas
82	Dr. Widi	RSUD Ploso Jombang	Director, RSUD Ploso Jombang
83	Dr. M. Darusalam	RS Muhammadiyah Jombang	Director, RS Muhammadiyah Jombang

84	Dr. Andri	Puskesmas Bareng	Head, Puskesmas
85	Dr. Hexawan	Puskesmas Tapen	Head, Puskesmas
86	Dr. Nanik	Puskesmas Bandar Kedung Mulyo	Head, Puskesmas
87	Dr. Ismindari	Puskesmas Tembelang	Head, Puskesmas
88	Dr. Pudji Umbaran, MKP	RSUD Jombang	Director, RSUD Jombang
89	Dr.M. Mahfudz, Sp.PD	RSUD Jombang	Deputy Director, Health Services
90	Dr. Hera Prasetia, Sp. BS	RSUD Jombang	Head, Medical Services and Nursing
91	Dr. Ulfah Khannatul Izzah, MKP	RSUD Jombang	Head, Medical Quality Control
92	Denok Eko Y, Amd.Keb.,S.Sos.,MM.Kes	RSUD Jombang	Head, Sie, Nursing Quality Control
93	Dr. Pudji Umbaran, MKP	RSUD Jombang	Director, RSUD Jombang
94	Dr.M. Mahfudz, Sp.PD	RSUD Jombang	Deputy Director, Health Services
95	Dr. Subur, Sp.OG	RSUD Jombang	Dr. Obgyn
96	Dr. Adi Nugroho,Sp.OG	RSUD Jombang	Dr. Obgyn
97	Dr. Rizal Fitni, Sp.OG	RSUD Jombang	Dr. Obgyn
98	Dr. Rahadi Hamsya, Sp.An	RSUD Jombang	Head, ER Central
99	Dr.Husnu Raji'in, Sp.An	RSUD Jombang	Staff, Medical Anaesthesia
100	Dr. Retno Wulandari, SpA	RSUD Jombang	Pediatrician
101	Dr. Tri Putri Y, Sp. PK	RSUD Jombang	Head, Clinical Pathology
102	Neny Nurmiwati, S.Si.,MSc.,Apt	RSUD Jombang	Head, Pharma-Installation
103	Slamet Djoko, S.Kep.,Ns	RSUD Jombang	Head, ER Central
104	Rahayu A, Amd.Keb	RSUD Jombang	Head, PONEK
105	Ani Kuncoro	RSUD Jombang	Deputy Head, Neonatal Room
106	Anik Masrifah	RSUD Jombang	Head, ER
107	Rahmi, Amd.Kep	RSUD Jombang	Head, IBS
108	Suhariyono	RSUD Jombang	Nurse Anesthesia, OR ER
109	Adi Fatkhur R, Amd.PK	RSUD Jombang	Staff, Medical Record
110	Wahyu, Amd.Keb	RSUD Jombang	Midwife

111	Erika Dian Ratri, SH	RSUD Jombang	Staff, Medical Services and Nursing
112	Ernia Rosita, S.Kep.Ns	RSUD Jombang	Staff, Medical Services and Nursing
113	Tamam, SH	RSUD Jombang	Staff, Public Relations
114	Indah Hera D, Amd.Kep	RSUD Jombang	Staff, Neonates
115	Arifin	RSUD Jombang	Staff, PONEK
116	Dr. Puspitasari	RSUD Jombang	Head, KSM General Practitioners (GPs)
117	Dr. Dewi Nugrahini	RSUD Jombang	ER Doctor
118	Tommy S	FMM Peduli KIA	Member Civicus Forum
119	Armie	FMM Peduli KIA	Treasurer Civicus Forum
120	Wahyuning Asri	FMM Peduli KIA	Secretary, Civicus Forum
121	Mitra Oktafista A	FMM Peduli KIA	Member Civicus Forum
122	Tophan Tohary	FMM Peduli KIA	Member Civicus Forum
123	Yati	FMM Peduli KIA	Member Civicus Forum
124	Dr. Suparman	RS Muslimat	Director
125	Dr. Teja	RS Muslimat	SpOG
126	Dr. H.	RS Muslimat	Pediatrician
127	Dr. Bagus	RS Muslimat	Doctor
128	Dewi Erma	RS Muslimat	Nurse
129	Solichan	RS Muslimat	Nurse
130	Sukma	RS Muslimat	Nurse
131	Akmal Fitri	RS Muslimat	Nurse

132	Umi R	RS Muslimat	Nurse
133	Suryono	RS Muslimat	Head, Operating Room
134	Tri A	RS Muslimat	Nurse
135	Soelistiyorini	RS Muslimat	Nurse
136	Titik	RS Muslimat	Midwife
137	Dr. Andri Suharyono	Puskesmas Bareng	Head, Puskesmas
138	Dr. Sri Rahayu	Puskesmas Bareng	Doctor
139	Dr. Sonni Eko W	Puskesmas Bareng	Doctor
140	Sutami	Puskesmas Bareng	Midwife PONED
141	Putuyah	Puskesmas Bareng	Midwife Coordinator PONEK
142	Ulfa Ida	Puskesmas Bareng	Midwife Koordinator
143	Umi Maslihah	Puskesmas Bareng	Village Midwife - Tebel
144	Wivi Setyaningrum	Puskesmas Bareng	Village Midwife B. Agung
145	Dina Yunita p. w	Puskesmas Bareng	Village Midwife Pulosari
146	Eka N	Puskesmas Bareng	Village Midwife Ngampungan
147	Elis Susanti	Puskesmas Bareng	Village Midwife Ngrimbi
148	S. Titik Parwati	Puskesmas Bareng	Coordinator ER
149	Ninik Ismiatin Ningsih	Puskesmas Bareng	Nurse ER
150	Syamsiah	Puskesmas Bareng	Midwife MCH
151	Kiswiyati Wahyuni	Puskesmas Bareng	Midwife MCH
152	Irin Suprihatin	Puskesmas Bareng	Midwife MCH

15 3	Mungky N. R	Puskesmas Bareng	Midwife PONED
15 4	Dini	Puskesmas Bareng	Midwife PONED
15 5	Vivin	Puskesmas Bareng	Midwife PONED
15 6	Iza Tri Rahmawati	Puskesmas Bareng	Village Midwife - Pakel
	NOTH SUMATERA		
15 7	Dr. Jenius L.Tobing, SpOG	RSU dr. Pringadi Medan	Head, Health Committee
15 8	Dr. Syamsul, SpOG	RSU dr. Pringadi Medan	Head, Ob-Gyn Dept.
15 9	Dr. Syamsul, SpAn	RSU dr. Pringadi Medan	Head, Anesthesia Dept.
16 0	Dr. Berliana Hasibuan, SpA	RSU dr. Pringadi Medan	Head , Pediatric Dept.
16 1	Bidan Fauziah	RSU dr. Pringadi Medan	Head, Birth Delivery Room
16 2	Bidan Rusmawati	RSU dr. Pringadi Medan	Head, Birth Delivery Room
16 3	Bidan Elizatuti	RSU dr. Pringadi Medan	Head, ER
16 4	Risda Nadeak	RSU dr. Pringadi Medan	Staff Perinatology
16 5	Endang	RSU dr. Pringadi Medan	Staff, Pre-eclampsia
16 6	Siti Aisyah	RSU dr. Pringadi Medan	Head, Obstetric Gyn.
16 7	Dr. Risma	RSU dr. Pringadi Medan	Medical Committee
16 8	Dr. Riza	RSU dr. Pringadi Medan	Secretariat, ObGyn
16 9	Syamsudin Angkat	RSUP H.Adam Malik	Director, RSUP Adam Malik
17 0	Dr. Fahdy, SpOG	RSUP H.Adam Malik	Head, Quality Committee
17 1	Dr. Hanudse, SpOG	RSUP H.Adam Malik	SMF ObGyn
17 2	Dr. Yudha, SpOG	RSUP H.Adam Malik	SMF ObGyn

173	Dr. Fera wahyuni, SpA	RSUP H.Adam Malik	SMF Pediatric
174	Dr. Andriamuri, SpAN	RSUP H.Adam Malik	SMF Anesthesia
175	Bd. Sumiariani	RSUP H.Adam Malik	Head, Obstetric Dept.
176	Bd Rosmahasa	RSUP H.Adam Malik	Head, ER
177	Rehulina	RSUP H.Adam Malik	Head, Perinatology
178	Masrida	RSUP H.Adam Malik	Head, Operating Room
179	Asni Angkat	RSUP H.Adam Malik	Staff PPI
180	Dr. Rizki harahap	RSUP H.Adam Malik	Head, Nursing
181	Dr. Marasi Sibarani, SE	PERSI	Vice Chairman PERSI North Sumatra Province
182	Drs. Afwan Apt	PHO North Sumatra	Secretary, PHO
183	Dr. Azwan Nasution	PHO North Sumatra	Coordinator, Maternal and Child Services
184	Rosidah Berutu, M.Kes	PHO North Sumatra	Head, Primary Health Care
185	Dr.Irma Nasution	PHO North Sumatra	Staff, Primary Health Care Referral
186	Dr. Masroel Siregar, MPH	PHO North Sumatra	Vice chairman of Joint Health Council
187	Choliqul Kamal, SKM	PHO North Sumatra	Member of Joint Health Council
188	Dra. Eli Suhaeriyah	PHO North Sumatra	Head of APTEL Diskominfo
189	Dedi Irawan	PHO North Sumatra	Staff DISKOMINDO
190	Mario Kasduri	Muhammadiyah North Sumatera	PWM SUMUT
191	Elynita	Muhammadiyah North Sumatera	PWA SUMUT
192	Azwinar	Muhammadiyah North Sumatera	Komite EMAS/ Majelis Kesehatab 'Aisyiyah
193	Partaonan Harahap	Muhammadiyah North Sumatera	ER Staff, RS Muhammadiyah

194	Dr. Herlina Sembiring	PKM Talun Kenas - Kabupaten Deli Serdang	Head, Puskesmas Talun Kenas
195	Dr. Eva R. Pinem	PKM Talun Kenas - Kabupaten Deli Serdang	Doctor, Puskesmas Talun Kenas
196	Rugun Sianipar	PKM Talun Kenas - Kabupaten Deli Serdang	Coord. Midwife (Bidan Koordinator) PKM Talun Kenas
197	Hieronimus Meliala	RS Sembiring	Head, Adm., RS Sembiring
198	Sarmana	RS Sembiring	Head, Nursing RS Sembiring
199	Dr. Hartaty Agnes Saragih	DHO Kab. Deli Serdang	Head, Health Services
200	Elmi Haryuni SKM, MKes	DHO Kab. Deli Serdang	Head, Bidang Kesehatan Keluarga
201	Sri Rejeki SKM	DHO Kab. Deli Serdang	Team ICT EMAS Deli Serdang
202	drg. Reshki Jonian	RSUD Lubuk Pakam	Director, RSUD Lubuk Pakam
203	Rosmawaty	RSUD Lubuk Pakam	Head, Nursing
204	Dr. Evi	RSUD Lubuk Pakam	Deputy Director, Medical Services
205	Martha Barus	RSUD Lubuk Pakam	Head, Perinatology
206	Heni	RSUD Lubuk Pakam	Head, Obstetric
207	Rasmi	RSUD Lubuk Pakam	Head, ER
208	Dr. Ratna Tanjung	PKM Aras Kabu	Head, Puskesmas Aras Kabu
209	Dr. Henny Andrianie	PKM Aras Kabu	Doctor, Puskesmas Aras Kabu
210	Rohana Simarmata	PKM Aras Kabu	Bidan Koordinator PKM Aras Kabu
211	Nensi Herlina	PKM Aras Kabu	Coordinator VK PKM Aras Kabu
212	Deliana	PKM Aras Kabu	MCH Motivator, Civic Forum Deli Serdang

	SOUTH SULAWESI		
213	Dr. Nurdin	EMAS	Team Leader, South Sulawesi Province
214	Dr. Mapatoba,	PHO South Sulawesi	Head, Health Services
215	Dr. Syamsurizal	RS Wahidin Sudirohusodo	Head, Medical Services
216	Dr. Effendi SpOG	RS Wahidin Sudirohusodo	Head, Obstetric Care
217	Dr. Hadiyah SpA	IDAI S.Sulawesi	Secretary
218	Dr. Bob Wahyudi SpA	IDAI S. Sulawesi	Member
219	Prof dr. Dazril Daud Sp A	IDAI S. Sulawesi	Head, Pediatric RSWS
220	Arief Setiadi	BPJS Makasar	Head, Information and Technology Dept
221	Ali	BPJS Makasar	Head, BPJS Makassar
222	Burhanuddin	RS Siti Khadijah	Coordinator
223	Hedijusumah	RS Siti Khadijah	Head/Owner of RSIA
224	Yulanti	RS Siti Khadijah	Deputy Director
225	Jh Isman Dahlan	RS Siti Khadijah	Deputy Director
226	Asawait	Civic Forum	Head, PKK Watansawito
227	Fatimah	Civic Forum - Aisyiyah	Secretary of Forum
228	Amrullah	Civic Forum	Muhammadiyah
229	Nurfoyri Aliah	BPJS RS Lansinrang	Staff
230	Dr. Asma	DHO Pinrang	-
231	Dr Nuryanti	DHO Pinrang	Head, Health Services
232	Dr. Nurhidi Fauzi	DHO Pinrang	Funding and Pharmacy Div
23	Dr. Aswar	DHO Pinrang	Community Services

3			
234	Dr. Ramli Yunus	Lampa Puskesmas	Head, Puskesmas
235	Augustina Am Keb	Lampa Puskesmas	Midwife, Puskesmas
236	Khadijah	Lampa Puskesmas	Village Midwife
237	Dr. Sriyanti	RS Lasinrang	Deputy Director, Public Services

Appendix 6 -Evaluation Team composition

1. Team Leader: Alfred Bartlett, MD, FAAP (Captain, US Public Health Service, retired; former Senior Advisor for Child Survival, USAID/Washington, and former Director Saving Newborn Lives Program, Save the Children/US)

2. USAID/Washington Maternal Expertise: **Marjorie Koblinsky, PhD** (Senior Maternal Health Advisor, USAID/Washington; former Senior Advisor for Women's Health, John Snow Inc., and former Director, Public Health Sciences Division, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR-B)

3. Indonesian MNH Policy and Health System Advisor: Broto Wasisto, MD (Member and Chairman of the Oversight Committee, Country Coordinating Mechanism (CCM) of the Global Fund Indonesia, and Vice Chair, Consortium of Health Care Services, MOH)

4. **Indonesian MNH Evaluation Specialist: Meiwita Budiharsana, PhD** (Teaching Faculty – Department of Biostatistics and Population, Faculty of Public Health, University of Indonesia, Jakarta, Indonesia; former Country Director and Senior Associate, Population Council – Viet Nam (Hanoi), and former Country Representative, The Ford Foundation, Jakarta, Indonesia)

Appendix 5

USAID EMAS Mid Term Evaluation
Schedule of Activities
April 7 – May 9, 2014

Week 1

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES	CONTACT PERSON
5-6 April 2014			Preparation: reading documents etc	**Anywhere**		
Monday, April 7, 2014	**Jakarta**	08.30 – 17.00	Team Planning Meeting	**USAID Meeting Room 810**, 17/F, Gedung Sarana Jaya Jl. Budi Kemulian I/1 Jakarta 10110	USAID and MTE team	• Amelia Ginting, Telp 021-34359485
Tuesday, April 8, 2014	**Jakarta**	09.00-12.00	Team planning meeting	**USAID Meeting Room 1710**	• MTE team • Irene Koek • Rachel Cintron • Massee Bateman • Mildred Pantouw • Ratna Kurniawati	• Amelia Ginting, Telp 021-34359485
		12.30-14.30	Meeting with Ministry of Health	**JH Luwansa Hotel** Jl. HR Rasuna Said Kav.C.22 Jakarta 12940	• Dr Anung Sugihantono (Head of GKIA) • Dr Gita Maya (Director Maternal Health) • Dr Kartini Rustandi (Dir. Basic Health Services) • Dr Dedi Teja Sukmana (Dir. Medical Services for Human Resources and Equipment)	• Ratna Kurniawati • MOH

Appendix 5

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES	CONTACT PERSON
					• Dr Erna Muladi (Head Div. Child Health) • Dr Nida, staff medical services • USAID	
		14.30 – 17.00	Team planning meeting continue	**EMAS Secretariat office, MOH fl.9th**	• MTE Team	• MTE Team
Wednesday, April 9, 2014	**Jakarta**	9.00 – 13.00	Team planning meeting	**Agenda Dev. by team leader and the team**	MTE Team	MTE Team
		13.00 – 16.00	Meeting with EMAS	**Borobudur Hotel**	• MTE Team • EMAS Leadership Team	Anne Hyre
Thursday April 10, 2014	**Jakarta**	09.00-17.00	Meeting with EMAS	**EMAS Office**, 16/F,Tempo Scan Building Jl. Rasuna Said Kav.10- 11 Kuningan, Jakarta Selatan	• MTE Team • EMAS Team	Anne Hyre
Friday April 11, 2014	**Jakarta**	08.00 – 12.00	Meeting with Ministry of Health (Child and Maternal department)	**MOH Office**	• MTE Team • Dr Jane Supardi (Director of Child Health) • Dr Eni , Sub directorate neonatal health • Dr Laveli Desi (Head of Div. standardization neonatal health) • Dr Meli (staff)	Ratna Kurniawati

Appendix 5

<table>
<tr><th colspan="3">DATE</th><th>TIME</th><th>ACTIVITIES</th><th>VENUE (ADDRESS)</th><th>ATTENDEES</th><th>CONTACT PERSON</th></tr>
<tr><td colspan="2"></td><td></td><td>13.00-17.00</td><td>Meeting with EMAS (Monitoring and Data Management; Program Learning)</td><td>EMAS Office, 16/F,Tempo Scan Building
Jl. Rasuna Said Kav.10- 11 Kuningan, Jakarta Selatan</td><td>• MTE Team
• EMAS Team</td><td>Anne Hyre</td></tr>
<tr><td colspan="2">Sat April 12, 2014</td><td>Jakarta</td><td>09.00-12.00</td><td>Visit Budi Kemuliaan Hospital</td><td>RSB Budi Kemuliaan
Jl. Budi Kemuliaan No.25
Jakarta Pusat</td><td>• MTE Team
• Dr Muhammad Baharuddin and Budi Kemuliaan staff</td><td>Budi Kemuliaan</td></tr>
<tr><td colspan="2">Sunday April 13, 2014</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Monday April 14, 2014</td><td rowspan="2">April 14-17,2014</td><td>Jakarta</td><td>09.00 – 12.00</td><td>Interviews – POGI; other (TBD)</td><td>EMAS Secretariat office, MOH fl.9th</td><td>• MTE Team
• Dr. Nurdadi Saleh (head of POGI)</td><td>Anne Hyre</td></tr>
<tr><td>Field visit to Medan</td><td>15.05-17.30</td><td>Field Work and Data Analysis – Interviews, site visits, and analysis of comparative performance data</td><td>Medan</td><td>• MTE Team
• EMAS province</td><td>EMAS Province</td></tr>
<tr><td colspan="2" rowspan="2">Friday April 18, 2014</td><td rowspan="2">Jakarta</td><td>10.00 -13.00</td><td rowspan="2">USAID Leadership meeting</td><td rowspan="2">Hotel Borobudur</td><td>• Irene Koek (Health Director)
• MTE Team</td><td></td></tr>
<tr><td>13.30-16.00</td><td>• Rachel Cintron (Deputy Director)
• MTE Team</td><td></td></tr>
<tr><td colspan="2">Saturday, April 19, 2014</td><td>Possible meetings</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Sunday April 20, 2014</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Monday April 21, 2014</td><td>Jakarta</td><td>08.30</td><td>Meeting with Director of Information Centre (PUSDATIN)</td><td>Ministry of Health
Dr. M. Adhyatma Building, 2/F, A Building, R. 207, Jl. HR. Rasuna Said, Blok X5, Kav. 4-9, Jakarta</td><td>• MTE Team
• Dr Oscar Primadi
• Dr Amnur Kayo
• Dr Rudy
• Dr Boga (Head of Sub</td><td>Ibu Ratna Kurniawati</td></tr>
</table>

Appendix 5

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES	CONTACT PERSON
				ROOM 614	Directorate Information and Communication Technology)	
		13.00	Meeting with Director of Support Services and Health facility (BUK Penunjang)	**Ministry of Health** Dr. M. Adhyatma Building, 2/F, A Building, R. 207, Jl. HR. Rasuna Said, Blok X5, Kav. 4-9, Jakarta **ROOM 517**	• MTE Team • Dr Deddy Tedjasukmana Basuni • Bapak Sodikin	Ibu Ratna Kurniawati
		19.00	Working Dinner with Dirjen G/KIA	**Sekai Restaurant** **Jl. Suryo No. 30, Blok S Senopati Jakarta Selatan**	• MTE Team • Dr Anung Sugihantoro, • Dr Gita Maya (Dir. Maternal health)	Ibu Ratna Kurniawati
Tuesday **April 22, 2014** **April 22-25, 2014**	**Jakarta**	07.30-08.30	Meeting with Director Basic Health Services (BUK Dasar)	**Ministry of Health** Dr. M. Adhyatma Building, 2/F, A Building, R. 207, Jl. HR. Rasuna Said, Blok X5, Kav. 4-9, Jakarta **ROOM 509**	• MTE Team • Dr Kartini Rustandi and staff	Ibu Ratna Kurniawati
		09.30	Meeting with IDAI	**RSCM** **Gedung PJT (Pelayanan Jantung Terpadu) Perinatologi Div. 3th floor** **Jl. Diponegoro No.71 Salemba Jakarta**	• MTE Team • Dr Rina Roshsiswanto	
		13.00-15.00	Meeting with Muhammadiah	**Gedung Dakwah Muhammadiyah** Jalan Menteng Raya No. 62 Jakarta	• Bapak Sudibyo Markus • MTE Team	
	Field visit Team 1	15.00	Field Work and Data Analysis – Interviews, site visits, and analysis of comparative performance data	Makassar (Pinrang District)	• MTE Team Ibu Marge and Bapak Broto • EMAS Province	• EMAS Province

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DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES	CONTACT PERSON
	Field visit Team 2	15.00	Field Work and Data Analysis – Interviews, site visits, and analysis of comparative performance data	East Java	• MTE Team Bapak Alfred and Ibu Meiwita • EMAS Province	• EMAS Province
Saturday April 26, 2014	**Jakarta**		Initial synthesis – In-country team work culminating in delivery of Detailed Evaluation Report Outline and draft PowerPoint presentation for review by Evaluation Committee. Additional meetings and interviews may also be scheduled to validate findings.			
Sunday April 27, 2014						
Monday April 28, 2014						
Tuesday April 29, 2014						
Wednesday April 30-May 5, 2014	**Jakarta**		Revision and refinement – In response to comments from Evaluation Committee, team will incorporate feedback and other input into finalized PowerPoint presentation and initial full report draft. Presentation to USAID/Indonesia and other stakeholders.			
April 30	**Jakarta**	09.00-12.00	Discuss Pre-finding with USAID and MTE team only	**USAID Meeting Room 1610**, 16/F, Gedung Sarana Jaya Jl. Budi Kemulian I/1 Jakarta 10110	USAID MCH Team and Health office Director	
		13.00-14.00	Discuss pre-finding with MTE Team, USAID, MCH,	**Front Office USAID**	• MTE Team • USAID • MCH	

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DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES	CONTACT PERSON
		14.30-16.00	Discussion on preliminary finding and recommendation	**USAID Office**	• USAID • MTE Team • EMAS (Kristina and Maya)	
May 2, 2014	**Jakarta**	9.00 – 10.30	Further discussion	**USAID Meeting Room 1410,** 14/F, Gedung Sarana Jaya Jl. Budi Kemulian I/1 Jakarta 10110	• USAID Team • MTE team	• Amelia Ginting, Telp 021-34359485
		10.30-12.00	Discussion on preliminary finding and recommendation	**Front Office**	• USAID • MTE team	• Amelia Ginting, Telp 021-34359485
		13.00-16.00	Discussion on preliminary findings and recommendation, and preparation of Ministry of Health debrief		• USAID • MTE Team • EMAS	
May 5, 2014	**Jakarta**	08.30-11.30	MTE presentation for USAID and EMAS Meeting with EMAS and Consortium members (Save the Children, LKBK, Muhammadiyah, EMAS staff, USAID John Rogosh< Irene K, Massee Bateman: Finding and recommendation	**EMAS Office**, 16/F,Tempo Scan Building Jl. Rasuna Said Kav.10- 11 Kuningan, Jakarta Selatan	• EMAS Team • MTE Team • USAID	• Anne Hyre
May 7, 2014	**Jakarta**	09.00	Meeting with Coord. Ministry of Social Welfare (Health and FP -- MOH and BKKBN)	**Min.ofSocial Welfare Jl. Medan Merdeka Barat No.3 Jakarta Pusat**	• MTE Team • Ministry of welfare, Deputy staff • USAID	• Ratna Kurniawati

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DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES	CONTACT PERSON
May 14, 2014	**Jakarta**	10.00-11.00	Meeting with the General Secretary of the Ministry of Health, and ….	**Ministry of Health** Dr. M. Adhyatma Building, 2/F, A Building, R. 207, Jl. HR. Rasuna Said, Blok X5, Kav. 4-9, Jakarta	• MTE Team • EMAS team • USAID • Secretary Jendral	• Ratna Kurniawati