

**STARH WORKPLAN  
2002**

**January 2002**

*The STARH (Sustaining Technical Achievements in Reproductive Health) Program is a three-year program funded by the U.S. Agency for International Development under Cooperative Agreement No. 497-A-00-00-00048-00, effective August 22, 2000. The program is implemented by Johns Hopkins Center for Communication Programs, Johns Hopkins Program for International Education & Training in RH, John Snow International, Yayasan Kusuma Buana and PT. Manggala Jiwa Mukti.*



*Any part of this document may be reproduced or adapted to meet local needs without prior permission provided the material is made available free or at cost. Any commercial reproduction requires prior permission from STARH. Permission to reproduce materials, which cite a source other than STARH, must be obtained directly from the original source.*

**For more information on this report/publication, please contact Indonesia USAID office or direct inquiries to the address below.**

***STARH Program  
Tifa Building 5/F  
Jl. Kuningan Barat 26,  
Jakarta 12710, Indonesia  
Phone: (62-21) 525 2174; Fax (62-21) 522 9271  
E-mail: starh@jhuccp***

## ABBREVIATIONS (in alphabetical order)

ARH	Adolescent Reproductive Health
BKKBN	<i>Badan Koordinasi Keluarga Berencana Nasional</i> (National Family Planning Coordinating Board)
CIDA	Canadian International Development Assistance
CSO	Civil Society Organization
DepKes	<i>Departemen Kesehatan</i> (Ministry of Health)
EC	Emergency Contraceptive
GoI	Government of Indonesia
HI 2010	Healthy Indonesia 2010
IBI	<i>Ikatan Bidan Indonesia</i> (Indonesian Midwives Association)
IDHS	Indonesia Demographic Health Survey
IPC/C	Interpersonal Communication/Counseling
MNH	Maternal & Neonatal Health
NCTN	National Clinical Training Network
NGO	Non Governmental Organization
PI	Performance Improvement
PKMI	<i>Perkumpulan Kontrasepsi Mantap Indonesia</i> (Indonesian Voluntary Sterilization Association)
PLKB	<i>Petugas Lapangan Keluarga Berencana</i> (Family Planning Field Worker)
POGI	<i>Perkumpulan Obstetri dan Ginekologi Indonesia</i> (Indonesian Society of Obstetrics and Gynecology)
PSA	Public Service Announcement
QI	Quality Improvement
QIQ	Quick Investigation of Quality
RH/FP	Reproductive Health/Family Planning
SO	Strategic Objective
SOAG	Strategic Objective Agreement Grant
UNFPA	United Nations Fund for Population Activities
VSC	Voluntary Surgical Contraception
YKB	Yayasan Kusuma Buana (Kusuma Buana Foundation)

# TABLE OF CONTENTS

<b>PART I: BACKGROUND.....</b>	<b>1</b>
<b>PART II: STARH PROGRAM APPROACH.....</b>	<b>3</b>
<b>STARH Strategic Framework .....</b>	<b>5</b>
<b>PART III: STARH IMPACT AREAS.....</b>	<b>6</b>
<b>Impact Area I: Supply of Quality Services and Expanded Choice Improved .....</b>	<b>7</b>
I.A. Service Quality Improvement (QI).....	7
I.B. Contraceptive Security.....	10
I.C. Expanding Choice .....	11
<b>Impact Area II: Demand for Quality Services and Informed Choice Increased.....</b>	<b>12</b>
II.A. Empowered Clients and Communities .....	12
II.B. Capacity Building for Advocacy.....	15
<b>Impact Area III: Environment for Sustaining Quality and Choice Strengthened.....</b>	<b>15</b>
III.A. Support for National and Regional RH/FP Policy.....	16
III.B. Support for Reproductive Rights.....	17
III.C. Utilization of Data .....	18
<b>PART IV: STARH Program Staffing.....</b>	<b>19</b>
<b>PART V: ACTIVITY MATRIX AND BUDGET.....</b>	<b>24</b>
<b>PART VI: ATTACHMENTS.....</b>	<b>31</b>
Attachment A – Quality Improvement Concept Paper .....	33
Attachment B – Smart Clients, Smart Provider & Smart Communities .....	43
Attachment C – Thoughts on STARH Field Level Activities .....	51

## STARH WORKPLAN 2002

STARH is pleased to submit its second year workplan. The workplan represents the culmination of discussions and consensus with our key partners, BKKBN and DepKes for the strategic direction of STARH in 2002 and beyond. This year's workplan builds on key aspects of the first year but places a greater focus on the integration of supply and demand initiatives at national, provincial and district levels. The purpose of the workplan is to present the program's strategic framework, key impact areas, strategies to achieve impact, and an activity plan for the period January 1 through December 31, 2002. This workplan is structured in five parts as follows:

**Part I: Background**, describes STARH's mission, accomplishments to date, and growing partnerships (page 1);

**Part II: Program Approach**, outlines STARH's strategic framework, role in decentralization, and links with on-going USAID funded programs (page 3);

**Part III: Impact Areas**, summarizes each impact area, how they support STARH's Strategic Objective, and program outputs expected in 2002 (page 6);

**Part IV: Staffing Plan** (page 19);

**Part V: Activity Matrix and Budget**, summarizes planned activities, timetable and estimated budget for 2002 and (page 24);

**Part VI: Attachments**, lists current STARH documents that provide more detail of activities supporting STARH's strategic framework (page 31).

### PART I: BACKGROUND

Building on the historic strengths of the Indonesian RH/FP program, the STARH program aims to: increase RH/FP quality and choices through an improved RH/FP service delivery system; increase client and community demand for quality services; and enhance the policy environment and political commitment for RH/FP. STARH's assistance to the Government, namely BKKBN and DepKes, as well as other partners in NGO and private sectors, focuses on coordinating efforts to expand national, provincial and district level capacity and commitment to providing quality and choice in RH/FP services in a transitional period.

During its first year, STARH has developed a successful program agenda with counterpart staff in BKKBN and DepKes. To date, STARH's primary focus has been at the central level. This investment has enabled STARH to better understand the institutional environment in which STARH operates and ensures our partners comprehend the program's objectives in relation to their own priorities. As a result, the first year workplan supported a range of activities that reflected the merging of BKKBN, DepKes and STARH agendas and helped STARH to define key impact areas and strategies for implementation during the remaining life of the program.

Highlighted below are examples of STARH's key technical achievements in 2000-2001.<sup>1</sup> These achievements form the basis of further work that will be developed and implemented in 2002.

**Supplying Quality Services through the Design and Implementation of a Quality Improvement Strategy:** STARH developed a quality improvement strategy that ensures consistency in quality standards at the national level. Significant progress has been made in revising and institutionalizing minimum standards and guidelines for Family Planning, Bleeding in Early Pregnancy, Voluntary Surgical Contraception (VSC) and in testing Performance Improvement (PI) models at the district level.

**Supplying an Expanded Choice of Quality Family Planning Methods:** STARH's assessment of VSC policy and practice highlighted serious deficiencies in the quality of VSC services. STARH support to BKKBN and DepKes has resulted in the adoption of short term measures to alleviate quality concerns and the development a long-term strategy. STARH assisted in the adoption of two significant policy changes that will improve quality and reduce the health risks VSC clients are exposed to. Both changes represent major departures from the traditional role and attitudes of the respective agencies.

**Increasing Demand for Quality Services:** In collaboration with BKKBN, STARH has developed and is implementing a communication and advocacy strategy to ensure a high profile media campaign of BKKBN's "Quality Family". Through the production of advocacy tools and campaign materials, STARH has assisted BKKBN in advocating its new vision to key stakeholders. The new vision is to redefine BKKBN as leading a mature RH/FP program with greater focus on quality, client choice, reproductive rights, and serving the most needy. The new vision is already being transferred to the BKKBN's field level structure. STARH has supported a repositioning of the PLKB (field worker) into a change agent for the communities they serve. Using materials and trainers developed under a grant from the Gates Foundation, STARH supported the adaptation of materials and training of trainers. Asia Development Bank funding is being used to expand the training to the remaining 35,000 PLKB. Approximately 2000 will have completed the training by the end of the year 2001.

**Strengthening the Environment for Sustaining Quality and Choice:** STARH has assisted BKKBN in the early stages of policy development by translating the concept of the Quality Family into a specific set of ideas to strengthen the policy environment for basic human rights at provincial, district and community levels. STARH facilitated an assessment of Tiahrt compliance in Indonesia with USAID/Washington and served as a resource in the ongoing dialogue on RH/FP policy. STARH's policy briefing paper, "The Indonesian National Family Planning Program and the Tiahrt Amendment of the US Congress" was extensively referred to during the assessment.

---

<sup>1</sup> For a more complete description of these areas, please refer to the Second Semi-Annual Report (dated 30 September 2001)

STARH has developed positive working relationships with its counterpart agencies, BKKBN and DepKes. These relationships have been built on ease of access, flexibility and a clear and shared agenda. Regular formal and informal contact with BKKBN's leadership, and to a lesser extent with DepKes staff, has facilitated the rapid development of major components of the program and has positioned STARH as a key technical resource with government and international donors in the field of RH/FP. This is further supported through relationships with our contracted partners (YKB, John Snow International, MIM, the Indonesian Midwives Association (IBI) and Indonesian Society for Obstetrics and Gynecology (POGI)) and through informal partnerships with the Indonesian Association for Voluntary Surgical Contraception (PKMI), Muhammadiyah and the National Clinical Training Network (NCTN), all of which enable STARH to design appropriate, high quality, specialized interventions.

## **PART II: STARH PROGRAM APPROACH**

In a recent management retreat, STARH critically assessed the scope of the program, ongoing activities and progress in achieving its Strategic Objective of increased acceptability and consistent use of high quality RH/FP services. It was recognized that formulating strategies and activities based on the IR structure<sup>2</sup> was increasingly problematic due to the complex and cross cutting nature of the program. As a result, STARH devised a strategic framework (see Figure 1) based on three "impact areas". The impact areas and associated activities outline STARH's plan to achieve the Strategic Objective. Although graphically represented as separate program areas, the three impact areas are mutually reinforcing.

STARH's strategic framework deliberately focuses on enhancing and improving the quality of the RH/FP service delivery system. The focus on matching an effective and efficient "supply side" to a proactive "demand side" and the concurrent health policy changes that accompany these efforts, form the basis of an integrated program. STARH's strategic framework also focuses on a series of cross cutting issues that underpin the design and implementation of activities and represent key program principles. Further integration of the three impact areas and cross-cutting issues will be strengthened by STARH's team-based approach. Multidisciplinary technical teams that work on more than one impact area will enhance linkages and ensure that technical strengths are deployed efficiently to maximize integration and achieve the objectives.

The strategic framework forms the basis of this workplan, the workplan activity matrix, our staffing plan and future reporting formats. Quarterly program reviews will be held to evaluate and monitor progress towards Strategic Objective. The next program review will be held in March in preparation for the 3<sup>rd</sup> Semi Annual Report.

Additionally, STARH will employ a set of criteria to guide decision-making regarding the focus of activities and support for an impact area. The criteria will also be used collectively to assess the acceptability of additional proposals and requests from partner institutions. The

---

<sup>2</sup> STARH's Workplan Matrix attached is organized according to impact area. The matrix also indicates which activities support appropriate **IRs**.

criteria are as follows:

Activities support the impact areas within the strategic framework

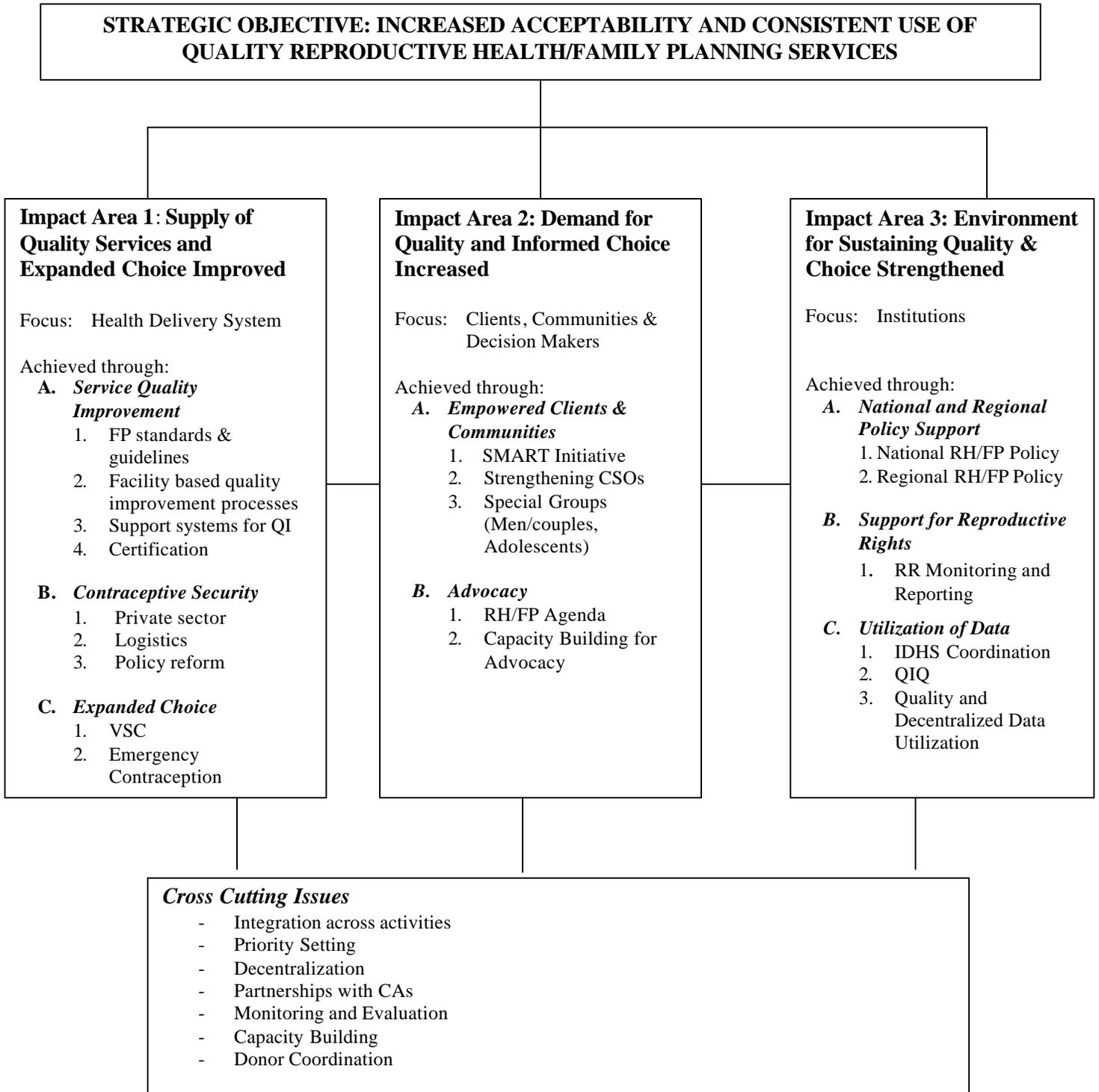
Activities demonstrate impact on quality and choice

Activities are sustainable

Partners are available

Activities assist the RH/FP program to manage change and innovation

Figure 1  
STARH Strategic Framework



STARH is committed to collaborating with donors to maximize impact and resources in RH/FP. During the first year of the program, STARH has collaborated with the European Commission, the Asia Development Bank, UNFPA, CIDA, Dutch Aid and the World Bank<sup>3</sup>. In addition, STARH will continue to work with other USAID-funded programs in Indonesia, namely HI 2010 Coalition and MNH. STARH will link with HI 2010 to develop an alliance of RH/FP civil society organizations to assist STARH in social mobilization efforts while MNH will work with STARH on the management of Bleeding in Early Pregnancy to ensure women are protected from future unwanted pregnancy. MNH collaboration also extends to male involvement, IPC/C skills for providers, and coordination of inputs to the National Clinical Training Network and IBI. New areas of collaboration may include a common facilitative supervision approach. STARH is actively collaborating on improving injection practices with MNH, Healthy Start plus the ASA Programs.

Integral to STARH's program approach in 2002 will be the implementation of managed activities to reach RH/FP service providers at provincial and district levels. STARH is currently considering issues like financing options, technical and administrative workloads, STARH representation at field levels, potential local partners for implementation, absorptive capacity of regional government and the role of other donors. These issues will provide a framework for decision making regarding STARH activities and locations during field assessments in early 2002. STARH, BKKBN and DepKes have recently agreed to a plan for field implementation, which essentially focuses on activities developed at the central level that have national and regional impact, and activities that directly support quality improvement and demand generation at regional levels. These activities will be focused at the provincial level (primarily for systems building, inter-province/inter-district coordination, and provincial/district priority setting) and district levels and may include district quality assessments; participatory planning; performance improvement interventions; community mobilization to generate demand for higher quality services; interpersonal communication/counseling; production of local media campaigns, and advocacy training.

The specifics of *what* is implemented *where* will be determined in meetings (late January 2002) with provincial and district officials. Districts and provinces are not expected to implement all core-package activities. Rather, absorptive capacity, financial resources, the prospect of sustainability, provincial and district interest and needs will determine the scale and nature of the intervention. STARH will play a key role in developing consensus on the criteria for district selection and partners at the regional level who will assist STARH in implementing activities.<sup>4</sup>

### **PART III: STARH IMPACT AREAS**

The following section describes the planned activities required to achieve STARH's desired impacts. Where relevant, STARH has highlighted linkages between activities and impact

---

<sup>3</sup> For more detail, please refer to the Second Semi-Annual Report dated 30 September 2001

<sup>4</sup> For a complete description of STARH's work at regional level and a more comprehensive understanding of the role of BKKBN at central, provincial and district level, please refer to the annexed document "Thoughts on STARH Field Activities" page 51.

areas and has referenced key documents, attached as appendices. For specific timelines, please refer to the Activity Matrix on page 24.

### **Impact Area I: Supply of Quality Services and Expanded Choice Improved**

STARH will contribute to its Strategic Objective through improving the supply of quality RH/FP services and expanding choice. STARH will achieve impact by focusing on three main activity areas: service quality improvement; contraceptive security; and expanding method choice. Focusing on improving quality and expanding choice at the service delivery level will assist in improving FP continuation rates, increase availability of FP methods, respond to the Government's program goals and enable local governments to become quality driven and more responsive and accountable to their constituents. Development of certification of quality will be an important part of the process of improving the supply of quality services and expanding choice. In 2002, STARH will initiate steps to encourage and assist clinics to improve the quality of service. As the program progresses, STARH will promote "certified" clinics to potential clients, so clients associate certification with assurance of quality services.

#### **I.A. Service Quality Improvement (QI)**

Research findings show that the quality of RH/FP services in Indonesia is poor. Many trained providers do not comply with national standards especially in IUD and implant insertion, and universal precautions in infection prevention are widely ignored. STARH's QI activities require a high degree of integration between two impact areas; Impact Area One focuses on developing and disseminating standards and guidelines, institutionalizing a QI process at the facility level and developing support systems; and Impact Area Two links the QI approach to the SMART Initiative (smart client, smart provider and smart communities) to promote empowered clients and informed choice. SMART seeks to improve the quality of client/provider communication and to increase community participation in quality improvement efforts.<sup>5</sup> The quality of client/provider communication will be improved by educating clients and providers about their roles and rights in giving and getting family planning information. The foundation of SMART is a media strategy that will have a national and provincial focus, with some activities using local media. Community mobilization activities will be concentrated benefit from and support the messages of the media strategy in the catchment areas of those clinics involved in QI efforts.

##### *I.A.1. General Family Planning Standards and Guidelines*

Expected outputs in 2002 (Jan – Dec):

- Revised clinical standards guide for FP services produced by 30 Jun 2002
- Strategy developed to orient and ensure application clinical standards to all service delivery environments.
- Interpersonal Communication & Counseling (IPC/C) and contraceptive technology short course developed.

---

<sup>5</sup> For a more complete description of the background, objectives, activities and content of STARH's QI approach and SMART Initiative please see the concept papers page 43 of this workplan.

Standards provide the benchmark for quality RH/FP clinical services and are an integral part of the delivery system. STARH and BKKBN will review and update *Panduan Baku Klinis Program Pelayanan Keluarga Berencana* (Clinical Standards Guide for FP Services). STARH will disseminate the revised standards to service delivery facilities and will develop activities to improve compliance of family planning providers in following the new standards. User friendly guidelines, effective supervision, self-assessment, training with guidelines, adequate copies and job aids will work to ensure compliance. The first compliance activity will be tested extensively and will be used as a model for other guidelines (i.e. supervision, VSC). Activities will be designed and implemented to link dissemination with information updates about contraceptive technology. Additionally, to strengthen the IPC/C and clinical skills of the provider, STARH will develop a contraceptive technology refresher and IPC/C orientation which will include peer review and self-assessment tools.

#### *I.A.2. Facility-Based Quality Improvement*

Expected outputs in 2002:

- QIQ baseline survey implemented and findings applied
- 11 district-level quality improvement workplans implemented

To improve quality at the facility level, managers must be familiar with conducting assessments, selecting appropriate interventions, and monitoring their progress. To facilitate the process and maximize coverage, STARH will work with those facilities which provide a significant portion of RH/FP services. STARH will conduct the Quick Investigation of Quality (QIQ) survey (commencing March 2002) and then select appropriate and effective interventions to increase the performance of the district health facilities, using an analysis of performance gaps. Interventions may include dissemination of standards, on site infection prevention training, clinical training for FP skills, IPC/C training, use of self-assessment tools, training in management of contraceptive stocks, and facilitative supervision. STARH will work with district program managers to develop and monitor district-level quality action plans. After selected interventions begin, focal districts will develop standards to be used as basis for certification. QIQ will be used as a diagnostic tool to monitor and evaluate the impact on quality (in 2003). The QIQ indicators will be the basis for setting and varying standards used for a certification exercise.

#### *I.A.3. Develop Systems for Quality Improvement*

Expected outputs in 2002:

- Facilitative supervision guidelines and tools tested, finalized and produced by 30 June 2002
- Facilitative supervision training initiated
- District training centers serving STARH districts identified, assessed and recommendations issued for developing their capacity as regional training centers

- 30 National Clinical Training Network (NCTN) trainers prepared or updated in infection prevention
- New training reporting forms designed, tested and approved for use throughout the NCTN

District managers have a tendency to resolve every gap in quality with training, when the root cause of that gap may not be a problem of provider skills. STARH will support training activities only when there is evidence that the knowledge and skills of providers is deficient. Supervision is a means to gather this information. Currently, district managers will admit that they rarely conduct supervision, mainly due to lack of resources. While STARH will attempt to change the emphasis between training and supervision, we will also prepare internal supervisors, i.e., those on site in the health facility, such as the head midwife or doctor, to set goals for the staff, monitor performance and provide ongoing feedback.

At the request of DepKes, STARH has revised a facilitative supervision guide and will pre-test and finalize this guide in 2002. STARH will also develop a short course for internal and external supervisors and begin training supervisors in STARH districts.

Additionally, STARH will support the National Clinical Training Network (NCTN) to strengthen their training centers serving STARH districts. If the QIQ finds IP practices deficient, STARH will work with NCTN to improve the infection prevention training and problem solving skills of NCTN trainers and develop a methodology for onsite training in infection prevention. Infection prevention training is due to be developed and undertaken between April – December 2002.

#### *I.A.4. Certification*

Expected output in 2002:

- Generic quality certification/branding model developed, for implementation at the district level

The STARH SMART strategy will develop and implement tools and processes that will serve as building blocks for a larger scale quality certification and recognition program in the future. The package of tools and processes will include things such as standard performance guidelines, self assessment and community engagement in quality improvement and will be implemented with varying intensity across STARH provinces and districts. The most intensive package will be implemented in approximately two focal districts and will include the development and testing of locally defined certification and recognition models. Experience in focal districts will inform future efforts to implement larger scale certification schemes. The experience will be complemented by lessons learned in STARH's work in VSC that links financial reimbursement with the achievement of quality standards.

## I.B Contraceptive Security

A major FP objective of the National FP Program is to ensure that contraceptive needs are met. BKKBN wants to revitalize self-sufficiency efforts to increase the proportion of the population purchasing RH/FP services from the private sector, thus relieving the Government to procure contraceptives for the most needy.

Research findings indicate that informal costs consumers pay for government supplied pills and injectables have risen to levels similar to those supplied through the private sector, with little or no effect on contraceptive use - even among the poor. This fact, combined with BKKBN's reduced procurement budgets, suggest a valuable opportunity for BKKBN to strategically shift most contraceptive procurement and distribution to the commercial sector. STARH will support contraceptive security through: promoting self-sufficiency and private sector provision of FP; strengthening the contraceptive logistics system to ensure consistent availability of a wide range of methods; and supporting policy changes to improve efficiency, rationalize commodity use and institutionalize the role of providers other than the government.

### *I.B.1. Private Sector*

Expected Outputs in 2002:

- Private sector development strategy paper

In early 2002, STARH will work with BKKBN to develop a strategy to increase the private sector's role in providing contraceptives. Private sector is defined as the commercial sector – primary drug manufacturers and distributors, NGOs providing health services and private practice physicians and midwives. Activities will focus on: increasing public awareness of private sector sources for RH/FP services; supporting expanded private sector distribution of commodities into traditionally under served markets; building collaboration between public and private sectors to allow for joint planning and management of decentralized procurement; and joint problem solving of costing and competition issues. STARH will also pilot financing schemes such as partially covering the clinical method costs. In the non-governmental sector, STARH is currently working with Yayasan Kusuma Buana to enhance the capacity of NGOs to develop and implement self-reliant reproductive health programs in nine STARH provinces.

### *I.B.2. Logistics*

Expected outputs in 2002:

- 5 provinces implementing new “pull” contraceptive distribution system
- 3 BKKBN logistics personnel trained by JSI/DELIVER in April 2002
- Logistics data flow mapped and recommendations made for improvement of information system

Currently, BKKBN uses data based on population numbers to determine the quantity of commodities delivered to a particular region (the “push” system). When actual demand is

different from population projections, contraceptive shortages or overstocks result. To address this, STARH and the European Commission plans to jointly support a “pull” system in five provinces (Bali, Yogyakarta, DKI, Banten and Bangka Belitung). The pull system requires that provinces request contraceptives based on actual need, to ensure a more accurate supply. Additionally, STARH will train central and provincial logistics staff in the area of stock management and will work with BKKBN to map and analyze data flows of contraceptive supplies to identify areas that need improvement. STARH will assist in receiving and planning the distribution of contraceptives recently supplied by USAID.

### *I.B.3. Policy Reform*

Expected Output in 2002:

- Participation in Technical Working Group for contraceptive security

STARH will work within the Logistics Technical Working Group to generate and monitor lessons learned from selected interventions tested by STARH or other donor programs. STARH will support the translation of lessons learned into policy and operational change.

### I.C. Expanding Choice

Contraceptive choice is a priority for BKKBN and an indicator of their commitment to support client-oriented services. STARH will support BKKBN by focusing on increasing family planning contraceptive choices, specifically Voluntary Surgical Contraception (VSC) and Emergency Contraception (EC). The rationale is to increase client access to family planning methods that best suit their needs.

#### *I.C.1. Improving the quality of VSC*

Expected outputs in 2002:

- New VSC guidelines documented, printed and disseminated
- Policy to ensure VSC reimbursement of quality services implemented
- Training materials updated for minilaparotomy and vasectomy
- Long-term VSC strategy drafted with BKKBN

VSC is a clinical unofficial method in Indonesia with approximately 100,000 acceptors reported annually in 2002. BKKBN, DepKes and USAID requested STARH to assess current VSC services and make recommendations for the program<sup>6</sup>. STARH facilitated a technical working group that produced a VSC quality action plan. In 2002 STARH activities will focus on finalizing guidelines and standards, and on establishing province level task forces (in selected areas) to oversee a VSC certification process. Facilities offering VSC

---

<sup>6</sup> STARH assessed the VSC program to see if continued donor support was necessary. The assessment found a program with limited institutional support, poor quality control, and a quality of service that represented a health risk to clients and providers. BKKBN and DepKes immediately accepted the findings of the assessment, reaffirmed their commitment to see VSC play a role in the program and made policy changes that will reduce risks and improve quality. For further background, please refer to the “Surgical Contraception and the New Era Strategy of BKKBN” assessment report submitted in 2001.

services will be assessed for compliance with standards. If compliance is lacking, BKKBN will withhold VSC reimbursement. In anticipation of the continued need for training of providers, STARH will update the training materials to be consistent with the new guidelines. STARH will assist BKKBN in preparing a strategy to ensure long term sustainability of quality VSC services.

### *I.C.2 Emergency Contraception*

Expected outputs in 2002:

- Information kit on EC developed and distributed to health professionals of the Muhammadiyah Health Network (112 health facilities and 40 schools)
- Community-based activities for disseminating information about EC designed in collaboration with Aisiyah and initiated

EC is a new family planning method in Indonesia. Given high rates of unmet need, method failure and a reported reliance on unsafe abortion, EC addresses the needs of a large group of family planning users. STARH will support efforts to pilot test the introduction of this method in Indonesia. STARH will work with the Muhammadiyah Health Council to develop and evaluate an information and education kit about EC for their providers. Once the kit has been distributed to providers, community-based activities will be implemented using the strong community networks of Aisiyah and Muhammadiyah's Women's Movement, in order to support awareness of this contraception option.

## **Impact Area II: Demand for Quality Services and Informed Choice Increased**

STARH will contribute to its Strategic Objective through increasing client and community demand for quality RH/FP services and informed choice. STARH will achieve impact by focusing on two main activity areas: empowering clients and communities and building capacity for advocacy. Both activity areas will work in tandem to ensure that RH/FP services meet client needs, and that providers are increasingly accountable to their clients. STARH's demand initiatives are closely integrated with supply-side quality improvement interventions in Impact Area One. In January 2002, STARH will develop critical pathways that demonstrate the intersection of supply and demand focused program-inputs required for the effective development of each. STARH's campaign to encourage greater client participation will set the stage for greater community level participation in the setting of quality standards and in certification of facilities and providers.

### **II.A. Empowered Clients and Communities**

The SMART Initiative will support overall quality improvement by promoting informed choice among clients, providers and communities. This Initiative will create SMART clients, SMART providers, and SMART communities. It will use mass media, interpersonal communication and community mobilization to change attitudes and behavior. The SMART community will empower local Civil Society Organizations (CSOs) to develop a collective demand for quality and choice. STARH will also focus special attention on those members

of the community who are traditionally less empowered to meet their reproductive health needs, such as adolescents.

#### *II.A.1. SMART Clients and Providers*

Expected Outputs in 2002:

- Series of community-based activities supporting client rights and responsibilities
- TV and radio spots on client rights and responsibilities
- Radio vignettes to coach clients on client-provider interaction
- Clinic and community print and video materials on client rights and responsibilities
- Short orientation course for PLKB and other community leaders on facilitation and advocacy/presentation skills
- SMART orientation for monthly *bidan* meetings

The aim of the SMART Client and SMART Provider is to improve the quality of communication and interaction between providers and clients. In conjunction with quality improvement activities in Impact Area 1, STARH will increase provider clinical performance and improve provider shared-decision making skills.<sup>7</sup>

STARH will conduct formative research activities to develop key campaign messages on clients' rights and responsibilities and develop a client/community working definition of quality. Clients are defined to include women, men and adolescents. The campaign will build client expectations for quality services and informed choice and will be produced for national TV and radio. STARH will also produce radio vignettes to coach clients to develop skills in negotiating and asking questions, before visiting a health facility. To complement community mobilization activities, STARH will develop and distribute print and video tape materials for BKKBN mobile vans and other activities to distribute key messages on clients' rights and responsibilities. STARH will also conduct an evaluation of the campaign to measure its impact on client behaviors.

To reinforce SMART key messages, STARH will provide an orientation on SMART at monthly *bidan* meetings in collaboration with IBI. Additionally, as change agents, PLKB roles will be supported by developing a leadership development course, focusing on advocacy and facilitation skill building.

#### *II.A.2. SMART Communities and Strengthening Civil Society Organizations (CSOs)*

Expected Outputs in 2002:

- RH/FP NGO/CSO coalition established
- Orientation for NGO/CSOs on community mobilization
- Institutional strengthening program for NGO/CSOs implemented through YKB

---

<sup>7</sup> For more information on the SMART Initiative, please see the SMART concept paper on page 43

The role of CSOs/NGOs is increasingly visible and complements Government efforts to provide quality RH/FP services. In collaboration with the HI 2010 Coalition, STARH and BKKBN will create a civil society coalition focusing specifically on RH/FP.<sup>8</sup> The focus on the RH/FP coalition will be to create pressure groups to ensure that district level governments include adequate levels of support for RH/FP programs. Within the RH/FP coalition, STARH will conduct organizational assessments to identify key collaborating partners to implement ARH and community mobilization activities. From January 2002, STARH will support the implementation of an NGO strengthening project, managed by STARH partner, Yayasan Kusuma Buana (YKB). This project will assist GoI to improve the reproductive health status of men and women through the active participation of self-reliant NGOs working in STARH provinces.

### *II.A.3. Special Groups (adolescents and men/couples)*

Expected Outputs in 2002:

- Adolescent Reproductive Health (ARH) strategy developed
- Orientation for district managers on ARH program development followed by small grants program
- NGO ARH programs supported, in correlation with ARH strategy
- Communication strategy for Men/Couples developed

Married women are the primary consumers of RH/FP services in Indonesia. BKKBN and STARH will focus on increasing access to RH/FP services and information for two underserved groups, adolescents and men/couples. In early 2002, STARH will review the recently conducted ARH situation analysis, focusing on NGO-based programs and the current policy environment. This paper will identify the focus for ARH activities on the basis of an analysis of unmet need, comparative advantage and maximum impact on two core National Development Plan (Propenas) indicators: delay of first birth and prevention of STI/HIV/AIDS. This strategy will also lay out the extent and type of support STARH will provide in ARH. Our current workplan describes activities already agreed with BKKBN. These include a capacity building exercise for provincial managers and trainers to allow them to develop small programs at provincial level, and subsequently to develop the capacity of district program managers. As a follow-up to training, provincial teams will prepare proposals and a small grant funding mechanism will be put in place. Developing small scale projects will enable regional managers to gain first hand experience in implementing ARH programs.

STARH's ARH initiatives will be linked to SMART campaign and will integrate specific messages targeting adolescents. Finally, the survey of NGO ARH activities will identify programs deserving of STARH support.

---

<sup>8</sup> STARH will explore the potential for developing a RH/FP civil society coalition through linkages with appropriate CSOs, currently part of the HI 2010 Coalition.

## II.B. Capacity Building for Advocacy

Decentralization and democratization have increased the number of new decision makers, from members of the National Assembly (DPR) to local elected assemblies (DPR-D). As a consequence, advocacy skills are much sought after by local program officials and organizations seeking to sustain their agendas. STARH initiatives to generate demand for quality health services will be reinforced through strengthening capacity for advocacy. Linking with Impact Area 3, STARH's advocacy plan embraces several different audiences and goals and will focus on the following areas: advocating BKKBN's Quality Family (QF) vision to BKKBN district level staff; developing the capacity of district program managers to advocate for RH/FP to local parliament and stakeholders; strengthening the RH/FP coalition as a powerful advocacy lobby at district level (see II A 3) and to develop a national advocacy campaign for ARH (referred to in Impact Area 3).

### *II.B.1. RH/FP Agenda*

Expected Outputs in 2002:

- Journalist tours to expose journalists to RH/FP issues and the QF program
- Fact sheets on RH/FP or parliament developed and disseminated through local newspapers
- PowerPoint presentation for BKKBN on RH/FP agenda of QF

Building on a previous advocacy campaign for BKKBN's new role in supporting QF (implemented in 2001), STARH will continue to work on communicating the main QF messages with journalist tours to produce and distribute a series of fact sheets for different target audiences. To support BKKBN in their advocacy efforts, STARH will develop a QF PowerPoint presentation, focusing on RH/FP.

### *II.B.2. Capacity Building for Advocacy*

Expected Outputs in 2002:

- Advocacy action plan developed to increase capacity building at all levels.
- Advocacy training module developed and implemented in 26 districts

To assist BKKBN and its partners in advocating its new vision, BKKBN and STARH will develop an advocacy action plan for capacity building at the district level. An advocacy training module will be adapted based on districts' needs and followed up with training for both BKKBN and the RH/FP coalition members.

## **Impact Area III: Environment for Sustaining Quality and Choice Strengthened**

STARH will contribute to the Strategic Objective through strengthening the institutional environment for quality and choice, especially the policy environment. STARH will achieve impact by focusing on three main activity areas: support to national and regional RH/FP policy; support for reproductive rights; and improved utilization of data. The rationale for

strengthening the institutional environment is that STARH impacts will concentrate on institutional factors which have a facilitative effect on increasing supply and demand. Strengthening the institutional environment will ensure the long-term sustainability of improved quality and choice and facilitate the pace, coverage and impact of STARH activities.

### III.A. Support for National and Regional RH/FP Policy

Strengthening the policy environment for RH/FP is especially important at this time when the country is going through a complex process of political reform and decentralization. Decentralization entails the rewriting of many laws and policies affecting the social sector, and requires the introduction of new programs and interventions at regional levels.

#### *III.A.1 National RH Policy Strengthened*

Expected outputs in 2002:

- Evidence-based policy options and recommendations for improving ARH developed
- Dialogue on ARH policy among principal stakeholders facilitated oriented to consensus building
- Advocacy strategy developed for ARH policy reform
- Policy analysis completed of Quality Family initiative with recommendations on how to more effectively promote RH/FP
- Policy briefs produced as required to advance policy reform on VSC, informed consent, gender, private sector involvement, changing role of BKKBN Pusat under decentralization, etc.

STARH believes its priorities for 2002 in the national policy environment will be ARH<sup>9</sup> and the Quality Family initiative, but recognizes the fluidity of the country's situation and is prepared to work in other areas if and when urgent concerns arise. ARH has already emerged as an urgent public health issue in Indonesia, and STARH is addressing some aspects under Impact Area 2. Efforts to address this problem are currently constrained by existing laws and government policies. STARH will support the needed policy analysis, and facilitate dialogue among the principal stakeholders, including adolescents, aimed at producing a workable consensus in support of policy reform and operational change.

The new Quality Family initiative is now official BKKBN policy. STARH will work with BKKBN to ensure that on-going QF policy and program development is consistent with ICPD and significantly advances this agenda. These activities will be coordinated with Quality Family advocacy activities, as outlined in Impact Area 2.

STARH will employ a range of appropriate tools such as technical assistance, policy analysis and policy briefs to promote policy reform and institutional change relating to other

---

<sup>9</sup> ARH has been highlighted by the new Chairperson of BKKBN as a priority for the national program and is integral to BKKBN's Quality Family initiative.

substantive areas addressed under Impact Area One and Two. These will be mainly for internal and partners' use when policy analysis is needed for making specific decisions or recommendations.

### *III.A.2 Regional RH/FP Policy Introduced*

Expected outputs in 2002:

- Preliminary study completed on the impact of decentralization on RH/FP at regional levels
- Capacity for policy development at 7 provincial levels strengthened
- Assistance to BKKBN for the devolvement of RH/FP policies to regional units
- Policy recommendations formulated & disseminated in 7 provinces and 11 districts
- Advocacy strategy developed to promote regional RH/FP policies

Decentralization will bring political and administrative decision making closer to the people, but there are potential pitfalls along the way. Many regional units (provinces and districts) recognize they need help building capacities to manage newly devolved programs and design new interventions. It is vital that as decentralization unfolds a sound policy environment is established at the district and provincial levels to protect the gains already achieved in RH/FP. The cornerstone of STARH's strategy will be to facilitate a series of "catalytic events" which integrate a participatory approach to defining problems and solutions with inputs from technical policy analysis. These events will include workshops, retreats, seminars and the facilitation of "policy networks". The concept of catalytic events is borrowed from the USAID GOLD (Governance and Local Democracy) Project in the Philippines. Additionally, STARH will ensure coordination and information exchange with the forthcoming MSH Management and Leadership Program and other donors such as GTZ and ADB working on decentralization capacity building.

### III.B. Support for Reproductive Rights

The main STARH support for reproductive rights in 2002 will be monitoring and reporting.

#### *III.B.1. Reproductive Rights Monitoring and Reporting*

Expected outputs in 2002:

- Assessment of current status of reproductive rights completed and disseminated
- Bi-annual reports on compliance with US legislation completed (USAID requirement)

There is at present no comprehensive review of Indonesia's laws and national policies concerning RH/FP or an assessment of their level of conformity with ICPD available. Additionally, STARH will produce bi-annual reports, monitoring compliance of STARH supported activities with requirements mandated by US law (e.g. Tiahrt Amendment, Mexico City Policy). The next bi-annual report is due on 30 June 2002.

### III.C. Utilization of Data

Activity areas for utilization of data for policy development and program planning will be coordinating selected in-country activities for the 2002 IDHS and conducting a QIQ (Quick Investigation of Quality) survey.

#### *III.C.1. IDHS In-country Activities Coordinated*

Expected outputs in 2002:

- Background activities (observation visits of IDHS management in the field, identification of IDHS variables needed for new policy development, etc.) completed for subsequent data analysis and policy development.

Coordination of data analysis and dissemination for use in policy development will take place mostly in 2003.

#### *III.C.2. QIQ*

Expected outputs in 2002:

- QIQ baseline survey implemented and findings applied
- National policy forum on Quality of FP Care produces recommendations
- Provincial or regional forums held to present findings and initiate local response
- QIQ 2003 implementation plan for provincial management of field work

QIQ will serve two purposes. The first is a diagnostic role in assessing facility level quality as part of the PI process (see Impact Area 1). The second is to provide a national picture of quality of FP services. QIQ findings will be used at national and regional levels to guide policy making, resource allocation, standard setting, and regional planning to improve RH/FP services and health services in general. The QIQ baseline will be implemented centrally and the second round will be implemented regionally and to build local level data utilization capacity. A provincial implementation plan for QIQ-2003 will be prepared based on the experience of fielding QIQ-2002.

#### *III.C.3. Quality and Decentralized Data Utilization*

Expected outputs in 2002:

- Improved use of family registration data for decision making

STARH is working with BKKBN to improve the use of family registration data for policy and program decision-making at the national, provincial and district levels.

#### **PART IV. STARH Program Staffing**

STARH has a core of experienced technical and administrative staff. This staffing complement is currently being revised to reflect the expansion of the program. The structure of the staff is presented in the attached Staffing Framework<sup>10</sup>. The Staffing Framework reflects STARH's strategic framework, the program management and reporting structure, and staff responsibilities at each level. The management and implementation of STARH's strategic framework involves some changes to the program management structure. One such change is the use of Impact Area Coordinators. These positions are designed to ensure each impact area is achieved through integration of activities and overall coordination between components. The use of Coordinators also enables greater delegation of authority from the Program Director who will oversee the program and ensure impact areas are working together to achieve the Strategic Objective. Under each impact area are technical teams, managed by a technical team leader. This is a continuation of the structure used over the past year, but it formalizes and strengthens the responsibilities of each team leader (and team members) to deliver the outputs stated in the workplan. Where technical skills overlap or complement a number of impact areas, STARH staff will sit on several teams. This strengthens integration of activities, ensures staff have a complete workload and provides staff with interesting opportunities to gain valuable experience in a number of related technical spheres. In addition, STARH has created a management advisor post which assists the Program Director with overall program management tasks such as, consistent and timely reporting, program oversight and implementation against the workplan outputs, and advice to technical teams on program implementation issues

As a technical assistance program, STARH is primarily a body of human resources available to the Indonesian FP Program. As such, the quality, flexibility, and appropriateness of these resources are paramount to the success of the program. STARH uses a range of flexible methods to ensure a full scope of technical expertise is available to meet the needs of the program.

Briefly these resources include:

- Core Staff - both technical and administrative: The current staff is being augmented by the recruitment of 5-7 positions identified as critical to the workplan. New positions include a communication advisor, a part-time research advisor, and a translator. Positions are also being considered for an activity manager for special groups (to support the growing portfolio of adolescent and men's activities), an NGO activity coordinator and a private sector advisor.

---

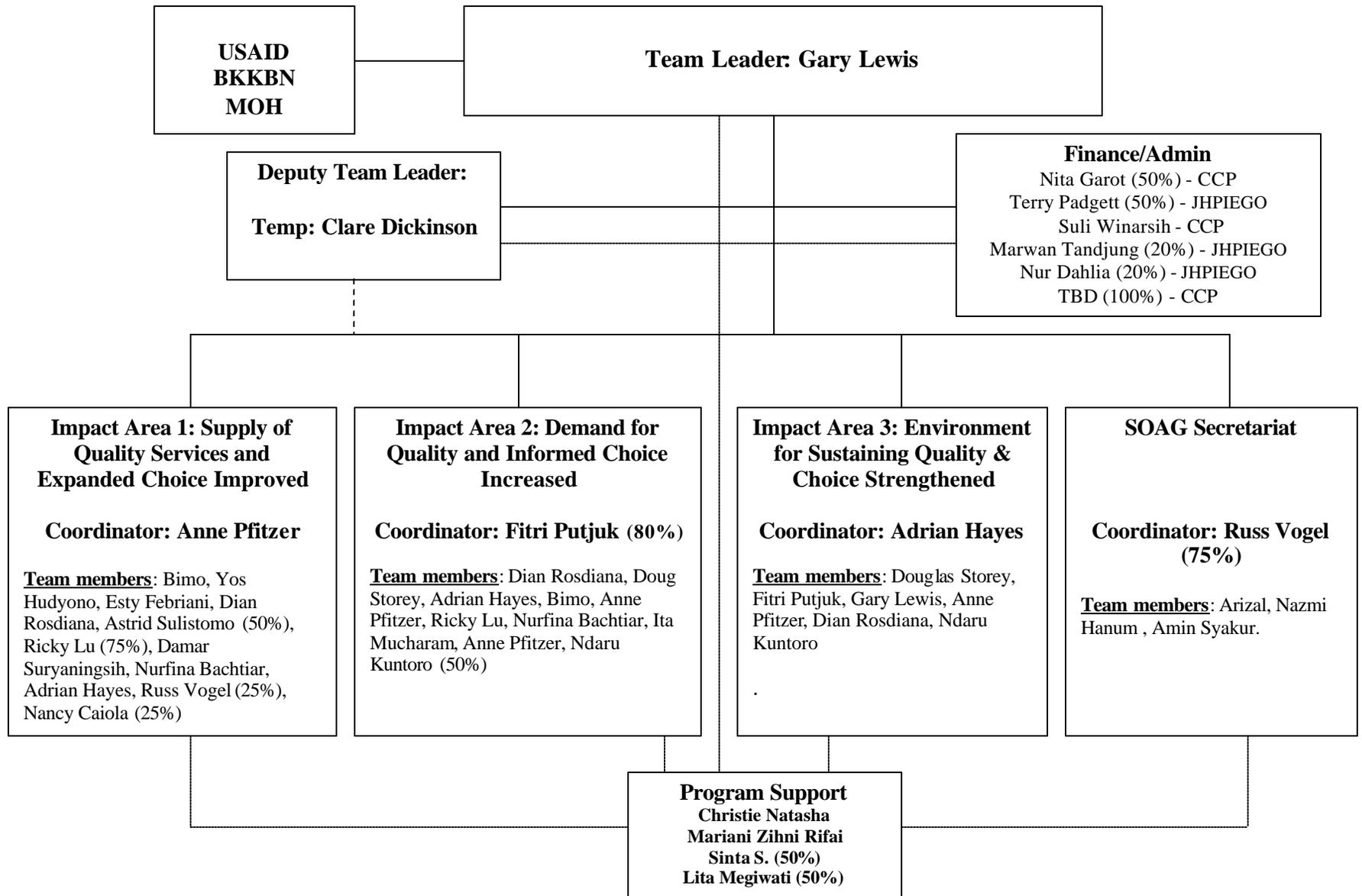
<sup>10</sup> There are two attachments to this plan. The first is the Staffing Framework that reflects the STARH Strategic Framework. The second is a staffing matrix which provides a more detailed outline of staff involvement in the key components of the workplan.

- Contracted Partners - YKB, JSI, and MJM: These partners are fully integrated and operating in ongoing activities. They also have some capacity to expand their support if new activities require their skills.
- Subcontracts and Grants: To give STARH access to a variety of organizations, NGOs and universities. This will be a key mechanism for implementing provincial and district level activities. As the contract/grant portfolio increases additional administrative and financial staff will be needed.
- International Expertise - Johns Hopkins University: Access to a body of expert international resources will continue to be used to augment the technical resources of STARH.
- Local Consultants: STARH has already identified a number of local consultants who are available for short term assignments. This resource is extremely important because it gives STARH the flexibility to meet constantly changing needs for skills and availability. Local consultants have been used for adolescent assessments, the VSC assessment, training, and for policy reviews.

The resources described above infer that STARH has the ability to meet its labor demands. However, two issues will require a review of this staffing plan in the near future.

- As province and district activities develop, staffing needs will depend on the activities selected, the availability of local institutions, the capacities of provincial BKKBN and DepKes, and the availability of existing STARH capacity. Staffing will be reconsidered in February and March as field agreements are made.
- While we are relatively confident that our staff, recent recruitment drive, and other available resources will meet the technical needs for 2002, the implementation schedule is fairly intense. As the workplan is reviewed, STARH will continue to assess staffing concurrent with detailed activity planning. This effort will help plan technical support from Baltimore, other consultants and contractual agreements. This planning is anticipated to begin in early January.

# STARH TEAM



<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality FP Services</b>
<b>IMPACT AREA 1: SUPPLY OF QUALITY SERVICES AND EXPANDED CHOICE IMPROVED</b>
<b>SERVICE QUALITY IMPROVEMENT</b>
<b>a. FP Standards and Guidelines (Technical Manager: Ricky Lu)</b>
• Team: Bimo, Fitri
<b>b. Facility-Based Quality Improvement Process (Technical Manager: Anne Pfitzer)</b>
• Team: Astrid Sulistomo, Bimo, Ricky Lu, Yos Hudyono & Esty Febriani, Damar Suryaningsih, Dian Rosdiana, Nancy Caiola, Doug Storey
<b>c. Support Systems for Quality Improvement (Technical Manager: Anne Pfitzer)</b>
• Team: Astrid Sulistomo, Bimo, Ricky Lu, Esty Febriani, Damar Suryaningsih, Dian Rosdiana, Nancy Caiola
<b>d. Certification (Technical Manager: Anne Pfitzer)</b>
• Team: Bimo, Nurfina Bachtiar
<b>CONTRACEPTIVE SECURITY</b>
<b>a. Private Sector (Technical Manager: Anne Pfitzer — acting)</b>
• Team: To be decided/JSI, Yos Hudyono, Esty Febriani
<b>b. Logistics (Technical Manager: Anne Pfitzer — acting)</b>
• Team: JSI, Yos Hudyono, Esty Febriani, JSI, Anne Pfitzer
<b>c. Policy Reform (Technical Manager: Anne Pfitzer)</b>
• Team: Bimo, Yos Hudyono, Adrian Hayes, Esty Febriani
<b>EXPANDING CHOICE</b>
<b>a. VSC (Technical Manager: Ricky Lu)</b>
• Team: Astrid Sulistomo, Adrian Hayes, Russ Vogel, Bimo
<b>b. Emergency Contraception (Technical Manager: Anne Pfitzer)</b>
• Team: Bimo, Anne Pfitzer, Esty Febriani, Adrian Hayes
<b>IMPACT AREA 2: DEMAND FOR QUALITY AND INFORMED CHOICE INCREASED</b>
<b>CLIENT AND COMMUNITY EMPOWERMENT</b>
<b>a: SMART Initiative (Technical Manager: Fitri Putjuk)</b>
• Team: Doug Storey, Dian Rosdiana, Ita Mucharam, Ndaru Kuntoro, Nurfina Bachtiar

<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality FP Services</b>
<b>b: Strengthening Civil Society Organizations (Technical Manager: Fitri Putjuk)</b>
• Team: Bimo, Nurfini Bachtiar, YKB, Ndaru Kuntoro
<b>c: Special Groups (including Adolescents and Men/Couples) (Technical Manager: Fitri Putjuk)</b>
• Team: Anne Pfitzer, Adrian Hayes, Ita Mucharam, Ndaru Kuntoro, Dian Rosdiana
<b>ADVOCACY DEVELOPMENT</b>
<b>a: Reproductive Health/Family Planning Agenda (Technical Manager: Fitri Putjuk)</b>
• Team: Ita Mucharam, Ndaru Kuntoro
<b>b: Capacity Building for Advocacy (Technical Manager: Fitri Putjuk)</b>
• Team: Ndaru Kuntoro, Dian Rosdiana
<b>IMPACT AREA 3: ENVIRONMENT FOR SUSTAINING QUALITY AND CHOICE STRENGTHENED</b>
<b>NATIONAL &amp; REGIONAL POLICIES STRENGTHENED</b>
<b>a: National RH/FP Policies (Technical Manager: Adrian Hayes)</b>
• Team: Anne Pfitzer, Fitri Putjuk, Ricky Lu, Doug Storey
<b>b: Regional RH/FP policies ( Technical Manager: Adrian Hayes)</b>
• Team: Anne Pfitzer, Fitri Putjuk, Ricky Lu, Bimo, Russ Vogel
<b>SUPPORT FOR REPRODUCTIVE RIGHTS (Technical Manager: Adrian Hayes)</b>
• Team: Gary Lewis, Ricky Lu, Bimo, Ndaru Kuntoro
<b>UTILIZATION OF DATA (Technical Manager: Doug Storey)</b>
<b>a: IDHS Field Activities Coordinated (Technical Manager: Doug Storey)</b>
• Team: Gary Lewis
<b>b: QIQ (Technical Manager: Doug Storey/Anne Pfitzer)</b>
• Team: Bimo, Astrid Sulistomo, Adrian Hayes, Gary Lewis
<b>c: Quality &amp; Decentralized Data Utilization (Technical Manager: Adrian Hayes)</b>
• Team: Doug Storey, Gary Lewis, Anne Pfitzer

**PART V: ACTIVITY MATRIX AND BUDGET**

<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality RH/FP Services</b>							
<b>Approach</b>	<b>Time</b>						
	<b>Jan-Mar Q1-02</b>	<b>Apr-Jun Q2-02</b>	<b>Jul-Sep Q3-02</b>	<b>Oct-Dec Q4-02</b>	<b>Date Complete</b>	<b>IR(s)</b>	<b>Responsible</b>
<b>IMPACT AREA 1: SUPPLY OF QUALITY SERVICES AND EXPANDED CHOICE IMPROVED</b>							
<b>SERVICE QUALITY IMPROVEMENT through</b>							
<b>A.1. FP Standards and Guidelines</b>							
<ul style="list-style-type: none"> <li>Review, update, approval and printing of FP guidelines</li> </ul>					15 May 2003	IR 1	Ricky
<ul style="list-style-type: none"> <li>Development and implementation of a FP guidelines dissemination/compliance strategy</li> </ul>						IR 2 IR 3	
<b>A.2. Facility-Based Quality Improvement Process</b>							
<ul style="list-style-type: none"> <li>Assessment of facilities using QIQ</li> </ul>					31 May	IR 2	Anne
<ul style="list-style-type: none"> <li>Identification of gaps, selection of interventions and implementation of district action plans (including infection prevention, IPC/C, contraceptive technology, clinical knowledge and skills, stock management and problem solving)</li> </ul>					Ongoing, until next QIQ	IR 2	
<ul style="list-style-type: none"> <li>Development and application by providers in <i>puskesmas</i>/clinic of self-assessment tools</li> </ul>					15 Nov	IR 2	
<b>A.3. Support Systems for Quality Improvement</b>							
<ul style="list-style-type: none"> <li>Facilitative supervision; development and pretesting of guidelines and materials</li> </ul>					31 May	IR 1 IR 2	Anne/ Damar
<ul style="list-style-type: none"> <li>Facilitative Supervision: training of internal and external supervisors</li> </ul>					31 Jul 03	IR 2	
<ul style="list-style-type: none"> <li>Clinical training system: assessment and strengthening of capacity in district training centers in STARH districts (NCTN)</li> </ul>					31 Dec	IR 2	
<ul style="list-style-type: none"> <li>Clinical training system: Strengthening capacity for infection prevention training</li> </ul>					30 Nov	IR 2	

Strategic Objective: Increased Acceptability and Consistent Use of High Quality RH/FP Services							
Approach	Time				Date Complete	IR(s)	Responsible
	Jan-Mar Q1-02	Apr-Jun Q2-02	Jul-Sep Q3-02	Oct-Dec Q4-02			
<ul style="list-style-type: none"> <li>Clinical training system: training quality assurance systems – including improved reporting and supervision of training by advanced trainers</li> </ul>					31 Dec	IR 2	
<b>A.4. Certification</b>							
<ul style="list-style-type: none"> <li>Development of generic model and discussion of this model with district-level stakeholders</li> </ul>					30 Oct	IR 1 IR 2	Anne
<b>CONTRACEPTIVE SECURITY through</b>							
<b>B.1. Private Sector</b>							
<ul style="list-style-type: none"> <li>Development of private sector strategy to increase access and accessibility to private sector contraceptives</li> </ul>					2003	IR 1 IR 2	JSI
<b>B.2. Logistics</b>							
<ul style="list-style-type: none"> <li>Assistance to BKKBN in implementing pull system for distribution of contraceptive supplies (first 5 provinces in collaboration with European Commission project)</li> </ul>					5 prov: 15 May	IR 2	Yos/ Esty
<ul style="list-style-type: none"> <li>Training of BKKBN logistics staff at JSI/DELIVER</li> </ul>					15 May	IR 2	
<ul style="list-style-type: none"> <li>Mapping data flow and implement improved reporting system</li> </ul>					30 Nov	IR 2	
<ul style="list-style-type: none"> <li>Facilitate USAID donation implants and injectables to BKKBN.</li> </ul>					30 Mar	IR 2	
<b>B.3. Policy Reform</b>							
<ul style="list-style-type: none"> <li>Continued facilitation of Technical Working Group for contraceptive security</li> </ul>					Ongoing	IR 1 IR 2	Bimo
<b>EXPANDING CHOICE through</b>							
<b>C.1. VSC</b>							
<ul style="list-style-type: none"> <li>Revision, approval and dissemination of revised VSC standards and guidelines</li> </ul>					30 Mar	IR 1 IR 2	Ricky/ Esty

<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality RH/FP Services</b>							
<b>Approach</b>	<b>Time</b>				<b>Date Complete</b>	<b>IR(s)</b>	<b>Responsible</b>
	<b>Jan-Mar Q1-02</b>	<b>Apr-Jun Q2-02</b>	<b>Jul-Sep Q3-02</b>	<b>Oct-Dec Q4-02</b>			
<ul style="list-style-type: none"> <li>Mapping of VSC sites and their performance</li> </ul>					15 Jul	IR 2	
<ul style="list-style-type: none"> <li>Development and implementation of policy quality assessment methodology to link quality with BKKBN reimbursements for VSC procedures</li> </ul>					31 Dec	IR 2	Ricky/ Esty
<ul style="list-style-type: none"> <li>Update of training materials and orientation of trainers on minilaporotomy and vasectomy</li> </ul>					30 Sept	IR 2	
<ul style="list-style-type: none"> <li>Development of a long-term strategy for quality assurance of VSC services, in conjunction with Technical Working Group</li> </ul>					30 Nov	IR 1 IR 2	
<b>C.2. Emergency Contraception</b>							
<ul style="list-style-type: none"> <li>Development and dissemination of information kits on EC for Muhammadiyah Health Network providers</li> </ul>					31 Jul	IR 2 IR 3	Bimo
<ul style="list-style-type: none"> <li>Dissemination of information on emergency contraception to key community groups, through Aisiyah, Muhammadiyah's Women's Movement</li> </ul>					31 Dec 03	IR 3	
<ul style="list-style-type: none"> <li>Facilitation of development of policies, regulations and operational guidelines for emergency contraception</li> </ul>					30 June	IR 1	
<b>IMPACT AREA 2: DEMAND FOR QUALITY AND INFORMED CHOICE INCREASED</b>							
<b>EMPOWERED CLIENTS &amp; COMMUNITIES through</b>							
<b>A.1. SMART Clients and Providers</b>							
<ul style="list-style-type: none"> <li>Formative research for intervention development on client rights</li> </ul>					30 Jun	IR 3	Fitri
<ul style="list-style-type: none"> <li>Development, production and national airing of TV and radio PSA's on clients rights and responsibilities</li> </ul>					31 Dec	IR 3	Ita/ Fitri
<ul style="list-style-type: none"> <li>Development, production and broadcast special radio vignettes</li> </ul>					31 Dec	IR 3	

<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality RH/FP Services</b>							
<b>Approach</b>	<b>Time</b>				<b>Date Complete</b>	<b>IR(s)</b>	<b>Responsible</b>
	<b>Jan-Mar Q1-02</b>	<b>Apr-Jun Q2-02</b>	<b>Jul-Sep Q3-02</b>	<b>Oct-Dec Q4-02</b>			
<ul style="list-style-type: none"> <li>Implementation of community discussions through mobile vans, radio, coaching and other community activities reinforcing key campaign messages</li> </ul>					31 Dec	IR 3	
<ul style="list-style-type: none"> <li>Development, production and dissemination of printed materials for client and community.</li> </ul>					31 Sep	IR 3	Ita/ Fitri
<ul style="list-style-type: none"> <li>Short orientation course for PLKB on facilitation and presentation skills</li> </ul>					31 Dec	IR 3	
<b>A.2. Strengthening NGO/Civil Society Organizations</b>							
<ul style="list-style-type: none"> <li>Conduct organizational capacity assessment to identify NGOs and CSOs active in FP/RH to create a civil society alliance on FP/RH under HI2010 Coalition</li> </ul>					30 Jun	IR 2 IR 3	Fitri
<ul style="list-style-type: none"> <li>Assessment and selection of district level NGO/CSOs conducting community mobilization.</li> </ul>					31 Mar	IR 3	Fitri
<ul style="list-style-type: none"> <li>Development of training materials, guidelines and train selected NGO/CSOs using participatory methods</li> </ul>					30 Jun	IR3	
<ul style="list-style-type: none"> <li>Implementation of training for selected NGO/CSOs on capacity to manage, monitor and sustain FP/RH programs</li> </ul>					30 Jun	IR 2	Nurfina
<b>A.3. Special Groups (including Men/Couples and Adolescents)</b>							
<ul style="list-style-type: none"> <li>Development of ARH strategy</li> </ul>					31 Mar	IR 3	Dian
<ul style="list-style-type: none"> <li>Train district level managers on ARH program planning using P-Process followed by small grant program mechanism</li> </ul>					30 Jun	IR 2 IR 3	
<ul style="list-style-type: none"> <li>Support program for NGOs for ARH activities</li> </ul>					31 Dec	IR 2	Fitri
<ul style="list-style-type: none"> <li>Development of communication strategy for men/couples</li> </ul>					31 Dec	IR 3	
<b>CAPACITY BUILDING FOR ADVOCACY through</b>							
<b>B.1. Reproductive Health/Family Planning Agenda</b>							
<ul style="list-style-type: none"> <li>Plan media tour and discussion on RH/FP</li> </ul>					Ongoing	IR 3	Ita

<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality RH/FP Services</b>							
<b>Approach</b>	<b>Time</b>				<b>Date Complete</b>	<b>IR(s)</b>	<b>Responsible</b>
	<b>Jan-Mar Q1-02</b>	<b>Apr-Jun Q2-02</b>	<b>Jul-Sep Q3-02</b>	<b>Oct-Dec Q4-02</b>			
<ul style="list-style-type: none"> <li>Preparation of series of fact sheets on RH/FP for parliament, local government, NGOs and other stakeholders</li> </ul>					Ongoing	IR 3	
<ul style="list-style-type: none"> <li>Development of RH/FP advocacy presentation kit for BKKBN</li> </ul>					Feb 28	IR 3	
<b>B.2. Capacity Building for Advocacy</b>							
<ul style="list-style-type: none"> <li>Development of RH/FP advocacy action plan for national, provincial and district levels</li> </ul>					31 Jan	IR 3	Fitri/ Dian
<ul style="list-style-type: none"> <li>Development of advocacy training modules for RH/FP</li> </ul>					31 Mar	IR 2 IR 3	
<ul style="list-style-type: none"> <li>Advocacy training of trainers at central, district and provincial level</li> </ul>					31 Dec	IR 2 IR 3	
<b>IMPACT AREA 3: ENVIRONMENT FOR SUSTAINING QUALITY AND CHOICE STRENGTHENED</b>							
<b>NATIONAL &amp; REGIONAL POLICY SUPPORT through</b>							
<b>A.1. National Policies Strengthened</b>							
<ul style="list-style-type: none"> <li>ARH policy analysis</li> </ul>					31 Mar	IR 1	Adrian
<ul style="list-style-type: none"> <li>ARH policy recommendations formulated &amp; disseminated</li> </ul>					30 Sep	IR 1	
<ul style="list-style-type: none"> <li>Advocacy for new ARH policies</li> </ul>					31 Dec 03	IR 1	
<ul style="list-style-type: none"> <li>Policy analysis of role of RH/FP in Quality Family Initiative</li> </ul>					30 Sep	IR 1	
<ul style="list-style-type: none"> <li>Policy briefs on selected topics as needed</li> </ul>					30 Jun 03	IR 1	
<b>A.2. Regional Policies Introduced</b>							
<ul style="list-style-type: none"> <li>Study of impacts of decentralization on RH/FP at regional levels</li> </ul>					30 Jun	IR 1	Adrian
<ul style="list-style-type: none"> <li>Strengthen policy development capacity at regional levels</li> </ul>					30 Jun 03	IR 1	
<ul style="list-style-type: none"> <li>Policy recommendations formulated &amp; disseminated</li> </ul>					31 Dec 03	IR 1	
<ul style="list-style-type: none"> <li>Advocacy for new policies</li> </ul>					31 Dec 03	IR 1 IR 3	

<b>Strategic Objective: Increased Acceptability and Consistent Use of High Quality RH/FP Services</b>							
Approach	Time				Date Complete	IR(s)	Responsible
	Jan-Mar Q1-02	Apr-Jun Q2-02	Jul-Sep Q3-02	Oct-Dec Q4-02			
<b>SUPPORT FOR REPRODUCTIVE RIGHTS through</b>							
<b>B.1. Reproductive Rights Monitoring &amp; Reporting</b>							
• Assessment of current status of reproductive rights					30 Sep	IR 1	Adrian
• Bi-annual Compliance Report					31 Dec	IR 1	
<b>UTILIZATION OF DATA through</b>							
<b>C.1. IDHS Field Activities Coordinated</b>							
• Coordination of IDHS data analysis					Ongoing	IR 1 IR 2 IR 3	Doug
• Facilitate fielding of survey					30 Jun	IR 2	
<b>C.2. QIQ</b>							
• QIQ baseline survey implemented					30 Jun	IR 2	Doug
• National policy forum on Quality & FP Care					31 Dec	IR 2	
• Provincial & regional forums to present findings					2003	IR 2	
• QIQ 2003 planning implemented					2003	IR 2	
<b>C.3. Quality &amp; Decentralized Data Utilization</b>							
• Technical working group to assess KS data system established					31 Mar	IR 2	Adrian
• Recommendations of working group disseminated					30 Sep	IR 2	
• System for use of data strengthened					2003	IR 2	

**PART V: ACTIVITY MATRIX AND BUDGET**

**STARH BUDGET FOR YEAR 2**

Dec.13, 2001

in US\$

<b>Impact Area # 1</b>	<b>Impact Area # 2</b>	<b>Impact Area # 3</b>
A. Service QI 827,832.00	A. Empowered 1,630,000.00	A. Policy Development 300,000.00
B. Contraceptive Security 295,182.00	B. Advocacy 520,000.00	B. Reproductive Rights 47,500.00
C. Expanded Choice 400,191.00		C. Utilizing Data 45,000.00
Sub Total: 1,523,205.00	Sub Total: 2,150,000.00	Sub Total: 392,500.00
Other direct Cost: 1,214,359.00	Other direct Cost: 1,063,504.00	Other direct Cost: 187,677.00
Indirect Cost: 307,174.00	Indirect Cost: 268,340.00	Indirect Cost: 62,707.00
Total: 3,044,738.00	Total: 3,481,844.00	Total: 642,884.00
Grand Total Y2 =		7,169,466.00

## **PART VI: ATTACHMENTS**

**A: Concept Paper: Quality Improvement Strategy – Companion to SMART Initiative**

**B: Concept Paper: Smart Clients, Smart Providers and Smart Communities: Redefining Roles in Improving Participation in Reproductive Health Care Delivery**

**C: Thoughts on STARH Field Level Activities**



**Concept Paper**

**Quality Improvement Strategy – Companion to SMART Initiative**

**INTRODUCTION**

The aim of the STARH Program is to assist the MOH, BKKBN and its partners in improving the quality and use of FP and RH services in Indonesia. This process requires that supply and demand interventions work in concert to reinforce efforts to improve quality. Indonesia has reached 54.7% percent contraceptive prevalence rate or CPR (1997 IDHS). In order to maintain and perhaps increase prevalence, the FP program must emphasize quality, especially as the population of women of reproductive age continues to increase despite the gains in CPR. The National FP Program administered by BKKBN has thus made quality of care the focus of its current strategy, as represented in its vision statement: A Quality Family by 2015. This statement represents both the Program's emphasis on the family, including men and adolescents and enhancing their quality of life through improved reproductive health.

The focus of this strategy is the quality of family planning services, given that this is one of the central mandates of the STARH program. In order to accomplish this goal, key interventions will include:

**Developing and demonstrating a process to continually improve quality in designated facilities;**

- Creating linkages of quality improvement interventions with client and community empowerment activities, including incorporating client and community definitions of quality into the selection and design of quality interventions;
- Developing systems and building capacity at district level to enable managers to implement and monitor quality improvement programs;
- Establishing coordination mechanisms at province level in support of district initiatives to improve quality.

In developing the quality improvement process, STARH and its partners will draw upon the principles and lessons learned from U.S. and international performance improvement approaches. Thus, analysis of gaps in quality will seek to identify performance factors which underlie the causes of these gaps. Performance factors which typically influence the behavior of service providers and the quality of reproductive health services include:

- job expectations,
- feedback on the provider's performance,
- provider motivation,
- management system and leadership, supplies or essential infrastructure,
- technical knowledge, awareness of service delivery guidelines, or skills of workers,
- responsiveness to, or knowledge of, the client's needs or the community's priorities.

District management teams will take a leadership role in both the performance analysis and the selection of interventions to improve quality which address those performance gaps often identified in the facilities of a particular district.

## BACKGROUND

Quality improvement is not new to Indonesia. In the family planning arena, efforts began in the context of voluntary sterilization, but have since been expanded within BKKBN to the development of family planning service quality indicators. Meanwhile, the Ministry of Health has also developed a number of quality of care initiatives, including a very elaborate process of team-based problem solving for key primary health care services under the World Bank-funded Health project IV.<sup>11</sup> While there are key lessons learned from these initiatives, in many cases, the assessments are too detailed and labor-intensive. One of the goals of the STARH strategy is to streamline the assessment stage, by using the Quick Investigation of Quality methodology<sup>12</sup>.

Past program evaluations, both for efforts funded by USAID and by other donors, have pointed to significant gaps in the quality of family planning services. Generally, providers often fail to comply with established standards of care. Of note, are substandard infection prevention practices, which endanger both clients and providers. Also, the quality of interpersonal communication and counseling remains weak, despite past efforts to implement large scale training programs.

Typically, Indonesian women and couples access short-term reversible methods from FP volunteers or *kaders*, private or village midwives, unless they are new acceptors. Pills and injectables are also the most commonly used methods. For long-term methods, such as IUDs and implants, clients are as likely to visit a puskesmas – community health center – as a village or private midwife. Vasectomy services are available in a limited number of puskesmas and hospitals, while tubectomy is mostly available in hospitals and a few puskesmas. Except in the remotest areas and in the outer islands, access to services seems to be generally good. However, the use of FP services in puskesmas facilities remains low for the most part.

While the Indonesian family planning infrastructure and coverage is adequate, evidence suggests that clients do make choices on the basis of their perceptions of quality. As in many countries, the 20/80 rule - where 20% of the sites provide 80% of the services - applies in Indonesia. The 1994 Situation Analysis measured that 25% of service delivery points provided anywhere between 63% and 88% of facility-based services depending on the province. Whether the 25% high caseload facilities are already operating at full capacity is unclear.

Service Provider motivation is a critical performance factor in the quality of public sector services in Indonesia. Most providers in public facilities work there in the morning and then work in private practice in the afternoons and evenings. Providers may lack external motivators

---

<sup>11</sup> STARH has prepared a short document summarizing this process. This is available upon request to the Performance Improvement Advisor.

<sup>12</sup> While STARH expects to use QIQ for family planning services only, other countries have adapted this tool to include either prenatal care or child health services. One can envision adding other aspects of primary health care as well.

for performing at their best, because compensation is low, management systems are weak and supplies are limited. As part of the STARH strategy, the specific ways in which motivation plays a role in the quality of services will be examined. Whenever possible, the strategy will work to reinforce positive motivating factors and reduce de-motivating factors. Approaches such as facilitative supervision and public recognition for improvement in quality, which are believed to contribute to motivation, will be pursued. The certification model described below will be one of the ways to help motivate service providers.

## OUTLINE OF QUALITY IMPROVEMENT STRATEGY

The focus of this quality improvement strategy will be on activities that support the following objectives.

### Objectives

- Improve the quality of services in designated facilities, as measured by using a composite score based on the QIQ methodology.
- Link facility-based quality improvement activities to the SMART community-based initiatives, so that the community acts as a pressure group to sustain and continually improve quality of services.
- Develop the capacity of district managers to manage quality improvement programs.
- Establish coordination mechanisms for district quality improvement mechanisms at province level.

### Scope

STARH will initially select 5 facilities in selected STARH districts<sup>13</sup>. Currently, plans are to work on various aspects of quality with 11 or 12 districts in 2002, 21 in 2003 and 40 by 2005. In order to obtain facility level data to use in implementing the quality improvement cycle, the facilities surveyed with QIQ should be those STARH intends to work with. District stakeholders will select sites according to criteria of their choosing.

Province	No of districts	No of puskesmas	Avg. No of puskk./distr.
East Java	38	924	24
Central Java	35	852	24
West Java / Banten	30	1112	37
DKI/Jakarta	6	328	55
So. Sumatra/Bangka&Belitung	13	272	21
Lampung	10	195	20
North Sumatra	20	394	20

Source: DepKes, 1999.

<sup>13</sup> As part of the district-level planning process, teams will be given considerable flexibility in selecting those interventions that best meet their needs from the “core package” (see concept paper for district implementation). STARH would ideally like the intensive facility- and community-based activities to be implemented in only 3-4 districts initially as these activities will be more time and labor intensive.

Each *puskesmas* is usually also linked to 5 or 6 *pustu* (or *puskesmas* pembantu - helping *puskesmas*). While we do not plan to use QIQ to assess the quality of services at these *pustu* initially, STARH will include in the quality standards, some indicators for how the *puskesmas* supervises and works with *pustus* as well as village midwives in its catchment area. Also, all providers supervised by the *puskesmas* will be included in the team organized to improve quality through self-assessment and the use of the performance improvement process. As described under the SMART concept paper, communities in the *puskesmas* catchment area will be mobilized to participate in the quality improvement effort.

Quality improvement activities may result in significant growth in service utilization ultimately overwhelming service providers and leading to a counterbalancing effect on quality. Such growth has been the case in other countries with quality improvement efforts (as, for example, in JHU projects such as Brazil's PROQUALI or the West African SFPS project). STARH will seek to monitor this dynamic carefully and, if observed, ensure balance between service utilization in the *puskesmas* and in the *pustus* and *polindes*, working with the community as appropriate.

### **The Quality Improvement Cycle**

In its essence, the STARH Quality improvement strategy is based on four steps:

1. Revise and update clinical standards and guidelines for the delivery of family planning services and define performance standards for FP service delivery points.
2. Conduct Quick Investigations of Quality facility surveys in STARH districts.

**Use PI principles to work with district teams to refine expectations for the performance of health care sites in their district, to analyze the results of QIQ, including the root causes for either high or low performance and the selection of interventions to correct gaps in performance. The resulting plan will form the basis for additional support by STARH in the area of quality improvement in selected districts. Repeat QIQ facility surveys (or some other district-led assessment process) periodically to fine-tune district-based interventions needed and revise workplans accordingly.**

A more detailed flow chart is in Appendix X.

Interactions with district managers need to be transparent and uphold the value of mutual respect so as to develop trust and the ability to work on difficult problems together in a constructive manner and without assigning blame for gaps in quality. STARH staff will need to model this value and approach during QIQ result analysis and workplanning meetings.

Implementing the workplan may lead to substantial management efforts as STARH cannot award grants to government agencies, but must develop systems to administer funds for activities. For service delivery quality improvement activities, STARH hopes to channel most funds through NGOs, such as POGI (NCTN) and IBI.

## Interventions offered during district workplanning

District planning teams will be offered a menu of interventions for which technical assistance can be offered and which will address varying performance factors. This menu includes (with performance factors listed in right margin):

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• Dissemination of service delivery guidelines and contraceptive technology updates.<br/><br/>STARH will develop training and non-training interventions to disseminate revised standards in family planning. Training interventions will rely on NCTN trainers at provincial and district level. This will ensure continued capacity for providing updates. Monthly meeting of midwives will provide a mechanism for further dissemination of new information to village and <i>pustu</i>-based midwives. Non-training interventions will be developed in conjunction with JHU/CCP and potentially use mass media and job aids. The dissemination strategy will be discussed with the technical group involved in updating the guidelines.</li></ul>   | Job expectations, technical knowledge                                  |
| <ul style="list-style-type: none"><li>• On-site infection prevention training and problem solving.<br/><br/>Changes in infection prevention practices require fundamental changes in provider and health staff behavior. Traditional group-based training is not effective in changing practices throughout a site. Therefore, STARH will prepare specialized NCTN trainers to visit <i>puskesmas</i> and conduct site-based training. This training will consist of an assessment of current practices, a brief half-day presentation on key infection prevention principles, followed by one or two days of problem-solving exercises to change systems and practices of all staff from cleaners to physicians. Because it is often difficult to affect infection prevention in only one unit of a facility, this intervention will involve the entire health center.</li></ul> | Job expectations, Performance feedback, Management, knowledge & skills |
| <ul style="list-style-type: none"><li>• IPC/C training and provision of counseling job aids (in collaboration with JHUCCP)<br/><br/>Targeted training in IPC/C will be provided to key staff, when needed. Because past studies have shown that when SMART clients ask more questions, providers often provide misleading information, IPC/C training will integrate a contraceptive technology update. In addition, IPC/C will be a focus area for supervision activities.</li></ul>   | Knowledge & skills, client focus                                       |
| <ul style="list-style-type: none"><li>• Clinical training for skills in FP services (IUD, implants, vasectomy)<br/><br/>When staff are identified who do not have adequate skills in providing long-term methods of family planning, training courses will be organized at the nearest DTC. Depending on the extent of need for IUD training, expanded use of the bahasa Indonesia ModCAL IUD training package will be explored.</li></ul>  | Knowledge & skills   |

<ul style="list-style-type: none"> <li>• Self-assessment and peer assessment processes</li> </ul> <p>A JHU/CCP-led study in Indonesia demonstrated the effectiveness of using self-assessment to improve IPC/C skill retention after training. Content for self-assessment will be expanded to cover key aspects of quality of care (following similar indicators as those included in QIQ), including infection prevention and clinical skills, thus also providing additional tools for on-site supervisors.</p>	<p>Performance feedback</p>
<ul style="list-style-type: none"> <li>• Training in site-level management of contraceptive stocks</li> </ul> <p>The contraceptives distribution system in Indonesia has traditionally been a “push” system, where BKKBN analyst determined the quantities of each type of contraceptive needed in a given district and at each site. Given resources constraints imposed by the economic crisis, Indonesia can no longer afford such a system. STARH will help implement a request system, integrating contraceptives with other pharmacy systems at the <i>puskesmas</i> level to ensure consistency and reliability. Targeted facilities will be supported to make additional changes to streamline the management of contraceptive stocks at the facility level, including integrating contraceptives with other pharmacy systems to ensure consistency and reliability.</p>	<p>Equipment &amp; supplies, job expectations, knowledge &amp; skills, management</p>
<ul style="list-style-type: none"> <li>• Technical assistance to develop problem-solving mechanisms to address issues with supplies and facilities.</li> </ul> <p>STARH does not have the resources to procure needed supplies for services; however, STARH can help in finding solutions to gaps in equipment and facilities. For example, we can work with district managers to analyze and shift resources available. Or, through STARH’s advocacy strategy, district managers can learn to make a better case for better equipping high caseload facilities.</p>	<p>Equipment &amp; supplies, management</p>
<ul style="list-style-type: none"> <li>• Facilitative supervision systems</li> </ul> <p>STARH has already begun work with DepKes on developing guidelines for facilitative supervision, using both existing materials developed with Engender Health (formerly AVSC) and the JHPIEGO supervision manuals as references. The draft guidelines will be field tested in one of the STARH districts before completion. Onsite supervisors from facilities selected to participate in STARH’s program will undergo training in onsite supervision initially, as STARH staff explore mechanisms for sustaining external supervision. If external supervision can be implemented, training for district managers will be conducted. IBI will be a key partner in this activity.</p>	<p>Performance feedback + All performance factors</p>

## Service Delivery Guidelines

STARH and its partners have identified the need for several clinical guidelines documents, as follows:

**General family planning guidelines, which define what services providers should offer, at what level of the health care system, under which conditions, and how (in general terms) these services should be provided. This document should include the essential information a provider needs to know in order to offer high quality family planning services. It should not be a training manual, but a summary of key information. Language used should be understandable to frontline providers, midwives and nurses at the community level.**

- General family planning guidelines for non-clinical personnel, such as field workers, *kaders*, etc. Since so much of the Indonesian family planning program relies on a network of field workers and volunteers to promote family planning in the community and to be the first line of information about family planning, it is essential that these agents have accurate basic information about contraceptives and how services are delivered. These guidelines could also include some tips for how to work at the community level.
- Guidelines for supervisors of family planning services. Once a FP guidelines document for providers is available, a separate document for supervisors may be needed, which includes tools for assessing compliance to the guidelines.
- More technical standards for family planning services offered by physicians, as in the case of tubectomy and vasectomy. Technical standards can take three forms: 1) detailed instructions as would be found in a training manual, 2) Service delivery guidelines, which define the conditions under which each service should be offered, including prerequisites in terms of facility, staff, equipment and supplies, informed consent, etc. – this aspect can be included in a general family planning document – and 3) succinct indicators of the technical/clinical standards which can be used for assessing compliance.

STARH is currently working with partners to update both VSC and general family planning guidelines for services providers. Also, facilitative supervision guidelines are being developed. Other guidelines will follow as time and resources allow.

## Support Systems

In parallel to the interventions described above which will improve quality of services at the facility level, STARH will also address gaps or needs in systems which support quality. Facilitative supervision systems will be one aspect of systems development. Otherwise, STARH will continue to work with the NCTN to ensure that quality standards are applied to clinical training. This will include developing supervision by advanced and master trainers of district-level clinical training activities, with a particular focus on the quality of clinical practice. The use of FP safaris to recruit clients to the district hospital for clinical training courses will be reviewed and replaced with the transportation of participants and the development of clinical instructors in sites where caseloads are reliably high. Special emphasis will be needed to refresh and

strengthen trainers who will conduct onsite infection prevention training, which requires excellent problem-solving skills.

Attention will also be paid to the quality of IPC/C training, which has not been consistent in the past, as indicated by a JHU/CCP evaluation report. Systems will be developed to ensure that trainers are really qualified to provide training in this skill as well as in contraceptive technology. Job aids will be developed to standardize training and to facilitate more effective skill transfer.

Another system is the contraceptive supply chain system. STARH will work with BKKBN to roll out the pull system for distributing contraceptives and work to improve efficiency, reliability and cost effectiveness in this critical function.

While supervision is key to enabling and sustaining change in how services are delivered, making supervision a sustainable and continuing aspect of the family planning system is likely to be a challenge. Puskesmas are supervised by the District Health office, but the latter often ignore family planning services, because BKKBN has a tendency to plan FP program activities independently. In addition, external supervision is generally weak, intermittent and lacks a focus on improving provider skills. STARH will seek to balance onsite supervision with external supervision to minimize the additional resources required. Also, part of our efforts will be to help advocate and make supervision a priority in budget allocations.

### **Certification**

In order to provide an impetus and reward system for quality improvement and to link it to community initiatives, STARH will encourage each district to develop a site quality certification process. Perhaps, the process will initially be piloted in only a very limited number of districts. When facilities reach a certain level of quality by objective and verifiable measures, the district teams composed of representatives from BKKBN, DinKes, professional organizations (IBI, IDI) and community groups, and headed by the Bupati will award certification to those facilities. Certificates will be accompanied with further event to provide recognition for quality both to the site as a whole and to the team of providers and workers.

Because decentralization has shifted so much responsibility to the district and that high level government agencies have difficulties cutting through their different bureaucratic systems to work together on common initiatives, STARH feels that certification is best managed and most sustainable at the district level. On the other hand, this means that separate systems need to be developed in each district. However, STARH will develop a common model, which districts can adapt.

### **Province level coordination**

One of the key roles of provinces under decentralization is to bring together and listen to the concerns of the districts and either offer solutions or advocate on these issues with the center policy-makers. Conversely, provincial managers can help districts advocate with district decision makers, such as the Bupati or the local legislature. Thus, STARH sees province-level managers as key to supporting district-level quality improvement activities. For instance, STARH will work at the national level to establishing clinical standards and guidelines for family planning services. These will be disseminated from the province down to the site level,

using the NCTN and professional organizations as resources. Similarly, NCTN provincial training centers (PTC) will provide support and coordination for district training centers (DTC) and PTC trainers will train and ensure competency of DTC trainers.

In order for STARH to manage activities in many districts and involve the province managers in the process, regular (quarterly or semiannual) coordination meetings will take place at the province level. District managers from *Dinkes*, BKKBN, partnering NGOs will attend these meetings. These meetings will provide a mechanism to determine the role of the province in providing technical assistance and support to the district programs.



**Concept Paper**

**Smart Clients, Smart Providers and Smart Communities: Redefining Roles in Improving Participation in Reproductive Health Care Delivery**

**Background**

The aim of the STARH Program is to assist the MOH, BKKBN and its partners in improving the quality and use of FP and RH services in Indonesia. This process requires that supply and demand interventions work in concert to reinforce efforts to improve quality. The program will be executed in a phased manner (see attached Summary Implementation Chart) using certification of private and public sector facilities as the overarching strategy to improve quality. This concept paper focuses primarily on the communication components of the quality initiative. Further discussion with partners is underway to elaborate the other program components (see attachment A).

Informed choice, a cornerstone for quality in a health service delivery program, is a primary area of focus in the STARH communication strategy. The strategy is based on a framework of the rights and responsibilities of clients, communities and providers in creating an environment that supports informed choice. The very concept of “Smart Client, Smart Provider, Smart Community” (or SMART) will be the STARH Program’s driving communication concept and serve as a catalyst for social change in related work with BKKBN. The SMART initiative uses three areas of intervention to address the challenge of improving client-provider communication. They are: quality and performance improvement in service provision; community mobilization, and mass media. In the STARH strategic framework, the SMART initiative is the core strategy for Impact Area 2, “Demand for Quality and Informed Choice Increased” and an important and complementary component for the Impact Area 1, “Supply of Quality Services and Expanded choice Improved”.

The two principle objectives under STARH’s SMART initiative are to:

- 1) improve the quality of clinical/technical performances, technical information exchange, decision making process, and interaction between reproductive health providers and clients; and
- 2) increase community participation in improving access to and delivery of quality reproductive health services.

While the SMART initiative as a whole is client-focused, the three communication channels will serve to reach multiple audiences. Activities in quality and performance improvement in service provision will primarily take place at the facility level and reach clients, a range of providers and facility managers. Clients will be broadly defined to include women, men and adolescents. A variety of community mobilization activities will be facilitated in collaboration with key NGOs and an alliance of RH/FP Civil Society Organizations (CSOs) to reinforce key mass media messages at the community level. While much of the mass media activities will reach the general public, content will include messages tailored specifically for clients, community members and providers. SMART will be implemented in three phases to span a four- to five-

year period of time. Although there will be active use of all three channels of communication throughout the three phases, the level of activity in each will vary by phase according to the main goals of each phase.

### **Phase 1**

Activities in Phase 1 will focus on the development and testing of approaches and tools that will be used under the “Smart” campaign. In this phase, a consensus-based operational definition of quality will be developed. This definition of quality, previous programmatic experience and formative research will inform the development of approaches and tools that will be used in the quality and performance efforts for STARH – both inside and outside of the service delivery sites. It will also inform message development for mass media campaigns and community-based activities to effect ideational change in support of STARH objectives. For instance, the monitoring tool QIQ, will be adapted to ensure adequate representation of priority components of the Indonesian generated definition of quality. Processes best suited for the Indonesian context will also be developed for effective engagement of the community in QI/PI priority setting and problem-solving.

The following provides greater detail on the specific goals, activities and illustrative indicators for Phase I.

#### Goals:

- 1) Define quality incorporating perspectives of Indonesian clients, community members, providers and technical experts.
- 2) Design interventions and tools that respond to top priorities in the Indonesian operating definition of quality.
- 3) Convey the key principles of the “Smart” initiative to the general public, specific communities, providers, and clients. (e.g. client, couples, men, adolescents, community and providers rights and responsibilities for quality RH service delivery.)
- 4) Achieve buy-in and commitment for the QI/PI initiative among leaders of stakeholder institutions.

#### Illustrative Indicators:

- 1) Operational definition of quality under STARH is agreed upon.
- 2) Range of tools and approaches developed and ready for broader field application.
- 3) Exposure to TV and radio messages.
- 4) % of public that believes clients have the right and responsibility to ask questions, express opinions of choice, etc. with the provider.
- 5) % of public that believes clients, community and providers all have a role in producing quality reproductive health.

#### Activities:

##### *QI/PI in service provision*

- Compile necessary data and achieve consensus on: 1) the operational definition of quality for STARH and 2) the design of the quality certification scheme.
- Short-technical orientation for providers, to ensure fundamental FP technical knowledge and re-emphasize critical IPC/C skills/process steps such as providing clients options and

promotion of dual protection. Providers will be also trained in the use of tools and job-aids to reinforce content of the orientation. Tools will include simplified technical guidelines, FAQ sheets, flip charts, self-assessment tools, and protocols for peer group meetings. Use of specific tools and/or demonstration of priority competencies such as promotion of dual protection will be included in the quality certification indicators.

- Develop/strengthen existing supervision and management protocols and tools to create an enabling environment that supports efforts to improve provider performance in clinical/technical and IPC/C aspects. Focus will be targeted on priority areas of content and processes based on existing evaluation data. Tools for this area will include standards and guidelines, monitoring and supervisory feedback mechanisms, self-assessment, peer group sessions, as well as tools that link in the community perspective on problem identification and solving. This work will be conducted with JHPIEGO.
- In close collaboration with JHPIEGO staff, establish quality certification processes and tools. Quick Inventory of Quality (QIQ) indicators will serve as the core certification criteria. This will include facilitating involvement of local communities, women's groups and religious leaders as joint stakeholders in the production of quality services.
- Establish QI/PI protocols to address barriers to desired performance. While some will be used within sites by site managers and providers, others will be designed to facilitate the work of QI teams that include representatives of both service provision and the community. This level of activity will be implemented in select districts in collaboration with JHPIEGO.

### **Community mobilization**

- A short orientation course will be designed and implemented for PLKB and other community leaders including those from the Civil Society Alliance on SMART initiative, facilitation and advocacy/presentation skills. This will include specific methods for increasing effectiveness of RH/FP communication and interaction of women, men and adolescents.
- Develop and test activities and materials to be used in a variety of forms of community-based outreach and education (e.g. peer education, facilitated group talks, and mobile van visits/events). The aim of these activities is to encourage clients' active solicitation of information and participation in decision making. Materials will include: "Smart Client-Smart Community" leaflets; client learning aids for preparation of questions for providers; "FAQ" sheets; and pocket calendars for recording menstrual cycle. Specific information about male involvement, adolescents, and reproductive health rights and responsibilities will be highlighted.
- Design a format for monthly *bidan* meetings to be conducted in collaboration with the Indonesian Midwife Association. These meetings will serve as a forum for continuing education to develop *bidan* skills in community outreach and mobilization to support the "Smart Client, Smart Provider, Smart Community" concept. The design will incorporate participatory methodologies with an aim at performance focused problem-solving. Specific topics should include focus on ensuring client rights, increasing male involvement, and reaching out to adolescents, among others.

In concert with JHPIEGO-led QI/PI efforts, community mobilization activities will support and facilitate ongoing community participation in the facility-linked quality improvement

teams to be formed in select districts. Community members, including women, men, and adolescents will be active members of these teams to ensure programs are client focused.

## **Mass Media**

- Production and airing of TV and radio spots to introduce and reinforce the key ideas and behaviors of the “Smart” campaign.
- Production of entertaining radio vignettes that will provide material for discussion in community mobilization activities and will focus on client coaching, male involvement and adolescents.
- Production of print materials (e.g. posters, brochures, and newspaper articles) that will be used to communicate with the general public, in the context of community-based activities, and in clinics.
- Produce video-taped materials for use by teams operating mobile vans to stimulate community involvement and dialogue.

## **Phase 2**

The emphasis in Phase 2 will be the implementation, inside and outside the clinic, of the QI/PI approaches and tools developed in Phase 1. Mass media will serve as a vehicle to model desired provider and client behaviors. Full explanation of the quality logo will be communicated. Community participation activities will expand based on results from phase one. The quality certification process will be implemented in the STARH provinces.

The following are the goals, activities and illustrative indicators for Phase II.

### Goals:

- 1) Address a range of facility-based performance factors to enable desired provider IPC/C behaviors.
- 2) Introduce strategies and tools that contribute to couples demonstration of desired family planning and RH health seeking behaviors.
- 3) Address a range of facility-based factors to enable desired client IPC/C behaviors.
- 4) Facilitate community and couple dialogue regarding social norms that support couples’ FP rights and responsibilities.

### Illustrative Indicators:

- 1) # of clients who clearly express the ‘RH need’ to be addressed in visit.
- 2) # of providers who clearly present client options for addressing ‘RH need’.
- 3) # of people who discussed content of community outreach activities with spouse and/or others.
- 4) # of women who prepare questions and concerns before meeting with the *kaders* and/or *bidans*.
- 5) Recognition and understanding of quality logo.

## Activities:

### *QI/PI in service provision*

- Roll-out provider and clinic manager training and orientations.
- Implement QI/PI tools and processes developed and tested in Phase 1.

### *Community mobilization*

- Roll-out of community mobilization activities and application of tools and processes designed in Phase 1.

### *Mass media*

- Production and airing of TV and radio spots to model desired behaviors and communicate specific calls to action for clients, providers and communities. The quality logo will be introduced and the spots will continue to communicate the same key concepts and themes presented in Phase 1 of the media campaign.
- Air entertaining radio vignettes that will provide material for discussion in community mobilization activities.
- Use print materials (e.g. posters, brochures, and newspaper articles) that help communicate with the general public, audiences of community-based activities, and providers and clients in clinics to further highlight and promote clients, providers and communities expanded roles and responsibilities. While the core materials would have been developed in Phase 1, there may be development/production of new materials in this Phase. This is especially true for communication through print journalism.

## **Phase 3**

By Phase 3, there should be some clinics that have achieved quality certification. The certification process will be institutionalized within lead agencies. Select districts and clinics will be targeted for focused QI/PI assistance. Also, as QI/PI activities continue, the media campaign will shift to promotion of certified sites, and high performing providers, clients and communities. There will be particular focus on the community mobilization activities to ensure they are sustained – even after the certification launch of a site for a given community.

The following are the goals, activities and illustrative indicators for Phase III.

### Goals:

- 1) Institutionalize the use of all strategies and tools that have proven most successful in supporting couples' FP rights and responsibilities.
- 2) Maintain couples' demonstration of desired family planning and RH health seeking behaviors.
- 3) Promote high performing sites, providers, clients, and communities.
- 4) Continue modeling desired RH behaviors.

### Illustrative Indicators:

- 1) Public recognizes and understands the quality logo.
- 2) Provider and client satisfaction.
- 3) # of facilities with quality certification.
- 4) # of new and continuing clients.

### Activities:

#### *QI/PI in service provision*

- Ensure that systems at multiple levels are well established and adequate resources allocated for successful institutionalization of those QI/PI approaches and tools that have contributed most to impact on quality.
- Continue provision of focused QI/PI technical assistance to selected districts and clinics.

#### *Community mobilization*

- Ensure sustained community engagement in: QI/PI process to achieve certification; ceremony in recognition of achieving certification and MAINTAINING quality after certification.

#### *Mass media*

- Production and airing of TV and radio spots to promote certified sites and continue behavior modeling.
- Use of local mass media to specifically cover launches of certified sites.

### **Monitoring and Evaluation**

The impact of the SMART initiative will be assessed at two levels: the community and the facility. Impact indicators will be coherent with the main STARH Strategic objective, “Increased Acceptability and Consistent Use of Quality Family Planning”.

- Indicators at the facility level will address such aspects as client participation, provider clinical/technical performance, provider IPC/C performance, implementation of guidelines, feedback mechanisms among supervisor, manager, provider, and client, problem identification and solving for quality improvement at facility level, adequate supply, capacity to anticipate and plan training needs, improved capacity to conduct quality training.
- At the community level they will cover areas like social norms and expectations on client informed choice and rights, advocacy through community meetings, and client advocacy events.

Data will be collected through household panel surveys, clinic audits and observation and special studies to understand change processes. These efforts will be linked and feed into, the overall monitoring and evaluation plan for STARH. The details of how studies will be linked will be mapped out later.

- Household panel surveys will be conducted to provide baseline data and at the end of each phase of the SMART initiative in selected intervention and control districts.
- Clinic quantitative and qualitative data will be collected at approximately the same points in time. This will be coordinated with QIQ monitoring activities.
- Special studies will be set up as needed by the STARH team to explain how and why some intervention components did nor did not work to produce behavior change or quality improvement. Possible study questions include: “How do the community interventions work to improve service quality and empower client communication with providers?” and “Why do some interventions have more impact on certain types of community and/or with providers?”

**Table 1. Summary Implementation Matrix for STARH Communication Strategy**

Channel	Phase		
	I Development	II Implementation	III Institutionalization
<p><b>Quality and Performance Improvement in Service Provision</b></p> <p>*'clinical'=CTU, IP and method specific skills</p>	<ul style="list-style-type: none"> <li>▪ Formative research</li> <li>▪ Develop &amp; communicate clinical*/IPC/C guidelines</li> <li>▪ Develop facility performance improvement processes and tools</li> <li>▪ Collect baseline performance data</li> <li>▪ Develop bidan clinical &amp; IPC/C training</li> <li>▪ Develop client learning aids for use in facilities</li> <li>▪ Develop feedback tools: enhanced supervision checklists, self-assessment, peer group protocols, etc.</li> <li>▪ Look for QI/PI synergies re: commodities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue communication of guidelines</li> <li>▪ Begin implementing facility performance improvement processes and tools</li> <li>▪ Implement provider clinical &amp; IPC/C training</li> <li>▪ Implement use of client learning aids</li> <li>▪ Implement improved feedback tools</li> <li>▪ In focal districts, design and test local quality certification and recognition schemes</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue implementation and institutionalize certification, provider orientation, client learning and feedback mechanisms.</li> <li>▪ Monthly bidan meetings.</li> <li>▪ More focused QI/PI assistance to select sites to improve performance.</li> <li>▪ Continue implementation of test certification assessment and recognition schemes in focal districts</li> </ul>

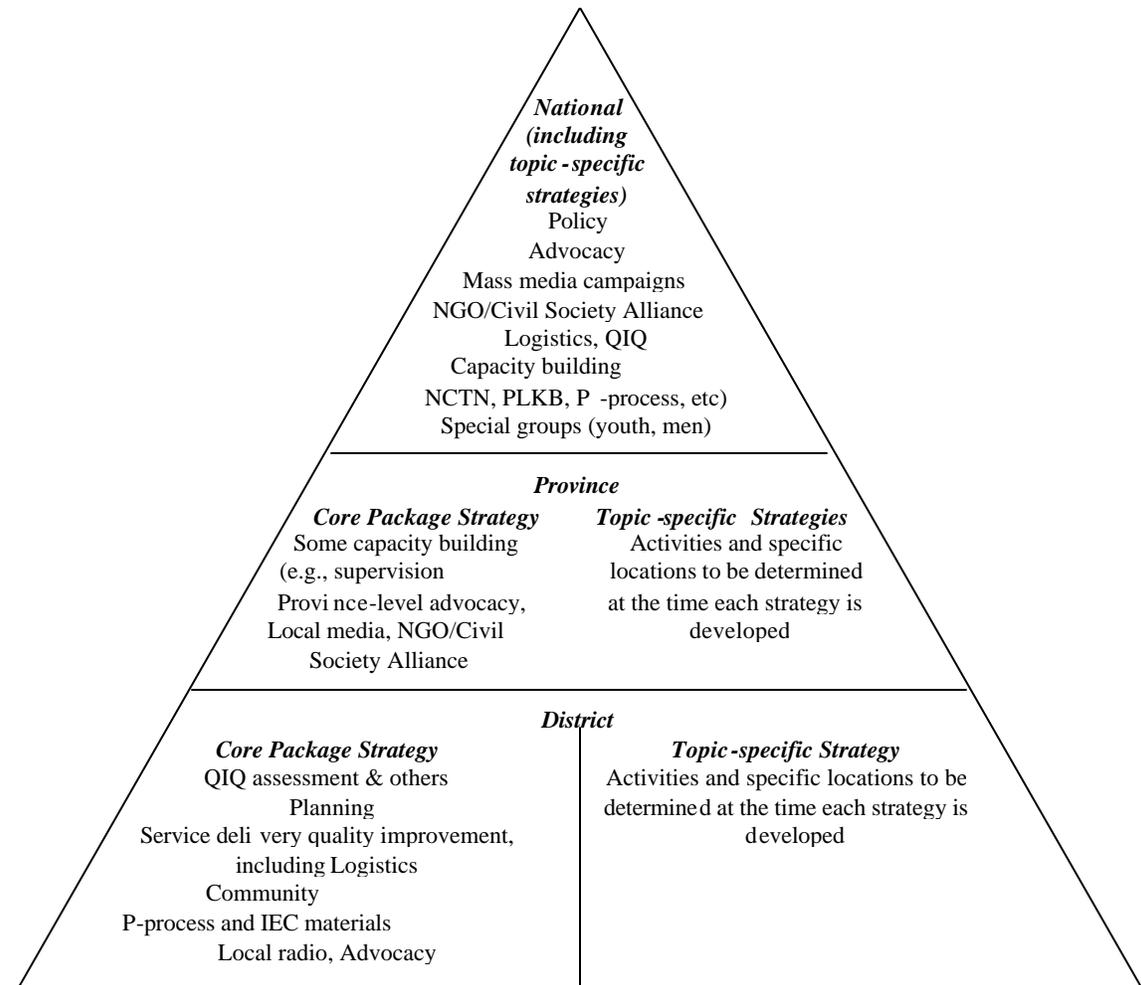
Channel	Phase		
	I Development	II Implementation	III Institutionalization
<b>Community Mobilization</b>	<ul style="list-style-type: none"> <li>▪ IPC/C orientation for PLKB and supervisors</li> <li>▪ Design &amp; test “Smart” mobilization activities: peer ed.; facilitated group talks and mobile van.</li> <li>▪ Monthly bidan meetings.</li> </ul>	<ul style="list-style-type: none"> <li>• IPC/C orientation for PLKB and supervisors</li> <li>• Implement: peer education; facilitated group talks, mobile van activities and bidan meetings.</li> <li>• Continue bidan meetings.</li> <li>• Comm. Participation in QI/PI</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to strengthen and support community involvement in QI/PI.</li> <li>• Community participation in launches of certified sites in focal districts.</li> <li>• Continue bidan meetings.</li> </ul>
<b>Mass media (TV, Radio, and Print)</b>	<p><b>Introduction of Key Concepts for Campaign</b></p> <ul style="list-style-type: none"> <li>▪ Position “Smart” in context of BKKBN Quality Family</li> <li>▪ Client rights (informed choice) and responsibilities (informed demand)</li> <li>▪ Community and provider responsibilities</li> <li>▪ Begin internal quality campaign</li> <li>▪ Develop quality logo</li> </ul>	<p><b>Specific Call to Action &amp; Model Desired Behaviors</b></p> <ul style="list-style-type: none"> <li>▪ Introduce ‘quality’ logo</li> <li>▪ Continue Quality Family</li> <li>▪ Model client rights and responsibility.</li> <li>▪ Model provider and community behaviors.</li> <li>▪ Air radio vignettes that support comm. mob. activities</li> <li>▪ Male participation (spousal communication)</li> </ul>	<p><b>Continued Modeling &amp; Promotion of High Performing Sites</b></p> <p><b>National:</b> Continue modeling desired behaviors of client, community and provider.</p> <p><b>Focal Districts:</b></p> <ul style="list-style-type: none"> <li>▪ <u>Using local media:</u> Full explanation of logo and promote high performing providers and facilities</li> </ul>

**THOUGHTS ON STARH FIELD LEVEL ACTIVITIES**

STARH is mandated to increase the acceptability and consistent use of high quality family planning services in 9 provinces. These provinces represent 70% of the total Indonesian population (preliminary data, 2000 Census). This document is meant to summarize what inputs STARH can provide at district and province levels. Discussions about this document are planned with central-level partners of STARH in preparation for visits to the provinces.

**Two-track Activities for STARH Field Implementation**

At this time STARH foresees two ways in which it will operate in the field, whether at province or district level. Each represents a different approach or strategy. The first, we will call “Topic-specific strategies”, and the second the “Core Package strategy”. Each is described further below under its own heading. However, the concept is also represented in a pyramid-shaped diagram here:



## **A. Topic-Specific Activities**

Topic-specific strategies developed centrally, with either national or subnational reach, which will flow down to provinces and districts. For example, capacity building for managing adolescent reproductive health activities could be one such strategy, where the content is developed with BKKBN pusat, workshops implemented for a provincial audiences, who then is expected to use BKKBN resources (e.g., through the DIP) to replicate the activity for the districts.

In the case of the first type of strategy, activities will be developed in conjunction with the relevant groups and stakeholders at the central level and separately for each type of intervention. In that process, provinces and districts may eventually be selected for training, testing or limited intervention on the basis of criteria defined specifically to meet the needs of that strategy. At this time, we envision that certain components of STARH, which are not part of the core package, will be implemented through these separate topic-specific strategies.

Examples of such strategies include:

- Development and dissemination of standards and guidelines for service delivery
- Adolescent reproductive health program
- Programs for other special groups, such as men
- Operations research and testing of new contraceptive distribution systems
- Initiatives to expand contraceptive choices, such as emergency contraception
- Repositioning and performance improvement of BKKBN field workers (PLKB)
- Improving the quality of voluntary surgical contraception (tubectomy and vasectomy)
- Quick Assessment of Quality (QIQ)<sup>14</sup>

## **B. Core Package for Quality and Choice Activities**

The second strategy represents core activities in improving the quality of services and generating community and client demand for high quality in reproductive health services and program activities. Aside from addressing the quality of services and enhancing community participation in the reproductive health program, this strategy seeks to improve local planning, management, implementation and monitoring capacity for family planning and reproductive health program activities. In developing that second strategy, STARH has to choose the right balance between wide coverage and more focused interventions.

STARH has developed a list of activities for a core package of activities to be implemented within the district capacity building strategy. This core package will represent the minimum package that would be implemented by each of the districts with whom STARH will work. Some of the same district may also be involved in other topic driven strategies; however, this

---

<sup>14</sup> QIQ is included in both 'streams' of STARH strategies, as both should contribute to quality improvements. Thus, STARH will develop a methodology for QIQ that samples facilities for a larger geographic area than those districts selected for the core package strategy. However, given that QIQ data will also form the basis for analysis and planning of quality improvement interventions, selected districts for the core package will be purposively selected for QIQ and over sampled.

will be a decision made on a case-by-case basis, with a view of not overloading any particular district.

The idea of a core package was developed for both practical and strategic reasons. The practical reasons are that the technical team can only address a limited number of activities and that our budget is relatively small for the number of provinces and districts involved. The strategic reasons are that any activity initiated by STARH must be such that it can be transferred to a local entity and sustained after the end of STARH.

### **Activities at Province Level in support of Core Package of Activities to Improve Quality and Choice**

Provincial level activities will be geared to the development of systems for program implementation and to capacity building. One area of particular focus will be the establishment of coordination systems between province and districts, such that there is ongoing shared vision regarding priorities, communication about the roles of each level, and areas in which districts expect assistance from the province. Additional interventions may include higher level supervision support systems, mass media activities through local and regional radio stations and province-level advocacy initiatives.

### **Core Package of Activities for STARH Districts**

The core “package” of activities at the district level will include the following components:

1. Assessments: Quick Investigation of Quality, CSO and other community communication assets (local radio stations, etc)

Once general agreement has been reached about STARH’s selection of a particular district, the first few activities will allow the STARH team to better understand the situation in the district. The Quick Inventory of Quality (QIQ) is a facility survey, which will be conducted in a coordinated fashion in the selected districts as well as for a larger sample of sites. Communication and community participation assessments will also be conducted and in some cases involve the use and institutionalization of participatory appraisal processes with community groups.

2. Participatory planning process with district teams → district-level workplan

Once the results of assessments are in hand, a process of planning will be initiated. District teams comprising of DinKes, BKKBN, Bappeda, NGOs, professional organizations and community groups will be oriented to the performance improvement process and use tools to identify priorities and to select interventions. In the communication arena, teams will be re-oriented to the P-process for designing communication campaigns as a planning tool. The output of these activities will be an annual workplan.

3. Performance improvement interventions to improve quality of services, including clinical and/or IPC/C training, supervision training and support, logistics support

Interventions which STARH foresees implementation include: more intense dissemination of clinical standards of services for FP, development of supervisory systems and tools, clinical training interpersonal communication/counseling training when provider skills are deficient, assistance in implementing a request system for contraceptive logistics and other similar activities to strengthen the quality of services. In this component of the core package, STARH may limit the number of interventions to 2 or 3 areas in each program year so as not to overload either the district teams or the STARH program. For example, after an analysis of results, a particular district may chose to work on interpersonal communication and counseling and contraceptive logistics in the first year and on disseminating standards and strengthening supervision in the second year.

4. Community Mobilization with NGOs, CSOs, Women's organizations, professional organizations, private sectors, universities

BKKBN will work with STARH in coordination with HI 2010 to develop an Alliance of NGOs for FP/RH at all levels (pusat, provincial and district). That alliance will implement community mobilization activities in the field.

CSOs and NGOs will also work with STARH to develop community mobilization activities geared to involving the community in reproductive health program activities in the context of the Smart Client, Smart Community strategy (see separate strategy document). For example, communities will be asked to play a role in giving feedback on the quality of the services they receive and on their interactions with PLKB. Educational activities using mobile vans and other enter-education will be organized.

5. Smart Client, Smart communities behavior change communication campaigns and production of materials

The districts selected will implement the Smart Client, Smart Community strategy. In so doing, district-level capacity building will include continued training and support for the local design of communication campaigns, approaches and materials to tailor the strategy to local needs. District-level activities will be linked to provincial or "regional" (meaning the geographic area covered by a radio station) mass media campaigns.

6. Advocacy (training, activities)

Advocacy materials produced nationally will be disseminated (both internal materials to educate BKKBN staff on new vision and mission and the 2015 strategy and external for outside audiences to build the constituency and support for FP program and budgets). In addition, training in advocacy skills will be offered to BKKBN and DinKes program managers as well as representatives of CSOs and NGOs.

### **Role of central level government agencies in the Core Package Activities**

Representatives of BKKBN and DepKes at central level will accompany STARH on introduction visits to provinces and districts to explain the Core Package Strategy. They will also be involved in some degree in the assessment activity and the analysis and planning activities, as needed. Mechanisms will be in place for them to participate with STARH in the review of the district workplans and provide input (assuming that representatives attend key meetings at the local level). Once the workplans have been finalized, central-level involvement will be limited as the authority to implement activities will be decentralized. However, the ACU may conduct monitoring visits as described in the SOAG.

A matrix is included in appendix to attempt to illustrate the varying roles of each level in the two strategies.

### **Number of Provinces and Districts for Core Package Activities**

While STARH intends to have an impact over as wide a geographical area as possible, field level activities can only be managed in a finite number of districts, given the resources available to us. In the proposal, target numbers of provinces and districts for the life of the project were set at 7 and 40 respectively, although it was understood that a phased strategy would be implemented. Two of the original 7 provinces divided, so there are now 9 provinces. In keeping with that original commitment, but with changes in the configuration of provinces under STARH, the following is a proposed target number of districts for each province:

#### **Distribution of STARH districts for Core Package Strategy by province and by year**

Provinces	Total # of distr.	# of districts Yr 1	# of districts Yr 2	# of districts Yr 3
East Java	38	2	4	9
West Java	24	2	3	6
Banten	6	1	1	2
Central Java	35	2	4	8
DKI Jakarta	6		1	2
South Sumatra	10	1	2	3
Bangka Belitung	3	1	1	1
Lampung	10	1	2	3
North Sumatra	20	2	3	6
TOTAL (cumulative)	152	12	21	40

The additional districts each year are 9 in year 2 and 19 in year 3, for a total at the end of Year 3 of 40.

STARH has laid out various options for funding activities at the district level. Final mechanisms will be discussed and selected in consultation with the individual provinces and districts.

### **Criteria for District Selection for Core Package Activities**

The STARH Program Management Unit will play a key role in developing consensus on the criteria for districts to be supported by STARH. Below is an initial list of criteria developed by the STARH team:

- Population (the larger in terms of population, the better).
- Capacity of district managers to absorb technical assistance and implement the core package (subjective – based on provincial managers' input).
- Capacity of district managers to sustain and institutionalize interventions beyond life of STARH (subjective – based on provincial managers' input).
- Consideration for other donor/project activities in the province and districts (opportunities to leverage funds vs. absorption capacity of managers).
- Some proportion of the districts selected (but not necessarily all) should be considered poor.

STARH proposes that the ultimate decision on which districts to select for the core package strategy be made in consultation with BKKBN and DinKes representatives in provincial offices. The importance of involving Bappeda for district planning activities has also been highlighted. To do so, province-level STARH coordination meetings will take place in the coming months before the end of the year. At these meetings, the contents of this paper will be discussed as well as the administrative and management mechanisms for the ongoing collaboration with STARH.

## Appendix. Roles of each level in specific strategies and components

STRATEGY & COMPONENT	PUSAT	PROVINCE	DISTRICT	STAKEHOLDERS <sup>15</sup>
<b>I. Core package strategy</b>				
- QIQ and other assessments	Design, Planning and Coordination, analysis of results	Participate in implementation	Facilitate implementation, Local analysis of results	Dep/Dinas Kesehatan, BKKBN, Bappeda, SDPs, communities
- Planning & workplan development	Review and approval	Facilitation of development (with STARH)	Analysis and selection of priorities, development of workplan	Dep/DinKes, BKKBN, Bappeda, NGOs, Prof. Orgs., Community groups, etc.
- PI interventions	Technical assistance as requested/defined in workplan	Technical assistance as requested/defined in workplan	Implementation	Dep/DinKes, BKKBN, JNPK, IBI, MJM and other technical partners
- Community mobilization	Strategy development	Input to strategy	Implementation	NGOs, community institutions, PLKB, universities, Prof. Org.
- Smart client, smart community	Strategy development and monitoring	Mass media and public relations programs at regional level	Implementation of Community mobilization activities	BKKBN, NGOs, IBI (assisted by professional advertising agency)
- Advocacy	Strategy development and production of generic materials	Implementation (e.g. for governors & province-level legislatures); adaptation as needed	Adaptation and implementation	BKKBN, DinKes, Prof. Orgs., NGOs, community groups
<b>II. Topic-specific strategies<sup>16</sup></b>				
- Standards and guidelines for FP services	Development, approval and dissemination	Dissemination to districts and hospitals	Dissemination to facilities, incorporation into supervision activities	DepKes, BKKBN, Prof. Orgs. (incl. PKMI for VS)

<sup>15</sup> Stakeholders will of course have different roles, but for simplicity's sake, we have listed all involved in some fashion in one or more of the roles listed.

<sup>16</sup> This is an illustrative list of topic-specific strategies, as these are continually evolving.

<b>STRATEGY &amp; COMPONENT</b>	<b>PUSAT</b>	<b>PROVINCE</b>	<b>DISTRICT</b>	<b>STAKEHOLDERS<sup>15</sup></b>
- Adolescent Reproductive Health (mostly implemented through NGOs)	Consultation on strategy; Partnership on implementing capacity building for managers,	Beneficiary of capacity building for managers, information sharing on NGO based activities	Beneficiary of capacity building, information sharing (implemented by NGOs)	NGOs, BKKBN
- PLKB repositioning	Strategy Development, Technical assistance for training program, guidelines development, etc	Flow down activities implemented with other donors; limited STARH involvement beyond initial monitoring; potentially pre-testing or piloting of guidelines/performance improvement mechanisms		BKKBN
- Operations research for new contraceptive distribution systems	Policy analysis, Design and implementation of research	Information sharing	Implementation of program part of operations research	BKKBN, Dep/DinKes, MJM
- Phasing in a pull system for commodity logistics	Design and strategy development	Implementation	Implementation	BKKBN, Dep/DinKes, MJM
- Emergency contraception (for now implemented through NGOs)	Information sharing	Information sharing	Information sharing	NGOs, BKKBN, DepKes
- Improving quality of VS services	Assessment and strategy development, standards and monitoring	TBD	TBD	DepKes/BKKBN, PKMI, other Prof. Orgs.
- Men, IDPs and other special groups	Strategy development;	TBD	TBD	BKKBN and TBD

