



HEALTH
SERVICES
PROGRAM
2006
ANNUAL
REPORT



USAID | **INDONESIA**
FROM THE AMERICAN PEOPLE





This document represents the Annual Report for Year One of the Health Services Program (HSP). This Annual Report for HSP is submitted by JSI Research and Training Institute, Inc. to the United States Agency for International Development in accordance with the terms of Cooperative Agreement No. 497-A-00-05-00031-00. The Health Services Program is a four and a half year program designed and developed by USAID/Indonesia to reduce mortality among mothers, newborns and children and to improve health facilities which deliver basic human services.

MESSAGE FROM THE CHIEF OF PARTY



Dr. Reginald F. Gipson with (from left) Vice Governor of DKI Jakarta Fauzi Bowo, USAID Indonesia Deputy Mission Director Rob Cunnane, Directorate of Maternal Health Head Dr. Sri Hermiyanti, and – at far right – DKI Jakarta Provincial Health Office Director Dr. Wibowo Sukijat.

To our donor and colleagues,

In the past decade, Indonesia has made tremendous progress in addressing the health of mothers and babies. Still, the Ministry of Health faces a host of challenges in accelerating improvements in maternal, neonatal and child health. The USAID Health Services Program (HSP) is designed to assist Indonesia in achieving its targets.

HSP works with the MOH, policy makers, NGOs, the private sector and other international agencies to scale up an integrated technical assistance package based of evidence-based interventions. Our assistance targets 31 districts in six of Indonesia's largest provinces, with benefits being made available nation-wide by the end of the program. HSP's strategy

complements the work of the MOH, and builds synergy with other USAID Basic Human Services programs.

It is my pleasure to present the achievements of HSP's work in Indonesia. We've had a productive year, and are on-target with completing the program's Milestones as articulated in our FY06 work plan.

I would like to take this opportunity to thank USAID, the MOH and our many other colleagues and partners, who have made HSP's first year of programming a success. I look forward to continued partnership in the coming year.

Sincerely,

Dr. Reginald F. Gipson
Chief of Party
Health Services Program

CONCENTRATING ON EVIDENCE-BASED INTERVENTIONS	2
ADVOCACY TO SUPPORT MNCH OUTCOMES	4
MOBILIZING COMMUNITIES FOR BEHAVIOR CHANGE	6
PROVIDING ASSISTANCE ON TECHNICAL INTERVENTIONS	10
HARNESSING THE COMMERCIAL SECTOR	13
HEALTH SERVICES PROGRAM INTERVENTION AREAS	14
STRENGTHENING THE DECENTRALIZED HEALTH SYSTEM	16
BUILDING NGO PARTNERSHIPS	17
SPECIAL ASSISTANCE TO ACEH	19
INTEGRATION WITH OTHER USAID/BHS PROGRAMS	22
REPLICATION & OTHER SPECIAL ASSIGNMENTS	24
MONITORING AND EVALUATION	26
ABBREVIATIONS AND INDONESIAN TERMS	28



Maternal,
Newborn,
and Child
Health
Program



Program
Kesehatan
Ibu, Bayi Baru
Lahir, dan
Anak



CONCENTRATING ON EVIDENCE-BASED INTERVENTIONS

In its first year, the Health Services Program built its technical approach on a strong, internationally-recognized evidence base, both to ensure the rigor and effectiveness of its program and to strengthen its credibility with policy-makers and other key influentials. To create a comprehensive framework, HSP reviewed the international literature alongside Indonesia health outcomes to ensure that the promotion of international evidence and models sat firmly within the realities of the Indonesia context.

The result (see table, top) now guides HSP's technical assistance and advocacy efforts, and offers a way for our staff to discuss assistance with partners, focusing on the technical interventions that are most likely to achieve MNCH impact. The presentation of evidence-based interventions has also been important in our work with policy makers, so that they understand the efficacy of the various MNCH programs offered by the MOH, and the value of HSP assistance.

As of June 2006, HSP had completed its baseline survey, as well as a situational analysis using secondary data on the status of maternal, newborn and child health in 31 districts. HSP packaged this evidence base and is using it to assist the MOH as it updates its Minimum Service

Evidence-based Interventions to Reduce Maternal, Newborn, and Child Mortality*

Cause of Death...	% of Death (Indonesia Figures)	Evidence-based Intervention	% Reduction in Mortality if EBI Universally Practiced
Post-partum hemorrhage	28% of maternal deaths	Active management of the third stage of labor	60%
Neonatal asphyxia	27% of neonatal deaths	Neonatal Resuscitation	5-30%
Complications of prematurity and LBW	29% of neonatal deaths	Care of LBWs and immediate breastfeeding	20-40%
Neonatal infections	15% of neonatal deaths	Immediate breastfeeding and maternal TT2	17-22%
Diarrhea and Acute Respiratory Infection	37% of under-five deaths	Handwashing and IMCI	40-60%
Measles	7% of under-five deaths	EPI	30-86%
Complications due to Malnutrition	contributes to 54% of under-five deaths	Essential Nutrition Actions (exclusive breastfeeding, feeding of sick children, micronutrients)	30-50%

* References on inside back cover.

Standards (SPMs), and completes a *District Guide to Operationalizing Making Pregnancy Safer*. The feedback to date is that the evidence-based intervention table assists the Ministry to stay focused, and gives health advocates a clear understanding of the efficacy of various interventions.

Because Provincial and District Health Offices are key replication agents, HSP utilizes the evidence-based table during its assistance to district planning and budgeting exercises. After reviewing data and helping districts prioritize the problems they want to address,

HSP promotes that they adopt proven solutions.

HSP is also assisting the MOH to strengthen and package "model" programs that can be utilized in other working areas with support from other donors. At the same time, HSP works with other donors to harmonize methodologies under the auspices of the MOH.

In the first year of the program, HSP achieved all of its targets in terms of output indicators (see table at left). The program's milestones, as articulated in the FY06 work plan, have been completed within the timeframe of the first year of programming. In 2006, HSP provided assistance to 13 districts located in six provinces – a map of our intervention areas is presented on page 14. Among the top achievements of the program in the first year include:

- provided support to community health committees in 159 villages
- trained 216 village midwives in basic delivery care
- trained and provided on-the-job support to 263 health providers in basic neonatal care
- trained 213 staff from 64 Puskesmas in Posyandu Revitalization

The remainder of this report outlines HSP's achievements over the past year.

HSP Output Indicators	2006 Target	2006 Achievements
Number of districts with advocacy campaigns under way with at least one partner on at least two priority topics	13 districts	13 districts
Number of advocacy partners for whom capacity building plans have been prepared	2 partners	2 partners
Number of district public sector health staff trained in the HSP package of priority interventions	400 staff	566 staff
Number of districts with a MNCH plan for FY 2007/8 in place	13 districts	13 districts
Membership in the Bidan Delima program	4,000 midwives	5,400 midwives
Number of villages conducting a behavior change communications (BCC) campaign on two priority topics	156 villages	159 villages
Number of villages with BCC/Desa Siaga	100 villages	134 villages
Number of BCC and community mobilization partners for whom capacity-building plans have been prepared	2 partners	3 partners
Number of districts with BCC campaigns underway	13 districts	13 districts



HEALTH SERVICES PROGRAM BASELINE SURVEY FINDINGS*

THE CHALLENGES OF MATERNAL, NEWBORN, AND CHILD HEALTH

Over the past two decades, the Indonesian government has made significant progress in maternal, newborn and child health (MNCH). A village midwife program was established in 1989, and placed 54,000 providers in the majority of Indonesia's villages. In 2001, the country launched the Making Pregnancy Safer (MPS) strategy, emphasizing improvements in the quality of services. More recently, the Minister of Health has introduced four simple, yet effective, pillars to improve health: social mobilization and empowerment; improved access to quality health services; improved surveillance and monitoring; and increased public financing for health.

Despite significant progress, maternal mortality at 307 per 100,000 live births remains one of the highest in Southeast Asia. The child mortality rate is better, but the large number of children in the population means that 450,000 under-five children die each year. Neonatal

mortality comprises 36% of child deaths, and can be traced, in part, to the high proportion of births not attended by a skilled provider (34%). Diarrheal disease is associated with 19% of child deaths.

The MNCH needs of the poor are the least likely to be met in Indonesia today. On just about every indicator except exclusive breastfeeding, the poorest households have alarmingly low levels of health achievement. More than half of infant and young child deaths occur in the lowest economic quintiles, whose families are also the least likely to immunize their children.

A significant challenge to making progress on MNCH is the recently-decentralized health system. While districts have the responsibility for planning and budgeting, their capacity to utilize data for planning is limited. Additionally, local funds for program implementation are extremely small, and often inflexible.

- Only 60% of women reported using a skilled health provider to attend their last delivery
- Around 30% of under-three children had diarrhea in the last two weeks
- Only 2% of caretakers washed their hands with soap at least three of the five critical times
- Only 29% of newborns were breastfed within one hour of delivery
- Only 20% of women could cite at least two pregnancy-related complications for which they should be alert
- While around 40% of deliveries suffered complications, only 20% of women experiencing complications were referred to a higher-level health facility

* A complete overview of HSP baseline survey findings is presented on page 26.

ADVOCACY TO SUPPORT MNCH OUTCOMES

A NATIONAL “CALL TO ACTION” FOR HEALTH

The Health Services Program (HSP) assisted the Ministry of Health and the Coordinating Ministry for People's Welfare (*Menkokesra*) to initiate a “National Call to Action for Health,” in November 2005. The meeting was opened by the Vice President and attended by six Ministers, 33 Governors, and Bupati from 63 of Indonesia's 440 districts. The United States Ambassador attended, pledging US government support.

HSP worked closely with USAID, WHO, Menkokesra, the National Planning Board (BAPPENAS), and the MOH to ensure an effective meeting. HSP staff assisted the Director General of Community Health to develop a compelling presentation of

the status of maternal, newborn and child health in Indonesia – highlighting the need for accelerated progress in order for Indonesia to achieve its Millennium Development Goals for Health. Similarly, HSP worked with the Directorates of

Maternal and Child Health to ensure that evidence-based MNCH interventions were highlighted at the meeting.

Most importantly, HSP assisted the Minister of Health to concisely



USAID, MOH and HSP representatives at Parliament.



Vice President Kalla opening the “Call to Action.”

PROMOTING GOOD GOVERNANCE FOR HEALTH AT THE LOCAL LEVEL

Having recently decentralized, Indonesia is taking steps to ensure that health services reach the poor. The Parliament (DPR) is amending the health law (Law 23/1992), and has passed a number of laws to transfer responsibility and authority for meeting development priorities to the district level (e.g., Law 25/2004 on National Development Planning; Law 17/2003 on State Finance; Law 32/2004 on Local Government and Law 33/2004 on the fiscal balance between central and local government). The MOH is revising its minimal service standards so that they have a stronger legal basis, so that local officials can be held accountable for meeting national standards. The Executive branch has also shown a tremendous commitment to health. In his August 2006 State of the Union address, President Yudhoyono outlined the nine priorities of the 2007 Draft State

Budget – one of which is to increase the accessibility and quality of health. He also announced a proposed 12% increase in expenditures for the health sector in 2007.

While some districts have embraced their new autonomy, the large majority have not yet taken advantage of the opportunities that decentralization has created. Decentralized health services benefit from a growing constituency, and an increased awareness in the general public about the importance of healthy living. However, one of the main barriers to improving health remains district-level Parliament (DPRD).

DPRD members authorize local budgets, and ensure that local programs adhere to national policies. Limited understanding of key health issues by Parliamentarians is a major challenge to program improvement. A study by The Asia Foundation found that

most Parliamentarians consider MNCH to be a woman's issue, which translates into low budget allocations. Moreover, many DPRD members have limited understanding of laws and policies, and varying interpretations about their roles and functions.

HSP has partnered with the Indonesia Forum of Parliamentarians for Population and Development (IFPPD) to complete a review of health sector laws. The review found numerous laws and decrees that support MNCH – such as those on human rights, health, child protection, population and development, the elimination of discrimination against women and the national development program and its financing. The review determined that to a large extent, the legal framework is sufficient to protect women and children's right to health. HSP is now working with IFPPD to package these laws in a user-friendly way that will assist local Parliamentarians to understand – and adhere to – their legally-mandated roles and responsibilities as related to MNCH.

package and communicate her “Grand Strategy” which has four simple, yet effective, pillars to improve health: social mobilization and empowerment; improved access to quality health services; improved surveillance and monitoring; and increased public financing for health. These strategies mirror the assistance being provided by USAID through the HSP.

At the meeting, all 33 governors committed to ensuring that their provinces will provide adequate budget to ensure improvements in maternal, newborn and child health, laying the ground work for HSP’s advocacy strategy.

At the national level, HSP first launched the Minister’s Grand Strategy to HSP target provinces and districts. HSP then hosted a National Parliamentarians’ Conference on maternal, newborn, and child health (MNCH) in February. This was followed by a series of advocacy meetings targeting provincial and district Parliamentarians. Advocacy efforts reiterated the low status of maternal, newborn and child health, and highlighted the opportunity to make significant progress given the large increase in central-level funding for MNCH in 2006.

To assist the Ministry of Health to support districts to improve MNCH, HSP is now

undertaking several initiatives. First, HSP oriented districts to the procedures required to access Deconcentration (*Dekon*) funds, which increased program budgets for MNCH five-to ten-fold. HSP is also providing technical support to the MOH as it revises its Minimal Service Standards (SPM), and passes policy to give the standards a stronger legal basis. Finally, HSP is assisting the MOH to develop *District Guide to Operationalizing Making Pregnancy Safer*, which will provide guidance to district planning teams on the evidence-based strategies and programs that are available to address the MNCH problems their districts face.



National Parliamentarians’ Conference on MNCH.



HSP, USAID and the White Ribbon Alliance at a national advocacy meeting.



Advocacy to Parliament on the International Code on Marketing of Breast Milk Substitutes.

SAVING LIVES, SAVING MONEY THE POWER OF BREASTFEEDING

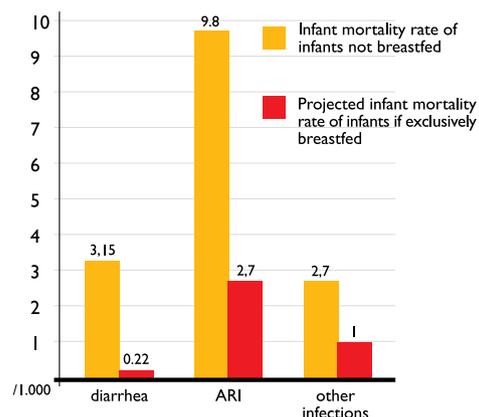
In view of the vulnerability of infants... and the risks involved in inappropriate feeding practices, including the unnecessary ... use of breast milk substitutes, the marketing of breast milk substitutes requires special treatment which makes usual marketing practices unsuitable for these products.” World Health Assembly, 1981.

Indonesia has astoundingly low rates of immediate and exclusive breastfeeding. In August 2006, HSP facilitated a coalition of partners to advocate to the Indonesia Parliament (DPR) to strengthen the language of the pending Health Law Amendment to create a stronger legal basis for enforcing the International Code on Marketing of Breast Milk Substitutes. Although Indonesia ratified the International Code in 2000, advocates noted that infant formula companies continue aggressive and misleading marketing of infant formula in Indonesia by giving

free samples of formula at hospitals and clinics, providing incentives to midwives to promote their products, and producing “educational” materials on infant feeding that promote breast milk substitutes.

Experts noted that the deaths of 23,000 Indonesian children could be averted if every mother immediately and exclusively breastfed their babies to the age of six months. They also noted that it costs about \$200 to feed an Indonesian baby infant formula for six months, which equals two and a half months of a full-time minimum wage salary.

As a result of the meeting, Indonesian legislators requested that they be provided with “model language” to ensure that any further revisions to the Health Law Amendment reflect international standards. This will lay the ground for HSP to support breastfeeding counseling training, starting in FY07.



The potential reduction in infant mortality if all infants were exclusively breastfed through six months of age.

Source: Infant mortality rates among babies not exclusively breastfed taken from MOH data. Projection in IMR reduction made based on published literature.

MOBILIZING COMMUNITIES FOR BEHAVIOR CHANGE

INVESTING IN PEOPLE: COMMUNITY HEALTH COMMITTEES IMPROVE MNCH

Indonesia has a long history of community mobilization efforts to promote maternal, newborn and child health (MNCH). However, it is broadly recognized that many of these community structures weakened during the reform era, in part because of decentralization. The Minister of Health has identified community mobilization as one of the four pillars of her national strategy to improve health, and is gearing up to invest significant resources in developing – and taking to scale – effective models of community participation.

HSP is assisting the MOH in these efforts, and helping to ensure that community mobilization sits firmly within the framework of behavior change. At the core of HSP's approach are health committees that have the capacity to identify and respond to locally-determined health priorities. In the first year, HSP utilized its own community facilitator staff (CFs) to support work in 159 communities. CFs assisted community volunteers to utilize participatory appraisal techniques to assess their health needs, focusing on MNCH. Findings were analyzed and presented back to a cross-section of the community, at which time health program priorities were agreed on.

As a next step, the community establishes a community health committee (CHC). HSP assists the committee to make an action plan to implement specific activities. The most common activities being implemented by CHCs include the village health post (*Posyandu*), environmental health, and birth preparedness and complication readiness (*Desa Siaga*). HSP – and other USAID partners – can then work through the CHCs to introduce a broader range of behavior change programming at the community level, such as hand washing.

Several features of the HSP community mobilization model are now under refinement, based on the experience to date. These include refining the selection criteria for those who participate in the village assessment team; focusing the assessment tool more specifically on evidence-based interventions; and developing more applied tools to support the village team during data analysis and presentation. As the program expands, HSP is increasing the involvement of the sub-district health center (*Puskesmas*) and the District Health Office staff in the participatory assessment and planning.

Pak Hidayat is an excellent example of the kind of person HSP seeks to get involved in its community-based efforts. An artist, a teacher and an Imam living in the Sindangsari village of Cianjur, West Java, he was identified by the village head as a good candidate for the village's CHC. He now leads efforts targeting environmental health, but says that child malnutrition is his greatest concern.

"I am often asked to speak to women's groups who study the holy Q'uran. My medium, *degung*, uses the gamelan and drums as a backdrop for storytelling. I like to weave in themes about the duty of a mother to her children, and a husband to his family. I use both Q'uran passages and poetry."

As part of the health committee, Pak Hidayat helped revitalize the village health post, which now boasts 35 volunteers. The village midwife practice is also bustling.

"I remember a time when it wasn't uncommon to hear of a woman dying in childbirth. Now, I can't remember the last time I heard of such a case."

Investing in people like Pak Hidayat has been one of the most important parts of HSP's work at the local level. With a strong network of committed, informed grassroots activists like Pak Hidayat, the MOH is on its way to meeting its goals for improved maternal and child health.

"I remember a time when it wasn't uncommon to hear of a woman dying in childbirth. Now, I can't remember the last time I heard of such a case."



OUR HEALTH IS IN OUR CLEAN HANDS: HAND WASHING CAMPAIGN LAUNCHED IN ACEH

Diarrhea remains a leading cause of child death, causing an estimated 17% of child deaths globally. Yet diarrhea can be prevented by simple and inexpensive solutions: improving the availability of a clean water supply, installing adequate sanitation facilities, and – most effectively – hand washing with soap.

Since the Aceh tsunami, government and international agencies have worked to build housing, install water-sanitation systems, and ensure basic hygiene supplies are available in tsunami-affected areas. Despite this, less than five percent of mothers that HSP surveyed a year after the tsunami hit were regularly washing their hands with soap – and most did not recognize that their behavior was problematic.

A consortium of USAID partners – including HSP, the Environmental Services Program (ESP) and the Safe Water Systems (SWS) program – launched a province-wide hand washing with soap campaign in partnership with the Aceh Provincial Health Office. Other organizations – CARE, UNFPA, People's Hope Japan Foundation, WSLIC-2 (a World Bank-funded water and sanitation project) and CWHSP (an Asian Development Bank water services project) – partnered with USAID to launch the campaign in May 2006.



Over 1,500 children, teachers and government officials – including the governor, Banda Aceh mayor, and Aceh Besar regent – turned out to show their support for hand washing. Games and contests were among the attractions that highlighted the importance of hand washing, and gave children the opportunity to practice proper hand washing with soap. CARE provided contest prizes that included hygiene kits, home hand washing stations and trash cans.

HSP is now supporting the provincial roll-out of hand washing campaigns to spread

community awareness and promote behavior change. For instance, HSP supported an Islamic school in Lhom, Aceh Besar, to host a hand washing carnival. By involving school children in the hand washing campaign, we hope to create a cadre of long-term change agents who promote consistent hand washing in their families and communities.

Health awareness and healthy behaviors are an individual responsibility. One small step – washing one's hands regularly – can translate into a giant step towards dramatically improving health.



MOBILIZING COMMUNITIES TO PROTECT MOTHERS & NEWBORNS

The leading killers of mothers and newborns in Indonesia are conditions that could mostly be addressed through prevention and proper treatment. These include post-partum hemorrhage (which causes 29% of maternal deaths) and neonatal complications such as asphyxia, low birth weight and infection (which cause more than 50% of newborn deaths).

Recognizing that maternal and newborn health needs both individual and collective action, the Ministry of Health developed the *Desa Siaga* approach in 1999 as part of the mother-friendly movement. Short for “a village prepared to assist and protect,” *Desa Siaga*

HSP is assisting MOH to expand the Desa Siaga birth preparedness and complication readiness program to more than 2,000 villages this year.

mobilizes communities to take concrete actions that can save lives.

In 2001, USAID assisted the MOH to strengthen the *Desa Siaga* model. Evaluations conducted by the previous USAID program, MNH, found increases in knowledge about maternal health, and increased utilization of services in cases of maternal emergencies. As a result, the MOH requested HSP assistance to document the model as a training package that could be utilized to roll *Desa Siaga* out nation-wide.

HSP worked with several MOH Directorates to develop a three-module set: one for provincial trainers to train districts, a second for district trainers to train village volunteers, and a third for village volunteers to implement the program. HSP trainers led a four-day training for 92 staff from 33 provinces to utilize the materials. HSP produced 1,300 kits, and gave 670 kits to HSP provinces and districts, and 560 to provinces outside of USAID catchment areas. Seventy kits were distributed to international agencies interested in replicating *Desa Siaga* with their own funds (e.g., World Bank, ADB, AusAID, UNICEF, JICA, UNFPA, GTZ, Ford Foundation, CARE, Save the Children, World Vision, etc.).



Initial feedback is finding district enthusiasm for the approach. District Health Offices from Medan, Deli Serdang and Cianjur have all officially requested HSP technical assistance to help them implement the model with their own funds.

A FATHER “DELIVERS”! COMMUNITY ACTION SAVES LIVES OF A MOTHER AND BABY



bu Dewi is from one of the poorest families in the Petojo Utara neighborhood of Central Jakarta.

Pregnant with her first child, on July 6, 2006, Dewi began to feel uneasy. Sure enough, she was going into labor. As her contractions grew stronger, her husband grew more anxious. Although she had planned to deliver at home, it was clear that the delivery was not going smoothly. Dewi needed immediate help.

The couple lives in a narrow alley, and the nearest clinic was 5 kilometers away. Seeing that there was not a moment to lose, Dewi's husband remembered that

the HSP-supported Community Health Committee had recently offered to help residents receive appropriate delivery care, including providing emergency transportation for maternal emergencies. He hurried off to find them

When Dewi's husband told them about her condition, they leapt into action. One of the vehicles that the committee had secured for emergency use was mobilized, and Mr. Gani, a driver by trade, took the couple to the emergency room where Dewi underwent an emergency Caesarean-section. Weeks later, both mom and baby are doing well.



PROFILE: WEST JAVA BLOOD DONORS SAVE LIVES

Ibu Asih, a 30-year-old mother of two, is pregnant with her third child. This resident of Cianjur, West Java, delivered her first baby with a traditional birth attendant. This year, on Indonesian Independence Day, she and 50 other pregnant women were called together by the Village Health Committee.

“I got a pre-natal exam from the village midwife,” said Ibu Asih. “The village health committee helped me contribute to the village emergency savings fund, and they recorded my blood type in case of an emergency.”

With support from the HSP, Sindangsari village is implementing a national birth preparedness and complication readiness initiative called *Desa Siaga*. The program links the village midwife with pregnant women, and ensures that all families are aware of the systems in place to address maternal emergencies: blood donors, funds and emergency transportation.

While HSP is supporting *Desa Siaga* in all of its target villages, the program is particularly important in West Java,

where use of traditional, untrained birth attendants is prevalent: only 49% of births in West Java are attended by a skilled birth attendant, compared to the national average of 66%.

The village health committee’s efforts focused on blood donors – appropriately, as post-partum hemorrhage is the leading cause of maternal death. Even when women are referred to hospitals, a lack of blood supply is often a barrier to saving lives.

“Giving blood is a simple thing we can do to help others,” said Pak Papar, a volunteer who donated blood during the event, which was co-sponsored with the Indonesia Red Cross (PMI). “Even though only 17 people donated blood today, I think many people are more aware, and would be willing to donate blood should someone need it.”

As for Ibu Asih, she now has a newfound intention to call the midwife for her next delivery. “I still plan to deliver at home,” she said, “but feel more confident that the midwife and my neighbors will support me should anything go wrong.”



WHAT IS DESA SIAGA?

Desa Siaga mobilizes communities to address the key behaviors that have the greatest impact on maternal and neonatal health. The program helps communities address the leading killers of mothers and babies, such as post-partum hemorrhage among women, and neonatal asphyxia, low birth weight and infection among newborns.

In *Siaga* villages, volunteers help ensure that all pregnant women deliver with a skilled midwife, recognize and seek care in the event of an emergency during delivery, immediately breastfeed their baby, and seek post-partum care. Communities provide emergency transport, blood donations and safety net funds for maternal emergencies.

The MOH is expanding *Desa Siaga* to more than 2,000 villages this year. In the photo at left, a village midwife explains the components of *Desa Siaga* using a poster that she received as part of the HSP/MOH-designed *Desa Siaga* training kit.

PROVIDING ASSISTANCE ON TECHNICAL INTERVENTIONS

This year, the Ministry of Health was allocated a tremendous windfall – around \$55 million in additional funding for maternal and child health. As a result, most districts saw a five- to ten-fold increase in the amount of funds available for MNCH programs. Deconcentration (or *Dekon*) is a mechanism that the central government uses to allocate authority and responsibility to the local level for programs that are in the national interest. In 1999, after Indonesia passed Decentralization Law 22/99, the amount of *Dekon* funds increased significantly as the national level transferred power to the districts. However, *Dekon* funds for maternal and child health had never been allocated.

Soon after she was appointed Minister in October 2004, Siti Fadilah Supari, Sp.JP(K), appealed to Parliament



FUNDS FOR MNCH PROGRAMS INCREASE TEN-FOLD

(DPR) about the dire status of infant and maternal health. She told them she needed additional support to meet the country's Millennium Development Goals. From there, advocates from within DPR's Commission IX, which covers health, started lobbying the budget committee to allocate *Dekon* funds for MNCH. Almost everyone was shocked when the state budget was approved in October 2005 – the *Dekon* funds for MNCH were much higher than the Ministry had expected to receive.

Wanting to put the resources to good use, the Directorates of Maternal Health and Child Health developed “menus” of evidence-based interventions that districts could utilize the funds for. At the top of the list was midwife training, *Puskemas* PONE training (basic obstetric and neonatal care), *Desa Siaga* (a community-based

birth preparedness and complication readiness program), and integrated management of childhood illness. Given that these reflected the evidence-based interventions that HSP is trying to promote, the program started an intensive effort to help districts access and utilize the funds.

Foremost among HSP's efforts was assisting the government to articulate the administrative procedures to transfer funds from the national level. Having never worked with *Dekon* funds previously, the Ministry needed assistance to develop a system that reflected the complex policies, laws and systems of decentralized government. HSP facilitated a MOH working group to take on this task, and by April had published the *Minister of Health Decree: Guidelines for Management of MNCH Dekon Funds*. HSP staff held half-day

workshops with district officials, helping them fill out their funding requests. By July, districts had started to utilize the funds – with most HSP districts reporting that they expected to utilize most of the money by December 2006.

HSP also continued to advocate to Parliament to continue *Dekon* funds for MNCH through at least 2010. Through a series of meetings and workshops, HSP has worked with the Indonesia Forum of Parliamentarians for Population and Development (IFPPD) to present the pressing needs of mothers and children. HSP has also persuaded Parliament that there are evidence-based solutions to those problems, and that DPR has a legal responsibility to address them. Our efforts have paid off: it was recently announced that DPR will allocate \$67 million in *Dekon* funds for MNCH in 2007, a 20% increase over 2005 funds.

STRENGTHENING ACCESS AND QUALITY OF VILLAGE MIDWIFE SERVICES

In 1989, the Government of Indonesia embarked on an ambitious plan to deploy 54,000 midwives to provide services at the village level. Still, in 2006 Indonesia's maternal and neonatal mortality rates are among the highest in Southeast Asia, raising questions about the access and quality of midwife services.

In its previous programs, USAID had helped the MOH and the National Clinical Training Network (JNPK) to establish competency-based training programs for village midwives. Under HSP, USAID's efforts have focused on strengthening midwife training materials, and ensuring post-training certification for both the provider and her workplace.

Referencing the short-list of evidence based interventions that the program focuses on, HSP is assisting JNPK to strengthen the Basic Delivery Care (APN) curricula in the areas of active management of the third stage of labor, lactation management, and neonatal resuscitation. APN training is being rolled out at a significant scale with government funds from both national (Dekon) and

provincial-district (APBD) funds. As the APN curricula is updated, HSP will assist JNPK to upgrade the skills of their trainers serving HSP target areas, so that future midwife training covers these important topics.

Additionally, HSP is also assisting JNPK to validate the accreditation of provincial and district clinical training centers (P2KS/P). HSP has provided technical support to develop standards and checklists to certify the classroom and clinical training sites, as well as the advanced trainers, clinical trainers and clinical instructors. The program then partnered with JNPK to accredit training sites and trainers in Aceh, DKI Jakarta (West Jakarta, Central Jakarta), North Sumatra (Deli Serdang, Pematang Siantar), Banten (Tangerang), West Java (Bandung, Cirebon, Cianjur) and East Java (Jember, Malang).

JNPK had already developed standards and protocols for certifying midwives two months after they were trained in APN, but the tools hadn't been properly field tested. This year, HSP assisted JNPK to certify 60 midwives in three provinces



(Aceh, Banten and DKI Jakarta), and helped them revise the certification tools so that they are easier to use. Certification is conducted by District Health Office staff alongside a JNPK trainer and covers two aspects: the qualification of a midwife's skills, and the accreditation of her facility.

In one of HSP's districts, Serang, the DHO was so convinced of the power of post-training certification that they drafted a policy that will require all midwives to be certified in order to retain their license to practice. It is expected that this policy might create a willingness-to-pay among midwives to fund their own certification.

A COMMUNITY TAKES ACTION: RESTORING VILLAGE MIDWIFE SERVICES

Can a community successfully demand their right to health services from the government? In the Serang district of Banten province, they have!

In 1996, villagers from Songgom Jaya used their own funds to build a house and clinic (*Polindes*) for the village midwife to live in. While a series of midwives served the community through 2002, the *Polindes* has been standing empty for six years.

"Our people are poor," said the village head, Bapak Subandi. "We were angry that our health post wasn't being staffed, but we didn't know where to turn."

Located in the Banten province, Songgom Jaya village has a relatively large population – close to 3,800 people.

The transportation cost to the nearest *Puskesmas* health center – Rp. 10,000 – is close to half of the daily average family income. Most Songgom Jaya residents work as farmers or factory workers.



After HSP staff facilitated villagers to conduct a participatory health needs assessment, community members identified the lack of a village midwife as a top priority. HSP assisted the Community Health Committee to bring the problem to the attention of the *Puskesmas* midwife coordinator, Ibu Puji.

Within weeks, the *Polindes* was open and staffed by a midwife who HSP had trained in Basic Delivery Care. The community provided new furniture, and services now include family planning, antenatal care, post-partum care and child health services. The midwife is also on-call to assist home deliveries. On an average Monday, the *Polindes* serves 15-20 clients.

"I am not sure why it took us six years to act," said Bapak Subandi, "but I sure am pleased with the results! Now women and children can get the health services they need, at an affordable cost."

FOCUSING ON THE NEWBORN TO REDUCE IMR

Despite extraordinary improvements in child survival in the past 25 years, advances in neonatal health have not kept pace. At least 36% of under-five deaths in Indonesia occur in the neonatal period; a child's risk of death is 15 times greater in the first month of life than it is at any other time during the first year of life.

USAID gave HSP a strong mandate to improve newborn health. To do so, the program created a strong partnership with the Indonesia Pediatric Association (IDAI). An initial review of IDAI's reference manuals identified that their neonatal protocols and standards were incomplete, and the tools to measure standard performance and quality of care had not yet been developed. Therefore, HSP brought in an internationally-recognized neonatal training team to work with IDAI trainers. A total of 96 pediatricians – including all of the country's neonatologists – received a two-week, practicum-based course in the “Principles of Basic Neonatal Care.” The baseline assessment of these providers' cumulative clinical performance was only 49%, well below the required basic competency (80%) and mastery (100%) levels. This confirmed for HSP and IDAI that before the program could address newborn care at the lower *Puskesmas* and *Polindes* levels, hospital-based teams needed to be strengthened.

HSP and IDAI established a neonatal training working group, and developed a competency-based curricula that covered 48 topics. The program recruited and trained 79 neonatal trainers that consisted of 44 pediatricians and 35 nurses and midwives. Seventy percent of trainers are posted at the district level, while only 30% are from the national and provincial levels. Once these trainers achieved basic competency, HSP supported training, on-the-job training (OJT) and supervision that benefited 263 neonatal unit practitioners who work in 18 provincial and district hospitals across six provinces.

Dramatic improvements were documented during the two-month period the program was evaluated. A 24% and 38% improvement in clinical performance was documented among providers in the Cianjur and Serang district hospitals respectively. Poor clinical performance

was often due to lack of basic equipment and supplies, deficiencies which could sometimes be rectified immediately during the first OJT visit. For example, the administration of the district hospital in Jember, East Java, made immediate improvements—such as outfitting the scrub sinks—that enabled providers to fulfill infection prevention protocols. The hospital director has also allocated \$550,000 of his 2007 budget to build a separate room for the neonatal intensive care unit.

IDAI, JNPK and HSP presented results of the program to the Minister of Health in September 2006. Dr. Fadilah was so impressed that she has since allocated \$440,000 in central-level funds for JNPK and IDAI to replicate the program in four

provinces where neonatal mortality rates are high: NTB, Central and Southeast Sulawesi, West Kalimantan, Maluku and Papua. JNPK has also requested an additional \$225,000 from the MOH to upgrade the skills of obstetricians in the 18 hospitals where HSP has already worked.

HSP also helped to introduce new approaches to post-training support, such as OJT. JNPK is now integrating the standards and methods of the HSP-IDAI neonatal package into its Comprehensive Emergency and Neonatal Care (PONEK) training program, and upgrading its on-the-job training for maternity ward providers to reflect the methods used in the neonatal training program.



District hospital neonatal unit staff receive on-the-job support.

REVITALIZING THE POSYANDU

Indonesia's 200,000 integrated, village-based health posts – *Posyandu* – deteriorated substantially after the economic crisis. Since various studies have shown that the presence of a *Puskesmas* staff at the *Posyandu* helps create demand for services, HSP worked with the MOH to develop a training program to support *Puskesmas* clinics to implement an action plan to revitalize *Posyandu* services, which has since been accredited by the MOH.

The curricula was piloted in 13 districts. During a monitoring team visit by the MOH and HSP to the program in Jember, East Java, evaluators found a high incidence of women receiving antenatal services, including tetanus toxoid immunization,

from the *Posyandu*. They also found that contraceptives, oral rehydration solution, Vitamin A and iron tablets were all available at the health post.

HSP has received several reports of the program being replicated. The Tangerang Kota district has requested the training materials to be used for a training conducted by CARE. The Banten province and East Jakarta district plan to train their Health Promotion staff with the curricula using Dekon funds. Finally, the Directorate of Community Health is now printing new national guidelines for *Posyandu* Revitalization, and has included the HSP training tool in its reference materials. It is anticipated that they will re-print and distribute the materials nationally.

HARNESSING THE COMMERCIAL SECTOR

PROUD TO BE A BIDAN DELIMA

As a group, midwives attend 50 percent of births, and fulfill the lion's share of the nation's family planning needs. They also provide the majority of ante-natal care and post-partum visits to mothers and newborns.

To improve the access and quality of midwife services, the Indonesia Midwives Association (IBI) introduced the Bidan Delima program to increase the professionalism and skills of private practice midwives. Started in 2003 with support from the USAID STARH program, this year saw a tremendous growth in the numbers of Bidan Delima midwives – from 2,000 members in 2005, to 5,400 members in 2006. As national television ads aired about the program, demand among midwives was higher than expected.

IBI only certifies midwives who meet national clinical standards as Bidan

Delima. "Their certification is a guarantee of quality that sets Bidan Delima midwives apart from all the rest," explains Harni Koesno, the President of IBI.

USAID also assisted IBI to develop a national media campaign to strengthen the Bidan Delima brand, and create public demand for the "extraordinary" services that these certified midwives provide. As more customers seek out Bidan Delima midwives for their reproductive health needs, the demand among midwives to become certified is also growing.

Midwife Puji Rochana, who practices in Jakarta, was certified as a Bidan Delima in 2004. She delivers up to 50 babies a month in addition to providing antenatal care, family planning, well-baby care and immunizations.

"After people saw the Bidan Delima TV campaign, my clientele definitely increased," said Ibu Puji. "This month,

I had around 140 visits – that's a 40% increase over what I used to see. My clients are not only from my neighborhood, but they drive from as far away as nine hours to seek my services. They say they feel comfortable with me, and that my clinic is clean and homey."

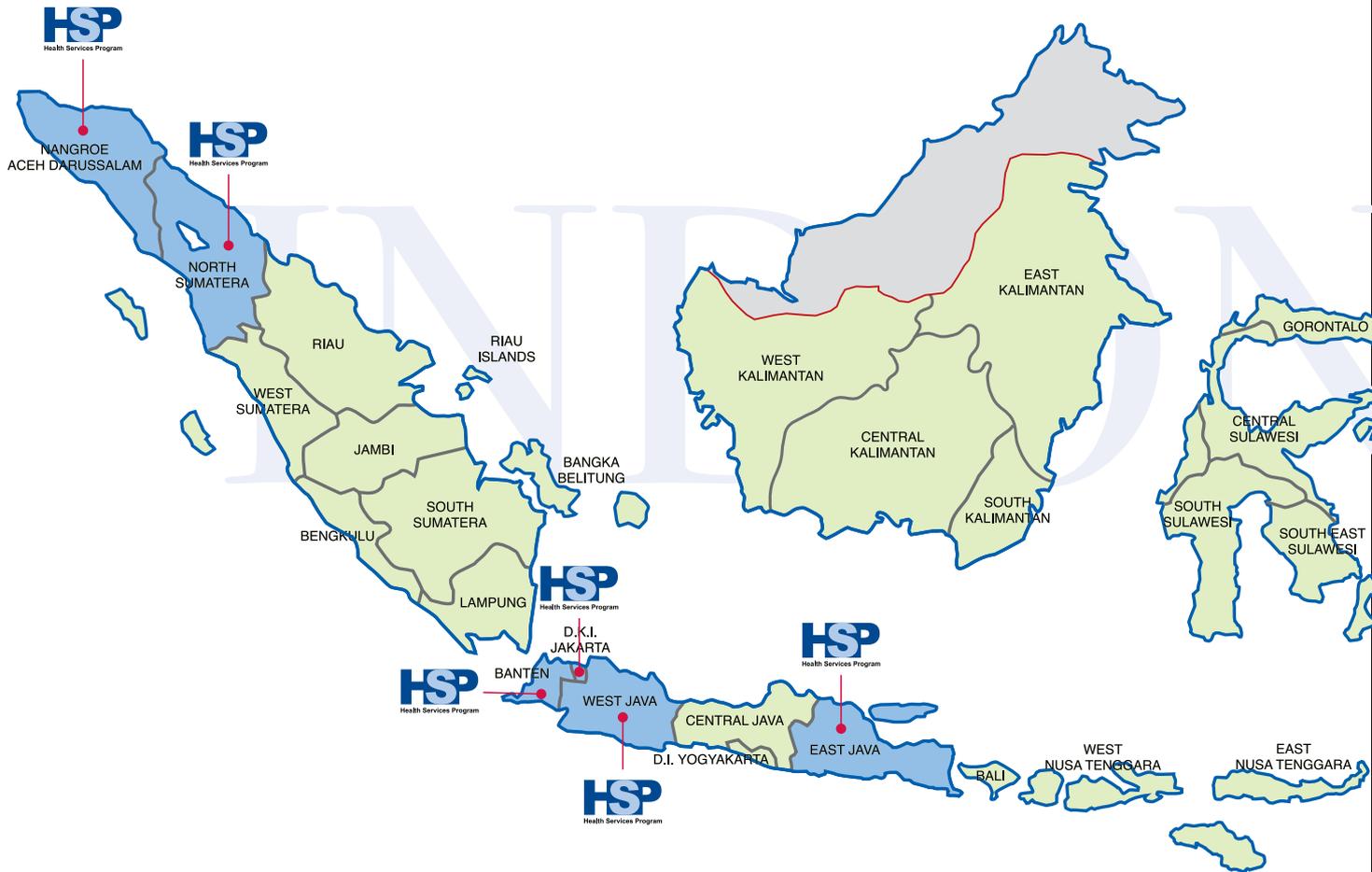
HSP has transitioned technical support for Bidan Delima from the STARH program, which ended this year. The program continues to support improvements IBI's quality assurance system, which ensures that all practicing Bidan Delima continue to maintain the standards IBI has set for them.

HSP is also assisting IBI to expand membership in Bidan Delima. As a private sector program, IBI provides services and benefits to midwives who enroll in Bidan Delima. To register and be validated as a member, midwives pay a fee of Rp. 50,000 (US\$5). If their skills and facility pass the test, they are certified. For an annual fee of Rp. 350,000 (\$39), they receive promotional materials and updated clinical reference manuals, and the right to use the Bidan Delima trademark to advertise their services.

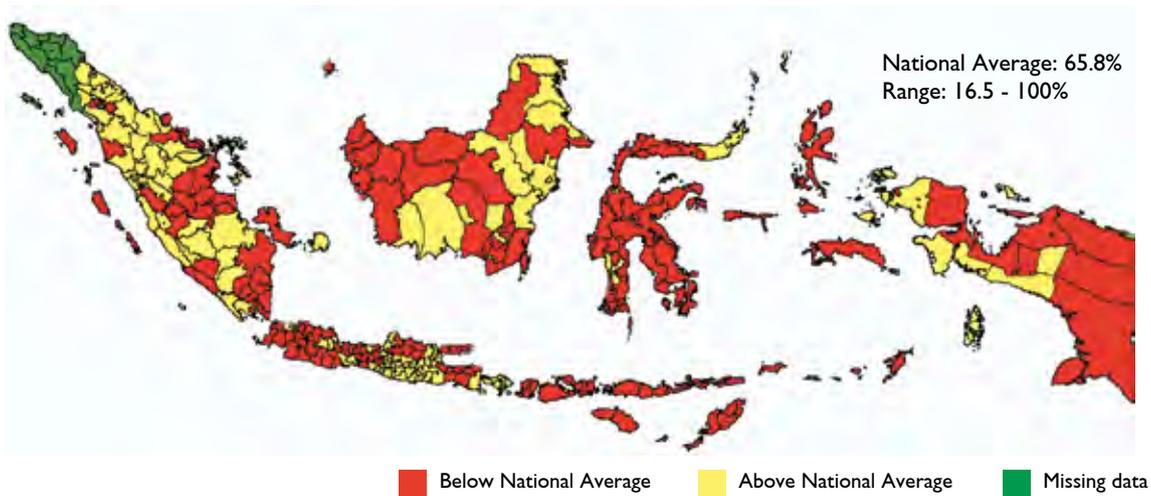
It is IBI's goal to take Bidan Delima nation-wide by 2008. As such, HSP provides support that focuses on the management and financial security of the program. We have helped IBI to do a financial analysis of their "break even" point – how many new members, and what rates of fee collection they need to ensure that the program is financially sustainable. HSP has also helped them to project fee increases to offset inflation, and is assisting them to upgrade their management information system to keep pace with the number of new members being certified. Other sustainability and scale issues such as marketing, continuous quality assurance and seeking private sector support for the promotion of Bidan Delima, are also areas in which HSP will provide technical assistance.



HSP INTERVENTION AREAS



SKILL BIRTH ATTENDANCE BY DISTRICT



Source: Susenas, 2001. "Skilled" is defined as attendance by a midwife, nurse or doctor.

HSP works in six provinces, which represent 43% of Indonesia's population. HSP provides direct assistance to 31 of the 121 districts in those provinces. We also make available technical assistance to replicate our models more broadly within, and outside, of HSP priority provinces.

In the first year of the program, HSP-developed tools – such as the *Training Kit for Implementing Desa Siaga*, the *Basic Neonatal Care Training Protocols* and the *Guidelines for Management of MNCH Dekon Funds* – have been used in all of Indonesia's 33 provinces, including by the USAID-BP Global Development Alliance program in Papua.

POPULATION

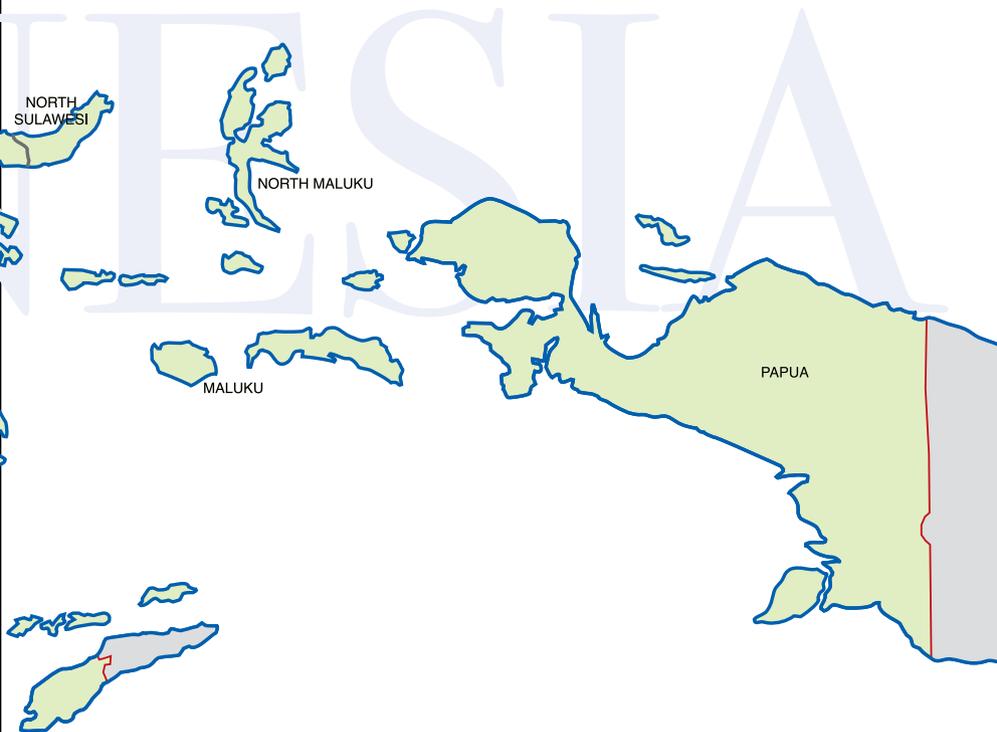
Indonesia	238.452.952
Aceh	4.031.589
North Sumatra	11.649.655
DKI Jakarta	8.389.443
Banten	8.098.780
West Java	35.729.537
East Java	34.783.640
All HSP Provinces	102.682.644

HSP DISTRICTS

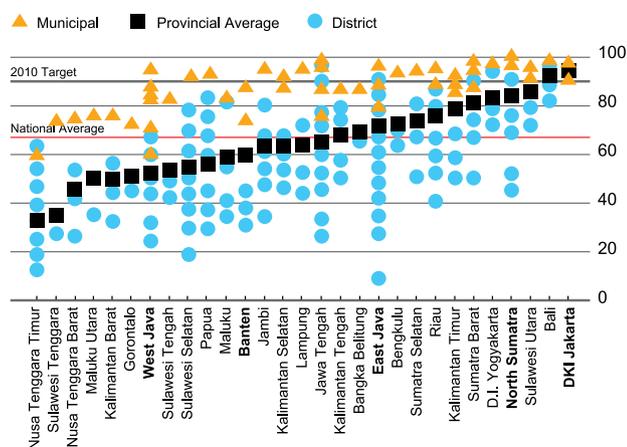
Aceh	4 out of 21
North Sumatra	7 out of 25
DKI Jakarta	2 out of 6
Banten	2 out of 6
West Java	8 out of 25
East Java	8 out of 38

HSP VILLAGES

Aceh	50 villages
North Sumatra	84 villages
DKI Jakarta	14 neighborhoods
Banten	24 villages
West Java	96 villages
East Java	96 villages
Total	364 villages

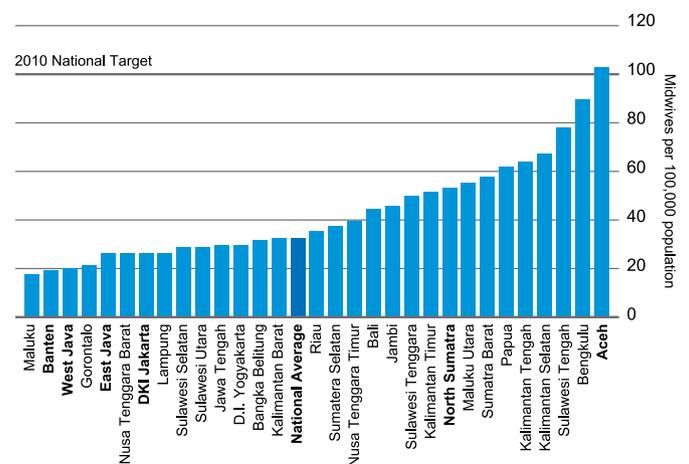


VARIATIONS IN SKILLED BIRTH ATTENDANCE WITHIN PROVINCES



Source: Susenas, 2001. "Skilled" is defined as attendance by a midwife, nurse or doctor.

MIDWIVES PER 100,000 POPULATION, BY PROVINCE



Source: Susenas, 2001. "Skilled" is defined as attendance by a midwife, nurse or doctor.

STRENGTHENING THE DECENTRALIZED HEALTH SYSTEM

INTEGRATED MATERNAL AND CHILD HEALTH DISTRICT PLANNING AND BUDGETING

Since it rapidly decentralized its health system five years ago, Indonesia has exhibited the inevitable tension between local and centralized authority. In the decade before decentralization, Indonesia was on a path towards better health for children under-five and their mothers. But when the country decentralized in 2001, district-level managers assumed the responsibility for planning, budgeting, implementing and monitoring primary health care services, including essential drugs and family planning. While many agree decentralization will eventually translate into increased benefits and accountability, the rapid changes have often led to insufficient local budgets and gaps in oversight, and undermined the availability of basic health services, particularly for the poor.

HSP is working on a number of fronts to improve decentralized MNCH services. Chief among these is work with the District Team Problem Solving (DTPS) approach. In 2004, the WHO introduced DTPS as a way to help district managers implement the Making Pregnancy Safer strategy. The approach centers around a five-day workshop that emphasizes using data, team problem analysis, and planning solutions that reach across sectors. However, since the tool was developed for MPS, its indicators were limited to maternal and neonatal health. HSP is now assisting the Directorate of Child Health to add additional service indicators to the DTPS tool, which is helping infant and child health—including nutrition—receive greater attention and resources.

In 2006, HSP facilitated 90 staff from ten districts to complete their MNCH plan using the DTPS approach. In workshops that included provincial representatives, HSP facilitated stakeholders to identify their priority health problems, and develop a plan to solve them. In addition to using

data to improve program performance, HSP also exposed district teams to the evidence base of interventions that have the biggest impact. The workshop also provided district planners with the skills to advocate for the budget they need once the plan is approved. After the five-day workshop, draft plans go through a review period where broader district and provincial stakeholders provide input.

HSP will soon add drug and commodity management as part of the DTPS

process. Increased stock-outs and quality problems have been the result of limited district experience planning, forecasting, purchasing and budgeting for commodities. HSP is assisting the Directorate of Pharmacy Services – which has existing tools that deal with logistics, supply management, forecasting, etc. – to create consensus on the types of commodities that will be prioritized for MNCH. Issues of MNCH drug supply and health commodity management will then be addressed during the DTPS workshop.

UTILIZING DATA AND A TEAM APPROACH IN SERANG, BANTEN

For years, the Serang district health office (DHO) annual budget was merely an increment over its previous year's allocation. Once a budget was approved, various directorates planned to use their funds without consulting with other departments, much less broader stakeholders.

But in 2006, the MOH and HSP introduced integrated MNCH planning using the DTPS approach in Serang. The district planning bureau (BAPPEDA), district clinical training center (P2KS), professional associations and the DHO itself all participated in the exercise. "This process was a great help to me," commented Dr. Sutadi, one of the workshop participants from the DHO. "The planning process was simple and easy to understand. We used data and a team approach to do our planning."

The method was so useful that Dr. Sutadi intends to use the DTPS approach to assist his 38 Puskesmas clinics to do their annual 2007 planning. Dr. Sutadi was so enthusiastic about DTPS, HSP asked him to be a co-facilitator when the method was introduced in Aceh by HSP.

Through the DTPS process, participants reviewed data and analyzed the MNCH problems their district faces. By the end of the week, stakeholders had agreed on four priorities for 2007: increasing skilled birth attendance, improving the MNCH referral system, better management of delivery complications, and increasing prenatal care visits. As a result, the DHO has proposed a 100% increase in the amount of funds for MNCH in 2007 – raising the total MNCH budget from around \$640,000 to \$1.3 million.

And the DHO is not leaving budget allocation to chance. With HSP's support, they have formed an advocacy working group with members from Parliament, the White Ribbon Alliance, 'Aisyiyah, the district clinical training center, the Indonesia Midwives Association and a local NGO, Yayasan Duafa. Together, this group is working to ensure adequate budget for MNCH.

In the mean time, they have won an interim battle. The DHO has issued a decree to form a cross-directorate planning committee, and have allocated funds to utilize DTPS for their planning next year as well.

BUILDING NGO PARTNERSHIPS



network of constituents, which includes members such as 'Aisyiyah, Fathayat, Muslimat, Wanita Katolik, PWKI, IAKMI, IDI, PKBI, POGI, IBI and the Scouts. She noted that improvements in MNCH would require a broad coalition of stakeholders, and laid out the plans of the MOH.

APPI leaders then launched their new national platform, "zero tolerance for maternal, newborn and child deaths." Workshop participants discussed how to expand affordable, effective practices such as skilled birth attendance, breastfeeding and hand washing through policy reform, awareness raising and mobilization. Success stories included everything from grassroots mobilization to district policy reform to a meeting with the President.

After a training from advocacy experts from the local NGO partner YPRI (*Yayasan Pendidikan Rakyat Indonesia*), provincial and district APPI chapters developed their 2007 advocacy plans. These included plans to lobby local government, utilize the mass media and mobilize public figures to promote their cause.

"On behalf of USAID, we send you our best as you return home to address maternal, newborn and child health at the provincial and district level," said Lynn Adrian, USAID/BHS Director of Health. "If anyone can do it, you can!"

ZERO TOLERANCE FOR MATERNAL & CHILD DEATHS INDONESIA WHITE RIBBON ALLIANCE

The Indonesia White Ribbon Alliance (APPI) is a network of more than 30 nongovernmental organizations that are advocating to policy makers, service providers and the general public about maternal health. In September 2006, with support from HSP, 150 APPI members met to review their advocacy achievements and to set advocacy goals

for 2007. The network also launched the expansion of their mandate to address newborn and child health.

The workshop was opened by the Director General for Community Health, Dr. Sri Astuty S. Soeparmanto, who noted the importance of NGO-government collaboration. Dr. Astuty expressed appreciation for APPI's

SAVING THE LIVES OF 100,000 WOMEN AND CHILDREN

Indonesia's maternal death rate could be reduced by 45% if all births were attended by a skilled health provider, and if every family recognized the danger signs and accessed emergency care when complications arise during delivery. These actions could save the lives of more than 6,500 women and 7,900 babies.

Immediate and exclusive breastfeeding, hand washing and appropriate treatment of childhood diarrhea and respiratory infections, and a full course of immunizations could save the lives of an additional 86,000 newborns and children.

If policy makers, health service providers and communities united to have "zero tolerance for maternal, newborn and child deaths," the deaths of 100,000 Indonesian women and children per year could be averted.



APPI members sign their "Zero Tolerance" commitment.



SPECIAL ASSISTANCE TO ACEH

RESTORING BASIC HEALTH SERVICES FOR MOTHERS AND CHILDREN

Aceh. Who doesn't remember the graphic images of destruction caused by the December 2004 earthquake and tsunami? The human toll of one of the largest-ever natural disasters left 126,000 dead in Indonesia, and 500,000 displaced. The World Bank estimated that the total losses amounted to \$4.5 billion, with livelihoods assets – housing, commerce, agriculture, and fisheries – most greatly affected. The impact on public infrastructure – whose losses total \$1 billion – were also staggering.

The United States committed over US\$400 million in tsunami relief and reconstruction aid to support immediate and long-term recovery in Indonesia. The Health Services Program accounts for \$5.4 million of those funds, with programs that address both maternal and child health, and the psychosocial protection of women and children. The majority of HSP's efforts target the approximately 200,000 people who live along the Banda Aceh-to-Meulaboh road, which is also being rebuilt with USAID support.

Among the first of HSP's efforts was to work with the Provincial Health Office to identify damaged health facilities that had not been repaired by other donors. In the first year of the program, HSP has re-built ten facilities, with a focus on village-based birthing clinics, or *Polindes*, in two districts – Banda Aceh, and Aceh Besar. In those facilities, HSP partners with USAID's Environmental Services Program to ensure water and

sanitation facilities met standards, and with the Safe Water System program to start promotion of a point-of-use water purification product through the midwife. HSP also ensured 36 midwives were trained in normal delivery care (APN), as part of the province-wide effort to support the training of midwives.

Since HSP's assistance, midwives in re-built facilities have covered 100% of families with pre-natal care, delivery services and childhood immunizations. One dramatic story concerns a woman in the Lam Gaboh village in Aceh Besar. Prior to USAID assistance, the village's midwife center sat empty because it had been damaged by the earthquake. After it was re-built with HSP assistance, Midwife Ratna moved back in last January. The first baby born in the facility was named "Usaidi" in honor of USAID.

More recently, Ratna's skills came into play when one of her patients, Yuliana, started to hemorrhage after giving birth. "I had been trained, so I knew what I was seeing," said Ratna. "I set her up on a saline drip, and set off to find a neighbor willing to help transport Yuliana to the hospital."

Amidst a heavy rain storm in the middle of the night, Ratna went door-to-door to find a car for the emergency trip. Soon after setting out, however, the car ran out of gas. Luckily, they were not too far from a private hospital. It was 3:00 am, and Ratna knew that if Yuliana didn't get help soon, she would die. So she convinced the doctor on-



M. Usaidi and his mother.

call to take her patient. Yuliana had already lost a liter of blood, but the hospital was able to stabilize her condition. Two days later she was discharged.

"I remember when I told my father I wanted to be a midwife, I knew I would be called on to save lives," said Ratna. "Even though this case was scary, my training had prepared me well."

HSP HIGHLIGHTS: ACEH

- Completed renovation and equipment of 10 health facilities in two districts
- Trained 36 midwives in basic delivery care
- Formed Community Health Committees in 23 villages
- Launched province-wide hand washing with soap campaign, in collaboration with ESP, CARE and other donors
- Mobilized "Healthy Market" vendor committees in Peunayong market, Banda Aceh
- Assisted health staff from all 21 districts to access and plan for the use of 2006 Dekon funds
- Launched community-based psychosocial activities through 150 volunteers in 30 villages
- Trained 24 nurses in community mental health nursing



The Lam Gaboh village midwife center before renovation...



... and after.



COMMUNITY MENTAL HEALTH PROGRAMS FOR ACEHNESE WOMEN AND CHILDREN

About a year after the tsunami hit, HSP assessed the ongoing psychosocial needs of women and children in Aceh. HSP districts all reported that during the civil conflict, human rights abuses occurred – including torture and sexual assault, physical and emotional abuse, abductions, extortion, and destruction of public facilities. This generated an attitude of fear and mistrust and imposed severe limitations on the civil participation of Acehese women and children, including social interaction, employment, schooling, business, and recreation. The tsunami and its effect on village infrastructure, human resources, economy, health care, education, family networks, and social relations had additional impact on women and children’s psychosocial health.

Broadly, women and children who survived the tsunami could be classified into three categories: those who coped in a positive manner, those who were having difficulty coping, and those who had become dysfunctional given their inability to cope. Most women and children have shown tremendous resilience, drawing on their culture and religion to move beyond the disaster. However, some still show signs of distress, ranging from poor concentration and anxiety to depression and anti-social behavior. A very small number have developed more severe mental illness, which carries great stigma in the community, and which families and the health system are ill-prepared to address.

Most communities – and the government – believed that if community-based women’s organizations were stronger and received targeted support, they would be able to better respond to the needs of vulnerable women and children. In most villages – even those with large numbers of displaced people

– women’s groups meet regularly, usually around religious activities. The aim of HSP is to increase the capacity and resources available to women’s groups to address specific psychosocial needs. HSP is partnering with PULIH, the leading national NGO in community-based mental health services for displaced and disaster-affected communities. To date, PULIH has developed a training series for community volunteers, and recruited thirteen NGOs to assist in supporting the 48 villages that HSP will work in. PULIH and HSP have already recruited and trained 150 volunteers from 30 villages in Banda Aceh, Aceh Besar and Aceh Barat, who are just starting to implement support programs in their home communities. The program aims to empower women at the village level to respond to the psychosocial needs and issues of their peers, with a focus on the most vulnerable women and children.

During the training, domestic violence emerged as one of the most pressing issues facing tsunami-affected women. To address violence against women,

HSP is also supporting PULIH and an Acehese NGO, Rabithah Thaliban Aceh (RTA), to work with religious leaders, who are publishing a twice-monthly bulletin on psychosocial issues such as gender discrimination, child rights, and the Q’uranic basis for gender equity. These materials are being used during workshops with religious leaders, aimed at getting them to incorporate these messages into Friday prayers. Since RTA is part of a strong network of religious education institutions – referred to as *dayah* – in Aceh, they are able to promote that religious leaders play a more active role in the psychosocial protection of women and children.

Over the next year, as villages start to address these difficult issues, HSP and PULIH have created a forum of support between village volunteers and NGOs working on a range of civil society issues – health, political participation, human rights, the performing arts, etc. The idea is that as women identify specific issues that they want to address, they can draw on these resources to support their programs. NGO involvement will provide

PILOTING COMMUNITY-BASED CARE FOR ORPHANED CHILDREN

In consultation with the Department of Social Affairs, HSP has entered into an agreement with Muhammadiyah—Aceh’s largest faith-based organization—to pilot a model of community-based care of orphaned children. There is increasing recognition in Indonesia that institutionalized care of children separated from their parents does not fully meet children’s developmental needs. Aceh provides an excellent opportunity to develop models that can inform the national reallocation of resources towards community-based care.

The Labui children’s center in Aceh Besar is managed by Muhammadiyah. It’s facility was built with funds from UNICEF, and it has 12 enthusiastic, committed volunteers. With both the University of Muhammadiyah Faculty of Public Health and PULIH providing technical support, Labui will be supported to assess the needs of orphaned children who utilize Labui’s services, and then develop a model child center program that will be able to engage with these children’s psychosocial needs and issues.



BUILDING THE CAPACITY OF COMMUNITY MENTAL HEALTH NURSES

The Aceh Provincial Health Office (PHO) started developing a community mental health nursing program with technical support from WHO and the University of Indonesia School of Nursing in 2005. Designed to enable *Puskesmas* nurses to provide mental health services, the program trains nurses to conduct outreach to identify and refer the severely mentally ill for in-patient services at the provincial hospital, and to provide community-based treatment of milder mental illness through an out-patient program at the *Puskesmas*. Although operational for more than a year, donor resources have not yet been enough to move the program past the first of its three phases of training. The PHO, therefore, asked for HSP assistance.

HSP is now working with 12 *Puskesmas* in our three target districts, with plans to expand to a fourth district next year. The 24 nurses trained in the basic level course have identified more than 250 mentally ill individuals, and provided treatment to 111 of them. HSP has been involved in the design of the intermediate-level course, which will provide 200 hours of instruction. Phase I (nursing management) includes three days of classroom instruction and two days of field practice. Phase II (psychosocial nursing care) including six

days of classroom instruction and four days of field practice. Finally Phase III (nursing case management) includes six days in the classroom and four days in the field. Starting in November 2006, HSP intends to train 44 community mental health nurses from 22 *Puskesmas* in Aceh Besar, using strict selection criteria, which will create a district-wide mental health system. HSP then intends to train 24 nurses from an additional 12 *Puskesmas* in other three target districts.

Meetings held to date with *Puskesmas* staff involved in the program consistently find a considerable positive effect on staff who have been trained. Numerous examples of community-level follow up of affected individuals are given. However, despite the encouraging start up of these activities, considerable challenges remain: securing adequate health funding and infrastructure support, the limited education and training of both doctors and nurses, establishing lines of authority and responsibility within the *Puskesmas* and MOH, and developing a viable documentation, monitoring, and reporting system. Still, the Ministry of Health sees the Aceh program as its main opportunity to develop and pilot test a model of community mental health nursing for replication throughout the country.

advocacy, structure, and institutional support to enhance and sustain the activities of women's groups over time. Volunteers will also be able to refer individuals in need of more intensive support to the health system.

In one district, Aceh Besar, HSP is assisting the district to establish a household-to-hospital continuum of care, which will be the first system of its kind in Indonesia. HSP is supporting village-based programming, as described above. We are also ensuring that each sub-district health center has nurses who are trained in community mental health to take on basic referrals that can be managed through community outreach. Finally, HSP also intends to support the development of a psychiatric ward as part of the district hospital, to reduce the burden on the provincial psychiatric hospital.

PROMOTING ENVIRONMENTAL HEALTH IN PEUNAYONG MARKET

In Aceh, HSP is working with the Provincial Health Office to revitalize the role of the sanitarian, the health system personnel responsible for environmental health. Based at the *Puskesmas*, sanitarians are responsible for ensuring that the environment does not adversely impact on community health. They do this by helping communities and the government address issues such as trash management, food safety, clean water, and vectors of infectious disease. As such, traditional markets are a major area for sanitarians to focus their efforts.

Peunayong market is where many Banda Aceh residents and restaurants purchase produce, fish and meat. The market was re-built by CHF International

with funds from AIG. HSP's assistance is now bringing together a multitude of stakeholders to identify and maintain an agreed-upon vision for health and safety in the market community. HSP has organized vendor groups to set and maintain standards of food storage, handling, preparation and display that reduce the risk of food-borne illnesses. HSP also assists vendors to ensure that governmental departments fulfill their public responsibility on issues such as trash removal, water supply, and standards of food handling. HSP is partnering with Muhammadiyah University School of Public Health to provide refresher training for the *Puskesmas* sanitarians responsible for educating vendors and monitoring healthy marketplace practices. The idea is to set



a model that can be replicated across Aceh, with HSP providing support in three additional districts to ensure the health office sanitarians have the capacity to support Healthy Markets in their areas.

Among the many benefits of a healthy marketplace are reduced incidence of food-borne illness and diarrhea, a safer and hygienic environment for market workers, improved relations between stakeholders and increased profit for vendors.

INTEGRATION WITH OTHER USAID/BHS PROGRAMS

USAID ASSISTANCE CREATES SYNERGY IN MEDAN

Three USAID Basic Human Services programs are currently assisting in the Tanjung Mulia sub-district of Medan Deli in Medan. HSP addresses maternal and child health issues among the urban poor in two neighborhoods; Save the Children's Food Security and Nutrition program provides assistance in 15 neighborhoods, and the Safe Water Systems (SWS) program is promoting a point-of-use water purification product in all 21 of the area's neighborhoods. Current USAID assistance builds on previous investments, which included assistance from the Sustaining Technical Achievements in Reproductive Health (STARH) program.

Around 585 families reside in the *Lingkungan 27* neighborhood of Tanjung Mulia, with most families working in nearby iron smelting, rubber and palm oil factories. In March, HSP supported the formation of a Community Health Committee that has undertaken a participatory mapping of health concerns in the neighborhood. The Committee formed four sub-committees to address the most pressing health concerns: under-five nutrition (*Posyandu*), maternal and neonatal health (*Desa Siaga*), environmental health, and community health education.

During a June 2006 visit by the USAID Mission Director, William Frej, the community showcased some of its more recent efforts. The *Desa Siaga* committee brought in the Indonesia Red Cross, which blood-typed over 200 people who volunteered to be blood donors in case of a maternal emergency. The environmental health committee was planning for a series of volunteer clean-up days to rid drainage ditches of trash and debris. The *Posyandu* committee was promoting the sale of the water treatment product, *Air Rahmat*.



United States Consul General in Sumatra, Paul Berg, visits a USAID/BHS site in Medan.

The Medan Deli Puskesmas health center provides health services to more than 92,000 people, including the *Lingkungan 27* neighborhood. For the past seven years, this clinic has been directed by a dynamic doctor, Dr. Lini. Last year, due to her efforts, this *Puskesmas* was upgraded to provide in-patient services, including delivery care. At the time this clinic started providing delivery services, the USAID STARH program provided training and on-site support to ensure infection prevention standards were followed. Since then, HSP has trained three of the center's nine midwives in the 10-day Basic Delivery Care (APN) training.

The Medan Deli Puskesmas oversees the Sidomulyo satellite health clinic (*Pustu*) located about one kilometer from the *Lingkungan 27* neighborhood, which has also benefited from USAID assistance. HSP has trained the *Pustu* nurse, Roidah, in *Posyandu* revitalization; she is also working with Save the Children to manage nutrition posts that rehabilitate malnourished children, and she markets *Air Rahmat* out of her home. The *Pustu*'s midwife, Hadjah Marfuah, has also been trained by HSP, and assists around 15 births per month. During the recent national immunization day, this clinic immunized over 2,500 children against polio.

MAKING A DIFFERENCE IN THE NEIGHBORHOOD

A walk through the neighborhood of Petojo Utara in Central Jakarta showcases the benefits of the \$311 million USAID has provided to support an integrated strategy to improve the quality and access of basic human services in Indonesia.

Petojo Utara is typical of many low-income communities in Jakarta. Populated by about 750 families, around one-third of whom live in poverty, most eke out a living as day laborers, small vendors, or public transport workers. What makes Petojo Utara a good partner for USAID is their locally-elected leader, Pak Irwansyah, a charismatic local business owner who has taken a pro-active role in improving community welfare.

Mercy Corps was the first to enter the Petojo community with a program focused on child nutrition, supported with funds from the USAID Food Security and Nutrition program. Using the Positive

Deviance methodology, community volunteers assess what habits allow poor families to keep their children well-nourished. These habits are promoted through a monthly "hearth" program for malnourished children, where mothers learn new recipes, hygiene habits and ways to treat and feed sick children. Mercy Corps has also supported a food-for-work program that improves sanitation facilities while providing resources to food-insecure households.

HSP built on the volunteers already mobilized for child nutrition to bring attention to the issues during pregnancy and delivery. The Desa Siaga committee has already provided emergency transport to one woman during a childbirth emergency, saving the life of both mother and baby.

The Environmental Services Program (ESP) and Safe Water Systems (SWS) programs address environmental management and water services. ESP

has provided technical assistance as sanitation facilities were improved, and also started a community clean river program. Their efforts also support community-based efforts to separate and compost solid waste. SWS is promoting safe drinking water through various outlets in the community that sell *Air Rahmat*, a point-of-use water purification product that is designed to meet the drinking water needs of poor communities.

Finally, the *Aksi Stop AIDS* (ASA) program is addressing a public health issue that the community is quite concerned about: intravenous drug use. ASA supports harm reduction activities that reduce the spread of HIV, and their NGO partner refers drug users for HIV testing and drug rehabilitation services.

Pak Irwansyah has only praise for the assistance he has received from USAID. "Any time you want to stop by, we'll take you on a walk through our neighborhood!" he says.



USAID Indonesia Mission Director William Frej is briefed on BHS's programs in Medan.



Congressman Robert Wexler gets a traditional Acehnese welcome.



USAID's Environmental Health Advisor, John Borazzo, samples *Air Rahmat* in Petojo Utara.

CONGRESSMAN WEXLER MEETS USAID'S NAMESAKE

"Thank you, America, for making a difference!" said a Village Health Committee member to US Congressional Representative Robert Wexler and his family during a July 2006 visit to Aceh. In the Lam Gaboh village, the Congressman saw integrated USAID/ BHS programs:

- HSP re-built the village health center where the village midwife lives, and trained the midwife in life-saving skills;
- The Environmental Services Program (ESP) upgraded the health center's water system;

- The Safe Water Systems (SWS) program promoted *Air Rahmat*, a safe drinking water product.

The Congressman received a warm welcome from villagers, which showcased a traditional Acehnese welcome dance. Two hundred school children demonstrated how they are using games and communications materials to promote hand washing with soap. The village midwife gave a tour of the village health center, and shared utilization statistics that showed she had delivered all of the babies born in the village since USAID completed reconstruction of her facility.

The midwife also demonstrated the correct use of *Air Rahmat*.

Before leaving, the Congressman visited the home of the mother of the first baby born in the village health center. As is customary in Aceh, the baby was given a meaningful name: in this case, "Usaidi," in appreciation of USAID's assistance in repairing the health center just in time for the baby's birth. The family recounted the birth of Usaidi (born in February 2006), at the health center. The baby's happy, healthy smile was proof of the real difference USAID assistance is making in the lives of Acehnese children.

REPLICATION & SPECIAL ASSIGNMENTS

PROMOTING REPLICATION OF HSP MODELS

The challenges of scaling-up programs in Indonesia are tremendous. With a population of around 225 million, Indonesia boasts more than 300 ethnic groups and 742 languages. The country is the world's 16th-largest in terms of land mass, and consists of over 6,000 inhabited islands. While HSP works in six of Indonesia's largest provinces, its program only directly supports activities in 31 of Indonesia's 498 districts. Therefore, strategies for replication and scale-up must be planned for from the start.

Fortunately, resources for health are expanding. This year, Parliament allocated \$55 million in additional funds for health programming, and intends to increase that amount in 2007. These funds give districts a head start, but the opportunity could easily be lost if they don't invest their funding wisely. Therefore, a main issue is matching districts' interests with the assistance HSP has to offer.

HSP has invested significant resources in our marketing phase – understanding the issues districts face, increasing their technical understanding of the solutions available to solve their problems, and persuading them that HSP has the capacity and the models to assist them. This has been achieved primarily through workshops with key stakeholders at the local level — health office officials, district Parliamentarians, and NGOs. As a result, HSP has fielded requests for technical support from districts trying to implement evidence-based models – foremost among them, Desa Siaga and midwife training.

HSP is also trying to ensure replication by having our evidence-based interventions and models institutionalized as MOH policy. This is why the program emphasizes the improvement of Minimal Service Standards (SPM) and the District Guidelines to Operationalizing

Making Pregnancy Safer. Once these are passed, districts will be held to a higher level of accountability in terms of achieving outcomes.

Other donors – e.g., Asian Development Bank, World Bank, AusAid, the European Union – are also an important replication resource. They offer funding, and have contacts with and influence over the health interests of many non-HSP districts. Through other donors, HSP can obtain a proxy understanding

of what districts want, and can pay for, without visiting many districts individually. HSP can also promote what we offer to other donors through events at the center.

Finally, another key to successful replication is an agent who can manage the transfer of models. HSP is partnering with a range of replication agents that include professional associations, NGOs and even high-performing district and provincial health offices.



THE UNITED STATES NAVAL SHIP MERCY ADDRESSES POLIO REHABILITATION

Faizah was five years old when she was attacked by polio, just a few days before her parents enrolled her in the first grade. Even after receiving treatment from local hospitals, her condition did not improve enough for her parents to allow her to go to school.

During a four-day visit to the US Naval Ship Mercy (USNS), Pak

Subakri, Faizah's father, was coached on what he could do at home to improve Faizah's condition. "I give my greatest thanks," said Pak Subakri. "I feel more motivated, and confident that Faizah's condition will improve enough for her to resume her schooling."

Polio was so close to being globally eradicated that many were shocked when the disease re-emerged. After having been polio-free for a decade,

HSP ASSISTS 13,000 PEOPLE IN EARTHQUAKE-AFFECTED CENTRAL JAVA

In the aftermath of the May 27th earthquake in Yogyakarta and Central Java, USAID asked HSP to support a 45-member medical team to provide mobile health services to one of the most-stricken areas of Klaten, Central Java.

Medical volunteers from the Associations of Pediatricians' (IDAI), Midwives' (IBI), and Nurses' (PPNI), and the Public Health Association (IAKMI) worked alongside Jogonalan Puskesmas staff to provide services to 14 villages. The focus was on immunizing against measles and tetanus, and providing care for common illnesses in the post-emergency environment such as respiratory infections, gastro-intestinal illness, and skin ailments.

From June 7-23, the HSP team provided services to 13,000 people, as follows:

- 10,335 tetanus toxoid immunizations
- 1,635 measles immunizations & Vitamin A
- 1,050 medical consultations & home visits

A HSP staff happened to be in Yogyakarta on the day of the earthquake, and accompanied the president of the Indonesia Obstetric Association (POGI) to assess immediate needs in Yogyakarta, Bantul, Solo and Klaten. HSP then assisted medical associations to coordinate 60 volunteer doctors to provide initial emergency treatment, stabilization and referral of quake victims to Sardjito and Solo hospitals over the three-day period immediately following the earthquake. HSP also helped prioritize needs for medical supplies to ensure that agencies such as the Indonesian Red Cross and UNICEF could target their health supplies effectively.



United States Ambassador to Indonesia, Lynn Pascoe, greets a victim of polio aboard the USNS Mercy.

in 2005 Indonesia recorded its largest polio epidemic ever. East Java, where Faizah is from, represented one-eighth of the 353 polio infections detected in 2005. Indonesia – supported by a range of donors, including USAID – has since executed five national immunization days, mobilizing more than 750,000 health workers to immunize 24 million children against polio. The effort seems to be paying off: only two polio cases have been detected in 2006.

Still, helping children paralyzed by polio remains a challenge. The USNS Mercy training, supported by HSP,

included providers from the East Java Health Office. "This has been a great learning opportunity for me," commented Dr. Kobal Sangaji of the Dr. Sutomo provincial hospital. "Having learned new physiotherapy exercises for children, I am motivated to support local health workers to rehabilitate children affected by polio."

In addition to the work associated with the USNS Mercy, HSP also provides two full-time technical consultants to assist the MOH and the World Health Organization during its National Immunization Days.

MONITORING AND EVALUATION

BASELINE SURVEY RESULTS SHOW MNCH NEEDS STILL HIGH

In November 2005, HSP led an ESP-SWS-HSP working group that collected baseline data to measure 97 key indicators across the USAID/BHS portfolio, with the objective of evaluating program impact at the household level at the end of the program. The survey sampled 7,200 households that had at least one woman with a living child under three years of age. The sample was drawn from 30 districts in six provinces (Aceh, North Sumatra, Banten, Jakarta, West Java, and East Java). Of the 30 districts, 24 were intervention while six were control sites.

Maternal and neonatal health: While 76% of women reported using a modern contraceptive method, around 20% of women stated their last child pregnancy was unplanned. Knowledge about maternal complications was low, with only 16% of mothers able to name at least two different maternal complications. Among those who could name two complications, about half knew where to seek care for treating the complication.

Over 85% of women said they received four antenatal care visits during their last child pregnancy; however, only 59% had received a second tetanus toxoid immunization. Around 40% of women also sought care from a traditional birth attendant. Only 60% of birth deliveries were attended by a health personnel, with the majority of these attended by a midwife. Approximately 40% of women stated they experienced complications during their last delivery. Of women who perceived having complications, only 20% were referred to a higher-level facility for treatment.

Within 28 days of birth delivery, two-thirds of neonates had contact with a health provider, and half (52%) had contact within the first week.

Child health: The incidence of diarrhea among children under-three years of

age was 15% in the past 24 hours, and 28% in the past two weeks. Among young children aged 12-35 months, a quarter had coughing and fever in the past two weeks. A similar treatment-seeking pattern was seen for children suffering from diarrhea, coughing and fever, with few parents seeking medical care or giving medicine.

The survey indicated that only 58% of children ages 12-35 months had received a full course of immunizations before their first birthday. However, approximately 70% of under-three children were reported to have received Vitamin A in the last six months.

Almost all children (97%) had ever been breastfed, and by twelve months of age 87% were still breastfed. However, only 29% of women breastfed within the first hour, and only 15% exclusively breastfed through six months. Moreover, 60% of mothers gave food or liquid to their newborn within the first three days after birth. The most common pre-lacteal food was milk formula, followed by water, honey, and banana.

The survey collected anthropometric data on height and weight of children by age and sex. Of children aged 12-35 months, 33% were under height, 40% under weight and 13% were wasted, indicating malnutrition.

Water treatment, sanitation and hygiene: If piped water, tube wells, protected dug wells, and protected springs are regarded as safe sources of drinking water, overall only two-thirds of households had safe sources of drinking water. Over 95% of households boiled water to make it safe to drink; however only one-quarter of households safely stored drinking water after it was treated. Sixty percent of households had toilets which flushed to a septic tank, while one-fifth of households had no toilet facility.



The practice of hand washing with soap at critical times is still rare. The percentage of women reporting hand washing with soap at one of five critical times (after defecation, after cleaning child's bottom, before feeding child, before preparing food, and before eating) was extremely low – only 6% of women washed their hands before preparing food, and 14% before eating.

Socio-economic differentials: The survey revealed notable socio-economic differentials in health knowledge and access to services. Women and households in urban areas had greater access to services than those in rural areas, and those with greater levels of education also had greater access. The survey found that cost of health services remains a constraint for poor families. However, a reversed pattern of practices emerged for breastfeeding, with urban women more likely to initiate immediate breastfeeding, but less likely to continue with exclusive breastfeeding as compared to women in rural areas and with lower educational levels.

HSP intends to track five indicators annually in 12 districts. These five indicators include prevalence of diarrhea, skilled birth attendance, modern contraceptive use, hand washing with soap and initiation of immediate breastfeeding. An endline survey will be conducted in 2009.

LOOKING FORWARD TO 2007

In 2007, HSP will continue to implement its integrated package of technical assistance, expanding the scale of its programming. A highlight of planned activities follows.

Behavior change communications support:

In 2007, HSP will work with the MOH to design and implement BCC training for partners in 13 districts on one of three key behaviors: skilled birth attendance, breastfeeding, or hand washing.

Mobilize community health committees:

HSP will expand community-level programs to a total of 398 villages, and seek to institutionalize its model within the MOH.

Provide assistance on technical interventions:

HSP will concentrate on a short-list of evidence-based interventions. The program will assist MOH and JNPK to upgrade the midwife training, post-training qualification and supportive supervision systems to reinforce active management of the third stage of labor, neonatal resuscitation and care of low birth-weight babies. HSP will assist MOH to upgrade and institutionalize capacity for integrated management of childhood illness (IMCI), and promote proper care of sick children through the Posyandu. The program will also develop a district-level training program on breastfeeding counseling, and strengthen micronutrient supplementation and nutrition management in the IMCI package.

Conduct advocacy: HSP's advocacy assistance will focus on building district capacity to advocate for adequate budget for MNCH. Support in ensuring that the district legislative and executive branches comply to their legally-mandated responsibility for MNCH will also be provided.

Systems strengthening: HSP will continue to support districts to access Dekon funds, and to conduct integrated maternal and child health planning and budgeting using the DTSP approach. MNCH commodity management will be added to DTSP.

Build NGO partnerships: HSP will continue its work with the Indonesia White Ribbon Alliance (APPI). It will also secure key NGO partners as replication agents for its community mobilization, BCC and advocacy models.

Harness the commercial sector: Support to IBI for the expansion of the Bidan Delima program will continue. The program will also secure at least two partners for public-private partnerships.

Leverage others for replication: HSP will continue to collaborate with the government and other donors that have the capacity to take HSP models nation-wide.

Integrate with other USAID partners: HSP will continue to play a leadership role in developing integrated activities at the community level with other USAID partners.

Special work in Aceh: In addition to the MNCH work already described, HSP will continue its psychosocial programs for women and children in Aceh. We will construct up to ten additional health facilities in tsunami-affected districts along the USAID-sponsored road. We will also continue activities related to the revitalized role of the Puskesmas sanitarian and healthy markets.



HSP'S DRAFT PMP INDICATORS

Indicator	HSP Baseline	HSP 2009 Target
Children less than 36 months of age suffering from diarrhea, last two weeks	28%	18%
Births attended by skilled health personnel	59%	65%
Modern contraceptive use	76%	80%
Caretakers washing their hands with soap, at least three of the five critical times	2%	6%
Initiation of breastfeeding within one hour of delivery	29%	35%

ABBREVIATIONS AND INDONESIAN TERMS

ADB	: Asian Development Bank	IFPPD	: Indonesia Forum of Parliamentarians for Population and Development
AIG	: American International Group	IMC	: International Medical Corp
<i>Air Rahmat</i>	: a point of use water purification product marketed by USAID-SWS program	IMCI	: integrated management of childhood illness
AMTSL	: active management of the third stage of labor	IMR	: infant mortality rate
APBD	: <i>Anggaran Pendapatan dan Belanja Daerah</i> (Government funds available from provincial and district income)	JICA	: Japan International Cooperation Agency
APN	: <i>Asuhan Persalinan Normal</i> (Basic delivery care training for midwives)	LBW	: low birth weight
APPI	: <i>Alliansi Pita Putih Indonesia</i> (Indonesia White Ribbon Alliance)	MNCH	: maternal, neonatal and child health
ARI	: acute respiratory infection	MNH	: Maternal and Neonatal Health (former USAID/Indonesia program)
ASA	: <i>Aksi Stop AIDS</i> (USAID program)	MOH	: Ministry of Health
AusAID	: Australia Agency for International Development	MPS	: Making Pregnancy Safer (MOH strategy)
BAPPEDA	: <i>Badan Perencanaan dan Pembangunan Daerah</i> (Regional Planning Board)	NGO	: non-governmental organization
BAPPENAS	: <i>Badan Perencanaan dan Pembangunan Nasional</i> (National Planning Board)	OJT	: on-the-job training
BCC	: behavior change communication	P2KS	: <i>Pusat Pelatihan Klinis Sekunder</i> (Provincial clinical training center)
BHS	: Basic Human Services (USAID unit)	P2KP	: <i>Pusat Pelatihan Klinis Primer</i> (District clinical training center)
CF	: community facilitator	PKBI	: <i>Perkumpulan Keluarga Berencana Indonesia</i> (Indonesian Family Planning Association)
CHC	: community health committee	PMI	: <i>Palang Merah Indonesia</i> (Indonesia Red Cross)
CHF	: Community Habitat Finance	PMP	: performance management plan
CM	: community mobilization	POGI	: <i>Perkumpulan Obstetri dan Ginekolog Indonesia</i> (Indonesian Obstetric Association)
CWHSP	: Community Water Services and Health project (Asian Development Bank project)	PONED	: <i>Pelayanan Obstetri Neonatal Dasar</i> (Basic Neonatal Obstetric Care)
<i>Dayah</i>	: a religious boarding school	PONEK	: <i>Pelayanan Obstetri Neonatal Komprehensif</i> (Comprehensive Neonatal Obstetric Care)
<i>Dekonsentrasi</i>	: Decentralization funds; central funds allocated by Parliament to ease the burden of decentralization; also referred to as <i>Dekon</i>	PPNI	: <i>Persatuan Perawat Nasional Indonesia</i> (Indonesian National Nurses Association)
<i>Desa Siaga</i>	: Siap Antar Jaga (literally, a village prepared to assist and protect; a national birth preparedness and complication readiness program)	<i>Puskesmas</i>	: <i>Pusat Kesehatan Masyarakat</i> (sub-district health facility)
DHO	: District Health Office	<i>Pustu</i>	: <i>Puskesmas Pembantu</i> (satellite health clinic)
DPR	: <i>Dewan Perwakilan Rakyat</i> (Parliamentary House of Representatives)	PWKI	: <i>Paguyuban Warga Katolik Indonesia</i> (Indonesian Association of Catholics)
DPRD	: <i>Dewan Perwakilan Rakyat Daerah</i> (Local House of Representative)	RTA	: <i>Rabithah Thaliban Aceh</i> , an NGO in Aceh
DTPS	: District Team Problem Solving (WHO-originated budgeting and planning tool)	SPM	: <i>Standar Pelayanan Minimal</i> (Minimum Service Standards)
EBI	: evidence-based intervention	STARH	: Sustaining Technical Advances in Reproductive Health (USAID program)
EPI	: Expanded Program of Immunization	Susenas	: <i>Survei Sosial Ekonomi Nasional</i> (National Social Economic Survey)
ESP	: Environmental Services Program (USAID program)	TT2	: Two doses of tetanus toxoid immunization
FY	: fiscal year	UNICEF	: United Nations Children's Fund
GTZ	: Deutsche Gesellschaft für Technische Zusammenarbeit	UNFPA	: United Nations Population Fund
HIV	: Human Immunodeficiency Virus	US	: United States
HSP	: Health Services Program (USAID program)	USAID	: United States Agency for International Development
IAKMI	: <i>Ikatan Ahli Kesehatan Masyarakat Indonesia</i> (Indonesia Public Health Association)	USNS	: United States Naval Ship
IBI	: <i>Ikatan Bidan Indonesia</i> (Indonesian Midwives Association)	WHO	: World Health Organization
IDI	: <i>Ikatan Dokter Indonesia</i> (Indonesian Medical Doctor Association)	WSLIC-2	: Water and Sanitation for Low-Income Communities, Phase II (World Bank project)
		YPRI	: <i>Yayasan Pendidikan Rakyat Indonesia</i> (Indonesia People's Education Foundation, an NGO based in Yogyakarta)



This report was developed through the Health Services Program (HSP), funded by the United States Agency for International Development (USAID) and implemented by JSI Research & Training Institute, Inc. in conjunction with Abt Associates, Mercy Corps, Manoff Group, and the Pusat Kesejahteraan Keluarga – Universitas Indonesia (PUSKA-UI).

This report is made possible by the generous support of the American people through USAID. The contents are the responsibility of JSI Research & Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States Government.



HEALTH SERVICES PROGRAM
2006 ANNUAL REPORT

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Figures on skilled birth attendance rates on pp. 14-15 reproduced from a presentation made by Dr. Bob Bernstein to the United States Indonesia Society (USINDO) in September 2006.

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