The Management & Leadership Program in Indonesia, 2002–2004

Management Sciences for Health

Final Report

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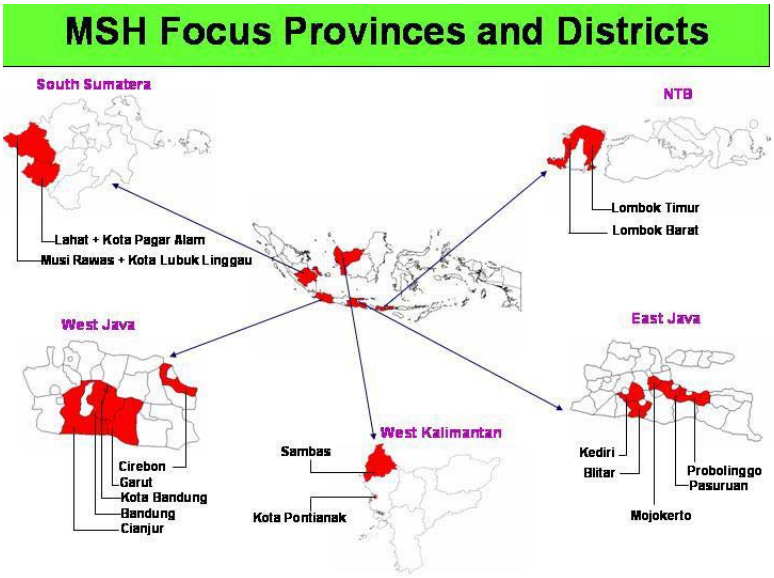


From February 2002 through December 2004, the Management & Leadership (M&L) Program supported decentralization of the health sector in Indonesia to ensure the delivery of basic health services (including family planning) in five provinces and more than 15 districts. In March 2004, the M&L Program began adapting its scope of work to focus on assessing and improving the performance of life-saving maternal and neonatal health (MNH) services to reduce maternal and newborn deaths, in conformance with USAID's new strategy, *Strengthening a Moderate, Stable and Productive Indonesia.* The Program developed a new district/municipal MNH service performance assessment and improvement approach that focuses on reducing maternal and neonatal deaths ("PROSPEK/MNH"). PROSPEK is the Indonesian acronym for the M&L Program's district/municipal performance improvement process.

The results and products described in this brochure were developed, field-tested, and implemented with central, provincial, and local (district and municipal) Government of Indonesia Health Department counterparts in a manner designed to foster institutionalization, expansion, and sustainability. The M&L Program in Indonesia contributed to results—including official ministerial decrees or other publications of the Ministry of Health—in five areas:

- Defining and establishing a legal framework for essential public health services (EPHS) and functions, including family planning, maternal, neonatal, and child health services, and high-priority infectious diseases, and determining minimum service standards;
- Building the capabilities of district/municipal health teams to assess and improve the performance of USAID high-priority health services, including family planning;
- Strengthening the management skills and systems of districts and municipalities;
- Improving district/municipal management of essential drugs, including drugs for tuberculosis, malaria control, and HIV/AIDS;
- Fostering the use of data by district managers to improve the performance of USAID high-priority health services and to advocate for public health funding.

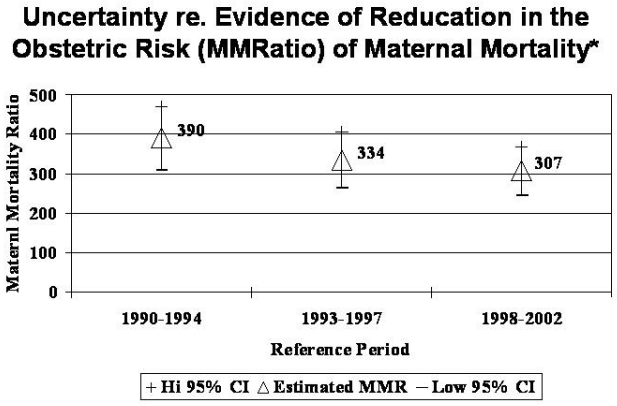
This report includes digital copies on CD-ROM of the results and products, in both English and Bahasa Indonesia.

II. Essential Public Health Services and Management Functions for Districts and Municipalities

- Situation Analysis for Essential Public Health Services, Access to and Use of EPHS, and Health Status
- Situation Analysis for Drug Logistics and Drug Management
- Technical Assistance on EPHS and Essential Public Health Functions
- Technical Assistance on Defining, Implementing, Assessing, and Improving the Performance of Obligatory Functions and EPHS in Accordance with Minimum Service Standards
- Technical Assistance for Ministerial Decrees and Guidelines on Obligatory Functions and Minimum Service Standards
- Technical Assistance for Reviewing and Improving Health Laws

As illustrated in the Figures 1-4, evidence from the Indonesia Demographic and Health Surveys and the annual National Survey of Economic and Social Conditions (Susenas) indicates that high rates of maternal and neonatal mortality are serious, widespread problems. The magnitude, distribution, and persistence of these problems are exacerbated by gaps in the performance of essential MNH and other essential public health services (such as emergency obstetric and neonatal care or EONC services). The data show that these performance gaps predated decentralization.

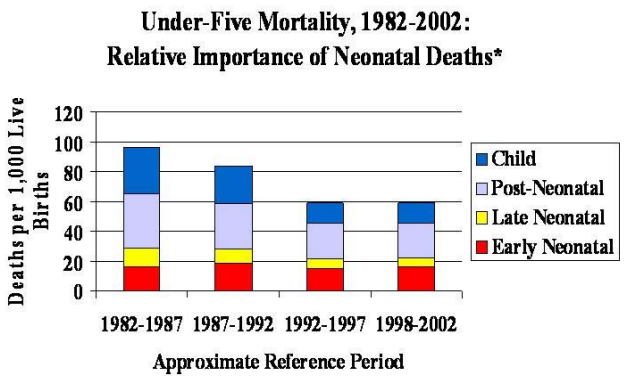
Figure 1



* Source: Indonesia Demographic & Health Survey, Chapter 16 (Adult & Maternal Mortality) and Chapter 10 (Infant & Child Mortality), 2002-2003. "+ Hi 95% CI" and "- Low 95% CI" are the upper and lower ranges of estimated values for the MMRatio -- one can be 95% confident that the true value is between these extremes.

In 1999, Law 22 stipulated that regions have functions and responsibilities in all sectors, except the sectors retained by the central government. Eleven sectors, including health, were identified as "obligatory sectors" to prevent districts and municipalities from neglecting costly functions related to basic services (BKKBN was not included). Although the law addressed the obligation of districts and municipalities to perform functions in specific sectors, the ministries responsible were slow in implementing regulations on obligatory functions. In 2000, a government regulation defined the authorities of the center and the provinces, stipulating that the center is responsible only for issuing guidelines for setting minimum service standards (SPMs) in the obligatory sectors. Local governments asked for clarification, because another regulation stipulates that they must prepare budgets based on performance, including service standards that serve as indicators of accountability.

Figure 2



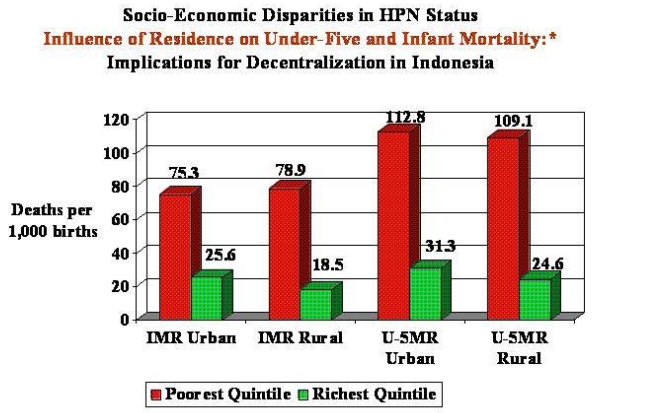
* Source: BPS (Indonesia DHS 1997 & preliminary results from IDHS 2002-2003); Percent Early Neonatal (first 6 days) = 77.2% (2002-2003); 71.3% (1992-1997; 66.2% (1987-1992); and 58.1% (pre-1987)

To provide clarification, the Ministry of Home Affairs issued a letter in July 2002 establishing the principles of obligatory functions and minimum service standards. The M&L Program assisted the MOH to participate in a model-building exercise in the Program's focus districts. This exercise led to a ministerial decree (No. 1457/MenKes/SK/X/2003), "Minimum Service Standards in the Health Sector in Districts and Municipalities," issued on October 10, 2003.

Since the ministerial decree was issued:

- The MOH has followed up by establishing guidelines (decree No. 1091/MENKES/SK/X//2004, issued on October 1, 2004) to help districts and municipalities implement basic health services in accordance with national standards.
- The governors of East and West Java have made decrees to support the MOH's minimum service standards.
- East Java has issued guidelines for district/municipal implementation of basic health services to national standards.
- Districts are setting realistic annual targets as a means of achieving national standards by 2010.

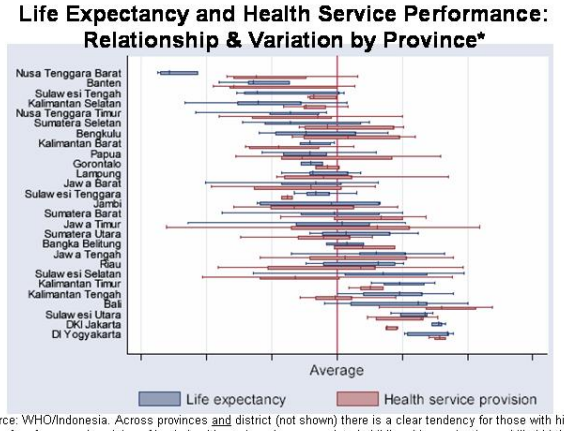
Figure 3



* Source: D.R. Gwatkin et al.: "Socio-Economic Differences in Health, Nutrition, & Population in 44 Countries"; HNP & Poverty Thematic Group; Washington, DC: World Bank and USAID MEASURE Project (MACRO International), May 2000. **"Poorest Quintile" refers to the poorest quintile with reliable data.**

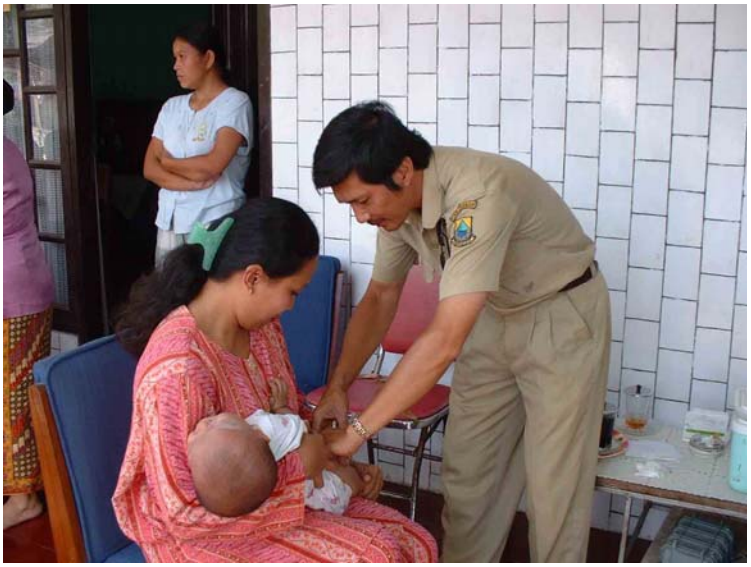
BKKBN transferred authority in January 2004 to all districts/municipalities, and by September 2004, 66% of districts/municipalities had issued laws that establish the local department with authority for family planning and family welfare services, and responsibility for implementing them. With technical assistance from the M&L Program, BKKBN also developed obligatory functions (KWs), basic services for family planning and family welfare, and minimum service standards for districts/municipalities (as well as for provinces and the center itself), and on September 1, 2004, the head of BKKBN issued the decree "Minimum Service Standards for Family Planning and Welfare for Districts and Municipalities" (No. 276/HK-010/B5/2004).

Figure 4



* Source: WHO/Indonesia. Across provinces and district (not shown) there is a clear tendency for those with higher levels of performance/provision of basic health services (e.g., completed childhood immunizations, skilled birth attendance, iodized salt content, access to health facilities, nurses per 100,000 population) to have higher levels of life expectancy. The relationship is significant, even when adjusted for income & education levels.

The M&L Program has developed tools to help districts and municipalities perform basic health services to standards. MSH developed a new rapid assessment methodology for MNH using lot quality assurance sampling and tested it in Kuningan District of West Java in July 2004. USAID partners PATH and JHPIEGO/MNH participated, as did staff from Kuningan's district health office and facilitators trained by MSH from the MOH and nearby Cianjur District. The assessment was followed by district team-building and performance improvement planning for MNH. Based on the assessment, the Kuningan district team selected two priorities for performance improvement: delivery by skilled health providers and management of obstetric complications in EONC facilities.



MSH and STARH have worked closely with BKKBN to develop, test, and implement an *Early Warning and Rapid Response System* that monitors changes in the family planning program associated with the transfer of authority to districts and municipalities. The system relies on regular collection of information from 42 sentinel districts.

III. Performance Improvement of Life-Saving MNH Services and Other Essential Health Services

- Syllabus and Training Documents for Managing the Assessment and Improvement of Performance of Essential Public Health Services at District/Municipal Level (PROSPEK)
- Essential Public Health Service Cost Analysis (Estimating the Cost of Performance Improvement Interventions)

The MOH, with assistance from MSH, is developing the capacity of district health offices to assume more responsibility in the context of the rapid decentralization taking place across most government sectors. This decentralization activity has benefited greatly from the application of Proses Peningkatan Kinerja (PROSPEK), a process that was applied to improve the performance of basic health services and adapted for MNH (PROSPEK/MNH).

Background: Establishment of obligatory functions. The government developed a conceptual and policy framework to guide the health sector in defining and pursuing obligatory functions. Each health function has minimum service standards, often expressed as population coverage indicators and targets. This set of obligatory functions clarifies districts' primary responsibilities in public health and provides the foundation for assessing district service performance and identifying services most needing performance improvement. The MOH will continually review and update the list of obligatory functions and standards to keep pace with the changing epidemiological, social-behavioral, economic, environmental, and political-administrative situation in Indonesia.

Rapid assessment and determination of priority health problems. Participating districts used detailed guidelines, forms, and technical information to carry out PROSPEK. A small group of central and provincial facilitators facilitated their work. In the performance assessment phase, the district teams assembled existing data related to the health problems and services in the list of obligatory health functions and identified 6–10 problems and services that they felt most deserved in-depth performance assessment. The teams conducted rapid assessments to collect data in communities and peripheral facilities to determine the level of performance of the selected essential services and to estimate the extent of the health problems in the districts. The district teams also identified subdistricts or catchment areas that serve the poor and vulnerable in communities in greatest need of performance improvement. The districts then chose the two health problems that most need attention and the related essential

services, which became the focus for performance improvement planning. Examples include management of high-risk pregnant women and management of pneumonia in children under five.

Problem analysis and strategy design. The district teams analyzed the problems, set objectives and targets for district performance improvement, identified resource needs, generated ideas for solving problems, and designed intervention strategies. The diagram on page 8 illustrates the problem analysis and strategy design for PROSPEK/MNH in one district of Indonesia. The team used the selection criteria shown to choose two priority problems: improvement of delivery by skilled health providers and improvement of management of obstetric complications. These were not the services with the largest *performance gaps* but the services the district team believed could be most improved with their limited resources in a short time. The *performance gap* for deliveries attended by a skilled health provider is the difference (43%) between actual performance (32%) and desired coverage (75%). The *performance gap* for management of obstetric complications is (44%), the difference between the actual performance (46%) and the desired coverage (90%).

The teams prepared an implementation plan, budget, and monitoring framework. They also formulated an advocacy plan. The last step was preparing and presenting their proposals. District leaders opened the planning process and attended the closing when the proposals are presented. Facilitators made every effort to engage both political leaders and technical managers in the process, to gain their support from the outset.

Implementation and evaluation phase. The district teams' first activities aimed to mobilize critical resources and obtain community support and participation. In the following year, after receiving allocations from the central government, they began implementing the interventions and using their monitoring procedures.

Results of PROSPEK. In less than two years, the PROSPEK process has enhanced data use as teams collect or assemble, analyze, and present data and use data for decision-making. They also design monitoring and evaluation schemes. The project has engaged 15 districts from five provinces of the country in PROSPEK, and the methodology is being used in schools of public health. Other implementing agencies of USAID and other donors are funding expansion of the process in the provinces and districts they assist. The MOH is seeking to institutionalize the PROSPEK process for performance improvement in the health system.

During the initial implementation of PROSPEK for Basic Health Services, 12 of 13 focus districts/municipalities selected MNH as one of the two highest-priority health programs for performance improvement. However, some of the planned interventions were not cost-effective in reducing maternal or neonatal mortality. Internationally accepted life-saving MNH services alone number almost 30. District and municipal teams therefore needed more guidance in setting priorities based on evidence and in advocating for the resources needed to improve essential MNH services (especially EONC services).

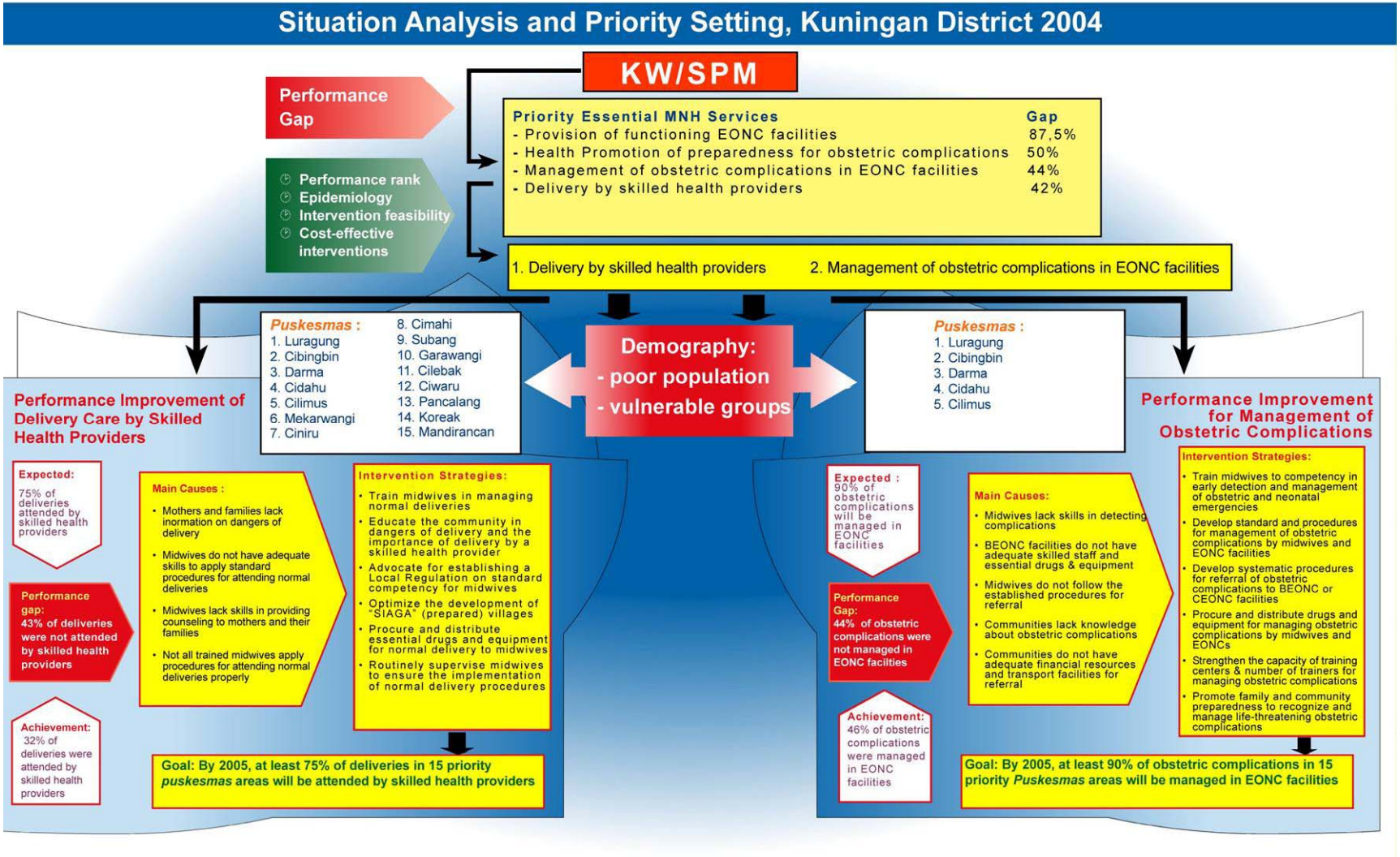
Performance assessment and improvement planning for MNH focused on cost-effective services to reduce maternal and neonatal deaths (see section V for a description of the M&L Program's new rapid assessment of life-saving MNH services). PROSPEK/ MNH is also being expanded and institutionalized:

- An additional 71 participants were trained in PROSPEK facilitation: 42 from provincial health offices; 2 from district/municipal health offices; 22 from the MOH; 2 from the Center for Health Training; and 3 from other implementing agencies.

- The MOH, using World Bank funds, is supporting expansion of PROSPEK in M&L focus provinces, as are the Asian Development Bank in Riau Province; the European Union in Papua, South Sumatra, and Jambi; and GTZ in NTT and NTB.

- The MOH has published and distributed the PROSPEK syllabus to all provincial and district/municipal health offices.

- PROSPEK/MNH was conducted in Kuningan and Pacitan districts. Results from Kuningan follow on p. 8.


Situation Analysis and Priority Setting, Kuningan District 2004
KW/SPM
Performance Gap
Performance rank
Epidemiology
Intervention feasibility
Cost-effective interventions
Priority Essential MNH Services
Gap
- Provision of functioning EONC facilities
87,5%
- Health Promotion of preparedness for obstetric complications
50%
- Management of obstetric complications in EONC facilities
44%
- Delivery by skilled health providers
42%
1. Delivery by skilled health providers
2. Management of obstetric complications in EONC facilities
Puskesmas :
1. Luragung
2. Cibingbin
3. Darma
4. Cidahu
5. Cilimus
6. Mekarwangi
7. Ciniru
8. Cimahi
9. Subang
10. Garawangi
11. Cilebak
12. Ciwaru
13. Pancalang
14. Koreak
15. Mandirancan
Demography:
- poor population
- vulnerable groups
Puskesmas :
1. Luragung
2. Cibingbin
3. Darma
4. Cidahu
5. Cilimus
Performance Improvement of Delivery Care by Skilled Health Providers
Expected:
75% of deliveries attended by skilled health providers
Performance gap:
43% of deliveries were not attended by skilled health providers
Achievement:
32% of deliveries were attended by skilled health providers
Main Causes :
• Mothers and families lack inormation on dangers of delivery
• Midwives do not have adequate skills to apply standard procedures for attending normal deliveries
• Midwives lack skills in providing counseling to mothers and their families
• Not all trained midwives apply procedures for attending normal deliveries properly
Intervention Strategies:
• Train midwives in managing normal deliveries
• Educate the community in dangers of delivery and the importance of delivery by a skilled health provider
• Advocate for establishing a Local Regulation on standard competency for midwives
• Optimize the development of "SIAGA" (prepared) villages
• Procure and distribute essential drugs and equipment for normal delivery to midwives
• Routinely supervise midwives to ensure the implementation of normal delivery procedures
Goal: By 2005, at least 75% of deliveries in 15 priority puskesmas areas will be attended by skilled health providers
Performance Improvement for Management of Obstetric Complications
Expected :
90% of obstetric complications will be managed in EONC facilities
Performance Gap:
44% of obstetric complications were not managed in EONC facilties
Achievement:
46% of obstetric complications were managed in EONC facilities
Main Causes:
• Midwives lack skills in detecting complications
• BEONC facilities do not have adequate skilled staff and essential drugs & equipment
• Midwives do not follow the established procedures for referral
• Communities lack knowledge about obstetric complications
• Communities do not have adequate financial resources and transport facilities for referral
Intervention Strategies:
• Train midwives to competency in early detection and management of obstetric and neonatal emergencies
• Develop standard and procedures for management of obstetric complications by midwives and EONC facilities
• Develop systematic procedures for referral of obstetric complications to BEONC or CEONC facilities
• Procure and distribute drugs and equipment for managing obstetric complications by midwives and EONCs
• Strengthen the capacity of training centers & number of trainers for managing obstetric complications
• Promote family and community preparedness to recognize and manage life-threatening obstetric complications
Goal: By 2005, at least 90% of obstetric complications in 15 priority Puskesmas areas will be managed in EONC facilities

IV. Provision of Essential Drugs and Commodities at Health Centers

- Guidelines and Training Materials on Drug Management and Logistics
- Drug Management Newsletters
- Pharmaco-Economics materials

Maternal, newborn, and child health services are not effective unless essential drugs, vaccines, and family planning commodities are available at health centers. The M&L Program has focused on drug management for national programs, such as TB and malaria control, and HIV/AIDS, and district procurement and distribution to address the need for a more reliable drug supply at health centers *(puskesmas)*. MSH, with its local subcontractor MJM, has developed and distributed the following manuals, and trained staff.

- *District Level Assessment Tool (DLAT) for Drug Management* (a methodology for measuring drug management performance in districts and municipalities)
- *Malaria Drug Assessment Manual (MAT)*
- *Drug Logistics System for TB Drugs*
- *TB Drug Puskesmas Dispensing Manual*
- *TB Drug Dispensing Manual for Fixed Dose Combinations (FDCs) at District Pharmaceutical Warehouses (GFK) and Puskesmas*
- *Training of Trainers Manual for TB Drugs*
- *Training Manual for Districts in Use of TB FDCs*
- *Pintu Mas Methodology of Pharmaceutical Service Improvement*

In addition, the M&L Program and MJM produced several important presentations and reports:

- "Review and Assessment of Vitamin A Program Drug Supply"
- "Monitoring of Global Drug Facility–Supplied TB drugs"
- "Review of Situation on Taxation of Drugs in Indonesia"
- "Review of Malaria Drug Situation at Puskesmas and Malaria Posts"
- "Discussion Document on Development of National Drug Policy"

Many local staff have been trained to better manage essential drugs and commodities, and national programs have been strengthened to support districts and municipalities.

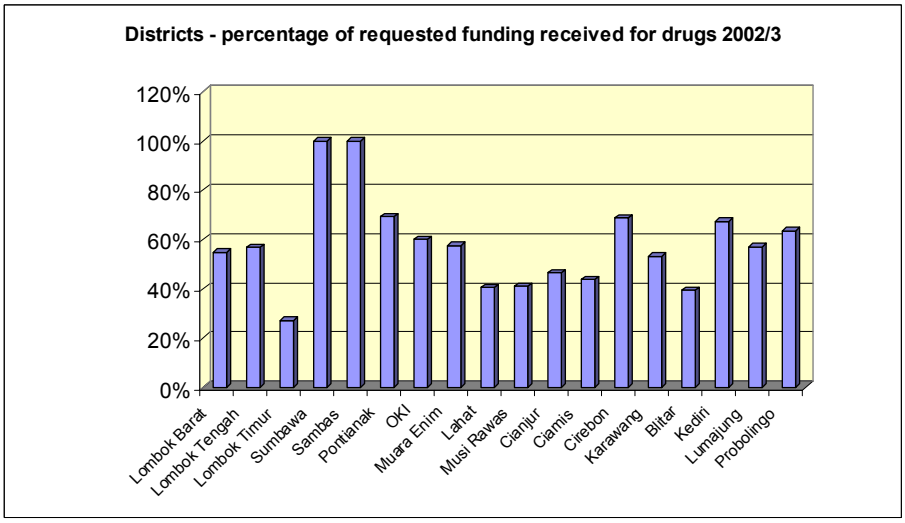
Training

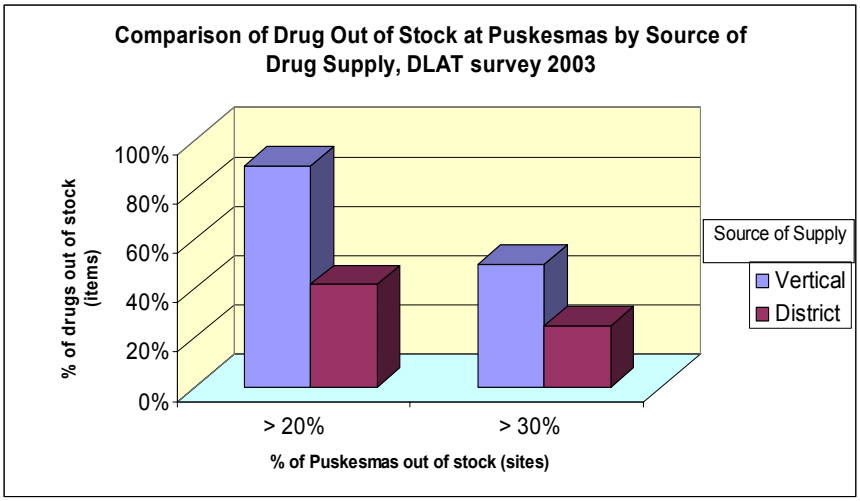
Subject Area	Provinces	Districts	Total Participants
Training of trainers on TB drugs, for provincial staff	4		40
Training of districts in using and dispensing new FDC drugs for TB; training by trainers from province and center	1 1	8 20	60 180
Support to data collectors for WHO drug price survey	2	4	10
DLAT 2 training workshops for districts	5	24	100
Pintu Mas pharmaceutical performance improvement	2	8	51

The Department of Pharmacy at the Ministry of Health (YanFar) has conducted more than eight major workshops and produced two major manuals on drug management with technical assistance from MSH. They are now beginning to emerge as a significant player in developing public-sector drug supply and are increasingly seeking to use evidence-based decision making for policy and systems development. Although still at an early stage, such development provides positive indication of a degree of sustainability for ongoing improvements in provision of drugs.

Results of measurements in districts, combined with data collected by YanFar, indicate that most district drug units are receiving only a fraction of the funding that they calculate they require for their annual drug needs.

In response to this situation, YanFar, supported by MSH, has promoted the establishment of an initial target minimum expenditure level of Rp 5,000 (US $0.45) per capita on essential drugs by districts and developed preliminary methods and systems for advocacy by district drug units to achieve their required funding levels from district parliaments.



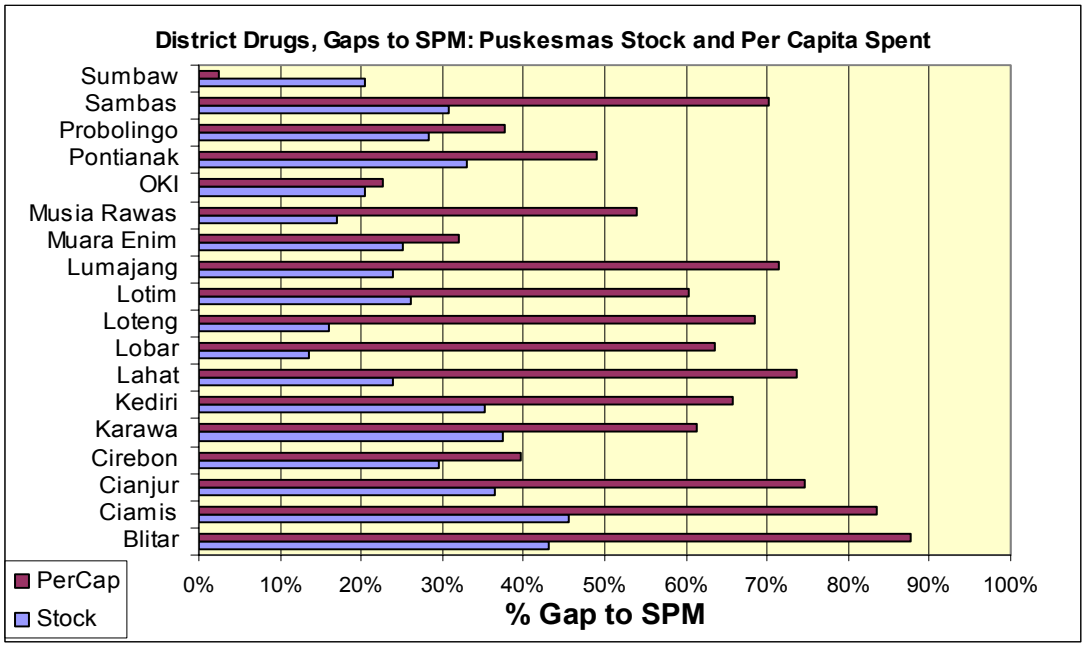


Results from the District-level Assessment Tool (DLAT) for drugs, along with conclusions of the large-scale consultative workshops undertaken by YanFar, identified the drugs supplied by vertical programs as the largest source of drug shortages at health centers.

There is now evidence that the extensive work undertaken with the TB and malaria control and vitamin A programs is starting to improve the reliability of drug availability at health centers, both directly, as demonstrated by TB drug availability during the reporting period, and indirectly, by sensitizing other vertical programs to the need for effective drug management. The TB Control Program has a highly ambitious plan to increase the case detection rate from less than 18% in 2002 to 70% by 2005, which has required a massive and very rapid restructuring of their drug planning and supply systems. In mid-2004 a potential crisis was averted when the province with the highest case load, which had procured on its own an entire year's supply of anti-TB drugs, had to withdraw the drugs because of quality problems. Emergency planning introduced by MSH had established a national buffer stock of anti-TB drugs,

so the newly strengthened supply system could respond immediately and provide the province with quality-controlled replacement drugs and thus ensure an uninterrupted supply to patients.

Pintu Mas (Golden Gate), a method of performance improvement for drug management at the district level, has been enthusiastically received. The key feature of Pintu Mas is that districts formally assume the entire responsibility for drug availability at health centers, regardless of the source of drug supply or funding, and seek to integrate all drug activities. In the first phase of the Pintu Mas approach, the gaps between the observed level of drug activity and the minimum service standards (SPMs) are measured. Huge variations between districts were observed. For example, Sumbawa District is spending close to the recommended per capita level of Rp 5,000, so it has only a small performance gap for this measure, but it is still about 20% below the target for achieving the standard of 90% of drugs available at puskesmas. In contrast, per capita drug spending in Blitar is 85% below the target level, and drug availability is some 40% below the standard.



In the next phase of Pintu Mas, districts and municipalities undertake planning to improve the performance of pharmaceutical management. Eight focus districts did this planning 2003-2004 and produced plans for achieving the SPM targets. The range of these plans reflects the huge diversity in current achievements amongst districts. For example, Probolinggo District has estimated that it will need to achieve a per capita drug spending level of Rp 9,000 to realize its plans, whereas Lumajang District estimates that it needs a per capita level of Rp 5,000. All districts, however, agree on the need to acquire skills in advocacy and drug management.

District	Per Capita Drug Spending in Rp, District Funds Only (2003)	% of Tracer Drug List in Stock at Puskesmas	Performance Plan Improvement to Meet SPM Targets by 2010	
			Planned Per Capita Spending, 2010 Rp	Plan Requirements
Probolinggo	2,500	72%	9,000	• Compilation of data • Integration of drug supply at district level • Advocacy skills to obtain funding • Strengthening of drug management skills
Lumajang	1,600	76%	5,000	
Mojokerto	1,200		5,000	
Kediri	1,400	65%	5,000	
Blitar	700	57%		
Pasuran	1,650		10,000	
Lotim	3,000	74%	5,000	
Lobar	2,000	86%	5,000	

There are encouraging signs of sustainable activity by YanFar to strengthen drug management systems and improve the availability of drugs at health centers. The successes surrounding improvements in the TB drug supply have led other vertical programs to start to recognize their drug deficiencies and to seek technical assistance to improve their performance. Target districts have embarked upon a process of performance improvement for drug management in which they assume responsibility for the total drug supply to puskesmas.

V. Information to Plan, Manage, and Implement Life-Saving MNH Services and Other Essential Health Services

- Drug Logistics Assessment Tool
- Lot Quality Assurance Sampling (LQAS) Survey Method for Assessing the Performance of and Prioritizing MNH Services and Other EPHS for Improvement
- BKKBN Early Warning and Rapid Response System
- Evaluation of the Surveillance and Response System for Communicable Diseases of High Priority to the MOH and USAID

In 2004, after publication of a ministerial decree and *Guidelines for Surveillance and Response* under decentralization, the M&L Program provided technical assistance to the MOH and WHO for a national assessment of the Surveillance and Response System. The performance of the system was assessed at the provincial and district levels in eight provinces (North Sumatra, West Java, East Java, East Kalimantan, NTB, South Sulawesi, Papua, and North Maluku). Seven of the eight provinces are of high priority or special interest to USAID. As expected from MSH's experience over the past two years, the results revealed major, widespread gaps and conflicts in the policies and laws, organizational structure, operation, and training necessary for an efficient and effective system capable of protecting the public's health and providing evidence for assessing and improving the performance of public health programs under decentralization. The roles of provinces and laboratories, early warning capacity, and especially evidence-based responses were found to be insufficient and inadequate. The M&L Program continued to work with district teams to improve surveillance activities for their highest-priority services as determined in 2003, but because the M&L Program was shortened by nine months, the focus was limited to surveillance and response related to life-saving MNH services and functions.

The purpose of M&L's new rapid assessment tool (*Assessing the Performance of Essential Maternal and Neonatal Health Services at the District Level: Focus on Cost-Effective MNH Services for Reducing Maternal and Neonatal Mortality*) is to monitor performance improvement

of MNH services that re most cost-effective in reducing maternal and neonatal deaths and the functional status of basic and comprehensive emergency obstetric and neonatal care (BEONC and CEONC) facilities. District and municipal team conduct the assessments themselves following training in using PROSPEK/MNH by MSH staff or other trained facilitators. As a result of the MNH assessment, district and municipal health offices identified performance gaps in MNH services and catchment areas and established priorities for improving those services.

The assessment uses Lot Quality Assurance Sampling (LQAS) of midwives and mothers who delivered in the past year, and an evaluation of the functional status of BEONC and CEONC facilitities. It includes five indicators from the *Safe Motherhood Needs Assessment* developed by WHO, UNFPA, and UNICEF, plus seven others from MEASURE and other interagency working groups. The survey can be completed and the data analyzed and reported in about five days.

Results from Kuningan District in West Java showed that access to BEONCs and the functional status of BEONCs and CEONCs did not meet the district's targets. The proportion of village midwives who had essential drugs and in-service training in life-saving skills did not meet targets either. Only 10% of mothers had made preparations for addressing obstetric emergencies and, in about half of the district sample, targets for neonatal exams within 7 days of birth were not met. There are similar results from a more recent MNH assessment in Pacitan District of East Java, where M&L is linking MNH performance improvement to the peformance-based planning activities of PERFORM.

Decentralized district health offices can use evidence and information from these rapid, inexpensive LQAS surveys to monitor progress, set priorities, design interventions, and improve essential MNH services. Even Pacitan, a lower performing district with very hard-to-reach areas, has demonstrated that its district health staff can be quickly trained and rapidly carry out the assessment within five days (see the results from the Kuningan and Pacitan assessments, below).

Summary of Results from Rapid Assessments of the Performance of Essential Maternal and Neonatal Health Services in Kuningan and Pacitan Districts, 2004					
No.	**Essential MNH Service Performance Indicator**	**National (MOH) & WHO Targets**	**District Targets**	**District Results**	**Target Met?**
1	Case fatality rate among women whose obstetric complications were managed in EONC facilities (%)	<1% (MOH and WHO)	<2.0% (K & P)	0.2% (K) 1.1% (P)	Yes (K) Yes (P)
2	Percent of pregnant women attended who received at least two doses of tetanus toxoid	95% (MOH) 100% (WHO)	80% (K) 90% (P)	88% (K) 93% (P)	Yes (K) Yes (P)
3	Percent of deliveries attended by trained health providers	90% (MOH) 100% (WHO)	80% (K) 90% (P)	86% (K) 94% (P)	Yes (K) Yes (P)
4	Percent of women with life-threatening complications of pregnancy, delivery, postpartum managed in EONC facilities	100% (MOH and WHO)	100% (K) 100% (P)	46% (K) 18% (P)	**No (K)** **No (P)**
5	Percent of live births in the population delivered by cesarean section	≥5% but <15% (MOH and WHO)	5-15% (K/P)	5.8% (K) 0.7% (P)	Yes (K) **No (P)**
6	Percent of neonates who had contact with health providers at least once in days 1-7 after birth	90% (MOH)	90% (K/P)	65% (K) 66% (P)	**No (K)** **No (P)**
7	Number of functioning BEONC facilities per 500,000 people in the district/city	4/district (MOH) 4/500,000 (WHO)	4/500,000 (K) 3/district (P)	0.5 (K) 1 (P)	**No (K)** **No (P)**
8	Number of functioning CEONC facilities per 500,000 people in the district/city	ea district hosp (MOH) 1/500,000 (WHO)	1 /500,000 (K/P)	1 (K) 1 (P)	Yes (K) Yes (P)
9	Percent of village midwives who possess all 4 essential tracer drugs for managing maternal complications (parenteral oxytocin, MgSO4, diazepam, and penicillin or ampicillin)	Not specified	80% (K) 100% (P)	Not met (K/P)	**No (K)** **No (P)**
10	Percent of village midwives who possess a neonatal resuscitator for managing newborns with asphyxia	Not specified	50% (K) 75% (P)	Met (K) Not met (P)	Yes (K) **No (P)**
11	Percent of village midwives who had in-service training in managing life-threatening complications of pregnancy, delivery, and postpartum	Not specified	90% (K) 50% (P)	Not met (K) Met (P)	**No (K)** Yes (P)
12	Percent mothers who can voluntarily name all 4 types of plans/preparations for managing life-threatening complications of pregnancy, delivery, and postpartum	Not specified (the following are IDHS 2002 results for "topic discussed," not for "planned/prepared")	60% (K) 50% (P)		
	- notify doctor, midwife, nurse	---	"		
	- plan/prepare transportation	38% (10-65%)	"		
	- plan/prepare blood donors	8% (3-31%)	"		
	- plan/prepare finance	61% (48-81%)	"		
	All four plans/preparations (SIAGA family)	no more than 3-31%	"	10% (K) 23% (P)	**No (K)** **No (P)**

Notes: "K" = Kuningan, West Java, and "P" = Pacitan, East Java; "IDHS" = Indonesia Demographic & Health Survey; and "SIAGA" = prepared

MSH has worked closely with a team at BKKBN and STARH to develop and implement an *Early Warning and Rapid Response System*. The system includes a set of 30 indicators of potential problems related to BKKBN's transfer of authority to districts/municipalities and provides information on policy, management, and service delivery conditions.

Routine data collection has been successfully implemented since May 2004. There are approximately 850 key informants from 42 districts. Data have been collected from over 80% of the informants from over 90% of the districts. BKKBN prepared feedback reports and sent them to stakeholders and to all 420 districts in the country.

The first three months of implementation revealed that:

- remote islands of Indonesia may be experiencing shortages in family planning commodities, especially IUDs;
- decentralization has apparently not led to dramatic increases in the user fees for family planning services or the prices of contraceptives;
- contraceptive side effects and the unavailability of supplies are the main complaints about the family planning program.

The early warning system is providing valuable information, especially on the availability and accessibility of family planning services. The system is also helping national managers to adapt and redefine their roles and responsibilities in the decentralized environment.

VI. Leveraging, Cost-Sharing, and Synergies

- AusAID Healthy Mothers and Healthy Babies (Southeast Sulawesi)
- Asian Development Bank/DHS (Riau)
- World Bank/PHP (West Java)
- GTZ/SisKes (NTT and NTB)
- PERFORM (Pacitan and Probolinggo, East Java)
- BIGG (Probolinggo, East Java)
- European Union/SCHS (Papua, South Sumatra, Jambi)

During implementation of its program of technical assistance for decentralization and the improvement of MNH and other EPHS, the MSH M&L Program has successfully leveraged additional resources and participated in cost-sharing and synergistic activities with other MOH Partners-in-Health. For example:

- The AusAID Program of Healthy Mothers and Healthy Babies was able to streamline the District Health Information System in several areas of Southeast Sulawesi Province with technical assistance from MSH.
- The MOH is using World Bank Provincial Health Project (WB/PHP II) funds to orient new provinces and expand PROSPEK to 20 new districts/municipalities in USAID high-priority provinces and provinces of special interest.
- The Directorate of Community Nutrition at the MOH has selected PROSPEK as its method of technical assistance to districts and municipalities for improving performance. MSH trained facilitators in October 2004.
- At the request of Riau Province and the ADB/DHS Executive Secretary, MSH trained provincial facilitators, who will expand PROSPEK to Riau's districts and municipalities with ADB/DHS I funds.
- MSH has trained provincial staff from the EU-funded Strengthening Community Health Services project in Papua, South Sumatra, and Jambi to facilitate PROSPEK in its three focus

provinces. The project is awaiting approval of its work plans.
- MSH has oriented GTZ/Siskes staff to PROSPEK. GTZ/Siskes is planning expansion in NTT and NTB.
- MSH and STARH have jointly planned and budgeted technical assistance to BKKBN for development and implementation of an Early Warning and Rapid Response System.
- MSH has developed a rapid assessment for life-saving MNH services with support and technical assistance from PATH and JHPIEGO/MNH.
- MSH, PERFORM, and BIGG have planned and coordinated technical assistance in selected districts of East Java to establish links between PROSPEK/MNH, and annual and mid-term performance-based planning and budgeting.
- MSH and PERFORM have coordinated implementation of minimum service standards with the Ministry of Home Affairs and the MOH.

VII. Summary of Accomplishments

The M&L Program has achieved important results in its strategic objective and in each of its impact areas, thereby contributing both to improvements in the performance of MNH and other basic health services, and to the health of the people of Indonesia:

Strategic Objective: Essential public health services, national health standards, and guidelines for districts and municipalities have been established by ministerial decrees as planned.

Impact Area 1:
- Significantly greater participation has been achieved by districts/municipalities in performance improvement planning for basic health services than was planned.
- PROSPEK/MNH has been successfully developed and introduced to Kuningan and Pacitan districts to transition to the new USAID strategy, including building links to PERFORM/BIGG annual and mid-term planning and budgeting.

Impact Area 2:
- Policies and procedures have been established for procurement, distribution, and treatment protocols for TB drugs, including FDCs. An assessment of antimalarial drugs revealed multiple sources of supply were unreliable; and Vitamin A Program assessment revealed erratic supply and certain doses unavailable.

Impact Area 3:
- MNH rapid assessments have been conducted in Kuningan, West Java, and Pacitan, East Java. See reports **"**Results from an Assessment of the Performance of Maternal and Neonatal Health Services Focused on Reducing Maternal and Neonatal Deaths for Kuningan" (July 2004) and Pacitan (October 2004).
- A National Early Warning and Rapid Response system for BKKBN has been developed and implemented, in cooperation with STARH. Monthly reports are available from May 2004.
- MSH assisted MOH and WHO in carrying out an assessment of the National Communicable Disease Surveillance and Response System, and the results and possible improvements are being discussed with donors as well as with provincial and district/municipal authorities.