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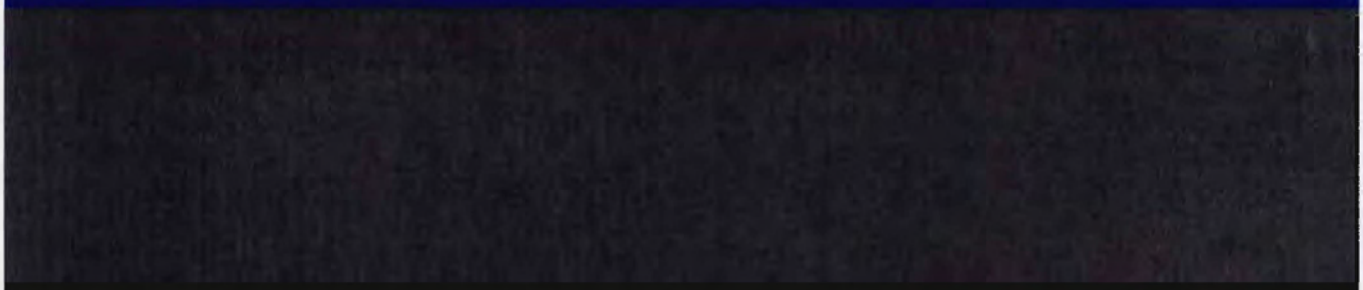
EVALUATION OF THE HEALTH SERVICES PROGRAM (HSP) IN INDONESIA:

Taking Stock and Looking Forward



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EVALUATION OF THE HEALTH SERVICES PROGRAM (HSP) IN INDONESIA:
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The Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
info@ghtechproject.com

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ACRONYMS AND TRANSLATIONS

ADB	Asian Development Bank
AMTSL	Active management of the third stage of labor
APN	Basic delivery care
Askeskin	Health insurance for the poor
AusAID	Australian Agency for International Development
BAPPEDA	Regional Planning Board
BCC	Behavior change communication
BEONC	Basic essential obstetric and neonatal care
BHS	Basic Human Services
Bupati	Elected executive official at the district level
CA	Cooperative agreement
CEONC	Comprehensive emergency obstetric and neonatal care
CHC	Community Health Committee
COP	Chief of Party
CRS	Catholic Relief Services
CSO	Civil society organization
CTO	Cognizant Technical Officer
Desa SiAGa	Birth preparedness and complication readiness program—now referred to as P4K
DHO	District Health Office
DPRD	Local House of Representatives
DTPS	District team problem-solving
EIBF	Early initiation of breastfeeding
GOI	Government of Indonesia
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HSP	Health Services Program
IBF	Immediate breastfeeding
IBI	Indonesian Midwives Association
IDAI	Indonesian Pediatrician's Association
IDHS	Indonesian Demographic and Health Survey
IMCI	Integrated management of childhood illness
IR	Intermediate result
JICA	Japan International Cooperation Agency
JNPK	National Clinical Training Network
JSI	John Snow, Inc.
LGSP	USAID Local Government Support Program
MCC	Millennium Challenge Corporation
MDG	Millennium Development Goal
MenkoKesra	Coordinating Ministry for People's Welfare
M&E	Monitoring and evaluation
MMR	Maternal mortality ratio

MNCH	Maternal, neonatal, and child health
MNH	Maternal and neonatal health
MOH	Ministry of Health
MPS	Making Pregnancy Safer
Musrenbang	Bottom-up planning process
NGO	Nongovernmental organization
OP	Operational plan
P2KS/P	Regional/District Clinical Training Centers
P4K	Birth preparedness and complication readiness program)
PC	Program Coordinator (HSP regional office staff)
Perda	District law
PHO	Provincial Health Office
PKK	National women's organization
PMP	Performance Monitoring Plan
PNPM	National community development/cash transfer program)
POGI	Indonesia Obstetrician and Gynecologists Association
Polindes	Community birthing facilities
POPPHI	Preventing Postpartum Hemorrhage Initiative
Posyandu	Integrated Service Post
POUZN	Point-of-use (POU) water disinfection and zinc treatment
PPP	Public-private partnership
PromKes	MOH health promotion unit
Puskesmas	Subdistrict Community Health Center
Pustu	Community Health Center (below the *puskesmas*)
RFA	Request for application
RH	Reproductive health
SBA	Skilled birth attendant
SDM	*Studio Driya Media* (local NGO partner of HSP)
SMFPA	Safe Motherhood Family Planning Assistance
SNL	Saving Newborn Lives
SPM	Minimal Service Standards
STARH	Sustaining Technical Achievements in Reproductive Health
TA	Technical assistance
UNICEF	United Nations Children Fund
UNIFEM	United Nations Fund for Development of Women
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

The purpose of this review is to provide a forward-focused evaluation of the USAID-funded Health Services Program (HSP) in Indonesia. The evaluation has two principal objectives:

1. To achieve a thorough understanding of the outcomes and results of HSP interventions and the effectiveness of HSP strategies in achieving results in the focus areas (advocacy, behavior change, role of private sector midwives, and technical support to the Government of Indonesia [GOI]). For evaluation purposes, effectiveness is defined by the extent to which results are (1) replicable; (2) sustainable by the GOI and local partners; (3) consistent with GOI national and subnational policies and programs; and (4) perceived as collaborative by GOI and civil society partners.

2. To develop recommendations for future activities and implementation strategies for immediate and midterm time frames consistent with USAID/Indonesia's commitment to Ministry of Health (MOH) priorities in maternal, neonatal, and child health (MNCH) (i.e., achieving Millennium Development Goals [MDGs] 4 and 5); building health system capacity where it can be directly linked to positive impact on MNCH outcomes; working closely with a broad range of civil society partners; and forging productive relationships with the private sector.

The challenge of the evaluation was to pivot deftly from assessment of an extensive and complex project to recommendations for future USAID MNCH interventions in a large and diverse country undergoing a dynamic process of decentralization. The report structure reflects the process the evaluators followed. It began with an analysis of what HSP has accomplished, moved to thinking about how those accomplishments contribute to the ultimate goal of reducing maternal and neonatal mortality and morbidity, and went on to make strategic suggestions about how to build on HSP successes to reinforce USAID's general approach to reducing maternal and neonatal mortality in Indonesia.

The evaluation was conducted by a four-person team composed of a leader with expertise in implementation and evaluation of maternal and neonatal health programs, a private provider network expert, an expert on health systems and governance, and an expert on behavior change and neonatology. The team spent four weeks in country, August 18–September 11, 2008, during which they reviewed program documents, visited field sites in five districts, and interviewed private, public, and commercial sector stakeholders.

HSP, USAID/Indonesia's flagship MNCH project, is a four-and-a-half-year cooperative agreement awarded to JSI Research and Training Institute and partners. Starting in April 2005, it was designed to address the major public health problems facing mothers, newborns, and children in Indonesia. HSP provides technical assistance (TA) to government counterparts, civil society partners, nongovernmental organizations (NGOs), and communities on implementation of selected evidence-based interventions.

The program was originally designed to reduce maternal, neonatal, and child mortality through an integrated package of technical interventions that could be made available to districts and a system for replicating that package widely to maximize the chance of national impact as quickly as possible. The project design emphasized rapid scale-up of pilot interventions. The original integrated package as presented in the request for applications (RFA) was designed around five strategic approaches to decentralized district provision of health care: (1) integrating technical components; (2) strengthening decentralized health systems and services; (3) leveraging funds from other donors; (4) harnessing NGOs and private voluntary organizations (PVOs); and (5) engaging the private sector. The project was to package and make available interventions based on evidence-based approaches to maternal, neonatal, child, and reproductive health; infectious diseases; drug and commodity management; and decentralization and reinforcement of district health systems and services.

In large measure the project produced results that are replicable, sustainable, and consistent with GOI policies, and it implemented its activities through collaborative relationships with GOI and civil society partnerships. HSP met or exceeded all of its targets. The project produced high-quality reports and effective communications on project progress and achievements. It also responded to USAID requests with skill and alacrity, even when they were outside the original scope of work (e.g., tsunami, national call to action for health).

HSP's principal strategy for ensuring that its technical inputs will be replicated and sustained is its collaboration with the MOH in updating guidelines and tools to reflect current evidence-based best practices. Although this strategy was not contemplated in the original design, which emphasized scale-up and replication, HSP seized upon the MOH's desire to update policies that seemed to be a barrier to scale-up and turned it into an opportunity to enhance the environment for reducing maternal and neonatal mortality. In addition, many of HSP's district and village-level interventions, such as P4K, a program dedicated to birth preparation and preparedness for complications, and district team problem-solving (DTPS), helped to improve and facilitate implementation of MOH strategies.

HSP worked very hard at the district level to ensure that most interventions had a sustainable home with the GOI or an NGO or professional organization and had prospects for financial support after the project ended. It supported NGOs, district advocacy and behavior change communication (BCC) teams, and professional organizations to mobilize corporate support to the extent possible within the constraints of being part of a USAID project. HSP worked with the MOH and other national organizations (e.g., JNPK, the National Clinical Training Network) to update national evidence-based training modules.[1] HSP has collaborated with other donors in efforts to identify partners, such as JNPK, the Indonesian Midwives Association (IBI), UNICEF, CARE, and the Australian Agency for International Development (AusAID), which can replicate activities beyond HSP districts.

Similarly, HSP adapted successful strategies developed by USAID and NGO partner organizations and applied them in reinforcing MNCH in HSP districts. These included the approaches developed by the USAID Local Government Support Program (LGSP) for drafting and passing local laws and BCC events proposed by NGO partners, such as the 1,001 mothers rally and the 2,010 couples rally on early initiation of breastfeeding (EIBF).

The project has a good track record of learning from first-round application of its tools to refine sequencing, quality, and integration of district, subdistrict, and village interventions (DTPS, training of trainers [TOT], fundraising, BCC, and advocacy). Throughout, HSP has shared information with other donors and USAID projects, supporting the Millennium Challenge Corporation (MCC), collaborating with the LGSP, and facilitating a smooth transition of the Bidan Delima program from the Sustaining Technical Achievements in Reproductive Health (STARH) project.

The evaluation also identified weaknesses in the project that can be attributed to challenges in design and implementation. The project design omitted critical interventions for reducing the maternal mortality rate (MMR) and the neonatal mortality rate (NMR), such as improvement in use and quality of comprehensive emergency obstetric and neonatal care (CEONC) services in hospitals, referral systems and support, supervision, and information/accountability systems focused on improving the response of the health system to maternal and neonatal complications. Although JSI proposed a critical pathways model that included interventions to address these concerns, it was discouraged from focusing too much attention on improving hospital-based CEONC and health center-based basic EONC (BEONC) as well as the supportive systems that link skilled community-based providers (e.g., community midwives and private

[1] The modules include Making Pregnancy Safer (MPS), Basic Delivery Care (APN), Basic Emergency Obstetric and Neonatal Care (BEONC), Comprehensive Emergency Obstetric and Neonatal Care (CEONC), and Integrated Management of Childhood Illness (IMCI).

midwives) to higher levels of the health system that are critical for addressing the major causes of maternal and neonatal mortality.

From the beginning HSP has had to deal with the trade-off between pressures to scale up and replicate across a large number of districts and giving attention to adapting strategies to the local context. In some circumstances this may have inhibited more sustainable community creativity and decision-making.

There was too much emphasis on replication through a TOT approach without adequate assessment of whether this leads to capable implementation (clinical, DTPS, and BCC). Except for its assistance to the MOH on national guidelines, the project has used TOT as its replication strategy rather than exploring others, such as district-to-district TA, peer-to-peer coaching, and whole-site training. There are indications that without considerably more time for repetitive trainings and continued TA, this strategy is not sustainable in most districts once the project ends.

Incentives and supports provided by the project may be intrinsic to the replicability and sustainability of activities (e.g., seed money for community health committees [CHC] and advocacy, facilitation, and TA for advocacy, BCC, DTPS activities, and support for materials). It is not clear if replication in new areas is possible without a similar incentive structure.

The evaluation strongly recommends extending the project to consolidate the package of interventions so that it is more integrated and solidified. An extension would also allow HSP to prepare the groundwork for scaling up in a district where it can build on HSP initiatives, such as passage of local MNCH laws and district-wide planning to formulate effective approaches to implementation and monitoring and evaluation (M&E). The extension would enable the project to further observe and document the replication process and compare project subdistricts with replication subdistricts.

USAID's interest in the sustainability and replicability of HSP interventions also argues for targeted research and evaluation during the extension period to further determine how much HSP's interventions have contributed to achieving the desired maternal and neonatal outcomes, what combination of interventions might be considered best practices, and how packages of interventions can be tailored to districts with different socioeconomic characteristics.

HSP has built a strong foundation for new USAID programming to reduce maternal and neonatal mortality, but there are four challenges that should be addressed in any new programming: (1) geographical focus and size of the project area; (2) emergency obstetrical and neonatal care and maternal and perinatal audits, which were not originally a major focus of HSP; (3) increased attention to gender, sociocultural, and economic differences in the design of programmatic approaches; and (4) greater attention to private healthcare providers and facilities. With these considerations in mind, the evaluation makes the following recommendations for the design of new MNCH programming in Indonesia:

1. **Focus on reducing maternal and neonatal mortality:** With resources limited, the best option is to focus on maternal and neonatal mortality to help Indonesia most effectively reach its MDG 4 and 5 goals.

2. **Narrow the geographic spread to three to seven districts that can implement integrated approaches based on a continuum of care or a critical pathways model adapted to the local context (see Results Framework 1 below):** The National Strategic Plan for Making Pregnancy Safer (MPS) provides the framework for approaches that implement interventions strategically throughout a district and cover all subdistricts based on a baseline needs assessment.

3. **Engage the MOH and other GOI organizations, donors, and NGOs as learning partners:** A comprehensive integrated approach will allow USAID to collaborate with the MOH and other donors to examine the effectiveness of different models. It is not necessary for USAID to be responsible for strengthening all dimensions of the health system in each district where the new program operates.

4. **Select districts according to specific criteria:** The districts selected for USAID programming should be representative of the diversity of circumstances found in Indonesia so that proven approaches and tools developed will be appropriate for replication in similar contexts.

5. **Prioritize the strengthening of information systems in communities, integrated service posts, community health centers, and hospitals:** At the community and integrated service post levels, engage local health committees to extend registration of pregnant women to the collection and analysis of information on maternal and neonatal outcomes. At hospitals and health centers, activate and strengthen MOH-mandated maternal and perinatal audit systems, which are currently not fully operational or effective. The audit systems should also cover private providers and maternal and neonatal healthcare facilities so that they too can be held accountable for outcomes. It is also recommended that the new program develop a district-wide surveillance and response system with oversight from safe motherhood committees at different levels of the district health system, with ultimate accountability residing with the district health officer (DHO), provincial health officer (PHO), and civil society monitoring groups.

6. **Give priority to actions that increase access to and the availability of quality 24/7 BEONC and CEONC in districts:** Nationwide, 59 percent of births in Indonesia now take place at home, where about half are assisted by skilled providers, who may or may not be linked to higher levels of care. This situation decreases the chance that a woman and her baby will receive timely and adequate care if there is a serious complication.

7. **Increase attention to gender-based, sociocultural, and economic constraints to accessing quality life-saving MNCH care through a rights-based approach to reducing MMR and NMR:** A rights-based approach empowers communities to ensure that every woman and newborn has access to skilled delivery care and to EONC when complications arise.

8. **Integrate the private health sector into district models for reducing MMR and NMR:** Private providers are a major source of maternal and newborn care in Indonesia. It is recommended that the new program pilot a variety of public-private provider partnerships to improve MNH service quality and accessibility.

9. **Build the capacity of IBI as a professional organization:** It is recommended that USAID develop a separate but linked activity to strengthen the Bidan Delima program and IBI's capacity to implement it. Midwives are also a major provider of MNH services, especially at the community level and in private practice.

10. **Invest in Bidan Delima in Indonesia:** IBI's Bidan Delima program has potential to enhance private provision of maternal and child health services, promote facility-based births, and improve the quality of care offered by private midwives.

11. **Support learning from experience in reducing MMR and NMR across Indonesia:** Knowledge management needs to be central to any future project because it will be important to widely disseminate lessons learned and best practices that emerge from working comprehensively at the district level.

I. INTRODUCTION

The Health Services Program (HSP) is a cooperative agreement awarded to JSI Research and Training Institute and partners to carry out a four-and-a-half-year program starting in April 2005 to address the major public health problems facing mothers, newborns, and children in Indonesia. HSP provides TA to government counterparts, civil society partners, NGOs, and communities on evidence-based interventions. USAID/Indonesia requested a forward-focused evaluation of the project within the context of the Mission's MNCH (CSH-funded) portfolio and contracted with GH Tech to conduct the evaluation presented here.

The evaluation responds to two principal objectives:

1. To achieve a thorough understanding of the outcomes and results of HSP interventions and the effectiveness of HSP strategies in achieving results in the focus areas (advocacy, behavior change, role of private sector midwives, and technical support to the Government of Indonesia [GOI]). For evaluation purposes, effectiveness is defined by the extent to which results are (1) replicable; (2) sustainable by GOI and local partners; (3) consistent with GOI national and subnational policies and programs; and (4) perceived as collaborative by GOI and civil society partners.

2. To develop recommendations for future activities and implementation strategies for immediate and midterm time frames, consistent with USAID/Indonesia's commitment to Ministry of Health (MOH) priorities in maternal, neonatal, and child health (MNCH) (i.e., achieving Millennium Development Goals [MDGs] 4 and 5); building health system capacity where it can be directly linked to positive impact on MNCH outcomes; working closely with a broad range of civil society partners; and forging productive relationships with the private sector.

This evaluation diverges from the standard assessment of achievements against quantifiable objectives. HSP regularly reports on both process and outcome indicators. In almost all cases, the project has met or exceeded those types of targets. The evaluation also does not review the situation of MNCH in Indonesia or provide an overview of the Indonesia health system. The former can be found in the scope of work provided in Appendix A and the latter in the recent World Bank report, *Investing in Indonesia's Health.*[2]

METHODOLOGY

A four-person team conducted this evaluation, consisting of a team leader with expertise in implementing and evaluating maternal and neonatal health programs, a private provider network expert, an expert on health systems and governance, and an expert on behavior change and neonatology. The team spent four weeks in Indonesia, August 18–September 11, 2008. Its members reviewed an extensive body of documents (see Appendix G) from the project, the government, NGOs, and others.

After an introduction to the project components and achievements by HSP central office staff, the evaluators visited six districts (Kota Malang, Kabupaten Malang, Kabupaten Deli Serdang, Kota Medan, Kabupaten Sumedang, and Kota Bandung) in three provinces (East Java, North Sumatra, and West Java) where HSP is working. During the field visits the team met with numerous and diverse stakeholders, including mayors, members of district parliaments, district and provincial health office staff, provincial and branch leaders of IBI, members of NGOs, community leaders and members, public and private healthcare providers (midwives, nurses, and doctors), community health volunteers, and women who are pregnant or have newborn babies. The evaluators also had an opportunity to exchange ideas with community health committees and to observe and converse with health volunteers during integrated service posts' monthly health days. The team had an opportunity to talk directly to HSP staff in the

[2] World Bank, 2008, *Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending* (World Bank: Jakarta).

regions visited, and all HSP staff were sent a set of questions about their involvement with and assessment of the project; the team compiled their responses as part of the evaluation. Upon return to Jakarta, the evaluation followed up with HSP central office staff to address additional questions and information gaps. (See Table 1 for meetings with HSP stakeholders.)

TABLE I: EVALUATION MEETINGS WITH HSP STAKEHOLDERS

ORGANIZATION TYPE	STAKEHOLDERS
Ministry of Health	Directors General of Community Health and Medical Services, Center of Health Promotion; Directors of Maternal Health, Child Health, Special Medical Care, and Basic Medical Services, and Head of Health Financing and Insurance
MenkoKesra	Department of Health Coordination
Bappenas	Health and Nutrition
Donors	WHO, World Bank, Ford Foundation, MCC, and USAID
Professional Organizations	IBI, POGI, JNKP, Indonesia Pediatrician's Association (IDAI), and Perinasia
Implementing Partners	JNPK. WRI, and HSP staff
Companies	Johnson and Johnson and OneComm
Village	CHC members, Kader, *Bidan di Desa, Bidan Delima* and other private midwives, pregnant and postnatal mothers, fathers, and babies
Provincial	PHO and hospital staff
District Partners	DHO, Local House of Representatives (DPRD), IBI, JNPK, *Bappeda*, NGOs, media, CSOs, FBOs; subdistrict: *puskesmas* staff and subvillage leaders
Experts	Technical experts and academics
HSP	National and regional staff

During the field visits the team visited a cross-section of public healthcare facilities, among them community birthing facilities (*polindes*), village health posts (*poskesdes*), satellite health centers (*pustus*), subdistrict health centers (*puskesmas*), and district and provincial hospitals. Some of these facilities have been supported by the HSP project; others had little contact with it. The team visited a midwifery school and training sites used by JNPK for clinical training and interviewed private midwives in their clinics, some of whom were part of the Bidan Delima program.

In Jakarta, the evaluation team met with staff of governmental agencies, including several offices of the MOH and two planning ministries, *MenkoKesra* and *Bappenas*, and a broad spectrum of donors, NGOs, professional organizations, and health and governance experts (see Appendix B for a complete list). The team also met with HSP technical advisors and management staff and with USAID staff.

OVERVIEW AND STRUCTURE OF THE REPORT

The challenge of the evaluation was to pivot deftly from assessing an extensive and complex project to making recommendations for future USAID interventions in MNCH in a large and diverse country undergoing a dynamic process of decentralization. The report structure tries to reflect the process followed by the evaluators: it began with an analysis of what HSP has accomplished, moved on to thinking about how those accomplishments contribute to the ultimate goal of reducing MMR and NMR, and made strategic suggestions about how to build on HSP's successes to reinforce USAID's general approach to reducing maternal and neonatal mortality in Indonesia.

Section II of the report addresses the first objective, analyzing how effectively HSP interventions demonstrated consistency with GOI policies, the degree to which they were undertaken in a collaborative fashion, and whether they are replicable and sustainable. The team made a detailed assessment of each component of the project. This section analyzes the strengths and weaknesses of each, raises issues for consideration by HSP and USAID, and proposes component-specific recommendations for the rest of the project. Section II ends with a general assessment of the strengths and weaknesses of the project and general recommendations that coalesce around the component-specific recommendations.

Section III focuses on the transition from HSP to USAID follow-on activities. To promote understanding of the extent to which HSP activities provide a foundation for future USAID MNCH programming, particularly mortality reduction, this section addresses two additional questions:

1. To what extent were HSP activities effective in changing the practices of healthcare providers, policy makers, women, and their families so as to contribute to greater maternal and neonatal survival?
2. Are HSP's activities, in the aggregate, the right combination and types of interventions necessary to reduce maternal and neonatal mortality and morbidity in Indonesia? If not, why not, and what else is necessary?

To address these two questions, the evaluation team found it useful to examine HSP design and activities in terms of a results framework that postulates critical interventions for reducing maternal and neonatal mortality based on current international consensus on what is necessary, effective, and evidence-based, summarized as:

1. Stronger policies and governance structures necessary to ensure universal access to skilled antenatal, delivery, postpartum, and essential newborn care (supportive enabling environment) and to basic and comprehensive EONC in case of complications
2. Improved quality, availability, acceptability, affordability, and timeliness of MNCH services, including normal delivery (preferably facility-based) and basic and comprehensive EONC in public and private sectors, supported by effective health management systems and evidence-based protocols (responsive health system)
3. Increased involvement of civil society organizations (CSOs) in planning, management, and oversight of public and private healthcare, advocating for the rights of pregnant women and children, and monitoring maternal and neonatal outcomes (empowered and engaged civil society).

Section IV proposes recommendations for future USAID MNCH programming and suggests general principles to guide the design of new programs and project design.

II. ASSESSMENT OF HSP

OVERVIEW OF HSP OBJECTIVES AND ACCOMPLISHMENTS

HSP is USAID/Indonesia's flagship MNCH project. It was originally designed to reduce maternal, neonatal, and child mortality through an integrated assistance package of evidence-based technical interventions that could be made available to districts and a system for replicating the package widely to maximize the chance of immediate national impact. The project design emphasized rapid scale-up of interventions. The original integrated package as presented in the RFA was designed around five strategic approaches focused on decentralized district provision of healthcare: (1) integrating technical components; (2) strengthening decentralized health systems and services; (3) leveraging funds from other donors; (4) harnessing NGOs and PVOs; and (5) engaging the private sector. The project was to package and make available such interventions as evidence-based approaches to MNCH and reproductive health, infectious diseases, drug and commodity management, and decentralization and strengthening of district health systems and services. [3]

Given the breadth of its original scope, the focus and objectives of HSP have not always been clear. The tsunami in Aceh, which occurred three months before the project agreement was signed, initially diverted much attention away from its original scope of work. That same year the USAID Mission also asked the project to lead a national health summit on reducing maternal mortality. Yet despite such added responsibilities, HSP has been very productive in developing district and national-level planning, budgeting, advocacy, and behavior change communication (BCC) tools, training modules, and clinical guidelines in close collaboration with the MOH, provincial and district health authorities, and other stakeholders. HSP has also engaged a broad spectrum of civil society groups and government officials in planning and advocating for increased district-level MNCH resources.

While most of the tools and guidelines have been adopted by the MOH and applied in HSP focus districts, few have been systematically evaluated for their effectiveness in changing healthcare provider practices or removing barriers to women's and newborns' access to life-saving interventions.[4] HSP was more concerned with replicating than validating approaches. The evidence on effectiveness is well established for some interventions the project addressed, such as active management of third-stage labor (AMTSL), immediate breastfeeding, birth preparedness and complication readiness, and essential newborn care. However, measuring the impact on maternal and neonatal mortality of evidence-based practices as implemented in the districts was not part of the original project design.

HSP has demonstrated impressive results in developing and replicating activities across many districts. Table 2 illustrates that 2007 program outputs have often exceeded targets.

Accomplishments include increases in district budgets for MNCH; drafting and passage of MNCH laws; upgrading training organizations to provide in-service training of public and private providers in MNCH clinical care and quality assurance; formation and funding of community health committees (CHCs) to establish birth preparedness and emergency response systems and promote hand-washing and breastfeeding; and building district and community capacity in MNCH planning and budgeting, advocacy, and BCC.

[3] The description in this paragraph is taken from the RFA program description.
[4] See Appendix C for complete list of tools and guidelines developed with HSP assistance.

TABLE 2. HSP: 2007 PROGRAM OUTPUTS			
PROGRAM AREA	**ACTIVITY**	**FY07 TARGETS**	**FY07 RESULTS**
Advocacy and Decentralized Planning	Number of national, provincial, or district-led advocacy initiatives in support of basic human services	18 initiatives	49 initiatives
	Number of districts reporting an increased share of the district budget for MNCH services	3 districts	22 districts
	Number of districts with increased financial resources accessed from government or other sources to deliver basic human services	3 districts	22 districts
	Number of people trained in advocacy techniques	360 people	350 people
	Number of districts with plans and budgets to improve MNCH service delivery	23 districts	14 districts
Provider Training	Number of health personnel receiving clinical training in basic delivery care	910 providers	1,266 providers
	Number of health personnel trained in basic or comprehensive obstetric and neonatal care	276 providers	500 providers
	Percentage of trained providers who perform to established standards	95% of providers visited	99% of 384 providers visited
	Midwife membership in the *Bidan Delima* Program	6,400	6,518
	Number of midwives trained in supportive supervision	48 supervisors	261 supervisors
PPP	Number of new public-private partnerships (PPPs)	1 partnership	12 partnerships
Community Mobilization and Behavior Change	Number of people trained in BCC techniques	150 people	108 people
	Number of people trained in community mobilization	800 people	1,067 people
	Number of Community Health Committees (CHCs) operational	350 committees	363 committees
	Number of CHCs established through replication by GOI or other donors		385 committees
From HSP, *2007 Annual Report*, p.3			

The results based on outcome indicators are somewhat mixed (see Table 3). In 2007 a rapid survey found that the percentage of births attended by skilled providers varied across HSP districts, with an average decrease (69.5% to 66.5%) as a result of a significant decline in two districts in Banten (which went from 80% to 47%) but an overall slight increase in all other districts (70.9% to 74.5%) compared with the 2005 baseline. However, the program's 2008 rapid survey saw an average increase in skilled birth attendance to 76 percent, which is closer to the 73 percent national average recorded by the preliminary results from the

Indonesian Demographic and Health Survey (IDHS), as compared to 66 percent in 2002–03. This puts HSP districts, exclusive of Banten, squarely in line with the national average.[5]

Similarly to the IDHS results, contraceptive prevalence rates seem to have stagnated or decreased slightly in HSP districts in 2007, although a slight increase is documented in the 2008 rapid survey. (Note: Because HSP has not been promoting family planning services in any of its districts, it is not possible to draw any direct conclusions about these outcomes).

Rates of childhood diarrhea have decreased steadily over the past two years in HSP target areas. At baseline, 28 percent of children less than 36 months of age had had diarrhea in the previous two weeks; in 2007 the rate was 25.8 percent and it dropped again in 2008 to 21.5 percent.

HSP has also recorded significant increases in the practice of initiation of breastfeeding within the first hour of life. At baseline, only 9.3 percent of mothers reported having immediately breastfed their newborns. In 2007, the rate had risen to 20.7 percent and in 2008 to 27.2 percent.

TABLE 3. HSP: 2007 PROGRAM OUTCOMES

OUTCOME INDICATOR	BASELINE (2006 Survey)	ACHIEVED (Rapid Survey 2007)	ACHIEVED (Rapid Survey 2008)[6]
% of children less than 36 months of age with diarrhea in last 2 weeks	28%	25.8%	21.5%
% of deliveries attended by skilled health personnel	69.5%	66.5%	76.0%
Modern contraceptive prevalence rate	75.8%	74.5%	79.5%
% of caretakers washing hands with soap at 3 of 5 critical times	6.6%	11.9%	7.4%
% of women initiating breastfeeding	9.3%	20.7%	27.2%

HSP 2007 Annual Report p.3, draft HSP 2008 Annual report p. 3

The rapid survey and IDHS results raise questions about whether HSP can attribute changes in outcome indicators to its interventions. A recent World Bank report on Indonesia's health system raises similar doubts about the impact of increases in district budgets alone on better MNCH outcomes. The findings from a regression analysis found little statistical correlation between district healthcare spending and coverage of child immunizations and skilled birth attendance (World Bank, 2008, p. 66).

Assessing attribution is further complicated by the fact that USAID asked HSP to work in 31 districts but only a few efforts took place at the district level, including planning and budgeting, advocacy, and BCC. HSP had little influence on other activities within the district, such as training of providers or upgrading facilities. Its other activities, such as community-level CHCs and preparedness programs (P4K) were implemented in a concentrated way only in about three villages in each of four subdistricts.

[5] While the rapid survey demonstrates large changes in the percentage of newborns and women receiving a visit from a midwife or nurse within one week postpartum, the results are not quite comparable because the questions used in the 2005 survey and the rapid survey in 2007 were not the same.

[6] These results were not reviewed by the HSP Evaluation Team for statistical significance, as they were not available before the team left Indonesia.

THE CHALLENGES OF THE PROJECT DESIGN

One of the most important lessons learned over the last 20 years is that to reduce maternal and neonatal mortality, women must have timely access to quality EONC, because every pregnancy entails risks that can develop into life-threatening complications for mother or baby.

- **Maternal mortality:** In virtually every country where maternal and neonatal mortality and morbidity are high, the principal causes of maternal death are hemorrhage, eclampsia, infection, obstructed labor, and unsafe abortion. Effective response to these life-threatening complications requires a skilled provider who can immediately detect complications, stabilize the woman for transport to a BEONC-level facility, and have prompt access to a CEONC level of care if a c-section and blood transfusion are necessary.
- **Neonatal mortality:** Newborns die principally of asphyxia, preterm births, and infection. For newborns, interventions can be initiated by a skilled provider trained in newborn resuscitation who recognizes the importance of skin-to-skin contact before and during transport to a higher level of care.

Because many life-threatening complications are neither predictable nor preventable, it is critical that all pregnant women have access to skilled birth attendants, who can recognize complications and make informed decisions to refer women or newborns with complications to EONC services.

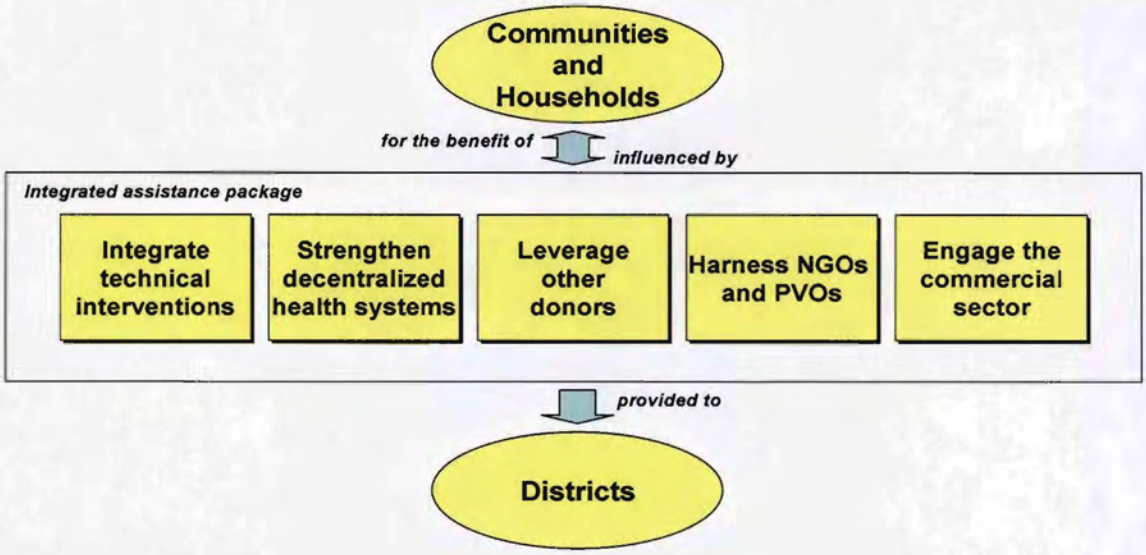
A second lesson learned is that skilled care is only effective if it is part of a functioning healthcare system that links women and newborns to higher levels of care. This means that the healthcare services adhere to national clinical guidelines that meet international standards for EONC and skilled birth attendance. A functioning system also depends on policies that support training and rational deployment of healthcare professionals, especially midwives.

The third lesson learned is that it is essential to have reliable information about the causes and circumstances surrounding maternal and neonatal deaths in order to understand how the health system needs to be improved to ensure that women and newborns have access to life-saving care when complications arise.

Elements Missing from Project Design and Implementation

Although the original goal of the project was to "reduce maternal, neonatal and child mortality and morbidity with a special focus on the poor and vulnerable through an integrated decentralized district approach," the objectives were largely related to process rather than impact. As reflected in Figure 1, project objectives did not prioritize implementation of an integrated strategy of interventions critical to reducing maternal and neonatal mortality.

Figure 1. HSP Objectives

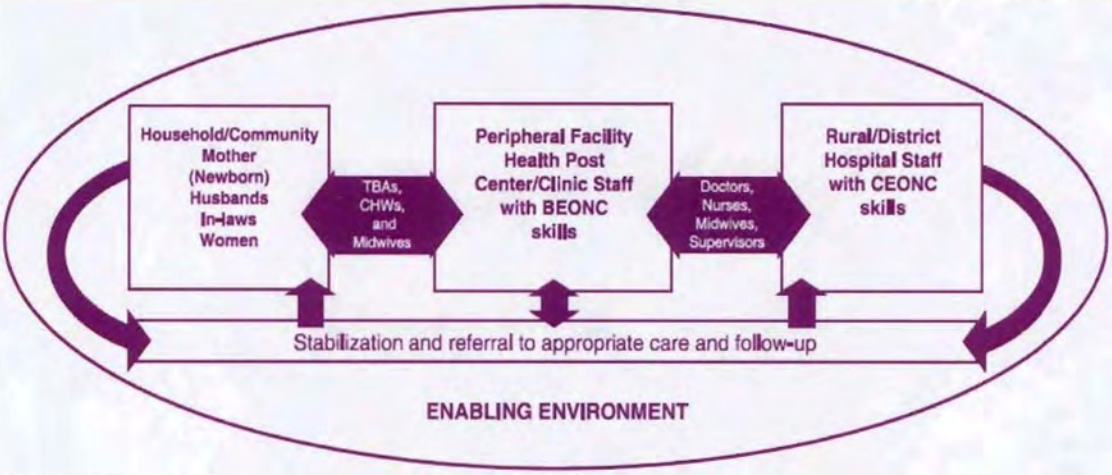


The RFA stipulated that the program should support decentralization of the Indonesia health sector through a replicable integrated assistance package. The emphasis on scale-up and replication was premised on the assumption that there were tools and policies to scale up in many districts.

Early in the project it became evident that many of the national guidelines and tools were out of date and not based on current evidence-based practices. HSP therefore spent much of the first year helping the MOH to update guidelines, tools, and training modules while emphasizing a community mobilization and BCC strategy in selected villages that was focused on birth preparedness, early initiation of breastfeeding (EIBF), and hand washing (Annual Report 2006). The project correctly attempted to rectify the omission of attention to EONC and routine auditing to understand, document, and address the causes of maternal and neonatal deaths at different levels of the health system. HSP undertook to train healthcare providers in essential newborn care in key national and provincial hospitals to strengthen their capacity to deliver and train providers in CEONC.

In its critical first year, USAID asked the project to curtail the essential building block of EONC training in hospitals and focus on district-level and community-based interventions. The result was to severely limit HSP's capacity to improve the quality of life-saving service delivery. Instead it worked with the MOH and JNPK on updating the training curriculum and supporting the training and certification of trainers on basic delivery care, BEONC, and CEONC. The restriction against working with CEONC health facilities to strengthen service delivery meant it was difficult for the project to implement an integrated strategy based on a continuum of care model (see Figure 2).

Figure 2. The Household-to-Hospital Continuum of Care



4 HHCC OF MATERNAL AND NEWBORN CARE

The project design omitted critical interventions for reducing MMR and NMR, such as improvement in use and quality of CEONC services in hospitals and referral, support, supervision, and information/ accountability systems in order to improve the response of the health system to maternal and neonatal complications. A study of 12 Indonesian hospitals showed that 92 percent of maternal deaths result from delays in referral and case management, and 40 percent of them occur on the way to the hospital. Delays result both from belated decisions to seek care and delays at referral facilities in getting women and newborns with life-threatening complications to the next level of care. The decision to seek care is greatly influenced by the perceptions of women and their families that quality care is lacking at primary health centers and hospitals, as well as by concerns about costs. Once women reach the health facility, they experience additional delays caused by the failure of providers to perceive the urgency of complications, inappropriate care, and lack of trained providers and supplies. Although JSI, the prime contractor, proposed a critical pathways model that addressed these concerns, it was discouraged from giving too much attention to improving hospital-based CEONC, health center-based BEONC, and the supportive systems that link skilled community-based providers (e.g., community and private midwives) to higher levels of the health system that are critical for addressing the major causes of maternal and neonatal mortality.

HSP primarily focused on interventions like clinical training and quality assurance efforts—AMTSL, EIBF, and immediate postpartum neonatal care in basic delivery care (APN), BEONC, CEONC, and supportive supervision—improving policies and guidelines, developing community-level birth preparedness plans, and promoting hand washing and EIBF. All of these, though important, are not adequate to improve maternal and neonatal outcomes if they are not part of an integrated strategy that incorporates CEONC and reinforcing essential health systems. Once HSP stopped working in hospitals, it was unable to ensure the continuum of care and give the needed support for referrals from community-based providers. It did provide support for pilot testing the introduction of kangaroo mother care (KMC) at the hospital level in 2008 in response to a recommendation made at a regional USAID conference in

Bangkok in 2007.[7] The project has been successful in promoting integration of AMTSL and EIBF among midwives.

HSP's primary contributions to reducing MMR and NMR were to help the MOH to identify evidence-based practices, disseminate them through updated guidelines, and integrate them into national clinical training modules. Critical elements that remain to be completed are to (1) implement guidelines at national scale and adapt them to different local contexts through an integrated strategy within a district, and (2) ensure that people who are trained in APN, BEONC, and CEONC are supported by strengthened supervision, information, and referral systems.

Multiple and Complex Components Too Widely Spread

The HSP project is spread thin over too many districts, which makes it extremely difficult to apply the whole package intensively enough to achieve the desired improvements in maternal and neonatal outcomes. The mandate to scale up too quickly pushed the project into 31 districts in six provinces (North Sumatra, Banten, West Java, Special Metropolitan of Jakarta, East Java, and Aceh).[8] It would be difficult for USAID to support a district-wide integrated systemic approach to reducing maternal and neonatal mortality in such a large number of districts for the amount of funding provided to HSP.

The focus on scaling up in a large number of districts rather than on impact resulted in HSP working at the district capital on advocacy, BCC, and DTPS planning but in only three villages in each of four subdistricts on other project activities. For example, in the Malang district, HSP provided direct support to CHCs in only 12 of the district's 390 villages, and gave supportive supervision in only four of the district's 39 community health centers. While health center and community activities were implemented in a way that built the capacity of DHOs to use HSP tools in other geographic areas, the project did not track how often this happened and on what scale. This makes it difficult to gauge its impact on the two health outcome indicators at the district level: incidence of diarrheal disease and skilled attendance at birth.

The breadth of the project also makes it difficult to assess the sustainability of individual components, if sustainability is defined as activities continuing to be operational at the same level without project support. Where there is a public sector organization, donor, or NGO that has assumed ownership of activities, there is more likelihood that those activities will be both replicable and sustainable within and beyond districts.

Inadequate Attention to Formative and Operations Research

Lack of research and evaluation components makes it hard to test methodologies, customize them to the local context, and attribute outcomes to a given activity. HSP was not designed as an operations research project, and from the beginning USAID made it clear that research and evaluation were not to be a focus of the project. Nevertheless, for HSP and USAID to convincingly link health outcomes to project interventions, it is necessary to demonstrate that similar changes did not occur in other districts without a donor presence.

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[7] In September 2007, representatives of USAID, the MOH, and HSP attended a regional conference on Scaling Up Best Practices in MNCH. The Indonesia country team prioritized KMC care for low-birth-weight newborns. USAID, through its Participant Learning Program, was able to make available support for a team of practitioners from three Indonesian teaching hospitals to go on a KMC study tour to Cape Town, South Africa, in May 2008. HSP has since provided a grant to the Indonesia Association of Perinatologists, Perinasia, to provide follow-on technical support to ensure KMC is well institutionalized in these facilities as well as being established by policies of the MOH and professional associations.

[8] Currently HSP is only in five provinces and 25 districts now that the post-tsunami work in Aceh has ended.

A Solid Foundation to Build On

Despite the significant design challenges, HSP has been very successful in laying a solid foundation to address the major causes of maternal and neonatal mortality in Indonesia. Among its accomplishments:

1. An integrated package of evidence-based national guidelines for reducing maternal and neonatal mortality
2. A district-level advocacy process for increasing political and financial commitment to MNCH in support of Indonesia achieving MDGs 4 and 5, including a process for passing local laws and decrees
3. An improved process for district-level MNCH planning and budgeting based on data for decision-making (DTPS)
4. An evidence-based integrated maternal-neonatal curriculum for normal delivery care, BEONC and CEONC, and supportive supervision for village midwives
5. Effective district-level BCC strategies focused on birth preparedness, EIBF and hand-washing, using public-private partnerships (PPPs)
6. A replicable strategy to mobilize communities to draft and implement village and household-level birth-preparedness plans
7. Expansion of the *Bidan Delima* program to improve the skills of private midwives through support to the Indonesia Midwives Association (IBI)

To address the first objective of the evaluation, the project interventions below are assessed according to whether they were consistent with MOH policies, the product of collaborative processes with different branches of the GOI and with civil society, replicable, and sustainable. The components are also grouped by their contribution to (1) an enabling environment that strengthens governance through better policies and guidelines, enhanced data collection and use, and improved planning and budgeting; (2) a health system that is responsive to the population's needs and increases access to and improves the quality of MNCH care; and (3) a civil society that is engaged and empowered to work actively to ensure access, uphold human rights, and monitor the quality of MNH care at all levels of the health system.

HSP COMPONENTS SUPPORTIVE OF AN ENABLING ENVIRONMENT

Improved Policies and Guidelines: Advocacy

The purpose of HSP assistance in advocacy is to establish a network of district-level advocates who, through their combined capacity and shared vision, are able to successfully advocate for better policies and a budget for expanded MNCH services. This advocacy work is closely related to providing assistance in decentralized planning and budgeting using the DTPS planning tool. This tool, created by MOH, was expanded by HSP to give more attention to MNCH and to cover drug commodity and supply management.[9]

The HSP advocacy component consists of building capacity in order to improve MNCH policies and increase and better target budgets. HSP provided technical training and TA to advocacy groups composed of diverse public and private stakeholders. The approach builds on Indonesia's tradition of local participatory planning to codify the planning process in legal (local MNCH laws) and administrative (DTPS and bottom-up planning process) instruments. Over the past two years HSP led and supported advocacy processes in 26 districts (2007 and 2008).

[9] See the next section for more detail on DTPS.

The advocacy training and support are supervised in each of the five regional HSP offices by a Program Coordinator (PC) for Advocacy. In 2007, the PCs each supported two districts. Before the first training session the PC identifies and contacts stakeholder groups, such as the DHO, parliamentarians, and NGOs, and invites them to participate in a three-day advocacy training. According to HSP, a typical group consists of three DHO staff, two from the district executive government, two from the district parliament, three members of professional organizations, 10 from different civil society organizations (CSOs), and representatives of the local media.

HSP subcontracted with the Women's Research Institute (WRI) to design and conduct the trainings. The first day is an orientation session on advocacy and understanding local MNCH issues and challenges; the second day orients the participants to different advocacy techniques; and the third day is a hands-on lobbying effort aimed at obtaining commitments from the parliament on MNCH funding. During the workshop the new advocacy team drafts a work plan for which HSP provides seed funding of up to Rp 45,000,000 ($5,000). The advocacy teams have used HSP support as matching funds for raising additional money to support the production of films, meetings with regional planning boards and parliament, and media coverage.

While the primary aim of the advocacy team was to lobby the Local House of Representatives (DPRD) for an explicit MNCH budget, after the workshop several advocacy teams initiated efforts to get district policies passed on MNCH, with a specific directive guaranteeing increased funding to improve the health of mothers and children. HSP hosted a series of workshops for legislators from the districts where advocacy teams were established to help them better understand their responsibilities and strengthen working relationships with authorities in drafting and passing legislation, as well as budgeting and monitoring. Consultants referred by LGSP helped to draft the district law.

In Sumedang, Indonesia's first MNCH-specific bill was enacted as law on June 2, 2008. In Malang District the DPRD passed the second law on September 26. Currently, 12 other MNCH advocacy teams in HSP partner districts are shepherding MNCH laws through various stages of passage: Aceh Besar, Aceh Barat (NAD), Pasuruan, Madiun, Kediri, Kab. Malang (East Java), Purwakarta, Cianjur, Sumedang, Kab. Bogor or Kab. Bandung (West Java), Medan, Deli Serdang, Siantar or Sibolga (North Sumatra), and Serang (Banten). In Sumedang and Malang the initiative for passing the law came from the DPRD while in Deli Serdang it was initiated by the district elected executive officer.

Strengths of the Advocacy Component

1. **Sustainability:** Districts that have initiated the process to pass an MNCH law are likely to sustain political and financial commitment to MNCH services even after new elections. The advocacy process built consensus and common purpose among a diverse group of stakeholders. As they move forward to enact and implement the law, however, members of the advocacy team may find their perspectives may not be as unified as their roles change to being funders, implementers, and monitors. Nevertheless, the experience of working together has given the teams an effective process for negotiating differences to reach consensus.

2. **Replicability:** Advocacy training and the process of drafting laws and lobbying for their passage have provided both governmental and nongovernmental organizations with new skills they can apply more generally. The HPS advocacy guide offers solid support to those who have been through the training and increases the likelihood that they can transfer some of their skills to new participants. The replicability of the guide has also been demonstrated. WRI facilitated the training in 15 districts in 2007. At the request of the MOH, national trainers were also oriented to the advocacy module. Participants were mainly staff from the MOH health promotion unit, although some were from the Directorates of Maternal and Child Health. Representatives of PHOs, DHOs, and local NGOs were also trained as trainers with HSP support and facilitated 11 district advocacy trainings supported by HSP in 2008.

3. Members of the advocacy team became **champions for MNCH** within their own organizations. This is particularly valuable in organizations like DPRDs, where MNCH had not previously been very visible. NGO members were also empowered to be more vocal within government institutions.

4. **Consistency with MOH policies**: The process gave participants knowledge of how to translate national guidelines into local action that is consistent with MOH policies. The advocacy manual has been printed as part of the MOH's own DTPS-MNCH efforts.

Weakness of the Advocacy Component

The teams required more support than was originally anticipated. Originally WRI was contracted just for the training, but after its first contract ended, HSP asked it to provide technical support to the advocacy teams. Similarly, LGSP was enlisted to help with drafting laws, which requires specialized skills that not easily transferable through short-term training. Training without follow-up support was not adequate for teams to function effectively. This is a lesson for future advocacy activities, such as drafting an implementation plan for laws once passed and monitoring its application. It is likely that different skills will be necessary for these steps. Whether the activities can be sustained without the assistance of HSP district PCs is not clear.

Issues

Having a district law for MNCH will guarantee the consistency of local government support to MNCH if and when the district official or DPRD changes after an election, although it is more likely that a newly elected official will drop a previous decree. However, in both cases, the real key to any impact and sustainability of passage of the law is monitoring its observance.

One of the lessons learned is that laws initiated by parliamentary committees that oversee social services appear to be more politically advantageous than laws initiated in the district official's office. Because consensus is built among various factions in parliament, including the official's party, laws initiated there pass more quickly with broader-based support and, once passed, the official's approval is virtually guaranteed. However, if the official initiates the process, there is the danger that opposition parties in parliament may oppose it, especially around election time, in order to deny the incumbent political advantage, particularly if the measure has popular support. This was illustrated by concerns among the Deli Serdang Advocacy Team, who reported that passage of the law might be delayed because some opposition factions in the DPRD did not want the incumbent official to claim credit for it before upcoming elections.

There has been considerable discussion within HSP districts and by several experts interviewed by the evaluators about the relative value of passing a specific MNCH law or incorporating MNCH articles into a more general health law. According to the HSP Advocacy Advisor, some districts had begun working on a general district health system law before HSP introduced the idea of a more focused MNCH law. These districts intend to incorporate specific MNCH articles into the general law. USAID LGSP staff believed it would be better to adopt the more general approach of a health law with MNCH components that can be followed up with regulations. It would be worthwhile to collect information on both processes to see which is more effective.[10]

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[10] Others, including Professor Laksono, an expert on decentralization and health, and Dr. Arum Atmawikarta from *Bappenas* also support passage of a general health systems law with MNCH articles, like the one in Serang. These more general laws can be supported with mayor's regulations or decrees. HSP recently contracted with Mahlil Ruby to create a tool that will standardize data collection and analysis of information about district budgets for MNCH activities. Dr. Ruby is now training provincial and district partners to use the tool to monitor funding in 23 districts that used the DTPS process and advocacy to draw up and pass MNCH budgets. Besides tracking budgets submitted, the teams will also try to ascertain whether funds allocated matched those budgeted.

There are a number of questions worth exploring about the sustainability of future applications of the advocacy tools in new districts:

- Is there a potential institutional home or host for this tool at the district or provincial level? The current institutional home is the central MOH Director General of Community Health, which is too far removed from implementation.
- Who can assess strategic stakeholders before the advocacy workshop and facilitate the advocacy process, as the HSP PC now does?
- Is HSP seed money a necessary ingredient to motivate advocacy teams? Who could provide this in the future? Will districts see value in supporting TA directly from their own resources?
- How well can advocacy coalitions be sustained without an external facilitator?

One initiative some MNCH advocacy teams are taking to address this challenge is to have the team mandated through a district decree. While that will ensure support from the district for team operations previously supported by HSP seed money, it may also compromise their political independence from the district government. However, with an increasing number of MOH staff involved in district-level advocacy initiatives, enthusiasm for this approach is growing.

Recommendations

1. It is recommended that HSP continue to provide technical support to districts that have either passed or are close to passing an MNCH law to help the DHOs draft viable implementation plans and support advocacy teams as they draw up and implement a monitoring plan.
2. HSP should further analyze the effectiveness of its TOT replication process to ascertain how much training is needed to develop capable facilitators and evaluate the level and kind of TA the advocacy teams need to draft and advocate for local laws; draft implementation and monitoring plans; and meet the requirements of the law and monitor its implementation.
3. The process of advocating for MNCH laws is one of the most innovative HSP activities. It is recommended that the wealth of lessons HSP has learned from the process be written up in five or six case studies from different districts. There has been widespread interest from non-HSP districts and other donors (see Appendix F, the NGO diary) in learning from and replicating this activity.
4. HSP and the Center for Health Promotion should include professional organizations (such as the Indonesian Health Promotion Association or the Indonesian Public Health Association) and higher institutions of public health (such as the Faculty of Public Health or the Association of Indonesian Schools of Public Health) in TOT on advocacy, to ensure that skills in advocacy are transferred throughout the educational system. This will contribute to both sustainability and replicability after the project ends.

Improved Decentralized Planning and Budgeting: DTPS

HSP revised and trained DHO staff on an MOH planning tool referred to as the *District Team Problem Solving* (DTPS) tool. The tool guides users through a planning and budgeting process that begins with collecting data on population and health in the district. The use of DTPS helped DHO staff to draw up budgets and plans that reflected district needs. HSP has helped the MOH to revise the tool to address both maternal and child health[11] and to incorporate drug and commodity management into planning. HSP regional office staff work with district planners in partner districts, helping them to collect and analyze MNCH data, draft plans and budgets that respond to district problems, and support DHOs in negotiations with the regional planning board and DPRD to ensure that their budgets are maintained. In 2006, when

[11] The previous version covered only maternal health.

central-level deconcentration funds were plentiful, the project also helped the MOH to draft guidelines for them and trained district officials in procedures to obtain and use them.

HSP supported the MOH revision of the DTPS Making Pregnancy Safer (MPS) planning methodology, and at the request of the MOH drafted a DTPS MNCH module that included both a reference manual and a participatory training module. The new DTPS incorporated drug and commodity management as part of MNCH planning and used the national standard annual budget planning template, which allowed the results of the DTPS to be dropped directly into the DHO budget proposal to the regional planning board.[12]

The revised DTPS changed the budgeting process from one in which the same budget allocation was repeated year after year regardless of the situation in the district to one based on evidence gathered by the DTPS team on the needs and health of the population and the operational costs required for proposed activities. An HSP District Facilitator worked with DTPS teams, composed mainly of DHO staff and a few representatives from NGOs, professional organizations, and the DPRD, to gather and analyze health information. HSP TA also provided training on how to apply the tool to match planning and budgeting to actual need.

Strengths of the DTPS

1. **Collaboration:** The DTPS promoted a team approach to MNCH planning by involving a variety of stakeholders who worked collaboratively with the DHO.
2. **Sustainability:** DTPS was influential in stimulating an appreciation by the DHO and other stakeholders for data collection and analysis as the foundation for planning and budgeting. It provided the DHO with evidence with which to argue for increased district budgetary allocations, and enabled the DHO to articulate a more compelling argument for giving MNCH priority for district funding. HSP assistance to the DHO on application of DTPS increased MNCH budgets in districts where the project is active.
3. **Consistency with MOH Policies:** Participants from the DHO believe that adhering to the MNCH Minimum Service Standard as part of the DTPS helped improve health service coverage. For example, in Malang district the DHO reported an increase in each woman getting four antenatal visits for high-risk neonates.
4. **Replicability:** The DTPS process provided a realistic framework for subdistrict planning as part of the DHO planning process. HSP also pilot-tested in three districts support for the bottom-up planning process (*musrenbang*, discussed more fully below). The pilot test was successful in focusing discussions between health center staff and village *musrenbang* participants on common criteria for selecting and planning health activities and investments.

Weaknesses of the DTPS

1. In the first districts where HSP helped with application of the DTPS, the process was not synchronized with the district-wide bottom-up planning process. Later the timing of the two processes was better synchronized, and in Sumedang, the district planning board created a way to combine the two planning procedures into a combined top-down and bottom-up approach.
2. Poor internal coordination and communication in HSP often confused the DHO partner in the field because tools and processes were being developed and rolled out at the same time (e.g., the delay by

[12] The earlier DTPS MPS produced a technical proposal that required additional work to adjust the results to the budget template used by the local planning body). The current DTPS is line with the latest government regulation number 13 on the standard government budget planning processes.

HSP in choosing between two different planning tools, DTPS and Prospect, both approved by the MOH). Some districts started with one and then had to switch to another.

3. Although the DTPS has been applied in 31 districts, very few trainers are independently capable of replicating the methodology in new districts. HSP has trained 119 trainers, but only 20 are considered fully qualified.

4. Health data collected for the DTPS are inconsistent. A 2008 HSP assessment of health information in Deli Serdang and Sumedang reported that information changes as it is passed up from lower levels to the DHO, and there are no standards for validating data.

5. Even though the DTPS has stimulated greater interest in the use of data for district planning, they are not used routinely to improve service delivery (i.e., to correct errors or increase coverage).

Issues

1. The main challenge is to determine how to build on advances in evidence-based planning and budgeting to improve services. There are many barriers, such as human resource allocation, deployment, and competency of health workers or inadequate referral, information, and supervision systems, that are not under the direct or exclusive control of the DHO. This is likely to constrain even the best of plans.

2. What is not clear from discussions and DTPS documentation is the extent to which services provided by private providers and health facilities are factored into planning and budgeting. For example, if plans are based on the needs of the district population as a whole but do not recognize that private providers may be meeting some of these needs, there may be a tendency to overdevelop the public supply side.

3. The lack of any system for tracking maternal and neonatal outcomes is a major constraint to elaborating reality-based plans and budgets that really address the problems in the health system that contribute to high rates of maternal and neonatal mortality. While there are guidelines for MPS and conducting maternal and neonatal audits of deaths and near misses, they have not yet been implemented at the district level; nor are they adequately budgeted for in the DTPS process.

4. The role of PHOs in the process is not clear, although they have facilitated the DTPS in some districts.[13] If they are to be effective in disseminating information, implementing guidelines, replicating evidence-based practices, and monitoring outcomes, they need to have a more prominent role in district-level planning and oversight.

5. HSP staff concurred with the opinion of national MOH staff that the DTPS process should be better integrated with other components of the project. Specific ways that MOH and HSP have agreed to integration in the future are to ensure that integrated management of childhood illness (IMCI) and supportive supervision efforts contribute to subdistrict health center planning and that BCC and provider training teams participate more fully in district DTPS planning

6. Given the breadth and intensity of HSP activities in some districts, regional staff were of the opinion that a single district facilitator, whose primary responsibility is community mobilization and who only secondarily provided support to planning, was not enough. They recommended that there be three staff members per district: a coordinator, a facilitator of district-wide processes like the DTPS, BCC, and advocacy, and a third person to facilitate social mobilization.

[13] Unfortunately, the evaluation team did not have a chance to speak with the provincial facilitators of the DTPS from PHO; field visits were focused at the district level.

7. The DTPS does not seem to be applied in a manner that results in rational planning for the distribution of services and personnel across the district. Districts could use help in determining where to upgrade primary health center services to include labor and delivery based on a district needs assessment. For example, at one of the districts visited, the BEONC health center was established because the facility already had beds so it could be easily converted. However, the facility has no patients despite the upgraded facility and staff, which suggests there may not be the need or demand for this service in its coverage area. Further, the facility's head indicated he had no input into the decision to upgrade. Districts can be supported to strategically plan for their service delivery needs based on an evaluation of local community needs; they need help in adapting MOH's "one size fits all" guidelines to their local context. This could be more readily accomplished in a project that takes a comprehensive approach to improving district planning, financing, and implementation.

Recommendations

1. There should be greater devolution of planning and use of information for decision-making to lower levels of the health system, such as the community health centers and their satellite facilities. HSP recently initiated efforts to strengthen health center planning and link it to the *musrenbang*, but there is still a need to reconcile the bottom-up process with the more top-down DTPS process. The supervisory and information systems that are vital to effective planning and implementation also need improvements. There is potential to empower communities to play a larger role in planning, budgeting, and monitoring by strengthening community health committees and community volunteers to effectively participate in the *musrenbang* and collect information about maternal and perinatal outcomes of pregnant women who are identified through P4K.[14]

2. HSP should advocate for adapting the Sumedang integrated planning approach in other HSP districts. Providing real budget ceilings during the *musrenbang* process greatly improved the quality of the proposals it generated.

Increased Leverage of the Commercial Sector: Public-Private Partnerships

HSP has sought private contributions to support program activities. The project was able to secure support from corporate resources, particularly for its humanitarian and relief efforts in Aceh and for the West Jakarta Flood Relief, among others. It has also trained district advocacy teams and IBI leadership on how to approach the corporate sector for financial support, and districts were able to secure some support for community events on breastfeeding. HSP also drew up simple proposal templates for approaching potential corporate sponsors.

Strengths

1. The program was able to raise considerable amounts of money in support of a variety of activities (see Table 4).

[14] There are several models for this type of effort in conjunction with community-based maternal and neonatal audits. UNICEF has recently done this successfully in several states in India (see UNICEF, 2008), and the MOH in Bolivia implemented a similar effort in rural areas of the Department of Potosí between 1999 and 2003 with the support of PAHO (see de la Galvez, 2004)

TABLE 4. FUNDS RAISED THROUGH PUBLIC-PRIVATE PARTNERSHIPS[15]		
COMPONENT	RUPIAH	US Dollars
Advocacy	Rp 2,104,000,000	$233,778
Breastfeeding advocacy events	Rp 534,713,200	$59,413
BCC hand-washing promotion	Rp 90,250,000	$10,028
Bidan Delima	Rp 50,000,000	$5,556
Community health committees	Rp 4,800,000	$533

2. HSP has also been assisting Johnson & Johnson (J&J) to program its 2008–13 support for the Bidan Delima program. Since 2005, when JHPIEGO secured support from J&J for Bidan Delima, the company has progressively expanded its support, committing more than $470,000 so far. J&J's corporate headquarters has recently made Bidan Delima one of the company's showcase programs globally, therefore securing a significant additional level of corporate social responsibility funding for Bidan Delima over the next five years. In 2008, J&J is supporting public service announcements on four national TV stations, training for another 500 Bidan Delima as facilitators, and underwriting printing valued at $170,000. J&J's five-year objective for Bidan Delima is to accelerate its expansion, starting by doubling membership in the next three years. As USAID's implementing partner, HSP has facilitated collaboration between the two donor agencies. HSP, as IBI's primary technical partner in managing Bidan Delima, has helped IBI to articulate its funding needs to J&J, and also helped it understand the opportunities and constraints of working with Bidan Delima. HSP and J&J are now asking IBI to formally establish a Bidan Delima stakeholder group so that donors can get regular updates on the program, encouraging transparency and accountability, and also helping IBI access additional technical support.

Weaknesses

1. While categorized broadly as public-private partnerships, these efforts have been more about fundraising and garnering outside financial support for activities than actual partnership.
2. The project has not been involved in designing or piloting PPPs that are specifically designed to address an MNCH issue and involve both public and private stakeholders in design of the intervention.

Issues

1. Indonesia's strong corporate social responsibility laws require corporations doing business in Indonesia to allocate funds for social causes. This creates an environment conducive to raising funds from corporate support for MNCH activities. The ability of a project to generate sustainable corporate support, however, is compromised by legal constraints preventing some US government-supported projects (which are not separate legal entities in Indonesia) for accepting other money for project activities. Corporate sponsors want to contribute to efforts and organizations that have a permanent presence. Conversations with USAID mission staff suggest that this has been a challenge for many USAID partners.
2. The term public-private partnership is very broad and can range anywhere from corporations offering financial or in-kind support to private sector health providers working with government. The PPPs

[15] This table does not include over $260,000 of cash and in-kind donations leveraged by HSP for Aceh and Jakarta flood relief efforts.

most likely to have a significant impact on reducing MMR and IMR are those between private and public healthcare service providers. The HSP project did not address these partnerships except for the Bidan Delima program.

Recommendations

1. Before it ends HSP might explore a more strategic PPP public private partnership in at least one district, such as involving the corporate sector in advocacy efforts. In future districts can explore other PPPs, such as a voucher program, an insurance scheme, or contracting with private organizations for services that fall within the purview of DHOs, such as health care delivery or monitoring.

HSP COMPONENTS THAT IMPROVE HEALTH SYSTEM RESPONSE

Reducing maternal and neonatal mortality requires that quality services be accessible at the community level for normal births with effective referral linkages to higher levels of care that meet quality standards in case obstetric or neonatal complications arise during pregnancy, labor, delivery, or postpartum.

Specific TA HSP provides to the MOH includes (a) updating standards in clinical guidelines, tools, and training modules; (b) strengthening district capacity in MNCH program management and quality improvement (supportive supervision, quality assurance); and (c) improving the quality of care (provider training).

Guidelines revised with HSP assistance include:

- DTPS
- Guidelines for the management of MNCH deconcentration funds
- Making Pregnancy Safer strategic implementing guidelines
- Minimum service standards
- Integrated technical manual maternal-perinatal audit at the district level
- IMCI.

The MOH has asked HSP to package these guidelines and those drafted by UNICEF on HMIS, the HSP advocacy manual/training module, the BCC training module, and the JNKP training modules (see below) into an integrated district MNCH health implementation toolkit.

HSP supported improvements in the quality of care at community health centers and satellite sites by emphasizing upgrading the skills of providers in normal delivery and newborn care and strengthening supervision to monitor and improve on the quality of care and MNCH management. During the first year of the project, HSP also helped improve provider capacity at the district hospital level in a few hospitals. However, its principal strategy has been to update training curricula and support the ability of the national training program through JNPK to incorporate these training packages into their activities.[16]

Improved Provider Capacity in Obstetric/Neonatal Care: Guidelines and Clinical Training

HSP worked collaboratively with the MOH, the University of Indonesia, professional organizations, and JNPK, the national clinical training network, to ensure that the guidelines and training modules reflected current evidence-based practices, including AMSTL, a tighter focus on neonatal care, IMCI, and EIBF. The clinical tools revised with HSP assistance include those for APN, BEONC, CEONC, and IMCI.

[16] For example, for normal delivery care (APN) the training curriculum was updated to include evidence-based practices in maternal and newborn care, such as AMSTL, management of birth asphyxia, and early initiation of breastfeeding.

HSP worked with JNPK master trainers to train JNPK provincial and district level trainers on APN using the updated guidelines and curriculum. In its districts, HSP also works with JNPK to certify provincial and district APN trainers by administering a competency assessment when the trainers replicate training for health center providers. After providers are trained, JNPK trainers visit each of them in their workplace to qualify the provider using a checklist (the same checklist is used for supportive supervision) and also accredit the health facility. HSP pays the cost of certification and accreditation because districts were not accustomed to doing this in the past. When a private midwife enrolls in APN training she pays the cost of her training, which also covers follow-up by the JNPK trainer who qualifies her and accredits her facility.[17]

HSP has followed a similar approach to upgrading provider skills in handling maternal and neonatal complications. The project worked with MOH and JNPK to update the training curriculum for health-center-level BEONC and with IDAI and JNPK to improve neonatal care as part of CEONC at provincial and district hospitals. In addition to following a TOT methodology, HSP support for CEONC also included on-the-job training (OJT) supervision of 263 neonatal unit practitioners in 18 provincial and district hospitals. This pilot training was incorporated into the standards and methods of the JNPK CEONC training program.

The project does not directly train providers or help districts determine their training needs and resources, although HSP supported JNPK when it conducted a training needs assessment in its districts early in the project. Each district through its annual planning process determines who is to be trained. It is not clear whether districts refer to the JNPK training needs assessment or do their own competency evaluation to determine which providers need training. HSP staff report that some districts prioritize who should be trained based on MNCH indicators within the district; others may use input from the supportive supervision process to identify trainees.

Strengths

1. **Consistency with MOH Policies**: HSP worked with the MOH to update the MNCH policies and guidelines that formed the basis for revising training curricula to ensure that they were standardized.
2. **Replicability and Sustainability**: The MOH's adoption of the guidelines, tools, and training modules revised by HSP supports their use in districts and their roll-out through the national training system (led by JNPK for APN, BEONC, and CEONC and the MOH for IMCI). Other donors using tools developed with HSP support include UNICEF, UNFPA, AusAID, Care International, CRS, International Organization for Migration, Save the Children, ADB and GTZ. For the CEONC package, MOH provided additional funds for JNPK to introduce the training in four other provinces.
3. **Collaboration with Pediatricians**: HSP's guidance on incorporating neonatal care into the APN, BEONC, and CEONC curricula and its intensive work to revise the IMCI package has had the additional benefit of involving pediatricians in the development of training curricula and in becoming trainers. Because of its history as a reproductive health training organization, JNPK has been dominated by OB/GYNs and midwives. The collaborative process to update the curricula facilitated by HSP has engaged the Indonesian Pediatric Association and the Association of OB/GYNs in working together and sharing ownership of the training network. This may also facilitate increased collaboration among perinatologists/neonatologists and OB/GYNs in clinical practice.

[17] This process is very similar to the process used by the Bidan Delima program and uses the same tools, except that the Bidan Delima self-assessment and validation tool also includes management and marketing components.

Weaknesses

1. While HSP support has improved training programs, it has not worked to reinforce systems to help districts optimize their investments in training. For example, records are not routinely kept or analyzed on the coverage of trained providers within health centers and satellites. Further, while the standard is to train 100 percent of providers, districts often do not meet the standard or strategically prioritize who is trained within a facility or across facilities. The lack of strategic prioritization compromises the investment.

2. Districts have limited or no provision for funding training follow-up and certification activities, and JNPK stated that it did not have adequate resources to certify all trainees. Follow-up support and training certification are essential to ensure that the training gets translated into effective practice at the worksite.

3. Some of the training sites visited that JNPK uses were underutilized. The clinics did not provide a sufficient clinical practicum experience for trainees.

Issues

1. One of the challenges HSP faces is determining the effectiveness of scaling up in-service training programs. The data suggest that APN training does improve provider competency. JNPK reports that of the 384 providers visited post-training in 2007, 99 percent were qualified as meeting basic APN competencies (HSP Annual Report, 2007). However, there is more that needs to be learned about how well APN training improves maternal and newborn services at the worksite. For example, since many work in health centers that do not have routine delivery services or in villages without a birthing facility, there is little opportunity for midwives, who mostly do home deliveries, to apply their new skills. So far there has been no assessment of the impact of APN training on the quality of care for home births or births at private midwife clinics.

2. Even among health centers with delivery services, it can be challenging to monitor the quality of services. For example, some that provide normal obstetric care or have received BEONC training do not have sufficient numbers of deliveries for trainers to assess competency.

3. The lack of clear criteria for deciding who receives training makes it difficult to assess how prepared districts are to provide skilled labor and delivery care. It is not clear how midwives with the required APN competencies are distributed throughout the district. Nor is it known how many midwives have been trained in APN or whether enough have been reached to have an impact on the quality of MNCH service delivery at the health center and satellite level in the HSP districts.

4. There is also the question of whether off-site training is the best strategy for improving quality of care at the facility level. It is worth considering whole facility training that would be geared to improving supportive systems as well as clinical skills.

5. One major question not addressed by the MOH, JNPK, or HSP is whether there is value in having a module on normal home-based delivery. Although the JNPK APN training package is designed for a normal delivery at a midwifery facility, the reality is that most births still occur at home, whether assisted by midwives or not.[18] To change the current situation requires intensive improvements in facility-based delivery care and aggressive BCC and advocacy to convince Indonesian women to deliver in facilities. Meanwhile, it may be worthwhile to improve the quality of care in home births

[18] For instance, a baseline study by the MOH project Save Newborn Lives 2 (SNL 2), supported by Save the Children in the Garut district in West Java found that 56 percent of the mothers already said they intended to deliver their babies with traditional birth attendants when they were pregnant; those who intended to deliver with midwives were only 37 percent.

while connecting to a referral strategy that gets home-delivery women and newborns with complications rapidly to higher levels of care.

Recommendations

1. There is a need to study how much APN and BEONC training contribute to improving the quality of MNCH. Additional formative research is required to understand if and how midwives are applying the skills they have learned in APN to the home birth setting. This research could consist of accompanying midwives to home births to observe maternal and newborn care practices. A maternal/perinatal audit process could also make it easier to understand the special needs that might attend home births.

2. Ways to leverage opportunities for trainees to update their colleagues on what they learned in training should be explored. HSP created a good model for this in its DVD on steps for integrating AMTSL with early initiation of breastfeeding for midwives who deliver unassisted. Providers who attended the workshop and received the one-day training were able to go back to their worksites and share the DVD and information with their colleagues. During the site visit, we encountered several midwives who reported practicing the immediate breastfeeding protocol because they had seen the video, even though they had not attended training.

3. HSP can also work with JNPK and others to find ways to shorten training or deliver it in different formats while preserving quality, so that the accessibility of the training programs is increased and costs are lowered. The JNPK pilot, which includes a self-study module and a five-day clinical practice program, is an example that has the added advantage of perhaps being more attractive to private providers, who are less likely to have time available for a long program.

4. HSP can also work with districts and JNPK to ensure adequate post-training support and certification. JNPK will either have to raise its charges for training to cover the costs of facility certification and qualification of providers, or the districts will have to bear the certification costs.

5. For the longer term, improvements in human resource management systems at the district level to rationalize selection for training and distribution of trained personnel would increase the impact of investments in APN, BEONC, and CEONC training. A more systematic approach for assessing provider competency would also help identify those who need reinforcement through training.

6. Because provider competency in maternal and newborn care is inextricably linked to the quality of pre-service education, so any later project should stay abreast of developments in improving the quality of pre-service education and what this might portend for in-service training needs.

Improved Quality of MNCH Services: Supportive Supervision

The skills and performance of the 56,000 village midwives deployed by the government since the 1990s vary greatly. HSP supported improving supervision of village midwives by training health-center-based midwife coordinators in supportive supervision. The MOH, with help from HSP and JNPK, revised the supportive supervision tool for MNCH services. The package consists of guidelines for midwife coordinators, a training package, and supervision checklists. With support from HSP, 406 staff from 115 facilities have been trained and are implementing supportive supervision, the phases of which include checklist orientation, self-assessment, verification and recapitulation, development of a self-improvement plan, and monthly meetings to monitor corrective actions. The guidelines have two checklists, one for MNCH services to be used at health centers and satellites generally and the second for centers that offer delivery services, including BEONC. The four components in each checklist—logistics (drugs and supplies); nonclinical (facilities and equipment); management (recordkeeping); and clinical procedures—deal with factors that affect service performance.

HSP created a training program on supportive supervision for midwife coordinators and conducted a training of trainers to build a group of 25 national trainers and 120 provincial and district trainers, including a provincial and district JNPK trainer, DHO representatives (district midwife coordinator and MNCH staff), and one PHO MNCH officer. The 145 trainers train the supervisory teams at community health centers.

HSP has conducted training in 23 districts at 92 health centers, where the head, the midwife coordinator, and the nurse or midwife in charge of the MCH program are trained in the guidelines, use of the checklist, and supportive supervision skills. The approach emphasizes improvement rather than more traditional fault-finding. Unlike with APN or BEONC training, HSP pays for all the costs of training staff in supportive supervision. HSP also created a software program to capture and analyze scores from the supportive supervision checklists.

The supportive supervision process uses the monthly meetings with midwives at the health centers to address quality improvement. The midwife coordinator is also supposed to visit each village midwife every quarter. Districts and facilities using the supportive supervision process are able to monitor quality indicators. Facilities where the program has been implemented report higher compliance with quality indicators over time, although the data on the performance of facilities participating in the program has not been aggregated and analyzed.

Strengths

1. **Consistency with MOH Policies, Replicability, and Sustainability**: As the supportive supervision guidelines come from the MOH, this aspect of the program facilitates sustainability and replicability at the provincial and district levels. MOH has trained PHO staff in the guidelines not only in the six HSP provinces but also in 23 others. Other donors, such as UNICEF, are using the trainers to replicate the approach in other non-HSP districts. Replication is thus happening before the program has been evaluated. HSP is undertaking a process review of the supportive supervision program in five provinces in September 2008.
2. **Sustainability**: Based on limited observations and interviews, the supportive supervision approach seems to have made it easier for midwife coordinators to carry out their supervisory responsibilities and energized a process that had only existed on paper. Staff now have the skills and tools to assess quality and take action to improve it.

Weaknesses

1. Because the process focuses on inputs, there is no link to the volume of services being provided at a clinic (which is also a dimension of quality). For example, a clinic could score well on all quality indicators but have no patients. At present the supervisory process does not hold providers accountable for increasing demand for services, yet the health center and satellite structure is designed to provide community outreach to increase service use.
2. The supervisory process does little to monitor or improve the quality of home births for mother or newborns that are assisted by village midwives or midwives in health centers without delivery services, who may attend births in facilities or homes through their private practices.

Key Issues

1. To further ensure sustainability, it is necessary for districts to budget for supportive supervision training in the future. While HSP bore these costs during the pilot phase, it is expected that the districts will pick them up as part of their annual budgets. HSP staff report that several districts were intending to use deconcentration funds to support the activity, but since these funds are not likely to

be available, it might jeopardize supportive supervision. (This reinforces the link of budgeting processes and advocacy discussed elsewhere).

2. Providers are being trained on APN, but unless they work in a health center with delivery services, their skills may neither be applied nor assessed.

3. The supervision process does not extend to private facilities in the community, although the DHO is responsible for licensing private health facilities in the district once every five years. In general, private providers are not supervised by the midwife coordinators in each district. (Within HSP districts there is an exception to this rule at Medan and Surabaya, where the midwife coordinator invites the private practice midwives to the monthly meeting). The Bidan Delima program described later is a vehicle for providing supportive supervision and quality improvement for private midwives, although this HSP assessment did not examine the efficacy of the model.

Recommendations

1. The effectiveness of supportive supervision in improving quality of services and continuous improvement needs assessment based on evaluation and field realities. Service utilization data could be introduced into the supervision process to reinforce the idea that health center providers are responsible for helping increase the number of clients served.

2. Also recommended is a search for approaches to monitor the quality of delivery and newborn services that take place in the home or a midwife's private clinic. For example, one approach could entail calling a midwife coordinator when a woman goes into labor so that she could assist, observe the community midwife and provide OJT support. This same approach might be used for facility births in private clinics, perhaps in coordination with IBI through the Bidan Delima program. One of the requirements for qualification could be that at least one birth be observed.

Improved Quality of MNCH Services: Bidan Delima

Private midwives are providing a large and growing proportion of maternal and newborn services in Indonesia. Ensuring the quality of those services is important to reducing MMR and IMR. HSP's principal vehicle for improving the quality of private provider services is through its support to the Bidan Delima program of IBI, the Indonesia Midwives Association.

IBI began the Bidan Delima program in 2003 under the STARH program to increase the quality of care private midwives provide. Since 2004 the program has expanded from 50 to 203 districts in 15 provinces with 7,462 members and 1,120 volunteer facilitator/supervisors. In some districts as many as one-third of the midwives have been validated as Bidan Delima. The program is managed through IBI's national office and provincial and district chapters.

The Bidan Delima program requires midwives to meet certain standards. To qualify, all midwives are expected to have completed the APN and Contraceptive Technology Update training. They must also complete a self-assessment evaluation and work with volunteer facilitators to improve their practices so that they can comply with all standards. The facilitator then validates that the midwife meets all standards and, upon payment of the initiation fee, the midwife receives her certificate and a kit including signage and permission to use the Bidan Delima logo to promote her services. Once a midwife is certified, the facilitator is expected to make supportive supervision visits to the midwife every three to six months. Annual dues for Bidan Delima midwives are Rp 250,000.

HSP support has been aimed at reinforcing the systems and staffing needed to expand the program. HSP supported revision of the program and implementation guidelines for central, provincial, and district branches and paid for the program launch in three districts in Aceh. It is working with UNICEF to launch the program in another two districts in Banten and paid for facilitator training and support for IBI

leadership and oversight. HSP also created a web-based tool for tracking membership and dues payments. It supports two program coordinators and two administrative staff at IBI offices and a program manager in the HSP office. HSP also supported an evaluation of the program and helped identify and approach potential corporate sponsors.

Through the STARH program, IBI received financial support for all training and materials and a mass media marketing campaign. For the past three years it has also received support valued at $470,000 from Johnson & Johnson, which is likely to continue for another five years. In 2008, J&J supported facilitator training, printing, and the costs of marketing the program using television spots developed during the STARH program. Through HSP's contacts, IBI also received some support from Exxon to launch the program in Aceh.

Strengths

1. **Replicability:** The rapid scale-up of Bidan Delima and the large number of midwives who want to be certified demonstrate that the program is replicable. IBI leaders have stated that the goal is to certify as many midwives as possible. While the program is sometimes referred to as a franchise model, it is more accurately described as a quality recognition program.[19]

2. The program seems to have stimulated **peer exchange and support** among midwives, which is particularly positive for midwives who work alone. However, there is little evidence that these gatherings are used to improve quality of care through review and analysis of cases.

3. The program has positioned the idea of **midwives as entrepreneurs** who have pride in their services and live up to a particular standard of care. The drawback is that there is still no effective way to guarantee the standards and quality of care because certification is a one-time, five-year qualification (see below for ways to set and maintain higher standards).

Weaknesses

1. The costs of operating the program, even with heavy reliance on volunteer facilitators, are more than IBI can support. Income generated from member fees is insufficient to cover expenses. A financial analysis of the program, assuming that all annual fees were collected and that adequate staff were in place to manage the program at all levels, showed that the program would require a subsidy of Rp 5 billion (about $555,000) to meet its annual operating expenses. This does not include provision for marketing the Bidan Delima brand.

2. The management capacity of IBI as an association is very limited. While the organization boasts 70,000 members, it has few staff and no executive secretary to manage it. The elected leaders at central level run its day-to-day affairs of the association, and these can change every five years with new elections. This limits the sustainability of leadership development and capacity building. IBI leaders commented that in the past the Mothercare MNH program supported a full-time executive secretariat which "became the motor of the board" and enabled the association to be more effective.

3. Further, the management and financial systems of the association are limited and lack transparency. Corporate or other donors are reluctant to contribute to an organization or program that lacks sound financial management. Interviews with potential funders and HSP staff engaged in looking for corporate support suggest that many companies would like to contribute to NGOs but only a few NGOs have credible financial management. Therefore, private companies have more confidence in

[19] Franchises require standardization of facilities, services, and management practices in return for promoting the brand and increasing market share for franchisees. To be successful, this requires exclusive coverage areas and substantial investments in brand development. IBI's desire for universal coverage of Bidan Delima rather than branding a select group of clinics with distinct market areas is antithetical to a franchise approach.

giving their funds to big agencies like UNICEF or other reliable international NGOs. In general, recognized professional organizations have more credibility in the eyes of the private companies, so a strengthened IBI could be well positioned to tap into corporate social responsibility and other support.

4. The success of the program depends heavily on local leaders and their interest in promoting the program in their area. Several individuals outside IBI stated that if the local chair is not committed to the program or does not have the leadership and management capacity to organize and mobilize the district, it is difficult to implement the program successfully.

5. The Bidan Delima program is highly dependent on volunteer support, which becomes more difficult to sustain as the program expands. The program relies on volunteer facilitators to recruit, validate, and provide continuing supportive supervision to certified midwives. Even with the goal of one facilitator per 10 midwives, this can be a significant commitment for the facilitator who must attend training to be certified as a facilitator and continually visit midwife clinics, especially during the recruitment and validation process. There are few incentives to become a facilitator. Reliance on volunteers to operate the program slows it down. If the program is to expand, a new system will be needed in which paid staff augment facilitators in performing validation and supervisory visits.

6. Midwives perceive limited continuing value added once they are validated as Bidan Delima. Many midwives perceive value in being Bidan Delima because it encourages them to upgrade their skills and facilities. They also notice that participation in the program has led to an increase in clients, not so much because the brand is recognized but because their practices have improved. Nevertheless, they do not necessarily perceive sufficient value to pay the annual fee, so payment rates are only 18 percent. (Facilitators are exempted from paying the annual fee.)

Issues

1. To be financially sustainable the program will need to derive support from multiple sources, including income-generating activities, such as fees and payments for services, donors, and corporate and government support. The program has achieved some success in this regard with support from J&J, and some district governments have also supported APN or facilitator training for midwives.

   The ability to secure more diversified funding requires that the program have the organizational capacity to obtain and manage such resources and the ability to demonstrate and document the effectiveness of the program as a worthwhile investment for donors, corporations, or government (see Appendix D for suggestions on how IBI might position the program to appeal to funders).

2. How effective the program is in achieving improvements in maternal and newborn care has not been quantified. An evaluation of the Bidan Delima program looked at just two districts; it is inappropriate to generalize from such a small sample to the program overall. In that study the program showed promise in several indicators, such as better infection prevention practices (as measured by availability of equipment) and improved knowledge and self-reported practice in delivery, neonatal, and postpartum care. Further, improvements were seen among both Bidan Delima and non-Bidan Delima midwives practicing in the same area, which may be attributable to peer education and support. The evaluation also identified possible deficiencies in the validation process that reinforce the need for an effective quality assurance mechanism for implementation of the program at the district level.

3. To secure the support of governments and corporations, the program will need to prove the model in a compelling and quantifiable manner. This will require greater investment of resources in evaluation, targeted market research, and routine collecting and analyzing of service use, outcome, and quality data from Bidan Delima midwives to show network reach, number of clients served, and the potential for positive health impacts. The project could look into innovative uses of technology to collect and

analyze data, such as using mobile phone technology and working with vendors of automated data reporting and recording systems.

4. Ultimately this program could demonstrate how private provider associations can increase the number of clients served, meet the MNH needs of communities, improve health care delivery, and ensure the quality of care among their private practice members, so that government might be willing to outsource service provision to them or delegate related regulatory functions to the association.

5. In addition to its financial, organizational, and managerial challenges, the program will need to evolve to ensure its continued relevance and value as government systems become stronger. Arguably, if government oversight functioned effectively, the recognition granted by the Bidan Delima program is no more than what the government would bestow in its regulatory capacity. Bidan Delima does not reflect higher standards than those required of all midwives. As the quality of care in facilities improves, Bidan Delima standards might be revisited to reflect achievement of more than the minimum standards of care. A gradient recognition system could be considered to acknowledge high performers.

6. Among the many options for increasing the value of the program are special educational opportunities and distance learning programs, marketing, technical updates through newsletters and the website, access to loan programs, and technology access and training.

Recommendations

1. HSP should continue to support the Bidan Delima program as it has been doing and also move to build management support. The program would benefit from a dedicated committee comprised of program staff, board representatives, and donors to guide management and expansion of the program. It might also be advisable to form a technical advisory group with more external stakeholders to build a constituency for the program.

2. More effort could also be directed to collecting service statistics, outcome data, and quality indicators from Bidan Delima members that can be used in advocacy and fundraising. It is not enough to know how many members there are but also how many clients they reach and the outcomes of their work. The web-enabled system that HSP already developed could be expanded to collect and publicize this information.

3. It is recommended that HSP support a study of the actual outcomes of the Bidan Delimas; changes in their caseloads since certification; documenting fees and services provided; and establishing what market share they have in HSP districts. It would also be useful to understand how many Bidan Delimas are also public sector midwives and to what extent their additional preparation spills over to that work.

HSP COMPONENTS THAT ENGAGE AND EMPOWER CIVIL SOCIETY

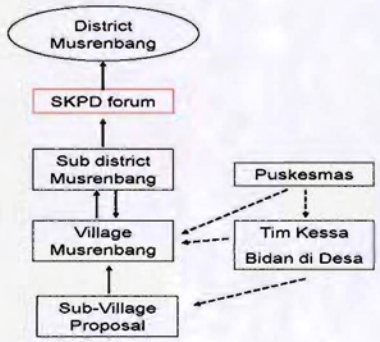
Increased Stakeholder Involvement in MNCH Services: *Musrenbang*

In 2008 HSP initiated additional activities in support of district-level planning through the *musrenbang*[20] process. HSP has been testing in Kediri, Sumedang, and Deli Serdang whether additional inputs to the

[20] The *musrenbang* is a deliberative multi-stakeholder forum that identifies and prioritizes community development policies. It aims to be a process for negotiating, reconciling, and harmonizing differences between government and nongovernmental stakeholders and reaching consensus on development priorities and budgets. Synchronized forums take place at the village, subdistrict, and district levels through a planning process that is both bottom-up and top-down (LGSP, *Musrenbang as a Key Driver In Effective Participatory Budgeting* Musrenbang Policy Brief March 28 draft).

process can result in more and more sustained attention to MNCH. HSP attempted to engage both community health committees (CHC/P4K) and health center staff more effectively in the process.

Sumedang has a special regulation on planning and budgeting, *Perda 1/2007*. As the only district in Indonesia to have this type of law, the Sumedang District government was able to decide on funding allocations for each subdistrict before the meeting of *musrenbang* in the subdistrict. Knowing what funding was allocated to each subdistrict allowed participants to make decisions based on actual resource availability. As a result, Rp 1,309,795,650 were mobilized for MNCH activities in the subdistrict budget as well as in the health center budget from DHO for the subdistrict. The total was more than double that of the year before.



With technical assistance from LGSP, HSP trained *musrenbang* facilitators from the community health centers and CHC in a one-day workshop. The inputs included (1) support for health center planning in several subdistricts, with participation of village CHC members in a planning workshop; (2) encouragement for CHC members and community midwives to be involved in drafting proposals in the subvillage for submission to their village *musrenbang*; and (3) health center involvement to actively advocate and negotiate during *musrenbang* for inclusion of MNCH support in the subdistrict budget. The workshops supported the idea of passing village level regulations to set MNCH as a priority and to provide a legal foundation for the CHC.

Strengths

1. **Sustainability:** passage of the budgeting *Perda 1/2007* and the MNCH law in Sumedang had a significant impact on gaining priority for MNCH in the *musrenbang*.
2. **Replicability:** The workshops increased participation by CHC members in the village *musrenbang*. They were also successful in producing more non-infrastructure health proposals than in subdistricts and villages that did not participate.

Weaknesses

1. In Deli Serdang and Kediri, the lack of clear budgetary guidelines at the subdistrict and village level made it hard to draft realistic plans, requests, and proposals for funding through the *musrenbang*.
2. The one-day HSP workshops were not successful in sustaining collaboration between health center staff and the CHCs.
3. Except in Sumedang, bottom-up, non-infrastructure health proposals generated by the *musrenbang* did not increase at the district level. It appears that workshop participants were not sufficiently convinced or empowered to lobby for their proposals going forward.

Issues

Village *musrenbang* planning processes offer opportunity for health centers and their networks to mobilize additional funding resource to support MNCH activities at the village level, such as integrated

service posts and CHC/P4K. The MOH should recommend each district to do the health center planning before the village *musrenbang*.

The Sumedang regional planning board and the advocacy team noted that the MOH is in the process of releasing a regulation about the planning and budgeting process using the Sumedang process as model. Once it is signed, all districts are obligated to follow it. This is an opportunity for MOH to disseminate guidance on how DHOs and community health centers should be involved in *musrenbang* planning.

There is room to increase women's participation in the planning process. In its *musrenbang* support activities, HSP missed the opportunity to build on its success with involving community volunteers, members of the PKK national women's group and other women's groups. With few exceptions, women's voices were lost by the second stage of the subdistrict process. PNPM, the national community development program, has crafted a process whereby women and men first meet separately to draft proposals and then come together at the village level to negotiate which proposals are adopted. This has given women a greater voice in community decision-making.

Recommendations

1. This component of the project needs more work before it is either replicable or sustainable. It deserves more attention; HSP might look to other examples of using the *musrenbang* for sectoral planning, such as the process employed by the PNPM, which uses conditional cash transfers as incentives to villages that come up with creative ideas for addressing priority community development problems. The *musrenbang* pilots show promise for using this process to leverage additional funds for MNCH, but there is still so much to be learned that further study and documentation would be justified. There could be closer coordination with PNPM, which uses bottom-up planning similar to the *musrenbang* and has a pilot program to support achievement of the MCH MDGs.

Improved Awareness and Promotion of Positive MNCH Behaviors: BCC and CHCs

BCC

HSP's BCC activities focused on building skills among district stakeholders to undertake BCC activities directed to individuals, households, providers, and communities. HSP put together 15 BCC district teams that concentrated principally on media campaigns and events to promote immediate breastfeeding, hand-washing, and birth preparedness. It trained the teams to undertake formative research to understand local practices and use the research findings to craft messages for mass media campaigns and materials.

HSP worked on BCC in close association with the MOH Health Promotion Unit, PromKes, in drafting the training and the TOT curricula. PromKes staff participated as trainers and trained other staff to replicate the training outside the HSP districts. There are now 34 provincial BCC trainers who are competent to replicate the training in other districts and provinces. PromKes has proposed a budget for 2009 to replicate the process in six more districts.

HSP also worked in partnership with other USAID programs (ESP and DAP partners) to promote hand-washing with soap, with the MCC on immunization and breastfeeding promotion, and with Mercy Corps and CARE on breastfeeding promotion. The program also participates in the World Bank-sponsored core group on hand-washing, which has developed protocols for seeking corporate support to promote hand-washing.

For the hand-washing with soap activity, HSP replicated materials designed by Studio Drya Media (a nonprofit NGO in Bandung that specializes in community empowerment, adult learning, and participatory process) for Save the Children's food security and nutrition program, also funded by USAID. The rapid

survey demonstrated that in 2007 hand-washing with soap at three of five critical times increased from 6.6 percent to 12 percent among caretakers but dropped back to the baseline rate (7.4%) in 2008.

The breastfeeding work is targeted to a variety of audiences and stakeholders. Because the definition of early initiation of breastfeeding (EIBF) was recently updated and highlights the importance of immediate skin-to-skin contact, all the interventions aim to provide correct information to a specific audience, such as health providers, policy makers, journalists, or community members.

JNPK gives health providers in-service training updates on EIBF in a one-day training that also covers neonatal care, oxytocin injection within one minute of delivery, delayed cord clamping, and controlled cord traction for placenta delivery. The training is reinforced with a clinical training DVD that has been widely distributed. HSP has also sponsored workshops on EIBF and the international code on marketing of baby formula to advise on the dangers of formula and the rapacious tactics of some formula companies.

In a survey of knowledge and practices carried out in May 2008, three-quarters of the midwives surveyed who attended the workshop could correctly define the EIBF process, compared to only half of those who had not attended. The survey also asked about reported practices during the month preceding the survey, and 93 percent of midwives who had attended the workshop reported helping their patients to initiate breastfeeding early, compared to 68 percent of those who had not attended.

EIBF interventions include community modules on EIBF and exclusive breastfeeding that include games and other participatory methods. In the most recent rapid survey, August 2008, EIBF rates reported by households for selected districts increased from the 9.2 percent to 27 percent.

Community Mobilization (CHC/P4K)

HSP is updating the P4K (formerly Desa SiAGa) operational guidelines for birth preparedness and complication readiness with the MOH Directorate of Maternal Health. The guidance sets out a process for engaging communities in drafting birth preparedness plans. HSP district facilitators train village leaders as community facilitators, who then lead a participatory needs assessment that establishes a CHC with subcommittees that address village needs. Once a village has formed a CHC/P4K, HSP provides support to implement modules on birth preparedness and complication readiness, hand-washing with soap, and early and exclusive breastfeeding.

HSP's support to P4K committees enables them to work with pregnant women on transportation plans, start emergency funds, and identify blood donors. The CHCs were charged with registering all pregnant women and helping each woman and her family to develop a birth plan that was summarized on a sticker on the outside wall of her house. The information includes her name, the place she intends to deliver, the name of her provider, due date, and blood type. HSP provided seed money to initiate the emergency funds, but almost all CHCs developed fundraising strategies to increase the amount.

To support effective community mobilization, HSP works primarily within the health system, building the capacity of district and health-center-level partners to facilitate community responses to health concerns. HSP's district facilitators work with their counterparts to identify community leaders, who are then given training and support. District staff are supervised by the same regional office staff who manage the BCC portfolio. In the early stages of community mobilization, tasks and skills addressed with HSP assistance include community involvement, participatory community health assessment, and planning.

According to project reports, by the end of 2007 HSP had supported 364 CHCs that had P4K plans. Of these, 156 have also implemented hand-washing with soap activities, and 182 will have implemented EIBF activities by the end of FY 2008.

Strengths

BCC

1. **Replicability and Sustainability:** By working closely with the MOH health promotion unit and training its staff, HSP guaranteed that BCC trainers would be available at the unit to replicate the process in other districts. Similarly, others that were trained were strategically located in partner organizations that are in a position to replicate the training (e.g., the Bapelkes training institute of the MOH, the OneCom advertising agency, PHO staff, and representatives of professional organizations, educational institutions, and NGOs). HSP BCC activities had the full support of PromKes and provincial and district staff, who played key roles at various points so that HSP could focus on providing TA and resource persons.

2. **Consistency with MOH Policies:** The component supported and strengthened the policies of the health promotion unit. Although district teams were free to adjust materials and promotional events to the local context, the unit was comfortable that HSP-supported BCC messages were consistent with national policy and standard BCC messages. HSP activities in promoting the MOH's national P4K initiative, also ensured consistency with MOH policies.

3. **Collaboration**: The various stakeholders involved in the district BCC teams worked well together, and there is respect for the different roles of private and public sector members. A number of local NGOs participate in district MNCH BCC teams and represent a broad range of civil society: health providers, women's organizations, religious organizations, and community-based organizations. Private and public sector members stated that HSP had created favorable working conditions and helped to build trust among team members and delineate clear responsibilities.

4. **Training and Media Approaches:** BCC team participants found the training interesting, entertaining, effective, and efficient, and believe that the content prepared them to run an effective campaign. Additionally, by involving the private sector (an advertising agency) the teams were able to make both the message and the delivery attractive. The use of local media was also a plus because they reached the local population more effectively than national campaigns.

5. The live events created **healthy competition** among district BCC teams. For example, when West Jakarta organized an event to support immediate breastfeeding by bringing together 1,001 pregnant woman, Deli Serdang responded by organizing 2,010 pregnant women, and then Surabaya responded with a rally of 2,010 couples (pregnant woman and their husbands). Further, the BCC teams were successful at raising money from private sources for these events.

CHC/P4K

1. The use of **games and other participatory techniques** helped engage communities in organizing and reinforcing CHC/P4K committees.

2. The seed funds and games helped to renew **community volunteer interest** and revitalized the integrated health posts in some communities. The most active CHCs appeared to be those that had successfully involved volunteers and PKK members. The CHC/P4K that had active participation of community volunteers and PKK members also seemed to have more women in leadership positions.

3. The seed funds were also effective in **leveraging community resources** for funds to support transportation of women and their families to health facilities when there were complications.

4. In many places, in addition to drafting birth preparedness plans, CHCs established **environmental health committees** to work on of water and sanitation problems in conjunction with hand-washing activities.

Weaknesses

BCC

1. The BCC process requires large numbers of staff and resources, which raises questions about its sustainability without an outside funding source. This might be partially compensated by generating private funding. PromKes staff voiced concerns about their limited numbers of central and regional staff and capacity to continue BCC activities without HSP support. Similarly, the DHO has limited resources, so continuation will depend on the capacity of local BCC teams to raise money from private sources.

2. The BCC training takes a relatively long time (10 days), which limits who can participate and also has cost implications for replicability and sustainability.

3. Often suggestions and the results of pretesting media were not taken into consideration in the final production of materials by the advertising agency. Although the suggestions indicate creativity and skills retained by district staff and were justified in terms of decentralized management, there were indications that the BCC teams did not understand the agency's production processes and constraints.

4. At times there were problems in coordinating BCC activities between HSP, local BCC teams, and PromKes due to staff turnover and the exigencies of their respective commitments.

5. The BCC process did not have an institutionalized way to test the impact of campaigns and messages. Nor was it possible to examine whether the efforts served to upgrade practices.

6. There was not always a good sequencing of BCC with other interventions. For instance, in some districts BCC activities preceded DTPS and advocacy activities, so there was no opportunity for synergy among them.

CHC/P4K

1. HSP worked in too few communities in each district to measure the district-wide impact of CHC/P4K.

2. The evaluation team had concerns about the effectiveness of what appeared to be a cookie-cutter approach to CH/P4K, which insisted on a fairly uniform organization despite different sociocultural contexts. MOH policies on allow for communities to choose their own organizational mechanisms according to what is most compatible with local practice.

3. The CHC/P4K process had no follow-up on registering birth outcomes for mothers and newborns. This was a missed opportunity for building in more accountability for outcomes.

Issues

1. There are concerns about the sustainability of the BCC training due to limited budgets at district and municipal levels. The high cost of training will permit PromKes to scale up only modestly. Its sustainability depends on how district governments perceive its importance and effectiveness and on the interest of corporate sponsors.

2. The high-profile activities of BCC posters, radio messages, and public events are unlikely to transform practices alone. There is a need to follow through on large-scale public events and mass media with community mobilization activities and with healthcare providers.

3. Discussions with WRI and Fatayat NU indicated that more could be done to address gender inequalities. These relate both to practices that affect pregnant women and to midwives who are mostly women and face gender challenges that men may not. Specific issues are sensitizing the community to (a) the importance of locating community birthing facilities in safe and accessible sites

to ensure the safety of midwives and their clients[21]; (b) the risks of early marriage and pregnancy; (c) the need for birth preparedness plans to also focus on alleviating gender-based constraints beyond transportation, such as childcare and expectations that women immediately resume their domestic duties after birth[22]; (d) the need to cover the transportation costs of community midwives so that they can reach their clients, especially in remote areas; and (e) the ban against allowing married midwives to live at the village birthing facility.

Recommendations

1. There should be a closer link between BCC and the DTPS process so that the DHO and the advocacy team better understand the value of BCC for supporting health practices in the district. As BCC may take place separately from planning for other service delivery, it may not always be on the planners' radar screen.

2. Community mobilization activities seem to be quite dependent on the HSP district and community facilitators, and it remains to be seen if the activities can be sustained without outside facilitation. Health center staff were not integrated into the community mobilization, so it is not clear who is prepared to step in to support CHC/P4K committees after the project. HSP should consider working with district-level PromKes on a process to fully engaging health center staff and community volunteers on health promotion.

3. HSP should concentrate on increasing BCC and CHC team capacity to raise funds from private donors and corporate sponsors. It is important that both governmental and nongovernmental members of the teams acquire skills in fundraising and advocacy.

4. There should be additional emphasis on community-level information, education, and communication linked to the wider BCC campaigns. There are opportunities to broaden the content of CHC/P4K training to include more on newborn care, data collection and analysis, EIBF, and exclusive breastfeeding, and give clearer guidance on where go in case of emergency. It would also be useful to have community midwives collect information on birth outcomes for every woman registered by the CHC.

5. There should be more emphasis on hand-washing by healthcare providers, as well as targeted messages for healthcare providers on EIBF through job aids, DVDs, and other accessible media.

6. As with the advocacy component, it is recommended that HSP and the MOH Center of Health Promotion train trainers from professional organizations and university-based schools of public health in BCC methodology to ensure an additional home for BCC training.

7. Any future BCC programs should include baseline and impact surveys on changes in knowledge, attitudes, and practices linked to mass media campaigns.

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[21] The WRI study of seven provinces noted that communities often locate community birthing facilities in isolated or unsafe places, such as the remote margins of rural communities or near cemeteries, which are perceived to be spiritually dangerous.

[22] This was one of the reasons given for women preferring to give birth at home rather than at a health facility. It is also one of the reasons given in some areas for preferring traditional birth attendants, who also help with cooking and childcare in the postpartum period.

SUMMARY OF STRENGTHS AND WEAKNESSES OF HSP TO DATE

In large measure the project has produced results that are replicable, sustainable, and consistent with GOI policies, and has implemented its activities through collaborative relationships with GOI and civil society partnerships. HSP has many strengths:

1. As a USAID partner organization, HSP met or exceeded all of its targets. It produced high-quality reports and strong communications materials on project progress and achievements. HSP also responded to USAID requests with skill and alacrity (e.g., tsunami, national call to action for health) even when they were outside the original scope of work.

2. HSP's principal strategy for ensuring that its technical inputs will be replicated and sustained is its collaboration with the MOH in updating guidelines and tools to reflect current evidence-based best practices. Although this strategy was not contemplated in the original design, which emphasized scale-up and replication, HSP seized upon the MOH's desire to update policies at first glance appeared to be a constraint to scale-up, and turned it into an opportunity to strengthen the environment for reducing maternal and neonatal mortality. In addition, many of HSP's district and village-level interventions, such as P4K and DTPS, helped to improve and facilitate implementation of MOH strategies.

3. HSP worked very hard at the district level to ensure that most interventions had a sustainable home with a GOI, NGO, or professional organization and had prospects for financial support beyond the end of the project. HSP supported NGOs, district advocacy and BCC teams, and professional organizations to mobilize corporate support to the extent possible within the constraints of being a USAID project. HSP worked with MOH and other national organizations (e.g., JNPK) to update national evidence-based training modules (MPS, APN, BEONC, CEONC, and IMCI). It has also collaborated with other donors in efforts to identify partners, such as JNPK, IBI, UNICEF, CARE, and AusAID, that can replicate its activities in districts other than those where HSP works.

4. Similarly, HSP adapted successful strategies developed by USAID and NGO partners for use in improving MNCH in HSP districts. Among these were the approaches developed by LGSP for drafting local laws and getting them passed, and BCC events proposed by NGO partners, such as the 1,001 mothers and the 2,010 couples EIBF rallies.

5. The project has a good track record of learning from first-round application of its tools to refine sequencing, quality, and integration of district, subdistrict, and village interventions (DTPS, TOT, fundraising, BCC, and advocacy). Throughout, it has done a good job of sharing information with other donors and USAID projects, supporting MCC, collaborating with LGSP, and facilitating a smooth transition of the Bidan Delima program from the STARH Project.

The evaluation also perceived some weaknesses:

1. From the beginning, HSP has faced the challenge of a trade-off between pressures to scale up and replicate across a large number of districts and giving attention to adapting strategies to the local context, which in some circumstances may have inhibited more sustainable community creativity and decision-making.

2. There was too much emphasis on replication through a TOT approach, without adequate assessment of whether this leads to capable implementation (clinical, DTPS, and BCC). Except for its assistance to the MOH on national guidelines, the project has used TOT as the replication strategy, rather than exploring others, such as district-to-district TA, peer-to-peer coaching, and whole-site training. There are indications that without a much longer time frame for repetitive training and continued TA, this strategy is not sustainable in most districts once the project ends.

3. HSP incentives and supports may be intrinsic to the replicability and sustainability of activities (e.g., seed money for CHC and advocacy; facilitation and TA on advocacy, BCC, and DTPS activities; and support for materials). It is not clear if replication in new areas is possible without similar incentives.

III. HSP AS A FOUNDATION FOR REDUCING MATERNAL AND NEONATAL MORTALITY IN INDONESIA

STOCKTAKING

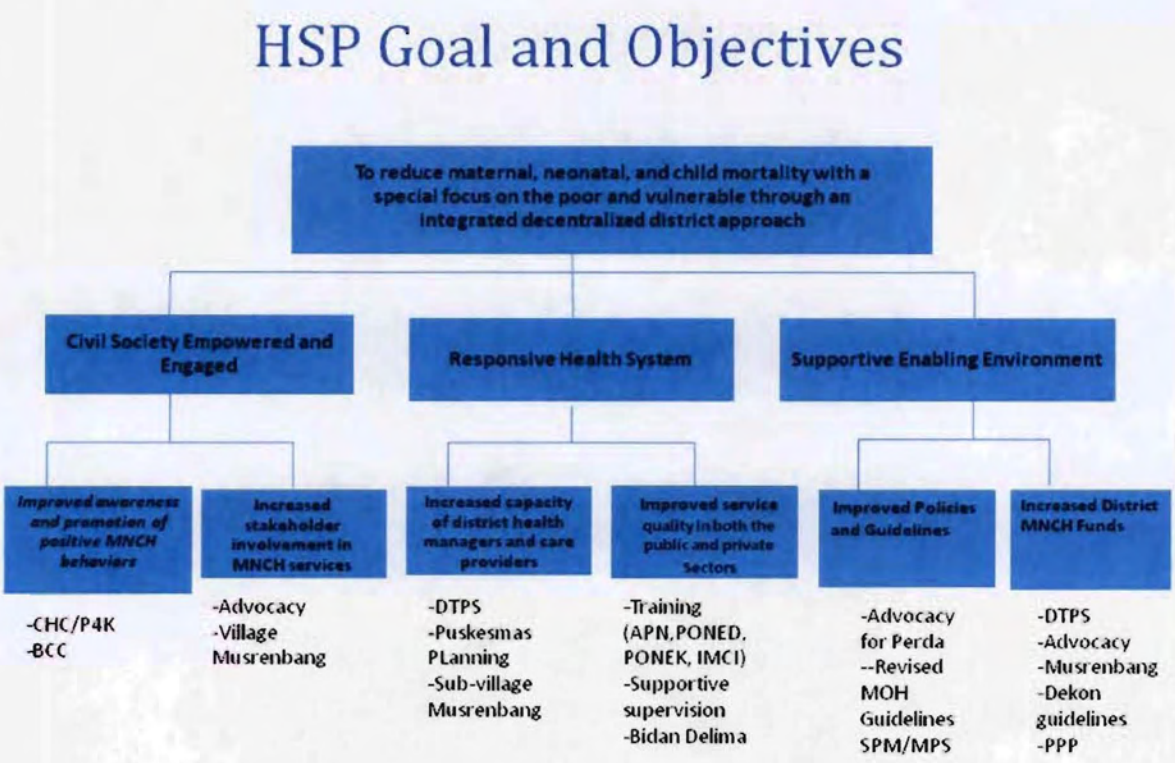
As HSP moves into its last year of operation, there appears to be consensus among USAID, HSP, and the MOH that the primary focus of USAID support in the future should be to build on HSP's accomplishments by helping districts to address more directly and systematically the causes of maternal and neonatal mortality in the context of decentralization. The evaluators posed two questions in order to provide guidance to USAID on how to build HSP's accomplishments into integrated approaches to reducing MMR and NMR at the district level:

1. To what extent were HSP activities effective in changing the practices of healthcare providers, policy makers, women, and their families to contribute to greater maternal and neonatal survival?
2. Are HSP's activities, in the aggregate, the right combination and types of interventions necessary to reduce maternal and neonatal mortality and morbidity in Indonesia? If not, why not, and what else is necessary?

Even though HSP has met or exceeded its targets on all project indicators, the evaluators had difficulty responding to the first question conclusively because the project did not have the opportunity to conduct formative and operations research to ascertain the extent to which health practices were more closely linked to better outcomes. HSP conducted a baseline survey and a midterm rapid assessment that showed mixed results. The findings from an impact survey scheduled for the end of the year may be more definitive. Nevertheless, it is difficult to link HSP interventions directly to positive changes in practices because the reach of the interventions is diffuse (e.g., only a relatively small number of villages) and the scope of activities does not include key components (e.g., hospital-based activity) required to lower MMR and IMR.

To address the second question, the extent to which HSP activities provide a foundation for future USAID MNCH programming, the evaluators examined HSP against a results framework that postulates critical interventions for reducing maternal and neonatal mortality based on current international consensus on what is necessary and effective (evidence-based) as shown in Figure 3.

Figure 3. HSP Goal and Objectives



The results framework demonstrates how HSP's accomplishments fit within a comprehensive and integrated structure and provides a strong foundation for future programming. It elucidates how HSP's primary interventions contribute to establishing the conditions necessary to reduce MMR and NMR.

1. Strengthening the enabling environment: encompasses the policies and governance structures necessary to ensure universal access to skilled antenatal, delivery, postpartum, and essential newborn care and to basic and comprehensive EONC in the case of complications.

The project effectively improved policies and governance related to MNCH. Through its work with the MOH, HSP revised national guidelines and tools (e.g., MPS, SPM, DTPS) in line with current evidence-based practice in a readily accessible form. It also contributed to strengthening governance through support to advocacy and DTPS committees, which were able to improve their planning and budgeting. This also reinforced the legal foundation for ensuring funding for MNCH through the drafting and passage of local regulations.

2. Improving the capacity of the health system to effectively respond to the primary causes of maternal and neonatal mortality by improving the quality, availability, acceptability, affordability, and timeliness of MNH services. This applies to both basic and comprehensive emergency obstetric and neonatal care in public and private sectors, supported by effective health management systems and evidence-based protocols.

HSP improved training modules to reflect current standards of practice, such as AMSTL, neonatal resuscitation, IMCI, and EIBF. The project updated BEONC and CEONC training modules and procedures for certifying facilities in BEONC or CEONC care. The supportive supervision module provides health center midwives with a tool for supervising village midwives. HSP support to IBI's Bidan

Delima program provided a similar supervision tool for private midwives. Its recent support for improved health center planning also helps improve service delivery in subdistricts and below. HSP also introduced diversified learning opportunities for healthcare providers, such as the EIBF DVD and the KMC study tour for NICU perinatologists, both of which appear to have had major impact in changing practices of healthcare providers.

3. Empowering civil society to be full and active participants in improving maternal and neonatal outcomes through increased involvement of CSOs in planning, management, and oversight of public and private healthcare, advocating for the rights of pregnant women and children, and monitoring maternal and neonatal outcomes.

HSP training of diverse civil society stakeholders, including NGOs, parliamentarians, and professional organizations, has provided citizens with the tools to advocate for policies, strategies, and funds for MNH. It is expected that, empowered with the advocacy toolkit, these same stakeholders will also assume a role in monitoring implementation of the laws, plans, and budgets they have fought for. HSP also helped the MOH to improve social mobilization processes so that communities can draft develop operational and funded birth-preparedness plans (P4K). The project's investment and training in BCC also empowered multisectoral BCC teams to create district BCC campaigns and raise funds from private donors in support of them. The remaining challenge is to measure the impact of these campaigns on changes in the knowledge, attitudes, and practices of district residents and healthcare providers.

While HSP made substantial contributions to the objectives required to reduce MMR and IMR, what is missing is full integration of these interventions with other necessary activities at a district level. These include attention to improving the quality of care at BEONC and CEONC facilities by focusing on information, referral, and supervision and accountability systems that are critical to identifying the causes of MMR and NMR, decreasing delays in reaching care, and improving the quality of care.

Another element that deserves attention is the role of private providers within the district health system and how they can effectively help increase access to quality care. HSP also did not focus directly on reducing financial barriers to care, except for providing seed money for village emergency transport funds and encouraging CHCs to connect eligible women to *askeskin/jamkesmas* insurance. They did not consider costs not covered by *askeskin/jamkesmas*, such as for certain drugs and supplies that may not be available in understocked health facilities.[23] It would be useful to at least understand the extent to which cost is a barrier in HSP districts and how well national and municipal insurance schemes help reduce those barriers. To fully empower civil society, it is necessary to actively engage them in collecting and using information to monitor the capacity and responsiveness of the health system to reduce the major causes of maternal and neonatal deaths and disabilities.

The recommendations proposed below suggest ways the HSP can move closer to a more integrated and effective district model in the final year of the project and any extension period.

RECOMMENDATIONS FOR THE EXTENSION PERIOD

It is recommended that USAID extend HSP for an additional 12 months. The reasoning for this is based on the following considerations:

- Many technical aspects of project start-up were delayed by a year because of the need to focus on the emergency in Aceh caused by the tsunami and HSP's involvement in the Health Summit. As a result, many activities have not been implemented long enough to fully understand their effectiveness or the susceptibility to replication.

[23] These issues are well documented in the study soon to be published study by WRI on access to maternal and neonatal care in seven provinces.

- There were many changes in Cognizant Technical Officer leadership, resulting in different interpretations of the core objectives of HSP that affected selection and continuity of activities.
- The project spent considerable time updating guidelines with the MOH. These have now been applied in most districts at least once but would benefit from additional application and assessment.
- The MOH has asked HSP to consolidate the package of interventions so that it is more integrated. The MOH indicated that the many guidelines and modules have not been sufficiently integrated or sequenced. An integrated package that includes not only HSP interventions but also UNICEF work on computerized data collection systems at health centers and JICA's 'pink book' on MNCH could become the MOH-recommended package for districts.
- The MOH is interested in moving forward with district-wide implementation with TA to different districts by different organizations under the rubric of a common integrated package and a common sentinel M&E framework. HSP could prepare the groundwork for such an effort by:
  - Going to scale in two HSP districts that have a firm foundation of local laws, district planning (DTPS), advocacy groups, significant numbers of providers trained, health center planning and *musrenbang*, and functioning CHCs.
  - Develop a district-wide M&E framework and recommendations for supporting information systems, and establish safe motherhood (MPS) committees at different levels, with a link to district planning to include maternal and perinatal audits at all facilities and in communities in one demonstration district.
- A project extension would enable the project to work more closely with the MOH Directorate of Hospital Services to review the availability and quality of data being collected on maternal and neonatal deaths and near misses at hospitals, as well as the systems for reviewing and improving procedures that contribute to deaths and near misses. This will serve as a foundation for new USAID activities that incorporate attention to CEONC and referral and supervision/accountability systems.
- The extension would also enable the project to implement the recommendations set forth in the earlier section for its various activities. Examples include:
  - Developing a process for monitoring DTPS and advocacy results, implementation of budgets, plans, and MNCH regulations, and preparing guidelines for other districts on how to advocate for effective implementation of regulations once passed.
  - The CHC/P4K model could give more attention to tracking the outcome of mothers and newborns and extending the model to include the newborn.
  - The website and data collection system of Bidan Delima could include midwife profiles, service statistics, and outcomes, and a management committee for the program could be established.
- The extension would enable the project to further observe and document the replication process and compare project subdistricts with replication subdistricts. This would make it clearer whether the tools and guidelines can be implemented without the additional support the project offered its intervention subdistricts (e.g., district coordinator, seed money, facilitation skills). Activities to assess could start with DTPS, CHC/P4K, and supportive supervision.
- USAID's interest in the sustainability and replicability of HSP interventions also argues for targeted research and evaluation during the extension period to determine how much HSP interventions contributed to achieving desired maternal and neonatal outcomes, which combination of interventions might be considered best practices, and which combination is appropriate for districts with different socioeconomic characteristics.

- Conduct evaluations of application of tools and research to understand how practices have changed as a result of project interventions:
  - Compare P4K in HSP and non-HSP districts (outcomes and process).
  - Analyze implementation of CEONC in hospitals trained in 2006: Have improvements been sustained? Was the initiative taken up by other hospitals?
  - Analyze how district health budgets that resulted from 2007 DTPS were actually expended in 2008.
- Prepare case studies of reputed best practices in non-HSP district-wide approaches (e.g., Subang, East Lombok) for input into the design of future activities. These districts merit examination because they have introduced innovative payment schemes, taken a different approach to the passage of local health laws than HSP districts, or introduced alternative health delivery systems.
- Assess representative districts where HSP has a presence to analyze what is needed to address MMR and NMR from a comprehensive and integrated health systems perspective that takes in both public and private health providers. This would entail identifying strengths and weaknesses and any critical elements that may be missing to ensure high-quality integrated MNH services. The assessment could include preparing briefing information on how to build up components that are critical for reducing MMR and NMR (e.g., audit process, supervision, referral systems, hospitals, home births, access to demand side financing, information systems) and how an integrated system might vary from one district to another.
- In preparation for a future project to strengthen IBI and the Bidan Delima program, HSP can help IBI conduct a needs assessment among members to gain an understanding of how the organization could better meet members needs, members' views on IBI's strengths and weaknesses and recommendations for the association, and their willingness to pay to be part of a more effective organization. Analyze (a) how much has been invested in IBI over the years (documentation of the LOE by MotherCare, STARH, and HSP) and the impact of this investment on the association and lessons learned; and (b) IBI's current organizational capacity and an estimate of the time and cost that would be required for IBI to become a more effective professional organization capable of running the Bidan Delima program, representing the professional interests of its members, and contributing to quality maternal and neonatal healthcare in Indonesia.

IV. RECOMMENDATIONS FOR NEW USAID PROGRAMMING

HSP has built a firm foundation for new USAID programming to reduce maternal and neonatal mortality. Four challenges HSP has faced should be addressed in new programming:

1. The project has been spread too widely, both geographically and technically. Consequently, its health impact is hard to determine.
2. The project was discouraged from introducing interventions that are critical to reducing maternal and neonatal mortality (e.g. information systems and audits, and emergency obstetric and neonatal care among public and private providers). Without giving these two critical interventions priority it is impossible to reduce maternal and neonatal mortality.
3. Although HSP supported many activities to engage and empower civil society, the project, as highlighted earlier in the key issues sections earlier, missed opportunities to more fully address gender and other sociocultural and economic constraints, in both communities and health facilities, that impede women from activating their rights to life-saving care.
4. Finally, HSP did not sufficiently address the private health sector, which provides 30 percent of outpatient healthcare, or the issue of dual public/private practice. Despite the large and growing percentage of births taking place with private providers and in private facilities, these are not integrated into national or local efforts to reduce maternal and newborn deaths. It will be difficult to reach MDG targets without involving this sector in health service planning and delivery.

With these challenges in mind, the evaluation recommends that the USAID mission invest in two programs: (1) an integrated district-wide approach and (2) development of a national network of Bidan Delima and building up IBI to support this network. In support of these two programs, it is recommended that the follow-on programs:

1. **Give priority to reducing maternal and neonatal mortality**: With the limited resources available, the best option is to focus on maternal and neonatal mortality so that Indonesia can most effectively reach its MDG 4 and 5 goals. MMR has been the most challenging. While there are some indications of progress in unofficial results from the most recent DHS, Indonesia will have difficulty reaching its MDG of 125/100,000 by 2015—it would have to cut its current rate in half. While there is progress on child mortality rates generally, that does not apply to neonatal mortality. Two-thirds of the under-5 deaths occur during the first year of life; about two-thirds of infant deaths took place during the neonatal period, the first month; and about two-thirds of neonatal deaths happened in the perinatal period—the first week of life). Focusing on neonatal deaths, which are 90 percent preventable, would make a large contribution to reducing overall child mortality. Other child survival activities, such as IMCI (except as it relates to neonatal survival), nutrition (except for immediate and exclusive breastfeeding), and water and sanitation (except as they relates to clinical and provider-focused infection prevention) should not be part of new MNCH activities.
2. **Narrow the geographic spread to implement integrated approaches in a few (three to seven) districts based on a continuum of care or critical pathways model adapted to the local context (see Results Framework 1 below):** The National Strategic Plan for Making Pregnancy Safer (MPS) provides the framework for district-wide approaches based on a baseline needs assessment that implement interventions strategically throughout the district and cover all subdistricts. It is not possible to reduce MMR and NMR without understanding why women and newborns are dying and addressing weaknesses in the health system that contribute to their deaths, both of which require considerable political will. During the evaluation, MOH staff expressed their commitment to testing different district models for reducing MMR and NMR. HSP districts demonstrate that effective

advocacy can achieve significant political commitment at the local level. There is an opportunity for USAID to team with the MOH, PHO, DHO, local governments, Bappeda, other donors, and CSOs as learning partners for designing and assessing comprehensive district-focused models for reducing MMR and NMR.

3. **Engage the MOH and other GOI organizations, donors, and NGOs as learning partners:** A comprehensive integrated approach will allow USAID to collaborate with the MOH and other donors to examine the effectiveness of different models. It is not necessary for USAID to be responsible for strengthening all dimensions of the health system in each district where the new program works. An initial needs assessment should identify strengths and weaknesses of the local health system, what other organizations and programs are active in the district, and what unique sociocultural and geographic challenges need to be addressed.[24] Involvement of the PHO and relevant MOH directorates will directly engage the MOH in improving district performance and translating knowledge (guidelines and training) into practice in other provinces and districts. Multiple MOH directorates should be engaged in reviewing needs assessments, participating in design of district models, and routinely reviewing research and outcomes. The project could support periodic site visits by MOH representatives to ensure their engagement.

4. **See criteria for selecting districts:** The districts selected for USAID programming should be representative of the diversity of circumstances found in Indonesia so that the approaches and tools developed will be appropriate for replication in similar contexts if proven effective. Some possible criteria for selecting districts are:
   - Political support of the Bupati, district parliament, DHO, and PHO (determined by previous HSP experience, existence of an MNCH law or general health law, and allocation of budget for MNH)
   - Low to mid-level performance on MPS service indicators
   - Coverage by other donors, to ascertain need for technical support
   - Potential for links with other projects of USAID or other donors
   - Priority areas for the BAPPENAS, MenkoKesra, and MOH
   - Poverty of population, as measured by income and access to services
   - Potential for partnering with CSOs, especially NGOs, gender advocacy and rights groups, private health providers, professional organizations, active community organizations, and corporations.

5. Give priority to building up information systems in communities, integrated service posts, primary health centers, and hospitals. At the community and integrated service post levels, engage local health committees and others to extend registration of pregnant women to the collection and analysis of information on maternal and neonatal outcomes. At hospitals and health centers, activate and strengthen MOH-mandated maternal and perinatal audit systems that are not yet fully operational or effective. The audit systems should also cover private providers and maternal and neonatal healthcare facilities so they can be held equally accountable for outcomes. The new program should also develop a district-wide surveillance and response system with oversight from safe motherhood committees established at different levels of the district health system, with ultimate accountability residing with the DHO, PHO, and civil society monitoring groups.

[24] The project needs to conduct research to shape an MNCH health system needs assessment to determine the health system interventions that would have the most impact in achieving district MMR and IMR reduction objectives. Project activities should be designed from the beginning with a focus on understanding the effectiveness, efficiency, and efficacy of the approaches. This will entail taking an operations research approach to testing models. It might be advisable to also propose up to four control districts to enable comparisons on key indicators.

6. **Give priority to actions that increase access to and availability of quality 24/7 BEONC and CEONC.** Currently, 59 percent of births in Indonesia take place at home, of which approximately half are assisted by skilled providers, who may or may not be linked to higher levels of care. This situation decreases the chance of a woman and her baby receiving timely and adequate care if there is a serious complication. Therefore, a priority focus of the new program must be on helping district health officials to identify and remedy weaknesses in the referral and supervision systems. It is also necessary to ensure availability of quality 24-hour BEONC and CEONC seven days a week.[25] In some districts, there is also the need to upgrade facilities, improve the capacity of healthcare providers, and rationalize the distribution of human resources. While these are not likely to be direct activities of the new project, it is important that district planning and information systems address these problems in a way that ensures availability of quality care.

7. Increase attention to gender-based, sociocultural, and economic constraints to accessing quality life-saving MNH care through a rights-based approach to reducing MMR and NMR. A rights-based approach empowers communities to ensure that every woman and newborn has access to skilled delivery care and to EONC when complications arise. Such an approach also empowers communities to constructively challenge gender norms, power structures, and relationships that limit women's capacity to make informed decisions and exercise agency with regard to seeking prenatal, delivery, and postpartum care. It also ensures that the community has a role in monitoring health services. The new program has an opportunity to build the P4K/CHC work into a process that goes beyond birth preparedness to monitor the degree to which women's rights to quality life-saving care are respected and realized. This can be accomplished by involving women's advocacy and rights groups in district, subdistrict, and village advocacy and social mobilization activities. The project can explore other methodologies, such as those used by PNPM, that increase women's participation in local planning and decision-making, and use targeted incentives through conditional cash transfers for communities to address inequalities that hinder the access of women and newborns to care.[26]

8. **Ensure that the private health sector is integrated into district models for reducing MMR and NMR:** Private providers are a major source of maternal and newborn care in Indonesia. Since many public sector providers also work in the private sector, distinctions between the sectors are blurred. [27] Private hospitals and clinics are common in urban and periurban areas but can even be found in more rural areas, and many of the midwives employed by the public sector in health centers or as

[25] A new project might also test more innovative approaches to building and retaining skills by rotating providers through various care settings. For example, the evaluation team visited one BEONC health center that was able to achieve its 24/7 coverage requirements by having the village midwives rotate for a 12-hour shift through the facility on a weekly basis. This gave the village midwife more opportunity to assist with facility births and interact with peers and the OB/GYN in the clinic. Yet while these midwives seemed comfortable handling normal deliveries, they were still reluctant to deal with complications despite having been through the BEONC training. A system that would enable health center midwives to also rotate through the district hospital to gain more hands-on experience with complicated deliveries and newborn care might enhance their confidence in handling these cases. Likewise, district hospital-based midwives or doctors could rotate through the BEONC facilities to provide OJT support. An integrated approach to addressing MNCH at the district level would facilitate such innovations that the current project has not been able to address given its focus on community care and its spread over so many districts.

[26] Current activities to mobilize the community about birth preparedness did not do much about also changing social norms. For example, interviews in at least one village suggested that some women prefer home births because they can be there to care for their other children and the husband and family can more easily participate in the birth experience. Using this type of information the *Desa SiAGa* program could be a vehicle for helping families plan for child care so that the woman can deliver in a facility or educate local providers about how to make families more welcome in their facilities. Introducing financial incentives to encourage facility births would also help.

[27] For example, 44 percent of live births at home were attended by a skilled birth attendant, who may have been a government employee or operating in a private capacity.

community midwives also have private practices. It is recommended that the new program pilot a variety of public-private partnerships to improve the quality and accessibility of MNH services.[28] To more fully engage private providers in improving MNH health outcomes, more information will be needed to assess whether the regulatory and reporting processes are adequate and how to improve implementation at the national and district levels. A new project could provide TA at the central and district levels to strengthen systems for supervision and licensing of private providers. Also, any demand-side financing initiatives could include the private sector, using this financial incentive as a way to enforce quality standards and offer choice and access to communities.

9. **Build the Capacity of IBI as a Professional Organization**: It is recommended that USAID develop a separate but linked activity to strengthen the Bidan Delima program and IBI's capacity to implement it (see Results Framework 2 below). Midwives are a major provider of MNH services especially in the community and in private practice. IBI is an association of over 70,000 public and private midwives—a potential force for improving maternal and newborn survival. It is recommended that IBI receive support to professionalize the association and build its ability to advocate for MNH services and better help its members to deliver quality care.

10. **Invest in Bidan Delima in Indonesia (IBI):** IBI's Bidan Delima program has potential to strengthen private provision of maternal and child health services, promote facility-based births and improve the quality of care offered by private midwives. The association has demonstrated a commitment to the program and has invested significant volunteer time in scaling it up. The program has attracted sustained corporate sponsorship (from J&J) with the promise of financial sustainability. It is recommended that USAID invest in building Bidan Delima into a network that provides a uniformly high standard of care with measurable outcomes at affordable prices.

11. **Support learning from experiences on reducing MMR and NMR across Indonesia:** Knowledge management needs to be built into the future project because it will be important to widely disseminate lessons learned and best practices that emerge from working comprehensively at the district level. Knowledge management will be pivotal in enabling the achievements of a few districts to benefit many more districts that can adapt program successes to their own contexts.

The two results frameworks below provide graphic pictures of a comprehensive district-level approach to reducing maternal and neonatal mortality and a program for strengthening IBI and the Bidan Delima program. Appendix C depicts the activities recommended by intermediate result for the proposed AIMS Program; Appendix D presents illustrative activities for the IBI Program.

[28] The new project could explore the feasibility of developing meaningful PPPs to reduce MMR and NMR that can focus on the district level. Opportunities might include piloting an outsourced management approach for operating health centers in which the district would contract with a management organization to run health center operations and tie the management contract to specific performance expectations (This model has been successful in Cambodia and elsewhere.). Another opportunity would be to organize and credential a network of private providers (which could include Bidan Delima midwife clinics, private maternity homes, and private hospitals) that could serve as the provider network for government and private insurance programs. A voucher program for pregnant women to seek facility births is another option, with the voucher tied to meeting certain performance standards on behalf of the public and private providers offering the services.

Figure 4: Goals and Objectives: Results Framework

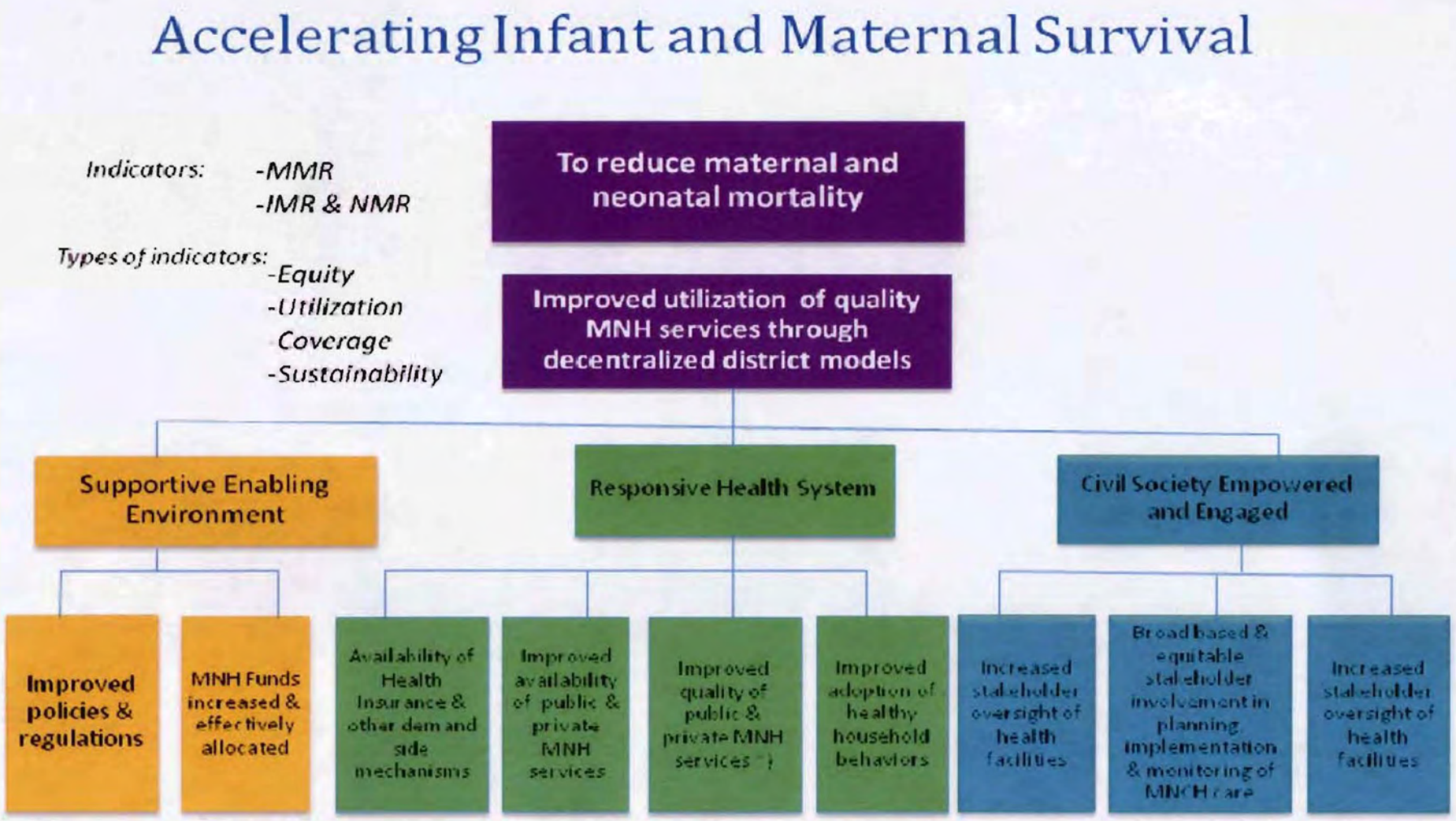
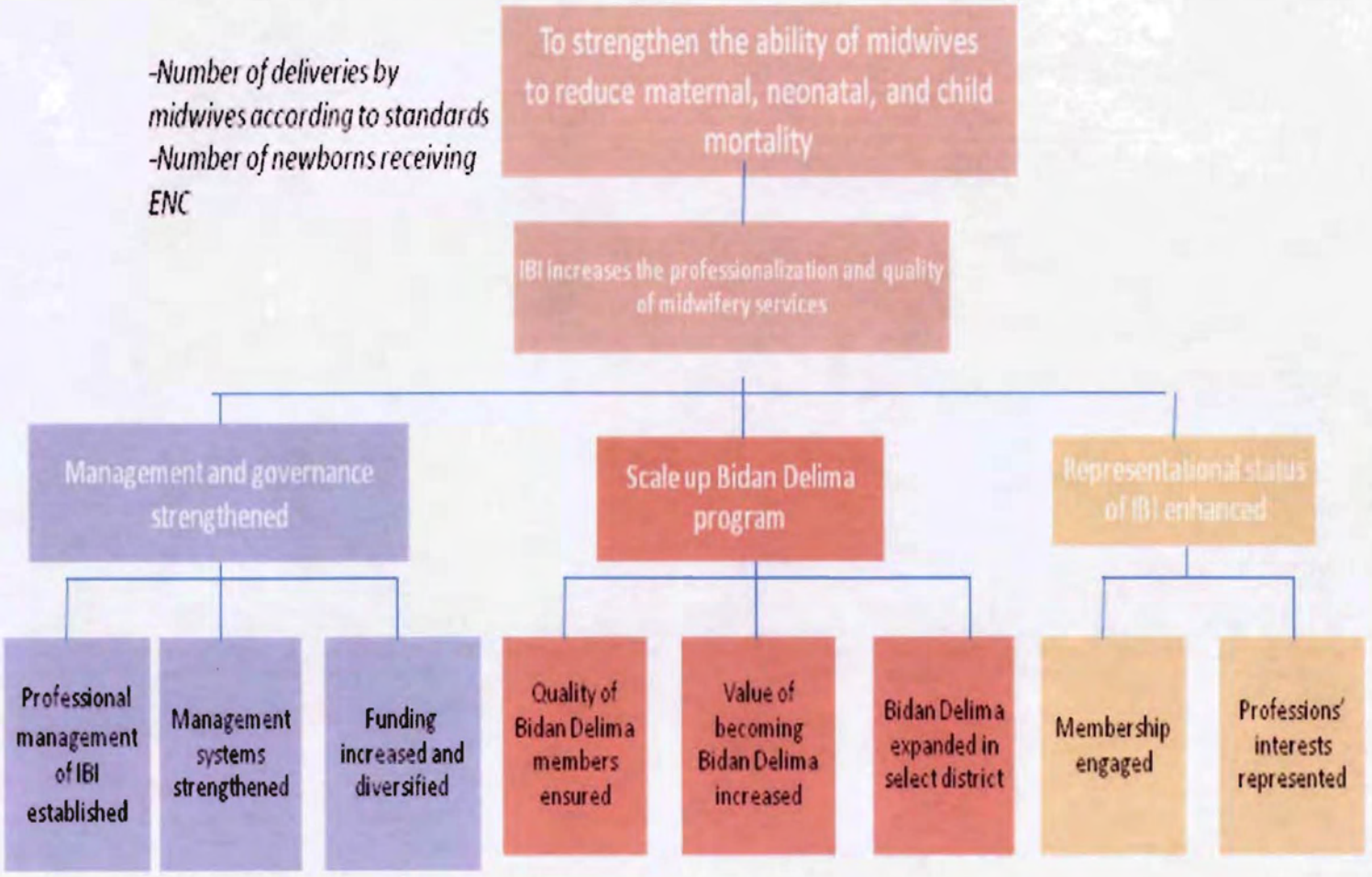


Figure 5: Investing in IBI



APPENDIX A: SCOPE OF WORK

HEALTH SERVICES PROGRAM EVALUATION & FOLLOW-ON ACTIVITY PLANNING

Scheduled: o/a August 18-September 11, 2008
Final: 06-25-08

SUMMARY

USAID/Indonesia wishes to conduct a forward-focused evaluation of the Health Services Program within the context of the Mission's MCH (CSH-funded) portfolio. The two primary objectives of the evaluation are

Obj 1: Achieve a thorough understanding of the outcomes/results of HSP interventions and the effectiveness of HSP strategies for achieving results in the key focus areas listed below. Effectiveness may be defined by the extent to which accomplishments are (1) replicable; (2) likely to be sustained by GOI and/or local partners; (3) viewed by GOI (national and subnational) as consistent with policy and programs; (4) viewed by GOI as developed through an appropriately collaborative process; and (5) viewed positively by civil society partners as the outcome of a collaborative effort.

Obj 2: Develop recommendations for future activities and implementation strategies for both immediate and mid-term time frames. Recommendations for future program activities/strategies should take into account USAID/Indonesia's commitment to MOH priorities in MCH (i.e., achieving MDGs 4 & 5); health system capacity-building where it can be directly linked to positive impact on MCH outcomes; working closely with a broad range of civil society partners; and developing productive relationships with the private business sector.

The above objectives apply to four key technical areas of focus:

1. **Advocacy** capacity-building activities that aim to improve MNCH budget and policies at national and subnational government levels, in partnership with civil society organizations, local leaders, elected officials, civil servants, the private sector, etc.
2. **Behavior change** interventions at individual, household, and community levels using a variety of strategies—community mobilization, community facilitators/trainers, district campaigns, radio, and targeted IEC materials. Comment on the strengths and weaknesses of these strategies in relation to specific technical areas emphasized. Comment on future recommendations for BCC investments, particularly with regard to regional or national-level media approaches and with regard to linking birth preparedness to increasing demand for facility deliveries.
3. Assess the **role of private sector midwives in MCH care**. Comment on how to maximize service coverage and quality to (a) the poor and (b) rural areas? Comment on how to improve management and leadership capacity within the Indonesian Midwives Association (IBI) to more effectively mobilize midwives toward better coverage and quality, and to more effectively manage (and successfully grow) the Bidan Delima program, a social midwife franchise with roughly 10% of all midwives having joined.
4. Review key technical areas in which the project has provided **support to GOI** (nationally and subnationally). These areas include (a) decentralization (district planning and budgeting); (b) district MCH program management and quality improvement capacity (supportive supervision, OJT); and (c) quality of care (provider training).

BACKGROUND

Overview: Decentralization and Health Services in Indonesia

Landmark decentralization legislation in 1999 fundamentally altered Indonesia's governance system. Indonesia transferred substantial responsibility and personnel to over 400 districts. Unfortunately, basic services delivery to those most in need has decreased as well. Many local governments remain poorly equipped to deliver quality services, particularly in health and education.

The laws were implemented rapidly, with little assistance to districts and no clarity in new national and subnational roles. There remains confusion with regard to the provincial role in coordinating programs administered by resources now largely allocated directly to the districts. Consistency and timeliness of national guidance to districts and provinces has been lacking.

Local governments make strategic choices in investment priorities. Social welfare and other sectors compete for limited resources against infrastructure and other investments that are typically viewed by local leaders as visible and linked to perceptions of good leadership and re-election opportunity.

The central Ministry of Health has maintained functions overseeing health policy and national program standards, indicators, and targets; communicable disease surveillance; overseeing standardized training modules for health professionals (primarily in reproductive, maternal, and neonatal health); overseeing pharmaceutical regulation and (some) essential drug distribution; and advocating to the national government for continued investment in public health programs.

Despite seismic shifts underlying the planning, budgeting, and implementation systems supporting health service delivery programs, some districts have responded in creative ways, and there are true "success stories" showing democratic leadership, commitment, accountability and improved health systems. On the other hand, there are many districts that have not yet made this transition work for the benefit of their inhabitants.

In the past three years, new financing initiatives in health have added greater confusion and opportunity to the mix. Additional funding to districts through provinces, from the national budget—*dekonsentrasi* funds—have been made available for the years 2006 and 2007. Accessing these funds proved difficult for most districts, and they were severely underutilized. The GOI's program of health insurance coverage for the poor—*Askeskin*—was enacted, and many very poor, near-poor, (and non-poor) citizens have accessed these funds for tertiary care. The program was under-funded, however, and hospital claims quickly ate the allocated budget, resulting in unscheduled reductions in Ministry of Health national operating budgets for 2007 and 2008.

Finally, the "elephant in the room" is the predominance of the private sector and market forces that hugely impact health-seeking and health-destroying behaviors (formula feeding, smoking, rising food costs, poor regulation of pharmaceuticals, etc.). People at all income levels, including those in the poorest wealth quintile, continue to "vote with their pocketbooks" by purchasing the health services they value for various reasons (convenience, service factors, lack of awareness of quality indicators, etc.). There are few systems in place to ensure that such services meet objective quality standards and are of "good value" given their costs. Rates of "self-treatment" (among those reporting illness) have increased from 32% in 1997 to 51% in 2005 (World Bank PER, 2007).

The central government faces growing responsibilities in stewardship and must consider ways to engage local governments in licensing, accreditation, and quality assurance programs. The central government also could play a far larger role in regulating industries that directly impact the health of all Indonesians.

National and local public allocations to the health sector constitute only 1% of GDP, among the lowest in the Asia/Near East region. Private health expenditure is double that amount at 2% of GDP, and three-fourths of all private health expenditures are out-of-pocket. As GDP grows, however, overall health

expenditure per capita has increased nearly two-fold since 2000, from US$18 to US$32 in 2004. Despite low proportionate investment, a population of about 240 million people and growing GDP mean that the health sector commands substantial financial resources.

National health data systems do not show an obvious decline in services over the past few years of decentralization, but there are several indications observed at the program level that point to a deterioration of services in public health areas once hailed as extremely successful in Indonesia. These include immunization, vitamin A coverage, and combating malnutrition. The rate of decline in infant and child mortality rates has slowed, if not stopped, but this phenomenon may be better explained by a worldwide weakness of recent public health programs in successfully targeting causes of neonatal mortality. Maternal mortality has arguably not declined at all over the past 15 years.

MCH Indicators and Services in Indonesia

In the fourth most populous nation, significant numbers of women of reproductive age, newborns, and children under 5 are affected by poor primary health systems, underdevelopment of water and sanitation infrastructure, and cultural patterns of health care-seeking and hygiene behaviors that contribute to poor health and mortality risk.

Through recent survey measurements, the most recently available estimate of maternal mortality is 307/100,000 live births (DHS, 2002/3). A new estimate from the DHS 2007 will be available by August 2008. WHO estimated maternal mortality to be 420 for 2005 according to their standardized adjustment methods. The Ministry of Health recently collected actual reports of maternal deaths, country-wide. Their results showed MMR to be 119 in 2007, 127 in 2006, and 151 in 2005. These national estimates are based on reported deaths from nearly all Puskesmas in nearly all districts. They show substantial variability by district, which is likely to reflect a real accuracy, but they are almost certainly underestimates by as much as one-third (though some districts are likely to be far more accurate than others).

Although overall child mortality indicators appear good (IMR: 35; under-5 mortality: 46), they hide considerable disparity by wealth quintile and urban-rural status. Indonesia is classified as a middle-income country, but about one-quarter of the population (>50 million) lives below $2/day. Indonesia is not accurately described by national or even provincial-level aggregate indicators, and misperceptions about the scope and reach of Indonesia's health system are a significant challenge for public health advocates who work in the country's remote or rural areas.

The bottom two wealth quintiles (40% of the population; over 90 million people) have under-5 mortality rates more than three times the rate in the top quintile. Under-5 mortality (DHS 2003) ranges from 22 in the highest wealth quintile to 77 in the lowest.

TABLE A.1. CHILD MORTALITY RATES (/1000 LB) BY TIMING AND WEALTH QUINTILE						
By Wealth Quintile	**Neonatal Mortality (<1 mos)**	**Post-neonatal Mortality (1-11 months)**	**Child Mortality (1-4 years)**	**Total Under-5 Mortality**	**Neonatal Mortality as % of Under 5**	**Neonatal Mortality as % of Infant Mortality**
Overall	20	15	11	46	43%	57%
Poorest 20%	28	33	17	77	36	**46**
Near poor	30	20	15	64	47	60
Middle	21	23	12	56	38	48
Upper middle	20	16	9	45	44	56
Wealthiest 20%	13	4	5	22	59	76
Ratio (poorest / wealthiest)	2.2	8.3	3.4	3.5	--	--

Source: DHS, 2002/3.
See Annex 1 for additional technical background on health systems, policy, and trends in MCH in Indonesia.

The BHS Framework Within the USAID/Indonesia Strategy

Over the past decade USAID assistance has been focused largely in partnership with the central level of the Indonesian government—the most appropriate and efficient strategy prior to decentralization. Significant investments were also made in building the capacity of nongovernmental organizations, professional associations, local health NGOs, and national faith-based organizations.

The current overall strategy in the MCH program is to build the capacity of government, private, and nongovernment sectors to expand delivery of quality health care services and empower communities to protect human life. The integrated MCH program implemented by the USAID Mission was developed under the 2004–2008 country strategy guiding the investment of a planned $650–$700 million to strengthen a moderate and productive Indonesia. This strategy is organized around four major program areas: (1) improved quality of decentralized basic education, (2) higher-quality basic human services, (3) effective democratic and decentralized governance, and (4) effective systems of economic governance to increase trade and investment and drive new job creation. The MCH program falls under the Health Team within the Basic Human Services Office at USAID. The BHS Office also includes food security and nutrition, infectious disease, avian influenza, water/sanitation, environment/ biodiversity and conservation.

Specifically, the "Higher Quality Basic Human Services" Strategic Objective (SO) aimed to improve access to and the quality of key human services, with special emphasis on implementation at the local (district) level of government. Vulnerable populations, namely the urban poor, women, and children, were the intended principal beneficiaries. The following intermediate results (IRs) were outlined and these IRs guided the program design and set of activities of MCH as well as other BHS programs.

1. Governments, community organizations, and the private sector mobilized to advocate for higher-quality basic health services
2. Basic human services delivered effectively at the local level
3. Improved practices and behaviors adopted at the community and household levels

USAID's technical assistance programs in BHS have been provided by cooperative agreements, grants, and contracts with U.S. implementing partners and local nongovernmental organizations. The BHS agreement with the Government (SOAG) is with MenkoKesra, the Coordinating Ministry of People's Welfare. Prior to 2004, USAID's agreement with the GOI for bilateral assistance in health was under an umbrella SOAG with the Ministry of Health, BKKBN, and the Ministry of Women's Empowerment.

The current MCH portfolio "mortgaged" to implementing partners is supported by CSH funding totaling nearly $52 million from FY 2004–2008 (funding projects largely from 2005–2009). This total does not reflect USAID costs associated with program management and "design and learning." HSP claims about 57% of those funds as the "flagship" integrated MCH program. Additional programs implemented with CSH funding include a Prevention of Malaria in Pregnancy Program in Eastern Indonesia (4% CSH funding); support to the Demographic Health Survey (3%); support to USAID/Washington-managed programs in polio and child survival (6% total); a social marketing of point-of-use (POU) chlorine solution program (11%); and water and sanitation through the Environmental Services Program (18%). Both the POU water program and the environmental program are managed by the water/environment team within BHS.

The Health Services Program

The Health Services Program (HSP) addresses the major public health problems facing mothers, newborns, and children in Indonesia. The program emphasizes a selected set of interventions that are most compelling, given the MCH burden of disease, GOI priorities, and institutional (public and private) opportunities. HSP provides technical assistance to government counterparts, civil society partners, NGOs, and communities on the implementation of selected evidence-based interventions. HSP is a 4.5 year program, starting April 2005 (to Sept 09 currently).

HSP is a cooperative agreement awarded to JSI Research and Training Institute. The original amount of the award was nearly $30 million, but an additional $5.6 million was awarded after the December 2004 tsunami for programming in selected districts of the Nangroe Aceh Darussalam province. This included $3.8 million to implement MCH technical and rehabilitation support to four districts in Aceh province, and $1.8 million to implement a psychosocial support program.

The overall aim of reducing maternal, neonatal, and child mortality guide the technical focus areas of HSP. In order to impact the major causes of maternal and newborn death, HSP activities address postpartum hemorrhage, neonatal asphyxia, complications of prematurity/LBW, neonatal infection. To address a predominant cause of postneonatal/child death, HSP also focuses on the prevention and management of child diarrhea (& IMCI). Young child malnutrition is addressed through HSP's intensive support to early initiation of breastfeeding and recommended breastfeeding practices up to two years. Additional MCH issues may also be addressed but with reduced intensity of effort (e.g., vitamin A, immunization, IMCI, comprehensive nutrition and young child feeding, etc.).

HSP's underlying strategy is to concentrate assistance on working with the GOI and civil society partners to operationalize best practices (i.e., evidence-based interventions) through public and private sector health systems at district, provincial, and national levels. This systems approach underlies all activities in the following areas:

1. Partnerships with district health officials for district planning and budgeting
2. Partnerships with health provider professional associations and GOI to improve the quality and impact of clinical training and supervision systems
3. Partnerships with local NGOs and community leaders, district health officials, and parliamentarians to advocate for bigger budget support to MCH services
4. Engagement with village leaders and health providers in social mobilization for behavior change
5. Engagement with private sector midwives, enabling them to expand geographical coverage of a quality assurance social franchise called Bidan Delima.

The rationale for the systems-level capacity building approach is the belief that participation in technical assistance processes fosters ownership of outputs and better-functioning and more sustainable systems, and facilitates the replication of best practices to geographic areas beyond USAID-supported target areas (through donor and GOI resources).

HSP's primary Ministry of Health counterpart, the Division of Community Health, views the project according to the conceptual framework below:

1. Behavior Change—community mobilization, national birth preparedness initiative (formerly Desa SiAGa, now P4K), BCC/IEC.
2. Decentralization (governance, policy)—planning and budgeting capacity of local governments and advocacy initiatives with CSOs, NGOs, local leaders, and local government representatives.
3. Clinical MNCH/RH—supportive supervision, provider training, clinical guidelines, and management tools to improve quality at primary (and up to hospital) levels of care. This category also includes current work and future opportunities to strengthen the quality and reach of services provided by private providers, primarily midwives.

Performance Monitoring

HSP's Performance Monitoring Plan (PMP) has been designed to overlap the USAID/BHS 2006 Performance Monitoring Plan of 2006—both to ensure consistency of thinking and approach, and to facilitate USAID's data acquisition for annual reporting purposes. The PMP is also aligned with the Operational Plan (OP) framework which began during the mid-period of HSP implementation.

The PMP outlines two sets of indicators, which are referred to as "USAID PMP indicators" and "OP indicators." The first set consists of 13 indicators which are HSP-specific and include the 9 BHS common indicators. The second set of indicators was selected from the FY2007 Operational Plan, first implemented in FY2007. Official guidance and a standard set of common indicators were provided by USAID/F Bureau. HSP selected 14 of these indicators, 10 from MCH, one from FP, and three cross-cutting indicators related to baseline/feasibility studies, evaluations and monitoring plans. Therefore, HSP has a total of 27 uniquely defined indicators (% and #).

SCOPE AND OBJECTIVES OF THE EVALUATION

This evaluation will concentrate on the Health Services Program's activities related to MCH systems capacity-building, support to decentralized governments, and behavior change aimed at reducing maternal and child morbidity and mortality. Aceh-based activities related specifically to tsunami recovery and outside the scope of the overall MCH systems approach applied in other project areas (e.g. psychosocial services, physical rehabilitation of health facilities/training infrastructure or markets) are not within the scope of this evaluation.

Obj 1: Achieve a thorough understanding of the outcomes/results of HSP interventions, and the effectiveness of HSP strategies for achieving results in the key focus areas listed below. Effectiveness may be defined by the extent to which accomplishments are (1) replicable; (2) likely to be sustained by GOI and/or local partners; (3) viewed by GOI (national and subnational) as consistent with policy and programs; (4) viewed by GOI as developed through an appropriately collaborative process; and (5) viewed positively by civil society partners as the outcome of a collaborative effort.

> NOTE: Replication is defined as other donors and/or localities implementing project tools/models at their own expense with little or no TA from project staff. Replication requires proper design of tools/modules and sufficient capacity of partners to implement project tools/models. Scale-up (linked to sustainability) is defined as project tools and/or models being adopted by the Ministry of Health or other national or "well-networked" civil society organizations. Scale-up has two phases: (1) Adoption, indicating ownership and intention; and (2) implementation, indicating provincial/district partners have demonstrated that they can access those tools/models, value them enough to cover costs

of implementation, and successfully implement them to a reasonable degree of compliance with what was intended by their design and piloting. Scale-up may require continued TA support from the project/USAID.

Obj 2: Develop recommendations for future activities and implementation strategies for both immediate and mid-term time frames. Recommendations for future program activities/strategies should take into account USAID/Indonesia's commitment to MOH priorities in MCH (i.e., achieving MDGs 4 & 5); health system-capacity building where it can be directly linked to positive impact on MCH outcomes; working closely with a broad range of civil society partners; and developing productive relationships with the private business sector.

NOTE: Immediate time frame refers to HSP's current end-date (Sept. 2009). The mid-term time frame refers to the follow-on project period of 4–5 years.

For the above two objectives, please focus on the following key areas or technical or strategic foci:

1. **Advocacy** capacity-building activities that aim to improve MNCH budget and policies at national and subnational government levels, in partnership with civil society organizations, local leaders, elected officials, civil servants, the private sector, etc.
2. **Behavior change** interventions at individual, household, and community levels using a variety of strategies—community mobilization, community facilitators/trainers, district campaigns, radio, and targeted IEC materials. Comment on the strengths and weaknesses of these strategies in relation to specific technical areas emphasized (birth preparedness, breastfeeding, hand- washing with soap). Comment on future recommendations for BCC investments, particularly with regard to regional or national-level media approaches and with regard to linking birth preparedness to increasing demand for facility deliveries.
3. Assess the **role of private sector midwives in MCH care.** Comment on how to maximize service coverage and quality to (a) the poor and (b) rural areas? Comment on how to improve management and leadership capacity within the Indonesian Midwives Association (IBI) to more effectively mobilize midwives toward better coverage and quality, and to more effectively manage (and successfully grow) the Bidan Delima program, a social midwife franchise with roughly 10% of all midwives having joined.
4. Review of key technical areas in which the project has provided **support to GOI** (nationally and subnationally). These areas include (a) decentralization (district planning and budgeting); (b) district MCH program management and quality improvement capacity (supportive supervision, OJT); and (c) quality of care (provider training).

   Please refer to Annex 1 for further details on specific technical issues to address in the evaluation investigations and final report.

Methodology

The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information that is required to assess the evaluation objectives. Data collection methodologies will be discussed with, and approved by, the USAID prior to the start of the evaluation. The evaluation should be a consultative and participatory process that includes key organizations from the GOI, civil society, NGOs, and private sector providers (midwives). The team will work in close collaboration with both national-level organizations and key district stakeholders including The Ministry of Health (including relevant subdirectorates of mother, child, nutrition, community health, health promotion, diarrhea management, etc.); the National Clinical Training Network (JNPK), professional medical associations in obstetrics (POGI), pediatrics (IDAI) and midwifery (IBI); Perinasia; partner NGOs; and other in-country partners. The final methodology and work plan will be developed as a product of the team planning meeting (TPM) and shared with the Mission prior to application.

Document Review

- USAID/Indonesia will provide the evaluation team with the key documents prior to the start of the in-country work. All team members will review these documents in preparation for the initial team planning meeting (refer to section 3.3 below)
- Secondary data may be assembled for background information. Most of these data should be available from readily accessible sources listed in this SOW as resource material. Additional data from institutions interviewed should be collected if available and relevant.

Team Planning Meeting

- A two-day team planning meeting will be held in Indonesia before the evaluation begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will
  - clarify team members' roles and responsibilities;
  - establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
  - review and develop final evaluation questions (work out realistic expectations of the team within each of the four topic areas during meetings with HSP, MOH, and USAID);
  - review and finalize the assignment timeline and share with USAID,
  - develop data collection methods, instruments, tools, and guidelines;
  - review and clarify any logistical and administrative procedures for the assignment;
  - develop a preliminary draft outline of the team's report; and
  - assign drafting responsibilities for the final report.

Interviews and Site Visits

- The evaluation team will meet with key stakeholders to conduct qualitative, in-depth interviews. The interviews should be loosely structured but follow a list of key discussion issues and questions as a guide. The interviewer should probe for information and take notes as necessary. The team should meet with and interview the institutions listed below, and others as they emerge and are considered relevant during the field work. Meetings may be conducted individually or in groups.
- Site visits should be made to at least three trips outside of Jakarta (North Sumatra, West Java, East Java—illustrative) in addition to one or two site visits in or near Jakarta. Evaluators may choose to visit some sites together and some sites separately. All site visits should be well-coordinated with HSP staff so that logistics are smooth, and proper introductions are made.

Organizations/institutions/individuals to meet:

- USAID staff in Washington and Jakarta
- MOH: National level counterparts in units related to maternal, neonatal, child, and nutrition at community/primary health care levels; medical (hospital) services; essential drugs; diarrhea unit in infectious diseases; health promotion; and provider training.
- MOH: provincial, district health teams
- Other key ministry officials at MenkoKesra, Ministry of Women's Empowerment, Bappenas, Ministry of Internal (Home) Affairs, BKKBN
- Indonesian Midwives Association (IBI)
- National Clinical Training Network (JNPK)
- Indonesian Association of Obstetrics/Gynecology

- Indonesian Association of Pediatrics
- Perinasia
- The Millennium Challenge Account program on immunization, currently entering the second year of a two-year, $20 million program.
- BHS implementing partners: SWS/JHUCCP, ESP/DAI, ASA/FHI, LGSP/RTI, Malaria in Pregnancy/UNICEF
- UNICEF (general programs and points of collaboration)
- WHO
- World Bank
- White Ribbon Alliance
- Women's Research Institute (WRI)
- Mercy Corps International (MCI)
- Others as appropriate

Applicable documents (additional documents will be provided in advance)

HSP annual reports
2008 Workplan
Decentralization working paper
Health sector reports (performance expenditure report, etc.)
Other reports/background information as assembled by USAID or HSP

Team composition and participation

The mission proposes a four-person team comprised of two international consultants from outside of USAID (one designated as team leader) and two Indonesian consultants hired locally who have the following expertise and qualifications:

1. (Independent Consultant) Team leader. The team leader should be expert in implementing public health programs with a special emphasis on reducing maternal and neonatal mortality risk. Experience in health systems capacity-building programs or activities and/or advocacy (community mobilization, partnerships with NGOs, governance) is required. The team leader should have 10+ years experience in field implementation of MCH programs in at least two different developing country settings. The team leader must also possess excellent interpersonal, management, and communication (oral, written) skills. The team leader will be responsible for making an oral presentation to the USAID Mission and delivering the written report. The team leader will be expected to plan, manage, and facilitate a participatory process that allows for discussion and consensus building among evaluation team members and maximizes the professional expertise that HSP and other partners in Indonesia bring to the evaluation.
2. (Independent Consultant) Private provider network (franchise) expert. Must have background in building capacity of professional organizations (doctors, midwives), implementing franchise endeavors, and/or improving quality of care within private provider networks.
3. (Local Consultant) Behavior change through community mobilization and the media, with background in public health.
4. (Local Consultant) Governance, health systems expertise. Some international experience (through academia, study tours, consultancies) helpful but not required. Thorough understanding of Indonesian history and current challenges with decentralization of health services required. Demonstrated understanding of private health providers in Indonesia, and private health seeking behaviors a plus.

Although the MOH cannot designate full-time evaluation participants, all site visits should be open to their attendance and they have expressed interest in several of their staff accompanying site visits. USAID/Mission staff may also attend site visits (at their own expense).

Schedule and logistics

Duration, Timing and Schedule

It is anticipated that the preparation, field work, and writing of the draft report will take approximately four to five weeks and that the final report will be submitted 5 days after comments are received from USAID/Indonesia. The evaluation team will be authorized to work a six-day work week when in country.

The following is an illustrative schedule.

	Task/Deliverable	Est. LOE
1.	Review background documents (out of country)	3 days
2.	Travel to/from country (for international consultants)	4 days RT
3.	Team planning meeting; meetings w/ USAID	2 days
4.	Information and data collection. Includes interviews with key informants (including partners and USAID staff) and site visits.	13 days
5.	Discussion, analysis, and draft evaluation report in country	5 days
6.	Debrief with team and stakeholders	1 day
7.	USAID & partners provide comments on draft report (out of country)—5 days	
8.	Team reviews and revises report – final	3 days (TL) 2 days (team members)
9.	USAID completes final review – 10 days	
	Total # days LOE	**33 days (TL)** **30 days (int. consultant)** **26 days (local consultants)**

The evaluation will occur in August. GH Tech will be responsible for all costs associated with the evaluation, including international and local consultant participation; international and local travel of team members and MOH staff accompanying site visits (per diem, hotel, transport hire); office and logistical costs for the team; and all costs associated with producing and disseminating the deliverables.

USAID will supply necessary contact information and will work to "socialize" approved SOW with MOH partners prior to the team's field work. USAID will suggest potential areas to be visited and ensure balance of project areas visited in the field.

Deliverables

Debriefing with USAID mission (BHS, Front Office) before completion of assignment, before submission of draft report and departure of team from country. Frequent contact with the USAID mission (MCH Advisor) on field work progress, and reporting of any change in timeline or sites proposed to be visited.

A written draft evaluation report, no longer than 30 pages, not including appendices, should be completed prior to the team leader's departure from Indonesia. The written report should be organized by objective but clearly describe sub-team findings and address cross-cutting themes. USAID will provide comment on the draft report within 5 working days of submission.

A PowerPoint presentation to be presented at dissemination meeting with MOH officials and other stakeholders. A designated evaluation team member (*Bahasa* speaker) will be designated to present. The evaluation team members should be present for commentary and discussion. USAID Mission staff will assist in organizing the meeting, which should take place toward the end of the assignment.

A final report that incorporates the team responses to Mission and MOH discussion, comments, and suggestions. The draft final report revisions should be completed within 5 working days after the team receives all comments from the Mission and provided to the USAID Mission for final comment. The final report (excluding executive summary and annexes) should be no more than 30 pages.

If the mission prefers to have two versions of the report: a version for public distribution and an internal version that may include sensitive information, the content of the two versions will be agreed upon at the time the first draft is submitted.

USAID will share the final but unedited report with the partners (without the forward-looking/future directions components) to give them an opportunity to review and make comments. After the final but unedited draft report has been reviewed by USAID and partners, GH Tech will have the documents edited and formatted and will provide both versions of the final report to USAID/Indonesia for distribution. It will take approximately 30 days for GH Tech to edit/format and print the final document.

The evaluation report will include, at minimum, the following: scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for modifications and future designs and for others to incorporate into similar programs) as well as the SOW, team composition, evaluation methods, documents consulted, individuals/institutions consulted, summary of field work (sites, programs seen, people consulted with, etc.).

Oversight and Management

The GHTech team will work under the direction of

Gretchen Antelman
USAID/Indonesia MCH Advisor,
gantelman@usaid.gov
62 812 10 63576)

Responsibilities:

USAID/Indonesia and/or HSP will be responsible for the following:

- Obtain country clearances for travel.
- Coordinate and facilitate initial assessment-related field trips, interviews, and meetings.
- Assist the team with in-country logistical arrangements.

GH Tech will be responsible for the following technical and logistical support:

- Identify and recruit team members—international and local consultants.
- Provide funds to the team for all in-country logistics.
- Provide administrative and management support to the team while on assignment.
- Provide support and editing services for the preparation of the final versions of the deliverables.

SCOPE OF WORK ANNEX 1

Specific Technical Issues to Investigate

Several cross-cutting technical issues and approaches should be considered by each team member within the context of the four technical focus areas of investigation. These are:

a) Epidemiology. How does the current portfolio of MCH activities appropriately address key MCH health burdens in Indonesia?

b) Geography. How appropriate has the current geographical focus of the MCH portfolio been in terms of reaching vulnerable populations, responding to GOI priorities, having national-level impact? Recommend future criteria for determining geographic focus.

c) Collaborative relationship and synergies with other BHS and donor partners. Where has collaboration been helpful to one or both partners? Where has such collaboration diverted HSP attention, resources, or energies from primary project aims? Distinguish between BHS (USAID) partners and non-USAID partners.

d) Relationship with Ministry of Health partners at national level, Provincial and District Health teams, and other key stakeholders representing local and national government. Responsiveness to emerging needs within national and subnational governments.

e) Sustainability of activities after HSP assistance stops. This may be evaluated informally as activities were implemented in a phased approach and some districts post-TA may be consulted.

f) Replication of HSP tools/modules. The extent to which steps toward replication have been taken, as well as actual replication achieved, should be noted.

g) Selection of evidence-based interventions. Are selected interventions appropriate for Indonesia? What areas of focus are recommended in the future?

h) Program planning, monitoring, and evaluation systems. Program marketing communications tools and dissemination of results to GOI, stakeholders, and USAID.

i) Leveraging resources through public-private partnerships (e.g., with private commercial business).

j) Effectiveness of "focus on the poor" underlying strategy and gender sensitivities of activities with regard to technical content and implementation strategy.

k) How should USAID determine the appropriate balance between investment in systems TA to national and subnational levels? Between facility and community-level interventions to increase access to quality delivery services?

SCOPE OF WORK ANNEX 2

Additional background information on health systems, policy, and trends in MCH Maternal, Child, and Neonatal Policy

Indonesia follows an adaptation of the Making Pregnancy Safer (MPS) policy which covers maternal delivery care and the newborn up to one hour after birth. Indonesia does not currently have a child health policy in place and the correct policy "placement" of the neonate is still under discussion. A draft child health policy was finalized two years ago but tabled by the Minister for technical reasons and has not been taken up again since. The MPS policy expires in 2010.

Indonesia has adopted the IMCI approach but has not actively implemented training, monitoring, and evaluation activities over the past 10 years since this program began. It is placed within the subdirectorate

of child health but must also coordinate closely with other subdirectorates overseeing training, *puskesmas* management and supervision, and infectious disease (diarrhea, malaria, HIV).

Facilities/Human Resources

The Government of Indonesia has employed a tiered approach representing a continuum of care from provincial and district public hospitals down to subdistrict and village health facilities. At the subdistrict level, primary health centers (*puskesmas*) are staffed with doctors, nurses, and midwives and are equipped to provide primary health care services to an area with about 30,000 people, or about 10 villages. There are about 8,000 *puskesmas* in the country.

The clinics offer a package of basic services including maternal and child health, family planning, out-patient care, and communicable disease control (TB DOTS, STIs). They also serve as primary level referral facilities linking patients to district hospitals. A number of health centers with beds have been established in order to provide service on site when referral to a district hospital is impractical. The *puskesmas* are supported by over 20,000 subhealth centers (*pustu*), mobile health centers (*posyandu*), and village-based maternity huts (*polindes*).

Puskesmas manage the *pustu,* and midwives hired on government contracts as part of an earlier program called Bidan di Desa (midwife in the village) manage the *polindes*. In the 1980s when the Bidan di Desa program was conceptualized, the midwives were meant to live in their assigned villages at the *polindes*. This is not currently the norm, however, as *polindes* frequently do not have running water, electricity, or toilets. Also, many "village midwives" now operate private clinics and therefore prefer to live in neighboring peri-urban areas. *Polindes* typically operate as village health posts providing morning primary health care services. The midwives provide delivery services in clients' homes or in their own homes, which may be set up as a private clinic attached to the midwife's residence.

Integrated Service Posts (*posyandu*) were established in the 1980s in order to strengthen community access to family planning and child health services. These are mobile health outreach activities at the village level that provide nutrition interventions (counseling, growth monitoring, and in some places positive deviance and nutrition rehabilitation activities), diarrhea management, family planning, routine immunization, and antenatal counseling. Fieldworkers (PLKB) and community volunteers (*kader*), organized initially in connection with the National Family Planning Coordinating Agency (BKKBN), have played an important role in mobilizing community members by providing health information, and encouraging women and adolescents to come to the *posyandu*. However, *posyandu* have weakened substantially since decentralization for a variety of reasons—human resources, *puskesmas* management, commitment and financial support from district government, etc.

Midwifery and Skilled Birth Attendance

Indonesia addressed the challenge of maternal mortality by showing a very strong commitment to scaling-up access to skilled birth attendants through an ambitious public health program called Bidan di Desa. Launched in 1989, the aim of the program was to reduce maternal mortality by increasing the proportion of deliveries managed by trained professionals, particularly among poor rural populations. There were some 15,000 community midwives in villages in 1991, which increased to 54,000 by 1997. It is estimated that about 30,000 midwives still participate in the program. This represents a ratio of one midwife per 2,400 population, or 54 births/year, far in excess of the international recommendation of one midwife per 175 births. District governments must now support the personnel costs of these midwives, and some are more committed than others to maintaining the model of a "midwife in every village."

Despite relatively high rates of coverage with a skilled health provider, the majority of deliveries still occur at home (76% in rural areas) and the quality of care provided by many skilled attendants is not at an acceptable standard. Access to emergency obstetric care is very limited (<2% c-section rate in rural areas,

DHS 2003). Over 50% of deliveries in the poorest quintile are NOT attended by a skilled provider (Susenas, 2005).

The Indonesian Midwives Association (IBI) estimates that there are 104,000 midwives total in Indonesia; 70,000 are IBI members; and 7,000 are members of a private midwife franchise called Bidan Delima (started 2004). Midwife training academies have burgeoned since the Bidan di Desa program. There are now over 400 midwifery schools country-wide, 100 under the auspices of the Ministry of Health and 300 under the Ministry of Education. Midwifery is a popular career choice for young women, and district-based schools of midwifery are reportedly profitable. They do follow a standard curriculum but are extremely weak in their quality of teaching and access to clinical sites for practice. There is no requirement of professional internship after midwife school.

Immunization

Immunization services are largely provided through the public sector, are centrally procured (locally produced), and are delivered at *puskesmas* and *posyandu*. Health service providers working at the *puskesmas* also provide immunizations through their private practices outside of the *puskesmas*, sometimes accessing the stocks from the *puskesmas*. Immunization coverage data suggests that services are in decline, and the country is just now recovering from a polio outbreak which triggered an emergency response and several NIDs. USAID currently manages a $20 million, 2-year MCC Threshold project in immunization in order to help Indonesia qualify for Compact status. A recent WHO/MCC coverage survey of 7 provinces showed DPT3 coverage at 70% and measles 78%. Rates varied significantly by province, however, with Banten's DPT3 only 38% and the highest coverage only 83% (Central Java). There was wide variety in place of DPT3 service as well: private clinic coverage ranged from 0 to 42%; outreach (*posyandu*) from 19% to 82%; and *puskesmas* from 3% to 28%. Child illness and mothers being unaware of need or where to go seemed to be the predominant reasons for children not being immunized properly. DHS data from 2002/3 showed fewer than 1/3 of mothers could show their child's immunization card to the interviewer. Service data reported by the MOH document higher rates of coverage than reported in survey data.

Vitamin A

Vitamin A is provided twice yearly in February and August through public health centers and outreach activities, and the national program has long been considered highly effective and internationally renowned. Most recently available DHS estimates of coverage of children with vitamin A supplements for 2002 show that urban coverage of children under 5 is 79% and rural coverage 71%. Only 59% of children aged 6-9 months were reported to have consumed vitamin A supplements, increasing to 75% or higher in older age groups.

Household Level Water and Sanitation

Indonesia is still far behind in its goal of achieving its MDG10, to "halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation." Water supply data show the number of people with access to piped drinking water was only 18% in 2006, far below the MDG target of 57%. The number of people with access to non-piped drinking water is 57%, compared to the MDG target of 69%. Furthermore, most water utilized by people for drinking and cooking is contaminated and would not pass "drinkable" standards.

Indonesia is also behind in sanitation. Although 69% of the population has access to sanitation facilities, most are public or individual latrines with a "soaking pit" or bottomless "septic tank" that simply leaks into the water table and contaminates groundwater, including nearby wells. Only 11 cities have centralized wastewater treatment facilities.

Minimum Service Standards and Local Area Monitoring (Health Information System)

The central MOH has developed a set of minimum service standards and indicators that all local public health programs are required to follow. These relate to antenatal, postnatal, and neonatal visits, skilled birth attendance, management of obstetric and neonatal complications, c-section, case fatality rate, detection of danger signs during pregnancy, low birth weight, malnutrition, and mortality indicators. Standard definitions are developed. Dissemination and training on these standardized indicators may not have been fully implemented in all districts.

Local Area Monitoring describes the system by which much of the health management information system data is collected, recorded, and reported. Midwives, fieldworkers, and cadres maintain detailed records of their activities and services and health outcomes in their respective areas. These data are reported to the district/subdistrict health centers, which then report them to district officials, who forward them to provincial officials for consolidation and reporting to the national Ministry of Health. Districts compile their reports quarterly; provinces compile reports and submit to central level annually. HIS data are reported in Excel format on five separate worksheets. They outline data at district level, providing provincial totals and simple indicator calculations. Data include demographics (population, pregnancies, deliveries, infants born), number of people who received services according to a range of indicators relevant to reproductive health and national targets, health facilities, health personnel, maternal and neonatal deaths, stillbirths, causes of maternal death, and timing of neonatal death.

Public and private hospitals report directly to the province. Hospital data are not compiled by district; only provincial totals are calculated. The hospital HIS data relevant to reproductive health includes total births in hospital, total complications managed by type of complication (bleeding, infection, eclampsia, abortion, other), c-sections, and mortality by cause. Hospital data are compiled at central level and generally not reviewed at district of provincial levels in the context of primary health care data.

Child Nutrition and Breastfeeding

An estimated 28% of children under 5 have moderate or severe malnutrition, with the majority of these cases occurring in children under 2. This is an important indicator to track because nutrition interventions are best targeted at children under 2 for maximum long-term public health benefit, and malnutrition among children under 2 is largely avoidable if proper breastfeeding behaviors were more prevalent. DHS data show substantial increases in rates of early initiation (<1 hour) increasing between 1994 (8%) and 2002 (38%), but only 61% had established breastfeeding within the first day (DHS 2002). Although less than 10% of mothers are not breastfeeding infants aged 4–6 months, more than one-third of mothers of infants 0–3 months supplement breast milk with other foods or liquids, and this increases to almost three-fourths among mothers of infants age 4–6 months. Overall rates of exclusive breastfeeding of infants <6 months are 39%. Infant formula and bottle+nipple use is relatively prevalent among infants <6 months (DHS, 2002/3). There are numerous reports of International Code violations, and high rates of ignorance among health providers about regulations against marketing of breast milk substitutes.

APPENDIX B. PERSONS CONTACTED

NAME	INSTITUTION	FUNCTION
Government		
Ms. Auly Altruiswaty	Asdep 1/III KPP (Min of Women Empow)	Assistant Deputy
Ms. Henni S	Asdep 2/III Coord Min of Welfare	Assistant Deputy
Mr. Bagus Satriya Budi	Directorate of Child Health, MOH	Staff of Directorate
Mr. Afrinaldi	KNPP (Min of Women Empow)	Head, Division of Data
Mr. Chatib Afwan	Coordinating Minister of Welfare	Division Head
Ms. Henny Nendra	Coordinating Minister of Welfare	Division Head
Ms. Nurbaeti Yuliana	Coordinating Minister of Welfare	Division Head
Ms. Diana Sista Dewi	Coordinating Minister of Welfare	Subdivision Head
Mr. Fardhon Hanafiah	Coordinating Minister of Welfare	Assistant Deputy, Population
Ms. Henny Setiawati	Coordinating Minister of Welfare	
Mr. Kusuma	Coordinating Minister of Welfare	
Ms. Meida	Coordinating Minister of Welfare	
Mr. Naalih Kelsum	Coordinating Minister of Welfare	Head, Division of HIV/AIDS
Ms. Hafni R	Central Health Promotion, MOH	Chief, Subdirectorate of Com. Facil.
Ms. Ratna Rosita	MOH Basic Medical Services	Director
Mr. Rochman Arief	Health Specialist Service, MOH	Head, Subdivision of Accreditation
Ms. Suginarti	Health Service, MOH	Head, Subdivision of Health Technology
Ms. Annie Trisusilo	Health Service, MOH	Staff
Mr. Noor Sardono	Health Service, MOH	Staff
Mr. Chandra	Health Service, MOH	Staff
Ms. Siti Romlah	Directorate General of Nursing, MOH	Staff
Mr. Dony Ahmad M.	Local Parliament, Sumedang	Vice Chairman
Mr. Dedy Ambara	Local Parliament, Sumedang	Head, Commission C
Mr. Aat Permana	Local Parliament, Sumedang	Member, Commission C
Mr. Rahmat	Local Parliament, Sumedang	
Mr. Choirun Anam	Local Parliament, Malang	Head, Commission B
Mr. Ari Wahyu	Local Parliament, Malang	Secretary, Commission B
Mr. Imron Rosyadi S	Local Parliament, Malang	Member
Mr. Akhmaddin	Local Parliament, Deli Serdang	
Ms. Hanny Ronosulistiyo	PHO Jabar	Head, PHO
Ms. Damayanti	PHO Jatim	Section Head, MCH
Mr. Achmad Rifai	PHO Sumut	Province Facilitator
Ms. Sri Indrawati	PHO Sumut	Province Facilitator
Mr. Sujud Pribadi	Local Government, Malang	Regent Chief
Ms. Lilis K.	Local Government, Sumedang, Law Division	
Mr. Sonteri Manurung	Local Superintendent, Deli Serdang	Head, Properity Subdivision
Ms. Aflah Kahirani	Local Superintendent, Deli Serdang	Staff
Mr. Usep	Local Superintendent, Sumedang	
Mr. Imron	Local Superintendent, Sumedang	
Mr. Andri	Secretariat, District of Sumedang	
Mr. Ferry	Secretariat, District of Sumedang	
Ms. Ninung	Secretariat, District of Sumedang	
Mr. Masdulhaq Srg	DHO, Deli Serdang	Head, DHO

Mr. Erwanto Indroyono Irsan	DHO, Deli Serdang	Head, PPL Division
Ms. Nurhayati	DHO, Deli Serdang	Head, Division of Family Welfare
Mr. Henrikus Sianturi	DHO, Deli Serdang	Head, Subdivision Program
Ms. Aida R Hutabarat	DHO, Deli Serdang	Head, Section of Health Promotion
Mr. Bahtera Barus	DHO, Deli Serdang	Head, Section of Disease Prevention
Ms. Elmi Haryani	DHO, Deli Serdang	Head, Section of Child Health
Ms. Lusiana Nasution	DHO, Deli Serdang	Head, Section of Family Nutrition
Ms. Suriani	DHO, Deli Serdang	Head, Section of MCH
Mr. Hieronimus M	DHO, Deli Serdang	Staff
Ms. Lady Rosary	DHO, Deli Serdang	Staff
Mr. Erfan	DHO, Deli Serdang	Staff
Mr. Hotman Saragih	DHO, Deli Serdang	Staff
Ms. Nurhayati	DHO, Deli Serdang	Staff
Ms. Rindang Simbolon	DHO, Deli Serdang	Staff
Ms. Veronika Sembiring	DHO, Deli Serdang	Staff
Ms. Siti Asnah	DHO, Deli Serdang	BCC Team
Ms. Elina Malau	District Information & Communication Office	Staff
Mr. Agus Wahyu Arifin	DHO, Malang	Head, DHO
Ms. Tutik Wahyuni	DHO, Malang	Head, Subdivision of Public Health
Ms. Anita Flora	DHO, Malang	Head, Section of MCH
Mr. Arbani M.W	DHO, Malang	Head, Section of Health Promotion
Mr. Joni ST	DHO, Malang	Head, Section of Prog. Development
Ms. Enny Sekar	DHO, Malang City	Head, DHO
Ms. Asih Tri Rahmie	DHO, Malang City	Head, Subdivision of Public Health
Ms. Ella Nurilla Sari	DHO, Malang City	Head, Section of MCH
Ms. Retno Ernawati	DHO, Sumedang	Head, Division of Family Welfare
Mr. Buddy K.	DHO, Sumedang	Staff
Mr. Cecep	DHO, Sumedang	Staff
Mr. Cecep N.	DHO, Sumedang	Staff
Mr. Dase S	DHO, Sumedang	Staff
Ms. Entin	DHO, Sumedang	Staff
Mr. Harry K	DHO, Sumedang	Staff
Ms. Tati	DHO Sumedang	Staff
Ms. Uyu W	DHO Sumedang	Staff
Ms. Yeni	DHO Sumedang	Staff
Ms. Diane Ocviyanti	RSCM (top National Referral Hospital)	Chief, Subdivision of Medical Services
Ms. Yuli	PHC, Turen	Chief, Public Health Center
Ms. Esti	PHC, Turen	Midwife Coordinator
Ms. Wiwin Kuraesin	PHC, Jatinangor	Staff
Ms. Imas Widowati	PHC, Jatinangor	Staff
Mr. Eri Dadan H.	PHC, Jatinangor	Staff
Ms. Juanita	PHC, Jatinangor	Staff
Ms. Apon	PHC, Sukamantri	Staff
Ms. Dedeh Sukmawati	PHC, Sukamantri	Staff
Mr. Nanang	PHC, Tommo	Staff
Mr. Puguh Y.	PHC	Staff
Mr. Wijayanto	P2KS (Secondary center of clinical training)	Head
Ms. Nurasiyah	P2KP (Primary center of clinical training)	Secretary, P2KP

Ms. Elis Rita		Midwife Coordinator
Ms. Wiwin K.		Midwife Coordinator
Ms. Heni Rohani		Midwife Coordinator
Ms. Lilis		Protocol
Ms. Ely Yani		Disduk (Population Office)
Mr. Dedi Kuswenda	Directorate of Maternal Health, MOH	Subdivision Chief
Ms. Sari Handayani	Perinasia	Administrative director

USAID, Project staff, Professional Associations, NGOs

Mr. Charles Oliver	USAID	
Ms. Gretchen A	USAID	Senior MCH Advisor, BHS
Mr. Reginald Gipson	HSP, Jakarta	Chief of Party
Mr. Anhari Achadi	HSP, Jakarta	Deputy Chief Officer
Ms. Laurel McLaureen	HSP, Jakarta	Deputy Chief Officer
Ms. Herlina	HSP, Jakarta	
Ms. Dewi T	HSP, Sumut	PC Advocacy
Ms. Fitri Irmadani	HSP, Sumut	Administration
Mr. Imam	HSP, Sumut	PC Training
Mr. Jeffry S	HSP, Sumut	BCC Commob
Mr. Masroel Siregar	HSP, NSRO	ROD
Mr. Muhtar Sijabat	HSP, Sumut	District Facilitator
Mr. Syah Sinar R	HSP, Sumut	PC HSM
Mr. Rudi P	BYM	
Ms. Susy H	BYM	
Mr. Badriul Hegar	IDAI (Indonesian Pediatrics Society)	General Chairman
Mr. Suryono S I Santoso	ISOG (POGI- Indo. Ob/Gyn Society)	General Chairman
Mr. Gulardi Wiknjosastro	JNPK (National Clinical Training Network)	Chairman
Mr. Ruslan Pandia	POGI	Member
Mr. Asril A	RSCM, Div Neonatology	Professor
Mr. Budi Iman Santoso	JNPK	Master Trainer
Mr. Julianto W	RSCM (Top National Referral Hospital)	Director of Medical Service
Ms. Rinawati	RSCM	Staff
Ms. Linda A	RSCM	Nursing Division
Mr. Indra S	Perinatology Working Group at IDAI	Secretary of Working Group
Mr. Trijatmo Rachimhadhi	Perinasia	General Chairman
Ms. Rulina Suradi	Perinasia	Member of the Board (Professor)
Ms. Sari Handayani	Perinasia	Staff
Ms. Harni Koesno	Indon. Midwife Association (IBI)	President
Ms. Mustika Sofyan	IBI	Chairperson I
Ms. Yumiarni	IBI	Chairperson II
Ms. Nur Ainy Madjid	IBI	Secretary General
Ms. Indah Hartati	IBI	Member
Ms. Tati R.	West Java Midwife Association	President
Ms. Mastinah	West Java Midwife Association	Vice President
Ms. Sri Purwani	West Java Midwife Association	Treasury
Ms. Soekaemi Soekir	East Java Midwife Association	President
Ms. Rosmini Sembiring	Deli Serdang Midwife Association	President
Ms. Titi Murdiati	Bandung Midwife Association	President
Ms. Ipah Saripah	Bandung Midwife Association	Secretary
Ms. Sri Ambarwati	Malang Midwife Association	President

Ms. Siti Chusnijah	Malang Midwife Association	President
Ms. Heri H	Cimahi Midwife Association	President
Ms. Agnia Restu S.	Midwife Association	Member
Ms. Ai Andriani	Midwife Association	Member
Ms. Emay	Midwife Association	Member
Mr. Syamsul Bahri	IPD (Institute for Village Development)	Executive Director
Ms. Siti Dahniar	IPD	District Advocacy Team
Mr. Rurit Rudyanto	Malang Budgetting Watch (MADEWA)	District Advocacy Team
Mr. Chusnul Hakim	Konsorsium Keadilan & Kesejahteraan	District Advocacy Team
Mr. Rusli Barus	P2KS	Secretary
Mr. Nandang Suherman	Advocacy Team	District Advocacy Team
Mr. Hendi Irawan	P3ML/Tim Advokasi	District Advocacy Team
Mr. Deden Hilga S.	FDA/P3ML	District Advocacy Team
Ms. Noerony Hidayat	NGO SSS	District Advocacy Team
Ms. Zenni M.	LSS	District Advocacy Team
Mr. Didin Nuradin	Lakesdam	District Advocacy Team
Mr. Waluyo	FD Sayang	District Advocacy Team
Mr. A.A. Raka	PC Kota Bandung	Treasury
Ms. Teti Rahmayati		Facilitator
Ms. Tuti		Facilitator
Ms. Andi Mala Ummu R	Fatayat NU	Member of the Board
Ms. Muzaenas Zein	Fatayat NU	Member of the Board
Ms. Ulfah Mashfufah	Fatayat NU	Member of the Board
Ms. Yusanti Mariyan	PT Radio	
Ms. Sinta Istadi Priyono	PT Optima Nara Ekspresi	Business Director
Ms. Sayu Ngurah	PT Optima Nara Ekspresi	Account Executive
Ms. Keety Salea	PT Optima Nara Ekspresi	BCC Trainer
Mr. Yogy Fabretta	PT Optima Nara Ekspresi	Art Director
Mr. Sabur Pramadi	PT Optima Nara Ekspresi	Art Director
Mr. Anugraha	PT Optima Nara Ekspresi	Copy Writer
Ms. Heryanti	HSP	Translator
Ms. Janti	USAID	Translator
Mr. M Nisramudin		Secretary
Mr. Effen		
Mr. Herman		
Mr. Cecep Ridwan		
Ms. Dedeh K.		Bidan Delima
Ms. Sri Sulami		Bidan Delima, Malang City
Ms. Tanti Budi		Bidan Delima, Tumpang Village
Ms. Fatimah	RBS Fatimah	Owner
Ms. Ina	BPS (Private Midwife)	Practitioner
Ms. Muchlis	CHC, Mergosono District	Head
Ms. Iri S. Haryana	CHC, Sumedang	Head
Ms. Nia K.	CHC, Sumedang	Vice Head
Ms. Anah Q.	CHC, Sumedang	Member
Ms. Enok Wartiwi	CHC, Sumedang	Member
Ms. Esih Kurniasih	CHC, Sumedang	Member
Ms. Euis B.	CHC, Sumedang	Member
Ms. Eva Susandiani	CHC, Sumedang	Member
Ms. Hani W	CHC, Sumedang	Member

Ms. Lilis N.	CHC, Sumedang	Member
Ms. Mela	CHC, Sumedang	Member
Mr. Syari	CHC, Sumedang	Member
Mr. Tulus	CHC, Tawangrejeni	Head
Ms. Ruminawati	CHC, Tawangrejeni	Village Midwife
Ms. Sinansari	FKM UI (Faculty of Public Health)	Student
Ms. Yenny Makasudede	FKM UI	Student

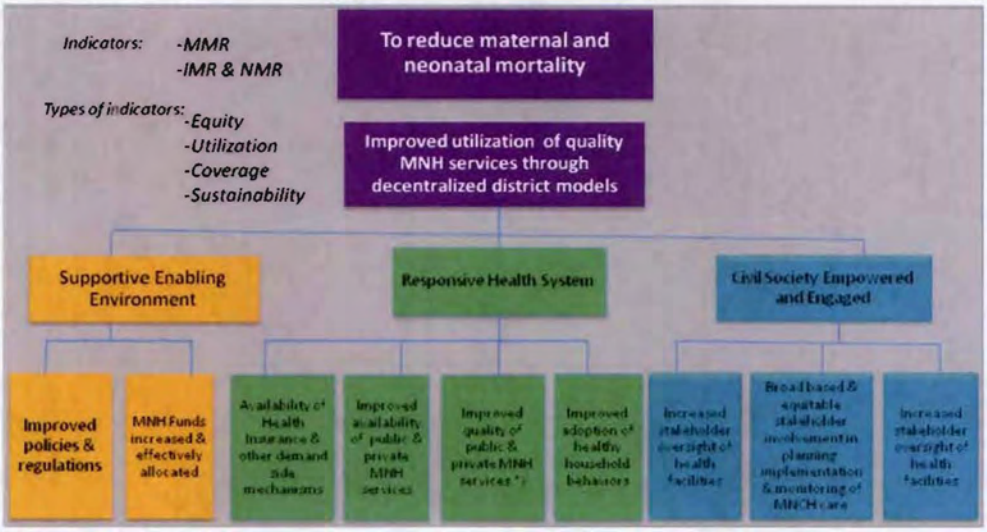
Others

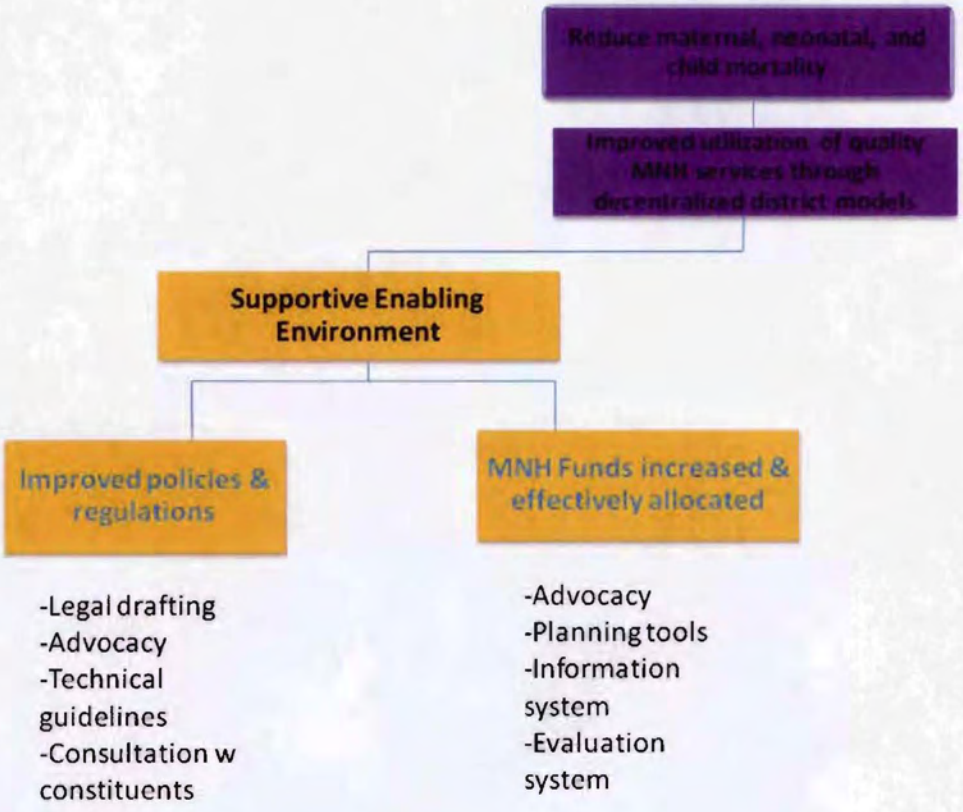
Mr. Arum Atmawikarta	Bappenas	Director of Health and Community Nutrition
Ms. Sita Ari Purnami	Women's Research Institute	Executive Director
Mr. James C. Sonnemann	Millennium Challenge Corp. Indonesia (MCCI)	Chief of Party
Ms. Sri Duryati Boedihardjo	MCC	Public Health and Immunization Advisor
Ms. Claudia Rokx	World Bank	Lead Health Specialist
Mr. Martin Weber	WHO	Child and Adolescents Advisor
Ms. Fitri Putjuk	Johns Hopkins University	Country Rep.
Mr. PA Kodrat Pramudho	Center of Health Promotion, MOH	Chief of Partnership Division
Ms. Meiwita Budiharsana	Ford Foundation	Representative
Ms. Sinta Istadi Priyono	ONE COMM	Director
Ms. Hermiyanti	Directorate of Maternal Health, MOH	Director
Mr. Lukman Hendrolaksono	Directorate of Maternal Health	Subdivision chief
Ms. Sulatni	Directorate of Child Health	Director
Ms. Erna	Directorate of Child Health	Subdivision chief
Ms. Atikah Adyas	Health Financing, MOH	
Prof. (M.r) Emil Salim	President Advisor	Member
Mr. Ascobat Gani	Faculty of Public Health	Expert, Health Economics
Mr. Mahlil Ruby	Financing Specialist	Expert, Health Economics
Mr. Laksono T	Gajah Mada University	Expert, Decentralization
Mr. Wijono	Local Governance Support Group (LGSP)	Advisor, Planning
Mr. Adam	LGSP	Advisor, Services
Mr. Djoko Soetikno	JHPIEGO	Director
Mr. Budihardja	MOH, Community Health	Director General
Ms. Widyastuty	WHO	Consultant on Health Financing
Ms. Elsa Handayani	Johnson & Johnson	
HSP JAKARTA	HSP	Advisors, Consultants, Staff

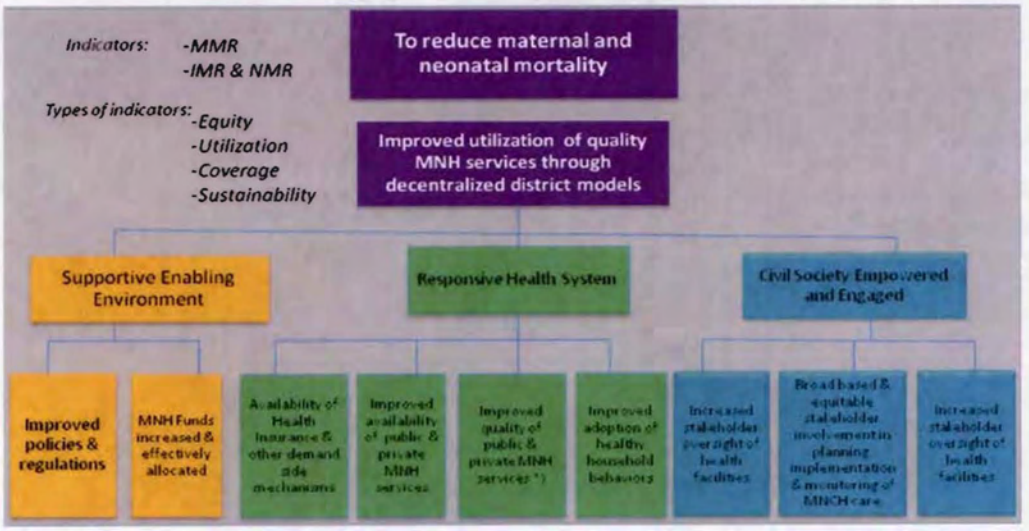
APPENDIX C: TOOLS AND GUIDELINES DEVELOPED WITH HSP ASSISTANCE

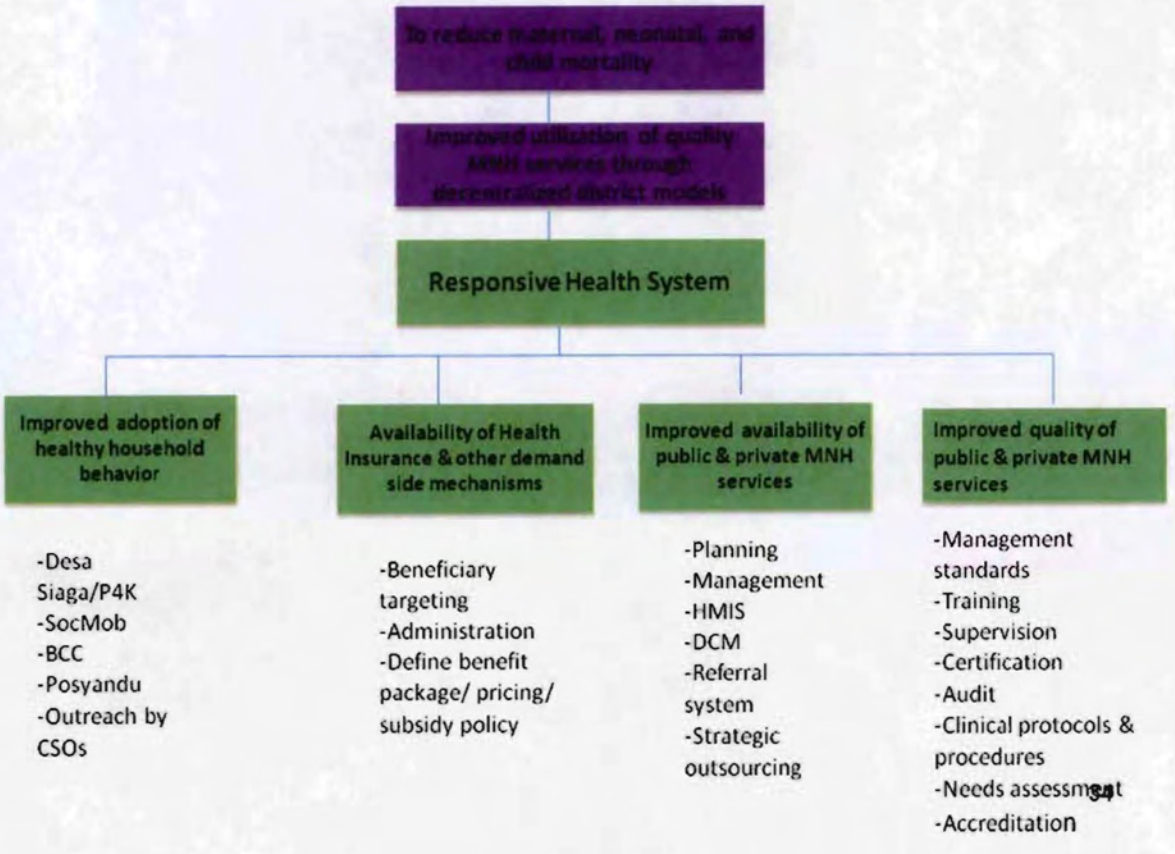
Tool	Contributors (Ownership)	National Trainers
DTPS-MNCH: Planning	*Dir. Ibu, Dir. Anak, Dir. Gizi, Yanfar* , UI, *Penala Hati*	15 master trainers 84 national facilitators 34 province facilitator
DTPS-MNCH: Advocacy	WRI, *Dir. Ibu, Dir Anak, PromKes, Pusdiklat*, ADB, WHO, UNICEF	19 master trainers, 69 national trainers
IMCI	UKK- IDAI, *Dir. Anak, Dir. Gizi, Dir.* Surveillance, Dir.P2ML and Dir. P2B2, WHO, Save the Children, GTZ, JICA, UNICEF	10 national IMCI facilitators 9 PHO trainers from 4 provinces 22 DHO trainers from 10 districts
APN 2008	JNPK, IDAI, IBI, *Dir. Ibu, Dir. Gizi, Dir. Anak,* WHO, UNICEF, Save the Children	JNPK national network of clinical trainers (P2KS/P)
APN Qualification & Accreditation tool	JNPK, *Dir. Ibu*	JNPK national network of clinical trainers (P2KS/P)
PONED (BEONC) 2008	JNPK, *Dir. Ibu, Dir. Anak*	JNPK national network of clinical trainers (P2KS/P)
Supportive Supervision	*Dir. ibu, Dir. Anak, Dir* P2PL, *Dir Yanmedik, Pusdiklat*, JNPK, IBI, UNICEF, WHO	20 MOH national trainers 5 JNPK national trainers 50 provincial trainers 111 district trainers 420 *puskesmas* staff trainees
Behavior Change Communications	*PromKes, Dir. Ibu*	MOH and PHO trainers
P4K modules	*Dir Ibu, PromKes*	Desa SiAGa module produced in 2006 – HSP trained trainers from all 31 provinces P4K – module pending approval
Breastfeeding – KADARZI Community Modules	*Dir. Gizi,* IBI	6 PHO trainers 16 DHO trainers

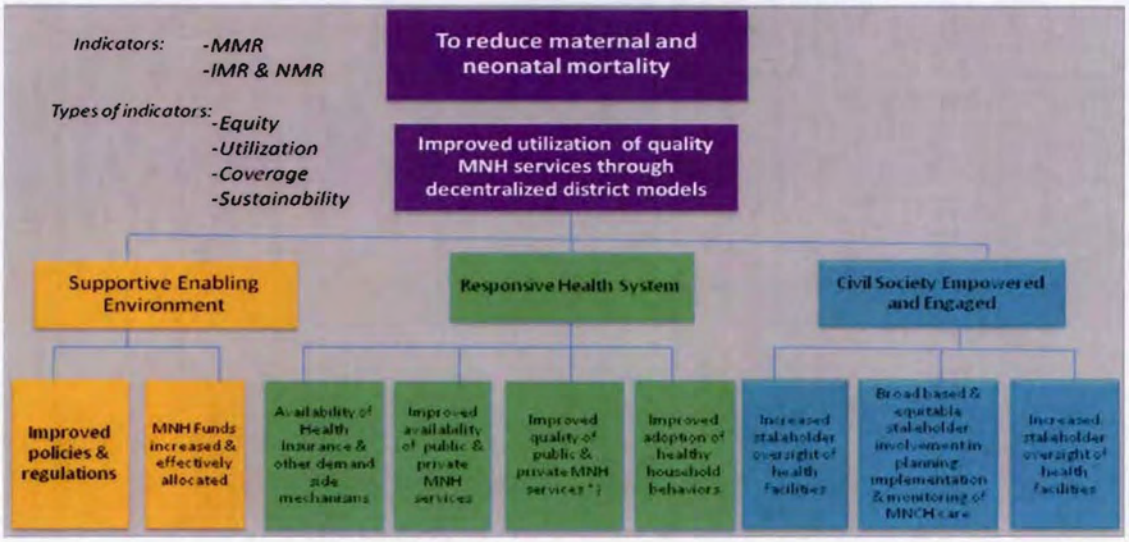
APPENDIX D. ACCELERATING INFANT AND MATERNAL SURVIVAL (AIMS)

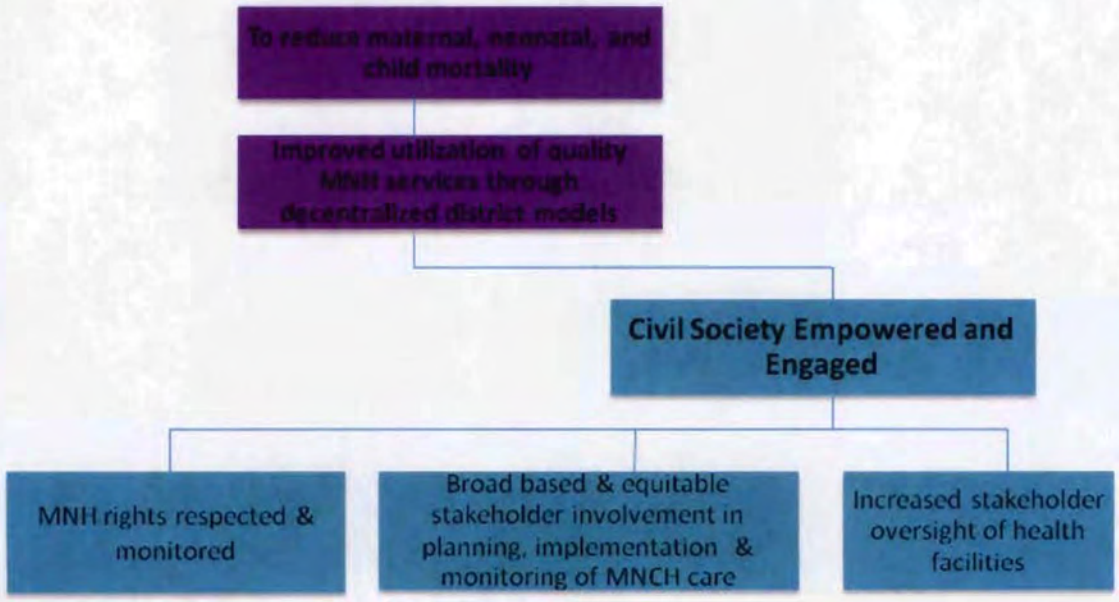





Indicators: -MMR -IMR & NMR
Types of indicators: -Equity -Utilization -Coverage -Sustainability
To reduce maternal and neonatal mortality
Improved utilization of quality MNH services through decentralized district models
Supportive Enabling Environment
Responsive Health System
Civil Society Empowered and Engaged
Improved policies & regulations
MNH Funds increased & effectively allocated
Availability of Health Insurance & other demand side mechanisms
Improved availability of public & private MNH services
Improved quality of public & private MNH services *)
Improved adoption of healthy household behaviors
Increased stakeholder oversight of health facilities
Broad based & equitable stakeholder involvement in planning implementation & monitoring of MNCH care
Increased stakeholder oversight of health facilities


To reduce maternal, neonatal, and child mortality
Improved utilization of quality MNH services through decentralized district models
Responsive Health System
Improved adoption of healthy household behavior
Availability of Health Insurance & other demand side mechanisms
Improved availability of public & private MNH services
Improved quality of public & private MNH services
-Desa Siaga/P4K
-SocMob
-BCC
-Posyandu
-Outreach by CSOs
-Beneficiary targeting
-Administration
-Define benefit package/ pricing/ subsidy policy
-Planning
-Management
-HMIS
-DCM
-Referral system
-Strategic outsourcing
-Management standards
-Training
-Supervision
-Certification
-Audit
-Clinical protocols & procedures
-Needs assessment
-Accreditation





-Consultation w clients
-Data collection
-Information dissemination
-Accountability mechanisms

-Planning
-Monitoring
-Information dissemination
-Mapping
-Consultation with constituents
-Musrenbang

-Organization
-Data collection
-Consultation w facilities & clients
-Epidemiological surveillance

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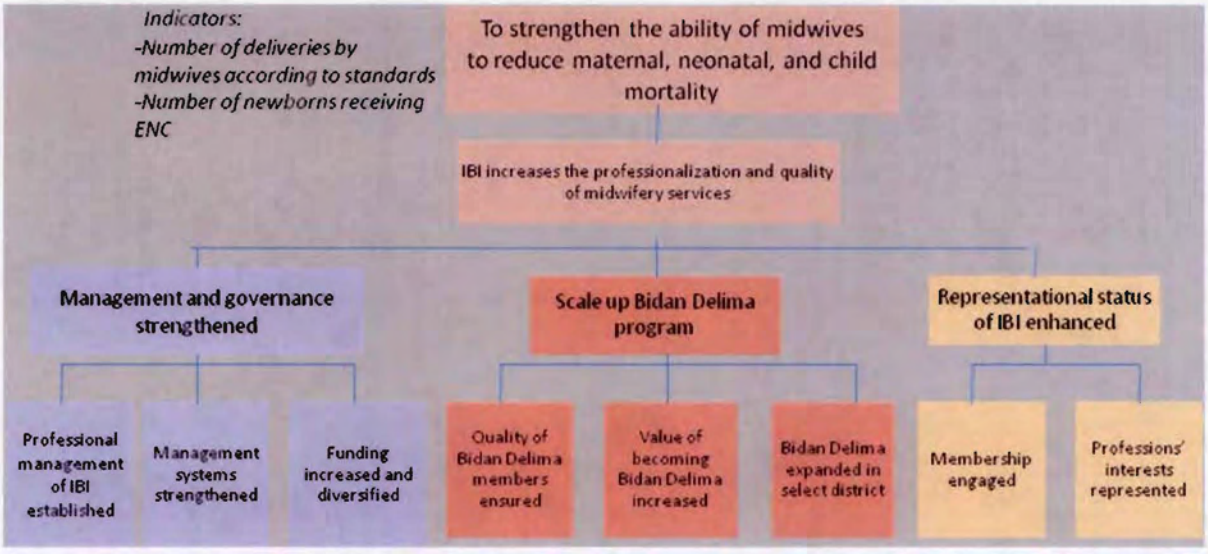
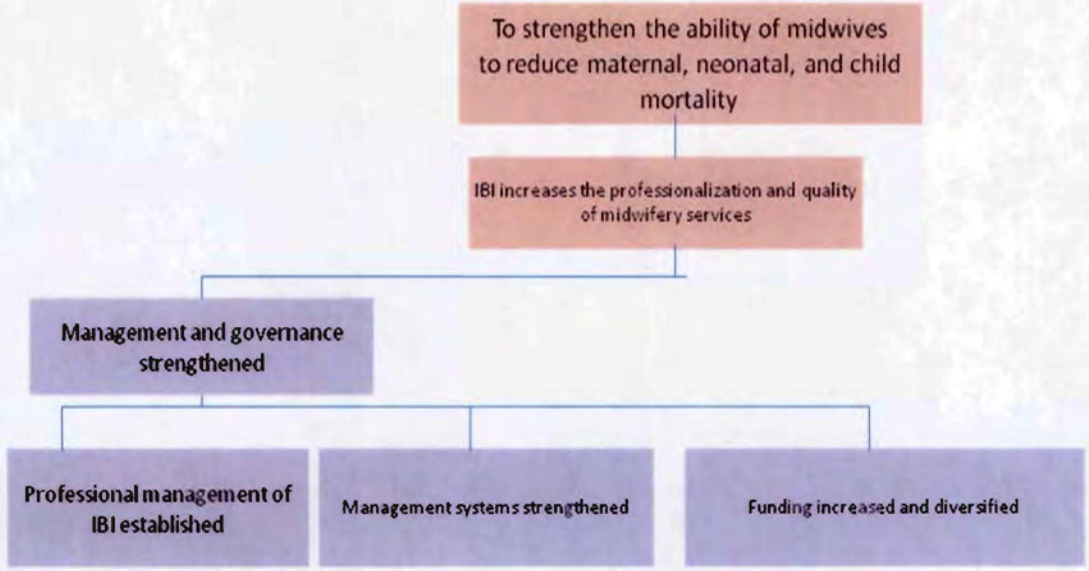
APPENDIX E: INVESTING IN IBI

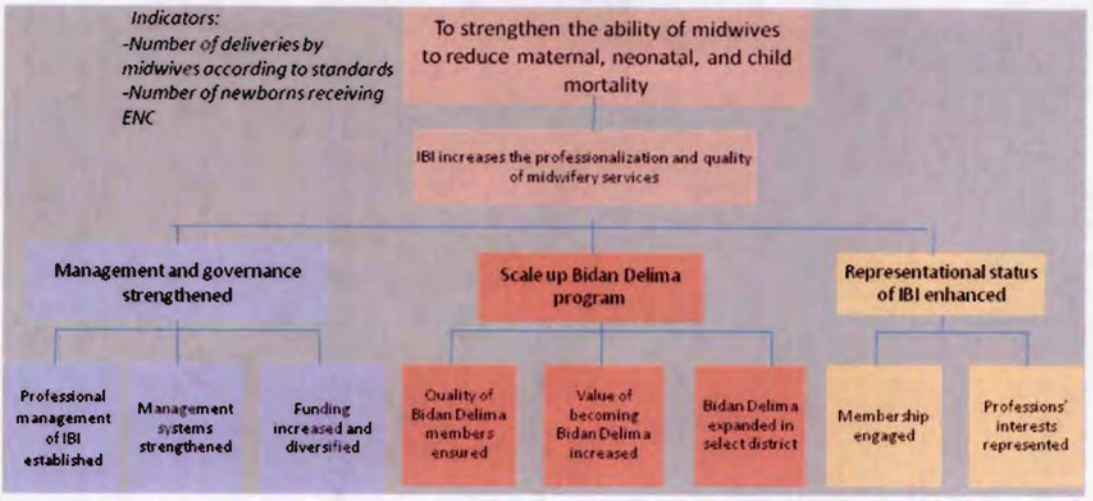


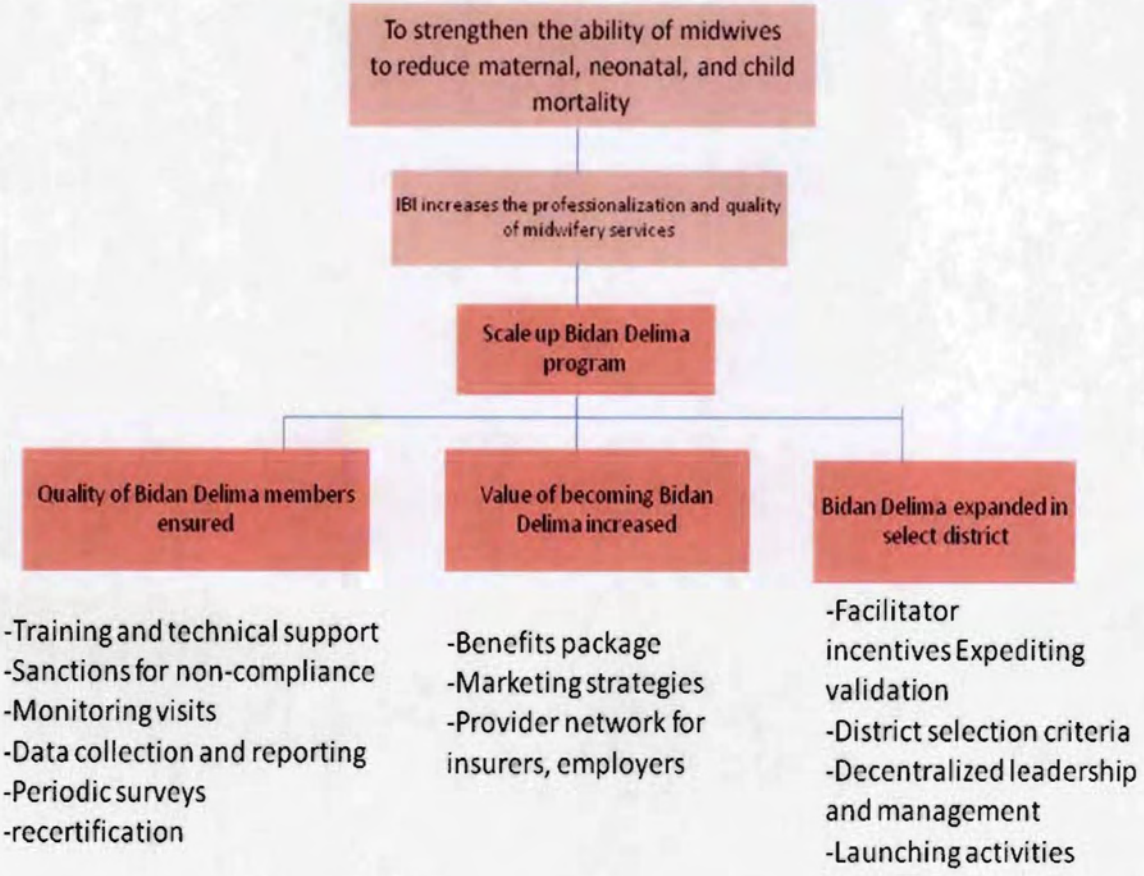


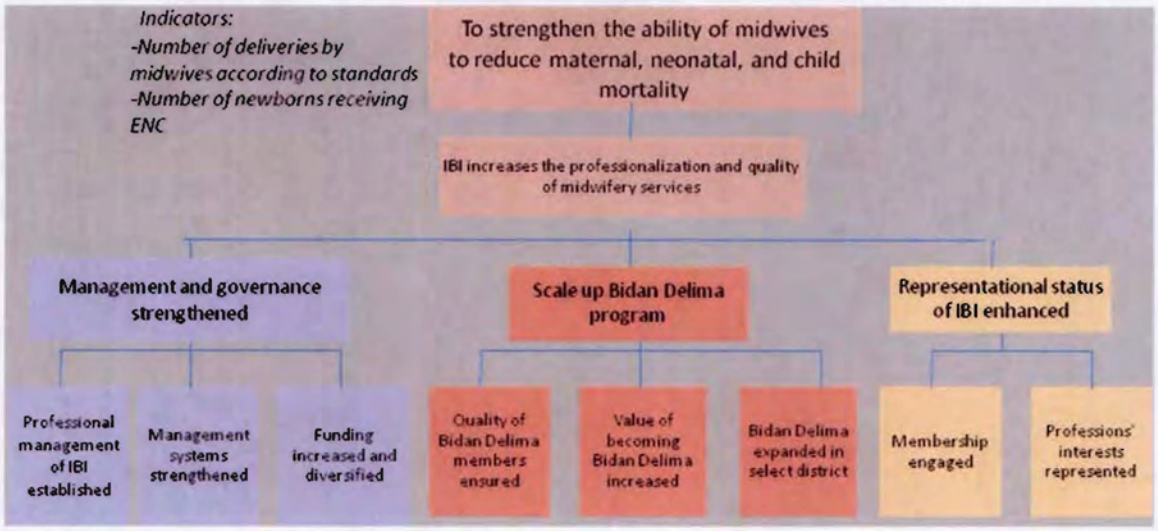
-Executive secretariat
-Management committee
-Technical advisory group
-Other association staff

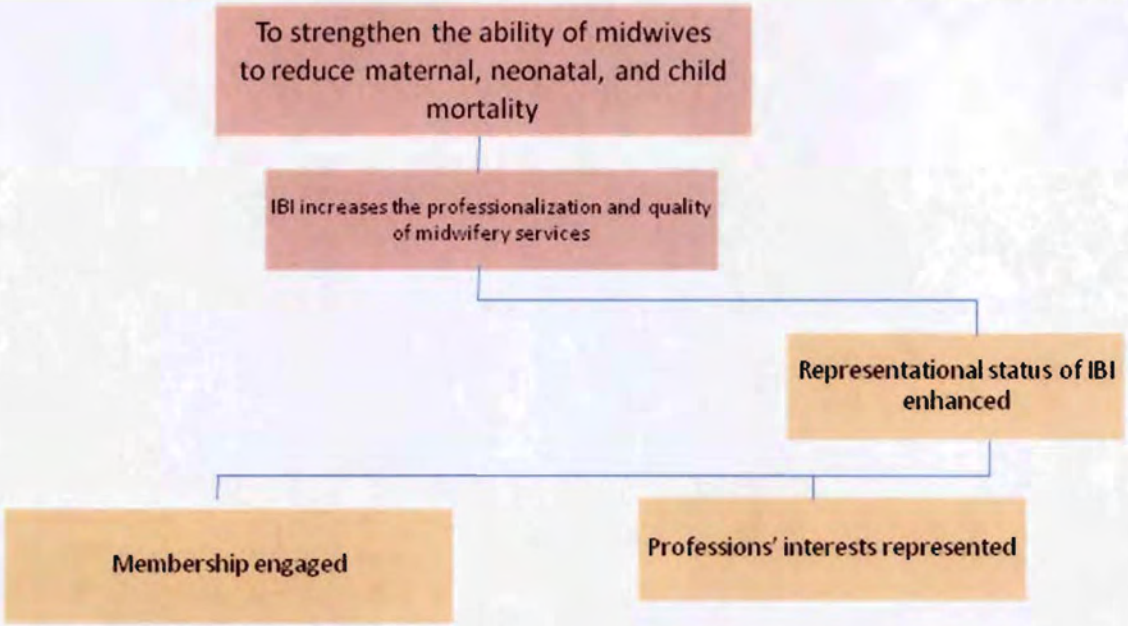
-Strategic planning
- Expanded information systems
-Budgeting and financial systems
-Board /leadership development

-Improved fundraising skills
-Outreach for govt , corporate and donor
support
- Membership fee collection
-Income generating activities
- IBI clinic business plan


Indicators:
-Number of deliveries by midwives according to standards
-Number of newborns receiving ENC
To strengthen the ability of midwives to reduce maternal, neonatal, and child mortality
IBI increases the professionalization and quality of midwifery services
Management and governance strengthened
Scale up Bidan Delima program
Representational status of IBI enhanced
Professional management of IBI established
Management systems strengthened
Funding increased and diversified
Quality of Bidan Delima members ensured
Value of becoming Bidan Delima increased
Bidan Delima expanded in select district
Membership engaged
Professions' interests represented


To strengthen the ability of midwives to reduce maternal, neonatal, and child mortality
IBI increases the professionalization and quality of midwifery services
Scale up Bidan Delima program
Quality of Bidan Delima members ensured
Value of becoming Bidan Delima increased
Bidan Delima expanded in select district
-Training and technical support
-Sanctions for non-compliance
-Monitoring visits
-Data collection and reporting
-Periodic surveys
-recertification
-Benefits package
-Marketing strategies
-Provider network for insurers, employers
-Facilitator incentives Expediting validation
-District selection criteria
-Decentralized leadership and management
-Launching activities





-Membership events/services
-Distance learning
-Leadership opportunities
-Outreach to members
-Support for new midwives
-Social networking
- Member communications

- Advocacy for midwifery law and council
- Advocacy for midwifery education
- Competency certification

OPPORTUNITIES FOR GENERATING RESOURCES FOR IBI

	Opportunities for Funding Support	Value Proposition for Funder
Government	Training support for facilitators Training support for midwives (AP, etc.) Participation in launch activities and promoting program in community Inclusion of qualified BD private providers in government insurance programs Could outsource oversight function to professional association.	Private providers can help district improve MMR and IMR. Helping private providers helps the public sector, since many work in both areas. Supporting IBI programs is in line with obligation to support CSOs. Engaging with private providers through BD will can give district leverage to ensure compliance with reporting, participation in audits by private providers. and participation in community activities such as CHCs, P4K, and integrated service posts. Engaging private providers through insurance eligibility strengthens ability to mandate quality standards. Part of the MOH obligation is to supervise private providers and this is an efficient way to do so.
Donor	Same activities as government, since donors are supporting government to improve the health system Can use network to pilot new interventions or approaches (e.g., voucher scheme, CCT, cervical cancer screening, etc.	Network with strong quality assurance and reporting mechanisms in place makes it easier to roll out interventions; offers an organizational structure to an otherwise unorganized sector.
Corporate	Sponsor training of facilitators Sponsor promotion of events Sponsor launch and support of program in key geographic areas Use network to provide health services to employees (at facility and through outreach)	Entry point into a market for new or existing products through provider referrals or distribution Fulfillment of CSR obligations Contribute to public relations objectives of corporate sponsor.

APPENDIX F: DIARY OF AN ADVOCACY PARTICIPANT

HSP—MNCH ADVOCACY TEAM JOURNAL OF ACTIVITIES IN SUMEDANG DISTRICT, 2007–2008

No.	Date	Activity	Output	Remarks
1	May 2007	Meeting to establish an Advocacy Team at the District Health Office	Establishment of an Advocacy Team	The first multistakeholder meeting, which initiated advocacy work and established an Advocacy Team.
2	23 May 2007	Coordinating Meeting on Team Development at Hotel Karya Nunggal, Legok	A list of stakeholders supporting advocacy for MNCH	The second multistakeholder meeting, in which HSP programs were introduced, especially one that focused on advocacy for MNCH to stakeholders and pushed for a *Bupati* Regulation (*Perbup*) on MNCH. An ad hoc team for *Perbup* consisting of representatives of different stakeholders was established during the meeting. The meeting was attended by government staff, CSOs, and HSP.
3	19 June 2007	Advocacy Team Coordinating Meeting at the District Health Office	Establishment of 3 working groups	The coordinating meeting was attended by the Advocacy Team, DHO, and HSP. Three working groups were established during the meeting: Working Group on Policy Analysis, Working Group on Program and Budget, and Working Group on Maternal & Perinatal Audit (MPA).
4	22 June 2007	Meeting on Follow-Up Plan between the Advocacy Team and HSP at P3ML office	Work Plan for the ad hoc team	The meeting produced a work plan for the ad hoc team, expected outputs, timeline for the activities, and persons in charge
5	3 July 2007	Signing of a Cooperation Agreement at Aston Atrium Hotel to focus on MMR/NMR	Signed Agreement	The meeting between HSP counterparts in West Java agreed to focus the activities on maternal, neonatal, and child health.
6	22 July 2007	Development of Work Plan for the Advocacy Team to advocate for a local regulation on MNCH	3 TORs for study analysis	TORs were developed by the Advocacy Team. Pak Deden wrote the TOR for Policy and Budget Analysis, Pak Hendi the TOR for Academic Paper, and Pak Zeni the TOR for Maternal & Perinatal Audit (MPA).
7	25-26 July 2007	Search for MPA cases by the MPA working group	A film about MPA cases in Sumedang	The MPA working group searched for and documented MPA cases in Sumedang. The film was prepared by Pak Zeni and Pak Hendi.
8	3-4 August 2007	HSP meeting at the TOGA food stall	Agreements between stakeholders involved in MNCH advocacy work	The meeting was a coordinating meeting to obtain commitment from all of stakeholders involved in MNCH advocacy work.
9	6 August 2007	Discussion on analysis design (M1) at P3ML Office	Overview of policy and budget allocation for reducing MNMR in Sumedang	It was a team meeting which tried to conclude the results of analysis conducted by the Working Group on Budget and Policy. The conclusions were later used in FGD.

No.	Date	Activity	Output	Remarks
10	7 August 2007	FGD on Budget Priorities at P3ML Office	FGD participants learned what the local govt. priorities were in terms of policy and budget to reduce MNMR	
11	10 August 2007	MNCH Advocacy Team Meeting at P3ML Office	Input for the academic paper	The meeting discussed division of work among Advocacy Team members. Pak Hendi was responsible for collecting and analyzing data on *Renstra* (Strategic Plan) and regulations related to the health sector and MNCH; Pak Deden was responsible for analyzing District Health Office's Work & Budget Plan and District Annual Budget and budget allocation for MNCH activities from 2005–2007; Pak Zeni was responsible for collecting data on MPA cases.
12	14-15 August 2007	Training in academic paper at Hotel BGG Jatinangor for HSP counterparts in West Java	3 members of the MNCH Advocacy Team learned how to draft a good academic paper.	3 members of the MNCH Advocacy Team (Pak Nandang, Pak Deden, Pak Zeni) participated in the training. The training really helped the team draft an academic paper on a regulation on MNCH for the district.
13	23-24 August 2007	Making Pregnancy Safer (MPS) Training in Garut	3 members of the MNCH Advocacy Team learned about MPS	3 members of the MNCH Advocacy Team (Pak Nandang, Pak Deden, Pak Zeni) attended.
14	24 August 2007	Discussion among the working groups (M2) at P3ML office	Preliminary draft of academic paper	The preliminary draft of academic paper was drafted based on the conclusions of analyses of the district strategic plan, health regulations, district budget, and maternal and perinatal audit findings.
15	29 August 2007	Handing over the master copy of a film created based on the results of MPA	A short film made based on the MPA results	The working group on MPA handed over the film that they created as advocacy material based on their MPA findings.
16	30 August 2007	Advocacy Team Coordinating Meeting at P3ML office	Initial legal draft of *Perbup* on MNCH	The meeting was aimed at coordinating the work of the 3 working groups. The meeting produced an initial draft of *Perbup* on MNCH.
17	31 August 2007	Revision by the Team (M3) at P3ML office	Revised academic paper	
18	4 September 2007	Mini-workshop on policy draft	A preliminary draft of MNCH dill	The preliminary draft of MNCH bill was developed based on the academic paper.
19	4-6 September 2007	Training and Workshop on MNCH Advocacy in Sumedang at the Hotel BGG Jatinangor	The stakeholders involved in the MNCH advocacy work learned about advocacy	All stakeholders involved in MNCH advocacy work in Sumedang received training in how to advocate. Participants included District Parliament members, DHO, Advocacy Team, Media, and HSP.
20	6 September 2007	Meeting with Sumedang Parliament members	District Parliament members agreed that	Following the advocacy training, the participants did real advocacy to Parliament members (Commission C) and wrote a press release that

No.	Date	Activity	Output	Remarks
		(Commission C) at the DPRD meeting room.	there should be a law specifically focused on MNCH issues; they appreciated the advocacy work.	was later distributed to all print media in Sumedang.
21	6 September 2007	Evaluation of Advocacy training and results of the meeting with Parliament members in Toga Village	Results of evaluation: the meeting with the district Parliament was effective.	After meeting with district Parliament members, the team evaluated the training and results of the meeting. It was concluded that the meeting with the district Parliament was a success.
	10 September 2007	Discussion with the NGO network	Support from the community for the Advocacy Team to continue their efforts to advocate for a policy that focuses on MNCH Input to improve the draft policy	
22	13 September 2007	Internal discussion on the draft law	Revised policy on maternal and child health	This meeting was a follow-up to the previous discussion with the NGO network that provided input for revision of the legal draft.
23	10 October 2007	Meeting between the Advocacy Team and HSP at P3ML office	Review of academic paper	The Advocacy Team, DHO, and HSP together reviewed the academic paper.
24	29 October 2007	Meeting between the Advocacy Team, DHO, and Bureau of Law of BAPPEDA at P3ML Office	Revised MNCH academic paper and draft bill	The meeting discussed the revisions that need to be made to the academic paper and draft bill.
25	17 November 2007	Meeting to prepare a discussion with the NGO/CSO network at P3ML Office	Work plan and division of work	Pak Deden developed the TOR for the activity.
	3 December 2007	Coordinating meeting between HSP and stakeholders involved in MNCH work in Kampung Toga	Plan of MNCH activities in Sumedang, MNCH problem map, and stakeholders' commitment	Discussion among stakeholders involved in MNCH programs about the HSP work plan in the district, progress achieved by the Advocacy Team, DHO work plan, and the district planning and budgeting process. They also discussed stakeholders' commitments. The meeting was attended by HSP, advocacy team, DHO, midwives, Head of Subdistrict, and the Desa SiAGa team.
26	13 December 2007	Discussion to review the academic paper and draft bill on MNCH	Reviewed academic paper and draft bill. Division of roles among stakeholders.	The reviewed academic paper and draft bill was edited to be submitted to the Special Committee of the District Parliament. But first, the DHO presented the maternal and child health profile in the district and gave an overview of the current status of public health

No.	Date	Activity	Output	Remarks
				facilities. The meeting was attended by: DHO, midwives (3), parliamentarians (6), and P3ML.
27	27-28 December 2008	Meeting to build common perception with the district Parliament	Common perception of the importance of MNCH and passage of local regulation on MNCH	Dr. Mahlil Ruby made a presentation on MNCH issues that received a good response from Parliament members, who agreed to make a local regulation on MNCH. The meeting was attended by HSP, the Sumedang Advocacy Team, North Sumatra Advocacy Team, parliamentarians, DHO, and BAPPEDA.
28	7 January 2008	Advocacy Team regular meeting at P3ML office	Preparedness of the team	The meeting was meant to prepare the team to lobby and consult with the district parliament.
29	8 and 22 January 2008	Lobby and consultation with the district Parliament	Dissemination of information on the work of the Advocacy Team in the district Stronger commitment of the district Parliament to passing a regulation on MNCH Mapping of issues within the Parliament that may hamper the effort to pass a regulation on MNCH List of inputs and recommendations from the Parliament for revising the draft bill	
30	14 January 2008	Advocacy Team Coordinating Meeting at P3ML Office	Work plan and division of work. Inputs for the academic paper and draft bill	The meeting discussed the inputs hat Dr. Mahlil Ruby gave during the meeting in Jatiluhur. Pak Deden was responsible for editing the draft bill, Pak Hendi was responsible for editing the academic paper, and Ibu Maya was responsible for videotaping all activities involved in advocacy for a regulation on MNCH.
31	16 January 2008	08.00 AM: videotaping a radio talk show, which was part of the advocacy work. Pak Nandang Suherman (head of the advocacy team) was cohost of the show.	A videotape on advocacy work carried out through a medium (radio)	Ibu Maya and Pak Deden filmed Pak Nandang at his radio talk show on MNCH advocacy at the Citra FM station in Sumedang.
32	16 January 2008	10:00 AM P3ML internal meeting discussing the revised draft bill on MNCH	Revised draft bill on MNCH	Discussion on the draft Bill edited by Pak Deden. Participant: P3ML.

No.	Date	Activity	Output	Remarks
33	16 January 2008	01:00 PM: Meeting on the draft bill on MNCH with DHO and district Parliament	Revised draft bill on MNCH	Discussion on the revised draft bill on MNCH and inputs from stakeholders. Participants: Advocacy Team, district Parliament, DHO, midwives
34	17 January 2008	Discussion on revision of the MNCH academic paper at P3ML office	Revised MNCH academic paper	An internal meeting at P3ML to edit and revise the MNCH academic paper. Editing team: Pak Hendi and Pak Didin
35	24 January 2008	Advocacy Team regular meeting at P3ML	Evaluation of activities	The meeting was to evaluate all activities in January.
36	6 February 2008	Advocacy Team regular meeting at P3ML	Optimal preparation for activities	The meeting was to prepare activities to implement community capacity-building and participatory budgeting process exercise in order to pilot-test the draft MNCH regulation.
37	9,11,15,18,22 February 2008	Community capacity-building and participatory budgeting process exercise to pilot test the draft MNCH regulation.	The community had a better understanding of the District planning and budgeting process. The community had a better knowledge of opportunities for involvement in the process. The community had better capacity to analyze the district government's budget priority for the health sector, especially for MNCH services.	
37	23 February 2008	FGD with the pro-health group and religious organizations at P3ML office	Increased awareness of high maternal and neonatal mortality rates in the district. Built commitment and support from religious leaders to promote awareness of the importance of MNCH service improvement. Schedule for regular	

No.	Date	Activity	Output	Remarks
			meetings between religious leaders and the community to discuss development issues, especially ones that are related to the health sector.	
38	25 February 2008	Advocacy Team regular meeting at P3ML office	Evaluation of activities	The meeting was to evaluate all activities during February.
39	13 March 2008	Hearing of the draft bill on MNCH at the local Parliament	The parliament accepted the MNCH draft bill to be included in their work agenda.	The Parliament established a Special Committee on MNCH, which was tasked with reviewing the draft bill as a follow-up.
40	14 March 2008	Coordinating meeting between HSP, DHO, and Advocacy Team at Joglo Restaurant, Sumedang	Review of work of advocacy team and DHO	Review of advocacy work by the Head of the Advocacy Team (Nandang Suherman), Head of DHO (Dr. Hilman), and HSP West Java regional director (Dr.Wahyu). Participants: Advocacy Team, DHO, and HSP.
41	17 March 2008	Response from the *Bupati*		
42	17-19 March 2008	Evaluation of HSP's work in the West Java region at Hotel BGG Sumedang	Results of performance evaluation of the Advocacy Team	3 members of the Advocacy Team (Pak Nandang, Pak Zeni and Pak Didin) attended the meeting, which was evaluating the work of HSP in the West Java region.
43	19 March 2008	Meeting to discuss the content of the MNCH bill	Revision of the MNCH bill	
44	24 March 2008	Advocacy Team evaluation meeting at P3ML	Results of internal evaluation of the advocacy team	Evaluation of the advocacy team and next follow-ups. It was decided that Pak Zeni and Pak Didin would attend the Old District Work Plan meeting at Hotel BGG.
45	5 April 2008	Old District Work Plan meeting at Hotel BGG	District Work Plan	The meeting decided among other things the follow-up activities of the advocacy team.
46	9-10 April 2008	Strengthening the Advocacy Team in 7 Districts, Round I. Venue: Puri Khatulistiwa	Strengthened Advocacy Team	Pak Nandang, Pak Zeni, and Pak Didin attended.
47	5 May 2008	Strengthening the Advocacy Team in 7 Districts, Round II. Venue: Puri Khatulistiwa	Strengthened Advocacy Team	Pak Nandang, Pak Zeni, and Pak Didin attended.
48	15 May 2008	Special Committee Meeting on the MNCH bill at the Parliament meeting room	Revision of the MNCH Bill by the Special Committee	The Special Committee set up by the Parliament to review the bill made some revision to the content. Participants: Special Committee, Expert Team, HSP, Bureau of Law of BAPPEDA, DHO, professional

No.	Date	Activity	Output	Remarks
				organizations, and CSO.
49	16 May 2008	Meeting between the Advocacy Team and HSP to evaluate the revisions of the MNCH bill made by the Special Committee	Plan to further revise the MNCH Bill with the Parliament and a resource person	Since the revision of the bill made by the Special Committee was not yet optimal, a plan was made to further revise the bill by inviting the Parliament and Dr. Mahlil as a resource person.
50	19 May 2008	Discussion on the revision of the MNCH Bill at Hotel Puri Khatulistiwa	Agreement to further revise the MNCH bill	The meeting agreed to further revise the bill as a follow-up to the revision made by the Special Committee. Dr. Mahlil Ruby would be invited as an expert resource person. The Parliament recognized that the revision they made was not yet optimal.
51	29 May 2008	Discussion on the MNCH Bill with the Special Committee and Dr. Mahlil Ruby	Agreement to change the content of the bill	After Dr. Mahlil Ruby made a presentation to the Special Committee and health professionals, it was agreed that the bill needed to be revised further.
52	2 June 2008	Plenary Session at the District Parliament to pass the bill	Passage of the MNCH bill as a regulation	After going through a tough hearing, the bill was finally passed and became a regulation.
53	3 June 2008	Press Release: Dissemination of information on the passage of the MNCH bill to become a regulation to the local media	Press Release on the passage of the MNCH bill	The press release was disseminated to local media in Sumedang and West Java.
54	15 June 2008	Meeting on Legal Framework for the MNCH regulation. Venue: Hotel BGG	Advocacy Team work plan	Pak Nandang, Pak Zeni, and Pak Didin attended the meeting.
55	24-25 June 2008	Workshop on the Roles of Stakeholders in the Implementation of the MNCH regulation, in Cipanas, Garut	Work map of stakeholders in implementation of the MNCH regulation, and establishment of a lead team	The meeting mapped the work of different stakeholders to implement the MNCH regulation and its work plan. A lead team of 5 people from different institutions was named during the meeting.
56	16 July 2008	Advocacy Team Meeting with HSP to evaluate the MNCH regulation at P3ML office.	Results of Advocacy Team work evaluation and a work plan for 2008–2009.	The meeting was to evaluate the work of the advocacy team and draft a work plan for 2008–2009.

APPENDIX G: REFERENCES

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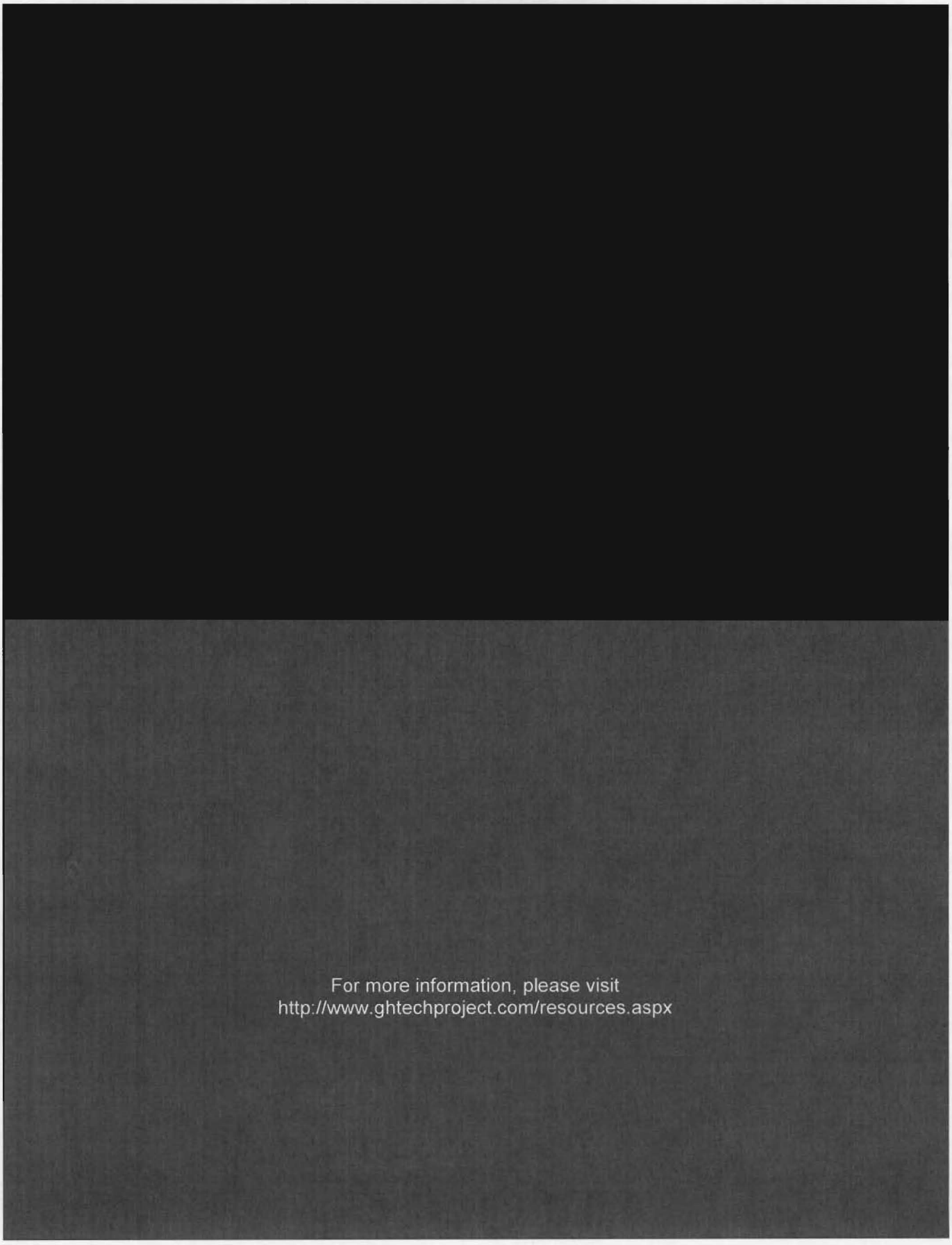
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1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
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