INDONESIA

MDG ACCELERATION FRAMEWORK

ACCELERATING PROGRESS TOWARDS IMPROVING MATERNAL HEALTH IN CENTRAL JAVA
INDONESIA

Accelerating progress towards improving maternal health in Central Java

October 2013


All rights reserved.

Layout:
José R. Mendes

Photo credits:
IFAD
INDONESIA

MDG ACCELERATION FRAMEWORK

ACCELERATING PROGRESS TOWARDS IMPROVING MATERNAL HEALTH IN CENTRAL JAVA

OCTOBER 2013
TABLES

**TABLE 1.** District/City Budget on Health, Central Java Province, 2010

**TABLE 2.** Total Indicative Budget Allocation (in millions of rupiah) for MDG Programmes in Central

**TABLE 3.** Indicative Budget Allocation (in millions of rupiah) for universal access to reproductive health care

**TABLE 4.** Health facilities that provide Jamkesmas Health Service Programme in Central Java

**TABLE 5.** Accreditation Status of Government and Private Hospitals in Central Java, 2011

**TABLE 6.** Definitions of Obstetric Emergency Complications and Obstetric Signal Functions

**TABLE 7.** Summary of Bottlenecks per Prioritized Interventions

**TABLE 8.** MAF Action Plan – Solutions and Partnerships to Reduce Maternal Mortality

FIGURES

**FIGURE 1.** Maternal Mortality Ratio of Indonesia and other Asian Countries, 1990 to 2008

**FIGURE 2.** National Trends and Projections for the Maternal Mortality Ratio 1991-2025

**FIGURE 3.** Percentage of Births Assisted by Skilled Providers, by Province, 2009

**FIGURE 4.** Comparison between Central Java’s MMR and the National Figure, and the MDG Target

**FIGURE 5.** Maternal Mortality Ratio in Central Java, 2005 – 2011

**FIGURE 6.** Number of maternal death cases by district/city in Central Java

**FIGURE 7.** Number of Maternal Death Cases by District, Central Java, 2010

**FIGURE 8.** The Comparison between ‘Indicative’ MMR versus Absolute Number of Maternal Deaths by District/City, Central Java, 2010

**FIGURE 9.** Total Indicative Budget to reduce MMR (Target 5A) and to provide universal access to reproductive health care (Target 5B)

**FIGURE 10.** Indicative Budget Allocation for Health Effort Programme (in millions of rupiah)

**FIGURE 11.** Indicative Budget Allocation for Nutrition and MCH Programme (in millions of rupiah)

**FIGURE 12.** Collaboration Status on Jamkesda by Districts/Cities

**FIGURE 13.** MAF and Developing Planning

**FIGURE 14.** Central government planning and budgeting cycle for the health sector

**FIGURE 15.** Place of Death of Maternal Deaths, Central Java, 2011

**FIGURE 16.** Post-partum Visit, Central Java, 2011

**FIGURE 17.** Time of Death in Relation to Pregnancy of Maternal Deaths, Central Java, 2011

**FIGURE 18.** Type of Birth Attendants of Maternal Death Cases, Central Java, 2011
FIGURE 19. Proportion of Deliveries at Health Facilities by District, Central Java, 2011
FIGURE 20. MMR by the district/city population size, Central Java Java, 2010
FIGURE 21. Cause of maternal deaths in Indonesia, 2001
FIGURE 22. Cause of maternal deaths in Central Java, 2001
FIGURE 23. Direct and indirect cause of death: Hospital and Community
FIGURE 25. Delivery Assisted by Skilled Birth Attendants by District/City, Central Java, 2011
FIGURE 26. ‘Indicative’ MMR and Skilled Birth Attendants by District/City, Central Java, 2010
FIGURE 27. ANC and SBA of Pregnancy-related Cases of Death and Women with Births for the Last Two Years, Serang and Pandeglang Districts, Banten Province, 2004-2005
FIGURE 28. The Number of Midwife and Traditional Birth Attendants in Central Java
FIGURE 29. Antenatal Care Coverage (K4) by District/City, Central Java, 2011
FIGURE 30. The Scheme of Referral Implementation Principles
FIGURE 31. Referral Pathway
FIGURE 32. Method of Delivery by Referral and Non-referral Cases, Kariadi Hospital 2011
FIGURE 33. Proportion of Obstetric Complication Managed by District/City, Central Java, 2011
FIGURE 34. Time of Death After Admission - Maternal Death Cases at Hospital, Central Java, 2011
FIGURE 35. Maternal Deaths by Mother’s Age
FIGURE 36. MMR by age group in 2004-2005, Serang and Pandeglang districts, Banten Province
FIGURE 37. Contraceptive Prevalence Rate by District/City, Central Java, 2011
FIGURE 38. Un-met Need of Family Planning Service in Central Java, by District/City, 2011
FIGURE 39. The Coverage of Health Care Insurance by District, Central Java, 2011
FIGURE 40. Coverage of Health Care Insurance for the Poor by District/City, Central Java, 2010
FIGURE 41. The Coverage of Health Care Insurance for Non-Poor by District/City, Central Java, 2010

BOXES

BOX 1. The impact of decentralization on health service delivery
BOX 2. Priority actions for H4+ agencies to reduce maternal mortality
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AKI</td>
<td>Angka Kematian Ibu (Maternal Mortality Ratio)</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>APBD</td>
<td>Anggaran Pendapatan Belanja Daerah (Regional Revenue and Expenditure Budget)</td>
</tr>
<tr>
<td>APBN</td>
<td>Anggaran Pendapatan Belanja Negara (National Revenue and Expenditure Budget)</td>
</tr>
<tr>
<td>APN</td>
<td>Asuhan Persalinan Normal (Normal Delivery Care)</td>
</tr>
<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>Bappeda</td>
<td>Badan Perencanaan Pembangunan Daerah (Regional Development Planning Agency)</td>
</tr>
<tr>
<td>Bappenas</td>
<td>Kementerian Negara Perencanaan Pembangunan Nasional (The National Development Planning Agency)</td>
</tr>
<tr>
<td>Bidan</td>
<td>Midwife</td>
</tr>
<tr>
<td>Bidan Delima</td>
<td>Standardization system for quality of care of private practice midwife.</td>
</tr>
<tr>
<td>Bidan Desa</td>
<td>Village Midwife</td>
</tr>
<tr>
<td>Bidkor</td>
<td>Bidan Koordinator (Coordinating Midwife)</td>
</tr>
<tr>
<td>BKKBN</td>
<td>Badan Kependudukan dan Keluarga Berencana Nasional (National Population and Family Planning Board)</td>
</tr>
<tr>
<td>BKKM</td>
<td>Balai Kesehatan Kerja Masyarakat (Occupational Health Services)</td>
</tr>
<tr>
<td>BKMM</td>
<td>Balai Kesehatan Mata Masyarakat (Community Eye Health Center)</td>
</tr>
<tr>
<td>BP4</td>
<td>Balai Pengobatan Penyakit Paru-Paru (Health Center for Lung Disease)</td>
</tr>
<tr>
<td>Bupati</td>
<td>Head of District Government</td>
</tr>
<tr>
<td>CBR</td>
<td>Crude Birth Rate</td>
</tr>
<tr>
<td>CoC</td>
<td>Continuum of Care</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CS/C-Section</td>
<td>Caesarean Section</td>
</tr>
<tr>
<td>DAK</td>
<td>Dana Alokasi Khusus (Specific Allocation Fund)</td>
</tr>
<tr>
<td>Desa</td>
<td>Village</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Office</td>
</tr>
<tr>
<td>Dinkes</td>
<td>Dinas Kesehatan (Health Office)</td>
</tr>
<tr>
<td>DPRD</td>
<td>Dewan Pimpinan Rakyat Daerah (Regional House of Representatives)</td>
</tr>
<tr>
<td>DTPK</td>
<td>Daerah Terpencil, Perbatasan, dan Kepulauan (remote, under-developed, border, and island areas)</td>
</tr>
<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
</tr>
<tr>
<td>EMAS</td>
<td>Expanding Maternal and Neo-natal Survival – USAID funded project in Indonesia</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FKD/Forkesdes</td>
<td>Forum Kesehatan Desa (Village Health Forum)</td>
</tr>
<tr>
<td>FKK</td>
<td>Forum Kesehatan Kelurahan (Kelurahan Health Forum)</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GDON</td>
<td>Gawat Darurat Obstetrik dan Neo-natal (Emergency Obstetric and Neo-natal Care)</td>
</tr>
</tbody>
</table>
IBI   Ikatan Bidan Indonesia (Indonesian Midwifery Association)
ICD-10  International Classification of Disease – tenth revision
IDI   Ikatan Dokter Indonesia (Indonesian Medical Association)
IEC   Information, Communication, and Education
IUD   Intra Uterine Device
Jamkesmas Jaminan Kesehatan Masyarakat (National Health Security Programme)
Jamperal Jaminan Persalinan (Free Delivery)
K4     Antenatal visit at least 4 time standard ANC
Kader  Health Volunteer
KAP    Knowledge, Attitude, and Practice
Kelurahan Village, usually refer to urban setting
Kemenkes RI Kementerian Kesehatan Republik Indonesia (Ministry of Health)
KKN    Kuliah Kerja Nyata (field work experience for college students)
Konselor Sebaya Peer Counselor
KPKIA  Kelompok Peminat Kesehatan Ibu dan Anak
        (Supporters on Maternal and Child Health)
LAM    Local Area Monitoring
LDU    Latihan Dasar Umum (General Basic Training)
MAF    MDG Acceleration Framework
MCH    Maternal and Child Health
MDG    Millennium Development Goals
MMR    Maternal Mortality Ratio
MNCH   Maternal Neo-natal and Child Health
MOH    Ministry of Health
MOP    Metode Operasi Pria (male operation method)
MOW    Metode Operasi Wanita (female operation method)
MPA    Maternal Perinatal Audit (Audit Maternal Perinatal)
NGO    Non-government Organization
ObGyn  Obstetrics and Gynecology
P4K    Programme Perencanaan Persalinan dan Pencegahan Komplikasi
        (Birth Preparedness and Emergency Readiness)
PEMDA  Pemerintah Daerah (Local Government)
Pendidik Sebaya Peer Educator
PERDA  Peraturan Daerah (Local Regulation)
PGRI   Persatuan Guru Republik Indonesia (Indonesian Teacher Association)
PHLN   Pinjaman/Hibah Luar Negeri (International Loan/Grant)
PHO    Provincial Health Office
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIK</td>
<td>Pusat Informasi dan Konseling (Information and Counseling Center/ICC)</td>
</tr>
<tr>
<td>PKB</td>
<td>Penyuluh Keluarga Berencana (Family Planning Counselors)</td>
</tr>
<tr>
<td>PKBR</td>
<td>Perencanaan Kehidupan Berkeluarga bagi Remaja (Preparedness of Family Life for Adolescence)</td>
</tr>
<tr>
<td>PKD/Poskesdes</td>
<td>Pos Kesehatan Desa (Village Health Post)</td>
</tr>
<tr>
<td>PKK</td>
<td>Pemberdayaan dan Kesejahteraan Keluarga (Women's Welfare Organization)</td>
</tr>
<tr>
<td>PKPR</td>
<td>Pelayanan Kesehatan Peduli Remaja (Youth Friendly Health Service)</td>
</tr>
<tr>
<td>PKRE</td>
<td>Pelayanan Kesehatan Reproduksi Essensial (Essential Reproductive Health Service)</td>
</tr>
<tr>
<td>PLKB</td>
<td>Petugas Lapangan Keluarga Berencana (field worker for family planning)</td>
</tr>
<tr>
<td>POGI</td>
<td>Perkumpulan Obstetri dan Ginekologi Indonesia (Indonesian Society of Obstetrics and Gynecology)</td>
</tr>
<tr>
<td>Polindes</td>
<td>Pos Bersalin Desa (Village Maternity Post)</td>
</tr>
<tr>
<td>PONED</td>
<td>Pelayanan Obstetrik dan Neo-natal Emergenesi Dasar (Basic Emergency Obstetric and Neo-natal Care/BEONC)</td>
</tr>
<tr>
<td>PONEK</td>
<td>Pelayanan Obstetrik dan Neo-natal Emergenesi Komprehensif (Comprehensive Emergency Obstetric and Neo-natal Care/CEONC)</td>
</tr>
<tr>
<td>Posyandu</td>
<td>Pos Pelayanan Terpadu (Integrated Post)</td>
</tr>
<tr>
<td>Puskesmas</td>
<td>Pusat Kesehatan Masyarakat (Primary Health Centre)</td>
</tr>
<tr>
<td>PWS</td>
<td>Pemantauan Wilayah Setempat (Local Area Monitoring/LAM)</td>
</tr>
<tr>
<td>RAD</td>
<td>Rencana Aksi Daerah (Regional Action Plan)</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RKA</td>
<td>Rencana Kerja Anggaran (Budgetary Workplan)</td>
</tr>
<tr>
<td>Saka Bakti Husada</td>
<td>Health Unit in Indonesia Scout</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled Birth Attendants</td>
</tr>
<tr>
<td>SMS</td>
<td>Short Message Service</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant (dukun bersalin)</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>Walikota</td>
<td>Head of Municipality Government</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Efforts to achieve the goals, targets, and indicators of the Millennium Development Goals (MDGs) are Indonesia’s commitment to increase people’s welfare while also contributing to the welfare of the world community. The need to accelerate the achievement of the MDGs has been a key reference in the National Long-Term Development Plan (RPJPN) for 2005-2025, the National Medium-Term Development Plans (RPJMN) for 2004-2009 and 2010-2014, Annual Government Work Plans (RKPs), and the State Budget (APBN) documents, while, at the regional level, it has also been integrated into the Subnational Medium-Term Development Plan (RPJMD) in each province, district and city.

In order to accelerate MDGs, Indonesia has issued Presidential Instruction No. 3 in 2010. As a follow-up, the Roadmap to Accelerate the Achievement of the Millennium Development Goals (2010-2015) was launched at the national level, while each province is preparing a Regional Action Plan (RAD) for the MDGs (2011-2015) at the subnational level.

Based on the Report on the Achievement of The Millennium Development Goals in Indonesia (2011), several indicators of MDGs have been achieved before 2015; most of the indicators will be achieved in 2015, while others need intensified efforts in order to be achieved.

Maternal mortality is one of the MDG targets that require accelerated efforts to achieve the national target of 102 per 100,000 live births by 2015, even though the maternal mortality rate (MMR) declined from 390 in 1991 to 228 per 100,000 live births in 2007.

In order to address the various barriers to improve maternal health, essential programmes have been developed, i.e., Health Operational Assistance (BOK); Government Financing for Maternal and Neonatal Health (Jampersal); Community Health Insurance (Jamkesmas); placing skilled midwives and doctors in district/city hospitals; as well as expanding health facilities that offer Basic Emergency Obstetric Neonatal Services (PONED) and Comprehensive Emergency Obstetric Neonatal Services (PONEK).
Maternal health is a national priority for the Government of Indonesia. However, maternal health cannot be confined to the health sector only. If we are to identify and implement sustainable, innovative and cost-effective solutions, we need to break down the sectoral silos. Bottlenecks hampering the reduction of MMR can be linked to education, gender and social development, family planning services and reproductive health, local governance, the provision of health care infrastructure, public awareness, and poverty reduction.

In Indonesia, an approach used to accelerate the reduction of maternal mortality is the MDG Acceleration Framework (MAF). The MAF is a flexible, yet systematic process of identifying and analysing bottlenecks and possible high-impact solutions to achieving a country’s MDG priorities that leads to a collaborative multi-stakeholder acceleration action plan. The MAF application started in the province of Central Java for several reasons: MMR prevalence is still high; the provincial government’s commitment and cross-sectoral cooperation to achieve the MDGs is very strong; and the lessons learned from Central Java could inform the acceleration work in other provinces.

Finally, I would like to thank the Central Java Provincial Government and all stakeholders in Central Java, the Ministry of Health, National Population and Family Planning Board (BKKBN), and as well as civil society, the United Nations System, the Asian Development Bank, the World Bank, and other international partners who are collaborating with the Government of Indonesia to support the implementation of the MDG Acceleration Framework Action Plan (MAF).

Prof. Dr. Armida S. Alisjahbana, SE, MA
Minister of National Development Planning and
Head of the National Development Planning Agency (BAPPENAS), Government of Indonesia
The Millennium Development Goals are an effort to improve the overall well-being of the people of Indonesia. Indonesia has developed various policies and plans to accelerate the achievement of the MDGs, including improving health-related interventions. The ability to provide access to quality health care plays a critical role in improving people’s lives.

As of 2010, Indonesia had achieved or was on track to achieve various MDG targets. On the health-related areas, the prevalence of tuberculosis, the prevalence of underweight children, and the mortality rate of children under five have decreased significantly. Despite the progress thus far, several challenges remain to be addressed, including reducing the maternal mortality rate and combating HIV/AIDS. Additionally, although national health sector indicators show encouraging results on average, the geographical disparities between some provinces and the urban-rural divide are still fairly wide.

Reducing maternal mortality is a top priority for the Government of Indonesia. The 2007 Indonesia Demographic and Health Survey shows the MMR in Indonesia at 228 per 100,000 live births, while data from the 2012 Indonesia Demographic and Health Survey showed no significant improvement. The country’s MDG target for 2015 is 102 per 100,000 live births and will be missed if we continue to do business as usual.

To address the challenges to reduce maternal mortality, the Ministry of Health has implemented various policies and programmes supported by increased resources, such as the implementation of the programme Community Health Insurance (Jamkesmas), Government Financing for Maternal and Neonatal Health (Jampersal) and Health Operational Assistance (BOK). These programmes, once implemented, are expected to increase access to maternal and child health services. Various initiatives for reducing MMR are being under implementation with the support of international partners, including the H4+ agencies (WHO, UNICEF, UNFPA, UNAIDS and the World Bank) and UNDP.
In order to accelerate progress in reducing maternal mortality, the Government of Indonesia, with support from the UN System, is applying the MDG Acceleration Framework (MAF) in the province of Central Java. The MAF is a comprehensive approach as it engages national and local government authorities and various stakeholders – including experts, service providers and partners – to review existing policies and interventions of relevance to maternal health; to identify gaps in existing policies and interventions; to identify and prioritize bottlenecks in policy and planning, budget and financing, service delivery, service use, and cross-cutting areas to the successful implementation of key interventions; to identify cost-effective and cross-sectoral solutions that can accelerate progress on maternal health, building on lessons learned locally on what does and does not work; and to help understand the reasons behind geographical differences in MMR progress and thereby to address them through tailored efforts.

Based on the experience of Central Java, the MAF approach will be replicated in other provinces in the country, taking into consideration the unique conditions of each locale.

I would like to thank the local government of Central Java for its strong commitment and perseverance to reduce maternal mortality; the various sectors at the national and regional levels that have supported the efforts to improve maternal health; and BAPPENAS for their leadership in the MAF process, with support from international partners.

Dr. Nafsiah Mboi, Sp.A, MPH
Minister of Health, Government of Indonesia
One of the Indonesian national development goals is to improve peoples’ well-being. Continuous efforts to contribute to peoples’ well-being are conducted through a planned, integrated, structured and sustainable way. These efforts are aligned with the commitment to achieve the Millennium Development Goals (MDGs), which reduce poverty, increase levels of education, encourage gender equality and the empowerment of women, and improve public health as well as environmental sustainability. To that end, the Central Java Provincial Government is committed to achieve the MDGs by the end of 2015 while contributing to the achievement of the MDGs nationally.

Based on Indonesia’s 2011 MDG Progress Report, there are still some indicators that will need accelerated efforts to achieve them, including the reduction of the maternal mortality rate (MMR). It thus takes commitment and concrete measures with synergy between government and partners to accelerate achievement of the MDG targets by 2015.

Specifically on maternal mortality, achievements in Central Java show fluctuating rates, where it decreased from 117.02 in 2009 to 104.97 per 100,000 live births in 2010; it subsequently increased to 116.01 in 2011 and to 116.34 in 2012. The reversal in the trend of MMR is of particular concern to the Provincial Government and requires intensified efforts to achieve the target of 102 by 2015.

In Indonesia, various initiatives have been implemented to support efforts to reduce maternal mortality. One initiative that has been applied is the MDG Acceleration Framework (MAF). Basically, the MAF is a fairly comprehensive method that starts from an analysis of the barriers to the implementation of priority interventions in accordance with the conditions of the province of Central Java. With this approach, an accelerated Action Plan has been successfully developed with measurable objectives to: (i) improve access to quality basic (PONED) and Comprehensive Emergency Obstetric Neonatal Care (PONEK) Services, including access to good quality midwifery services; (ii) improve access to good quality basic health services at the community level (Poskesdes); (iii) increase access to good quality services for an effective referral system; and (iv) improve access to good quality services for family planning and reproductive health.
The development process of the MAF Action Plan for Central Java went through a fairly intensive process of discussion with stakeholders at various levels among provincial, district/municipality, and health centre (Puskesmas) implementers. The end result is an Action Plan that has been agreed upon by all local stakeholders in collaboration with national stakeholders. The MAF Action Plan builds on the Central Java Provincial MDG Local Action Plans (RAD MDGs), which were established by Governor Regulation No. 20 in 2011 on Local Action Plans to accelerate achievement of the MDGs by the Central Java Province from 2011 to 2015.

I would like to thank all parties that have participated in the preparation of this MAF document for Central Java at the district/municipality, provincial and national levels, and to international partners with their support through collaboration with the Government of Indonesia and UNDP.

Ganjar Pranowo
Gubernur Jawa Tengah
Governor of Central Java
Indonesia signed the Millennium Declaration in 2000 and since then has remained fully committed to the achievement of the Millennium Development Goals (MDGs). Significant progress has been made towards many of the MDGs – for example, the poverty goal has already been achieved at the national level. The maternal mortality ratio (MMR), too, has gradually been reduced from 390 in 1991 to 228 per 100,000 live births in 2007. However, the Government of Indonesia and its partners recognize that accelerated efforts will be needed to achieve the target of 102 by 2015. There are significant disparities across provinces, with the poorest living in small islands or in remote areas, that have to be tackled.

In Indonesia, the MDG Acceleration Framework (MAF) – a bottleneck-solving approach endorsed by the UN Development Group – is being applied to address maternal mortality in Central Java, a populous province where the rate of progress in reducing maternal mortality appears to have stalled, although indicators of service provision have improved. Helping the province to further accelerate the decrease of MMR would have a meaningful impact on efforts at the national level to improve maternal health and carry valuable lessons for the rest of the country.

Central Java has demonstrated strong commitment towards achieving the MDGs at the provincial, district and municipal levels. It is the first province to complete a Provincial MDG Action Plan with clear targets, indicators, and timeline and budget requirements as part of the efforts to implement the national MDG Roadmap to Accelerate the Achievement of the MDGs, which was launched in 2010. The MAF application capitalizes on this process and leverages the demonstrated political commitment of the leadership.

In Central Java, the MAF process has been led by the provincial planning authority, BAPPEDA, working closely with the national planning agency, BAPPENAS. It has been supported by UN agencies (including UNDP, UNFPA, UNICEF, UNAIDS, WHO and the World Bank), domestic NGOs, professional associations and academia.
The MAF in Central Java has provided a platform for cross-sectoral collaboration, breaking down the sector silos across national and provincial levels. It has helped to determine priorities in existing planning and strategy based on research results so as to accelerate the reduction of maternal mortality. This approach has delivered a focused, agreed-upon Action Plan to address maternal mortality that rallies the efforts of national and subnational governments and their partners, including civil society and the private sector, to provide the investments and services needed to advance key policy reforms and overcome identified constraints. It highlights actions to improve service quality and access.

We are confident that the lessons learned from the MAF application in Central Java, and the implementation of the Action Plan, will inform the roll-out to other provinces in Indonesia as well as to other MDGs where progress is slow and generate traction for the achievement of the targets contained in the 2010 National MDG Roadmap to Accelerate the Achievement of the MDGs.

Finally, we extend our thanks to all experts and development partners who have contributed their time and expertise to advance this process and to accelerate the reduction of maternal mortality in Central Java.

Douglas Broderick
UN Resident Coordinator
EXECUTIVE SUMMARY

Maternal mortality rates in Indonesia continue to be high and decreasing too slowly for MDG 5 to be achieved by 2015. Achieving universal coverage with key health interventions and health insurance is slow, despite efforts such as Jamkesmas, Jampersal, and others. Decentralization has affected functions of central and peripheral levels of government, and financial flows to finance health are fragmented, regulations are complex and sometimes conflicting between central and local levels and, as a result, resources are not spent efficiently. Providing quality care to the population, especially in remote and poor areas, is a major challenge.

The push for a formal strategy to accelerate MDG achievement, while ensuring synergy among ministries and between central and local governments, has been enhanced by the Presidential Decree No. 3/2010. The Government of Indonesia has recently put in place a Roadmap to Accelerate Achievement of the MDGs, including the challenge of curbing maternal mortality. In addition, all provinces, in collaboration with districts/municipalities, are developing Provincial Action Plans (RAD) for the MDGs based on a decree of Minister of Planning/Bappenas.

**MAF PROCESS**

The MDG Acceleration Framework (MAF) is being applied to accelerate progress towards the MMR target in the province of Central Java. With around 15 percent of the country’s total population, the large numbers of maternal deaths in Central Java contribute significantly to the country’s high MMR. Although lower than the national average, provincial data shows that the MMR in Central Java has stagnated since 2005. At the current rate, the province is likely to miss the MDG target by 2015 if additional efforts are not put in place.

In Central Java, the MAF process has been led by the provincial planning authority, BAPPEDA, working closely with the national planning agency, BAPPENAS. It has been supported by international agencies, domestic NGOs, professional associations and academia. The exercise systematically:

- Reviewed existing policies and interventions of relevance to maternal health
- Identified gaps in existing policies and interventions
- Identified and prioritized bottlenecks in policy and planning, budget and financing, service delivery, service utilization, and cross-cutting areas to the successful implementation of key interventions
- Identified cost-effective and cross-sectoral solutions that can accelerate progress on maternal health, building on lessons learned locally on what works and what does not
- Helped to understand the reasons behind geographical differentials in MMR progress and thereby address them through tailored efforts.

**MAF ANALYSIS**

In Indonesia, the current policy encourages that all deliveries should be attended in the facility by a trained health provider. In Central Java, the proportion of delivery in a facility is currently quite high – about 80.4 percent – with little variation across districts. Based on the analysis, a fundamental bottleneck relates to the quality of services provided. Accordingly, the MAF prioritizes four interventions:

1. Improve access to quality basic (PONED) and Comprehensive Emergency Obstetric Neonatal
Care (PONEK) Services

2. Improve access to quality primary health care
the at the community level (e.g., Community
Village Health Policlinics (PKDs))
3. Strengthen a quality referral system
4. Increase access to quality family planning (FP)
   and reproductive health services.

Solutions to improving maternal health will be focused on expanding better quality health care and comprehensive obstetric care by upgrading the skills of health care providers; removing administrative bottlenecks to allow trained staff to work more effectively; mapping services provided at PONED (basic EmONC) and POKEK (comprehensive EmONC) levels; and proposing a redistribution of facilities as per needs. Others include: improving family planning services and engaging the community in their use.

The MAF analysis also highlights that there are several problems with measuring the MMR and collecting appropriate, policy-relevant data that need to be tackled: vital registration systems and hospital records might be inadequate, maternal deaths occurring outside health facilities are not always recorded, and maternal deaths might be misclassified.

VALUE ADDED FROM THE MAF APPLICATION

Promoting Cross-Sectoral Collaboration

The MAF in Central Java has provided a platform for cross-sectoral collaboration, breaking down the sector silos across national and provincial levels to accelerate the reduction of maternal mortality. Overall, the MAF is helping to:
- Overcome fragmented resources from ministries/agencies, development partners and stakeholders
- Determine priorities in existing planning and strategy based on research results, the latest information on statistical data, evaluation and experience
- Resolve ‘sectoral ego’ with a pragmatic way of thinking, across sectors, becoming more results-oriented and enlisting partnership cooperation and strengthened synergy
- Support to target MDG efforts to overcome disparity between population groups and geographically disadvantaged areas.

Strengthening Partnerships to Accelerate MDG Progress

The MAF has delivered a focused, agreed upon Action Plan to address maternal mortality that rallies the efforts of national and subnational governments and their partners, including civil society and the private sector, on providing the investments and services needed to advance key policy reforms and overcome identified constraints.

The MDG Acceleration Framework (MAF) helps operationalize the MDG Regional Action Plan/RAD for the Central Java province, which was formulated through a collaborative effort between the central government and subnational authority in 2010.

MOVING FORWARD: MAF ACTION PLAN IMPLEMENTATION

Lessons learned from the MAF application in Central Java, and the implementation of the Action Plan, are expected to inform the roll-out to other provinces and generate traction for the achievement of the targets contained in the 2010 National MDG Roadmap to Accelerate the Achievement of the MDGs. The MAF is also expected to mobilize partnerships and additional efforts, including the identification of financial mechanisms and possible allocation of financial incentives for MDG acceleration within the government planning.
I. BACKGROUND
GLOBal and reGIonal sItuatIon

As the deadline for the MDGs fast approaches, countries around the world are reviewing their efforts to reach the goals and make improvements to accelerate MDG achievement. The progress in many countries varies according to each goal. In some countries, most or all MDGs are likely to be achieved, while in others only a few will be. It is recognized that MDG 5 (to improve maternal health), more specifically the reduction of maternal mortality ratio, is globally among those that need more attention. It is also well recognized that reducing maternal mortality is not an easy task, given the complex nature of the pathway to maternal survival. Many factors beyond health are imperative to contributing to maternal deaths. Unless supported by a high commitment from all stakeholders and accelerated efforts, the achievement of MDG 5 by 2015 will be almost impossible.

To address the concerns and obstacles faced by many countries, UNDP in 2009 developed and tested a breakthrough strategy covering components on accelerating and sustaining MDG progress. One component of this strategy called the MDG Acceleration Framework (MAF) identifies bottlenecks in the implementation of high-impact interventions and related high-impact and feasible solutions. Results obtained from countries that have applied the framework so far demonstrate the potential of the MAF to make a concrete difference 1) by focusing the fragmented efforts and resources of government ministries, development partners and other stakeholders on concrete and targeted measures designed to address off-track MDGs; 2) by determining priorities within existing strategies and plans (thus ensuring country ownership) through a consideration of evidence (making use of, and in some cases supplementing, existing studies, statistics, evaluations and lessons learned); and 3) by breaking down the silos between sectors and MDGs in favour of a pragmatic, cross-sectoral, problem-solving approach that exploits synergies and leads to new types of collaboration and partnership.

Indonesia is among the countries with a strong commitment to achieve all MDGs and, therefore, it has decided to develop an acceleration plan to address maternal mortality. The MAF aims to produce a focused and agreed Action Plan specifically targeted to MDG 5. Central Java is the first province to develop an MDG Acceleration Action Plan.

The position of Indonesia’s achievement for maternal health relative to several Asian countries

The maternal mortality rate (MMR) in Indonesia decreased from 450 per 100,000 live births in 1990 to 228 in 2007. Despite the decrease, it is well understood that, to reach the target of MDG 5 by 2015, there needs to be more intensive and focused effort. As Figure 1 shows, Indonesia’s MMR is far better than those of Cambodia and Bangladesh; however, it is still much higher than those of other neighboring countries like Malaysia, Thailand, Vietnam, the Philippines and China. These countries experienced much lower MMR decades ago when Indonesia was still struggling with a very high MMR.

1. Data used in figure 1 is based on data gathered by WHO in order to facilitate internal comparison. This differs from the data provided by the Government which is used for the MAF analysis and Action Plan.
**FIGURE 1: MATERNAL MORTALITY RATIO OF INDONESIA AND OTHER ASIAN COUNTRIES, 1990 TO 2008**

Source: WHO, 2010

**FIGURE 2: NATIONAL TRENDS AND PROJECTIONS FOR THE MATERNAL MORTALITY RATIO 1991-2025**

Source: BPS, IDHS several years.
NATIONAL CONTEXT

Of all the MDGs, the lowest rate of global achievement has been recorded in the improvement of maternal health. In Indonesia, the MMR remains high despite a gradual decline from an estimated level of 390 in 1991 to 228 deaths per 100,000 live births in 2007, as seen in Figure 2. At this rate, the MDG target is unlikely to be met unless extra efforts are undertaken to achieve 102 deaths per 100,000 live births by 2015 (SDKI, 2007).

One of the most effective ways to reduce maternal mortality is to have births attended by skilled health personnel (doctor, nurse or midwife). In Indonesia, about 77 percent of births are currently assisted by skilled personnel, an increase from 73 percent and 66 percent in 2007 and 2002/03, respectively. The percentage of births assisted by skilled health personnel increases with the age of the mother, her level of education, and her income status. Only 14 percent of poor women deliver with a trained provider, compared with 83 percent of non-poor women.\(^2\) Regional differences are important, ranging from 97 percent in DKI Jakarta to 33 percent in Maluku. There are substantial variations in the place of delivery by province as well as by residence. There is a huge difference in percentage of births assisted by skilled health personnel between urban areas (70 percent) and rural areas (29 percent). A mother’s education is another crucial variable – although this tends to be correlated with income as well as urban/rural location. Mothers with secondary and higher education are much more likely to give birth with assistance from skilled health personnel than mothers without any education.

\(2.\) The lowest quintile compared to the highest quintile.
Similar characteristics are true of women receiving antenatal care, another important determinant of maternal health. Ninety-three percent of women received antenatal care (at least one visit) from a health professional during pregnancy for the most recent birth in the past five years, while 4 percent received no antenatal care – and that number has remained steady throughout the latest decade. Sixty-six percent of pregnant women have the recommended four or more antenatal care visits (57.5 percent in rural and 76.5 percent in urban), compared to the national target rate of 90 percent set by the MoH. Rural women are more likely to receive such care from a traditional birth attendant (TBA) – some 11 percent of rural women consult TBAs. Likewise, urban women are more likely to go through the full cycle of four antenatal care visits (90 percent, compared to 76 percent for rural women). Regional variations in antenatal care are significant: almost 100 percent of pregnant women in DKI Jakarta receive antenatal care, but only about 70 percent in Maluku and Papua do so.

Yet other indicators of maternal health relate to the availability and use of family planning services. Nationally, the contraceptive prevalence rate (CPR) is low, around 60 percent for any method. Contraceptive use rates declined from 2002 to 2007, in contrast with the steady increase in usage rates during the 1990s. Use varies among provinces and regions and by socio-economic status. The CPR is lowest, irrespective of method, in Maluku at 34.1 percent and lowest for modern methods in Papua at 24.5 percent. It is highest for any and modern methods in Bengkulu, at 74.0 percent and 70.4 percent, respectively. Disparity of CPR among provinces indicates uneven coverage of family planning programmes.

The number of couples of childbearing age who want to space pregnancy or limit children, but do not use contraception (unmet need), has increased from 8.6 percent to 9.1 percent. Unmet need for contraception varies greatly among provinces, the lowest in Bangka Belitung (3.2 percent) and the highest in Maluku (22.4 percent). In addition, a high unmet need was found in rural areas (9.2 percent), in underserved, remote, and border areas (20.4 percent), and among those who had no education (10.6 percent). The high unmet need is caused by fear of side effects and by the inconvenience of using contraceptives, which reflects the low quality of family planning services as well as different preferences due to socio-cultural and economic backgrounds, and lack of access of information and services.

The unmet need contributes to fertility, which in itself carries the inherent risk of leading to maternal death. In addition, maternal mortality is also increased through unsafe abortions, with an estimated 6 percent to 16 percent caused by this factor alone. Unmet need leads to unwanted and unintended pregnancies, which in turn lead to termination of pregnancy. As abortion is illegal in Indonesia, pregnant women seek unsafe services. The need for family planning is further underlined by the high adolescent birth rates in Indonesia, especially in rural areas.3 In some measure, the absence of adequate family planning services also affects the accuracy of fertility data, primarily because of underreporting of births (especially children who died in early infancy) and misreporting of dates of birth.

3. Adolescent Birth Rate is counted by using the proxy of ASFR aged 15 to 19 years (number of birth by women aged 15 to 19 years divided by number of women aged 15 to 19 years).
nomic status remains. ASFR aged 15 to 19 years were highest in Central Sulawesi (1992 births) and lowest in Yogyakarta (seven births). The high birth rate among teenagers is caused by the lack of information, poor access and quality of family planning and insufficient reproductive health services.

Adolescent fertility raises health and demographic concerns. From a health perspective, risks to the mother and the child increase in particular during the perinatal and neo-natal periods, resulting in elevated infant and maternal death figures. From a demographic point of view, increasing childbearing years as a result of early marriage raises fertility rates, while later marriage and access to family planning tend to lower fertility.

PROVINCIAL CONTEXT – CENTRAL JAVA

Comprising around 15 percent of Indonesia’s overall population, Central Java has an incidence of maternal death that contributes significantly to the country’s high MMR. It is therefore considered one of the most significant MMR pockets in Indonesia. Helping the province to further accelerate the decrease of MMR would improve efforts at the national level to accelerate the attainment of MDG 5.

The MMR in Central Java has slightly increased from 115.57 in 2005 to 116 deaths per 100,000 live births in 2011. By 2015, the province has set the target at a rate of 60 deaths per 100,000 live births, almost a half of the national MDG target (i.e., 102 per 100,000 live births).

Compared with the national figure, the MMR in Central Java has been much lower, and it has shown continuous progress as per the data available (see Figure 4). Nevertheless, given the population size of Central Java, it is imperative that the MMR in Central Java be low, as it will contribute to a significant reduction of the national MMR. Notwithstanding the low MMR figure of Central Java, inaccuracy of information and discrepancies of data do exist.
FIGURE 4: COMPARISON BETWEEN CENTRAL JAVA'S MMR AND THE NATIONAL FIGURE, AND THE MDG TARGET

Source: Central Java Provincial Government and Health Office, 2011

FIGURE 5: MATERNAL MORTALITY RATIO IN CENTRAL JAVA, 2005 – 2011

Source: Central Java Provincial Government and Health Office, 2011
2011 figures showed an increase (Figure 5) consistent with a fluctuating trend in this figure. Nevertheless, it should be interpreted carefully because it is hard to state unequivocally that this fluctuation is the result of yearly programme performance, especially for the years 2005, 2006 and 2007. It is very likely more a problem of the information system (of reporting/recording), rather than a problem of programme performance itself. There is no MMR figure for districts/cities, presumably because the absolute number of deaths is too small to build up an MMR.

Despite the low level of MMR, the number of maternal death cases in the province is high. In 2010, for example, there were 611 cases of maternal death reported in Central Java. There are also significant variations in maternal death cases among districts and cities, ranging from 3 in Magelang to 48 in Pemalang district in 2010, as shown in Figure 6 below.

Central Java’s good performance in the attainment of many MDG targets, including MDG 5, is partly attributed to strong commitment of the local leadership and its apparatus at the provincial and district/city levels. As part of the efforts to implement the national MDG roadmap that was launched in 2010, Central Java has become the first province to complete a Provincial MDG Action Plan with clear targets, indicators, timelines and budget requirements.

Figure 7 shows the absolute number of deaths by district/city and the target of the number of deaths to be achieved by the year 2015. Most of the districts/cities are facing big challenges to reach the target by 2015; the current number of maternal deaths is much higher than the target. Some of the districts/cities have to reduce the number of maternal deaths by more than one half of the current level; these include the Pemalang, Brebes, Kendal, Jepara, Magelang and Sokaraja districts, which were among districts with the highest number of maternal deaths.
In an attempt to reduce maternal mortality ratio in a region (province), it is helpful to use the absolute number of maternal deaths and the MMR. The MMR is more representative of the effectiveness of a maternal health system, while the absolute number is good for monitoring deaths. In Figure 8, for example, among the six districts with the biggest target to reduce the absolute number of maternal deaths (Pemalang, Brebes, Kendal, Jepara, Magelang and Sukoharjo districts), Pemalang, Kendal, and Sukoharjo districts apparently have the highest indicative MMR among all provinces in Central Java, while Jepara and Magelang have a relatively lower one, and Brebes is among the lowest.

Figure 8 shows the ‘indicative’ MMR per district/city in comparison with the absolute number of maternal deaths. The indicative MMR was estimated using the number of maternal deaths per district (Pemerintah Provinsi Jateng, 2011) and the number of babies born alive (Dinas Kesehatan Provinsi Jateng, 2010). Estimating the indicative MMR seeks to balance the interpretation of the absolute number of maternal deaths and the indication of MMR. The comparison of the two data confirms that using absolute numbers alone has to be interpreted carefully, while absolute numbers are a good source for monitoring the progress of the reduction of MMR.
Almost 46.7 percent of the population lives in urban areas. The education level is lower in the rural areas than in the urban areas. The percentage of population that finished junior high school or higher is significantly lower in rural areas (26.58 percent) than in urban areas (46.98 percent). Comparing female and male education, female's education (33.54 percent) is in general comparable to male's education (38.32 percent).

The average age of first marriage is 25.3 years for men and 22.1 years for women. 26.9 percent of the total population are women of reproductive age and adolescent girls (from 15 to 19 years) constitute 4 percent of the total population.

Based on 2010 national census, the crude birth rate (CBR) in Central Java was 18.3 per 1,000 population, which is slightly lower than national figure of 19 per 1,000 population (IDHS, 2007).
II. THE MDG ROAD MAP AT NATIONAL AND PROVINCIAL LEVELS
NATIONAL AND PROVINCIAL PRIORITIES, POLICIES AND STRATEGIES FOR MATERNAL HEALTH

In Indonesia, maternal health policy emphasizes expanding the service network, improving the quality of services and raising community awareness. As such, existing programmes and initiatives provide a comprehensive overview of the interventions currently in place and are reviewed here in order to inform the first step of the MAF analysis: identifying and prioritizing interventions.

A strategy document, ‘Health Indonesia 2010: Making Pregnancy Safer’ (MPS), was launched to improve mothers’ and infants’ access to appropriate health services, including through effective inter-sector partnering, programmes to empower women and their families, and stimulation of public involvement in building healthy households and communities. The decision to place village midwives in underserved villages is a key element in the battle to reduce maternal mortality. The Continuum of Care Programme,\(^4\) under the Ministry of Health, is an important element of this strategy.

In order to accelerate achievement of maternal health, reduce maternal mortality and increase access to reproductive health services, the immediate action plan and targets have been set out in the recent Presidential Decree No. 3/2010, which prioritizes and targets the following activities and indicators:

- The percentage of primary health care services with capacity to provide basic emergency obstetric and neo-natal care (BEONC) is targeted to reach 60 percent of all Puskesmas by 2010 and 70 percent in the following year. The percentage of hospitals with comprehensive emergency obstetric and neo-natal care (CEONC) services is targeted to cover 80 percent of total district hospitals by 2010 and 85 percent by 2011. The results achieved so far vary across provinces.
- Strategic health human resources (doctors, midwives, nurses, dentists, sanitarians, pharmacists, public health personnel, and nutritionists) will be placed in health facilities, especially in Puskesmas and District Hospitals in areas with health problems (DBK) and remote, underdeveloped, border and island areas (DTPK) based on needs and existing staffing. The target set for this activity is adequate staffing in 30 percent of locations by 2011, increasing every subsequent year.
- Increasing coverage and quality of family planning services will be prioritized and targets set to meet unmet needs.
- Priority will be given to provinces with CPR below the national average.

In emphasizing these strategies, the National Medium-Term Plan (RPJMN) 2010-14 has set annual targets on maternal health to ensure progress in achieving the MDG targets by 2015. The Provincial Medium-Term Development Plan (RPJMD) has also set annual targets on maternal health and the MDG Regional Action Plan/RAD of Central Java province contains annual targets, indicators, timelines and budget requirements.

---

4. Government’s strong commitment to health and work towards attainment of UN Millennium Development Goals (MDGs) is reflected inter alia in Ministry of Health’s Strategic Plan 2010-2014.
The programmes and activities stated in the Provincial Plan of Action (RAD) related to the acceleration of access to quality care are as follows:

**Nutrition and Maternal and Child Health Programme**

The programme has covered the improvement of human resources, including APN training, supervisory/assistance efforts, and orientation efforts for coordinating midwives (Bidkor) at Puskesmas facilities and local area monitoring implementation, including with private services. The activities will occur in phases, as stated in the budgetary component, which needs consideration when trying to speed up the effort. For example, finishing APN training by 2013 will give two years for the programme to provide quality care at the community level.

The programme encompasses a post-partum care programme, which is important because almost half of the deaths happen during the post-partum period. The programme also includes special efforts for remote areas, such as advocacy for the establishment of waiting huts/homes (rumah tunggu) for mothers at risk of having complications.

In addition, the programme addresses the implementation of a midwife and TBA partnership. It seems that the partnership has been working well, i.e., because skilled birth attendance services coverage is almost universal, TBAs no longer deliver babies. The programme also takes up the important move of facility-based delivery. As mentioned earlier, facility-based delivery is key to addressing complications. Nevertheless, the number of TBAs is far superior to the number of SBAs, and TBAs are still well respected by the community.

**Health Efforts Programme (Programme Upaya Kesehatan)**

As in the previous programme, this programme's components focus on improving the quality of the staff, especially of the PONED team. The activities for the improvement of PONED services include: PONED training for the PONED team with post-training evaluation in Puskesmas; training in post-abortion care; provision of infrastructure and equipment for PONED; family planning and post-partum abortion care; orientation in integrated ANC at PONED Puskesmas; technical assistance and supervision from a PONEK hospital at the district/city level; clinical training on family planning methods in district/city hospitals; and assistance from a PONEK hospital to district/city hospitals, private hospitals as well as PONED Puskesmas.

The programme also covers adolescents by providing essential reproductive health services at PONED Puskesmas. The commitment to this programme component is shown by the increased budget from APBN (central budget) from 19.474 billion rupiah in 2011 to 59.968 billion rupiah in 2015.

**Health Human Resources Development and Empowerment Programme**

This component supports other human resource development components and is focused on 10 priority districts/cities that have a high MMR. The programme focuses on increasing the role of other partners, such as NGOs, faith-based organizations and professional organizations. It includes the establishment of 11 professional organizations that have roles in the quality assurance of its members through certification and other methods.
One of the programmes, early detection of mothers with high risk for maternal death through community-based surveillance, can be useful in improving the data on maternal deaths in Central Java.

**Public Health Services Access Programme**

This programme is not as large as the first two programmes already mentioned. The focus of this programme component is on the PONED Puskesmas. One area of activity is the maintenance or improvement of the quality of care of the PONED team in the Puskesmas through several means, including supervisory/assistance visits from hospital PONEK teams to four PONED Puskesmas, at least four annual visits to supervise and/or assist Puskesmas per year and accreditation of Puskesmas. The PONED will be supported with the facilitation of SK Bupati/Walikota (head of district/mayor decree) or local regulation (PERDA) on delivery, waiting home and PONED. There is one programme to map PONED Puskesmas equipment, but it is unclear whether it fulfils the needs for equipment.

The programme covers the reproductive health and nutritional needs of female workers through Puskesmas provision of reproductive health and nutrition services.

**Health Promotion and Community Empowerment Programme**

For a country like Indonesia, where the level of education of the population varies broadly, having a strong information, communication and education (IEC) system is very important. Despite efforts to improve the health and nutrition status of the people, Indonesia is still challenged by the poor knowledge, attitudes and bad practices related to health and nutrition. Preventive health behaviour, even though it has been increasing since the expansion of Puskesmas throughout all subdistricts, is still dictated by ‘illness’ and the need for cure rather than by the desire to prevent the illness in the first place. The low education of the population adds to the problem. Therefore, a well-built IEC system is crucially needed.

This component of the programme attempts to strengthen the IEC system, including advocacy, social mobilization and health promotion. A sub-component of this programme seeks to make mothers’ class (for pregnant women) function as a forum for pregnant women to enrich their knowledge of the process of pregnancy and the importance of exclusive breastfeeding (EBF), with assistance from EBF motivators and counselors.

The programme is trying to increase the role of Posyandu and FKD/FFK (Forum Kesehatan Desa/Forum Kesehatan Kelurahan – Village Health Forum) to reduce maternal mortality. While the purpose is good, clear guidance for the Posyandu, FKD/FFK and Puskesmas is required.

The budget is expected to more than double from 1.968 billion rupiah in 2011 to 4.925 billion rupiah in 2012, but to decline to 4.750 billion rupiah in 2013, to 2.825 billion rupiah in 2014, and to 2.400 billion rupiah in 2015. Nevertheless, these sums are still too small to respond to the challenges of changing attitude and behaviour of Indonesian society.

**Health Resources Programme (Programme Sumber Daya Kesehatan)**

This component covers coordination among health data managers at the district/city level, including the assessment of health data and evaluation of the health data management. Recognition of the importance of data seems to receive more attention in the regional action plan.
Health Programme under Provincial PKK
(Women's Welfare Organization)

PKK is an organization of the wives of local government civil servants under the Ministry of Internal Affairs. Its role in health programmes through Posyandu (integrated health services) and other programmes has been important. Therefore, maintaining and increasing its role in the community health system is imperative.

In this component, the knowledge of PKK members about reproductive health will be empowered to mobilize the community through socialization of KPKIA (Kelompok Peminat Kesehatan Ibu dan Anak – Supporters of Maternal and Child Health).

Family Planning and Population

The FP and population programmes are as follows:

a. Assistance, enrollment and self-sufficiency on FP Programme through 23,500 government and private clinics.
b. Increase the capacity of human resources of FP service providers in 1,630 government and private clinics to provide assistance and encourage enrollment and self-sufficiency in FP.
c. Increase the KAP (knowledge, attitude and practice) of adolescents about the preparation of PKBR (Kehidupan Berkeluarga Bagi Remaja – Family Life for Adolescents).
d. Increase the KAP of the community regarding population control and FP.
e. Increase the involvement of NGOs and the private sector in the management of FP programmes.
f. Increase FP self-sufficiency among the poor and near-poor.

Maternal and Child Nutrition and Health Programme

Under the MCNH Programme, the FP and Reproductive Health component has been integrated into different health facility levels at the community level. The programme covers various activities such as assistance and supervision, updating training of health providers on FP methods, human resources empowerment, identification and information collection of pregnant women, and supporting Puskesmas in a range of FP-related activities.

The programme supports the establishment of mobile teams for remote, underdeveloped, border and island areas (Daerah Terpencil, Perbatasan, Kepulauan – D tPK) areas and the inclusion of ARH (Adolescence Reproductive Health) in the curriculum. Currently, three districts (Banjarnegara, Rembang and Wonogiri) are categorized as D tPK areas and all of them have mobile teams. Two other districts, i.e., Cilacap and Jepara, will be proposed for consideration as D tPK.

A buffer stock of contraceptive methods will be improved at the provincial level. Material on FP and RH is also a target activity.

Contraceptive Prevalence Rates Programmes

The efforts to increase CPR will include increasing MOW (female operation method), MOP (male operation method), IUD, implant, injection, pills and implant removal through static and mobile services; increasing the role of the private sector and community in FP programme; developing an IEC media; and mobilizing front-line staff. In addition, there will be an effort to increase the self-efficacy of the poor and the near-poor in order to utilize the services available.

Adolescents’ Reproductive Health Improvement Programme

The programme will be implemented through quality improvement of the Adolescents' Repro-
ductive Health (ARH) and the establishment of an Information and Counseling Centre for ARH (ICC – ARH).

**Health Efforts Programme**

The focus of this programme component is on the improvement of PONEK hospitals through different activities. These are:

a. Technical training, supervisory and assistance for the district/city PONEK hospitals, government and private hospitals, delivery of the needed standard facility and equipment. This will be supported with a Letter of Decree from the district/city local government.

b. Assistance and supervisory support to B- and C-class PONEK hospitals.

c. Training of the family planning service team (PKBRS) in the B class hospital.

d. Mapping of the facility and equipment availability/completeness of PONEK hospital.

e. Inventory of hospitals that have a Letter of Decree for a PONEK team.

f. Improve the quality of hospitals in providing referral services. Referral from the community (Pustu, Puskesmas atau Bidan Desa) level should be linked to MCH LAM (Maternal and Child Health Local Area Monitoring) data through the call centre in the district/city PONEK hospital.

**Health Human Resource Development and Empowerment Programme**

The programme will be focused on strengthening the quality of human resources in the 10 priority districts/cities.

**Family Planning Service Programme**

It covers operation, IUD, implant, injection, pill, and implant removal. Family planning services are provided through static and mobile team services.

The Jampersal insurance strategy to restrict the eligibility of women with no more than two children has been beneficial to the FP programme as a social marketing tool.

**Referral System**

In the RAD 2011-2015, the specific activities of the referral system are the regionalization of maternal and neo-natal health referral systems in districts/cities. In 2011, the indicative budget allocation for this activity was 86 million rupiah, which increased to 172 million in 2012. For the years 2013 through 2015, the indicative budget allocation remains relatively unchanged, i.e., from 172 million rupiah to 175 million rupiah. Another activity that can indirectly improve the referral system is the improvement of care at the primary and referral levels.

**BUDGET ALLOCATION**

In 2010, the total budget for health for all districts/cities in Central Java was 3,428,234,362,358 rupiah (an increase of almost 62 percent from 2,121,096,713,805 rupiah in 2009), with a 51.73 percent contribution from APBD district/city. The allocation of the budget from APBD for health expenditure in districts/cities in 2010, was only 0.25 percent, a decrease compared to the 2009 budget (0.57 percent). The contribution of DAK in health districts/cities is 43.97 percent (Table 1) (Source: Health Profile, 2010).

The health budget per capita increased from 64,541 rupiah in 2009 to 105,866 rupiah in 2010 – an increase of about 65 percent.
Overall, the budget to reduce MMR has steadily increased (Figure 10). The commitment to accelerate the achievement of MDG 5 on maternal health is shown by the plan to increase the total budget to reduce MMR between 2011 and 2015. The increase of the total budget is significant, i.e., from 82 billion rupiah in 2011 to 348 billion rupiah in 2015, which is more than a fourfold increase.

On the other hand, the planned budget allocation to reproductive health care is not increasing. It even decreased sharply in 2012, before increasing in 2015 back to the same level as in 2011 (Figure 9).

### TABLE 1. District/City Budget on Health, Central Java Province, 2010

<table>
<thead>
<tr>
<th>Source of funding</th>
<th>Health Budget Allocation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rupiah</td>
<td>%</td>
</tr>
<tr>
<td>APBD District/City</td>
<td>1,773,285,470,201</td>
<td>51.73</td>
</tr>
<tr>
<td>APBD Province</td>
<td>8,632,597,867</td>
<td>0.25</td>
</tr>
<tr>
<td>APBN:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Special Fund Allocation (Dana Alokasi Khusus - DAK)</td>
<td>1,507,283,193,313</td>
<td>43.97</td>
</tr>
<tr>
<td>- Askeskin</td>
<td>93,758,322,470</td>
<td>2.73</td>
</tr>
<tr>
<td>Loan/Grant – international</td>
<td>13,496,489,957</td>
<td>0.39</td>
</tr>
<tr>
<td>Other source of income</td>
<td>31,778,288,550</td>
<td>0.93</td>
</tr>
<tr>
<td>TOTAL HEALTH BUDGET</td>
<td>3,428,234,362,358</td>
<td>100</td>
</tr>
<tr>
<td>TOTAL APBD DISTRICT/CITY</td>
<td>23,948,313,691,529</td>
<td></td>
</tr>
<tr>
<td><strong>% APBD HEALTH TO TOTAL APBD DISTRICT/CITY</strong></td>
<td><strong>14.32</strong></td>
<td></td>
</tr>
<tr>
<td>HEALTH BUDGET PER CAPITA</td>
<td>105,866</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Health Profile of District/City, 2010*
FIGURE 9: TOTAL INDICATIVE BUDGET TO REDUCE MMR (TARGET 5A) AND TO PROVIDE UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH CARE (TARGET 5B)

Source: Central Java Provincial Government, 2011

TABLE 2. Total Indicative Budget Allocation (in millions of rupiah) for MDG Programmes in Central Java

<table>
<thead>
<tr>
<th>Source of funding</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated in Nutrition and MCH Programme</td>
<td>50,878</td>
<td>52,809</td>
<td>54,293</td>
<td>58,011</td>
<td>63,152</td>
</tr>
<tr>
<td>Health Effort Programme</td>
<td>19,971</td>
<td>276,728</td>
<td>363,800</td>
<td>380,429</td>
<td>406,743</td>
</tr>
<tr>
<td>Human Resource Development and Empowerment Programme</td>
<td>3,166</td>
<td>3,506</td>
<td>3,720</td>
<td>3,915</td>
<td>4,117</td>
</tr>
<tr>
<td>Management support Programme and other Technical Tasks</td>
<td>1,035</td>
<td>1,250</td>
<td>1,150</td>
<td>1,900</td>
<td>150</td>
</tr>
<tr>
<td>Public Health Service Access Programme</td>
<td>4,243</td>
<td>7,627</td>
<td>8,343</td>
<td>9,633</td>
<td>9,490</td>
</tr>
<tr>
<td>Community Empowerment and Health Promotion Programme</td>
<td>1,968</td>
<td>4,925</td>
<td>4,750</td>
<td>2,825</td>
<td>2,400</td>
</tr>
<tr>
<td>Health Resources Programme</td>
<td>1,135</td>
<td>1,591</td>
<td>2,665</td>
<td>1,715</td>
<td>1,775</td>
</tr>
<tr>
<td>Health Programme (Provincial PKK)</td>
<td>105</td>
<td>105</td>
<td>105</td>
<td>105</td>
<td>105</td>
</tr>
<tr>
<td>Total</td>
<td>82,501</td>
<td>348,541</td>
<td>439,281</td>
<td>458,533</td>
<td>488,438</td>
</tr>
</tbody>
</table>

Source: Central Java Provincial Government, 2011
Looking at the budget allocation for maternal mortality reduction, the budget component that is increasing the most is associated with the Health Effort Programme or Programme Upaya Kesehatan. This programme consists of human resources improvement through training and assistance for PONED and PONEK staff. The budget increased almost 14-fold, from about 20 billion rupiah in 2011 to 276 billion rupiah in 2012, and it is continuing to increase, but proportionally less until 2015.

Another component that is increasing steadily until 2015 is the Programme Bina Gizi KIA. This programme covers home visits to increase the coverage of post-partum women, the provision of delivery facility in Puskesmas, and APN training.

Source: Central Java Provincial Government, 2011
One of the main constraints to using a health facility is cost. The government has addressed this problem through various health insurance schemes, Askeskin, and Jamkesmas, with Jampersal being the latest. Overall, about half of the population is covered by a health insurance scheme, with quite a big variation among districts/cities, between slightly less than 30 percent (Kota Salatiga) to slightly over 70 percent (Kota Surakarta).

**HEALTH INSURANCE COVERAGE**

<table>
<thead>
<tr>
<th>Programme</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated in Nutrition and MCH Programme</td>
<td>23,139</td>
<td>10,154</td>
<td>14,886</td>
<td>20,078</td>
<td>21,963</td>
</tr>
<tr>
<td>Improvement of Adolescence reproductive Health Programme</td>
<td>1,635</td>
<td>1,810</td>
<td>2,021</td>
<td>2,201</td>
<td>2,422</td>
</tr>
</tbody>
</table>

Source: Central Java Provincial Government, 2011
### TABLE 4. Health facilities that provide Jamkesmas Health Service Programme in Central Java

<table>
<thead>
<tr>
<th>No</th>
<th>Facility Type</th>
<th>2011</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Puskesmas</td>
<td></td>
<td>867</td>
</tr>
<tr>
<td>2</td>
<td>General Hospital, Special Hospitals – Central</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>General Hospital, Special Hospitals – Local (Province/District)</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>4</td>
<td>General Hospital, Special Hospitals – Army/Police</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>BKPM/BKIM (Community Pulmonary Health Services)/Community Sensory Health Services): Central and Local</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>Private hospitals that collaborate to provide Jamkesmas and Jampersal</td>
<td></td>
<td>93</td>
</tr>
</tbody>
</table>

Source: Provincial Health Office Pocket Book, 2011

### FIGURE 12: COLLABORATION STATUS ON JAMKESDA BY DISTRICTS/CITIES

**KESEPAKATAN BERSAMA JAMKESDA**

Source: Provincial Health Office Pocket Book, 2011
COMMUNITY ENGAGEMENT IN THE RAD

The province RAD 2011-2015 plans to increase partnership with NGOs, the private sector, community organizations, and faith-based organizations to reduce maternal deaths. The target for 2011-2015 is being implemented in phases, across three districts/cities in 2011, 10 districts/cities in 2012, 10 districts/cities in 2013, six districts/cities in 2014 and six districts/cities in 2015. The budget comes from APBN (National Revenue and Expenditure Budget) allocation.

The role of PKK (Women’s Welfare Organization) in the health sector has been long known. In the RAD, their role will be maintained and strengthened. The programme under PKK includes a talkshow about the problem with women’s reproductive health for PKK members, community mobilization through the development of KPKIA (Kelompok Peminat Kesehatan Ibu dan Anak - MCH supporter group), and the development of TOGA (Taman Obat Keluarga - Family Medicine Garden). The total budget is 105 million rupiah per year, with APBD (Regional Revenue and Expenditure Budget) funding.

IMPACT OF DECENTRALIZATION IN CENTRAL JAVA

Indonesia’s decentralization has led to a significant increase in regional expenditures; central civil servants were re-assigned; over 16,000 public service facilities were handed over to the regions; and a brand new intergovernmental fiscal system was put in place. All of this was achieved without a major disruption in government services. Over time, Indonesia has become one of the most decentralized countries in the world, much more decentralized than would be expected on the basis of the country’s structural characteristics. This large degree of decentralization requires a sound intergovernmental fiscal system to ensure efficient service delivery, macroeconomic stability, local accountability, and an alignment of local spending with national priorities (World Bank, Indonesia).

Central Java province is divided administratively into 29 districts and 6 municipalities/cities. According to the 2010 population census, the size of the population is 32,382,657, located in 573 subdistricts and 8,576 villages (desa/kelurahan), which makes service delivery quite challenging.

MDG ACCELERATION IN INDONESIA

The push for a formal strategy to accelerate MDG achievement, while ensuring synergy among ministries and between central and local governments, has been enhanced by the Presidential Decree No. 3/2010. The Government of Indonesia has recently put in place a Roadmap to Accelerate Achievement of the MDGs, including the challenge of curbing maternal mortality. In addition, all provinces, in collaboration with districts/municipalities, are developing Provincial Action Plans (RAD) for the MDGs based on a decree of Minister of Planning/Bappenas.

The MDG Acceleration Framework (MAF) helps operationalize the MDG Regional Action Plan/RAD for the Central Java province, which was formulated through a collaborative effort between the central government and the sub-national authority in 2010. Lessons learned from the MAF application in Central Java, and the implementation of the Action Plan, are expected to inform the roll-out to other provinces and generate traction for the achievement of the targets contained in the 2010 national MDG Roadmap to Accelerate the Achievement of the MDGs. The MAF is also expected to mobilize partnerships and additional efforts including the identification of financial mechanisms and possible allocation of financial resources.
Indonesia has implemented a decentralized governance system over a decade. This new governance has affected the implementation of many programmes, including those involving health. By law, the government is divided into central and local governments. Central government consists of the President of the Republic of Indonesia, who governs the country. The local government consists of the governor, bupati (district head), or mayor and their local instruments. The central government covers six governance matters: international affairs, defense, security, justice, national monetary and fiscal policy, and religion.

The local government is widely autonomous, except with respect to national government matters. In governing, the local government has relationships with national government as well as other local governments, covering authority, finance, public service, use of natural and other resources that are executed in equality and harmony. The head of local government must report to the government and the local parliament about the implementation of its local government matters and inform the local community about the implementation of policies.

Local government matters are divided into obligatory and optional matters. The obligatory matters of the local government have to follow the minimal service standard that was decided by the government. These obligatory matters covering 26 activities include: 1) education; 2) health; 3) development; 4) women’s empowerment and child protection; 5) local autonomy, general governance, local budget administration, local instruments, employment; and 6) community and village empowerment. The optional matters are those that could improve community welfare and suit the local condition and circumstances and are decided by the local government. The optional matters include fishery and marine resources, farming, forestry, energy and mining, tourism, industry, trading and immigration.

The Local Parliament (DPRD – Regional House of Representatives) is part of the local governance institution. DPRD has legislative, budgetary and monitory functions. Each member of DPRD has the right to propose Local Regulations (PERDA). DPRD has the obligation and authority to: develop PERDA and discuss them with local government to get joint agreement; discuss and agree on PERDA of APBD (local expenditure); supervise the implementation of PERDA and other regulations, regulations of the local government head, APBD, local government policy in implementing the local development programme, and international cooperation in its area; and propose the promotion or revocation of the head of the government or the president.

It can be concluded that the implementation of programmes, including health, is very much influenced by the local government’s decision with the support of DPRD.
incentives for MDG acceleration within the government planning.

THE ROLE OF LOCAL PARLIAMENT (DPRD) IN BUDGETING

The role of DPRD (Regional House of Representatives) in decision making regarding the budget is very strong. Therefore, BAPPEDA and the Regional Health Office have to advocate with the Parliament E-Commission for the importance of reaching the MDGs effectively, including maternal health, and their budget implications. Thus far, DPRD has expressed its commitment to achieve the MDGs targets.

Allocation of Funds from the Local Government (PEMDA) to the Provincial Health Office (PHO) and the District Health Office (DHO)

Provincial level responsibilities:

- Assessment of the problems/issues in the PHO/DHO
- Formulating the strategic issues based on the assessment
- Currently focus on acceleration of MDG achievement
- Develop Work Plan (Renja – Rencana Kerja)
- Propose to Bappeda
- Bappeda issues an indicative/temporary budget
- PHO will make an adjustment to the budget
- Formulate the Budgetary Workplan (RKA – Rencana Kerja Anggaran)
- Send to E-Commission of Local Parliament (DPRD)
- Meeting with the Local Parliament to get Final Budget Allocation
- Disbursement

From the flow, it is clear that the role of the Regional Parliament is significant. Fortunately, the Parliament in Central Java recognizes the need for programme acceleration to achieve MDGs. Therefore, the budget for the achievement of MDG targets is expected to be prioritized.

Specific information on the budget for MDG 5 (source: Dokumen Pelaksanaan Anggaran 2010 – 2012).

There is a significant increase in the province APBD budget for maternal health, which can be observed from 2010 to 2012. In 2010, the allocation was 547 million; this increased almost five-fold for 2011 (2.5 billion), and, from 2011 to 2012, the increase is small (2.62 billion). Despite the significant increase of resources, the amount is not sufficient to cover all the expenditures in order to provide quality health care services.
Budget expenditures indicators demonstrate the need for improvement in budget performance in the health sector. Actual expenditures have consistently deviated from plans, and subsidies through Askeskin, as well as transfers through regions via the deconcentration mechanism, have been disbursed late. Spending starts slowly in the budget year and, for the past five years, Indonesia has spent 50 percent of its total capital expenditures during the last quarter of the year.

In health, for example, several programs that are known to be less cost effective are prioritized in budget allocation just because they produce more tangible outputs. As planning and budgeting is a political process, this may result in sub-optimal policies and budget allocations. Also, the deliberation of the sectoral work plan and budget by parliament sometimes extends too far into implementation details, such as how and where a public health facility should be built, undermining work plans that have been developed based on sound evidence. Figure 14 provides an overview of the central level’s planning and budgeting process for the health sector.

5. Extracted from World Bank, 2008, Investing in Indonesia’s Health: Challenges and Opportunities for Public Spending
6. Ibid.
FIGURE 14: CENTRAL GOVERNMENT PLANNING AND BUDGETING CYCLE FOR THE HEALTH SECTOR

Based on MoH proposal (MoH annual work plan)

Circulating letter MoF & Bappenas No. 1046/M. PPN/03/2005-SE 49/MK/2005

Indicative budget ceilings decided (MoF/Bappenas), informed to MoH

Discussed at MoH senior management meeting

MoH develops and proposes temporary budget

MoH subunits develop budget (including for provinces)

Each unit allocate budget to their subunits

Lobbying and Negotiations

Proposed and discussed in parliament

Confirmed as definitive budget

MoF decides temporary budget ceiling

III. PRIORITY INTERVENTIONS TO ACCELERATE PROGRESS ON MATERNAL HEALTH IN CENTRAL JAVA
This section focuses on key interventions with documented effectiveness that are aimed at preventing the causes of maternal mortality in Central Java and highlights the extent to which they have been implemented. To put the interventions into perspective for non-medical readers, it is important to provide some explanation. First, a maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy. Second, Maternal Mortality Ratio (MMR) is the ratio of maternal deaths per 100,000 live births. The MMR is computed by estimating the number of maternal deaths, dividing this by the number of live births in a population for the same period of time, and multiplying this by 100,000.

The computation brings out three important aspects: first, all pregnancies that end up in induced abortion or miscarriage increase the number of maternal deaths, but do not add to the number of live births. This means that MMR is higher when abortions or miscarriages are high. Abortions are most common when pregnancies are unintended. In Indonesia, abortion is an illegal practice, which leads to pregnant women seek unsafe services.

**DESCRIPTION OF MATERNAL DEATHS IN CENTRAL JAVA**

This section will provide information that can help guide an understanding of which interventions could be the most effective in addressing maternal deaths.

In Central Java, most of the deaths happened in the community or during transportation to the referral hospital (RAD 2011-2015). This information, however, differs from other resources (PHO, 2012) received, i.e., 83 percent of the deaths happened in hospital and the rest were in homes (9 percent), en route (6 percent), and at puskesmas (2 percent). These two different data regarding the place of maternal death need to be clarified because the implications for action will be different.

**FIGURE 15: PLACE OF DEATH OF MATERNAL DEATHS, CENTRAL JAVA, 2011**

![Bar chart showing the place of death with 83% in hospital, 9% at home, 6% en route, and 2% at health center.](Source: Central Java PHO, 2011)
Almost half of maternal deaths happened during the post-partum period (47 percent), 27 percent during delivery and 26 percent during pregnancy. This figure is quite different from data from other places, which showed that most deaths occur around time of delivery (during delivery and within the first 24 hours post-partum). This could be caused by the aggregation of all post-partum period, and not separating the first 24 hours after delivery. Data from Banten Province, for example, showed that 38 percent of the deaths happened during delivery and within 24 hours, about 22 percent during pregnancy, 15 percent between days 8 to 42 post-partum, and the rest were between days 2 to 7 post-partum. In both cases, it is implied that there is a great opportunity to save a mother’s life during delivery and within the first 24 hours post-partum.

It is important to note that first post-partum visit (KN1) is quite high, despite the fact that MMR is also high. The ineffectiveness of high post-partum visits in averting maternal death is probably due to the timing of the visit and the quality of post-partum care. The first post-partum visit covers the time between day 1 and day 8, while the critical point of time to save mother’s life is in the first 24 hours. Therefore, if KN1 missed to monitor the first 24 hours after delivery, the opportunity to save many mothers’ lives might be missed.

The fact that in Central Java most of the deaths happened in the community or during transportation to the referral hospital, based on RAD 2011-2015, and happened around delivery and post-partum, might represent a complex situation and point toward the need for increasing the facility-based delivery in Central Java. Maternal deaths at community level or during transportation signify the situation where the need to get emergency obstetric care was not met. The explanation can be that there is no access to services at the time of the event; that there is late identification of complication because of lack of skills of the health provider; that there is sub-standard care in managing complication given by the health provider; or
that there is late or in-effective referral. Facility-based delivery will increase the opportunity that a mother will get more ready services needed, provided that the facility has the capacity to give basic essential services in 24 hours, with standard quality of human resources and availability of standard equipment and drugs. The facility should be able to function in preventing certain complications (e.g., practicing AMTSL, using partograph), identifying complications early, providing first aid and maintaining/stabilizing the patient when complications arise, and refer the patient effectively. In a facility, a midwife will not work solely as in the home, but instead get assistance from another staff or work in a team; therefore the service given might be better. In a facility, the availability of equipment and drugs is more secured. In addition, delivery at a facility will also allow quicker transportation to hospital, because the location of a facility usually can be reached more easily by transportation.

On the part of the community, knowledge, behaviour and financial motives are usually dominant barriers. While no data on these aspects in relation to the use of maternal services is available, data on the significant increase of attendance of the hospitals since the application of Jampersal indicates that the financial barrier is one significant factor to use of services in Central Java.

It is worth noting that more than two thirds of maternal deaths (77%) were attended by a doctor, 19 percent were attended by a midwife and 4 percent were attended by traditional birth attendants (TBAs). This high mortality rate despite the presence of doctors most likely suggests that the mothers came to the health provider already in a terminal stage.

**FIGURE 17:**

TIME OF DEATH IN RELATION TO PREGNANCY OF MATERNAL DEATHS, CENTRAL JAVA, 2011

<table>
<thead>
<tr>
<th>Stage</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>26%</td>
</tr>
<tr>
<td>Delivery</td>
<td>27%</td>
</tr>
<tr>
<td>Post-partum</td>
<td>27%</td>
</tr>
</tbody>
</table>

Source: Central Java PHO, 2011
However, even when maternal mortality is measured, the majority of aggregated information sources tends to group all maternal deaths together and there is a failure to differentiate between different categories of maternal death. According to the International Classification of Diseases (ICD), 10th revision, maternal death is classified using two main categories: direct and indirect maternal death.

In Indonesia, current policy encourages that all deliveries should be attended in a facility by a trained health provider. As explained earlier, facility-based deliveries will reduce the risk of maternal death. However, even when maternal mortality is measured, the majority of aggregated information sources tends to group all maternal deaths together and there is a failure to differentiate between different categories of maternal death. According to the International Classification of Diseases (ICD), 10th revision, maternal death is classified using two main categories: direct and indirect maternal death.

In Indonesia, current policy encourages that all deliveries should be attended in a facility by a trained health provider. As explained earlier, facility-based deliveries will reduce the risk of maternal death.

There are a number of problems inherent in measuring maternal mortality: vital registration systems might be inadequate, hospital records might be poor, maternal deaths occurring outside health facilities might not be registered, pregnancy status might not be disclosed, and maternal deaths might be misclassified. Nevertheless, various measurement tools are available for tracking trends, including censuses, household surveys and the examination of hospital records. Each has its own advantages and disadvantages, such as the cost of administration, a lack of statistical capacity and a requirement for large sample sizes.

### TRACKING MATERNAL MORTALITY

Given the current lack of progress in tackling maternal mortality, it is critical that effective interventions be implemented. Clearly, careful monitoring and evaluation of these interventions are crucial for determining what works and for ensuring that scarce resources are allocated effectively. This is particularly true when maternal mortality is high and access to maternal health services is poor.

Nevertheless, various measurement tools are available for tracking trends, including censuses, household surveys and the examination of hospital records. Each has its own advantages and disadvantages, such as the cost of administration, a lack of statistical capacity and a requirement for large sample sizes.
represents different constraints to be addressed. For example, it is expected that most of the cases managed by hospitals are complicated and emergency cases. Conversely, Puskesmas, because of its limited services and infrastructure, is not a place for managing complications and ought to function as a site for screening complications, and for referring effectively when the complication cannot be managed at the site.

**FIGURE 19: PROPORTION OF DELIVERIES AT HEALTH FACILITIES BY DISTRICT, CENTRAL JAVA, 2011**

Source: Central Java PHO, 2011

**DIRECT AND INDIRECT CAUSES OF MATERNAL DEATH**

Maternal death is direct or indirect. Direct obstetric deaths are those resulting from obstetric complications of the pregnant state (i.e., pregnancy, labour and the puerperium), from interventions, omissions or incorrect treatment, or from a chain of events resulting from any of the above. Indirect obstetric deaths are those resulting from a previously existing disease or a disease that developed during pregnancy and that was not due to direct obstetric causes, but that was aggravated by the physiological effects of pregnancy (WHO, 2010, Bulletin 88).
In the context of developing countries, it is useful to use the direct–indirect dichotomy, even though the two terms are broad. Moreover, discriminating between them may be difficult at times and misclassification can occur. The only concrete way of accurately determining the cause of death is by autopsy. However, this is simply not a viable option for most cases in resource-poor settings. In addition, recent discussions about the classification of maternal death recognize the difficulty of identifying maternal deaths and it is recommended that new coding instructions be included.

The most common causes of direct maternal death are haemorrhage, sepsis, pregnancy-induced hypertension and complications of unsafe abortion, while the most common causes of indirect maternal death are anaemia, HIV/AIDS and malaria. It is important to note that for Central Java, malaria is not a relevant indirect cause of maternal mortality.

While many of the problems associated with measuring maternal mortality have been discussed for a number of years, it is only recently that indirect maternal death has been attracting more attention as it becomes the leading cause of maternal death in many countries. The earlier lack of attention to indirect maternal death may stem from a number of factors, such as the measurement of difficulties previously mentioned and the fact that, until recently, indirect causes of maternal death were dwarfed by direct causes. This situation is changing with the increase in HIV/AIDS and the growing relative importance of non-communicable diseases, such as cardiovascular disease, diabetes and respiratory disease.

**FIGURE 20:** MMR BY THE DISTRICT/CITY POPULATION SIZE, CENTRAL JAVA JAVA, 2010 *

The four figures below attempt to assess the cause of maternal deaths in Indonesia and Central Java Province.

In Indonesia (Bappenas, 2010c) as a whole, 80 percent of maternal deaths are caused by direct obstetric causes, mainly haemorrhage, eclampsia, Infection, sepsis and obstructed/long labor, while the rest were by indirect causes (Figure 21).

However, in Central Java, the main cause of deaths is related to indirect causes (46 percent), followed by eclampsia (30 percent), hemorrhage (20 percent) and infection (4 percent).

However, the difference between direct and indirect causes was not as big as the national figure. Despite the differences, it seems that the proportion of indirect maternal deaths is quite significant; therefore, attention to the causes needs to be raised as one important consideration to the strategy to reduce maternal death. For example, the prevalent diseases in Indonesia such as anemia, tuberculosis, and malaria in the endemic areas, can be reduced through different efforts. Unfortunately, the diagnosis of the indirect causes in Central Java shows wide variations, which means that tackling them is not straightforward, but needs special different actions. For example, on the list of other causes of death, there were more than 30 diagnoses determined, for example heart failure, tuberculosis, embol, severe anemia, cardiac arrest, asthma, illeus, renal failure, typhoid, diabetes, myoma uteri, several types of cancer, dengue shock syndrome, ectopic pregnancy, hepatitis, diarrhea, pulmonary edema, pneumonia, gastritis, psychosomatic, cardiomyopathy, neurological disorders, breathing difficulties and vomiting, fever, cardiomegaly, malaria, etc. (Figure 22).

**FIGURE 21: CAUSE OF MATERNAL DEATHS IN INDONESIA, 2001**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eclampsia</td>
<td>24%</td>
</tr>
<tr>
<td>Infection</td>
<td>11%</td>
</tr>
<tr>
<td>Haemorrhage</td>
<td>28%</td>
</tr>
<tr>
<td>Others</td>
<td>11%</td>
</tr>
<tr>
<td>Puerperium complication</td>
<td>8%</td>
</tr>
<tr>
<td>Obstetric trauma</td>
<td>5%</td>
</tr>
<tr>
<td>Obstetric embolism</td>
<td>3%</td>
</tr>
<tr>
<td>Obstructed labor</td>
<td>5%</td>
</tr>
<tr>
<td>Abortion</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Source: Indonesia Household Survey, BPS 2001*
The pattern of the causes of maternal deaths obtained from the community level might be different from the hospital level. The proportion of indirect causes of mortality is much higher at hospital setting (82 percent) than at the community (56 percent). It depends on the accuracy of the diagnosis, the stage of the patient’s condition, and the reporting and recording system. For example, the results from impact study in Banten province revealed a very different figure. The direct causes were 56 percent from the community level, but 82 percent from the hospital level (Figure 23).

The explanation for the higher indirect cause of deaths at the hospital level is related to a more precise diagnosis made by the doctors, while, in the the community level, the cause of deaths in this study was analysed using the InterVA-M computer programme, which shows that, from the census of all deaths (474 maternal death) in the study districts in two years, hemorrhage accounted for 26.4 percent of pregnancy-related deaths, followed by pregnancy-related sepsis (16.9 percent). These data also shows that a high proportion of indirect obstetric causes accounted for more than one third of total deaths. These were non-pregnancy related infection (14.7 percent), chronic non-infection (13.9 percent), anemia (3.4 percent), undetermined (1.7 percent), other maternal causes (1.1 percent) and accidental/incidental (0.8 percent). (Figure 24).

Based on the data provided previously, Central Java has prioritized four interventions that should significantly improve maternal health. These interventions, which focus on the direct and indirect causes of highest impact on maternal health, are:

1. Improve access to quality Basic (PONED) and Comprehensive Emergency Obstetric Neonatal Care (PONEK) services
2. Improve access to quality primary health care at the community level (e.g., Community Village Health Policlinics (PKDs))

3. Strengthen a quality referral system

4. Increase access to quality family planning (FP) and reproductive health services

**FIGURE 23:**
**DIRECT AND INDIRECT CAUSE OF DEATH: HOSPITAL AND COMMUNITY**

<table>
<thead>
<tr>
<th>Community (N=474)</th>
<th>Hospital (N=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Direct</td>
</tr>
<tr>
<td>Indirect</td>
<td>Indirect</td>
</tr>
<tr>
<td>Suicide-injury</td>
<td>Not Known</td>
</tr>
</tbody>
</table>

- Community: 43% Direct, 56% Indirect, 1% Suicide-injury
- Hospital: 15% Direct, 82% Indirect, 3% Not Known

Source: Qomariyah, 2006

**FIGURE 24:**
**CAUSE OF DEATH, PREGNANCY-RELATED DEATH, SERANG AND PANDEGLANG DISTRICTS, BANTEN PROVINCE, 2004-2005 (N=474)**

- Causes of death: Hemorrhage, Septicaemia, Non-PN infection, Chronic non-infection, Pregnancy-induced Hypertension, Obstetric shock, Anemia, Ectopic pregnancy, Indetermined, Abortion, Other maternal causes, Accident/Other

Source: Qomariyah, 2006
3.1 IMPROVE ACCESS TO QUALITY BASIC (PONED) AND COMPREHENSIVE EMERGENCY OBSTETRIC NEO-NATAL CARE (PONEK)

ACCREDITED HOSPITALS IN CENTRAL JAVA

There are 224 Hospitals throughout Central Java province, 58 government and 166 private hospitals, and there are 157 OB-GYNs. Of those hospitals, 24 can function as PONEK Hospitals and 124 have the potential to provide EmOC services (mampu PONEK). It means that not all districts/cities have PONEK hospitals. Among 124 hospitals that have the potential to provide EmOC, 44 were government hospitals.

The percentage of hospitals with a 24/7 functioning Blood Transfusion Unit (PMI) is only 19.2 percent (43 hospitals) of the total hospitals, 31 public and 12 private.

The role of private hospitals is very relevant, given the number of facilities compared to public hospitals. A private hospital has its own regulations in term of service fees. However, government regulations stipulate that private hospitals must provide services for the poor, and coverage for the service fees set by the Jamkesmas/Jamkesda/Jampersal programmes, under an MoU with the PHO/DHO.

One important indicator to predict the problem that deters maternal survival is the management of obstetric complication in EmOC facilities. The coverage of those with complications who are managed in adequate hospitals will give an indication of the likelihood of mothers to be saved. For Central Java, the percentage of complications is estimated to be 20 percent of all pregnancies and deliveries. Among these estimated complications, the percentage of complications managed in hospitals is calculated, independent of whether a mother survives. The current results show that 75.28 percent of the total estimated complications were managed at hospitals, which is quite high. It is likely that the target of 80 percent recommended in the minimal service standard

<table>
<thead>
<tr>
<th>Type of hospitals</th>
<th>Number of hospital</th>
<th>5 Services</th>
<th>12 Services</th>
<th>16 Services</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public general hospital</td>
<td>50</td>
<td>6</td>
<td>2</td>
<td>18</td>
<td>52</td>
</tr>
<tr>
<td>Private general hospital</td>
<td>118</td>
<td>48</td>
<td>11</td>
<td>12</td>
<td>60.2</td>
</tr>
<tr>
<td>Public Special Hospital</td>
<td>6</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>33.3</td>
</tr>
<tr>
<td>Private Special Hospital</td>
<td>63</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>3.2</td>
</tr>
<tr>
<td>Indonesian Police/Army Hospital</td>
<td>10</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>60</td>
</tr>
<tr>
<td>TOTAL</td>
<td>247</td>
<td>62</td>
<td>15</td>
<td>30</td>
<td>43.3</td>
</tr>
</tbody>
</table>

ISO:
1. RSUD Dr. Margono Soekarjo Purwokerto
2. RSUD Tugurejo Semarang
3. RSUD Dr. Moewardi Surakarta

Source: Central Java PHO, 2011
(MSS - SPM) will be achieved. However, the figure given was not common for PONEK hospitals or Puskesmas PONED; therefore, it is assumed that the figure will be much lower than this.

**COVERAGE OF PONED AND PONEK SERVICES**

<table>
<thead>
<tr>
<th>Obstetric emergency complications (EOC)</th>
<th>Emergency obstetric care (EmOC) signal functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Antepartum hemorrhage</td>
<td><strong>Basic EmOC (BEmOC/PONED)</strong></td>
</tr>
<tr>
<td>• Post-partum hemorrhage</td>
<td>1. Injectable oxytocyn drugs</td>
</tr>
<tr>
<td>• Prolonged/obstructed labour</td>
<td>2. Injectable antibiotics</td>
</tr>
<tr>
<td>• Puerperal sepsis</td>
<td>3. Injectable anticonvulsants</td>
</tr>
<tr>
<td>• Pre-eclampsia/Eclampsia</td>
<td>4. Manual removal of placenta</td>
</tr>
<tr>
<td>• Ruptured uterus</td>
<td>5. Removal of retained products (e.g. MVA)</td>
</tr>
<tr>
<td>• Abortion complications</td>
<td>6. Assisted vaginal delivery (e.g. vacuum extraction)</td>
</tr>
<tr>
<td>• Ectopic pregnancy</td>
<td></td>
</tr>
<tr>
<td>• Retained placenta</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Comprehensive EmOC (CEmOC/PONEK)</strong></td>
</tr>
<tr>
<td></td>
<td>All the BEmOC functions (1-6 plus):</td>
</tr>
<tr>
<td></td>
<td>7. Blood transfusion</td>
</tr>
<tr>
<td></td>
<td>8. Caesarean section</td>
</tr>
</tbody>
</table>

The quality of care provided by PONEK or non-PONEK district hospitals remains a question. Not all PONEK hospitals have complete facilities, such as an HCU (high-care unit), so that they cannot fully function as PONEK hospitals. In many government district hospitals, only one OB-GYN specialist is available.

Since the implementation of Jampersal, the number of patients has increased sharply. This has raised some issues. One is that the load of the hospitals has increased which is not adjusted in advance with the capacity of the hospitals. The increase is not only for complicated but also for normal deliveries. The fact that in Central Java 83% of maternal deaths happened in hospitals raises some concerns. One argument is that the cases when came to the hospital were already in terminal stage, while others argued that the services in the hospitals were not quick and adequate. Both arguments are possible and valid. Information from RAD (Rencana Aksi Daerah) (2010-2014) provides a different scenario, most of the deaths happened at the community and enroute to the hospital. Higher death rates in the hospitals indicate the poor quality of care in the hospitals, while deaths in the community indicate lack of good decision making and timely and effective referral. Many studies, in Indonesia and other countries, showed that delays and ineffective actions happened in different levels, in the community during decision making for
Unlike MMR, the indicator for universal coverage of deliveries by a skilled birth attendant (SBAs) was very high (Figure 25) all over Central Java. Almost all births were attended by a SBAs in all districts/cities. This is a high-impact intervention that is likely to lead to a better MMR; however, the success at this level will not result in maternal survival unless the mother receives adequate care when the complication occurs.

**DELIVERY ASSISTED BY SKILLED BIRTH ATTENDANTS**

Overall, there are only two functions covered by the PONEK Hospital facility that is not provided by a Puskesmas PONED, which includes blood transfusion and caesarean section. These services can only be provided by an OB-GYN specialist. These differences are relevant to determine the specific needs for the implementation of priority interventions, which will then affect in the identification of bottlenecks/constrains.

**FIGURE 25:** DELIVERY ASSISTED BY SKILLED BIRTH ATTENDANTS BY DISTRICT/CITY, CENTRAL JAVA, 2011

Source: Central Java Provincial Health Office (PHO), 2011
Figure 26 shows that there is no relationship between skilled birth attendance and the indicative MMR. This suggests that skilled birth attendance alone cannot reduce MMR.

**FIGURE 26: ‘INDICATIVE’ MMR AND SKILLED BIRTH ATTENDANTS BY DISTRICT/CITY, CENTRAL JAVA, 2010**


**FIGURE 27: ANC AND SBA OF PREGNANCY-RELATED CASES OF DEATH AND WOMEN WITH BIRTHS FOR THE LAST TWO YEARS, SERANG AND PANDEGLANG DISTRICTS, BANTEN PROVINCE, 2004-2005**

Source: Qomariyah, 2006
3.2 IMPROVE ACCESS TO QUALITY PRIMARY LEVEL HEALTH CARE SERVICES AT THE COMMUNITY LEVEL

ANTENATAL VISIT (K4)

It is commonly assumed that high skilled birth attendance as well as ANC are related to lower MMR. However, in Central Java the correlation was not shown. While the skilled birth attendance (Figure 11) and ANC (Figure 15) were very high – almost universal across districts/cities – the MMR varies, meaning that high-skilled birth attendance and ANC are not always associated with lower MMR. These three reasons, individually or in combination, can explain these inconsistencies. First, ANC was not effective in promoting birth preparedness and emergency readiness to avert maternal deaths. Second, the services provided by the birth attendants were perhaps not adequate or the referral was not successful. Third, assuming that promotion through ANC was effective and the quality of care provided by birth attendants was adequate and the referral was timely and effective, an endangered mother’s life cannot be saved if the care at the referral hospital is not adequate. This situation indicates the need for a continuation of care to save an endangered mother’s life.

K4 refers to pregnant women who have had four standard ANC visits by trimester, and received 5 Ts services (weight and height measurement, blood pressure, fundal height, iron folate tablets, tetanus toxoid). Currently, two more ‘T’ services were added to the programme (interpersonal communication and laboratory test (Hb and urine protein) and/or laboratory examination by indication). The coverage of K4 is quite impressive: almost all districts/cities have reached 90% or over, except for a couple of districts/cities.

The ANC programme currently in place provides for all pregnant women to have at least four ANC visits (K4). Data confirms, though, that, despite good ANC coverage for women who received more than four times visit during their pregnancy, ANC could not prevent deaths. This interesting result can possibly be explained by two reasons. One is that the ANC is not effective in advocating good practices during pregnancy and delivery, especially regarding birth preparedness and emergency readiness. Anecdotal findings indicate that midwives do not have the right perception about birth preparedness and emergency readiness (BPER), even though it has been implemented through a community level programme called P4K. The problem is compounded by the fact that the midwives also lack community and counselling skills. This issue is very important, because the lack of understanding about the unpredictability of complication and therefore the need for birth preparedness and emergency readiness will lead to a delay in getting the right care.

The other possible explanation is that the quality of services is not matched with access to the services. While we do not have clear data on the quality of care provided by the programme, it is widely admitted that the clinical competence of many midwives is questionable as the result of a ‘crash’ approach of the midwife training programme to meet the universal coverage of deliveries by skilled attendants by placing a trained midwife in each village. This is the time when more than 54,000 midwives were trained in about six years in the early 1990s. In many
cases, the midwives graduated with insufficient experience in delivering even normal births and moreover did not have opportunity to see complications, including complications that emerge during pregnancy. It is understandable that during ANC the midwives may not be able to deliver the right messages to the women about potential complications – for example hemorrhage during pregnancy, blurred vision, etc. – and cannot take the correct action to prevent the complication.

In many cases, the focus of ANC is more on the achievement of K4 coverage and less on the quality of the visits. For example, despite the fact that one ANC programme gives pregnant women at least 90 tablets to be taken one tablet daily during pregnancy in the first trimester to reduce anemia, current national survey data (Depkes, 2010) showed that only 18 percent of pregnant women consumed 90 tablets or more during their pregnancy.

Good care at community and primary care level (Pos Kesehatan Desa/PKD, Puskesmas and Puskesmas PONED) will ensure that most of the complicated cases will either be prevented or identified early so that women can receive adequate first aid and be referred effectively.

Access to a midwife for delivery care seems to be already very good. This explains why the largest share of deliveries is attended by health providers. Among the total of 11,409 Bidan, 9,004 were Bidan Desa. Most of the Bidan Desa stayed in the village, and these numbers are larger than the number of villages in Central Java. It is interesting to see that, despite the large number of midwives, the number of Traditional Birth Attendants (TBAs) is still very high: 1.43 times more than those Bidan who live in villages. It is understood that almost all TBAs work in partnership.

**Figure 28:**

<table>
<thead>
<tr>
<th></th>
<th>Total midwives</th>
<th>Total villages</th>
<th>Village midwives</th>
<th>Midwives reside in the village</th>
<th>Total TBAs</th>
<th>TBA with partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11,409</td>
<td>8643</td>
<td>9,004</td>
<td>8,063</td>
<td>12,941</td>
<td>12,119</td>
</tr>
</tbody>
</table>

Source: Central Java PHQ, 2011
In 2011, all deliveries were attended by a health provider. There is small variation in the achievement of birth attendance by a health provider among districts/cities. All districts/cities have achieved more than 90 percent attendance by health providers, being the lowest in Boyolali district and the highest in Pekalongan district.

Post-partum visits KF1, KF2 and KF3 are already around 90 percent at provincial level and vary from one district/city to another. KF is defined as a post-partum visit between the first six hours up to 42 days post-partum in accordance with standards to give care for post-partum mothers and the neo-natal. KF1 is the first, KF 2 is the second and KF 3 is the third visit. So KF3 is the cumulative of three visits, post-partum. High post-partum visits supposedly can contribute to a reduction of maternal death post-partum, as most of the deaths (46 percent) happen in the post-partum period.

Source: Central Java PHO, 2011

HUMAN RESOURCES: MIDWIVES

Among 11,409 midwives, slightly more than one half (6,012) have received APN (Asuhan Persalinan Normal) training. The APN training covers normal delivery care with specific focus on the active management of the third stage of labor, the use of partograph, infection prevention, neo-natal resuscitation, newborn care, and the manual removal of placenta. Eighty percent of total Bidan Desa have Bidan’s Kit (midwife kits).
HUMAN RESOURCES: MIDWIVES

Among 11,409 midwives, slightly more than one half (6,012) have received APN (Asuhan Persalinan Normal) training. The APN training covers normal delivery care with specific focus on the active management of the third stage of labor, the use of partograph, infection prevention, neo-natal resuscitation, newborn care, and the manual removal of placenta. Eighty percent of total Bidan Desa have Bidan’s Kit (midwife kits).

Of all midwives, 2,475 have received GDON (Gawat Darurat Obstetri and neo-natal) training. The components of GDON (emergency obstetric and neo-natal) training include partograph, clinical management of emergency obstetric, abortus management, post-partum haemorrhage, pre- and eclampsia, distocya, post-partum infection, asphyxia, low birth weight, hypothermia, hyperbilirubinemia, neo-natal infection, and icteric.

We can assume that at least half of the midwives can function well in the village, because most of them have Bidan’s Kit and live in the village, and half of them have been trained in APN. IBI, the Indonesia Midwifery Association, has launched a programme called Bidan Delima that ensures the professionalism of its members in providing quality services to clients in accordance with standards. A Bidan Delima is required to fulfill not only clinical competence, but also competence with equipment and drugs and other aspects related to their professional care. In Central Java, about 30 percent of the midwives are Bidan Delima. This is quite impressive and could reduce the incidence of maternal deaths.

Central Java Province has applied a policy for delivery called “pertolongan empat tangan” or “four-hands care”, which indicates that every midwife has to be in partnership with another midwife while attending a birth. The benefits of this policy to the midwives include boosting the confidence of midwives to make decisions and deliver the services required, improving and transferring knowledge between the two midwives, sharing equipment and drugs, and convincing the community of the value of the services provided.

3.3 STRENGTHEN A QUALITY REFERRAL SYSTEM

REFERRAL SYSTEM

The pathway to maternal survival has to be linked with an effective referral between the service at the community/primary level of care and the referral hospital. Therefore, a good referral system will ensure that all complications referred will reach the designated hospital in a timely manner.

In the Central Java Provincial Action Plan, there is a plan to increase access to services through regionalization of the maternal and neo-natal referral system in district/city. The existing referral system that is used for guidance is indicated below.
In addition, currently there is an effort at the provincial level to strengthen the referral system through mapping the referral process pathway from PKD – Puskesmas – PONED – PONEK.

Source: Central Java PHO, 2011
Related to the mapping, eight districts/cities were visited by the PHO team in 2011 to coordinate the PONED-PONEK referral system. Three of the districts have finished the mapping.

On the other hand, there is an effort in Kebumen District to improve the quality of the referral system through a Memorandum of Understanding between a 24-hour PONEK hospital and the ‘PONED – PONEK’ referral system with nine hospitals/maternity hospitals, including the district hospital and the District Health Office. One issue, among others, that has been agreed upon is the division of the role and responsibilities for each hospital. The District Health Office has also developed an agreement with retired OB-GYN specialists to continue giving obstetric services.

In Tegal, since last December 2011, there has been a process for developing referral guidelines. Data from Dr. Kariadi Hospital showed that 70.96 percent of deliveries with C-section came from Semarang City, 3.7 percent from Semarang District, and the rest from other districts, for example, 17.1 percent from Demak District. The pattern is similar with normal delivery: most of the respondents (81.1 percent) were from Semarang City and 13.2 percent were from Demak.

Figure 32 indicates methods of delivery by referral and non-referral cases, by Jampersal status among operative and non-operative cases.

**Figure 32:** Method of Delivery by Referral and Non-Referral Cases, Karyadi Hospital 2011 (N=3386)

Source: Dr. Kariadi Hospital, 2012
FACILITY-BASED DELIVERY

Consensus among the medical community indicates that facility-based delivery will be more beneficial for a mother’s survival. Delivery in a facility will put a mother in a better situation for several reasons. First, the unpredictability of complication demands that a mother should have timely access to a skilled provider; if complications arise, a quick decision to stabilize the mother’s vital condition and to refer her can be obtained. Second, a facility has more resources, e.g., equipment, drugs, human resources, than just a birth attendant working alone in a village/village health post (PKD). Third, usually in a facility there is more than one health staff member who can support the birth attendant in different ways while the birth attendant is doing other important tasks, for example monitoring vital signs, so that the mother and the child are being monitored closely. And fourth, usually the location of a facility is closer to a hospital than a PKD/Bidan’s home and might have more readily available transportation such as an ambulance, which expedites the referral. In short, a facility-based delivery will provide mothers with better access to the services needed.

The fact that most deaths happened at home or enroute (RAD 2011-2015) suggests that there are problems at community level with decision making and/or referral. Applying facility-based delivery will remove some of the problem, i.e., allow for quicker decision making and referrals.

The proportion of delivery in a health facility is quite high – 80.4 percent for provincial level – but varies between districts/cities from less than 10 percent to 100 percent. However, there is no distinction of the type of facility. Health facilities include Pelayanan Kesehatan Desa (PKD), health centres, PONED health centres, hospitals, etc.

![Figure 33: Proportion of Obstetric Complication Managed by District/City, Central Java, 2011](image)

Source: Central Java PHO, 2011

6. PKD (Pelayanan Kesehatan Desa), which is at village level, is a centre where very limited health services are provided, usually by midwife and/or nurse, while a health centre is at subdistrict level that provides basic health, mostly out-patient, services. Most health centres are served by medical doctors, nurses and midwives. Some health centres have in-patient facilities (for general health conditions).
The survival of a complicated case that arrives at the referred hospital is more likely if the obstetric care in the hospital is effective. This includes a quick response time in the hospital and the provision of quality care. Many complicated cases that arrived at the referral hospital cannot be saved because of one or more reasons, i.e., the mother arrived too late, the response time at the hospital was too long, or the services provided were not of high quality.

Figure 34 shows the estimated time of death after admission. This data cannot represent the exact problem, because the data received is not linked with the cause of deaths. However, in general, it can be assumed that the events leading to a longer time of death after admission to the hospital are likely related to the quality of care in the hospital, while the events leading to a shorter time of death after admission are likely related to late referral with/without quality of care factor.

Information from Tugurejo Hospital in Semarang revealed that the percentage of complications (153) over total deliveries (1,686) is less than 10 percent. It seems that the number of post-abortion cases in Tugurejo Hospital is quite high (428). Both situations should lead to more attention and clarification, for example, about why the proportion of complicated cases is small and why abortion is high.

About 64 percent of the deliveries there were referred. Two thirds of the deliveries used the Jampersal scheme, and, among Jampersal cases, around 75 percent were referred and one third of deliveries were normal deliveries.

The proportion of C-sections in this hospital is high – around 40 percent – with 68.1 percent of them being Jampersal cases.

**Figure 34:**

**TIME OF DEATH AFTER ADMISSION - MATERNAL CASES OF DEATHS AT HOSPITAL, CENTRAL JAVA, 2011**

Source: Central Java PHO, 2011

Data from Dr. Kariadi Hospital in Semarang (a central hospital) showed that, of 3,386 deliveries in 2011, only 31.2 percent were normal deliveries. This can be expected, because Kariadi Hospital is the top referral hospital for Central Java Province.
3.4 IMPROVE ACCESS TO QUALITY FAMILY PLANNING (FP) AND REPRODUCTIVE HEALTH SERVICES

AGE BRACKET

Further analysis of the MMR revealed that, of the 668 maternal deaths in 2011 in Central Java, 69 percent were among those aged 20 to 35 years, 25 percent among those aged 35 years or older, and 6 percent among those aged less than 20 years.

However, this should not be interpreted to mean that the risk of dying was the highest among women aged 20 to 35 years, but rather that the proportion of pregnant women of this age group is the highest. An example from a rigorous study of 474 maternal deaths in two districts in Banten Province (Qomariyah et al., 2006) showed that those who are at higher risk of dying were women aged less than 20 years or those aged 40 years or older, even though almost half of the deaths were among women aged 20 to 29 years. The mean age of marriage among women in Central Java is 22.1 years, while the proportion of women marrying for the first time before 20 years of age is small at 2.2 percent (BPS, 2010). This means that, even though the risk of dying is higher among those who are too young and too old, the attention paid to those aged 20 to 35 years should be significant because the proportion of this age group is large.

CONTRACEPTIVE PREVALENCE RATE

Currently, the contraceptive prevalence rate (CPR) for Central Java is 79.3 percent, which is over the MDG target of 70 percent. All districts and cities have reached the target. It is important to maintain and even increase this achievement, but it is as important that other indicators for MDG 5B be achieved to attain the overall goal of MDG 5, because CPR does not stand alone in contributing to the goal achievement.
FIGURE 36: MMR BY AGE GROUP IN 2004-2005, SERANG AND PANDEGLANG DISTRICTS, BANTEN PROVINCE,

![Graph showing MMR by age group in Serang and Pandeglang districts, Banten Province, Indonesia.](image)

*Source: Qomariyah, 2006*

FIGURE 37: CONTRACEPTIVE PREVALENCE RATE BY DISTRICT/CITY, CENTRAL JAVA, 2011

![Bar chart showing contraceptive prevalence rate by district/city in Central Java, Indonesia.](image)

*Source: Central Java Provincial BKKBN, 2011*
UNMET NEED FOR FAMILY PLANNING

The unmet need for family planning is 11.59 percent, with quite a wide variation among districts/cities. This position is still very high for the 4.1 percent target to be attained. Much more effort is needed to achieve the target, especially among those districts with a very high rate. Indeed, fifteen districts/cities have rates that are higher than the provincial rate.

FIGURE 38: CONTRACEPTIVE PREVALENCE RATE BY DISTRICT/CITY, CENTRAL JAVA, 2011

Source: Central Java Provincial BKKBN, 2011

ADOLESCENCE PREGNANCY

Adolescence pregnancy and delivery are related to a higher risk of maternal and neonatal morbidity and mortality. This is the age at which a girl is still growing physically and experiencing mental development, and in many cases experiencing emotional stress. Pregnancy will put the girl in competition with her baby in developing, thereby adding emotional burden. The number of adolescence deliveries (15 to 19 years) in Central Java province in 2010 was 25.3 per 1,000 women and currently is 24.8 percent. It is likely that the target of 22.9 per 1,000 women can be achieved by 2015.
IV. IDENTIFYING AND PRIORITIZING BOTTLENECKS IMPEDING PROGRESS OF MATERNAL HEALTH INTERVENTIONS IN CENTRAL JAVA
To identify and prioritize barriers impeding the success of maternal health intervention, a bottleneck analysis was conducted. A bottleneck analysis is a systematic and focused approach to assess and identify the bottlenecks that slow down the interventions to performing effectively. A bottleneck analysis should be able to answer several essential questions concerning the constraints in the implementation of a programme/intervention that work better in other settings or other areas such as in other countries, or between national and regional/local levels within a country. The analysis should also assess whether there are disparities among the beneficiaries of the interventions and, if so, why.

It is acknowledged that health problems are the result of many factors and not of the health sector alone. The important role of many non-health factors on the performance of the health care system has been proven and accepted. The bottleneck analysis conducted in Central Java therefore prioritizes four specific categories: policy and planning, budget and financing, service delivery (supply side), and service utilization (demand side), as well as cross-cutting issues.

1. Policy and planning: The areas of assessment include the existence and adequacy of strategies to achieve MDG 5, and how the strategies are supported or not supported by sector policies and plans, regulations, standards, and guidelines, and the legal aspect of the implementation of the strategies, which can influence effective implementation of the strategies.

2. Budget and financing: It is obvious that the implementation of strategies is very much dependant on budget and financing schemes and implementation. The assessment of this aspect covered the amount of the central and local budgets allocated for MDG 5 achievement, the expenditure and the disbursement, as well as the policy related to the scheme.

3. Service delivery (supply side): Accessibility and affordability of quality health services are essential components. The assessment therefore covered elements that will influence the coverage and the quality of the services, which include the availability of human resources and their quality in providing the care, the supplies and logistics, the management/organizational system in the facilities, as well as the payment system for the staff and for the patients.

4. Service utilization (demand side): Low use of health services is the combined result of low accessibility and low demand from users, which can be caused by poor quality of services. Hence, information on potential causes for low demand from the users was assessed, for example, level of education, geographical difficulties, and the availability of information regarding health services to users.

5. Cross-cutting bottlenecks: Because health problems are multi-programme and multi-sectoral, an integrated and coordinated effort is needed. Therefore, cross-cutting issues were also assessed, for example, the coordination between public and private health sectors and the Marriage Law of 1974 regarding the minimum age of marriage for a woman.
The UN system and the World Bank have been active in helping address maternal health issues in Indonesia, focusing on improving access and quality, against a backdrop of extensive decentralization. Many of the priorities and concrete actions identified in the MAF Central Java Action Plan (see Table 8) are active areas of work for the agencies, as illustrated below.

Enhancing human resources: Although midwives have been deployed in many villages, their training is often inadequate, and they may not be present at their assigned locations. Maintaining internationally accepted standards at training institutions, and helping deliver effective pre-service and in-service training is critical not just for midwives but for other health professionals as well. At the same time, improving the capacity for supervising and managing human resources efficiently at all levels is needed, as is clarifying accountability and empowerment. For example, nurses and midwives need clear authority for the curative services they provide. Apart from medical staff, others such as community health volunteers who can help mobilize demand while assisting with service delivery also need training and operational support to expand the reach of the frontline providers.

Improving service quality: While human resources are an essential element for quality services, several other factors contribute as well. Scaling up BEmONC and CEmONC through PusKesMas and district hospitals require supplies and equipment, maintaining standards of service, and ensuring accreditation based on technical and administrative criteria. Similar considerations would apply to family planning services as well. In addition, effective and clear referral pathways are needed.

Facilitating access: Indonesia has an array of social assistance programs that are geared towards reducing financial barriers to accessing quality maternal health care. At the national level, the most prominent are SJSN (Sistem Jaminan Sosial Nasional); JAMKESMAS (as the replacement for ASKESKIN); JAMPERSAL; and BOK (Bantuan Operasional Kesehatan); while many more are provided by local governments. However, implementation challenges and inadequate benefit levels remain an enduring challenge. Collectively, these programs have the potential to complement one another, but more can be done to maximize their impact and ensure appropriate coverage, especially of the most vulnerable. CSO partners can also assist in actively bringing services to traditionally marginalized groups such as youth in prison, indigenous populations, those living with HIV/AIDS and others.

Enhancing coordination between different levels of government: Considerable gains are possible through better coordination across levels, and across ministries. In some cases, national and sub-national priorities may not be completely aligned. For instance, access to family planning services, for both married couples and others, was adversely impacted following decentralization when it was de-prioritized by decision makers at many sub-national locations. Improving the management of public finances, for example the timing of financial flows from the centre to provinces and districts, would help implementation. Other ministries such as BAPPENAS, the Ministry of Home Affairs and those of Education and Culture have crucial roles to play in resolving coordination and demand side bottlenecks, and providing a coherent response to challenges.

Data and evidence to improve decision making: Lack of a comprehensive vital registration system with causes of deaths in the country means that these data are neither complete nor representative. Additional data collection exercises through well trained workers are needed, with an emphasis on ensuring quality and representativeness. Such data needs to be made available in time to be useful for district planning. Further, well-designed and objective analysis of the data can lead to significant improvements in the impacts of existing and new interventions such as Jampersal and Jamkesnas.

8. Given the size and diversity of the country, different regions will have additional priorities or challenges, but the ones captured here appear to be common across the country.
The results of the Bottleneck Assessment

While public policy for maternal health is relatively well focused, outcomes in the main areas of intervention are still insufficient. Some of the key challenges facing Central Java and many other regions in Indonesia are:

1. **Service facilities are** not yet universal and, in some places where they exist, they are **inadequately staffed**. In addition, staff is sometimes insufficiently trained and sometimes lacks necessary materials, medicines and blood supplies to handle obstetric emergencies. This is especially so in remote and poor areas, where risks related to pregnancy and childbirth are particularly high.

2. While births are increasingly attended by **midwives**, they are still insufficient in numbers, distribution and quality. Where the number of midwives is inadequate, communities come to depend on traditional birth attendants (TBAs), often with fatal consequences.

3. **Community motivation and mobilization** are particularly important tools in an environment of uncertain service provision, where affordability and education are low and where cultural factors may constrain demand. Conventional intervention strategies may also not be sufficient for all circumstances, if one considers the potential diversity of situations in Indonesia.

4. **Low contraceptive prevalence rate and the high unmet need of family planning are major challenges** generating a series of contributing factors to maternal mortality and point to weak family planning as an important driver of maternal mortality.

5. **The system for recording causes of maternal deaths is not robust and so estimates of MMR remain uncertain.** Rates are currently obtained mostly from maternal deaths that occur in the hospitals and other facilities; ideally, they should be compiled through civil registration or a population census.

Following is a bottleneck assessment for the prioritized intervention across the proposed categories: policy and planning, budget and financing, service delivery and service utilization.

### 4.1 POLICY AND PLANNING

**POLICIES THAT REGULATE DISTRIBUTION OF HEALTH PROVIDERS AND FACILITIES ARE NOT EFFECTIVE**

To increase access to primary care, there are two policies laid down by the government: the placement of a midwife in each village since early 1990s and the establishment of at least four Basic Emergency Obstetric Care (PONED) facilities in each district. In spite of these efforts, some problems remain.

In Central Java each village has a midwife. However, even then, there is no guarantee that the midwife can provide 24-hour services seven days a week (24/7) because the midwife is not always available.

While almost all districts in Central Java have at least 4 PONED facilities, only one third of the PONED facilities can function optimally because they are not furnished with sufficient equipment and supplies. The provision of equipment and supplies for PONED depends on the central

---

9. The rapid expansion of education and training programmes has sometimes resulted in health workers graduating with insufficient skills, especially for work in difficult circumstances where they are most needed.
became the leading institution in providing and expanding the capacity of hospitals to become a training centre for APN, PONED and PONEK training.

**LACK OF POLICY TO MANDATE MIDWIVES TO OBTAIN APN TRAINING**

APN training has been ongoing nationally, but the proportion of those who have been trained in APN is still low. For example, in Central Java, slightly more than 50 percent of the midwives are trained in APN, which is considered relatively high compared to other provinces. While the APN component has been inserted into the D3 (three-year diploma) midwife training curriculum, there is no obligatory national policy for in-service midwives to obtain APN training. The competence of the graduates of the D3 pre-service training itself can vary, although there is already a national standard that needs to be followed. Current law under the Ministry of Education and Culture (Undang-undang Sisdiknas) No. 20 from 2003 on campus autonomy allows the institution to have local variations in addition to the national standard (only a certain proportion of the curriculum standards are determined nationally), which can lead to variations in the competence of the health providers, including that of midwives.

**LACK OF A POLICY TO COMMIT STAFF TO STAY AFTER GRADUATION**

To ensure that the PONED team can be coherent, there needs to be a policy for those who have been trained in PONED to stay for a certain period of time, e.g., two years. This issue is raised because, in some cases, the member is rotated/promoted to another position. Other issues raised were the clarity of midwives' authority to perform certain services and the authority of PONED facilities to carry out the services. It is felt that PONED facilities' provision of services needs
Another example of a potential problem in HIS is the figure on maternal death cases by age. Unlike other findings, those who are 20 to 35 years old are at higher risk for maternal death than those who are younger than 20 or older than 35; indeed, the risk is more than 2.5 times greater.

4.2 BUDGET AND FINANCING

LOCAL BUDGET FOR MATERNAL HEALTH PROGRAMME IS NOT SUFFICIENT

The budget for service programmes at the referral hospital level is the largest, and the increase of the budget from 2011 to 2015 is significant. For example, the budget allocation for the Health Effort Programme increased from 497 million rupiah in 2011 to 231,708 billion rupiah in 2012. It is expected to continue rising to 346,775 billion rupiah by 2015. This budget also comes from APBN.

However, in general, the budget allocation from the local government for the Maternal Health Programme is low. The proportion of the central budget as compared to the total province budget is high. For example, the budget for training (APN, PONED and PONEK) as well as its equipment and supplies is allocated in the central budget.

The current central government programme to increase people’s access to health care is the Jampersal (Delivery Care Insurance) Programme (see more details in Annex III). While it is very useful for many people to access health care, especially the poor, the implementation is quite challenging.
First of all, the Jampersal budget is considered as local revenue, therefore, for all government health facilities, all the money will go to the local government unless its status has already become a BLUD (Badan Layanan Umum Daerah) (which has independence in managing financial matters). The money will be reimbursed later, but only a proportion of it. For Puskesmas, at least 75 percent of the money will be given back to Puskesmas and, for hospitals, at most 44 percent will be reimbursed. The disbursement of the compensation to the health facilities takes a long time and the disbursement does not necessarily cover actual costs.

Another challenge that can demotivate the health staff is the local government regulation (PERDA) on staff incentive for delivering the care, especially outside working hours. The rate for service incentive is considered very small by the health care provider. The challenge becomes bigger when the government’s facilities have to compete with private facilities.

**JAMPERSAL PAYMENT FOR HEALTH STAFF SERVICES IS CONSIDERED LOW**

The payment scheme of Jampersal for government health staff is considered low, which is in accordance with PERDA. The incentive scheme is not attractive to PONED staff, especially in delivering services beyond working hours. There are different policies throughout provinces on service fees for village midwives during and beyond working hours. The payment scheme regulation of Jampersal is different among provinces, as, for example, in regards with the definition of facility. In Central Java, PKD and Polindes are considered as facilities, while in others it is not. The incentive for providing the service inside or outside the facility is different, i.e., lower in the facility. Therefore, in one province, the scheme has discouraged facility-based delivery (Puskesmas, PKD, Polindes), while in others it has increased unnecessary hospital-based delivery.

**BUDGET ALLOCATION FOR QUALITY IMPROVEMENT IS NOT YET SYSTEMIC NATIONALLY**

The plan for staff training lacks consistency between different levels of services and with the capacity of facilities. It can be that training is more focused on midwives, but less on PONED or PONEK teams. In other situations, the training of staff is not in line with the improvement of facilities or vice versa. In Central Java, a plan to train the staff in APN, PONED and PONEK has been arranged. However, the budget allocation for APN training will be disbursed mainly in the last two years (2014-2015). With this arrangement, the leverage effect to achieve MDG 5 by 2015 will be small. Budget disbursement for training of PONED teams is not in line with the budget disbursement for its facilities/equipment/supplies. Sometimes, the team has been trained, but the equipment and supplies are not available, and vice versa. Similarly, central budget allocation for pregnant mothers in Central Java will be mostly disbursed in 2014-2015.

**REFERRAL SYSTEM FOR OBSTETRIC CARE: FEE FOR HEALTH PROVIDER AND TRANSPORTATION ARE NOT DEFINED ACROSS DISTRICTS**

For Jampersal cases, the fee for referral transportation is settled, however the fee for a midwife to accompany the patient to the referral facility depends on the regulation of the local government (PERDA), which might vary among province/districts. When there is no fee provided for a midwife, it is possible that the midwife will not accompany the patient. In this case, the monitoring and the stabilization of the patient is compromised, putting the patient at risk of dying.
Local regulations allow limited flexibility on the fees for services, i.e., too small incentives, especially for a rare provider (e.g., OB-GYN and anesthesiologist) who is expected to deliver services beyond working hours. The case is similar with PONED, as there are different units within the health office dealing with human resources and facilities/equipment/supplies, and budget disbursement for training of human resources that are not in line with the budget disbursement for facilities/equipment/supplies.

The effort to increase CPR and reduce unmet need and increase access to quality reproductive health is hampered by the small operating budget, even though the availability of FP methods is secured by the central government on the basis of requests from the province and district/municipality levels.

HEALTH INSURANCE COVERAGE FOR MATERNAL HEALTH SERVICES IS NOT DISAGGREGATED

**Figure 39** shows health insurance coverage across the districts/cities in Central Java. It is clear that the proportion of those covered and not covered by insurance is balanced across the districts/cities. When separated between the poor and non-poor, the picture is very different. In most of the districts/cities, all poor people were covered by a health insurance (Figure 40). However, there is no information currently on the type of health insurance coverage, so it is not possible to distinguish the proportion of maternal and neonatal health covered by insurance.
FIGURE 40: COVERAGE OF HEALTH CARE INSURANCE FOR THE POOR BY DISTRICT/CITY, CENTRAL JAV A, 2010

Source: Central Java PHO, 2011

FIGURE 41: THE COVERAGE OF HEALTH CARE INSURANCE FOR NON-POOR BY DISTRICT/CITY, CENTRAL JAV A, 2010

Source: Central Java PHO, 2011
The coverage of health insurance among the non-poor, as expected, is low (21.59 percent for the Province). No information can be obtained from five districts/cities among 35 districts/cities. In eight districts/cities, the coverage of health insurance is one third or more. In Rembang district, the coverage is 100 percent. This is because there is ‘Asuransi Rembang Sehat’ or Healthy Rembang Insurance provided by the local government.

4.3 SERVICE DELIVERY

Most obstetric complications are unpredictable but can be either prevented or managed if they are identified early and receive timely and adequate treatment. Some complications need to be managed in a few hours, some within 12 hours and some in a longer time period. For that reason, the availability of quality 24/7 services at different levels of services is very important. In the case of Central Java, which is likely to be similar nationwide, the availability of quality 24/7 services at all levels is lacking. This leads to missed opportunities for lives to be saved.

INCREASE ACCESS TO QUALITY CARE AT COMMUNITY/PRIMARY CARE LEVEL: HUMAN RESOURCES, INSUFFICIENT FACILITIES/EQUIPMENT/SUPPLIES AND QUALITY OF CARE

Lack of human resources, insufficient facilities/equipment/supplies and quality of care have hindered the provision of a continuum of obstetric care, which is also likely nationwide. In Central Java, only half of the midwives are trained in APN and only around one-fifth are trained in emergency obstetric and neo-natal care. The PONED facilities, which are supposed to be able to manage mild complications, only function in one third of them. Quite a large proportion of PONEK and district hospitals cannot function 24/7 because either there is no or only a limited number of OB-GYN specialists, there are insufficient facilities/equipment/supplies, or services are of a sub-standard quality.

EFFORT TO ASSURE QUALITY OF CARE IS NOT INTEGRATED BETWEEN PROGRAMME AND ACROSS SECTORS

Questions about the quality of care concern not only human resources but also facilities/equipment/supplies. In regards to the human resources, questions about quality are not only about clinical skills per se, but also about the skills of the health providers to convey health messages to patients effectively. Information from Central Java indicates some ineffectiveness in providing messages to patients. Examples include delays in referring the case to the hospital or poor understanding of P4K messages about how to be prepared for births and ready to anticipate complications.

One programme to empower pregnant women to have a healthy pregnancy is the Pregnant Women Class Programme (Kelas Ibu Hamil). However, the programme is limited in two areas: 1) how to empower women to make their own decisions related to pregnancy and service delivery; and 2) how the unpredictability of obstetric complications requires having a skilled health provider to enable early identification of complications and to refer the case effectively (timely and stabilized).

PONED TEAM IS NOT ADEQUATELY EMPOWERED TO PROVIDE SERVICES

PONED training does not include APN training. Therefore, some doctors complain of not having the same knowledge and skills regarding APN as midwives. Regarding the provision of services, the PONED team is not confident because there
is uncertainty on whether what they are doing is protected by law/regulation. In addition, PONED is not always well equipped, e.g., there is broken equipment or antidote for MgSO4 is unavailable. These are the reasons, among others, that they do not promote PONED services aggressively. Technical assistance and supervision of PONED by the PONEK Team has not been settled.

**REFERRAL SYSTEM: CLEAR GUIDELINES ON REFERRAL IMPLEMENTATION**

In general, it is recognized that the referral mechanism is from community-level health care to primary health care (Puskesmas/PONED facility and to the referral hospital level, with possible direct referral from midwife in the community to the hospital for complicated cases). However, there is a lack of clear guidelines to implement the referral system. Examples includes cases in which the district hospital has no OB-GYN specialist available, no more beds, or no blood, or there are no guidelines about how the lower level facility should receive information in advance and what other hospital to go to and whether the alternative hospital can even accept the patient.

The guidelines are important, particularly because many district hospitals in Indonesia do not have 24/7 services, mostly because of a lack of human resources (e.g., OB-GYN). The guidelines are also important to include private facilities and private practice doctors and midwives in the referral system.

**IMPROVE ACCESS TO QUALITY EMERGENCY OBSTETRIC CARE (PONEK): DISTRIBUTION OF HEALTH PROVIDERS AND THE SKILLS OF THE HEALTH PROVIDERS.**

To increase access to emergency obstetric care, the government dictated that each district must have at least an OB-GYN specialist. To improve the services, the government could opt to upgrade the district hospital to become a PONEK (Comprehensive Emergency Obstetric and Neonatal Care) hospital. The budget for upgrading the hospital mainly comes from central level. Nationally, not all district/ municipality hospitals are PONEK hospitals, as in the case in Central Java. The establishment of PONEK hospital needs not only human resources (and training of them), but also facilities, equipment and supplies. There are different responsible units that provide human resources including staff training and a unit that is responsible for equipment and supplies procurement. This clearly requires better coordination.

The availability of 24/7 services is also lacking, mostly because of the availability of human resources. Not all districts hospitals (PONEK or non-PONEK) have an OB-GYN specialist currently; for example, in Central Java, around 40 percent of district hospitals do not have one. The 24/7 availability of emergency obstetric services is lacking due to: 1) only one OB-GYN specialist being available in the government hospital; 2) no OB-GYN resident working in the government hospital to assist; and 3) no use of or agreement with private hospitals/clinics to provide EmOC in the government hospital. The policy to place an OB-GYN specialist in each district hospital was decided by the local government and apparently this policy has not been adhered to by all districts.

The most direct cause of maternal death in Indonesia is hemorrhage, while in Central Java it is the second most frequent. Regarding the availability of blood for transfusion, in general this is a problem at national level, although in some provinces such as Central Java, all district hospitals have their own blood transfusion units. In Central Java, the coordination between the hospitals and PMI (Indonesia Red Cross) is good, which may not be the case in other provinces.
30 percent to 50 percent of newborn deliveries in health facilities now take place in private clinics (as compared to approximately 10 percent a decade ago). Preference for private sector services may be due, in part, to understaffing of public health facilities, and high absenteeism. The government allows ‘dual practice’ whereby civil servant health providers are allowed to establish a private practice outside of official work hours. As a result, studies show an average of 40 percent of doctors absent from their public post during work hours.

INCREASE CPR AND REDUCE UNMET NEED AND INCREASE ACCESS TO QUALITY REPRODUCTIVE HEALTH: SMALL OPERATIONAL BUDGET AND INSUFFICIENT NUMBER OF FPFW

Because the operational budget for the family planning programme is small, as the case in Central Java, the mobilization of FP acceptors is limited and has to be integrated with other programmes and sectors (e.g., Army, Health, Education, and Religion Offices). On the other hand, the number of Family Planning Field Workers (FPFWs) is much smaller than before. The ideal situation is one FPFW per village, while the current situation is one FPFW for every four to five villages. It is problematic for the province to reduce its unmet need rate by more than one half by 2015. The overload burden is compounded by the demand for good counseling skills of the FPFWs to achieve such target, which is also lacking.

GOVERNMENT SPENDING ON HEALTH DOES NOT BENEFIT THE POOREST

Overall, per capita spending on health in Indonesia is much lower than in other countries in the region, and insurance coverage is limited. Health financing is overwhelmingly private, with individuals paying for around 80 percent of all health outlays, mostly out of pocket. Disturbingly,
the poor utilize fewer publicly-funded health services provided by the state: the poorest 20 percent of the population captures less than 10 percent of total public health subsidies, while the richest one fifth captures almost 40 percent. Policy analysts also point to added problems to health financing caused by inadequate distributions in health funding among provinces, and major inefficiencies in how funds are spent.

LACK OF FISCAL CLARITY AND RESPONSIBILITIES DUE TO DECENTRALIZATION

Concerns surrounding Indonesia’s decentralization policy are centered on the lack of legal and fiscal clarity to support its implementation at the provincial level. On the fiscal side, most local governments are highly dependent on transfers from the central government. The tight fiscal situation leaves little room to initiate programmes for development, although programmes in the health and education sectors have increased over the last few years. Furthermore, the importance of the provincial governments’ roles and functions is not clearly elaborated in the decentralization laws (Law No. 32/2004 and Law No. 33/2004). This jeopardizes the planning, budgeting, and monitoring processes that will have direct consequences on the way public services are administered by local governments. Moreover, although the provincial governments have no clear functions, the national government needs them to undertake a range of national government functions.

Actual governmental functions remain unclear. It is not yet clear whether functions of policy making, monitoring, and implementation should be divided or shared, nor is it apparent to whom the local governments should be accountable. Provinces do not have administrative power over the districts/municipalities, the latter are not answerable to the former and, hence, this renders monitoring difficult. This resulted in the lack of provincial financial power over the districts/municipalities.

Government health spending also occurs in the context of Indonesia’s rapid decentralization of government services, whereby local government is now the focal point for providing health care. Decentralization was meant to bring those responsible for health services closer to their constituents. In reality, districts’ limited financial resources are extremely constraining. In another recent example from East Java, advocates from one district were elated when their legislature passed a 2009 operating budget that quadrupled the allocation for maternal and child health. But upon delving deeper, their jubilation may have been premature: even at four times the amount of funding allocated, per capita spending on maternal and child health was a mere 13 cents per capita.

DIFFICULTY IN ACCESSING EMERGENCY OBSTETRIC CARE

The many challenges of health financing and governance are compounded by policies that keep the health system from effectively addressing leading causes of maternal death. While Indonesia’s village midwife strategy significantly increased the number of deliveries attended by a midwife, and in so doing addressed many preventable causes of maternal death, emergency obstetric care is still difficult to access and often poor in quality. Of the 15,000 Indonesian women who die from pregnancy-related causes annually, most deaths are now related to unpreventable conditions that require access to emergency care. Yet around half of Indonesian women deliver at home – and delays during maternal emergencies that prevent women from accessing emergency care are well documented. Clearly, Indonesia needs to adjust
its policies to encourage women to make the transition to delivering in health facilities where emergency care is easy to access.

**DATA FOR MONITORING MATERNAL DEATHS IS SOMETIMES INACCURATE**

Finally, there is the challenge of getting an accurate measurement of maternal mortality rates. Without this, it is hard to target public policies in a way that benefits the mostly marginalized people. As in other countries, measuring maternal mortality is difficult. Vital registration systems are not functioning and estimates provided by population-based surveys may not be accurate, because many maternal deaths are misclassified and attributed to non-maternal causes. The most credible population-based survey in Indonesia, the Demographic Health Survey (DHS), has documented a declining trend in maternal mortality. The DHS recorded 307 deaths per 100,000 live births from 2000 to 2004. During 2004 to 2008, the survey recorded 228 such deaths.

**QUALITY SERVICES AT PONED FACILITIES**

80.45 percent of a total of 590,921 deliveries were delivered in facilities (Dinkes Jateng, 2011). However, the data does not differentiate among hospital, Puskesmas and other health facilities. All Puskesmas have a doctor. A total of 1,972 doctors work in 869 puskesmas.

The function of Puskesmas PONED needs to be improved; even though almost all districts/cities in Central Java have four Puskesmas PONED, less than one third can function optimally. The proportion of Puskesmas with beds that have the capacity to provide Basic EmOC (PONED) services is only 31.1 percent (Central Java Government, 2011). Several of the Puskesmas PONED are located in a place that does not meet criteria, for example, located in an urban setting, but the location is near to a hospital or two PONEDs are located close to each other. Not all Puskesmas PONED are equipped with standard equipment and by the end of 2010 not all midwives from Puskesmas PONED had been trained in PONED. Of 229 PONED in Central Java, only 71.9 percent have PONED teams, 55.9 percent PONED have a complete team trained, and only 29.6 percent of them have been equipped completely. An additional problem is staff rotation, including staff who have been PONED staff. Consequently, less than one third of PONED facilities can function optimally.

To ascertain the quality of services, several efforts have been applied. One is technical assistance from PONEK hospitals. However, the technical assistance from the PONEK hospital team to the Puskesmas PONED has not been optimal, for various reasons such as human resources. From discussion with one provincial PONEK team member, it became clear that attempts to optimize the assistance to the Puskesmas PONED have been increased as planned. To improve the function of Puskesmas PONED particularly related to PONEK hospital, the Provincial Health Office (POH) visit districts/cities yearly to strengthen coordination between PONED and PONEK. However, not all districts/cities are visited every year; for example, in 2011, only eight districts were been visited with APBN (Anggaran Pendapatan Belanja Negara - National Revenue and Expenditure Budget) funding, although this number was set to increase to 23 districts/cities in 2012.

Increasing access to services through regionalization of the maternal and neonatal referral system in district/city is among programme/activity being planned in the RAD. There is an attempt to put an OB-GYN specialist as chairperson of the PONED team at district/
city level, with the intention that the PONED team, especially when there is no doctor, can consult and be given instructions from the OB-GYN specialist via phone. Furthermore, a midwife will not be blamed for the action she is taking. However, this effort is limited by the availability of the OB-GYN specialist and his/her acceptance of the position.

LACK OF CLARITY OF MINISTERIAL DECREES ON MIDWIVES’ AUTHORITY

While the national midwife programme certainly enjoyed some initial results, today, Indonesia’s maternal mortality rate remains one of highest in Southeast Asia. Experts closely studying the problem generally conclude that a change in course is needed for Indonesia to make further progress.

The Indonesia Midwifery Association (IBI) has often argued that there is a need to clarify midwife’s authority for conducting certain tasks. The Minister of Health Decree No. 1464/MENKES/PER/X/2010 is perceived by some midwives to be limiting their authority, for example in insertion of IUD. The decree stated that a midwife who is carrying out a government programme may provide injectable contraception, post-partum IUD insertion, and implant. Unclear to them is the meaning of ‘carrying out government’s programme’. Does this authority apply to a private practice midwife? Is it only during working hours? Does a private midwife who holds a MoU with Health Offices have the same authority?

The lack of clarity of midwives’ authority to perform their duties has been discouraging and lowers the confidence of midwives to perform their tasks, and therefore reduces women’s access to obtain family planning services.

HUMAN RESOURCES AND EQUIPMENT FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH CARE IS LIMITED

Type and number of contraceptive methods currently available at province BKKBN seems very limited. The availability of IUD kits is 3,349; gyn beds is 2,150; implant kits is 3,015; vasectomy kits is 356; minilab kits is 172; laparascopy is 97; and laprokator is 72.

Equipment currently available includes: 257 operating facilities; 52 micro-surgery kits; 1,628 sphygmomanometers; 526 counseling kits; 734 sterilisators; and 520 manual needle destroyers.

Referring to Figure 38, the unmet need rate for family planning at present is 11.59 percent, which is still very far from the target of 4.1 percent for 2015. Special effort is needed to achieve the goal, especially for the number of family planning field workers (PLKB/PKB). The number of trained family planning field workers (Family Planning Field Workers/PLKB; Family Planning Counselors/PKB) is 2,046 PKB and 481 PLKB. With the number of villages being 7,810, this means that the ratio of FP field workers per village is one for three to four villages, which is a very high load.

In terms of the quality of the human resources for family planning services, the number of trained family planning field workers who received general basic training (LDU-Latihan Dasar Umum) is 2,184, and the number of those who are not yet trained is 381.

PROPORTION OF ACCREDITED HOSPITAL FACILITIES IS LOW

Accreditation of health facilities can be used as a measure of quality of care, on condition that the criteria used and the procedure applied are valid. Other important aspects of accreditation
are the period of accreditation and the reward and punishment system.

In general, the number of hospitals with standard quality care is still discouraging. The proportion of hospitals that have been accredited in Central Java is low (43.32 percent). And not all of those accredited are completely accredited. Only 18 percent of the hospitals have been accredited for 12 types of services, including providing operation for obstetric complication.

Not all district or PONEK hospitals are well equipped, which hinders optimal provision of services. For example, a high care unit (HCU) that is needed to closely monitor certain cases, such as severe pre-eclampsia/eclampsia, was not available in one of the hospitals visited. A quality assurance mechanism exists, but is not yet systemic. The common quality assurance mechanism is through internal audit and MPA (Maternal Perinatal Audit) activities.

QUALITY ASSURANCE SHOULD BE CONDUCTED MORE FREQUENTLY

The mechanism of quality assurance at community and primary health care levels is conducted through the MPA programme, Puskesmas accreditation, and supervision from the District Health Office (DHO). However, there is still a need to make it stronger and conduct quality assurance more frequently and intensively, and adjust to the new guidelines from the Ministry of Health.

In general, efforts for quality assurance at the hospital level are in place. These include internal audit, internal meeting for obstetry and gynaecology unit, and involvement in MPA programme. A high proportion of hospitals implements MPA activities: 71.9 percent. However, there is no detailed information on the frequency of MPA conducted by each hospital. In addition, the Provincial Health Office implements a technical facilitation programme through direct visits to hospitals to evaluate the services provided.

Nevertheless, the quality assurance programme needs to be improved. For example, there is a lack of clear guidelines on how to assure the quality of services, not only from a clinical aspect but also from a managerial one (e.g., response time, etc.).

4.4 SERVICE UTILIZATION

JAMPERSAL INSURANCE SCHEME IS NOT BROADLY UNDERSTOOD

In terms of the Jampersal programme, a significant rise in the number of patients has increased the burden on hospitals. For example, at Dr. Kariadi Hospital, two thirds of the patients are under the Jampersal scheme and three quarters of them were referred cases. Among C-section cases, two thirds were Jampersal. The increased number of patients is attributable not only to complications, but also to normal and mildly complicated cases. It is not clear whether the staff at the community/primary care level have the ability to recognize complications that should be referred or to manage mild complications.

Probably because Jampersal is quite a new programme, there is still limited understanding of the process. There is concern about the process to get reimbursement, i.e., about the documents required and the time necessary for processing.
LIMITED AVAILABILITY OF QUALITY CARE AT COMMUNITY/PRIMARY CARE LEVEL LEADS TO LOW ATTENDANCE AT PONED FACILITIES

Utilization of PONED services is still low. The incomplete services provided in PONED facilities can and have discouraged the community to use PONED’s services.

LOW COMMUNITY DEMAND FOR OBSTETRIC CARE HEALTH SERVICES

A midwife is still considered a general health provider. Demand from the community to obtain all kinds of health services from village midwives is high, which can burden them. On the other hand, for obstetric matters in some areas, the community seeks initial advice from traditional birth attendants (TBAs). In Central Java, partnership between midwives and TBAs is strongly recommended, as TBAs are not allowed to attend delivery. Therefore, the skilled birth attendance is very high.

WOMAN AT THE VILLAGE LEVEL ARE OFTEN NOT EMPOWERED TO SEEK EMERGENCY OBSTETRIC CARE (PONEK)

To refer a woman with obstetric complications is not straightforward. Decision making is mainly not under women’s authority. In Central Java, husbands and mothers-in-law play great role in making decisions for referral. Another reason for the preference for home delivery is that such births are surrounded by the family.

There is a lack of understanding about the importance of P4K among pregnant women and family. Understanding of birth preparedness and emergency readiness is still lacking. For example, the woman and family are not always financially ready for delivery, which should be part of being prepared for delivery. Therefore, despite the Jampersal programme, they are still reluctant to be referred because they do not have mone.

IMPROVE ACCESS TO QUALITY EMERGENCY OBSTETRIC CARE (PONEK): JAMPERSAL IS NOT ONLY FOR THE POOR

Because Jampersal is not focused only for the poor, there is a possibility (already existent in Central Java) that the utilization of Jampersal will be very high while the adjustment in the hospital capacity has not been made.

UNMET NEED FOR CPR AND ACCESS TO QUALITY REPRODUCTIVE HEALTH IS STILL HIGH

There is a perception among the community that women 35 years or older are no longer fertile. Even though it is anecdotal in Central Java, it is likely that this situation can be found in other parts of Indonesia. Therefore, family planning field workers (FPFW) and health providers should be better instructed to understand what the real needs are.

NON-TECHNICAL ISSUES, SUCH AS LACK OF COMMUNITY EMPOWERMENT, DELAY WOMAN FROM SEEKING SKILLED HEALTH CARE

The fact that most of maternal deaths occurred in the community and on the way to hospital indicate that there is a problem concerning decision making and/or transportation.

The problem of delay is not only technical but also non-technical. Another main problem is the cost. Not all communities fully understand the health insurance scheme, their eligibility, how to use it and the services they can get in a facility. The first step toward appropriate usage of Jampersal consists in providing good information about it to the community.
One programme called *Surveilans Berbasis Masyarakat* (Community-based Surveillance/CBS) aims to provide early detection of the risk factors. However, it should be kept in mind that most obstetric complications are unpredictable. The target in 2011 was implemented in 10 districts/cities and 20 villages. In 2012, it will include another 20 villages from 10 other districts/cities, 18 villages in 9 districts/cities in 2013; by 2014, it is expected to be implemented in 70 villages in 35 districts/cities. The budget comes from APBN allocation.

One activity at community level with potential to reduce the risk of maternal mortality is the P4K programme (*Programme Perencanaan Persalinan dan Pencegahan Komplikasi*). Through this programme, the active involvement of the husband (Suami Siaga) as well as the community in supporting a woman to plan her safe delivery and to be prepared in case of complications can be expected. Almost all villages in the province had implemented the P4K programme by 2011. The P4K programme is also expected to encourage women to obtain adequate ANC, delivery with skilled birth attendants, and information on early initiation of breastfeeding and exclusive breastfeeding up to six months.

In Kebumen district, according to the DHO staff, the collaboration between DHO with other sectors is quite good, including with the subdistrict head (Camat) and PKK. They hold three monthly meetings at the subdistrict level (usually integrated in the Puskesmas Mini Workshop), which is attended by Camat, the head of the village, and PKK. The role of Camat to promote health issues seems very important in some instances, because she or he will be heard by the village heads.

In Tegal district, the scout (*Pramuka*) was also being involved in the P4K programme in villages through a programme called Saka Bakti Husada (health unit in the scout).

**NEED FOR REPRODUCTIVE HEALTH PROGRAMMES TARGETING ADOLESCENTS**

The initiative to include Adolescence Reproductive Health (ARH) in the school curriculum is a good step, not only because it easily reaches young people through school but also only because adolescents will be a good entry point for a lifelong behaviour change.

The province started with three schools in 2010 and three schools in 2011. It planned to add five schools in 2012, 35 schools in 2013, 70 schools in 2014 and 70 schools in 2015. In total, 186 schools will have been reached by 2015 (RAD 2011-2015).

Another programme for adolescents is the empowerment of the family on the growth and development care of the adolescents. The indicator is the number of adolescents’ families who are actively involved in the Adolescents Family Care Activity Group (*Kelompok Kegiatan Bina Keluarga Remaja*). In 2010, as many as 275,841 adolescents’ families were involved. The targets for the next years were 300,090 families in 2011, 303,090 families in 2012, 306,091 families in 2013, 309,092 families in 2014, and 312,093 families in 2015. By 2015, almost 2 million adolescents’ families are expected to be involved (RAD 2011-2015).
TABLE 7. SUMMARY OF BOTTLENECKS PER PRIORITIZED INTERVENTIONS

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Policy</th>
<th>Budget and Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to quality PONED (Basic Emergency Obstetric and Neo-natal Care - BEONC)</td>
<td>Location of PONED is not always in the right place. For example, a PONED can be located close to a hospital or other PONED. Staff rotation/promotion of the trained PONED team to other places. The obligation of government facilities to submit compensation to local government. There is no law/regulation protection for trained PONED team to deliver the services. Provision of health facilities depends also on the local government.</td>
<td>Budget disbursement for training is not in line with the budget disbursement for facility, equipment, and supplies. Jampersal is considered as local revenue. Therefore the government facility (Puskesmas and PONED facility) has to submit Jampersal revenue as compensation to the local government. The disbursement of submitted compensation to the government health facilities takes a long time and not necessarily represents what is needed by each facility. The local payment scheme of Jamersal for government facility staff is considered low. There is no special incentive scheme for PONED staff, especially in delivering services beyond working hours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th>Service Utilization</th>
<th>Cross-cutting issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete facilities/ equipment/supplies and/ or lack of competent health providers has discouraged the PONED Team in providing and promoting services. PONED training does not include APN training. Therefore, some doctors complain of not having the same knowledge and skills about APN as midwife. The PONED Team is not confident in providing the services because there is uncertainty about whether what they are doing is protected by law/ regulation. Technical assistance and supervision of PONED by PONEK Team have not been settled.</td>
<td>Utilization of PONED services is still low. The incomplete services provided in PONED facilities can and has discouraged the community from using PONED’s services.</td>
<td>Financing is still partial, between facilities/ equipment and human resources.</td>
</tr>
<tr>
<td>Intervention area</td>
<td>Policy</td>
<td>Budget and Financing</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Improve access to quality PONEK (Comprehensive Emergency Obstetric and Neo-natal Care - CEONC)</strong></td>
<td>Not all districts have PONEK hospital, for the reasons of lack of budget and human resources. Availability of 24 hours services for 7 days (24/7) of the PONEK is lacking due to: 1. Only 1 Ob/Gyn available in the government hospital 2. No Ob/Gyn resident working in the government hospital to assist Ob/Gyn 3. No use of or agreement with private hospitals/clinics to provide EmOC in the government hospital</td>
<td>Because <em>Jampersal</em> increases the caseload of hospitals, it to some extent reduces the proportion of non-<em>Jampersal</em> cases, which affects the financial cross subsidies. <em>Jampersal</em> is considered as district revenue. Local regulation focuses on limited flexibility of the fee of services, i.e., too small incentive especially for a rare provider (e.g., Ob/Gyn and anesthesiologist) who is working beyond working hours.</td>
</tr>
</tbody>
</table>

Service Delivery

Because *Jampersal* is not an insurance for the poor only, there is possibility (is already happening in Central Java) that the utilization of *Jampersal* will be very high. Demand for skilled health care will increase, but if facilities are not ready to provide quality health care, then people may be discouraged to seek care at public facilities.

| Cross-cutting issues | Quality assurance mechanism is unclear in the private hospitals. Financing is still partial, between facilities/ equipment and human resources |

*Jampersal* has increased the caseload of hospitals, not only in complicated cases but also in normal deliveries. Lack of facilities at PONEK hospital. For example, a high-care unit that is needed to closely monitor certain cases such as severe pre-eclampsia/eclampsia. Specialists also work in private hospitals as ‘dual practice’ is accepted. Thus full commitment to the government hospital is questionable. Quality assurance mechanism is not yet systemic.
### 2. Improve access to quality primary health care at the community level

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Policy</th>
<th>Budget and Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to quality primary level health care services at the community level</td>
<td>Availability of midwife in each village is not yet universal. It has been achieved in Central Java. Different policies throughout provinces regarding distribution of midwives in villages. Midwife’s authority regarding certain obstetric and FP services. The competence of pre-service training has not been standardized. Law No. 20 of 2003 under the Ministry of Education and Culture on campus autonomy can lead to variation in the competence of health providers. Policy on training for in-service midwives to obtain standard competence has not been universal. Prohibition on TBAs to deliver is not yet part of a policy. PKD/Polindes is defined as facility. The service provided by PKD/Polindes is different from Puskesmas/PONED. This can mislead one to believe that the services provided in PKD/Polindes are of the same kind of services as in Puskesmas, for example, vacuum extraction and first management of complications. The interpretation and implementation of Pregnant Mother Class programme varies between provinces.</td>
<td>Different policies throughout provinces on service fee for village midwife beyond working hours. Budget allocation for quality improvement is not systemic and universal, varies among provinces. In Central Java, budget allocation to improve the skills of midwives (through APN training) has been disbursed mainly within the last two years (2014-2015), thus the leverage to achieve MDG 5 by 2015 is small. Budget allocation only for facility and equipment, but not including human resources. The disbursement of submitted compensation to the government health facilities takes a long time and not necessarily represents what is needed by each facility. Jampersal is considered as local revenue. Therefore the government facility (puskesmas and PONED facility) has to submit Jampersal revenue as compensation to the local government. The local payment scheme regulation of Jampersal is different among provinces, as in the definition of facility. In Central Java, PKD and Polindes are considered as facilities, while in others they are not. Therefore in one province, the scheme has discouraged facility-based delivery (Puskesmas, PKD, Polindes), while in others has increased unnecessary hospital-based delivery. Budget allocation for Pregnant Mother Class in Central Java is mostly disbursed for 2014-2015, thus the leverage to achieve MDG 5 by 2015 is small.</td>
</tr>
<tr>
<td>Intervention area</td>
<td>Policy</td>
<td>Budget and Financing</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Not always available 24 hours. Burdens of non-obstetric service. Skills in early detection, first management, and stabilization of complications. Interpersonal communication and counseling skills (vis-à-vis the patients, families, and communities). The number and quality of the Puskesmas with delivery care in Central Java is still small. The understanding of P4K concept among providers is questionable. Lack of two importance messages: 1. How to empower mothers to make their own decisions related to pregnancy and delivery services 2. Unpredictability of obstetric complications that leads to the need to have a health provider present to enable early identification of complications and to refer the case effectively (timely and with stabilization of the patient).</td>
<td>Demand from the community to obtain all kinds of health services from village midwives. In some areas, the community initially seeks advice from TBA. Lack of understanding of the importance of P4K among pregnant women and families. Weak decision making on the part of women and lack of knowledge about the unpredictability of complications.</td>
<td>Financing is still partial, between facilities/ equipment and human resources Lack of understanding of the importance of P4K among village leaders and community.</td>
</tr>
</tbody>
</table>
### 3. Strengthen a quality referral system

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Policy</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen a quality referral system</td>
<td>Lack of clear guidance for province and district levels regarding referral mechanism.</td>
<td>Incentive for preparation of referral and transport cost for referral has been included in <em>Jamper sal</em>. The amount of the transport cost is in accordance with central and local standards. Although there is incentive for health personnel who accompany patients during referral depends on the local regulation, in the absence of strong commitment from the local government for this matter, this issue may hamper referral practice.</td>
<td>Lack of referral link between primary care level and hospital level. For example: in a district that has no PONEK hospital, the referral link is not optimal or can be worse because it can increase the delay time. Sub-optimal use of private hospital resources in the referral system and network. Lack of capacity of referee facilities/providers to give first management, stabilization and prompt referral.</td>
</tr>
<tr>
<td>Service Utilization</td>
<td>Prompt referral is still lacking due to decision making in the community, which partly may be caused by the ability of the midwife to influence the family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-cutting issues</td>
<td>Decision making is mainly not under women’s authority. For example, in Central Java, husbands and mothers –in-law play great role in making decisions for referral. Understanding of birth preparedness and emergency readiness are still lacking. For example, the woman and family are not always financially ready for delivery. This is one area that hinders the use of <em>Jamper sal/ Jamkesmas/Jamkesda</em>, because they feel that they should have their own money – even a small amount, although <em>Jamper sal</em> has covered them for transportation and facility fee. In some areas, referral can be hampered by the situation where private providers and/or facilities offer incentives for midwives who refer patients to the provider/facility. The preference for home delivery because the family is present.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 4. Increase access to quality family planning (FP) and reproductive health services

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Policy</th>
<th>Budget and Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to quality FP services</td>
<td>Midwives are trained in IUD and implant insertion and implant removal. However, the authority in providing those services is still unclear. Jampersal supports post-partum FP. The current low number of FP field workers is not backed up by a plan to increase the number. It depends on the commitment of local governments. The availability of FP methods is secured by the central government based on the request from the province and district/municipality level.</td>
<td>The central budget only covered the provision of FP method but very little of its operationalization.</td>
</tr>
</tbody>
</table>

**Service Delivery**

Because of the very small operational budget, the mobilization of FP acceptors is limited and has to be integrated with other programmes and sectors (e.g., Army, Health, Education, and Religion Offices), which has led to poor achievement, especially with respect to reducing unmet need. The interpersonal communication and counseling skills of the FP workers may be lacking. In Central Java, there is concern about the age of pregnant women older than 35 years old, because they feel that they are not fertile anymore.

**Service Utilization**

Pregnancy in older age, which may be caused by drop out or the perception that such women are not fertile anymore.
### Intervention area

**Improve access to quality reproductive health services**

<table>
<thead>
<tr>
<th>Policy</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of clear guidance for province and district levels regarding referral mechanism.</td>
<td>Budget for reproductive health programmes is very limited.</td>
<td>Due to the limited budget, the implementation of the reproductive health programmes is not optimal in Central Java.</td>
</tr>
</tbody>
</table>

### Service Utilization

<table>
<thead>
<tr>
<th>Cross-cutting issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Marriage Law of 1974 dictated that the minimum age to marry is 19 for a man and 16 for a woman. This leads to high incidence of teenage pregnancies.</td>
</tr>
</tbody>
</table>
V. IDENTIFYING SOLUTIONS AND DEVELOPING AN MDG COMPACT
To address the identified and prioritized bottlenecks in order to accelerate the reduction of MMR, the Central Java Province has identified potential solutions that can improve access to quality basic and comprehensive emergency obstetric neo-natal care; improve access to quality primary health care at the community level; strengthen a quality referral system; and increase access to quality family planning (FP) and reproductive health services.

Prioritized bottlenecks were selected based on the assumption that reducing these barriers will reduce maternal and neo-natal deaths significantly. Solutions areas will demand greater effort and actions from various stakeholders. The discussions among main stakeholders from various consultations identified concrete interventions and subinterventions, the prioritized solutions for acceleration based on prioritized bottlenecks, and determination of the related stakeholders.

1) To improve access to quality basic and comprehensive emergency obstetric neo-natal care, three main sub-interventions have been selected, including:
   a. Increase Puskesmas PONED availability to deliver its services. To achieve this purpose, about 20 activities were identified, but will be prioritized more to improve the human resources through training or internship, re-allocation/re-distribution of the health professional, provision of logistic needs and supportive regulation/policy.
   b. Improve the performance of PONEK hospitals by increasing the availability of human resources (specialists) by deploying more specialists and/or residents in OB-GYN and pediatrics in the PONEK hospitals. The effort also includes the strengthening of integrated standard operating procedure with the involvement of other disciplines in the hospitals.
   c. Strengthen the Maternal Perinatal Audit (MPA) activity to monitor the quality of care. The MPA activity has been conducted for some time and the benefit has been recognized. However, the programme is hampered by the limited availability of the human resources. The use of residents and the development of an integrated schedule are planned to increase the availability of human resources.

2) Improve access to quality primary health care at the community level. A number of solutions have been identified, including improvement of the health facilities with equipment and strengthening of the involvement of the community in a number of planning and activities in the community.

3) Strengthen a quality referral system. The Ministry of Health has released and communicated its Decree (Permenkes No. 1/2012) regarding the Guidelines on National Health Referral System. Therefore, the local government is planning to make adjustments to accommodate local needs, which will be supported by clear regulations and a mechanism for referral. In addition, potential innovative approaches, for example applying mobile-phone based system such as SMS to improve and expedite referral systems in rural and remote areas will be explored.

4) Increase access to quality family planning (FP) and reproductive health services. The quality of services in the hospitals and clinics as well as of the community health providers (midwives) should be improved. To increase the demand in the community, the role of the community will be strengthened; for example, a religious leader, head of the village and other prominent community members can raise awareness about pregnant related risks within the community. A collaborative effort among various stakeholders, backed up by local regulation, will be explored.
To overcome the issue of high incidence of adolescent pregnancy, various efforts will be made at schools through extra-curricular activities and activities at the community level.

In addition, to ensure the availability of health workers at various levels of services to accelerate the reduction of MMR, several main actions were identified to inform the MAF Action Plan implementation. To achieve this, a collaborative effort of several stakeholders is needed, including the Ministry of Health, BAPPEDAS, Provincial, District, City Health Services, Hospitals, Professional Organizations (POGI, IDI, IBI). Those are:

1. A policy to ensure the availability of health workers (24/7) that can perform their function adequately at every service level, including placement/distribution and relocation of health workers based on the needs of the community.
2. A policy is needed on the arrangement of health worker placement according to his/her function.
3. Coordination and clear task distribution is needed between the various health workers and their individual functions, both for the individual institute's services as well as in developing facilities and health workers under their supervision.
4. Health worker arrangements are needed to conduct their functions better; for example, cooperation with the Faculty of Medicine to utilize PPDS, cooperation with hospitals to train general doctors to be skillful in Seksio, etc.
5. Develop quality service assurance systems for health workers through training, in-house training as well as internships.

6. Develop a reward and punishment system that is adequate for health officials in conducting their duties.
7. Need to revisit local policies related to health worker service rates in providing service to Jampersal users, in order to create a better incentive system.
VI. TOWARDS AN ACTION PLAN FOR ACCELERATED PROGRESS ON MATERNAL HEALTH
Success in achieving the MDGs in Indonesia depends on the achievement of good governance, productive partnerships at all levels of society and the implementation of a comprehensive approach to achieving pro-poor growth, improving public services, improving coordination among stakeholders, expanding partnerships, increasing the allocation of resources, and developing decentralized approaches to reducing disparities while empowering communities in all regions of Indonesia.

In planning to achieve the MDGs, the size, growth and distribution of the population is one important consideration. Accelerating the achievement of the MDGs and all related targets requires that population problems are addressed in a comprehensive and integrated approach, including expanding access to reproductive health services and family planning while protecting reproductive rights. This will have a significant impact on maternal mortality reduction across the country.

Furthermore, the successful implementation of the prioritized interventions under the MAF Action Plan largely depends on the success of other sectors of the economy. For example, roads, electricity and water sectors are critical for the effective implementation of emergency obstetric care. Other sectors are education, gender and social development, and local governance. Third and last, the prioritized interventions are essential to accelerate the attainment of other MDGs since maternal health is not an issue that should be confined to the health sector alone.

The MAF Action Plan focuses on expanding better quality health care and comprehensive obstetric care, improving family planning services and provision of information, education and communication (IEC) message to the community in order to reduce MMR.

In 2001, Indonesia enacted one of the most ambitious decentralization policies in the world. While implementation of programs and service delivery is decentralized, health sector planning remains centralized, including control over human worker regulations and placements. Local governments have reduced input into program design and planning. Central or provincial governments often determine the types of programs to be provided. However, decentralisation shifted more authority and responsibility to local governments for health care service delivery at primary levels. Therefore, the implementation of the MAF Action Plan needs to follow a multi-tier approach focusing on key allies at the various levels of government to ensure effective delivery and results.

The MAF Action Plan calls for strengthen collaboration between the Central and Local Governments to establish and implement minimum health service standards to provide for uniformity and increase the quality of services, and to eliminate inequalities of access, particularly for the poor and those living in remote areas.

Despite the challenges faced for reducing maternal mortality in Central Java and in Indonesia overall, the prospects for collaboration between Central and Local Governments, with the support from local community members and partners, provides a strong basis for achieving sustainable results. The MAF Action Plan for Central Java aims to capitalize on existing initiatives by the Government and various partners for improving maternal health.

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase Puskesmas PONED availability to deliver its services</td>
<td>1.1 PONED Teams at Puskesmas are incomplete, for instance due to Official Rotation (Workers is inserted in its own bottleneck, bearing in mind that issues related to workers is interrelated with the level of health services, including workers at Hospitals and PONEK Hospitals)</td>
<td>1.1.1 On the job training for health workers at Puskesmas PONED</td>
<td>Responsible Party: Provincial Health Services - District/City Health Services Partner: Hospitals</td>
</tr>
<tr>
<td></td>
<td>1.2 Facility and infrastructure of PONED are incomplete, including training</td>
<td>1.2.1 Map PONED facilities and infrastructure especially through DAK with special menu and operational training on Facility and Infrastructure (Sarpras)</td>
<td>Responsible Party: Provincial Health Services - District/City Health Services Partner: Hospitals</td>
</tr>
<tr>
<td></td>
<td>1.3 Map of Health Workers in Puskesmas PONED</td>
<td>1.1.3 Map of Health Workers in Puskesmas PONED</td>
<td>Responsible Party: Hospitals</td>
</tr>
<tr>
<td></td>
<td>1.4 Development of macro and fundamental policy, related to Puskesmas covering Puskesmas concepts, specific workers and financial management[13].</td>
<td>1.1.4 Development of macro and fundamental policy, related to Puskesmas covering Puskesmas concepts, specific workers and financial management[13].</td>
<td>Responsible Party: Ministry of Health Partner: - Ministry of Home Affairs - BPJS - BKKBN</td>
</tr>
<tr>
<td></td>
<td>1.2.2 Procurement of PONED facility and infrastructure especially through DAK with special menu and operational training on Facility and Infrastructure (Sarpras)</td>
<td>1.2.2 Procurement of PONED facility and infrastructure especially through DAK with special menu and operational training on Facility and Infrastructure (Sarpras)</td>
<td>Responsible Party: Ministry of Health Partner: Ministry of Finance - Provincial Health Services - District/City Health Services</td>
</tr>
</tbody>
</table>

13. The process of developing Government Regulation related to the implementation of BPJS (Badan Penyelenggara Jaminan Sosial – Social Insurance Implementation Agency) is estimated to be completed by November 2012 (NEED TO CHECK THE STATUS). If possible, policy related to workers for Children and Maternal Health services can be included inside it.
1. Improve access to quality basic and comprehensive obstetric neo-natal emergency care

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Increase Puskesmas PONED availability to deliver its services | 1.2 Facility and infrastructure of PONED are incomplete, including training | 1.2.1 Determine priority locations for health services by the Governor.  
- Central (Government) identifies Locations with Health Problems (DBK – Daerah Bermasalah Kesehatan) including its guidelines, and give mandate to Governors to determine DBK at the Sub-district level. | Responsible Party:  
- Ministry of Health  
Partner:  
- Provincial Health Services  
- District/City Health Services  
- Provincial Bappeda |
| 1. Accelerate PONED training | 1.2.2 Supply contraception equipment for after childbirth. | 1.2.2 | Responsible Party:  
- BKKBN  
Partner:  
- Provincial Health Services  
- District/City Health Services |
| 1. Identify Puskesmas PONED that does not have Decision Letter (SK) for PONED Teams and SOPs | 1.2.3 In House Training (training at Puskesmas PONED) | 1.3.1 | Responsible Party:  
- District/City Health Services  
- Puskesmas PONED  
Partner:  
- Trained PONED Teams  
- JNPK Team  
- Team PONEK at District Hospitals |
| 1. Re-allocation of budget for PONED training at PPSDM and BUK | 1.3.3 Re-allocation of budget for PONED training at PPSSDM and BUK  
- Rearrangement of implementation plans for training activities to prioritize PONED training  
- Budget adjustment for training by JNPK with SBU rates (SBU = Standar Biaya Umum = General Cost Standards) | 1.3.3 | Responsible Party:  
- PPSSDM  
Partner:  
- Poltekes (Politeknik Kesehatan – Health Polytechnic) |
| 1. Not all Puskesmas PONED have Decision Letter (SK) for PONED Teams and SOPs | 1.4.1 Identify Puskesmas PONED that does not have Decision Letter for PONED Teams and SOPs | 1.4.1 | Responsible Party:  
- Provincial Health Services  
Partner:  
- District/City Health Services  
- Puskesmas PONED |
| 1. Issue SK PONED Teams and their SOPs, including Clinical SOP (algoritmes) and Management | 1.4.2 | 1.4.2 | Responsible Party:  
- Provincial Health Services  
Partner:  
- District/City Health Services  
- Puskesmas PONED |

14. Input for Ministry of Health: To reconsider “Training rates by JNPK above SBU” to be presented because this phrase does not suit certain parties, and there is currently no special assessment/report/objective data about it, unless it has been agreed with Central Java Health Services.
### 1. Increase Puskesmas PONED availability to deliver its services

1.5 Insufficient information on PONED services for the community.

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.1 Increase awareness, outreach and promotion of PONED services</td>
<td></td>
<td>Provincial Health Services, District/City Health Services</td>
</tr>
</tbody>
</table>

Partner:
- TOGA and TOMA
- Community Organization
- Print and electronic media

1.6 Placement / location of PONED is not appropriate, in some places

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6.1 Re-arrange Puskesmas PONED based on mapping results.</td>
<td></td>
<td>Provincial Health Services</td>
</tr>
</tbody>
</table>

- Strategic Puskesmas PONED locations need to be identified including their workers.
- Partner: District/City Health Services

1.7 Low interest of specialist doctors to develop Puskesmas PONED

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7.1 Provision of support funds from specialist doctor activities to develop Puskesmas PONED</td>
<td></td>
<td>Provincial Health Services, District/City Health Services</td>
</tr>
</tbody>
</table>

- Assignment of special residents:
  - Cooperation with education institution
  - Authority is given to professional organizations
  - Legality Aspects (Assignment Letter)
- Partner: Provincial Health Services, District/City Health Services

1.8 PONED Training Cost is too high

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1.8.1. Develop a number of competent PONED Training Institutes | | Ministry of Health (PPSDM Agency)

- Authority in PONED training is not only by a certain institution, but can also be done by other institutions that have competency in PONED training.
- Universities
- JNPK and its network (Regional P2Kt, Provincial P2KS, District and City P2KP)

1.8.2 Bargain for training authority with existing training institutes (JNPK)

1.8.3 Enforcement of the new 2009 Ministry of Health Decree on health training through PPSDM

### 1. Improve access to quality basic and comprehensive obstetric neo-natal emergency care

#### Intervention and Sub-intervention Priorities

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 Insufficient information on PONED services for the community.</td>
<td>1.5.1 Increase awareness, outreach and promotion of PONED services</td>
<td>Provincial Health Services, District/City Health Services</td>
</tr>
</tbody>
</table>

Partner:
- TOGA and TOMA
- Community Organization
- Print and electronic media

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6 Placement / location of PONED is not appropriate, in some places</td>
<td>1.6.1 Re-arrange Puskesmas PONED based on mapping results.</td>
<td>Provincial Health Services</td>
</tr>
</tbody>
</table>

- Strategic Puskesmas PONED locations need to be identified including their workers.
- Partner: District/City Health Services

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7 Low interest of specialist doctors to develop Puskesmas PONED</td>
<td>1.7.1 Provision of support funds from specialist doctor activities to develop Puskesmas PONED</td>
<td>Provincial Health Services, District/City Health Services</td>
</tr>
</tbody>
</table>

- Assignment of special residents:
  - Cooperation with education institution
  - Authority is given to professional organizations
  - Legality Aspects (Assignment Letter)
- Partner: Provincial Health Services, District/City Health Services

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1.8 PONED Training Cost is too high | 1.8.1. Develop a number of competent PONED Training Institutes | Ministry of Health (PPSDM Agency)

- Authority in PONED training is not only by a certain institution, but can also be done by other institutions that have competency in PONED training.
- Universities
- JNPK and its network (Regional P2Kt, Provincial P2KS, District and City P2KP)

15. Input for Ministry of Health: This is meant for Kepmenkes No. 725/2003 regarding Guidelines on Implementing Health Training, while the Kepmenkes regarding clinical reproductive training through JNPK is Kepmenkes No. 786/1999.
## 1. Improve access to quality basic and comprehensive obstetric neonatal emergency care

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Improve the performance of PONEK Hospitals</td>
<td>2.1 Limitation of the PONEK team’s human resources to support 24 hour services</td>
<td>2.1.1 Utilize residents (ObGyn, anesthesia) as part of the PONEK team</td>
<td>Responsible Party: - District/City Health Services - Provincial Health Services Partner: - Universities - Professional Organizations</td>
</tr>
<tr>
<td></td>
<td>2.2 Implementation arrangement (SOP) of PONEK teams to function 24 hours for 7 days</td>
<td>2.2.1 Complete and implement SOPs that can be applied and integrated through the involvement of multisectors: hospital (IGD, labor room, IBS, ICU, High Risk Perinatal, blood bank, and all support facilities) and involve Health Services. - Accredit Hospitals - Monitor SOPs by Health Services to develop routine accreditation.</td>
<td>Responsible Party: - Provincial Health Services Partner: - District/City Health Services - KARS - Hospitals - Indonesia Red Cross (PMI)</td>
</tr>
<tr>
<td></td>
<td>2.3 Communication and information system for emergency referral has not been developed</td>
<td>2.3.1 Develop call centers and information networks between Puskesmas PONED and intra hospital referrals. High risk data is connected within Health Services and referral hospital databases Provide guidance in referral that is effective and efficient. Call centers include doctor’s advise that will receive referrals.</td>
<td>Responsible Party: - Provincial and District/City Health Services Partner: - Private and Public Hospital - Dishubkominfo - Cellular Operators</td>
</tr>
<tr>
<td></td>
<td>2.4 Local budget (APBD) limitation to support PONEK activities</td>
<td>2.4.1 Push BLU Hospitals to support PONEK 24/7 activities</td>
<td>Responsible Party: - BLU Hospital Partners: - Health Services</td>
</tr>
</tbody>
</table>
1. Improve access to quality basic and comprehensive obstetric neo-natal emergency care

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 3. MONEV - Maternal Perinatal Audit (MPA)   | 3.1 Human resource and time limitation to facilitate MPA (e.g. ObGyn, Child Specialist) | 3.1.1 Improve sustainable competency through group studies, internship, case studies, and others | Responsible Party: - Faculties of Medicine  
Partners: - Professional Organizations  
- Hospitals  
- Health Services |
|                                             | 3.1.2 Resident utilization in implementing MPA with Specialist supervision. | | Responsible Party: - Health Services  
Partners: - Faculties of Medicine  
- Hospitals  
- Professional Organizations (POGI, IDAI, IDI) |
|                                             | 3.1.3 Arrange an integrated schedule and an MPA follow-up that is agreed by relevant parties | | Responsible Party: - Health Services  
Partners: - Hospitals  
- Faculties of Medicine |
| 4. Ensure the availability of health workers at various level of services (community levels, Puskesmas PONED, PONEK Hospitals and other referral hospitals) to accelerate the reduction of MMR | 4.1. In reality, not all health service facility at various service level:  
a. Have the right number of workers so that the 24/7 service function can not be provided  
b. Can provide quality services, because of inadequate health worker skills as well as because there is insufficient facility and infrastructure at these health facilities  
c. In several cases, rotation of health workers, including trained health workers that can conduct their functionality at their institute | 4.1.1. A policy is needed to ensure availability of health workers (24/7) that can perform their function adequately at every service level, including placement/distribution and relocation of health workers that consider the needs of the community  
4.1.2. A policy is needed on the arrangement of health worker placement according to his/her function  
4.1.3. Health worker arrangement is needed to conduct their functions better, for example cooperation with the Faculty of Medicine to utilize PPDS, cooperation with hospitals to train general doctors to be skillful in Seksio, etc.  
4.1.4. Develop quality service assurance systems for health workers through training, in-house training as well as internships | Responsible party: - Ministry of Health  
- Bappeda  
- Provincial, District, City Health Services  
- Hospitals  
Partners: - Professional Organizations (POGI, IDI, IBI) |
|                                             | 4.2. Unclear role division for each level of health services, so much so that referral hospitals and PONEK cannot fully conduct their function to prioritize the handling of complication cases, not normal labor | 4.2.1. Coordination and clear task distribution is needed between the various health workers and their individual function, both at the individual institute's services as well as in developing facilities and health workers under his/her supervision  
4.2.2. Develop a reward and punishment system that is adequate for health officials in conducting his/her duties. | Responsible party: - Ministry of Health  
- Bappeda  
- Provincial, District, City Health Services  
- Hospitals  
Partners: - Professional Organizations (POGI, IDI, IBI) |
|                                             | 4.3. Local policies related to the amount of service fees (Jampersal) for health workers are influenced by the motivation of the official to provide services. | 4.3.1. Needs to revisit local policies related to health worker service rates in providing service to Jampersal users. | Responsible party: - Ministry of Health  
- Bappeda  
- Provincial, District, City Health Services  
- Hospitals  
Partners: - Professional Organizations (POGI, IDI, IBI) |
### 2. Improve access to quality primary health care at the community level

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access to quality primary level health care services at the community level</td>
<td>1.1 Inadequate PKD Facility/Infrastructure</td>
<td>1.1.1 Map out health equipment availability for basic services facilities</td>
<td>Responsible Party: Health Services Partners: Health Dept Research and Development Agency (Risfaskes Results)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2 Lack of involvement from Community Leader (Tokoh Masyarakat – toma) and Religious Leader (Tokoh Agama – toga) in improving access</td>
<td>1.2.1 Conduct meetings with toga and toma to improve access to PKD, through: Religious and socio-cultural approach through optimization of the Village Health Forum</td>
<td>Responsible Party: Provincial and District/City Health Services Partners: Religious Leader Community Leader Religious Institute Community Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.2 Socialize/disseminate maternal and children’s health (KIA) to toma and toga, especially Complication Planning and Avoidance Programme (PAK)</td>
<td>Responsible Party: Health Services - BKKBN Partners: Print and electronic media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.3 Advocate for increasing the marriage age based on health</td>
<td>Responsible Party: Health Services - BKKBN Partners: Ministry of Religious Affairs</td>
</tr>
<tr>
<td></td>
<td>1.3 Support for KIA services funds at the village and kelurahan is still insufficient</td>
<td>1.3.1 Advocate KIA to Village Council Agency (BPD - Badan Permusyawaratan Desa) and village health forum</td>
<td>Responsible Party: Village Midwives Partners: Head of Village (Kades) - BPD - Head of Village (Lurah)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.3.2 Include KIA activities in Village and Kelurahan budgets (sourced by government and other resources)</td>
<td>Responsible Party: Village Midwives Partners: BPD - CSR</td>
</tr>
</tbody>
</table>
## 2. Improve access to quality primary health care at the community level

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Improve access to quality primary level health care services at the community level | 1.4 KIA (Maternal and Child Health) activities are not integrated within community empowerment programmes | 1.4.1 Advocate for the planning arrangement of community empowerment programmes | Responsible Party: 
- Health Services 
- Bapermasdes 
- BP3AKB 
Partners: 
- Community Facilitator 
- Community groups that conduct community empowerment programmes 
- Village Midwives |
| | 1.4.2 Arrange programme planning for community empowerment that include KIA components | | Responsible Party: 
- Health Services 
- Bapermasdes |
| | 1.4.3 Implement community empowerment programmes that side with KIA | | BP3AKB 
Partner: 
- Community Facilitator 
- Community groups that conduct community empowerment programmes |
| | 1.5 Programmes related to Childbirth Complication Planning and Avoidance (P4K) are not effective | 1.5.1 Reorient health workers on the concept and importance of P4K which is based on the unpredictability in midwife complication, and that every childbirth has risks, and that there needs to be childbirth planning and anticipate and avoid complication | Responsible Party: 
- Provincial Health Services 
- District/City Health Services 
Partner: 
- Puskesmas 
- Bapermasdes 
- PKK 
- Village Midwifes |
| | | 1.5.2 Disseminate concept and importance of P4K by health workers to cadres and community | Responsible Party: 
- District/City Health Services 
- Puskesmas 
- District/City SKPD for Family Planning |
| | | 1.5.3 Integrate material related to Family Planning (KB) programmes as a childbirth planning method for cadres and community, through Poktan KB | Partner: 
- Bapermasdes 
- PKK 
- Village Midwife 
- BKKBN |
### 3. Strengthen a quality referral system

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Strengthen a quality referral system    | 1.1. Non-existence of special regulation on referral system from community level to hospital including referrals between provinces and district/city | 1.1.1 Socialize Permenkes No 1/2012 regarding the Guidelines on National Health Referral System | Responsible Party:  
- Ministry of Health,  
Partner:  
- Print and electronic media |
|                                            |                       | 1.1.2 Develop the Nasional Health Referral System guidelines by accommodating local needs and conditions and still refer to the Permenkes | Responsible Party:  
- DG Health Efforts Development (BUK)  
- Ministry of Health  
Partner:  
- Provincial and District/City Health Services |
|                                            |                       | 1.1.3 Develop regulation and guideline on referral systems at district and city level:  
a. District Regulation / Mayor Regulation  
b. Develop mechanisms on referral / regionalization of referral flow to Puskesmas PONED and Hospitals | Responsible Party:  
- District and City Health Services  
Partner:  
- Bappeda, legal dept, cooperation dept, social dept, Health Services Association,  
Professional Organization |
|                                            |                       | 1.1.4 Develop regulations and guidelines on referral system at provincial level:  
a. Governor Regulation  
b. Develop mechanism of referral/ regionalization of referral flow from hospitals, cross boundaries between district/city and province | Responsible Party:  
- Provincial Health Services  
Partner:  
- Bappeda, law bureau, cooperation bureau, social development bureau, Health Services Association, Arsada, Persi, Professional Organization, bakorwil |
| 1.2. Utilization of insurance funds for maternal health services are not optimum | 1.2.1 Increase awareness and outreach about the referral system | 1.2.2 Create inventory and disseminate contact numbers that can be called to inform on high risk pregnant mother cases during ANC and for emergency complication for pregnant mothers | Responsible Party:  
- Provincial and District/City Health Services  
Partner:  
- Village Midwives  
- Puskesmas Doctor and Staff  
Hospital  
Private Sector Midwives Practice  
Childbirth Hospital  
Community  
Print and electronic media |
|                                             |                       | 1.3 Communication and Information system on maternal health services before and while in a hospital is not optimum | Responsible Party:  
- Provincial and District/City Health Services  
Partner:  
- Government Hospital  
Private Hospital  
Puskesmas  
Private Facilities  
Diskominfo |
|                                             |                       | 1.3.1 Develop a communication and information system to support the KIA referral system by using text messages (sms) and phones | Responsible Party:  
- Provincial and District/City Health Services  
Partner:  
- Government Hospital  
Private Hospital  
Puskesmas  
Private Facilities  
Diskominfo |
### 3. Strengthen a quality referral system

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Strengthen a quality referral system     | 1.3 Communication and Information system on maternal health services before and while in a hospital is not optimum | 1.3.1 Determine a contact number and responsible party at the referral Puskesmas PONED level and hospitals, for direct communication, e.g. to ensure room availability, ensure the correct doctor availability (e.g. ObGyn Specialists), etc, and also for clinic guidelines by ObGyn Doctor/Doctor on alert/Senior midwife during and while in the referral process | Responsible Party:  
- Provincial and District/City Health Services  
Partner:  
- Hospital  
- Puskesmas  
- Midwife  
- SPOG  
- Puskesmas PONED Doctor  
- Hospital PONEK Doctor |
|                                             | 1.4 A feedback referral system has not been developed from hospital to basic health services (feedback referral is needed, for example, to monitor patients after treatment can adequately be continued by the referral) | 1.4.1 Develop a Referral Feedback SOP feedback from Hospital to the Referral Issuer | Responsible Party:  
- Provincial and District/City Health Services  
Partner:  
- Hospital  
- Puskesmas  
- Midwife  
- SPOG  
- Puskesmas PONED Doctor  
Hospital PONEK Doctor |
## Intervention and Sub-intervention Priorities

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Improve access to Family Planning (FP) services and quality reproductive health for fertile couples (PUS – Pasangan Usia Subur) | 1.1 FP services are not completely available, including FP counseling at hospitals according to community needs (number of service days for FP at hospitals need to be added) | Responsible Party: BKKBN  
Partner:  
- Health Services  
- Hospital  
- Professional Organization  
- PERSI                                |
| 1.2 Lack of engagement of the community in FP                                                                 | 1.2.1 Empowerment of PLKB (FP Field Officer), TP PKK, FP Cadres, and BABINSA (Military) as spearheads to move FP | Responsible Party: BKKBN  
Partner:  
- District/City SKPD FP  
- Health Services                                                                                           |
| 1.2.2 Improve FP partnership network with TOMA and TOGA                                                            | 1.2.2 Improve FP partnership network with TOMA and TOGA                                                        | Responsible Party: BKKBN  
Partner:  
- Religious organization (MUI, Asiyah, Muslimat, Fatayat, FKUB: Forum Kerukunan Umat Beragama (Forum for Religious Harmony), dan Fapsedu-Forum Antarumat beragama Peduli keluarga sejahtera dan kependudukan (Forum for intra religion that care for family welfare and population)  
- TP PKK  
- CSO                                                                                                             |
| 1.2.3 Maximize the role of Village Head (Camat) to improve FP services                                             | 1.2.3 Maximize the role of Village Head (Camat) to improve FP services                                         | Responsible Party: BKKBN  
Partner:  
- Provincial BKKBN  
- Health Services                                                                                           |
| 1.2.4 Provide reward of FP cadres achievements                                                                      | 1.2.4 Provide reward of FP cadres achievements                                                                    | Responsible Party: BKKBN  
Partner:  
- District/City SKPD FP  
- Health Services  
- Provincial Government                                                                                  |

4. Increase access to quality Family Planning (FP) and reproductive health services
4. Increase access to quality Family Planning (FP) and reproductive health services

<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Improve access to Family Planning (FP) services and quality reproductive health for fertile couples (PUS - Pasangan Usia Subur) | 1.3 Service by trained FP officers is not optimal competency certificate should be awarded as proof. | 1.3.1 Map FP trained and non-trained health workers | Responsible Party:  
- Health Services (as Coordinator)  
Partner:  
- IDI  
- IBI  
- BKKBN  
- Hospital |
|  | 1.4 Limited midwife authority in providing FP services which is arranged by Permenkes 1464/2010 regarding permits on midwife practice implementation (by definition "Midwife is conducting government programme" in the Permenkes)  
1.4.1 Advocate to Head of District and City Health Services to give Assignment Letter to midwives as the FP service provider | 1.4.1 Advocate to Head of District and City Health Services to give Assignment Letter to midwives as the FP service provider | Responsible Party:  
Provincial Health Services  
Partner:  
- District/City Health Services  
- BKKBN |
|  | 1.4.2 Issue Assignment Letter to midwives that are trained to provide FP services that are outside of Permenkes (Ministry of Health Regulation) 1464/2010 | 1.4.2 Issue Assignment Letter to midwives that are trained to provide FP services that are outside of Permenkes (Ministry of Health Regulation) 1464/2010 | Responsible Party:  
- Head of District and City Health Services |
|  | 1.3.2 Implementation of training and refresher training for FP services officials, especially on installing IUD (Intra Uterine Device) Post Childbirth, for Midwives and Doctors | 1.3.2 Implementation of training and refresher training for FP services officials, especially on installing IUD (Intra Uterine Device) Post Childbirth, for Midwives and Doctors | Responsible Party:  
BKKBN  
Partner:  
- Health Services  
- P2KS  
- P2KP |
|  | 1.3.3 Validate the competency of trained FP service workers | 1.3.3 Validate the competency of trained FP service workers | Responsible Party:  
BKKBN  
Partner:  
- Health Services  
- IBI  
- IDI |
|  | 1.3.1 Issue a competency certificate to trained officials (consider Temporary Work Letter related to authority to conduct services that was trained if the number of total number of cases does not meet the requirement to obtain a certificate) | 1.3.1 Issue a competency certificate to trained officials (consider Temporary Work Letter related to authority to conduct services that was trained if the number of total number of cases does not meet the requirement to obtain a certificate) | Responsible Party:  
- P2KS  
- P2KP  
Partner:  
- Health Services  
- BKKBN  
- IBI |
|  | 1.3.2 Provide reward to FP Service Provider | 1.3.2 Provide reward to FP Service Provider | Responsible Party:  
BKKBN  
Partner:  
- Health Services  
- PERSI  
- IBI |

Intervention and sub-intervention priorities:

- 1.1.1 Increase access to FP services
- 1.1.2 Quality of FP services
- 1.1.3 Service delivery

Bottleneck priorities:

- Access to FP services
- Quality of FP services
- Service delivery

Accelerated solutions:

- Mapping FP trained and non-trained health workers
- Implementation of training and refresher training for FP services officials
- Validation of the competency of trained FP service workers
- Issue a competency certificate to trained officials
- Provide reward to FP Service Provider

Responsible parties and partners:

- Health Services (as Coordinator)  
- IDI  
- IBI  
- BKKBN  
- Hospital
- BKKBN  
- Health Services  
- P2KS  
- P2KP
- Health Services  
- BKKBN  
- IBI
- P2KS  
- P2KP
- P2KS  
- P2KP
- P2KS  
- P2KP
- BKKBN  
- PKMI
- Health Services  
- BKKBN  
- PERSI  
- IBI
- Province Health Services  
- District/City Health Services  
- BKKBN
- Head of District and City Health Services
<table>
<thead>
<tr>
<th>Intervention and Sub-intervention Priorities</th>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
</table>
| 1. Improve access to Family Planning (FP) services and quality reproductive health for fertile couples (PuS – Pasangan Usia Subur) | 1.5 Insufficient laparoscopic equipment for MOW (Medis Operatif Wanita – Female Medical Operative) at Hospitals | 1.5.1 Map out laparoscopic equipment at health facilities that have ObGyn | Responsible Party: Provincial Health Services  
Partner: - BKKBNN |
| | | 1.5.2 Procurement of laparoscopic equipment | Responsible Party: - BKKBNN |
| | | 1.5.3 Train MOW laparoscopic for ObGyn and Hospital Teams | Responsible Party: BKKBNN  
Partner: - PKBS  
- PKMI (Persatuan Kontrasepsi Mantap Indonesia – Indonesian Association of Contraception)  
- POGI |
| | | 1.5.4 Evaluate and monitor the utilization of laparoscopic equipment | Responsible Party: BKKBNN  
Partner: - Health Services  
- Hospitals that have laparoscopic equipment |
| 1.6 Low rate of male participation in FP (under 5%) | 1.6.1 Socialize FP for men at TOGA and TOMA  
1.6.2 Workshops on Improving the Role of Priok Utomo (FP for men participation group) | 1.6.1 Socialize FP for men at TOGA and TOMA  
1.6.2 Workshops on Improving the Role of Priok Utomo (FP for men participation group) | Responsible Party: BKKBNN  
Partner: - Health Services  
- TOGA  
- TOMA  
- PKK  
- CSO  
- Print and electronic media |
| | | 1.6.2 Workshops on Improving the Role of Priok Utomo (FP for men participation group) | Responsible Party: BKKBNN  
Partner: - Health Services  
- TOGA  
- TOMA  
- PKK  
- CSO  
- Print and electronic media |
| 1.7 Limited amount of Field Officers for Family Planning (PLKB – Petugas Lapangan Keluarga Berencana) | 1.7.1 Empower village FP cadres, PKK Cadres, Babinsa (Bintara Pembina Desa – Army level Village Development), and Binmas (Bimbingan Masyarakat – Community Guidance) as officials for KIE KB (FP Communication of Information and Education) | 1.7.1 Empower village FP cadres, PKK Cadres, Babinsa (Bintara Pembina Desa – Army level Village Development), and Binmas (Bimbingan Masyarakat – Community Guidance) as officials for KIE KB (FP Communication of Information and Education) | Responsible Party: BKKBNN  
Partner: - Provincial/District/City Health Services  
- TNI (Army)  
- Polri (Police)  
- PKK |
## Intervention and Sub-intervention Priorities

<table>
<thead>
<tr>
<th>Bottleneck Priorities</th>
<th>Accelerated Solutions</th>
<th>Responsible Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access to Family Planning (FP) services and quality reproductive health for fertile couples (PUS – Pasangan Usia Subur)</td>
<td>1.8 High rates for FP services at several districts that have been determined by area regulations to serve FP especially MOW and MOP (Medis Operatif Pria – Male Medical Operative)</td>
<td>1.8.1 Advocate on the needs to reduce Perda (Local Regulated) rates to serve MOW and MOP Responsible Party: - BKKBN - Health Services Responsible Party: - Governor - District Head (Bupati) - Mayor (Walikota)</td>
</tr>
<tr>
<td>2. Improve access to quality reproductive health services for youth</td>
<td>2.1 Youth PIK (Pusat Informas dan Konseling – Information and Counseling Centers) and PKPR (Pelayanan Kesehatan Peduli Remaja – Health Services for Youth) activities are not integrated</td>
<td>2.1.1 Include Youth PIK and PKPR into extra curricular activities at Middle School (SMP), High School (SMA), and University (PT – Perguruan Tinggi) Responsible Party: - BKKBN Partner: - Education Services - Health Services - OSIS - BEM</td>
</tr>
<tr>
<td></td>
<td>2.1.1 Integrate Youth PIK and PKPR into extra curricular activities in Middle School (SLTP), High School (SLTA), and peer counselors (Karang Taruna organization, mosque's youth organization, Boy/Girl Scouts, church's youth organization, and others)</td>
<td>Responsible Party: - Ministry of Education and Culture - Ministry of Health Partner: - BKKBN - Health Services - Education Services</td>
</tr>
<tr>
<td></td>
<td>2.1.2 Improve Youth PIK and PKPR networks Middle School (SLTP), High School (SLTA), and peer counselors (Karang Taruna organization, mosque's youth organization, Boy/Girl Scouts, church's youth organization, and others)</td>
<td>Responsible Party: - BKKBN Partner: - Health Services - Puskesmas - Peer Counselor</td>
</tr>
<tr>
<td></td>
<td>2.2 Reproductive health education is not maximum at education levels of SMP, SMPA, University and Karang Taruna</td>
<td>2.2.1 Cooperation with School Guidance and Counselors (BP – Bimbingan Penyuluhan) with Youth PIK Responsible Party: - BKKBN Partner: - National Education Services - Bapermades - Health Services</td>
</tr>
<tr>
<td></td>
<td>2.2.2 Create and develop an integrated youth PIK</td>
<td>Responsible Party: - BKKBN Partner: - National Education Services - Bapermades - Health Services</td>
</tr>
<tr>
<td></td>
<td>2.3 KIE is not maximized for to-be-wed-couples on reproductive health</td>
<td>2.3.1 Orientation and increase awareness among health professionals about the KUA (Kantor Urusan Agama - Religious Affairs Office) officials and Civil Registrar (Catatan Sipil). Responsible Party: - Ministry of Religious Affairs Partner: - Health Services - BKKBN - Print and electronic media</td>
</tr>
<tr>
<td></td>
<td>4. Increase access to quality Family Planning (FP) and reproductive health services</td>
<td></td>
</tr>
</tbody>
</table>
I. ANNEXES
### ANNEX I: SUMMARY SITUATION OF PRIORITY INTERVENTIONS

#### FIGURE 1. SUMMARY SITUATION OF PRIMARY LEVEL HEALTH SERVICES (PONED LEVEL)

<table>
<thead>
<tr>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Placement of doctor in every health centre</td>
<td>- Health care insurance (including Jampersal)</td>
<td>- Fulfilment of human resources, facilities and infrastructure of PONED health centre</td>
<td>- Cases managed at health centre and PONED level</td>
</tr>
<tr>
<td>- Health centre accreditation</td>
<td>- Budget for APN and PONED training</td>
<td>- PONED services: only around one third could function optimally:</td>
<td>- FP services at primary health care</td>
</tr>
<tr>
<td>- Establishment of delivery care at health centre</td>
<td></td>
<td>o 55.9% of full team were trained</td>
<td>- Mother’s Class</td>
</tr>
<tr>
<td>- Establishment of PONED health centre</td>
<td></td>
<td>o 29.6% of facilities are in place</td>
<td>- Insertion of Adolescent Reproductive Health issues in school curricula</td>
</tr>
<tr>
<td>- Assistance/ supervisory from PONEK Team to PONED health centre</td>
<td></td>
<td>- 80.5% of facility deliveries</td>
<td>- Partnerships with community and faith-based organizations</td>
</tr>
<tr>
<td>- Establishment of PKPR (Youth Friendly Health Services) and PKRE (Essential Reproductive Health Services) Health Centre</td>
<td></td>
<td>- APN training in phases</td>
<td></td>
</tr>
<tr>
<td>- The role of professional organizations in MPA</td>
<td></td>
<td>- Lack of skills of the PONED Team low confidence in case management tend to refer cases to hospital</td>
<td></td>
</tr>
<tr>
<td>- Regulation from the Ministry of Home Affair on health centre financing</td>
<td></td>
<td>- Maternal and Perinatal Audit (MPA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Web-based recording and reporting system for Nutrition-MCH in selected areas</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ratio of FP field worker : village=1 : 3-4 villages</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Doctor and midwife were trained for FP service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- PKPR dan PKRE in Health Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Role of private sector</td>
<td></td>
</tr>
</tbody>
</table>
**FIGURE 2. SUMMARY SITUATION OF PONEK**

<table>
<thead>
<tr>
<th>Hospital/PONEK</th>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placement of OB-GYN and arrangement of OB-GYN working sites</td>
<td>- Health care insurance (including Jampersal)</td>
<td>- 24/7 PONEK services, including blood availability</td>
<td>- Proportion of complication managed</td>
</tr>
<tr>
<td></td>
<td>Establishment of PONEK hospital</td>
<td>- Claims for Jampersal are not yet smooth</td>
<td>- Obstetric Emergency Room</td>
<td>Not all referred cases are complications that need to be referred</td>
</tr>
<tr>
<td></td>
<td>PONEK post-training evaluation</td>
<td>- Fee for maternal and neo-natal services are available, but small</td>
<td>- Hospital internal audit</td>
<td>Training for PONEK Team</td>
</tr>
<tr>
<td></td>
<td>Assistance/supervisory from PONEK to PONED</td>
<td></td>
<td>- PONEK Hospital only 40% among all hospitals</td>
<td>Human resources, facilities and infrastructure of PONEK</td>
</tr>
<tr>
<td></td>
<td>Hospital accreditation</td>
<td></td>
<td>- Quality assurance mechanism is not yet systemic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regulation of OB-GYN's role in MPA</td>
<td></td>
<td>- Referral system is not yet clear for all</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Border areas issue: need coordination between districts</td>
<td></td>
<td>- Jampersal increased the burden of hospital (1/3rd of referral are normal cases)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Training for PONEK Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Human resources, facilities and infrastructure of PONEK</td>
<td></td>
</tr>
</tbody>
</table>
### FIGURE 3. SUMMARY SITUATION OF PRIMARY LEVEL HEALTH SERVICES (COMMUNITY LEVEL)

<table>
<thead>
<tr>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
<th>Cross-cutting</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Policy on universal placement of village midwife</td>
<td>- Health care insurance (including Jampersal)</td>
<td>- 93.3% of villages have midwife residing in the village</td>
<td>- K4: 93.7%</td>
<td></td>
</tr>
<tr>
<td>- Regulation of establishment of Poskesdes (Village Health Post)</td>
<td>- Budget allocation for Normal Delivery Care Training (APN)</td>
<td>- 71% of villages have Poskesdes/Polindes</td>
<td>- SBA: 96.8%</td>
<td></td>
</tr>
<tr>
<td>- Regulation of midwife’s practice, including midwife’s authority in assisting delivery and providing FP services</td>
<td>- Budget allocation for Emergency Obstetric and Neonatal Care Training (GDON)</td>
<td>‘Four hands care’ (‘Pertolongan empat tangan’)</td>
<td>- Access and ‘acceptance’ to TBA’s care</td>
<td></td>
</tr>
<tr>
<td>- Jampersal to also encourage post-delivery FP</td>
<td></td>
<td>TBA-Midwife partnership</td>
<td>- CPR: 79.3%</td>
<td></td>
</tr>
<tr>
<td>- Policy on P4K (Birth Preparedness and Complication Readiness)</td>
<td></td>
<td>52.6% of midwives have been trained on APN</td>
<td>- Unmet Need for FP: 11.6%</td>
<td></td>
</tr>
<tr>
<td>- Cross-sector collaboration for P4K Programme</td>
<td></td>
<td>Detection of women with high obstetric risk</td>
<td>- Bidan Delima: 30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Logistics, infrastructure</td>
<td></td>
<td>- Education level of the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Socio-cultural issues (including religious issues)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Need to synchronize regulation that ruled out private midwife’s authority in providing FP services</td>
</tr>
</tbody>
</table>

- K4: 93.7%
- SBA: 96.8%
- Access and ‘acceptance’ to TBA’s care
- CPR: 79.3%
- Unmet Need for FP: 11.6%
- Bidan Delima: 30%
### FIGURE 4. SUMMARY OF THE SITUATION OF THE HEALTH REFERRAL SYSTEM

<table>
<thead>
<tr>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Midwife’s authority in case management</td>
<td>- Fee for pre-referral service</td>
<td>- TBA-Midwife partnership</td>
<td>- Proportion of complications managed in facilities is 75%, but cannot distinguish the proportion to PONEK hospital</td>
</tr>
<tr>
<td>- Policy on admission of referred patient to hospital</td>
<td>- Jampersal has increased referred cases financial constraints reduced</td>
<td>- Screening for referral (Penapisan rujukan)</td>
<td>- Normal cases referred to hospital</td>
</tr>
<tr>
<td>- Assistance/supervisory from PONEK to PONED</td>
<td>- Patient stabilization during referral</td>
<td>- Patient stabilization during referral</td>
<td>- Delay in referral, but not all referred cases are complications that need to be referred</td>
</tr>
<tr>
<td></td>
<td>- Communication between midwife and referral hospital</td>
<td>- Communication between midwife and referral hospital</td>
<td>- Low community’s ‘acceptance’ of referral</td>
</tr>
<tr>
<td></td>
<td>- Not all districts/cities have established regionalization of referral system</td>
<td>- Not all hospitals provide feedback for referral</td>
<td>- Road condition</td>
</tr>
<tr>
<td></td>
<td>- Not all hospitals provide feedback for referral</td>
<td>- Transportation cost</td>
<td>- Transportation</td>
</tr>
<tr>
<td></td>
<td>- Ambulance and driver at health center</td>
<td>- Gender, decision making</td>
<td>- Gender, decision making</td>
</tr>
</tbody>
</table>

- Normal cases referred to hospital
- Delay in referral, but not all referred cases are complications that need to be referred
- Low community’s ‘acceptance’ of referral
- Road condition
- Transportation
- Gender, decision making
## ANNEX II: BOTTLENECK ANALYSIS

### STEP 2: BOTTLENECK ANALYSIS FOR MATERNAL HEALTH

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PONED</strong></td>
<td>1. Not all PONED teams have appointment letters</td>
<td>1. High costs for training</td>
<td>1. PONED teams are not complete because of work mutation/rotation/promotion</td>
<td>1. Low utilization of PONED</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Incomplete infrastructure and facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Placement of PONED Puskesmas that are not suitable (close to hospitals)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Lack of facilitation by OB-GYNs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Lack of information about services provided by health facility</td>
<td></td>
</tr>
<tr>
<td><strong>PONEK: OB-GYN Placement</strong></td>
<td>1. Budget proportion at each city is relatively small, under 11%. 2. Budget allocation including for specialist workers are low.</td>
<td></td>
<td>1. Limited availability of OB-GYN specialist doctors</td>
<td>1. Limited performance support for specialist doctors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Interest in going to areas is low</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Placements are not well distributed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. The domiciles of specialist doctors are not in the areas of their assignment. Limited availability of specialist doctors.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Improve quantity of specialist doctors graduating without compromising quality. 6. Budgets for procurement of specialist doctors are available (recruitment), but interest is low for specialist doctors to become Civil Servants (Calon Pegawai Negri Sipil - CPNS) in areas.</td>
<td></td>
</tr>
<tr>
<td><strong>PONEK: Emergency Facilities</strong></td>
<td>1. Lack of a policy that supports PONEK activity for patient flow</td>
<td>1. Local budget (APBD) is limited so that it still needs support from national budget (APBN)</td>
<td>1. Limited human resources for the PONEK team, which does not match the population that needs to be served</td>
<td>1. Request for PONEK services is high, but human resources are limited.</td>
</tr>
<tr>
<td><strong>PONEK: MONEV - Reward for general doctor and midwife</strong></td>
<td>1. Limited Budget</td>
<td></td>
<td>1. There has not been any follow-up on government regulation/policy that prioritizes medical workers who qualify as civil servants (PNS) 2. Problem: no follow-up process for medical workers who have achievements/have become models to be prioritized to increase their competence</td>
<td></td>
</tr>
</tbody>
</table>
### PONEK: Maternal Perinatal Audit (MPA)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PONEK: Maternal Perinatal Audit (MPA)</strong></td>
<td>1. Limited budget so that not all maternal deaths can be MPA-audited. 2. No efficiency is shown because MPA has not been running smoothly.</td>
<td>1. Not all maternal deaths are audited. 2. Obedient health workers on SOP 3. Limited human resources to facilitate MPA (e.g., OB-GYN, Child Specialist) 4. Because of lack of human resources to facilitate, utilization of the MPA result has not been used for learning. 5. Innovative ideas for quality improvement are not realized → repeats of the same case can happen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. Improve access to quality primary health care at the community level

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improve access to quality primary-level health care services at the community</strong></td>
<td>1. PKD Policy is not perfect (there is no workforce ratio policy within the population of 1 PKD). No reward and punishment system exists.</td>
<td>1. No available operational budget for PKD</td>
<td>1. Not all Village Health Polyclinics (Poliklinik Kesehatan Desa – PKD) are optimally utilized (24-hour functional) 2. PKD facility are inadequate so that midwives are not available 24 hours. 3. Equipment not complete 4. PKD workers not onsite 5. Not all Puskesmas are capable of providing normal childbirth services (limited workers and adequate facility)</td>
<td>1. Utilization of maternal health care services is not optimal. 2. Utilization of pusat RJ and RI as a labor room is not optimal. (There are still some people that prefer to give birth at their homes and accompanied by their families.) 3. Decision making is still dependent on their husbands and families.</td>
</tr>
<tr>
<td><strong>Improve access to quality primary-level health care services at the community - P4K (Birth Planning and Prevention of Complication) outside the health sector</strong></td>
<td>1. Limited budget for moving Village Health Forum (FKD) as a discussion forum of the P4K results</td>
<td>1. Lack of health workers' understanding about P4K (completing P4K stickers are based on family discussions) 2. Quality of midwives that still do not understand P4K 3. Not all villages implement P4K 4. Not all P4K are functional 5. Lack of support from cross sectors for P4K</td>
<td>1. Community's understanding (mother and family) about P4K is still lacking (some are shy of putting a sticker on their house) 2. Lack of the community's awareness on the importance of FKD (causing FKD to be inactive) 3. Lack of Community Leader (Tokoh Masyarakat – TOMA) involvement in the acceleration process to reduce MMR (many religious teachings are wrongly interpreted by the community that does not support health interventions)</td>
<td></td>
</tr>
</tbody>
</table>
## 3. Strengthen a quality referral system

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
</table>
| Referral System | 1. There is no specific regulation of the referral system.  
2. There are no details regarding national regulation of referral.  
3. A regional regulation was not finalized in 2009 because of cross-sector synchronization. A governor's regulation was planned but not executed.  
4. No regulation of the maternal neo-natal system exists. | 1. Jampersal does not cover other complications during labor for the mother or for the Jampersal participant who is not a poor family member.  
2. Not all districts/cities can implement Jamkesda sharing; district/city 60%, and province 40%. If district/city is not capable of 60%, then the cost is covered by the patient.  
3. Delays in claim payment in the referral service | 1. A tiered referral system is not working.  
2. Implementation of referral SOPs does not comply with standards for treating pre-referred and patient stabilization.  
3. Response time is too lengthy.  
4. A 24/7 readiness officer has not been formed in the referral facility.  
5. Communication and information system are not optimal at pre-hospital and hospital.  
6. Human resources and facility/infrastructure are not adequate. Not all hospitals have equipment for special cases. Readiness of facility/infrastructure true ICU at PONEK hospital  
7. Central Java only has 2 hospitals that are pure PONEK, which are Hospital Kariadi and Hospital Moewardi.  
8. Standard health rates for the same treatment in different classes in a hospital are given different rates.  
9. Arrangement of the referral system. Lack of filtering in referral cases resulting in services done at lower health facilities that are referred to higher class facilities; those referred to for strata 2 are instead referred to strata 1.  
10. Different rates between strata 2 and referred strata for the same treatment/case.  
11. Only 25 out of 247 hospitals in Central Java have been accredited as PONEK.  
12. Geographical condition and transportation facility are not adequate  
13. Implementation of P4K is not optimal. | 1. Delays in referral decisions at the family level  
2. Lack of community movement in preparing for referral transport by themselves |
## 4. Increase access to quality family planning (FP) and reproductive health services

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Policy and Planning</th>
<th>Budget and Financing</th>
<th>Service Delivery</th>
<th>Service Utilization</th>
</tr>
</thead>
</table>
| **Family Planning (FP)** | 1. Lack of commitment toward the national FP programme (related to autonomy areas).  
2. Laws No. 36 and 52, 2009, regarding FP and KESRO’s targets are more towards couples of childbearing age (PUS). | 1. Availability of local budget (APBD) at each district/city is still small.  
2. Lots of cuts in national budget (APBN) and provincial budget (APBD) (21%) so that the budget recipient gets very little. | 1. Decrease in commitment and morale/motivation of medical workers because of inadequate reward or incentives.  
2. Several local regulations charge compensation to service providers.  
3. Inadequate FP service facilities (example OB-GYN bed, gynecologist’s table)  
4. Lack of trained health workers  
5. Lack of family planning field workers (PLKB) as motivators for FP at fields  
6. Obstacles on the authority of midwives that have been trained in FP services.  
7. Increase in contraception equipment price | 1. The community’s expectation of implants and injection contraception, though not enough. |
| **Reproductive Health (KESPRO)** | 1. Obstacles by the Marriage Law of 1974 regarding marital age | 1. Budget for Youth Reproductive Health (Kesehatan Reproduksi Remaja – KRR) is too small/considered not a priority. | 1. Reproductive health services often do not engage the community in service delivery.  
2. Education about reproduction is not optimal in junior high school, high school, university and youth organization Karang Taruna. | 1. The community is not optimizing the use of available reproductive health (Kesehatan Reproduksi – kespro) services.  
2. Husbands are not involved in decision making related to reproductive health (kespro). |
ANNEX III: JAMPER SAL – UNIVERSAL DELIVERY CARE

Legal framework

1. Law No. 11/2009 on Social Welfare
2. Law No. 36/2009 on Health

Jampersal is a new Ministry of Health programme (started early 2011) that provides women universal free delivery care, including pre-natal and post-natal consultations. Consultation and delivery care are provided in health centres or third class wards in hospitals.

Since 2010, Jamkesmas also offered a program called Free Birth Delivery for All (Jaminan Persalinan / Jampersal). This program is part of the Jamkesmas program. This program is directed towards pregnant women, postpartum mothers (up to 42 days postpartum), as well as new born babies (0 – 28 days) who have not been covered by any maternal health program. Participants of Jampersal program can utilize services in all health care centre and facilities; both first level and advanced level in III class, that already have Cooperation Agreement with the Jamkesmas Management Team as well as BOK district level. Jampersal services is not limited to birth delivery service only, but also cover pregnancy check-up, ante natal care (ANC), and post natal care (PNC).

With this program, pregnant women could obtain free birth delivery, attended by skilled health personnel, by only showing their National ID Card. This program aims to reduce MMR and Infant Mortality Rate to achieve MDGs in 2015.

Financing

The budget in 2011 was IDR 1.2 trillion, targeting 2.6 million deliveries or 60 per cent of the total estimated 4.8 million deliveries. The scheme uses a direct payment mechanism based on a flat rate capitation amount, which means the patients do not pay anything. The total delivery package cost is IDR 420,000, including IDR 350,000 for delivery, IDR 40,000 for four anti-natal care visits, and IDR 30,000 for three post-natal care visits. The costs for special delivery cases are determined by the Indonesia Case Base Group (INA-CBGs) costing guidelines (MOH Decree No. 631/2011 regarding the Technical Guidelines of Jampersal).

ANNEX IV - PRIORITY ACTIONS FOR COUNTRY REPRESENTATIVES OF UNFPA, UNICEF, WHO AND THE WORLD BANK

DECREASING MATERNAL DEATHS AND IMPROVING CHILD SURVIVAL IN INDONESIA

Introduction

Maternal and child mortality in Indonesia are high and decreasing too slowly to achieve the MDGs. Achieving Universal Coverage with key health interventions and health insurance is slow, despite efforts such as Jamkesmas, Jampersal, and others. Decentralisation has affected functions of central and peripheral levels of government, and financial flows to finance health are fragmented, regulations are complex and sometimes conflicting between central and local levels and as a result resources are not spent efficiently. Providing quality care to the population, especially in remote and poor areas, is a major challenge. This note addresses key issues affecting maternal and child health which the international community, represented in the H4, aims to address, together with the Government of Indonesia, to find adequate solutions which can be implemented in the mid-term and which accelerate the decline in maternal and child deaths.

MAIN AREAS OF ACTION

1. Human resource planning

Standards for human resource deployment

Human resources are the backbone of any health service. However, there is limited understanding of the human resource needs to serve the population, and the level of training of many health professionals is inadequate for providing quality medical services. The country should consider undertaking a detailed mapping of the existing human resources and their training status, measured against service provider standards which are meeting the needs. Based on this mapping, a gap analysis can be undertaken with development of realistic projections of the human resource needs and scaling up plans. The needed finances can be described, but clear responsibility needs to be given to the different actors for meeting the scaling up target, and finances need to be made available. In the longer term, most of the training should be pre-service (see below), but for existing human resources, a training plan for in-service training needs to be developed. The H4 partners can help with this and some collaboration is already ongoing. Capacity for human resource deployment and development needs to be developed at the district level, where responsibility for human resources needs to be devolved to, with clear civil service criteria for employment and promotion, which need to be monitored centrally. It is crucial in this task that not only the public sector is targeted, but that the private health providers are fully taken into account in the mapping and subsequent activities.
Midwives as the spearhead of the MCH services

Launched in early nineties, The “Bidan di Desa” (Community Midwife) programme trained midwives to be deployed in every village to increase skilled birth attendance and reduce maternal deaths. The Government managed to deploy more than 60,000 midwives to the villages; but the programme was not able to maintain the availability of the midwife at the village; less than 50% of them currently remain in the villages, and many of those who remain at the villages are lacking skills and competency due to improper recruitment as well as un-standardized pre-service education, and lack of technical supervision. There is a need to review the programme (and see below 6.), and if maintained, to develop a full scaling up plan with appropriate supervision and in-service training in place. The recent World Bank document “...and then she died.” concluded midwives are very necessary but not sufficient by themselves to reduce maternal mortality.

2. Quality of care

Outpatient care

Indonesia has a well established system of PusKesMas which are delivering preventive and curative interventions and are supervising nurses and midwives in the community. The backbone of child health services is the Integrated Management of Childhood Illness (IMCI, MTBS). Coverage with IMCI trained health workers is around 50% of PusKesMas, and many health workers do not manage children according to IMCI. Standards for Adolescent Friendly Health Services have been agreed upon but are being implemented slowly. Antenatal care has reached high coverage, although not with well defined contents and delivery channels. To remedy this, mapping of human resources and access to care, a district training plan and supervision need to be implemented and monitored. Nurses and midwives need clear authority for the curative services they deliver. Because of the perceived low quality of services, many Indonesians give preference to private providers (which might not provide better care). Linking in the private sector into service provision and make them follow government guidelines is a further challenge to the government.

Inpatient care

Indonesia is committed to the expansion of basic and comprehensive emergency obstetric and neonatal care (BEONC and CEONC) through PusKesMas with beds and district hospitals. Scaling up is facing problems by manpower, supplies and equipment, skills and quick rotation of staff. As a result of low demand for higher level services, trained health professional loose their skills due to lack of practice. Hospital care for children has been found deficient in a recent assessment, with poor knowledge of and adherence to standard treatment guidelines, and poor monitoring and supportive care for very sick children. Clear communication of service standards and networks for quality improvements needs to be established.

Referral system

Sick patients need referral to higher level of care, particularly around delivery, for newborns and sick children. However, the next level of care from the community, i.e. the PusKesMas is neither well equipped nor staffed to fulfil such a recipient function. Clear referral pathways need to be established, with an analysis of bottle necks for patient flow, and analysis of performance to learn from deficiencies.
Standards and accreditation

Indonesia has established minimum service standards and a hospital accreditation system, but the standards, although compulsory, are not applied consistently. A recent assessment of 18 hospitals found that only one was accredited. In addition, the accreditation is mainly administrative and not technical. Clear service standards need to be developed together with an accreditation system, communicated and promoted to the population at large. Health insurance system should consider only reimbursing for services delivered at accredited facilities to support and promote accreditation.

Professional regulation of health providers

As part of the proposed mapping exercise, official documents need to be reviewed in order to identify gaps but also potential enabling legal documents to rationalize the deployment of staff with consideration to local needs and constraints and the urgent need to reduce inequity in the access to health care. In areas of need of health workers, there needs to be clear authorisation of task shifting to health workers of different grades after they have been trained appropriately. This is in the interest of the country, the health professional and the general public.

Health providers have a financial incentive to over-prescribe drugs, use particular ways of family planning, and encourage the use of formula by mothers. Government needs to find ways to discourage those harmful practices by health care providers and encourage rational of medicines, and sanctioning unethical practices by commercial entities.

3. Pre-service training of health professionals

There has been an enormous expansion of nursing and midwifery schools over the past few years in Indonesia. However, there are concerns about the practical skills and competencies taught, and the level of competencies at the end of training. The current policy for midwifery training is D3 education, a 3 years Direct Entry Midwifery Education Programme for High School (girl) graduates. There are more than 400 midwifery schools in the country (around 80 public and 340 private); but only few of them are accredited. Similarly, there are more than 500 nursing schools following a D3 and S1 curriculum with similar concerns about the quality of education. Medical education was modified several times, with some schools now following a 5 years’ curriculum without any internship phase, which leaves graduates largely without clinical skills. This is suggested to become compulsory, but care is needed to include compulsory training of clinical skills and procedures before a doctor can practice. Assessment of the existing curriculum is needed; followed by adjustment (revision) of the curriculum to meet the WHO-ICM competencies. A quality assurance process has been initiated, including monitoring and accreditation. Sanctions need to be in place in case of non-compliance. This is the aim of the ongoing Health Professional Education Quality project co-financed by the World Bank.
4. Data collection and use

Quality of data collection

Indonesia has a wealth of data which can be used for health planning. However, many data sets have limited precision for district planning. An attempt to remedy this with a Basic Health Survey was hampered by concerns about the quality of the data collected. There is no comprehensive vital registration with causes of death in the country, and sentinel surveillance of deaths has not been representative. Future data collection exercises are needed and should pay attention to the quality of data and their representativeness. There needs to be a mechanism to make such data available in time to be useful for district planning. Digital maps and data sources in the country are diverse and often not matching. There needs to be a central body which makes authoritative and accurate maps available to districts with geographical coordinates of health facilities and the attribution to administrative units, with a mechanisms or quick updates.

Evidence based programming at district level and local data collection and use

There are several protocols for local data collection which should all feed into the District Team Problem Solving (DTPS) as the core annual planning exercise. Local area monitoring of pregnancies should give data on pregnancy outcomes, maternal perinatal audits examine causes of deaths, service availability mapping gives data on human resources and their training needs, and intervention coverage surveys such as the MCH household survey and the EPI cluster surveys give community data of the coverage of interventions to identify gaps. However, districts and health providers do not undertake these exercises meaningfully.

There needs to be a mechanism to build capacity in districts to perform these exercises as a basis for their annual planning, by capacity building or technical support.

5. Policy on Bidan di Desa and institutional deliveries

For more than 10 years, Indonesia has bet on the Bidan di Desa programme for having 100% deliveries by Skilled Birth Attendants and reduce MMR. During the same 10 years, MMR has been stagnant. Large countries of Asia who have seen a significant decrease in MMR in the past years (e.g. Bangladesh, China) attribute this decrease to an increase in institutional deliveries. Indonesia has no clear policy on institutional deliveries. Is it something the country wants? Is it feasible and realistic throughout the whole archipelago? Should institutional deliveries be promoted in at least part of the country where the health system can provide it?

While the increase in coverage for SBA is still valid, there is an urgent need for a policy decision on institutional deliveries, together with a scaling up strategy and a monitoring/evaluation plan.

6. Financing schemes for maternal and child health care

The Government of Indonesia established different types of social safety schemes to assist the people in getting adequate maternal and child health care. Those include: SJSN (Sistem Jaminan Sosial Nasional); JAMKESMAS (as the replacement for ASKESKIN); JAMPERMAS; and BOK (Bantuan Operasional Kesehatan); and many others, not to mention those provided by the local government which are local specific.
It is important to understand the different schemes that exist in the country: how they benefit the at-risk groups, how they finance the health system, and how they complement each other. Despite decentralization, there is still considerable funding given by the central level, and districts wait for funds to come from there, instead of budgeting locally. The investment case found that the funding schemes are so complex they are not used properly, and funds have to be returned. There is an urgent need to simplify financial streams and make sure that funds are used for health.

7. Family planning

Weakening of the FP programme

Following the decentralization of the government system, the District FP offices (which used to be called district BKKBN offices) do no longer exist. This resulted in a weakened FP programme in many districts. The FP programme is no longer on the agenda of many local governments. The latest IDHS (2007) shows stagnant coverage of FP indicators, despite a high unmet demand for the services.

With the new Law on Population and Family Development No 52/2009, the roles of the BKKBN and FP institutions at sub national levels have changed. With these changes, the different roles and coordination among the key sectors (Dinkes, PPKB office, and BKKBD offices) needs to be clarified. Advocacy for advancement of the FP programme into the local government agenda needs to take place.

Imbalance of contraceptive mix

Although the data (IDHS) show stagnancy of contraceptive prevalence rate, contraceptive use among married couples is considerably higher compared to other countries in the region. However, the contraceptive mix tends to be imbalanced. Use of hormonal/short term contraceptive methods, especially injectables, has increased over time. Hull & Mosley in 2009 analyzed that the situation is more provider driven than demand driven. While there was no doubt that women did show their preference for injectables, some studies show that demand for implant and sterilization (both women and men) are also high, which are not yet met.

The government needs to address this issue by a detailed study and appropriate regulation of the FP providers.

Meeting the needs of unmarried, including the adolescents

Public service restricts access non-married to family planning (contraceptives), many studies show that more and more non-married and adolescents are sexually active. Although some of them may access services through the private sector, the needs of a large proportion of them remain unmet.

A study of access to and use of contraceptives among unmarried and adolescents is to be carried out to help the Government in analysing the situation and understanding the consequences of not meeting their needs. This should result in change of rules allowing access (see below).
8. Legal regulation issues and international obligations

**Female Genital Mutilation (FGM)**

Despite all international commitments against FGM, and more recent concerns of its practice by health care providers, Ministerial Decree 1636/2010 authorizes a minimal form of FGM, to be done and only be done by doctors, nurses or midwives. H4 needs to communicate clearly that this is in breach of the government’s international obligations.

**Expulsion of pregnant girls from schools and professional education**

There is anecdotal evidence that unmarried students at all levels of education are forced to give up their studies if they become pregnant. This is presented at provincial level as a “regulation” coming from the national level: e.g. the Centre for Health Human Development of the MOH. The concerned department denies the existence of such a regulation. This practice is in clear violation of Indonesia’s human rights obligations, as it is discriminatory to girls, denying them the right to education and professionals schooling without a legal basis and good reason. H4 needs to speak out about this.

**Access of adolescents to RH services**

Access of adolescents and unmarried girls is important for reaching MDG5 and is stipulated as such in MDG5B. However, health care providers do not seem to know this, and some regulations/decrees or free/loose interpretation hamper access of adolescents to RH services and family planning (see 7 above). The MoH needs to take initiative to clarify the situation and improve access.

ANNEX V: FRAMEWORK OF THE CONTINUUM OF CARE

I. The Conceptual framework for Maternal Health

The pathway of maternal death and its determinants can be explained by the following three conceptual frameworks: a) Framework for determinants of maternal mortality (McCarthy & Maine, 1992), b) framework on the continuum obstetric care, and c) framework on the cascade of missed-opportunities at different level of services.

A. Framework for Analyzing the Determinants of Maternal Mortality

The framework indicates that the outcome of a reproductive health operate through a sequence of outcomes, starting with a pregnancy, that can be ended with a maternal survival, complication or maternal disability/maternal death. Maternal death and disability happened when a complication due to or aggravated by a pregnancy cannot be managed in a timely and adequate manner. These outcomes are directly influenced by intermediate determinants: maternal health status, reproductive health status, access to health services, and health care behaviour or use of health services. These determinants are the results of socio-economic and cultural factors. On the other hand, there are unknown or unpredicted factors affecting the occurrence of obstetric complications.

The concept indicates that maternal mortality can be reduced in careful consideration of three essential situations, i.e., reducing pregnancy with potential risks of dying, preventing complications and, if complications arise, managing the complications adequately.
**B. Framework on the Continuum Obstetric Care**

WHO has predicted that about 85 percent of the total deliveries are normal, and 15 percent are likely to suffer from different severity of complications. Most of the complications can be prevented and managed, and therefore the proportion of women who die from complications should be very small. However, in many developing countries, including Indonesia, maternal deaths are still very high. This situation can be explained through the concept of Continuum of Obstetric Care.

The main problem of maternal death is rooted in the fact that most complications cannot be predicted, consequently requiring the 24/7 readiness of care. All women should be treated as at risk of having complications and thus should have access to 24/7 care to ensure that, whenever a complication arises, she can have the appropriate care. This means that the health provider who gives first care to the pregnant or delivering woman is required to have the ability to: 1) prevent certain complications; 2) detect complications as early as possible; and 3) when complication cannot be avoided, give appropriate first aid and refer the patient effectively (timely and stabilizing the patient) (Figure 5).

Health providers working in Polindes and Puskesmas are usually the first health providers who give care to mothers. Therefore, there are two important issues that need to be secured. First is the accessibility to the service, in this case affordable 24/7 care. Second is the quality of care available. A mother who cannot access quality care at any time she needs, will be at risk of dying. Hence, the availability of 24/7 services at different levels of service will reduce the risk of missed-opportunity cases to be prevented, detected early and/or to be refer effectively, and eventually to be saved. Unfortunately, health providers such as midwives are not
always available. Many villages do not have a bidan to give the service at any time needed or the midwives do not stay in the designated villages. Consequently, when a woman with a complication needs a bidan service and decision for referral, she will be at risk of dying because she is likely to be not referred or, if referred at all, then very late.

On the other hand, accessibility to the health provider services does not guarantee that the mothers will be saved. It very much depends on the quality of care provided by bidan and the timeliness of the care given. If the bidan do not have sufficient skills to prevent complication, or making early identification of complication or facilitating an effective referral, the complication is unlikely to be managed appropriately in a timely manner to save the woman's life.

Each of the three delays in reaching the adequate care will increase the risk of maternal deaths significantly. This is because some of the complications can cause maternal deaths very shortly after the complication takes place (such as post-partum haemorrhage), some within 12 hours, and some will take a longer time. The delays can happen for many reasons, including culture, tradition, geography, health system, the skills of providers, quality of care and finance. Evidence indicates that the three delays are equally important, including the delay in the management of complication in the hospital. Research results in Indonesia (Immpact, 2008) showed that delays in hospital count for 44 percent of delays. This suggests the level of quality of care in the hospital.

The problem of quality of care is not merely a problem at facility level. There is ample evidence on the poor quality of care at community level, such as a study conducted in Indonesia by D’Ambruoso, et al., (2009), which revealed that the care provided by midwives was sub-standard.

FRAMEWORK ON CONTINUUM OF OBSTETRIC CARE

![Diagram showing the continuum of obstetric care with nodes for births by midwife, mother's survival, use of health provider at Puskesmas, quality of services, timely access to EmOC facility, and effective referral.]

Source: McCarthy & Maine, 1992
C. The consequences of not receiving a continuum of care: the cascade of missed opportunities at different levels of service

The figure below illustrates the implications for a mother with a risk of complication or of dying who is not receiving a continuum of care. If almost all complications can be prevented, detected early, referred in a timely and effective fashion, and managed appropriately, almost all deaths can be prevented. However, this is not what is happening in many cases. We use four scenarios to illustrate the risks of dying due to the failure to receive a continuum of care. Scenario A demonstrates the absence of good care at all levels, from community to Emergency Obstetric Care facility. The results can be anticipated, i.e., a very small proportion of women survived. Scenario B shows good service at primary level, for example universal access to skilled professional attendants; however, it is not complemented by good service in the following levels, leading to only a small proportion of women with complications being referred to and receiving adequate obstetric care. As a result only a small proportion of women survived. Scenario C illustrates the existence of a continuum of care, however the coverage of the services at each level was not high. Scenario D demonstrates an interesting situation, even though it is not very common in the Indonesia context. In this scenario, a good service in the EmOC hospital is useless in saving women’s lives because the women who need care rarely use the services.

**FRAMEWORK ON THE CASCADE OF MISSED OPPORTUNITIES AT DIFFERENT LEVELS OF SERVICE**

<table>
<thead>
<tr>
<th>Scenario A</th>
<th>Scenario B</th>
<th>Scenario C</th>
<th>Scenario D</th>
</tr>
</thead>
<tbody>
<tr>
<td>No CoC</td>
<td>Good service at primary level, but no CoC</td>
<td>CoC, and need to increase coverage</td>
<td>No CoC even though good services are available in the hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All births</th>
<th>Complication: 15%</th>
<th>Complication</th>
<th>Complication</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal: ≥ 85%</td>
<td>Prevented/detected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effective referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers survived</td>
<td>Almost all complications can be saved, because they are prevented/detected early/referred/managed adequately</td>
<td>Alive</td>
<td>Died</td>
<td>Alive</td>
</tr>
</tbody>
</table>

Different Outcome

Source: Achadi, E, 2010

*CoC: Continuum of Care.
The cascade of missed opportunities explained above mostly reflects the direct causes of obstetric complications. The pathway of indirect causes might be different in certain cases, because it starts with non-obstetric symptoms/problem and the motivation to seek care may also different. For example, a pregnant women with high fever for several days will go directly to a health professional or facility. From there, the flow of further services received/obtained will be led by the type of sickness.

The main implication of indirect cause of death is the reporting and recording of maternal death data. There is a potential missed opportunity of recording the indirect cause of death, which can be caused by a lack of knowledge about the definition of maternal death, which can lead to underestimating the real figure of incidence of MMR.
REFERENCES


Bappenas. 2010. Pedoman Penyusunan Rencana Aksi Percepatan Pencapaian Tujuan MDGs di Daerah (RAD MDGs).

Bappenas. 2010. The Roadmap to Accelerate Achievement of the MDGs in Indonesia.


Department of Cundinamarca Colombia. 2010. Regional Document for Accelerating Progress toward the MDGs. September 2010.


Republic of Indonesia Laws No. 32 Year 2004 on Local Governance (Undang-Undang Republik Indonesia Nomor 32 Tahun 2004 tentang Pemerintahan Daerah)

Republic of Indonesia Laws No. 38 Year 2007 on the Division of Governance Roles between Central, Provincial and District/City Governments. (Peraturan Pemerintah Republik Indonesia Nomor 38 Tahun 2007 tentang Pembagian Urusan Pemerintahan antara Pemerintah, Pemerintahan Daerah Provinsi, dan Pemerintahan Daerah Kabupaten/Kota)

RSUD Dr. Soeselo Slawi, Tegal. 2012. Laporan Kegiatan Rekam Medis Tahun 2011.


