REMARK FROM THE MINISTER OF HEALTH

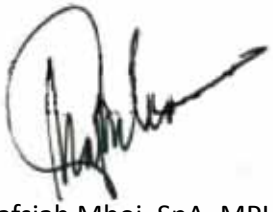
The targets of the Millennium Development Goals (MDGs) are due to be reached in 2015, just two years after the publication of this book. The Government of Indonesia has dedicated strong attention to reaching these targets. This attention has only been strengthened by an increased allocation of health funds, with about 80% of this increase occurring in the regions. However, several MDG indicators, which are also included in the targets of the National Medium Term Development Plan (RPJMN) for 2010-2014, will be difficult to achieve under the current efforts and strategies. Various projections and estimates have found that the Maternal Mortality Rate (MMR) will not drop fast enough to achieve the target by the deadline in 2015 without a renewed approach.

The results of surveys and research conducted over the past five years have generally shown that under the current approach, the targeted decrease in the MMR will not be achieved by the deadline of the MDGs in 2015. This indicates that a more cost-effective and evidence-based approach is needed. Furthermore, the country's stagnant Total Fertility Rate (TFR) over the past 10 years shows that the Government's Reproductive Health Programme and Family Planning Programme require special attention. In recent years, maternal deaths have mostly occurred among women aged under 20, or over 35, and greater numbers of women have begun to have more than three children, with shorter spacing between births.

Health programme managers at the national, provincial and district levels should be able to identify the existing problems and find solutions, using the interventions that have proven to work successfully with the use of local resources. Optimization and synchronization of activities must be conducted. Every district and city must re-examine whether the action plans developed have addressed the existing problems in their region. The role of provinces should be promoted as an extended arm of the central government to assist the districts and cities in carrying out the development of public health. Strategic steps that need to be carried out to optimize efforts to accelerate the reduction of the MMR are detailed in this book.

I extend my appreciation to all stakeholders who have already, are currently, or are planning to participate in accelerating the reduction of the MMR in this country, and all who have contributed to the publication of this book. It is my hope that this book will be useful as a reference for the acceleration of the reduction of the MMR in Indonesia, and can bring the greatest possible results for the health of its people.

Jakarta, 30 April 2013



Dr. Nafsiah Mboi, SpA, MPH,
Health Minister of the Republic of Indonesia

FOREWORD DIRECTOR GENERAL OF NUTRITION, MATERNAL AND CHILD HEALTH

Thanks to Almighty God for His blessings and the abundance of His grace, that the National Action Plan for the Acceleration of the Reduction of the Maternal Mortality Rate can finally be published. This book was jointly prepared by all programmes involved in the Ministry of Health, as well as professional organizations and donor agencies involved in maternal health in Indonesia.

The National Development Planning Board (Bappenas) has developed a Regional Action Plan to achieve the Millennium Development Goals, or MDGs. In 2010, this Regional Action Plan should be followed up with concrete actions, particularly because the MDG target on reducing maternal deaths is predicted to be difficult to achieve before the deadline in 2015. It is important for stakeholders to read this book, which details the principles of maternal mortality prevention, strategies and interventions − interventions that have proven to be effective for preventing maternal mortality − and the parameters that must be considered by programme managers.

It is expected that this book can serve as a set of guidelines for all actors involved in maternal health at the national and regional levels in developing the programmes and targets that suit the conditions of each region.

Thanks to all parties that have contributed to the preparation of the National Action Plan for the Acceleration of the Reduction of the Maternal Mortality Rate, and especially to Dr. Endang Achadi, MPH, who helped with the formulation of this National Action Plan.

Jakarta, March 2013
Director-General of Nutrition, Maternal and Child Health

Dr. Slamet Riyadi Yuwono, DTM&H, MARS

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
APBD	*Anggaran Pandapatan dan Belanja Daerah* (Regional Budget)
APN	*Asuhan Persalinan Normal* (Normal Delivery)
Balitbangkes	*Badan Penelitian dan Pengembangan Kesehatan* (National Institute of Health, Research and Development)
Bappeda	*Badan Perencanaan Pembangunan Daerah* (Regional Development Planning Board)
Bappenas	*Badan Perencanaan Pembangunan Nasional* (National Development Planning Board)
BDRS	*Bank Darah Rumah Sakit* (Hospital Blood Bank)
BKKBN	*Badan Kependudukan dan Keluarga Berencana Nasional* (the National Population and Family Planning Board)
BPPSDM	*Badan Pengembangan dan Pemberdayaan Sumber Daya Manusia* (Human Resources Development and Empowerment Board)
BPS	*Bidan Praktik Swasta* (Private Practice Midwife)
CSR	Corporate Social Responsibility
DPRD	*Dewan Perwakilan Rakyat Daerah* (Regional Representatives Council)
DTPK	*Daerah Tertinggal, Perbatasan dan Kepulauan* (Underdeveloped, Border and Island Regions)
GDON	*Gawat Darurat Obstetri dan Neonatal* (Emergency Obstetrics and Neonatal Care)
GSI	*Gerakan Sayang Ibu* (Mother-Friendly Movement)
HDK	*Hipertensi Dalam Kehamilan* (Hypertension in Pregnancy)
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immuno-deficiency Syndrome
HOGSI	*Himpunan Obstetri dan Ginekologi Sosial Indonesia* (Indonesian Social Gynaecology and Obstetrics Association)
IAKMI	*Ikatan Ahli Kesehatan Masyarakat* (Indonesian Public Health Association)
IBI	*Ikatan Bidan Indonesia* (Indonesian Midwives Association)
ICD 10	International Classification of Diseases
IDAI	*Ikatan Dokter Anak Indonesia* (Indonesian Pediatrics Society)
IDI	*Ikatan Dokter Indonesia* (Indonesian Medical Association)
IDHS	Indonesia Demographic and Health Survey
IDI	*Ikatan Dokter Indonesia*(Indonesian Medical Association)

IDSAI	*Ikatan Dokter Spesialis Anestesiologi dan Reanimasi Indonesia* (Indonesian Society of Anesthesiologists and Reanimateurs)
K4	Antenatal visits occurring four times (4 *kali*) throughout pregnancy: once each in the first and second trimesters, and twice in the third trimester.
KARS	*Komisi Akreditasi Rumah Sakit* (Hospital Accreditation Commission)
KB	*Keluarga Berencana*, Family Planning
Kemenkes	*Kementerian Kesehatan*, Health Ministry
KIA	*Kesehatan Ibu dan Anak* (Maternal and Child Health)
KIE	*Komunikasi, Informasi dan Edukasi* (Communication, Information and Education)
MMR	Maternal Mortality Rate
MDGs	Millennium Development Goals
MoU	Memorandum of Understanding
NGO	Non-Governmental Organization
P4K	*Program Perencanaan Persalinan dan Pencegahan Komplikasi* (Complication Prevention and Delivery Planning Programme)
Pemda	*Pemerintah Daerah* (Local Government)
Perda	*Peraturan Daerah* (Regional Regulation)
PERSI	*Perhimpunan Rumah Sakit Seluruh Indonesia* (Indonesian Hospital Association)
PKK	*Pemberdayaan Kesejahteraan Keluarga* (Empowerment of Family Welfare)
PMA	Perinatal Mortality Audit
PMD	*Pemberdayaan Masyarakat Desa* (Empowerment of Village Community)
PMI	*Palang Merah Indonesia* (Indonesian Red Cross)
PODES	*Potensi Desa* (Village Potential Statistics)
POGI	*Persatuan Obstetri dan Ginekologi Indonesia* (Indonesian Society of Obstetrics and Gynecology)
PONED	*Pelayanan Obstetri Neonatal Emergensi Dasar* (Basic Emergency O*bstetric* and Neonatal Care)
PONEK	*Pelayanan Obstetri Neonatal Emergensi Komprehensif* (Comprehensive Emergency Obstetric and Neonatal Care)
PP AKI	*Percepatan Penurunan Angka Kematian Ibu* (Acceleration of the Reduction of the Maternal Mortality Rate)
PPDS	*Program Pendidikan Dokter Spesialis* (Doctorate Program in Medicines)

PPIA	*Pencegahan Penularan HIV dari Ibu ke Anak* (Prevention of the Tranmission of HIV from Mother to Child)
PPNI	*Persatuan Perawat Nasional Indonesia* (Indonesian National Nurses Association)
Puskesmas	*Pusat Kesehatan Masyarakat* (Community Health Centre)
Pusrengunakes	*Pusat Perencanaan dan Pendayagunaan Tenaga Kesehatan* (Center for Health Personnel Plannning and Utilization)
Pustanserdik	*Pusat Standardisasi, Sertifikasi dan Pendidikan* (Center for Standardization, Certification and Education)
RAD	*Rencana Aksi Daerah* (Regional Action Plan)
RAN	*Rencana Aksi Nasional* (National Action Plan)
RB	*Rumah Bersalin* (Birthing House/Maternity Hospital)
Rifaskes	*Riset Fasilitas Kesehatan* (Health Facility Research)
Riskesdas	*Riset Kesehatan Dasar* (Basic Health Research)
RPJMD	*Rencana Pembangunan Jangka Menengah Daerah* (Regional Medium-Term Development Plan)
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional* (National Medium-Term Development Plan)
RPJPN	*Rencana Pembangunan Jangka Panjang Nasional* (National Long-Term Development Plan)
RS	*Rumah Sakit* (Hospital)
SDKI	*Survei Demografi dan Kesehatan Indonesia* (Indonesian Demographic Health Survey)
SJSN	*Sistem Jaminan Sosial Nasional* (National Social Security System)
SPOG	*Spesialis Obstetri dan Ginekologi* (Gynaecology and Obstetrics Specialist)
SUSENAS	*Survey Sosial Ekonomi Nasional* (National Socioeconomic Survey)
UKS	*Usaha Kesehatan Sekolah* (School Health Programme)
UTD	*Unit Transfusi Darah* (Blood Transfusion Unit)
WHO	World Health Organization
WUS	*Wanita Usia Subur* (Reproductive Age Women)

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CHAPTER I

INTRODUCTION

A. Background

Maternal mortality is a result of the interaction of various aspects, which include clinical aspects, health care system aspects and non-clinical aspect affecting the clinical service delivery and implementation of the optimal health care system. Therefore, a common perception and understanding of the stakeholders on the importance and the role of these aspects in addressing maternal mortality are required, and the strategies to address the maternal mortality should be a comprehensive integration of these various aspects.

Based on the estimation derived from IDHS in 1990 until 2007 that uses the exponential calculation, the maternal mortality rate in Indonesia in 2015 is 161/100.000 live births, while the MDG target of Indonesia is 102/100,000 live births. The Presidential Instruction No. 3 of 2010 on equitable development requires all governors, head of districts and mayors to prioritize the achievement of the MDG targets in their regional development programs as outlined in the Regional Action Plan for MDGs achievement.

In focusing the achievement of MDG Goal 5, that is improve maternal health, the collaboration of all stakeholders to perform effective, efficient and consistent measures is required to accelerate the maternal and neonatal mortality rate reduction in Indonesia. Therefore, the Ministry of Health establishes an action plan for the acceleration of maternal mortality rate reduction 2013-2015, which focuses on 3 strategies and 7 main programs.

This Action Plan is expected to create the same understanding for all stakeholders about the concept of maternal and neonatal mortality and the effective and efficient measures to prevent them. These efforts require a strong commitment from all stakeholders to accelerate maternal mortality rate reduction in Indonesia, which is set forth in the Regional Action Plan.

B. Goal

General

Achieve the maternal mortality rate target in Indonesia, which is 102/100.000 live births in 2015, and meet the maternal mortality rate target in the regions according to the Regional Action Plan/MDGs/Regional Mid-Term Development Plan for the regions that have achieved the national target.

Specific

a) Describe the presidential vision, mission and program that are developed based on the National Long-Term Development Plan 2005-2025. In this plan, the maternal mortality rate is targeted to fall from 307/100.000 live births in 2008 to 118/100.000 live births in 2014.
b) Provide guidance and directions for the implementation of maternal and neonatal health development at national, provincial, district and city levels, both for the government

institutions and the community and other stakeholders involved in the improvement of maternal and neonatal health.

c) Focus on improving the health care system to ensure the availability of access to quality obstetric and neonatal care.

C. Target

Decision makers at national, provincial, district/city level; program managers; health professionals; professional organizations; community organizations; business sector; and groups that are concerned with maternal health.

CHAPTER II

SITUATION ANALYSIS

A. Maternal Mortality

1. Definition of maternal mortality

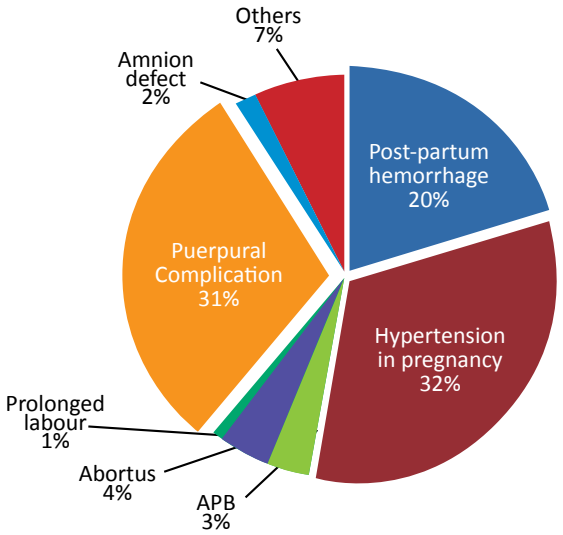
According to ICD 10, maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."

The definition explicitly explains that maternal mortality covers a wide scope, which is not only related to the deaths during delivery, but also includes the death of mothers during pregnancy and postpartum.

The definition also distinguishes maternal deaths into two categories. The first is a death caused by direct obstetric causes, that is the death directly resulting from pregnancy and childbirth. The second is a death caused by indirect causes, that is the death resulting from previous existing diseases, and is not due to pregnancy or childbirth.

2. Direct causes of maternal mortality

Globally, the five major causes of maternal death are hemorrhage, hypertension in pregnancy, infection, obstructed labor and abortion. In Indonesia, maternal mortality is still dominated by three main causes of death, which are hemorrhage, hypertension in pregnancy and infection, but the proportion of these three causes of death have changed. Hemorrhage and infection are decreasing, while hypertension in pregnancy is increasing, with almost 30% of maternal mortality in Indonesia in 2010 are due to hypertension in pregnancy.



(Source: Population Census 2010)

Figure 1: Causes of maternal mortality 2010

3. Indirect causes of maternal mortality

The definition of maternal mortality indicates that maternal mortality does not only include the deaths caused by delivery, but is also related to deaths caused by non-obstetric causes. An example is a pregnant woman who dies from tuberculosis, anemia, malaria, heart disease, etc. These diseases are considered to aggravate pregnancy, increase the risk of morbidity and mortality**.**

The proportion of indirect causes of maternal deaths in Indonesia is quite significant, which is about 22%, so attention should be given to prevention and treatment. In dealing with the indirect causes, coordination with other medical disciplines in a hospital or between hospitals, such as with internal medicine and surgery, is required.

4. Maternal mortality in Millenium Development Goals

Indicator for improved maternal health in the Millennium Development Goals (MDGs) is a reduction of maternal mortality rate associated with improved childbirths attended by skilled health personnel (MDG Target 5a). But this effort is not enough, because reducing maternal mortality rate can not be done simply by addressing the direct causes, but also by overcoming the indirect causes. Therefore, the efforts to reduce maternal mortality rate should also be supported by other reproductive health-related efforts, including increased antenatal care coverage, declined adolescent birth rate, increased contraceptive prevalence rate and declined unmet need of family planning. The four indicators are set forth in the MDG Target 5b: universal access to reproductive health, while the last two additional indicators are the efforts of the family planning program. The "4 Too" factor (too young, too close, too many and too old) is one of the indirect causes of maternal mortality that can be overcome with family planning services.

B. *Pathway* of maternal mortality

It is estimated that 15% pregnancy and birth will have complications. Most of these complications can be life-threatening, but most of them can be prevented and treated if: 1) the mothers immediately seek medical treatment, 2) the health personnel perform the appropriate treatment procedures, including using a partograph to monitor the progress of labor and implementation of the active management stage III to prevent postpartum hemorrhage; 3) the health personnel are able to identify early complications; 4) if complications occur, the health personnel are able to provide first aid and perform stabilization to the patients prior to making referral; 5) the referral process is effective; 6) the hospital services are prompt and appropriate.

Thus, the complications that require treatment in a hospital need a continuum of care, covering the basic services through hospital services. The above mentioned step 1 through step 5 will not be helpful if the step 6 is inadequately performed. On the contrary, the adequate hospital care will not be beneficial if the patient suffering from complications is not referred to hospital services (Figure 2)

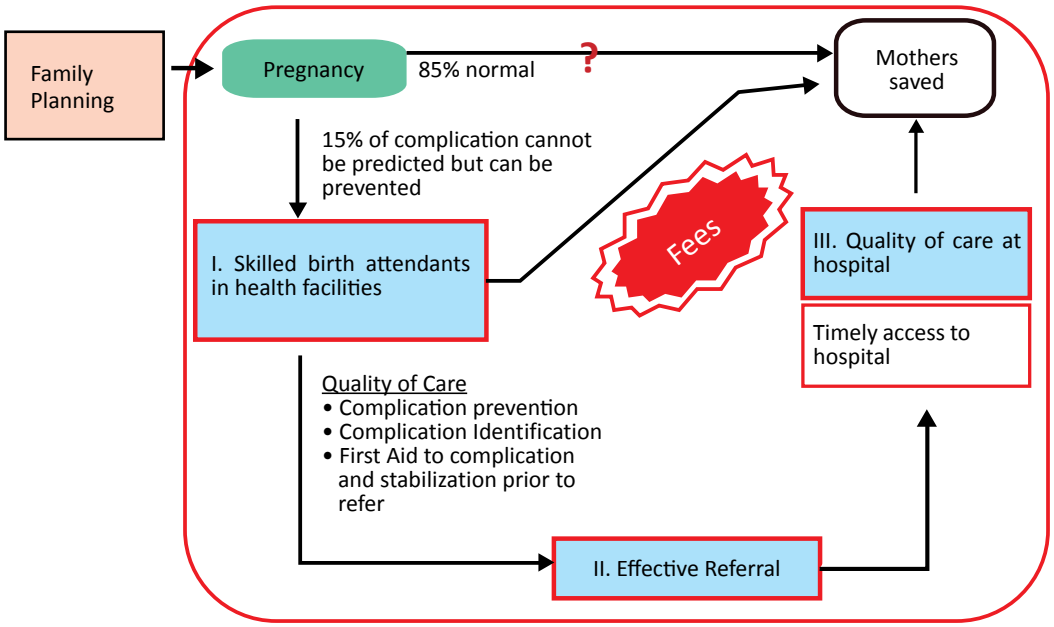


Figure 2. Framework of Pathway Concept of Maternal Mortality

C. Principles of maternal mortality prevention

Most of the maternal deaths should be preventable, because most obstetric complications can be handled. At least there are three conditions that need to be observed to save a mother:

a) **First, obstetric complications are unpredictable,** so they will occur to any pregnant woman at any time (during pregnancy, childbirth or postpartum, especially the first 24 hours after delivery). This condition puts **any pregnant woman at risk of having obstetric complications that may threaten their life.**

b) **Secondly**, every pregnancy has a risk, so **every pregnant woman should have an access to adequate services required when complications occur**. Most complications can be life-threatening and should be immediately attended at the hospitals that can provide obstetric and neonatal emergency care.

c) **Thirdly, most of the maternal deaths occur during delivery and in the first 24 hours** after delivery, which are a very short period, so the access and quality of care in this period should be prioritized to give high leverage in reducing maternal mortality.

A pregnant/giving birth mother dies because the complications they are suffering from are not attended in timely and appropriate manner

In reality, preventive measures and treatment of complications mentioned above are not usually performed, because of the delays, which include:

a) <u>Delays in making a decision</u>

Delays in making a decision at the community level are attributed to the following conditions:

1) The mother is late to seek assistance from health professionals despite the available access to them for 24 hours a day and 7 days a week due to the constraints of traditions/beliefs in decision-making in the family, and the inability to provide non-medical costs and other medical costs (particular type of medicines, blood type check, transportation to find blood/medicines, etc.).
2) The family is late to refer the mother to health professionals due to lack of understanding about the life-threatening signs.
3) The health professionals are late to perform the preventive measures and/or identify the complications early due to lack of optimal competence, such as handling normal delivery care according to the standard and providing first aid for obstetric and neonatal emergency.
4) The health professionals are not able to advocate the importance of making a prompt referral to the patient and her families to save the mother's life.

b) <u>Delays in reaching the referral hospitals and ineffective referral</u>, which can be caused by:

1) Geographical issues
2) Constraints of means of transport
3) Stabilization of patients with complications (such as pre-shock) is not performed/not effective, because the health professionals' skills are not optimal and/or the medicines/medical devices are not available.
4) Monitoring of the referred patients is not performed or performed but is not followed by necessary actions.

c) <u>Delays in getting adequate care in referral hospitals</u>, which can be caused by

1) Ineffective administrative system of emergency care in hospitals.
2) The required health professionals (obstetrician/gynecologist, anesthesiologist, paediatrician, etc.) are not available.
3) Lack of skillful health professionals despite available access to them
4) Incomplete/unavailable infrastructure, such as emergency room, delivery room, medical instruments and medicines.
5) Blood is not immediately available
6) Patients arrive at the hospital in a critical condition that is difficult to save.
7) Lack of clear admission procedure for emergency cases to prevent rejection of patients or to make an effective referral to other hospitals.
8) Lack of information for the community about the capacity of the health care facilities that are referred to in handling obstetric and neonatal emergency, so adequate service is not obtained

D. Program Achievement

One of the massive government efforts to reduce maternal mortality rate is the program that assigns midwives in the villages, which has been initiated since the 1990s. The program aims to bring people's access closer to the health services for mothers and newborns, especially during pregnancy and childbirth. However, since the midwife education only

takes a short time, approximately 54,000 in 6 years, the quality of some midwives still needs to be improved to meet the standards of competence
Based on the regular reports on maternal health from the Provincial Health Office in 2011, until today there are 66,442 village midwives that are registered, but only about 54,369 of them (82%) live in the villages. In addition, village midwives' ability in providing standardized delivery care is hampered by housing facilities that also serve as a village health post. The Indonesia Health Profile Data of 2011 shows that the number of village health posts in 2011 are only 53,152. In addition, the number of midwives who have received training on normal delivery care is only 35,367 (52.6%). The training components include the active management stage III to prevent partial postpartum hemorrhage and the use of partograph to detect problems in delivery process.

Since not all villages have a midwife, and only some midwives are trained to have adequate skills, delivery care that meets the standards can be performed in health care facilities (community health centers that provides inpatient care or basic obstetric and neonatal emergency care/PONED). Delivery in health care facilities has several advantages: there are more than one health personnel to attend the delivery, especially in the case of complications, and thus monitoring of patients can be done more intensively by turns; overcome the shortage of midwives as rotational assignments can be done in a health care facility; since the delivery is not taken place at the patient's home, family pressure and unfavorable conditions of the house for the midwife can be avoided; the availability of equipment and medicines in the health care facilities is more certain; health care facilities are usually located in the area from which it is more convenient to reach the hospital.

The implementation of normal delivery care standards in basic health facilities has met the expectation as shown by the declining proportion of hemorrhage and infection. However, the quality of maternity care still needs to be improved. The results of Quality Maternal Health Services Study in 2012, which was conducted in 20 districts/cities in Indonesia, show that the adherence of health professionals in using a partograph, performing a physical examination and documenting the examination results is still low, whereas a thorough physical examination and proper use of a partograph can prevent delivery complications. (Table 1)

Table 1: data on normal delivery care quality

NORMAL DELIVERY CARE	Hospital*	Community health center*
Complete the medical record	68,6%	61,4%
Complete the general physical and obstetric examination	52,1%	57,3%
Use a partograph	41,0%	68,3%
Use a cardiotography (CTG)	19,0%	2,5%
Perform delivery care stage I	73,8%	83,8%
Observe indication and symptom stage II	80,0%	85,0%
Prepare delivery care	60,6%	65,8%
Ensure full opening of the cervix	72,5%	77,5%
Ensure good condition of the fetus	77,5%	75,0%
Document the examination results	20,0%	42,5%

(Source: Quality maternal health services study, Min. of Health- WHO-HOGSI, 2012)

The maternal and neonatal deaths are highly influenced by the promptness and and accuracy of the measures taken during emergency. The existence of the community health centers that have a capacity to provide PONED is a solution to bring the public access closer to obstetric and neonatal care to prevent complications and/or get a first aid during obstetric and neonatal emergency on the conditon that the service provided meets the adequate standards of care. However, the coverage and quality of basic services still need to be improved. The data from the 2011 health facilities research shows that 241 districts in Indonesia (60%) do not have 4 community health centers that provide PONED per district as required. Only 69.7% of community health centers have a medical device to check the hemoglobin (Hb) and only 42.6% of community health centers that provide PONED have MgSO4, while hemorrhage and eclampsia are two major causes of maternal death. Of all the community health centers that provide emergency care, including PONED, only 76.5% have a means of transportation (ambulance or motor boat). Most obstetric and neonatal emergency cases can be treated in a basic health care facility using a simple technology, so the improved emergency obstetric and neonatal emergency care at community health centers should provide a substantial contribution to the prevention of maternal and neonatal mortality.

Hospital as a final referral place of obstetric and neonatal cases has an important role in saving mothers and newborns, because about 5-15% of complications cases require actions that can only be performed at hospitals, such as caesarean sectio and blood transfusions. The 2011 Health Care Facilities Research shows that only 7.6% of public hospitals meet the 17 criteria for hospitals which have the capacity to provide PONEK for 24 hours and 7 days a week (Figure 3). Lack of means and retention of Obstetrician and Gyneacologist is the major cause that makes a hospital unable to provide PONEK for 24 hours and 7 days a week.

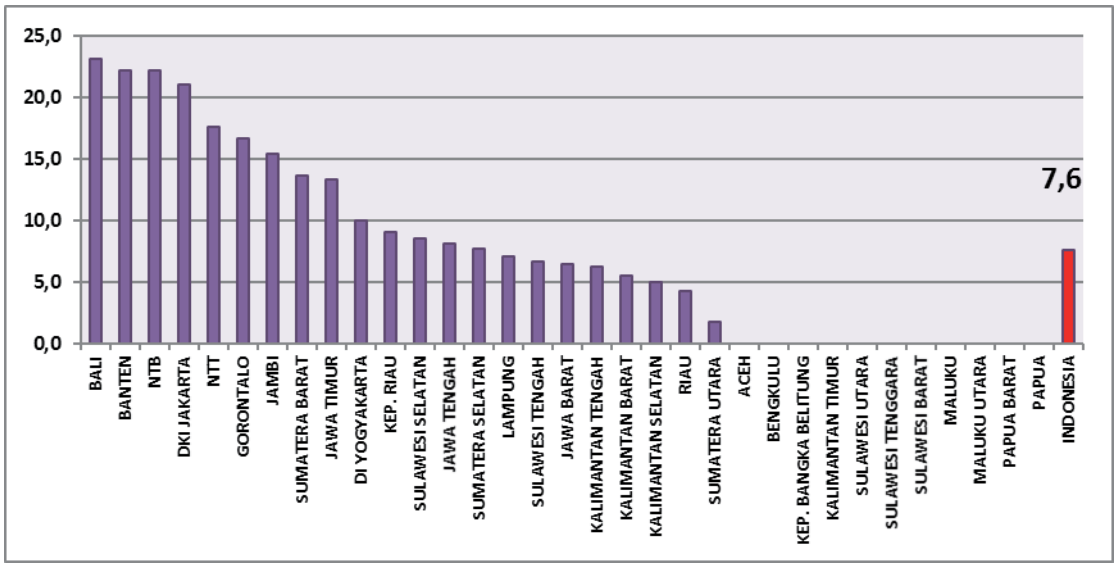


Figure 3: Proportion of the public hospitals that meet the 17 criteria for hospitals that provide PONEK for 24 hours
(Source: Basic Health Care Facilities Research 2011)

One of the successful prevention of maternal mortality lies in the accuracy of decision making in the event of complications. It can be achieved if the family has a good basic knowledge about pregnancy and childbirth, so they can make a delivery planning and are prepared to face the complications as early as possible.

Table 2: Data on Antenatal Care Quality

ANTENATAL CARE	Hospital*	Community health center*
Complete the medical record	33,86%	48,52%
Complete the general physical and obstetric examination	50,00%	59,38%
Provide counseling and education	24,17%	45,00%
Perform regular supporting examination	39,38%	19,69%
Perform supporting examination in the event of indications	49,00%	52,50%
Provide supplements and vaccination	62,50%	73,13%

(Source: Maternal Care Quality Study, Min. of Health-WHO-HOGSI, 2012)

The results of the 2010 Basic Health Research shows that about 45% of mothers claim to receive information about the danger signs of pregnancy during ANC (Figure 4). This is reinforced by the results of the 2012 Maternal Care Quality Study that shows that only 24% of hospitals and 45% of community health centers perform appropriate counseling and education according to the current standard during ANC. Both of these indicate that the role of health professionals in providing information and advocacy to mothers and families during ANC is still weak, so the knowledge of families and communities to develop a childbirth planning is also poor (Table 2).

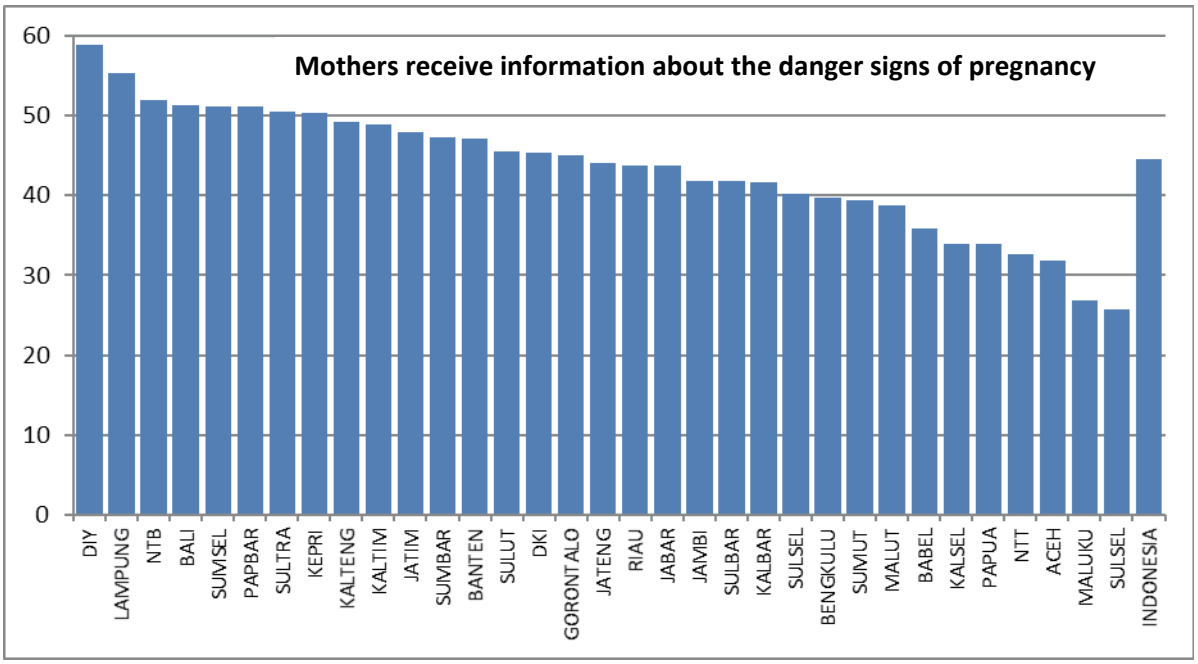


Figure *4: Proportion of mothers receiving danger signs of pregnancy in 2010 (Source: Basic Health Care Research 2010)*

Delivery Planning and Complications Prevention Program, which was introduced in 2007, was implemented in 63,000 villages across Indonesia in 2011. It is necessary to ensure the implementation of this program in these villages to help families develop a delivery planning and realize the plan well in time.

Other activities prior to this program that involve the community is Mother Friendly Movement which was popular in the year 2000s. Unfortunately this activity has faded lately, whereas it is considered to be quite capable of raising the maternal health issues in the community because it increases the decision makers' concern at all government levels. The integration of strengthened delivery planning and complication prevention program, alert villages and Mother Friendly Movement is one of the solutions to empower families and communities in maternal health.

CHAPTER III

NATIONAL ACTION PLAN

A. Goal

Accelerate the reduction of maternal and neonatal mortality and morbidity rate in Indonesia.

B. Challenge, Strategy and Main Program

The National Action Plan is implemented in the decentralization context in the form of the Regional Action Plan, which ensures a steady integration in health development planning and budget allocation process. It focuses on mothers and newborns health care according to the current standard, which is cost-effective and based on the evidence at all health care levels and health referrals in both government and private sectors.

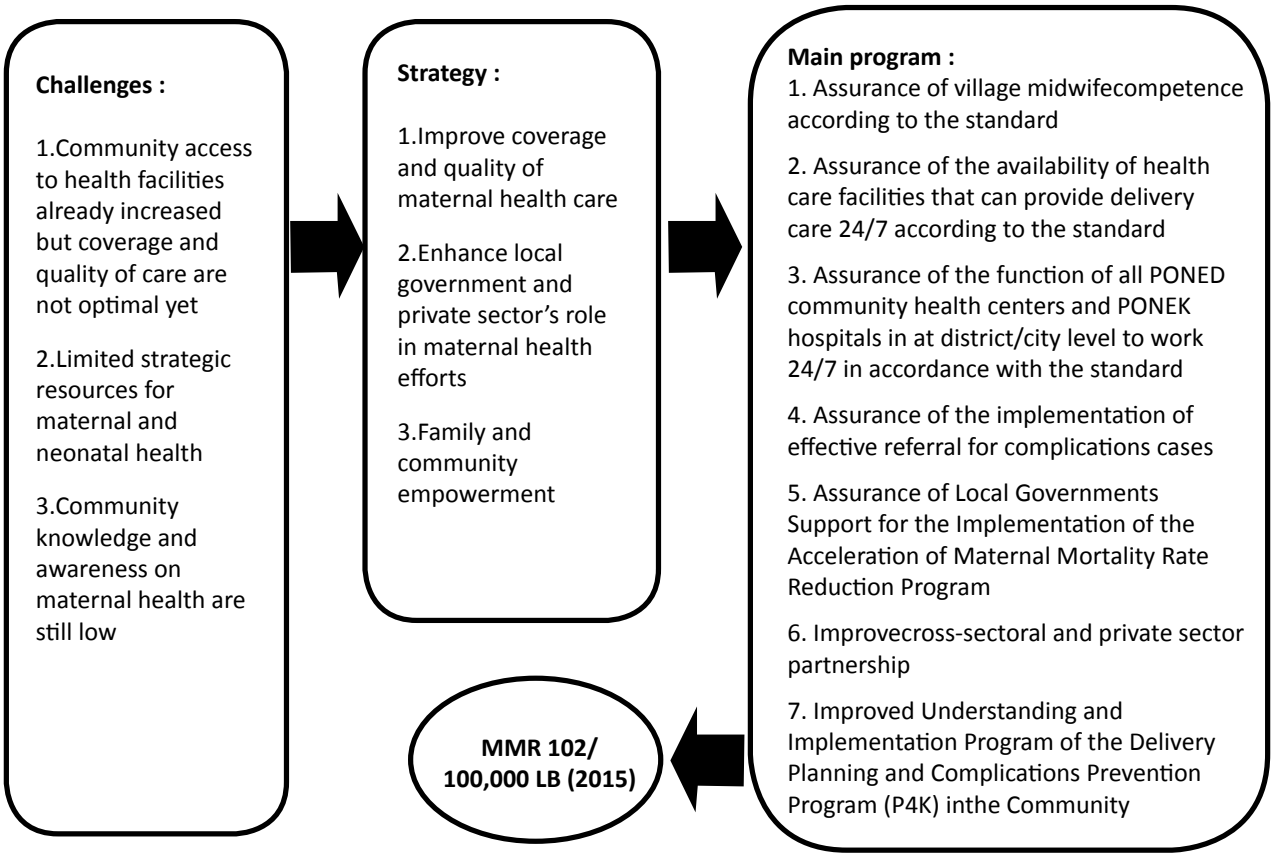


Figure 5: National Action Plan Framework for the Acceleration of MMR Reduction 2013 – 2015

1. Challenges

Three main challenges related to the acceleration of maternal mortality rate reduction are access to the quality services in health care facilities that is not optimal, limited strategic resources for maternal and neonatal health, and community knowledge and awareness on maternal health are still low.

2. Strategies used to achieve the maternal mortality target in 2015

2.1. Improved coverage and quality of maternal health care

Very strong evidences suggest that the life safety of women during pregnancy, childbirth and puerperium is strongly influenced by the access to quality obstetric care at all times, especially since every pregnancy and childbirth have a risk of life-threatening complications.

The concept of continuum of obstetric care that is delivered in the previous chapter underlies the significance of the improved coverage and quality of care as such that every woman who is undergoing complications during pregnancy and childbirth has an access to the quality health care in a timely and appropriate manner. This continuum of care is particularly important during the period of laboring process and during the first 24 hours after delivery for in these very short periods the majority of maternal deaths occur.

Access to health care for certain cases that can aggravate the condition of women during pregnancy, childbirth and puerperium, and for the cases that have widespread health and social implications in the future, namely anemia, malaria in endemic areas, HIV and AIDS, post abortion care and teen pregnancy, needs attention significantly.

2.2. Enhancing the role of local governments in the regulations that can effectively support the implementation of the program

Health care system is a part of a public service system that is in some aspects is highly regulated by local policies and regulations, such as the provision and placement of health professionals and supporting health personnel, and the provision of health infrastructure.

Health professionals are at the forefront of the implementation of health care programs. Therefore, the policy on health professional assignment has a very strategic position that needs to be regulated clearly and firmly. The policy needs to be complemented with a clear application of reward and punishment, both for specialists, medical doctors, midwives, and other health-related personnel.

Since the optimal health care outcomes are strongly influenced by the quality of service, the assurance of health professional competence requires attention through various actions, including adequate pre-service education, in-service training for health professionals, appropriate implementation of health

professionals' authorities, certification for health professionals and health care facilities, and audit of health professionals' services and health care facilities. The role of local and central government in the regulation about the availability and quality of health professionals is expected to function effectively.

The availability of competent personnel is not enough without the support of adequate means and infrastructure, including the availability of blood 24/7. Good coordination between the blood transfusion unit of general hospitals at district level and the Indonesian Red Cross, the blood transfusion unit of genral hospitals at provincial level and the blood transfusion unit of private hospitals in the provision of blood for patients is necessary.

Strengthening the referral system requires a strong support from the local governments and other stakeholders as such that patients who are referred are attended immediately. Support is very much needed given the referral process requires involvement of various stakeholders, namely the community, health professionals and basic health care faclities, hospitals (public and private) including blood transfusion unit of hospitals and the Indonesian Red Cross. Regionalization which is adapted to the conditions of each region needs to be considered to clarify the referred destination. Regionalization include clusters of island, coast, urban area and the nearest district, etc. In this case, support through gubernatorial regulations may help the referral regionalization efforts.

The role of private sector in health care to public can not be ignored given the capacity of the government health care facilities is limited and lately people tend to choose the health care provided by private sector, especially in urban areas. Therefore, private sector should have an active role in jointly delivering the best health care that suits the public needs, regulated by a regional regulation.

The explanation above indicates that a strong role of the local governments in regulating the optimal implementation of health care for public is essential, including regulating the role of various government sectors, the role of civil society organizations and private sector. The central government's role needs to be coordinated in order to mutally complement the good implementation of health care in the regions.

2.3. Family and Community Empowerment

Decision on pregnancy and childbirth arrangement should be made together by a mother with her husband and her family. It is not a decision that is not desired by the mother, either because of medical reasons or other reasons related to readiness. Families should have an understanding that every pregnancy is desired by the mother, including when pregnancy is wanted and how many children are desired.

It is also necessary to improve the knowledge and attitudes of family and society in general regarding the importance of understanding that every pregnancy has a risk of life-threatening complications, and therefore a planning for good delivery and

prevention, and for finding immediate help in the event of complications is required (the availability of transportation, funding and potential blood donors).

Knowledge of the risk of complications in pregnancy, childbirth and puerperium as well as information about family planning are important to gain since adolescence, so teenagers can plan the right age to get married, the number of children desired and arrange the pregnancy interval. Education to improve the knowledge, understanding and participation of youth/community including teachers is given through youth friendly health service program that aims to prevent teens from having risky sexual behavior, such as unwanted pregnancy, whch may result in unsafe abortion and may ultimately lead to maternal death.

3. Main Program

The selected main program is the program that is considered to have high leverage for accelerating maternal mortality rate reduction, because it ensures the availability of quality services that can be accessed at any time, which include:

1. Mother and child health service delivery at village level in accordance with the standards
2. Provision of basic health care facilities which are able to provide delivery care according to the standard for 24 hours 7 days a week
3. Assurance of the entire PONED community health center and PONEK hospital for 24 hours 7 days a week to work according to the standard.
4. Implementation of effective referral in case of complications
5. Strengthening the district/city government in decentralized health governance programs (regulation, financing, etc.).
6. Implementation of cross-sectoral and private partnership.
7. Improved behavior change and community empowerment through understanding and implementation of delivery planning and complications prevention program and integrated service posts.

4. Program and Activities

4.1. Assurance of village midwife competence according to the standard

4.1.1. Provide health care facilities in the village (village health posts) at the locations where access to a more complete service has not been met. Clarification about the functions of village health posts is needed based on the conditions of each region.

a. Provision of health care facilities at village health posts
b. Provision of midwife kits, including Hb checking device

4.1.2. Improve midwife skills on delivery care and integrated antenatal care

a. Normal delivery care training: for village midwives who have not receive such training (including adequate hands-on training) and for midwives whose competence has not met the standards.

b. Integrated training on normal delivery care
c. Training for midwives in providing counseling and education to the community about maternal and infant health and nutrition, so the midwives can be more effective in changing people's attitudes and make them more vigilant in dealing with pregnancy and better prepared in the event of complications.

   The training programs must be equipped with the post-training evaluation component and periodic monitoring, for example through self assessment using checklists.

4.1.3. Maintain/improve the quality of mother and child health care by increasing facilitative supervision on village midwives.

4.2. Assurance of the availability of health care facilities that can provide delivery care 24/7 according to the standard

4.2.1. Improve detection and first aid for complications cases and effective referrals

a. Increase the number of community health centers which can provide delivery care in accordance with the working standard 24/7
   - Complement/add maternity room at community health centers
   - Complement the infrastructures, including medicines
   - Train the community health centers' team to work 24/7, including performing detection and first aid for complications cases and effective referrals.
b. Conduct an integrated antenatal care, including prevention of HIV transmission from mother to child.
c. Conduct screening of hemoglobin examination for any mother who checks their pregnancies at health care facilities.

4.2.2. Increase the number of health care facilities that can handle complications:

a. Increase the number of community health centers that provide PONED 24/7 :
   - Fill/add PONED trained team. Ideally, 2 trained teams are available in every community health center that provides PONED, so the service is available for 24 hours 7 days a week. In circumstances where two teams can not be afforded, it is expected that an in-house training can be given to the staff of community health centers.
   - Complement the facilities and infrastructures of community health centers that provide PONED, including medicines
   - Conduct a refreshment training for the existing PONED team given complications cases are rarely encountered
   - Ensure the availability of referred means of transportation and adequate communication

b. Establish community health centers which can provide PONED 24/7 in remote areas and islands, with special guidance and supervision from PONEK hospitals, so community health centers that provide PONED and effective referral can function properly.

4.2.2.1. Build coordination and cooperation with referral hospitals, which are located in the same region and in other regions (provincial hospitals, hospitals in border regions, military hospitals, private hospitals) to expand the access to complications case referrals in hospitals.

4.2.3. <u>Optimize the utilization of health insurance for eligible people (maternity insurance, national social security system) by:</u>

a. Building coordination with various stakeholders to implement maternity insurance/national social security system at every level of service, so the main tasks and functions of every stakeholder are clear.
b. Providing information to the public about the rights and obligations related to health insurance.

4.2.4. <u>Improve quality of service</u>

a. Improve the skills of health professionals at basic level using a variety of approaches, including training, apprenticeship, and in-house training, to make them competent in performing normal delivery care, including prevention of complications, so the cases referred to the hospitals are not normal delivery cases. Conversely, improve the ability of health professionals to be able to identify complications cases early, provide first aid for complications cases and make a referral for cases that require effective treatment in hospital, including monitoring and stabilizing the patients during referral process so they arrive at the hospital in timely and appropriate manner.
b. PONEK hospitals provides guidance for PONED community health centers
c. Perform the Maternal Perinatal Audit on maternal and neonatal mortality cases and provide the follow-up actions.
d. Implement back referral to allow the referrers learn from the results of their actions and continue to perform the monitoring of post-hospitalized patients.
e. Conduct facilitative supervision on PONED services performed by a coordinating district midwife or other designated health professionals.

4.3. <u>Assurance of the function of all PONED community health centers and PONEK hospitals in at district/city level to work 24/7 in accordance with the standard</u>

4.3.1. Improve the quality of health personnel in referral hospitals in handling complications cases in a timely and appropriate manner, including the availability of service standards guidelines for complication cases

4.3.2. Build coordination and cooperation with other referral hospitals, either in the same region or the nearest region, which are the hospitals of higher type, private hospitals/maternity hospitals and military hospitals, to expand

the access for complications cases to the hospitals as part of a referral network.

4.3.3. Ensure the access to safe blood

a. Improve and strengthen the cooperation with the Indonesian Red Cross.
b. Improve the function of blood transfusion unit
c. Ensure all hospitals have a hospital blood bank
d. Establish a network of inter-hospital blood provision, both between hospitals in the same region and or in different region, to improve the cooperation between hospitals, both in the same region and outside the region (province or district and other cities) on blood provision.

4.3.4. Improve postpartum family planning services in collaboration with other relevant sectors, notably hospitals and the National Family Planning Coordinating Board.

4.3.5. Ensure the availability of obstetric and neonatal care at any time (24 hours 7 days)

a. Complement/add personnel to ensure the service delivery for 24/7:
   At least 1 team that is able to perform PONEK or handle emergency cases is available with such arrangement that the services are available for 24 hours 7 days. In circumstances where a full team can not always be available, it is expected that an in-house training is given by the trained team/staff to other hospital staff, so the service can still be provided. In circumstances where there is no PONEK team or team that can provide emergency care, especially in remote areas and islands, it is necessary to consider specific approach, including building cooperation with post-graduate training institutions and provincial hospitals. The team includes caesarean section operators (obstetrician and gynecologist/post-graduate student of obstetrics), anesthesia operators (anesthesiologist/post-graduate student of anesthesiology, assistant), midwives and nurses.
b. Complement/add the facilities and infrastructure: operating room and its priority use arrangement, C-section kits, medicines, blood, etc.
c. Conduct innovative approaches for the hospitals undergoing human resources shortage, particularly in remote border areas and islands. Provision of guidance model and assignment of personnel from larger hospitals in the same region or outside the region (provincial hospitals or nearest hospitals) in regional hospitals are an alternative to be explored. For example is the sister hospital program which supports mother and child health revolution program in East Nusa Tenggara, so the continuum of care can be provided.

4.3.6. Improve the quality of mother and child health care

a. Improve the skills of health professionals: midwives, physicians and specialists, through trainings, apprenticeships, in-house trainings and guidance.

b. Conduct audits on every maternal and neonatal death occurring in the hospitals.
c. Optimize supervision and quality assurance in the hospitals.
d. Use a service edict to increase the role of the society in improving the service quality.

4.3.7. Strengthen the health care system in hospitals
a. Develop/modify policies in health care facilities: admission flow and handling of obstetric and neonatal emergency cases, availability and proper functioning of the emergency room, etc.
b. Implement back referral made by the hospitals to the referrers, so the referrers can get a learning and perform monitoring of the post-hospitalized patients.

4.4. Assurance of the implementation of effective referral for complications cases

4.4.1. Ensure the availability of referral guidelines.

a. Develop/establish clear referral guidelines at national level.
b. Develop/establish clear referral guidelines and operations at local level, including the function and role of every level of service, as such that the service is utilized as needed.
c. Develop guidelines for back referral, which is made by the hospitals to the referrers.
d. Develop guidelines for referral system for patients who use the maternity insurance program/National Social Security System or other government health insurance programs.

4.4.2. Ensure the availability of firm referral system:

a. Develop/strengthen a mutually agreed networking system, which includes "Vertical Reference Network" between basic services and services at a higher level (hospital services), and "Horizontal Referral Network" between hospitals (public and private); between village midwives or midwives at a community health center and the Central Statistics Agency, between a PONED community health center and a maternity hospital, etc.
b. Develop/strengthen a mutually-agreed regional networking system, especially to handle remote and border areas.
c. Develop a referral communication system that has two objectives as follows:
a. Provide service guidance (by an obstetrician/gynecologist to general practitioners or midwives in the field, by a senior midwife to midwives in the field, etc.)
b. Obtain a confirmation about the availability of the referral hospital services (the availability of doctor, bed, blood, medicines, etc.).
d. Strengthen the admission and handling system for emergency cases in the hospitals, including handling flow, coordination with obstetrician or post-graduate students of obstetrics, and coordination with other specialists associated with maternal deaths due to indirect causes.
e. Develop/strengthen a mutually-agreed networking system for remote areas and islands.

4.5. Assurance of Local Governments Support for the Implementation of the Acceleration of Maternal Mortality Ratio Reduction Program.

The local government support is generated through the District Team Problem Solving (DTPS) approach, which includes

4.5.1. Regulation on the procurement and assignment of health professionals

a. Submit a proposal to the central and local governments to meet the manpower needs at various levels of health care facilities, so people have access to maternity and neonatal services required at all times.
   The proposal includes
   - Completing the manpower at PONED and PONEK health care facilities that do not have trained personnel.
   - Gradually assigning at least 1 PONED team, and if possible 2 teams PONED health care facilities in certain areas gradually.
   - Gradually assigning at least 1 PONEK team, and if possible 2 teams at PONEK hospitals in certai areas.
   - Ensuring the availability of medical specialists at PONEK hospitals or public hospitals that have not obtained PONEK status.

b. Submit a proposal to the local governments to secure the assignment of health professionals who have received PONED/PONEK training, so they will not be transferred or replace them with other personnel who have equal capacity and have been previously prepared.

4.5.2. Regulation on the procurement and assurance of the availability of necessary equipment and medicines in every health care facility.

a. Improve and strengthen coordination with the national and local governments, so the availability of necessary equipment and medicines is assured at all times, including the process of application, procurement, distribution, and storage
b. Improve and strengthen coordination with the Indonesian Red Cross regarding the blood provision, if necessary through a Memorandum of Understanding at local level.
c. Improve and strengthen coordination between hospitals, public and and private, both within the region and outside the region (provincial hospitals or the nearest hospital), in the provision of equipment, medicines and blood, if necessary through a Memorandum of Understanding at local level.

4.5.3. Regulation on the administrative and financial governance

a. Submit a proposal to the local governments to increase the regional budget allocation to support health activities that have a high leverage to achieve the MDG 5, that is the availability of continuum of care, which includes the availability of competent midwives, health care facilities capable of providing PONED and hospitals capable of providing PONEK

b. Submit a proposal to the local governments about the need for breakthrough efforts related to maternal and neonatal care, including considering the emergency aspects in service delivery (after working hours).
c. Submit a proposal to the local governments to make clear regulations for border and remote areas, including the regulation governing the referral system of obstetric and neonatal cases to facilitate the people in these areas to access the health care facilities nearby.

4.5.4. Regulation on improved quality/skills of health professionals

a. Submit a proposal to the local governments to improve the quality and clinical skills of health professionals through training, apprenticeship or other training programs.
b. Recommend licensing for establishing schools and colleges in the regions that refer to the applicable standards of professional competence. The local government can work together with the relevant professional organizations. Ministry of Health also oversees the implementation of teaching-learning process in medical educational institutions.
c. Conduct socialization of the Health Minister Decree of 2009 on health training through the board of human resources development and empowerment.

4.5.5. Regulation on maternal and neonatal health information system

a. Develop guidelines on integrated recording and reporting system (vertically and horizontally).
b. Establish key indicators for monitoring and evaluation purposes
c. Conduct an analysis and utilization of information as a basis for determining policies and programs.

4.5.6. Assurance of support for other required regulations

1. Develop macro and fundamental policies related to community health center. These policies include the concept of community health center, specific workforce and financial governance.
2. Develop regulations to determine priority health care areas.
3. Conduct socialization of the national referral guidelines (Health Minister Regulation No. 1/2012).
4. Develop regulations on the referral system at district/city level.
5. Conduct advocacy on delayed marriage based on health considerations.

4.6. Cross-Sectoral and Private Partnership Improvement Program

Work with other sectors as follows:

1. Medical education institutions to work in local hospitals to ensure the availability of adequate service 24 hours/7 days, such as through the assignment of post-graduate students of obstetrics program.

2. Private sector which directly provides obstetric care (maternity hospitals, clinics, general hospitals) is expected to build coordination in providing obsetric care to the community, including in the referral system, through a Memorandum of Understanding (MoU) on Cooperation.
3. Private sector which has indirect roles (medical educational institutions, companies' CSR program) is expected to work together to improve the obstetric coverage and care, either through the improved quality of students of health-related program based on the national standards, or through the utilization of CSR funds.
4. The National Family Planning Coordinating Board, to improve access for all women of childbearing age to information on reproductive health and access to family planning methods.
5. Primary and secondary education sectors, to increase access for all adolescents, especially girls, in schools (school health unit) to information on reproductive health. The implementation of 12-year compulsory education is expected to be utilized by the health sector to convey the information related to reproductive health and other health-related information.
6. Professional organization, to increase its role in improving the quality of services of its members, such as through training, apprenticeship, coaching and arrangement of professional licence registration. The local governments and the local health offices are expected to work with the professional organizations in accordance with their respective roles as agreed upon.
7. Religious sector, to improve access for all girls in religion-based schools, *madrasah* (school health unit) and all brides-to-be who register their marriage at the office of religious affairs, to information on reproductive health, including body readiness for first pregnancy.
8. Religious organizations can play a role in at least two aspects
   - Delivery of health information, such as information on reproductive health and health insurance (maternity insurance, national social security system), through the existing organization networks, and
   - As part of the Local Health Service Network
9. Develop/improve other partnerships according to the circumstances and conditions of the regions.

4.7. Improved Understanding and Implementation Program of the Delivery Planning and Complications Prevention Program in the Community

4.7.1. Conduct a reorientation and reactivate the concept of community preparedness in facing the delivery

a. Conduct a reorientation for all relevant health personnel regarding the delivery planning and complications prevention program to create the same and appropriate understanding about the program concept, including the purpose and benefits of the program, and the measures that must be taken.
b. Conduct an orientation for health cadres and communities about the danger signs of pregnancy and childbirth as well as their role in the delivery planning and complications prevention program.

c. Reactivate the mother friendly movement at all levels (national, provincial, and district)

4.7.2. <u>Conduct an orientation about the importance of necessary measure during pregnancy and childbirth</u>

a. Conduct maternal class using mother and child health guide book
b. Socialize the danger signs of pregnancy and childbirth through appropriate media to every segment of society in accordance with the acceptable culture and norms.

CHAPER IV

MONITORING AND EVALUATION

A. Achievement Indicator

1. Achievement of the Acceleration of Maternal Mortality Ratio Reduction Program

a) **Outcome Indicator**

- **Maternal Mortality Ratio:**

  The total number of maternal deaths (according to the definition of ICD 10) in a region divided by the total number of live births in the same region in a specified period of time, represented in unit per 100,000 live births

- **Delivery assisted by skilled attendants:**

  The total number of births attended by health professionals in a region divided by the total number of women giving birth in the same region in a specified period of time, represented in percent.

- **Age Specific Fertility Rate, 15-19 years old**

  The total number of birth to women of a specified age group (15-19 years) per 1000 women of the same age group in the same region in a specified period of time, represented in per mil.

- **Antenatal care visit in 4 times during pregnancy :**

  The total number of antenatal care visits in 4 times in a region, which are at least 1 time in Trimester 1, 1 time in Trimester 2 and 2 times in Trimester 3, divided by the total number of pregnant women in the same region in a specified period of time, represented in percent.

- **Delivery in health care facilities:**

  The total number of births assisted by health professionals in health facilities (community health centers and hospitals) in a region divided by the number of women giving birth in the same region in a specified period of time, represented in percent. It is necessary to distinguish delivery in non-hospital health care facilities from delivery in hospitals.

- **Proportion of obstetric complications attended in the hospitals that provide obstetric and neonatal emergency care (PONEK hospitals or hospitals that have**

not gained/do not gain PONEK status, but capable of providing emergency care):

The total number of obstetric complications attended in a hospital (PONEK hospitals or hospitals that have not gained/do not gain PONEK status, but capable of providing emergency care) in a region, divided by the estimated total complications (= number of pregnancies * 15%) in the same region in a specifed period of time, represented in percent.

b) **Output/Process Indicator:** As outlined in the attached matrix, including policies and regional regulations.

2. **Regional Budget Allocation:** trend and amount of the allocation in accordance with the needs of maternal and neonatal health programs.

3. **Cross-sectoral and Private Cooperation:** a cross-sectoral and private cooperation document (MoU).

B. Mechanism for monitoring of the National Action Plan for the Acceleration of Maternal Mortality Ratio Reduction

Monitoring of the National Action Plan for the acceleration of maternal mortality ratio reduction can be done using the monthly activity report of maternal health programs on

1) **Strengthening and development of integrated recording and reporting system** which becomes the consensus on the data/information that needs to be collected regularly or periodically. It has a simple format but contains important information about maternal health (MDG 5 indicators and other output/outcome indicators which is considered important) and reporting flow (vertical from community health centers to the health office, and horizontal between hospitals and the health office).
2) **Analysis of regular reports from provincial and district/municipal health offices on the key indicators,** including health professionals' delivery coverage, delivery at health care facilities, delivery location, number of maternal deaths and activity reports according to the established indicators.
3) **Periodic dissemination of information** on the development of key indicators of maternal and neonatal health to various stakeholders.
4) **Supervision conducted in stages** for provinces and districts/cities to directly identify the problems on the acceleration of maternal mortality rate reduction and try to solve them.
5) **Monitoring and evaluation team meeting on the acceleration of maternal and neonatal mortality reduction** that involves all relevant stakeholders, namely: Ministry of Internal Affairs, Ministry of Health, Ministry of National Development Planning/National Development Planning Board, Ministry of Women's Empowerment and Child Protection, National Family Planning Coordinating Board, Family Welfare Empowerment Movement Team, professional organizations (POGI, IDAI, IDSAI, IDI, IBI, PPNI, IAKMI), KARS, PERSI, Arsada, NGOs and maternal health oberservers organizations.
6) **Data-based annual planning** that is integrated with all of the available funding resources

In addition to regular/periodic data collection, other data that is available can be used for evaluation, such as SP, IDHS, SUSENAS, PODES, basic health research and health care facilities research.

Attachment:
Explanation about Matrix Strategy, Output, Program/Activities, Indicators, Targets and Implementation Actor

The following matrix describes the sub-programs or activities of the 7 main programs that need to be done in the period of 2013-2015 to accelerate the achievement of maternal and neonatal mortality rate target. The main programs selected for the National Action Plan 2013-2015 are the programs that focus on the continuum of care, which, if implemented entirely, has proven to have high leverage for reducing maternal and neonatal mortality rate. Therefore, although other programs are also important, within the next 3 years it is expected that the programs focus and activities refer to the 7 main programs.

Each activity will have the indicators that will be used as the basis for periodic progress evaluation, which are conducted quarterly, annually or in other periods of time. Baseline data can be filled with the achievements in 2012 according to the available data. In circumstances where there is not any data at all, it should be denoted by "no data", then the data in 2013 is used as a baseline for evaluation in subsequent years. Annual achievement targets need to be filled in accordance with the existing conditions.

Since the reduction of maternal and neonatal maternity rate involves cross programs and cross-sectors, including the government at national, provincial, district and city level, private sector, universities, professional organizations and communitis, the responsible party of every activity should be clarified. Thus the efficiency and effectiveness of the program can be achieved.

It is expected that every province, district and city can fill in the Matrix in its Regional Action Plan

Matrix of Strategy, Output, Program/Activity, Indicator, Target, and Executor

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
		Initial Activity					
	Orientation of pathway concept and continuum of carefor all health personnelare necessary, so they have the same reference and perceptions about the direction of the policy and program			Implementation of the orientation for health personnel at national, provincial and district level	All districts and cities have received the orientation by the end of second quarter 2013		
		Strategy 1: Improving coverage and quality of maternal health service delivery					
	1. Assurance of village midwife competence according to the standard	1.1. Provide health care facilities in villages(village health posts)	1.1.1. Provision of village health posts	Number of village health posts available in a subdistrict	The number of village health posts increases everyyearaccording to the target of each region, andin 2015the number of village health posts haveincreasedat leastby 30% compared to 2012 (10% peryear)	Center for health promotion	Min. of Health, Health Office at Provincial, District and City, Local Government, Regional Development Planning Board; professional organization

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			1.1.2. Provision of midwife kits equipped with Hb checking device	Number of midwives who has midwife kits in a district and city	By the end of 2013 or the latest at the beginning of 2014 all midwives already have midwife kits according to the standard	Directorate of Maternal Health	
		1.2. Improve midwife skills on childbirth and integrated antenatal care	1.2.1. Normal delivery care training for village midwives	Number of midwives who has attended the normal delivery care training and/or other skills improvement trainings	Number of midwiveswhohave adequate competencethroughtrainingsincrease everyyear according to the target of each region.By 2015allmidwivesalready haveappropriatecompetence according to the standard	Directorate of Maternal Health	
			1.2.2. Training on integrated ANC	Number of integrated ANC trainings which have been conducted	Number of the integratedANCtrainings that have been conducted increase everyyear according to the target of each region. In2015the ANCintegratedtraining has been implementedforallpersonnel	Directorate of Maternal Health	
			1.2.3. Training for village midwives in giving counseling and education to the community to make them more alert	Number of village midwives trained in giving counseling and education	Training for village midwives in giving counseling and education begins in 2013 and increases every year according to the target of each region. In 2015 the counseling and education	Directorate of Maternal Health	Directorate of nursing service and public health Min. of Health,

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
					training is conducted for 30% of village midwives		Provincial, , District/City Level
		1.3. Maintain/increase the quality of mother and child health care	1.3.1. Improve facilitative supervision for village midwives	Number of community health centers conducting facilitative supervision	Number of community health centers conducting facilitative supervision increases every year in accordance with the target of each area. In 2015 all community health centers have conducted facilitative supervision for all village midwives regularly	Directorate of Maternal Health	Directorate of nursing service and public health Min. of Health, Provincial, , District/City Level
	2. Assurance of the availability of health care facilities capable of providing delivery care 24/7 in accordance with the working standard	2.1. Improve detection and first aid for complications cases and effective referrals	2.1.1. Increase the number of community health centers capable of providing delivery care according to the working standar 24/7 • Complement/add maternity room at community health centers • Complement means and infrastructures, including medicines • Train the community	Number of community health center capable of providing maternity care 24/7	Number of community health centers capable of providing maternity and neonatal care increases every year in accordance with the target of each region. In 2015 50% of the community health centers in district areas and 100% in city areas are capable of providing maternity and neonatal care.	Directorate of Basic Health Care Development (BUKD)	Provincial, District and City Health Office, Local Government, Regional Development Planning Board; hospitals; professional organization

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
			health centers' team to work 24/7, including performing detection and first aid for complications cases and effective referrals				
			2.1.2. Conduct an integrated ANC, including prevention of HIV transmission from mother to child	% of community health centers in district and city areas implementing the integrated ANC	Number of community health centers in ditrict and city areas implementing the integrated ANC increases every year in accordance with the target of each region. In 2015 all community health centers have implemented the integrated ANC	Directorate of Maternal Health	Min. of Health, Health office at provincial, district and city level Directorate of nursing service and public health Min. of Health, Provincial, , District/City Level
			2.1.3. Conduct Hb screening for every pregnant woman checking their pregnancy at health care facilities	% of community health centers conducting Hb examination and reporting the annual anemia prevalence	Number of community health centers conducting Hb examination and reporting the anemia prevalence of pregnant mothers increases every year. By the end of 2013 or the latest at the beginning of 2014 all community health centers have conducted Hb examination regularly and reported the annual anemia prevalence every year	Center of Data and Information	
				An integrated mother and	An integrated mother and child health	Center of Data	Provincial,

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
				child health information system is established	information system is available in 2013	and Information	District and City Level
		2.2. Increase the number of facilities which can provide treatment for complications	2.2.1. Increase the number of community health centers which provides PONED 24/7, prioritizing the remote areas: • Fill /add trained PONED team • Complement the means and infrastructure, including medicines, at community health centers • Conduct a refreshment training for the existing PONED team given complications cases are rarely encountered • Ensure the availability of referred means of transportation and adequate communication	% of community health centers **capable of providing** PONED 24/7 in district and city areas	All of the exisiting PONED community health centers are functioning 24/7 by the end of 2013. Number of community health centers capable of providing PONED increases every year in accordance with the target of each region, and in 2015 all community health centers that provide emergency care can provide PONED24/7	Directorate of Basic Health Care Development	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
		2.3. Buildcoordination and cooperation with referral hospitals, which are located in the same region and in other regions (provincial hospitals, hospitals in border regions, military hospitals, private hospitals) to expand the access to complications case referrals in hospitals	2.3.1. Build coordination with the relevant sectors to establish a system of referral from community health centers to hospitals.	Number of districts and cities that have a referral system and MoU	Guidelinefor referral system is completed by Min. of Health in 2013, and distributed to all provinces. At provincial level, the guidebook is adapted to the local conditions of each region (including development of MoU, cooperation/coordination with, stakeholders, namely the local governments, district hospitals, health offices, private hospitals and private clinics) and then distributed to the districts and cities in mid/the end of 2013. The MoU is issued and the referral Guidelinestarts to be used by all regions at the beginning of 2014.	Directorate for development of referral standards (BUKR)	
				The integrated mother and child information system is established	The integrated mother and child health information system (vertical and horisontal) is available by the end of 2013	Center of Data and Information	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
		2.4. Optimize utilization of health insurance for eligible people (maternity insurance, national social security system)	2.4.1. Build coordination with various stakeholders to implement maternity insurance/national social security system at every level of service, so the main tasksand functions of every stakeholder are clear	The coordinating mechanism for the implementation of maternity insurance/national social security system is established	Coordinating mechanism for the implmentation of maternity insurance/national social security system in district and city areas is established in 2013	Center for Health Security Financing	
			2.4.2. Provide information to the public about the rights and obligations related to health insurance	Dissemination of information to public about the rights and obligations related to health insurance has been done	Dissemination of information to public about the rights and obligations related to health insurance has been conducted in all subdistricts and villages by health personnel at the beginning of 2014	Center for Health Security Financing	
		2.5. Improve quality of service	2.5.1. Improvethe skills of health professionals at basic level through trainings, apprenticeships, and in-house trainings in	Number of heath professionals attending PONED training: midwives,	All PONED teams (midwives, physicians, nurses) at community health centers have attended PONED training by the end of 2013 Number of health professionals at	Center of Education and Training for Apparatus	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			both ini PONED or non-PONED community health centers	physicians, nurses Number of health professionals who has taken apprenticeship/ attended PONED in-house training: midwives, physicians, nurses	PONED community health centers (other than PONED team) taking apprenticeship/attending PONED in-house trainings increases every year Number of health professionals at non-PONED community health centers that has taken apprenticeship/attending PONED in-house trainings increases every year according to the target of each region		
			2.5.2. PONEK hospitals provide guidance for PONED community health centers. It can be done in the community health centers or in PONEK hospitals	Number of PONED community health centers receiving regular guidance	In 2013 strategies of guidance provided by PONEK hospitals for PONED community health centers have been developed and agreed upon by all stakeholders in the regions. In 2014 all PONEK hospitals have provided guidance for PONED community health centers periodically	Directorate of Basic Health Care Development	
			2.5.3. Perform the Maternal Perinatal	Number of districts/cities	Number of districts/cities performing Maternal Perinatal Audit and its	Directorate of Maternal Health	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			Audit and follow up actions which may include improved knowledge and skills of health personnel, fulfilling the need for medical equipment and medicines, modified policies, etc.	performing Maternal Perinatal Audit minimum 2 times a year	follow-up action increase every year. In 2013 at least the 2-time Maternal Perinatal Audit that is followed by the necessary actions is conducted. In 2015 all districts and cities conduct the Maternal Perinatal Audit that is followed by the necessary actions 4 times		
			2.5.4. Implement back referral to allow the referrers learn from the results of their actions and continue toperform the monitoringof post-hospitalized patients	Number of districts/cities that have back referral mechanism	Guidelineon the referral system (including back referral) is completed by the Min. of Health in 2013 and is adapted to the local conditions of each region. The Guidelinestarts to be used by all regions at the beginning of 2014	Directorate for development of referral standards	
			2.5.5. Conduct facilitative supervision on PONED care performed by a coordinating district midwife or other designated health professionals	Number of district and cities in a province conducting facilitative supervision on PONED	Number of districts and cities conducting facilitative supervision on PONED services regularly increases every year in accordance with the target of each region. In 2014 all districts and cities have conducted facilitative supervision regulary	Directorate of Maternal Health	Directorate of nursing service and public health Min. of Health, Provimce, District/City

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
	3. Assurance of the function of all PONEK hospitals at district/city level to work 24/7 in accordance with the standard	3.1. Improve the quality of health personnel in referral hospitals in handling complications cases in a timely and appropriate manner, including the availability of guidelines on standard of carefor complication cases	3.1.1. Conduct clinical management trainings, including trainings on PONEK, life saving skills and other trainings, for health professionals in hospitals to enable them handle complications cases referred to hospitals	Clinical management trainings, including trainings on PONEK, life saving skills and other trainings, for health professionals in hospitals are conducted to enable them to handle the complications cases referred to hospitals	All district hospitals have a team of trained health professionals (obstetrics/gyneology, pediatrics and anesthesiology and post graduate students of PPDS) who is capable of providing PONEK service by the end of 2014.	Directorate for development of referral standards	Local Government; Regional Development Planning Board; Health Office at Provincial, District and City Level; Hospitals; Professional Organizations
		3.2. Build coordination and cooperation with other referral hospitals, including the hospitals of higher type, private hospitals/matern	3.2.1. Build coordination and develop a coopeative consensus with other referral hospitals, which are the hospitals of higher type, private hospitals/maternity hospitals and	MoU or mechanism/guidelines for coordination and cooperation with referral hospitals is developed	Every district/city already has an MoU or cooperation in 2014	Directorate for development of referral standards	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
		ity hospitals and military hospitals, to expand the access for complications cases in hospitals	military hospitals, to expand the access for complications cases in hospitals				
		3.3. Ensure the access to safe blood	3.3.1. Improve and strengthen the cooperation with the Indonesian Red Cross	Cooperation between the Indonesian Red Cross and hospitals' blood transfusion unit on blood provision is established	Cooperation between the Indonesian Red Cross and hospitals' blood transfusion unit in all districts/cities on blood provision is agreed upon by the end of 2013	Directorate of Basic Health Care Development	
			3.3.2. Improve the function of blood transfusion unit	A blood transfusion unit is available in hospitals and functioning in accordance with the standard	All public hospitals' blood transfusion unit are functioning by the end of 2013	Directorate of Basic Health Care Development	
			3.3.3. Improve the cooperation between hospitals,	MoU/cooperation between	MoU/cooperation between hospitals, in the same region or ouside the	Directorate of Basic Health	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			both in the same region and outside the region,on blood provision	hospitals, in the same region or ouside the region, on blood provision	region, on blood provision is established by the end of 2013	Care Development	
		3.4. Improve post partum family planning acceptors		Number of postpartum family planning acceptors in hospitals increases every year	Number of postpartum family planning acceptors in hospitals increases every year in accordance with the target of each region In 2015 the number of postpartum mothers who become family planning acceptors increase by 50% compared to the previous year	Directorate of Maternal Health	
		3.5. Ensure the availability of obstetric and neonatal care at any time (24 hours 7 days)	3.5.1. Complement/add personnel to ensure the service delivery 24/7. Provide a PONEK team capable of providing emergency care, including a caesarian section operators (obstetrician/gynecologist, post-graduate student of obstetrics),	Number of PONEK hospitals capable of providing services 24/7	In 2014 all district public hospitals can serve as a PONEK hospital 24/7	Directorate for development of referral standards	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			pediatrician, Anesthesiologist and paramedics, midwife and nurse				
			3.5.2. Complement /addthe infrastructure: operating room and its priority use arrangement, C-section kits, medicines, blood, etc	District public hospitals have facilities and infrastructures according to the service standard	All district hospitals have complete facilities and infrastructures in 2014	Directorate for development of referral standards	Provincial, District/City Level
			3.5.3. Conduct innovative approaches according to the local conditions for the hospitals undergoing human resources shortage, particularly in remote border areas and islands. For example is the sister hospital program implemented in East Nusa Tenggara	Innovative actions to reduce human resources gap, including medical specialists, are taken	In 2013study on the innovative actions is available In 2014 the implementation begins	Directorate for development of referral standards	National, Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
		3.6. Improve the quality of services	3.6.1. Improve the skills of health professionals: midwives, physicians and specialists, through trainings, apprenticeships, in-house trainings andguidance	Number of hospital personnel: midwives, physicians, post graduate students of medicines, attending PONEK training or in-house training or taking internship	In 2014 all PONEKteams in hospitals have been trained In 2015 all district hospitals have conducted improvement of knowledge and skills on maternity and neonatal for all health personnel (physicians, midwives and nurses) who have not receive PONEK trainings through apprenticeship/in-house training	Center of Education and Training for Health Professionals, Min. of Health BPPSDM	
			3.6.2. Conduct audit on all maternal and neonatal mortality occuring in hospitals, followed by necessary actions (improvement of human resources competence; provision of medicines, blood and equipment,	% of hospitals conducting audit on maternal and neonatal mortality	In 2014 all district hospitals conduct audit on maternal and neonatal mortality that is followed by necessary actions.	Directorate of Maternal Health	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			modification of policy)				
			3.6.3. Optimize supervision and quality assurance in hospitals	Supervision and quality assurance in hospitals are conducted regularly	In 2014 all district hospitals have guidelines and conduct supervision and quality assurance in hospitals regularly	Directorate for development of referral standards	District/City Level
			3.6.4. Usea service edict to increase the role of the society in improving the service quality	% of hospitals at district/city level that have a service edict	In 2014 all district hospitals have service edit	Center for health promotion	
		3.7. Strengthen maternity and neonatal service system in hospitals	3.7.1. Develop/modify policies in health care facilities: admission flow and handling of obstetric and neonatal emergency cases, availability and proper functioning of the emergency room, etc	Policies on hospital services are available, including admission flow and handling of obstetric and neonatal emergency cases, availability and proper functioning of	By the end of 2013 all district hospitals have and implement clear and adequate policies on hospital services	Directorate of Maternal Health	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
				the emergency room, etc			
			3.7.2. Implement back referral made by the hospitals for the referrers, so the monitoring of the post-hospitalized patients can be provided by the referrers	% of district hospitals making back referral and record and conducting a regular reporting	By the end of 2013 all district hospitals make back referrals and make a record and conduct a regular reporting	Directorate for development of referral standards	
	4. Assurance of the implementation of effective referral for complications cases	4.1. Ensure the availablity of referral guidelines	4.1.1. Develop/establish clear referral guidelines at national level	Number of provinces and districts and cities that has guidelines on maternal and neonatal referral system	Guidelineon the referral system (including back referral) is completed by the Ministry of Health in 2013.	Directorate for development of referral standards; Directorate of Maternal Health	Health Office at Provincial, District and City Level, Local Government, Regional Development Planning Board; hospitals; professional organization
			4.1.2. Develop/establish clear referral guidelines and	Number of district/cities that have	The guidelines are adapted to the conditions in each region. The guidelines are already available and	Directorate for development of referral	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			operations at local level, including the function and role of every level of service	guidelines on maternal and neonatal referral system	implemented at provincial, district and city levels.	standards	
			4.1.3. Develop guidelines on back referral, which ismade by hospitals to the referrers	Guidelines on back referral are available	In 2014 guidelines on referral system, including back referral, are available and implemented in the regions	Directorate for development of referral standards	
			4.1.4. Develop guidelines on referral system for patients who utilize the maternity insurance programor other government health insurance programs	Guidelines on referral system for patients who utilize the maternity insurance programor other government health insurance programs are available	Guidelines on referral system for patients who utilize the maternity insurance program are completed in 2013 Guidelines on referral system adapted to the national social security sytem program is completed in 2014	Directorate for development of referral standards, Center for Health Security Financing	
		4.2. Ensure the availability of firm referral system	4.2.1. Develop/strengthen a mutually agreed networking system, which includes "Vertical Reference Network" between	The referral system network is available	Guidelines on referral system at provincial, district and city leves are completed and implemented in 2014, including vertical networking system (between higher-type hospitals and	Directorate for development of referral standards	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
			basic services and services at a higher level (hospital services), and "Horizontal Referral Network"		low-type hospitals), horizontal networking system (between public and private hospitals) and cross-regional networking system		
			4.2.2. Develop/strengthen a mutually-agreed regional networking system, especially to handle remote and border areas	Regional networking of referral system is available		Directorate for development of referral standards	Provincial, District/City Level
			4.2.3. Develop a referral communication system that has two objectives: to provide guidance and services for obtaining the confirmation about the availability of the referral hospital services (the availability of doctor, bed, blood, medicines, etc.)	The referral communication system is established	In 2015 all districts/cities that have a good telecommunication network have developed and implemented the referral communication system	Directorate for development of referral standards, Center of Data and Information	
			4.2.4. Strengthen the	Admission and	By the end of 2013 all district hospitals	Directorate for	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			admission and handling system for cases in the hospitals, including handling flow, coordination with obstetrician or post-graduate students of obstetrics, and coordination with other specialists associated with maternal deaths due to indirect causes	handling system for emergency cases in hospitals are implemented in accordance with the hospitals accreditation standards.	have and implemented the policy on emergnecy care for emergency cases in hospitals according to the hospital accreditaton standards	development of referral standards	
			4.2.5. Develop/strengthen a mutually-agreed networking system for remote areas and islands	Networking system in remote areas and islands is available	Networking system in remote areas and islands is established by the end of 2013		
	5. Adolescent reproductive health services as early intervention effort to prevent	5.1. Ensure availability of youth-friendly health services that focus on promotion and prevention	5.1.1. Increase number of youth-friendly puskesmas (PKPR) through training of health workers and technical assistances	Coverage of districts that have minimal 4 PKPR puskesmas	95% of total districts that have minimal 4 PKPR puskesmas by 2014	Directorate of Child Health	Health Office and Public Hospital at Provincial, District and City Level;

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
	adolescent pregnancy	through IEC and counseling					
	Strategy 2: Enchancing the local governments' and private sector's role in improvingmaternal health						
	6. Assurance of the local governments'endorse for the regulations than can effectively support the program implementation	6.1. Regulation on the procurement and assignment of health professionals	6.1.1. Submit a proposal to the central and local governments to meet the manpower needs in health care facilities at various levels, so people have access 24/7 to maternity and neonatal services which are required. The proposal includes • Completing the manpower at PONED and PONEK facilities that do not have trained personnel • Assigning a PONED team at PONED facilities gradually • Assigning a PONEK team at PONEK	• Number of PONED community health centers in a district and city that has the required specialists • Number of PONEK hospitals in a province that has the required specialists	• By the end of 2013 all PONEK hospitals have been completed with the required specialists, so they can function 24/7 • In 2013 all PONED community health centers are completed with the required specialists so they can function 24/7 • In 2015 all community health centers that provide emergency care have health personnel who are capable of providing PONED 24/7	BPPSDM (*Pusrengunakes*)	Health Office at Provincial, District and City Level, Local Government, Regional Development Planning Board; hospitals; professional organization

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
			hospitals gradually • Ensuringthe availability of specialists atPONEK hospitals or public hospitals that have not obtained PONEK status				
			6.1.2. Submit a proposal to the local governments to secure the assignment of personnel who have received PONED/PONEK training, so they will not be transferred or replace them with other personnel who have equal capacity and have been prepared	% of districts and cities in a province that have officially obtained PONED status through a decree (including decree for personnel) % of districts and cities in a provice that have officially obtained PONEK status through a decree (including	In 2014 all PONED community health center have officially obtained PONED status through a dcree In 2014 all PONEK hospitals have officially obtained PONEK status through a decree	Directorate of Basic Health Care Development Directorate for development of referral standards	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
				decree for personnel)			
		6.2. Regulation on the assurance of the availability of necessary medicines in basic health care facilities	6.2.1. Improve and strengthen coordination with national and local government, so the availability of the medicines required is assured at all times, including the planning process, management and monitoring-evaluation	Percentage of the availability of essential medicines for mothers and newborns.	In 2014, 100% of essential medicines for mothers and newborns are available according to the type and amount of the medicies.	Directorate of Public Medicinesand HealthSupplies	National, Health Office at provincial, district/city level
			6.2.2. Improve and strengthen coordination with the Indonesian Red Cross regarding the blood provision, if necessary through a Memorandum of Understanding at local level	MOU on blood provision between health office and the Indonesian Red Cross is established	In 2014, MOU between all health offices at provincial, district/city levels and the Indonesian Red Cross is established	Directorate of Basic Health Care Development	Provincial, District/City Level
			6.2.3. Improve and	MOU on blood	In 2014, MOU between all hospitals	Directorate of	Provincial,

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			strengthen coordination between hospitals, public and and private, both within the region and outside the region (provincial hospitals or the nearest hospital), in the provision of equipment, medicines and blood, if necessary through a Memorandum of Understanding at local level	provision between hospitals and the Indonesian Red Cross is established	and the Indonesian Red Cross is established	Basic Health Care Development, Directorate for development of referral standards	District/City Level
		6.3. Regulation on administrative and financial governance	6.3.1. Submit a proposal to the local governments to increase the regional budget allocation to support health activities that have a high leverage to achieve the MDG 5:	Local budget allocation for the activities that have high leverage to achieve MDG 5 increases as needed	Services provided by PONEK hospitals for 24/7 and by at least 4 PONED community health centers for 24/7 per district and by trained midwives are performed every year The number of community health centers providing emergency care that	Local Government, Local Parliament	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			PONEK hospitals, referred hospitals, PONED community health centers and competent midwives		are converted into community health centers providing PONED 24/7 increase to 4 per district in 2014		
			6.3.2. Submit a proposal to the local governments about the need for breakthrough efforts related to maternal and neonatal care, including considering the emergency aspects in service delivery (after working hours)	Regional regulation on breakthrough efforts for maternal and neonatal care, including provision of services by specialists, is developed	In 2013 the regional regulation regarding maternal and neonatal care is modified	Directorate of Maternal Health, Directorate of Child Health	
			6.3.3. Submit a proposal to the local governments to make clear regulations for border and remote areas, including the regulation governing	Policies/local regulations on referral system for border and remote areas	In 2014 policies/local regulations on referral system for border and remote areas are effective	Directorate of Basic Health Care Development	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			the referral system of obstetric and neonatal cases to facilitate the people in these areas to access the health care services nearby				
		6.4. Regulation on improved quality/skills of health professionals	6.4.1. Submit a proposal to the local governments to improve the quality and clinical skills of health professionals through training, apprenticeship or other training programs	Annual plan on clinical training for health personnel is available	In 2013 a clinical training planning is developed for 2014 and 2015	Center of Education and Training for Health Professionals	
			6.4.2. Regulate the permit for establishing schools or academy in the regions to refer to the current professional standard of competence			Pustanserdik BPPSDM	
			6.4.3. Conduct socialization of the			BPPSDM	

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			Health Minister Decree of 2009 on health training through the PPSDM				
		6.5. Regulation on maternal and neonatal health information systems	6.5.1. Develop guidelines for integrated recording and reporting system (vertically and horizontally)	An integrated mother and child health information system is available	In 2013 the integrated mother and child health information system is available	Center for Data and Information	Provincial, District/City Level
			6.5.2. Establish key indicators for monitoring and evaluation purposes	Key indicators for monitoring and evaluations are agreed upon: Outcome Indicators: maternal mortality rate, delivery assisted by health professionals, delivery at health facilities (with details of	Districts and cities record and report the key indicators regularly using the valid data starting in 2013	Center for Data and Information	Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target 2012 (Baseline) - 2015	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
				facilities type), obstetric complications receiving treatment at PONEK hospitals, teen birth rate, 4-time visit			
			6.5.3. Conduct an analysis and utilization of information as a basis for determining policies and programs	Policies on program implementation based on information/data analysis are available	In 2013 policies on program implementation based on the annual information/data analysis are available.	Balitbangkes	Provincial, District/City Level
		6.6. Assurance of support for other required regulation	6.6.1. Develop macro and fundamental policies related to community health center. These policies include the concept of community health center, specific workforce and financial	Policies on community health centers which includes the concept of community health center, specific workforce and financial governance are	Starting in 2014 community health centers have macro and fundamental policies which include the concept of community health center, specific workforce and financial governance	Directorate of Basic Health Care Development, Financial Office and BMN	Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			governance	available			
			6.6.2. Develop regulations to determine priority health care areas	Regulations to determine priority areas for maternal and neonatal care are available	In 2013 the regulations on the determination of priority health care areas are available	Directorate of Maternal Health	Provincial, District/City Level
			6.6.3. Conduct socialization of the national referral guidelines (Health Minister Regulation No. 1/2012)	Socialization of the regulations on the determination of health care priority areas is conducted	In 2013 the regulation is disseminated	Directorate of Maternal Health	Provincial, District/City Level
			6.6.4. Develop regulations on the referral system for maternal and neonatal health at district/city level	Guidelines for maternal and neonatal health referral are available	In 2013 guidelines for maternal and neonatal health referral are available	Directorate of Maternal Health	Provincial, District/City Level
			6.6.5. Conduct advocacy on delayedmarriage based on health considerations through various approaches, including dissemination of	Advocacy materials/messages about biological and psychological readines of teens for pregnancy are	In 2013communication, information and education materials about teenage marriage are available and ready for distribution	Directorate of Child Health	Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			communication, information and education materials about biological and psychological readiness of teens for pregnancy	available			
	7. Improved Cross-Sectoral and Private Partnership		Work with other sectors other than local government: 1. Medical education institutions to work in local hospitals to ensure the availability of adequate service 24 hours/7 days, such as through the assignment of post-graduate students of obstetrics program 2. Private sector which directly provides obstetric care (maternity hospitals, clinics, general	MoU on any form of cooperation is established	In 2013, 2014 and 2015 the number of MoU on cooperation at provincial, district and city level, both with government and private sector increases	Directorate of Maternal Health	Health Office at Provincial, District and City Level, Local Government, Regional Development Planning Board; hospitals; professional organization, Educational Institution, Religious Insitution, Private Sector

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			hospitals) is expected to build coordination for providing midwifery services to the community, including the referral system, through a Memorandum of Understanding (MoU) on Cooperation 3. The National Family Planning Coordinating Board, to improve access for all women of childbearing age to information on reproductive health and access to family planning methods 4. Religious sector, to improve access for all girls in religion-based schools, *madrasah*(school health unit) and all				

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			brides-to-be who register their marriage at the office of religious affairs, to information on reproductive health, including body readiness for first pregnancy 5. Primary and secondary education sectors, to increase access for all adolescents, especially girls, in schools (school health unit) to information on reproductive health. The implementation of 12-year compulsory education is expected to be utilized by the health sector to convey the information related to reproductive health and other health-related information	% of private companies that have CSR program on maternal health			

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			6. Private sector which has indirect roles(educational institutions for health personnel, companies' CSR) is expected to work together to improve midwifery coverage and services, either through the improved quality of students of health-related program based on the national standards, or through the utilization of CSR funds 7. Professional organization, to increase its role in improving the quality of services of its members, such as through training, apprenticeship, coaching and				

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
			arrangement of professional licenceregistration. The local governments and the local health offices are expected to work with the professional organizations in accordance with their respective roles as agreed upon 8. Religious organizations can play a role in at least two aspects ▪ Delivery of health information, such asinformation on reproductive health and health insurance (maternity insurance, national social security system), through the existing organization networks, and				

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
			▪ As part of the Local Health Service Network 9. Develop/improve other partnerships according to the circumstances and conditions of the regions		2012 (Baseline) - 2015		
	Strategy 3: Empowering family and community						
	8. Improved Understanding and Implementation of Delivery Planning and Complications Prevention inthe Community	8.1. Reorientation for all relevant health personnel regarding the delivery planning and complications prevention program to create the same appropriate understanding about the program concept, including the	8.1.1. Reorientation for all relevant health personnel regarding the delivery planning and complications prevention program to create the same appropriate understanding about the program concept, including the purpose and benefits of the program, and the measures that must	Number of community health centers conducting reorientation about the delivery planning and compilications prevention for health personnel	In 2014, 90% of community health centers have conducted orientation about the delivery planning and complications prevention program for health personnel.	Center for Health Promotion, Directorate of Maternal Health	Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
		purpose and benefits of the program, and the measures that must be taken	be taken				
			8.1.2. Conduct orientation for health cadres and society about the danger signs of pregnancy and childbirth as well as their role in the delivery planning and complications prevention program	Number of community health centers conducting orientation for health cadres about the benefits and steps of the delivery planning and complications prevention program	In 2014, 90% of community health centers conduct orientation about the delivery planning and complications prevention program to health cadres	Center for Health Promotion, Directorate of Maternal Health	Provincial, District/City Level and cross-sector (PKK, PMD)
		8.2. Reorientation about the importance of necessary measures during	8.2.1. Conduct maternal class using mother and child health guide book	Number of community health centers conducting maternal class using mother	Number of community health centers conducting maternal class increases every year and by the end of 2013 50% of publich health centers have conducted maternal class using	Directorate of Maternal Health	Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
		pregnancy and childbirth		and child health Guideline	mother and child health Guideline		
			8.2.2. Socialize the danger signs of pregnancy and childbirth through appropriate media to every segment of society in accordance with the acceptable culture and norms	% of pregnant mothers who understand the danger signs of pregnancy	In 2015 , 70 % of pregnant mothers understand the danger signs of pregnancy, childbirth and puerperium	Center for Health Promotion, Directorate of Maternal Health	Provincial, District/City Level
			8.2.3. Conduct socialization about the importance of anemia prevention through healthy lifestyle, consuming blood supplement pills, and consuming nutritious balanced food during pregnancy	Socialization about the importance of anemia prevention for pregnant mothers is conducted through suitable media for all public segments: pregnant mothers who come to health care facilities,	By the end of 2013 communication, information and education materials about anemia on pregnant mothers are available for various segments of society at national level At the beginning of 2014 communication, information and education materials about anemia on pregnant mothers are available for various segments of society at district and city level and in community health centers	Center for Health Promotion, Directorate of Maternal Health	Provincial, District/City Level

No	Strategy/Main Program	Sub Program	Activity	Indicator	Target	RESPONSIBLE UNIT	Executor: at national, provincial, district/city level
					2012 (Baseline) - 2015		
				brides-to-be, teenage students at public schools/madrasah	In 2015 100% of community health centers conduct socialization about anemia, either directly or through cooperation with other sectors.		