# Table of Contents

Kinerja Overview..................................................................................................................3

A New Partnership Tackles Education Inequality in Barru, South Sulawesi .................................7

Public Participation Improves School Management in Bener Meriah, Aceh ......................................18

Improving ante-natal care through service SOPs and control cards in Bengkayang, West Kalimantan ................................................................. 34

Improving health service quality through service charters ......................................................47

Improving promotion of immediate and exclusive breastfeeding ...........................................60

Partnerships between midwives and traditional birth attendants help to improve maternal health in Aceh and South Sulawesi ..............................80

Preventing child marriage through reproductive health education for teenagers in Bondowoso, East Java ................................................................. 98

Community Participation in Health Minimum Service Standards Planning in Jayapura, Papua .....................................................................................114

Advocating for Improved Health Services through Citizen Journalism and Radio Talk Shows in Jayawijaya, Papua .................................................124

Integrated Services for Survivors of Domestic Violence in Kota Jayapura, Papua ..............................................................................................................139

Business-Enabling Environment ..........................................................................................153
A community forum member meets with the government in Jayawijaya, Papua.

Midwives weigh a baby in Aceh Singkil, Aceh.
Kinerja Overview

About Us
Kinerja is a USAID project that aims to improve public service governance in Indonesia. We work with local governments to assist them in providing services in line with need and based on evidence. We also support the community to advocate for improvements in service quality.

Our Approach and Strategy
Kinerja only implements methods and approaches that have already been tested by Indonesia’s government and donor partners. Kinerja builds partnerships between local governments and communities to ensure that public service delivery is of high quality, through encouraging the adoption of good governance principles: transparency, responsiveness, accountability, and public participation.

Women attend a maternal and child health services visit in a village in Aceh.
Our Programs

Health
Kinerja works with community health centers (puskesmas), District Health Offices (DHOs), and community forums to improve maternal and child health and strengthen health systems. We support the community to become more involved in planning and budgeting, and encourage the government and health facilities to provide health services that are standardized, effective, and efficient.

Education
Kinerja assists schools, District Education Offices (DEOs), school committees, and community members to work together to achieve national standards and create healthy and safe learning environments. Our programs are School-Based Management, Education Unit Cost Analysis, and Proportional Teacher Distribution.

Business-Enabling Environment
Kinerja builds local government capacity to create a business-enabling environment, primarily through improving and simplifying business licensing processes through supporting One Stop Shops and by working with business associations to encourage genuine public participation.

Public Service Oversight
Kinerja supports public involvement and oversight in all aspects of public services through establishing multi-stakeholder forums to monitor service delivery and advocate for improvements.

Media and Citizen Journalism
Through its citizen journalism program, Kinerja builds the capacity of community members to oversee public services, identify problems, and push for improvements by creating media products such as articles and short films.
Minimum Service Standards
Kinerja assists local governments to evaluate MSS achievements in the health and education sectors to ensure that MSS targets can be met in a transparent, accountable, and responsive manner.

Gender Mainstreaming
Kinerja assists local governments and community forums to ensure women’s meaningful participation in all programs. In Papua, Kinerja also supported the initiation of integrated services for family violence survivors at community health centers.

Our Sites

Key Achievements

- 176 partner schools have improved their services, increased planning and budgetary transparency, and are working more closely with community forums.

- 41,116 new business licenses were issued in one day at the Free Licensing Festival in South Sulawesi.

- Integrated services for family violence survivors trialed at two community health centers in Papua.

- 73 partner community health centers have improved service quality through SOPs and community feedback.

- Short films made by Papuan citizen journalists were screened at the New Media Festival in Seoul, South Korea.

- 273 community forums have been established and are actively advocating for public service improvements.

- 85% of local government partners have incorporated MSS targets into their planning and budgeting documents.
A New Partnership Tackles Education Inequality in Barru, South Sulawesi

Background
Inequitable teacher distribution is one of the major problems facing public education in Indonesia. With more teachers preferring to work in urban areas, many schools in rural and remote areas are under-staffed and under-served. Despite the national government’s legislative efforts aimed at regulating teacher distribution, such as through the 2011 joint decision of five ministries on proportional teacher distribution (PTD), many districts have struggled to successfully implement the program. Political constraints, poor human resource management, and the personal preferences of teachers are key factors behind the lack of success.

Barru, a coastal district in South Sulawesi, was one of many Indonesian districts facing the problem. In 2015, the district had 2,715 teachers, mostly teaching at urban schools. The Head of the Barru District Education Office said that uneven teacher distribution disadvantaged both students and teachers. Students at schools with teacher shortages were not able to study full school days, and teachers often had to teach more than one class at the same time. Meanwhile, at schools with too many teachers, teachers of certain subjects (such as religion and physical education) were not able to meet nationally-mandated minimum teaching hours (24 hours per week). As a result, they were not able to enter the government certification program,
which requires fulfillment of minimum teaching hours, and consequently did not receive the certification wage bonus.

Inequitable teacher distribution in Barru contributed to its low education index, which was measured based on number of literate citizens and time spent for education. Barru’s education index from 2004 to 2007 was below the provincial and national standard.

<table>
<thead>
<tr>
<th>Year</th>
<th>Barru</th>
<th>South Sulawesi</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>71.29</td>
<td>71.44</td>
<td>76.27</td>
</tr>
<tr>
<td>2005</td>
<td>71.91</td>
<td>71.96</td>
<td>76.82</td>
</tr>
<tr>
<td>2006</td>
<td>73.07</td>
<td>74.37</td>
<td>77.41</td>
</tr>
<tr>
<td>2007</td>
<td>73.56</td>
<td>74.37</td>
<td>77.84</td>
</tr>
</tbody>
</table>

To address the challenge, the government of Barru implemented a proportional teacher distribution program by observing Ministry of Education (MOE)’s policies, such as technical guideline on government-recruited teacher distribution and a guideline on certification. The program was implemented with support from Kinerja USAID.
Strategy and Approach

Uneven teacher distribution has become one of the major education challenges in Indonesia. The problem reflects poor education management, in which teachers are posted based on likes and dislikes rather than schools’ needs. District Education Offices (DEOs) often do not have valid data on teacher distribution, nor maps of schools needing teachers.

To address the problem, the Barru district administration, through the DEO, decided to implement proportional teacher distribution with technical support from Kinerja. The DEO implemented the program in a fully participatory manner, engaging all relevant stakeholders. The office followed the strategy and approach as follow:
1. The district administration established a proportional teacher distribution (PTD) team which was responsible for program implementation. The team then worked closely with a civil society organization, LPKIPI (Lembaga Pendidikan dan Konsultan Inovasi Pendidikan Indonesia – Indonesian Consultancy for Innovative Education). The organization trained the team on better data management using software. The training aimed to leverage the team’s capacity to produce more valid and meaningful data. This information was later used as the basis for the DEO to transfer teachers.

The teacher distribution team and LPKIPI visited schools to validate the data, rather than waiting for monthly and annual reports from schools. The accurate and well-maintained data would later help the district education office to make sound decisions of education programs and policies.

2. In addition to working with Kinerja and LPKIPI, Barru local government engaged multi-stakeholders, such as parents, students, school staff, and community members. They held discussions with stakeholders to gather information on the number of teachers needed and on other issues related to school services.
3. When calculating schools’ needs for teachers, the district education office referred to the nationally-mandated minimum service standards (MSS), a set of basic service quality standards that all citizens should receive. Following the MSS guidelines, the DEO assessed its teacher distribution based on the ratio of students to teachers.

The Barru government implemented proportional teacher distribution based on the following principles:

1. Teachers should be assigned based on schools’ needs, rather than teachers’ or principals’ preferences. Assessments of needs and the distribution process should be conducted in participatory manner, involving students, parents, and the community.
2. DEO data should be regularly updated and well-managed.
3. DEO should assess the teaching needs and distribution by referring to MSS targets.
4. The District Head should issue a regulation to ensure program sustainability.
5. PTD should be regularly monitored and devalued to ensure it is on track and meeting targets.
6. DEO should respond to public complaints on teacher shortages.

**Implementation**

With commitment from local government, parliament, and community stakeholders, the district education office implemented the proportional teacher distribution through the following phases:
a. **Calculation of number of teachers needed**
The district education office calculated the total number of teachers needed by analyzing indicators, MSS targets, and national education standards. In doing so, the DEO took into account subjects, required teaching hours, the number of classes, and the ratio of students and teachers.

b. **Gap analysis**
The DEO held meetings and discussions with relevant stakeholders, such as other technical government offices, schools and community members, to analyze the gaps between the number of teachers that each school has and their actual needs.

c. **Technical recommendations**
After discussions, stakeholders worked together to develop a number of technical recommendations in order to push the local government decision-makers to implement proportional teacher distribution.

d. **Public testing**
The district education office, parliament and community members conducted follow-up discussions to learn more about the gap analysis and technical recommendations. This step was important to garner public input on how PTD should be implemented.

e. **Development of supporting regulations**
After all relevant stakeholders agreed upon the gap analysis results and technical recommendations, the Head of Barru District issued a regulation on the program implementation.
The regulation’s enactment was followed with the development of technical guidelines.

f. Planning and budgeting
The district education office and other relevant government technical offices allocated funds to implement teacher redistribution in their work plans.

g. Implementation
Teachers were redistributed based on the gap analysis, district head regulation, and technical guidelines.

h. Monitoring, evaluation, and reporting
The DEO monitored program implementation to ensure that it was right on the target. The office also developed regular reports to relevant stakeholders to demonstrate its accountability.

Results and Impact
Based on their analysis, the Barru district administration decided to transfer 326 public teachers. The decision was supported with an Executive Decision from the District Head.

The impact of PTD was not only felt at the end of the program, when the teachers were successfully redistributed.

Through learning to better collect and analyze data, the DEO improved the capacity of its data management staff. The data itself also helps the DEO to make more appropriate decisions and develop relevant policies that can bring about genuine improvements in education quality. Trainings and discussions
Kinerja Good Practices

have also helped improve the knowledge of government and school staff on key issues such as minimum service standards.

Additionally, the citizens of Barru are now more involved in education oversight, as many took part in discussions on PTD. They now feel that they have a way of participating in improving the quality of education in their district.

Monitoring and Evaluation
PTD in Barru was monitored by both the government and community.

Support from other government institutions
DEO is not the sole institution responsible for education services. Other government institutions, such as the district planning agency, administrative and organizational bureau,
finance bureau, legal bureau, and human resource bureau, were also important in carrying out PTD.

**Multi-stakeholder forums (MSFs)**
Community members must be involved in implementing and overseeing public education services. Public participation helps governments provide transparent and accountable education services.

**Program sustainability**
Education programs should be sustainable to ensure long-term benefits. To sustain PTD, local government and community members monitored program implementation and discussed their findings in government and community meetings. In addition, local media played an important role to oversee implementation. Public complaints and feedback was often discussed in newspapers, for example, which ensured the redistribution went smoothly.

**Challenges**
During the preparation phase, Barru’s DEO experienced some technical, human resource, and financial challenges, including:

a. The timeline for teacher redistribution was not in line with existing program timelines. This meant that if amendments to the program were needed, they had to occur within a specific budget cycle.

b. PTD requires a large amount of funding, and many local governments do not have the budget. To address the issue, the Barru local government had to limit what it was able to
implement (e.g., distribute only primary school teachers first).

c. Lack of capacity became one of the major issues in program implementation. Therefore, many trainings and capacity building programs for local government staff were required.

d. Lack of commitment and discipline by some government staff meant the entire implementation process was threatened. To overcome these challenges, Barru’s DEO had to conduct intensive discussions with its staff and other institutions so that they would better understand their responsibilities and the importance of PTD.

A strong partnership between local governments and community member turned these obstacles into points of successes.

**Sustainability**
Barru’s district administration has already provided legal and financial support to sustain the proportional teacher distribution program. Responding to the analysis of teacher distribution and recommendations from the DEO, Barru’s District Head issued an executive decision to support program implementation. He also allocated funding for teacher transfers, which were used to finance data management and hold public meetings. The program also remains under close watch by community members and the media.
Lessons Learned and Recommendations
The key lessons learnt from implementing proportional teacher distribution in Barru included:

a. Local government should involve the community in all program phase to ensure that needs are met.

b. Local government should use existing employees to implement the program, rather than recruiting new staff.

c. Due to many different stakeholders, program implementation required intensive coordination and clear targets. These must be firmly outlined from the start to ensure smooth implementation.

Contact Person

DR. Ir. Abustan, M.Si
Head of Barru District Education Office
Jl. H.M. Saleh Lawa No.40
Barru, South Sulawesi
Telp: 0427-21105
Public Participation Improves School Management in Bener Meriah, Aceh

Background

Bener Meriah, one of the districts in mountainous central Aceh, has a population of around 130,000 people (Statistics Bureau, Bener Meriah, 2012). The district has been pushing forward with strong education plans. However, although more than 90% of citizens are literate, only 50% have completed primary education, and less than 25% graduated senior high school. These low levels of formal education are partly due to poor quality services, causing many children to drop out of school in favour of work, and forcing others to move to big cities to continue their education after primary or junior high school.

Poor school management has contributed to the low quality of education services in the district. School staff with lower capacity tended to use conventional teaching methods, students had limited access to facilities, and school management was not transparent, accountable, or participatory. Cooperation between parents and school representatives was also minimal.

From the community side, unfortunately many parents and students alike were not aware how schools should be or what standardized education should include. Although some community members occasionally gave suggestions to schools, they felt that schools did not respond to their problems. A lack
of formal complaint mechanisms and well-functioning school committees to handle complaints further complicated matters.

The problems described above demonstrate that schools in Bener Meriah were not properly implementing the school-based management system, despite the fact that the policy had been issued in 2005. Based on the Government Regulation No. 19/2005 on the National Education System, schools implementing school-based management should demonstrate independence, partnership, public participation, openness, and accountability. It means that schools that did not engage society and which were not transparent, were not implementing school-based management.

**Strategy and Approach**

Public participation in school management is necessary to improve education services. Kinerja chose to support school-based management because it enables schools (service providers) and the community (service users) to work together to bring about higher quality education. One of the major school-based-management components that the project supported is known as a complaint survey. A complaint survey is a mechanism for schools to garner feedback and expectations from students, parents, and community members.

The school-based management emphasizes the partnerships of schools and community by applying the following strategies:
### 1. Schools as service providers:

a. District education office and schools were trained on school-based management and learnt about how other schools implement it.

b. Schools attended workshops on roles of school committees and community members. The school operators learnt how to engage school committees and other people to address education issues.

c. District Education Office (DEO) staff and school operators were trained to develop feedback mechanisms which community members could use to share their input with the schools. These trainings helped education staff to understand the role of public participation in genuine school-based management.

> “The school committee helped the school to achieve minimum service standards. It could identify targets that school could achieve itself, and indicators which required external assistance.”

- Salmiati
  
  School Committee member,
  
  MIN Janarata

### 2. Students, parents and community members as service users:

a. Education stakeholders at sub-district and district level received capacity building so that they could perform their roles optimally.
b. Seminars for school committee taught members about their roles as the partners of school principals and teachers.

c. A complaint survey was conducted to encourage public participation in schools planning and monitoring.

A high level of communication between service users and providers was maintained to increase trust between stakeholders. In addition, several capacity building activities were developed for both service providers and users, such as:

**Policy making and appointment of regional facilitators**
The first task was to push the Bener Meriah local government to develop policies on school-based management. The administration agreed to share the cost of implementation with Kinerja USAID. This was a good sign that the local government was committed to improving education services in the district.

The Bener Meriah district administration also assigned regional facilitators to provide intensive guidance for schools and community members. The district education office appointed 15 facilitators (primarily school principals and supervisors), who were trained as district instructors. The appointment was conducted gradually – five school principals were selected in the first year, and ten school supervisors in the second year.

Given that the school-based management program in Bener Meriah was also implemented at madrasas (Islamic boarding schools), the District Education Office and the Religious Affairs Office (which supervises madrassas) developed an integrated work plan. It was an important step to ensure that everyone
involved understood the program implementations and their respective roles.

**Capacity building for community forums**

When the community is involved in overseeing and improving public service delivery, they must have understand their roles and have strong skills to push for improvements.

Recognizing the importance of capacity building, the district administration supported several community empowerment activities, including:

a. **Establishment of an Education Concern Forum (Forum Peduli Pendidikan)**

With Kinerja’s assistance, community representatives including religious and women’s leaders, universities, civil society organizations, school supervisors, and others held a series of formal and informal meetings. The events resulted in a consensus to establish a community forum for education at the district level, which later was called *Forum Peduli Pendidikan Bener Meriah* (Bener Meriah Education Concern Forum/FPPBM).

This forum, which has voluntary membership, aims to facilitate community involvement in policy advocacy. It encourages wide participation through regular meetings with community forums at the sub-district level.
b. Establishment of community forums at sub-district level
Another important requirement for the school-based management program was functioning a school committee at every school, because they represent parents and the community. To ensure the committees functioned well, an education forum at the sub-district level was established. The forum, whose membership consisted of members of the school committees from Kinerja’s 20 school partners, head of villages, women and young leaders, aimed to serve as a medium for committees to discuss problems that each school was facing. The forum held quarterly meetings.

c. Capacity Building for Schools
The capacity building for schools was conducted gradually. First, all schools were invited to a workshop on public service-oriented school-based management and its implementation in a participatory, accountable, transparent and responsive manner.

Second, regular discussions involving parents and school committee were held to gain commitment from school stakeholders. Third, schools received trainings on how to develop participatory school work plans and budgets, and on working with school committees and other stakeholders. The schools were also encouraged to publish their values, teachers’ information, school plans, and expenditure reports to increase accountability.

1. Establishment of Public Service Teams
To support their service improvements, schools established public service teams, comprising of teachers and school committee members. The teams worked to develop complaint
handling mechanisms, such as complaint surveys, suggestion boxes, and SMS complaint systems.

**Implementation**
After establishing community forums, the school-based management program implementation focused on carrying out complaint surveys. All service delivery units, including schools, need a good system to garner feedback from service users as a way to improve their services. Complaint surveys are a good way of starting out when encouraging public participation.

In Bener Meriah, complaint surveys were conducted through the following steps:

1. **Training on managing public complaints**
   A number of two-day training sessions were held for students, parents, school committee members, community members, and school representatives. The trainings aimed to raise awareness of the benefits of complaints and of complaint surveys; to gain commitment from the community to participate in school improvements; and to begin identifying public complaints about school services in Bener Meriah.

   The trainings also introduced the nationally-mandated Minimum Service Standards (MSS). School-based management relies on MSS for setting targets and measuring achievements.

2. **Complaint Survey Preparation**
   A complaint survey team was established at each partner school, consisting of a regional facilitator, school committee members, and students. The team was trained on how to
conduct a complaint survey, from framing questions to interviewing respondents.

The team was also mentored by PKPM, one of Kinerja’s intermediary organizations that was assigned to assist the school-based management program in Bener Meriah. They further discussed the logistics of the survey, such as number of respondents, tools, and distribution areas, as well as strategies to communicate with respondents.

3. Complaint Survey Implementation
Complaint surveys were carried out at Kinerja’s 20 partner schools in Bener Meriah and involved 3,752 respondents, including students, parents, and community members who lived nearby. When distributing the questionnaires, the survey teams visited the schools and handed out the questionnaires to the students. The team invited parents to come to schools on the survey day. The teams then finished the survey in one day.

Parents filling out complaint survey questionnaires at one of Kinerja’s partner schools in Bener Meriah, Aceh.
4. Analysis of Survey Findings
Having generated data from the questionnaires, recorded the data and created a complaint index.

a. **Data recording:** The survey team recorded the data that they gathered from the survey every day. After all the data was collected, the survey team made a final recapitulation and checked if it was in line with their daily recapitulation.

b. **Complaint index:** the team made a complaint index by sorting problems identified in the survey by the most common complaints. The team then published the complaint index on announcement boards at schools.

5. Workshop on the survey results analysis
The next step was a workshop to disseminate the survey findings, which was attended by school principals, teachers, school committee members, and community representatives.

The objectives were:

a. Conducting detailed analysis on problems and identifying causes.

b. Discussing possible solutions.

c. Identifying and agreeing upon prioritized problems and approaches to address them.

d. Drafting service charters – a pledge of service improvements that schools would be responsible for.

6. Service Charters
Schools, and other relevant stakeholders, including the school committee, discussed the analysis of the complaint surveys, and they drafted service charters. Service charters are a kind of
pledge that promises particular service improvements. They had to ensure that the pledges were feasible for the schools. The schools then integrated plans to fulfill the service charters into their annual budgets and work plans.

On May 2, 2013, education stakeholders in Bener Meriah attended a large public ceremony at which all 20 school service charters were signed. It was a significant event to start improving school services.
Implementation of the school-based management program in Bener Meriah was supported by many different stakeholders, including:

a. **District Education Office and District Religious Affairs Office.** As policy makers, they develop policies and provide inputs on program implementation. They also monitor and evaluate the program.

b. **Regional facilitators** provide training and mentoring for schools.

c. **Bener Meriah Education Concern Forum.** This community forum advocates for local governments and schools to build the capacity of both the service providers and users so that they could implement the public oriented school-based management.

d. **Teachers and school principals** strengthen their relationships with school committees and community members. They also work together with school committees to conduct complaint surveys and fulfilled service charters.

e. **Students** are one of the complaint survey respondent groups. They describe the problems they faced at school.

f. **School committees** are the schools’ partners in implementing school-based management. They encourage community members to participate in school programs.

g. **Local media** help the schools communicate their programs, problems and improvements to the public.
**Results and Impact**
Implementation of the complaint survey as a component of school-based management in Bener Meriah brought concrete results and impact. The survey has strengthened partnerships between schools and community members, and has clarified that both are working together to achieve the same goal: better education services.

**Improved school transparency and accountability**
By implementing the complaint survey, Bener Meriah’s schools demonstrated their good will to improve, and by making their financial reports, work plans, and complaint indexes publicly available for public, parents and community members can use the documents to oversee the schools’ quality.

**Increased public participation**
With increased public participation, schools in Bener Meriah can address problems related to school facilities – a problem that many schools cannot solve themselves due to lack of resources. The school committees can assist schools to repair damaged classrooms and toilets and to build fences and school gardens.

*Community members work together to make a garden as a response to complaint survey results.*
**Improved school responsiveness**
The public service team and the complaint survey team at schools were more responsive to public complaints. They discussed the people’s feedback in regular meetings.

These good results have brought positive impacts to education services in Bener Meriah. People now trust schools and teachers more than before, because they can observe that the schools are trying to be more transparent and accountable. Furthermore, community members are willing to help schools address problems, and to participate in school programs. In other words, with public participation, the schools in Bener Meriah have become a model schools, implementing genuine public service-oriented school-based management.

**Monitoring and Evaluation**
Implementation of school-based management in Bener Meriah is evaluated by school supervisors on behalf of the District Education Office. After conducting field visits, the supervisors discuss their findings with the District Education Office, schools, and other stakeholders.

In addition, the Bener Meriah Education Concern Forum holds quarterly meetings to discuss the schools’ progresses in fulfilling their service charters.

Besides external evaluation, school principals are responsible for internal evaluation. They evaluate the school’s programs with teachers and school committee members.
**Sustainability**

The District Education Office has integrated the school-based management program, particularly complaint survey at schools, into its work plan and has allocated funds to provide training for schools beyond the original 20 partner schools.

The regional facilitators who assisted schools in implementing school based management are invaluable resources. With their experience and expertise, they can be recruited by schools and the local government to assist replication and to support sustainability.

The complaint handling mechanisms developed by the schools will help sustain the program. Using this procedure, schools and community members can identify problems and work together to seek out solutions. Strong partnerships and open communication between schools and community members improves people’s trust and increases participation in school programs.

Community forums such as the Bener Meriah Education Concern Forum greatly help program sustainability. They provide strong channels for community members to support their local governments and schools to improve education services.

**Lessons Learned and Recommendations**

1. Initially, it was hard to convince schools to be transparent and accountable. They had believed that people would demand more from the schools when they knew about the schools’ plans and reports. To address this issue, the
schools were exposed to real examples of the benefits of public participation. The examples came from other schools that had successfully improved their services thanks to increased community support.

2. The program implementers’ capacity to understand the program was varied. School principals, teachers, and school committee members had not been able to implement the school-based management program optimally since they were not exposed to adequate examples. Therefore, regional facilitators had to be creative when assisting program implementers so that everyone could understand and play their roles better.

3. Many community members believed that education was the sole responsibility of government. Although some people did have concerns about education services, they felt that they could not raise their concerns as there was no forum to do so. To address this problem, the program encouraged community members to establish forums at district and sub-district level so that they could discuss the education issues regularly and seek for the solutions.

4. Complaint handling mechanisms were initially hard to implement since they were a new concept for many people in Bener Meriah. Therefore, complaint handling mechanisms were introduced only after careful preparation. Another challenge with regards with the complaint survey was convincing parents, students, and community members to take part in the survey. Therefore, the complaint survey team had to use efficient and creative approaches to convince the respondents. Behaviour change activities
should be conducted first before beginning the complaint handling introduction.

5. Without channels to pass on complaints, the public will not participate. Once methods exist, such as community forums, community members will feel more comfortable in putting forward their concerns and suggestions, and are more likely to actively take part in efforts to improve education services.

**Contact Person**

**Jailani, S.Pd**  
Head of Program Department  
Bener Meriah District Education Office  
Jl. Seurule Kayu, Kompleks Perkantoran  
Bener Meriah, Aceh  
Telp: 085260663548  
Email: kabid.programbm@gmail.com
Improving ante-natal care through service SOPs and control cards in Bengkayang, West Kalimantan

Background
One of the biggest challenges facing Indonesia in its attempt to meet its maternal health targets for the Millennium Development Goals (MDGs) is that health care is not even or standardized throughout the archipelago. Health services are particularly below standard in remote areas far from major cities.

Puskesmas Sungai Raya Kepulauan, a small *puskesmas* (community health center) in Bengkayang district, West Kalimantan Province, serves around 400 pregnant women every year despite limited facilities and staff. The *puskesmas* and its village-level birthing clinics have just one ambulance between them, even though their catchment area covers both the mainland and a large number of islands and river-side communities. Puskesmas Sungai Raya Kepulauan has one doctor and 12 midwives. Twenty traditional birth attendants (TBAs) are also active in the sub-district. The *puskesmas* itself does not have a delivery room, so women must give birth at the village-level birthing clinics closer to their homes.

Despite its limitations, Puskesmas Sungai Raya Kepulauan has committed to providing a high standard of maternal and child
healthcare. In 2012, the center’s doctor and midwives assisted 338 births at facilities or at homes, while TBAs assisted 29 births. No maternal deaths were recorded, but there were two still-births and 12 neonatal deaths.

As with other areas in Indonesia, the ante-natal services provided by Puskesmas Sungai Raya Kepulauan vary from facility to facility. No standards are followed, so the quality varies significantly. To overcome this challenge and to standardize ante-natal care, Kinerja assisted the puskesmas to develop and implement standard operating procedures for ante-natal care (SOP ANC). The SOP focused less on the details of medical procedures and more on the manner of services required to be given, as it was assumed that all medical staff have been trained in carrying out the required tasks.

The staff of Puskesmas Sungai Raya Kepulauan.
Program Innovation

Public service provision, including health service provision, must be able to be relied upon. One way of ensuring consistency and reliability is to implement standard operating procedures (SOPs).

SOPs are documents with written instructions on how to carry out an activity, when to carry it out, where to do so, and who is responsible for doing so. By standardizing a process in this way, SOPs ensure that the same tasks will always be carried out in the same way, even if they are performed by different people, at different times, and in different places. This means that activities should always meet the same standard.

SOPs are very useful tools for organizational activities that are routine or occur frequently. The consistent implementation of SOPs means that comprehensive guidelines for all activities exist, and that there is no reason for deviation. This makes organizations more accountable and reliable, and there is less chance of mistakes being made – something that is particularly crucial in health care.

SOPs act as guides for health workers. They are based on medical and scientific knowledge, and are developed in line with national standards for health care. They must be mandatory with regards to implementation. SOPs also assist with monitoring and evaluation, as they provide a benchmark for what should be done.

SOPs are mandated by the Indonesian government through Law no. 25/2009 on Public Service Delivery. All public service providers are required to develop service delivery standards.
that are non-discriminatory, respect diversity, and prioritize community consensus.

The service SOPs that Kinerja supported the development of are similar to medical SOPs, but instead of providing information on medical procedures, they guide workers on service provision and administrative processes.

Kinerja assisted Puskesmas Sungai Raya Kepulauan by developing a number of service SOPs relating to ante-natal care. They include:
- Service standards for ante-natal care (ten services, known as ‘10T’ in Indonesian, which include measuring the mother’s nutritional status, measuring uterine height, measuring blood pressure, measuring iron levels, providing iron tablets, and vaccinating for tetanus toxoid)
- Service flowchart for ante-natal care (indicating where a patient should go and in what order, e.g. midwife first, then laboratory, then pharmacy)
- Referral mechanism for obstetric and neonatal emergencies
- Service fee list
- Waiting time standards.

The puskesmas also made a ‘control card’ that serves as a monitoring tool to analyze whether staff are following the ante-natal care procedures. The control cards are made up of three sections: the first is a list of the ten services a woman should receive during ante-natal care; the second is a box for feedback; and the third contains information on nutrition for mothers and babies, safe delivery, and immediate and exclusive breastfeeding.
Half the control card is taken home, while half is put into the suggestion box for follow-up by the puskesmas.

All SOPs were developed jointly by administrative and medical staff at the puskesmas, and were socialized to all staff after being signed by the head of the center. In order to ensure compliancy and to build patients’ knowledge on their rights to healthcare, the puskesmas displayed the SOPs on the walls and doors of both the waiting room and the ante-natal care room. The control cards are also given to all women visiting for ante-natal care upon registration with the front desk.

Implementation Process

1. **Mapping existing SOPs and service standards.** Before developing new SOPs – whether medical or service SOPs – existing SOPs and service standards at the puskesmas and District Health Office (DHO) need to be mapped and analyzed. The staff of Puskesmas Sungai Raya Kepulauan compiled all of their SOPs and standards, and evaluated whether they met national standards and whether they were properly implemented.
2. **Mapping SOPs and service standards that should be implemented.** The *puskesmas* staff and the local multi-stakeholder forum (MSF) – a type of community forum for public service oversight – came together to discuss the services delivered by the *puskesmas*. They identified which services did not yet have SOPs or did not have SOPs in line with national standards. One of these was ante-natal care – although the *puskesmas* had already developed an SOP for ANC, it did not state the amount of time procedures should take nor the costs for such services.

3. **Drafting of new SOPs.** All new SOPs were developed in a participatory and transparent fashion. Unlike the traditional top-down method where the head of the *puskesmas* or the head midwife drafts the SOPs, at Puskesmas Sungai Raya Kepulauan, all staff and MSF members were invited to take part. This ensured that all stakeholders felt involved and listened to, and that all could fully commit to implementing the new SOPs.

4. **Socialization of new SOPs.** After being drafted and agreed upon, all SOPs were socialized to all staff and were trialed before being officially implemented. It is vital that all staff have a strong understanding of what each SOP contains and what services it guarantees to give patients. Without proper socialization, staff may ignore the new SOPs and not implement them.

5. **Transparent publishing of SOPs.** All new SOPs were printed and displayed on the walls and doors of the *puskesmas*. This transparency increases the trust of the community towards health workers and improves the
quality of the services they receive for two reasons – one, because health workers are constantly reminded of what they should do, and two, because patients are aware of what they should receive. The 'ten steps' of ante-natal care SOP is displayed in the ANC Room and on its door, along with the service flowchart, waiting times, and referral mechanism. The list of service costs is displayed in the waiting room. Displaying these SOPs in these locations gives pregnant women the greatest amount of time to read and understand the types of ante-natal care they should receive at the puskesmas.

6. **Implementation, display, and socialization of SOPs to all public health facilities in the sub-district.** After trialing and implementing the new SOPs at the puskesmas, the staff ensured that all other public health facilities under their management also implemented and displayed the SOPs. This included at village-level birthing clinics (polindes and poskesdes) and monthly mother-and-baby sessions at the integrated health posts (posyandu). This was done to ensure that ante-natal care quality did not vary from one facility to another. The list of fees for services and the new referral mechanism were also displayed at all facilities to make sure that the information reached all residents.

7. **Routine re-socialization of SOPs.** To ensure compliance with SOPs, routine re-socialization to staff is necessary. The staff should then continue this by reminding the community of the standards of services they should receive. This is important to make sure that SOPs are not forgotten or ignored.
8. Development of ANC control card for monitoring SOP compliance. Puskesmas Sungai Raya Kepulauan was the first *puskesmas* to implement Kinerja’s ANC control card. The card includes information for patients on the ANC services they should receive, offers a section for feedback, and provides information on maternal health, nutrition, and breastfeeding. The cards are printed on ordinary white A4 paper and cut to make two cards per sheet. At Puskesmas Sungai Raya Kepulauan, 500 cards are enough for all pregnant women for one year.

**Results and impact**

The biggest impact of implementing SOPs and the control card for ante-natal care at Puskesmas Sungai Raya Kepulauan was the standardization of services across all public health facilities in the sub-district. Now, pregnant women can receive the same quality of service whether she goes to the *puskesmas* or to a village-level birthing clinic, because all have implemented clear SOPs on ante-natal care.

Since introducing service SOPs, the number of patient complaints regarding costs and waiting times have dramatically reduced. The staff see this as a result of displaying standard fees and waiting times in the waiting room.

The other impact has been an increase in the number of women coming to facilities for ante-natal care and childbirth. A marked increase occurred between 2012, when service SOPs were introduced, and 2013. The staff at the *puskesmas* explain this as a result of women now knowing more about the services they should receive, which has resulted in higher levels
of trust. The clarity with which services are outlined in the SOPs means that women feel more comfortable in coming to the puskesmas and other facilities, as they know exactly what will happen, who will perform it, how much it will cost, and when they can receive the service.

Related to the increase in facility-based births is that immediate breastfeeding rates have more than doubled between 2012 and 2013. This is because all midwives are now required to perform immediate breastfeeding for births both at facilities and at homes. Midwives also assist in performing the procedure when called by TBAs or families to assist with deliveries, even if they arrive too late to assist the birth itself. This has also had a small impact (13% increase) on exclusive breastfeeding rates. Neonatal deaths have also decreased by more than 40%.

| Maternal health statistics for Sungai Raya Kepulauan sub-district, Bengkayang 2012-2013 |
|-------------------------------------------------|---------------------------------|---------------------------------|---------------------------------|------------------------|
| Births assisted by trained medical workers       | Births assisted by TBAs         | Immediate breastfeeding         | Exclusive breastfeeding          | Neonatal deaths        |
| 2012                                            | 338                             | 29                              | 208                              | 77                      | 14                     |
| 2013                                            | 418                             | 24                              | 451                              | 87                      | 8                      |

**Monitoring and evaluation**

Although Puskesmas Sungai Raya Kepulauan began implementing its SOPs in late 2012 and early 2013, it did not develop the ANC control card until 2014 when the staff realized they needed a better method of monitoring compliance.
The control card enables the puskesmas to explore what services are being provide, and if they are not, why not. All ANC patients return half of their control cards to the puskesmas after their check-ups; the patients keep the other half. As the control cards list the ten services all pregnant women are supposed to receive, the staff can examine the services one by one. For example, if multiple cards indicate that the patient did not receive iron tablets (which all patients should receive), the staff will investigate the issue and find out why: was it because the women did not want the tablets? Was it because there are no tablets in stock? Was it because the midwife did not offer them? After identifying the problem, the staff can then work to find a solution.

Challenges
At the beginning, many staff at Puskesmas Sungai Raya Kepulauan lacked knowledge of SOPs. Not only were they not aware of how to develop medical and service SOPs, staff did also not know about the importance of having SOPs and standardized services. This meant that Kinerja spent some months raising the knowledge and understanding of puskesmas staff first, before beginning to examine existing SOPs and drafting new ones.

Another significant challenge that became obvious during the assistance period was that there was confusion over the different between medical SOPs and service SOPs. Medical SOPs contain the steps required to carry out medical procedures on patients, whereas service SOPs cover how the non-medical aspects of services are implemented. For example,
A service SOP for ante-natal care on display on the door of the MCH room at Puskesmas Sungai Raya Kepulauan.

an SOP on childbirth is a medical SOP, while an SOP on complaint handling is a service SOP. This issue emerged a number of times, especially when new staff began working at the puskesmas and had never encountered service SOPs before.

Transparency was also an issue. Many SOPs, both medical and service, had been developed over the years. However, few were displayed for staff and/or public consumption – the vast majority were simply stored in drawers or cupboards and never looked at. This meant that SOPs largely went unimplemented and unfollowed, and that staff did not understand why SOPs should be displayed on walls or doors. This was especially the case amongst medical staff, some of whom believed that SOPs were private documents that should not be available to the community.
Sustainability
The implementation of SOPs on ante-natal care will be sustainable at Puskesmas Sungai Raya Kepulauan if they are regularly monitored. Without monitoring, they are likely to disappear off the walls and end up in drawers and cupboards once more, unimplemented. The display of and compliance towards SOPs should be monitored not just by the head of the puskesmas and the head midwife, but also by the community. All people are entitled to have oversight over implementation. If staff or community members see a member of staff not following an SOP, they should report it to the head of the puskesmas or the head midwife to ensure it does not happen again. This means that SOPs should be regarded as living documents that can be altered based on feedback, monitoring and evaluation, and new developments in technology and policies.

Cost-wise, SOPs do not require any finance upkeep. Control cards can be printed and/or photo-copied once a year for a small fee.

The DHO of Bengkayang has stated that they will replicate SOPs for ANC to all puskesmas in the district in 2015.

Lessons learned and recommendations
Puskesmas Sungai Raya Kepulauan is now regarded by the Bengkayang DHO as one of the district’s most innovative puskesmas in terms of maternal and child health.

Puskesmas Sungai Raya Kepulauan’s experience proves that service SOPs on ante-natal care can have a significant and
immediate effect on the quality of care. By following standard procedures and meeting national standards, the puskesmas and its staff can show patients that they are providing appropriate care that is as good as at any other puskesmas elsewhere in the country.

Service SOPs are most effective when they are developed and implemented in a participatory and transparent manner. Community representatives should be involved in the design and monitoring processes, as should all puskesmas staff. Service SOPs should also be displayed in public on the walls and doors of health facilities, to ensure compliance from staff and to build public awareness of the rights to quality health care.

Both medical and service SOPs should ideally be standardized across the country, with allowances for local variations and add-on services (such as HIV testing and urine testing for puskesmas with appropriate laboratory facilities, and ultrasounds for facilities with USG machines). Doing so will reduce the chance of non-compliance to standard care procedures, and will ensure that all mothers and babies receive the same services.

Contact details

Mahlil Ruby
Former Health Specialist, Kinerja USAID
drmahli@hotmail.com

Kate Walton
Knowledge Management and Training Specialist, Kinerja USAID
kwalton@kinerja.or.id / katewalton.au@gmail.com
Improving health service quality through service charters

Background
Probolinggo District in East Java covers a population of more than one million people living across a large area. This means there is a high demand for healthcare. The District has 33 puskesmas, including 19 which provide in-patient facilities.

One of these is Puskesmas Sumberasih. Despite being one of the best puskesmas in the district, Puskesmas Sumberasih still witnesses multiple maternal and neonatal deaths every year. Before the puskesmas began working with Kinerja, field data revealed numerous issues: partnerships between midwives and traditional birth attendants did not run smoothly; standard operating procedures (SOPs) on pregnancy, delivery and neonatal care had not been developed; no complaint surveys had ever been carried out; waiting times averaged over 30 minutes; formula milk was commonly promoted at health facilities; no staff member was tasked with overseeing the daily running of healthcare; and there was no public joint commitment from the management and the staff to provide the best health services possible.

Puskesmas Sumberasih serves around 1,000 pregnant women every year. This led to the management agreeing to work with Kinerja to improve their maternal and child health (MCH) services to ensure that mothers and babies made it through pregnancy and delivery safely.
**Program Innovation**

In order to improve the quality of its MCH services, Puskesmas Sumberasih decided to focus on improving its management. This was because the medical care provided by the *puskesmas* was deemed to already be sufficient, with the problems experienced at the facility originating more from administrative and operational processes.

The *puskesmas* undertook the following activities:

1. **Developing SOPs** for both medical and service procedures relating to MCH.
2. **Implementing a complaint survey** to show that the *puskesmas* was open to changing and receiving feedback from patients and the broader community.
3. **Informal relationship building between traditional birth attendants and *puskesmas* medical staff**, led by the head of the *puskesmas*.
4. **Introducing a ban on formula milk** in the sub-district’s health facilities and at private midwifery clinics, and **providing breastfeeding equipment** such as breastmilk pumps and fridges for storage at the *puskesmas*.
5. **Establishment of a Manager on Duty position** to oversee the daily provision of services, including ensuring that staff arrive and leave on time, that staff are providing services in line with SOPs, and that patients are able to pass on any complaints or suggestions.
6. **Provision of nutrient-rich plants to pregnant mothers after attending ante-natal check-ups**, particularly after the first and second trimester check-ups. Mothers were given *daun katuk* and *daun kelor* plants, which are both highly nutritious and promote breastfeeding.
7. Carrying out a complaint survey and developing a service charter containing agreed improvements that need to be made, along with technical recommendations for the District Health Office (DHO).

For Puskesmas Sumberasih, one of the most meaningful activities they conducted was the complaint survey and its resulting service charter. All 61 of Kinerja’s partner puskesmas throughout Indonesia, including Puskesmas Sumberasih, were required to develop service charters as a way of involving the community in improving service quality. Service charters were developed following a complaint survey, in which a structured questionnaire was used to gather complaints and feedback from service users. The survey was carried out by members of the local sub-district multi-stakeholder forum (MSF), which is made up of community members. The complaints fielded during the survey were ranked in a complaint index by the quantity of responses to certain issues.

The complaints were then discussed in a number of FGDs, and solutions were put forward by both community members and puskesmas staff. Once solutions were agreed upon, the puskesmas drafted a service charter which outline the problems that could be solved internally by the puskesmas itself. For external problems, which required the assistance of the local government, a list of technical recommendations was given to the DHO. Both were signed by the head of the puskesmas. The service charter was printed as a standing banner and displayed in the puskesmas waiting room so that it was visible to all patients.
Service charters are a useful way to increase meaningful civic engagement in public service delivery. They help to ensure that services are accountable and transparent, and that providers are responsive to service users’ needs. Puskesmas Sumberasih worked on fulfilling its service charter promises over the 12 months following its development; the banner was displayed throughout this entire period.

**Implementation Process**

1. **Initial meeting between puskesmas and Kinerja’s implementing organization, the Children’s Protection Organization (Lembaga Perlindungan Anak – LPA).** LPA met with the head of Puskesmas Sumberasih to discuss both Kinerja’s and the puskesmas’ aims and hopes. The head of Puskesmas Sumberasih stated that community members have the right to participate in public service improvement efforts, and that he was interested in exploring how community complaints could help.

2. **Changing ideas of what complaints mean.** The head of Puskesmas Sumberasih knew his staff were reluctant to deal with community complaints, as they felt as though they were simply being criticized. He worked hard to convince his staff that complaints were actually a source of information that could help them improve their services, and that one way of accessing this was through a complaint survey.

3. **Establishment of a multi-stakeholder forum (MSF).** With Kinerja’s assistance, Puskesmas Sumberasih
established a sub-district MSF in November 2012 that aimed to oversee, mediate, coordinate, and advocate for improvements in public health care. MSF members included community leaders, religious leaders and traditional cultural leaders, as well as government staff and CSO members. To open the door to increased public participation, one of the first activities the MSF carried out was the complaint survey.

4. **Workshop on complaint handling and questionnaire development.** As the first step in the complaint survey, the *puskesmas* and the MSF jointly held a complaint workshop consisting of 80% service users and 20% service providers. The workshop identified complaints regarding services at the *puskesmas*, and a list of complaints was drafted. This list became the basis of the questionnaire.

5. **Complaint survey.** In January 2013, Puskesmas Sumberasih’s MSF carried out the complaint survey by interviewing 140 users of MCH services. All respondents were pregnant mothers or mothers with children under two years of age.

6. **Complaint index.** The results of the complaint survey were ranked by frequency of response and were listed in the form of a complaint index.

7. **Complaint survey analysis workshops.** The complaint index was jointly analyzed by MSF members, community representatives, and *puskesmas* staff at a series of workshops that aimed to identify the root causes of complaints.
8. Drafting and signing of service charter and technical recommendations. Two types of issues were identified – internal problems that could be solved internally by the puskesmas itself, and external problems that required the help of the local government. Internal problems and their solutions were then compiled into a service charter; external problems and their solutions were written up as technical recommendations to be given to the DHO. Both documents were signed by the head of Puskesmas Sumberasih at a public event witnessed by DHO, Bappeda, the MSF, and the community. This was done in an effort to support transparency. The technical recommendations were handed to the DHO while the service charter was printed as a standing banner and displayed in the puskesmas waiting room until all complaints had been sufficiently dealt with.

9. Monitoring of service charter and technical recommendations. The local MSF was responsible for monitoring the implementation of both service charter and technical recommendations. The MSF carried out regular checks to see whether improvements had been made and promises had been fulfilled. The heads of the puskesmas and DHO were informed of monitoring results and reminded to overcome complaints that had not yet been solved.

10. Repeat of complaint survey. Puskesmas Sumberasih was so pleased with how the complaint survey helped identify problems and improve services that at the time of writing, they were planning to repeat the process and make complaint surveys a regular part of their programs.
Results and impact
Puskesmas Sumberasih and its MSF agree that a number of significant improvements have taken place since the complaint survey was carried out.

Previously, the puskesmas felt as though it was solely responsible for making improvements and overcoming any problems that occurred. The community also felt that all issues about health care were the responsibility of the puskesmas alone. Since the complaint survey, the community’s feelings of ownership and trust have increased, and the puskesmas frequently involves the MSF in meetings and workshops.

There has been a measurable increase in the number of pregnant women seeking the services of Puskesmas Sumberasih since the puskesmas began actively working to improve its management of MCH services. The table below illustrates how these numbers have grown since 2011, the year before Kinerja began assisting Puskesmas Sumberasih. After two years of support, the number of deliveries assisted by medical professionals rose 6%, first ante-natal check-ups by 13%, and fourth ante-natal check-ups by 7%. This indicates that more women trusted the puskesmas to provide them with high-quality MCH services.

<table>
<thead>
<tr>
<th>MCH services at Puskesmas Sumberasih, Probolinggo</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries assisted by medical professionals</td>
<td>926</td>
<td>963</td>
<td>979</td>
</tr>
<tr>
<td>First ante-natal check-up</td>
<td>1,125</td>
<td>1,181</td>
<td>1,268</td>
</tr>
<tr>
<td>Fourth ante-natal check-up</td>
<td>860</td>
<td>848</td>
<td>918</td>
</tr>
</tbody>
</table>
This increase is also due to the number of new partnerships between midwives and traditional birth attendants (TBAs). In 2011, 128 TBAs had not yet joined into partnerships with midwives; by 2014, just 8 TBAs remained un-partnered. These partnerships require TBAs to no longer assist deliveries by themselves but to instead refer pregnant and delivering women to the *puskesmas* where they can be assisted by midwives. As community members trust TBAs, they then come to trust the *puskesmas* and its midwives.

In terms of *puskesmas* administration and how services are provided, the biggest impact has occurred as a result of installing a fingerprint registration system for patients. During the complaint survey, 85 respondents complained that waiting times were too long (over 30 minutes on average) and that part of this problem was that the registration process took too long. The MSF and the *puskesmas* discussed this issue, and agreed to trial a fingerprint registration system that automatically links patients’ medical files with their fingerprints. Registering for an appointment now only takes a few seconds; previously, it took more than three minutes per patient. The system works even if patients have left their ID or insurance cards at home. Although it seems like only a small difference, it must be remembered that the *puskesmas* serves more than 100 patients a day – a saving of 2.5 minutes per patient means the system can flow much more smoothly and efficiently.

The head of Puskesmas Sumberasih, Hariawan Dwi Tamtomo, said the fingerprint registration system was a direct result of the complaint survey results. “We found out that many patients complained about having to wait a long time. We’ve been using
a digital medical file system, SIMPUSTRONIK, since 2007, so we added the fingerprint registration system,” he said.

Since working to improve its management and administrative systems, Puskesmas Sumberasih has won a number of awards. In 2012, it won the awards for Cleanest In-Patient Facilities and Best Performance of all *puskesmas* in Probolinggo district. In 2014, Puskesmas Sumberasih was ranked by the Provincial Health Office as the Second-Best Puskesmas in all of East Java.

**Monitoring and evaluation**
Monitoring and evaluation is a joint activity at Puskesmas Sumberasih, carried out by DHO, MSF, and *puskesmas* staff themselves. In terms of the service charter and technical recommendations, the MSF monitored its implementation once during the twelve months after the complaint survey. MSF members checked whether improvements had taken place, and
reminded the puskesmas and the DHO to follow-up if no improvements had occurred. When the puskesmas decided to run a second complaint survey, the MSF ensured that previous complaints that had not yet been dealt with were also part of the new questionnaire.

Monitoring at Puskesmas Sumberasih also takes place through complaint handling mechanisms. If any complaints are received by the puskesmas, the staff discuss them and find solutions for them with MSF members at a regular mini-workshop.

The Probolinggo DHO also carries out regular monitoring and evaluation of Puskesmas Sumberasih, as it does for all puskesmas in the district.

Challenges
When first training puskesmas staff on the complaint survey process, Kinerja and its IOs received some initial resistance towards the idea. Many staff members – medical professionals and administrative staff alike – were of the opinion that criticism of the puskesmas from the community would give the facility a bad reputation. Fortunately, the head of the Puskesmas believed that complaints would actually help the centre improve, and worked with the MSF to convince his staff members to give the complaint survey method a try. The head explained that criticism helps him and his staff identify what problems exist and what community needs are going unmet.

The community also had some reservation towards the complaint survey at first. Service users were worried that if they complained about the puskesmas and its services, they
would later receive sub-standard health care. The community slowly began to shift their perceptions after the *puskesmas* explained that they were genuinely open to community feedback and promised that whatever was said would not have a negative impact on the services they provide to patients.

The other main challenge was that Puskesmas Sumberasih had never carried out a complaint survey before, so they did not know how to do so. Kinerja’s IO, LPA, trained both *puskesmas* staff and MSF members on the process and its implementation, and incorporated complaint surveys, service charters, and technical recommendations from other districts as examples.

**Sustainability**
The high level of public participation and oversight at Puskesmas Sumberasih, as demonstrated by the local MSF, means that there is a strong likelihood that the changes achieved will be sustained. Sumberasih’s MSF has been consistently active in the two years since its establishment, and its members are still enthusiastic and interested to continue their work.

The Puskesmas itself has stated its commitment to civic engagement, and has begun to involve the public in more of its regular management and administrative activities, such as planning, budgeting, and monitoring. The head of the Puskesmas is keen to continue working with the MSF.

Kinerja and its IOs have supported more than 100 *puskesmas* throughout Indonesia to carry out complaint surveys since 2012. Local governments have begun replicating the process at
other puskesmas since seeing the impact it has had on pilot puskesmas, while many puskesmas who have already run the complaint survey once are interested in repeating the activity. On average, 80% of complaints put forward during the survey have been dealt with at Kinerja’s original 61 partner puskesmas.

**Lessons learned and recommendations**

Puskesmas Sumberasih’s experience in carrying out a complaint survey and implementing a service charter has shown that cooperation between community members and health facilities has a positive impact on the quality of public service delivery. Problems are not only more easily identified but also more easily solved.

The key lessons can be summarized as follows:

- A service charter and list of technical recommendations become a bridge to improved transparency and accountability because they are based on not what the puskesmas thinks the community needs, but on what the community thinks the community needs.

- Technology can be an effective way of speeding up services and increasing efficiency. Technology such as fingerprint registration is also simple to use and makes life easier for patients, as they no longer need to bring their ID and insurance cards.

- Having a manager on duty to oversee daily activities at the puskesmas is an effective way of ensuring SOPs are followed and that patient needs are met.

- Personal and informal advocacy from key figures, such the head of the puskesmas, can change long-held attitudes and mindsets.
Over 100 puskesmas throughout Indonesia have now undertaken the complaint survey process and developed service charters. In general, puskesmas who have made improvements based on service charters are cleaner and in better condition in terms of infrastructure; are served by friendlier, more polite staff; provide services in line with national standards; deliver more babies; carry out more antenatal check-ups; and support more mothers to immediately and exclusively breastfeed their babies. Most importantly, both staff and patients are more satisfied with puskesmas services, and health outcomes are starting to improve.

Contact details
Dr Hariawan Dwi Tamtama
Head of Puskesmas Sumberasih
+62 335 427268

Lily Pulu
Former Public Service Oversight Specialist, Kinerja USAID
lily.pulu@gmail.com
Improving promotion of immediate and exclusive breastfeeding

Background
Exclusive breastfeeding is when babies are fed only breastmilk for the first six months of their lives, and receive a combination of breastmilk and other foods until the age of two years. Exclusive breastfeeding has been proven to improve the nutritional status of babies and strengthen immune systems.

Levels of exclusive breastfeeding are low in Indonesia. According to national data from 2012, only 33.6% of babies under two are breastfed by their mothers. This is influenced by low levels of understanding about breastfeeding in addition to local cultural beliefs and misconceptions. Many mothers believe that breastmilk does not provide adequate nutrition for their babies, so they give them additional food and drink (such as honey, coconut water, and over-cooked rice) even though they are under six months of age. A high proportion of mothers also choose to give formula milk rather than breastmilk because it is considered to be better for babies’ growth, more modern, and healthier. In some parts of Indonesia, mothers also believe that colostrum (the first breastmilk) is dangerous for babies and must be disposed of, which leads to a reliance on formula milk during the very important first few days of life. Some mothers avoid breastfeeding because of the belief that it will cause their breasts to droop and sag. Many are also embarrassed to
breastfeed in public, or simply find using formula and a bottle easier.

Other factors also come into play. In Indonesia, one key influencer is the formula milk industry, which carries out intense advertising and promotion of its products. Following bans on advertising formula milk for babies under the age of two on TV and in print, formula milk producers instead have widely entered into partnerships with health facilities and midwives, offering prizes and rewards for those who promote and sell formula milk. It is common to see formula milk logos and slogans on medical products and products for new mothers, and many midwives have side businesses in selling formula milk. This issue is compounded by the lack of promotion on immediate and exclusive breastfeeding from health facilities and district health offices (DHOs), although the situation has begun to change in the last few years.

On paper, some community health centers (puskesmas) have plans to promote immediate and exclusive breastfeeding, but many do not. Unfortunately, even amongst puskesmas who do carry out breastfeeding promotion, activities are generally limited in scope and have minor impact. In an attempt to improve the quality and impact of such activities, Kinerja worked with puskesmas to make their breastfeeding promotion more relevant, more interesting, and more participatory.

Some of the most interesting approaches to breastfeeding promotion occurred in Bener Meriah in Aceh, in Tulungagung and Probolinggo in East Java, and in Makassar in South Sulawesi. In 2010, exclusive breastfeeding was low in all four of these districts. In Bener Meriah, just 40% of children under the age of
two were exclusively breastfed. In Tulungagung, the rate was 52.5%; in Probolinggo, 34%; and in Makassar, 59%. Kinerja’s aim was to improve the awareness of the importance of immediate and exclusive breastfeeding, with the longer-term goal of improving breastfeeding rates.

Program Innovation
Each Kinerja partner district that worked on improving breastfeeding promotion developed its own approach, designed to be effective in the local cultural context.

Co-operation between the Office of Religious Affairs and puskesmas: Bener Meriah, Aceh
A long-held myth in Bener Meriah is that breastmilk contains bacteria that are dangerous for babies. Called dena in the local language, this myth is so wide-spread that the majority of mothers in the district give their babies formula milk, with some also using the water in which rice is cooked as an additional drink.

This myth also means that many new mothers refuse to carry out immediate breastfeeding, despite the advice of midwives. Colostrum is considered to be ‘bad milk’ that has gone stale, so is generally not given to babies.

Local knowledge of the importance of exclusive breastfeeding is also low, as many midwives and doctors do not explain this to pregnant women and their families. Unfortunately, this has led to weakened immune systems amongst babies. Diarrheal illnesses are also common due to a lack of clean water available for mixing formula milk.
Bener Meriah decided to attempt to improve rates of immediate and exclusive breastfeeding by including information on these topics in the pre-marital courses run by the local Office of Religious Affairs. All couples intending to marry are required to attend these courses, and since 2013, health professionals such as the head of puskesmas and the head midwife have been included in the courses to give information on breastfeeding and safe childbirth. Crucially, the Office of Religious Affairs provides religious justification for breastfeeding in the form of a fiqh booklet containing religious law that supports breastfeeding. The booklet was developed in coordination with the District Ulama Council, the Islamic Law Office, the District Health Office, puskesmas, and local religious and community leaders.

All couples intending to marry must participate in the one-week pre-marital course before their wedding. On average, Bener Meriah holds five or six courses every year. Couples receive information on maternal and child health, preparing for childbirth, the delivery process, and immediate and exclusive breastfeeding. All couples are given a copy of the fiqh booklet. The booklets are also available to read at the puskesmas.

**Formula Milk Ban: Puskesmas Beji, Tulungagung, East Java**

Puskesmas Beji, one of Kinerja’s partner puskesmas in Tulungagung district, East Java, took the brave decision in May 2013 to ban all formula milk promotion and sale in their catchment area. The puskesmas ended its partnership with a formula milk producer and stopped offering products at both the puskesmas itself and the numerous village-level birthing...
clinics. Staff are also forbidden to become promoters or salespeople for formula milk products.

The decision was made by the head of the puskesmas following demands from community oversight bodies. It was also in line with a new district regulation that forbids the promotion and sale of formula milk in health facilities.

![Breastfeeding mothers say 'Breastmilk is the best!' at Puskesmas Beji, Tulungagung.]

In order to support the ban, the puskesmas stepped up its efforts to promote immediate and exclusive breastfeeding. The staff began new community education programs which aimed to overcome two key local misconceptions: that babies only cried because they were hungry, and that formula milk is the best food for babies.

**Integrated Breastfeeding Campaign: Probolinggo, East Java**

The government of Probolinggo district in East Java are strong supporters of immediate and exclusive breastfeeding because of
the huge nutritional and immune benefits they provide to babies. Since beginning its work with Kinerja, the district government has so far developed a district head regulation that supports breastfeeding and safe childbirth; sponsored community festivals and healthy food competitions; elected breastfeeding ambassadors; and provided training to religious figures on how to support breastfeeding and why they should do so.

One high impact activity the government of Probolinggo did was to elect the District Head, Hj. P. Tantriana Sari, as a breastfeeding ambassador in 2014. As both the elected leader of the district and a mother herself, the District Head can play an important role in convincing families on the importance of breastfeeding. Ms Tantri, as she is commonly called, even made a commitment to continue breastfeeding her young child while working as District Head. She also issued a decree that instructed all work places and public places to establish breastfeeding rooms and that forbade health facilities and private midwives from selling formula milk. Ms Tantri also regularly drops in at puskesmas unannounced to ensure they are not promoting or selling formula milk products. A number of government buildings have already followed the decree and have set up breastfeeding rooms, including at the district parliament, the district health office, two hospitals, and seven puskesmas.

With the clear and active support of the District Head, the people of Probolinggo can see that the government is truly committed to supporting immediate and exclusive breastfeeding. Mothers report feeling strengthened in their
decisions to breastfeed, and as though they are able to do so without worrying about discrimination or stigma.

The community has also been active in supporting breastfeeding mothers. Twenty-two sub-districts have each formed Breastfeeding Support Groups. Consisting of mothers and community members concerned about low breastfeeding rates, the groups meet regularly to discuss challenges and successes, and to share information about breastfeeding and child health.

One of the most creative breastfeeding promotion activities has been carried out by the district’s puskesmas – the planting of katuk and kelor plants. Both are locally-grown but not widely-consumed, despite their nutritional value, as are often viewed as ‘poor people’s food’. Katuk (sauropus androgy nous) is a leafy plant which, if consumed, is believed to encourage the production of breastmilk. Kelor (moringa oleifera), on the other hand, is a nutritious leafy plant which contains high levels of Vitamins A, B2, B6 and C, iron, and magnesium. A District Head Decree has instructed all health facilities to develop and maintain small gardens that include both katuk and kelor plants, and to prepare meals for new mothers made of these leaves. Some puskesmas also give out seedlings of katuk and kelor to expecting mothers as an incentive to attend ante-natal check-ups.

**Our Community Cares about Breastfeeding: Makassar, South Sulawesi**

Although there are now numerous breastfeeding movements throughout Indonesia, the majority are dominated by women. Few men tend to be involved. This is because breastfeeding is considered to be a ‘women’s issue’.
With Kinerja’s assistance, the city of Makassar in South Sulawesi has carried out a wide-reaching breastfeeding awareness raising campaign directed at men. It aims to encourage men to become advocators for and supporters of breastfeeding. The campaign began by attempting to change the idea that breastfeeding is only something women should care about, by establishing groups called Fathers Who Care about Breastfeeding. The groups’ members are made up of professors, public servants, religious leaders, community leaders, neighborhood heads, and other community members. The groups aim to increase the rates of immediate and exclusive breastfeeding through making men aware that their children’s health is not just their wife’s responsibility but theirs as well.

Inaugurating the city’s new Exclusive Breastfeeding Ambassadors in Makassar, South Sulawesi, in 2013.
The Fathers Who Care about Breastfeeding groups run education activities at the sub-district and neighborhood levels. They provide advice to new mothers and fathers on exclusive breastfeeding, and promote its nutritional benefits over formula milk. The groups’ members are also now often involved in discussions, workshops and trainings on breastfeeding as facilitators and presenters.

In 2014, the groups worked with the city’s Multi-Stakeholder Forums (MSFs – community forums established by the Kinerja program to oversee public service provision) to develop a peer learning module for breastfeeding supporters. The module was designed to increase the knowledge and understanding of supporters on immediate and exclusive breastfeeding, and to improve their capacity to provide support and advice to families encountering breastfeeding problems.

**Implementation Process**

Co-operation between the Office of Religious Affairs and puskesmas: Bener Meriah, Aceh

Bener Meriah’s District Health Office (DHO) realized that one of the biggest factors behind low breastfeeding rates in their district was the persistence of the *dena* myth, which claims that breastmilk contains bad bacteria. The DHO began a series of discussions with local partners, such as puskesmas, the Office of Religious Affairs, the Islamic Law Office, and others, talking about what could be done to eradicate the myth. The stakeholders agreed to develop a program to overcome the misconception.
One of the recommendations that came out of the discussions was to develop a partnership between the Office of Religious Affairs and the district’s puskesmas in order to promote good maternal and child health to couples about to be married. This was considered a strategic way of reaching key communities, as both men and women have to attend pre-marital courses run by the Office of Religious Affairs. A Memorandum of Understanding (MOU) was developed between the Office of Religious Affairs and Bener Meriah’s puskesmas to run pre-marital courses that include information on safe delivery and immediate & exclusive breastfeeding in addition to the regular material provided.

Following the signing of the MOU, staff from the Office of Religious Affairs were trained by staff from the DHO and puskesmas on safe childbirth and breastfeeding. These staff were required to share their new learning with other staff at the Office of Religious Affairs to ensure that all were aware of not just breastfeeding but of how the Qur’an and hadiths support it.

A separate team was established to oversee the creation of a fiqh booklet (Islamic law booklet) about breastfeeding from an Islamic perspective. The team included members from all key stakeholders, both religious and health. The booklet would be given to couples about to be married, as well as to Islamic scholars and preachers to use in their sermons and study sessions.

**Formula Milk Ban: Puskesmas Beji, Tulungagung, East Java**

As with many other districts in Indonesia, Tulungagung’s hospitals, puskesmas and private midwifery practices have
previously signed contracts to become distributors of formula milk. According to the head midwife of Puskesmas Beji, Ari Murtiningtyas, this was because the health workers feel that they are making it easier for mothers to purchase formula milk, because they do not have to go to a separate shop anymore. Fortunately, this attitude is now changing.

Puskesmas Beji decided to end their contract in May 2013 and ban the promotion and sale of formula milk throughout their catchment area. To ensure this ban is implemented, village midwives undertake monitoring visits to private midwives to ensure they are not selling formula milk, and house visits to educate families on breastfeeding.

**Integrated Breastfeeding Campaign: Probolinggo, East Java**
The government of Probolinggo began its integrated breastfeeding campaign by developing a district head regulation. This regulation gives a strong legal basis for breastfeeding campaign activities; regulations like these are very important in Indonesia.

After the development of the regulation in mid-2013, the government carried out the following activities:
1. The District Head was elected as a breastfeeding ambassador for 2013.
2. A workshop for Islamic scholars and preachers on safe childbirth and immediate & exclusive breastfeeding to ensure religious leaders were in agreement with and supported the campaign.
3. Twenty-two sub-district Groups who Care about Breastfeeding groups were formed.
4. In November 2013, the District Head instructed health facilities to plant *katuk* plants to support breastfeeding.

5. In January 2014, the District Head instructed health facilities to plant *kelor* plants to improve maternal and child nutrition.

6. In March 2014, the government held a *katuk* and *kelor* food festival at which more than 200 different menu items were cooked.

7. A series of trainings for 60 traditional medicine sellers, vegetable sellers, and make-up artists were held to encourage them to share information on safe delivery and breastfeeding with their customers and clients.

8. A training for health volunteers on how to better support breastfeeding mothers was run.

9. A training on breastfeeding was held for 49 breastfeeding counsellors.

10. In October 2014, 24 new breastfeeding ambassadors at the sub-district level were elected. After being elected, the new ambassadors were trained on safe delivery and immediate & exclusive breastfeeding, and developed their work plans for the next 12 months.

A bridal make-up artist (left) who received training on how to discuss breastfeeding with brides-to-be.
Our Community Cares about Breastfeeding: Makassar, South Sulawesi

The pro-breastfeeding movement in Makassar began in 2012 with a new district head regulation on exclusive breastfeeding. This provided the legal framework for promotional activities on breastfeeding.

Kinerja supported the district to establish multi-stakeholder forums (MSFs) on health service delivery in its partner sub-districts. The community took this idea one step further after realizing that there was a lack of men involved in maternal and child health issues, and established a series of Fathers who Care about Breastfeeding groups. The MSFs and the Fathers groups then worked together to develop the peer learning module for breastfeeding supporters.

Results and impact

Co-operation between the Office of Religious Affairs and puskesmas: Bener Meriah, Aceh

Since incorporating safe delivery and breastfeeding information into pre-marital courses, the rates of newly-wed couples carrying out immediate and exclusive breastfeeding have increased. For example, during the first six months of the program (that is, between June and December 2013), 13 couples took part in the course. Ten have since become pregnant, and eight of these have given birth. All eight chose to do immediate breastfeeding, and were still breastfeeding their children at the time of writing. This means that there is a 100% success rate so far.
From January to September 2014, 28 couples took part in the course. All have stated their commitment to carry out both immediate and exclusive breastfeeding.

**Formula Milk Ban: Puskesmas Beji, Tulungagung, East Java**
The impact of Puskesmas Beji’s formula ban is impressive. Within just two months of implementing the ban in May 2013, the rate of breastfeeding in the puskesmas’ catchment area increased from 55% to 88%. Eight villages were already formula milk-free within a month of the ban. It is clear that the increase was related to the ban, as rates of immediate breastfeeding were already 100% at the puskesmas and there were no other promotional activities that went on at the time.

In addition, 80% of privately-practicing midwives have ceased promoting or selling formula milk at their clinics.

**Integrated Breastfeeding Campaign: Probolinggo, East Java**
Immediate and exclusive breastfeeding have been proven to improve a baby’s nutritional status. Although this link has not been explicitly studied in Probolinggo, the District Health Office believes that better maternal nutrition and increased rates of immediate breastfeeding are part of the reason behind a drop in the neonatal mortality rate (NMR). In 2012, 230 babies died in Probolinggo; this fell to 201 in 2013, representing a drop in the NMR from 12.43 deaths per 1,000 live births to 11.04 deaths per 1,000 live births.

**Our Community Cares about Breastfeeding: Makassar, South Sulawesi**
As a result of numerous promotional and awareness raising activities, exclusive breastfeeding rates increased significantly in
Makassar between 2012 and 2014. At Kinerja’s three partner puskesmas in the district, rates increased by more than 20 percentage points on average.

### Rates of exclusive breastfeeding at Kinerja’s partner puskesmas in Makassar, South Sulawesi

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puskesmas Cenderawasih</td>
<td>58%</td>
<td>76%</td>
</tr>
<tr>
<td>Puskesmas Batua</td>
<td>61%</td>
<td>84%</td>
</tr>
<tr>
<td>Puskesmas Patingalloang</td>
<td>48%</td>
<td>72%</td>
</tr>
</tbody>
</table>

The overall average breastfeeding rate in Makassar also increased, reaching 67.8% in 2013, up from 61.35% in 2012.

The change in attitudes of mothers and fathers to breastfeeding has also been positive. Women are no longer embarrassed that they breastfeed their child (breastfeeding is seen as something that only poor women do in many parts of Indonesia); in fact, now they are proud. Their husbands and families are also much more supportive of their choice to breastfeed than previously.

**Monitoring and evaluation**

**Co-operation between the Office of Religious Affairs and puskesmas: Bener Meriah, Aceh**

The head midwife of each puskesmas monitors the rates of immediate and exclusive breastfeeding at her own puskesmas and at the village-level birthing clinics. She also meets with new mothers and mothers with young children to discuss their breastfeeding problems and successes, and to ask for feedback on how the puskesmas can better support them.
The staff of the Office of Religious Affairs work together with midwives from the puskesmas of Bener Meriah to examine the impact of the program. They compare data to see whether couples have undertaken the pre-marital course and if they then follow through with immediate and exclusive breastfeeding.

Formula Milk Ban: Puskesmas Beji, Tulungagung, East Java
There is no formal system for monitoring the sale of formula milk at facilities in the sub-district yet, but some informal monitoring has taken place. The head midwife regularly visits the village-level birthing clinics and the private homes of midwives to ensure they are not selling formula milk and to remind them to provide information on breastfeeding to all pregnant women and their families.

One unexpected result of this program has been that the quality of data recorded by the puskesmas and the village-level birthing clinics has improved. Data is more regularly recorded than previously, and the clinic believes it is more accurate because of this.

Integrated Breastfeeding Campaign: Probolinggo, East Java
The monitoring of the breastfeeding campaign in Probolinggo has so far been limited to activities carried out by the multi-stakeholder forums (MSFs). The MSFs have developed monitoring tools to gather data on the rates of breastfeeding in the district, and will use the data collected to make recommendations to the DHO.
Our Community Cares about Breastfeeding: Makassar, South Sulawesi

The Fathers who Care about Breastfeeding groups have no external monitoring or evaluation. They monitor their own activities, and solve problems collectively. They also take up more complex issues with the DHO and the *puskesmas*.

Challenges
The challenges experienced in each of the four districts profiled in this story are similar. Each faces continuing strong cultural beliefs and misconceptions about breastfeeding, as well as the Indonesia-wide preference for formula milk because it is thought to be healthier and more ‘modern’ than breastmilk. Even when mothers themselves understand the importance of breastfeeding and wish to breastfeed their babies, they will frequently encounter resistance from their husband, mother, or mother-in-law. Each district is working hard to slowly overcome these beliefs.

Other problems include the low level of understanding of midwives on immediate breastfeed and the proper way to perform it; the lack of breastfeeding facilities in work places and public places; and the lack of desire among families to continue breastfeeding after the first few months.

Sustainability
The sustainability of each of the pro-breastfeeding programs implemented in Kinerja’s four partner districts profiled here relies heavily on community participation and support. Without the full involvement of the community, these programs will not
be successful and will not sustain themselves over the next few years. If the community continues to take part, however, as they are currently doing, all four of these programs have a high chance of being sustainable.

Each program will also require support from the local governments, particularly from the District Health Offices. This support must include financial support to ensure the programs are able to continue.

All of these programs have the potential to be replicated throughout the rest of Indonesia. Breastfeeding rates are low across the country, and districts would do well to consider the programs presented here for implementation in their own areas.

Lessons learned and recommendations

- **District head regulations are important.** Regulations such as those issue by the district head provide a legal basis for health workers to point to when they suggest to community members that they exclusively breastfeed their babies. With the regulation in place, health workers report feeling braver and more comfortable in giving breastfeeding advice to patients because they know the law and the government supports what they are doing.

- **Innovative campaign methods are key to building momentum.** Formula milk promotion is so widespread and so strong that it has reached even the most isolated villages in Indonesia. When families see on TV or read in the newspaper that formula milk makes babies healthy and
happy, they can be easily influenced to abandon breastfeeding. This means that creative and interesting methods of promoting breastfeeding are necessary if the aim is to change behavior.

- **Individual commitment is as important as organizational commitment.** The role that individuals can play is often overlooked. Kinerja’s experience in supporting districts to promote exclusive breastfeeding has shown that key individuals, such as the District Head, can have a significant impact on behavior. That said, the commitment of individuals at a smaller level is also crucial – if a few midwives do not support exclusive breastfeeding and continue to sell formula milk, for example, it is unlikely that their patients will change their behavior. Only when individuals commit to change will the community follow.

- **Data collection needs to be improved.** One issue in almost every district Kinerja supported was the lack of or poor quality of data on immediate and exclusive breastfeeding. Data was often missing or incomplete, or had never been collected in the first place. When data did exist, it had sometimes been collected through inappropriate methods and did not actually reflect the real situation. This makes monitoring and evaluation incredibly difficult.
Contact information

Bener Meriah
Risnowati
Head of Puskesmas Bukit
Jl. Mesjid Babussalam, Simpang Tiga Redelong, Kab. Bener Meriah

Puskesmas Beji, Tulungagung
Winny Isnaini
Staff, Lembaga Perlindungan Anak (Child Protection Organization) Tulungagung
wisnaini2003@yahoo.com

Probolinggo
Ana Maria
Secretary, Probolinggo District Health Office
annamariads@ymail.com

Makassar
Siti Rohani
Former staff, USAID Kinerja
sitirohani.mks@gmail.com
Partnerships between midwives and traditional birth attendants help to improve maternal health in Aceh and South Sulawesi

Background
The Indonesian government worked hard in its bid to achieve the Millennium Development Goals (MDGs), and especially focused on Goal 5 (Reducing Maternal Mortality). Indonesia’s goal for reducing the maternal mortality rate (MMR) was a 75% reduction to 112 maternal deaths per 100,000 live births. However, according to the 2012 Indonesian Health Demographic Survey (IDHS), Indonesia was not on track to meet this target. In fact, Indonesia’s MMR was increasing, and had jumped from 228 deaths per 100,000 live births in 2008 to 359/100,000 in 2012. Based partly on this, the United Nations Population Fund (UNFPA) considers Indonesia to be one of the world’s ten worst countries to be a pregnant woman.

One of the reasons behind Indonesia’s continuing high MMR is that many births are not assisted by trained medical professionals and do not occur in health facilities. This is particularly the case in rural areas, where families often choose to use traditional birth attendants (TBAs) because they are closer, cheaper, understand the local culture and religion, have spiritual knowledge, and are generally seen to be more experienced than midwives. However, TBAs are not medically trained and many do not fully understand what is needed for a safe birth to take place.
Although they are medically trained, midwives are often considered to be too young and too inexperienced, in addition to being too expensive and not familiar with local culture, religion, or language. Many midwives also do not live in the villages where they have been assigned, and so are not always available. This perception further encourages local communities to choose TBAs over midwives when a woman gives birth.

To overcome this issue, the Indonesian Ministry of Health established partnerships between midwives and TBAs more than two decades ago. Kinerja’s approach has been to make these partnerships more desirable, more transparent, and more participatory. Two areas which had good success in doing so were **Aceh Singkil** in Aceh Province, and **Luwu** in South Sulawesi Province. Both districts’ programs aimed to increase the co-operation between midwives and TBAs, but took slightly different approaches and created different incentive schemes.

**Aceh Singkil, Aceh**

Kinerja assisted Aceh Singkil to establish a midwife-TBA partnership program in 2011. At the time, the district experienced a high number of maternal and neonatal deaths – five women and 35 babies died in 2011. Overall, around 30% of the district’s births were assisted by TBAs, 66% by midwives, and just 4% by doctors.

Aceh Singkil has a population of around 110,000 people, who live in mountainous regions, along river banks, by the ocean, and on small islands. There are 122 active TBAs in the district and just 11 community health centers (called *puskesmas* in Indonesian), with only one that can take in-patients. Just two
puskesmas are able to provide basic emergency obstetric and neonatal care (BEmONC). There is one hospital, but it is not yet capable of comprehensive emergency obstetric and neonatal care (CEmONC).

Luwu, South Sulawesi
Around 10% of deliveries in Luwu are assisted by TBAs. In some rural areas, however, the rate is much higher (up to 30%). Around 330,000 people live in Luwu, which reaches from the coast into the mountains. In 2012, the district recorded 15 maternal deaths, mostly due to post-partum haemorrhage and eclampsia. 49 babies also died in 2012. Like Aceh Singkil, Luwu’s health facilities do not yet meet the communities’ needs – of the 21 puskesmas in the district, seven provide in-patient
facilities and six can provide BEmONC services. There is no CEmONC-capable hospital.

Program Innovation
Although midwife-TBA partnerships have existed throughout Indonesia for some time, most are not well-implemented. The approach needs some improvement – for example, it is generally too top-down, does not properly take into account the interests of TBAs, does not provide strong enough incentives for TBAs to participate, does not involve the community in design or implementation, and does not incorporate enough monitoring and evaluation.

Kinerja developed a new approach to implementing midwife-TBA partnerships, based on key governance principles, as outlined below.

1. Participation. Kinerja and its implementing organizations (IOs) – usually local CSOs – involved a huge range of stakeholders in developing, implementing and monitoring the midwife-TBA partnerships. They included community members, village heads, government staff, puskesmas staff, village midwives, TBAs, and the media. Kinerja’s IOs also helped establish multi-stakeholder forums (MSFs) made of community members and government representatives that assisted in monitoring the program, incorporating community feedback, and developing memoranda of understanding (MOUs).

2. Transparency. The development and signing of MOUs between midwives and their TBA partners were done
openly and involved all the different stakeholders. The MOU signing events were held in public places, and were even sometimes attended by the Mayor or District Head as a witness. Details of the MOUs were then disseminated to the public.

3. **Accountability.** The content of the MOUs were agreed upon by both midwives and TBAs before being signed, and points were altered if the parties did not agree. This included information on financial incentives to be paid to the TBAs.

4. **Responsiveness.** Key stakeholders such as puskesmas, village heads and District Health Offices (DHOs) agreed to take action on any problems that may emerge during the partnerships’ implementation.

Through these good governance principles, both midwives and TBAs can benefit from participating in the partnerships. As they can now work together to assist women in childbirth, their workload becomes lighter and easier – midwives are responsible for medical aspects, while TBAs are responsible for spiritual aspects and for looking after the newborn.

**Aceh Singkil, Aceh**
The District Health Office (DHO) of Aceh Singkil agreed to pilot Kinerja’s approach in two villages in 2012. After two years, the number of births assisted by trained medical workers had increased two-fold, and the number of risky births had decreased dramatically. The DHO decided to replicate the program to 29 other villages in four other sub-districts.
Aceh Singkil’s approach to midwife-TBA partnerships is quite unique. As Kinerja was aware, one of the main problems in implementing these partnerships in Indonesia has been the lack of strong financial incentives for TBAs. Without receiving some form of compensation, the TBAs feel disrespected and as though midwives have taken away their only source of income. To overcome this, the DHO of Aceh Singkil decided to pay decent incentives to TBAs agreeing to join the partnerships and no longer assist births by themselves. Every month, each TBA receives Rp.100,000 (US$10) from the DHO and an additional Rp.50,000 (US$5) from the village. For each birth she assists with her midwife partner at a health facility, she receives another Rp.50,000 (US$5) from the puskesmas through the new National Insurance Scheme. The TBAs of Aceh Singkil therefore feel appreciated and respected.

By holding big events for the signing of MOUs between midwives and TBAs, the level of commitment and enthusiasm for the partnerships was high. The TBAs and midwives both felt as though they were now important players in the health status of their community, as they were being recognized at such a formal event.

**Luwu, South Sulawesi**

A different but also unique approach to developing midwife-TBA partnerships was also developed at one particular puskesmas in Luwu, South Sulawesi. Puskesmas Bajo Barat is one to two hours away from the capital city, Belopa, which means that local residents rely heavily on the puskesmas for healthcare. Fortunately, Puskesmas Bajo Barat offers in-patient facilities.
To encourage more women to give birth at the health facility with a midwife, Puskesmas Bajo Barat decided to increase the costs patients must pay if they give birth at home but are still assisted by a midwife. Giving birth at the puskesmas costs Rp.600.000 (US$60) but is reimbursed by the National Insurance Scheme (JKN) for patients who are members. Giving birth with a midwife at home, however, now costs Rp.700.000 (US$70), of which JKN will only reimburse Rp.600.000, meaning that the family must pay the gap of Rp.100.000. This strategy has been successful in encouraging more women to give birth at the puskesmas and its village-level facilities, poskesdes.

The TBAs of Bajo Barat also receive financial incentives to take part in the partnerships. If they refer a woman in the early stages of labor to the health center, the TBAs will receive between Rp.100.000 (US$10) and Rp.250.000 (US$25) for each referral. In late 2014, the local multi-stakeholder forum (MSF) and the puskesmas advocated to the DHO to increase this fee. The DHO agreed to provide Rp.300.000 per referral from the 2015 budget.

Midwives and TBAs in Bajo Barat hold yearly meetings to assess the partnerships. Their MOUs are re-affirmed, successes are discussed, and any challenges or problems are solved or passed onto the DHO for further action. If any midwives or TBAs are found to be disobeying the MOUs, they are sanctioned.

On top of this, Bajo Barat does its best to make sure its midwives are well-equipped and always available, so that women are not scared of giving birth with them. Four midwives work at the puskesmas, and one midwife lives in each of the sub-district’s nine villages, working at the local poskesdes.
head midwife also makes sure that all of sub-district’s midwives have complete midwife kits on them at all times. This is an impressive achievement, as only 39 out of 233 (17%) of midwives in the whole of Luwu district had midwife kits in 2014. This helps reassure women that their midwives are well-prepared to assist them in childbirth.

**Implementation Process**
The processes followed in Aceh Singkil and Luwu were very similar.

1. **Identification of problems**
The first step was to identify problems and challenges relating to pregnancy and childbirth in the district. A meeting was held and attended by *puskesmas* head and staff, midwives, village midwives, health volunteers, village heads, community figures, religious figures, representatives of the Indonesian Midwives Association, youth representatives, the media, local NGOs, members of the district’s Health Board, and government staff. The meeting identified the causes of low numbers of births assisted by midwives, deciding that some of the reasons included low levels of public trust in newly-graduated midwives, midwives’ lack of ability to speak local languages, midwives’ relative lack of experience, poor relationships between midwives and the community, and the poor quality of staff and facilities at the district’s *puskesmas* and hospitals.

2. **Establishment of multi-stakeholder forums (MSFs)**
MSFs were established at both the sub-district and district levels. At the sub-district level (that is, at the *puskesmas* level), the MSFs are responsible for advocacy, mediation, and
Kinerja Good Practices

monitoring and evaluation of health programs, including the midwife-TBA partnerships. The forums are made up of community members, government staff, health volunteers, and others interested in quality healthcare.

3. **Informal co-ordination**
Kinerja’s IOs worked closely with *puskesmas* and DHOs to overcome the problems identified in step one.

4. **Building a common understanding**
Mini workshops were held to develop common understandings and goals as to what the midwife-TBA partnerships would involve, including financial incentives. The agreement was written down in a draft MOU on Midwife-TBA Partnerships. The workshops were attended by midwives, TBAs, the DHO, health workers, village heads, *puskesmas*, and religious figures.

5. **Village Head Decrees on incentives for TBAs**
To formalize and guarantee the incentives to be provided to TBAs, the village heads signed and published Village Head Decrees.

6. **MOU signing**
After agreeing to all the conditions, the midwives and TBAs signed their MOUs at a public event witnessed by village heads, *puskesmas* heads, heads of DHOs, representatives of the Indonesian Midwives Association, and the community. The MOUs are to be renewed once every three years.

7. **Monitoring**
Implementation of the partnerships are regularly monitored by MSFs. MSFs report their findings to the DHOs and *puskesmas*. 
Village midwives are also responsible for monitoring the partnerships, primarily to ensure that no TBAs continue to assist deliveries by themselves.

8. Replication
In Aceh Singkil, the program was replicated to an additional 29 villages in the first two years. In Luwu, the head of the DHO issued a decree to replicate Kinerja’s approach at nine additional puskesmas, including the midwife-TBA partnerships.

Results and impact
The level of trust between midwives and TBAs has increased significantly since the beginning of the partnerships. Both midwives and TBAs acknowledge that the MOUs make their rights, duties, and responsibilities clear, as well as making their everyday jobs easier and smoother, because now there are two pairs of hands instead of just one pair. Midwives are happy that the TBAs can handle the spiritual aspects of deliveries (such as giving prayers), and TBAs are happy that midwives can deal with the medical aspects.

The heads of Kinerja’s partner puskesmas say that because of the midwife-TBA partnerships, midwives now know about pregnancies earlier than before. This is because TBAs now refer newly-pregnant patients immediately to the midwives for ante-natal care. Previously, this did not always happen.

Through the partnerships, mothers can now access professional health care in their local languages. Many village midwives do not speak local languages, but now they are assisted by TBAs, who are generally from the local area. The
TBAs thus act as a bridge between the community and the midwives.

Public events and discussions during the development process have increased the community’s awareness of the importance of facility-based, midwife-assisted birth.

**Aceh Singkil, Aceh**

A small but significant increase (6%) has occurred in the number of births occurring at the five sub-districts with Kinerja’s innovative midwife-TBA partnerships since they began in 2011.

<table>
<thead>
<tr>
<th>Years</th>
<th>Births Assisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1,476</td>
</tr>
<tr>
<td>2012</td>
<td>1,532</td>
</tr>
<tr>
<td>2013</td>
<td>1,509</td>
</tr>
<tr>
<td>2014</td>
<td>1,561</td>
</tr>
</tbody>
</table>

At Puskesmas Singkil, the pilot puskesmas for the program, the most impressive result is that the number of births assisted by TBAs has fallen from 17 in 2011 (when the program started) to none in 2014. The biggest drop was within the first 12 months of the program.

<table>
<thead>
<tr>
<th>Years</th>
<th>Births Assisted by TBAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>17</td>
</tr>
<tr>
<td>2012</td>
<td>8</td>
</tr>
<tr>
<td>2013</td>
<td>2</td>
</tr>
<tr>
<td>2014</td>
<td>0</td>
</tr>
</tbody>
</table>
The co-operation between midwives and TBAs has also led to a higher rate of pregnant women seeking ante-natal care in their first trimester. This has been a huge change for Aceh Singkil, as culturally, many women believe that if they speak aloud of a pregnancy during the first three months, the baby will be susceptible to black magic or spirits. More than 200 more women had a check-up in their first trimester in Kinerja’s five partner sub-districts in 2014 as compared to 2011.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1,525</td>
</tr>
<tr>
<td>2012</td>
<td>1,603</td>
</tr>
<tr>
<td>2013</td>
<td>1,649</td>
</tr>
<tr>
<td>2014</td>
<td>1,739</td>
</tr>
</tbody>
</table>

Aceh Singkil also entered its TBA-midwife partnership program into the 2015 United Nations Public Service Awards (UNPSA). It won second-place for the Asia-Pacific region – the first time that Indonesia has ever won an award from UNPSA. The District Head and the Head of DHO attended the award ceremony in Colombia and presented about the program, its implementation, and its benefits.

**Luwu, South Sulawesi**

As with Aceh Singkil, Luwu also experienced an increase in the number of births assisted by medical professionals in the three districts supported by Kinerja.
Births assisted by medical professionals in Kinerja’s three partner sub-districts in Luwu, 2011-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>730</td>
</tr>
<tr>
<td>2012</td>
<td>782</td>
</tr>
<tr>
<td>2013</td>
<td>778*</td>
</tr>
</tbody>
</table>

*A small decrease occurred at Puskesmas Bajo Barat in 2013 due to the end of the clove and cacao farming seasons, when many migrant workers returned to their home districts.

The number of pregnant women seeking ante-natal care in Kinerja’s three partner sub-districts also increased.

Number of pregnant women receiving at least four ante-natal checkups in Kinerja’s three partner sub-districts in Luwu, 2011-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>670</td>
</tr>
<tr>
<td>2012</td>
<td>766</td>
</tr>
<tr>
<td>2013</td>
<td>697*</td>
</tr>
</tbody>
</table>

*As noted above, a small decrease occurred at Puskesmas Bajo Barat in 2013 due to the end of the clove and cacao farming seasons, when many migrant workers returned to their home districts.

**Monitoring and evaluation**

To ensure they have a good understanding of what is going on in their districts, puskesmas and DHOs run regular monitoring activities in both Luwu and Aceh Singkil. Head midwives visit their village midwives every month to ensure they are following the terms of the MOUs and to see how the program is progressing. The head midwives also collect monthly records of patient services during these visits.
In Aceh Singkil, the district’s Health Board also undertakes field visits to monitor developments. Members of the Health Board meet with midwives and TBAs to discuss problems and successes, and they later share this information with and make recommendations to the DHO.

One example of how regular monitoring had a positive impact in Aceh Singkil was the creation of an emergency contact card. When a monitoring team discovered that the residents wished to be able to directly contact key persons in an emergency – such as the village midwife, the head of the puskesmas, the head midwife, or the DHO itself – they worked with the puskesmas to develop a contact card. The card lists the mobile phone numbers of people who families might need to call if a mother goes into labor and needs a midwife or ambulance.

In Luwu, the multi-stakeholder forums established by Kinerja regularly attend the puskesmas’ monthly update meetings. At the meetings, they pass on community feedback and gather information to share with community members.

**Challenges**
The main challenge in implementing an innovative, transparent and participatory midwife-TBA partnership program was the resistance to cultural change. Both Aceh Singkil and Luwu are located far from major metropolises, for example, and remain quite traditional in their cultural practices. Islam is also a major influence in both areas. TBAs are seen as having not just medical knowledge but also cultural understanding and spiritual power, so it can be hard to convince mothers to give birth with midwives instead of TBAs.
Midwives’ low medical skills, a lack of local language ability, and a lack of understanding of local cultural beliefs was another significant change. Patients were reluctant to give birth with midwives because they often could not communicate very well, or dismissed their cultural beliefs without explanation.

A lack of financial support for multi-stakeholder forums (MSFs) limited their ability to carry out oversight and monitoring activities. Most MSF members are ordinary community members, and do not have a lot of spare money to contribute.

**Sustainability**

Kinerja’s midwife-TBA partnerships are more likely to be sustainable than the previous top-down versions. This is because they have taken into account the needs of both midwives and TBAs, as well as those of the community. The partnerships are based on mutual co-operation and understanding, and seek to benefit both parties. This is key, as previously many TBAs felt that their incomes were being taken away from them; now, they receive incentives for referring patients to midwives, and are able to work together with the midwives to deliver babies in facilities.

The formalization of the relationships between midwives and TBAs was also crucial to their sustainability. By working together to develop MOUs and by signing these agreements at a public event witnessed by senior government members, both midwives and TBAs feel that their roles are important, respected and acknowledged. They are also able to refer back to the MOUs if they have any doubts about their roles, rights
and responsibilities. The MOUs also make clear any sanctions that may be implemented if the terms of the MOU are breached. The publishing of decrees from the village heads and the heads of the DHOs also helps support this formalization process, as these decrees are held in high regard by both government staff and community members. The program is also more likely to be sustained because it fulfills not only the needs but the desires of mothers. Mothers in Luwu and Aceh Singkil are very happy to be able to receive modern medical care from a midwife at the same time as getting spiritual care from a TBA. Health outcomes are also likely to improve, as the midwife can look after the mother and the TBA can look after the newborn.

A TBA (left) and her midwife partner at an event in Jakarta celebrating Aceh Singkil’s second-place win at the 2015 United Nations Public Service Awards for its TBA-midwife partnership program.
Lessons learned and recommendations
The midwife-TBA partnerships in Aceh Singkil and Luwu only succeeded because of high levels of commitment from both the community and the government. Without this strong cooperation, it is unlikely that the programs would have had a significant impact.

- **Community participation is key to success.** Community members will have a hard time accepting and supporting new programs if they have not been actively involved in all phases, from design through to implementation and monitoring.

- **Stakeholders must trust each other.** It is important that the roles of all parties involved in a program are acknowledged and respected as actors of change.

- **Appropriate incentives are required for behavior change.** Incentives that are deemed sufficient by all parties are necessary to garner support. It is important that the source, amount, and method of provision of incentives is clearly defined in official documents such as MOUs, in addition to who is entitled to incentives and for what tasks they will receive incentives.

- **Regular and consistent communication makes implementation smoother.** Regular supervision and monitoring visits from head midwives to villages, for example, ensured the midwife-TBA partnerships remained active and were well-implemented. Creative methods of encouraging communication are also useful, such as the development of the emergency contact card in Aceh Singkil,
which provided the contact details of key parties (head midwife, village head, DHO, etc.) to expecting mothers.

- **Changing cultures and traditions is not easy.** Traditions are obviously well-embedded in communities, and require significant time and effort to change. To do so, strategies and approaches that are culturally-relevant and appropriate to the local context must be developed and used. The midwife-TBA program is a good example of this, as it combines the traditional health practice (giving birth with a TBA) with the modern health practice (giving birth with a medical professional), and offers patients the best of both. This has meant that the community has been happy to alter their behaviors.

**Contact information**

**Aceh Singkil, Aceh**
Edy Widodo  
Head of Aceh Singkil District Health Office  
[edywidodo1967@gmail.com](mailto:edywidodo1967@gmail.com) / +62 6581202

**Luwu, South Sulawesi**
H. Abdul Aziz  
Head of Service Provision, Luwu District Health Office  
+62 47121145
Preventing child marriage through reproductive health education for teenagers in Bondowoso, East Java

Background
Gender inequality remains a major challenge in Indonesia with regards to development. According to the United Nations Development Program (UNDP)’s gender inequality survey, Indonesia ranked only 102 out of 148 countries in 2012. Just 36.2% of Indonesian women have a completed junior high school, for example.

Maternal mortality and teenage pregnancy occur significantly more frequently in Indonesia than in neighbouring Southeast Asian and Pacific countries. It is estimated that 48 of every 1,000 live births in Indonesia in 2015 was to a teenage mother. Teenage pregnancy is also one of the driving causes of maternal mortality, which remains incredibly high throughout the archipelago, with 359 mothers dying for every 100,000 live births in 2014.

In recent years, the government of Indonesia has focused its efforts on reducing the number of maternal deaths. In 2014, the national government launched a national action plan on how to reduce maternal mortality. The plan focused on improving access to ante-natal care for all mothers, including teenagers. The issue of teenagers was seen as key to the success of the plan, as child marriage remains common especially in rural areas.
where health access is more difficult. According to a 2013 report from SMERU, economic factors are the main factor behind child marriages in Indonesia. Social and cultural forces are also influential.

Bondowoso, a district in East Java, is one district where child marriage is widely-practiced. In fact, Bondowoso ranks as the district with the highest rate of child marriage in all of East Java, with more than 50.9% of marriages in 2011 involving children. Unfortunately, child marriage is more common amongst underprivileged families because it is seen as a way of reducing a family’s financial burden.

Child marriage is also seen as a cultural tradition in Bondowoso. In Javanese and Madurese culture, especially in rural areas, parents begin to worry about their children if they are not married by the age of 15.

Religion, specifically Islam, also contributes to high levels of support for child marriage in Bondowoso. Many people believe that the best way of ensuring that children avoid pre-marital sex, which is seen as a sin, is to get married young. This belief is complicated by low levels of knowledge about reproductive and sexual health for adolescents. The information that early marriage can be physically dangerous for girls is not widely-known, for example.

Child marriage not only impacts a girl’s health but her welfare. Many girls are forced to drop out of school when they get married. This leads to a cycle of poverty that is hard to break: because she has only a basic education, she cannot get a well-paying job, and because she cannot get a well-paying job, she
cannot pay for her children’s schooling and health needs. This is reflected in Bondowoso’s continually low Human Development Index (HDI), which is the second lowest of all 38 districts in East Java.

**Program Innovation**

In order to begin solving the problem of high maternal mortality and high rates of child marriage, the government of Bondowoso worked with Kinerja and its implementing organizations (IOs) to develop a reproductive health program for students, parents, and broader society. The main objective of the program is to increase awareness of the importance of reproductive health education for teenagers, to reduce the frequency of child marriage, and to reduce the maternal and neonatal mortality rates.
In 2012, the government of Bondowoso worked with the Indonesian Family Planning Association (PKBI – Perkumpulan Keluarga Berencana Indonesia) to conduct a baseline survey on maternal and neonatal death in the district.

Following the baseline, a community forum known as the multi-stakeholder forum (MSF) was developed, made up of community members who care about maternal and child health. The MSF advocated to the government to give extra attention to youth reproductive health, following which the District Head developed a decree covering safe delivery, immediate & exclusive breastfeeding, and youth reproductive health.

The District Head also issued an instruction letter which identified a number of community figures, including his own wife, who would become Reproductive Health Ambassadors. The District Head’s wife was elected as the lead ambassador and was given the title of ‘Mother of Reproductive Health’. She became very active in promoting youth reproductive health, and has taken part in many activities since assuming her role.

Religious figures, both male and female, play an influential role with regards to child marriage in Bondowoso. The community strongly respects religious figures, and frequently consults them on important issues. In order to ensure they give accurate and relevant advice on child marriage, the Bondowoso District Health Office (DHO) worked with religious figures and provided them with training on maternal and child health. Following the trainings, religious figures who attended were able to provide information on the physical and mental risks of child marriage and pregnancy. Religious figures in Bondowoso
are now strong supports for the district government’s youth reproductive health program.

The DHO worked with a national NGO, the Women’s Health Foundation (YKP – Yayasan Kesehatan Perempuan), to carry out awareness raising activities and trainings on youth reproductive health at schools in Bondowoso. These activities involved both students and teachers, and led to the formation of a number of community groups. One of these is the Union of Teachers who Care about Reproductive Health, which was founded by a number of teachers who were concerned about the high rate of girls who dropped out of school following getting married and/or pregnant. The teachers in the group began including reproductive health information in the annual orientation sessions for new junior and senior high school students and during biology classes. The teachers worked together with community leaders and members of the Family Welfare Movement (PKK – Pembinaan Kesejahteraan Keluarga) to share reproductive health information with young people and their parents to ensure that all are aware of the risks associated with child marriage.

The students themselves also formed a community group and a peer-learning program. The group, called the Blue Sky Community (Komunitas Langit Biru), worked with a local NGO, Hometown (Kampung Halaman), to use media to raise young peoples’ awareness of their reproductive health. This activity has been strongly supported by the DHO, as they recognize the fact that young people are more likely to listen to their friends and peers. The group meets every two weeks, and runs regular awareness raising activities. A peer-learning program was established in four sub-districts, and has since
been expanded to a total of 25 sub-districts. From reaching just 24 students in the program’s first year, by 2015 the peer-learning program has trained 279 students in reproductive health issues.

Together, all these activities have contributed to a significant decrease in the rate of child marriage in Bondowoso. In 2011, 51% of all marriages in Bondowoso involved children under the age of 18; in 2012, the percentage fell to 50%, and in 2013, it fell again to 43% - a huge drop of seven percentage points, or 14% of total marriages, in just one year. Such a large improvement has never before been recorded in Bondowoso.

**Implementation Process**

Kinerja and the government of Bondowoso jointly decided that a program focused around youth education and empowerment as likely to be the most effective way of reducing rates of child marriage. If children can be reached while they are still teenagers, they are more open to learning different ideas. This is important, because in 2011, 51% of marriages in Bondowoso involved children. Research from PKBI also showed that 52% of women with children under the age of 12 never graduated from primary school, meaning that early intervention is crucial to reversing child marriage rates.

Based on PKBI’s research and advocacy from the district’s MSFs, the District Head of Bondowoso issued a District Head Regulation in 2012 on safe delivery and exclusive & immediate breastfeeding. The regulation also covers reproductive health education for young people. The District Head also appointed his wife as the ‘Mother of Reproductive Health’ and the wives
of village and sub-district heads as reproductive health ambassadors, tasked with supporting youth reproductive health education in their respective areas.

The women elected as reproductive health ambassadors involved young people in their outreach work by including them on monitoring visits to villages. The women aimed to investigate whether there were any families planning on marrying off their young daughters. If such cases were identified, the ambassadors and young people provided the family with information on the risks of child marriage and the benefits of delaying marriage. The families were encouraged to let their daughters finish school before marrying.

To expand the reach of the program, the District Head and the District Health Office decided to involve all layers of society, including religious figures, community figures, teachers, health workers, NGO workers, women’s groups, and youths. These representatives were chosen as program implementers because they are the people who interact directly with youths every day.

Everyone involved plays a slightly different role based on their usual tasks and responsibilities. For example, the DHO and partner NGOs carry out reproductive health education for teenagers, teachers, health workers, and religious figures. Other community members became involved in different ways, e.g. 50 religious teachers took part in a competition and developed special seven-minute sermons on youth reproductive health and the importance of delaying marriage. After the competition, the religious teachers took their new
knowledge back to their mosques and began incorporating the material into their other work.

One unique element of the program is the incorporation of youth reproductive health into orientation week for all new junior and senior high school students. Previously, new students never received this sort of information during their orientation period.

School teachers were also taught how to add reproductive health knowledge into their existing classes. Teachers involved in the Teachers who Care about Reproductive Health group also visited every sub-district in Bondowoso to reach out to local officials and parents to improve their knowledge of youth reproductive health and child marriage.
Community awareness raising on the dangers of child marriage was carried out through a range of different events, such as trainings, festivals, and competitions. One of the most successful events was the ‘My Health, My Future’ competition. Local teenagers wrote articles, made short films, and designed promotional posters on youth reproductive health. The festival was held at the District Head’s office and was attended by around 400 students from 27 junior and senior high schools. More than 300 students registered for filmmaking training sessions, despite only 50 places being available. The students learnt to make short films, some of which are now available on YouTube, such as ‘Tak Mau Seperti Ibu’ (‘I Don’t Want to Become Like Mum’), a film about a woman who married when she was just 12 years old. The film aims to encourage young girls to stay in school and delay marriage.

Awareness raising was also carried out through radio talk shows. A number of Bondowoso radio stations regularly allocated time to talk about reproductive health and child marriage, especially on Saturdays when many young people tend to listen to the radio. The radio shows also gave teenagers the opportunity to call or SMS questions to have them answered on air.

Results and impact
Many useful outputs emerged from the youth reproductive health program in Bondowoso, including:

a. The District Head Regulation on Safe Delivery and Immediate & Exclusive Breastfeeding.
b. Two District Head Decrees on reproductive health ambassadors, which encouraged the wives of village and
sub-district heads to support youth reproductive health. At the time of writing, 219 wives of sub-district heads and 23 wives of village heads had agreed to become reproductive health ambassadors in their areas. The position of reproductive health ambassador is now respected in Bondowoso and recognized as a source of accurate information and knowledge.

c. Peer educators, who were trained and educated on reproductive health and child marriage. Peer educators came from all age groups, not just teenagers but also parents, teachers, and other community members.

d. The inclusion of reproductive health information into orientation week material for new junior and senior high school students.

e. The establishment of the Teachers who Care about Reproductive Health group. The group has so far undertaken a roadshow to sub-district and village heads in Bondowoso to spread the message of how child marriage endangers young women.

f. The founding of the Blue Sky Community. The teenagers involved in this group target other youths and aim to improve their understanding of their reproductive health and rights. The Community has already printed articles in local newspapers, made short films, and participated in radio talk shows.

The outcomes of Bondowoso’s program to delay child marriage have also been positive:

a. The percentage of marriages in Bondowoso involving children under the age of 18 fell by 14% in just two years. In 2011, 51% of all marriages involved children, and in 2012, this remained high, at 50%. However, by 2013, this rate had
fallen to 43% - a drop of seven percentage points in just one year. This is a great success.

b. Anecdotal evidence indicates that more young girls are staying in school and delaying marriage. This means they are able to earn a better salary and do not need to get married for purely economic reasons.

c. Young girls are better-supported to make decisions for themselves based on fact, rather than being pushed by family members to make hasty choices.

d. Girls are empowered to protect their reproductive health and control their own fertility. By taking part in youth reproductive health education programs, girls receive information that they otherwise miss out on, meaning that they will be healthier throughout their whole lives.

e. The risk of maternal and neonatal mortality and morbidity decreases as women know more about their own body, health, and rights. Young girls have been shown to be at significantly increased risk of death as a result of pregnancy and childbirth because their bodies are not yet physically ready; by delaying marriage and childbearing, girls are more likely to have safe and healthy pregnancies and children.

f. The Human Development Index (HDI) has improved in Bondowoso in line with reduced child marriage rates. In 2011, it was 63.81, and by 2013, had risen to 65.42.

g. Traditional beliefs are slowly disappearing. Reproductive health is no longer seen as a taboo topic in Bondowoso, and is now discussed openly by all. The stigma surrounding unmarried girls over the age of 15 has also begun to decrease, primarily thanks to the strong involvement of religious teachers and community leaders in the district’s anti-child marriage campaign.
Monitoring and evaluation
The government of Bondowoso primarily monitors changes in attitudes towards child marriage by analyzing marriage statistics. The DHO collects annual data on youth reproductive health, and compares its own data and data from other government bodies with the information collected by PKBI in 2011. This helps the DHO see trends and year-on-year changes.

Informal monitoring is carried out by groups and individuals such as the reproductive health ambassadors and peer educators, who monitor occurrences of child marriage and attempt to discourage families from marrying off their young daughters. Many community members are now also paying careful attention to local gossip and rumours, and if they hear of any upcoming child marriages, they contact a reproductive health ambassador, who visits the family in question. All of this information is generally passed on to the district government for recording.

Challenges
This program aims to change old ways of thinking and traditional beliefs on child marriage in Bondowoso. It is not surprising, then, that the major challenge has been cultural, particularly in terms of overcoming the genuine belief that girls who are not married by the age of 15 will face problems finding a husband.

Child marriage is also seen by many Bondowoso residents as a way of ensuring young people are not sexually active before marriage. Pre-marital sex is a major taboo in the district, and is generally seen as something that should be avoided at all costs.
However, this mindset is problematic, because it means that even talking about sex is taboo, which results in young people not being given the reproductive health information they need.

Economically, it has also been hard to change parents’ ways of thinking. Marrying off a teenage daughter is often seen as a solution to financial challenges, as it means that there is one less family member to feed.

These cultural and economic challenges will inevitably take many years to overcome. The situation is made even more difficult because of low levels of education – the average resident of Bondowoso has just 5.94 years of schooling.

The district government and local NGOs are attempting to solve this issue by making broad public participation a central element of their programs, targeting not just children but also their parents and key community figures.

**Sustainability**

The issuance of a District Head Regulation and two decrees relating to youth reproductive health and child marriage mean that the legal basis exists for continued focus on these topics. This is very important as it illustrates to the community that the government and its elected head supports change.

The inclusion of reproductive health information in school subjects and the orientation period for new students is an excellent development, and will be crucial moving forward. It will ensure that all students are reached with information on the importance of knowing their bodies and delaying marriage.
The government has committed to continue the reproductive health-inclusive orientation program into the future.

The fact that both men and women (and boys and girls) are actively involved in the program greatly supports its chances of sustainability. The involvement of male religious figures is particularly exceptional as, unfortunately, Islamic figures throughout Indonesia frequently provide incomplete reproductive health information. The district head’s wife and women’s groups have been excellent role models in promoting youth reproductive health and the risks of child marriage to local residents, especially women and girls in marginalized communities. Most importantly, teenagers themselves have been involved in the program with a leading role as educators and role models for their peers through art and the media, as well as through the election of youth ambassadors – a highly-coveted position. Local teens are now encouraged to speak publicly about youth reproductive health. This ensures that the topics of reproductive health and child marriage will not disappear from sight.

**Lessons learned and recommendations**

The key to the success of the reproductive health program in Bondowoso lies in co-operation. The program was (and continues to be) implemented by a wide range of partners: Kinerja USAID, a number of local NGOs, the Bondowoso District government, the Bondowoso District Head and his wife, village and sub-district governments, health workers, teachers, the media (both mass media and citizen journalists), religious figures, and community figures. This proves that even when attempting to change long-held cultural beliefs, change is
possible through working together in a genuinely participatory way.

One crucial lesson is the role that can be played by religious figures. In Bondowoso, religious figures are hugely respected and listened to. When they began advising against child marriage, the impact was immediately noticeable, with the rate of child marriage dramatically falling from 50% to 44% in just one year (2012 to 2013).

As child marriage most severely affects the lives of children, it is clear that children themselves should be involved as not just recipients but as leaders. By educating young people on reproductive health, they are able to become peer educators
and share their knowledge with their friends and schoolmates. This is a very effective manner of changing young people’s attitudes, because they are more likely to listen to and believe their friends than their teachers or parents. The young people of Bondowoso were offered the chance to become reproductive health ambassadors, make their own anti-child marriage films and posters, and form community groups.

Overall, changing long-held community beliefs cannot be done from above, led solely by the government. Bondowoso’s experience in successfully reducing child marriage rates supports this theory. Their active involvement of all sectors of society – from teachers and health workers to religious figures and the wives of government officials – shows that change is possible when all are genuinely involved and understand the reasons why change is necessary.

Contact details

Dr. Titik Erna Erawati
Head of Family Health Section, Bondowoso District Health Office
titikernaerawati@yahoo.com
Community Participation in Health Minimum Service Standards Planning in Jayapura, Papua

Background
Between 2009 and 2013, the budget allocated to public health services in Jayapura District dramatically decreased. While in 2009 the health budget represented 11 per cent of the government’s total budget, by 2013 it had fallen to just 5 per cent. The local government’s supposed commitment to health was not reflected in this allocation, and the district was not able to meet its Minimum Service Standards (MSS) targets as mandated by the national government. In 2013, Jayapura only achieved 36% of its MSS targets.

A medical worker inspects the teeth of a patient in Jayapura.
Although MSS became a national requirement in 2008 through the Minister of Health Regulation No. 741/ Menkes/ PerVII/ 2008, many health office staff do not understand the regulation and do not consider MSS important. Consequently, MSS is not used as a reference for developing new health programs; furthermore, it is not used to evaluate the government’s performance.

In addition, the government of Jayapura does not involve community members in the development of health policies and programs. Many community members also do not understand their rights to quality health services, so demand for improvements is low.

**Innovation**
The low quality of health services in Jayapura is mainly caused by poor funding, inadequate understanding of MSS, and the absence of community participation. In order to improve Jayapura’s health services, Kinerja not only works with the government but with the community, building the capacity of local organizations to raise public awareness on people’s rights. Once the people understand their rights, they can demand quality public services.

Recognizing that genuine partnerships between the government and the community are the key to implementing good governance in the public sector, Kinerja works closely with Jayapura District Health Office (DEO). With Kinerja’s assistance, DEO staff improve their understanding of MSS and are able to apply the standards in their efforts to provide quality health services. Kinerja’s assistance in Jayapura covers three main stages: (i) identifying MSS achievements, (ii)
identifying gaps, and (iii) estimating the costs and developing scenarios to close gaps and meet targets through new policies and programs.

In brief, Kinerja’s MSS program is carried out in the context of citizens’ health rights. Both government staff and community members are expected to understand that the government is responsible for providing standardized health services for the people and it has to prioritize it.

**Implementation Process**

Health service improvement programs are implemented by district technical team, whose membership consists of the decision makers from different relevant offices. The team advocates to the district administration to involve community

![District health office staff identify problems in health services at a workshop.](image)
members in the process of integrating MSS in health into district planning and budgeting.

Program implementation began with capacity building for local government staff, which was conducted through the following steps:

1. Raising awareness of relevant stakeholders (decision makers, policy implementers, and community members) on MSS in the health sector.
2. Reviewing and updating policies as needed.
3. Collecting data that would be used for calculating MSS achievements.
4. Analysing gaps.
5. Estimating budget and resources that are needed to close the gaps (‘costing’).
6. Public consultancy and oversight.
7. Integrating MSS targets and costs needed to achieve them into district health office’s and local government’s plans and budget.
8. Budget advocacy to decision makers to ensure the budget is signed off on.
9. Evaluating MSS achievements and collecting input for the next planning process.

In Jayapura, public consultancy was carried out to discuss MSS costing results with broader stakeholders. The consultancy involved technical offices and other governing bodies since MSS achievements required inter-sectoral co-operation. The consultancy also provided room for community members to give their feedback and to support the district health office when it implemented the programs.
The Kinerja-supported multi-stakeholder forum (MSF), as a community forum, was committed to monitoring health MSS achievements. MSS-related issues are discussed at MSF meetings both at the district and sub-district level so that citizens can better understand the issue. In addition, a number of radio talk shows on MSS have been carried out by local radio stations, Radio Kenambai Umbai and Radio Suara Kasih. These outdoor and indoor talk shows help to create momentum on standardized health service delivery. A citizen journalist forum called CYCLOPS and a forum of citizen documentary video makers, HILOI, also cover issues about standardized health services.

**Results and Impact**

Jayapura District has calculated the resources needed to achieve health MSS targets for four years – 2014 to 2017. The budget needed in 2014 was IDR 6,271,382,000 (approximately US$475,000), and it will increase to IDR 14,232,772,161 (approximately US$1 million) for 2017. The budget increase is based on how to achieve the annual increases in targets. The Jayapura administration is committed to providing funds for to achieve MSS in the health sector in coming years.

“MSFs encourage governments to implement good governance. Government works with people to identify problems that health clinics face, discuss and address them. People should share responsibilities and have good understanding on how to be healthy.”

-Amos Soumilena
MSF Coordinator, Jayapura.
Kinerja’s MSS program has successfully improved the awareness of government staff and community members on the importance and usefulness of MSS. It has also increased government staff’s skills in assessing MSS achievements, estimating costs needed to achieve targets, and integrating standards into work plans and budgets. In 2014, the District Health Office allocated IDR 6.69 billion (approximately US$500,000) to fund programs to achieve MSS targets.

The relationship between the District Health Office, the community health centers and the community is much stronger than it used to be. Both the government and the health centers involve MSFs as community representatives in their program planning and monitoring meetings. Being involved in the government program development, community members trust the local government more, and are more willing to support and to contribute to program implementation.

For example, Kampung Yoboi in Sentani used village funds to provide financial support for four tuberculosis (TB) volunteers, who conduct TB education and observe treatment compliance. Previously, the volunteers only received a very small stipend form the health centers. Also in Sentani, an MSF called Forum Dobonsolo successfully advocated the sub-district administration to build TB posts in seven villages using Village Economic Empowerment funds.
A pregnant women undergoes a prenatal check in one of Kinerja’s partner clinics. With improved skills of MSS achievement analysis, health clinic staff are able to provide standardized health services.

**Monitoring and Evaluation**

With Kinerja’s help, the Jayapura District Health Office evaluated MSS implementation results in 2014 by involving MSFs. During the evaluation, government staff and community members assessed activity status, results, and challenges. This collaborative monitoring and evaluation will be conducted annually. If the activities are under target, the government and community seek solutions through broad consultation.

**Challenges**

The biggest challenge relating to implementing the MSS program in Jayapura was to maintain stakeholders’ commitment and develop appropriate skills. This problem was addressed through advocacy (both formal and informal), workshops and meetings, especially with senior and mid-level staff.
Sustainability

MSS program sustainability is highly reliant on the commitment of the head of the district health office. Based on Kinerja’s experiences, the head will commit to sustaining MSS if they have evidence about the program success. In Jayapura, Kinerja believes the MSS program is likely to be sustained since the costing results, including indicators of the MSS targets, and activities to achieve the MSS have been integrated into the five-year strategic plans of the district health office, as well as annual plans since 2014.

Lessons Learned and Recommendations

The lessons learnt from the benefits of community involvement in MSS include:

1. Awareness raising is vital for both service providers and service users. It means that people are able to give meaningful feedback to health service providers because they have been involved since the program’s inception and are aware of targets.

2. Programs that are based on the local context lead to increased levels of support. The MSS program in Jayapura not only took into account local values and beliefs, but was clearly based on local needs and evidence. This resulted in genuine support for the program from both government staff and community members, as they were able to understand why MSS is important for health services in their district.
3. Mainstream media, citizen journalism, and community forums such as MSFs can be powerful agents of change. Their position allows them to disseminate MSS-related information and to improve people’s knowledge on how MSS helps to fulfill their rights. In addition, partnerships of government, media, MSFs, health centers, and the district health office create joint opportunities for stakeholders to mobilize local government and community resources.

4. Implementing MSS in the health sector has led to a good appreciation for accurate data. Government decision makers are now aware that data is needed to develop strong work plans, create targets, and assess achievements. Learning about MSS has helped them to do this. Now, having seen benefits of MSS, the Jayapura district administration plans to adopt the program in other government technical offices.

A number of recommendations can also be made on how to better incorporate MSS into health sector planning, budgeting, and monitoring:

a. Community members should be involved in the full program cycle (activity and budget planning, costing, MSS integration into budgets and planning, implementation, and monitoring and evaluation). Public participation is essential to ensuring that health services are delivered in line with MSS and that people’s rights to health services are fulfilled. Community participation is vital in all areas, including areas with high levels of political and social tension.
b. **Intensive mentoring on MSS implementation, including for community members, should be continued** to ensure local governments and health centers deliver services in line with national standards. It should be noted that Law no. 25/2009 confirms that people have the right to oversee public services. Their ability to do so must be strengthened. There are two important activities to ensure citizens are able to oversee service delivery (i) establishment of community forums, and (2) transparent information among local governments, community members, district health office, and health clinics.

c. **Capacity building for district health offices is still needed** as some health offices do not understand how to synchronize their budgets so that they confirm to regulations from both Ministry of Home Affairs and Ministry of Health. This lack of understanding means that government staff cannot use their budgets innovatively to meet local needs and increase the human development index.

**Contact Person**

**Amos Soumilena**
MSF Co-ordinator, Jayapura District
081248263822
Advocating for Improved Health Services through Citizen Journalism and Radio Talk Shows in Jayawijaya, Papua

Background
Despite the media’s strong influence in Papua, many local media outlets do not use their power to oversee public service or to advocate for improved health services. Many editors, especially in more remote areas such as Jayawijaya, do not believe health is an appealing topic that their audience wishes to read about. Even newspapers that do report on health issues tend to do so only irregularly and lack depth. This means that there is a lack of public oversight towards health services, which in turn has

A citizen journalist interviews a religious and community leader in Papua.
led to a decrease in service quality. In many districts in Papua, health facilities are dirty deteriorated the health service delivery since there was no public supervision. In many districts, health clinics were dirty, medical equipment is often either broken or stolen, services are extremely slow, and health workers are often absent without reason.

In Jayawijaya, with Radio Republik Indonesia (RRI) Wamena as the sole local media catering to audiences in the central highlands of Papua, the people have very limited sources of information on local issues. The other sources available to them tend to cover Papua as a whole, with minimal local news. Thus, many people are not aware of the situation in their own district, and are unable to compare the services they receive with other districts.

Kinerja and its local partner NGO, the Indonesian Media Development Association (Perhimpunan Pengembangan Media Nusantara – PPMN), are assisting RRI Wamena to run campaigns that advocate for improvements in health services. The programs, which have been piloted in three Kinerja-supported areas in Jayawijaya – Hom-hom, Hubikosi and Musatfak – include indoor and outdoor radio talkshows and public service announcements. In addition to working with the local media mainstream, Kinerja is also training citizen journalists to demand better quality health services.

**Innovation**

A lack of news and poor access to media sources is one of the major reasons behind why health services remain of poor quality in Jayawijaya. Without oversight from the public and the
media, services have little incentive to improve. In order to overcome this, Kinerja and PPMN began working with RRI Wamena and training citizen journalists. The program aims to increase the quantity and quality of local media products, as well as to encourage new types of media, to push for health service improvements.

Kinerja’s media support in Jayawijaya is focused on two different forms of media: citizen journalism, and radio talk shows.

1. **Citizen Journalism**
Kinerja’s citizen journalism program aims to increase public participation in service delivery oversight by training community members on media creation and dissemination. The citizen journalists are expected to cover public service delivery issues, which in turn causes increased demand for better services.

   a. *Capacity building for citizen journalists*
Citizen journalists (CJs) are not professional journalists. They are community members from a large range of different backgrounds, interests, and journalistic capacities. Therefore, before being able to properly cover public service delivery issues, they needed in-depth training and mentoring on how to write, how to research, and how to use facts and evidence. The trainings use a module that Kinerja had developed and used in similar trainings in all five partner provinces: Aceh, East Java, Papua, South Sulawesi, and West Kalimantan.

   b. *Publication of CJ products on various media channels*
The citizen journalists of Jayawijaya publish their works through a wide variety of media: they use notice boards at health
centers, upload products on social media networks (Facebook, Twitter, YouTube), and share stories with community members using SMS. Unfortunately, social media access is limited due to poor internet connections, so as an alternative, CJs work with RRI Wamena, whose anchors read out CJ work. Starting from July 2015, RRI Wamena also allows citizen journalists themselves to read our their own articles in morning news programs.

2. Radio Talkshows
Although RRI Wamena had produced radio talkshows before working with Kinerja, the programs were not always well-planned or flowed smoothly. Kinerja assists the radio station to improve the quality of their talkshows by training the head of programming on how to better manage talkshows, including on how to brief anchors and participants to ensure the discussion runs well.

Implementation Process
1. Citizen journalism
Kinerja’s CJ program consists of several phases that were designed to ensure that citizen journalists are capable of sharing information on health services and health rights. The phases included:

   a. Identifying and selecting candidates for CJ training
Since citizen journalism is a long-term commitment and is done on a voluntary basis, training candidates had to be carefully selected. Each candidate ought to meet at least some of the following requirements:
- Strong interest and/or good understanding of public service delivery issues, especially in the health sector. It was hoped that good knowledge of local government services would increase the quality of reporting and reduce the likelihood of mistakes.

- Community members who represent certain community groups and who have experience in carrying out advocacy, such as members of Kinerja-supported multi-stakeholder forums (MSFs) or local government staff. With this background, CJs would be able to access health facilities and investigate issues.

- Be familiar with using simple communication technology, such as computers, mobile phones, and the internet (particularly social media and email).

- Live in areas with reliable mobile phone and internet connections, to ensure that CJs can easily access information and share their work.

- Live in areas with local radio stations, so that CJs can submit their work.

- Be interested in at least one form of journalism, such as writing, radio broadcasting, or film making.

- Be from or have lived in a certain area for a long period of time. This ensures that CJs understand the local context of the news they are reporting, especially with regards to culture.

- Both men and women are invited to become CJs, but a balance between the two genders must be maintained.

b. Training
After being selected, the candidates were invited to a three-day basic journalism training. They learnt about journalism theories and practices, and were introduced to local media mainstream
media producers so that they could work together. Once the candidates completed the training, they were asked to make a commitment to become citizen journalists and to cover local public service issues.

c. **Mentoring**
The new citizen journalists were closely mentored by Kinerja and PPMN, as many of them struggled at first and were not confident in their products. Monthly meetings were held at which they could discuss their stories and problems, while informal discussions were held over social media. PPMN staff also frequently met with the CJs to help them develop and edit their stories.

In addition to discussing technical aspects of journalism, the mentoring program was designed to motivate CJs to cover issues and to discuss their progress. During meetings, the citizen journalists shared their experiences and challenges, and other CJs helped to address them.

d. **Joint production with professional journalists**
Working together with professional journalists enriches the skills and knowledge of citizen journalists. When first starting out, CJs tend to write simple stories – mostly presenting facts and people’s experiences without analysis. Kinerja hoped that by encouraging CJs to work together with and learn from professional journalists, their products would improve and become better tools for advocacy.

Professional journalists and CJs worked together in two different ways in Jayawijaya. The first was more straightforward, involving joint discussions and writing stories together.
The second approach was for CJs to write their own stories then submit the draft to a newspaper editor or journalist, who helped them sharpen the story. The newspaper would then publish the final piece.

e. **Broadcasting CJ stories on RRI Wamena**
Initially, CJs tended to simply submit their stories to RRI Wamena to be read out on air by the news anchor. But later, as the CJs became more confident and learned more about broadcasting techniques, some CJs were allowed to broadcast their own stories on air.

2. **Radio talk shows**
RRI Wamena’s talk shows discussed various health issues important to Papua. They were attended by government staff, NGO workers, community members, and others, and were carried out live both indoors and outdoors. The public was always invited to attend and participate by asking questions. To reach people who did not have radio, talkshows were recorded and played at Kinerja-supported health centers.

Unfortunately, the radio staff initially experienced some difficulties in managing the talkshows. To address them, PPMN assisted RRI Wamena through:

a. **Assistance**
Many pieces of equipment at the local radio stations were damaged due to frequent electricity outages. PPMN allocated some of their reserve funds to repair the equipment.
b. **Training for RRI Wamena staff and management**

The trainings aimed to increase knowledge of RRI Wamena staff and management on their responsibilities and targets. The training included program management, evaluation, and program and administration reporting. PPMN also taught the radio management how to better manage talk shows, including how to decide on themes, how to plan the talk show, how to identify resource persons, and how to develop questions. PPMN also mentored RRI staff during talk show broadcasts to ensure that they managed the program well.

**Results and Impact**

Three years after the first citizen journalism trainings and radio talk shows were conducted in Jayawijaya, the programs have brought tangible impacts for the citizen journalists, health centers, District Health Office, mainstream media, and community members.

Benefits for **citizen journalists** include:

a. **Increased capacity and knowledge.** Through the mentoring and joint production program with professional journalists, CJs improved their writing skills and built their knowledge on health issues. Many citizen journalists’ works were published in local media and on Kinerja’s partners’ website. This motivated the citizen journalists to continue their works.

b. **Improved communication skills.** The journalism training helped CJs (many of whom are also health workers and multi-stakeholder forum members) to push the District Health Office and local parliament for improvements in health services.
c. Establishment of a citizen journalist community. Citizen journalists from Jayawijaya established a Facebook group called Komunitas Jurnalis Warga Noken Jayawijaya (Jayawijaya ‘Noken’ Citizen Journalist Community) where they share information and stories. As of August 2015, the group had 234 members, including government staff and people from other districts and provinces.

An article by a citizen journalist from Jayawijaya published in a local paper.

Benefits for **mainstream media** include:

a. Able to provide more information for people living in Jayawijaya.

b. Able to provide more information from districts and villages where citizen journalists live. Professional journalists are now able to cover issues all over Jayawijaya with the help of CJs, especially in areas where they previously did not have a presence.

c. RRI Wamena staff are better prepared to run talkshows and discuss health issues.
Benefits for **health centers and the District Health Office** include:

a. Radio talkshows and CJ media products acted as a trigger to build higher levels of willingness and initiative among health workers and government staff to provide services that meet people’s needs. By writing and talking about health services, CJs have made it clear to health centers and the DHO that community members are overseeing what they are doing. Some examples of impacts include how Kinerja’s partner health centers to extend their service hours and to keep their centers cleaner and more organized.

b. The mainstream media, such as RRI Wamena, supported the District Health Office to disseminate its programs to change people’s behaviors. For example, people living around Puskesmas Hom Hom are now appear to care more for the clinic, and even worked to fix the center’s bathrooms.

Benefits for **community members** included:

a. Improved access to information, especially for people living in remote areas away from larger towns. Community members are now able to learn more about important health issues in their regions, for example by reading CJ articles displayed on notice boards at health centers and listening to radio talkshows. This improved access to information has helped people to better understand their health rights. The program has also successfully encouraged community members to work more with CJs and mainstream media to advocate for public service improvements.
b. Increased confidence to talk to decision makers. MSF members and CJs, for example, are now able to talk to the District Head and the Head of the District Health Office to discuss problems in health service delivery.

**Monitoring and Evaluation**
Kinerja, PPMN, and RRI Wamena conduct routine monitoring and evaluation. PPMN staff use monthly meetings with the citizen journalists to evaluate the program. They also invite RRI Wamena, District Health Office staff, health center staff, and community leaders to participate in the evaluation. Evaluation results are then discussed together and disseminated to relevant stakeholders. For example, in response to problems identified during previous evaluations, RRI Wamena allocated a spot (*Warga Bersuara – People Talk*) in the morning news for a citizen journalist to read their article, while a local NGO, Yayasan Teratai, created ID badges for citizen journalists so that people would trust them more.

In addition to the monitoring and evaluation by Kinerja and PPMN, the Jayawijaya District Health Office and local multi-stakeholder forums often conduct field visits to assess progress and impact. Their findings are passed on to relevant government and health center stakeholders to be dealt with.

**Challenges**
The main challenge of the citizen journalism program in the central highland of Papua is poor internet access and weak mobile phone signals. These problems prevent the citizen journalists to send their works to PPMN, who help upload them on JW Noken Facebook group or edit them before being
broadcast in RRI Wamena. To address these issues, the citizen journalists often submit their works when they go to Wamena, the capital city of Jayawijaya where PPMN staff live.

**Sustainability**

As of August 2015, citizen journalism and radio talk shows have received very positive responses from the community, mainstream media, and government. Kinerja believes these programs are sustainable because the CJs are highly committed to work there and have established an active community.

In addition, RRI Wamena shares the same vision as the citizen journalists. They believe that health services are not the sole responsibility of the government, and that instead people should work together to improve services. Furthermore, RRI Wamena plans to provide RRI contributor IDs to all citizen journalists.

In 2014, a CJ from Jayawijaya, Dolly, was invited by the U.S. Embassy to share her experiences being a citizen journalist to advocate for public services at the Five Regions, One Mission event in Jakarta. The event was intended to act as a source of inspiration to encourage more people to become CJs and oversee public services.

**Lessons Learned and Recommendations**

Kinerja and PPMN learn many worthwhile lessons during the implementation of the citizen journalism program in Jayawijaya.
a. Strong working partnerships between community members, the government, and health facilities is a key driver of success when establishing a media or information sharing program. All partners need to be aware of the importance of accurate news and information, and must understand why sharing such information is important. Without strong relationships between all partners, some may resist because they feel that citizen journalists are too critical of their work, for example, or because they feel local reporting is not necessary. District Health Offices and planning agencies (Bappeda) are recommended to involve citizen journalists and mainstream media in both planning and monitoring programs.

b. It is important for governments and health centers acknowledge the role of the citizen journalists and RRI Wamena, as their work successfully pushed for change in Jayawijaya. Service providers and the government should be open to accepting their inputs and praise them for their efforts to advocate for improvements. That said, CJs and mainstream media should also cover good stories and stories of success, not just problems and challenges. A mutually-beneficial relationship between government/service providers and the community must exist to make and sustain changes.

c. Incentives for citizen journalists accelerate people’s behavior change. The incentives were given in the form of funding and work partnerships. Government offices at the district and village levels should allocate funds to citizen journalism and mainstream media development, and should assign journalists to
produce media as part of their efforts to improve public service.

d. Regular meetings between government staff, citizen journalists, and mainstream media reduced the potential for misunderstandings. For example, if people misunderstood what had been reported, then stakeholders were able to clarify issues through dialogue. This is important because media is a key pillar of democracy. **Government staff, citizen journalists, and the media should hold regular meetings to develop and sustain strong relationships.**

**Contact details**

**Veronika Asso**  
Coordinator *Jurnalis Warga “Noken” Jayawijaya*  
0852 4432 5882

**Assalaus Alua, SKM**  
Head of Puskesmas Hom-hom  
0812 4011 7877

**Pastor John Jonga**  
MSF Jayawijaya  
0812 4878 7338

**Supriyono**  
Head of Services and Business Development, RRI Wamena  
[espy517@gmail.com](mailto:espy517@gmail.com) / 0969 31380
Monica Malisa, SKM
Head of Facilities of Jayawijaya Health Office
0812 4862 570

Ronny Hisage
PPMN staff
hiron_hisager@yahoo.com / 0852 4415 9864

Marthen Abidondifu
Local Health Governance Specialist KINERJA - USAID
mabidondifu@kinerja.or.id / marthenlaniejaya@yahoo.co.id / 0852 5494 1773

Firmansyah MS
Media Specialist KINERJA - USAID
firmansyah@kinerja.or.id / firmansyah.ms@gmail.com / 0811 9527 645 / 0852 8772 2888
Integrated Services for Survivors of Domestic Violence in Kota Jayapura, Papua

Background
The domestic violence rate in Papua is one of the highest of all provinces in Indonesia. According to the Ministry of Women’s Empowerment and Child Protection, Papua is one of five provinces with the highest domestic violence rates. Between January and November 2013, Papua police department received reports of 154 violence cases, 40 neglect cases, 31 rape cases, 37 infidelities, and 24 physical violence cases.¹

¹ Meeting minutes of Workshop on Joint MSF Activity Planning, Kota Jayapura, January 30 2014.
Meanwhile, the Center for Integrated Services for the Protection of Women and Children (P2TP2A) in Kota Jayapura recorded cases of violence from 2011 to 2013 as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of cases</th>
<th>Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>9</td>
<td>Two neglect cases, Six physical abuse cases, One child protection case.</td>
</tr>
<tr>
<td>2012</td>
<td>13</td>
<td>Five physical abuse cases, Six neglect cases, Two child protection cases.</td>
</tr>
<tr>
<td>2013</td>
<td>12</td>
<td>Five neglect cases, Two infidelities, Two physical abuse cases, One forced marriage, Two child protection cases.</td>
</tr>
</tbody>
</table>

A study by a local NGO, the Organization for Study of Women’s and Children’s Development (LSPPA) in three Kinerja-supported health centers in Kota Jayapura in 2013 found the following cases:

<table>
<thead>
<tr>
<th>Health Clinics</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanjung Ria</td>
<td>Seven domestic violence cases</td>
</tr>
<tr>
<td>Abepantai</td>
<td>Four domestic violence cases</td>
</tr>
<tr>
<td>Koya Barat</td>
<td>Koya Barat does not record domestic violence cases but the staff claim there is at least one case every month.</td>
</tr>
</tbody>
</table>
P2TP2A and partnering health clinics recorded that cases increased in 2014 and 2015. The following cases were recorded between January 2014 and March 2015:

<table>
<thead>
<tr>
<th>Health Clinics</th>
<th>Cases</th>
<th>Victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puskesmas Tanjung Ria</td>
<td>15 physical abuse cases</td>
<td>Adult women</td>
</tr>
<tr>
<td></td>
<td>One sexual abuse case</td>
<td>Adult woman</td>
</tr>
<tr>
<td></td>
<td>Four sexual abuse cases</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>1 domestic violence case</td>
<td>Domestic worker</td>
</tr>
<tr>
<td>Puskesmas Abepantai</td>
<td>7 domestic violence cases</td>
<td>Adult women</td>
</tr>
<tr>
<td>P2TP2A, Kota Jayapura</td>
<td>10 neglect cases, Four infidelities, Two forced marriages, 24 physical abuses cases 24 protection cases.</td>
<td>Adult women</td>
</tr>
</tbody>
</table>

Unfortunately, services for survivors of domestic violence in Kota Jayapura are far from optimal. There are multiple challenges in providing assistance to women and children, including:

1. **Lack of inter-sectoral co-operation.** Health centers, P2TP2A, and the police do not understand the roles of each other’s organizations with regards to assisting survivors of domestic violence. Additionally, so far P2TP2A and health centers work solely on outreach programs, and there is no system that allows health centers to refer domestic
violence cases to P2TP2A. Consequently, survivors do not receive appropriate assistance.

2. **Limited capacity of health workers and P2TP2A staff on domestic violence handling.** Although Kota Jayapura’s P2TP2A center was established in 2008, five years later it did not have written standard operating procedures (SOPs), and many of its staff do not understand the flow of violence case management. Staff tend to refer victims straight to police without referring them to health centers, so many victims do not have accurate medical evidence to support their case.

Additionally, health centers, as frontline health facilities, only focus on physical treatment for injuries; most do not explore suspected cases of domestic violence further. Staff also often do not keep records of cases, leading to a lack of accurate data. This is because most staff have never been trained on handling domestic violence cases. “We, health workers, only treat wounds, give [the victims] physical treatment,” said Syiska, a midwife at Puskesmas Koya Barat.

3. **Community members do not understand domestic violence or the impact it has on women and children.** Many survivors do not realize that they actually experienced domestic violence, and the issue is not considered important by the society. This situation makes many people unaware of services for women and children who experienced violence.
A health worker at Puskesmas Tanjung Ria gives counselling to a survivor of domestic violence.

Innovation

P2TP2A is the first center of its kind in Kota Jayapura. Previously, there was no integrated services center for survivors of domestic violence. P2TP2A aims to assist local governments in tackling violence against women and children by referring to public service standards, and the program is expected to decrease rates of violence.

Although P2TP2A centers have been established in many areas throughout Indonesia, the program in Kota Jayapura has been slightly different. With Kinerja’s support, their services were developed using a two-pronged approach, working on both supply and demand sides.

On the supply side, Kinerja assists local government, health centers and P2TP2A to:
• strengthen relationships between community members and relevant district technical offices, such as the district health office, social affairs office, women’s empowerment and family planning body, police department, district secretary, and planning agency;
• develop joint work plans to address violence against women and children;
• involve community members (through multi-stakeholder forums and survivor support groups) in fighting violence against women and children;
• improve capacity of technical staff of organizations managing domestic violence cases, such as training health centers, police, and P2TP2A on basic counselling;
• develop pilot facilities to manage violence against women and children;
• raise public awareness on violence against women and children, and on services for survivors;
• evaluate program implementation at health centers and at the district level;
• build capacity of health workers as front-line service providers for survivors.

On the demand side, Kinerja assists community members to:
• provide feedback on developing SOPs on managing domestic violence cases and on the regional action plan on the prevention and management of domestic violence;
• establish support groups to assist survivors in sharing experiences and learning skills;
• identify, provide initial counselling, and refer survivors to health facilities quickly;
• be involved in service provision oversight and program evaluation.

Implementation Process
Between 2013 and 2015, the Kota Jayapura government worked with LSPPA, a Kinerja partner NGO, to begin providing standardized services to survivors of domestic violence.

The program included the following steps:
1. **Obtaining the commitment of relevant technical offices and other organizations responsible for managing domestic violence cases.** All stakeholders responsible for domestic violence management must work together and work effectively. Kinerja’s assistance program was led by the Women’s Empowerment and Family Planning Agency (BPPKB), and began by disseminating information on integrated services for survivors and developing joint work plans. These activities involved the district health office, social affairs office, P2TP2A, police, district secretary, regional planning agency, and community members.

Outreach was followed by the development of SOPs on domestic violence case management. Hospitals, health clinics, police, district health office, social affairs office, P2TP2A, and district-level multi-stakeholder forums (MSFs) all participated. As Kota Jayapura had never before developed SOPs on management of domestic violence cases, examples from other districts were used as starting points for discussion.

A regional action plan was developed in order to ensure the sustainability of services for survivors of domestic violence. The plan was developed in an open and participatory
manner, involving the district health office, district education office, manpower office, legal bureau, health centers, police P2TP2A, traditional leaders, and community members develop a regional action plan.

2. **Strengthening staff technical capacity to address cases of violence against women and children.** This involved building the capacity of the staff of health centers, P2TP2A, BPPKB, district health office, and police to identify domestic violence cases and to assist survivors. Trainings focused on how to provide basic counselling, medical assistance, and legal assistance.

3. **Piloting in-center counselling facilities to assist survivors.** The facilities were developed within existing health centers. Centers with the highest domestic violence rates were prioritized, but it was also important to select centers with sufficient staff capacity. Puskesmas Tanjung Ria and Puskesmas Koya Barat were selected to pilot the counselling facilities.

4. **Raising public awareness on violence against women and children.** This step involved disseminating information on services for women and children experiencing violence. In their outreach activities, P2TP2A developed brochures and posters about how domestic violence cases are managed. In addition, a public awareness campaign was carried out through electronic media, such as radio and TV talk shows.

5. **Establishing support groups and improving knowledge and skills of survivors.** This step facilitates
the violence survivors to share their experiences and to discuss women and health issues. Besides, the survivors learn skills, which eventually will help them economically independent. These activities are led by LSPPA.

6. **Building capacity of MSFs and support groups to help survivors.** Members of MSFs and support groups were trained on case identification and basic counselling for survivors. The community forum members also learned how to report cases of domestic to Kinerja’s local NGO partner, Jerat, through an SMS Gateway. Jerat forwards reports to P2TP2A for further action.

7. **Involving community members in policy making.** MSFs and support groups are involved in the development of SOPs and action plans to ensure that documents meet the survivors’ needs.

8. **Monitoring and evaluation.** The program is evaluated quarterly by all stakeholders involved: BPPKB, P2TP2A, police, health office, health centers, and community members. BPPKB and P2TP2A also regularly visit health centers to supervise program implementation.

**Results and Impact**
For health workers as service providers, the program brings the following benefits:

1. The program improves the technical capacities of health workers to manage domestic violence cases. They are now
better able to record cases, to provide counselling for the survivors, and to refer them to police.

2. With SOPs in place, health workers are able to manage domestic violence cases better. The SOPs provide clear service and reference flows. The clear reference system helps survivors receive appropriate assistance in time.

3. Strong inter-sectoral cooperation to manage cases of violence against women and children improves budget efficiency. Now, all stakeholders understand their responsibilities in domestic violence case management so that budget allocations do not overlap or become the sole responsibility of P2TP2A.

4. The mayor’s decision on P2TP2A was revised to specifically name the staff assigned to be part of the domestic violence management team. With this amended regulation, BPPKB (as the supervising body for P2TP2A) does not need to train new staff repeatedly whenever there is a staff transfer.

5. The regional action plan will be included in the annual plan of relevant technical offices to ensure sustainability of the program.

6. The counselling facility makes health workers feel more comfortable when doing counselling.

7. Regular monitoring

“...managing violence cases require specific skills to explore [the cases], and different people need different counselling approaches. Counselling is very important; focusing only on physical treatment does not help.”

- Syiska
  A midwife at Puskesmas Koya Barat
and evaluation strengthens cooperation between the district health office and health centers. Staff also uses evaluation meetings to share experiences.

For **service users**, the program helps them to:

1. Increase women’s awareness on violence against women and children. Grace Makanuay, a member of the MSF says, “Now, I know there is this kind of organization [helping survivors of violence]. I will not keep silent. I will share this information with other people.”
2. People better understand the referral system and who should be contacted when cases of domestic violence are identified.
3. The members of MSFs and support groups who have been trained on basic counselling are able to encourage women who experience violence to talk about their cases and to seek help from health centers and police. With the improved counselling ability, MSFs and support groups gain more trust from community members; now, more women talk to them when they experience violence.
4. Having been involved in the development of SOPs and action plans, people better trust their governments and have a sense of ownership of the program.
5. Life skill trainings for the violence survivors increase their self-confidence and help them become economically independent.

**Sustainability**

With the development of the regional action plan for domestic violence survivors for the period of 2015 to 2016, the program is likely to be sustained. The action plan gives a bigger
opportunity for technical offices to allocate budgets to fund the program. Efforts to gain commitment from all stakeholders should be rolled out to other areas that experience similar levels of domestic violence to Kota Jayapura.

At Puskesmas Abepantai, the management of violence against women and children is integrated into pregnancy classes. Puskesmas uses one of the series of eight pregnancy classes to discuss services for women and children experiencing violence. The health clinic also developed a class for teenagers to discuss violence.

Lessons Learned and Recommendations
a. Inter-sectoral meetings, which involve multi-stakeholders, should be held regularly to develop common agreement and mutual understanding.

b. Community involvement in the development of SOPs and action plans is important to ensure the documents meet the people’s needs. Community meetings should be conducted regularly.

c. Organizations that are potentially able to protect women and children, such as manpower office, trade office, industry and cooperative office, and education office, should be involved in action plan development. Their involvement will ensure that the action plan includes programs to prevent and to manage violence cases as well as to empower women. The action plan should also be integrated into each technical office’s
work plan. After being implemented, the action plan should be evaluated and updated at least once a year.

d. SOPs, which cover roles and responsibilities of each entity, help all relevant stakeholders understand the coordination and referral flows.

e. Construction of new counselling facilities requires much work, including assessing the pilot clinics, proposing permits, meetings to discuss the facility arrangement. Therefore, the facility development and funding should be discussed and agreed by multi-stakeholders.

f. Trainings for health workers should include role plays which portray real violence cases.

g. Community improves their understanding on SOPs and action plan because they are genuinely involved in the development process. Therefore, specific activities for community members should be designed to increase their knowledge on relevant issues. Also, community members should be involved in training activities related to case management.

h. Longer-term (more than one year) capacity building should be given to support community groups so that they are better able to organize themselves and to educate their peers.
Contact details

Betty Anthoneta Puy
Head of BPPKB Kota Jayapura
Kantor BPPKB
Kantor Walikota Jayapura Lt. 2
Jalan Balai Kota No. 1, Entrop

Berta Mansawan
Technical staff, P2TP2A Kota Jayapura
Kantor Walikota Jayapura Lt. 2
Jalan Balai Kota No. 1, Entrop
(0967) 524401

Dr Liny Pande and Suster Alce
Puskesmas Tanjung Ria
Kelurahan Tanjung Ria, Distrik Jayapura Utara

Ifanny Elizabeth Korwa
Puskesmas Abe Pantai
Jl. Abe Pantai, Distrik Abepura

Syiska Wangloan
Puskesmas Koya Barat
Jl. Koya Barat, Distrik Muara Tami
Business-Enabling Environment

Delegation of Licensing Authority for Micro, Small and Medium Enterprises

One Stop Shops (OSS) are established with the aim of making business licensing easier, faster, cheaper, more transparent, and more accountable for community members, especially for business owners. Where previously people requesting business licenses had to visit multiple offices to gain the correct license, now with OSS, it is enough just to put in a request at one single office. The OSS will organize everything, and will issue the license itself. When permission from technical government offices is needed, OSS will also take care of it.

In other words, One Stop Shops were intentionally designed to oversee the entire business licensing process. This is very different to the traditional system, which required relevant technical offices to issue licenses. Thus, a well-functioning OSS is one that has successfully overseen the delegation of licensing authority for all business licenses to the OSS itself. If an OSS’ authority is limited or weak, it will have minimal impact on improving business licensing processes. This is a common problem faced by OSS throughout Indonesia, with some districts taking years to overcome it. But it is necessary to do so, as OSS will only be useful if they can properly operate and issue licenses.

Experiences from multiple OSS in Indonesia have shown that in order to successfully achieve a delegation of authority for
business licensing, OSS must be able to gain the trust of technical offices and the District Head. This is best done through slowly building relationships and proving that the OSS is a worthwhile initiative. OSS must demonstrate not only that their performance is of high quality but that their existence has a positive effect on other parts of the government, too, especially in the eyes of the public. In other words, OSS must prove that it is worthwhile to delegate the authority for business licensing to them. An OSS official explained it like this: “Our approach was to ensure we all had the same perception [of OSS] by demonstrating OSS’ benefits. ... We looked at licenses one by one, we talked [to technical offices] both formally and informally, at workshops, in coffee shops.”

To ensure all stakeholders were of the same mindset, Kinerja helped its partner OSS to hold regular cross-sectoral meetings. For example, within the government itself, the OSS would meet with bureaus from the District Head’s Office, such as the legal bureau and the organizational bureau. This was done because the OSS knew that when they approached the District Secretary to discuss their work, the Secretary would certainly ask the legal and organizational bureaus for their input and recommendations, and would pass them on to the District Head. By meeting with the legal and organizational bureaus first and ensuring they had a good understanding of the benefits of delegating business licensing authority to the OSS, the OSS had a better chance of gaining the agreement of the District Secretary and District Head.

One example of a successful OSS is Kubu Raya District in West Kalimantan Province. Kubu Raya’s OSS initially selected 14 different business licenses that they would deliver, based on
their staff’s existing abilities. In order to combat technical offices that rejected their requests to delegate authority to the OSS, the OSS developed databases and reports that showed how OSS-led business licensing would make the work of technical offices easier. The OSS also made sure to continuously involve technical offices in their planning meetings. “In the end, the number of different types of licenses delegated to us grew and grew. In fact, some technical offices even began asking us when their licensing authority would be removed!” an OSS manager from Kubu Raya said.

Before beginning to request the delegation of authority from technical offices, Kubu Raya’s OSS made sure that their staff genuinely understood relevant government regulations. Workshops and technical meetings were held to discuss the law, and external speakers were often invited to deepen OSS staff knowledge. This was particularly effective when the speaker was a senior staff member or leader from the national or district government, as staff are more likely to listen and take on board what is said when a speaker is of the same or higher rank.

In the case of Kubu Raya, the OSS asked the District Head to speak at a forum where all the heads of technical offices were meeting. The OSS informed the District Head that the reluctance of technical office heads to delegate licensing authority to the OSS was impacting on their ability to work and essentially causing the OSS to stand still. The Bupati agreed that this was a problem, and, following the OSS’ presentation on recent developments and challenges, he spoke at the forum and requested that all licensing authority to be delegated to the OSS. Kubu Raya’s OSS views this moment as the moment
where everything changed and their work began to proceed smoothly.

Delegation of authority means that all business licensing is centralized under the One Stop Shop. Depending on their current level of successful delegation, OSS in different districts can now develop business licensing mechanisms, determine what documents are required, and provide licenses under the authority of the District Head. This means that business owners need to visit only one office – the OSS – to get their business licenses. The process is also more clear, easier, and faster. With more responsibility, the OSS can also be more creative and innovative in their work, and actively focus on improving services.

After successfully becoming legally responsible for issuing licenses, many OSS decide to establish a technical team made up of representatives from district technical offices. The technical team provides limited advice on licensing and ensures good relationships between the OSS and other offices.

**Business Licensing Simplification**

Many One Stop Shops (OSS) in Indonesia are attempting to simplify the business licensing process by reducing the total number of licenses on offer. Many licenses overlap and can actually be combined into one single license.

In general, there are two different approaches that OSS can take when simplifying licenses: 1) they can gain the authority for license issuing first, then simplify the licenses; or 2) they can
work with technical offices to simplify licenses first, then be
delegated the authority to issue them.

Based on Kinerja’s and The Asia Foundation’s experience, most
OSS have found the first approach to be easier, primarily
because the licenses requiring simplification are already under
the OSS’ authority. However, the challenge encountered by
both approaches is generally the same: it is hard to convince
technical offices of the necessity of simplifying license types.
Even when the OSS already has the authority to issue licenses,
they still need the recommendations of the technical offices.

Licensing simplification has a significant impact on whether an
OSS will be able to provide service that is easy, fast and cheap.
Simplification aims to reduce the overlap between licenses, as
overlap tends to have a negative effect on business owners.
This argument is useful when working to convince technical
offices and senior government officials of the importance of
licensing simplification.

A bakery owner and her new business license, issued by
the local One Stop Shop in Jeneponto, South Sulawesi.
The development of One Stop Shops generally happens gradually over time. OSS should start by using the authority they have to begin with, however small, to fulfill their responsibilities. The good results and positive impacts of the OSS’ work should be demonstrated to other stakeholders as a way of proving the usefulness of an OSS for business licensing. This should be done through a process that is not confrontational and that is accommodative to input and feedback from other stakeholders.

Unfortunately, some OSS have encountered serious problems in convincing other stakeholders of the need for licensing simplification. They have found that not even rational arguments suffice. These OSS have then decided that they must involve other stakeholders, especially high-ranking officials, leaders and private sector representatives, at every point of policy-making to ensure that their work is successful.

Before talking with stakeholders, though, OSS should identify all the types of licenses available in their district. One OSS manager said, “It took us one year to identify all the licenses, because had to keep going back and forth with the technical offices.” Some OSS choose to focus on business licenses first, such as those relating to investment and business activities, while others go even further, identifying licenses relating to civil registration. After identifying all the different licenses available, OSS analyze the licenses by seeing how they relate to policies and regulations, district programs, and the needs and desires of business owners and community members. They can also begin
to sketch out ways in which licenses can be merged or even deleted altogether.

In Kubu Raya District, West Kalimantan Province, the OSS worked with the District Inspectorate, the Legal Bureau, the Economic Bureau, Organizational Bureau, and the District Planning Agency to identify and simplify licenses. Together, they identified 215 different licenses that were available in the district, including those not related to business activities. This information was passed on to the District Head and senior members of technical offices, and the OSS made sure to continue updating those stakeholders throughout the entire simplification process.

Meanwhile in Barru District, South Sulawesi Province, licenses were simplified first by the relevant technical offices before the authority to issue those licenses was handed over to the OSS. The head of the Barru OSS felt that this was simpler and more effective, because the technical offices themselves could decide how to simplify licenses. Once the licenses were simplified, the handover process was easier because there were many less licenses that needed their authority transferred.

The Barru OSS was very progressive in how it simplified licenses. They managed to get around many issues by describing their work as (correctly) in line with regional autonomy. Their main aim was to make their services better and easier for business owners and community members, and they did so by reducing the total number of license types from 129 to just 22. After working with technical offices to examine licenses one by one, most licenses were deleted outright, while a minority was combined. Authority for all 22 licenses is now held by the OSS.
Barru implemented a unique policy where they removed the need for all businesses to hold Nuisance Permits. Businesses still need to obtain a Place of Business Permit, which gives them permission to run business activities at a certain location. This policy has reduced the government’s income from Nuisance Permits, but the OSS successfully argued that this was not a problem, as removing the costs associated with getting Nuisance Permits would encourage more micro and small businesses to open, which in turn would drive economic growth. The District Head of Barru agreed so strongly with this that he even became the head of the district licensing technical team.

It is OSS’ responsibility to ensure that technical offices understand that license simplification does not mean the eradication of the substance of licenses. Licensing remains important; the difference is that for businesses who meet the licensing requirements, the processes become more straightforward and licenses are easier to obtain. As one OSS manager said: “Business owners used to complain that they had to visit many different places to get different kinds of licenses, and that there were no standards or SOPs. So we started thinking, if the licenses can be simplified, why not?”

**Provincial One Stop Shop Forums as Learning Events**

In this area of regional autonomy, when more and more government responsibilities are devolved to the district and city levels, it cannot be forgotten that provincial governments still play an important role. With regards to One Stop Shops (OSS), provincial OSS should not only be responsible for issuing
provincial licenses but should function as an ‘information center’ for OSS in districts and cities.

This simple idea was the thinking behind the formation of Provincial OSS Forums in a number of Kinerja- and The Asia Foundation-supported provinces. These provincial forums are non-structural and do not intend to become a sort of coordinator for district OSS. The Provincial OSS Forum rather functions as a place where district OSS can share information and learn about OSS management in other districts.

A Provincial OSS Forum can act as an initiator for knowledge sharing by holding events and inviting all district OSS to attend. The Forum will create the schedule and invite speakers to discuss their activities. The Provincial OSS itself can share information to the districts, too.

South Sulawesi and East Java have both established well-functioning Provincial OSS Forums in the last few years. The forums act as places where district OSS can learn about new government policies and programs, particularly those relating to OSS management. Generally-speaking, provincial OSS have better access to central government information than district OSS, so it is important that provincial OSS open up communication channels such as through forums. For example, the central government provided information on Law no 23/2014 on Regional Autonomy only to the provinces. The Provincial OSS Forum of East Java then continued the socialization process by sharing information on licensing to district OSS. The funding for such activities should be allocated by the provincial OSS itself.
Provincial OSS Forums have also been shown to be useful for new staff. When transferred to work for a district OSS, it often happens that staff have never before worked at an OSS. The provincial forums help them learn from other districts and improve the services provided by their own OSS.

**Encouraging citizens to apply for licenses**
Business owners need to obtain licenses to legalize and to grow their businesses. Business licenses are required when an entrepreneur penetrates a certain market or when they apply for bank loans. Licenses also benefit the community by driving economic development.

However, some business owners are reluctant to apply for licenses due to the long and complex bureaucratic processes. In such a situation, licensing reforms will not achieve their goals of improving economic and social activities by simplifying and accelerating the licensing process and reducing associated costs.

*A young woman applies for a business license at a One Stop Shop in South Sulawesi.*
Many One Stop Shops (OSS) note that business owners are not very interested in applying for licenses, so those that have reformed their licensing services actively try to encourage more people to apply for permits. One OSS manager says, “We have to be active. The OSS’ success is measured by number of licenses that it issues. We are supported by the Head of District, since our programs are pro-business, especially SMEs.”

Success of licensing service reforms is not only measured by regional income (how much licensing contributes to regional revenue) but also by the increase of applicants due to easier, faster services with sensible prices. It is easy for the OSS to reduce the cost. Yet, it has to work harder to increase the number of licenses issued. Once the OSS has improved its services, it has to show the citizens its improvements.

To ensure good community understanding of business licensing, One Stop Stops should conduct intensive public awareness through mass media, such as on the radio and in local newspapers. Additionally, some offices regularly run radio talk shows on licensing services by inviting relevant resource persons and answering questions from the audience. The OSS itself pays all expenses related to the talk shows, including paying for the airtime itself.

Radio talk shows are effective because they allow people to consult their problems with relevant staff and government officials. Taking part in radio shows helps gain the support of key government staff, too, as they become more understanding of the need for reform. Many OSS also use feedback gathered during radio talk shows in their evaluation processes.
Public awareness raising is also conducted through events at public places, such as schools, exhibitions, and festivals. During these activities, the OSS shares information on licensing services and distributes license application forms to people who plan to apply for licenses. OSS staff are also available to talk to attendees.

Some OSS also work with sub-district and village offices to disseminate information of the licensing services. People who require further information can contact the OSS. Cooperation with the sub-district and village offices improves understanding of the two offices’ staff on licensing reforms, so that they are able to deliver services to the same standard as the OSS.

Some OSS, such as OSS Barru in South Sulawesi, allocate funds to conduct free licensing services every year to attract more applicants. A number of licenses are distributed free, for example building licenses for poor families. The OSS in Barru issues around 95 free building licenses every year.

The Head of OSS Barru, Syamsir, says that the district focuses on business licensing since very few business entities have licenses. In 2010, only 26% of businesses in the district had licenses. In 2014, since licensing reforms and awareness raising, 85% of businesses in Barru now have licenses.

Barru’s OSS also set up a website and SMS Gateway to disseminate information on licensing services. Community members can access basic information through the website and send e-mails when they have inquiries. Additionally, the website helps applicants living in other districts to understand the licensing process in Barru. For example, an investor in Makassar
who plans to open a business in Barru can obtain basic information about the licensing process before driving the three hours to Barru. Unfortunately, internet access is still limited, so the use of the website remains minimal.

The SMS Gateway helps people to receive information and to monitor progress of their license application. Using the gateway is easy and more user-friendly than calling or visiting the office, especially for those living in remote areas.

**Involving the Community in OSS Management**

Licensing is a public service, so its management and implementation should involve community members. People are the ultimate beneficiaries of licensing services, and understand their needs better than government officials do. One OSS manager says, “Without community involvement, we would not know if the improvements we make meet the people’s needs and expectations.”

Community members play two important roles in licensing services. First, they are the ultimate evaluators of the licensing services. Second, people should be involved in planning processes, providing input on policies and programs. OSS need to understand the pivotal part community members can play.

Some OSS have established multi-stakeholder forums (MSFs) consisting of community representatives, business owners, government staff, NGOs, media, and academics. The MSF acts as a place where business licensing services can be discussed, problems identified, and solutions identified. In Barru, South Sulawesi, the head of the OSS issued a decree on the structure
and membership, and provides an annual budget for MSF activities. In the MSF structure, the OSS and government officials act as the advisory board, while community members make up the committee.

In Barru, the MSF is involved in the licenses simplification process. The MSF, the government, and other relevant stakeholders hold regular meetings to discuss how to simplify licenses. During the meetings, the people also share problems relating to licensing services, and provide technical and policy inputs.

Currently, the MSF is focusing on exploring how to maintain their independence. They require funding to carry out activities, but at the same time, they must be able to oversee OSS services and provide input to the government.

MSFs are not the only way OSS involve community members. Some OSS assign staff to record stories on licensing services at coffee shops and other public places, for example. The stories are then used to evaluate OSS services and to promote their work to the community more broadly.

**Garnering Public Feedback**

Many OSS have improved their services with the assistance of Kinerja, The Asia Foundation, and local partners. A number have even received rewards from the national government. Kinerja assists its partner OSS to garner public feedback through a customer satisfaction survey, as mandated by the Decision of the Minister of Bureaucratic Reforms No. 25/ 2004 on the General Guideline for Implementation Customer
Satisfaction Index at Government Offices. Kinerja-supported OSS made their own additions to the survey, adding two questions which are more appropriate to local contexts.

In order to make the survey objective, the OSS ensures that the surveyors have sufficient capacity and strong integrity. Using Kinerja’s networks, the project-supported OSS can easily find surveyors who meet the requirements. Non-Kinerja partner OSSs can find surveyors by asking other OSS who are more experienced in running satisfaction surveys.

Based on the OSS’ experiences, the survey effectiveness depends on the survey content. The OSS can alter the questions according their preferences, or so that they look for the issues that community members are most interested in.

In Barru, South Sulawesi, the district’s OSS has implemented customer satisfaction surveys each year for the last three years. The last survey involved 150 respondents in seven sub-districts. The survey respondents are selected from the individuals and companies who applied for a license in the previous year. The OSS recruits external surveyors to ensure the survey is objective, and uses a questionnaire based on the Ministry of Bureaucratic Reform’s survey. The survey uses both closed and open-ended questions to obtain in-depth information. Survey findings are shared with the OSS.

OSS Barru spends IDR 26 million (approx. US$2000) to conduct each survey. The budget is used to fund workshops on survey methods, fees for surveyors, enumerator trainings, administration, report writing, and dissemination of results.
Barru OSS considers the costs of running a customer satisfaction survey as worthwhile because it helps the office to improve their services. The feedback they receive during the survey ranges from simple complaints such as broken air conditioners in the office that make the waiting room too warm, to issues that would not be immediately obvious to staff, such as the fact that the OSS does not supply drinking water to clients waiting to meet with licensing staff.

The OSS takes this feedback seriously, and tries to respond to all complaints. For example, in 2011, people complained about unclear fees. Now, the office includes a list of fees in all application forms. Additionally, when applicants receive their license, the staff will ask them if they were asked to pay unofficial fees. If yes, the applicants are directed to the complaint section at the OSS. If no, the applicants are asked to declare that they were not charged unofficially.

In addition to the customer satisfaction survey, Barru OSS regularly distributes questionnaires to collect public feedback and discusses the findings at evaluation meetings. Questionnaires are available from the OSS front desk.

The Head of Barru OSS, Syamsir, says that public feedback is shared among all staff for their attention. The office also submits findings from the customer survey to the district head for evaluation and follow-up.
USAID Kinerja
Sampoerna Strategic Square
South Tower, 18th Floor
Jl. Jend. Sudirman Kav. 45-46, Jakarta 12930
email: info@kinerja.or.id
www.kinerja.or.id