CONTEXT ANALYSIS: CLOSE-TO-COMMUNITY MATERNAL HEALTH PROVIDERS IN SOUTH WEST SUMBA AND CIANJUR, INDONESIA

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Reachout
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EXECUTIVE SUMMARY

INTRODUCTION

REACHOUT 'Reaching out and linking in health systems and close-to-community services' is an eight-country, five-year consortium funded by the European Commission. Its aim is to maximize the equity, effectiveness and efficiency of close-to-community (CTC) services in rural and urban slums of six partner countries: Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique, with support provided by its European partners: the Netherlands and the UK. In Indonesia improvement of maternal health is a nationwide priority, and REACHOUT focuses on strengthening community maternal health services.

The health care system in Indonesia emphasizes community empowerment. Three initiatives — namely, the Community Health Centres known as *Puskesmas*, community-integrated village health service called *Posyandu* and the Village Midwife Programmes (VMPs) — were started in the latter half of the 20th century to bring health services closer to the community and to reduce the high maternal mortality rate (MMR). The initiatives function to provide integrated curative, preventive and health promotion activities — particularly mother and child health services — to rural communities. In the initial phase considerable progress in maternal mortality was observed; however, the poor maternal health outcomes persisted, and drawbacks of the VMPs were evident. At present the target MMR of 102 deaths per 100,000 live births by 2015 set by the Millennium Development Goals remains a challenge. The 2013 estimates show an average MMR of 190, with a lower limit of 120 and an upper limit of 300 per 100,000 live births. Additionally, the decentralization of the health system in 2001, giving management authority to the districts, further shifted health care delivery closer to the community.

REACHOUT collaborates with the Eijkman Institute, Jakarta, an institute with experience in conducting research involving midwives in rural areas. The first phase of the research was to conduct a country context analysis, which includes a desk review, mapping of CTC providers and qualitative studies. This report provides findings of these studies, which will be used to guide interventions for the service quality improvement cycles.

RESEARCH METHODS

Desk review

We reviewed published and unpublished work, mainly government and non-government reports and policy documents on CTC providers in Indonesia covering the period 2003–2013. We then held consultations with the District Health Officers (DHOs) and other stakeholders to obtain their inputs. Information was synthesized using a pre-determined REACHOUT framework of factors affecting the performance of CTC

providers. These included the types of CTC providers and their roles, the performance and impact of CTC providers and services, and health system, intervention design and contextual factors.

Stakeholder mapping

We held a brainstorming session within our team to identify the key maternal health service stakeholders. They were identified at central, provincial and district level, and separated into government, non-government and local partners at sub-district and village level who influence policy and implementation.

Qualitative study

Study sites: Guided by the Ministry of Health and with district selection criteria agreed across the consortium, we selected South West Sumba and Cianjur, two districts with poor maternal health indicators but contrasting in population size, socio-cultural background and district management experience. In each district we selected two sub-districts: one with good maternal health indicators and one with poor indicators. We further selected four villages per sub-district as follows: one which is close (10km or less) to the sub-district health centre and performing well, and one performing poorly in maternal health. Likewise, we chose villages that were far (approximately 10–12km or more) from the sub-district health centre, with one in each sub-district performing poorly and one performing well, making a total of eight villages per district.

Ethical approval: A country-specific protocol was developed and ethical approval was obtained from the Research Ethics Committee of the Eijkman Institute.

Informants: We selected village midwives, *Posyandu kaders* (village health volunteers) and Traditional Birth Attendants (TBAs) working in our selected villages as service providers, and mothers and husbands as service users. The key management informants were the heads of *Puskesmas* and midwife coordinators in the *Puskesmas,* and policymakers were section heads of maternal health at DHOs.

Sampling and data collection: We used a purposive sampling. Data were collected through focus group discussions (FGDs) and semi-structured interviews (SSIs). Topic guides were developed, and a one-week workshop was held to train the data collectors.

Data management and analysis: We piloted the data tools prior to data collection, and audio files were transcribed in Bahasa Indonesia and counterchecked and translated into English. A workshop was held in Jakarta facilitated by senior researchers from the Royal Tropical Institute (KIT), the Netherlands, and the Liverpool School of Tropical Medicine (LSTM), the UK, who trained the staff in qualitative data analysis. Data were imported into Nvivo 10 software and analysed.

Stakeholder meeting: We presented the preliminary findings to the respective district- and provincial-level stakeholders to discuss the outcomes and their input for implications of the quality improvement cycle.

MAIN FINDINGS

Human resources

The main CTC providers of maternal health care are the village midwives or nurses, the *Posyandu kaders* and TBAs. The village midwive*s* are involved in providing midwifery care and attending to deliveries at facilities or at home. Since they might be the only health care provider in the village, in addition to their 24-hour availability for deliveries, they provide general health care, care for elderly people and health promotion activities such as family planning and nutrition, which is beyond their training. In Cianjur some midwives are also involved in female genital cutting. Midwives in rural areas provide a 24-hour service and find that their workload has increased with additional services and is challenging for their competencies..

Posyandu kaders are non-salaried workers who are chosen by the community to serve in the *Posyandu.* The *kaders* are responsible for arranging the *Posyandu*, weighing children, assisting in registration and providing nutritional and health promotion such as family planning. They receive a financial incentive from the DHO and a week of training for their *Posyandu*-based tasks.

TBAs are non-salaried informal workers whose roles and training vary; some inherit the role. They are involved in providing local traditions such as massage to position the foetus, attending home deliveries and after-delivery care of bathing mother and child.

Selection and recruitment of CTC maternal health providers

Midwives are recruited on the basis of academy certification and appointed by the DHOs. *Kaders* are selected by the community, with a strong influence of village leaders on the selection, based on literacy capabilities; however, increasingly, village midwives play a role in their selection. Communities expressed a preference for married, older midwives. However, this is a challenge. Older, married midwives often have a house, family and school-aged children and find it difficult to be based in remote villages without schooling for their children. The desk study shows that assigned midwives who are not resident spend less than half the number of days on village-based clinical work, and this differs significantly by location, and remote areas show a high turnover of midwives.

Supervision

The desk review and interviews show that the monthly supervisory meetings with midwife coordinators mainly accounts for the activities in the *Posyandu* and records of the number of pregnant women in the village and deliveries that occurred in the preceding month. A report that looked into service quality states that quality improvement approaches for the technical supervision of midwives/nurses are lacking. Since there is no standardized supervisory system, the quality of supervision varies and does not support capacity strengthening or motivation of midwives/nurses. The few studies that describe supervisory processes consider them weak.

Community structures and support

Heads of the village and village health committees were allocated a supportive role in the organization of the *Posyandu* and support for the midwives and *kaders.* Comparison between villages that are performing well and those performing less well shows that the villages performing well (in terms of utilization of services) have much more supportive and active village heads and other stakeholders such as the managers of the *Puskesmas* than those performing less well. In addition, the attitudes of midwives play an important role.

Collaboration and coordination

Some collaboration between midwives, *kaders* and TBAs exists. In Cianjur the collaboration is more formalized than in Sumba. TBAs accompany women to the midwife and health facilities and are supported by the midwives in return.

Influences on maternal health-seeking behaviour

Antenatal and postnatal care: Most pregnant women attend the monthly *Posyandu* to check whether their pregnancy is normal and whether delivery would have any complications. The postnatal services are less clearly defined, and many women felt that postnatal *Posyandu* attendance was for a check-up for their baby.

Preference for home delivery and TBA attendance: The health-seeking behaviour of women regarding where to deliver and who is in attendance is influenced by a long-standing tradition of TBA culture. The comfort and familiarity of the home environment and availability of aftercare according to tradition was also a reason given for preferring home births. This preference can cause delays in presenting to health facilities when there are delivery complications.

Access to care and the lack of a referral system: Factors such as transport cost, distance to health facilities and availability of a village midwife as opposed to the close proximity and convenience of a TBA to the delivering women all influence the place women choose to have their delivery. Ambulances are often not available, and payment for

transport services is expected. These factors contribute to delays for women needing to reach health facilities during labour.

Perceptions of the health facility: A lack of health worker responsiveness to traditional beliefs and practices is an important barrier that prevents pregnant women from delivering in a health facility. One such belief is that hot water baths are needed to ensure the dirty blood leaves the mother and prevent future back pain, so mothers are reluctant to deliver at health facilities where hot baths are not available. Another is the fact that the midwife is not seen to take the mucus out of the baby's mouth, as the TBA does.

Decision-making and gender norms: Decision-making related to antenatal care, delivery and family planning is influenced by gender norms. It is influenced by the husband and key family members such as parents and parents-in-law, as well as encouragement or instruction from the village head and midwives.

Health insurance: Indonesia has an insurance scheme, Jampersal, that covers maternal health services, including delivery. This has improved access to health facilities, but many communities are not clear how the scheme works, and the bureaucracy and reimbursement of the scheme remains a problem.

DISCUSSION

Although there is a well-laid-out community maternal health infrastructure, many challenges persist. Midwives form the core of CTC health providers and are deployed to serve rural areas. However, they are required to give services additional to their midwifery practice, beyond their capacity and skills. Similarly, the *Posyandu kaders* are also expected to provide services beyond their defined role. The increased workload of midwives and poor referral systems hamper the quality of care, and the retention of midwives in rural areas is an ongoing issue.

Many women prefer home delivery and TBA services despite regularly attending the *Posyandu* for antenatal services in both districts. The preference for TBAs partly comes from a deep-rooted tradition of trust in TBAs who practice local traditions. This reveals a crucial role of TBA services, although some differences exist between the two districts in their roles. It is also noteworthy that building up tripartite collaboration between village midwives, the *kaders* and the TBAs is important in supporting women to deliver in health facilities by accompanying them to the health facility. Other factors for the preference for home delivery and the persistence of TBA usage is the poor response to community cultural practices at facilities, and poor understanding of the benefits of giving birth at a health facility, coupled with perceived low risk to the mother and baby with normal antenatal findings during pregnancy.

Limitations within the existing maternal health system hinder the quality of care provided at the health facility, which can be compounded by unfriendly attitudes of health staff. There are several factors relating to accessibility including poor roads, lack of transport and poor communications system. Although a health insurance scheme exists, and delivery care is free, there is a perceived indirect cost for accommodation for family members who accompany the woman, and the transport cost if they use their own transport. These are costs not covered by the Jampersal health insurance scheme.

In conclusion, despite concerted efforts to improve maternal health and some increase in the proportion of facility deliveries, many issues contribute to women continuing to choose home deliveries, the root causes of which will be addressed in the improvement cycle that targets two of the REACHOUT focal areas: community engagement and coordination and referral.

- **Implications for quality improvement cycles and potential areas for intervention: Coordination/referral** to initiate or support the three-way collaboration between village midwives, *Posyandu kaders* and TBAs to facilitate timely referral of women in labour to attend health facility. This intervention is aimed at addressing preferences for home delivery, and limited communication of information about delivery from TBAs to midwives. This may be achieved through regular monthly meetings. This mechanism could then be used to:
    - improve TBAs' willingness and capacity to refer women, inform village midwives in advance of an upcoming birth and accompany women for facility delivery, with an emphasis on stimulating birth preparedness;
    - follow up the Training Act as a supportive structure that can link to supervisory support by sharing problems and possible solutions; and
    - provide a forum for regularly updating the skills of midwives and *Posyandu kaders*.
- **Health promotion** to improve the communication skills of CTC health providers such as *Posyandu kaders* and village midwives to explain the benefits of antenatal care and facility delivery to the mothers. The intervention could, therefore, train providers to enhance their communication skills and initiate discussion with women, supported by well-developed health promotion materials. The aim would be to enable them to more effectively communicate with women during antenatal care on the benefits of facility delivery, the risks despite a normal pregnancy and the cost and coverage of the health insurance scheme.
- **Improve community support** to address traditional practices, decision-making and preparedness for referral at birth. The intervention would involve the development of participatory learning and action in community groups with the

aim to generate reflection on decision-making and the development of action plans to overcome barriers to access health facilities for delivery.

- **Cultural sensitivity:** Give consideration to locally practised norms and acceptable services such as the provision of hot water baths after delivery at health facilities to improve the responsiveness of health services to local traditional practices that could encourage women to deliver at a health facility.
- **Support from strategic stakeholders**: Utilizing important stakeholders such as village authorities, the Family Welfare Movement (PKK) and the National Programme for Community Empowerment (PNPM) to become involved and support maternal health services, and action plans developed by the community.
- Encourage setting up a **village transport network** particularly for delivery emergencies, with the involvement of key figures in the village such as village chief and family welfare services, and develop a reimbursement system for transport and family accommodation costs.

CONTENTS

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
BEONC	Basic emergency obstetric and neonatal care
CEONC	Comprehensive emergency obstetric and neonatal care
CHW	Community Health Worker
CTC	Close-to-community
DHO	District Health Office
FGD	Focus group discussion
IDHS	Indonesia Demographic and Health Survey
KIT	Royal Tropical Institute, Amsterdam
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and evaluation
MoH	Ministry of Health
MMR	Maternal mortality rate
NGO	Non-government organization
PHO	Provincial Health Office
PKK	Family Welfare Guidance
PNC	Postnatal care
PNPM	National Programme for Community Empowerment
SSI	Semi-structured interview
TBA	Traditional Birth Attendant
VMP	Village Midwife Programme
WHO	World Health Organization

CHAPTER 1 – INTRODUCTION

BACKGROUND, CONCEPT AND OBJECTIVES

The health care system in Indonesia emphasizes community empowerment. Three initiatives — namely, the Community Health Centres known as *Puskesmas*, community integrated village health posts called *Posyandu* and the Village Midwife Programmes (VMPs) — were started in the latter half of the 20th century to bring health services closer to the community and to improve the high maternal mortality. The initiatives function to provide curative, preventive and health promotion activities particularly mother and child health services to the rural communities. Maternal health services are at the core of the outreach initiative, with midwives as the front-line health worker. This initiative makes Indonesia one of the few countries that have brought midwifery services into the community. At the initial phase considerable progress in maternal mortality was observed; however, the problem persisted, and drawbacks of the VMP were evident [1].

Maternal health remains a major public health problem in Indonesia. At present the target maternal mortality rate (MMR) of 102 deaths per 100,000 live births by 2015 set by the Millennium Development Goals remains a challenge. The 2013 estimates show an average MMR of 190, with a lower limit of 120 and an upper limit of 300 per 100,000 live births [2]. Additionally, the decentralization of the health system in 2001, giving management authority to the districts, further shifted health care closer to the community. In Indonesia, as in many public health systems, there is a divide between the close-to-community (CTC) providers and policymakers. Research is needed to understand the interactions between CTC providers and health systems to avoid repetition of the factors that led to the decline of the VMP.

THE REACHOUT PROJECT

REACHOUT 'Reaching out and linking in: health systems and close-to-community services' is a five-year research project that started in February 2013 funded by the European Commission FP7. The primary aim of the research is to maximize the equity, effectiveness and efficiency of CTC services in rural areas and urban slums of the six partner countries: Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique, together with expertise from partner institutes in the Netherlands and UK.

The REACHOUT research in Indonesia concentrates on identifying ways to improve maternal health using the existing system of CTC providers in rural areas. REACHOUT collaborates with the Eijkman Institute, Jakarta, an institute with experience in conducting research involving midwives in rural areas. The first phase of the research was to conduct a country context analysis which includes a desk review, mapping of CTC providers and qualitative studies. This

report presents the findings of these studies, which will be used to guide interventions for the service quality improvement cycles.

OBJECTIVES OF REACHOUT

The objectives of REACHOUT are:

- to identify how community context, health policy and interactions with the rest of the health system influence the equity, effectiveness and efficiency of CTC services;
- to develop and assess interventions that have potential to make improvements to CTC services;
- to inform evidence-based and context-appropriate policymaking for CTC services; and
- to build capacity to conduct and use health systems research to improve CTC services.

KEY PRINCIPLES OF REACHOUT

The key principles of REACHOUT are:

- to include input from CTC providers, the community, policymakers and other stakeholders;
- to assess the evidence for or deficiency of impact of the interventions;
- to ensure that lessons learned are able to influence future programming at national level;
- to develop a common methodology so that inter-country comparison is possible;
- to ensure synergistic working with similar research studies funded by the European Commission; and
- to include capacity-building as an integral component at all levels.

PHASES OF REACHOUT

The objectives of REACHOUT will be achieved in two phases:

Phase 1: Conducting a context analysis through an international literature review, six national desk studies and six qualitative studies to identify contextual factors that influence the performance of CTC providers and services.

Phase 2: Implementation of two improvement cycles in six countries to test interventions for improving CTC providers' performance and their contribution to CTC services.

The findings of the country context analysis, which include a desk review, a mapping of providers and qualitative studies, are used to guide the interventions for the service improvement cycles. The context analysis of the various countries will assist the adaptation and further development of an analytical framework that identifies facilitators of and barriers to CTC services and forms the basis for the development of logical pathways for interventions.

To conduct the research stated above, each partner country has chosen a health theme which is a priority in their country. The theme chosen by Indonesia for the REACHOUT research is '**strengthening community-level maternal health provision**'. The activities related to the chosen research will be developed into a country-specific work package covering the overall objectives of REACHOUT.

DEFINITION OF CTC HEALTH SERVICE PROVIDERS

The REACHOUT definition of CTC providers covers a broad variety of health workers in both government and non-government bodies. It was derived based on the definition of Lewin *et al* (2010)[3] for lay health workers and the World Health Organization (WHO) definition for auxiliary health workers (WHO, 2012).

> "*A CTC provider is a health worker who carries out promotional, preventive and/or curative health services and who is first point of contact at community level. A CTC provider can be based in the community or in a basic primary facility. A CTC provider has at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training*."

In the Indonesian context CTC providers are formal or informal front-line health workers who function as first point of contact at community level. Maternal health front-line workers in Indonesia are the village midwives and nurses. Although they have undergone formal midwifery/nursing education, for the purposes of REACHOUT they are included as CTC providers. We also include trained or untrained Traditional Birth Attendants (TBAs), since they have a strong influence and are like the gatekeepers of maternal health at community level.

CONTEXT ANALYSIS

This report presents the results of the phase 1 context analysis outlined above. The purpose of the context analysis is to develop an analytical framework that will be used to design and analyse the improvement cycles in phase 2.

OBJECTIVES OF THE CONTEXT ANALYSIS

The objectives of the context analysis are:

- to identify evidence for interventions which have an impact on the contribution of CTC providers to the delivery of effective, efficient and equitable maternal health care;

- to map the types of CTC providers;
- to assess structures and policies of the health system for strengths and weaknesses regarding the organization of CTC services and management of CTC providers;
- to identify and assess contextual factors and conditions that form barriers to or facilitators of the performance of CTC maternal health care providers and services; and
- to synthesize evidence on key barriers and facilitators to be built on in future CTC interventions and identify knowledge gaps to be filled regarding CTC services.

COMPONENTS OF CONTEXT ANALYSIS

The following tasks were carried out to complete the context analysis:

Desk review: we undertook a review of existing reports, records and literature on CTC services and providers to identify gaps in knowledge.

Qualitative research: we conducted research consisting of semi-structured interviews (SSIs) and focus group discussions (FGDs) involving four types of CTC providers and key informants such as village heads, heads of local organizations, health managers and policymakers in the two selected districts: SW Sumba and Cianjur. In each district, two sub-districts and four villages per sub-district was chosen for this component.

Stakeholder meeting: a meeting was held with the district health officials in each study district to map the type and function of maternal health CTC providers and to identify their training and support provided within the health service. Later a meeting was conducted involving the full spectrum of stakeholders, including policymakers, administrative and programme implementers and non-government organizations (NGO), to discuss their interest in and alignment with REACHOUT activities and to explain the REACHOUT project.

ROLE OF PARTNER INSTITUTE

The consortium partner institute in Indonesia is the Eijkman Institute in Jakarta. It is an established research institute under the Ministry of Research and Technology. The institute contributes to advancing evidence-based policy through its laboratory and field research. This role is reflected by the recognition given to its research by the Ministry of Health (MoH), and its membership of the ASEAN Expert Committee on Infectious Diseases and the Roll Back Malaria in Pregnancy working group. The Eijkman Institute also has long-standing collaborations with many reputable international research institutes and organizations. Through its past field research engaging Community Health Workers (CHWs), midwives, rural communities and District Health Offices (DHOs), it has considerable knowledge of the health system infrastructure in the target districts. The Eijkman Institute takes the lead in carrying

out the activities of the country work package and is responsible for liaison with local authorities, policymakers and other stakeholders in Indonesia. It will also be responsible to disseminate the outcomes of this work to the relevant policymakers.

REPORT SECTIONS

The report describes the context analysis and its findings. The first section provides an executive summary of the report. The next part consists of the chapters outlined below, and the last section provides relevant annexes.

Chapter 1 provides an introduction to the REACHOUT consortium, the country work package and the role of the partner institute, together with an overview of the context analysis.

Chapter 2 presents a desk review on the situation analysis, identifying the types of maternal health CTC providers and policies relating to their services, with a description of the major issues and barriers to the performance of CTC providers.

Chapter 3 describes the content and outcomes of discussions in the stakeholder meeting on the type and tasks of CTC providers, and stakeholders' alignment with and interest in supporting REACHOUT.

Chapter 4 provides an overview of the qualitative research method, covering the study design, study areas and population, study tools, data collection and analysis.

Chapter 5 highlights the research findings, with a description of the characteristics of the CTC providers and narratives on facilitators and barriers on major themes based on the draft framework. Limitations of research are also discussed.

Chapter 6 discusses the major findings, with triangulation of Chapters 3 and 4 linking with the desk review.

Chapter 7 provides the implications for the draft framework in the country context and for the quality improvement cycle.

CHAPTER 2 – DESK REVIEW

COUNTRY PROFILE

Indonesia is a diverse country with a population of 237.5 million people spread over 17,500 islands divided into 34 provinces, 465 districts and 95 municipalities [4]. Administratively the districts are further divided into 6093 sub-districts and 65,189 villages. The diversity is also evident both within and between provinces, districts and sub-districts in ethnicity, religion, culture, beliefs and dialects. The large population is growing at a rate of 1.03% and a fertility rate of 2.2 [5].

Providing health services to the widespread and diverse population is challenging. One strategy the country has put in place is outreach care. Under this initiative midwives and nurses are placed in the community so that they can attend to the health needs of village populations.

COMMUNITY HEALTH CARE DELIVERY SYSTEM

The health care system in Indonesia emphasizes community empowerment; with the decentralization of the health system, the administration and programme implementation is passed to the district health authorities (Table 1). The main facility responsible for delivering health care to the community is the *Puskesmas* (community health centre)

The *Puskesmas* system was started in accordance with the concept of the health promotion and prevention approach set out in the 1951 Bandung Plan [6]. Based on this concept, the function of the *Puskesmas* is to provide comprehensive health care to individuals and to carry out health promotion and prevention activities for the community. There is one *Puskesmas* per sub-district or part of a sub-district. In 2010 there were 9005 of them, with each one serving about 30,000 people.

At the sub-district level, under the umbrella of the *Puskesmas,* health care delivery is further broken down into *Pustu, Polindes* and *Posyandu* to serve village populations as shown in Figure 1.

A *Pustu* is a simple health service unit serving two or three villages with a nurse or midwife in place. *Polindes* is a village midwife clinic with obstetric care serving one or two villages and a building allowing midwives to stay. *Posyandu* is a community integrated health post that provides antenatal care (ANC), health promotion and prevention activities, child growth monitoring and immunization. The activities are held monthly and take place in the village.

The village community is responsible for organizing the *Posyandu,* and activities are carried out with assistance from the *Puskesmas* staff.

Table 1. Administration of the Indonesian health system

Level	Position
Central: Ministry of Health	Minister — national policy
Provincial: Provincial Health Office (*Dinas Kesehatan Propinsi*)	Head of Provincial Health Office (*Kepala Dinas Kesahatan Propinsi*)
District: District Health Office (Dinas Kesehatan kabupaten)	Head of District Health Office (*Kepala Dinas Kesehatan Kabupaten*)
Sub-district: Community Health Centre (Puskesmas)	Head of Puskesmas (*Kepala Puskesmas*)

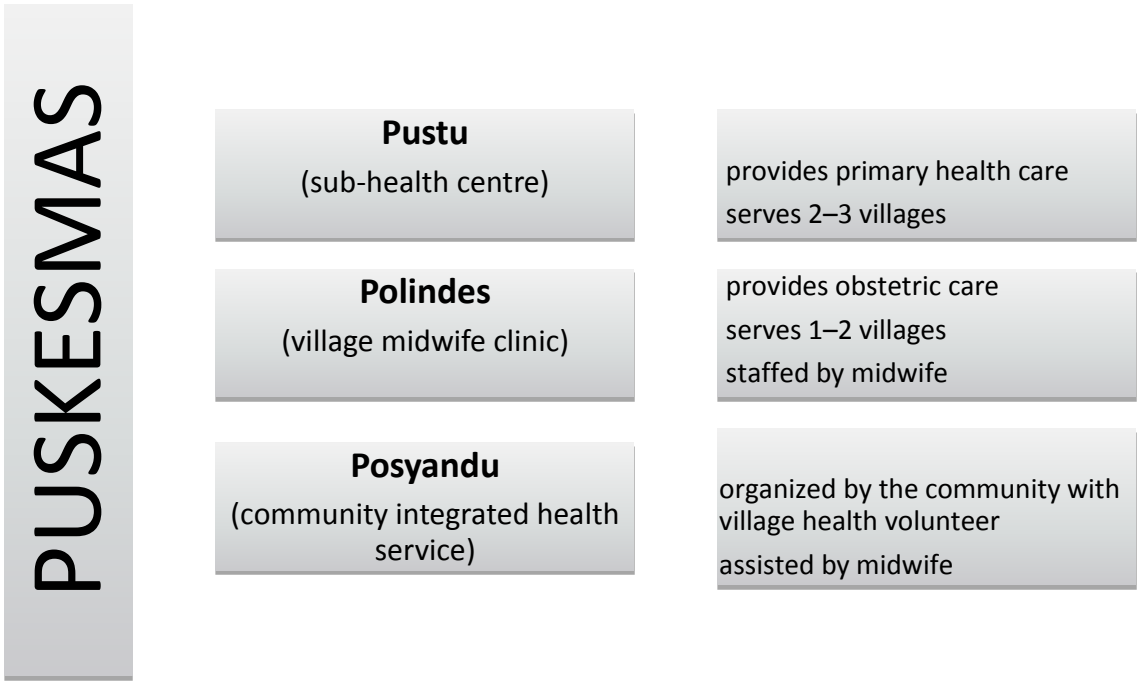


Figure 1. Organization of Puskesmas

DEVELOPMENT OF THE COMMUNITY MATERNAL HEALTH PROGRAMME

The primary focus of the community-empowered health care system is on maternal and child health [1]. The second half of the 20th century saw several initiatives put in place to improve maternal health. Most noteworthy of these were the Safe Motherhood Programme introduced in 1988 and the Village Midwife Programme (VMP) which started in 1989. The objective of the VMP was to place one trained midwife in each village (particularly in underserved and rural areas) to provide ANC and postnatal care (PNC) and conduct childbirth

by skilled health care providers. The deployment of 60,000 village midwives in the 1980s saw dramatic improvements in maternal health indicators.

However, despite over two decades of concerted government effort, the maternal mortality issues persisted, and drawbacks of the VMP were evident[1]. This brought revisions to the Minimum Service Standard which included: practice of ANC; treatment of obstetric complications; delivery by skilled providers; PNC; family planning; and coverage of costs for poor people. The guidelines for these measures were not clear and were not applied by many districts. The current maternal health activities stems from the WHO Making Pregnancy Safer programme and the government policy of Healthy Indonesia 2010 with a focus on community empowerment.

CURRENT MATERNAL HEALTH SITUATION IN INDONESIA

In the five years preceding the 2012 Indonesia Demographic and Health Survey (IDHS), coverage in several aspects of maternal health had improved. Out of every 25 pregnant women surveyed, 22 reported to have made four or more ANC visits, and 90% received ANC by a skilled health provider, defined as an obstetrician or gynaecologist, doctor, nurse or midwife. The proportion of births assisted by a skilled provider increased to 83% in 2007, with nearly two thirds (63%) taking place in a health facility and 80% receiving PNC within two days of delivery. These are promising improvements from the figures found in the 2007 IDHS. Nevertheless the high MMR suggests poor maternal health compared to other East Asian countries with similar GDP per capita, and action is needed to achieve the objectives of MDG5 and the Indonesian strategic health plans [7].

OBJECTIVES OF DESK REVIEW

The *Puskesmas* health care system has shaped Indonesian maternal health services. As part of the REACHOUT consortium activities we performed a country desk review with a focus on the contribution of CTC providers to the provision of effective, efficient, and equitable health care in Indonesia, and identification of health system factors, intervention design factors and contextual factors and conditions that form barriers to or facilitators of the performance of CTC providers and services.

Specific objectives were to:

- identify the type of CTC providers and their role in the maternal health programme;
- identify existing evidence and knowledge gaps on what works and does not work for CTC providers, and use it for planning the qualitative component of the country context analysis;
- identify health system, intervention design and contextual factors that form barriers to or facilitators of the performance of CTC providers and services; and

- synthesize evidence on key barriers and facilitators to be built on in future improvement cycles of CTC services.

METHODS

Database searches: The information for this review was gathered using a PRISMA statement as a guide and through searches in PUBMED, ISI Web of Knowledge and GOOGLE. In addition, theses, books and individual references identified from publications were also used. We also searched the UNCIEF, UNFPA, USAID, WHO and World Bank websites for reports and collected grey literature including official reports from government and non-government organizations through personal contact.

***Search terms*:** A broad search was undertaken initially, applying sub-headings and truncations. The search was refined later using MeSH (Medical Subject Headings) terms in various combinations and Boolean operators such as 'AND' and 'OR' and key words such as 'allied health personnel', 'paramedical personnel', 'community health worker/s', 'community health aide', 'village health worker/s', 'TBA', 'village midwives' '*kaders*' '*Puskesmas*' and '*Posyandu*' combined with 'Indonesia'.

***Selection criteria*:** Titles were scanned, and abstracts of titles considered relevant to the objectives were reviewed and retrieved to obtain the full text. All electronically selected references were downloaded and managed for citation in Endnote-X3. Both English-language and Bahasa Indonesia articles and documents from 2003 to 2013 were used. This period was chosen to limit the large amount of literature on the broad topic and assuming that systemic reviews would cover information prior to 2003.

Search results and topics included for information synthesis: The initial online search yielded 2047 articles. After removing duplicates and screening for title and abstract, we finally narrowed it down to 26 published articles. In addition, we used relevant reports and other grey literature. To synthesize information, we used the following topic guides in the framework developed by REACHOUT:

- the type of CTC users and their role;
- the performance and impact of CTC providers and services; and
- health system, intervention and contextual factors.

MAPPING OF CTC PROVIDERS

In addition to the literature searches, in each study district we also had a face-to-face meeting with the maternal health section of the DHO and obtained their input in identifying the

maternal health CTC providers and their responsibilities. The main CTC providers of maternal health are shown in Table 2.

Village midwives (*bidan desa*) are salaried health workers, responsible for providing services at village level. Their role involves carrying out ANC, outreach care and providing safe delivery within a health facility and at home, postnatal checks, immunization and other tasks as assigned by the DHO. As village midwives may be the only health provider in a village, their roles expand to other tasks including providing general medical care to adults and elderly people, visiting schools for public health programmes, visiting houses for environmental public health programmes and providing family planning. Two grades of midwives exist at village and community health centre level. Permanent government employees are formal civil servants (*bidan desa pegawai negri sipil*) who mainly work in the *Puskesmas* and provide assistance in the *Posyandus*. These workers undergo three years of formal training at a nursing academy, along with additional training from the district where they are posted (although this is not uniform and does not happen in some districts). The other category is contracted midwives (*bidan desa pegawai tidak tetap*), mostly based at village level and employed on a contractual basis. They are responsible for providing outreach care and home births. They were trained in the 1980s with a one-year training, and some are still in post today. There are also unpaid apprentice midwives. Unlike CHWs in many settings, village midwives are not expected to come from the community in which they work.

Midwife coordinators manage and supervise village midwives at the *Puskesmas*. They ensure the effectiveness of the midwife programme and that it is carried out according to the minimal service standards, which includes the provision of at least four ANC visits for pregnant women, management of obstetric complications by a trained midwife, coverage of pregnant women assisted by a skilled attendant, coverage of three PNC visits for each woman, and management of neonatal complications.

Community health volunteers, known locally as ***kaders***, are non-salaried and work closely with the village midwives guided by the midwife coordinator. They are responsible for covering a village of 200–1500 people, although some villages may have more than one *kader*. Their primary role is to organize the monthly *Posyandu* and assist village midwives with *Posyandu* activities. *Posyandu* activities are community-driven and held in the village to provide maternal and child health care, family planning, immunization, nutrition education and, in some areas, distribution of supplementary food to babies. Services for elderly people have recently been integrated. The *kaders*' role in the *Posyandu* is to conduct registration, weigh children under five years of age and pregnant women and fill in the record book, provide health and nutritional counselling and give additional food supplementation and help the midwives with family planning services [8]. They are also expected to identify and report

pregnant women in their village, informing them of the *Posyandu* day and reporting malnourished children. Recently they have also taken on a role in referring women to health facilities for delivery.

Traditional birth attendants **(TBAs)** are informal workers, and it is accepted that they provide an important service to pregnant women. Their roles and integration with public services vary according to geographical location and the extent of traditional practices. They attend home deliveries, partner with midwives to increase coverage of skilled birth attendance, and provide massage and psychological support to pregnant and labouring women. The role is typically an inherited one, with community acceptance being important. Training of TBAs is variable, depending on the district programme. They do not receive a salary, but are typically given gifts in kind (such as rice or chicken) by the community. They receive incentives from the DHO when pregnant woman are referred or brought to deliver in a health facility. They typically cover one village.

FINDINGS

INTERVENTION AND DESIGN FACTORS: HUMAN RESOURCES

Education and training of midwives and *kaders*

Midwifery training: In 1989, with the initiation of the VMP, the government started the basic nursing plus one year of midwifery training programme (D1 midwifery). This programme was changed to the three-year midwifery diploma (D3 midwifery) in 1998. The full syllabus includes a range of theoretical and practical work. Prior to these programmes there used to be a one-year midwifery programme after completing junior high school. In 2009 across the country there were 93,889 midwives trained under all the three programmes, and a ratio of 13.8 midwives/nurses per 10,000 population [9, 10].

Permission to practice/licensing: Midwifery is recognized as an autonomous profession, and a licence is required to practise midwifery. Under government regulations, once licensed, midwives are authorized to prescribe life-saving medications, and private practice is permitted. The Provincial Health Office (PHO) issues a licence to nurses or midwives on the basis of their graduation certificate. There is no licence renewal system and no compulsory continuing education that could assure standards for licence renewal. In addition, there is no central register of all the registered midwives/nurses; thus, accounting for the total licensed workforce is difficult.

Table 2. Types of CTC provider, work location and role in community

CTC provider	Employment type	Place of work	Role in community
Midwife coordinator	Government civil service	*Puskesmas*	Coordinates work in *Puskesmas*; supervisory role of village midwives
Midwife (*bidan di desa pagawati negeri sipil*)	Government employee, permanent	Mostly in *Puskesmas*, sometimes in village clinic or *Posyandu*	Assists in homebirths, ANC and PNC
Midwife (*bidan desa pegawai tidak tetap*)	Contract-based	Village-based, often in *Polindes*	Midwifery care; general health care; organizes *Posyandu*
Nurse	Government employee	*Pustu* sometimes village-based	General health care; may provide midwifery care in emergencies
Posyandu kader	Health volunteer	*Posyandu*	*Posyandu* activities; weighing of infants; health promotion: nutrition advice and diarrhoea control
Family planning *kader*	Active in the 1980s, no longer separated from *Posyandu kader*		
TBA (*dukun/paraji terlatih*/trained)	--		Attends home births; provides referrals; culture-based care
TBA (untrained)			Attends home births; culture-based care

Continuing education and training: The DHO holds several refresher/in-service training courses. These include a 10-day training on Basic Emergency Maternal Obstetrics and Neonatal Care (BEMONC) and a five-day training on normal delivery management and how to identify risky deliveries. In addition, midwives also receive five days of training on child health asphyxia and a follow-up visit from trainers after three months. These training courses are held infrequently, vary between districts and are not required for promotion. There are no available studies on the content or gaps in the training curricula or associated deficiencies in the skills and competencies of midwives.

Kader orientation and training: The *Puskesmas* is responsible for orienting *kaders* to the activities carried out in the *Posyandu*. A week of training is held on the tasks they perform, such as weighing babies and mothers and keeping records. No formal training or supervisory

system is in place, and there is no formal curriculum for *kaders;* rather, it is just orientation, and village midwives are expected to check their work. There is no specific training on communication about the benefits of ANC, calculating last menstrual period or identifying risky delivery. The *kaders* attend the monthly meeting at the *Puskesmas* to present the registry records, which are checked by the midwife coordinator and sometimes used to assess their performance.

RECRUITMENT OF MIDWIVES AND *KADERS*

***Midwives*:** Once their licence is issued, midwives can work in the *Puskesmas* or in health posts on contract or as permanent civil servants. Following the decentralization process, the DHO is responsible for recruiting nurses and midwives in their district. Village midwives are recruited mainly on contracts of one to three years (PTT). These contracts can be renewed twice, after which the midwife is eligible to become a civil servant or continue with private practice. Permanent civil service positions are announced by the central government, and staff are recruited if they pass the special civil service examination. Whether midwives are recruited on a contract basis or as civil servants, there is no clear job description provided at the start of their employment. There is also no clear-cut job differentiation based on whether they follow the D1 or the D3 programme, which limits performance assessment.

***Kaders*:** Typically a *kader* is expected to have basic literacy and school certification to function as a health volunteer. Their selection is conducted during a special meeting that invited community leaders and elected community members attend. The invitation is prepared by the *Puskesmas* and signed by the head of the village. The selection is conducted according to consensus agreement of the meeting attendees [8]. Names suggested by the community leaders and village midwives are considered during selection.

An earlier study that examined the role of family planning volunteers in three districts (West Java, Central Java and Yogyakarta) described that elite women with social status in the community, such as teachers and wives of government officials, were often identified to become family planning volunteers [11]. The selection of women with social recognition might have had important implications to make the programme effective in a traditional society which required behaviour change. However, social hierarchies may also hinder community participation and effectiveness. In India it was reported that volunteers from a very different social status from the target group may hinder the communication and effectiveness of a CHW programme [12]. The influence of social hierarchies is complex and needs to be placed in a specific context to allow for feasible interventions, as a study in northern Nigeria showed[13].

WORKLOAD

At the outset village midwives (VMWs) were placed to provide midwifery care to the village community. Several project-based studies indicate that VMW delivery services might be underutilized and vary across the country. For example, on average a midwife could attend fewer than four deliveries a month outside Java and Bali and approximately double that in Java and Bali [14]. Another study indicated that utilization of midwife services increased proportionately with the length of time they lived in a village: a significant increase was found if a woman lived in a village for more than five years compared to one year, reflecting that community trust in the midwife influenced the use of their services.

Midwives spend on average 10 days per month doing village-based clinical work in their assigned village. In remote areas they spend seven days per month — significantly fewer than the 20 days spent in urban areas. An assigned provider who is resident in her village of responsibility spends a median of 20 days of clinical work there, irrespective of the location of the village [15]. Assigned midwives who are not resident spend less than half the number of days on village-based clinical work, although this differs significantly by location.

Their services have expanded over time outside midwifery, particularly in situations where they are the only health provider in the village. They now provide childhood immunization, family planning services and general curative care including care of elderly people [15]. There is no system to measure the overall utilization of the VMW service.

DISTRIBUTION AND RETENTION OF VILLAGE MIDWIVES

The government policy is to place one midwife in each village, although sometimes one midwife could be responsible for more than one village. The midwife assigned to a village might be village-based or could be a health centre midwife assigned to a village to take responsibility for *Posyandu* activities. Although great progress has been made in the deployment of the midwife workforce, disparity exists between urban and rural areas in the distribution of midwives, with a wide variation between districts and provinces. In 2005, nationally 40% villages had a midwife, yet in some districts the figure was less than 10% [16]. A recent study in two districts in eastern Indonesia found that nearly a third of the villages had a resident midwife, and half had a visiting midwife. Reports have also indicated differences between the distribution of public- and private-sector midwives, although the distinction between public and private is not clear in Indonesia, since a midwife employed in a health centre could also have a private practice. The World Bank showed that the number of health centre midwives decreased to 3.7 per 10,000 population in 2007 from 5.8 in 1997, and attributes this shift to a 158% increase in midwives going into private practice in that period [17].

The midwife density is associated with the level of skilled birth attendance. The density of midwife distribution varied across the country, with the lowest ratio of 8.9 per 100,000 population in Banten province and the highest ratio of 74 per 100,000 population in Papua. A study conducted in Serang and Pandelang districts in Banten province found that in a village with 2–4 midwives per 10,000 population one in three women gave birth with a health professional, and this increased to two out of three women in villages with 6 or more resident midwives per 10,000 population [18]. Once adjusted for confounding factors such as distance to facility, midwife density was not significant, but, interestingly, there was an association between midwife density and uptake of caesarean sections. The explanation for this was that midwives recognized complications and the necessity for referral and transfer to hospital, thus improving access to emergency obstetric care.

Retaining midwives in their assigned villages and placing them in rural and remote areas is one of the biggest challenges faced by the government. A study conducted by Ensor et al. in Banten province highlighted that midwives were reluctant to move from their family village and demanded high pay to move to remote places. For example, if they were to move to a village one hour away, they demanded double their public salary, or triple salary for a distance of five hours from their place of residence. One of the common reasons for midwives' reluctance to move to remote places was family. The same study stated that more established midwives were reluctant to move, whereas younger midwives were more likely to move. Another study done in 2008 in Ciamis, Garut and Sukbumi districts in West Java found that 30% of midwives had moved to another location within 12 months, although 40% of them stayed within the public health system. Some characteristics found in those who moved were younger age, qualification with D3 midwifery and the length of time in the village being less than five years. Makowiecka et al. suggested that the demands of the job and professional isolation lead to the high turnover rate in more remote areas.

SALARY AND INCENTIVES

Midwives in Indonesia commonly supplement their salaries through private practices, even if they are on salaried civil service. One study conducted in Banten province found that midwives obtained almost two thirds of their income from private clinical practice [19]. The 1998 Indonesian Midwifes Association recommendation allowed only D3-trained midwives to have a private practice. This policy was relaxed, and, as an incentive to retain midwives in remote areas, private practice is permitted even during contract years. Income varies between districts and between rural and urban locations. Even though in remote areas the income of the population is low, midwives capture a sufficient number of women to generate an adequate income.

The World Bank (2010b) stated the difficulty of accurately quantifying the income generated by midwives. In 2007, under the MoH Regulation No. 508.2007 a midwife could earn IDR2.5 million (US$208) per month in remote areas. The basic salary varied depending on contract status, whereas the income generated privately is closely related to the years of experience since certification. The income generated from private practice for the more experience midwives could account for more than two thirds of their salary. There is also a difference in annual salary between central-level contracts (US$1179) and local-level contracts (US$1072) [20]. The base salary comprises 79% of total earnings, while the rest is earned through bonuses and reimbursement from insurance schemes such as Askeskin and Jamkesmas. Studies that looked into the VMW incentive schemes showed that allowing private practice as an incentive to retain midwives in remote areas could restrict access to skilled birth attendance for rural women who cannot afford midwives' fees [21].

The *kaders* receive IDR50,000 (just over US$4) every three months as an incentive provided by the DHO for their voluntary work, together with a uniform T-shirt (personal communication with the Section Head for Maternal Health, DHO, SW Sumba). In addition they also receive financial incentives from the village office.

SUPERVISION

An adequate supervisory scheme is important to ensure the quality of care and work output. Information on the VMW programme's supervisory system was limited, although we managed to obtain information from the Section Head for Maternal Health at DHO, SW Sumba, on the supervisory system (verbal communication). Overall supervision not specific to VMW is conducted twice a year by a five-member team using a checklist. The members of the team are the Head of the DHO or a designate, Head of Family Health, Head of Public Health and Head of Maternal and Neonatal Health. The midwife coordinators directly supervise the VMW, and they in turn supervise the *Posyandu kaders*. A coordination meeting is held three times a year with all the VMW coordinators at district level and each month in each sub-district at the *Puskesmas* with VMWs and attended by *kaders*. The monthly meeting mainly covers the activities in the *Posyandu* and records of the number of pregnant women in the village and deliveries that occurred in the preceding month. A report that looked into service quality states that a quality improvement approach for the technical supervision of midwives/nurses is lacking. Since there is no standardized supervisory system, the quality of supervision varies, and it does not support capacity strengthening or motivation of midwives/nurses. The few studies that described the supervisory process reported it as weak [16, 17, 22]. One report stated that this weakness is recognized by the government and that efforts are ongoing to formulate a better structured supervisory process.

MONITORING AND EVALUATION

Similar to supervision, information on monitoring and evaluation (M&E) is limited. The reports that are available suggest that M&E is poorly structured. The World Bank (2010b) states that in the Making Pregnancy Safer programme the MoH outlines a renewed emphasis on M&E and collecting data for planning purposes. Currently at district level the data presented in the monthly meetings at the *Puskesmas* described above are sent as an activity report to the DHO and are used for M&E purposes. However, this does not encompass an M&E and feedback mechanism on the coverage and performance of the roles and tasks of the health care providers.

A satisfactory health information system is yet to be developed and is being planned. Data collected at health facilities are poorly collated, and private providers do not participate in the system, which means that nearly 50% of providers' information is not collated. At *Puskesmas* level, although data are collected, they are poorly integrated.

PROGRAMME AND HEALTH SERVICES

UTILIZATION OF ANTENATAL SERVICES

ANC is a strategy which aims to improve maternal health through the early identification of risky pregnancies. WHO recommends a minimum of four ANC visits during pregnancy. The IDHS 2012–2013 reported that 80% of women made four or more ANC visits during their pregnancy [5]. A mother's educational level and economic status was positively associated with ANC attendance and the components of services received. The MoH recommends that ANC services include: height and weight measurement, blood pressure assessment, provision of iron tablets, tetanus toxoid, abdominal examination, blood and urine testing, and providing information on signs of pregnancy complications. Women who were pregnant for the first time were informed more often of preparations for delivery and complications related to pregnancy, and this decreased as the number of pregnancies increased. One study identified distance to health facility, mothers reporting no obstetric complications during pregnancy, residents of rural areas, low household wealth index and low maternal educational level as factors for under-utilization of ANC services [23, 24] .

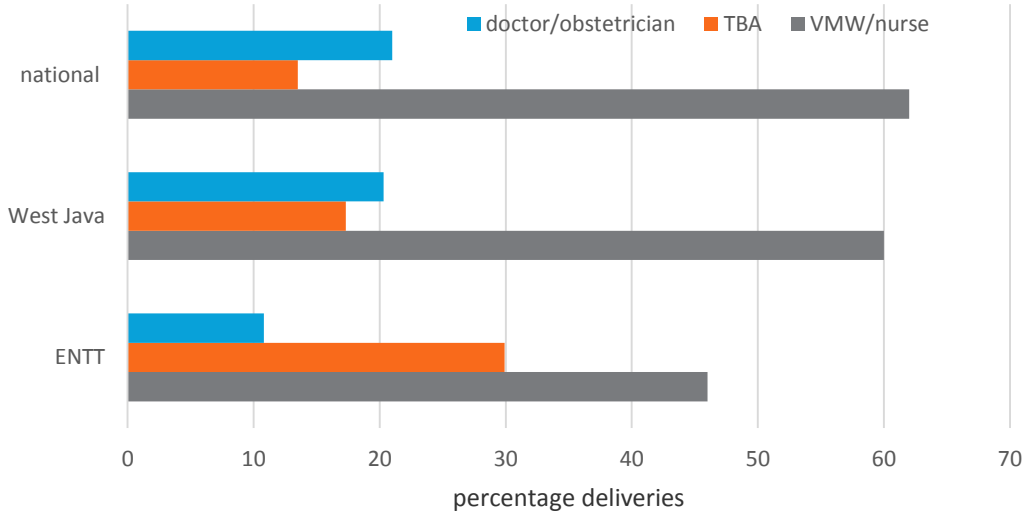
TYPE OF HEALTH PROVIDER USED FOR ANTENATAL CARE

The VMWs are at the forefront of the maternal health programme in Indonesia. This is clearly evident by the fact that 75% of ANC services are provided by a midwife, nurse or VMW, whereas 19% are provided by an obstetrician (IDHS, 2012). As expected, the type of service provider differed between rural and urban areas and based on the mother's level of education and wealth. Overall the number of instances of a physician/doctor providing ANC is low.

UTILIZATION OF SKILLED HEALTH PROVIDERS AT DELIVERY

Indonesia has made progress in increasing the proportion of deliveries attended by skilled providers. The IDHS 2012–2013 reported that 83% of deliveries nationally were attended by skilled providers. The numbers are lower in the two provinces of our study districts: East Nusa Tenggara and West Java (see Figure 2). The increase in the proportion of deliveries attended by skilled providers indicates the success in shifting TBA care to skilled providers. However, there is huge difference in the use of skilled providers between districts, between remote rural and urban areas, and by distance to a health facility. For example, the IMMPACT analysis showed that 66% women delivered with a skilled attendant when their village of residence was close to the hospital (<5km), whereas only 9% of deliveries were attended by a skilled provider when the village was more than 60km from a hospital [25].

The ongoing use of TBAs is considered to contribute to the high MMR. A study conducted in 2009 in Cianjur district in West Java showed that out of 85 maternal deaths reported for 2008, the majority occurred in women assisted by a TBA.



date source: IDHS 2012-2013

Figure 2. Percentage of deliveries assisted by skilled providers and TBAs in West Java and ENTT province

A study in six districts of West Java found that many women thought that skilled attendants and health facility deliveries were for women with complications in pregnancy. The other reasons cited were physical distance, financial constraints and limited availability of health care providers in the village. A UNICEF report indicates that cultural comfort provided by the TBA, including the traditional massage, is the main factor for preferring TBAs. There are differences between districts in the use of TBAs; as expected, their use is higher in areas where there are fewer skilled providers. Some of the other factors that predispose home

births are older and higher gravidity status, and Muslim religion. However, not all older women prefer home births; some older mothers had a preference for trained providers [26].

Several approaches have been tried to reduce the use of TBAs. One approach was to build a partnership between TBAs and midwives after a pilot programme in Sulawesi by UNICEF. Under this approach the cultural importance of TBAs is accepted, and TBAs are given the chance to assist with traditional practices and be present at delivery to give the women psychological support, while delivery was conducted by the midwife. The TBAs also receive a financial incentive when they refer a pregnant woman to the midwife or health facility. A second approach that was initiated was to get children of TBAs to join the midwife programme. The evaluation of the pilot programme in Bogor, West Java, by UNICEF found that children of TBAs did not have the basic qualification to join the programme, and it was discontinued. In the efforts to make the transition from TBAs to deliveries attended by skilled providers a success, the government has ended the skills training provided to the TBAs. The success of the transition from TBAs to skilled birth attendants is evident in West Java, where over 80% of deliveries were reported as being attended by TBAs in the IDHS 2007, and only 17% in the IDHS 2013 report. This might be a reflection that the national policy of the TBA–midwife partnership is working.

PLACE OF CHILDBIRTH

The government encourages facility deliveries and defines a *Puskesmas* with beds, private midwifery clinics and any hospital (private or public) as a health facility appropriate for delivery. Yet there is no formal policy on where women should deliver. Accessing health facilities, particularly in rural areas, is difficult in Indonesia. To overcome this difficulty and to provide suitable birthing facilities to rural women, *Polindes* (birthing huts) were developed at the time of the *Puskesmas* initiative. The *Polindes* is provided with basic equipment to conduct normal deliveries and with the facility for the midwife to reside there. This scheme has declined in recent decades, and may be taken over by maternal ‘waiting homes’. The Maternal Health Director was quoted in the *Lancet* (2012) as stating that the government was planning to open 2800 waiting homes where rural women can stay under the supervision of midwives near medical clinics [27].

It is common for women to deliver at home despite various efforts to discourage it. The difficulty to change this practice was indicated in a quote by the Director of Programming for the Indonesian Midwives Association: “many rural women saw birth as a natural process that family members could handle with assistance from the traditional healer” [27, 28]. Nonetheless, the proportion of home-based deliveries is decreasing, as reflected by the IDHS 2012 figure of 36% compared to 53% in the IDHS 2007 report .

Not all home deliveries are attended by TBAs, and the quantification of home deliveries should be approached with caution (some home deliveries are assisted by VMWs). The VMP allows midwives to attend deliveries in the home and is based on the concept that birth with a skilled health provider would reduce mortality. Despite high ANC attendance and the increasing proportion of births with skilled providers, the national MMR remains tenaciously high (IDHS, 2012). Interestingly, a study that analysed IDHS data between 1991 and 2002/3 found no significant differences in the first-day or early neonatal death rates when comparing home births with or without professional midwives. Its findings suggested a need for training in immediate newborn care and emergency referral [20].

Nusa Tenggara Timur (NTT) is one of the provinces with a high MMR (306 per 100,000 live births) (IDHS, 2012). To address the issue, the government of NTT, supported by AUSAID, introduced the Revolusi KIA programme (Revolution of Mother and Child Health) in 2010.

Figure 3. Billboard displaying the points of Revolusi KIA in Waitabula, SW Sumba

The programme stresses four points:

- a minimum of four ANC visits;
- mothers to give birth at a health facility;
- delivery is assisted by a skilled health care provider; and
- follow-up after delivery (PNC).

The motto seen on the Revolusi KIA billboard put up in SW Sumba (Figure 3) states "*cannot go home only one or none; the mother is healthy, and the baby is safe"*, stressing the importance given to improving maternal and newborn health. Facility-based delivery is

strongly emphasized in the programme, and to implement it, VMWs are no longer allowed to assist home births. In a community where women were used to seeking a midwife's assistance during home births and where home birth is common, the impact of Revolusi KIA is yet to be seen.

Preference for a TBA and place of birth all play a role in the delay in seeking professional care. A study conducted in Serang and Pandeglang, two districts in West Java, showed that delay in seeking professional help contributed to the high MMR, even though women were attended by skilled providers, and maternal mortality was more common in women in the lower wealth quintile [18, 29]. Midwives and nurses are deployed to serve rural communities, but many lack the experience and skills needed for the work required of them [10]. Attendance by a skilled birth attendant may still cause a delay in referral when complications occur.

REFERRAL SYSTEM

According to government policy, the first point of referral by a VMW is to the *Puskesmas,* which could provide basic emergency obstetric and neonatal care (BEONC). Ideally, services provided by a BEONC *Puskesmas* include vaginal delivery assisted with vacuum extraction, equipment for handling incomplete abortion and or manual removal of placenta and a supply of drugs for BEONC. The next level of referral after *Puskesmas* is to the district hospital, where comprehensive emergency obstetric and neonatal care (CEONC), including blood transfusion and surgical care, is available. At village level the first referral for obstetric care is from a TBA or *kader* to the VMW.

Several studies have highlighted shortcomings in the referral system. Only 30% of all the *Puskesmas* nationally have in-patient beds, and of these only 22% are equipped to provide BEONC. The CEONC services are irregular in the hospitals, although the majority have had CEONC. Other limitations of the system were comprehensively outlined by the World Bank [14] as follows:

- delays in making referral;
- referral to a facility that is not equipped to deal with BEONC;
- multiple referrals;
- refusal to act on the referral on the part of the family;
- the accepting provider hospital does not have the necessary skill level to determine the nature of the emergency;
- midwives are not usually present in the hospital emergency rooms;
- *Puskesmas* doctors have not implemented the appropriate procedures for stabilization; and
- standard protocols for dealing with maternal emergencies are scarce.

A 2012 publication that assessed the quality of and access to emergency obstetric care through critical incident audits conducted in two rural districts in Java found that families were often unprepared and uninformed of obstetric complications, and when it occurred, often care was unaffordable and unavailable [30, 31]. VMWs facilitated referrals, but they were not always present in remote and rural villages, emergency transport was frequently unavailable, and private transport was unreliable and incurred costs.

PNC is important, as most maternal and neonatal deaths occur in the first two days after delivery. Yet management of peri-partum emergency care is less well defined, and literature from Indonesia is scarce. The current postpartum policy expects midwives to observe a woman for two to six hours following delivery. A study that analysed deaths in the antepartum and postpartum period found that two out five women died in the first 24 hours of delivery . It is clear that two areas that need to be addressed to improve maternal health are emergency obstetric care and a practical, affordable and timely referral system.

HEALTH EXPENDITURE AND HEALTH INSURANCE

The spending on health through the national budget is low in Indonesia. UNICEF (2012) and the World Bank (2010) showed that 2–2.6% of GDP is allocated to health, which is low in comparison to other East Asian countries and globally. Another shortcoming cited by the reports were the delay in receiving the funds at district level and that the Special Allocation Fund (DAK) for health constitute less than 1% of the total local government budget. The low budgetary allocation has been suggested to contribute to the poor quality of care at public health facilities. The World Bank report showed that excessive reliance on a central budget for maternal and newborn programme implementation, inefficient channelling of allocated funds, low absorption of funds into the provincial and district budget and limited ownership at district level were some of the issues that contributed to poor programme structures [14]. Indonesia has made great progress in its commitment to provide universal health insurance coverage. In recent years several schemes have been put in place, including the Universal Coverage of Social Health Insurance in Indonesia which started on 1 January 2014. Other schemes are *Jamkesmas*, an insurance scheme for poor people at central level, *Jamkesda*, a scheme for poor people at provincial and district level, and *Jampersal*, which covers universal delivery care. The *Jampersal* scheme, which uses a direct payment method, started in early 2011 and covers delivery care, including ANC and PNC consultations. The total delivery package includes IDR420,000, including IDR350,000 for delivery, IDR40,000 for four ANC visits and IDR30,000 for three PNC visits.

There is a fee for the maternal health scheme, and it varies between provinces and the class of service. Indonesia classes its hospitals, and the allocated cost for a normal delivery is US$70

in Class C hospitals and US$154 in Class A hospitals. The average cost of a normal delivery in a Class C hospital was found to be US111, which is more than the cost allocated by the local government for a normal delivery.

The effect of health insurance on the use of skilled birth attendants was evaluated and cited by the World Bank (2010b). It found that, among households in the lower three deciles, 67% with *Jamkesmas* used a skilled birth attendant, compared to 71% among households without any health insurance. Although the *Jamkesmas* scheme was introduced to ensure that poor women had access to maternal health care, many barriers exist [14, 20, 22, 32]. First, women are unaware of the eligibility and benefits of the scheme. Second, reimbursement is insufficient, and the scheme does not cover the cost of transport to attend the health facility. Third, midwives are uncertain about reimbursement for their services, particularly for referring women to hospital and when the referred woman delivers in the hospital. This has negative repercussions for referral and transfer of women for obstetric complications. The uncertainties behind the insurance package, therefore, discourage women from seeking care at a health facility using the insurance scheme.

EFFECT OF DECENTRALIZATION

With the decentralization of the public sector in 2001, Indonesia shifted the management of maternal health care to the district level. Among the challenges and disarray that came with it, one of the programmes that suffered was the family planning programme. The BKKBN was previously responsible for the family planning fieldworkers. With the merging of their offices with other sectors, several of the family planning workers were moved, and the quality of the programme activities deteriorated.

The central-level support for the VMP ended in 2007 with a new policy that midwives should be transferred to the local district staff or stay in their assigned villages but earn income from private practice. A study by Heywood (2010) states that salaries and conditions of hiring and firing were under the control of the central government, although public-sector staff were transferred to district level[1]. Their work also evaluated changes in the utilization of maternal and child health services in 10 districts since decentralization and found no marked improvement in the services between 2003 and 2007. However, what was evident was a dominance of the private sector in providing ANC and delivery services. Another study that looked into the quality of health services since decentralization highlighted that there was a lower level of accountability and that the district level was poorly prepared for planning and implementation, with a lack of skills and trained staff [1]. The decentralization also negatively impacted the health information system due to a lack of coordination and integration of district and central data.

DISCUSSION

Our review of the literature on CTC providers in Indonesia found that the majority of studies were on VMWs and the VMP. An explanation for this could be that Indonesia gave high priority to the programme, with a target of one midwife per village to improve maternal health. However, this emphasis overlooked the work of other functional personnel in the maternal health programme. There were commendable achievements in the contribution of VMWs to the increased use of skilled birth attendance and as the main providers of ANC. It also highlighted that the health-seeking behaviour of this society was changing.

The placement of midwives in the villages benefited the poorest quintile, with a higher proportion of women receiving skilled care; however, not all women received skilled care, as the majority of women delivering at home without the attendance of a skilled provider were also from the lower income quintile. The factors that influenced the uptake of skilled provider assistance in rural areas were education, distance to health facility, and the midwife's experience and years of residence in the village.

The community health structure is based on the *Puskesmas-Posyandu* system, with its emphasis on health promotion and prevention. One of the most prominent CTC providers in the community are the *Posyandu kaders,* who play an active role in propagating the *Posyandu.* They are the front-line CTC providers who make an important link between the community and the health system. Surprisingly, their function has not been fully explored. Few past studies provided information on the family planning *kaders*, whose activities have declined in recent times.

Home births and the influence of TBAs are dominant in the local culture. A general notion was that the high MMR was related to the use of TBAs. Deliveries assisted by the TBA are on the decline, reflecting that the transition efforts from TBAs to births assisted by skilled providers are working. One of the leading issues why TBAs are preferred is that midwives are not always available in their assigned village. The partnership between midwives and TBAs shows potential for addressing the TBAs' preference for a combined use of TBAs and midwives.

While great attention is paid to decreasing maternal mortality, the limited training of midwives and limitations in emergency obstetric care stand out as important factors that need to be addressed. Other influencing factors have been studied and identified. At national level, it is important to understand the dynamic of human resources and financial policy, and its effect on the delivery of services, as well as the insurance system and the dominance of private practice. At district level, with decentralization, it is important to ensure that the broadened authority is used to increase the quality of services, rather than the opposite. At community level, barriers were identified.

Although the health infrastructure is well laid out for mother and child health, and the community strategy well documented, many challenges persist. There is a lack of management skills and central data collection as well as interruptions in services at the community health facilities. Since decentralization, the division of responsibilities has been unclear. Together with poor referral systems, poor M&E and unclear job descriptions hamper the quality of care [16]. Incentives for VMWs need a more coordinated approach[19].

CHAPTER 3 – STAKEHOLDER MAPPING

CTC STAKEHOLDER MAPPING

The MoH is a key player and an important focus for REACHOUT to generate ownership of findings and support for implications. Communication through formal presentations and informal meetings are considered the best type of approach. Face-to-face communication provides the opportunity to seek clarification, validate findings, discuss implications and develop solutions. This approach has led to interactions between REACHOUT staff and the district-level Maternal Health Department, which is enthusiastic and supportive about the research project.

There are a number of health- and non-health-related stakeholders which influence the development of policy within Indonesia. In addition, there are many donor agencies which set agendas, such as WHO, UNFPA, JHEIPIGO, AUSAID and NGOs. The media also plays an important role. Stakeholders within the formal government structures include the MoH (and the Health Minister), PHOs and DHOs. The Director of Maternal Health at the Maternal Health sub-directorate of the MoH is a key figure in formulating maternal health policies nationally. At PHOs and DHOs the heads of the Division of Maternal Health plan and implement health policy. At the sub-district level, influential people and bodies for maternal health include the *Puskesmas*, the heads of the primary health centres and the midwife coordinators. Across all levels the Indonesian Midwife Association exerts influence on midwives' work.

Outside the health sector, non-health-related influencers include: the heads of districts (*Bupati*), district secretaries (*Sekda*) and heads of sub-districts. The heads of villages (elected) and the heads of Family Welfare Guidance (PKK) and the National Programme for Community Empowerment (PNPM) at district, sub-district and village level are influential particularly in the village integrated health activities (*Posyandu*) and with village health volunteers (*Posyandu kaders*). The regional development body (BAPPEDA) at the district level and the national family planning coordinating body (BKKBN) are also organizations with which REACHOUT should engage. At sub-district and village level, the village elders, traditional healers and religious leaders play a role in influencing maternal health. Some local religious NGOs at sub-district level are active bodies that could align with REACHOUT.

INTEREST AND ALIGNMENT OF STAKEHOLDERS

The assessment of stakeholder interest and alignment was carried out using the grid matrix shown in Figure 4. The coloured grids show each stakeholder's level of interest according to their respective roles and responsibilities. The MoH at national level is engaged in policy development and budget allocation. It also makse decisions regarding the provision of services and allocation of budget and staff salaries. The PHO supports the health system and

policy implementation and the employment of staff for the VWP. The DHOs work closely with the PHOs in carrying out programmes and the recruitment of staff and functioning of the *Puskesmas* and related health sub-facilities. The PKK and the PNPM are responsible for the health volunteers (*kaders*) and the functioning of *Posyandus*. The village office and the community are influential in the *Posyandu* function and activities. The United Nations bodies support the government in policy development and programme implementation. The District Planning Board is responsible for the construction of facilities.

Figure 4. Interest and alignment matrix

Alignment with the project	**High**	• Heads of village s • Custom leaders • Community leaders • Community health centres • Local NGOs	• Family Welfare Guidance (PKK) • Provincial Health Office (PHO) • Ministry of Health (MoH) • District Health Office, Maternal Health (DHO)
	Low	• Religious leaders • Caregivers • Traditional healers • Head of Sub-district • Head of District • District Planning Board (*BAPPEDA*) • Head of Province • Midwives' private practices • House of Representative at district level (DPRD)	• UNICEF • WHO • PNPM • Other NGOs
		Low	**High**
		Interest in the project	

OUTCOME AND STAKEHOLDER ENGAGEMENT

High interest and alignment (green quadrant): The organizations in this quandrant are those whose roles have a high level of alignment with and interest in our project. We should advocate with the MoH in Indonesia by involving it from the beginning of the research, so that results can be adopted as part of the existing national programme. Once the MoH adopts policy, it is implemented by PHOs and DHOs.

Low interest, high alignment (blue quadrant): Village, community and custom leaders are influential in the community but are less engaged in maternal health. Their interest is sought to strengthen community-level maternal health care. The village head has the authority to provide appropriate facilities to CTC providers for holding *Posyandus*. The *Puskesmas* play an

important role as a technical advisor and should become a leading actor in supporting and empowering CTC providers to overcome maternal health issues.

High interest, low alignment (pink quadrant): United Nations agencies are interested in supporting the Indonesian government to develop programmes for improving maternal health care and as such interested are in the performance of CTC providers and the factors that influence it. They can play an important role in sharing information and lessons learned and assist in influencing policy based on the findings of the study.

Low interest, low alignment (grey quadrant): Religious leaders are useful in raising the community's awareness of the importance of CTC providers at the community level in strengthening maternal health care. They are important, together with community leaders, to disseminate the results of the research. Heads of District, Province and District Planning Boards are willing to allocate some budget into regional budgets, to improve the skills and capacity of CTC providers; produce local regulation to support their sustainability; incorporate some activities related to CTC providers into regional medium-term development plans (RPJMD); and improve awareness at the House of Representatives at district level as a policymaker that development is not merely infrastructure but also building the capacity of human resources that have direct interaction with and an impact on the community.

Implications

Communicating with stakeholders is a priority and has strong implications for the success of REACHOUT activities. We identified strategically placed persons such as MoH officials and United Nations agencies and selected them to be members of the Country Advisory Group. District health officials who falls into the high interest and high alignment category have been approached in each district, and regular meetings are planned with them. NGOs with good alignment with REACHOUT will be invited to stakeholder meetings to discuss collaboration and coordination. For the community members with high and low interest a review of their engagement is planned, and they will be invited to monthly meetings during the quality improvement cycle. For the stakeholders with low levels of interest and alignment we plan a review to improve their awareness and encourage their engagement.

CHAPTER 4 – QUALITATIVE RESEARCH METHODOLOGY

METHODOLOGY

A qualitative design was used to explore the perceptions and experiences of the informants on the structure and policies of the maternal health system and the functions of CTC maternal health service providers. We further obtained the views of community members and mothers (women who had delivered in the past year) on the accessibility and responsiveness of health facilities to community needs and the quality of services provided at the health facilities and by the CTC providers.

Objectives

The objectives of the research were:

- to identify the contribution of CTC providers to the delivery of effective, efficient and equitable care;
- to assess the strengths and weaknesses of the health structure and policies on CTC services and the management of CTC providers; and
- to identify the contextual conditions that form barriers to and facilitators of the performance of CTC providers and services.

Data were collected using semi-structured interviews (SSIs) and focus group discussions (FGDs) to explore perceptions and experiences. Data were collected through SSIs with CTC providers (the heads of *Puskesmas*, midwife coordinatorsVMWs, village nurses, volunteers/*kaders* and TBAs), as well as with mothers, village heads, policymakers and managers (maternal health coordinators in DHOs). In addition, FGDs were conducted with VMWs and with mothers' support groups — i.e. husbands.

STUDY SITE SELECTION

We selected East Nusa Tenggara and Cianjur, two provinces with poor maternal health indicators and high MMR, following suggestions from the stakeholders and Country Advisory Group members. These two provinces are among five provinces which contribute to 50% of maternal deaths in Indonesia. In East Nusa Tenggara, SW Sumba was the district selected because of its high maternal death rate and the availability of infrastructure due to another ongoing research project. Cianjur in West Java was selected because of its poor coverage of basic health services and easier access from Jakarta, where the coordinating institute is based. Both are rural districts; however, rural settings in Java and outside Java vary widely in terms of socio-economic level, education and other indicators that are likely to reveal different factors influencing the performance of CTC providers. There other notable differences between the two districts are a predominantly Christian population in SW Sumba, a less dense

population and lower socio-economic level, whereas in Cianjur the population density is higher, and the population is largely Muslim. We describe the site and informant characteristics separately for the two districts.

SOUTH WEST SUMBA

Selection of sub-districts and study villages

In SW Sumba we selected two sub-districts, Radamata and Palla, and their respective *Puskesmas*. The selection of the sub-districts was based on health facility deliveries, geographical distance to Weetabula, the district capital where the referral hospital is located, and the ability of all the study informants to speak Bahasa Indonesia. Based on these criteria and the distance to the *Puskesmas,* we chose four villages for each *Puskesmas,* which is the first referral centre (see Table 3). A village between 1km and 10km away from the *Puskesmas* was considered near, and a village over 10km away (12–20 km) was considered far. In both *Puskesmas* areas, the near villages have a tarmac road up to the main road, with non-tarmac road access in some hamlets. In the far villages, the road and access conditions were more difficult. *Puskesmas* Radamata has better maternal indicators in terms of ANC attendance and facility deliveries and is nearer to Weetabula, while Palla has poorer maternal health indicators and is further away from Weetabula. The data on maternal health indicators for 2011–2012 were obtained from the Mother and Child Health section of the DHO.

Description of the study villages in SW Sumba

SW Sumba is a largely rural population (85%), and the villagers are engaged in subsistence farming. The characteristics of the study villages are provided in Table 4. The population of the villages ranged from 1300 to 4000, with the villages of Palla sub-district having a higher population density than those in Radamata. Palla has better access to clean water than Radamata. More schools with classes available from kindergarten up to senior high were found in the villages closer to *Puskesmas* than in far villages.

Table 3. Criteria for sub-district and village selection

Criteria for villages	*Puskesmas* Radamata	*Puskesmas* Palla

	Close to the district capital	Far from the district capital
Good, close to *Puskesmas*	**Ramadana** *Health facility delivery: 63%* *1km, tarmac road*	**Weepaboba** *Health facility delivery: 90%* *1km, tarmac road*
Good, far from *Puskesmas*	**Bondo Boghila** *Health facility delivery: 65%* *20km, tarmac and non-tarmac road*	**Wanotalla** *Health facility delivery: 89%* *12km, non-tarmac road*
Poor, close to *Puskesmas*	**Letekonda** *Health facility delivery: 41%* *10 km, tarmac road*	**Puupoto** *Health facility delivery: 53%* *7km, tarmac and non-tarmac*
Poor, far from *Puskesmas*	**Totok** *Health facility delivery: 48%* *15km, tarmac and non-tarmac road*	**Weenamba** *Health facility delivery: 37%* *~10km, tarmac and non-tarmac road*

Table 4. Descriptive characteristics of the selected villages in SW Sumba

Puskemas area	Village	Population number	Number of families	Main source of income	Population density (people/km^2)	Schools available				
						kinder garten	elementary school	junior high school	senior high school	Market
Radamata	Ramadana	2049	449	agriculture	146	2	2	2	0	0
	Bondo Boghila	1332	278	agriculture	39	0	3	1	0	0
	Letekonda	3595	839	agriculture	143	1	3	2	1	0
	Totok	2046	506	agriculture	140	1	1	1	0	1
Palla	Weepaboba	4017	657	agriculture	344	1	2	1	0	1
	Wanotalla	2026	414	agriculture	189	0	3	0	0	0
	Puupotto	1888	456	agriculture	203	1	2	1	0	1
	Weenamba	2100	384	agriculture	235	0	3	1	0	0

Source of population data : Village chief, based on the latest village survey
Source of area data: Sumba dalamangka 2012

Selection of study sites in Cianjur

The process to select study sites in Cianjur was similar to that described above for SW Sumba. We selected Ciranjang and Sindangbarang sub-districts, taking into consideration health facility deliveries and skilled birth attendants in the villages and distance to the district referral hospital. Based on maternal health data obtained from the DHO for 2011–2012, *Puskesmas* Ciranjang performed better and is located nearer to Cianjur, while *Puskemas* Sindangbarang had poorer indicators and was far from Cianjur. The selected villages with the proportion of health facility deliveries and distance to *Puskesmas* are shown in Table 5.

Table 5. Villages selected in Cianjur district and selection criteria

Criteria for villages	***Puskesmas* Ciranjang**	***Puskesmas* Sindangbarang**
	Close to the district capital	**Far from the district capital**
Good, close to *Puskesmas*	**Ciranjang** *Health facility delivery: 80.1%* *1km, tarmac and non-tarmac road*	**Saganten** *Health facility delivery: 74.25%* *300m, tarmac and non-tarmac road*
Good, far from *Puskesmas*	**Karangwangi** *Health facility delivery: 77.4%* *5km, tarmac and non-tarmac road*	**Jatisari** *Health facility delivery: 56.6%* *20km tarmac and non-tarmac road*
Poor, close to *Puskesmas*	**Mekargalih** *Health facility delivery: 57.7%* *2km, tarmac and non-tarmac road*	**Sirnagalih** *Health facility delivery: 51.0%* *1.3km tarmac and non-tarmac road*
Poor, far from *Puskesmas*	**Sindangsari** *Health facility delivery: 53.3%* *6km, tarmac and non-tarmac road*	**Girimukti** *Health facility delivery: 48.9%* *8km, tarmac and non-tarmac road*

Description of the villages chosen as the study sites in Cianjur

The population in the eight villages selected in Cianjur ranged from 5000 to 16,000 people, and the main source of income is agriculture (see Table 6). All villages had kindergarten and elementary schools, whereas senior high schools was less common in the remote villages which were far from the health centre. In the *Puskesmas* Ciranjang area, the availability of health care professionals is better than in Sindangbarang. For instance, three out of the four villages had medical doctor and private midwife practices, whereas in Sindangbarang there was only one village, Saganten, that had a medical doctor in the village.

Table 6. Description of study villages in Cianjur

Puskemas area	Village	Population number	Main source of income	Schools available				
				Kindergarten	Elementary school	Junior high school	Senior high school	Market
Ciranjang	Ciranjang	16,689	agriculture	3	13	4	0	1
	Karangwangi	1332	agriculture	1	2	0	0	0
	Mekargalih	3595	agriculture	1	2	1	1	0
	Sindangsari	2046	agriculture	1	4	1	1	0
Sindangbarang	Saganten	6054	agriculture	1	5	1	1	1
	Jatisari	5802	agriculture	3	4	1	0	1
	Sirnagalih	6909	agriculture	3	4	1	0	0
	Girimukti	6146	agriculture	5	5	1	0	0

Data source: village survey of 2012 from Village Chief Office

RECRUITMENT OF RESEARCH INFORMANTS

In both districts we chose four categories of informants for the study:

- CTC providers;
- clients and their support groups;
- village heads; and
- health managers at district level and district health officials.

Recruitment of study informants

The study was introduced to the heads of *Puskesmas* and midwife coordinators, and they were invited to participate. With their help, VMWs gave their consent to participate. Since the midwives were familiar with the village, we sought their assistance to invite the *kaders*, TBAs, mothers and men to participate in the study.

SELECTION OF STUDY INFORMANTS

All respondents were selected from the villages that were chosen based on the performance of their maternal health indicators. The mothers selected were women who had delivered in the previous 12 months.

The selection criteria for CTC providers were: midwives assigned to the selected villages, *kaders* based in the villages and TBAs who resided in the villages. The health managers and implementers were the head of the *Puskesmas* and midwife coordinators.

Key informants were selected from all villages, and included village heads and other influential committee members based on information provided by the village and district heads. At the district level the Maternal and Family Health section heads were selected.

For the FGDs the respondents selected in each village were husbands of women who had delivered. In addition FGDs were held with the midwives in each sub-district and with TBAs in Cianjur.

DATA COLLECTION

We collected data using SSIs and FGDs. Tables 7 and 8 provide the number of SSIs and FGDs and the number of informants from whom information was obtained in each district. In total we had 65 SSIs and three FGDs in SW Sumba and 45 SSIs and four FGDs in Cianjur.

SSIs were conducted by trained data collectors overseen by the Research Assistants. A five-day workshop was held in each district to train the data collectors in obtaining consent, interviewing and transcribing data. The Senior Researchers trained the staff. New graduates with a health education background from the district of SW Sumba were chosen and consisted of one male and three females. In Cianjur the data collectors consisted of four females with a health background and one female from a non-health education background. FGDs were conducted by the Research Assistants, but due to the language barrier presented by the local dialect, FGDs for TBAs in Cianjur were conducted by a trained field supervisor whose mother tongue is Sundanese, the dialect used in Cianjur.

Table 7. Number of informants, SSIs and FGDs in SW Sumba

Type of informants	Method	Frequency of data collection/*Puskesmas* area		Total
		Radamata	Palla	
Village midwives	SSI	4	3	7
	FGD	1		1
Village nurse	SSI	2	-	2
	FGD	-	-	-
TBAs	SSI	4	4	8
	FGD	-	-	-
Kaders	SSI	5	6	11
	FGD	-	-	-
Village stakeholders (head of village, head of PKK)	SSI	5	4	9
Mothers	SSI	14	9	23
Husbands	FGD	1	1	2
Head of PHCs, midwife coordinator	SSI	2	2	4
Head of district MCH section	SSI	1		1
Total	**SSI**	**37**	**28**	**65**
	FGD	**3**		**3**

Table 8. Number of informants, SSIs and FGDs in Cianjur

Type of informants	Method	Frequency of data collection/*Puskesmas* area		Total
		Ciranjang	Sindangbarang	
Village midwives	SSI	4	4	8
TBAs	FGD	1	1	2
Kaders	SSI	4	4	8
Village stakeholders (head of village)	SSI	4	4	8
Mothers	SSI	8	8	16
Husbands	FGD	1	1	2
Head of *Puskesmas*	SSI	1	1	2
Midwife coordinator	SSI	1	1	2
Head of district MCH section	SSI	1		1
Total	**SSI**	**45**		**49**
	FGD	**4**		

DATA ANALYSIS

A combination of 'grounded theory'[33], which means a reading of the transcripts and noting issues emerging from the text and a 'framework approach' [34], which uses the objectives and the issues explored in the topic guides, formed a lead for the development of a coding framework. The transcripts were entered in an electronic qualitative data management and analysis software (Nvivo) and coded. Data were further analysed by themes and sub-themes and summarized in narratives for each theme and sub-theme. The narrative led to further questions and associations between the themes.

We conducted the data analysis in the country and identified contextual factors that need to be taken into account for the development of the first improvement cycle. Inter-country analysis will take place during workshops with all countries present, to develop a common analytical framework of similar and context-specific factors that influence the implementation of CTC provider programmes.

QUALITY ASSURANCE

To ensure that the data collected are of an acceptable quality, the following measures were taken:

- To ensure data quality, the ability of the interviewers and FGD facilitators is vital. Training workshops were conducted by senior qualitative researchers. During the researchers' training, key terms were translated into the local language and translated back by others to confirm that terms were understood in the same way. The creation of a safe environment, respect and sensitivity were emphasized, and the interviewers' probing ability was central to the training.
- Oversight for field-testing and supervision during fieldwork was conducted by the Research Assistants. Quality assurance procedures were applied, such as checking recordings, keeping field notes etc., as well as debriefing sessions.
- All FGDs and interviews were digitally recorded, transcribed and checked with original recordings of a particular transcriber by the Research Assistant.
- Data validity was judged via triangulation (comparing and contrasting results from FGDs and SSIs and answers from different groups of respondents) and the mixed-methods approach (comparing and contrasting results from desk review and primary data).
- Due to language difficulties (translating from Bahasa Indonesia into English), the Research Assistants and Senior Research Fellow as well as a scientist from LSTM and one from KIT with expertise on qualitative data analysis in social science, health and gender contributed differing perspectives. A field visit during or prior to the analysis workshop assisted in understanding the specific local context.

- All field staff were trained in data collection by senior qualitative researchers, common terminology was identified for specific terms during the training, and instruments were adapted during the training and the field-testing.

STUDY LIMITATIONS

The study had the following limitations:

- We were constrained by funds and the geography to limit the sites to two sub-districts per province and eight villages in each sub-district. This is limiting the generalization to the whole district. To optimize the identification of influencing factors, we have chosen extreme sampling and included villages that are performing well and villages that are not performing so well.

- It was challenging to identify data collectors experienced in qualitative research. The training and field supervision assisted in generating skills, but during the first interviews probing was still difficult. Extra interviews were conducted to overcome the initial learning process.

- Data quality was subject to the ability of the interviewers and FGD facilitators' fluency in the local dialect of the region and the respondents' fluency in Bahasa Indonesia. We had to translate the interviews from Bahasa Indonesia to English, and some expressions might have been affected by the translator's interpretation. Again, due to cost and time constraints, a back translation was not possible to verify the quality of translation. Instead, transcripts of each transcriber were checked by the researchers comparing them with the oral recordings until they were satisfied with the quality.

- Indonesia is a diverse country, and the findings of this study could only be applied to the site of the study and to areas with similar situations.

CHAPTER 5 – QUALITATIVE RESEARCH FINDINGS

OVERVIEW

The qualitative study consisting of SSIs and FGDs was conducted in SW Sumba district in August and September 2013 and in Cianjur in October and November 2013. We show how common a response is by using terms such as 'a few' or 'some' for less than half, 'many' or 'a majority' for more than half, and 'all or almost all'. Quotations are presented along with the type of technique used, type of informant and the area recorded between brackets. Other specific identifiers have not been reported, to ensure the anonymity of the informants.

CTC PROVIDERS IN THE STUDY VILLAGES IN SW SUMBA

In SW Sumba we found that the assigned midwives resided in only two of the eight villages; in the other six villages they were residing elsewhere (see Table 9). In three villages in Radamata there were nurses available, whereas a resident nurse was not present in any of the Palla villages. There were five *kaders* per village *Posyandu,* and all resided in their villages. In SW Sumba there are two two categories of TBA: those trained in the previous system and untrained TBAs. It is noteworthy that sometimes family members such as mothers, fathers or parents-in-law can assist the delivery of the daughter or daughter-in-law and act in a similar way to an untrained TBA.

The health infrastructure and the physical conditions of the facilities in Radamata were poorer than in Palla. In both sub-districts there were more *Pustus* than *Polindes.* These sub-level facilities were not present in the two villages, Ramadana and Weepaboba, which were close to the *Puskesmas,* on the expectation that residents could access the *Puskesmas* easily. Since most health staff were not resident in their assigned villages, these facilities did not provide 24-hour services. The nurses carry out general consultations in *Pustus* during their working hours (morning to afternoon, four or five days a week). Sometimes the *Pustus* or *Polindes* are used for the monthly *Posyandu* activities. The *Posyandu* activities were held in all the villages.

CTC PROVIDERS IN THE STUDY VILLAGES IN CIANJUR

The situation in Cianjur was different from that in SW Sumba, with all the study villages having a minimum of one resident VMW. The Sindangbarang *Puskesmas* was located close to the villages of Saganten and Girimukti and had no *Pustu,* while all the other villages had a *Pustu*. The *Posyandu* is available in each village and is held monthly. Each *Posyandu* is run by at least five *kaders*. All *kaders* resided in their villages. As in SW Sumba, there are both trained and untrained TBAs in Cianjur. In Sindangbarang there were 5–12 TBAs available per village, while in Ciranjang this number dropped by half, between one and six TBAs per village.

Table 9. Number and distribution of CTC providers in the study villages in SW Sumba

Puskesmas	Village	CTC providers						
		Village midwife		Village nurse		Number of *kaders* per village *Posyandu*	TBAs	
		Resident	Non-resident	Resident	Non-resident		Trained	Untrained
Radamata	Ramadana	1		none		5	4	6
	Bondo Boghila		1	1	1	5	3	4
	Letekonda		1	1	1	5	4	6
	Totok		1		1	5	1	5
Palla	Weepaboba	1		0		5	1	5
	Wanatalla		1			5	1	0
	Puupotto		1			5	1	0
	Weenamba		1			5	1	1

Table 10. Number and distribution of CTC providers in the study villages in Cianjur

Puskesmas	Village	CTC providers						
		Village midwife		Village nurse		Private practice midwife	Number of *kaders* per village *Posyandu*	TBAs	
		Resident	Non-resident	Resident	Non-resident			Trained	Untrained
Ciranjang	Ciranjang	2	-	0	0	0	5	6	-
	Mekargalih	2	-	0	0	3	5	1	-
	Karangwangi	1	-	2		1	5	2	-
	Sindangsari	1	-	0	0	1	5	4	-
Sindang-barang	Saganten	3	-	1		2	5	5	-
	Sirnagalih	2	-	0	0	0	5	12	-
	Jatisari	2	-	0	0	1	5	5	-
	Girimukti	2	-	2		0	5	6	-

INTERVENTION DESIGN FACTORS

HUMAN RESOURCES

The main CTC providers engaged in maternal health are VMWs and *kaders* (community volunteers) of the village integrated health service (*Posyandu*) and TBAs.

Responsibilities and workload

VMWs: The main responsibility of the VMWs is to provide ANC and PNC in the *Posyandu* and to attend to childbirth and family planning, providing 24-hour care. Midwives provide care in health facilities, and recently times their workload has expanded beyond midwifery care. In SW Sumba and Cianjur the midwives are expected to perform several other tasks, including child health care, immunization and nutrition, and treatment of ailments. Almost all the midwives mentioned the increase in their workload and the multiple activities they are performing outside midwifery. In Cianjur midwives are also performing piercing and female circumcision. This is not practiced in SW Sumba.

> *"My primary jobs as midwife are examining pregnant women, organizing antenatal care, home visiting..."* (SSI, VMW, SW Sumba).

The round-the-clock work of VMWs was described by one midwife in Cianjur:

> *"A midwife's working hours are actually 24 hours. We must be ready at any time for 24 hours. People give birth at any time; we cannot predict precisely. I also don't put a specific hour for my practice. They can come as they want; even at midnight I still receive patients*." (SSI, VMW, Cianjur)

Their additional tasks and roles were described by many midwives:

> *"I mostly do midwifery activities, though occasionally I also deal with general health problems like upper respiratory tract infection and also skin infection*." (FGD, VMW, SW Sumba)

Some midwives mentioned their new task of caring for elderly people in the *Posyandu*:

> *"There is also a Posyandu for old people. [I said to the old people] 'you can come. I will weigh you; I will give you drugs.*" (SSI, VMW, SW Sumba).

The additional workload was confirmed in Cianjur:

> *"Integrated Management of Young Children [MTBM], this is not their [the midwives'] responsibility. It is their additional duty, and they usually do it with nurses. However, in the field, I found out that MTBM was still a burden to the midwives. They even have to guide the elderly programme, the immunization and nutrition. …The point is they usually become the bearer of every programme in the village*." (SSI, Manager, Cianjur)

The role of midwives in female circumcision and the type of circumcision was not systematically explored, but from the information given by a mother it seems that the clitoris is not always cut. A *kader* in Cianjur also mentioned:

> *"Now, circumcision is done by the midwife. Before, it was done by the paraji [TBA], but paraji rarely do it now.*" (SSI, *Kader*, Cianjur)

According to a mother in Cianjur:

> *"The paraji [TBA] did the circumcision, but the midwife said the clitoris was just being cleaned with alcohol*." (SSI, Mother, Cianjur)

***Posyandu kaders*:** The respondents suggested that the main role for the *kaders* is the same in SW Sumba and Cianjur. They assist the VMW in organizing the monthly *Posyandu*, registration of mothers and children, weighing children and providing health promotion and education. They also do home visits to encourage pregnant women to attend the *Posyandu*. While describing their work, many *kaders* emphasized the importance of their health education activities in family planning, sanitation and the distribution of vitamin A to anaemic mothers and children:

> *"We organize counselling about pregnancy like how to prevent anaemia or give counselling about child health such as the importance of vitamin A supplementation for the children.*" (SSI, *Kader*, SW Sumba)

Another *kader* described the importance of home visits to persuade pregnant women to attend the *Posyandu:*

> *"To visit young mothers in their second month of pregnancy, for the newly birthing mother, we advise them to do the family planning programme and also visit the newborn baby and toddler.*" (SSI, *Kader*, SW Sumba).

The *kaders* are also engaged in referring women to the midwife and to the health facility:

> *"I usually remind them. Like for those women who want to deliver, I said, 'please do not seek the paraji's service but the midwife; here is the [phone] number.' Then I give them the midwife's phone number.*" (SSI, *Kader*, Cianjur)

TBAs: There is no formal role for the TBAs (*dukun* in Sumba and *paraji* in Cianjur) in the health system. Yet TBAs are generally the first point of call in the village and play an important role during pregnancy and delivery. This important role of the TBAs during pregnancy was mentioned by almost all informant groups in both SW Sumba and Cianjur; its most important aspect is the traditional massaging of the abdomen of the mother early in pregnancy and positioning of the baby late in pregnancy. They also help during delivery and provide care after delivery:

"I give massage and help at delivery." (SSI, TBA, SW Sumba)

"*From what I know of the TBA, they help the mother do 'muku' [pushing the baby] and also touching the belly so it'll help to give birth quickly*." (SSI, *Kader*, SW Sumba)

SELECTION AND RECRUITMENT

VMWs: Recruitment of midwives is by the health service on the basis of graduation certificates and the appointment letter awarded by the district government (DHO), but the community can indicate the need for a village midwife, as explained by a midwife:

"If there's a village without a midwife, the village [community] will ask for a midwife, and the village will ask the District Health Office." (SSI, VMW, SW Sumba)

Kaders: In both SW Sumba and Cianjur the community are engaged in *kader* selection, while the village chief makes the final decision. Their selection criteria are school graduation and literacy capabilities. Often VMWs play an increasing role in their selection. In both districts the wider community is involved in the selection of *kaders* at village meetings. The VMW also has a say. The process was explained by the head of a community health centre (*Puskesmas*):

"The [kaders'] recruitment is done through the village chief, the village midwife and with the head of Puskesmas. If there's a kader who's going to be replaced, we will come to the community, ask them [the elders] who they want. We only require that a kader has to be graduated from school and is a literate person." (SSI, Manager, SW Sumba)

TBAs: TBAs in both SW Sumba and Cianjur are not recruited formally and come to the job at the request of the community, and in response to a call from their ancestors according to tradition.

PLACEMENT OF MIDWIVES IN VILLAGES

The midwives are placed in villages to work in the *Puskesmas*, village health post (*Pustu*), birthing hut (*Polindes*) and in the village *Posyandu*. The midwives assigned to a village do not necessarily come from that village, which makes it challenging, and not all midwives reside in their assigned village. Reasons given for difficulties in placing midwives in the village were: married women who have their own houses away from the village, partner's willingness and ability to move to the village, security and housing conditions or schooling options for children.

One midwife in a village in SW Sumba explained:

"I stayed in a health post in my assigned village for three years. But when my child was ready to enter kindergarten I didn't have any other choice, so I moved to Tanggolo Village, which is closer to the kindergarten." (SSI, VMW, SW Sumba)

Another informant highlighted the fear and isolation of the birthing huts, and the lack of infrastructure and supplies:

> *"Some of the village birthing huts or the village health posts are far from neighbourhood areas. They fear they will be disturbed; the neighbourhood isn't always safe.*" (SSI, Manager, SW Sumba)

He added that the limited basic facilities such as water and electricity are also a hindering factor:

> "*The house isn't a permanent one; it's an emergency shelter. How can a woman live there? The solar panel can't be used to charge a cell phone, can't play music maybe, TV, to entertain them. And the water is hard to get; the water source is far.*"

However, he emphasized that:

> *"Even if they [VMWs] don't live in the village, they have to be present every day in the village, as if it's their office.*"

EDUCATION AND CAREER ADVANCEMENT

VMWs: In both SW Sumba and Cianjur, the DHO organized training for midwives relating to their tasks such as the management of normal deliveries, newborn care and asphyxia management, and on health promotion activities related to nutrition, family planning and vaccination. However, the VMWs in both districts mentioned problems with continuing education and challenges to keep their skills up to date. The main challenges mentioned were a lack of funds for training, and insufficient supplies and equipment to apply their skills. In addition, midwives did not always adhere to the guidelines. As a midwife coordinator explained:

> *"In the emergency situations when our aid is needed, many of them don't use the masks, caps. They'd just wear the apron used to help with deliveries. I think it's because of their habits.*" (SSI, Manager, SW Sumba)

In Cianjur the managers emphasized the insufficient application by the midwives of what was taught:

> *"Every midwife has been taught about PPWS [Local Area Surveillance] before they go to do their work in the village. However, when I did technical coaching of the midwives who have already been taught about PPWS at the health service level, the algorithm that we expected to be applied in the field was not shown.*" (SSI, Manager, Cianjur)

Another challenge mentioned was the lack of supplies hindering the application of what was learned:

"When I participated in the asphyxia training, I wanted to disseminate it to village midwives, but we don't have ambubag [breathing aids] up until now. So when I wanted to disseminate it, I did't have any related materials, which made it useless." (SSI, Midwife Coordinator, SW Sumba)

COMPETENCIES OF CTC PROVIDERS

VMWs: Differences in the levels of self-confidence to respond quickly and creativity were reported between those midwives who hold a one-year diploma and those with a three-year diploma:

"There is a big difference. From my point of view those who hold a three-year diploma and above have more creativity. They who are not from midwifery school, they don't know what to put on. Those three-year diploma graduates have different knowledge." (SSI, Manager, SW Sumba)

One midwife who had not yet completed the three-year midwifery education felt that she lacked competencies to deal with various elements:

"When there's a pregnant woman who had haemorrhage, I felt my skill was lacking, that's what made me want to study again. ...There's once a baby who died in my own lap; I cried because the asphyxia handling for the baby was not accurate." (SSI, Midwife Coordinator, SW Sumba)

However, the absence of scholarships for further study and challenges for women to study far from home also deter lower-qualified midwives from further study:

"I do not want to study in a place far away such as Java." (SSI, Midwife Coordinator, SW Sumba)

"In this programme [D4 Midwifery] that I follow, there is none [no scholarship]. Before, there was a government programme." (SSI, Midwife Coordinator, Cianjur)

In addition, though VMWs in SW Sumba and Cianjur had participated in several training courses, including in health promotion, they still addressed the need to improve midwives' capacity in health promotion to further increase ANC and facility delivery.

Kaders and TBAs: In both SW Sumba and Cianjur informants addressed the need for more training to increase competencies of *kaders* in areas such as reporting skills and health education. In Cianjur informants mentioned in particular the wider range of skills and competencies of the neonatus caregiving *kaders*:

"The neonatus caregiving kaders generally have more competencies. They had more training." (SSI, Manager, Cianjur)

In Cianjur some training of TBAs was recalled:

> *"I attended a training for paraji [TBAs]. We practised washing hands using soap. It has to be flushed. And then if there's a home birth I need to check the opening. ...The signs are the face gets pale, the opening is 2cm to 10cm long. We practised at the graduation [of the training].*" (FGD, TBA, Cianjur)

CAREER PROSPECTS

There are rules in place for career advancement; however, some midwives, in both districts, reported the difficulties they face, particularly among civil service employees. They emphasized the complicated nature of the process they have to face in their efforts to be promoted. Some informants were irritated by promotions being awarded based on aspects other than merit:

> *"The grading in civil servant [employment rule], the rule is not being applied correctly. Even if a person works badly, he or she still get promoted.*" (SSI, Manager, SW Sumba)

In addition, in Cianjur informants mentioned the lack of access to further study when a midwife is on a contract:

> *"I want to have continued education, but if I am PTT [contract-based employee midwife], the village midwife is the PTT one, so it is hard to continue the study, and the service will be abandoned. That's why I want to be a civil servant."* (SSI, VMW, Cianjur)

FINANCIAL INCENTIVES

VMWs: Financial incentives for VMWs consist of their salary and incentives from the National Insurance for Delivery (*Jampersal*) and the Health Operational Fund (BOK). Deductions and sharing of the incentives take place in SW Sumba and Cianjur; although the details differ somewhat, the principle is similar. In SW Sumba, if deliveries occurred outside the health facility, the incentives cannot be claimed. In Cianjur the midwife can claim from the insurance. In SW Sumba the lack of incentives for home deliveries was stated as one reason for disappointment.

> *"The pregnant women who wanted to deliver in the health facility sometimes ended up delivering in the middle of her way to the health facility, or have already delivered at home when we picked her up. Like she already has complete openings and strained, and in that case it can't be claimed and paid anymore. To be able to claim the money, the woman must really deliver the baby in the health facility. We helped the mother to deliver in the Pustu. In that case too, it can't be claimed.*" (SSI, Midwife Coordinator, SW Sumba)

Informants also reported problems with disbursement of the insurance money:

> *"I wish that in the future, the claim and verification for the disbursement [of the Jampersal fee] could be counted on for our needs. Every month there are claims, but the disbursement took months."* (SSI, Midwife, Cianjur)

However, managers also claimed improved home visiting for ANC:

> *"There's an incentive for every time they work, like doing home visits, ANC. The incentive affects their coverage, which improves with the incentive.*" (SSI, Manager, SW Sumba)

It is noteworthy that these financial incentives sometimes cause misunderstandings, as mentioned by VMWs in the FGDs. The community has the impression that the midwives receive all money and, as will be reported under perceptions of health workers, some community members resent the money health workers receive.

Posyandu kaders: The *kaders* are non-salaried health volunteers. Yet they receive financial incentives from three different sources: the DHO, the village office and for referral of pregnant women to the health facility. A *kader* reported what they receive from the DHO:

> *"Since 2012, it is 50,000 rupiah per month, given every three months.*"

And then added the amount they get from the village office:

> *"It's from the village administrative. There is allocation for 20 kaders per village: 125,000 rupiah per volunteer per year. We already got it for two years.*"

The amount *kaders* receive for referral is based on the distance:

> *"We also need to pay attention to the distance. If the place is too far, we give Rp.25,000; as for nearer places, we give them Rp.20,000 or Rp.15,000. It all depends on the distance.*" (SSI, Midwife Coordinator, SW Sumba)

TBAs: In both SW Sumba and Cianjur the financial incentives for TBAs come from the community, and the money received ranges from substantial to nothing, depending on the social and economic position of the clients. The payment is for services during pregnancy until the umbilical cord falls off:

> *"I don't want to ask [for a certain amount of money]. They are all clients ranging from government employees to farmers. I only helped; the rest is based on their conscience. I don't determine [the fee].*" (SSI, TBA, SW Sumba)

In one community in Cianjur the men felt that TBAs need to be given good money; otherwise, the family may be shamed by the community, and they fear that she may not help them for the next delivery:

> *"If we give her a small amount of money, she will tell other people. I dislike it. If someone ever gave her small money, she won't come if we call her to assist for a second delivery.*" (FGD, Men, Cianjur)

Similar to *kaders,* there are financial incentives for TBAs when they bring a pregnant woman to deliver in a health facility:

> *"Usually by using the Health Operational Fund, every TBA as well as kader who brings [women to deliver] will get Rp.20,000 as an incentive. If they inform by short message or phone, we'll give them the credit money for Rp.7,000, which we transfer directly to their phones by electronic top-up.*" (SSI, Midwife Coordinator, SW Sumba)

NON-FINANCIAL INCENTIVES AND INTRINSIC MOTIVATION

VMWs: Besides financial incentives, VMWs in SW Sumba and Cianjur also mentioned non-financial incentives such as gifts that they occasionally receive from the villagers after assisting childbirth:

> *"It's like a culture in this place. If they have money, they will give us some money, but if they don't have money, they will give us a chicken.*" (SSI, VMW, SW Sumba)

A midwife in Cianjur mentioned similar things:

> *"Sometimes they give me things like bananas or any other fruits that they have.*" (SSI, VMW, Cianjur)

The desire to help other people and to serve the community are also important intrinsic motivation mentioned by many VMWs:

> *"Since in primary school I always have a dream to help people. So I dream to be a doctor. I cannot be a doctor because going to medical school is expensive. So I became a midwife. I like to serve the people around me."* (SSI, VMW, Cianjur)

In addition, the status of being a midwife is also very attractive in the community. Wearing a uniform is part of that:

> *"If you're a midwife, it looks good. I like seeing people using white clothes. It's nice, cool.*" (SSI, *Kader*, SW Sumba)

Posyandu kaders: Many *kaders* emphasized the voluntary nature of their work and mentioned that other things than money form an incentive. Incentives are the intrinsic value of being a volunteer, the effect of their work on others, the respect received from the community, the knowledge and respect they gain and the health services they receive for free. One *kader* emphasized that the work is not about the financial incentives:

> *"We work voluntarily. Even when there is no money, like what we experienced in the past, we still do our job."* (SSI, *Kader*, Cianjur)

A *kader* in SW Sumba emphasized the meaningfulness of being a *kader:*

> *"Those who support me are myself, my husband and my children. They said, 'it is good for you [to be a kader] so that you're happy.' ...So it's not because of the money. My children and husband advised me like that.*" (SSI, *Kader*, SW Sumba)

She added that *kaders* receive free health care in *Puskesmas*:

> *"The head of Puskesmas also serve us if we're sick without any charges.*"

The *kaders* are motivated when the community responds well to their work and shows appreciation:

> *"If they respond that they would join it [family planning] without making any comment, …we feel happy; we feel satisfied. Even though we are wasting our time, leaving our duties at home, but if they respond to it positively, we're also satisfied, happy.*" (SSI, *Kader*, SW Sumba)

According to another *kader*:

> *"When I do health promotion in the Posyandu I joke around with the people so that we have a good spirit and laugh. If we see the community understand [the health promotion] that we do, we are happy*." (SSI, *Kader*, SW Sumba)

The *kaders* reported the added knowledge and learning that comes with the job as a motivating factor*:*

> *"I feel happy because, first, I have so many friends, so much knowledge. I didn't know about immunization; I didn't know about BCG. Now, I know about that, a little bit. I have more knowledge, so I share my experience with friends, give them advice to the mothers, what is the importance of immunization, the importance of child health*." (SSI, *Kader*, Cianjur)

However, several *kaders in* SW Sumba and Cianjur expressed their disappointment when mothers do not adhere to their health promotion programmes in *Posyandu:*

> *"It is disappointing when they [mothers] do not follow our advice to come to Posyandu or to give birth in Puskesmas. ...It's like we have told them many times to come, but they don't listen, and when we asked them why they don't come, they made many reasons."* (SSI, *Kader,* SW Sumba)

A *kader* in Cianjur shared a similar experience:

"As a kader I'm sad and feel discouraged when I have told them [pregnant women] about the importance of giving birth assisted by midwives but they still prefer to be assisted by paraji. ...In fact I keep repeating the same message, but some of them are stubborn." (SSI, *Kader,* Cianjur)

TBAs: TBAs in both SW Sumba and Cianjur mentioned that they receive non-financial incentives such as chicken, sarongs or fruits for the care they provide:

"There was someone who gave me a chicken or a sarong. But most of them didn't give me anything." (SSI, TBA, SW Sumba)

A TBA in Cianjur mentioned that self-fulfilment as a TBA is another form of non-financial incentive:

"I'm happy to help the women to deliver their babies and to clean them and their children. I like to see the mothers who delivered who are also happy, since I've cleaned them and their children." (SSI, TBA, Cianjur)

A similar feeling of being happy to serve and proud of what they can offer was expressed by another TBA in SW Sumba:

"I'm happy because in my village I've been helping those who're pregnant and delivering babies. Like when there's no transportation at midnight, it becomes my happiness if I can help them in times of need." (SSI, TBA, SW Sumba)

MEDICAL SUPPLIES AND LOGISTICS

Issues related to logistics and supplies emerged among VMWs in SW Sumba. Many of them complained about the lack of availability of instruments such as for measuring blood pressure and listening to the foetal heart rate. A midwife coordinator in SW Sumba said:

"Many pregnant mothers like to come to Posyandu because they want to have their blood pressure measured or they want to listen to baby's heart rate. They really like these, but not all village midwives have these instruments. Or some of them have them but then they are broken and cannot immediately be replaced." (SSI, Midwife Coordinator, SW Sumba)

Similar problems of a lack of facilities were mentioned in Cianjur:

"Here, we don't have laboratory tests. ...Sometimes they go to [Puskesmas] Sindangbarang to check their pregnancy. Sindangbarang has USG, so they also get a USG examination." (SSI, VMW, Cianjur)

A VMW mentioned the lack of health promotion materials:

> *"The people in the village like our health education if we can show them pictures. In the past we have had some posters and pictures, but we don't have that now."* (SSI, VMW, SW Sumba)

The lack of availability or deteriorating conditions of some village birthing huts that prevent some VMWs from living in their assigned village was also an important issue in SW Sumba. Moreover, some VMWs complained about the lack of availability or the deteriorating conditions of the motorcycles that are supposed to enable them to do home visits:

> *"Not all village midwives have a motorbike. I have a motorbike, but it is already very old and frequently broken. This motorbike was given by the government, but I often have to spend my own money to fix it."* (SSI, VMW, SW Sumba)

In addition, the main concern among *kaders* in SW Sumba regarding supplies and logistics is the lack of availability of chairs and tables in several *Posyandu*. As we explained in the desk review, there are five table programmes in *Posyandu* (from registration to health education). However, some *Posyandu* have no chairs and tables available:

> *"Our Posynadu is under the tree. The method will be five thighs, not five tables; we can say the five tables is only the theory, but the practice is the five thighs. I suggested the health office or any stakeholders not to use the five-thigh method anymore*." (SSI, *Kader*, SW Sumba)

SUPERVISION

In SW Sumba and Cianjur informants mentioned the monthly meeting in *Puskesmas* as a form of supervision by the head of *Puskesmas* and midwife coordinators of the performance and activities of VMWs. During the meeting they share their experiences and discuss the problems they face. Most VMWs acknowledged the benefits of this supervision, but in SW Sumba some complained about the lack of supportive supervision, particularly related to supplies and logistics:

> *"I have informed the head of Puskesmas several times about my motorbike, and she just said, 'be patient and wait.' I have waited for quite a long time."* (SSI, VMW, SW Sumba)

Another midwife in SW Sumba emphasized to tendency to simply blame the midwives when a maternal death happened:

> *"The downside of the maternal and child health revolution in this province is we [midwives] are always blamed, especially when a mother dies. What we want actually is more support in like trainings and instruments so we can work better."* (SSI, VMW, SW Sumba)

Additionally, many informants in SW Sumba and Cianjur addressed the need for more supervision of the *kaders* by VMWs. More frequent and structured supervision of *kaders* by VMWs will increase the motivation of the *kaders* to encourage pregnant women to attend the *Posyandu* and to delivery at a health facility, as can be seen in several villages with higher levels of ANC and facility delivery.

HEALTH-SEEKING BEHAVIOURS FOR ANTENATAL CARE, DELIVERY AND POSTNATAL CARE

BROAD CONTEXTUAL FEATURES

SERVICES PROVIDED

ANC, PNC, family planning and child health services are provided through the *Posyandu* and are described in the desk review. The next level of services is provided by the health post (*Pustu*), mainly for delivery, and at sub-district level services are provided in the *Puskesmas* (health centre). Referral from the village could be to the *Puskesmas* for deliveries and from there to the district hospital for complicated cases. It is common for women to use the services of both the midwife and a TBA.

UTILIZATION OF ANC AND DELIVERY SERVICES

Almost all informants stated that most pregnant women used the *Posyandu* for ANC. Women and their husbands often recognize signs of pregnancy due to ways in which women change their behaviour. A husband in SW Sumba said:

> *"When my wife had her 'injak bulan' [missing period], she was ill and asked many things, just like a child. She asked for a banana cake. That is how I knew [that she was pregnant]. She then went to Posyandu to get checked.*" (FGD, Men, SW Sumba)

Another husband in SW Sumba emphasized the importance of *Posyandu* for ensuring safety of the mother and the baby:

> *"My wife went to Posyandu so she and the baby would be safe. So the baby would be healthy and have normal birth."* (FGD, Men, SW Sumba)

In Cianjur a husband explained the benefits of attending ANC in *Posyandu*:

> *"My wife went to Posyandu to confirm her pregnancy. Going to Posyandu makes her and myself feel safe. There are midwives there. If there's something not good they have the drugs.*" (FGD, Men, Cianjur)

There are several factors that were described by respondents as encouraging pregnant women's access to ANC and delivery services. These include the belief that by having the

mother and baby checked, the baby will be safe and healthy and the delivery normal; to get vitamins, medicinse, injections, bed nets and check-ups; that the services are free; the friendly attitude of VMWs; and also the risk of facing a penalty from the village office if they do not attend the ANC and delivery services (e.g. the threat of withdrawing their incentive from PKK). Some women start visiting the *Posyandu* from three to five months onwards and attend ANC four times or more before delivery:

> *"ANC starts from the age of four months. They start to check on pregnancies until four times, until they delivered.*" (SSI, *Kader*, SW Sumba)

There are some differences in Cianjur; to avoid the waiting time in the *Posyandu,* many mothers prefer to pay go to the private midwife:

> *"I guess they want the easiest way, and it only costs the 5000 [Rupiah] for those who have no insurance, but there are other consequences that they have to take the long queue. For others they said that they are willing to go to the Puskesmas but could not stand the queue, and if they brought their children, they have to provide snacks while waiting. That cost more at the end in comparison to the clinic's fee. So they prefer to come to the private [midwife] practice that does not need to wait for long.*" (SSI, VMW, Cianjur)

BARRIERS TO ANC AND DELIVERY SERVICES

It is noteworthy there are still several import cultural or socio-economic barriers in both SW Sumba and Cianjur that contribute to pregnant women choosing not to access ANC. These include traditional beliefs and the lack of mothers' motivation such as:

> *"Our ancestors won't allow it.*" (SSI, Village Head, SW Sumba)

The daily activities of the pregnant women that need attention as well as disillusionment with the services were also described as a hindrance to ANC services:

> *"Sometimes, they [pregnant women] were busy in their houses. Sometimes when they want to go to the Posyandu, a guest shows up at their house. Or perhaps there was another urgent thing that they needed to do.*" (SSI, *Kader*, SW Sumba)

> *"Sometimes when we heard the announcement of Posyandu activity in the pengajian [prayer meeting], some of us said, 'ah, only weighing; we get nothing.' What we mean is we get nothing after weighing*." (SSI, Mother, Cianjur)

REASONS FOR USING TBA SERVICES AND HOME DELIVERIES

In some villages and households in both SW Sumba and Cianjur, traditional beliefs are also a reason for not going for ANC or not delivering at a health facility and leading to the use of TBA services. One head of a village in SW Sumba mentioned the taboo of being exposed to modern

equipment and practices that are unacceptable for the ancestors. Not listening to the ancestor may cause a miscarriage and/or be a reason for not becoming pregnant again:

> *"It's like this: the equipment you're using, they [the ancestors] don't want it. The grandmother, or we call it here 'Merapu' [Sumba's traditional religion], but that's what they don't want. …The ancestors or Merapu, they don't want it, and it can cause miscarriage or they can't get pregnant."* (SSI, Village Head, SW Sumba)

Moreover, a VMW in Cianjur stated that among some pregnant women, particularly those with a low level of educational attainment, the taboo of leaving the house, especially in the early months of pregnancy, contribute to choosing TBA services over other providers:

> *"Pregnant mothers with a low level of educational attainment usually still have many taboos, like the taboo of going out of the house [during pregnancy]. Because of this, they prefer to use TBA services. The paraji [TBA] usually lives close to their house, and she can be called to come to the pregnant mother's house any time."* (SSI, VMW, Cianjur)

However, a more common practice is that pregnant women actively attend the *Posyandu* for ANC and also use TBA services, particularly massage. Most mothers mentioned the importance of TBAs' massage during pregnancy:

> *"I felt nauseous and wanted to vomit when I was pregnant. I also lost my appetite. After getting the massage from a TBA, I felt better and getting my appetite again, not really nauseous. I loved being massaged. The TBA always gave me a massage on my belly. Because I felt really comfortable like that. After I got the massage I felt more relaxed.*" (SSI, Mother, SW Sumba)

If pregnant women found out through their ANC at *Posyandu* that they have no discernible problems with the pregnancy, many of them then choose to deliver at home with a TBA in attendance:

> *"I went to the Posyandu, and we found out that I am OK. ...When my delivery time came, I didn't feel much pain, so we decided to call a TBA, and I delivered my baby at home.*" (SSI, Mother, SW Sumba)

Previous experience of smooth delivery at home was also mentioned by a *kader* as a reason for women to choose to deliver at home:

> *"Well, when we interviewed them in Posyandu after they've delivered, some said that because it was for the third or fourth child. In their experience in giving birth at home with a TBA for the first child, it was fine. Moreover, there was no [negative] symptom found by the midwife in the examination during the pregnancy. So they just delivered at home.*" (SSI, *Kader*, SW Sumba)

The promptness and proximity of the TBAs is also a reason why there is still a strong preference for home delivery assisted by TBAs. According to a mother in Cianjur:

> *"They serve us quickly when we need them. When we are about to deliver, they will come and serve us immediately after we call them.*" (SSI, Mother, Cianjur)

The perception of TBAs' quality of care, their sensitivity and the issue of privacy are also influential:

> *"She [TBA] is good. She helps the labour in the pregnant woman's house, so it could be in their own room; the room's door is closed. She lets the pregnant woman wear a sarong, then when the woman is about to push the baby out, she receives the baby with her hands, then she cuts the umbilical cord.*" (SSI, Mother, SW Sumba)

In addition, the perception in communities that TBAs are more important and experienced than midwives may also contribute to home delivery assisted by TBAs:

> *"In my village, though it [delivery] is free, many are still assisted by a TBA and deliver at home. Maybe this is because they think a midwife is less important than a TBA. For them a TBA is most important and a midwife is just a kid."* (FGD, VMW, SW Sumba)

TBAs are also considered by some as role models in society who are trusted by the community, particularly by the many who hold strong traditional beliefs:

> *"They [TBAs] are like role models too. We cannot ignore the fact that they have more trust from the society. That's why we have to approach and persuade them to refer the delivery to us*." (SSI, Midwife Coordinator, Cianjur)

> *"Paraji [TBAs] are figures who are considered elders here. The community already trust the paraji and won't go anywhere else. Paraji stay there continuously, while the midwives do not. The community tends to consider the paraji like a mother.*" (SSI, VMW, Cianjur)

> *"The community still believes strongly in paraji. Paraji sends the prayers for the safety of both the mother and the baby. She is believed that she can also protect them from the bad influence from outside, especially when the baby just gets delivered.*" (SSI, Village Head, Cianjur)

A lack of facilities and a lack of responsiveness to traditional beliefs and practices is, therefore, an important factor that contributes to the preference to deliver at home assisted by a TBA:

> *"My wife gave birth at home, not in the Puskesmas. The Puskesmas was limited. No hot water. While in here we believe that it is a custom for mothers to have a bath with*

warm water after delivery. ...They frequently cannot do that in the Puskesmas. That is the unpleasant experience, and we are not happy with the deliveries in the Puskesmas." (FGD, Men, SW Sumba)

OTHER BARRIERS TO FACILITY DELIVERY

It is worth noting that there are numerous barriers that hinder pregnant women from delivering at a health facility besides traditional beliefs, such as distance to the facility, the poor road infrastructure, lack of transport including the cost of transportation, the costs and lack of means to contact the midwife, the difficulty of being away from home for a longer time, the health facility's lack of responsiveness to local beliefs, and the cost of food and accommodation for the family members who accompany the parturient. These barriers contribute to the high level of preference for home delivery assisted by TBAs.

Cost

Though the cost for delivery at a health facility is free due to the availability of delivery health insurance (Jampersal), there are other barriers to facility delivery such as distance to the facility, the poor road infrastructure, the lack of transport and the cost of transportation:

"If the mother's house is far, it takes time to get a motorbike taxi, and it is not rare I arrive at the mother's house when the opening is already complete, and I have to assist the delivery in her house." (FGD, VMW, SW Sumba)

"Because she [his wife] gave birth in the night and the midwife was not there at night, and there was no transportation, she finally gave birth at home assisted by the paraji [TBA]." (FGD, Men, Cianjur)

Besides the cost of transportation, indirect costs such as for accommodation and food for the family members who accompany the pregnant woman to deliver at a health facility is also a hindering factor:

"For mothers who live in a remote village, even if the mother wants to deliver in Puskesmas, the family is usually concerned about the cost of accommodation and food for their family. Even if they have a relative close to the Puskesmas, people here are reluctant to come to the house of somebody else without carrying stuff like rice, bananas or chicken. They feel ashamed if they give a burden to other people. ...This frequently become a reason that prevents them from going to Puskesmas to give birth." (SSI, VMW, SW Sumba)

Accessibility

The *Puskesmas* is supposed to provide an ambulance to take the parturient woman to deliver at a health facility, but this is not always achievable due to the limited availability of drivers or fuel:

> *"Sometime we face difficulties like the ambulance had no fuel and the driver refused to come. I tried to ask the driver to find another vehicle, but no money for that. If I ask the villagers to hire a vehicle, many cannot do this because the cost is high.*" (FGD, VMW, SW Sumba)

Stigma

Stigma may also cause pregnant women to be reluctant to deliver in a health facility, particularly those who are not yet married and are, therefore, reluctant to notify health workers or other community members of their pregnancy:

> *"The mother didn't have a legal husband. So she was scared to show up.*" (SSI, Manager, SW Sumba)

> *"In my village, a woman who is pregnant without a husband is ostracized. They usually deliver the baby at home.*" (SSI, VMW, Cianjur)

USE OF PNC

A preference for using a TBA is again a common reason that prevents mothers from accessing formal PNC services. The root causes for this are similar to the reasons for preferring home delivery, and include practical and cultural reasons:

> *"Sometimes it's hard [for midwives] to go to the village to conduct postnatal and neonatal visits. Sometimes she did so, but if the place is too far, she can't do so. So that's one of the factors: the distance and the bad road, where even motorcycles can't get in.*" (SSI, Manager, Cianjur)

> *"The reason was they still believe in traditional beliefs. Like believing that after giving birth the TBA will provide a bath.*" (SSI, VMW, SW Sumba)

USE OF FAMILY PLANNING

Respondents suggested that some of these facilitators that influence the uptake of family planning are similar to facilitators for ANC and facility delivery, such as the services being free, and the skills and friendly attitudes of the midwives and *kaders*. In addition, using contraception to enhance their lives, reduce the burden on the family and space childbirth was also addressed:

"The reason my wife uses the sterile method is to lighten the family burden. Many children, lots of burden, many risks. During the old time there is a saying 'many children, many fortunes', but now 'many children, many risks'. We have to enable the two or three children we have to get better education." (FGD, Men, Cianjur)

The combined social, cultural and economic barriers all have a contributory role in the low numbers of facility deliveries and delayed management of services related to delivery in both SW Sumba and Cianjur.

DECISION-MAKING AND GENDER NORMS, VALUES AND ROLES

Decision-making related to ANC, delivery and family planning is influenced by gender norms, including the role of the husband and key family members such as parents and parents-in-law, as well as by other factors such as encouragement or instruction from the village head and midwives.

DECISION-MAKING RELATED TO ANC

In both SW Sumba and Cianjur, husbands and members of the family such as parents and parents-in-law play an important role in decision-making about whether or not to access services in health facilities such as ANC in *Posyandu:*

"Most women are dependent on their husband's decision, or at least the women tell their husband." (SSI, Village Head, SW Sumba)

"The husband is not too supportive, not encouraging her to go to Posyandu to get checked." (SSI, *Kader*, SW Sumba)

"The husband was the one who usually made the decision. The mother could not decide in every aspect. It was the same with family planning." (SSI, Manager, Cianjur)

There was some variation between respondents, however, and some women felt able to make their own decision:

"Well, my husband is giving me freedom, but for precautions it would be better if I check, so if anything happened, it could be handled earlier." (SSI, Mother, Cianjur)

In both districts some pregnant women showed they contributed to the decision to check their pregnancy in *Posyandu.* When asked about who made the decision to go to *Posyandu*, a pregnant woman in Cianjur said:

"Me, my husband and my mother-in-law." (SSI, Mother, Cianjur)

Additionally, a different mother in this area described in greater detail how she talked with her husband about going to *Posyandu*:

> *"I already know at what date the Posyandu is — for example, on the 10th. The night before I told my husband, 'there will be Posyandu tomorrow. I will go there to be checked.' I said it like that. My husband said then, 'go so that you know how your pregnancy is and you can also get vitamins.' That's it. We both agreed. Then the next day I went to Posyandu.*" (SSI, Mother, Cianjur)

In SW Sumba, pregnant women's decision-making to access ANC services is influenced to some extent by instruction or pressure from village heads and midwives in relation to the Maternal and Child Health Revolution in East Nusa Tenggara Province:

> *"At first there was a pressure from the village government and midwife. After that they realizedthe importance of health.*" (SSI, Village Head, SW Sumba)

The influence of the village head can also be found in Cianjur:

> *"The village head frequently tells the mothers to go to Posyandu. He likes to say, 'go [to Posyandu] to get medicine, vitamins and weight measurement for your children.*" (SSI, Midwife Coordinator, Cianjur)

DECISION-MAKING RELATED TO DELIVERY

As with ANC, the role of the husband in decision-making related to delivery such as the place of delivery and who assists delivery is also crucial. When asked about the decision to call a TBA to assist her delivery in her house, a mother in a village in SW Sumba said:

> *"It was my husband's decision. If my husband has already called the TBA, I don't [refuse]."* (SSI, Mother, SW Sumba)

However, this mother also added that, though she preferred to be assisted by a midwife, she was pleased that a TBA came to help her, as she felt the time left to go to the hospital was too short:

> *"Calling the TBA is already helpful for me because I felt really painful. It seems that there is no time anymore to go to the hospital. ...My feeling: full of relief after I could give birth.*" (SSI, Mother, SW Sumba)

In Cianjur a similar pattern emerged:

> *"Of course he [the husband] also decides where to go to get the treatment for the delivery. If the husbands insist to have it with the Paraji's service, so the wives will just follow and obey.*" (SSI, Village Head, Cianjur)

> *"The midwife made a delivery date prediction, and assignment about who will assist the delivery. The mother obeyed. But on the due date, she was not the one who made the decision, but her husband, parents-in-law or parents.*" (SSI, Manager, Cianjur)

A different experience was shown by another mother in SW Sumba who also gave birth at home, but, unlike the above mother, she was visited by the midwife, and the decision to call the midwife indicated the agreement within her family to call her. A key informant explained the variation in terms of place to give birth and the importance of the husband's role in deciding the location to deliver. He added that the role of other people in decision-making related to delivery usually increases if there are any risks:

> *"Sometimes there is contradiction; it can be the mother's decision, but if there's any risk usually there is another person who gives advice to give birth by another means. If faced with a risk, well... We encourage them so that the decision is not solely on the mother herself but also on other people.*" (SSI, Village Head , SW Sumba)

Respondents also indicated that some women make their own decisions with regards to delivery:

> *"Well, from the beginning I've already told the midwife that I wanted to deliver my baby with her assistant. I asked for her phone number. So that night when I felt like the water came out and I was having contractions, I woke up my parents and asked them to call the midwife. "* (SSI, Mother, Cianjur)

> *"It's me [who decided to deliver the baby with a paraji]. My husband was about to call a midwife, but I told him not to."* (SSI, Mother, Cianjur)

When there is a need for referral, the situation becomes more complicated. Delays during referral occur because of discussions about who should go with the woman, finding transportation etc. These can require extensive family gatherings:

> *"Many obstacles, different areas, different situations and conditions. If I wanted to refer them, they did 'riungan' [gather with their family] first. They would discuss who would accompany the patient to hospital, and then where to find transportation and more discussions.*" (SSI, VMW, Cianjur)

Moreover, some husbands are indifferent:

> *"Most husbands think pregnancy and taking care of the children are entirely the mother's responsibility. They only think that their role is only to provide money. ...The husbands are never there during delivery; only neighbours, mother-in-law and kader.*" (SSI, VMW, Cianjur)

DECISION-MAKING RELATED TO FAMILY PLANNING

As in the cases of ANC and delivery, the role of the husband is also important in decision-making related to family planning. Occasionally this was cited as problematic, and one case

was found in which a mother in a village in SW Sumba had to lie to her husband due to his refusal to allow her to use contraception although they already had six children. The experience of this mother also demonstrated her agency to act in a way that she is thinks is better for herself:

> *"My husband didn't agree [with her to use contraception] because at that time he wanted to have more children, but I looked for any reason to make him agree. I told him a lie. I said that if we use a sterile method we can still get more children. He then agreed.*" (SSI, Mother, SW Sumba)

Another mother in a village in SW Sumba showed a more consensual process with her husband related to the decision to use contraception:

> *"Me and my husband [decided]. Actually, I've been wanting to join ever since I was having my first child, but he said, 'not yet until we have two children: a boy and a girl.*" (SSI, Mother, SW Sumba)

In Cianjur, sometimes the whole family is involved:

> *"My father-in-law said that we were not ready to have children. My husband should have a job first, find the money, save the money. We worried that if we had children then we cannot take care of them.*" (SSI, Mother, Cianjur)

It is noteworthy that there are several barriers for mothers to access family planning, including traditional beliefs, aspiring to complete a family by having both a boy and a girl and a lack of support from the husband:

> *"The same thing with family planning. There's the traditional taboo, so people are very careful to do it, whether it's the device or everything about contraception. It's just the same with this, to get examined [using medical equipment], the ancestors or Merapu, they don't want it, and it can cause miscarriage, or they can't get pregnant*." (SSI, Village Head, SW Sumba)

> *"Many reasons. For example, they have several children, but all are males. In here, we usually wait until we have a girl or a boy to use contraceptives. That's the reason. Because they do not have a complete set of male and female children, they don't want to use contraceptives yet.*" (SSI, VMW, Cianjur)

> *"My husband still has traditional views. He believes that having many children will bring more fortune. ...He does not allow me to use contraception."* (SSI, Mother, Cianjur)

COLLABORATION BETWEEN VILLAGE MIDWIVES, *KADERS* AND TBAS

Our data from SSIs and FGDs showed that a certain degree of collaboration between VMWs, *kaders* and TBAs exists in some villages in SW Sumba and Cianjur. This collaboration is aimed particularly at encouraging villagers to attend *Posyandu* and pregnant women to deliver in a health facility. A *kader* in a village in SW Sumba appreciated the TBA services in her village and the cooperation between *kaders* and TBAs:

> *"The TBA in this village is excellent, because some TBAs cooperate with us to give good understanding to the mothers of the babies and toddlers to scale their weights in Posyandu, to care for their children well, to give nutritious food to the children, so that they become healthy.*" (SSI, *Kader*, SW Sumba)

She added that the current policy (Maternal and Child Health Revolution) in SW Sumba does not allow delivery assisted by TBA:

> *"TBAs aren't allowed to help pregnant women to deliver, and they must advise the pregnant women to go to a health facility to deliver. ...They [TBAs] really should guide the women, especially the pregnant women; they should always remind them when it is already the month of delivery so that they deliver at the Puskesmas. Before delivery, if there's any pain or uneasiness in their pregnancy, their roles, together with us as kaders, are to suggest they go to Puskesmas for examination, and we suggest in the delivery month that they deliver at the health facility*."

Another VMW in SW Sumba explained her collaboration with TBAs in her village in greater detail:

> *"These days, some TBAs are good. If somebody reported that they [pregnant women] missed their period, some TBAs inform me. If there is somebody about to deliver, they [TBAs] also report to me, and some of them also come with us [to the house of the pregnant woman]. Sometimes they take the pregnant women to the Puskesmas. Now they also can have some incentive if they accompany the pregnant women to the Puskesmas. They can have Rp.15,000 if they report a pregnant woman who is about to deliver to us. Usually we give an explanation, though we [midwives] are the one who assisted the delivery, the TBA will be the one who does the massage afterwards, so they still can receive the chicken from the family of the pregnant woman. Then we give an explanation to the mother to give clothes as an appreciation of the TBA, because they have delivered with no cost in the Puskesmas.*" (SSI, VMW, SW Sumba)

Similar collaboration between midwives, *kaders* and TBAs can also be found in Cianjur:

> *"We don't work alone. Working alone made us tired, right? Usually, there is training for kaders and also for paraji [TBAs] about delivery. So, if there is a delivery, we partner with the paraji. The partnership is, if there is delivery, the paraji will call us; they will call the midwife. If a woman about to deliver meets the kader, the kader will call us.*

But usually in the village, they trust more the paraji, thus we should collaborate with the paraji better and closer." (SSI, VMW, Cianjur)

"Sometimes a midwife cannot handle the delivery, and she will work together with a paraji. And a paraji also will do the same if she cannot handle it. She will call a midwife. So they are working together." (SSI, Mother, Cianjur)

This collaboration is not without challenges or difficulties, however:

"At the beginning when we said that TBAs cannot assist delivery anymore, just collaborate with us, they seemed like they were jealous. They were worried they won't be used anymore. But we gave them an explanation that the purpose is not to make the TBAs vanish. We told them that they can remain and do their tasks like massaging or taking care of the baby." (SSI, VMW, SW Sumba)

The head of a *Puskesmas* in SW Sumba also identified some challenges to increasing collaboration with TBAs:

"Some TBAs don't want to cooperate. ...Some don't understand what we said to them due to their old age. They can't cooperate because they're too old to understand, and they don't really understand the Indonesian language that we use. ...The TBAs have their own limitations: they didn't study at schools, and their practice is only based on experience. There are already midwives in the villages now, so they [pregnant women] shouldn't rely on TBAs anymore. TBAs should only accompany the midwives. They shouldn't aid the delivery, because the TBAs don't know about the timings of the complete openings, whether there's foetal membrane fluid, and when the baby has to be delivered." (SSI, Manager, SW Sumba)

However, he added:

"Some TBAs have already understood the current policy [maternal and child health revolution]. People often talk about it, like the kaders, village chief; there's also socialization about it in the Posyandus. Some of them understood that nowadays delivery must be done with midwives' aid at a health facility."

COMPARATIVE ANALYSIS

FACTORS THAT INFLUENCE THE DIFFERENCE IN MATERNAL HEALTH INDICATORS IN THE CHOSEN VILLAGES (STUDY SITES)

Our data showed two important factors that may contribute to the differing levels of maternal health indicators among villages that we selected as the study sites: the performance and enthusiasm of the VMW and the level of support from stakeholders (such as the village head,

the wife of the village head, religious leaders, the PKK and the PNPM). Villages with better maternal health indicators (higher attendance at ANC and facility delivery) generally have more enthusiastic VMWs. In these villages there is also better support from the stakeholders for the activities of VMWs and *kaders.*

VILLAGE MIDWIFE'S PERFORMANCE AND ENTHUSIASM

The performance and enthusiasm of VMWs were frequently mentioned by mothers and *kaders* in the villages with higher attendance at ANC and facility delivery in SW Sumba. Mothers especially appreciated the care for sick children, nutrition advice and other health advice. For example, a mother in a village in Radamata (close to a health facility and with high attendance at ANC and facility delivery) appreciated the performance of the VMW:

> *"She [the VMW] does her work very well. She helps the sick children. She keeps giving us advice, such as to consume more vegetables. She examines our pregnancy conditions and responds it well if we are not well. ...She gives us health education; for instance, she forbade me to eat carelessly. She told me to be careful in consuming the medicines from the market. She paid attention to these kinds of issues."* (SSI, Mother, SW Sumba)

A *kader* in the same village also mentioned the enthusiasm and hardworking ethics of the VMW, and the community's respect for her:

> *"I think she [the VMW] is a really hard worker. She is very good and respected by the people here. …Because without looking at the status of the persons she will help. She also has a baby at home, but she still helps. She never made the people desperate and is always ready to serve. I think this is because she doesn't feel it as merely her task but she loves the people. ...For example, when someone is in labour, she just has be texted that someone has abdominal pain, and she will immediately come."* (SSI, *Kader*, SW Sumba)

Positive comments about the performance and enthusiasm of the VMW were also mentioned by mothers and *kaders* in another village in Radamata (far from a health facility but with high attendance at ANC and facility delivery):

> *"I think she [the VMW] is OK. She and the kaders are active in managing Posyandu. She and the kaders always watch out for the undernourished children. They also look after the women who have an undernourished child and give health advice. ...If someone wants to use contraception, the village head reports it to the midwife, and the midwife will serve her."* (SSI, Mother, SW Sumba)

> *"The midwife here is very nice. Usually other health personnel are hard to approach. But this one, she's willing to help in everything. ...For instance, we ask her to help us in*

recording this data. She's very open. She also always keeps her promise [to come to Posyandu]. We, the kaders, work closely with her. Like when a young mother who was never pregnant before and doesn't know the signs of pregnancy, I can help her to consult with the midwife. Then she will get a pregnancy test." (SSI, *Kader*, SW Sumba)

Similar appreciation can be seen for the performance and enthusiasm of the VMW in a village close to a health facility and with higher attendance at ANC and facility delivery in the Palla area in SW Sumba:

"She [the VMW] is good. She is always present in Posyandu events every month. When she was called in the middle of night [to help the pregnant woman to give birth], she did come." (SSI, *Kader*, SW Sumba)

"Her performance is excellent. Though without enough budget, she still organizes the self-empowered milk and additional food programme [in Posyandu] by always asking the mothers to bring tubers or sweet potatoes. This through a shared approval between the village authority and the midwife. ...The way she does the service to help pregnant mothers is very good. [For example], if someone [a pregnant woman] is calling her from the village, although she must travel across the mountain, she still comes to help." (SSI, Village Head, SW Sumba)

In contrast, negative comments about the VMW were frequently mentioned by mothers or *kaders* in a village in Radamata which is close to a health facility but has lower attendance at ANC and facility delivery:

"She [the VMW] is frequently absent from Posyandu. I came, but many times only kaders were there." (SSI, Mother, SW Sumba)

"She is not good. Sometimes she comes, and sometimes not [to Posyandu]; sometimes she also forgets the schedule. Many mothers in this village say, 'why should we come [to Posyandu] if the midwife is not there and we come for weighing only?'" (SSI, *Kader*, SW Sumba)

The key role of the VMWs' performance and enthusiasm and the differing levels of maternal health indicators were also evident in the villages that we chose as the study sites in Cianjur district. Informants in villages close to a health facility and with high attendance at ANC and facility delivery) in Ciranjang and Sindangbarang appreciated the performance and attitude of their VMW:

"She is nice and active. ...She speaks politely and is not arrogant." (SSI, Mother, Cianjur)

> *"Thank God, we have a good midwife. She is always ready. If we call her, she is always available."* (SSI, *Kader*, Cianjur)

The attitude of the VMW was also appreciated by informants in villages far from a health facility but with high attendance at ANC and facility delivery, both in Ciranjang and Sindangbarang:

> *"Though she is not from this village, she accepts to live in the village where she works. She always presents in Posyandu activities. …Well, sometimes she has another thing to do such as shopping in the city. But if she was out and a patient needs her, just call her. The midwife will return as fast as possible. She never leaves for more than one day. They [the villagers] trust her."* (SSI, Village Head, Cianjur)

> *"We thank the midwife. She is willing to be woken up in the middle of the night. She is very good in treating pregnant women. For delivery, she is always ready even though it is raining."* (SSI, *Kader*, Cianjur)

It is noteworthy that some *kaders* and village heads in villages with higher attendance at ANC and facility delivery in both SW Sumba and Cianjur emphasized that the performance and enthusiasm of their VMWs encourage them to support the VMWs' activities.

SUPPORT FROM STAKEHOLDERS

Our data also showed the crucial role of stakeholders (such as the village head, the wife of the village head, religious leaders, the PKK and the PNPM) in the villages with higher attendance at ANC and facility delivery. In SW Sumba this can be seen particularly in the two villages in Radamata and one village in Palla. In a village in Radamata which is close to a health facility and has high attendance at ANC and facility delivery, the support from the village head in particular is important:

> *"I usually communicate with the village head. He frequently helps in motivating the pregnant women so that even if there was no vehicle, they had to think about their own way of reaching the health facility [to deliver]."* (SSI, VMW, SW Sumba)

When asked about the result of her communication with the village head, this midwife explained:

> *"There were positive responses from the people. For example, when there's a health promotion in the village, the village head helps in communicating with the people so they can understand. ...When he comes to visit the houses [of the pregnant women], he also helps them to understand."*

In another village in the Radamata area which is far from a health facility but has high attendance at ANC and facility delivery, the support of the village head is also evident. However, the village head emphasized that it is the good performance of the midwife that encouraged him and the head of the hamlets in his area to provide their support:

> *"People like the midwife's services and her personality. Her dedication fits with her oath as a midwife to do the task unconditionally. Because of these, the village head and the head of the hamlets support her work."* (SSI, Village Head, SW Sumba)

We can also see the support of a village head and other stakeholders such as the PKK in Palla in a village which is close to a health facility and has high attendance at ANC and facility delivery:

> *"I keep communicating with the village head, particularly to encourage them [pregnant women] to deliver in a health facility and to come to Posyandu. Fortunately she is very committed. So in every meeting she conducts with hamlet heads she always emphasizes these issues. So we have some improvements. I also discuss with my midwife coordinator that we have to keep approaching the head of the village and the hamlet heads because they are the ones who have real power in the village. We, midwives, are like only guests. Villagers mostly respect the village head and hamlet heads."* (FGD, VMW, SW Sumba)

> *"We're happy if the village head participates; this has a big impact. For example, most people think that Posyandu is from health officials only, which it is not. Posyandu is actually the village asset. That's why the village head's participation is important. So it's also the responsibility of the village head and the head of the Family Welfare Movement [PKK]."* (SSI, Midwife Coordinator, SW Sumba)

The support of stakeholders (village heads, in particular) is also evident in villages with high attendance at ANC and facility delivery in Cianjur (Sindangbarang and Ciranjang):

> *"Me and my wife frequently went to the Posyandu; we had meals together with the community there. ...My frequent attendance to Posyandu has a good impact to encourage pregnant women to come to Posyandu."* (SSI, Village Head, Cianjur)

> *"In the past, the maternal indicator in this village was poor. Now it is better. The partnership is good, between us [midwives], kaders and the head of the village. We work together. In other villages the partnership is not as good."* (SSI, VMW, Cianjur)

It is worth noting that VMWs and *kaders* in villages with higher ANC attendance and facility delivery in Cianjur mentioned more varied stakeholders such as the wife of the village head,

religious leaders, the PKK and the PNPM. A midwife in a village far from a health facility but with higher ANC attendance and facility delivery in Sindangbarang said:

> *"I need more help. So I asked help from other people like religious leaders and the wife of the village head who is also the head of the Family Welfare Movement. They support me. Like the religious leaders deliver messages in their sermon during the pengajian [Islamic recitation meeting] in the mosque. They also allow me to use the mosque to announce the Posyandu day. I ask for help from them, because we [midwives and kaders] cannot work alone. If there is a problem, they can help. We communicate with them, so they feel these health issues are also their needs."* (SSI, VMW, Cianjur)

A VMW in Ciranjang, far from a health facility but with higher ANC attendance and facility delivery, also mentioned the support from other stakeholders such as Healthy and Smart Generation (GSC) organized by the PNPM in her village:

> *"We now have pregnancy class supported by GSC. More pregnant women come here. We also try to solve problems together. For example, a pregnant woman doesn't want to go to ANC. We find out the problem. If the problem is money, we do not give her money, but we replace her transportation cost. So the pregnant women can claim their transportation cost to GSC."* (SSI, VMW, Cianjur)

These levels of performance and enthusiasm among midwives and support from stakeholders are less visible in the the villages with lower ANC attendance and facility delivery.

CHAPTER 6 – DISCUSSION

The REACHOUT CTC provider performance and services study in Indonesia is aimed at improving maternal health services because of the low proportion of health facility deliveries. We have, therefore, assessed the barriers to accessing maternal health services, as these influence the end-user results of the CTC providers' services and performance, and the role of the CTC provider in addressing these barriers. In this discussion we draw on the desk study and the findings of the qualitative study.

BARRIERS TO ACCESSING MATERNAL HEALTH SERVICES

ANC

ANC is an approach aimed at improving maternal health outcomes by early identification of risk pregnancies. It is recommended that pregnant women have a minimum of four ANC visits during pregnancy. However, as presented in our findings, there are several important barriers that may hinder pregnant women in SW Sumba and Cianjur from accessing ANC in *Posyandu.* Our findings identify that pregnant women's priority-setting and their disillusionment with the services were important factors. In addition, other studies have indicated distance to health facility, mothers reporting no obstetric complications during pregnancy, residents of rural areas, low household wealth index and low maternal educational level as factors for under utilization of ANC services [24, 32].

Facility delivery

Despite the increase in the proportion of deliveries at health facilities in both SW Sumba and Cianjur since the introduction of health insurance for delivery (*Jampersal*), as mentioned by some informants, this increase is not as high as the health authorities in both districts anticipated. Our study results show that this is in part due to the presence of numerous obstacles such as traditional beliefs, a lack of responsiveness from health facilities to cater for those traditional beliefs and practices, and previous experience of normal delivery meaning that some women did not recognize any benefit of facility delivery. These findings are in line with other study findings from Indonesia [22, 24].

Practical difficulties such as distance, poor road conditions, lack of availability of transportation (including the cost of transportation) and indirect costs (e.g. the cost of accommodation and food for family members who accompany the parturient to deliver in a health facility) were also identified. Our findings are in line with the findings of other studies such as the IMMPACT analysis that addressed the importance of distance to health facility, which found that 66% of women delivered with a skilled attendant when their place of residence was close to the health facility (<5km), whereas only 9% of deliveries were attended

by a skilled provider when the women lived more than 60km from the health facility [25]. A lack of preparedness for a complication in terms of transport, the costs of accommodation for extended families and other requirements also reduce the likelihood of facility delivery during complications.

Some factors related specifically to human resources planning for maternal health, such as the lack of availability of a VMW (particularly in SW Sumba because many midwives do not reside in their assigned village) or difficulties in contacting the midwife due to distance and a lack of communication tools, also emerged.

Difficulties in contacting the midwife are due to the fact that there are numerous factors that do not support the midwives to live in their assigned village (e.g. basic facilities, safety and family reasons). Our findings also confirm the findings of previous studies that explored factors that influence the retention of midwives in their assigned villages[16, 18].

Our findings show that poor perception of the benefit of delivery at a health facility, negative perceptions of health workers (midwives, in particular) and health facilities, preference for home delivery and preference for TBA services as well as limited communication and referral of pregnant women from TBAs to midwives are barriers to delivery at a health facility. These findings support the findings of other studies such as a study in six districts in West Java in which the limited availability of health care providers and the geographical, psychological and cultural proximity of TBAs in the village hinder facility delivery [7]. Moreover, a UNICEF report indicated that psychological and cultural support provided by the TBA such as massage and herbal medicine are important factors for pregnant women to prefer using TBA services[22].

PNC and family planning

Traditional beliefs, preference for the services provided by TBAs and a lack of transportation were also mentioned by informants as hindrances to accessing PNC. Regarding barriers to accessing family planning, again traditional beliefs emerged, as did the aspiration to have a complete family by having a boy and a girl and a lack of support from the husband. Furthermore, access to child health services is hindered by disillusionment or negative perceptions of health workers and health facilities.

The data show how traditional beliefs and practices continue to hinder access to maternal health services at all stages: ANC, delivery at a health facility and family planning. This indicates that although modernity in the forms of modern education and modern health services have been intensively introduced and developed in Indonesia in the last few decades, this does not necessarily influence practice and health-seeking behaviour relating to pregnancy and delivery [7, 35, 36]. This is the case particularly in remote hamlets of Radamata

(SW Sumba), but it can also still be found among pregnant women in some hamlets in the sub-district of Sindangbarang (Cianjur), located on the island of Java, which has the most advanced development in Indonesia.

FACILITATORS TO ACCESS MATERNAL HEALTH SERVICES

HEALTH PROMOTION AND PERCEPTIONS OF QUALITY OF CARE

Despite the presence of barriers, several factors were identified that may encourage or facilitate pregnant women to access maternal and child health services. It is worth noting that our desk study indicates that access to ANC (*Posyandu* attendance) increases as a result of the local policy known as the Maternal and Child Health Revolution (Revolusi KIA) in East Nusa Tenggara province and in Cianjur. Facilitators for ANC include the belief that having the mother and baby checked will make the baby safe and healthy; to obtain vitamins, medicines, injections or bed nets; the fact that the services are free; the trusted position of VMWs; and the presence of social control and penalties for not attending ANC. Perception of quality appeared to be a crucial facilitator for health facility delivery — for example, the belief that there are better instruments and equipment in a health facility, specifically those to measure blood pressure or to listen to the baby's heart, and that the midwives are better skilled to manage risks for the mother and the baby. Provision of beneficial supplies such as vitamins or injections also contributed to motivate women to give birth at a facility.

Effective health promotion to improve knowledge about the benefits of delivering in a health facility and assisted by health professionals such as midwives may improve health-seeking behaviour. Research from beyond Indonesia suggests that such health promotion programmes may also facilitate behavioural changes to make pregnant women more motivated to give birth at a health facility [28, 37, 38]. In addition, birth preparedness can be enhanced through participatory learning and action using groups in the community to develop action plans to support women to use health facilities and speed up referral.

SUPPORT FROM STAKEHOLDERS

In addition, our data indicate that the support of stakeholders (including the village head, the wife of the village head, religious leaders, the PKK and the PNPM) is also crucial to assist VMWs and *kaders* in delivering maternal health services in the villages. These stakeholders have the potential to improve maternal health services. In many cases, the support of the strategic stakeholders emerged due to the communication initiatives of the VMWs. Our comparative analysis suggests that the existence of highly motivated midwives combined with support from key stakeholders may have had a positive effect on improving outcomes in

villages that are a long way from health facilities. There is no published literature yet to support this observation, which is worthy of further investigation.

STAFF ATTITUDES

The friendly attitudes of the midwives are also important facilitators for mothers to access PNC services. The desire to enhance quality of life and to reduce the burden on the family emerged as a facilitator to spacing childbirth and accessing family planning. The presence of these facilitators is in line with the findings of other studies internationally that highlight factors that may enhance access to maternal and child health services [28, 37]. Our findings in SW Sumba and Cianjur also show the essential role of the VMWs' performance and enthusiasm to facilitate higher attendance at ANC and facility delivery. Their performance, enthusiasm and friendly attitude may also motivate the *kaders* to improve their performance in organizing the *Posyandu* and encouraging pregnant women to attend ANC and deliver in a health facility. Several studies have emphasized the important role of VMWs as the front line providers of maternal health services in rural settings [28, 39] .

HUMAN RESOURCES

TYPOLOGY OF CTC PROVIDERS AND WORKLOAD

The main CTC providers of maternal health care are the VMWs or nurses, the *Posyandu kaders* and TBAs. The VMWs are involved in providing midwifery care and attending deliveries at facilities or at home. Since they might be the only health care provider in the village, in addition to their 24-hour availability for deliveries, their roles expand to provide general health care, care for elderly people and health promotion activities such as family planning and nutrition, which is beyond their training. In Cianjur some midwives are also involved in female genital cutting/circumcision. Midwives provide a 24-hour service in remote areas and find the additional workload a challenge for their competencies.

Posyandu kaders are non-salaried workers who are chosen by the community to serve in the *Posyandu* (community integrated health post). The *kaders* are responsible for arranging the *Posyandu*, weighing children, assisting in registration and providing nutritional and health promotion such as family planning. They receive a financial incentive from the DHO and a week of training for their *Posyandu*-based tasks.

TBAs are non-salaried informal workers whose roles and training vary; some inherit the role. They are involved in providing local traditions such as massage to position the foetus, attending home deliveries and providing post-delivery care such as bathing mother and child.

SELECTION AND RECRUITMENT OF CTC MATERNAL HEALTH PROVIDERS

Midwives are recruited on the basis of an academy certification and appointed by the DHOs. *Kaders* are selected by the community, with a strong influence of village leaders on the selection, based on literacy capabilities; however, increasingly, VMWs play a role in their selection. Communities express a preference for married, older midwives. However, this is a challenge. Older, married midwives often have a house, family and school-age children and find it difficult to be based in remote villages without schooling for the children. The desk study shows that midwives who are not resident in their assigned village spend less than half the number of days on village-based clinical work than those who are resident, although this differs significantly by location. Remote areas show a high turnover of midwives.

SUPERVISION

From the interviews with midwives, supervision is perceived as not very supportive or motivating. Our desk review confirms this finding, adding that the performance of VMWs and *Posyandu kaders* could be further increased by providing a structured and more supportive supervisory system. Several reports in Indonesia have stated that this weakness is recognized by the government, and efforts are ongoing to formulate a better structured supervisory process [14, 22]. The decentralization policy implemented since 2001 could be used to strengthen supervision and support to increase the performance of VMWs and *Posyandu kaders.*

PLURAL HEALTH-SEEKING BEHAVIOURS AND COLLABORATION BETWEEN TBAS, *KADERS* AND VMWS

While there is an increasing number of pregnant women who access ANC services and deliver at health facilities in SW Sumba and Cianjur, our data in both districts clearly reveal the plural health-seeking behaviours among pregnant women in these locations. Numerous pregnant women use ANC services in *Posyandu*, but they also still use TBA services such as massages. TBA services are considered important by most pregnant women and husbands in SW Sumba and Cianjur during pregnancy and delivery and after delivery. TBA services are perceived as valuable not merely for physical reasons (such as massage to relieve pain during pregnancy and after delivery) but also for psychological support for pregnant women and their husbands. These views reveal the still crucial role of TBAs among people in the study sites in SW Sumba and Cianjur and indicate the importance of maintaining or improving collaboration between TBAs, *kaders* and VMWs.

There is a certain amount of collaboration between VMWs, *kaders* and TBAs in some villages in SW Sumba and Cianjur. The impact of this collaboration is the encouragement of pregnant women to attend *Posyandu* for ANC and to deliver in a health facility; it is also considered an important facilitator to access maternal and child health services.

Several studies had advocated strategies to reduce the utilization of TBA services such as to establish a TBA–midwife partnership. Under these strategies the cultural importance of TBAs is respected, and TBAs are allowed to assist with local beliefs and practices and be present at delivery to provide psychological support to the parturient while the delivery is conducted by the midwife [22, 40]. Moreover, the TBAs are encouraged to refer pregnant women to the midwife or health facility, and in return they receive a financial incentive. It is noteworthy that the success of the transition from TBA to skilled birth attendant has been shown in West Java, with the proportion of TBA-attended deliveries decreasing from over 80% in the IDHS report of 2007 to 17% in 2013 [5, 9].

DIFFERENCES BETWEEN SW SUMBA AND CIANJUR

In the above section we presented some similarities between SW Sumba and Cianjur, particularly those related to barriers to and facilitators of maternal and child health services, plural health-seeking behaviours related to maternal and child health as well as collaboration between TBAs, *kaders* and VMWs in both districts. It is noteworthy that there are also differences between the two districts:

VMWs: In Cianjur all VMWs live in their assigned villages. Several villages that we chose as study sites have more than one VMW. In SW Sumba only three VMWs reside in their assigned villages. The better availability of basic facilities such as clean water, electricity and educational facilities such as kindergarten and primary school (for the children of the midwives) in Cianjur may cause this phenomenon. Cianjur is a much older and better developed district than SW Sumba. In addition, VMWs in villages in Cianjur with higher attendance at ANC and facility delivery obtain more support from more varied stakeholders (village head, the wife of village head, the PKK and the PNPM) compared to those in villages in SW Sumba, who are merely supported by village heads.

Kaders: *Kaders* in villages that we chose as study sites in Cianjur are involved in more varied programmes than their counterparts in SW Sumba, including their involvement in Healthy and Smart Generation (GSC) organized by the PNPM. This programme is more available in Cianjur then in SW Sumba. Again, this may be partly caused by the fact that Cianjur is a much older and better developed district than SW Sumba.

TBAs: TBAs in Cianjur are generally more empowered than their counterparts in SW Sumba. TBAs in Cianjur also receive greater financial or non-financial incentives for the services they provide. In addition, compared to SW Sumba, there is a higher level of collaboration between TBAs, *kaders* and VMWs in Cianjur.

Free insurance for facility delivery (Jampersal): There is also a stark difference regarding Jampersal between Cianjur and SW Sumba. In the villages that we chose as study sites in

Cianjur, VMWs may claim their incentives from Jampersal when they assist delivery in the house of the parturient mother. This cannot be done in SW Sumba due to the local policy in East Nusa Tenggara province, Maternal and Child Health Revolution.

Private midwife practices: In Cianjur there are numerous midwives who have private practices. The higher level of availability of midwives and the greater financial capacity to pay for private midwife practices may explain this situation.

Issues related to supplies and logistics: Issues related to supplies and logistics emerged more clearly in SW Sumba than in Cianjur. These could be influenced by the more remote location of SW Sumba and the fact that it is a newer and less developed district than Cianjur.

CHAPTER 7 – IMPLICATIONS

FOR THE DRAFT FRAMEWORK

From the Indonesian context analysis data there are several implications for consideration within the context analysis framework. These relate to the health system's lack of responsiveness to local practices which leads to the still high preference for TBA services and home delivery. Another implication is the need to make more visible the potential and the importance of strategic stakeholders (such as village heads) to support the work of CTC health providers.

THE QUALITY IMPROVEMENT CYCLE

LOW HEALTH FACILITY DELIVERY RATES

We found common problems in our study in SW Sumba and Cianjur which need to be prioritized i.e. low rates of delivery in a health facility. There are several factors contributing to this problem, including the lack of consideration at health system level to the preference for home delivery; poor perception of the benefit of facility delivery; a lack of birth preparedness to overcome access barriers such as transport either by ambulance or other ways; the cost of food and accommodation for family members in case of referral; and limited communication and information about delivery from TBAs to midwives.

PREFERENCE FOR HOME DELIVERY

There are several factors that contribute to the preference for home delivery, such as the poor response to community cultural practices within the existing health system and facilities that leads to the preference for TBA assistance for delivery; poor road infrastructure leading to poor access; non-functioning or a lack of communication services that also prevent timely attendance at the health facilities for deliveries; and poor perception of the quality of facility-based services. The poor perception of service quality is caused by a lack of flexibility in accommodating local practices such as massage, hot baths and prayer recitations by TBAs, as well as supply stock-outs and a lack of facilities and supervision from DHOs.

The preference for home delivery assisted by TBAs is also influenced by TBAs' greater responsiveness to cultural practices, their continuous support and presence during delivery, community pressure to adopt local practices, and local customs related to delivery in which the presence of TBA is considered obligatory. In addition, the preference for TBA services is also caused by midwives' limited proximity and availability compared to TBAs'. We have presented in the findings that in SW Sumba in particular, there are several VMWs that do not reside in their assigned village due to several factors such as the lack of basic facilities (e.g.

housing, clean water, electricity), family reasons and the lack of educational facilities for their children.

POOR PERCEPTION OF THE BENEFITS OF DELIVERY AT A HEALTH FACILITY

As can be seen in our findings and root cause analysis, a low level of community awareness regarding delivery shapes the poor perception of the benefits of facility delivery. We also found that the following factors may contribute to this situation: the perceived low risk to the mother and baby with normal antenatal findings during pregnancy; mothers' previous experience of normal delivery and the lack of health promotion programmes in *Posyandu;* the lack of a *kader* role outside *Posyandu;* and the lack of involvement of village authorities and other important stakeholders (such as the PKK and the PNPM) in health promotion related to the benefits of facility delivery and maternal health services.

INDIRECT COSTS

The indirect costs related to facility delivery may also contribute to the low rate of facility delivery, including costs for accommodation and food for members of the family who accompany the pregnant woman when they attend a health facility for delivery, as well as the cost of using their own transport if an ambulance service is not available. These are costs not covered by the *Jampersal* health insurance scheme provided by the government for free delivery at health facilities.

LIMITED COMMUNICATION AND INFORMATION ABOUT DELIVERY FROM TBAS TO MIDWIVES

In addition, our findings and root cause analysis indicate that, despite the presence of a certain degree of partnership between VMWs and TBAs in severel villages in SW Sumba and Cianjur, limited communication and information about delivery from TBAs to midwives also contributes to the low facility delivery rate in both districts.

POTENTIAL AREAS FOR INTERVENTION

Based on the abovementioned factors that contribute to the low rate of facility delivery in SW Sumba and Cianjur, we recommend the following areas of interventions for improving the performance of the CTC providers in the quality improvement cycle:

***Coordination/referral*:** to initiate or support the three-way collaboration between VMWs, *Posyandu kaders* and TBAs to facilitate timely referral of women in labour to attend a health facility. This intervention is aimed at addressing the prevailing preference for home delivery and limited communication and information about delivery from TBAs to midwives. This may be achieved through regular monthly meetings. This mechanism could then be used to:

- improve TBAs' capacity and willingness to refer women, inform VMWs in advance of an upcoming birth and accompany women for facility delivery, with an emphasis on stimulating birth preparedness and capacity to refer;
- follow up the Training Act as a supportive structure that can link to supervisory support by sharing problems and possible solutions; and
- provide a forum for regularly updating the skills of midwives and *Posyandu kaders*.

Health promotion: to improve the communication skills of CTC health providers such as *Posyandu kaders* and VMWs to explain the benefits of ANC and facility delivery to pregnant women. The intervention could, therefore, train providers to enhance their communication skills and initiate discussion with women, supported by well-developed health promotion materials. The aim would be to enable them to more effectively communicate with women during ANC about the changes and developments in the health insurance scheme, on the benefits of facility delivery, the risks despite a normal pregnancy etc.

Improve community support: to address traditional practices, decision-making and preparedness for referral at birth. The features of the intervention could involve the development of participatory learning and action in community groups with the aim of generating reflection on decision-making and the development of action plans to overcome barriers to accessing health facilities for delivery.

Cultural sensitivity: to give consideration to locally practised norms and acceptable services such as the provision of hot baths after delivery at health facilities, to improve the responsiveness of health services to local traditional practices that will encourage parturient mothers to deliver at a health facility.

***Support from strategic stakeholders*:** such as village authorities, the PKK and the PNPM to become involved in and support maternal health services, and action plans developed by the community.

Village transport: Encourage setting up a village transport network particularly for delivery emergencies, with the involvement of key figures in the village such as the village head and the PKK, and develop a reimbursement system for transport and family accommodation costs.

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ANNEXES

ANNEX 1. DEFINITION OF CTC PROVIDER

Definition of CTC provider

A CTC provider is a health worker who carries out promotional, preventive and/or curative health services and who is first point of contact at community level. A CTC provider can be based in the community or in a basic primary facility. A CTC provider has at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training.

Some considerations and clarifications

CTC providers include a broad variety of health workers, including community health workers. We will use the definition of lay health workers of Lewin et al. (2010)[1], which refers to community health workers (we will not use the term 'lay health workers', as they may be regarded by some as having no training in the intervention). Other names that are used for community health workers include, for example: village health workers, health promoters etc.

CTC providers also include auxiliary health workers. For auxiliary workers we use definitions proposed by WHO.[2]

In REACHOUT, the focus is to improve the performance of CTC providers that have a link with either the government or an NGO programme. For Mozambique, Malawi and Kenya these are CHWs, and for Ethiopia these are the Health Extension Workers. The latter cadre has a one-

[1] Lewin et al. (2010): definition of lay health worker: "Any health workers carrying out functions related to health care delivery; trained in some way in the context of the intervention, and having no formal professional or paraprofessional certificate or degree in tertiary education."

[2] WHO (2012): definition of auxiliary nurse: "Have some training in secondary school. A period of on-the job training may be included, and sometimes formalised in apprenticeships. An auxiliary nurse has basic nursing skills and no training in nursing decision-making. However, in different countries the level of training may vary between few months to 2–3 years. Different names for this cadre are: auxiliary nurse, nurse assistant, enrolled nurse (also called nurse technicians or associate nurses)."

Definition of auxiliary nurse midwife: "Have some training in secondary school. A period of on-the job training may be included, and sometimes formalised inapprenticeships. Like an auxiliary nurse, an auxiliary nurse midwife has basic nursing skills and no training in nursing decision making. Auxiliary nurse midwives assist in the provision of maternal and newborn health care, particularly during childbirth but also in the prenatal and postpartum periods. They possess some of the competencies in midwifery but are not fully qualified as midwives."

year para-professional education and is employed by the government health services and, therefore, could be regarded as falling within the WHO definition of an auxiliary worker.

For the purpose of the international literature review, it was necessary to develop the definition of CTC provider with clear limits (mainly regarding educational level). Informal providers are considered within the definition of CTC providers when they have a link with a government or NGO programme and when they are trained. This is relevant for Bangladesh.

The definition of CTC providers excludes informal cadres such as community pharmacists, informal private practitioners, traditional healers and TBAs who are not trained for an intervention or who do not collaborate with other actors in the health system. The definition also excludes cadres with tertiary education. This does not mean that they are completely excluded from the REACHOUT literature review or processes; we will address the ***interactions*** between CTC providers and these cadres. Nor are they excluded from the quality improvement cycles.

What we include in the international literature review

In the international literature review we will particularly focus on the broad categories of community health workers and auxiliary health workers. When it comes to other providers (doctors, midwives and nurses with tertiary education who form a first contact with the community) and informal cadres, we will include the ***interactions*** of community health workers and auxiliary health workers with these cadres.

The table below contains some information on the cadres being included in the international literature review:

	Auxiliary health workers	**Community health workers**
Examples of cadres and nomenclature	▪ Auxiliary nurses ▪ Nurse assistants ▪ Enrolled nurses ▪ Nurse technician ▪ Associate nurses ▪ Auxiliary nurse-midwives ▪ Health extension workers	▪ Lay health workers ▪ Health promoters ▪ Trained Traditional Birth Attendants ▪ Expert patient volunteers ▪ Lay counsellors ▪ Trained informal providers ▪ Many more
Characteristics		

	Auxiliary health workers	**Community health workers**
Residence	Often not living in community (as catchment area often consists of more than one community)	Often living in community, but not always the case (catchment area may consist of more communities)
Selection	Not selected by community (mostly)	Selected by community (ideally) (and, in principle, accountable to community)
Origin	Not necessarily coming from the community	Coming from the community (mostly)
Organizational set-up	▪ Public sector and private ▪ Part of formal health system (government or NGO representing the government)	▪ Public and private sector ▪ Some part of formal health system (government or NGO) ▪ Others not part of but collaborating with other actors in the health system
Level of training	Formal para-professional training (some secondary schooling plus on-the-job, apprenticeship) (may have certificate)	▪ Trained in some way related to intervention ▪ No formal (para-professional) training
Remuneration	Paid/employed	Paid/employed or volunteer
REACHOUT countries and their CTC providers included in the research		
Ethiopia	Health extension workers*	Volunteer community health promoters
Indonesia	Village/community midwives**	Family planning volunteers TBAs
Kenya		CHWs Lay counsellors
Mozambique		CHWs
Malawi		▪ Health Surveillance Assistants ▪ Community volunteers: community home-based care volunteers, health promoters, village health committee members (as

	Auxiliary health workers	Community health workers
		health promoters), expert patients
Bangladesh		CHWs Trained informal providers

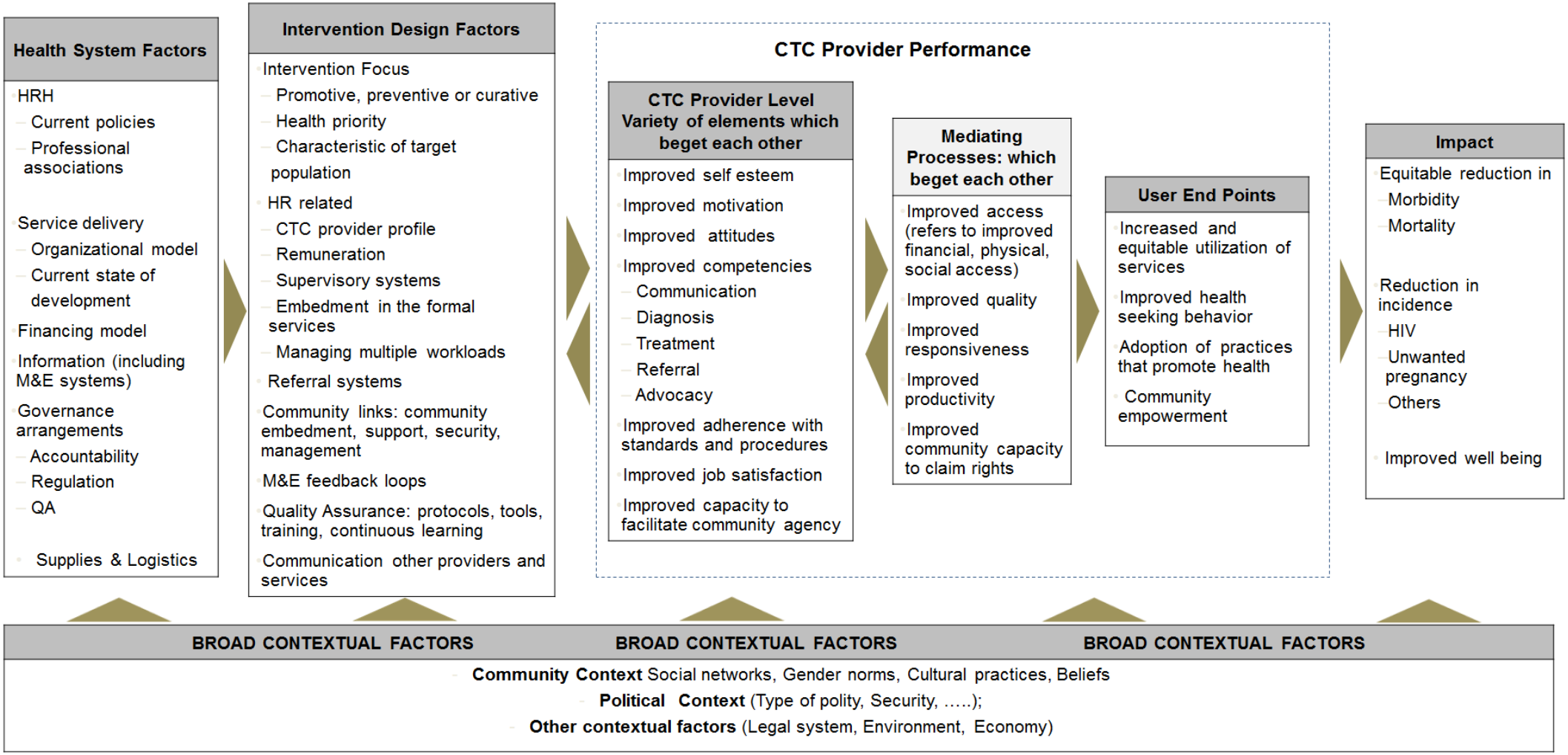
*Health extension workers are selected with the involvement of community and are expected to live in the community. They kind of fall in between CHWs and auxiliaries.

**This cadre officially does not fall in the auxiliary cadre as defined by WHO.

ANNEX 2. DRAFT FRAMEWORK

Major themes from the framework (see diagram below) on factors influencing CTC provider performance:

- Broad contextual factors
    - Community factors
    - Policy factors
- Health system factors
- Intervention design factors
    - Human Resource Management
    - Quality Assurance
    - Monitoring & Evaluation


Health System Factors
HRH
Current policies
Professional associations
Service delivery
Organizational model
Current state of development
Financing model
Information (including M&E systems)
Governance arrangements
Accountability
Regulation
QA
Supplies & Logistics
Intervention Design Factors
Intervention Focus
Promotive, preventive or curative
Health priority
Characteristic of target population
HR related
CTC provider profile
Remuneration
Supervisory systems
Embedment in the formal services
Managing multiple workloads
Referral systems
Community links: community embedment, support, security, management
M&E feedback loops
Quality Assurance: protocols, tools, training, continuous learning
Communication other providers and services
CTC Provider Performance
CTC Provider Level Variety of elements which beget each other
Improved self esteem
Improved motivation
Improved attitudes
Improved competencies
Communication
Diagnosis
Treatment
Referral
Advocacy
Improved adherence with standards and procedures
Improved job satisfaction
Improved capacity to facilitate community agency
Mediating Processes: which beget each other
Improved access (refers to improved financial, physical, social access)
Improved quality
Improved responsiveness
Improved productivity
Improved community capacity to claim rights
User End Points
Increased and equitable utilization of services
Improved health seeking behavior
Adoption of practices that promote health
Community empowerment
Impact
Equitable reduction in
Morbidity
Mortality
Reduction in incidence
HIV
Unwanted pregnancy
Others
Improved well being
BROAD CONTEXTUAL FACTORS
BROAD CONTEXTUAL FACTORS
BROAD CONTEXTUAL FACTORS
Community Context Social networks, Gender norms, Cultural practices, Beliefs
Political Context (Type of polity, Security, …..);
Other contextual factors (Legal system, Environment, Economy)

ANNEX 3. SEARCH STRATEGY

We based our search strategy on Lewin 2010 but added CTC providers (CTC providers are broader than LHWs and include for example also auxiliary staff and informal providers). We combined CTC providers with the term 'health' (or 'primary health care') and with impact or outcome measures and with specific search terms relating to either HRM, QA, M&E, community or policy factors. Limiters were: from 2003 till now, English language and LMIC.

EMBASE search

Regarding Embase, we used Emtree terms to develop search terms, but while searching, we did not use them as search terms as such, because the results are less if you do so. Reason is that not all articles containing this term have been labeled. We searched for the terms in whole text.

Searches CTC providers

Green = added to Lewin 2010.

#1	'voluntary worker' OR 'voluntary workers' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#2	'paramedical personnel' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#3	'health auxiliary' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#4	'peer group' OR 'peer groups' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#5	'health visitor' OR 'health visitors' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#6	doula OR doulas OR douladural? AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#7	(lay OR voluntary OR volunteer OR volunteers OR untrained OR unlicensed OR non+professionals OR non+professional OR nonprofessionals OR nonprofessional OR 'non professional' OR 'non professionals' OR informal OR 'non formal' OR non+formal) NEAR/5 (worker OR workers OR visitor OR visitors OR attendant OR attendants OR aide OR aides OR support OR support* OR person* OR person OR helper OR helpers OR carer OR carers OR caregiver OR caregivers OR consultant OR consultants OR assistant OR assistants OR staff OR visit* OR visit OR midwife OR midwives OR provider OR providers OR 'care giver' OR 'care givers' OR practitioner OR practitioners) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#8	paraprofessional OR paraprofessionals OR paramedic OR paramedics OR 'paramedical worker' OR 'paramedical workers' OR 'paramedical personnel' OR 'allied health personnel' OR 'allied health worker' OR 'allied health workers' OR 'support worker' OR 'support workers' OR 'home health aide' OR 'home health aides' AND [humans]/lim AND [english]/lim AND [2003-2013]/py

#9	trained NEAR/3 (volunteer OR volunteers OR 'health worker' OR 'health workers' OR mother OR mothers) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#10	(community OR communities OR 'community based' OR village OR villages) NEAR/3 ('health worker' OR 'health workers' OR 'health care worker' OR 'health care workers' OR 'healthcare worker' OR 'healthcare workers' OR distributor OR distributors) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#11	(community OR communities OR 'community based') NEAR/3 (volunteer OR volunteers OR aide OR aides OR support) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#12	(birth OR childbirth OR labor OR labour) NEXT/1 (attendant OR attendants OR assistant OR assistants) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#13	monitrice OR monitrices AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#14	(lay OR peer) NEXT/1 (volunteer OR volunteers OR mentor* OR mentor OR counsel* OR support OR intervention OR interventions) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#15	'church based' NEAR/3 (intervention OR interventions OR program* OR program OR counsel*) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#16	linkworker OR linkworkers OR 'link worker' OR 'link workers' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#17	'barefoot doctor' OR 'barefoot doctors' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#18	outreach AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#19	home NEXT/1 (care OR aide OR aides OR nursing OR support OR intervention OR interventions OR treatment OR treatments OR visit* OR visit) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#20	(care OR aide OR aides OR nursing OR support OR intervention OR interventions OR treatment OR treatments OR visit* OR visit) NEAR/3 (lay OR volunteer OR volunteers OR voluntary) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#21	auxiliary NEAR/3 (worker OR workers OR nurse OR nurses OR midwives OR midwife) AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#22	'expert patient' OR 'expert patients' OR 'health promoter' OR 'health promoters' OR 'health extension worker' OR 'health extension workers' OR 'mentor mother' OR 'mentor mothers' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#23	#19 AND #20
#24	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #21 OR #22 OR #23

Health or primary health care combined with impact and outcome measures

#25	health AND (efficiency OR equity OR 'health care utilization' OR 'patient compliance' OR 'patient attitude' OR 'patient attitudes' OR 'health care quality' OR 'patient satisfaction' OR 'cost effectiveness analysis' OR 'cost benefit analysis') AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#26	'primary health care' AND (efficiency OR equity OR 'health care utilization' OR 'patient compliance' OR 'patient attitude' OR 'patient attitudes' OR 'health care quality' OR 'patient satisfaction' OR 'cost effectiveness analysis' OR 'cost benefit analysis') AND [humans]/lim AND [english]/lim AND [2003-2013]/py

Searches related to HRM, QA, M&E, community and policy factors

#27	'performance appraisal' OR 'personnel selection' OR 'personnel recruitment' OR 'personnel turnover' OR 'staff development' OR workload OR remuneration OR motivation OR incentive OR incentives OR disincentive OR disincentives OR 'job satisfaction' OR 'job performance' OR retention OR supervision OR 'task+shifting' OR 'task shifting' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#28	'quality assurance' OR 'continuing education' OR 'management quality circles' AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#29	'monitoring and evaluation' OR 'medical information system' OR 'medical information systems' OR 'mobile health' OR mhealth OR ehealth AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#30	'community participation' OR ownership OR empowerment OR gender OR accountability OR 'village health committees' OR 'village health commitee' AND [humans]/lim AND [english]/limAND [2003-2013]/py
#31	decentralization AND [humans]/lim AND [english]/lim AND [2003-2013]/py
#32	#27 OR #28 OR #29 OR #30 OR #31

LMIC

#33	'low and middle income countries' OR lmic OR 'low income countries' OR 'low income country' OR 'middle income countries' OR 'middle income country' OR africa OR asia OR 'developing country' OR 'developing countries' AND [humans]/lim AND [english]/lim AND [2003-2013]/py

Concluding searches

#34	#24 AND #25 AND #32 AND #33	1539 hits
#35	#24 AND #26 AND #32 AND #33	115 hits

After selection of articles based and title (and when doubt abstract): 242 out of 1539 for abstract reading.
Next database searches: CENTRAL, SCOPUS and PUBMED.

ANNEX 4. DATA COLLECTION TOOLS

CONSENT FORM

4. 1. 1. Consent Form – Indonesia

SURAT PERSETUJUAN

Saya bekerja di Lembaga Penelitian Eijkman yang saat ini bekerja sama dengan Dinas Kesehatan Kabupaten, beserta 6 negara lain dan Fakultas Kedokteran Tropik Liverpool, Inggris untuk mempelajari bagaimana meningkatkan program kesehatan ibu. Judul penelitian ini ialah **"Analisa konteks kinerja dan kesinambungan tenaga kesehatan di lini terdekat dengan masyarakat untuk meningkatkan pelayanan kesehatan ibu di Indonesia."**
Sebagai bagian dari penelitian ini, kami akan mewawancara anda secara perorangan. Namun sebelumnya kami akan menyampaikan informasi tentang penelitian ini lalu dilanjutkan dengan wawancara. Hal-hal yang akan anda sampaikan berkaitan dengan kerja anda bersifat penting untuk bisa mengatur dan meningkatkan pelayanan kesehatan ibu kepada masyarakat. Penting bagi anda untuk memahami terlebih dahulu mengapa kami melakukanpenelitian ini dan terkait dengan apa saja.

Apabila anda tidak mengerti mohon disampaikan dan saya akan menjelaskan. Jika anda memiliki pertanyaan tentang penelitian ini, saya akan meninggalkan nomor telepon dan anda bisa menghubungi saya.

Tujuan Penelitian
Kami ingin mempelajari tentang tenaga kesehatan di lini pertama (kader kesehatan, bidan atau perawat desa, dukun bayi) dan peran mereka dalam program kesehatan ibu. Kami juga ingin menggalisaran-saran anda untuk pemerintah dan organisasi non pemerintah dalam mendukung kerja mereka dalam peningkatan pelayanan kesehatan ibu.

Siapa saja yang bergabung dalam penelitian ini
Kami akan memilih dan mewawancara beberapa informan kunci seperti ibu, bidan atau perawat desa, tenaga sukarela desa (kader posyandu), dukun bayi, suami, perangkat desa atau kepala desa, bidan coordinator, kepala Puskesmas, dan petugas kesehatan ibu dan anak di dinas kesehatan kabupaten.

Apa yang kami harapkan dari anda

Bila setuju, kami akan mewawancara anda hari ini. Hal-hal yang akan ditanyakan meliputi 1) Pengetahuan anda, dan hubungan anda dengan tenaga kesehatan lini terdepan (kader kesehatan, bidan atau perawat desa, dukun bayi), 2) Pandangan anda terhadap peran tenaga kesehatan tersebut dalam program kesehatan ibu, 3) Faktor-faktor yang mempengaruhi peran tenaga kesehatan tersebut, dan 4) Saran anda untuk meningkatkan kinerja mereka. Wawancara berlangsung selama 1.5 – 2 jam. Kami ingin belajar dari anda. Karena itu penting bagi kami bahwa anda merasa bebas nyaman menjawab pertanyaandan bahwa anda mengerti tentang pentingnya pendapat dan ide anda bagi kami.

Risiko dan manfaat berpartisipasi dalam penelitian ini

Tidak ada manfaat langsung bagi anda yang berpartisipasi dalam studi ini, namun kami berharap penelitian ini berkontribusi dalam meningkatkan pelayanan kesehatan ibu bagi masyarakat Indonesia di masa yang akan datang. Kami akan mengidentikasi masalah-masalah dalam peningkatkan kerja dan pelayanan anda di bidang kesehatan ibu. Kami meminta partisipasi anda dalam penelitian ini setelah mendapatkan persetujuan dari Komite Etik Lembaga Penelitian Eijkman di Jakarta dan ijin dari Dinas Kesehatan terkait.

Bila saya memutuskan untuk berpartisipasi

Anda tidak perlu berpartisipasi bila anda memutuskan demikian. Anda bebas memutuskan karena partisipasi anda bersifat sukarela.Sebelum memutuskan, jangan ragu bertanya mengenai apa yang sudah kami sampaikan sebelumnya. Bila setuju kami akan meminta anda menandatangani formulir yang menunjukkan bahwa kami telah menjelaskan kepada anda tentang penelitian ini dan anda bersedia utuk berpartisipasi.

Bila saya memutuskan untuk tidak berpartisipasi

Anda bebas untuk menolak berpartisipasi atau tidak menjawab pertanyaan tertentu. Selama wawancara, anda bisa meminta saya untuk berhenti. Partisipasi anda juga bisa dibatalkan kapan saja. Pekerjaan anda tidak akan terpengaruh karena hal tersebut.

Informasi yang diperoleh bersifat rahasia

Kami akan mengumpulkan informasi dari semua partisipan penelitian. Nama anda akan tertulis hanya di lembar persetujuan yang akan disimpan dengan baik, terpisah dari hasil wawancara dan diskusi. Hanya orang-orang tertentu yang berwenang mengakses berkas tersebut. Untuk memastikan data penelitian digunakan secara benar, informasi yang kami dapat akan direkam dengan alat perekam dan catatan pendek.Nama anda tidak akan disebutkan dalam rekaman tersebut, tidak ditulis dan tidak diketik. Tidak akan ada orang yang akan tahu hal-hal apa saja yang kita diskusikan.

Prosedur

Wawancara akan dilakukan di tempat tertutup dimana diskusi tidak didengar oleh orang lain.

Kontak bila anda memiliki pertanyaan atau kekhawatiran

Bila ada memiliki kekhawatiran atau pertanyaan berkaitan dengan topik wawancara dan diskusi,anda bisa menghubungi Dr. Syafruddin di Lembaga Penelitian Eijkman di Jakarta di nomor telepon +62-81315093271.

DEKLARASI: UNTUK DITANDATANGANI OLEH PARTISIPAN

1. Saya setuju bahwa saya sudah membaca tentang informasi (mengerti informasi verbal yang telah dijelaskan kepada saya) yang menjelaskan latar belakang penelitian dan prosedur yang akan saya jalani
2. Saya mengerti bahwa saya bebas memilih untuk berpartisipasi atau tidak dalam penelitian ini dan tidak ada tekanan atas diri saya untuk berpartisipasi.
3. Semua pertanyaan saya mengenai penelitian telah dijelaskan kepada saya
4. Saya mengerti bahwa saya bisa meminta agar wawancara berhenti dan wawancara tersebut akan berhenti atas permintaan saya

Mohon untuk memberi tanda (√) pada kotak yang tersedia

	Ya	Tdk
1. Saya bersedia untuk berpartisipasi	☐	☐
2. Saya setuju bahwa kutipan dan hasil penelitian lain dari partisipasi saya dimasukkan secara anonim dalam laporan apapun berkaitan dengan penelitian ini.	☐	☐

_____

Tanda tangan Tanggal

TANDA TANGAN SAKSI

_____

Tanda tangan Tanggal

Cap Jempol Partisipan

Jika anda memiliki pertanyaan atau ingin mengajukan keluhan, anda bisa menghubungi:

Nama organisasi bertanggung jawab atas penelitian di Indonesia	**Nama Komite Etik di Indonesia**
Lembapa Penelitian Biomolekuler Eijkman Jl Diponegoro 69	Komite Etik Eijkman Jl Diponegoro 69

Jakarta 10430	Jakarta 10430

4. 1. 2. Consent Form – English

CONSENT FORM

I am working for the Eijkman Institute who is doing a study with the District Health Office and 6 other partner countries and the Liverpool School of Tropical Medicine, UK to learn ways to improve the maternal health program. Our study title is **"Context Analysis of the performance and sustainability of close-to-community (CTC) providers to improve CTC maternal health services in Indonesia."**

As part of this study we are going to interview you individually, but before doing this we want to give you more information about our study. After that I will invite you to join the interviews. What you tell us about your work in the program is important to better organize and improve the services offered to your community by the maternal health program. It is important that you understand why we are doing this study and what it involves.

If there is anything you do not understand please stop me and ask questions and I will explain. If you have any questions later about the study I will leave my phone number and you may call me.

Purpose of study

We want to learn about the CTC provider and their work in the maternal health programme. We want to understand your suggestions to be considered in the way the government and non-government organisations support their work and ways to improve their service to improve the programme.

Who is being asked to join the study

We are asking several key informants to join the interview: mothers, village midwives/ nurses, village health volunteers (*Posyandu Kader*), Traditional Birth Attendances (TBAs), husbands, village authorities (village head), midwives coordinators, *Puskesmas* head, and Maternal and Child Health District Health Officers.

What are we asking from you

If you agree we will like to interview you today. We will ask you questions about 1) Your knowledge about and relation with the CTC providers 2) Your views about their work related with maternal health 3) Factors influencing the CTC providers' work in maternal health, and 4) Your suggestions to be considered to improve their work. Our interviews would last about 1.5- 2 hours. We are here to learn from you and it is therefore important for us that you feel free to answer in a way you feel most appropriate and that you understand all your opinions and ideas are valuable for us.

What are the risks and benefits of joining the study

There will be no direct benefit to you by agreeing to join the interviews but we are hoping it can contribute to better maternal health service for the Indonesian community in the future. We are identifying issues in order to help optimise your work and the service offered to the maternal health programme. We have approached you to take part in this study after obtaining approval from the Ethical Committee of the Eijkman Institute in Jakarta and the permission of the District Health Office.

What happens if I decide join

You do not have to take part if you do not wish to. You are free to decide to take part in the study. Your participation is voluntary. Before deciding to take part to support our study please feel free to ask questions about what we have just told you. If you agree we will ask you to sign a form to show that we have explained to you about the study and that you volunteered to participate

What happens if I decide not to join

You are free to refuse to join or to respond to any questions that you do not want to answer. Anytime during the discussion you can ask me to stop. If you decide not take part or withdraw you can do so anytime. Your work in the programme or organization will not be affected in anyway

Information collected is confidential

We will bring together what everybody is telling us. Your name will only be recorded on the consent form, which will be kept locked up and separate from the interviews and discussions. Only authorized persons have access to it. To make sure that the information is correctly used the conversation will be recorded on a tape recorder in addition to taking notes. Your name will not be mentioned in relation to anything that will be said, written down and taped.No one will be able to identify what exactly we discussed.

Procedures

The interview or FGD will be conducted in a private place where nobody can hear what is said.

Contacts if you have any further questions or concerns

If you have any concerns or questions about the questions we are asking you may contact Dr. Syafruddin at the Eijkman Institute in Jakarta on his phone +62-81315093271.

DECLARATION: TO BE SIGNED BY THE RESPONDENT GIVING CONSENT

1. I agree that I have read the information (have understood the verbal information) that explains the reason for the study and procedures I will be asked
2. I understand that I am free to choose to participate or not to participate in the study and that no pressure is put on me participate
3. All questions I had about the study has been explained to me
4. I understand that I can request to stop questioning any time and that it will be stopped on my request

Please tick (√)in the correct box Y N

1. I agree to participate ☐ ☐

2. I do agree that quotes or other results arising from my participation being included even anonymously in any reports about the study. ☐ ☐

_____

Signed Date

WITNESS SIGNATURE

_____

Signed Date

Thumbprint respondent

If you have any questions or want to file a complaint about the research you may contact:

Name organization responsible for the study	**Name Ethics Committee in country**
Eijkman Institute for Molecular Biology Jl Diponegoro 69 Jakarta 10430	Eijkman Ethics Commitee Jl Diponegoro 69 Jakarta 10430

6 4.2. PARTICIPANT INFORMATION SHEET

4. 2. 1. Participant Information Sheet – Indonesian

4. 2. 1. 1. SSI Village midwife and *Kader*

Lembar rekaman pengumpulan data Bidan Desa dan *Kader*

FILE	
PEWAWANCARA	
TANGGAL	
KECAMATAN	
DESA	
INDIKATOR DESA	
DURASI WAWANCARA Mulai wawancara Selesai wawancara Lama wawancara	
KOMENTAR UMUM	

Lembar Informasi Bidan Desa dan *Kader*

JENIS KELAMIN		
UMUR		
STATUS PERNIKAHAN		
TINGKAT PENDIDIKAN		_____ Jurusan:
LAMA PERIODE BERTUGAS		
STATUS BIDAN	PNS	☐
	PTT	☐
	TKS	☐
WILAYAH KERJA	PUSKESMAS	
	DESA	
LOKASI KERJA	FASILITAS KESEHATAN	☐
	RUMAH	☐
	MASYARAKAT	☐
BIDANG PEKERJAAN	KESEHATAN IBU DAN BAYI	☐
	KESEHATAN ANAK	☐
	GIZI	☐
	TB	☐
	HIV/AIDS	☐
	MALARIA	☐
	LAINNYA ...	
TUGAS UTAMA	FASILITAS KESEHATAN *(pustu, polindes,poskesdes)*	
	RUMAH	
	MASYARAKAT *(posyandu,pokbang)*	
WILAYAH POSYANDU YANG DICAKUP		_____ POSYANDU/ _____ RW
JUMLAH WAKTU KERJA		_____ Jam/hari _____ Hari/minggu
TINGGAL DI DESA		☐ Ya ☐ Tidak
PENDAPATAN PER BULAN		Tetap :Rp. _____ Tidak tetap:Rp. _____
PELATIHAN		Jenis Pelatihan: Lamanya: Tahun:

4. 2. 1. 2. SSI TBA

Lembar Informasi Penolong Persalinan Tradisional (Dukun bayi)

Jenis kelamin	Perempuan / Laki-laki
Umur	..... tahun
Tingkat pendidikan	Tidak sekolah SD SLTP SLTA D1 D3 S1
Mulai bekerja sebagai dukun bayi / kader	Tahun .....
Bidang pekerjaan sebagai dukun bayi (bisa lebih dari 1 bidang)	Kesehatan Ibu dan Neonatus Kesehatan anak, TB, HIV, Malaria Lainnya.....
Tugas utama sebagai dukun bayi	
Jumlah waktu kerja	...hari / minggu ...jam / minggu
Apakah anda menerima pendapatan rutin?	Ya/Tidak Jika ya, berapa? Rp.....
Pelatihan yang pernah diterima :	Topik: Kapan: Lama:

4. 2. 1. 3. SSI Mother

Lembar Informasi Ibu

JENIS KELAMIN	
UMUR	
PEKERJAAN	
TINGKAT PENDIDIKAN	
STATUS PERNIKAHAN	
JUMLAH KEHAMILAN	
JUMLAH ANAK	
ASURANSI/JAMINAN KESEHATAN	Ya □ Jenis asuransi/jaminan kesehatan: _____ Tidak □
JARAK KE FASILITAS KESEHATAN (Puskesmas, Pustu, Poskesdes, Polindes)	_____ KM _____ menit menggunakan transportasi _____ ongkos transport Rp. _____
KONDISI JALAN KE FASILITAS KESEHATAN	
RIWAYAT PEMERIKSAAN KEHAMILAN	kali (selama kehamilan terakhir)
RIWAYAT PERSALINAN	Ditolong oleh: Tempat: I. II. III. IV. V.

4. 2. 1. 4. SSI Village Head

Lembar Informasi Tokoh Desa

JENIS KELAMIN	
UMUR	
TINGKAT PENDIDIKAN	Jurusan:
STATUS PERNIKAHAN	
JABATAN	
LAMA PERIODE BERTUGAS	
WILAYAH KERJA (NAMA DESA)	
JUMLAH POPULASI YANG DICAKUP	_____ RW _____ RT _____ KK _____ Jiwa
TUGAS UTAMA	

4. 2. 1. 5. SSI Midwife Coordinator, Puskesmas Head, and DHO MCH Officer

Lembar Informasi Health Manager

JENIS KELAMIN		
UMUR		
TINGKAT PENDIDIKAN		Jurusan:
JABATAN		
LAMA PERIODE BERTUGAS		
WILAYAH KERJA	DINAS KESEHATAN	☐
	PUSKESMAS	☐
	DESA	☐
BIDANG PEKERJAAN	KESEHATAN IBU DAN BAYI	☐
	KESEHATAN ANAK	☐
	GIZI	☐
	TB	☐
	HIV/AIDS	☐
	MALARIA	☐
	LAINNYA ...	
JUMLAH WAKTU KERJA		
PENDAPATAN TETAP/TIDAK TETAP		Tetap :Rp. Tidak tetap:Rp.
TUGAS UTAMA		
PELATIHAN		Jenis Pelatihan: Lamanya: Tahun:

4. 2. 1. 6. FGD Husband/Men

NO	NAMA	JENIS KELAMIN	UMUR	PEKERJAAN	Pendidikan

4. 2. 1. 7. FGD TBA (Cianjur)

NO	NAMA	UMUR	PENDIDIKAN	WILKER (DESA)	LAMA KERJA	KEMITRAAN	JLH KLIEN PER BLN	INCOME PER BULAN		BIDANG KERJA	TUGAS UTAMA	PELATIHAN (TAHUN)
								KLIEN	BIDAN			

4. 2. 1. 8. FGD Midwives (SW Sumba)

NO	NAMA	JENIS KELAMIN	UMUR	PEKERJAAN	Pendidikan

4. 2. 2. Participant Information Sheet – English

4. 2. 2. 1. SSI Village midwife and *Kader*

Data Collection Form for Village Midwife and *Kader*

FILE	
INTERVIEWER	
TRANSCRIBER	
TRANSLATOR	
DATE	
SUBDISTRICT	
VILLAGE	
VILLAGE INDICATOR	
DURATION OF INTERVIEW Start Finish Length	
General Comments:	

Information Sheet for Village Midwife and *Kader*

SEX		
AGE		
MARITAL STATUS		
EDUCATION LEVEL		MAJOR:
WORKING PERIOD		
STATUS	PNS	☐
	PTT	☐
	TKS	☐
COVERAGE	PUSKESMAS	
	VILLAGE	
LOCATION	HEALTH FACILITIES	☐
	HOUSE	☐
	COMMUNITY	☐
WORKING FIELD	MCH	☐
	CHILD HEALTH	☐
	NUTRITION	☐
	TB	☐
	HIV/AIDS	☐
	MALARIA	☐
	OTHERS	
MAIN TASK	HEALTH FACILITIES *(pustu, polindes,poskesdes)*	
	HOUSE	
	COMMUNITY *(posyandu,pokbang)*	
POSYANDU COVERAGE		POSYANDU/ RW
WORKING HOUR		Hours/day Days/week
LIVE IN THE VILLAGE		☐ YES ☐NO
MONTHLY INCOME		Fixed :Rp. Non Fixed:Rp.
TRAINING		Type: Length: Month/Year:

4. 2. 2. 2. SSI TBA

Information Sheet for TBA

SEX	MALE/FEMALE
AGE	..... YEARS OLD
EDUCATION LEVEL	NO SCHOOL ELEMENTARY SCHOOL JUNIOR HIGH SCHOOL HIGH SCHOOL D1 D3 BACHELOR
START WORKING	YEAR.....
WORKING FIELD	MCH CHILD HEALTH TUBERCULOSIS HIV MALARIA OTHERS.....
MAIN TASKS	
WORKING HOUR	...HOUR / WEEK ...DAY / WEEK
DO YOU HAVE FIXED INCOME	YES/NO IF YES, HOW MUCH Rp.....
TRAINING :	TOPIC: WHEN: LENGHT:

4. 2. 2. 3. SSI Mother

Information Sheet for Mother

SEX	
AGE	
OCCUPATION	
EDUCATION LEVEL	
MARITAL STATUS	
NUMBER OF PREGNANCY	
NUMBER OF CHILDREN	
HEALTH INSURANCE	YES□TYPE: _____ NO □
DISTANCE TO HEALTH FACILITIES (Puskesmas, Pustu, Poskesdes, Polindes)	_____ KM _____ min using _____ transport expenses Rp. _____
ROAD CONDITION TO HEALTH FACILITIES	
ANC	times (during the last pregnancy)
DELIVERY	Assisted by: Location: I. II. III. IV. V.

4. 2. 2. 4. SSI Village Head

Information Sheet for Village Head

SEX	
AGE	
EDUCATION LEVEL	
MARITAL STATUS	
POSITION	
WORKING PERIOD	
VILLAGE	
POPULATION NUMBER	RW RT Family Resident
MAIN TASKS	

4. 2. 2. 5. SSI Midwife Coordinator, Puskesmas Head, and DHO MCH Officer

Information Sheet for Health Manager

SEX		
AGE		
EDUCATION LEVEL		
POSITION		
DURATION OF DUTY		
FIELD OF DUTY	HEALTH OFFICE	☐
	PUSKESMAS	☐
WORKING FIELD	MOTHER AND CHILD HEALTH	☐
	CHILD HEALTH	☐
	NUTRITION	☐
	TB	☐
	HIV/AIDS	☐
	MALARIA	☐
	OTHERS ...	
WORKING HOURS		
FIXED/NON FIXED INCOME		
MAIN TASKS		
TRAININGS		

4. 2. 2. 6. FGD Husband/Men

Information Sheet for Husband

NO	NAME	VILLAGE	SEX	AGE	OCCUPATION	EDUCATION

4. 2. 2. 7. FGD TBA (only in Cianjur)

Information Sheet for TBA

NO	NAME	AGE	EDUCATION	VILLAGE	YEAR OF WORK	PARTNERSHIP	NUMBER OF CLIENT	INCOME/MONTH FROM		WORKING FIELD	MAIN TASKS	TRIANING (YEAR)
								CLIENT	MID WIFE			

4. 2. 2. 8. FGD Village Midwives (only in SW Sumba)

Information Sheet for Village Midwife

NO	NAME	VILLAGE	SEX	AGE	OCCUPATION	EDUCATION

7 4.3. INTERVIEW GUIDELINES INDONESIAN

4.3.1. SEMI-STRUCTURED INTERVIEW

4. 3. 1. 1. SSI Village Midwife

Panduan wawancara Bidan Desa

Tugas dan Klien

1. Bagaimana ceritanya anda menjadi bidan/perawat desa dan bekerja di sini?
2. Dapatkah Anda memberikan gambaran tentang pekerjaan anda?
   Jajaki tentang:
   - Jenis-jenis tugas (SaatPosyandudan di luarPosyandu)
   - Alasan mengapa menjadi bidan/perawat desa
3. Dari mana sajaasal masyarakat yang anda layani?
   (Gunakan/gambar peta setempat untuk meminta informan menunjukkan dari wilayah mana masyarakat yang mereka layani)
   Jajaki tentang:
   - Apa motivasi atau alasan mereka menggunakan pelayanan Anda?
   - Apa motivasi atau alasan mereka tidak menggunakan pelayanan Anda?
   - Layanan apa yang paling banyak dipakai masyarakat? (poliklinik umum, pelayanan kesehatan ibu, dll)
   - Sesuai pengalaman anda, apa yang dilakukan para ibu didesa ini saat:
     - Kehamilan. Apakah memeriksakan diri? Kemana? Mengapa?

- Persalinan. Dimana? Mengapa?
- Pasca persalinan. Apakah memeriksakan diri? Dimana? Mengapa?
- Keluarga berencana. Apakah melakukan KB? Dimana? Mengapa?

- Layanan apa yang banyak digunakan para ibu?(ANC, persalinan, PNC, keluarga berencana) Mengapa?
- Layanan apa yang kurang digunakan para ibu? (ANC, persalinan, PNC, keluarga berencana) Mengapa?

Motivasi dan kepuasan kerja

4. Bagaimana pendapat anda tentang pekerjaan anda sekarang? Apakah anda puas? Mengapa? Pekerjaan apa yang anda merasa puas? Mengapa? Apa contohnya? Pekerjaan apa yang anda merasa tidak puas? Mengapa? Apa contohnya
   Jajaki tentang:
   - Insentif non-finansial (kepercayaan dari masyarakat, dukungan dari masyarakat, status sosial)
   - Bagaimana respons masyarakat tentang pelayanan informan? Contohnya?
   - Apa yang masyarakat sukai dari layanan anda? Mengapa ? Contohnya?
   - Apa yang masyarakat kurang sukai dari layanan anda? Mengapa ? Apa contohnya?
   - Insentif finansial (pendapatan rutin)
   - Perasaan tentang insentif finansial tersebut
   - Pekerjaan lain, pemasukan lain?

Mutu Pelayanan

5. Menurut anda, apakah pelayanan kesehatan yang bermutu itu?. Mintalah informan untuk memberi contoh pelayanan yang menurut informan telah dilakukan dengan mutu yang baik dan kurang baik. Hal-hal apa yang mendukung anda untuk bisa bekerja dengan baik? Mengapa? Hal-hal apa yang menghambat anda untuk bisa bekerja dengan baik? Mengapa?
   Tanyakan berkali2 pertanyaan ini, bila belum muncul, tanyakan faktor pendukung dan penghambat informan dalam bekerja:
   - Anda telah menjelaskan tentang tugas-tugas anda sebelumnya, bagaimana perasaan anda atas beban kerja tersebut?
   - Bagaimanakah infrastruktur tempat kerja anda?,
   - Bagaimana lingkungan pekerjaan (kolega, atasan) anda?
   - Bagaimana kondisi keamanan di tempat kerja anda? Bagaimana perasaan anda atas hal tersebut?
   - Bagaimana rencana karir di masa depan?
   - Bagaimana perasaan anda atas pedoman-pedoman tindakan medis yang ada?

Supervisi

6. Bagaimana pengalaman anda tentang supervisi yang anda terima?
   Jajaki:
   - siapa supervisor-nya,
   - kapan terakhir menerima supervisi,

- seberapa sering supervisi dilakukan?
- bagaimana supervisi dilakukan, apa-apa saja yang dilakukan dalam supervisi? Jajaki: diskusi target-target program, pelaporan
- Bagaimana umpan balik dilakukan?
- bagaimana dukungan pemecahan masalah (termasuk dukungan sosial). Mengapa? Contohnya?
- bagaimana ketrampilan anda setelah supervisi? Contohnya?
- bagaimana pandangan tentang supervisi tersebut? Mengapa? Apa contohnya yang bermanfaat? Apa contohnya yang kurang bermanfaat?

M&E

7. Bagaimana pencatatan dan pelaporan dari pelayanan kesehatan ibu yang anda alami selama ini?
   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:
   - Bagaimana cara pencatatan dan pelaporan anda? Hal-hal apa yang dilaporkan?
   - Bagaimana laporan anda dikirimkan? Menggunakan alat apa?
   - Siapa yang memberikan umpan balik? Bagaimana umpan balik dilakukan? Apa bentuk umpan baliknya? Contoh bagaimana umpan balik diterapkan?
   - Bagaimana pandangan anda tentang sistem pelaporan dan umpan baliknya? Apa ada manfaat? Mengapa? Apa contohnya? Apa ada yang kurang bermanfaat? Mengapa? Apa contohnya?

Hubungan dengan sistem kesehatan (termasuk kolega) dan pemuka masyarakat

8. Ketika anda menghadapi persoalan dalam pelayanan kesehatan, dengan pihak mana anda berkomunikasi?
   Jajaki tentang:
   - Dengan siapa anda berkomunikasi?
   - Berapa kali / seberapa sering anda berkomunikasi dengannya?
   - Dimana atau apa alat / medianya?
   - Siapa yang menyediakan alatnya?
   - Bagaimana komunikasinya? Berikan contoh2 hal yang dikomunikasikan
   - Apakah anda senang dengan komunikasi ini? Apa yang disenangi? Beri contohnya.Mengapa? Apa yang kurang disenangi? Beri contohnya. Mengapa?
   - Apakah komunikasi tersebut bermanfaat bagi kinerja anda?
9. Bagaimana anda berinteraksi dengan pemuka desa, staf puskesmas, rumah sakit dan dinas kesehatan
   Jajaki tentang: forum, frekuensi, isi pertemuan
10. Bagaimana anda menangani kasus yang perlu dirujuk selama inidaritingkatdesakePuskesmas?
    Jajaki tentang:
    - Jenis kasus apa yang selama ini anda rujuk? Berikan contohnya (Kasus kebidanan, Kasus umum,gawat dan gawat darurat) Mengapa anda merujuknya?
    - Berapa sering anda perlu merujuk?

- Fasilitas kesehatan mana yang dituju? Mengapa?
- Bagaimana cara anda merujuk?
- Apa yang cukup baik dalam rujukan itu? Mengapa?
- Hambatan apa yang dihadapi? Apa yang anda lakukan kemudian?

11. Bagaimana pendapat anda tentang dukun bayi? Yang baik apa contohnya? yang kurang baik apa contohnya?
    Jajaki:
    - Bagaimana hubungan anda dengan dukun bayi selama ini? Mengapa? Beri contohnya.
    - Bagaimana anda melihat potensi kemitraan anda dengan dukun bayi? Apakah kemitraan tersebut pernah anda coba? Apa yang terjadi kemudian?
    - Bagaimana tanggapan masyarakat atas pekerjaan yang dilakukan dukun bayi?
12. Apakah anda pernah mendengar tentang sunat anak perempuan?
    Siapa yang melakukan sunat? Alasannya? Ceritakan tentang proses sunat perempuan. (Pertanyaan hanya di Cianjur).
13. Bagaimana pendapat anda tentang kader? Yang baik apa contohnya, yang kurang baik apa contohnya?
    Bagaimana pendapat anda tentang "kesukarelaan" dari kader dan kaitannya dengan mutu pelayanan.
    Bagaimana cara memantau mutu pelayanan kader? Siapa pihak yang berwenang memantau mutu?
    Apakah masyarakat ikut serta dalam memantau pelayanan kader? Bagaimana?
    Jajaki:
    - Bagaimana hubungan anda dengan kader selama ini? Beri contohnya.
    - Bagaimana anda melihat potensi kemitraan anda dengan kader? Apakah kemitraan tersebut pernah anda coba? Apa yang terjadi kemudian?
    - Bagaimana tanggapan masyarakat atas pekerjaan yang dilakukan kader?

Keterlibatan dalam masyarakat

14. Bagaimana hubungan anda dengan komunitas? Contohnya ? Mengapa?
15. Bagaimana anda menjalin dan membina hubungan tersebut? Contohnya?
16. Bagaimana penempatan bidan desa disini?
    Jajaki:
    - Apakah masyarakat berperan dalam proses penempatan bidan desa tersebut? Bagaimana bentuk keterlibatan tersebut?
    - Bagaimana penilaian kinerja bidan?
    - Apakah masyarakat ikut memantau kinerja bidan? Bagaimana?

Pemekaran(hanya di SW Sumba)

17. Sumba Barat Daya terbentuk sebagai pemekaran dari Sumba Barat. Apakah anda melihat perbedaan pelayanan kesehatan sebelum dan sesudah pemekaran?

Revolusi KIA(hanya di SW Sumba)

18. Apakah anda pernah mendengar tentang revolusi KIA?

Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan?Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

19. Menurut anda, hal-hal apa yang perlu dan memungkinkan untuk dilakukan supaya tugas anda dalam pelayanan kesehatan ibu bisa lebih baik?

4. 3. 1. 2. SSI *Kader*

Panduan Wawancara Kader

Tugas dan Klien

1. Dapatkah Anda memberikan gambaran tentang pekerjaan anda?
   Jajaki tentang:
   - Mengapa anda memutuskan menjadi kader?
   - Jenis-jenis tugassehari-hari
2. Siapakah masyarakat yang anda layani?
   Jajaki tentang:
   - Apa motivasi atau alasan mereka menggunakan pelayanan Anda?
   - Apa motivasi atau alasan mereka tidak menggunakan pelayanan Anda?
   - Sesuai pengalaman anda, apa yang dilakukan para ibu disini saat:
   - Kehamilan. Apakah memeriksakan diri? Kemana? Mengapa?
   - Persalinan. Dimana? Mengapa?
   - Pasca persalinan. Apakah memeriksakan diri? Dimana? Mengapa?
   - Keluarga berencana. Apakah melakukan KB? Dimana? Mengapa?

Motivasi dan kepuasan kerja

3. Bagaimana pendapat anda tentang pekerjaan anda sekarang? Apakah anda puas? Mengapa? Pekerjaan apa yang anda merasa puas? Mengapa? Apa contohnya? Pekerjaan apa yang anda merasa tidak puas? Mengapa? Apa contohnya?
   Jajaki tentang:
   - Insentif non-finansial (kepercayaan dari masyarakat, dukungan dari masyarakat, status sosial)
   - Insentif finansial (pendapatan rutin)
   - Perasaan tentang insentif tersebut
   - Pekerjaan lain, pemasukan lain?

Mutu Pelayanan

4. Menurut anda, apakah pelayanan kesehatan oleh kader bermutu itu?. Mintalah informan untuk memberi contoh pelayanan yang selama ini menurut informan telah dilakukan dengan mutu yang baik dan kurang baik.
   Hal-hal apa yang selama ini mendukung anda untuk bisa bekerja dengan baik? Mengapa?

Hal-hal apa yang selama ini menghambat anda untuk bisa bekerja dengan baik? Mengapa?

Apa pendapat anda tentang "kesukarelaan" dan kaitannya dengan mutu pelayanan anda

Tanyakan berkali2 pertanyaan ini, bila belum muncul, tanyakan faktor pendukung dan penghambat informan dalam bekerja:

- Anda telah menjelaskan tentang tugas-tugas anda sebelumnya, bagaimana perasaan anda atas beban kerja tersebut?
- Bagaimanakah infrastruktur (fasilitas, alat, sarana) tempat kerja anda?
- Bagaimana lingkungan pekerjaan (kolega, atasan) anda?
- Bagaimana kondisi keamanan di tempat kerja anda? Bagaimana perasaan anda atas hal tersebut?

Hubungan dengan sistem kesehatan dan pemuka masyarakat

5. Ketika anda menghadapi persoalan dalam melaksanakan tugas anda, dengan pihak mana anda berkomunikasi?

   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:

   a. Dengan siapa anda berkomunikasi?
   b. Berapa kali / seberapa sering anda berkomunikasi dengannya?
   c. Dimana atau apa alat / medianya?
   d. Siapa yang menyediakan alatnya?
   e. Bagaimana komunikasinya? Berikan contoh2 hal yang dikomunikasikan
   f. Apakah anda senang dengan komunikasi ini? Apa yang disenangi? Beri contohnya.Mengapa? Apa yang kurang disenangi? Beri contohnya. Mengapa?
   g. Apakah komunikasi tersebut bermanfaat bagi kinerja anda?

6. Bagaimana anda berinteraksi dengan pemuka desa, staf puskesmas, rumah sakit dan dinas kesehatan. Jajaki tentang: forum, frekuensi, isi pertemuan
7. Pernahkah anda melakukan rujukan? Beri contohnya.

   Jajaki tentang:

   - Jenis kasus apa yang selama ini anda rujuk? (Kasus kebidanan, Kasus umum, dan gawat darurat) Mengapa anda merujuknya?
   - Berapa sering anda perlu merujuk?
   - Fasilitas kesehatan mana yang dituju? Mengapa?
   - Bagaimana cara anda merujuk?
   - Apa yang cukup baik dalam rujukan itu? Mengapa?
   - Hambatan apa yang dihadapi? Apa yang anda lakukan kemudian?

Supervisi

8. Bagaimana pengalaman anda tentang pemantauan kerja yang anda terima?

   Jajaki:

   - siapa pemantau kerjanya,
   - kapan terakhir menerima pantauan kerja
   - seberapa seringpemantauan kerja dilakukan?

- bagaimana pemantauan kerja dilakukan, apa-apa saja yang dilakukan dalam pemantauan kerja?
- Bagaimana umpan balik dilakukan?
- bagaimana dukungan pemecahan masalah (termasuk dukungan sosial). Mengapa? Contohnya?
- bagaimana ketrampilan anda setelah disupervisi? Mengapa? Contohnya?
- bagaimana pandangan anda tentang supervisi tersebut? Mengapa? Apa contohnya yang bermanfaat? Apa contohnya yang kurang bermanfaat?

M&E

9. Bagaimana pencatatan dan pelaporan dari pelayanan kesehatan ibu yang anda alami selama ini?
   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:
   - Bagaimana cara pencatatan dan pelaporan anda? Hal-hal apa yang dilaporkan?
   - Bagaimana laporan anda dikirimkan? Menggunakan alat apa?
   - Siapa yang memberikan umpan balik? Bagaimana umpan balik dilakukan? Apa bentuk umpan baliknya? Contoh bagaimana umpan balik diterapkan?
   - Bagaimana pandangan anda tentang sistem pelaporan dan umpan baliknya? Apa ada manfaat? Mengapa? Apa contohnya? Apa ada yang kurang bermanfaat? Mengapa? Apa contohnya?

Persepsi tentang petugas kesehatan

10. Bagaimana pendapat anda tentang bidan/perawat desa?
    Bisa anda ceritakan tentang bidan di desa ini?
    Bagaimana menurut anda tentang kinerja bidan desa? (Perawat desa bila bidan tidak ada)
    Apa saja tugas mereka?
    Tugas mana yang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Contohnya?
    Tugas mana yang kurang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut tidak dikerjakan dengan baik? Contohnya?
    Bila belum muncul saat wawancara, jajaki :
    - Usia
    - Asal
    - Kompetensi klinis
    - Sikap
    - Alat medis
    - Situasi tempat bersalin (privasi, kebersihan,dll)
    - Alat komunikasi (telepon genggam)
    - Sistem rujukan
11. Bagaimana menurut anda supaya layanan bidan dalam kesehatan ibu lebih bermanfaat bagi masyarakat desa?
12. Bagaimana kerjasama antara bidan dan anda? Contohnya? Apakah kerja sama tersebut pernah anda coba? Apa yang terjadi kemudian?

13. Hal apa yang akan membuat anda senang untung merujuk persalinan ke bidan?

Persepsi tentang dukun bayi

14. Siapa saja dukun bayi di desa ini?
15. Apa pendapat anda tentang dukun bayi di desa ini?
16. Apa saja yang mereka lakukan sebagai dukun bayi ?
    Bila belum muncul jajaki: kehamilan, persalinan, pasca persalinan, perawatan bayi, membantu rumah tangga atau yang lain
    Menurut anda, hal apa yang dikerjakan dengan baik? Mengapa? Contohnya?
    Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Mengapa? Contohnya?
    Menurut anda, hal apa yang dikerjakan dengan kurang baik? Mengapa? Contohnya?
    Bila belum muncul saat wawancara, jajaki :
    - Usia
    - Kompetensi klinis
    - Sikap
    - Alat medis
    - Situasi tempat bersalin (privasi, kebersihan,dll)
    - Alat komunikasi (telepon genggam)
    - Sistem rujukan
17. Apakah anda pernah mendengar tentang sunat anak perempuan?
    Siapa yang melakukan sunat? Alasannya? Ceritakan tentang proses sunat perempuan.
    (Pertanyaan hanya di Cianjur).
18. Bagaimana menurut anda supaya layanan dukun bayi bisa lebih baik?
19. Bagaimana kerja sama antara anda dan dukun bayi? Contohnya. Apakah kerja sama tersebut pernah anda coba? Apa yang terjadi kemudian?

Pemekaran(hanya di SW Sumba)

20. Sumba Barat Daya terbentuk sebagai pemekaran dari Sumba Barat. Apakah anda melihat perbedaan pelayanan kesehatan sebelum dan sesudah pemekaran?

Revolusi KIA(hanya di SW Sumba)

21. Apakah anda pernah mendengar tentang revolusi KIA?
    Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
    Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
    Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan?Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

22. Menurut anda, hal-hal apa yang perlu dan memungkinkan untuk dilakukan supaya tugas anda dalam pelayanan kesehatan ibu bisa lebih baik?

4. 3. 1. 3. SSI TBA (only in SW Sumba)

Panduan Wawancaran Dukun Bayi

Tugas dan Klien

1. Dapatkah Anda memberikan gambaran tentang pekerjaan anda?

Jajaki tentang:

- Bagaimana ceritanya anda menjadi dukun bayi?
- Jenis-jenis tugas (untuk dukun bayi jajaki: kehamilan, persalinan, pasca persalinan, perawatan bayi, dll)

2. Siapakah masyarakat yang anda layani? Gali profil masyarakat yang biasanya dilayani dukun bayi

   Jajaki tentang:

   - Apa motivasi atau alasan mereka menggunakan pelayanan Anda?
   - Apa motivasi atau alasan mereka tidak menggunakan pelayanan Anda?
   - Sesuai pengalaman anda, apa yang dilakukan para ibu disini saat:
   - Kehamilan. Apakah memeriksakan diri? Kemana? Mengapa?
   - Persalinan. Dimana? Mengapa?
   - Pasca persalinan. Apakah memeriksakan diri? Dimana? Mengapa?
   - Keluarga berencana. Apakah melakukan KB? Dimana? Mengapa?

Motivasi dan kepuasan kerja

3. Bagaimana pendapat anda tentang pekerjaan anda sekarang? Apakah anda puas? Mengapa? Pekerjaan apa yang anda merasa puas? Mengapa? Apa contohnya? Pekerjaan apa yang anda merasa tidak puas? Mengapa? Apa contohnya?

   Jajaki tentang:

   - Insentif non-finansial (kepercayaan dari masyarakat, dukungan dari masyarakat, status sosial)
   - Insentif finansial (pendapatan rutin)
   - Perasaan tentang insentif tersebut
   - Pekerjaan lain, pemasukan lain?

Mutu Pelayanan

4. Menurut anda,bagaimana pelayanan dukun bayi yang baik itu?. Mintalah informan untuk memberi contoh pelayanan yang menurut informan telah dilakukan dengan baik dan kurang baik.

   Hal-hal apa yang mendukung anda untuk bisa bekerja dengan baik? Mengapa?

   Hal-hal apa yang menghambat anda untuk bisa bekerja dengan baik? Mengapa?

Hubungan dengan sistem kesehatan dan pemuka masyarakat

5. Ketika anda menghadapi persoalan dalam membantu persalinan, dengan pihak mana anda berkomunikasi?

   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:

   a. Dengan siapa anda berkomunikasi?
   b. Berapa kali / seberapa sering anda berkomunikasi dengannya?
   c. Dimana atau apa alat / medianya?
   d. Siapa yang menyediakan alatnya?
   e. Bagaimana komunikasinya? Berikan contoh2 hal yang dikomunikasikan
   f. Apakah anda senang dengan komunikasi ini? Apa yang disenangi? Beri contohnya.Mengapa? Apa yang kurang disenangi? Beri contohnya. Mengapa?

g. Apakah komunikasi tersebut bermanfaat bagi kinerja anda?

6. Bagaimana anda berinteraksi dengan pemuka desa, staf puskesmas, rumah sakit dan dinas kesehatan ? Jajaki tentang: forum, frekuensi, isi pertemuan
7. Pernahkah anda melakukan merujukkasuskebidandesa? Beri contohnya.
   Jajaki tentang:
   - Jenis kasus apa yang selama ini anda rujuk?Mengapa anda merujuknya?
   - Berapa sering anda perlu merujuk?
   - Bagaimana cara anda merujuk?
   - Apa yang cukup baik dalam rujukan itu? Mengapa?
   - Hambatan apa yang dihadapi? Apa yang anda lakukan kemudian?

Persepsi tentang petugas kesehatan

8. Bagaimana pendapat anda tentang bidan/perawat desa?
   Bisa anda ceritakan tentang bidan di desa ini?
   Bagaimana menurut anda tentang kinerja bidan desa? (Perawat desa bila bidan tidak ada)
   Apa saja tugas mereka?
   Tugas mana yang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Contohnya?
   Tugas mana yang kurang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut tidak dikerjakan dengan baik? Contohnya?
   Bila belum muncul saat wawancara, jajaki :
   - Usia
   - Asal
   - Kompetensi klinis
   - Sikap
   - Alat medis
   - Situasi tempat bersalin (privasi, kebersihan,dll)
   - Alat komunikasi (telepon genggam)
   - Sistemrujukan:apakahandamengetahuibagaimanabidandesamembantumerujukibumelahirkan? Bagaimanaceritanya?
9. Bagaimana kerjasama antara bidan dan anda? Contohnya? Apakah kerja sama tersebut pernah anda coba? Apa yang terjadi kemudian?
10. Hal apa yang akan membuat anda senang untung merujuk persalinan ke bidan?
11. Bagaimana menurut anda supaya layanan bidan dalam kesehatan ibu lebih bermanfaat bagi masyarakat desa?

Persepsi tentang kader

12. Siapa saja kader di desa ini?
13. Apa pendapat anda tentang kader di desa ini?
14. Apa saja yang mereka lakukan sebagai kader ?
    Menurut anda, hal apa yang dikerjakan dengan baik? Mengapa? Contohnya?
    Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Mengapa? Contohnya?
    Menurut anda, hal apa yang dikerjakan dengan kurang baik? Mengapa? Contohnya?

Hal apa yang membuat tugas tersebut dikerjakan dengan kurang baik? Mengapa? Contohnya?

Bila belum muncul jajaki deskripsi kerja berikut :

- Mengingatkan ibu hamil dan keluarganya untuk melahirkan didampingi tenaga terlatih (bidan desa atau Puskesmas) (bila jarak rumah jauh, ibu bisa menunngu di rumah tunggu)
- Mobilisasi untuk Posyandu
- Melaksanakan kegiatan penyuluhan, penimbangan, pencatatan dan pelaporan di Posyandu
- Kunjungan rumah untuk mendata ibu hamil, melahirkan, nifas, menyusui, bayi dan pasangan usia subur
- Melaporkan kepada bidan / tenaga kesehatan lain saat ada ibu yang melahirkan

15. Bagaimana menurut anda supaya layanan kader dalam kesehatan ibu bisa lebih baik?
16. Bagaimana kerja sama antara anda dan kader? Contohnya. Apakah kerja sama tersebut pernah anda coba? Apa yang terjadi kemudian?

Pemekaran

17. Sumba Barat Dayaterbentuksebagaipemekarandari Sumba Barat. Apakahandamelihatperbedaanpelayanankesehatansebelumdansesudahpemekaran?

Revolusi KIA

18. Apakah anda pernah mendengar tentang revolusi KIA?
    Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
    Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
    Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan?Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

19. Peran apa yang sekiranya anda bisa lakukan selain menolong persalinan? Bagaimana caranya untuk mengatur ini bisa terjadi?
20. Hal-hal lain apa yang menurut anda bisa dilakukan untuk meningkatkan pelayanan kesehatan ibu?

4. 3. 1. 4. SSI Mother

Panduan Wawancara Ibu

Kehamilan dan ANC

1. Bagaimana anda mengetahui bahwa anda hamil?
2. Apa yang anda lakukan pertama kali saat mengetahui bahwa anda hamil? Mengapa?Lalu apa yang terjadi? Apa yang anda lakukan kemudian?
   Bila pernyataan tentang ANC belum keluar, baru jajaki :
3. Apakah anda melakukan pemeriksaan rutin kehamilan (ANC)? Mengapa? Dimana? (medis, non medis / dukun bayi, atau tidak melakukan apa2) Mengapa?
4. Bagaimana anda memutuskan untuk hal tersebut?

5. Pada usia kehamilan berapa anda melakukan pemeriksaan? Mengapa?
6. Apakah anda periksa lebih dari 1 kali? Mengapa anda pergi ke 2, 3 dan 4 kali?
7. Tanyakan apalagi alasannya, bila belum muncul baru jajaki :
   - Jarak ke fasilitas kesehatan
   - Biaya transportasi dan konsultasi
   - Keberadaan petugas
   - Kepercayaan pada petugas (umur petugas, kompetensi medis, sikap, kelengkapan alat medis)
   - Kebiasaan lokal
8. Bagaimana menurut anda pelayanan pemeriksaan kehamilan yang ada? Mengapa? Bagian mana yang baik? Beri contohnya? Bagian mana yang kurang baik? Beri contohnya?
9. Menurut anda, apa manfaat melakukan pemeriksaan rutin kehamilan?
10. Menurut anda, apa yang terjadi bila anda tidak melakukan pemeriksaan rutin kehamilan?

Kelahiran

11. Saat bulan-bulan terakhir menjelang kelahiran apa yang anda lakukan saat mulai merasakan sakit yang sangat saat akan melahirkan (kontraksi)? Mengapa? Siapa yang anda beritahu pertama kali? Mengapa? Apa yang dilakukan selanjutnya? Mengapa? Lalu apa yang terjadi?
12. Kemana anda pergi untuk bersalin? Mengapa? Lalu apa yang terjadi?
13. Siapa yang menolong anda melahirkan? Mengapa?
14. Dengan siapa anda memutuskan untuk bersalin di tempat tersebut dan/atau ditolong orang tersebut? Apa alasan anda mengambil keputusan tersebut?
    - Bila belum muncul saat wawancara, jajaki alasan Jarak ke fasilitas kesehatan
    - Biaya transportasi dan konsultasi
    - Keberadaan petugas
    - Kepercayaan pada petugas (umur petugas, kompetensi medis, sikap, kelengkapan alat medis)
    - Adanya asuransi kesehatan: Setahu anda, apa manfaat asuransi tersebut? Jenis layanan apa yang anda bisa dapatkan dengan asuransi tersebut? Ceritakan pengalaman anda dalam menggunakan asuransi tersebut. Bagaimana asuransi mempengaruhi keputusan dalam kelahiran (di fasilitas kesehatan/di dukun)
    - Kebiasaan setempat

    Bila belum muncul, tanyakan:
15. Apa pendapat anda tentang persalinan yang ditolong dukun bayi? Manfaat dan kerugiannya
16. Apa pendapat anda tentang persalinan yang ditolong bidan desa? Manfaat dan kerugiannya

Pasca Persalinan Dan Keluarga Berencana

17. Apa yang anda lakukan setelah melahirkan? Mengapa ? Apa yang anda lakukan selanjutnya? Mengapa?
18. Bagaimana pendapat anda tentang KB? Apakah anda ber KB? Mengapa?

Bila ia menggunakan KB, tanyakan dimana ia melakukan KB? Mengapa?

Persepsi tentang bidan desa

19. Bisa anda ceritakan tentang bidan di desa ini?
20. Apa pendapat anda tentang kader di desa ini?
    Bila belum muncul saat wawancara, jajaki :
    - Usia
    - Asal
    - Kompetensi klinis
    - Sikap
    - Alat medis
    - Situasi tempat bersalin (privasi, kebersihan,dll)
    - Alat komunikasi (telepon genggam)
    - Sistem rujukan: apakahandamengetahuibagaimanakadermembantumerujukibumelahirkan? Bagaimanaceritanya?
21. Bagaimana menurut anda tentang kinerja bidan desa? (Perawat desa bila bidan tidak ada)
    Apa saja tugas mereka?
    Tugas mana yang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Contohnya?
    Tugas mana yang kurang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut tidak dikerjakan dengan baik? Contohnya?
22. Bagaimana menurut anda supaya layanan bidan dalam kesehatan ibu lebih bermanfaat bagi masyarakat desa?
23. Apa saja yang telah dilakukan untuk mendukung kerja mereka?

Persepsi tentang kader

24. Siapa saja kader di desa ini?
25. Apa pendapat anda tentang kader di desa ini?
26. Apa saja yang mereka lakukan sebagai kader ?
    Tanyakan berkali-kali sebelum menjajaki deskripsi kerja berikut :
    - Mengingatkan ibu hamil dan keluarganya untuk melahirkan didampingi tenaga terlatih (bidan desa atau Puskesmas) (bila jarak rumah jauh, ibu bisa menunngu di rumah tunggu)
    - Mobilisasi untuk Posyandu
    - Melaksanakan kegiatan penyuluhan, penimbangan, pencatatan dan pelaporan di Posyandu
    - Kunjungan rumah untuk mendata ibu hamil, melahirkan, nifas, menyusui, bayi dan pasangan usia subur
    - Melaporkan kepada bidan / tenaga kesehatan lain saat ada ibu yang melahirkan
27. Menurut anda, bagaimana kinerja kader?
    Hal apa yang dikerjakan dengan baik? Mengapa? Contohnya?Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Mengapa? Contohnya?

Hal apa yang dikerjakan kurang baik? Mengapa? Contohnya? Hal apa yang membuat tugas tersebut dikerjakan kurang baik? Mengapa? Contohnya?

28. Bagaimana menurut anda supaya layanan kader bisa lebih baik?

Persepsi tentang dukun bayi

29. Siapa saja dukun bayi di desa ini?
30. Apa pendapat anda tentang dukun bayi di desa ini?
    Bila belum muncul saat wawancara, jajaki :
    - Usia
    - Layanan
    - Sikap
    - Situasi tempat bersalin (privasi, kebersihan,dll)
    - Sistem rujukan
31. Apa saja yang mereka lakukan sebagai dukun bayi ?
    Bila belum muncul jajaki: kehamilan, persalinan, pasca persalinan, perawatan bayi, membantu rumah tangga atau yang lain)
    Hal apa yang anda sukai dari layanan dukun bayi? Mengapa? Contohnya?
    Hal apa yang anda kurang suka dari layanan dukun bayi? Mengapa? Contohnya?
32. Apakah ada sunat perempuan di desa ini? Bisa ceritakan tentang proses sunat perempuan? Apakah anak perempuan Anda di sunat? Alasannya? (pertanyaan hanya di Cianjur)
33. Bagaimana menurut anda supaya layanan dukun bayi lebih baik?

Kerjasama

34. Bagaimana menurut anda kerjasama antara bidan dan dukun bayi di desa ini? Contohnya?
35. Bagaimana menurut anda kerjasama antara bidan dan kader di desa ini? Contohnya?
36. Bagaimana menurut anda kerjasama antara dukun dan kader di desa ini? Contohnya?
37. Menurut anda, bagaimana bisa meningkatkan kerjasama tersebut untuk meningkatkan pelayanan kesehatan ibu?

Pemekaran(only in SW Sumba)

37. Sumba Barat Dayaterbentuksebagaipemekarandari Sumba Barat.
    Apakahandamelihatperbedaanpelayanankesehatansebelumdansesudahpemekaran?

Revolusi KIA (Only in SW Sumba)

38. Apakah anda pernah mendengar tentang revolusi KIA?
    Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
    Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
    Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan?Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

39. Hal-hal lain apa yang menurut anda bisa dilakukan untuk meningkatkan pelayanan kesehatan ibu?

4. 3. 1. 5. SSI Village Head

Panduan Wawancara Tokoh Desa

Kehamilan dan ANC

1. Bagaimana para wanita mengetahui bahwa mereka hamil? Apa yang mereka lakukan pertama kali saat mengetahui dirinya hamil? Lalu apa yang terjadi? Apa yang mereka lakukan kemudian?
   Bila pernyataan tentang ANC belum keluar, baru jajaki:
   Apakah mereka melakukan pemeriksaan rutin kehamilan (ANC)? Mengapa ada yang melakukannya dan ada yang tidak? Mengapa? Beri contohnya
2. Pada usia kehamilan berapa biasanya mereka memeriksakan diri? Mengapa?
   Apakah mereka periksa lebih dari 1 kali? Mengapa ada yang melakukan 2, 3 dan 4 kali?
   Biasanya kapan mereka pergi memeriksakan diri? Mengapa?
   Tanyakan apalagi alasannya, bila belum muncul baru jajaki :
   - Jarak ke fasilitas kesehatan
   - Biaya transportasi dan konsultasi
   - Keberadaan petugas
   - Kepercayaan pada petugas (umur petugas, kompetensi medis, sikap, kelengkapan alat medis)
   - Siapa yang memutuskan bahwa seorang wanita melakukan pemeriksaan rutin kehamilan?
3. Bagaimana menurut anda pelayanan pemeriksaan kehamilan yang ada?
4. Apa yang terjadi bila seorang wanita tidak melakukan pemeriksaan rutin kehamilan?

Kelahiran

5. Apa yang dilakukan wanita hamil di sini saat mulai merasakan kontraksi? Apa yang dilakukan selanjutnya? Mengapa? Lalu apa yang terjadi?
6. Siapa yang paling sering menolong wanita bersalin di desa ini? Mengapa?
7. Apakah ada perbedaan antara para wanita di desa ini antara yang menggunakan jasa bidan dengan yang tidak? Mengapa? Beri contohnya.
8. Bagaimana para wanita mengambil keputusan dalam bersalin? siapa yang biasanya memutuskan wanita bersalin di mana dan oleh siapa?
9. Apa yang menghambat para wanita melahirkan di fasilitas kesehatan?
   Bila belum muncul saat wawancara, jajaki alasan tidak bersalin di polindes / bersalin tidak didampingi tenaga terlatih :
   - Jarak ke fasilitas kesehatan
   - Biaya transportasi dan konsultasi
   - Keberadaan petugas
   - Kepercayaan pada petugas (umur petugas, kompetensi medis, sikap, kelengkapan alat medis)
   - Adanya asuransi kesehatan

10. Apa pendapat anda tentang persalinan yang ditolong dukun bayi? Manfaat dan kerugiannya
11. Apa pendapat anda tentang persalinan yang ditolong bidan desa? Manfaat dan kerugiannya

Pasca Persalinan Dan Keluarga Berencana

12. Apa yang mereka lakukan setelah melahirkan? Mengapa ? Apa yang mereka lakukan selanjutnya? Mengapa?
13. Bagaimana pendapat mereka tentang KB? Apakah mereka ber KB? Mengapa?
    Bila mereka menggunakan KB, tanyakan dimana mereka melakukan KB? Mengapa?

Persepsi tentang petugas kesehatan

14. Bagaimana menurut anda tentang kinerja bidan desa? (Perawat desa bila bidan tidak ada)Apa saja tugas mereka?
    Tugas mana yang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut dikerjakan dengan baik?
    Tugas mana yang kurang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut tidak dikerjakan dengan baik?
    Bila belum muncul saat wawancara, jajaki :
    - Usia
    - Kompetensi klinis
    - Sikap
    - Alat medis
    - Situasi melahirkan (birthing environment)
    - Alat komunikasi (telepon genggam)
    - Sistem rujukan
15. Bagaimana peran kader di desa anda?
16. Bagaimana peran dukun bayi di desa anda?

Pemekaran(only in SW Sumba)

17. Sumba Barat Dayaterbentuksebagaipemekarandari Sumba Barat.
    Apakahandamelihatperbedaanpelayanankesehatansebelumdansesudahpemekaran?

Revolusi KIA (Only in SW Sumba)

18. Apakah anda pernah mendengar tentang revolusi KIA?
    Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
    Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
    Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan?Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

19. Hal-hal lain apa yang menurut anda bisa dilakukan untuk meningkatkan pelayanan kesehatan ibu?

4. 3. 1. 6. SSI Midwife Coordinator, Puskesmas Head, and DHO MCH Officer

Panduan Wawancara Bidan Koordinator, Kepala Puskesmas, dan Petugas/Kepala Bidang KIA

1. Dapatkah anda ceritakan tentang pekerjaan anda yang terkait dengan bidang kesehatan ibu?
2. Bagaimana pendapat anda tentang tugas dan fungsi bidan/perawat desa, penolong persalinan tradisional dan kader (terkait kesehatan ibu)? Berikan alasan atas pendapat anda.
   Jajaki tentang: system rujukan antara bidan/perawat desa, puskesmas dan rumah sakit.
3. Apakah factor pendukung dan penghambat tugas dan fungsi bidan/perawat desa, penolong persalinan tradisional dan kader (terkait kesehatan ibu)?
   Jajaki:
   - Aspek kebijakan kesehatan: regulasi, komitmen politis (tingkat kabupaten, desa)
   - Aspek sistem kesehatan: trainings, financial incentives, M/E, supervision, human resource management
4. Apa saran/pendapat anda mengenai kemitraan antara bidan/perawat desa dengan penolong persalinan tradisional dan kader?
   Jajaki:
   - Contoh model kemitraan
   - M/E dan supervisi
   - Insentif
   - Hambatan dan antisipasinya

4.3.2. FOCUS GROUP DISCUSSION

4. 3. 2. 1. FGD Husband/Men

Panduan Diskusi Kelompok Terarah Suami

<u>Kehamilan dan ANC</u>

1. Bagaimana para wanita mengetahui bahwa mereka hamil? Apa yang mereka lakukan pertama kali saat mengetahui dirinya hamil? Lalu apa yang terjadi? Apa yang mereka lakukan kemudian?
   Bila pernyataan tentang ANC belum keluar, baru jajaki:
   Apakah mereka melakukan pemeriksaan rutin kehamilan (ANC)? Mengapa ada yang melakukannya dan ada yang tidak? Mengapa? Beri contohnya
2. Pada usia kehamilan berapa biasanya mereka memeriksakan diri? Mengapa?
   Apakah mereka periksa lebih dari 1 kali? Mengapa ada yang melakukan 2, 3 dan 4 kali?
   Biasanya kapan mereka pergi memeriksakan diri? Mengapa?
   Tanyakan apalagi alasannya, bila belum muncul baru jajaki :
   - Jarak ke fasilitas kesehatan
   - Biaya transportasi dan konsultasi
   - Keberadaan petugas

- Kepercayaan pada petugas (umur petugas, kompetensi medis, sikap, kelengkapan alat medis)
- Siapa yang memutuskan bahwa seorang wanita melakukan pemeriksaan rutin kehamilan?

3. Bagaimana menurut anda pelayanan pemeriksaan kehamilan yang ada?
4. Apa yang terjadi bila seorang wanita tidak melakukan pemeriksaan rutin kehamilan?

Kelahiran

5. Apa yang dilakukan wanita hamil di sini saat mulai merasakan kontraksi? Apa yang dilakukan selanjutnya? Mengapa? Lalu apa yang terjadi?
6. Siapa yang paling sering menolong wanita bersalin di desa ini? Mengapa?
   Apakah ada perbedaan antara para wanita di desa ini antara yang menggunakan jasa bidan dengan yang tidak? Mengapa? Beri contohnya.
7. Bagaimana para wanita mengambil keputusan dalam bersalin? siapa yang biasanya memutuskan wanita bersalin di mana dan oleh siapa?
8. Apa yang menghambat para wanita melahirkan di fasilitas kesehatan?
   Bila belum muncul saat wawancara, jajaki alasan tidak bersalin di polindes / bersalin tidak didampingi tenaga terlatih :
   - Jarak ke fasilitas kesehatan
   - Biaya transportasi dan konsultasi
   - Keberadaan petugas
   - Kepercayaan pada petugas (umur petugas, kompetensi medis, sikap, kelengkapan alat medis)
   - Adanya asuransi kesehatan: Setahu anda, apa manfaat asuransi tersebut? Jenilayanan apa yang anda bisa dapatkan dengan asuransi tersebut? Ceritakan pengalaman anda dalam menggunakan asuransi tersebut. Bagaimana asuransi mempengaruhi keputusan dalam kelahiran (di fasilitas kesehatan/di dukun)

   Bila belum muncul, tanyakan:
   Apa pendapat anda tentang persalinan yang ditolong dukun bayi? Manfaat dan kerugiannya
   Apa pendapat anda tentang persalinan yang ditolong bidan desa? Manfaat dan kerugiannya

Pasca Persalinan Dan Keluarga Berencana

9. Apa yang anda lakukan setelah melahirkan? Mengapa ? Apa yang anda lakukan selanjutnya? Mengapa?
10. Bagaimana pendapat anda tentang KB? Apakah anda ber KB? Mengapa?
11. Bila ia menggunakan KB, tanyakan dimana ia melakukan KB? Mengapa?

Persepsi tentang petugas kesehatan

12. Bagaimana menurut anda tentang kinerja bidan desa? (Perawat desa bila bidan tidak ada)
13. Apa saja tugas mereka?
    Tugas mana yang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut dikerjakan dengan baik?

Tugas mana yang kurang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut tidak dikerjakan dengan baik

Bila belum muncul saat wawancara, jajaki :

- Usia
- Kompetensi klinis
- Sikap
- Alat medis
- Situasi melahirkan (birthing environment)
- Alat komunikasi (telepon genggam)
- Sistem rujukan: apakah anda mengetahui bagaimana bidan desa membantu merujuk ibu melahirkan? Bagaimana ceritanya?

14. Bagaimana peran kader di desa anda?
15. Bagaimana peran dukun bayi di desa anda?
16. Apakah anda pernah mendengar sunat perempuan? Bagaimana proses sunat perempuan? Apakah semua anak perempuan harus di sunat? Alasannya? (Hanya di Cianjur)

Pemekaran (only in SW Sumba)

17. Sumba Barat Dayaterbentuksebagaipemekarandari Sumba Barat. Apakahandamelihatperbedaanpelayanankesehatansebelumdansesudahpemekaran?

Revolusi KIA (Only in SW Sumba)

18. Apakahandapernahmendengar tentang revolusi KIA?
19. Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
    Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
    Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan? Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

20. Hal-hal lain apa yang menurut anda bisa dilakukan untuk meningkatkan pelayanan kesehatan ibu?

4. 3. 2. 2. FGD TBA (only in Cianjur)

Panduan Diskusi Kelompok Terarah Dukun Bayi

Tugas dan Klien

1. Dapatkah Anda memberikan gambaran tentang pekerjaan anda?
   Jajaki tentang:
   - Bagaimana ceritanya anda menjadi dukun bayi?
   - Jenis-jenis tugas (untuk dukun bayi jajaki: kehamilan, persalinan, pasca persalinan, perawatan bayi, dll)
   - Peran dalam sunat perempuan (hanya di Cianjur)
2. Siapakah masyarakat yang anda layani? Gali profil masyarakat yang biasanya dilayani dukun bayi

Jajaki tentang:

- Apa motivasi atau alasan mereka menggunakan pelayanan Anda?
- Apa motivasi atau alasan mereka tidak menggunakan pelayanan Anda?
- Sesuai pengalaman anda, apa yang dilakukan para ibu disini saat:
- Kehamilan. Apakah memeriksakan diri? Kemana? Mengapa?
- Persalinan. Dimana? Mengapa?
- Pasca persalinan. Apakah memeriksakan diri? Dimana? Mengapa?
- Keluarga berencana. Apakah melakukan KB? Dimana? Mengapa?

Motivasi dan kepuasan kerja

3. Bagaimana pendapat anda tentang pekerjaan anda sekarang? Apakah anda puas? Mengapa? Pekerjaan apa yang anda merasa puas? Mengapa? Apa contohnya? Pekerjaan apa yang anda merasa tidak puas? Mengapa? Apa contohnya?
   Jajaki tentang:
   - Insentif non-finansial (kepercayaan dari masyarakat, dukungan dari masyarakat, status sosial)
   - Insentif finansial (pendapatan rutin)
   - Perasaan tentang insentif tersebut
   - Pekerjaan lain, pemasukan lain?

Mutu Pelayanan

4. Menurut anda,bagaimana pelayanan dukun bayi yang baik itu?. Mintalah informan untuk memberi contoh pelayanan yang menurut informan telah dilakukan dengan baik dan kurang baik.
   Hal-hal apa yang mendukung anda untuk bisa bekerja dengan baik? Mengapa?
   Hal-hal apa yang menghambat anda untuk bisa bekerja dengan baik? Mengapa?

Hubungan dengan sistem kesehatan dan pemuka masyarakat

5. Ketika anda menghadapi persoalan dalam membantu persalinan, dengan pihak mana anda berkomunikasi?
   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:
   a. Dengan siapa anda berkomunikasi?
   b. Berapa kali / seberapa sering anda berkomunikasi dengannya?
   c. Dimana atau apa alat / medianya?
   d. Siapa yang menyediakan alatnya?
   e. Bagaimana komunikasinya? Berikan contoh2 hal yang dikomunikasikan
   f. Apakah anda senang dengan komunikasi ini? Apa yang disenangi? Beri contohnya.Mengapa? Apa yang kurang disenangi? Beri contohnya. Mengapa?
   g. Apakah komunikasi tersebut bermanfaat bagi kinerja anda?
6. Bagaimana anda berinteraksi dengan pemuka desa, staf puskesmas, rumah sakit dan dinas kesehatan ? Jajaki tentang: forum, frekuensi, isi pertemuan
7. Pernahkah anda melakukan merujukkasuskebidandesa? Beri contohnya.
   Jajaki tentang:
   - Jenis kasus apa yang selama ini anda rujuk?Mengapa anda merujuknya?

- Berapa sering anda perlu merujuk?
- Bagaimana cara anda merujuk?
- Apa yang cukup baik dalam rujukan itu? Mengapa?
- Hambatan apa yang dihadapi? Apa yang anda lakukan kemudian?

Persepsi tentang petugas kesehatan

8. Bagaimana pendapat anda tentang bidan/perawat desa?
   Bisa anda ceritakan tentang bidan di desa ini?
   Bagaimana menurut anda tentang kinerja bidan desa? (Perawat desa bila bidan tidak ada)
   Apa saja tugas mereka?
   Tugas mana yang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Contohnya?
   Tugas mana yang kurang dikerjakan dengan baik? Mengapa? Hal apa yang membuat tugas tersebut tidak dikerjakan dengan baik? Contohnya?
   Bila belum muncul saat wawancara, jajaki :
   - Usia
   - Asal
   - Kompetensi klinis
   - Sikap
   - Alat medis
   - Situasi tempat bersalin (privasi, kebersihan,dll)
   - Alat komunikasi (telepon genggam)
   - Sistemrujukan:apakah anda mengetahui bagaimana bidan desa membantu merujuk ibu melahirkan? Bagaimana ceritanya?
9. Bagaimana kerjasama antara bidan dan anda? Contohnya? Apakah kerja sama tersebut pernah anda coba? Apa yang terjadi kemudian?
10. Hal apa yang akan membuat anda senang untung merujuk persalinan ke bidan?
11. Bagaimana menurut anda supaya layanan bidan dalam kesehatan ibu lebih bermanfaat bagi masyarakat desa?

Persepsi tentang kader

12. Siapa saja kader di desa ini?
13. Apa pendapat anda tentang kader di desa ini?
14. Apa saja yang mereka lakukan sebagai kader ?
    Menurut anda, hal apa yang dikerjakan dengan baik? Mengapa? Contohnya?
    Hal apa yang membuat tugas tersebut dikerjakan dengan baik? Mengapa? Contohnya?
    Menurut anda, hal apa yang dikerjakan dengan kurang baik? Mengapa? Contohnya?
    Hal apa yang membuat tugas tersebut dikerjakan dengan kurang baik? Mengapa? Contohnya?
    Bila belum muncul jajaki deskripsi kerja berikut :
    - Mengingatkan ibu hamil dan keluarganya untuk melahirkan didampingi tenaga terlatih (bidan desa atau Puskesmas) (bila jarak rumah jauh, ibu bisa menunngu di rumah tunggu)

- Mobilisasi untuk Posyandu
- Melaksanakan kegiatan penyuluhan, penimbangan, pencatatan dan pelaporan di Posyandu
- Kunjungan rumah untuk mendata ibu hamil, melahirkan, nifas, menyusui, bayi dan pasangan usia subur
- Melaporkan kepada bidan / tenaga kesehatan lain saat ada ibu yang melahirkan

15. Bagaimana menurut anda supaya layanan kader dalam kesehatan ibu bisa lebih baik?
16. Bagaimana kerja sama antara anda dan kader? Contohnya. Apakah kerja sama tersebut pernah anda coba? Apa yang terjadi kemudian?

Saran

17. Peran apa yang sekiranya anda bisa lakukan selain menolong persalinan? Bagaimana caranya untuk mengatur ini bisa terjadi?
18. Hal-hal lain apa yang menurut anda bisa dilakukan untuk meningkatkan pelayanan kesehatan ibu?

4. 3. 2. 3. FGD Village Midwife (only in SW Sumba)

Panduan Diskusi Kelompok Terarah Bidan Desa

Tugas dan Klien

1. Bagaimana ceritanya anda menjadi bidan/perawat desa dan bekerja di sini?
2. Dapatkah Anda memberikan gambaran tentang pekerjaan anda?
   Jajaki tentang:
   - Jenis-jenis tugas (SaatPosyandudan di luarPosyandu)
   - Alasan mengapa menjadi bidan/perawat desa
3. Dari mana sajaasal masyarakat yang anda layani?
   (Gunakan/gambar peta setempat untuk meminta informan menunjukkan dari wilayah mana masyarakat yang mereka layani)
   Jajaki tentang:
   - Apa motivasi atau alasan mereka menggunakan pelayanan Anda?
   - Apa motivasi atau alasan mereka tidak menggunakan pelayanan Anda?
   - Layanan apa yang paling banyak dipakai masyarakat? (poliklinik umum, pelayanan kesehatan ibu, dll)
   - Sesuai pengalaman anda, apa yang dilakukan para ibu didesa ini saat:
     - Kehamilan. Apakah memeriksakan diri? Kemana? Mengapa?
     - Persalinan. Dimana? Mengapa?
     - Pasca persalinan. Apakah memeriksakan diri? Dimana? Mengapa?
     - Keluarga berencana. Apakah melakukan KB? Dimana? Mengapa?
   - Layanan apa yang banyak digunakan para ibu?(ANC, persalinan, PNC, keluarga berencana) Mengapa?
   - Layanan apa yang kurang digunakan para ibu? (ANC, persalinan, PNC, keluarga berencana) Mengapa?

Motivasi dan kepuasan kerja

4. Bagaimana pendapat anda tentang pekerjaan anda sekarang? Apakah anda puas? Mengapa? Pekerjaan apa yang anda merasa puas? Mengapa? Apa contohnya? Pekerjaan apa yang anda merasa tidak puas? Mengapa? Apa contohnya
   Jajaki tentang:
   - Insentif non-finansial (kepercayaan dari masyarakat, dukungan dari masyarakat, status sosial)
   - Bagaimana respons masyarakat tentang pelayanan informan? Contohnya?
   - Apa yang masyarakat sukai dari layanan anda? Mengapa ? Contohnya?
   - Apa yang masyarakat kurang sukai dari layanan anda? Mengapa ? Apa contohnya?
   - Insentif finansial (pendapatan rutin)
   - Perasaan tentang insentif finansial tersebut
   - Pekerjaan lain, pemasukan lain?

Mutu Pelayanan

17. Menurut anda, apakah pelayanan kesehatan yang bermutu itu?. Mintalah informan untuk memberi contoh pelayanan yang menurut informan telah dilakukan dengan mutu yang baik dan kurang baik. Hal-hal apa yang mendukung anda untuk bisa bekerja dengan baik? Mengapa? Hal-hal apa yang menghambat anda untuk bisa bekerja dengan baik? Mengapa?

Tanyakan berkali2 pertanyaan ini, bila belum muncul, tanyakan faktor pendukung dan penghambat informan dalam bekerja:

- Anda telah menjelaskan tentang tugas-tugas anda sebelumnya, bagaimana perasaan anda atas beban kerja tersebut?
- Bagaimanakah infrastruktur tempat kerja anda?,
- Bagaimana lingkungan pekerjaan (kolega, atasan) anda?
- Bagaimana kondisi keamanan di tempat kerja anda? Bagaimana perasaan anda atas hal tersebut?
- Bagaimana rencana karir di masa depan?
- Bagaimana perasaan anda atas pedoman-pedoman tindakan medis yang ada?

Supervisi

6. Bagaimana pengalaman anda tentang supervisi yang anda terima?
   Jajaki:
   - siapa supervisor-nya,
   - kapan terakhir menerima supervisi,
   - seberapa sering supervisi dilakukan?
   - bagaimana supervisi dilakukan, apa-apa saja yang dilakukan dalam supervisi? Jajaki: diskusi target-target program, pelaporan
   - Bagaimana umpan balik dilakukan?
   - bagaimana dukungan pemecahan masalah (termasuk dukungan sosial). Mengapa? Contohnya?
   - bagaimana ketrampilan anda setelah supervisi? Contohnya?

- bagaimana pandangan tentang supervisi tersebut? Mengapa? Apa contohnya yang bermanfaat? Apa contohnya yang kurang bermanfaat?

M&E

7. Bagaimana pencatatan dan pelaporan dari pelayanan kesehatan ibu yang anda alami selama ini?
   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:
   - Bagaimana cara pencatatan dan pelaporan anda? Hal-hal apa yang dilaporkan?
   - Bagaimana laporan anda dikirimkan? Menggunakan alat apa?
   - Siapa yang memberikan umpan balik? Bagaimana umpan balik dilakukan? Apa bentuk umpan baliknya? Contoh bagaimana umpan balik diterapkan?
   - Bagaimana pandangan anda tentang sistem pelaporan dan umpan baliknya? Apa ada manfaat? Mengapa? Apa contohnya? Apa ada yang kurang bermanfaat? Mengapa? Apa contohnya?

Hubungan dengan sistem kesehatan (termasuk kolega) dan pemuka masyarakat

8. Ketika anda menghadapi persoalan dalam pelayanan kesehatan, dengan pihak mana anda berkomunikasi?
   Tanyakan dulu berkali-kali. Bila belum keluar saat wawancara, baru jajaki tentang:
   a. Dengan siapa anda berkomunikasi?
   b. Berapa kali / seberapa sering anda berkomunikasi dengannya?
   c. Dimana atau apa alat / medianya?
   d. Siapa yang menyediakan alatnya?
   e. Bagaimana komunikasinya? Berikan contoh2 hal yang dikomunikasikan
   f. Apakah anda senang dengan komunikasi ini? Apa yang disenangi? Beri contohnya.Mengapa? Apa yang kurang disenangi? Beri contohnya. Mengapa?
   g. Apakah komunikasi tersebut bermanfaat bagi kinerja anda?
9. Bagaimana anda berinteraksi dengan pemuka desa, staf puskesmas, rumah sakit dan dinas kesehatan
   Jajaki tentang: forum, frekuensi, isi pertemuan
10. Bagaimana anda menangani kasus yang perlu dirujuk selama ini dari tingkat desa ke Puskesmas?
    Jajaki tentang:
    - Jenis kasus apa yang selama ini anda rujuk? Berikan contohnya (Kasus kebidanan, Kasus umum,gawat dan gawat darurat) Mengapa anda merujuknya?
    - Berapa sering anda perlu merujuk?
    - Fasilitas kesehatan mana yang dituju? Mengapa?
    - Bagaimana cara anda merujuk?
    - Apa yang cukup baik dalam rujukan itu? Mengapa?
    - Hambatan apa yang dihadapi? Apa yang anda lakukan kemudian?
11. Bagaimana pendapat anda tentang dukun bayi? Yang baik apa contohnya? yang kurang baik apa contohnya?
    Jajaki:

- Bagaimana hubungan anda dengan dukun bayi selama ini? Mengapa? Beri contohnya.
- Bagaimana anda melihat potensi kemitraan anda dengan dukun bayi? Apakah kemitraan tersebut pernah anda coba? Apa yang terjadi kemudian?
- Bagaimana tanggapan masyarakat atas pekerjaan yang dilakukan dukun bayi?

12. Apakah anda pernah mendengar tentang sunat anak perempuan?
    Siapa yang melakukan sunat? Alasannya? Ceritakan tentang proses sunat perempuan.
    (Pertanyaan hanya di Cianjur).
13. Bagaimana pendapat anda tentang kader? Yang baik apa contohnya, yang kurang baik apa contohnya?
    Bagaimana pendapat anda tentang "kesukarelaan" dari kader dan kaitannya dengan mutu pelayanan.
    Bagaimana cara memantau mutu pelayanan kader? Siapa pihak yang berwenang memantau mutu?
    Apakah masyarakat ikut serta dalam memantau pelayanan kader? Bagaimana?
    Jajaki:
    - Bagaimana hubungan anda dengan kader selama ini? Beri contohnya.
    - Bagaimana anda melihat potensi kemitraan anda dengan kader? Apakah kemitraan tersebut pernah anda coba? Apa yang terjadi kemudian?
    - Bagaimana tanggapan masyarakat atas pekerjaan yang dilakukan kader?

Keterlibatan dalam masyarakat

14. Bagaimana hubungan anda dengan komunitas? Contohnya ? Mengapa?
15. Bagaimana anda menjalin dan membina hubungan tersebut? Contohnya?
16. Bagaimana penempatan bidan desa disini?
    Jajaki:
    Apakah masyarakat berperan dalam proses penempatan bidan desa tersebut?
    Bagaimana bentuk keterlibatan tersebut?
    Bagaimana penilaian kinerja bidan?
    Apakah masyarakat ikut memantau kinerja bidan? Bagaimana?

Pemekaran

15. Sumba Barat Daya terbentuk sebagai pemekaran dari Sumba Barat. Apakah anda melihat perbedaan pelayanan kesehatan sebelum dan sesudah pemekaran?

Revolusi KIA

16. Apakah anda pernah mendengar tentang revolusi KIA?
    Revolusi KIA merupakan kebijakan NTT untuk menurunkan angka kematian ibu dan bayi baru lahir dengan mewajibkan ibu melahirkan di fasilitas kesehatan
    Bagaimana menurut anda pelaksanaan kegiatannya di tingkat desa?
    Apakah anda melihat perbedaan dengan masa sebelum peraturan ini diberlakukan? Apa perbedaan tersebut? Bagaimana bisa terjadi perbedaan itu?

Saran

17. Menurut anda, hal-hal apa yang perlu dan memungkinkan untuk dilakukan supaya tugas anda dalam pelayanan kesehatan ibu bisa lebih baik?

INTERVIEW GUIDELINE ENGLISH

4.4.1. SEMI-STRUCTURED INTERVIEW

4. 4. 1. 1. SSI Village Midwife

Interview Guideline for Village Midwife/Nurse

Tasks and Client

1. Can you explain how did you end up working as village midwife/nurse in this health facility?
2. Can you describe about your job?
   - The tasks (The task in *posyandu* and outside *posyandu*).
   - The reason behind the participant wants to be a village midwife/nurse.
3. Which are your working areas?
   - Who are you clients or people who utilise your service?
   - Why do they use or not use your service?
   - What kind of health services that most utilised by the community? (Policlinic, maternal health service, etc)
   - According to your experience, what do the women in this village do when:
     * They wanted to have pregnancy check-up
     * They were going into the labor process
     Where did they go for assistance in those two occasions? Why did they go there?
   - After childbirth, did they have check-up? Where? Why did they choose that place?
   - In terms of family planning program, did these women follow the program? Where?
   - What are the most utilised health services? (ANC, labor process services, after-birth services, family planning program)
   - What are the least utilised health services? (ANC, labor process services, after-birth services, family planning program)

Motivation and job satisfaction

4. What do you think about your current job/role? Are you happy with your job? Why? What are the things that make you feel happy or do not feel happy about your job? Why? Can you give me some examples?
   Ask the participant about:
   - Non-financial incentive (Gain trust from the community, community's support, social status).
     - What is the response from community? Give me some examples.

- What do the community like and dislike in relation with your services? Give me some examples.

- Financial incentive (income).
- The participant's feeling/opinion about those incentives.
- Other job or income.

Service quality

5. What is your opinion about midwife/nurse's good quality health services? According to your ownexperience, can you give me some examples about midwife/nurse's good and bad quality health services?
   In terms of good quality service, what are the things that support you and not support you in performing your role as a midwife/nurse? Why?
   Ask the participant about:
   - The workload. What does he/she feel about it?
   - The workplace infrastructure
   - The work environment (colleague, supervisor)
   - The safety in the workplace
   - The future career
   - The feeling/opinion about existed medical guidelines

Supervision

6. What is your experience about work supervision?
   Who does supervise your work?
   When was the last time you get supervised?
   How often does the supervision conducted?
   How was the supervision conducted? (The target of the program and the reporting)
   What is the feedback?
   How about the problem solving (including social support)? Why? Give me an example.
   Does your skill improved after supervision? Why? Give me an example.
   What is your opinion about the supervision? Why? Did you get or did not get some benefits from supervision?Can you give me some examples?

Monitoring and Evaluation

7. Can you explain about the recording and reporting of maternal health services?
   Ask:
   - How do you do the recording and reporting? What is the content of the report?
   - How do you send your report files? What instrument do you use?
   - Who does give you the feedback? How is the feedback conducted? How is the feedback applied?
   - What do you think about the reporting system and the feedback? Is there any benefits? Why? Can you give some examples?

The relationship with health system and community leaders

8. When you were facing difficulties in performing your job:
   - Who do you contact?

- How often?
- Where? Do you use any media to communicate with that person? If yes, who did provide the communication tool?
- What do you feel about your communication and relationship with this person? What do you likeor dislike about it? Why?
- Does the communication give you benefit to perform your job?

9. How do you communicate with community leaders, *puskesmas'* staffs, hospital, and health institution?
   - The forum
   - The frequency
   - The content of the meeting
10. How do you handle the referral cases? (From village to *puskesmas*)
    - What were the referral cases you had? Give some examples. Why did you refer those cases?
    - How often do you do the referral?
    - Where did you refer those cases?
    - How did you do it?
    - What are the good things about referral? Why?
    - What are the obstacles? What did you do next (to overcome the obstacles)?
11. What do you think about *kader*? What are the good and bad things about kader? Give me some examples.
    - What do you think about *kader*'s "voluntarism" and what is the relationship with the health service quality?
    - How do you monitor the quality of *kader*'s health services?
    - Does the community participate in monitoring *kader*'s health services? How?

    Ask about:
    - The participant's relationship with *kader* and the examples.
    - The participant's view about his/her partnership with *kader*. Does the partnership ever exist? Then, what happened?
    - What is the community's response regarding *kader*'s services?

Relationship with TBA

12. Is there any TBA in this village?
    What is their TBA role in MCH?
    Can you tell me more about their role during ANC, delivery, PNC, child health and FP?
13. Is there any female circumcision in this village? Does evet female must be circumcised? The reason? Can you tell me the process? (Only in Cianjur)

Community Involvement

14. How is your relationship with the community? Give me some examples. Why?
15. How do you develop that relationship? Give me some examples?
16. How is the midwives' placement in this village?
    - Does the community take part in that placement? How is their involvement?

- How is the evaluation of midwives' performance conducted?
- Does the community involved in that evaluation? How?

Regional Expansion (only in SW Sumba)

17. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution(only in SW Sumba)

18. Have you ever heard about mother and children health revolution?
    Mother and children health revolution is a part of East Nusa Tenggara policy to decrease the maternal mortality rate and new-born baby mortality rate.
    What do you think about the implementation of this policy in village level?
    Do you see if there any difference before and after mother and child health revolution?
    What are the differences? How do the differences happen?

Suggestion

19. In your opinion, what are the things that can be done to improve your performance in supporting better maternal health services?

4. 4. 1. 2. SSI *Kader*

Interview Guideline for Kader

Tasks and Client

1. Can you explain me about your job?
   - Why did you decide to be a kader?
   - What is your daily job?
2. Who are your clients? Which are your working areas?
   Why do they use or not use your service?
   According to your experience, what do the women in this village do when:
   - They wanted to have pregnancy check-up
   - They were going into the labor process

Where did they go for assistance in those two occasions? Why did they go there?
After childbirth, did they have check-up? Where? Why did they choose that place?
In terms of family planning program, did these women follow the program? Where?
Why did they choose to follow or not to follow the program?

Motivation and job satisfaction

3. What do you think about your current role as a kader? Are you happy with your job? Why?
   What are the things that make you feel happy or do not feel happy about your role? Why? Can you give me some examples?
   Ask the participant about:
   - Non-financial incentive (Gain trust from the community, community's support, social status).
   - Financial incentive.
   - The participant's feeling/opinion about those incentives.

- Other income.

Service quality

4. What is your opinion about kader's good quality health services? According to your own experience, can you give me some examples about good and bad quality kader's health services?
   In terms of good quality service, what are the things that support you or not support you in performing your role as a kader? Why?
   What is your opinion about "volunteerism" in relationship with your service quality?
   Ask the participant about:
   - The supporting and inhibiting factors in performing the his/her role as a kader.
   - The workload. What does he/she feel about it?
   - The facilities in the workplace.
   - The work environment (colleague, supervisor).
   - The safety in the work place. What do you feel about it?

The relationship with health system and community leaders

5. When you were facing difficulties in performing your job:
   - Who do you contact?
   - How often?
   - Where? Do you use any media to communicate with that person? If yes, who did provide thecommunication tool?
   - What do you feel about your communication and relationship with this person? What do you like or dislike about it? Why?
   - Does the communication give you benefit to perform your job?
6. How do you communicate with community leaders, *puskesmas'* staffs, hospital, and health institution?
   - The forum
   - The frequency
   - The content of the meeting
7. Have you ever done a referral? Can you give me some examples?
   What were the referred cases? (Obstetric cases, general health cases, and emergency cases)
   Why did you do a referral?
   How often do you need to refer a patient?
   How do you do a referral?
   What are the good things about a referral? Why?
   What were the obstacles you face? What did you do?

Supervision

8. What is your experience about work supervision?
   Who does supervise your work?
   When was the last time you get supervised?
   How often does the supervision conducted?

How was the supervision conducted?
What is the feedback?
How about the problem solving (including social support)? Why? Give me an example.
Does your skill improved after supervision? Why? Give me an example.
What is your opinion about the supervision? Why? Did you get or did not get some benefits from supervision?Can you give me some examples?

Monitoring and Evaluation

9. Can you explain about the recording and reporting of maternal health services?
   Ask:
   - How do you do the recording and reporting? What is the content of the report?
   - How do you send your report files? What instrument do you use?
   - Who does give the feedback? How is the feedback conducted? How is the feedback applied?
   - What do you think about the reporting system and the feedback? Is there any benefits? Why? Can you give some examples?

Perception about health care providers

10. What do you think about village midwives or nurses?
    Can you tell me about the midwives in this village?
    How is their performance?
    What are their roles?
    Which role was good executed and which role was not? Why?
    What are the things that make their roles were well executed and were not well executed? Can you give some examples?
    Ask the participant about: age, origin, clinical competencies, attitude, medical equipment, maternity environment (privacy, cleanliness, etc), communication tools (cell phone), and referral system.
11. What is your suggestion to improve the midwives services?
12. How is your relationship with the midwives? Have you ever work with them in the past? Can you give some examples? The, what happened?
13. What do make you feel glad to refer childbirth process to the midwives?

Perception about TBAs

14. Who are the TBAs in this village?
15. What do you think about them?
16. What are their roles? What do they do?(in pregnancy, during childbirth process, after childbirth process, neonatal care, etc)
    Did the tasks were well performed? Why? Can you give some examples?
    What are the things that make the tasks were well performed? Why? Can you give some examples?
    What are the things that make the tasks were poorly performed? Why? Can you give some examples?
    What is your suggestion to make the TBAs services better?

How is your relationship with the TBAs? Have you ever work with them in the past?
Ask the participant about: age, origin, clinical competencies, attitude, medical equipment, maternity environment (privacy, cleanliness, etc), communication tools (cell phone), and referral system.

17. Is there any female circumcision in here? Why female must be circumcised? The reason? What is the process? (Only in Cianjur)

Regional Expansion(Only in SW Sumba)

18. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution(Only in SW Sumba)

19. Have you ever heard about mother and children health revolution?
    Mother and children health revolution is a part of East Nusa Tenggara policy to decrease the maternal mortality rate and new-born baby mortality rate.
    What do you think about the implementation of this policy in village level?
    Do you see if there any difference before and after mother and child health revolution?
    What are the differences? How do the differences happen?

Suggestion

20. What are the things that can be done to improve maternal health services?

4. 4. 1. 3. SSI TBA

Interview Guideline for TBA (Only in SW Sumba)

Tasks and Client

1. Can you explain me about your job?
   - Why did you decide to be a TBA?
   - What is your daily job? (Ask the participant about the type of tasks, e.g. during pregnancy, the childbirth process, neonatal care, etc).
2. Who are your clients? Which are your working areas?
   - Why do they use or not use your service?
   - According to your experience, what do the women in this village do when:
     - They wanted to have pregnancy check-up
     - They were going into the labor process
   - Where did they go for assistance in those two occasions? Why did they go there?
   - After childbirth, did they have check-up? Where? Why did they choose that place?
   - In terms of family planning program, did these women follow the program? Where?
   - Why did they choose to follow or not to follow the program?

Motivation and job satisfaction

3. What do you think about your current role as a TBA? Are you happy with your job? Why?
   What are the things that make you feel happy or do not feel happy about your role? Why? Canyou give me some examples?
   Ask the participant about:

- Non-financial incentive (Gain trust from the community, community's support, social status).
- Financial incentive.
- The participant's feeling/opinion about those incentives.
- ther income.

Service quality

4. What is your opinion about good quality health services by a TBA? According to your own experience, can you give me some examples about good and bad quality TBA's health services?
   In terms of good quality service, what are the things that support you and not support you in performing your role as a TBA? Why?

The relationship with health system and community leaders

5. When you were facing difficulties in performing your job:
   - Who do you contact?
   - How often?
   - Where? Do you use any media to communicate with that person? If yes, who did provide the communication tool?
   - What do you feel about your communication and relationship with this person? What do you like or dislike about it? Why?
   - Does the communication give you benefit to perform your job?
6. How do you communicate with community leaders, *puskesmas'* staffs, hospital, and health institution?
   - The forum
   - The frequency
   - The content of the meeting
7. Have you ever done a referral? Can you give me some examples?
   - What were the referred cases?
   - Why did you do a referral?
   - How often do you need to refer a patient?
   - How do you do a referral?
   - What are the good things about a referral? Why?
   - What were the obstacles you face? What did you do?

Perception about health care providers

8. What do you think about village midwives or nurses?
   - Can you tell me about the midwives in this village?
   - How is their performance?
   - What are their roles?
   - Which role was good executed and which role was not? Why?
   - What are the things that make their roles were well executed and were not well executed?
   - Can you give some examples?

Ask the participant about: age, origin, clinical competencies, attitude, medical equipment, maternity environment (privacy, cleanliness, etc), communication tools (cell phone), and referral system.

9. How is your relationship with the midwives? Have you ever work with them in the past?
10. What do make you feel glad to refer childbirth process to the midwives?
11. What is your suggestion to improve the midwives services?

Perception about Kader

12. Who are the kaders in this village?
13. What do you think about them?
14. What are their roles?
    - What are the tasks they performed well? Why? Give me some examples.
    - What are the things that make the task were well performed? Why? Can you give some examples?
    - What are the things that make the task were poorly performed? Why? Can you give some examples?
    - What is your suggestion to make the kader's services better?
    - How is your relationship with the kaders? Have you ever work with them in the past?
15. How can the kader's services be improved?
16. How is your relationship with kaders?(in terms of the opportunity to work together) Have you ever have one? Then, what happened?

Regional Expansion

17. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution

18. Have you ever heard about mother and children health revolution?
    Mother and children health revolution is a part of East Nusa Tenggara policy to decrease the maternal mortality rate and new-born baby mortality rate.
    What do you think about the implementation of this policy in village level?
    Do you see if there any difference before and after mother and child health revolution?
    What are the differences? How do the differences happen?

Suggestion

19. What else can you do besides helping the women go through the labor process?
20. In your opinion, what are the things that can be done to improve maternal health services?

4. 4. 1. 4. SSI Mother

Interview Guideline for Mother

Pregnancy and Antenatal Care (ANC)

1. How did you know if you are pregnant?
2. What did you initially do when you knew you were pregnant? Why? Then, what happen?

If ANC's statements were not sufficient yet, ask:

3. Did you have or have regular ANC? Why? Where? (medical/non-medical ANC)
4. How did you decide that?
5. In which gestational age did you have ANC? Why?
6. Did you have ANC for more than one time? Why did you have second, third, and fourth ANC?
7. Ask the participant the reason behind for her statement above.
   If ANC's statements were not sufficient yet, ask:
   - The distance of health facilities
   - The cost of transportation and consultation
   - The health provider's presence
   - The trust issue in relation with the health providers (their age, medical competencies, and attitude; and the completeness of medical equipment).
   - The culture in the community
8. What do you think about the existed ANC service? Why? What are the good and bad things about ANC? Can you give some examples?
9. What do you think about having regular ANC?
10. In your opinion, what will happen if a woman does not have regular ANC?

Childbirth Process

11. What did you do when you started feel contraction? Why? Whom did you inform your contraction for the first time? Why? The, what did you do next? Why?
12. Where did you seek help to deliver the baby?
13. Who did help you during the labor process?
14. Who did make decision to give birth in *puskesmas* or helped by TBA? Why?
    If ANC's statements were not sufficient yet, ask:
    - The distance of health facilities
    - The cost of transportation and consultation
    - The health provider's presence
    - The trust issue in relation with the health providers (their age, medical competencies, and attitude; and the completeness of medical equipment).
    - The culture in the community
15. What do you think about the childbirth process aided by TBAs? (The advantages and the disadvantages.)
16. What do you think about the childbirth process aided by midwives? (The advantages and the disadvantages.)

After Childbirth Process and Family Planning

17. What do you do after the childbirth process? Why? What do they do afterwards?
18. What do you think about family planning program? Do you follow the family planning program? Why?
    If the participant follows the family planning program, ask her where and why she follows the program.

Perception about village midwives

19. Can you tell me about the village midwives?
20. What do you think about them?
    Ask the participant about: age, origin, clinical competencies, attitude, medical equipment, maternity environment (privacy, cleanliness, etc), communication tools (cell phone), and referral system.
21. What do you think about the village midwives' (or nurses) performance?
    What are their duties?
    Which tasks are well performed? Why? What are the things that make the tasks were well performed? Can you give me an example?
    Which tasks are poorly performed? Why? What are the things that make the tasks were poorly performed? Can you give me an example?
22. What can be done to improve the midwives' services to improve maternal health?
23. How can it be supported?

Perception about Kader

24. Who are the kaders in this village?
25. What do you think about them?
26. What are their roles?
27. What do you think about kader's work performance?
    What are the tasks they performed well? Why? Give me some examples.
    - What are the things that make the task were well performed? Why? Can you give some examples?
    - What are the things that make the task were poorly performed? Why? Can you give some examples?
28. What is your suggestion to make the kader's services better?

Perception about TBAs

29. Who are the TBAs in this village?
30. What do you think about them?
    Ask about: age, services, attitude, birthing environment, referral system
31. What are their roles? What do they do?(in pregnancy, during childbirth process, after childbirth process, neonatal care, etc). The role of TBA in female circumcision (only in Cianjur).
    What do you like about their services? Why? Can you give me an example?
    What do you dislike about their services? Why? Can you give me an example?
32. What is your suggestion to make the TBAs services better?

Cooperation

33. What do you think about the cooperation between midwives and TBAs in this village? Give me an example.
34. What do you think about the cooperation between midwives and kaders in this village? Give me an example.

35. What do you think about the cooperation between kaders and TBAs in this village? Give me an example.
36. What can be done to improve their cooperation?

Regional Expansion (Only in SW Sumba)

37. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution (Only in SW Sumba)

38. Have you ever heard about mother and children health revolution?
    Mother and children health revolution is a part of East Nusa Tenggara policy to decrease
    the maternal mortality rate and new-born baby mortality rate.
    What do you think about the implementation of this policy in village level?
    Do you see if there any difference before and after mother and child health revolution?
    What are the differences? How do the differences happen?

Suggestion

39. What are the things that can be done to improve maternal health services?

4. 4. 1. 5. SSI Village Head

Interview Guideline for Village Head

Pregnancy and Antenatal Care (ANC)

1. How do the women know if they are pregnant?
2. What do they initially do when they know they are pregnant? Then, what happened? What do they do afterwards?
   If ANC's statements were not sufficient yet, ask:
   - Do they have regular ANC?
   - Why do some women have the routine ANC and some have not? Why? Give an example.
   - In which gestational age they have the ANC? Why?
   - Do they do the ANC for more than one time? Why do some women have the ANC for 2, 3 or 4 times?

   If the statements were not sufficient yet, ask:
   - The distance of health facilities
   - The cost of transportation and consultation
   - The health provider's presence
   - The trust issue in relation with the health providers (their age, medical competencies, and attitude; and the completeness of medical equipment).
3. Who does decide if a woman should have regular ANC?
4. What do you think about the existed ANC service?
5. What does usually happen when pregnant women do not have regular ANC?

Childbirth Process

6. What do the pregnant women do when they start to feel contraction? What do they do afterwards? Why? Then, what happened?
7. Who does usually help the women during the childbirth process? Why?
8. Is there any difference between those who utilise midwives health services and those who do not? Why? Give an example.
9. How do the women make decision in the childbirth process? Who does decide it for them?
10. What are the obstacles for the women to give birth in health facilities?
    If the statements were not sufficient yet, ask the participant the reason why the pregnant women do not utilise polindes or do not assisted by trained health providers during the childbirth process. Several things to be considered are:
    - The distance of health facilities
    - The cost of transportation and consultation
    - The health provider's presence
    - The trust issue in relation with the health providers (their age, medical competencies, and attitude; and the completeness of medical equipment).
    - Health insurance
11. What do you think about the childbirth process aided by TBAs? The advantages and the disadvantages.
12. What do you think about the childbirth process aided by midwives? The advantages and the disadvantages.

After Childbirth Process and Family Planning

13. What do the women do after the childbirth process? Why? What do they do afterwards?
14. What do you think about family planning program? Do you follow the family planning program? Why?
15. If the participant follows the family planning program, ask him/her where and why he/she follows the program.

Perception about health service providers

16. What do you think about the performance of village midwives? (Village nurses if there is no presence of village midwives).
    - What are their tasks?
    - Which tasks do they performed well? Why? What are the things that make them do the tasks well?
    - Which tasks are poorly performed? Why? What are the things that make them do the tasks poorly?

    If the statements were not sufficient or have not answered the questions yet, ask the participant:
    - Age
    - Clinical competencies
    - Attitude

- Medical equipment
- Birthing environment
- Communication tools (cell phone)
- Referral system

17. What is the kader's role in your village?
18. What is the TBAs' role in your village?
19. Is there any female circumcision in this village? Can you explain about it? What is the reason if it is a must? Can you tell me the process? (Only in Cianjur)

Regional Expansion (Only in SW Sumba)

20. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution (Only in SW Sumba)

21. Have you ever heard about mother and children health revolution?
    Mother and children health revolution is a part of East Nusa Tenggara policy to decrease the maternal mortality rate and new-born baby mortality rate.
    What do you think about the implementation of this policy in village level?
    Do you see if there any difference before and after mother and child health revolution? What are the differences? How do the differences happen?

Suggestion

22. What is your suggestion to improve the health services provided by village midwives in ANC and childbirth process to give the community more health benefit?
23. How can the cooperation betwwen TBAs and midwives be improved in order to improve maternal health service?

4. 4. 1. 6. SSI Midwife Coordinator, Puskesmas Head, and DHO MCH Officer

Interview Guideline for Midwife Coordinator, Puskesmas Head, DHO MCH Officer

1. Can you tell me about your task related to MCH?
2. What do you think about the tasks of village midwife, TBA and kader in relationship with MCH? Give the reason about your opinion. (Asking about referral, coordination, supervision).
3. What are the supporting factors and the inhibiting factors of the tasks of village midwife, kader and TBA regarding MCH?
   Asking about:
   - Health policy (regulation, political commitcment in the village and district)
   - Health system (trainings, financial/non-financial incentives, M/E, supervision, human resource management)
4. What is your suggestion regarding the partnership between village midwife and kader and/or TBA?
   Asking about:
   - Partnership model
   - M/E and supervision

- Incentive
- Obstacles and the anticipations

4.4.2. FOCUS GROUP DISCUSSION

4. 4. 2. 1. FGD Husband/Men

FGD Guideline for Men

Pregnancy and Antenatal Care (ANC)

1. How do the women know if they are pregnant?
2. What do they initially do when they know they are pregnant?
   Then, what happened?What do they do afterwards?
   If ANC's statements were not sufficient yet, ask:
   - Do they have regular ANC?
   - Why do some women have the routine ANC and some have not? Why? Give an example.
   - In which gestational age they have the ANC? Why?
   - Do they do the ANC for more than one time? Why do some women have the ANC for 2, 3 or 4 times?
   - When do they usually have the ANC? Why?

   If the statements were not sufficient yet, ask:
   - The distance of health facilities
   - The cost of transportation and consultation
   - The health provider's presence
   - The trust issue in relation with the health providers (their age, medical competencies, and attitude; and the completeness of medical equipment).
3. Who does decide if a woman should have regular ANC?
4. What do you think about the existed ANC service?
5. What does usually happen when pregnant women do not have regular ANC?

Childbirth Process

6. What do the pregnant women do when they start to feel contraction? What do they do afterwards? Why? Then, what happened?
7. Who does usually help the women during the childbirth process? Why?
8. Is there any difference between those who utilise midwives health services and those who do not? Why? Give an example.
9. How do the women make decision in the childbirth process? Who does decide it for them?
10. What are the obstacles for the women to give birth in health facilities?
    Several things to be considered are:
    - The distance of health facilities
    - The cost of transportation and consultation

- The health provider's presence
- The trust issue in relation with the health providers (their age, medical competencies, and attitude; and the completeness of medical equipment).
- Health insurance

11. What do you think about the childbirth process aided by TBAs? The advantages and the disadvantages.
12. What do you think about the childbirth process aided by midwives? The advantages and the disadvantages.

After Childbirth Process and Family Planning

13. What do the women do after the childbirth process? Why? What do they do afterwards?
14. What do you think about family planning program? Do you follow the family planning program? Why?
15. If the participant follows the family planning program, ask him/her where and why he/she follows the program.

Perception about health service providers

16. What do you think about the performance of village midwives? (Village nurses if there is no presence of village midwives).
    - What are their tasks?
    - Which tasks do they performed well? Why? What are the things that make them do the tasks well?
    - Which tasks are poorly performed? Why? What are the things that make them do the tasks poorly?

    If the statements were not sufficient or have not answered the questions yet, ask the participant:

    - Age
    - Clinical competencies
    - Attitude
    - Medical equipment
    - Birthing environment
    - Communication tools (cell phone)
    - Referral system
17. What is the cadre's role in your village?
18. What is the TBAs' role in your village?
19. Is there any female circumcision in here? Does it must be done? The reason? How is the process?

Regional Expansion(Only in SW Sumba)

20. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution(Only in SW Sumba)

21. Have you ever heard about mother and children health revolution?

Mother and children health revolution is a part of East Nusa Tenggara policy to decrease the maternal mortality rate and new-born baby mortality rate.
What do you think about the implementation of this policy in village level?
Do you see if there any difference before and after mother and child health revolution?
What are the differences? How do the differences happen?

Suggestion

22. What is your suggestion to improve the health services provided by village midwives in ANC and childbirth process to give the community more health benefit?
23. What do you think about the cooperation between TBAs and village midwives?
24. How can the cooperation betwwen TBAs and midwives be improved in order to improve maternal health service?

4. 4. 2. 2. FGD TBA (only in Cianjur)

FGD Guideline for TBA

Tasks and Client

1. Can you explain me about your job?
   - Why did you decide to be a TBA?
   - What is your daily job? (Ask the participant about the type of tasks, e.g. during pregnancy, the childbirth process, neonatal care, etc).
   - Is there any female circumcision in Cianjur? How is it? Who does the circumcision?
2. Who are your clients? Which are your working areas?
   - Why do they use or not use your service?
   - According to your experience, what do the women in this village do when:
     - They wanted to have pregnancy check-up
     - They were going into the labor process
   - Where did they go for assistance in those two occasions? Why did they go there?
   - After childbirth, did they have check-up? Where? Why did they choose that place?
   - In terms of family planning program, did these women follow the program? Where?
   - Why did they choose to follow or not to follow the program?

Motivation and job satisfaction

3. What do you think about your current role as a TBA? Are you happy with your job? Why?
   What are the things that make you feel happy or do not feel happy about your role? Why? Canyou give me some examples?
   Ask the participant about:
   - Non-financial incentive (Gain trust from the community, community's support, social status).
   - Financial incentive.
   - The participant's feeling/opinion about those incentives.
   - ther income.

Service quality

4. What is your opinion about good quality health services by a TBA? According to your own experience, can you give me some examples about good and bad quality TBA's health services?
   In terms of good quality service, what are the things that support you and not support you in performing your role as a TBA? Why?

The relationship with health system and community leaders

5. When you were facing difficulties in performing your job:
   - Who do you contact?
   - How often?
   - Where? Do you use any media to communicate with that person? If yes, who did provide the communication tool?
   - What do you feel about your communication and relationship with this person? What do you like or dislike about it? Why?
   - Does the communication give you benefit to perform your job?
6. How do you communicate with community leaders, *puskesmas'* staffs, hospital, and health institution?
   - The forum
   - The frequency
   - The content of the meeting
7. Have you ever done a referral? Can you give me some examples?
   - What were the referred cases?
   - Why did you do a referral?
   - How often do you need to refer a patient?
   - How do you do a referral?
   - What are the good things about a referral? Why?
   - What were the obstacles you face? What did you do?

Perception about health care providers

8. What do you think about village midwives or nurses?
   - Can you tell me about the midwives in this village?
   - How is their performance?
   - What are their roles?
   - Which role was good executed and which role was not? Why?
   - What are the things that make their roles were well executed and were not well executed?
   - Can you give some examples?

   Ask the participant about: age, origin, clinical competencies, attitude, medical equipment, maternity environment (privacy, cleanliness, etc), communication tools (cell phone), and referral system.
9. How is your relationship with the midwives? Have you ever work with them in the past?
10. What do make you feel glad to refer childbirth process to the midwives?
11. What is your suggestion to improve the midwives services?

Perception about Kader

12. Who are the kaders in this village?
13. What do you think about them?
14. What are their roles?
    - What are the tasks they performed well? Why? Give me some examples.
    - What are the things that make the task were well performed? Why? Can you give some examples?
    - What are the things that make the task were poorly performed? Why? Can you give some examples?
    - What is your suggestion to make the kader's services better?
    - How is your relationship with the kaders? Have you ever work with them in the past?
15. How can the kader's services be improved?
16. How is your relationship with kaders?(in terms of the opportunity to work together) Have you ever have one? Then, what happened?

Suggestion

19. What else can you do besides helping the women go through the labor process?
20. In your opinion, what are the things that can be done to improve maternal health services?

4. 4. 2. 3. FGD Village Midwife (only in SW Sumba)

FGD Guideline for Village Midwife

Tasks and Client

1. Can you explain how did you end up working as village midwife/nurse in this health facility?
2. Can you describe about your job?
    - The tasks (The task in *posyandu* and outside *posyandu*).
    - The reason behind the participant wants to be a village midwife/nurse.
3. Which are your working areas?
    - Who are you clients or people who utilise your service?
    - Why do they use or not use your service?
    - What kind of health services that most utilised by the community? (Policlinic, maternal health service, etc)
    - According to your experience, what do the women in this village do when:
      * They wanted to have pregnancy check-up
      * They were going into the labor process
      Where did they go for assistance in those two occasions? Why did they go there?
    - After childbirth, did they have check-up? Where? Why did they choose that place?
    - In terms of family planning program, did these women follow the program? Where?
    - What are the most utilised health services? (ANC, labor process services, after-birth services, family planning program)

- What are the least utilised health services? (ANC, labor process services, after-birth services, family planning program)

Motivation and job satisfaction

4. What do you think about your current job/role? Are you happy with your job? Why? What are the things that make you feel happy or do not feel happy about your job? Why? Canyou give me some examples?
   Ask the participant about:
   - Non-financial incentive (Gain trust from the community, community's support, social status).
     - What is the response from community? Give me some examples.
     - What do the community like and dislike in relation with your services? Give me some examples.
   - Financial incentive (income).
   - The participant's feeling/opinion about those incentives.
   - Other job or income.

Service quality

5. What is your opinion about midwife/nurse's good quality health services? According to your ownexperience, can you give me some examples about midwife/nurse's good and bad quality health services?
   In terms of good quality service, what are the things that support you and not support you in performing your role as a midwife/nurse? Why?
   Ask the participant about:
   - The workload. What does he/she feel about it?
   - The workplace infrastructure
   - The work environment (colleague, supervisor)
   - The safety in the workplace
   - The future career
   - The feeling/opinion about existed medical guidelines

Supervision

6. What is your experience about work supervision?
   - Who does supervise your work?
   - When was the last time you get supervised?
   - How often does the supervision conducted?
   - How was the supervision conducted? (The target of the program and the reporting)
   - What is the feedback?
   - How about the problem solving (including social support)? Why? Give me an example.
   - Does your skill improved after supervision? Why? Give me an example.
   - What is your opinion about the supervision? Why? Did you get or did not get some benefits from supervision?Can you give me some examples?

Monitoring and Evaluation

7. Can you explain about the recording and reporting of maternal health services?
   Ask:
   - How do you do the recording and reporting? What is the content of the report?
   - How do you send your report files? What instrument do you use?
   - Who does give you the feedback? How is the feedback conducted? How is the feedback applied?
   - What do you think about the reporting system and the feedback? Is there any benefits? Why? Can you give some examples?

The relationship with health system and community leaders

8. When you were facing difficulties in performing your job:
   - Who do you contact?
   - How often?
   - Where? Do you use any media to communicate with that person? If yes, who did provide the communication tool?
   - What do you feel about your communication and relationship with this person? What do you likeor dislike about it? Why?
   - Does the communication give you benefit to perform your job?
9. How do you communicate with community leaders, *puskesmas'* staffs, hospital, and health institution?
   - The forum
   - The frequency
   - The content of the meeting
10. How do you handle the referral cases? (From village to *puskesmas*)
    - What were the referral cases you had? Give some examples. Why did you refer those cases?
    - How often do you do the referral?
    - Where did you refer those cases?
    - How did you do it?
    - What are the good things about referral? Why?
    - What are the obstacles? What did you do next (to overcome the obstacles)?
11. What do you think about *kader*? What are the good and bad things about kader? Give me some examples.
    - What do you think about *kader*'s "voluntarism" and what is the relationship with the health service quality?
    - How do you monitor the quality of *kader*'s health services?
    - Does the community participate in monitoring *kader*'s health services? How?

    Ask about:
    - The participant's relationship with *kader* and the examples.
    - The participant's view about his/her partnership with *kader*. Does the partnership ever exist? Then, what happened?
    - What is the community's response regarding *kader*'s services?

Relationship with TBA

12. Is there any TBA in this village?
    What is their TBA role in MCH?
    Can you tell me more about their role during ANC, delivery, PNC, child health and FP?
13. Is there any female circumcision in this village? Does evet female must be circumcised? The reason? Can you tell me the process? (Only in Cianjur)

Community Involvement

14. How is your relationship with the community? Give me some examples. Why?
15. How do you develop that relationship? Give me some examples?
16. How is the midwives' placement in this village?
    - Does the community take part in that placement? How is their involvement?
    - How is the evaluation of midwives' performance conducted?
    - Does the community involved in that evaluation? How?

Regional Expansion

17. Southwest Sumba is developed from the regional expansion of West Sumba. Do you see the difference of health services before and after the expansion?

Mother and Children Health Revolution

18. Have you ever heard about mother and children health revolution?
    Mother and children health revolution is a part of East Nusa Tenggara policy to decrease the maternal mortality rate and new-born baby mortality rate.
    What do you think about the implementation of this policy in village level?
    Do you see if there any difference before and after mother and child health revolution?
    What are the differences? How do the differences happen?

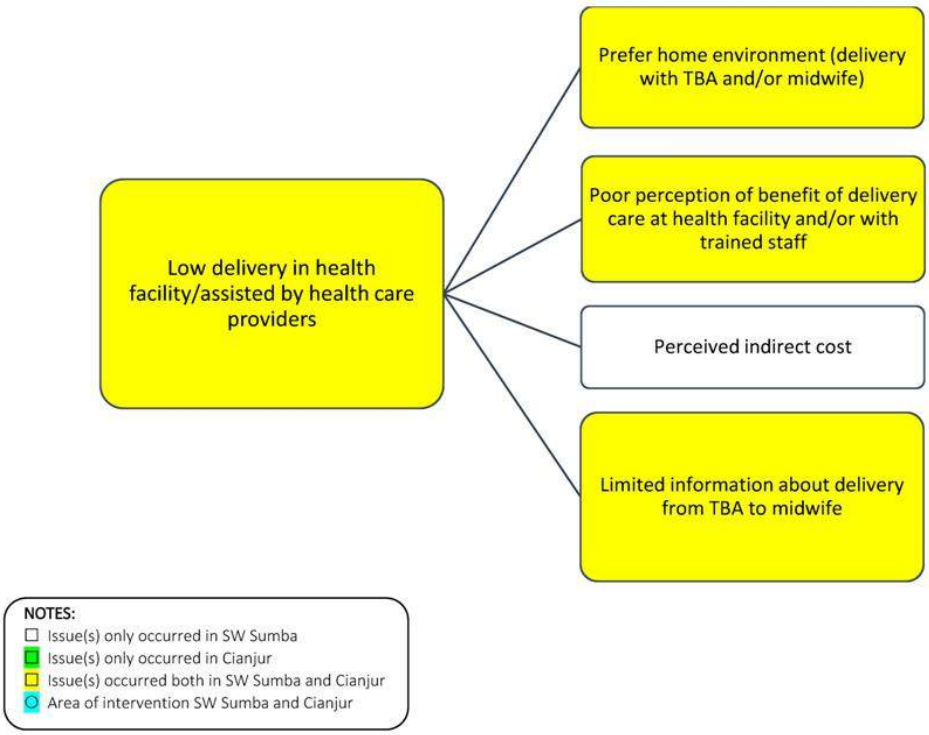
Suggestion

19. In your opinion, what are the things that can be done to improve your performance in supporting better maternal health services?

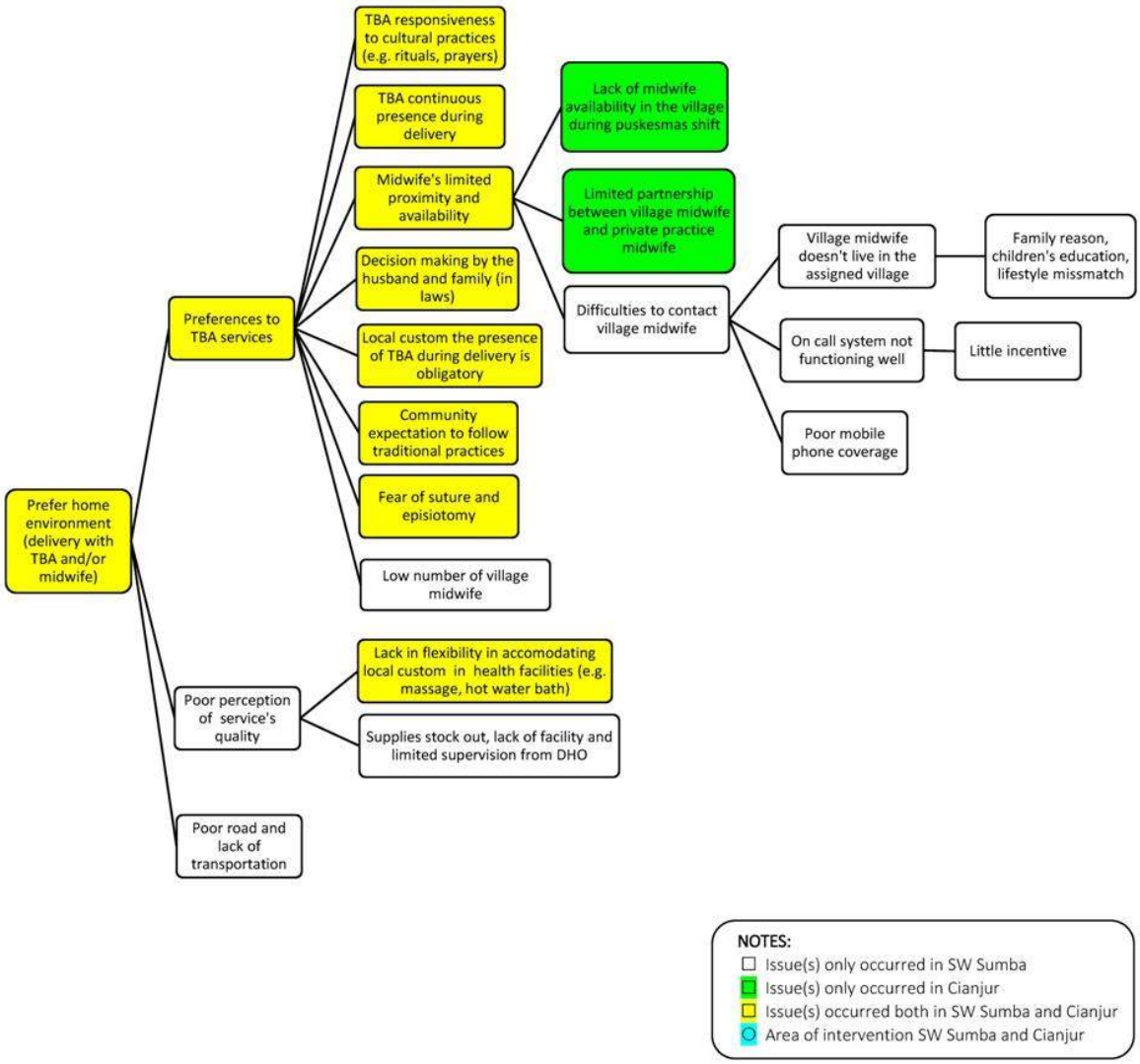
ANNEX 5. ROOT CAUSE ANALYSIS AND PROBLEM STATEMENT

PROBLEM STATEMENT 1: LOW DELIVERY IN HEALTH FACILITY/ASSISTED BY HEALTH CARE PROVIDER

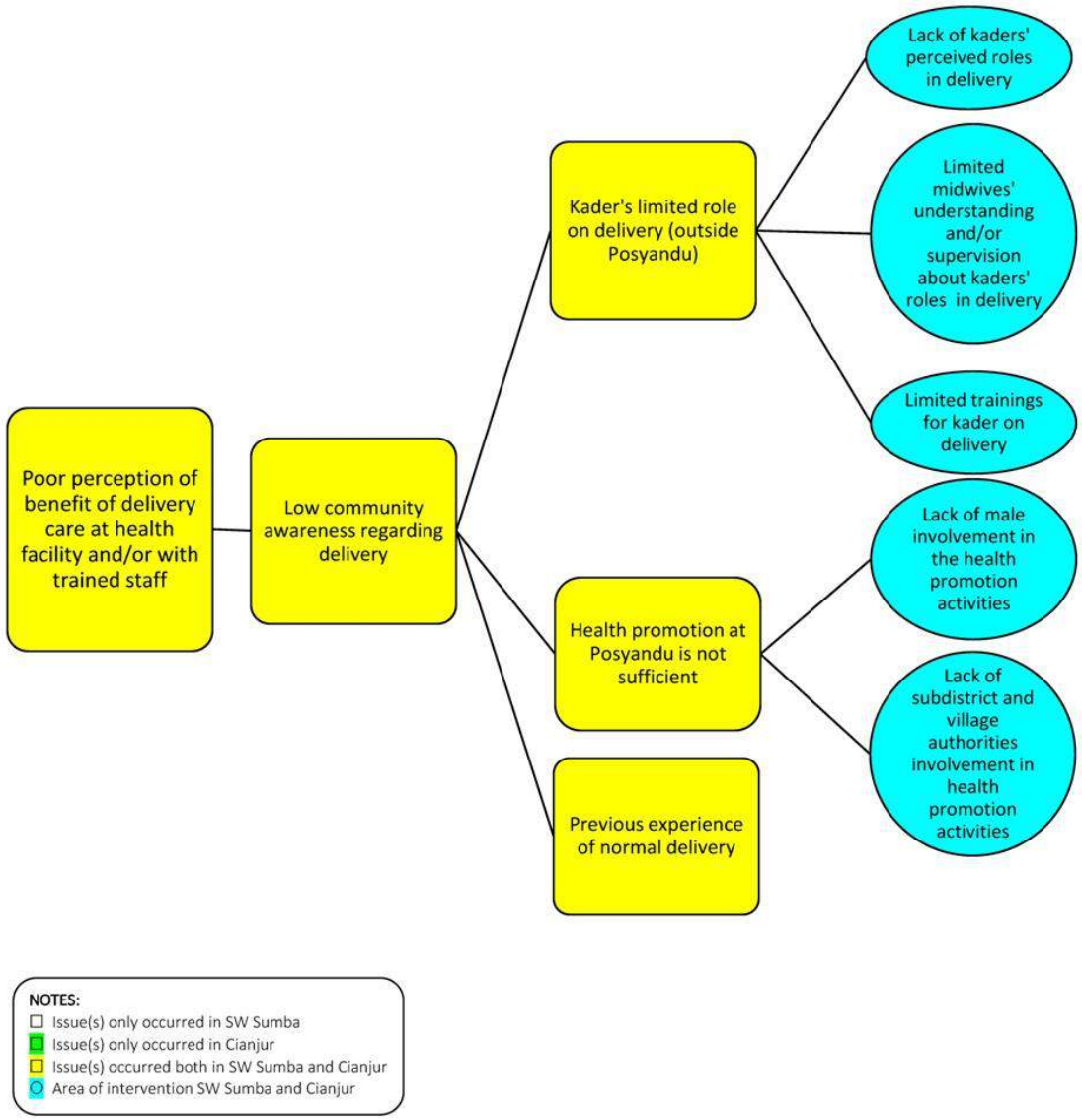
Problem statement 1 is divided into 4 charts: 1.1, 1.2, 1.3, and 1.4



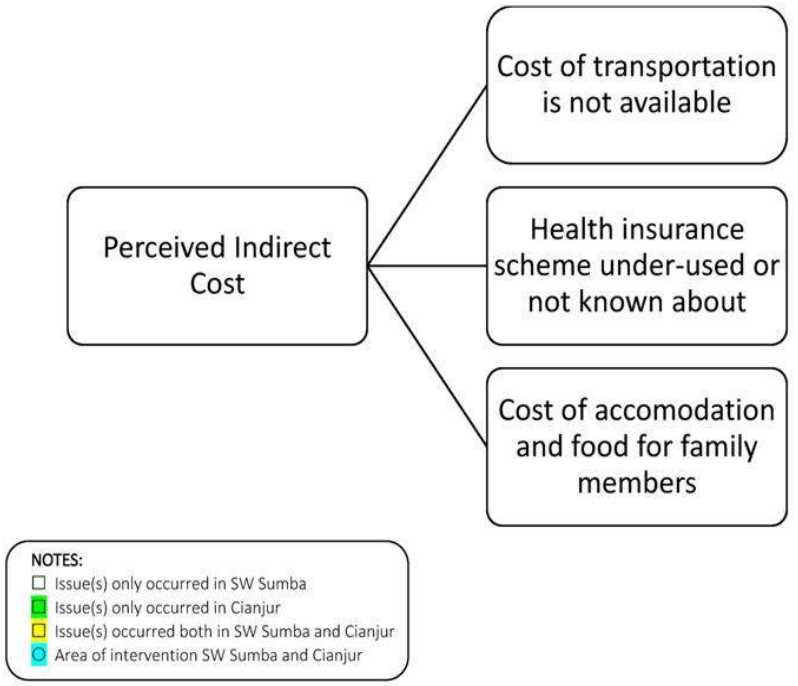
PROBLEM STATEMENT 1.1. PREFER HOME ENVIRONMENT (DELIVERY WITH TBA AND/OR MIDWIFE)



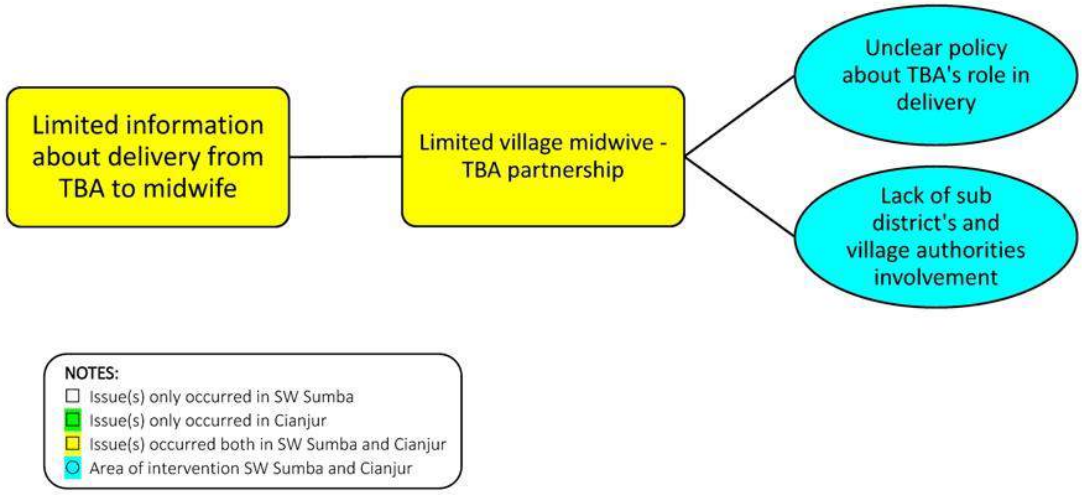
PROBLEM STATEMENT 1.2. POOR PERCEPTION OF BENEFIT OF DELIVERY CARE AT HEALTH FACILITY AND/OR WITH TRAINED STAFF



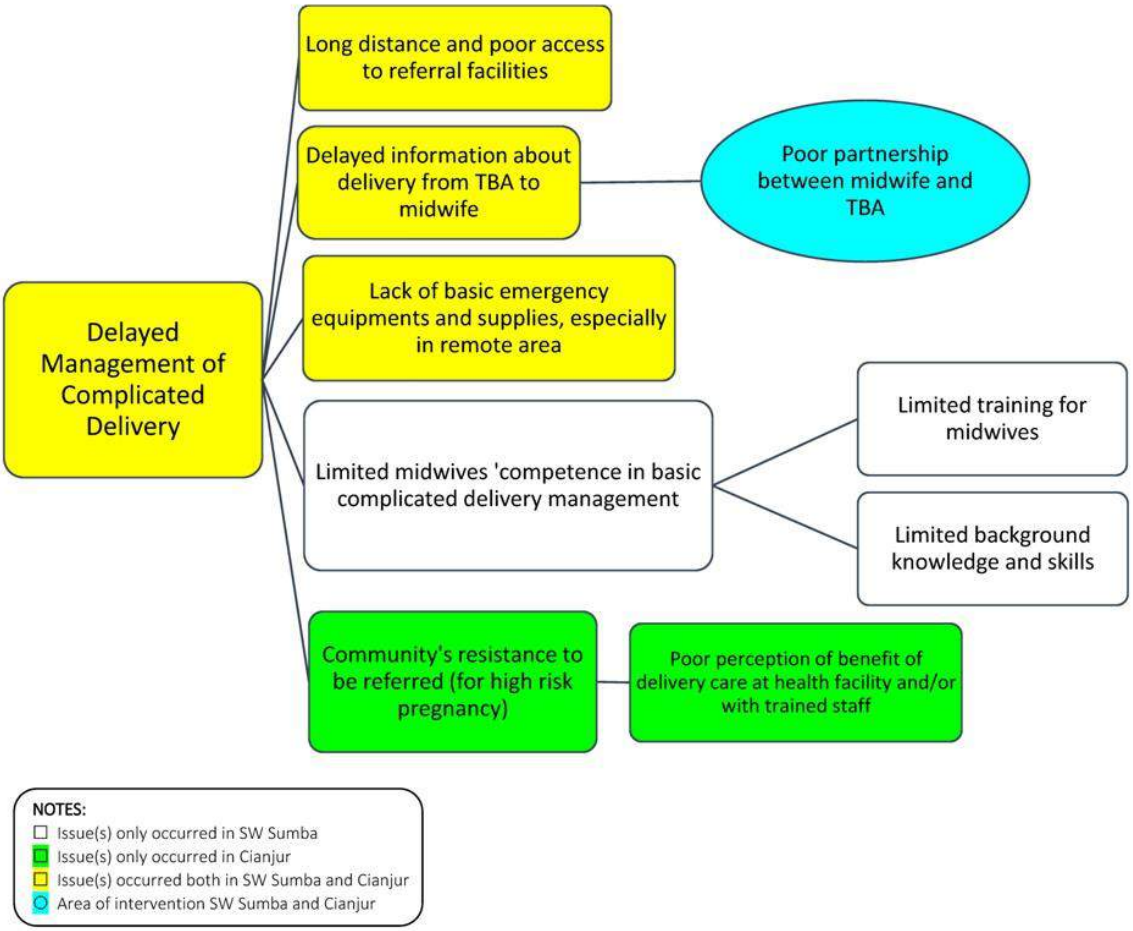
PROBLEM STATEMENT 1.3. PERCEIVED INDIRECT COST



PROBLEM STATEMENT 1.4. LIMITED INFORMATION ABOUT DELIVERY FROM TBA TO MIDWIFE



PROBLEM STATEMENT 2: DELAYED MANAGEMENT OF COMPLICATED DELIVERY



ANNEX 6. NVIVO CODING FRAMEWORK

Indonesia NVIVO Coding Framework

NAME	SOURCES	REFERENCES	CREATED ON	CREATED BY	MODIFIED ON	MODIFIED BY
1. CTCP description	123	2308	9/23/2013 1:07 PM	OT	3/10/2014 4:39 PM	L
1.1 Midwife coordinators	12	37	10/9/2013 3:59 PM	LL	1/14/2014 7:40 AM	LL
1.2 Village midwife	120	946	10/9/2013 3:59 PM	LL	3/13/2014 8:02 AM	L
1.3 TBA	117	597	10/9/2013 3:59 PM	LL	3/13/2014 8:02 AM	L
1.4 Kader	115	580	10/9/2013 3:59 PM	LL	3/13/2014 8:02 AM	L
1.5 Other	29	93	10/9/2013 3:59 PM	LL	3/13/2014 7:55 AM	L
1.6 Private midwife	22	44	12/31/2013 7:58 AM	L	3/13/2014 8:02 AM	L
2. Community	1	1	9/23/2013 1:22 PM	OT	10/4/2013 7:13 AM	RU
2.1 Community context	18	26	9/23/2013 1:22 PM	OT	3/13/2014 7:59 AM	L
2.1.1 Religion, culture, social	84	282	9/23/2013 1:22 PM	OT	3/13/2014 8:02 AM	L
2.1.2 Gender, norms, values, roles	42	94	9/23/2013 1:22 PM	OT	3/13/2014 8:02 AM	L
2.1.3 Stigma, discrimination	12	18	9/23/2013 1:26 PM	OT	3/6/2014 9:37 AM	L
2.2 Community engagement with CTCP	9	10	9/23/2013 1:29 PM	OT	3/13/2014 8:02 AM	L
2.2.1 Recruitment and selection	37	45	9/23/2013 1:29 PM	OT	3/6/2014 9:12 AM	L
2.2.2 Comm support	47	81	9/23/2013 1:31 PM	OT	3/13/2014 7:55 AM	L
2.2.3 Financial and non-fin incentives	52	125	9/23/2013 1:31 PM	OT	3/13/2014 8:02 AM	L
2.2.4 Dis-incentives	13	32	9/23/2013 1:34 PM	OT	3/10/2014 4:39 PM	L
2.2.5 Governance	33	75	9/23/2013 2:40 PM	OT	3/13/2014 7:55 AM	L
2.2.6 Awareness of rights	14	19	9/23/2013 2:58 PM	OT	3/13/2014 8:02 AM	L
2.3 Community Expectations	73	208	9/23/2013 3:01 PM	OT	3/13/2014 7:53 AM	L
2.4 Perceptions of provider	112	577	9/23/2013 3:03 PM	OT	3/13/2014 8:02 AM	L
2.5 Health seeking behaviour	0	0	9/23/2013 3:05 PM	OT	9/23/2013 3:07 PM	OT

NAME	SOURCES	REFERENCES	CREATED ON	CREATED BY	MODIFIED ON	MODIFIED BY
2.5.1 Understanding, knowledge belief	81	230	9/23/2013 3:06 PM	OT	3/13/2014 8:02 AM	L
2.5.2 Health practice	106	471	9/23/2013 3:06 PM	OT	3/13/2014 8:02 AM	L
2.5.3 Decision-making	72	163	9/24/2013 4:03 PM	OT	3/13/2014 8:02 AM	L
2.5.4 Reasons for using or not using MH services	111	622	9/24/2013 4:04 PM	OT	3/13/2014 8:02 AM	L
3. Human Resources	0	0	9/23/2013 3:10 PM	OT	9/30/2013 12:29 PM	KDK
3.1 Selection and recruitment	53	88	9/23/2013 3:10 PM	OT	3/13/2014 7:59 AM	L
3.2 Provider role	0	0	9/23/2013 3:16 PM	OT	9/23/2013 3:21 PM	OT
3.2.1 Focus and tasks	100	560	9/23/2013 3:21 PM	OT	3/13/2014 8:02 AM	L
3.2.2 Location	76	143	9/23/2013 3:22 PM	OT	3/13/2014 8:02 AM	L
3.2.3 Competencies	22	39	9/30/2013 12:33 PM	KDK	2/27/2014 10:18 AM	L
3.3 Total workload	49	111	9/23/2013 3:26 PM	OT	3/13/2014 8:02 AM	L
3.4 Continuous education	20	35	9/23/2013 3:29 PM	OT	3/13/2014 7:55 AM	L
3.5 Career perspective	15	24	9/23/2013 3:32 PM	OT	3/13/2014 8:02 AM	L
3.6 Incentives	91	278	9/23/2013 3:33 PM	OT	3/13/2014 8:02 AM	L
3.7 Non-financial incentives	41	63	9/23/2013 3:38 PM	OT	3/13/2014 7:22 AM	L
3.8 Supervision	51	127	9/23/2013 3:40 PM	OT	3/13/2014 8:02 AM	L
3.9 Motivation Job satisfaction and Attrition	57	228	9/30/2013 9:03 AM	OT	3/13/2014 8:02 AM	L
4. Programme management and implementation	4	12	9/23/2013 3:54 PM	OT	1/2/2014 8:24 AM	L
4.1 Access including availability	103	375	9/23/2013 4:00 PM	OT	3/13/2014 8:02 AM	L
4.2 Service delivery	109	610	9/23/2013 4:00 PM	OT	3/13/2014 8:02 AM	L
4.3 Staff availability	68	154	9/23/2013 4:02 PM	OT	3/13/2014 7:55 AM	L
4.4 Recording, reporting, data systems	47	112	9/23/2013 4:07 PM	OT	3/13/2014 8:02 AM	L
4.5 Referral	82	177	9/23/2013 4:08 PM	OT	3/13/2014 8:02 AM	L
4.6 Coordination and communication	105	501	9/23/2013 4:21 PM	OT	3/13/2014 8:02 AM	L
4.7 Logistics and supply chain	66	190	9/23/2013 4:23 PM	OT	3/13/2014 8:02 AM	L
4.8 Sustainability	17	24	9/23/2013 4:25 PM	OT	3/10/2014 2:46 PM	L

NAME	SOURCES	REFERENCES	CREATED ON	CREATED BY	MODIFIED ON	MODIFIED BY
5. Quality	0	0	9/23/2013 4:16 PM	OT	3/6/2014 9:30 AM	L
5.1 Manuals and protocols	24	31	9/23/2013 4:27 PM	OT	3/13/2014 8:02 AM	L
5.2 M&E loops and feedback	45	149	9/23/2013 4:28 PM	OT	3/13/2014 8:02 AM	L
5.3 Problem solving mechanisms	48	133	9/23/2013 4:28 PM	OT	3/13/2014 8:02 AM	L
5.4 Policy and strategies	84	324	9/23/2013 4:33 PM	OT	3/13/2014 8:02 AM	L
5.5 Perception of quality	71	231	9/24/2013 3:39 PM	OT	3/13/2014 7:53 AM	L
6. Governance	58	196	9/23/2013 4:34 PM	OT	3/13/2014 8:02 AM	L
7. TBA	0	0	9/23/2013 4:39 PM	OT	9/29/2013 11:06 AM	OT
7.1 TBAs' perspective on policy and practice	10	29	10/10/2013 9:53 AM	LL	3/6/2014 9:12 AM	L
7.2 Perspecitives on TBAs	102	275	9/24/2013 4:43 PM	OT	3/13/2014 8:02 AM	L
8. Health issue	6	8	9/23/2013 4:59 PM	OT	3/13/2014 7:55 AM	L
8.1 FP	106	207	9/23/2013 5:00 PM	OT	3/13/2014 8:02 AM	L
8.2 Delivery	111	505	9/23/2013 5:00 PM	OT	3/13/2014 8:02 AM	L
8.3 Neonatal	60	134	9/23/2013 5:00 PM	OT	3/13/2014 8:02 AM	L
8.4 Child health	64	170	9/23/2013 5:01 PM	OT	3/13/2014 8:02 AM	L
8.5 ANC PNC	112	574	9/23/2013 5:01 PM	OT	3/13/2014 8:02 AM	L
9. Examples training	42	93	10/1/2013 12:47 PM	KDK	3/13/2014 8:02 AM	L
Great quotations	46	119	9/23/2013 5:07 PM	OT	3/13/2014 8:02 AM	L

ANNEX 7. ETHICAL APPROVAL LETTER

THE EIJKMAN INSTITUTE FOR MOLECULAR BIOLOGY

Project Number
(For Official Use Only) 6 4

EIJKMAN INSTITUTE
for molecular biology

EIJKMAN INSTITUTE RESEARCH ETHICS COMMISSION

ETHICAL APPROVAL

Eijkman Institute Research Ethics Commission (EIREC) has convened a meeting on 30th May 2013 as requested by the Director of Eijkman Institute for Molecular Biology, to review the proposal entitled: **Context Analysis for the Performance and Sustainability of Close to Comunity (CTC) Providers to Improve CTC Maternal Health Services in Indonesia** With **Dr. Syafruddin Ph.D** and **Dr. Rukhsana Ahmed Ph.D** as the Principal Investigator

After considering the ethical aspects of the research project, EIREC has decided to grant the project an ethical approval.

Jakarta, 31st July 2013

Prof. Dr. R. Sjamsuhidajat
Chairman