Republic of Indonesia

Ex-Post Evaluation of Japanese Technical Cooperation Project

"Project for Ensuring Maternal and Child Health Service with MCH HB Phase II"

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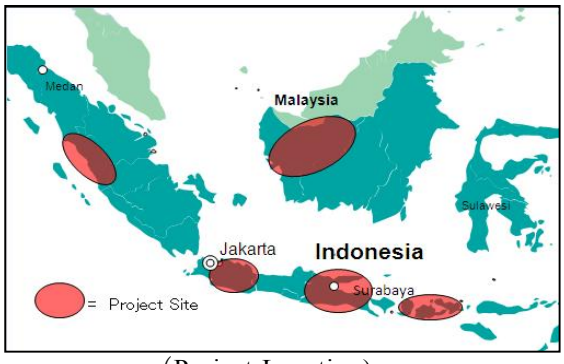
## 0. Summary

This project was conducted to integrate the Maternal and Child Health (hereinafter referred to as "MCH") service by utilizing the MCH Hand Book (hereinafter referred to as "HB") and strengthening a system for sustaining the MCH service through the MCH HB in Indonesia. The project direction was consistent with Indonesian policies and strategies, which have emphasized improving the MCH services, the development needs and Japanese assistance policy, hence the relevance is high. Furthermore, the MCH HB has functioned as an integrated tool for health management in the process of raising children, hence pregnant women who utilize the MCH HB have steadily increased. On the other hand, the expansion of use of the MCH HB among mothers with children under five years old has been limited and challenge still remains in terms of role sharing among the central and local Governments (hereinafter referred to as "LGs"). Therefore the effectiveness and impact is fair when considering the purpose to establish a system to continue the service by utilizing the MCH HB. The efficiency of this project is high since both project cost and period are within the plan. Its sustainability is considered fair, because there is some room to improve in the awareness of Health Volunteers who support the users of the MCH HB and in the operation of the monitoring system, and furthermore there is a concern for securing the printing and distributing budget for the MCH HB in the future, despite the fact that the system to maintain the use of the MCH HB by mothers and medical workers has been developed. In light of the above, this project is evaluated as satisfactory.

## 1. Project Description




(Project Location)

(Mothers and Child who come for health check by using the MCH HB at Posyandu)

## 1.1 Background

The general condition of medical health in Indonesia at the time of the project planning had improved significantly over the past 30 years. The condition of MCH had also improved likewise. Nevertheless, Infant Mortality Rate (hereinafter referred to as "IMR") and Maternal Mortality Rate (hereinafter referred to as "MMR") show seriousness of the medial health condition in comparison with those neighboring countries. Such a high figure of MMR can be attributed to three delays, namely in 1) detection of general danger signs to pregnancies, 2) transportation to medical facilities, and 3) the treatment at medical facilities, along with the lack of basic knowledge about pregnancy and delivery by mothers and their family members.

In order to improve the above-mentioned conditions, the Japan International Cooperation Agency (hereinafter referred to as "JICA") had cooperated with Indonesia with emphasis on MCH in medical health cooperation, and the MCH HB was developed and experimented. Thus, the cooperation to promote the MCH HB for improving MCH had been conducted as shown in table 1. During this period, the MCH HB was introduced as a tool to improve MCH conditions through health awareness and behavior changes. As a result, the MCH HB was disseminated to targeted provinces and various regions of Indonesia. In 2004, the Ministerial Decree on the MCH HB was issued and a de-concentration special fund by the Ministry of Health (hereinafter referred to as "MOH") was placed in 2006. Following this situation, the expansion of the MCH HB made steady progress.

On the other hand, in order to achieve the broader use of the MCH HB among mothers and healthcare personals, challenges such as developing better utilization of the MCH HB, institutionalizing of the HB into relevant medical health systems, mainstreaming the HB as an integrating tool for MCH services and development of orientation to healthcare personnel remained. In order to grapple with the above-mentioned challenges, the technical cooperation project was launched and the project aimed to improve the use of the MCH HB functions in a qualitative and quantitative manner as a tool to integrate MCH services and a system to sustain MCH services with the MCH HB being strengthened.

Table1 JICA Cooperation for the MCH HB and the Dissemination of MCH HB

| | |
|---|---|
| 1993-1994 Phase 0 | "Family Planning and MCH" (extended cooperation): Commenced the development and experiment at Salatiga City of Central Java Province as a pilot area. |
| 1994-1996 | Expanded the MCH HB within West Java Province |
| 1997 | Expanded the MCH HB to five provinces |
| 1998-2003 Phase I | "Ensuring the Quality of MCH Services through MCH HB": Expanded the MCH HB quantitatively. Covered area expanded to 23 provinces in 2003. |
| 2004 | Ministerial Decree on the MCH HB |
| 2006-2009 Phase 2 (This project) | "Ensuring MCH services with MCH HB": Ensuring quality improvement and sustainability of the MCH HB |

## 1.2 Project Outline

| | | |
|---|---|---|
| Overall Goal | | 1. MCH services with MCH HB became available at every health facility.<br>2. All pregnant women and children under five years old have their own health record. |
| Project Objective | | MCH HB functions as a tool to integrate MCH services and a system to sustain MCH services with MCH HB is strengthened. |
| Output(s) | Output 1 | Accessibility to MCH HB by community people is increased. |
| | Output 2 | The system of orientation on MCH HB for relevant healthcare personnel is strengthened. |
| | Output 3 | The system of monitoring and reporting on MCH HB is strengthened. |
| | Output 4 | Models for better utilization of MCH HB are developed. |
| | Output 5 | Results of survey and evaluation of MCH HB on improvement of MCH are reflected in MOH's policy making and implementation process. |
| | Output 6 | The capacity of MOH and relevant LGs to effectively share the experiences of improving MCH services with MCH HB is strengthened. |
| Inputs | | < Japanese Side ><br>1) Experts: 5 long-term experts and 8 short-term experts<br>2) Counterpart training in Japan: 35 participants<br>3) Equipment: 3.71 million yen<br>4) Local cost: 96.8 million yen<br><Indonesian Side ><br>1) Counterparts: 14 persons<br>2) Counterparts expenses<br>3) Others (Project office, Utilities) |
| Total Cost | | 290 million yen |
| Period of Cooperation | | October, 2006 – September, 2009 |
| Implementing Agency | | Ministry of Health (MOH) |
| Related Projects | | "Family Planning and MCH"(1989-1994), "Ensuring the Quality of MCH Services through MCH HB" (1998-2003), "International Training on Strengthening District Health Planning in the era of Decentralization for Improvement of the Health Status of Children and Mothers" (2007-2012) |

## 1.3 Outline of the Terminal Evaluation

### 1.3.1 Achievement of Overall Goal

Regarding the overall goal, 1) MCH services with MCH HB became available at every health facility, and 2) All pregnant women and children under five years old have their own health record, the terminal evaluation judged that it was too early to state

conclusively on the progress of the overall goal, because sufficient data to scale the achievement level was not available and the achievement of the overall goal is expected to appear several years after the end of the project.

### 1.3.2 Achievement of Project Objective

With regard to the second indicator for the project purpose, models for better utilization of the MCH HB had been prepared as the project output. On the other hand, with regard to the first indicator, the terminal evaluation report indicated that the project would not likely reach the goal of 80% of pregnant women antenatal services using the MCH HB by the end of the project since it was only 58%[1] at the time of terminal evaluation.

### 1.3.3 Recommendations

At the terminal evaluation, four recommendations were made as follows: 1) Secure the budget for printing and distribution of the MCH HB, 2) Strengthen the monitoring system for the MCH HB, 3) Strengthen the collaboration and partnership with related institutions, 4) Maintain the institutional memory related to the MCH HB.

In response to each recommendation, the optimal balanced cost sharing between the national (MOH) and region (provincial and district/city offices)[2] through 1), strengthening the monitoring system learning from the experience of difficulties in getting the data at terminal evaluation 2), collaboration within the health sector and partnership with other ministries for the utilization of the MCH HB as an effective tool 3) and developing an institutional memory by sharing and transferring the knowledge and experience of predecessors in Indonesia where frequent changes of personnel has been made, were introduced 4).

【Organization Structure of Health service system in Indonesia】

In Indonesia, the Provincial Health Offices (hereinafter referred to as "PHO") at provincial level, and District/City Health Offices (hereinafter referred to as D/CHO) at the district or city level were located depending on LG level.(Currently, there are 33 provinces in Indonesia and 399 districts and 98 cities under provinces. (Basically cities are located in urban area and districts are located outside of urban areas.)) Each village is placed under districts/cities, and have Puskesmas, a health center for medical care activities and preventive health hygiene. Each village has a Posyandu, health clinic, where Kadar, who are elected as Volunteers from each village, support the activities mainly for weight check of infants and child, family planning, classes for pregnant women, etc. (An excerpt from JICA "Professional Challenge Series No.6)

[1] In reality, it indicates the distribution rate of MCH HB, not the ratio of pregnant mothers who receive antenatal services by using the MCH HB. For details, please refer to "3.2.1.2 Achievement of Project Objectives".

[2] Refer to the "Organization Structure of Health service system in Indonesia" in the box for the details on the organization Structure of Health service system in Indonesia.

## 2. Outline of the Evaluation Study

### 2.1 External Evaluator

Hisae Takahashi, Ernst & Young Sustainability Co., Ltd.

### 2.2 Duration of Evaluation Study

Duration of the Study: September, 2012 –November, 2013

Duration of the Field Study: January 6 - 12 and March 12 – April 9, 2013

### 2.3 Constraints during the Evaluation Study

【Limitation of availability of necessary data】

In Indonesia where decentralization has proceeded, available data is generally limited. Reporting from LGs to MOH are required but not compulsory, therefore all the necessary data for the evaluation was not available at MOH. Under such circumstances, regarding the data at LG level which was not available at the central level, analysis was made based on the data which the ex-post evaluation mission collected through site visits. In addition to several sections of MOH, LGs as well as many medical institutions were involved in the project. In this ex-post evaluation, it was not realistic to visit all related institutions due to the time limitation, needed information was collected at visited LGs or medical institutions and through the main actors of the project, Directorate of Child Health[3] in MOH.

## 3. Results of the Evaluation (Overall Rating: B[4])

### 3.1 Relevance (Rating: ③[5])

3.1.1 Relevance to the Development Plan of Indonesia

Mid-term Development Plan (RPJM 2005-2009), a development policy in place when planning this project, placed the improvement of MCH, part of "Welfare of people," as one of the five priority goals since it was considered as an area to contribute to quality health services. Accordingly, the planned rate of IMR or MMR were set quantitatively as indicators to show the improvement on undernourished children under five years old. More importantly, "Healthy Indonesia 2010", which was published in 1999 by MOH as a mid-term policy target of health care, also placed the improvement of reproductive health as a priority area. In addition, MOH issued the "Ministerial Decree on the MCH HB" in 2004 since they recognized the efficacy of the MCH HB. This Decree defined the MCH

[3] Directorate of Child Health, one of the departments of Directorate of Nutrition, Child and Maternal Health in the MOH is the responsible entity of supplying the MCH HB.

[4] A: Highly satisfactory, B: Satisfactory, C: Partially satisfactory, D: Unsatisfactory

[5] ③: High, ②: Fair, ①: Low

HB as the only tool for maintaining the health record and informed decision making to utilize the MCH HB on MCH services. In addition, the printing budget for the MCH HB was allocated in 2006 in the de-concentration special fund by MOH. These decrees and special budget allocation for the MCH HB were valid at the time of the project completion.

The project was therefore consistent with Indonesia's policy for improving the MCH services; both at the time of the ex-ante evaluation and the project completion.

3.1.2 Relevance with the Development Needs of Indonesia

The condition of MCH service in Indonesia had improved significantly over the past 30 years. For example, IMR improved from 145 per 1,000 live birth in 1967 to 53 in 2000 and 35 in 2003. Though MMR had also improved, both IMR and MMR were still higher than those of other ASEAN countries as shown in table 2 and table 3. Consequently, the improvement in MCH remained to be an imminent issue to be resolved. At the project completion, IMR and MMR were still higher than those of neighboring countries. Accordingly, the needs to improve the MCH service remained high at the time of the project completion.

Table 2 Under Five Infant Mortality Rate (per 1,000 live birth)

| | Indonesia | Malaysia | Philippine |
|---|---|---|---|
| 2003 (At the time of the project planning) | 35 | 8 | 29 |
| 2009 (At the time of the project completion) | 34 | 8 | 25 |

Source: Project documents and documents provided by MOH

Table 3 Maternal Mortality Rate (per 100,000 live birth)

| | Indonesia | Malaysia | Vietnam | Philippine |
|---|---|---|---|---|
| 2001 (At the time of the project planning) | 307 | 39 | 95 | 204 |
| 2008(At the time of the project completion) | 228 | 27.3 | 69 | 162 |

Source: Project documents and documents provided by MOH

Under these serious circumstances, JICA has cooperated with the development, experimentation and utilization of the MCH HB. As a result, quantitative expansion of the MCH HB has made steady progress. On the other hand, challenges remained in terms of better utilization of the MCH HB as well as stable procurement and delivery of larger numbers of the MCH HB. It was also necessary to develop the utilization model of the MCH HB and facilitate LGs to promote the procurement and delivery of the MCH HB. Afterwards, although at the project completion qualitative expansion of the MCH HB had been made through the projects, the needs to continue activities to promote the effective utilization of the MCH HB still remains in Indonesia which is composed of a number of islands.

3.1.3 Relevance to Japan's ODA Policy

In the Japanese Government's Country Assistance Policies for Indonesia at the time of the project planning, improving the basic health and medical services was raised as a priority area to deal with high IMR and MMR. Country specific programs for Indonesia also included the health and medical service in "poverty reduction" which was a priority area, "social development" which was categorized as a development objective, as well as in the "Civil Minimum Millennium Development Goals (hereinafter referred to as MDGs)" for cooperative programs. Furthermore, MCH was placed as one of the priority issues for health and medical system development, regional medical service improvement and measures for infection diseases in assistance strategies of health and the medical sector. Hence, the Project, focusing on improvement of MCH service with utilization of the MCH HB was consistent with Japanese ODA policy.

As mentioned above, this project has been highly relevant with the Indonesia's development plan, development needs, as well as Japan's ODA policy, therefore its relevance is high.

**3.2 Effectiveness and Impact[6] (Rating: ②)**

3.2.1 Effectiveness[7]

3.2.1.1 Project Output

Output 1 Accessibility to MCH HB by community people is increased.

*[Indicator 1]MCH HB are printed to cover 75% of the estimated pregnant women by relevant stakeholders such as central and LGs and professional organization by September 2009.*

*[Indicator 2]Distribution of MCH HB at hospitals and private clinics is institutionalized.*

*[Indicator 3]Number of LGs institutionalizes securing the budget to supply MCH HB by LG budget (APBD) is increased by 2009.*

*[Indicator 4]Relevant national committee and working group become set up and held for enhancement of implementation of MCH HB.*

As for output 1, all indicators, except indicator 3, where the accurate picture was not captured due to the lack of information, mostly achieved the target, thus it can be said that the accessibility to the MCH HB by community people has been increased.

[6] Sub-rating for Effectiveness is to be put with consideration of Impact.

[7] Effectiveness is to analyze the achievement level of output and project purpose at the time of the project completion. Under this ex-post evaluation, however, the situations of output at the time of ex-post evaluation are also explained to confirm their contribution to the impact.

At the project completion, printing numbers of the MCH HB to estimated pregnant women was 73%, which was 97% of the target of indicator 1 as shown in table 4. This number included the MCH HB printed by MOH, thus the actual printing rate would be slightly higher than 73% when taking into account the number of HB printed by LGs, Indonesian Midwife Association, etc. It should also be noted that the printing number was zero in 2010 since 30% of the national budget was cut due to the financial conditions of Indonesia and the printing budget not being available[8]. According to the staff of MOH, the printing number of MCH HB is decided depending on the numbers of stock and the budget status of the country for each year.

Table 4 Number of MCH HBs to Estimated Number of Pregnant Women

(Unit: Million)

| | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|
| Estimated pregnant women | 5.0 | 4.8 | 4.8 | 5.0 | 5.1 |
| Printed number of MCH HB | 3.9 | 3.5 | - | 6.1 | 4.0 |
| Printing rate | 79% | 73% | - | 122% | 78% |

Source: The document provided by MOH.

Prior to the terminal evaluation, Health Minister' Decrees on promoting the use of the MCH HB at hospitals and private clinics were promulgated (indicator 2), committees for revising the MCH HB, working groups and sub-working groups were established and managed to hold meetings to enhance the usage of the MCH HB (indicator 4).

Meanwhile, with regard to increasing numbers of LGs that secure the budget to supply the MCH HB with their own budget (indicator 3), it is difficult to collect reliable data from the LGs across the country at the time of the project completion, as was also the case with the survey /project consultation team and terminal evaluation. Therefore, in this ex-post evaluation, the situations as of the project completion were confirmed at the D/CHO where site visits were conducted. As a result, it was confirmed that LGs also shouldered the burdens to a certain degree at the time of project completion, since the average financial sources were 36% from MOH, 11% from Province, 47% from District/City and 6% from others including professional organizations and Non Governmental Organizations (hereinafter referred to as "NGO", etc. (although the situations are varied from place to place since it would depends on the financial situation of each LGs[9]).

According to the staff of the MOH and LGs, however, the Minister of MOH indicated his intention in 2009 that the central government would print and provide the MCH HB for all pregnant women, thus the number of LGs, which institutionalize securing the

[8]Though MCH HB were printed for 73% of the estimated pregnant women in 2009, budget for delivering MCH HB to each region except Java and Bali islands were not secured, thus MCH HB printed in 2009 were stocked in MCH. In 2010, budget for delivering were secured, thus, MCH HB stocked in MOH were delivered across the country.

[9] The situation varied from regions to regions. For example, DHO of West Lombok in West Nusa Tenggara Province secured all budget for printing MCH HB by themselves, while Bangkalan District relies on all printing budget to MOH.

budget to supply HB by LGs themselves, are currently limited and LGs have tended to rely on MOH compared to the situation at the time of the project completion[10]. Study report prepared by University of Indonesia in 2011[11] also surveyed the presence or absence of LG's budget plan for supplying HB. In the result, 44% of respondents of D/CHO had budget plans for supplying HB in 2009 while it decreased to 34% in 2011.

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| Output 2 The system of orientation on MCH HB for relevant health personnel is strengthened.<br>*[Indicator 1]MOH agrees to request Ministry of National Education to include MCH HB into curriculum for midwife academies by 2009.*<br>*[Indicator 2] Relevant Programs[12] include MCH HB related item(s) by 2009.*<br>*[Indicator 3]Orientation package for health personnel related to MCH HB is available by 2009.* |

Relevant items on the MCH HB were integrated not only in the standard curriculum of approximately 400 nursing schools but also midwife academies (indicator 1). It was confirmed by the terminal evaluation that promotion of using the MCH HB had been integrated in manuals or training programs in all relevant programs of MOH (Indicator 2). The module of Orientation Package for introducing the MCH HB was developed during the project implementation and distributed to all PHO in Indonesia (indicator 3). Hence, all the indicators of output 2 were therefore achieved.

After the terminal evaluation, MCH HB related items in relevant programs or trainings of the MOH and curriculums of midwife academies and nursing schools have continuously been included without deletion. The module of Orientation Package which was developed to standardize the use of the MCH HB by healthcare personnel has also been utilized at each province. Thus, it is considered that the system of orientation of the MCH HB in Indonesia had been strengthened by project completion.

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| Output 3 The system of monitoring and reporting on MCH HB is strengthened.<br>*[Indicator] By September 2009, Distribution rate of MCH HB is started to be monitored at national level.* |

[10] Regarding the information on the current budget of LGs on MCH HB printing, please refer to the "3.4.4 Financial Aspects of the Implementing Agency".

[11] Center for Family Welfare, Faculty of Public Health University of Indonesia, (2011), "Self -reliance on MCH HB in Indonesia-Study Report".

[12] Village alert program, Normal birth module, preparation for childbirth and complication, Emergency obstetric and neonatal care, Comprehensive measure for neonatal infant, Birth asphyxia measure, Measure for infant of low birth weight, Program for promotion of child development, Emergency measures for obstetric and neonatal care, Training for communication of midwife and counseling.

MOH started monitoring the distribution rate of the MCH HB at the national level in 2008, thus output 3 had also been achieved. Specifically, the distribution rate of the MCH HB was integrated in Regional Monitoring System on MCH (hereinafter referred to as "PWS-KIA"), and some question items on bringing the rate of the MCH HB was included in Basic Health Research (hereinafter referred to as "RISKESDAS") too. PWS-KIA is implemented once a year and RISKESDAS once in three years, hence the monitoring and reporting system had been enhanced. The distribution rate is important information for understanding the printing number and then budget allocation for the next year, therefore, understanding the data on the MCH HB highly contributes to the development of the system for continuing MCH services. However, reporting responsibilities from LGs to MOH have not been fully enforced under the current environment of decentralization and there are cases where the data of LGs are not reported to MOH. As mentioned in the recommendations of the terminal evaluation report, strengthening the operation of the monitoring system is considered as a challenge for the future.

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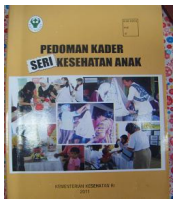
| Output 4　Models for better utilization of MCH HB are developed. |
| *[Indicator 1] Model to utilize MCH HB for child health is available by 2009.* |
| *[Indicator 2] Model to facilitate other programs such as birth registration to utilize MCH HB is available by 2009.* |
| *[Indicator 3] Model to utilize MCH HB during pregnancy and post partum is available by 2009.* |
| *[Indicator 4] Model to introduce MCH HB to health volunteers is available by 2009.* |
| *[Indicator 5] Model to utilize MCH HB at hospitals and private clinics is available by 2009.* |

"Models for better utilization of the MCH HB" were all developed through the project activities in five model provinces[13] and they were available for use by project completion, hence the project accomplished output 4. In addition, facilitator and trainers who utilize these models were fostered, and trainings for "Kadar", health volunteers who support the activities at Posyandu, were also conducted. Some models are now utilized even outside the model provinces and contribute to promoting the use of the MCH HB as shown in table 5. Meanwhile, those models cannot be copied and used as they are, since the life style, culture and customs differ from island to island or region to region in Indonesia.

[13] Model provinces for each model are West Java Province for the model to introduce the MCH HB to health volunteers (indicator 4), East Java for the model to facilitate other programs such as birth registration (indicator 2 and 5), West Smatra Province for the model to utilize the MCH HB for child health (indicator 1), West Nusa Tenggara Province for the Model to utilize the MCH HB during pregnancy and post partum for indicator 3, West Kalimantan Province for the Model to utilize the MCH HB at hospitals and private clinics (indicator 5).

For example, the cover pages of most of the MCH HB use photos which naturally fit into each region. In the process to continue activities for promoting the MCH HB in the future, it is hoped that they will be with modifications as necessary.

Table 5 Cases for Using Developed Model

| Each Model and Their Status of the Utilization of each Model at the time of Ex-post Evaluation | |
|---|---|
| [Model to utilize MCH HB for child health]<br>Classes for mothers with children are planning to be commenced across the country as one of the national programs, though there are regions which have not introduced them yet. Guidance for the necessary information on hygiene, nutrition, immunization, etc are provided in the classes. Classes conducted in Tanah Datar District, a model area, are taken as a model case, so D/CHO visit for study tours, and kit for conducting classes have been distributed to all Puskesmas in West Sumatra Province. |  <br>Class for mothers with children |
| [Model to facilitate other programs such as birth registration to utilize MCH HB]<br>Page for filling the necessary information for birth registration has been inserted to promote the use of the MCH HB for birth registrations. Some districts/cities including Lumajang District in East Java Province, Salatiga City of West Java Province, and Bukittinggi City in West Sumatra Province have made registration free in cooperation with the Ministry of Home Affairs, which administers birth registration, if pregnant women use the MCH HB. In some regions, an effort to cooperate with the Ministry of National Education has been started, such as making bringing the MCH HB a requirement in order to enter nursery schools. |  <br>Page of MCH HB for Birth Registration |
| [Model to utilize MCH HB during pregnancy and post partum]<br>A class for “pregnancy and partum women” as one of the national programs has been conducted and utilized across the country as Classes for “mothers with children.” Now they are important places to provide information on the MCH HB. Since it is difficult to offer the classes to all pregnant women, women with high risk pregnancies or for their first child would be prioritized at the moment. The Directorate of Maternal Health in MOH plans to start the promotion of activities to encourage the classes since they also recognize its importance. |  <br>Poster prepared for dissemination of class for pregnant women |
| [Model to introduce MCH HB to health volunteer (Kadar)]<br>Kadar is a health volunteer group who supports activities for health checks of children and some education activities at Posyandu which is under the jurisdiction of the Ministry of Home Affairs. Since they are not healthcare personnel, training for areas such as how to fill in the information for the HB are necessary. In this model, orientation packages for Kadar were developed and a modified guideline for using the MCH HB for Kadar was also confirmed at the ex-post evaluation in West Kalimantan Province. Now the orientation for Kadar is conducted as a part of Health Promotion (Family Planning) activities which was planned by the Directorate of Health Promotion in MOH. |  <br><br>Teaching materials for Kadar |
| [Model to utilize MCH HB at hospitals and private clinics]<br>This model was developed at the model area, Madiun city in East Java Province and Singkawang City in West Kalimantan Province. Therefore the cases where this model is utilized were not confirmed except in the model area and dissemination of MCH HB to private hospitals is one of the biggest challenges hereafter, according to the MOH. In Singkawang City which has two private hospitals in total, both private hospitals used MCH HB. One of them even plans to print and distribute the MCH HB with their own budget for the next year since occasionally there were not enough numbers of the MCH HB available from CHO. |  <br>Midwife who explains MCH HB in private hospital |

Source: The results of a questionnaire survey and interview survey to D/CHO of each model province.

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| Output 5 Results of survey and evaluation of MCH HB on improvement of MCH are reflected in MOH's policy making and implementation process.<br>*[Indicator 1] The impacts of MCH HB on health indicators such as Ante Natal Care (hereinafter referred to as "ANC") rate (K1 and K4), delivery attended by trained health personal are collected.*<br>*[Indicator 2] MCH HB is revised incorporating the evidences from the field by the end of 2008.*<br>*[Indicator 3] Advocacy tools of MCH HB for LGs and relevant ministries are prepared based on the evidences from the field by 2009.* |

Output 5 has been achieved as follows.

(P4K cardattached to MCH HB)

With regard to the health indicators on MCH services such as the ANC rate, delivery attended by trained health personnel (indicator 1) as well as the bringing rate of the MCH HB were integrated with RISKESDAS in 2007 during the project implementation and in 2010 after the project completion. Furthermore, the usage of the MCH service and MCH HB was surveyed at Garut District in West Java Province during the project, accordingly the result was introduced in the leaflet of the MCH HB. The MCH HB is required to be revised every five years, and when the HB was revised in 2009, results of needs surveys to HB users and professional organizations as well as good practices of utilization of the MCH HB were reflected, thus the target indicator 2 was also achieved. For example, a revised Health Card (modified card for growth curve,[14] hereinafter referred to as "the KMS card") has been inserted into the MCH HB based on the opinions raised from users and health personnel. Information on nutrition, including recipes, were added and the illustrations and design of HB were also modified based on the reports which were summarized by regions. A "P4K card[15]"for safe delivery was also added at the time of modification.

Since MOH recognized that the MCH HB is an efficient integrated tool to keep the health record for all information from the antenatal care to delivery and post-partum, a

[14] KMS is a card for recording the growth curve of height and weight of a child.

[15] P4K card is a sticker attached to the MCH HB. Basic information of pregnancies, such as the mother's name, estimated delivery date, person who will attend the delivery, the medical institution for delivery, the name of midwife, etc.), are written in the P4K card and put into on the entrance of the house. The P4K card is widely utilized since neighbors or the community can get the situation of the pregnant woman and they can help her even if family members are out of the house just by looking at this sticker.

delivery insurance called Jampersal[16] has been introduced. To receive this insurance, it is required to submit the copied page which has needed information in the MCH HB. Thus it can be said that the importance of the MCH HB has been reflected in the health system in Indonesia.

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| Output 6 The capacity of MOH and relevant LGs to effectively share the experiences of improving MCH services with MCH HB is strengthened. |
| *[Indicator 1]Experiences of improving MCH services with MCH HB are reflected in the materials of TCTP with ICTP, and relevant meeting.* |
| *[Indicator 2]In the second TCTP with ICTP, satisfaction rates of the participants are more than 80% in average.* |
| *[Indicator 3]By September 2009, experiences of improving MCH services with MCH HB are shared in national meetings of MOH.* |

Three TCTPs/ICTPs were conducted during the project in the model provinces[17]. Training courses to share the experiences were included, such as the cooperation with women's association for having mother's classes, the cooperation with the Ministry of Home Affairs for utilizing the birth registrations, and examples for utilizing the MCH HB at non public medical institutions (Indicator 1). 80% of participants of trainings answered that they were "highly satisfied" or "satisfied" with the training on average, thus the satisfaction rates were more than the planned rate (Indicator 2). In addition, the number of national evaluation meetings was larger than planned (Indicator 3) which has contributed a place to share cases and experiences effectively to strengthen the system and capacity for better utilization of the MCH HB, thus the output 6 has been achieved.

As described above, places were set up to share cases of experiences for better MCH HB utilization during the project implementation. It was confirmed, however, that the places are currently limited since only representatives selected by the MOH from provinces have gathered for these. Therefore, in the interview survey, many D/CHO and Puskesmas requested to PHO or MOH to provide them with opportunities to share the good practices, ideas or experiences of activities for effective usage of the MCH HB or examples such as those written in the [Column] in this report for dissemination.

[16] Jampersal is the Indonesian insurance system for delivery. It is applied to the delivery at the public health institutions or affiliated maternity center. To take this insurance, submitting a copy of the MCH HB which has the record of antenatal services is required.

[17] Contents and places for each training are as follows; 1. Integrated Maternal and Child Health service with MCH HB in the Era of Decentralization (East Java province", 2. Inter Sectoral Support in MCH through MCH HB Implementation (West Java), 3.LG Support and Intersectoral Collaboration in MCH Program Through MCH HB in Indonesia (West Sumatra).

3.2.1.2 Achievement of Project Objectives

| |
|---|
| Project Objective MCH HB functions as a tool to integrate MCH services and a system to sustain MCH services with MCH HB is strengthened. |
| *[Indicator1] By September 2009, at least 80% of pregnant women receive antenatal services using the MCH HB.* |
| *[Indicator2] The model(s) for better utilization of MCH HB is reflected in MOH's policy.* |

To confirm the attainment level of the project purpose, the evaluation team clarified what "functions of MCH HB as a tool to integrate MCH services" exactly means. According to the staff of MOH, it was related to the background of introduction of the MCH HB in Indonesia.

Before the MCH HB was introduced to Indonesia, there were more than 10 varieties of MCH related cards including growth cards prepared by donors, pregnancy cards, immunization cards, cards developed by MOH or some regions and etc. Cards were used depending on who used, which donors supported, regions or places, etc. Then, the MCH HB integrated one card for "recording the health of pregnant women and their child" and "information of health education for mothers", has been introduced on a trial basis with the purpose of managing them continuously. Thus, the "MCH HB functions as a tool to integrate MCH services" shown in the project purpose which indicates that one MCH HB can be utilized as an integrated tool to manage mother and child health continuously for 6 years from the time of pregnancy to the time when the child turns 5 years old.

Under this project, the ratio of pregnant women who took the ANC was taken as the indicator to see the achievement level of the project purpose. In reality, however, the data to show the rate was not available in a detailed manner, therefore the distribution rate which indicates the rate of pregnant women who received the MCH HB was confirmed in this ex-post evaluation since it was done in the same manner in the terminal evaluation. Since the distribution rate was 56% at the terminal evaluation, it was expected that the project purpose would not be achieved by the project completion. At the time of project completion, it went up to 67%, which means that it went up to 80% of the planned ratio though it was not fully achieved. On the other hand, the distribution rate showed a great improvement, a 43 points increase compared to the time of the project start as shown in table 6[18]. Regarding the five models which were developed at each model area to promote the MCH usage, except the one to facilitate other programs such as birth registration to utilize the MCH HB, they were all reflected in some letters, guidelines and integrated into national programs.

[18] It should be noted that theses data did not cover all provinces, and the information of private medial institution were not fully included. (Information of private medical institutions are written in the next section of Impact.)

Table 6 Distribution Rate of MCH HB

| | Before the project (2005) | Terminal evaluation (2008) | Planned | Project completion (2009) |
|---|---|---|---|---|
| Distribution rate | 24% | 56% Note 1 | 80% | 67% Note 1 |
| Attainment rate | - | 70% | | 84% |

Note 1: Based on the data from 12 provinces which answered the questionnaire of a total 33 provinces in Indonesia.
Source: The project documents and documents provided by MOH.

As described above, access to the MCH HB has been increased and MCH HB has been utilized as an integrate tool of MCH service. In addition, models developed for better usage of the MCH HB have been reflected in the policy of Indonesia. On the other hand, some vulnerabilities were identified in terms of the supply system of the MCH HB by LGs and the monitoring and reporting system from the perspective of establishing a system to sustain MCH services with MCH HB. Thus, this project has somewhat achieved its objectives.

### 3.2.2 Impact

#### 3.2.2.1 Achievement of Overall Goal

Overall Goal

1) MCH services with MCH HB became available at every health facility.

2) All pregnant women & children under 5 years old have their own health record.

*[Indicator 1] Coverage of MCH services with MCH HB at health facilities is increased.*

*[Indicator 2] Distribution rate of MCH HB among pregnant women and mothers with child under 5 years is improved to 80%.*

*[Indicator 3] Relevant output indicators, including ANC access rate (K1, K4) , delivery attended by trained health personnel, exclusive breastfeeding rate, are improved.*

Two overall goals were set and accordingly three indicators were given to measure the degree of their achievement.

As for the indicator 1, “Coverage of MCH services with MCH HB at health facilities is increased”, reliable data was not available at MOH. However, it was confirmed that 97% of Puskesmas[19] provided MCH services with the MCH HB in the terminal evaluation. In addition, it was observed during the site visits of ex-post evaluation that most of the Puskesmas and other public health facilities have provided the MCH service with the MCH HB, hence it can be judged that coverage at major public health facilities[20]

[19] This data does not cover two thirds of the total provinces in Indonesia.
[20] Public health facilities indicate nonprofit health facilities which receive the support of government, religious institutions, etc while health facilities for profit with no subsidies are categorized as private health facilities. Currently, there are 9,321 Puskesmas, 1,545 public hospitals and 585 private hospitals in Indonesia.

have increased compared to the situation before the project. However, it should be noted that this data of the terminal evaluation did not include information from private hospitals and clinics. Even in the interview survey conducted for ex-post evaluation, the fact that there is a low utilization rate of the MCH HB in private health facilities was pointed out. MOH explained that the MOH cannot force private facilities to use the MCH HB. Also, one challenge to be addressed is that sufficient numbers of the MCH HB cannot be ensured to cover all medical facilities, including private ones, despite there being some LGs that are spreading the MCH HB to private health facilities.

The distribution rate of the MCH HB (indicator 2) has increased among pregnant women, especially after the introduction of Jampersal in 2011 as shown in table 7. On the other hand, the rate among mothers with children under 5 years[21] went no further than 62.7%[22] because the priority of its distribution went to pregnant mothers in the area where the number of the HB is not enough, while other mothers do not fully understand the importance of the MCH HB. In fact, there were some Posyando where use of the MCH HB by pregnant mothers and the KMS card for mothers with a child under five was occurring in West Java Province during the site visit of ex-post evaluation. In addition, the above mentioned survey report by the University of Indonesia indicated that a portion of pregnant mothers did not understand that the MCH HB would be utilized until the child reached the age of five. According to MOH, there are some mothers with a child under five who use a KMS card under the current situation. However, it can be expected that the bringing rate of the MCH HB would be increased spontaneously in the future if pregnant mothers keep using the MCH HB after giving birth.

Table 7 Distribution Rate of the MCH HB to Pregnant Mothers

| 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|
| 67% | 68% | 81% | 87% |

Source: Document provided by MOH

Through the MCH HB, relevant output indicators on MCH have been increased as shown in table 8 (indictor 3). For example, K4 and deliveries attended by trained health personnel have improved. Even in the interview survey to the Puskesmas, many people stated that pregnant women who receive K4 have increased due to the MCH HB. In addition, while it was common to have a delivery with a Dukun Bayi[23] who is the traditional supporter who uses spiritual prayer or herbs in rural areas, there have been

[21] MCH HBs are distributed during pregnancies, therefore, technically the distribution rate for mothers with children under 5 years indicates the bringing rate.

[22] Based on the data from RIAKESDAS in 2010.

[23] Since Dukun Bayi are very familiar especially in rural areas, the families of pregnant women often ask a Dukun Bayi to attend the delivery. Recently, some efforts, such as conducting seminars for hygiene and attendance of both a midwife and Dukun Bayi for the delivery, have been made.

problems from a hygiene and medical/technical perspective. Therefore, recently, pregnant mothers who learned basic knowledge from the MCH HB tend to desire a safe and clean delivery. On the other hand, the exclusive breast feeding rate has been decreasing partly because some mothers considering powdered milk to be richer in nutrients than breast feeding because of advertisements for powder milk, and also because working mothers tend to rely on powdered milk due to a lack of freezing technology.

Table 8 Improvement of related Output on MCH

| | Before the project | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| K1 | 98% | 94% | 95% | 96% |
| K4 | 79% | 87% | 86% | 87% |
| Delivery attended by trained health personnel | 76% | 84% | 85% | 87% |
| Exclusive breastfeeding rate | 64% | 61% | 62% | 48% |

Source: The documents provided by MOH.

Regarding each indicator for overall goals, achieving coverage of MCH service with the MCH HB at public health facilities though usage in private hospitals remains a challenge (Indicator 1). In addition, the distribution rate of the MCH HB to pregnant women has achieved its target, however the rate of mothers with a child under five was below the target (indicator 2). Although the overall goal was somewhat achieved for target indicator 1 and 3, the achievement of indicator 2 was lower than the plan. Therefore, the overall goal was partially not achieved.

3.2.2.2 Other Impact

In this project, other positive impacts were confirmed mainly in model areas thanks to various activities that are outlined below. Negative impacts were not found.

(1) Improvements in knowledge about pregnant mothers through MCH HB usage

Thanks to the MCH HB, knowledge of users and families for the health of pregnant mothers and infants has been enhanced. Results of the beneficiary survey[24] conducted in ex-post evaluation shows that 85% of responding pregnant mothers and mothers with a child under five answered that knowledge on health conditions of pregnant mothers and recommended dietary and immunization for infants has been increased by the MCH HB, and they would purchase it even if the MCH HB came at fee[25]. According to the midwives at Puskesmas in the interview survey, there were many cases of serious situations resulting in miscarriage because many pregnant mothers previously did not understand

[24] In ex-post evaluation, a beneficiary survey was conducted to capture the effect of utilizing the MCH HB at 6 districts/cities in 4 provinces out of 10 districts/cities in 5 provinces. The details of responding beneficiaries are 61 health personnel, including doctors, midwives and nurses, and 43 users of MCH HB including pregnant mothers and mothers with a child under five years.

[25] MCH HB is basically free of charge.

that bleeding is one of the symptoms of miscarriage and would ignore it. Using the MCH HB with illustrations for easy understanding made it possible to learn how to deal with each symptom, which resulted in improving pregnant mother's and family's knowledge on MCH.

(2) Increase of family and community support

It has been stipulated that the MCH HB has to be read not only by pregnant mothers but also family, especially husbands at home. During the site visits, the support of husbands or family of pregnant mothers, including attending checkups, and the cooperation of community leaders, who knew the importance of the MCH HB, to promote the use of the MCH HB in their communities, was confirmed.

(3) Promoting the MCH HB's usage in each region

Before this project started, it was decided to promote use of the MCH HB by replacing the cover page of the MCH HB with familiar photos, such as a person from that particular region. In ex-post evaluation, in some cases, modifying the HB to meet the nature of the region or communities and conducting original activities, was reported. It is prohibited to change or delete the original contents of the MCH HB but adding some content when PHO or D/CHO print the MCH HB is allowed. With that, some examples such as inserting a card called a "High Score Card" to help for checking the risks to pregnancies in East Java Province, and putting the teaching of Islam on the back of the cover page, were observed. In addition, some Puskesmas have been conducting activities for more pregnant mothers to understand the contents of the MCH HB as shown in the Column.

(High Score Card which is inserted into the HB in East Java Province)

**【Column：Case of activity for promoting better understanding of MCH HB – 10 Minute activity at Puskesmas Kopo -】**

Puskesmas Kopo which is located at Bandung City in West Java Province started doing "Ten Minutes Activity" in the morning in its waiting room in 2012 to promote better utilization of the MCH HB. The head of the Puskesmas Kopo, who visited Nagano Prefecture in Japan for training, was inspired by the fact that all pregnant women have a MCH HB and vouchers for taking the ANC.
She then thought that Bandung City can also do something to contribute for better MCH services which resulted in starting this activity. In this activity, a nurse or midwife will, after planning in advance, explain a few pages of the MCH HB for about ten minutes to waiting pregnant mothers in the waiting room. For busy pregnant mothers it is difficult to have time for mother classes, however, it is essential to have activities for understanding the importance and contents of the HB by pregnant mothers. Thus, ten minutes activities are utilized for explaining and answering the issues in the MCH HB by utilizing the time before or after examination. This activity was introduced to neighboring Puskesmas and will be spread to all Puskesmas in Bandung City in 2013, according to the head of CHO.

In addition, it has been decided that any organization which supports printing the MCH HB are not required to print the Logo of JICA on the front page in order to spread the MCH HB further[26]. It is even free for Midwife Associations or private companies supporting the printing of the MCH HB, as a part of Corporate Social Responsibility (hereinafter referred to as "CSR"), to add their logo mark. Thanks to this flexibility, various institutions, International Organizations, including the United Nations Children's Fund, World Bank and Global Fund, Bilateral organization, including the US Agency for International Development, European Union and the Australian Agency for International Development, and professional organizations such as the Midwife Association, International Non Government Organization, Religions organization, etc., provided support during the project. After the terminal evaluation, some private companies also offered support[27].

(4) Contribution to the improvement of IMR and MMR

At the time of the project planning, IMR and MMR were expected to be improved by the project implementation. As shown in table 9, IMR and MMR improved after the project. Since various factors are related to the change of IMR and MMR, it is difficult to measure the causal correlation with this project. Midwives or users at Puskesmas and Posyandu, however, explained that "Risks to pregnancy were acknowledged", "Pregnant mothers who take ANC increased", "Knowledge on immunization and a variety of diseases of infants were enhanced" along with the spread of the MCH HB. In the beneficiary survey, all responding midwives, nurses and doctors answered that MCH HB are useful tools for pregnant mothers, and 96% answered that MCH HB has contributed to the improvement of mother and infant health. Surveys conducted before the project described the lack of basic knowledge of mothers on pregnancy and delivery as a challenge to improving the IMR and MMR, hence, it can be considered that enhancing the knowledge of pregnant mothers by promoting MCH HB use have contributed to improving IMR and MMR to a certain degree.

Table 9 IMR and MMR

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| IMR (per 1,000 birth) | 42 | 40 | 38 | 37 | 35 | 33 | 32 |
| MMR (per 100,000 birth) | 270 | — | — | 240 | — | 220 | — |

Source: World Data Bank, *World Development Indicators* (http://data.worldbank.org/)

[26] However, it is always noted that in the back of the front page that the MCH HB was developed with the support of JICA. In addition, in case private companies support the printing of the MCH HB, they are allowed to seal the company's logo but are not allowed to insert any advertisement.

[27] According to MOH and LGs, a large food related company, car production company as well as palm company, etc. support or supported the printing and supplying of the MCH HB as a part of CSR activities.

As mentioned above, this project has somewhat achieved its objectives, therefore its effectiveness is fair. Regarding the project purpose, there are some problems with establishing a system to sustain MCH services with the MCH HB while the MCH HB functions as a tool to integrate MCH services. As for the overall goal, though the ratio of pregnant mothers who have a health record has increased, the ratio of mothers with a child under five with a health record has remained within a limited range. Use of the MCH HB in private hospitals has been confirmed in certain areas but further improvement is expected.

### 3.3 Efficiency (Rating: ③)

3.3.1 Inputs

Planned and actual inputs for the project are shown in Table 10.

Table 10 Plan and Actual Inputs

| Inputs | Plan | Actual Performance (As of terminal evaluation) |
|---|---|---|
| **Japanese Side** | | |
| 1. Experts | Long term expert: 3<br>Short term expert: 2-3/year | Long term expert: 5<br>Short term expert: 8 |
| 2. Trainees received | C/P training<br>5 per year for two weeks ×4year | Training in Japan : 35<br>Training in Indonesia:42 |
| 3. Equipment | Not stated | 3.71 million yen |
| 4. Local cost | Daily expense, special project cos | 96.84 million yen |
| 5.Project total cost | 320million yen | 290million yen |
| **Indonesian Side** | | |
| 1. C/P personnel | Not stated | 14 C/P |
| 2. C/P budget | Conference cost, traveling cost, trainers fee | C/P expenses |
| 3. Others | Office for JICA experts with utilities | Office for JICA experts with utilities |

Source: Terminal evaluation report

3.3.1.1 Elements of Inputs

(1) Japanese Side

【Dispatch of experts】

Long term experts: Chief advisor, MCH advisors, Coordinator
Short term experts: Survey design, Education material, Third country training

Japanese experts were dispatched as planned[28]. Experts who were dispatched for this project used to also be members of Phase 0 and Phase II, as long or short term experts,

[28] 3 long term experts of the original plan increased to 5 in total. This includes the people who changed their status and were counted twice, hence the actual input of man/month can be considered as planned. The short term experts were dispatched as originally planned.

JOCVs, as well as Senior Volunteers. Thus, this made project implementation more efficient.

【Counterpart Trainings】

35 C/Ps received trainings in Japan[29] which exceeded the original plan because trainings needed to cover a broad area. This increase was judged as appropriate since C/Ps need to take trainings for all areas when considering the nature of the project which has plural institutions as C/Ps. The details of participants are 14 from MOH, 2 from the Ministry of Home Affairs, 5 from PHO and 5 from D/CHO and 9 from professional institutions[30] and hospitals. In addition, 42 participated in ICTP and TCTP to share their experience of utilizing the MCH HB and further promote it.

【Equipment】

15 sets of equipment, personal computers, printers, related software, and desktop computers, monitors and projectors, needed for collecting data relevant to the MCH HB, and developing and conducting model activities, were provided to five model provinces.

【Local Cost】

The local cost occupied 30% of Japanese input. It contained 60% of operation costs which include the activities for promoting the MCH HB, the printing cost for the materials, guidelines and publicity leaflets.

(2) Indonesia Side

【Counterpart assignment】

14 counter personnel were assigned from the Department of Child Health in the MOH and other departments. Unlike regular projects which have one department as a C/P, this project was implemented with 3 of 4 directorates of MOH as C/Ps. Apart from MOH, 5 PHO and 10 D/CHO were also included as C/Ps for the activities to develop models for utilizing MCH HB.

【Counterpart budget】

The budgets for having workshops, seminars, orientations and trainings in Indonesia and for travelling costs were covered by the Indonesian side.

[29] Trainings for MCH HB utilization and an MCH HB symposium were held once a year in Japan.
[30] It includes the Indonesian Obstetrician, Indonesian National Nurse Association, Indonesian Obstetrician and Gynecologist Association, and Family Welfare Movement.

【Project office and utilities】

The Project office and utilities were covered as planned by the Indonesian side.

3.3.1.2 Project Cost

The planned cost to the Japanese side totaled 320 million yen, and the actual total project cost was 290 million yen, within the plan (91%).

3.3.1.3 Period of Cooperation

The actual cooperation period was 36 months as planned.

As described above, input was appropriate to produce the output, and both project period and cost were within the planned scope, therefore the efficiency of the project is high.

**3.4 Sustainability (Rating: ②)**

3.4.1 Related Policy towards the Project

The Indonesian Development Plan, as of ex-post evaluation, clearly mentioned the strategy of placing importance on MCH improvement synonymous with that mentioned at the time of the project planning. In RPJM (2010-2014), accelerating the improvement of MMR and IMR is raised as a strategy to achieve the International development goals, Millennium Development Goal (hereinafter referred to as "MDG"), with the one of basic purpose of "Improvement of welfare". In the Heath sector, "Goal 1. Eradicate extreme poverty and hunger[31]", "Goal 4. Reduce child mortality", and "Goal 5. Improve maternal health," as outlined within the 8 MDGs, are taken as priority areas of Indonesia's "MDGs 145". "A Roadmap to Accelerate Achievement of the MDGs in Indonesia" published in 2010 also shows concrete numerical targets, as shown in table 11, as issues to be managed continuously.

Table 11 Target and Actual Data related to MCH in Indonesia

| | Original (1991) | At the time of preparing report(2007) | Target (2015) |
|---|---|---|---|
| Goal 1: Rate of child under 5with serious malnutrition | 7.2%note1 | 5.4% | 3.6% |
| Goal 4: IMR (per 1,000 birth) | 68 | 34 | 23 |
| Goal 5: MMR (per 100,000 birth) | 390 | 228 | 102 |
| Rate of delivery attended by health personnel (%) | 40.7note2 | 77.3Note 3 | Increase |

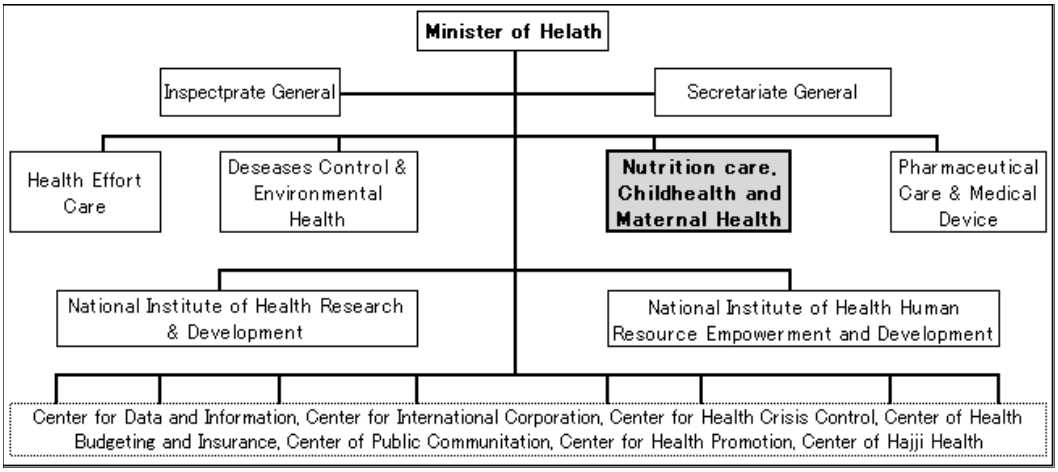
Note 1: Data in 1998 Note2：Data in 1992 Note 3：Data in 2009
Source: Extracted from Ministry of National Development Planning/National Development Planning Agency (2010), "A Roadmap to Accelerate Achievement of the MDGs in Indonesia"

[31] Since it includes the indicator on nutrition for infants, executing agency of this project is the one to look after.

In addition, Jampersal was introduced in 2011 and made bringing the MCH HB mandatory and promoted the improvement in the bringing rate of the MCH HB. The MCH HB's usage has been integrated into various health sector programs in letters and notices, guidelines and manuals which were formulated during the project implementation. Not only in the systems of the heath sector, MCH HB related items were integrated in the curricula of midwife academies and nursing schools for ensuring the capacity of health personnel, thus it has contributed to ensuring the sustainability of the project effect as of ex-post evaluation.

3.4.2 Institutional and Operational Aspects of the Implementing Agency

The Department of Child Health, Directorate of Nutrition, Child Health and Maternal Health in MOH is in charge of all the activities including revision, printing and supplying of the MCH HB (Refer to Figure 1). In the department of Child Health, 6 staff are involved in the MCH HB. After project completion, 2 staff and 4 administrative staff were assigned additionally, however, sufficient numbers of staff are not assured since they are assigned work other than that of the MCH HB. Furthermore, D/CHO have the responsibility to procure the MCH HB for Puskesmas and other health facilities, and in case of a lack of MOH HB, health facilities would ask for the support of PHO or MOH through D/CHO. The majority of PHOs have very little direct involvement with printing, distribution and awareness activities but mainly have responsibilities with coordinating between D/CHO and MOH, as well as with monitoring works. The main actors for activities disseminating and promoting the MCH HB use is done by D/CHO, Puskesmas and Posyandu.




Source: Website of MOH http://www.depkes.go.id/en/

Figure 1 Organization Chart of MOH (excerption)

Future challenges in terms of institutional aspects are raised with the operation and implementation of a monitoring system. As indicated in output 3, a reporting system from

LGs to MOH has not been strengthened under decentralization and the issue, that appropriate information on output has not been collected, was made clear during this evaluation. In the future, measures and efforts have to be made to strengthen the monitoring system in order to report the appropriate data between MOH and LGs.

3.4.3 Technical Aspects of the Implementing Agency

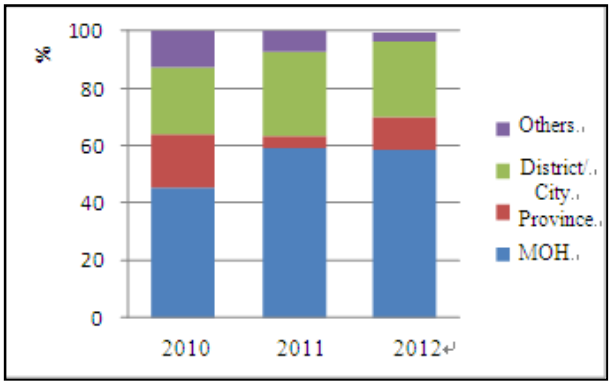
The project enhanced the capacity for promoting better utilization of the MCH HB through trainings for all stakeholders including the staffs of MOH, PHO, D/CHO, health personnel, Kadar, etc. Even after the project completion, it was confirmed that MOH has been able to continue the revision of the MCH HB, hence there are no major issues on the technical capacity of the implementing agency as well as at the LG level. As for health personnel, items related to the MCH HB have been integrated in the curriculums of educational institutions, therefore, midwifes and nurses who fill in the information for the MCH HB do not have any issues with their capacity.

On the other hand, there is the issue of users not familiar with reading the HB at home, despite bringing the HB for their checkup, in some regions. Beneficiary survey results also showed that 70% of responding doctors, nurses and midwifes answered that not all mothers read the MCH HB[32]. According to an interview to D/CHO, Puskesmas and Posyandu, a concern on the lack of capacity of some Kadars, who were assigned after the project completion, to utilize the MCH HB was mentioned. Currently, the orientation of MCH for Kadars was included in the activities conducted by the Directorate of Health Promotion in the MOH and the situations of monitoring differ from region to region. Hence, the level of understanding by Kadars also varies widely and continuous trainings or activities for awareness as well as proper monitoring to capture the current situation are needed.

3.4.4 Financial Aspects of the Implementing Agency

The Terminal Evaluation Report explained that the responsibility to supply MCH HBs falls on LGs. However, since the Minister of MOH declared in 2009 that the MOH would print and supply MCH HBs to all pregnant women, the portion covered by the MOH has been increased, as shown in Figure 2. Currently, MOH firstly provides the MCH HB to LGs, then filling the gap by the budgets of LGs and the support of CSR or professional institutions. Meanwhile, the sharing of the responsibility of supplying the MCH HB, in financial terms, is not clear so far and remains a concern for future sustainability.

[32] According to the result of the beneficiary survey, 23% of the responding health personnel answered that all pregnant mothers read the MCH HB, 68% of them answered that not all pregnant mothers read the MCH HB and only 9% answered almost of all pregnant mothers do not read the MCH HB.




Source: Prepared based on the interview survey results conducted at 11 D/CHO.

Figure 2 Proportion of Sharing the Budget for Printing the MCH HB

Table 12 shows the recent printing budget for the MCH HB by MOH. The printed number was decided based on stock from the previous year and the budget allocated for each year. In 2013, the MOH decided to cover 80% of estimated pregnant mothers, however, MOH would like to examine a gradual reduction in the share of MOH following discussion with LGs. To do so, MOH needs to coordinate with LGs to adjust the burden adequately, any clear ideas for financial cooperation with NGOs and CSR activities as measures to print and supply the MCH HB, however, have not been shown. Since MOH cannot tell until when the budget can be continuously allocated, it is urgently necessary to consider the future budget plan.

Table 12 Printed Number and Budget for MCH HB Allocated by MOH

| | 2009 | 2010 | 2011 | 2012 | 2013[Note 1] |
|---|---|---|---|---|---|
| Printed Number | 3,548,498 | 0 | 6,166,670 | 4,000,000 | 4,000,000 |
| Budget(Mil. Rupiah) | 12,420 | 0 | 21,583 | 14,000 | 14,000 |

Note 1：Data in 2013 is an estimate.
Source：Data provided by MOH.

On the other hand, LGs which were visited during ex-post evaluation expressed that the MCH HB will become absolutely insufficient if they do not get a supply from MOH. Furthermore, MOH and many LGs did not capture the budget and the number of the MCH HB correctly, thus LGs remain an issue for printing and supplying the MCH HB autonomously (Refer to Table 13).

Table 13 Current Situation Future Prospect of Shearing Budget between MOH and LGs by Provinces

| | | | |
|---|---|---|---|
| West Java Province | Many D/CHO rely on the budget allocated by MOH. According to PHO, MOH shared 80% of the printing budget and the remaining 20 % is shared by districts or cities. | West Nusa Tenggara Province | Though the situation varied by districts and cities, 90% of the budget was allocated by MOH and the remaining 10% was managed by LGs on average. In 2012, the ratio changed to 70% from MOH and 30% by LGs. PHO would aim to be independent, but it would be difficult to do so completely by considering |

| | | | |
|---|---|---|---|
| | | | the current financial situation |
| West Sumatera Province | In 2013, Governors of provinces and districts/cities exchanged an agreement which reduced the burden of MOH to 10% and 90%, to be covered by LGs. In interview survey, all visited LGs, Tanah Datar District, Solo City and Bukittinggi City, have shared this idea and plan to propose the budget to achieve this goal. | East Java Province | 65 % of MCH HBs were supplied by MOH, 9% by Provinces and 26% by districts /cities on average among D/CHO visited during the ex-post evaluation. Among them, there are cases like Lumajang District where 20% of MCH HBs were supplied with the support of NGOs and Communities, while there are also cases where 100% of MCH HB rely on MOH. |
| West Kalimantan Province | According to PHO, if no supply was made by MOH, only 2 or 3 can self sustain among 14 districts/cities in this province. | | |

Source: The interview survey and responses of the interview survey

As mentioned, no major problems were observed in terms of policy background and the technical aspect while some concerns still remain on the structural and financial aspect of the implementing agency, hence the sustainability of the project effect is fair.

## 4. Conclusion, Lessons Learned and Recommendations

### 4.1 Conclusion

This project was conducted to integrate the MCH service by utilizing the MCH HB and strengthening a system for sustaining the MCH service through the MCH HB in Indonesia. The project direction was consistent with Indonesian policies and strategies, which have emphasized improving the MCH services, the development needs and Japanese assistance policy, hence the relevance is high. Furthermore, the MCH HB has functioned as an integrated tool for health management in the process of raising children, hence pregnant women who utilize the MCH HB have steadily increased. On the other hand, the expansion of use of the MCH HB among mothers with children under five years old has been limited and challenge still remain in terms of role sharing among the central and LGs. Therefore the effectiveness and impact is fair when considering the purpose to establish a system to continue the service by utilizing the MCH HB. The efficiency of this project is high since both project cost and period are within the plan. Its sustainability is considered fair, because there is some room to improve in the awareness of Health Volunteers who support the users of the MCH HB and in the operation of the monitoring system, and furthermore there is concern for securing the printing and distributing budget for the MCH HB in the future, despite the fact that the system to maintain the use of the MCH HB by mothers and medical workers has been developed. In light of the above, this project is evaluated as satisfactory.

## 4.2 Recommendations

### 4.2.1 Recommendations to the Executing Agency

【Balance of cost sharing on MCH HB printing for the future】

Currently, the cost of printing and distributing the MCH HB depends heavily on MOH, however, MOH is assuming that LGs will take the burden gradually. While cost sharing is not defined among MOH and LGs, LGs which can secure the budget are limited and many LGs expect that MOH will continuously provide the support. The MOH is required to inform the necessity of balance in cost sharing to LGs, and discuss and consider the realistic balance of cost sharing.

【Strengthen the implementation and operation of a Monitoring System】

As is the case with the terminal evaluation, a great deal of data for the indicators was not available for ex-post evaluation. During the project implementation, data related to the MCH including the distribution and bringing rate of the MCH HB were included in PWS-KIA and RISKSDAS, however, there was no obligation for LGs to report data to MOH, and thus, it remains a difficult situation for MOH to collect the data from all provinces. Sharing of information between MOH and LGs is essential to continuously promote the MCH HB usage. In this case, Country Countdown, which is confirming the progress status of Goal 4 and 5 of MDGs, may be one option to be used for sharing the data and information. Also, including budget information, following up the data through sharing the updated data once a year would be preferred.

【Set up a place for sharing cases of good practices】

To promote the MCH HB's use, each region has taken its own approach. There is, however, currently no place to share each practice, so staff of D/CHO, Puskesmas and Posyandu have requested places be set up for sharing the good practices from each region. Though it is not realistic to set a gathering place only for the MCH HB, it is desirable to set up a place or system by incorporating existed meetings for MCH and MDGs, then the information would be distributed from D/CHO level to Provincial level and then to MOH, then finally the information would be given back to the sites.

【Strengthen of awareness activities for MCH HB users】

Though the printing and distribution rate of the MCH HB has been improved, some issues, such as some users not having a custom to read the MCB HB, and mothers who do not utilize the MCH HB, were confirmed in the user's side. In order for users to utilize the MCH HB effectively, to prevent cases where the HB is not sufficiently read by users,

its importance has to be informed to everyone. Guidance is necessary to strengthen the advocacy activities for users to utilize HB correctly from MOH to LGs and then LGs to Puskesmas or Posyandu. In this case, it should be effective to conduct trainings for not only pregnant mothers but also for Kadars who do not fully understand its importance.

【Measures for utilization of MCH HB in private health facilities】

Staffs of PHO and D/CHO which were visited by site surveys at the ex-post evaluation expressed the future challenge of utilization of the MCH HB in private health facilities. For the MCH HB to function as a referral tool, various types of health facilities need to use the MCH HB. In Indonesia, where improvement of MCH care, including a referral service, is an important issue, it is necessary to figure out the factors resulting in a lack of full dissemination and use of the MCH HB at private health facilities.

**4.3 Lessons Learned**

4.3.1 Lessons Learned to JICA

【Considerations which meet the local situation】

When printing and revising the MCH HB, it is prohibited to change and modify the contents, however, it is permissible to add some contents as attachment and replace the front page with contents relevant to each region. In fact, each region makes distinct front pages which have a sense of closeness for those using. In addition, putting the logo of JICA on the front page is not compulsory (though it is necessary to put that the MCH HB was developed with the support of JICA) and UNICEF and other private companies were able to easily support printing as a part of CSR activities. As such, the making of various efforts and ideas for dissemination of MCH is considered to have contributed to the spreading of the MCH HB.

【Impact caused by the involvement of many stakeholders】

Apart from the main C/Ps, the Department of Child Health in MOH, various stakeholders, including the Department of Maternal Health, Regional Nutrition, Regional Health, Medical Services, each model province and district/city, as well as professional institutions, religious organizations, and women's associations were involved in the project activities. Also when conducting the trainings, not only health facilities or ministries, but also health volunteers who are closest to users, were included. In this way, involving various institutions and actors resulted in each of them playing an important role to promote utilization of the MCH HB. Meanwhile, a high capacity for coordination is essential in the case where various factors are involved. A lack of coordination among various stakeholders may adversely cause confusion. In this project, almost of all experts

have experience in joining the activities of the MCH HB either in Phase 0 or 1, thus experiences and networks accumulated from Phase 0 resulted in this success. For future projects where many stakeholders are involved, it is essential to ensure an implementation structure which has sufficient function and experience. In this case, rather than following this Project, making a plan after examining the implementation structure, considering the function of coordination, the capacity of C/Ps, experience of experts, and based on the individual situation is recommended.

(End)