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The Life Saver: The Mother Friendly Movement in Indonesia

Abdullah Cholil

Meiwita B. Iskandar
Population Council

Rosalia Sciortino

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THE MOTHER FRIENDLY MOVEMENT IN INDONESIA



ABDULLAH CHOLIL ● MEIWITA B. ISKANDAR ● ROSALIA SCIORTINO



The Life Saver:
**THE MOTHER
FRIENDLY
MOVEMENT**
IN INDONESIA

A movement

carried out by the community and the government,
for the advancement of the quality of life of women,
especially in accelerating the reduction of
maternal morbidity and mortality rates,
in the interest of human resources development

Abdullah Cholil
Meiwita Budiharsana Iskandar
Rosalia Sciortino

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FOREWORD



It is high time to reduce the rate at which women in Indonesia die from pregnancy and childbirth. Recent studies show that it is unlikely Indonesia will reach its goal of cutting that rate in half by the end of this decade. Recognition has come from President Soeharto in his speech in December, 1996 that without improvements in women's health, our national development efforts cannot be considered a success. The health of women during their reproductive years is a key determinant of the nation's human capital development. Interventions affecting reproductive health contribute directly to socio-economic development by increasing the human capital of women.

The reasons that women die from maternal causes are based on delays and barriers to care which can only be overcome with inter-sectoral, multi-pronged and community-based initiatives, involving community members, health workers, and government representatives from all sectors, from the central to the village level. We must work to educate everyone about the alert signs of high-risk pregnancy and the need to seek proper medical care without delay. For many low-income families, this will require community and governmental assistance to overcome financial and geographic barriers to seeking care, such as the provision of transportation or financial aid for pre-natal care and emergency treatment. We must also upgrade the quality of the available health care services for pregnant mothers. However, all of these initiatives can only be successful if based on a foundation of increased status for women and concern for their health.

The President of the Republic of Indonesia on the occasion of the National Mother Day on 22 December, 1996, has officially launched a national movement for accelerating the reduction of maternal mortality and morbidity, called Gerakan Sayang Ibu (GSI) or the Mother Friendly Movement. Through the new campaign initiatives of GSI, Indonesia optimistically expects that its commitment to bring down the Maternal Mortality Rate (MMR) to only 225 per 100,000 live-births will be achieved by the end of the Sixth Five-Year Development Plan. Furthermore, we hope to bring the MMR down to only 80 by the year of 2018, the end-year of the Second 25-Year Long-term Development Plan.

We are very proud to present this book, which is the final product of much tireless work. The authors and their support team have done an impressive job of presenting the issues surrounding maternal mortality and the results of all our efforts over the last year to begin the implementation of the Mother Friendly Movement in eight trial districts in Indonesia. We have also been very pleased with the success of the campaign so far, the commitment shown from the community and the local government with all its development sectors and health workers. However, much remains to be done and we hope that this movement will receive the continued support and attention needed to grow and spread across the country, improving the health and well-being of Indonesia's women. Indirectly, this movement will contribute to the human capital development of young children, by keeping their mothers alive and healthy.



Jakarta, October 1997
The State Minister for The Role of Women

Mrs. Mien Supandhi

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The idea of documenting the Mother Friendly Movement or *Gerakan Sayang Ibu* (popularly abbreviated as *GSI*) was originally suggested by Her Excellency Mien Sugandhi, the State Minister for the Role of Women¹, Republic of Indonesia, in the belief that the Indonesian experience in reducing maternal mortality would be relevant to other countries struggling with the same problem.

The authors were entrusted with the task of producing an illustrated monography on the pilot projects implemented in eight districts from June until December 1997. Besides extensively monitoring these activities, we were given the responsibility for collecting relevant literature and statistical material, and supervising the photographic reporting. The actual production of photographic material was undertaken by Agus Leonardus, Ali Budiman, Layung Buworo, and Aris Pramono, and the graphic design by Butet Kartaredjasa, Martopo Waluyono and the Galang Communication staff.

The publication of this book would not have been possible without the generous support of the Ford Foundation. We are also grateful to the district and subdistrict officials, the health workers and the community members in the eight districts for the hospitality and the assistance they provided during our visits. For organizational support and advice, the authors would like to thank the Mother Friendly Movement Technical Assistance Team, especially Syafri Guricci, Setiawati and Muhammad Warid, and the staff of the Ministry for the Role of Women, especially Abdullah Attamimi, Ida Suselo Wulan, and Erwin Budilaksono.

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NOTES

1. In the following, for stylistic reasons, this official denomination will be shortened in 'Ministry for the Role of Women'

CHAPTER I BACKGROUND

INDONESIA: A BRIEF OVERVIEW

The focus of this book is the Mother Friendly Movement in Indonesia, an important collective effort to reduce maternal mortality. Before proceeding to share the valuable experiences of this movement, we will briefly introduce the country to provide a contextual framework. The name Indonesia originates from two Greek words: 'Indos'

meaning 'Indian' and 'Nesos' meaning 'islands'. This is a fitting description of the world's largest archipelago, 17,508 islands strewn across 3,200 miles of tropical ocean, just south of the equator. Superimposed on a map of North America, Indonesia would extend from Oregon all the way to Bermuda. Approximately 6,000 of these islands are inhabited, including the five major islands (Sumatra, Kalimantan, Sulawesi, Irian Jaya and Java) serving as home to the majority of the population¹

Map of Indonesia—the world's largest archipelago





Indonesian rice fields

Known as the "Spice Islands of the East", Indonesia encompasses a variety of unique geographical and climatic conditions, resulting in a whole spectrum of spectacular tropical habitats. These range from the exceptionally fertile rice lands of Java and Bali to the abundant rain forests of Sumatra, Kalimantan, Sulawesi and Maluku, the savannah grasslands of Nusa Tenggara, and the jungle-laced, snow-capped peaks of Irian Jaya. The inner islands (Java and Bali, including Madura) are characterized by labor-

intensive irrigated agriculture wherein the principal farming method employed is *sawah*, or wet-rice paddy cultivation. All other islands, also called outer islands, are home of rain forests, thinly-spread farming communities and riverine trading networks. Moving east from Java across Bali and Nusa Tenggara, the climate becomes drier and lowland jungles are replaced by deciduous monsoon forests and open savannah grasslands.²

With a total land area of 2 million square kilometers (780,000 square miles), and a total population of over 200 million people, Indonesia is the fourth most populous nation in the world. Java and Bali are the most densely populated islands, representing only 7 percent of Indonesia's total land area, but housing two-thirds of the population. In both islands, average rural population densities can reach up to 2,000 people per square kilometer. In an effort to ease the pressure, the Indonesian government has encouraged transmigration of Javanese and Balinese villagers to the more sparsely populated islands such as Sumatra, Kalimantan, and Sulawesi, while undertaking an intensive nationwide family planning program.³

A democratic republic, Indonesia is divided into 27 provinces and special territories. Executive power is vested in the president who is elected by the People Consultative Assembly for a five-year term, and in the president's appointed cabinet. For more than 30 years the New Order government has been led by President Soeharto assuring po-

litical stability and economic development in a very complex and diverse country. The national motto *Bhinneka Tunggal Ika*, or 'Unity in Diversity' accurately describes the colorful tapestry of life-styles and cultures which make up Indonesia. Although Islam is the dominant religion, practiced by nearly 90 percent of the population, there are significant Christian (Protestant and Catholic), Bhuddist and Hindu minorities. Religious beliefs and practices are further enriched by the local traditions and customs, or *adat*, of over 300 ethnic groups. The largest groups are the Javanese (constituting 40-50 percent of the total population), the Sundanese (Western Java) around 15 percent, and the Madurese an estimated 5 percent. Smaller, but regionally important, ethnic groups include Balinese (Bali), Batak (Sumatra), Dayak (Kalimantan), Papuans (Irian Jaya), Acehese (Aceh) and Toraja (Sulawesi). Ethnic Chinese communities, constituting 3

percent of the total population, live mainly in urban areas. Each one of these groups boasts unique rituals and ceremonies to celebrate important life events, their own characteristic performing arts, and very diverse language dialects. For all official and educational purposes, the national language, Bahasa Indonesia, serves as a unifying device.⁴

From the early days of the republic, Indonesia's leadership realized that a broad education system was a necessary founda-



Different ethnic groups, different customs



tion for modern nationhood.⁵ The schools system currently consists of four levels: six years primary, three years each of lower and upper secondary, and a range of options for further education. Venues include secular schools, Islamic boarding schools allocating a significant

part of their curriculum to Islamic teachings; and religious schools representing the other main religions. In 1990, the government set a new goal of nine years compulsory education, an increase from the previous six years minimum target. In general access to primary



Education of girls – an asset to the country

school education has improved dramatically over the last ten years, rising from 60 percent to 94 percent participation. The 1995 Intercensal Population Survey estimated a 12.6 percent illiteracy level among the population ten years of age and older, with a higher illiteracy level among women (17.1%) than men (7.9%).⁶ These percentages show a reduction from 1992, when the illiteracy level

was 16 percent, 21.3 percent among women and 10.6 percent among men.⁷

Educational improvements are closely related to the rapid economic growth between 1980 and 1993, when expanding incomes were reflected in a 6 percent annual growth rate of the gross national product (GNP). Per capita GNP reached US\$740 in 1993.⁸ As a result of conscientious government policies, the industrial sector is gaining strength. Still, Indonesia is predominantly agrarian with 90 percent of the population deriving some portions of their livelihoods from agriculture. Major agricultural products for domestic consumption and export include rice, corn, cassava, soybeans, timber, rubber, palm-oil and spices. The country is rich in natural resources, as oil and gas contribute up to 70 percent of total export earnings and 60 percent of government revenues. In recent years a number of steps have been taken to promote and stimulate tourism and non-oil exports which include handicraft, textiles, precious metals, tea, tobacco, cement, fertilizers as well as manufactured goods. The rapid expansion of telephone, television, and broadcasting facilities to all 27 provinces in recent years has affected local cultures and life-styles dramatically.⁹

These rapidly changing socio-economic and cultural conditions greatly influence the level of women's participation in the nation's development process, women's role in the community and families, and women's health.



Socio-economic conditions are highly correlated with the health of women and children



Contributing to family and society

WOMEN'S POSITION IN INDONESIAN SOCIETY

The Indonesian Constitution of 1945 does not distinguish or discriminate on the basis of gender. Articles 17 and 21 guarantee equal rights and responsibilities in the fields of labor, health, politics and law. Indonesia has ratified the 1952 United Nations Convention on the Political Rights of Women, which ensures equal rights to employment, to vote, to stand for election, and to hold public office.¹⁰ Equal treatment for men and women is further guaranteed by the United Nations Convention of 1979 on the Elimination of All Forms of Discrimination Against Women (CEDAW), which was ratified by the Indonesian government at an early stage, becoming Law No.7/1984.

These sanctioned rights, however, are not widely exercised. For example, the political arena is still primarily regarded as men's domain. The present Cabinet, consisting of 41 members, includes only two women, the Minister of Social Welfare and the State Minister for the Role of Women.¹¹ The absolute number of women representatives in

the People's Consultative Assembly increased slightly from 98 in 1995, to 103 in 1997, out of 1,000 members. In contrast, however, the number of women representatives for the House of Representatives decreased from 60 in 1995, to 56 in 1997, out of 500 members.¹²



Girls demand education

Women –as previously seen– are also disadvantaged in terms of education. Although over the past decade there has been a rapid closing of the gender gap in primary school attendance rates, gender disparity is still significant in lower and upper secondary school enrollment. The household's socio-economic environment continues to



Culture and values –passed down generations

favor sons' access to higher level education and the enrollment rate of girls in upper secondary school remains low.¹³ Female participation in education varies widely among provinces. The rates of women with no schooling range from 53.7 percent in East Timor to 4.5 percent in North Sulawesi. Nationwide, approximately 10 percent of female students between 10 and 14 years drop out compared to 8.7 percent of male students. The gender gap widens in the 15-19 age group, where 55.5 percent of female students drop out as compared to 49.5 percent of male students.¹⁴ It is interesting to note that education level is related to age at first marriage. As the 1994 Indonesian Demographic Health Survey (IDHS) showed, women with less than secondary education

marry at an earlier age than women with secondary or higher education.¹⁵

Traditional values continue to exert a pervasive influence, upholding submissiveness and obedience as ideal feminine qualities. In traditional Javanese society, a woman is expected to obey her husband, as expressed in the proverb '*suwarga nunut neraka katut*', which means that a woman should follow faithfully whether her husband goes to heaven or to hell.¹⁶ Although many of the younger generation have started to disagree, feeling that women are equal to men and should not walk 'behind' but 'beside' them, women still put the needs of all other family members before their own. In regions with a strong preference for sons, patterns of food distribution within a family usually give pri-



A woman's work: still considered domestic service.

ority to any males in the household. Consequently, young girls are more likely to be malnourished, which stunts their physical development over time, and in turn threatens their ability to give birth to healthy babies.

Cultural values also emphasize the need for girls to be married at an early age to minimize the danger of premarital conception.¹⁷ There is a pervasive community norm that a girl who is not married by the age of 15 is referred as 'not saleable' and soon become an 'old maid'. Even though Marriage Law No 1/1974 prescribes 19 years for boys and 16 years for girls as the legal age of first marriage, 'child marriages' still take place in rural areas, often around the time of the girl's first menstruation. Nowadays, many

of these women regret the fact that their parents' poverty forced them to marry at a very young age, often preventing them from continuing school.¹⁸

Once married, a woman starts to fulfill the socially prescribed roles of housekeeper, child rearer, and nurturant supporter of her husband.¹⁹ With the notable exception of the matrilineal tradition of the Minangkabau society in West Sumatra, Indonesian society is patrilineal. The husband is regarded as the head of the family, whose duty it is to provide adequate food, housing, and clothing for his wife and children. If the wife works, her income is merely seen as supplementary, and regardless of her work status, her main duty is still to provide domestic services. Married women only have autho-



A working mother, yet without work status

rity to administer family finances and childrearing, but this limited sphere of influence does not foster a sense of independence, autonomy, or control.²⁰ These and other disparities between the rights and obligations of men and women within families and in their roles in the community also lead to greater leeway for men in issues of marriage, divorce, and inheritance. In many ethnic groups, men may inherit a greater share of family wealth or land than women, they may have more than one wife, and may exercise the right to unilaterally divorce their wives.

In addition to undermining social and economic security for women, dominant values also allow the occurrence of violence against women. Three of the largest newspapers in Indonesia, Kompas, Republika and Pos Kota, reported between 77 and 106 cases of violence against women in 1994, mostly consisting of rape.²¹ Such cases are rarely pursued in court because laws place the burden of evidence and blame on the women. The existence of domestic abuses or violence is formally denied and awareness of sexual harassment is only a recent phenomenon. Violence, early age of first sexual intercourse

or first marriage, unequal access to higher level education and job opportunities, nutritional deficiencies and other areas of inequality, tend to be conducive to lower health status among women. Specifically, gender inequity is implicated in high rates of maternal mortality, one of the most serious reproductive health problems in Indonesia.

MATERNAL MORTALITY: A PERSISTENT PROBLEM

Maternal mortality has a long history in Indonesia. Even during Dutch colonial times it was recognized as a pressing public health problem requiring prompt intervention. In 1852 the *School voor Inlandsche Voedvrouwen* (School for Indigenous Midwives) was established to reduce the high mortality rate of newborn children and their mothers. These Western-trained midwives were supposed to gradually take the place of the practicing traditional midwives (*dukun bayi*) who, by biomedical standards were considered ignorant, and even dangerous.²²

After Independence was proclaimed in 1945, more emphasis was put on services in rural areas, since 70 percent of the population lived in the countryside. Multifarious preventive structures were developed around the existing network of curative facilities. In an effort to reduce the high maternal and infant mortality rates (were respectively 1.2 and 30 percent prior to the Independence), mother-and-child care received special at-

tion. Starting in 1952, Centers for Mother-and-Child Welfare (*Balai Kesejahteraan Ibu dan Anak* or BKIA) were established in each district to provide assistance to pregnant women, babies and infants through health education, vaccination and simple curative practices.²³

With the ascent of President Soeharto and the New Order Government in 1965, the BKIA and other bodies of disease prevention and control were merged with the polyclinics in the community health centers (*pusat kesehatan masyarakat* or *puskesmas*) which became the primary level referral services for each subdistrict. By the end of the Second Fifth Five-Year Development Plan (*Repelita II*: 1974-1979), the aim of building a health center in each subdistrict was

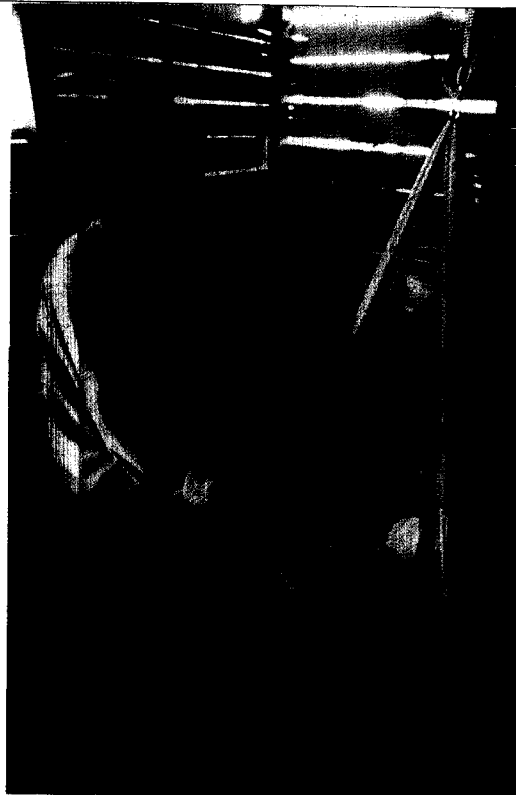
The goal, Safe Motherhood



achieved, but the plan of staffing them with a midwife and a doctor was only partially realized. Partly because of the scarcity of health personnel, during the following Five-Year Development Plan (*Repelita III*: 1979-1984) community participation came to be regarded as the key to health improvement in Indonesia.

This new participatory framework maintained a special focus on the high maternal and infant mortality in the country. A system known as *pos pelayanan terpadu* (*posyandu*) or integrated service posts, was established. This was a package of community-based and community-organized mother-and-child care programs targeting five priorities: nutrition, diarrhea control, family planning, vaccination and maternal and child health (MCH). These activities were entrusted to volunteer health workers (*kader*) under the supervision of trained midwives.

To increase the coverage of health services, in successive years village-based subcenters (*puskesmas pembantu*) and mobile health centers (*puskesmas keliling*) were established. By the end of *Repelita V* (1989-1994) there were 6,227 *puskesmas* and 17,116 *puskesmas pembantu* throughout the country although the staffing, quality of care and utilization levels vary widely, each *puskesmas* has at least one physician and one midwife, with a service area covering approximately 30,000 persons, while a subcenter usually serves a total of 11,000/12,000 persons.²⁴



A focus on mother-and-child health

During the same time period (*Repelita V*), a program of active deployment of midwives in every village (*bidan di desa*) was started in efforts to reduce maternal mortality. By 1995/96, the Ministry of Health had deployed 46,590 village midwives or 86% of the overall target villages (54,120).²⁵ Out of 27 provinces, twelve provinces have had 100 percent of their villages served by the placement of a *bidan di desa*.²⁶ It is hoped that village midwives can successfully compete with traditional birth attendants (TBAs) and provide safe delivery services in the communities.

This rapid expansion of health care facilities and services has resulted in the rapid decline of infant mortality rates (IMR). During a fifteen-year period (1979-1994), infant mortality declined 24 percent from 75 to 57 deaths per 1,000 live births, and it is expected that the goal of 45 per 1,000 live births by the year 2000 will be met. In the

same period, post-neonatal mortality, child mortality, and under-five mortality declined at an even faster rate (30 percent, 31 percent, and 26 percent respectively).²⁷ On the other hand, these interventions to improve access to maternal health services have not succeeded in curbing the high maternal mortality rate. While exact maternal mortality figures for Indonesia are not readily available, the 1994 Indonesian Demographic and Health Survey presented a direct estimate of 390 maternal deaths per 100,000 live births for the time period of 1989-94, a slight increase from the 360 per 100,000 live births reported for the period 1984-88.²⁸ However, applying a weighted regression procedure to the 1994 IDHS data, this estimate increases to 647 per 100,000 live births.²⁹ These fi-

gures are relatively high when compared to neighboring countries. Maternal mortality in Indonesia is at least fifteen times as high as Malaysia (26 per 100,000 live births), more than ten times that of Thailand (37 per 100,000 live births), and around five times that of the Philippines (74 per 100,000 live births).³⁰

Within Indonesia maternal mortality varies widely. For Bali estimates range from 718 to 2,30 maternal deaths per 100,000 live births in 1985/86.³¹ In Java, for 1989 reported rates per 100,000 live births vary from 490 in West Java and 340 in Central Java to as low as 130 in Yogyakarta. Meanwhile in East Nusa Tenggara, maternal mortality has been reported horrifically high, at 1,340 per 100,000 live births.³² These figures reflect

Maternal mortality – a real problem



an enormous range of socioeconomic conditions. For example, Yogyakarta is well-known as the province with the highest contraceptive prevalence rate, high education level, longer years of schooling on average, and greater access to both information and health services, all factors that contribute to a low maternal mortality rate.

Notwithstanding regional diversity, underlying causes of maternal mortality in Indonesia can be broadly divided into three main areas: the general health of women and their state of readiness for pregnancy; accessibility and quality of antenatal and delivery care; and actual clinical causes.³³ More particularly, at the individual level, woman's age, parity, nutrition, family planning practice and obstetric history are associated with maternal health and morbidity. In this context it should be noted that the Indonesian family planning program strongly discourages 'risky' pregnancy, defined as before the age of 20 and above 35 years. Married couples are also encouraged to limit the number of children they have to two. These efforts have been successful in promoting contraceptive use across the country, thus reducing the risk of maternal mortality by reducing the number of pregnancies. Nowadays, 55 percent of married women use contraception, composed of 52 percent modern methods (mostly the pill, injectables and the IUD), and 3 percent traditional methods.³⁴

Still, the 1994 IDHS data show that younger and older women, whose pregnancies are more likely to be 'high-risk', are less

inclined to use contraception than women in the mid-childbearing ages. Between 10 and 20 percent of pregnancies occur among women below 20 years of age, especially in the rural areas, due to early marriage and lack of reproductive health³⁵ information and services. Quality of care and better information are also necessary to support the correct and effective use of family planning methods. Furthermore, policy and programs need to involve men. Despite nationwide contraceptive availability for married couples, prevail-

Unmet needs resulting in teenage pregnancy



ing traditional male dominance in the household has made it difficult for women of reproductive age to prevent unintended pregnancy and/or protect themselves against sexually transmitted diseases. On their side, men's use of male contraceptive methods is very low, with condom use accounting for only 0.9 percent and male sterilization for 0.7 percent of family planning coverage in 1994.³⁶

Another important factor lowering the general health status and resilience of pregnant women is nutrition. Food intake of women before and during pregnancy and lactation have been found to be inadequate in term of energy and micro-nutrients. Iron deficiency anemia, which affects a majority of pregnant Indonesian women, aggravates maternal depletion during pregnancy and increase the risk of death in case of hemorrhage.³⁷ According to the 1986 National Health Survey, 75 percent of pregnant mothers in Indonesia were anemic, which was higher than in other ASEAN countries such as Singapore, Malaysia, Thailand, and Philippines. Almost ten years later, the 1995 Household Health Survey found that 55 percent of pregnant women were still suffering from anemia.³⁸

Shifting the focus to service delivery, it is important to note that while antenatal care is available at all levels of the health care system, the overall national coverage is still below 50 percent. Currently almost 60% of deliveries are assisted by *dukun bayi* (TBAs), both trained and untrained, who usually do

not provide antenatal care or carry out screening for health risks. Moreover, screening of high risk cases is still inadequate at modern facilities. Each *puskesmas* is generally equipped to manage normal pregnancies and to treat only minor deliver complications. Most cases of abnormal labor or serious complications have to be referred to the district hospital, either directly by the village midwives, or from the *puskesmas*. Various studies have shown that weakness in the referral system are one of the most important contributing factor to maternal mortality. Cost and transportation also seem to contribute to this delay in referral.³⁹

A closer analysis of the principal clinical causes of maternal mortality reveals that 75 to 85 percent of maternal deaths in Indonesia involve hemorrhage, the most common direct cause, followed by infection, and hypertensive disorders of pregnancy (pre-eclampsia and eclampsia).⁴⁰ Pre-eclampsia usually occurs in the second or third trimes-

Pre-eclampsia, a dangerous obstetric complication





Family planning: a persistent need

ter of pregnancy, and if not properly treated could lead to eclampsia. Fortney's study in Bali (1985) showed that 67 percent of maternal deaths were related to excessive bleeding before, during or after delivery—an indication that delivery management and prompt emergency action at the referral level are absolute necessities. Most postpartum hemorrhage cases were caused by retained placenta, defined as a placenta or placental part that is not delivered within two hours after delivery. Other clinical causes include prolonged labor, obstructed labor, sometimes complicated with a ruptured uterus, cervical or vaginal laceration, and placenta previa.⁴¹

The high occurrence of infection is closely related to unsafe abortion. Abortion is illegal in Indonesia. The Health Law No.23/1992 only including a paragraph that states that 'in case of emergency, and with the purpose of saving the life of a pregnant woman or her fetus, it is permissible to carry out certain medical procedures.'⁴² Still, clandestine abortion is widespread, and experienced by many women who find themselves with unwanted pregnancies. Although there are no comprehensive community or hospital based data available, the ratio of abortion in 1989 was estimated between 16.7 and 22.2 abortions per 100 live births.⁴³ Taking

these figures into account, members of the medical profession persistently seek a compassionate policy to reduce the number of unsafe abortions carried out by traditional practitioners and paramedical personnel. They also emphasize the need for effective use of contraceptives to prevent unintended pregnancies and thus reduce obstetric deaths.⁴⁴

From the above it appears that maternal mortality is a complex problem, involving not only technical, but also social, political, educational and economic factors. Clearly these cannot all be adequately addressed with interventions from the Ministry of Health alone. The situation demands a multisectoral, holistic approach. As we will see in the next chapter, the Ministry for the Role of Women has taken a leading role in this direction.

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CHAPTER 2

THE MOTHER FRIENDLY MOVEMENT: FROM POLICY TO ACTION

A NEW PARTNERSHIP APPROACH

Political commitment to reduce the burden of reproductive morbidity among women, and especially maternal mortality, has been repeatedly expressed by the Indonesian government. In June 1988, the Presi-

dent announced the Safe Motherhood Initiative (SMI) which called for all sectors to promote a 50 percent reduction in maternal mortality from a rate of 450 per 100,000 live births, by the end of *Repelita VI* (1994-1998). This movement recognized the importance of community participation through a strategy called 'the 60 - 60 - 60% strategy' in reference to the set targets. In particular,

Safe Motherhood: a long-term commitment





Tetanus toxoid immunization

the aim was that at the end of the intervention period, 60 percent of district health centers would be able to provide basic essential obstetric care; 60 percent of birth deliveries would be attended by trained health personnel; and 60 percent of high-risk cases would receive appropriate care at referral facilities.

The Indonesian pledge to reduce maternal mortality was also publicly stated in various international fora. In 1990, President Soeharto attended the World Summit for Children in New York, where 159 countries agreed to halve maternal mortality rates by the year 2000, and to make family planning information and services available to all those who needed them.¹ Motivated by this commitment, the National Family Planning Coordinating Board (BKKBN) joined in the support of the Safe Motherhood Initiative. In 1991, the BKKBN mobilized the 'Healthy

and Prosperous Mother Campaign' or '*Kampanye Ibu Sehat Sejahtera (KISS)*', which was upgraded to a community-based national movement called the 'Healthy and Prosperous Mother Movement' or '*Gerakan Ibu Sehat Sejahtera (GISS)*' in the following year. More recently, the program has been redefined as 'Family Health and Welfare Movement' or '*Gerakan Keluarga Sehat Sejahtera*'.² The undertaken activities range widely, including: improvement of households' socio-economic status, mobilization of community participation in promoting nutrition, antenatal care, and tetanus toxoid immunization for pregnant women, as well as provision of appropriate delivery care by trained village midwives.

These concerted efforts greatly improved the quality of antenatal services and raised community awareness of 'high-risk' crite-

ria for pregnant women, which include: age below 20 or over 35 years; having already delivered four or more children; pregnancy interval less than two years; mother's height of 140 centimeters or less; pre-pregnancy weight of less than 40 kilograms; paleness, edema and pregnancy-induced hypertension. However, despite people's increased knowledge, trends still suggested that the goal of reducing maternal mortality to 225 per 100,000 by 1998 was out of reach, and that poor maternal health persisted in Indonesia.

In 1996, a very concerned President Soeharto reminded the population that 'without acceleration of maternal mortality reduction, our progress is not complete; and without women's development, efforts to improve the quality of human resources in Indonesia will be imperfect.' National authorities and health specialists felt that the conceptual framework within which participating organizations were functioning needed to be restructured. A national workshop on 'Acceleration of Maternal Mortality Reduc-

A concerned and involved President Soeharto



tion' held by the Ministry for the Role of Women in June, 1996, concluded that efforts to enhance women's health, especially prevention of maternal mortality and reduction of women's reproductive health burden, needed to address women's poor reproductive rights and gender inequalities which put women at disadvantage, as well as continuing to improve access to appropriate health services.³

In response to these recommendations, the President officially launched the Mother Friendly Movement or *Gerakan Sayang Ibu* (GSI), during the National Mother's Day celebration on December 22, 1996. GSI is defined as 'a movement implemented by the community in collaboration with the government for the advancement and betterment of women's quality of life, especially in accelerating maternal mortality reduction, for the sake of human resources development.

In recognition of the important role of women's empowerment in maternal health, the leadership of this new national movement has been entrusted to the State Ministry for the Role of Women, under a mandate for collaboration with the Ministry of Health, the National Family Planning Coordinating Board, and the Ministry of Home Affairs. At each administrative level, the movement also promotes involvement of the Ministries of Religion, Information, Education, Transportation, and Agriculture. After all, maternal health means more than bio-medical intervention and—as we have seen in the previous chapter—it is affected by the community economic circumstances, dominant social and gender relations, and the traditional and legal structures within which women live. At the same time, the movement encourages the involvement of local NGOs to maintain reproductive health and manage

Launching the Mother Friendly Movement





The Mother Friendly Movement's destiny carved in stone

problems when they arise. In particular, the Family Welfare Movement or PKK, a community-based women's organization, is seen as a key collaborator for promoting messages about women's sexual and reproductive health and right, and for supporting specific interventions to overcome causes of maternal morbidity and mortality.

The key feature of this multi-sectoral approach is to empower the individual woman, her family and the community so that they can participate fully in the acceleration of maternal mortality reduction. Upholding the principles of the 1994 International Conference on Population and Deve-

lopment (ICPD), the Ministry for the Role of Women has made an unprecedented move towards a people centered approach, which recognizes reproductive health as a pre-requisite for sustainable development. Broadening the scope of previous policies, the Mother Friendly Movement combines mobilization of various resources on the supply side with steps to foster greater community demand for improved reproductive health care. GSI uses strategies both to move services closer to women and to move women closer to the services. Working on the interlinks between gender, reproductive health and human development, the Ministry for the Role of Women aims to accelerate the decline of maternal mortality in Indonesia by promoting six complementary foundations, namely:

- harmonious gender partnerships;
- empowerment of women, pregnant women, families, and communities;
- a quality family planning program;
- accessible basic maternity care;
- community-based pregnancy enumeration and referral system;
- available and accessible essential obstetric care.⁴

This new approach to reduce maternal mortality is in line with other policies in the Sixth five-year Development Plan (*Repelita VI*), which are directed toward greater community participation, improved quality of human resources, poverty alleviation, national stability and sustainable gender-based development. These broad national ideals have

been incorporated in a comprehensive plan of action, and subsequently operationalized at the district and subdistrict levels in a multi-sectoral effort to transform the Mother Friendly Movement from theory into action.

THE IMPLEMENTATION OF THE MOTHER FRIENDLY MOVEMENT

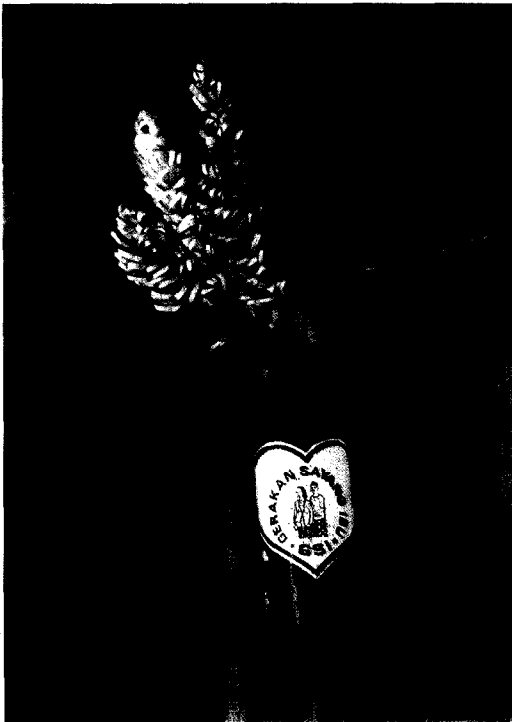
The implementation of the Mother Friendly Movement requires multi-pronged efforts by dedicated and competent people from different disciplines. Skilled trainers, effective communicators, sensible operations researchers, efficient program managers and

supportive political leaders are absolutely necessary, in addition to supplies, equipment, facilities, and financial resources. To enhance effectiveness and assure coordination of activities, funds and manpower, the intervention strategy has been carefully designed and directed to meet five basic principles, which are:

- cross-sectoral and multi-disciplinary approach;
- integrative and synergistic intervention;
- male participation and responsibility;
- continuous monitoring system;
- effective coordination by local and regional government.⁵

Taking these principles into account a complex organizational structure has been established. At the central level the Mother Friendly Movement Technical Assistance Team (*Tim Asistensi GSI*) coordinates the national planning, implementation, monitoring and evaluation activities. The Technical Assistance Team consists of fourteen representatives from the following sectors: health, family planning, office of statistics, public hospitals, community development, religion, social affairs, education and culture, public works (*Cipta Karya*), livestock, agriculture, and fisheries. At the province and district level, the Mother Friendly Movement Working Groups (*Kelompok Kerja Tetap GSI*) follows-up the implementation of the plan of action. Finally, at subdistrict and village levels the Mother Friendly Movement Task Force (*Satuan Tugas GSI*) is responsible for implementing the planned activities.⁶

Promoting the Mother Friendly Movement

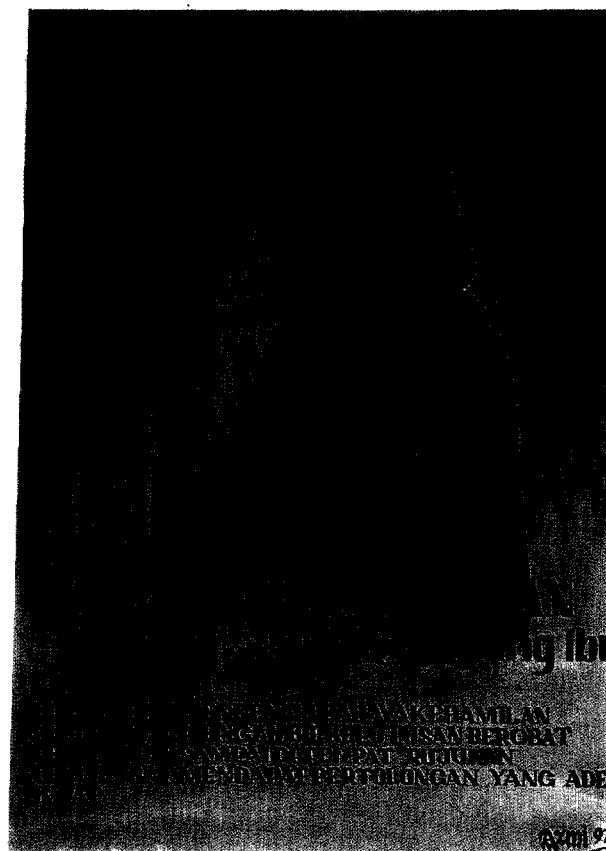


The Ministry for the Role of Women believes that the strategies to implement the GSI concept must accommodate the fact that each province is unique, so that responses in each location will reflect to different socio-cultural and economic conditions. Therefore in addition to collaborations at the national level, the new GSI program has been designed specifically to include a re-emphasis of local intersectoral commitment and to increase the role of District and Provincial Governments, under the Ministry of Home Affairs. Specifically, the *Bupati* as the head of the District Government, the assistant to the *Bupati*, or *Sekwilda*, and the District Planning Board, or *Bappeda* are closely involved in the formulation, monitoring and implementation of the plan of action at the district and subdistrict levels.

In line with national directives, at lower administrative levels, the Mother Friendly Movement framework is operationalized and contextualized by applying the awareness that 'delay can kill'.⁷ The concept of 'delay' as both an analytical and operational tool has been divided into three phases:

- first delay : delay in the decision to seek care;
- second delay : delay in arrival at a care facility;
- third delay : delay in receiving adequate care upon arrival at the facility.

Any one of these three delays can result in maternal death, but at each phase is caused by different contributing factors and there-



The delays that kill

fore has different implications for intervention. Factors that contribute to the first delay are: low economic status of the family; low educational status of the family; low value placed on women's lives; traditional belief systems; and inability to promptly recognize the 'danger signs'. Factors that contribute to the second delay are: the distance from the primary health center; lack of proper transport; poor roads; and the high cost of transport options. Factors that contribute to the third delay are: lack of emergency obstetric care facilities and skilled staff. To address these different kinds of contributing factors and prevent the 'three delays', different kinds of activities have to be undertaken

Specifically, six categories of interventions have been devised. Each district has

been encouraged to undertake synergistic efforts to achieve all of the following:

- To mobilize the local district, subdistrict, village officials (under the Ministry for Home Affairs) and informal community leaders to take the responsibility for developing, monitoring and supervising data collection on the number of pregnant mothers, percentages of high-risk cases, number of referrals made, and the final pregnancy outcomes of women, as part of their development planning responsibilities.
- To empower pregnant women and their families, by informing the community of the criteria for 'high-risk' pregnancy and the availability of referral services, and by mobilizing community financial and transportation resources for the movement.
- To increase access to training and additional guidance for local officials, infor-

mal leaders, family welfare volunteers (PKK *kader*), and village midwives, about the development of community interventions to address 'the three delays', and raise their awareness of the criteria used to identify a 'high-risk' pregnancy.

- To improve registration of pregnancy, birth and postpartum outcomes by generating data through the *dasa wisma* mechanism. *Dasa wisma* is a community-based reporting system, where 10-20 households are monitored by one PKK *kader*. Numerical data are gathered on the number of pregnant mothers, percentages calculated on high-risk cases, complete with notes on dates of expected labor, plans for transportation to the referral site, and pregnancy outcomes.
- To address the importance of having written protocols defining a standard level of services and performance, since quality of care will affect access and utilization of Maternal and Child Health (MCH), and Emergency Obstetric Care (EOC) services.
- To enhance the effectiveness of referrals and improve linkages between different levels of the health system by obtaining community support, resources and participation.⁸

Helping the community identify danger signs



In the implementation of the movement, two essential units must be developed: the Mother Friendly Sub-Districts (*Kecamatan Sayang Ibu*) which are districts where pregnant women are well monitored, and the



A Mother Friendly Hospital

Mother Friendly Hospitals (*Rumah Sakit Sayang Ibu*) where appropriate obstetric care is available. To be defined as a Mother Friendly Hospital, the facility must fulfill ten criterias of quality improvement essential to overcome 'the third delay', which include:

- developing a written hospital policy on the management of emergency obstetric care;
- expanding the capacity to deliver essential and comprehensive obstetric care;
- delivering adequate care for antepartum morbidity;
- delivering adequate safe birth services;
- delivering adequate care for post-partum morbidity;
- delivering adequate family planning services;
- delivering adequate health education to mothers;
- playing a leading role in the existing referral system;
- implementing routine maternal and perinatal audits;
- improving the quality of care and utilization of hospital services by the community.⁹



Post-partum care

Being aware of the complexity of initiating such a wide range of interventions, implementation prior to the implementation of the Mother Friendly Movement nationwide, the Ministry for the Role of Women decided to undertake a pilot project in eight provinces starting in June 1996 to try-out specific activities, assess their impact and identify any challenges in replicating them on a broader scale throughout Indonesia.¹⁰

THE MOTHER FRIENDLY DISTRICTS

The pilot project covered eight of Indonesia's 27 provinces: three on the island of Java (West Java, Central Java and East Java); another three on the island of Sumatra (North Sumatra, South Sumatra and Lampung); plus South Sulawesi, and West

Nusa Tenggara. These provinces were chosen because together they account for 70 percent of all maternal deaths in Indonesia. Within each of these provinces, one district (*kabupaten*) was selected to become a Mother Friendly District, namely: Karawang in West Java, Pemalang in Central Java, Malang in East Java, Deli Serdang in North Sumatra, Ogan Komering Ulu in South Sumatra, Central Lampung in Lampung, Bone in South Sulawesi, and Central Lombok in West Nusa Tenggara. These districts were chosen based on a combination of factors: they covered sufficiently large populations, they had adequate existing health care infrastructure and village level –midwives serving at least 50% of villages– and they accounted for a significant propor-

tion of the reported maternal deaths in each province

The eight Mother Friendly Districts are all categorized as rural but vary widely in area and population size. The smallest district is Pemalang in Central Java which has an area of approximately 1,115 square kilometers, while the largest is Ogan Komering Ulu in South Sumatra covering 13,684 square kilometers. Interestingly Ogan Komering Ulu has the lowest population density with 80 persons per square kilometer,¹¹ while the highest densities are in the three Javanese districts, of which Pemalang has the highest with 1,074 inhabitants per square kilometer. More generally –as can be seen in the table below– population size varies greatly from about 600 thousands people in Bone to over 2 million in Malang.

The eight provinces where Mother Friendly Movement Districts are located

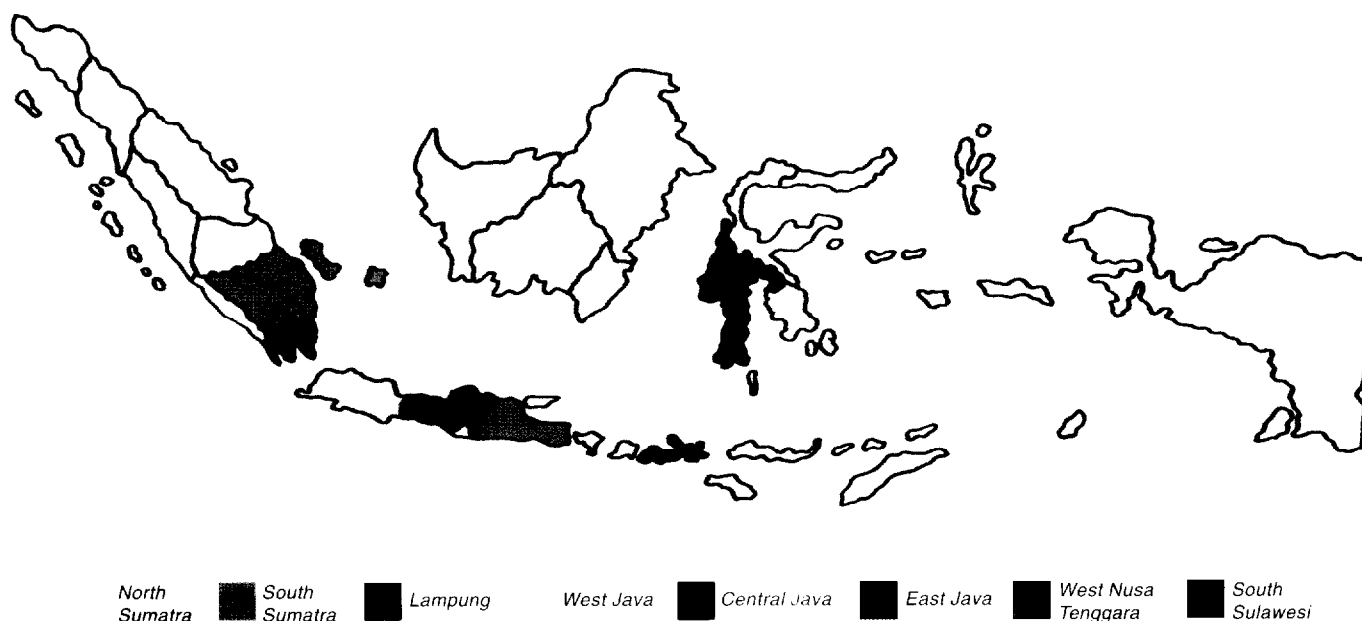


TABLE 2.1: GEOGRAPHIC AND DEMOGRAPHIC PROFILES

Districts	Province	Area (km ²)	Population	Density (/km ²)
Karawang	West Java	1,753	1,600,516	913
Pemalang	Central Java	1,115	1,197,754	1,074
Malang	East Java	3,348	2,321,965	694
Deli Serdang	North Sumatra	4,397	1,755,499	399
Ogan Komering Ulu	South Sumatra	13,684	1,104,000	80
Central Lampung	Lampung	9,212	1,917,225	208
Bone	South Sulawesi	4,556	623,550	137
Central Lombok	West Nusa Tenggara	1,208	730,714	605

The districts are also very diverse in administrative terms since the number of subdistricts (*kecamatan*) they encompass varies from only nine in Central Lombok, up to 35 in Malang. Central Lombok has also by far the fewest number of villages or *desa*

(111) while the district of Deli

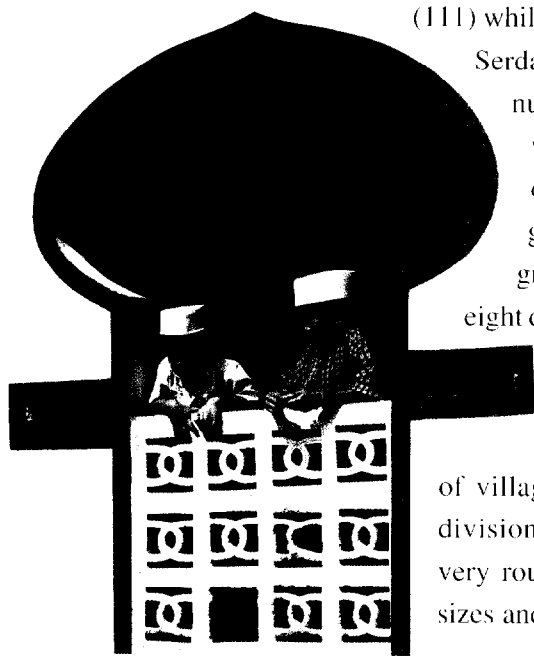
Serdang has the highest number (637 *desa*). If

we compare these data to the geographic and demographic profiles of the eight districts—as summarized in table

2.1—it is apparent that the number

of villages and subdistrict divisions correspond only very roughly to population sizes and densities.

The majority of people in all of the selected districts practice Islam, but religious minorities can still be found in every district. For example in Deli Serdang and Malang, there are sizable Christian populations while in Central Lombok, Hindus form a significant group. Ethnic diversity is even greater. The Mother Friendly Districts are inhabited by different ethnic groups with their own unique traditions and culture. People living in Karawang, West Java, belong to the Sundanese ethnic group; those who live in Pemalang in Central Java belong to the Javanese ethnic group; and those in Malang, East Java are a mixture of Eastern Javanese, Madurese and Balinese. People in Deli Serdang are known as Batak Karo; while those in Ogan Komering Ulu are part of the Komering group. A majority of people in Central Lampung derive their identity from the Javanese tradition since they have



Young Muslims

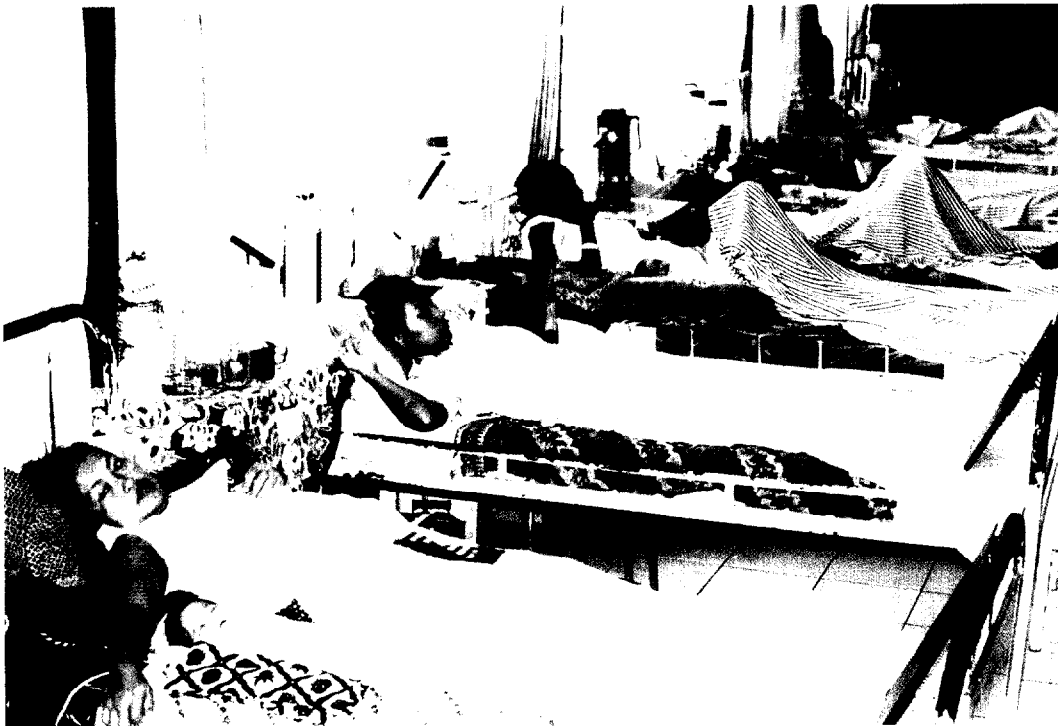
migrated from Java to Sumatra about thirty years ago. The Bone population are known as Bugis, a well-known seafaring ethnic group, and most people in Central Lombok belong to the Sasak ethnic group.

Shifting the focus to socio-economic characteristics, it is important to know that based on the 1995 Intercensal Survey data, Central Lombok has the lowest literacy level among the eight districts, at only 84 percent, while Deli Serdang has the highest, reaching 97 percent. The remaining districts have similar educational levels, ranging from 89 to 95 percent.¹² These figures reflect the district economic situation, where Central Lombok and Pemalang show the lowest per capita Gross Regional Domestic Product

(GRDP) of Rp. 949,090 and Rp. 886,695 (or US\$380 and US\$355) respectively,¹³ while Deli Serdang and Karawang show the highest GRDP among the eight Mother Friendly Districts (Rp. 1,681,717 and Rp. 1,865,956 respectively).¹⁴ People's spending for health is certainly lower in the poorer districts. Furthermore, infrastructure improvements, such as new roads in rural areas or bridges for isolated areas, are common, which creates transportation problems for mothers who need emergency surgical/obstetric care at the district hospital.

With regard to existing health infrastructures, districts on Java and Sumatra have a better distribution of facilities. The three districts in Java and the three in Sumatra all

Maternity ward in a Mother Friendly Hospital



have access to three or more public and private hospitals, although only one public hospital is appointed as a Mother Friendly Hospital in each. Malang, which has the highest population, has eight hospitals, plus one public mental hospital. Deli Serdang, because



Birth delivery facility in Malang

of its proximity to the North Sumatra provincial capital, Medan (a one hour drive), has access to the highest number of hospitals, of which some are located in the border area with Medan. Malang and Deli Serdang also have the highest number of private and semi-private clinics, indicating a greater role of the private sector in delivering health care services as well as higher purchasing capacity of patients. Outside Java and Sumatra, on the other hand, health facilities are relatively scarce. Central Lombok, with the second lowest population and area, has only one public district hospital in Praya, while Bone has only two hospitals, one public and one private.

The number of *puskesmas* –whether full service, sub-facilities or mobile– varies in relation to the population served, but in general it can be said that districts in Java and Sumatra are relatively better equipped. Central Lampung has the highest number of community health centers to serve its large population. Deli Serdang is notable again for having the second highest number of *puskesmas* and the second highest number of sub-centers (*puskesmas pembantu*). Malang, despite having the largest population, comes third in health centers, probably also due to the high concentration of hospitals in the area. Again, Central Lombok is notable for having the fewest health centers.

While Central Lombok fares poorly in terms of its number of hospitals, health centers and private clinics, it has the highest number of *rumah bersalin* or registered maternity clinics to serve its small population. This is because of the severity of Central Lombok's maternal health problem, which

A community health center in Lampung



accounts for one of the highest maternal mortality rates in the country. A large number of *rumah bersalin*, headed by an obstetrician-gynecologist, a general practitioner or a midwife, can also be found in Deli Serdang and Malang. Bone, with the smallest population, has no registered maternity clinics.

In addition to these maternity clinics, which are clustered around the district urban areas, there are also rural maternity posts, known as '*polindes*' (headed mostly by newly graduated midwives), and integrated

mother and child care service posts or *posyandu*. Their number do not correspond directly to the total numbers of *puskesmas*, which support and supervise the monthly activities, but they correspond well with the populations of the districts. Once more the three most populated districts, Deli Serdang, Malang and Central Lampung, rank highest, while Central Lombok and Bone have the fewest *posyandu* and relatively few *polindes*. More detailed information on the health care infrastructure in the eight districts can be read in the table below:

TABLE 2.2: HEALTH CARE INFRASTRUCTURES

Districts (Provinces)	Hospitals	Primary Health Centers (1)	Maternity Clinics (2)	Village Maternity Posts (3)	Mobile MCH Posts (4)	Village Medicine Posts (5)
Karawang (West Java)	1 public 4 private	38 full 77 sub 25 mobile	8	32	1,730	0
Pemalang (Central Java)	3 public 45 sub	32 full	4	131	1,137	176
Malang (East Java)	4 public 5 private	41 full 95 sub	19	234	2,886	97
Deli Serdang (North Sumatra)	3 public 6 private	47 full 160 sub	41	406	2,647	406
Ogan Komering Ulu (South Sumatra)	4 public	37 full 29 mobile	9	226	1,601	0
Central Lampung (Lampung)	1 public 3 private	60 full 185 sub 45 mobile	5	275	2,702	81
Bone (South Sulawesi)	1 public 1 private	33 full 68 sub	0	133	817	33
Central Lombok (West Nusa Tenggara)	1 public	19 full 57 sub	63	48	942	0

(1) Puskesmas, Puskesmas pembantu, and Puskesmas keliling. (2) Rumah bersalin. (3) Polindes. (4) Posyandu; (5) Pos obat desa



Sanrio: a male TBA in Bone

The proportions of health care providers per population also vary greatly among the districts. Ogan Komering Ulu has the best ratio of general practitioners serving in public facilities at one to approximately 15,000 people while that is almost halved in Deli Serdang where there is only one doctor for every 30,000 people. It is surprising that Deli Serdang comes last in this ranking since it has the most hospitals and the second highest numbers of health centers, sub-centers,

clinics and maternity clinics. Each district also has a number of specialist doctors working in public facilities, ranging from only two in Central Lombok to 25 in Karawang.

Grouping together nurses, midwives, and village-based midwives, again Ogan Komering Ulu has the best ratio per population: one to almost every 1000 people, while Central Lombok fares poorly with only one per 8,200 people. Deli Serdang, which had a very low proportion of doctors, has a high

proportion of nurses to make up for it. Besides doctors and nurses, there are also traditional birth attendants (TBAs), both trained and untrained. The number of trained TBAs seems to inversely correspond to the number of biomedical personnel. Central Lombok has the highest proportion, one for every 500 people, while Ogan Komering Ulu has very few trained TBAs, with only one for every 6,000 people. Meanwhile, the latter district has a relatively high proportion of untrained TBAs: one for every 1,000 people. In every Mother Friendly District, except in Ogan Komering Ulu, there are also many *kaders* per village who carry out outreach activities for preventive and promotive health care.

Furthermore they can play a crucial role in raising people awareness and mobilizing the community in an effort to address the many underlying causes of maternal mortality. Their joint effort is essential to overcoming the key problem-areas which were identified as demanding improvement within the eight Mother Friendly Districts.

A CHALLENGING TASK

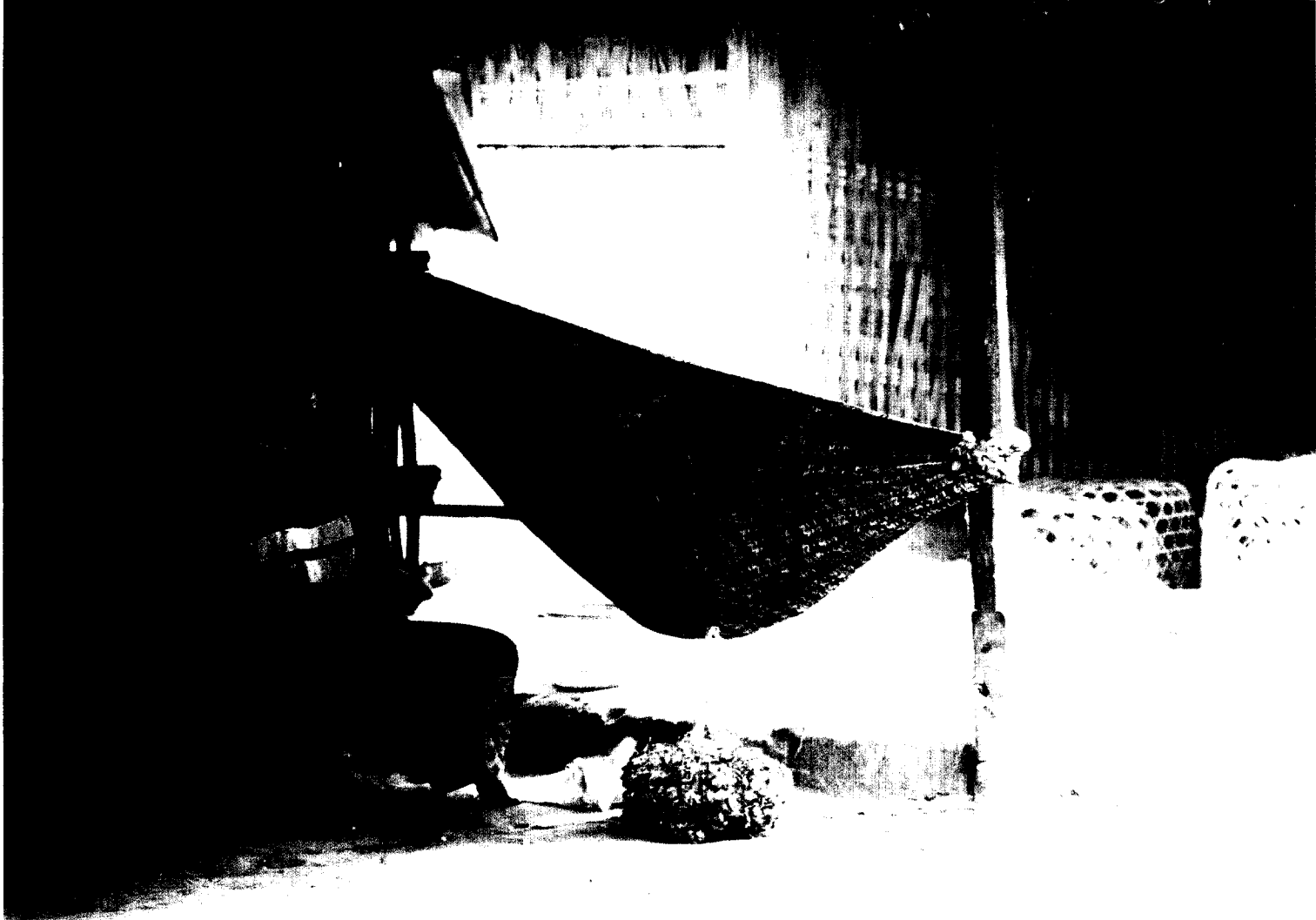
Notwithstanding inter-district variations, before the implementation of the Mother Friendly Program, all districts shared five main problem areas, namely the infrequent involvement of district officials; families'

TABLE 2.3: RATIOS OF HEALTH CARE PROVIDERS TO POPULATION

Districts	General Practitioners	Nurses/ midwives	Trained TBAs	Untrained TBAs	Health/PKK <i>kaders</i>
Karawang	1:18,839	1:5,557	1:1,949	1: 12,804	1:233
Pemalang	1:26,617	1:1,951	1:1,340	1: 11,300	1:270
Malang	1:22,990	1:4,483	1:1,849	1: 13,988	1:140
Deli Serdang	1:29,754	1:1,299	1:2,304	1:219,437	1:146
Ogan Komering Ulu	1:15,333	1:969	1:6,651	1:953	1:3,418
Central Lampung	1:24,899	1:1,761	1:1,454	1:11,690	1:137
Bone	1:17,816	1:1,992	1:1,307	1:5,375	1:153
Central Lombok	1:19,749	1:8,210	1:467	1:6,038	1:130

These various levels of health personnel are directly involved in the provision of antenatal and obstetric care and when properly skilled and equipped can be of great help in reducing the burden of reproductive mor-

fatalistic perceptions of obstetric complications and maternal death (and the consequent low level of care-seeking behavior); a lack of systematic data collection on maternal mortality; a dangerously inadequate referral



The bearing of children: a natural role for women?

process; and a lack of written protocols for care of high-risk pregnant women or women with complications.

More particularly, heads of districts, sub-districts and villages did not pay careful attention to community awareness and efforts to reduce maternal mortality. Interactions with the health sector were at the level of courteous coordination, rather than effective problem-solving. In general, the causes of maternal mortality were perceived as purely medical problems by district heads, village heads, and other non-health sector representatives. They did not recognize delayed response and existing barriers to care seeking.

Similarly the community, including pregnant women and their relatives, were not sufficiently aware of the well-defined risk factors for maternal mortality and morbidity. This is not to say that community health education programs were never implemented in the area. In all selected districts, the Ministry of Health's on-going antenatal care program and BKKBN's 'Family Health and Welfare Movement' had disseminated information about 'high risk pregnancy'. Nevertheless, the vast majority of families still regarded the bearing of children as a natural role for women, not a life-threatening process. Obstetrics risks were therefore not

taken seriously. This perceived low danger of obstetric morbidities frequently led to delays in the decision-making process to seek medical attention. Only those who assessed the risk signs as serious sought care, and this was infrequent. The pregnant women themselves often said that they felt fine and that care was unnecessary. They also feared the financial consequences of a hospital delivery, since many do not have sufficient savings. Even after a decision was made to seek care at an appropriate medical facility, families were reluctant to go to a hospital. Besides economic obstacles, most villagers also experienced difficulties in finding transportation.

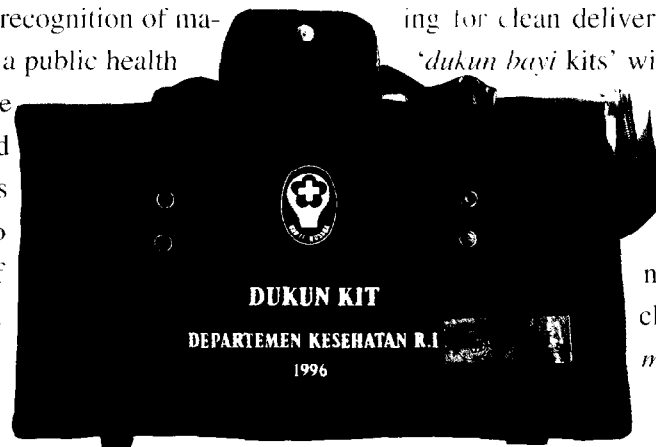
Community support was not directed toward overcoming these problems. On the contrary, people did not seem to 'believe' that safe motherhood could be accessible to every woman if proper treatment is not delayed. Their attitude was often fatalistic, claiming that maternal deaths are God's will. In some places, for example in Central Lombok, traditional norms even regarded maternal death as a form of highly valued holy death, which should not be questioned.

This lack of recognition of maternal deaths as a public health problem by the community and its leaders was closely related to the scarcity of information on how to identify

high-risk pregnancies, and insufficient data collection on where, when and under what circumstances women were dying. Full responsibility to record and report the number of pregnant mothers, cases with high-risks, and dates of expected labor was placed on the health care providers, not in the hands of community members themselves. The information collected was often incomplete and could not be utilized for district planning purposes.

Notwithstanding their limitations, these available data clearly showed that: most women still gave birth at home; village midwives were not fully aware that even a low risk pregnancy can develop sudden life-threatening complications during labor and post-partum; and, their clinical skills needed to be strengthened to improve their job performance. In all eight pilot districts, TBAs provided home birth delivery, post-partum and newborn care for the majority of women. In recognition of the important role TBAs fulfill in providing emotional, ritual and obstetric care, over the past two decades the government has attempted to enhance their skills by providing basic training for clean delivery and distributing

'*dukun bayi kits*' with obstetric equipment. While these efforts have enlightened *dukun bayi* about the need to refer their clients to the *puskesmas* for additional



TBA kit: enhancing competency

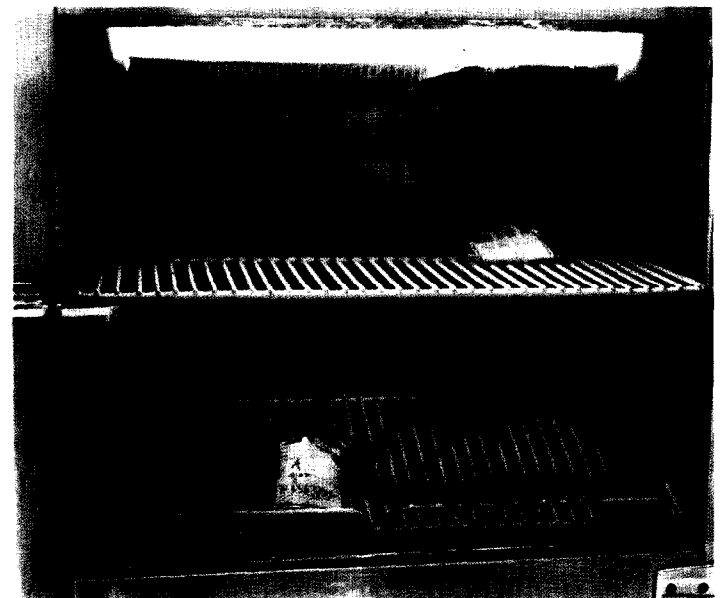
maternal and child health care, such as, immunizations, they have not been very effective in changing TBAs' unhygienic practices. Before the Mother Friendly Movement began, in the selected districts the kits were generally just displayed and most of the *dukun bayi*, both trained and untrained, did not fully realize that unhygienic delivery practices – such as inadequate hand washing and an unclean surface for the mother to lie on – could cause infection. Or, that if the placenta was not appropriately managed, retained pieces could cause postpartum bleeding. Even if they delivered their assistance compassionately, TBAs were poorly equipped to recognize the danger signs of complications and promptly respond to obstetric emergencies. Consequently very few cases were referred by village TBAs for comprehensive emergency obstetric care at the district hospital.

More generally, the referral system was not functioning properly. Although each district health office was supposed to strengthen referral networks, there was no community-based program to facilitate prompt identification of pregnant women in need of emergency referral services. Both village heads and district health officials admitted that the hesitancy to refer women to the district hospitals for emergency care had caused a large proportion of maternal deaths in the past. There was a long 'second delay', between making the decision to refer until the time of arrival at the referral facility. Referral linkages with district hospitals could be des-

cribed as 'poor', and there was no community-based emergency transport system in place. Furthermore, referred women were rarely accompanied by TBAs or village midwives.

The probability of death further increased since the village midwives were not always prepared to provide essential obstetric care for obstetric complications. Treatment was often delayed even when there were trained health care personnel available because they were not sufficiently skilled or experienced to provide first aid in obstetric emergencies. This situation was exacerbated by the lack of written guidelines on the minimum standard medical steps to be performed by the health care providers when giving treatment to a woman with obstetric complications, either at village maternity posts, at PHCs, or at hospital emergency care units. Further-

Inadequate supply of safe blood – a critical issue



more, facilities and equipment were not always adequate and a need for an improved safe blood supply was evident.

To address these problems and overcome the 'three delays', three kinds of activities were implemented. As will be described in the next chapter, in the eight Mother Friendly

Districts synergistic efforts were made to :

- generate demand for safe motherhood among women, families and communities;
- improve access to trained village midwives and quality maternal health services;
- improve community and district linkages to enhance referrals and emergency care.

NOTES

- 1 UNICEF, *The State of The World's Children 1994*, (n.d): 11.
- 2 Kantor Meneg. Kependudukan/BKKBN, *Pedoman Gerakan Keluarga Sehat Sejahtera (GKSS)*, 1996: 2-3.
- 3 *With support by the Ford Foundation*.
- 4 State Ministry for the Role of Women, *Guideline for Implementing the Mother Friendly Movement (Pedoman Pelaksanaan Gerakan Sayang Ibu)*, 1996.
- 5 A. Cholil, Pointers of the welcoming speech delivered by the Assistant to the Minister of Women's Affairs (ASMEN-1 UPW) in the *Opening Ceremony of Safe Motherhood Asia'97*, 1997.
- 6 A. Cholil, *Menyongsong Diluncurkannya Gerakan Sayang Ibu Sebagai Gerakan Nasional (Approaching the Mother Friendly Movement as A National Movement)*, 1996: 2, 8-10.
- 7 S. Thaddeus and D. Maine, *Too Far To Walk: Maternal Mortality in Context*, 1990.
- 8 A. Cholil, *Menyongsong Diluncurkannya Gerakan Sayang Ibu Sebagai Gerakan Nasional (Approaching the Mother Friendly Movement as A National Movement)*, 1996: 2, 8-10.
- 9 A. Muslihuddin, *Rumah Sakit Sayang Ibu*, 1996: 48.
10. This pilot project was funded by the Government of Indonesia in collaboration with UNICEF. For the preparation phase funds were also granted by WHO and UNFPA.
- 11 This density rate is closest to the 1993 national average density of 99. CBS, NI-PCB, MOH, Macro International Inc., *Indonesia Demographic and Health Survey 1994*, 1995: 2, 73-74, table 5.2.2 p 76, 79-84, 104, 124-125, 210.
- 12 BPS, *Population of Indonesia: Results of the 1995 Intercensal Population Survey - Series S2*, 1996b: 204.
- 13 Based on rupiah foreign exchange rate of US\$1 to Rp. 2.500 in June 1997. As of January 7, 1998, the foreign exchange rate of US\$1 is Rp. 7,300.
- 14 Based on Central Bureau of Statistics' comparison of GRDP at 1995 current price and 1993 as the base-year for constant price. BPS, *Gross Regional Domestic Product of Regencies/Municipalities in Indonesia*, January 1997: 56-77.

CHAPTER 3

CREATING A GREATER DEMAND FOR SAFE MOTHERHOOD

IMPROVED CROSS-SECTORAL COORDINATION

The first set of the Mother Friendly Movement's interventions focuses on generating greater demand for safe motherhood in the community. The key to attaining this main objective lies in the creation of a sense of 'ownership', over the problem of high maternal mortality and the means to a proper solution, across all different sectors of society and leadership. This process begins with the recognition that the magnitude and significance of maternal death is not well understood among many of the non-health officials and local planners. In the interest of generating demand among women and their families for maternal services, it is important to provide accurate information to the district, subdistrict and village officials and involve them in every step of the program, since they play a crucial role in mobilizing the community.

During the pilot project, the *Bupatis* of Karawang, Pemasang and Ogan Komering Ulu appear to have been more demanding than other district heads in monitoring and

supervising the implementation of activities. These district heads regularly undertook field trips to promote the goals of the movement, sending a clear signal about the local government's commitment in addressing maternal mortality. They also required their subdistrict and village heads to commit to memory the latest data on pregnant women and pregnancy outcomes in their area. The *Bupati* of Karawang instructed all non-health officials to question the village heads as to the number of high-risk pregnant women and maternal deaths in their area each time they visited the villages. In due time, all village heads began to check the data provided by village midwives on the number of pregnant women and the proportion at high risk. Lessons learned indicate that the higher the involvement of the *Bupati*, the more motivated the staff and the greater the participation of the lower echelons in the Mother Friendly Movement.

To improve cross-sectoral collaboration it is also critical to eliminate the so-called 'sectoral ego', which compels each department to narrow-mindedly pursue only its specific concerns, without taking into account existing common purpose and poten-

tials for productive collaboration. The *Bupati* of Karawang proactively approached all officials from the health and non-health related sectors by visiting their offices and discussing with them how to reduce the embarrassingly high maternal mortality reported in the area. In this way, non-health officials became alert of the magnitude of obstetric complications and maternal deaths in their subdistricts. Similarly, in the district of Pematang, the district council (*Muspida*) regularly briefed non-health sector representatives on safe motherhood issues at its quarterly coordination meetings (*Rakorda*) which took place every three months. Furthermore, the Mother Friendly Assistance District Team periodically supervised the district area. With these kinds of approaches a broader awareness is fostered among those in charge at the district, subdistrict and village levels, which is an absolute prerequisite for sub-

sequent cross-sectoral efforts directed at overcoming the 'three delays'.

One clear example of such co-operative undertakings can be found in Bone where implementation of community efforts involves the collaboration of the District Military (*Koramil*), the District Branch Offices of the Ministry of Education and Culture and of the Ministry of Information, and the staff of the Office of Religious Affairs. These representatives work with the local *BKKBN* officials to organize safe motherhood lectures every three months targeted at informal community leaders. The district of Bone also takes advantage of its history to implement a socio-culturally oriented intervention. The descendants of the Bone royalty, who are highly respected and admired, have become willing role models in the Mother Friendly Movement and actively promote birth delivery by village midwives.

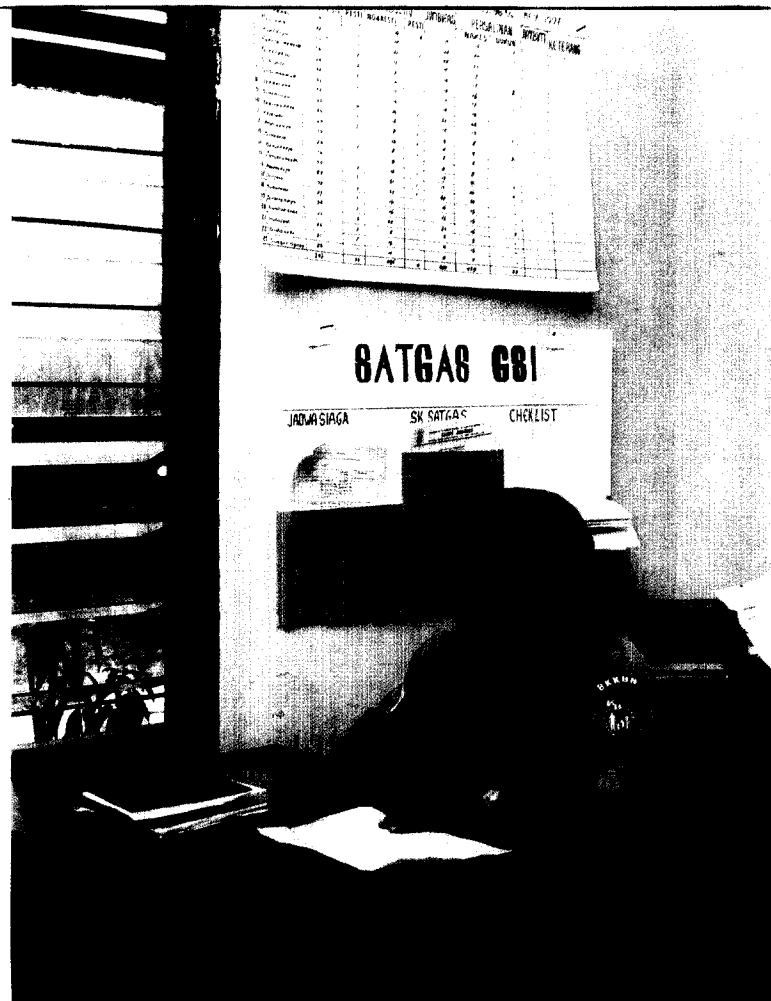
United by a common concern



This greater involvement of local informal leaders, government officials, and representatives of non-health sectors significantly improves the coordination and management of multifarious safe motherhood initiatives. In addition—as we shall see below—it positively affects the quality of statistical records on maternal health at the sub-district level.

THE CREATION OF A COMMUNITY-BASED REPORTING SYSTEM

Prior to the Mother Friendly Movement, little attention was paid to data on pregnancies and deliveries by local government agencies. Existing records on maternal deaths were often incomplete and inconsistent, with the result that the actual incidence of such tragic events remains anyone's guess. Such indifference is indicative of how little importance has been assigned to women's reproductive health. In trying to address these negative attitude and ignorance, the Mother Friendly Movement has promoted the establishment of a community-based reporting system to provide a clear, accurate and complete picture of maternal mortality during 1997 and 1998. More particularly, the system aims to count all ever-married women (or, where marriage is not well documented, all women older than 15 years), and calculate how many have died during pregnancy, childbirth, or puerperium, to derive



Recording data on pregnancies

the proportion of mothers who have died of maternal causes and use it as an indicator to estimate the probability of maternal mortality in the area.

The new community-based reporting system employs existing the organizational structure of the *dasa wisma*, in compliance with the same principle of self-reliance which is embodied the Indonesian primary health care system. The responsibility for reporting is no longer placed on the shoulders of the health care providers, but on the community members themselves. In particular, each PKK volunteer or *kader* is entrusted with the identification of all pregnant women living in a range of 10-20 households. Every house where a pregnant woman lives is



Traditional wooden bell to indicate high risk

identified with a tag, the design of which is adapted for acceptability in the local culture. In Karawang, Pematang, Malang, Bone and Deli Serdang, yellow stickers are displayed near the front door to indicate 'high risk' pregnancies and white stickers to indicate 'normal' pregnancies. Pematang reports that families with pregnant women prefer cards than the proposed flags, because yellow and white flags are perceived as bringing 'bad luck'. In Central Lampung, pregnancies are signified by hanging a traditional wooden bell (*kentongan*) on the porch. 'Normal' pregnancies are indicated by a green bell, 'risky' pregnancies by a yellow bell, and 'very high risk' pregnancies by a red bell. All these signal contribute to a broader effort to map out the locations and risk levels of pregnancies.

The monitoring of pregnant women is further enhanced by the use of standardized Mother Friendly 'Pregnancy Monitoring Cards' (*Kartu Monitor Ibu Hamil*) in some districts called 'Alert Cards' (*Kartu Waspada, or Sistem Kewaspadaan Ibu Hamil*). Karawang, Pematang, Malang, Bone, and Central Lombok have developed this device to assist midwives in monitoring pregnancies and outcomes. The cards record a woman's name, age, parity, expected delivery date, place of delivery, type of birth attendants, dates of antenatal care (1st to 4th visit), name of the village midwife in charge

Pregnancy Monitoring Card

GERAKAN SAYANG IBU PEMALANG IKHLAS

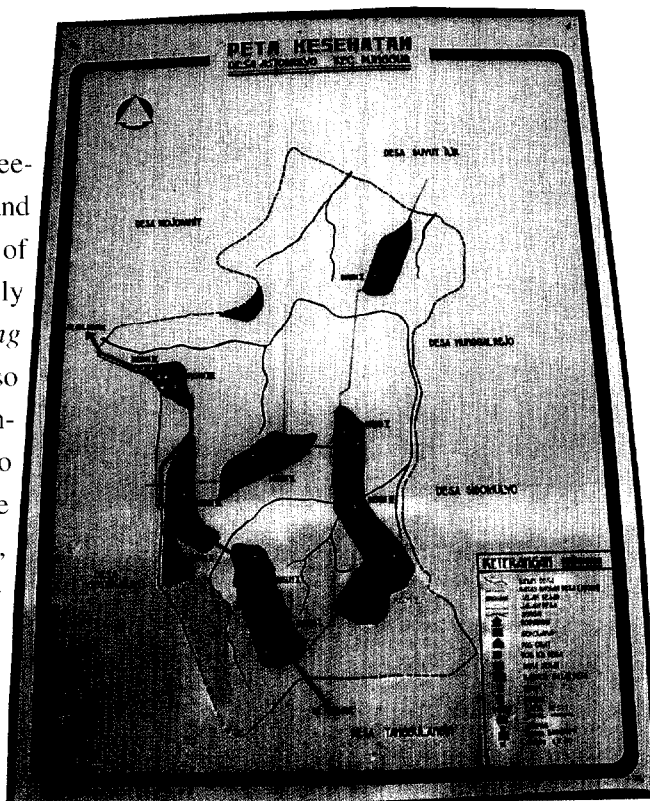


SISTEM KEWASPADAAN IBU HAMIL

Name ibu / suami : Umur : tahun
 Alamat : RT..... RW.....
 Desa / Kecamatan :
 Dasawisaha : Posyandu.....
 Puskesmas : Bidan :
 Hamil ini yang ke... Persalinan sudah..... kali Keguguran.....kali

of the area, husband's agreement for referral if needed, and the name of the coordinator of the village Mother Friendly Ambulance (*Mobil Sayang Ibu*). Malang and Bone also put danger signs and high-risk criteria on the cards to facilitate easy recall of these risks by local volunteers, smoothing the referral process. Besides identifying and monitoring pregnant women, the *kaders* are also responsible for observing and recording all kinds of data related to maternal health in the hamlets they supervise. The community-based reporting system, besides utilizing technical and medical indicators, also employs social and behavioral tools to measure attitudinal changes. The qualitative and quantitative data gathered are eventually combined to measure the number of high risk pregnancies and maternal deaths in each catchment area. The district of Ogan Komering Ulu has taken the Mother Friendly Movement's strategy a step further by integrating its data with those of the BKKBN's Family Welfare mapping system (or *Pendataan Keluarga Sejahtera*).

After being analyzed and prepared for presentation, the data are displayed in public. In all the health centers of the eight pilot districts, visitors can see: an organizational chart that shows the relationship between the



Eyeball-friendly data presentation

local Mother Friendly Task-Force members and the health providers; growth charts indicating the increase of important socio-economic and health variables over time; a colorful household composition map with descriptions of the pregnancy status by location

and family welfare status; and other descriptive matrices, all in a format where the data can be easily 'eyeballed'.

These chart and graphics are used to increase knowledge of pregnancy complications among women, their families and their communities. Without the easily understood displays of data on needs, risks, death rates and their causes, few people would be aware of the high incidence of maternal mortality and the need to take prompt action when complications arise.

The community-based reporting system is also intended to help identify and prioritize necessary actions to strengthen the district health infrastructure, to plan interventions, to devise effective messages for the community, to mobilize community groups, to address financial and transportation problems, and to train both clinical and non-clinical stakeholders. Since the local government officials are fully involved in the on-going data analysis and meet periodically to discuss emerging issues, any relevant information can be incorporated into the policy process and promptly implemented, greatly enhancing the program's effectiveness.

The observed impact of information collection and dissemination seems to suggest that non-medical interventions are just as important as medical interventions in preventing maternal deaths. After all, maternal mortality is not only determined by clinical factors. As we have seen in the first chapter, community values can also at times become an obstacle to optimal maternal health.

DISMANTLING SOCIAL BARRIERS

Socio-cultural barriers which prevent women and their families from seeking appropriate medical care are of serious concern to the Mother Friendly Movement. In all the eight pilot districts an information campaign has been launched to 'deconstruct' existing 'myths' on maternal health, and rectify inaccurate assumptions. Basic information on maternal health is continuously disseminated through local radio stations and newspaper, and informal meetings are regularly held by the *Lembaga Ketahanan Masyarakat Desa* (LKMD: Institution for the Maintenance of Village Society) and other community-based organizations to provide reproductive health education to villagers.

'May Allah be with you'



In the explanations, particular attention is given to the danger signs which may arise during pregnancy, delivery, and after delivery, in order to enable the community to recognize these signs and promptly seek appropriate assistance.

Other strategies to increase community knowledge and support have benefited from collaborations with religious leaders. In Pematang, the Office of Religious Affairs has provided Moslem teachers (*kyai* or *ulama*) with manuscripts consisting of relevant verses from the two most important sources of Islamic tradition, the Koran and the *Hadith*,¹ to be used for educational *khótbah* (sermons) on the theme of family welfare and safe motherhood. In the district of Karawang, the many community gatherings for Koran reading sessions (*pengajian*) have provided valuable opportunities to introduce and discuss the concept of high-risk pregnancy and related signs.

Through these concerted educational efforts, the Ministry for the Role of Women hopes to change people's fatalistic attitude of *'pasrah'* (resignation) which leads them to accept maternal death as God's will: 'her time has come'. To counter the community's passive disposition, a new vision is promoted which stresses that 'miracles can happen' since most obstetric complications can be successfully assisted if promptly referred. In addition to this, the information campaign confronts women's tendency towards self-sacrifice, which makes them vulnerable to dangerous delays, because they feel com-

pelled to be 'brave' and endure pain for a long time before asking help.

Although it is often regarded as a matter of individual perception and resilience, women's high level of tolerance for pain is actually shaped by society, religion, and traditional customs.² In most rural communities, pain is perceived as a natural symptom of labor, and home is considered as the safest place for the mother to deliver. Partly because of the traditional belief that to give birth is a natural process, women, as well as their husbands, accept as natural all the difficulties they experience during pregnancy, such as edema, blurry vision, or headaches. Consequently, they do not feel the need to discuss problems with their relatives, or to seek for professional help. Women's reluctance to consult obstetric specialists is further influenced by existing moral norms precluding village women from being seen by male doctors. The common view is that a pregnant woman should feel ashamed to give birth in the hospital in front of strangers and any male other than her spouse.

To change these attitudes and create an environment more conducive to safe motherhood, the Mother Friendly Movement specifically targets women to inform and empower them to recognize and make known their needs while asserting their reproductive rights. In every village, PKK volunteers have been extremely active in spreading relevant information among women. Along with recording pregnancies and related data through the *dasa wisma* mechanism, they



Health education for women

distribute Mother Friendly Movement leaflets containing simple but complete information on safe motherhood and high-risk pregnancy criteria.

Furthermore, PPK volunteers regularly hold informal training sessions on reproductive health for women in the community. The district of Bone has been particularly active in organizing lectures for local health educators (PKK volunteers) and their *dasa*

wisma members about safe motherhood issues. Gradually, safe motherhood has become a favorite topic of discussion at women's group rotating lottery meetings (*arisan*) and at regular PPK meetings. Preliminary results in the eight pilot districts indicate that knowledge of the minimum 'high-risk' pregnancy criteria (known as *resiko tinggi* or *resti*; see box) have empowered 'high-risk' pregnant women to gain

their husbands' and their community's support in seeking prenatal care and timely assistance for labor.

DANGER SIGNALS OF COMMON COMPLICATIONS

- Any vaginal bleeding

During pregnancy

- severe headache and increasing dizziness
- generalized swelling (edema)
- convulsions
- breathlessness and tiredness (anaemia)

During labour

- labour pains for more than 12 hours
- excessive bleeding
- rupture of membranes without labour for more than 12 hours
- prolapsed cord, foot or hand

After delivery

- excessive bleeding, fever, severe headache, dizziness, edema

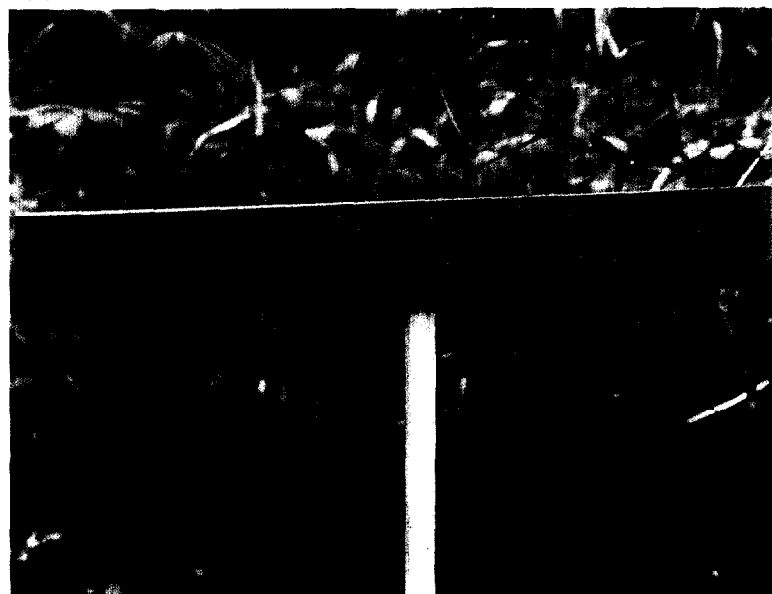
Aside from disseminating information, the *kaders* encourage women to improve their nutritional intake by taking regular vitamin-A capsules against anemia, and by eating a more diversified diet. Entering Bone, one is impressed by the view of Mother Friendly Gardens (*Kebun Sayang Ibu*) in front of each house, where tomatoes and other vegetables are planted to provide nutritious vegetables for daily food consumption.

Similar to the PKK, Muslim women's organizations such as Muslimat N.U., Fatayat N.U. and Aisyiah Muhammadiyah have taken an active role in educating their

members about maternal health. In the district of Malang, these organizations have also provided important inputs to the subdistrict Mother Friendly Task Force in defining effective strategies to reduce maternal deaths.

All these combined activities have greatly increased women's knowledge and provided them with the skills necessary to take control over their reproductive life and to play a greater role in the decision making process. Women's empowerment in itself is, however, only partially effective when it is not complemented by a similar process among men, given men's considerable impact on women's health, including maternity issues. For this reason, the intervention paradigm promoted by the Mother Friendly Movement also calls for the involvement and participation of men.

Mother Friendly Garden – nutritional value recognized and enjoyed

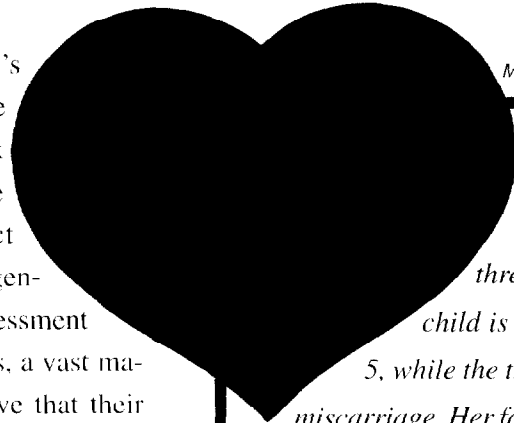


PROMOTING MEN'S ROLE

Generally, in Indonesia men's involvement in maternal care and childbirth is low. Men lack relevant information and are therefore not prepared to act promptly when obstetric emergencies arise. During the initial assessment phase in the eight pilot districts, a vast majority of men would not believe that their wives' pain and other symptoms during pregnancy may deserve medical attention. In their view—similar to that of their wives and other community members—'women are supposed to suffer during delivery'.

When asked about their interaction with health personnel, most husbands further stated that they do not have contacts with PKK *kaders*, *puskesmas* midwives, or village midwives, since they are rarely at home during daytime. Many of them also feel shy to talk with service providers about reproductive health or family planning since these topics are considered to be women's issues. What is more, men feel uncomfortable expressing their anxiety about possible pregnancy complications, and explaining their concerns about transportation and hospital costs. On the other hand, service providers rarely feel the need to involve men in their consultation and merely interact with their female clients. This lack of communication can lead to tragic events as the following case shows:

Men's involvement logo



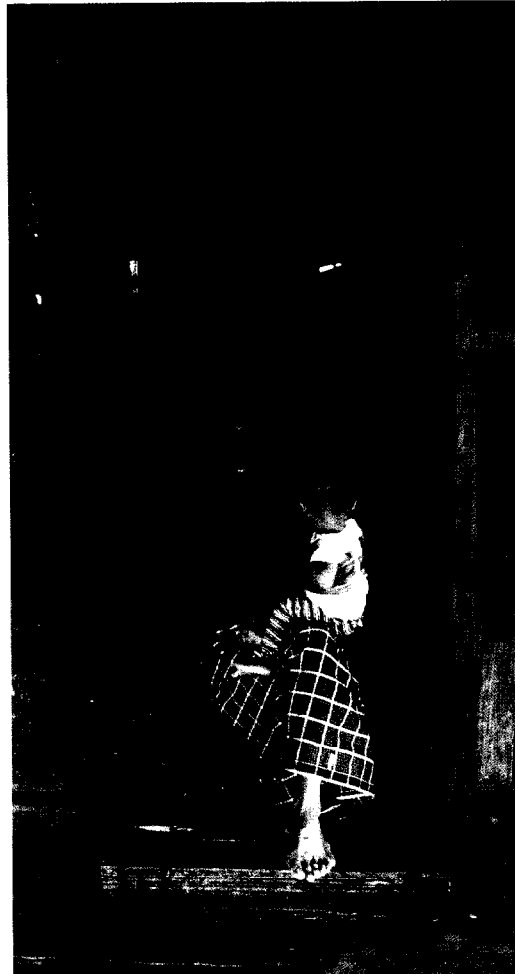
Mrs. Fatimah, aged 26, had been pregnant three times before. The first child is 8 years old, the second, 5, while the third pregnancy ended in miscarriage. Her fourth pregnancy reached the end of its ninth month, when she began to feel contractions at about 11.00 O'clock in the evening. When the midwife was finally called, she found that Mrs. Fatimah was still able to talk, but her systolic blood pressure was already very high at 200 mmHg. The midwife diagnosed her as having Pre-Eclampsia, and rushed her to the Mother Friendly district hospital. She arrived there around midnight, still conscious. But at 3.00 o'clock in the morning she started to have convulsions and died within two hours, with the baby still in her womb.

Her husband could not understand what went wrong with his wife's pregnancy. He perceived her as being as healthy as usual.

Still shocked, he recalled that just two days before the fatal event she had attended a wedding in the neighborhood and was looking happy. The husband explained that his wife never complained, and she did all daily housework as usual, throughout the pregnancy. The midwife was surprised since with her Mrs. Fatimah had complained about severe headaches that blurred her vision occasionally. The midwife had actually informed Mrs. Fatimah a month before that she suffered from high blood pressure and had an edema in her limbs. These danger signs were not communicated to Mrs. Fatimah's husband, neither was any practical nutritional advice explained to him. The pregnant woman maintained her regular daily diet which generally included salty fish, a catalyst for higher blood pressure in pre-eclamptic conditions. When all of this was discovered it was just too late.

There is an urgent need to broaden dissemination of information to reach men, especially on how to look out for danger signs during the third trimester of the pregnancy, and how to respond if complications appear at the time of labor. To be able to support their wives, men need to better estimate the risks involved in pregnancies that takes place too early or too late in a woman's life, and pregnancies that are too soon after the last pregnancy.

Encouraging men to share responsibility





Recognition of male involvement

For this reason, all eight pilot districts have made a strong effort to involve men in the Mother Friendly Movement. In the area of male participation, formal community leaders (who are generally men) have played a key role, becoming the agents in spreading greater understanding of women's reproductive health and the importance of men's involvement. In particular, the *Bupatis* have worked hard to create a sense of responsibility among men, encouraging them to help their pregnant wives in household chores, to be aware of their wives' maternal health status and to encourage and to support their use of antenatal care services. The *Bupatis* of Karawang and Malang have even formally

recruited men to accompany their wives during antenatal care visits. If the women were diagnosed as high-risk, their husbands were also expected to devise transportation plans to allow delivery at the district hospital when the time arrives.

Other districts have approached this problem with a stronger reliance on public education methods. They have disseminated safe motherhood information to men at various public events and through a mass media campaign via local newspapers and private radio stations. In the district of Pematang, once every 35 days, right after the Friday religious lecture (*khotbah Jumat*), all informal leaders meet at the village meeting hall (*Balai*

Desa) to participate in an educational forum on safe motherhood issues attended by male villagers, especially farmers. Deli Serdang distributes a sympathetic Mother Friendly Movement logo designed by the PKK organization, showing a husband with his pregnant wife in an affectionate pose, to convey the message that a husband should be supportive of his wife and actively involved in the prevention of maternal suffering and death.

In these various ways, the Mother Friendly Movement tries to motivate men to change their attitudes and become '*Suami Sayang Ibu*' or 'Mother Friendly Husbands'. Whether these new values, promoting more respectful gender relations, will gradually substitute existing cultural patterns and on the long run become dominant over time depends partly on future generations. No wonder that the Mother Friendly Movement, besides working to modify adult behavior, also has an high stake in preparing adolescents to become more knowledgeable and attentive couples.

ADOLESCENTS REPRODUCTIVE HEALTH

Four districts out of the eight have demonstrated particularly concern about the lack of information on reproductive health hazards targeted at youth, such as information on prevention of unwanted and unsafe pregnancies. Recognizing the need to pre-

pare both female and male adolescents for marriage and responsible parenthood, the authorities in the district of Pematang, Malang, Central Lampung and Bone, have integrated an adolescent reproductive health education component into their Mother Friendly Movement campaign activities.

In the planning phase, input was sought from parents, community and religious leaders on relevant community norms and religious values to secure the social and moral acceptability of the program. Thereafter, several training sessions were held to discuss responsible reproductive health issues with the local community youth association (*Karang Taruna*). In Malang and Pematang reproductive health education emphasizing the risks and realities of childbearing was also provided to students in Islamic boarding schools (*pesantren*). In Bone youth cultural groups were involved in the development of a video and theater drama showing a women's struggle for survival during complicated birth delivery and how the Mother Friendly Movement can reduce such agony. Information regarding safe-motherhood is also disseminated through songs, poem reading, and dances.

While very different in approach, all these types of interventions addressed the same concerns, including: 'immorality' of pre-marital sex; dangers of early sexual relationships and pregnancy; access to advice on early marriage; gender roles in the family and society, and greater men's involvement in family responsibilities. Even if this scope



Young people from Irian Jaya

of issues is still very limited compared to the magnitude of the problem, nonetheless it suggests a major shift in attitude from denial to recognition of adolescent sexual behavior and related reproductive problems. As stated by a government official in Pernalang: 'we must protect the future of our young people by giving them reproductive health information, if we want them to be

well-prepared to participate physically and socially in society as healthy adults'.

Hopefully these initiatives will help young people to learn decision-making skills and to take care of their sexual health, so that they become empowered to take destiny into their own hands and start to envision a 'life plan' that is not resigned to 'fate'.

NOTES

- 1 The Hadiths are oral sayings attributed to the Prophet.
- 2 K.I. Kennedy, "Fertility, Sexuality and Contraception During Lactation", 1993: p.453.

CHAPTER 4 INCREASING QUALITY OF CARE

ENHANCING MIDWIVES' KNOWLEDGE AND SKILLS

In the second set of the Mother Friendly Movement's interventions, emphasis is placed on the improvement of maternal health services, aimed at combating the 'third delay'. The main program strategy is to enhance access to trained midwives and assure that they acquire sufficient knowledge and

skills to recognize obstetric complications when they arise, take proper action, and know where to refer a woman in labor for emergency care. To do this, a consistent and integrated effort is needed which includes provision of in-service training for midwives, as well as for health center and hospital staff, in addition to procurement of necessary medical equipment. As the head of the District Health Office in Malang stated, it will not be possible to ensure safe preg-

Improving quality of interaction between provider and client



nancy and childbirth for all women by addressing only a few pieces of the broader puzzle, like teaching only certain skills, training some TBAs or doing only few maternal perinatal audits.

Starting from this premise, the district of Malang is devoting full attention to the distribution of village midwives, aiming to



Delivery in a puskesmas setting

place one in each of its 406 villages and increase the ratio of midwives to patients. Currently, midwives are deployed in only 234 villages, where an estimated 70 percent of births occur. Besides increasing their numbers, efforts are being made to improve midwives' communication and technical skills. To ensure that the appointed village midwives acquire some minimum standard of competency in essential emergency obstetric care, in-service training is being provided

to them at the teaching hospital of the Department of Obstetrics and Gynecology at the University of Brawidjaya. Distance Learning Modules (*Modul Diklat Jarak Jauh*) for village midwives have also been developed by the District Health Office in consideration of the fact that there is only one obstetric specialist available in the rural area.

Also based on the assumption that quality care begins with upgrading current sub-standard care, all other pilot districts also emphasize in-service training to village midwives in their intervention programs. More particularly, the district of Bone started to provide hospital in-service training to village midwives in 1996. At that time, the District Health Office sent a list of names of village midwives to the Mother Friendly Hospital and with the cooperation of the hospital director and the head of the obstetric department, five midwives were selected to participate in a 4-week in-service training at the hospital. During this training program, each midwife was required to attend a total of 45 deliveries. Within one year, all 135 village midwives participated in the program, practicing their technical skills and learning about management of obstetric complications. Similarly, in the district of Pematang, midwives are offered the opportunity to do a two-week on-the-job training (*magang*) at the Dr. M. Ashari Hospital, a Mother Friendly Hospital, with close supervision from the two obstetrician-gynecologists. Meanwhile, in Deli Serdang,

the district hospital Lubuk Pakam provides training for village level midwives twice a year. Plans in this direction are also being made in Ogan Komering Ulu, but funds are not yet available.

Training is not only being provided at the district hospitals but also at the subdistrict

level. In Central Lampung, a team consisting of one obstetrician-gynecologist and one pediatrician comes to the *puskesmas* on request from the staff or the village midwives, to give advanced competency-based training on emergency obstetric and pediatric care. The team believes that midwives learn

Enhancing midwives' skills



Photo: UNICEF

best by observing the correct performance of a certain clinical procedure as demonstrated by an expert practitioner. In cases where a midwife does not dare to conduct certain techniques, such as manual placenta removal at the *polindes* or *puskesmas*, she can accompany her patient to the hospital. The obstetrician will then use this occasion to encourage the midwife to practice such technique under his guidance, unless the patient is in a state of shock.¹ So far, more requests for training are received from *puskesmas* headed by civil servant physicians (PNS) rather than by non-permanent physicians (PTT), probably because the latter feel less invested in their work as they do not enjoy the same guarantee of employment as the PNS have.

In Central Lombok, the Mother Friendly Movement benefits from successful collaboration at the district level among representatives of the local chapter of the Indonesian Obstetrician-Gynecologists Association (POGI), the District Health Office, and the district hospital in auditing cases of maternal death. Through the auditing process, the obstetric specialist coaches *puskesmas* doctors and midwives in basic emergency obstetric care. Mini workshops are further held for village midwives and nurses in the form of weekly meetings. In addition, short-term on-the-job training has been made available for village midwives and *dukun bayi* (TBAs) to familiarize them with the hospital surroundings. These courses last 7 to 12 days for village midwives, and only 2 days for

TBAs. As found in Central Lampung, PTT-headed *puskesmas* in Central Lombok show less compliance and motivation in supporting training activities than PNS-headed *puskesmas*.

Skilled staff at the village and subdistrict level can only succeed in reducing maternal mortality if at higher level facilities qualified personnel are available to assist pregnant women who are referred for comprehensive emergency care. The Mother Friendly Movement acknowledges that a major role in saving women's lives must be played by obstetricians and gynecologists. As the providers with the most complete and up-date knowledge, they are expected to provide direction, guidance, and leadership in improving the quality of obstetric care, while also providing training and supportive supervision to nursing and midwifery personnel employed at the hospital and at community-based facilities. Currently, not all personnel in charge of the hospital's emergency units are qualified to provide obstetric care at the degree of complexity needed. Many of them have general training but do not always have the specific obstetric skills required. To improve this situation, plans are being made to provide refresher training to medical and nursing personnel in emergency units. Changes in the current basic training curriculum are also being planned to enhance the skills of the providers in managing obstetric complications and counseling pregnant women.



Qualified workers are needed in the obstetric ward

FROM TRADITIONAL TO MODERN BIRTH ATTENDANTS

The greater responsibility entrusted to biomedical personnel inevitably influences the terms of their relationship with TBAs. In the implementation of the Mother Friendly Movement, redesigning services by increasing the ratio of midwives to patients, improving midwifery skills, and limiting the TBA's role in delivering babies, are complementary program strategies which are expected to greatly contribute to the acceleration of maternal mortality reduction. Although the TBAs are still in high demand, the Mother Friendly Movement seems inclined to limit their role in view of the fact that—as argued in chapter 2—the many interventions directed toward training TBAs have had little impact so far.

This line of thought is clearly expressed in the following statement made by the head of the District Health Office in Malang: 'I believe that strengthening the midwifery skills of the village midwives will increase their confidence, increase demand for their services, and sustain them as providers of health services at the village level. Eventually, all births should be attended by village midwives, not by TBAs anymore'. This opinion is fully supported by the PKK leader, the *Bupati's* wife. She explained: 'we are not ignoring the TBAs' role, but it is time that we call for a safer pattern of collaboration, by us defined as '*pendampingan dukun*', wherein village midwives stand by the TBAs

This *pendampingan* arrangement clearly divides the medical tasks between the two birth attendants: provision of intrapartum care is the responsibility of the village midwife, while the clean cord-care and other



Traditional meets science with attendants

post-partum mother care such as bathing and massaging are allocated to the TBA. On the 7th and 40th day post-partum, the village midwife is supposed to make follow-up visits to the mother and child to monitor their health status. Similar *pendampingan* arrangements with a clear articulation of separate duties are also in the works for the dis-

tricts of Pematang and Bone, although they are not as strict a policy as in Malang.

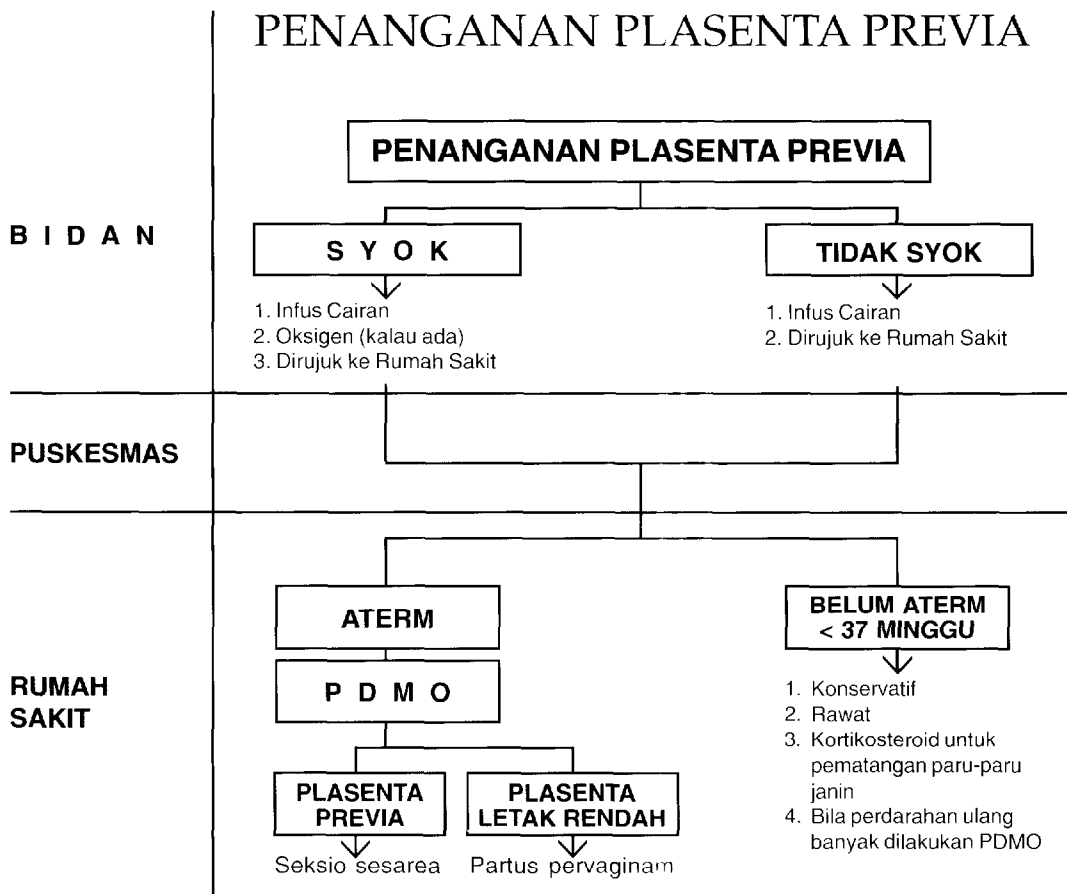
The district of Karawang seems at first sight to have a somewhat different approach, since it encourages the involvement of traditional birth attendants—in the local Sundanese language called *dukun paraji*—as working partners. District authorities realize that little success has been achieved in improving the safety of delivery practices of TBAs, but believe that their role cannot be eliminated completely since a majority of women prefer them. Therefore, they have chosen to give TBAs refresher lectures on recognition of high-risk pregnancies, in order to improve referrals for hospital delivery. This somewhat condescending approach however does not lead to a complete acceptance of TBAs. The final intention is still to ensure that only a trained midwife perform deliveries, eventually employing the TBA as assistant. In the long run, it is intended that TBAs should limit their role to pre-natal and post-partum care activities, and refer all deliveries to their 'modern' colleagues.

In general, it can then be said that the Mother Friendly Movement envisions for TBAs a temporary, subordinate role in the provision of maternal care. In this conceptual framework, the solution to clinical problems causing maternal mortality does not lie in the improvement of TBAs' skills, but in the establishment of new standards of care for midwives, obstetricians and gynecologists.

FORMULATION OF STANDARD PROCEDURES

It is usual for medical practice to vary somewhat from one health care provider to another. Still, to ensure the welfare of the patients it is crucial to define and promote standard procedures of high quality. One of the breakthrough initiatives of the Mother

Friendly Movement has been the development of written protocols describing specific steps for the management of emergency obstetric cases referred to the hospital by village maternity posts, *puskesmas*, or directly from village midwives and TBAs. During the initial phase of the Mother Friendly Movement, in the eight pilot districts the obstetrician-gynecologists working at the Mother Friendly Hospitals developed writ-

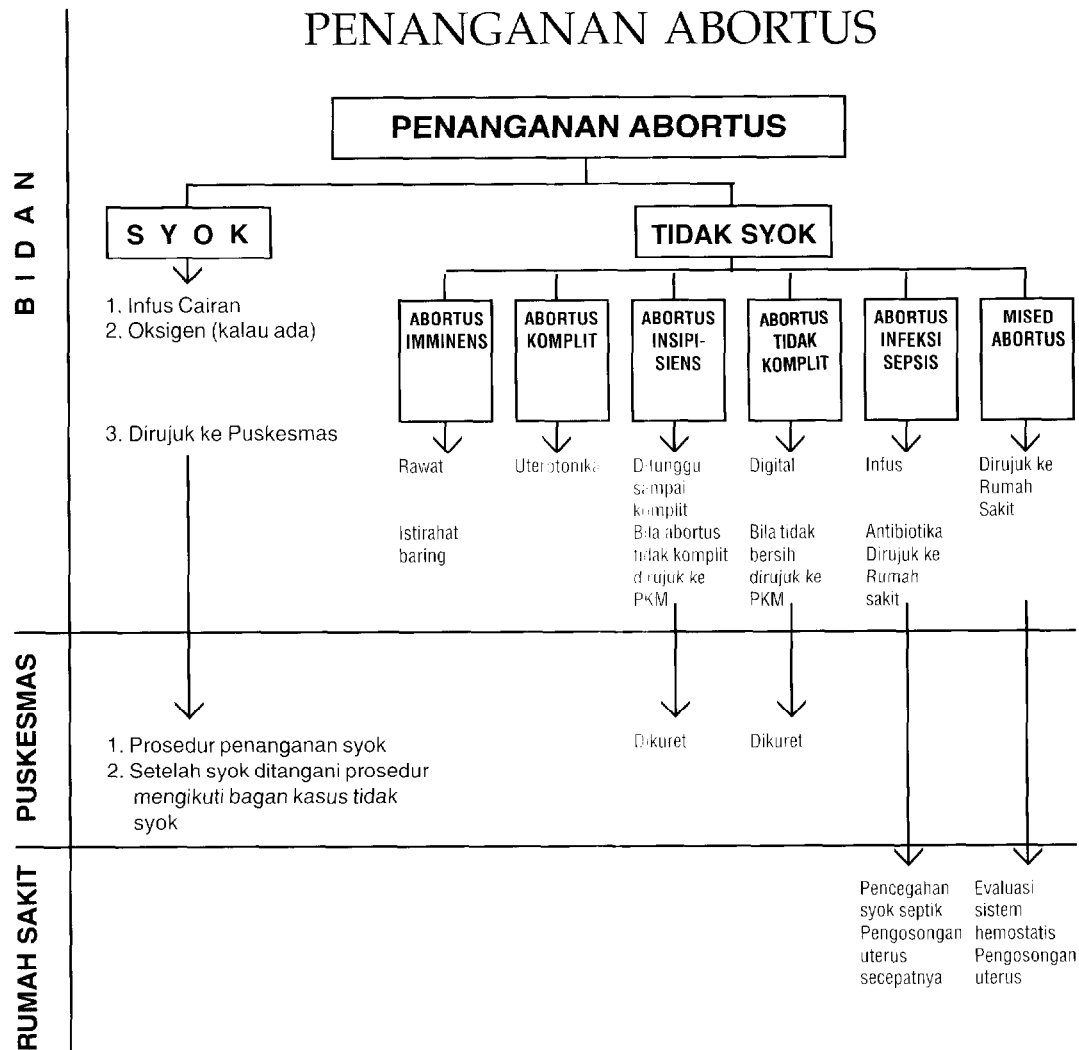


PDMO: Periksa dalam dimeja Operasi

Written protocols for case management a significant breakthrough

ten protocols regarding obstetric nursing procedures, such as administration of medications to stop bleeding, and procedures to treat shock, to provide rehydration through infusion, and for blood transfusion. In a few hospitals, standard procedures for infection control have also been formulated.

These protocols are displayed, readily available to all staff who are on duty at the time when a referral arrives, and remind them of the steps they must take. At the same time, the protocols clearly articulate to clients the care that they can expect to receive.



Written protocols for case management - a significant breakthrough

BBLR/BBLSR

- Bersihkan jalan nafas
- O₂
- Penajasan handu
- Cegah hipotermi ~ diselimuti
- Pemberian cairan : 4 : 1 + Glukosa 40% 30ml,
 - BB < 2500 Gr ~ IV ~ VI tetes / mikro
 - BB > 2500 Gr ~ VI tetes / mikro

Tindakan ibu hamil di UGD

1. Perdarahan

- IVFD Nacl dengan atocath no.18 dan tranusi set
- Periksa Hb, Golongan darah, CT, BT
- PP 1,2 juta iu / test darah
- Rencanakan tranusi hingga Hb = 8 Gr %
- Kirim ke bangsal

Krampsi

VFD Dex 5%

Sedang kejang

~ Diazepam 20 mg iu

~ Diazepam 20 mg / drip 40 tetes / menit

Tidak kejang

~ Diazepam 20 mg / drip 40 tetes / menit

~ Periksa lab ~ Hb, gol, CT, BT, ureum creatinin

Kirim ke bangsal

Display of standard procedures

With the protocols as their guidance, members of the hospital staff working in the emergency unit will be able to carry out correct procedures of basic emergency obstetric care for referral cases. From a manager's or supervisor's perspective, the protocols also provide a clear standard by which to evaluate the performance of the staff. These standards in turn serve as starting point for long-term quality of care improvement.

In Pematang, standard procedures for village midwives have also been developed by the District Health Office, in collaboration with POGI, and the *puskesmas* doctors. These guidelines prescribe basic care provision for pregnant women and child birth, addressing complications such as anemia, raised blood pressure and vaginal bleeding in the first trimester of pregnancy. In this way, district authorities hope to enhance providers' skills and thereby greatly reduce the number of maternal deaths.

The thoroughness of these various kinds of protocols still varies by district and it is foreseen that they will be improved and standardized further with regular review and systematic evaluation in the coming years. In the meantime, the written protocols ensure more consistent and faster response, in the fight to overcome undue delays in maternal care.

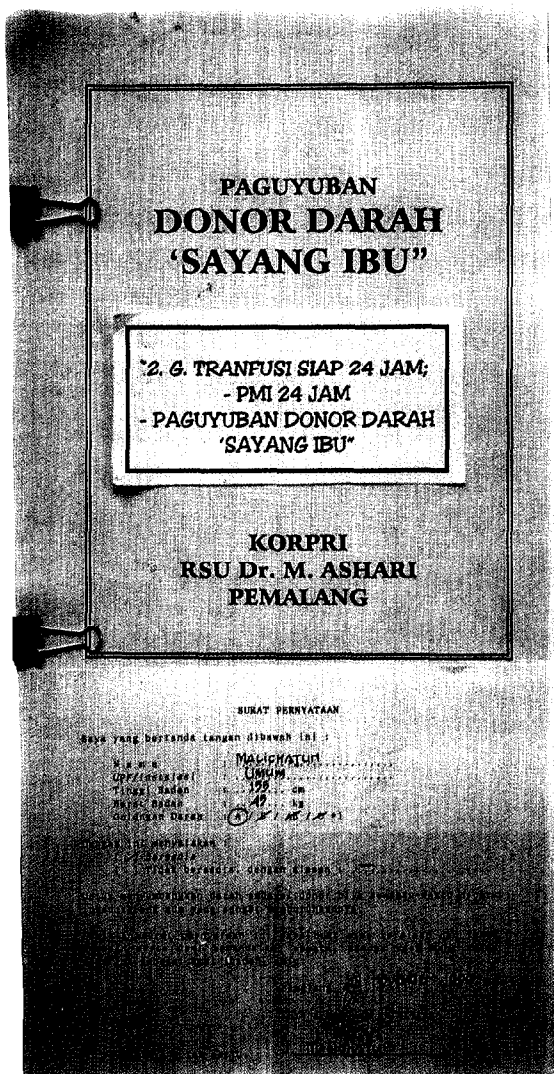
BLOOD SUPPLIES

From the discussion so far, it would appear that in the area of increasing quality of care, the Mother Friendly Movement has invested most energy and resources in enhancing providers skills, while logistics improvements have been reduced to a minimum.² Still, there is one specific area that has received a fair amount of attention and will need more attention in the continuation phase of the Mother Friendly Movement. This area is provision of safe blood supplies at the district level.

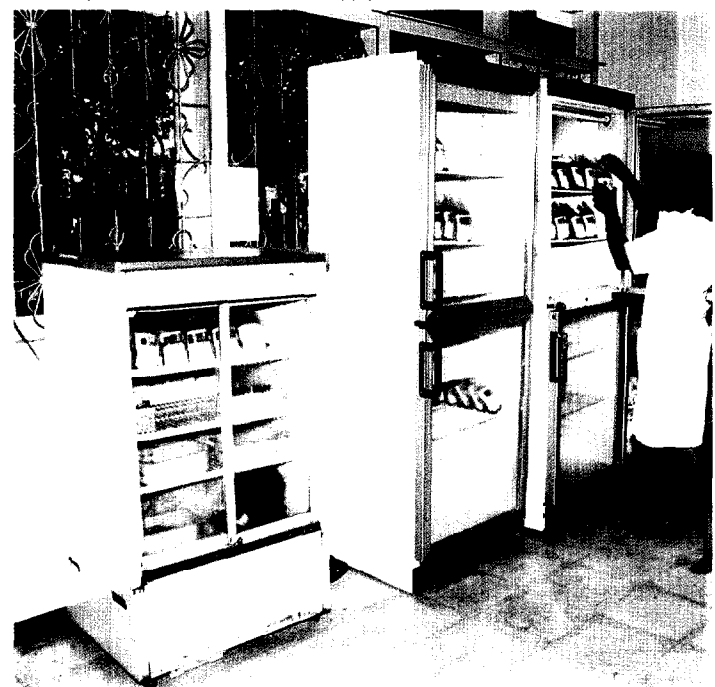
The provision of adequate and safe blood is an absolute necessity in the struggle against maternal mortality. It is not enough to create a demand for emergency care by instilling in the community the belief that women's lives can be saved by the timely provision of blood transfusions and emergency obstetric care—as a replacement of the predominant fatalistic beliefs—if these words are not followed up with action. Even the

most skilled health workers are powerless when a pregnant woman is brought in to the district hospital with acute blood loss if there is no blood supply or blood transfusion units available.

To eliminate this third delay and ensure timely provision of blood transfusions, the district of Pematang applies the strategies of a traditional association (*paguyuban*) to obtain blood donation from among the staff of the local Mother Friendly Hospital. A list of their addresses and blood groups is kept in the nursing division. Similarly, in Central Lombok an emergency list of donors is kept in the obstetric ward of the district hospital, consisting of members of the Dharma Wanita—an association of wives of government officials.



Voluntary donations for safe blood supply



In Malang, the only mobile blood unit circulates as frequently as possible among the surrounding *puskesmas*, schools and factories to recruit more blood donors. In addition, the local blood bank has established a written standard procedure for blood request that simplifies bureaucratic procedures, so that matched blood can be processed within 45 to 60 minutes. This services is available to the public 24 hours a day and the blood is provided free-of-charge to those who cannot afford to pay.

The blood transfusion unit of Bone district hospital has attracted a number of young adults as regular donors by providing free

coffee and milk to local male adolescents who usually gather in the hospital hall across the unit. On average, the unit can obtain 70 bags of blood every month.

In summary, district authorities have put efforts into replenish inadequate blood supplies, while educating people about the importance of donating blood. With the intensification and upgrading of these efforts in the next phase of intervention, the Mother Friendly Movement will ensure that safe blood is made promptly available, to pregnant women, thus immensely improving the quality of available birth delivery services.

NOTES

- 1 Shock is a condition with the following symptoms: low blood pressure under 60 mmHg diastolic, fast pulse over 110/minute, fast breathing, cold skin.
- 2 See also next chapter.

CHAPTER 5

STRENGTHENING THE REFERRAL SYSTEM

BRINGING HEALTH SERVICES CLOSER TO THE COMMUNITY

The third set of activities of the Mother Friendly Movement is directed at improving referrals and health care linkages, in order to enhance people's access to the health system. Major efforts are being made to overcome geographic barriers which impede pregnant women from getting timely assistance. The specific barriers vary in each of the eight districts, to some extent influenced by population density and the distribution of settlements. The majority of the population of Karawang, Pematang, Malang, Deli Serdang and Central Lombok lives within reasonable distance of the district hospital or community health centers with obstetric care facilities. This is not the case in the districts of Ogan Komering Ulu, Central Lampung, or Bone where great distance between the consumers and the available health facilities, scarce and poor quality roads, and short supply of vehicles, all impede access to care.

Recognizing that referral time and transport are crucial for the survival of women with obstetric complications, the movement has mobilized local government and communities to identify the problems and devise solutions. Broadly speaking, two complementary strategies have been developed. These aim to bring comprehensive obstetric care facilities closer to the communities, and, to improve communication and transportation between the community and the various health care facilities. The first strategy has been mostly implemented in districts with poor road infrastructures. In Ogan Komering Ulu, the sheer size of the district is a barrier to easy and quick transport to the only hospital with complete surgical facilities, in the district capital of Baturaja. Thus, transportation problems between the *puskesmas* or hospitals and the distant villages can only be overcome by adding operation venues at certain health centers with in-patient facilities (*puskesmas tempat tidur*). The *Bupati* has approved a plan to build a surgical operation room to provide comprehensive emergency obstetric care (especially



A Mother Friendly Waiting Home –a home away from home

Cesarean section) at three in-patient health centers where there is great demand for maternity care. This expansion of surgical facilities should ideally be accompanied by 24-hour staffing for Cesarean section services, as well as provision of sufficient drug and blood supplies, anesthesia, and laboratory equipment. Currently, the district health officer is in the process of requesting competency-based training for in-coming *puskesmas* doctors to allow them to perform specialist obstetric care such as Cesarean section, forceps delivery, manual removal of the placenta, and evacuation of retained products of conception. Unlike a regular 4-5 years obstetrical specialization course, these competency-based training programs, –to be conducted by members of the provincial chapter of POGI– are planned for shorter periods of 1.5 to 2 years.

Besides upgrading existing facilities, the district of Ogan Komering Ulu has also tried to improve communications between private and public health linkages. In the subdistrict of Belitang, which is about 80-100 kilometers from Baturaja, a close collaboration be-

tween the *Camat* (subdistrict head) and the mission hospital has resulted in the participation of the Caritas Hospital as a referral center.

In Central Lampung, district authorities dealt with geographic barriers by establishing Mother Friendly Waiting Homes '*Pondok Sayang Ibu*'. This approach, conceived by the PKK provincial head, is based on the idea that a temporary transit place for high risk pregnant women who live in isolated villages is an important step towards overcoming the second delay (i.e., reaching services). With the consensus of the community, the village head has chosen one house near the main road leading to the hospital to become a *Pondok Sayang Ibu*. The resident of this house volunteered a room for this purpose. There a pregnant woman can stay as her due date approaches. Whenever the need arises, it will be much easier to transport the woman from this temporary residence to the hospital. Even a if pregnant woman prefer to stay at home, her husband can still come to the *Pondok Sayang Ibu* for various purposes: advice on symptoms that may require attention; information on emergency referral services; transportation to the hospital; financial assistance to access health facilities; and other related concerns. The daily functions of the Mother Friendly Waiting Home are managed by the and other health volunteers according to daily duty schedules. By pre-empting an emergency situation and panic, the severity of complications can be minimized.

IMPROVING TRANSPORTATION AND COMMUNICATION

As previously mentioned, besides bringing obstetric care closer to the community, the Mother Friendly Movement aims to improve transportation and communication between the community and health facilities.

Within six months of implementation, each district was able to create a 'village ambulance cooperative' involving the establishment of the local Mother Friendly Movement's Task Force to assure sustainability of the mechanism through capacity building for administrative, financial, and managerial tasks. Informal community leaders acting as members of the Task Force have proven capable of raising community awareness

Improving transportation



among family members about the need to overcome delays in transporting pregnant women suffering from obstetric complications to the hospital. Evidence shows that the community, when sufficiently motivated, is able to organize efficient emergency transportation.

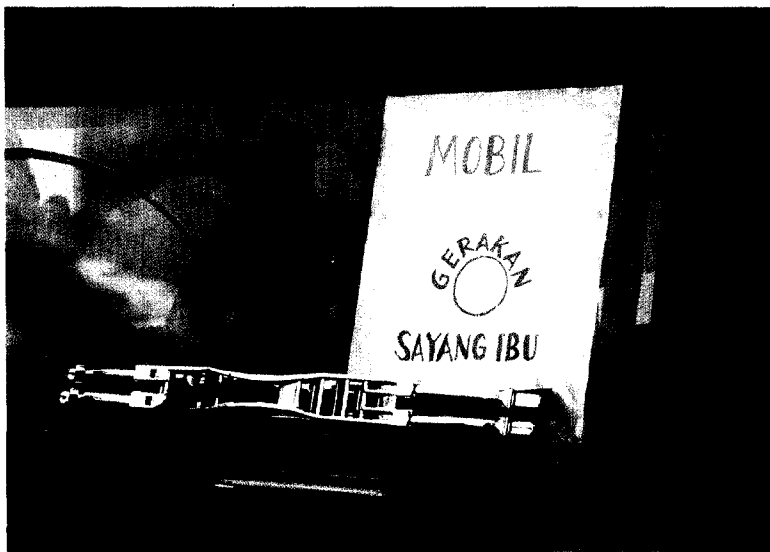
These village-based transportation interventions utilize different strategies depending on the road conditions and distance. For example, Central Lampung, a district that has no significant infrastructure problems, mobilize local vehicle owners in each village's 'ambulance' schedule. Similarly, in Malang, vehicle owners are encouraged to voluntarily make their vehicles available and to agree on a monthly schedule of duty. The village midwives inform the vehicle owners about which women will be giving birth during the month when they are on duty. To back-up this system of Mother Friendly

Ambulances (*Mobil Sayang Ibu*), Malang has established a 'fast communication network', by distributing walkie-talkies to all *Camats* and village-heads. District authorities have also donated two ambulance cars, one to the Mother Friendly Hospital Kepanjen, and another one to the *puskesmas* in the subdistrict of Singosari which has been particularly active in the movement.

The district of Bone has also made use of willing vehicle owners to provide ambulatory transportation. A list of their names is kept by the LKMD. By agreement, each day certain vehicles are available to be used for transporting pregnant women with complications to the health center or district hospital.

In Karawang, the *Bupati* has instructed the district heads to ensure that all pregnant women with complications are transported to the hospital on time, by using vehicles belonging to local officials if necessary. Since January 1997, each *Camat* has been equipped with a radio-telecommunication system to directly contact the district hospital when woman with obstetric complications is on her way. Along the same lines, the *Bupati* of Pematang has ordered that all vehicles belonging to the *Camat* and the local officers (*wedana*) must be made available as ambulances for women in labor. Infrastructures have also been enhanced by building new roads in isolated areas. In particular, a bridge was built with assistance from the military program which serves the community, known as 'ABRI *Masuk Desa*'

Making vehicles promptly available





A mother friendly 'cidomo' in Central Lombok

(which literally translated means: 'the Militaries Enter the Villages').

In the smallest district of Central Lombok, *cidomos* (horse carts) have been employed as village ambulances, to carry pregnant women from the village to the health center, since distances are relatively small. The *cidomos* have painted signs stating 'Mother Friendly Transportation' (*Angkutan Sayang Ibu*) on the side. Every *cidomo* driver who participates receives a Mother Friendly Movement T-shirt. In addition, to reduce distance between the *puskesmas* and higher level referral services, larger size in-patient health centers have been upgraded to serve as referral points for surrounding health centers. For example, the *puskesmas* at Kopang serves the three surrounding *puskesmas* of Muncan, Mantang and Tratak in the case of emergencies.

Traditional patterns of transportation have also been employed in Deli Serdang. In mountainous areas, such as in the sub-district of Sibolangit, village 'ambulances' consist of a long piece of cloth tied onto two bamboo poles (like a *tandu* or stretcher). In areas with good roads, ambulances are regular four-wheel vehicles, voluntarily provided by the community.

In these creative ways, accessibility to obstetric services has been dramatically increased. However, eliminating geographical barriers is not enough to make referrals to Mother Friendly Hospitals happen, if economic barriers still persist.

Road conditions determine forms of 'ambulance' transportation



ELIMINATING ECONOMIC BARRIERS

Poverty, one of the root causes of maternal morbidity and mortality, can make a referral suggestion looks unrealistic to a woman and her family. In the assessment phase, all districts reported that financial concerns are the main source of anxiety for families who do not seek medical attention at any primary health care facility. Each district recognized that a significant proportion of obstetric complications occurs among women who cannot afford appropriate care. Moreover, their husbands are often unaware of the costs involved when surgical or comprehensive emergency obstetric care is needed. In response to this situation, the Mother Friendly Movement has explored effective ways to alleviate these financial concerns and help pregnant women and their families to plan realistically for pregnancy costs. In general, local government support has been made available in the form of subsidies for families of pregnant women who cannot afford to pay.

In Pematang district, a budget of Rp. 20 million was allocated through the 1996-97 Local Government Annual Budget (APBD II) to support the Mother Friendly Movement activities. An additional Rp. 30 million has already been earmarked for the year 1997/98. Part of this amount has been used to provide the volunteers in each village with 'seed money' of Rp. 50,000 per village from

the district's budget, to activate 'Social Funds for Maternity Care' or *Dana Sosial bagi Ibu Bersalin* (*Dasolin* for short). A special *Dasolin* was also set up for the Movement through the Muslim collection program *Badan Amal Zakat Infaq & Shadaqah* (BAZIS) involving obligatory alms (*zakat*).

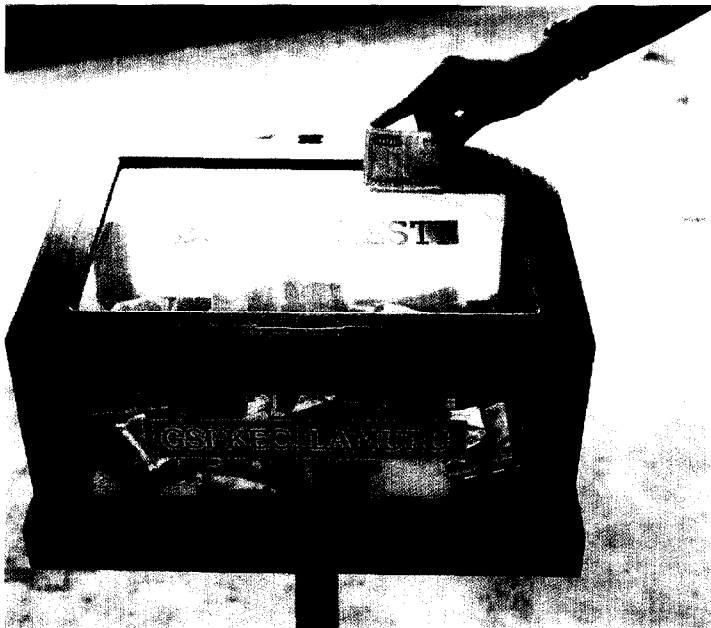
The *Bupatis* of Karawang and Malang district allocated a subsidy of Rp. 50 million to the Mother Friendly Hospital in their respective districts to provide free admission to women with obstetric complications as long as they are provided with a letter from their village head verifying the family's inability to pay. In Malang, subsidies cover not only hospital charges, but also blood transfusions. In Bone, the *Bupati* has made a similar decision to support the Mother Friendly Movement activities by waiving fees for those who are unable to pay. The policy of free care for pregnant women who have a verification letter, has further been implemented in Ogan Komering Ulu and Central Lampung.

Through this strategy, local governments have developed a new socio-economic climate in which hospitals are much more client-friendly, especially for women at risk. What is more, they have successfully eliminated cost as a deciding factor for low income families deciding whether or not to seek emergency obstetric care. The hospital admission records, indicating the proportion of low income mothers seeking care for obstetric complications in Karawang, show an 82 percent increase in the past year (July

1996-June 1997) compared to the same period the previous year.

These positive results are also due to complementary efforts directed at promoting this new policy among the villagers. Village heads are authorized to inform couples in need of financial aid that they are entitled to seek free hospital care if they acquire a verification letter. The subdistrict heads also use the BKKBN's map system to identify families categorized as 'below prosperity' (*pra-sejahtera*) and inform them that they are entitled to a health card (*kartu sehat*) which allows them to receive free care at the health center and district hospital. This and similar kinds of contributions greatly help many women in need. Still, in some cases, remains the problem of paying for effective but expensive treatment drugs.

Public donation box for Safe Motherhood



The various models of hospital subsidies described above are further complemented by other forms of financial aid for pregnant women with obstetric complications. In gathering funds, the *Bupati* of Malang has solicited donations from the business partners of the district and subdistrict government. The *Bupati* of Karawang also called for participatory support, asking each village to allocate a minimum of Rp. 1 million to cover health care and transportation costs incurred by high-risk pregnant women. More generally, in all the Mother Friendly Districts, different kinds of savings schemes at village and subdistrict levels have been organized by PKK *kader* and their *dasa wisma* catchment areas, to help provide cash for transporting high-risk pregnant women with obstetric complications to the district hospital. In each neighborhood, a savings scheme for pregnant women or *Tabulin* (*Tabungan Ibu Bersalin*) organized by the heads of the *dasa wisma* collects members' contributions monthly. In some places, the *Tabulin* receives contributions not only from pregnant women and their communities, but also from civil servants, via donations or direct civil servants' salary cuts.

Besides the *Tabulin*, which collects Rp. 1,000-1,500 from each pregnant woman every month, in Central Lombok a savings scheme has also been established for newlyweds in collaboration with the Office of Religious Affairs. During consultations in preparation for their marriage, couples are required by religious authorities to save



Nurture our children

money for the future birth of their first child. The engaged couple must open a 'Savings Account for the First Child' or *Tabungan Dana untuk Kelahiran Anak Pertama (Tadukap)* with an initial deposit of Rp. 15,000 at the local bank *Bumi Daya* and Village Agricultural Credits Union (*Lumbung Kredit Pedesaan*).

In Malang, fund-raising also comes from selling handicrafts made from the leaves of the *lontar* palm by the PKK volunteers. In addition, mothers with children under-five have their own savings schemes (*arisan balita*) which they take turns to draw. The *arisan balita* provides cash for nutritious supplementary food (*pemberian makanan tambahan* or PMT) for mothers and newborns in need.

The Mother Friendly Movement in Central Lampung also benefits from the existing community-based care system or *Jaminan Pelayanan Kesehatan Masyarakat (JPKM)* established in 1990. By paying Rp. 1,000 per year, each member can get access to free treatment from a list of providers for

that one year period. Pregnant women who cannot afford maternal care are strongly motivated to use the JPKM to gain access to medical check-ups and complete antenatal care.

Although the concept of maternal mortality is new, these kinds of activities are based on traditional patterns of community cooperation. In Java this is called *gotong royong*, meaning that a certain burden can be carried (*gotong*) together (*royong*) by the community. People believe that illness and death are life-events that will be faced by everyone, and *gotong royong* in assisting others facing life-threatening risks is a social duty. As a PKK *kader* explained: 'today it can happen to Mrs. X, who knows next time it will be my sister, daughter or another member of my family.' Building on this spirit of reciprocity, the Mother Friendly Movement has significantly dismantled existing economic barriers thereby rescuing many mothers and newborns from unnecessary deaths.

LOOKING AHEAD

In the first twelve months of intervention, the Mother Friendly Movement has yielded quite impressive preliminary results in the eight pilot districts. Maternal mortality has become a concern of the entire community. Pregnant women, their families and their communities have learned about causes of maternal deaths, high-risk pregnancy signs, the crucial role of men in preventing maternal deaths, and the importance of monitoring maternal and child health.

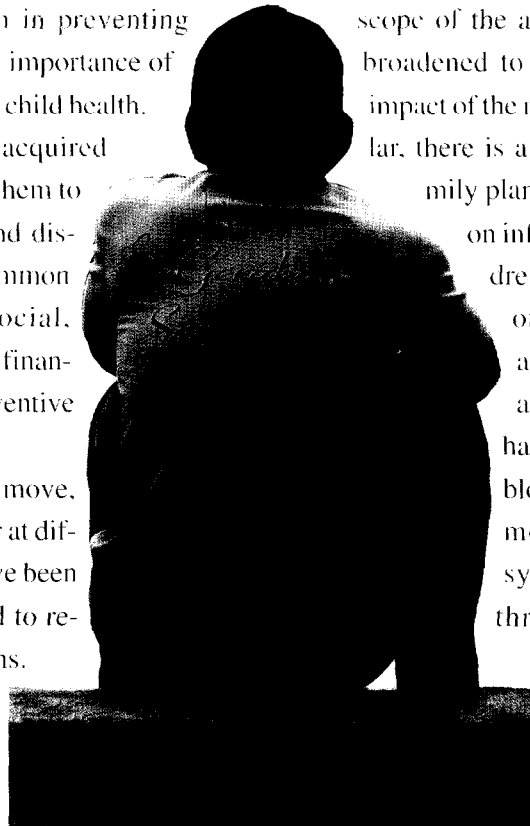
In turn, this newly acquired knowledge has enabled them to join hands with local and district authorities in a common effort to dismantle social, medical, geographic and financial barriers through preventive and promotive action.

In an unprecedented move, resources and manpower at different decision levels have been synergetically employed to reduce unnecessary deaths. Preliminary data seem to suggest that the efforts of the Ministry for the Role of Women and

its multifarious partners have not been in vain. Maternal mortality in the eight Mother Friendly Districts has on average decreased below the national figure, reaching 325 versus 390 per 100,000 live births. Although still preliminary, these results suggest that the strategy followed has taken us in the right

direction. In the intervention area, the scope of the activities can now be broadened to further enhance the impact of the movement. In particular, there is a need to promote family planning decisions based

on informed choice: to address the consequences of unsafe abortion and adolescent sexuality; and to continue to enhance provision of safe blood supplies. Furthermore, upgraded and systematic education through the Mother Friendly Movement could become a primary channel for women to learn more



'Ensure the success of the Mother Friendly Movement'

about their place in society and their decision-making role in relation to reproductive behavior.

Enriched by these additional activities, the Mother Friendly Movement can be replicated nation-wide. In its continuation phase, the many innovative strategies already successfully tried-out by the eight Mother Friendly Districts in overcoming common delays to receiving emergency obstetric care can be replicated and adapted to other socio-

cultural contexts. Gradually more and more districts can become part of the Mother Friendly Movement, and start to mobilize their communities in the national struggle against maternal mortality. Embracing more and more people, this comprehensive, community-powered movement will surely continue to dramatically reduce Indonesian women's likelihood of dying in childbirth, improving the quality of all the nations human resources.

Healthy mother. healthy baby





GLOSSARY

<i>ABRI Masuk Desa</i>	A program through which the military mobilizes its resources to serve or assist with certain village needs
<i>Adat</i>	Customary law
<i>Aisyiah Muhammadiyah</i>	Islamic women organization, associated with the Muhammadiyah organization
<i>Angkutan Sayang Ibu</i>	Mother friendly transportation
<i>APBD II</i>	Local government annual budget
<i>Arisan</i>	Savings scheme
<i>Arisan balita</i>	Saving scheme among mothers with children under-five.
<i>ASEAN</i>	Association of South East Asia Nations
<i>Badan Amal Zakat Infaq & Shadaqah (BAZIS)</i>	Muslim collection program
<i>Badan Koordinasi Keluarga Berencana Nasional (BKKBN)</i>	The National Family Planning Coordinating Board
<i>Badan Penasehat Perkawinan Perselisihan dan Perceraian (BP4)</i>	Islamic board for pre-marital, disagreement and divorce counseling
<i>Bahasa Indonesia</i>	Indonesian Language
<i>Balai Desa</i>	Village meeting hall
<i>Balai Kesejahteraan Ibu dan Anak (BKIA)</i>	Centers for maternal & child welfare
<i>Bangsawan</i>	Aristocrat
<i>Badan Perencana Pembangunan Daerah (Bappeda)</i>	The District Planning Board
<i>Batak Karo</i>	North Sumatra ethnic group
<i>Bhinneka Tunggal Ika</i>	Unity in Diversity
<i>Bidan di desa</i>	Village-based midwives
<i>Bugis</i>	Ethnic group in Bone, South Sulawesi
<i>Bupati</i>	District Head (local government)
<i>Camat</i>	Subdistrict Head

<i>Cidomo</i>	Horse carts (in Lombok island)
<i>Cipta Karya</i>	Public works
<i>Dai</i>	Muslim religious teacher
<i>Dana sosial bagi ibu bersalin (Dasolin)</i>	Social funds for maternity care
<i>Dasa Wisma</i>	Community-based reporting system
<i>Departemen Pendidikan dan Kebudayaan (DepDikBud)</i>	Ministry of Education and Culture
<i>Departemen Penerangan</i>	Ministry of Information
<i>Desa</i>	Village
<i>Dewan Perwakilan Rakyat (DPR)</i>	The House of Representatives
<i>Dokter PTT (PTT = Pegawai Tidak Tetap)</i>	Non-permanent physicians
<i>Dukun</i>	Traditional healers
<i>Dukun Bayi</i>	Traditional birth attendant
<i>Dukun Paraji</i>	Traditional birth attendant (in West Java)
<i>Fatayat N.U.</i>	Fatayat Nahdlatul Ulama, a Muslim young women organization associated with N.U.
<i>Gerakan Ibu Sehat Sejahtera (GISS)</i>	Healthy and Prosperous Mother Movement
<i>Gerakan Sayang Ibu (GSI)</i>	The Mother Friendly Movement
<i>Gotong Royong</i>	Collective support
<i>IDHS</i>	Indonesian Demographic Health Survey
<i>Jaminan Pelayanan Kesehatan Masyarakat (JPKM)</i>	Community-based care system
<i>Kabupaten</i>	District
<i>Kader</i>	Community volunteer
<i>Kampanye Ibu Sehat Sejahtera (KISS)</i>	Healthy and Prosperous Mother Campaign
<i>Kantor Urusan Agama (KUA)</i>	Office of Religious Affairs
<i>Karang Taruna</i>	Local community youth association
<i>Kartu Monitor Ibu hamil</i>	Pregnancy monitoring card
<i>Kartu Sehat</i>	Health card
<i>Kartu Waspada</i>	High-risk pregnancy monitoring card
<i>Kecamatan</i>	Subdistrict
<i>Kecamatan Sayang Ibu</i>	Mother Friendly Sub-district
<i>Kelompok Kerja Tetap GSI</i>	Mother Friendly Movement working group
<i>Kentongan</i>	Traditional wooden bell
<i>Khotbah</i>	Muslim sermon

<i>Khotbah Jumat</i>	Muslim Friday sermon
<i>Komering</i>	Ethnic group in Ogan Komering Ulu, South Sumatra
<i>Koramil</i>	District military command
<i>Koran</i>	Islam's Holy Book
<i>Lembaga Ketahanan Masyarakat Desa (LKMD)</i>	Village community resilience board
<i>Lingkar Lengan Atas (LILA)</i>	Measurement of upper arm circumference
<i>Lontar</i>	Palmyra palm, the leaves of which may be written on
<i>Lumbung Kredit Pedesaan</i>	Village agricultural credit program
<i>Lurah</i>	Village Head
<i>Magang</i>	On-the-job training
<i>Majelis Permusyawaratan Rakyat (MPR)</i>	The People's Consultative Assembly
<i>Mobil Sayang Ibu</i>	Mother Friendly Ambulance
<i>Modul Diklat Jarak Jauh</i>	Distance learning modules for midwives
<i>Muslimat N.U.</i>	Muslimat Nahdlatul Ulama, a Muslim women organization associated with N.U.
<i>Musyawarah Pimpinan Daerah (Muspida)</i>	The District Council
<i>Naskah</i>	Manuscript
<i>Paguyuban</i>	Traditional cultural organization in West Java
<i>Pasrah</i>	Fatalistic traditional value
<i>Pegawai Negeri Sipil (PNS)</i>	Civil servant
<i>Pemberian Makanan Tambahan (PMT)</i>	Supplementary food
<i>Pemerintah daerah (Pemda)</i>	Local Government
<i>Pendampingan dukun</i>	Cooperative partnership between village-based midwives and TBAs (<i>dukun</i>)
<i>Pendataan Keluarga Sejahtera</i>	Family welfare community-based mapping system
<i>Pembinaan Kesejahteraan Keluarga (PKK)</i>	The Family Welfare Movement
<i>Pengajian</i>	Koran reading session
<i>Persatuan Obstetrik Ginekologi Indonesia (POGI)</i>	Indonesian Obstetrics and Gynecology Association
<i>Pesantren</i>	Islamic boarding school
<i>PKK kader</i>	Family welfare volunteers
<i>Pondok Bersalin Desa (Polindes)</i>	Village maternity post, usually headed by newly graduated midwives
<i>Pondok Sayang Ibu (PSI)</i>	Mother Friendly Waiting Home
<i>Pos obat desa</i>	Village medicine post

<i>Pos Pelayanan Terpadu (Posyandu)</i>	Integrated services for family planning and child health
<i>Pra-sejahtera</i>	Below prosperity line (official terminology indicating low-income or poor)
<i>Pusat Kesehatan Masyarakat (Puskesmas)</i>	Primary health center
<i>Puskesmas pembantu</i>	Primary health care sub-center
<i>Puskesmas tempat tidur</i>	In-patient primary health center (with overnight facilities)
<i>Rapat Koordinasi Daerah (Rakorda)</i>	Local Coordinating Meeting
<i>Rencana Pembangunan Lima Tahun (Repelita)</i>	Five-Year Development Plan
<i>Resiko tinggi</i>	High-risk
<i>Rumah bersalin</i>	Registered maternity clinic
<i>Rumah Sakit Sayang Ibu</i>	Mother Friendly Hospital
<i>Rupiah</i>	Indonesian currency (as of January 7, 1998, US\$ 1.00 = Rp. 7,300)
<i>Safari</i>	Term commonly used for field trips, or government campaigns conducted at the community level
<i>Sasak</i>	Ethnic group in Central Lombok, West Nusa Tenggara
<i>Satuan tugas (Satgas)</i>	Task Force
<i>Satuan Tugas GSI</i>	Mother Friendly Movement Task Force
<i>Sawah</i>	Rice field
<i>Sekretaris Wilayah Daerah (Sekwilda)</i>	Assistant to the District Head or <i>Bupati</i>
<i>Sistem Kewaspadaan Ibu Hamil</i>	High-risk pregnancy monitoring card
<i>Suwarga nunut neraka katut</i>	Javanese proverb meaning that a women should follow faithfully wherever her husband goes, to heaven or to hell
<i>Tabungan Dana untuk Kelahiran Anak Pertama (Tadukap)</i>	Savings account for the first child
<i>Tabungan Ibu bersalin (Tabulin)</i>	Savings scheme for pregnant women
<i>Taman Sayang Ibu</i>	Mother Friendly Garden
<i>Tandu</i>	Stretcher
<i>Tim Asistensi GSI</i>	Mother Friendly Movement Technical Team (at province level)
<i>Ulama</i>	Muslim religious leader
<i>Wedana</i>	Local officer at the subdistrict level

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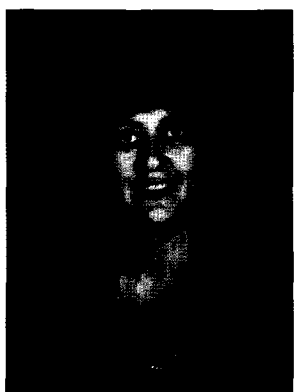
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ABDULLAH CHOLIL was born in Pati, Central Java. He graduated from the Faculty of Medicine at the University of Indonesia, Jakarta in 1965 and from the School of Public Health Johns Hopkins University, Baltimore, USA in 1976. He joined the Army Medical Services in 1967, and the National Family Planning Coordinating Board (BKKBN) in 1973. Between 1973 and 1993, he dedicated himself to the successful promotion of the family planning in Indonesia, and became the Assistant to the State Minister for Population in 1994. He assumed the responsibility as Assistant to the State Minister for the Role of Women in 1995. The Government of Indonesia has awarded Dr. Cholil two honors: *Bintang Kartika Eka Paksi Nararya* and *Bintang Dharma*.



MEIWITA BUDIHARSANA ISKANDAR was born in Jakarta. She received her *dokter* (equal to Medical Doctor) degree from the Faculty of Medicine Atma Jaya Catholic University in Jakarta in 1980 and pursued her Master of Public Administration at the University of Southern California in Los Angeles, graduating in 1983. She earned her PhD in Health Services at the School of Public Health, University of California, Los Angeles (UCLA) in 1993. Currently, she is a faculty member of the University of Indonesia (UI), Faculty of Public Health (Department of Population and Biostatistics, since 1984), a research associate at the Center for Health Research, Research Institute - UI (since 1986), and the Resident Advisor of Population Council, Jakarta (since 1996).



ROSALIA SCIORTINO was born in Palermo, Italy. She studied Cultural Anthropology and Development Sociology at the Free University in Amsterdam where she graduated in 1987. She received her PhD in Social Sciences at the same university in 1992, earning the predicate *cum laude* for her study of health centre nurses in rural Central Java. In the past she has worked as a research assistant at the Center for Asian Studies (CASA), as a researcher at the Free University, and as a lecturer in the Medical Anthropology Unit of the University of Amsterdam. At present she is the Program Officer for Reproductive Health and Human Development at the Jakarta Office of the Ford Foundation, Indonesia.

**A movement
carried out by the community and the government,
for the advancement of the quality of life of women,
especially in accelerating the reduction of
maternal morbidity and mortality rates,
in the interest of human resources development.**

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