

PROGRAMME EXPERIENCES IN INDONESIA
DOCUMENTATION COLLECTION

good practice

lessons learned

innovations

from the field

lessons learned

good practice

from the field

innovations

Foreword

UNICEF is the only inter-governmental agency devoted exclusively to children and is mandated by the world's governments to promote and protect children's rights and their well being. Along with other UN agencies and global partners, UNICEF has taken the Millennium Development Goals as part of its mandate. From working with local policymakers towards health care and education reform to delivering vaccines, each UNICEF action is a step toward a Millennium Development Goals. Within this framework, UNICEF's activities focus on (a) strengthening alliances to promote investments for children and families; (b) supporting national capacity building to fulfil children's rights; (c) generating evidence to inform decision-making, and supporting advocacy and partnerships in favour of children.

UNICEF is therefore rich in experience, and one objective of this publication is to share it. Identifying, validating, and documenting different practices fosters collaboration, encourages the generation of new ideas, aids organisational learning, and can allow successful strategies or initiatives to be replicated. In this spirit, 24 reports are presented in four formats:

- **Good practice:** Documents well assessed programming practices that have evidence of success/impact. These may be valuable for replication, scaling up and further study.
- **Lessons learned:** Offers reflections on the implementation of a particular programme or operation. Reports of both successes and failures are encouraged.
- **Innovation:** News of new thinking in programming and operations. These may be pilot projects or new approaches that demonstrate initial results.
- **From the field:** Flexible short reports for sharing ideas, field experiences, observations, new literature, and so on. Results are not required.

The projects described range from simple innovations such as issuing invitations encouraging pregnant women to have their health checked, to long-standing, large-scale projects UNICEF and partners support nationwide.

It is with great pleasure that we present this publication which gives an insight into the scale and the breadth of UNICEF's work in Indonesia, contributes to better understanding of it, and strengthens alliances and partnerships in support of women's and children's rights.

UNICEF Indonesia
Jakarta, May 2010

The UNICEF work agenda focuses on five areas as outlined in the Medium Term Strategic Plan (2006-2011):

1. Young child survival and development:

Support in regular, emergency and transitional situations for essential health, nutrition, water and sanitation programmes, and for young child and maternal care at the family, community, service-provider and policy levels.

2. Basic education and gender equality:

Focus on improved developmental readiness for school; access, retention and completion, especially for girls; improved education quality; education in emergency situations and continued leadership of the United Nations Girls' Education Initiative (UNGEI).

3. HIV/AIDS and children:

Emphasis on increased care and services for children orphaned and made vulnerable by HIV/AIDS, on promoting expanded access to treatment for children and women and on preventing infections among children and adolescents; continued strong participation in the Joint United Nations Programme on HIV/AIDS (UNAIDS).

4. Child protection from violence, exploitation and abuse:

Strengthening of country environments, capacities and responses to prevent and protect children from violence, exploitation, abuse, neglect and the effects of conflict.

5. Policy advocacy and partnerships for children's rights:

Putting children at the centre of policy, legislative and budgetary provisions by: generating high-quality, gender-disaggregated data and analysis; using these for advocacy in the best interests of children; supporting national emergency preparedness capacities; leveraging resources through partnerships for investing in children; and fostering children's and young people's participation as partners in development.

The UNICEF work in Indonesia is aimed at supporting the Government of Indonesia to achieve the Millennium Development Goals:

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria, and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for development

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FA 1 Good practice: Monitoring pregnant and lactating women

Summary:

Midwives and community volunteers collect household data to be stored and analysed by Local Area Monitoring and Tracking (LAMAT), a management tool that monitors health care delivery to pregnant and lactating women.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

Provinces of Banten, West Java, Central Java, East Java, South Sulawesi, West Sulawesi, Maluku, North Maluku, East Nusa Tenggara - total 24 districts, 109 health centres; Papua - total 4 districts, 8 health centres.

Timeline:

April 2007 - February 2009 & June 2008 - March 2010.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
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Local Area Monitoring and Tracking (LAMAT) is a management tool that continuously monitors the delivery of health care services to pregnant and lactating women. Midwives and community volunteers collect household level data that are entered and stored in a database. Analysis of the database enables midwives to know what services which individuals require, and provide them in a timely and efficient manner.



Midwives receive training on LAMAT
(UNICEF Indonesia/Widiastuti)



Community volunteers concentrate on LAMAT mapping
(UNICEF Indonesia/Widiastuti)

Benefits include improved quality and coverage of maternal and neonatal health care services; improved collection of key outcome data; improved monitoring of services; and improved opportunities for coordination and planning. The programme's objectives of reducing maternal and neonatal mortality fit with the Government of Indonesia's Making Pregnancy Safer strategy.

LAMAT has increased efficiency at health centres and improved the coordination of staff activities. With the help of community volunteers, all pregnant women are now identified and allocated to midwives for support during pregnancy, delivery and the postpartum period. The programme focuses on village midwives but also strengthens collaboration between midwives, traditional birth attendants (TBAs), community volunteers, and health administrators. Midwives' records are now used in monthly planning meetings, which improve service quality and capacity. Improved data also allow for greater macro-level understanding of the maternal and neonatal health situation. Pregnant women are identified irrespective of their socio-economic situation. (In fact, the poverty status of the family is reported alongside the pregnancy status of the woman.) Through the national public health insurance programme (*JAMKESMAS/Program Jaminan Kesehatan Masyarakat*), poor people have access to free maternal health care. LAMAT helps ensure that all pregnant women may now receive it, even in remote areas.

There is strong national support for the programme, which builds on a 1990s national maternal and child health monitoring project, Local Area Monitoring (LAM). In 2007, working with the Ministry of Health (MoH), UNICEF piloted LAMAT in a total of six health centres. In 2008, another 22 UNICEF focus districts replicated the programme, and 13 sub-districts of the Wonosobo district implemented the programme using government funds. Now, all 21 health centres in Wonosobo use the LAMAT system. With three maternal deaths per 1,000 live births, maternal mortality remains a challenge in Indonesia. The inability to adequately monitor and track services at the community level has limited access to maternal and newborn health services. The existing

monitoring system (LAM) is hampered by low coverage and poor data quality, and the information that is collected is not used to its full potential. Indonesia's recent and extensive regional decentralization programme has reduced coordination between various levels of the health system. Consequently, health problems often remain undetected, and effective intervention strategies are not always implemented in a systematic and continuous manner.

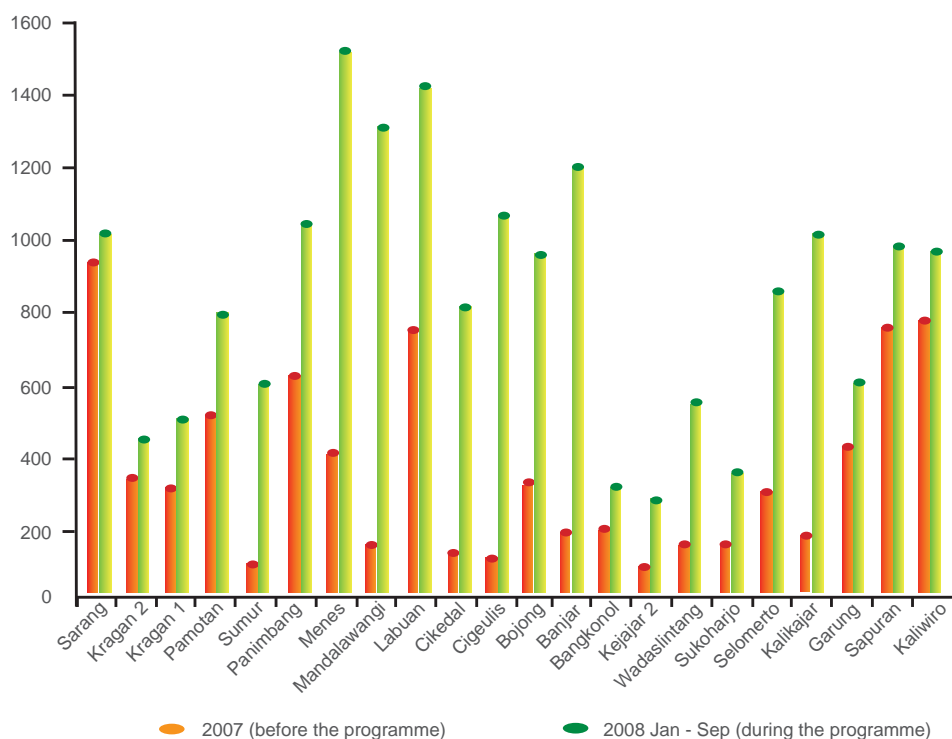
LAMAT aims to revitalize the current national system (LAM) by building the capacity of health centre staff to track individual antenatal, delivery and postnatal care services, and enhance the coverage, quality, planning and coordination of Maternal and Child Health (MCH) services in each focus area. TBAs and village volunteers map out and enrol pregnant women in their coverage area. Once a woman's pregnancy has been confirmed by the midwife, her house is marked with a sticker. Pregnant women are allocated to midwives, who follow them through the delivery and postnatal periods recording a set of health factors. In addition, the midwife fills in an informative Maternal and Child Health booklet that stays with the pregnant woman. Every registered woman has a unique ID number. Data operators enter the data provided by the midwives every two weeks and summarize the information in monthly reports. This summary data is used in monthly meetings held by midwives to plan the delivery of services for the next month. Midwife supervisors and the head of the district hospital monitor the delivery of services and identify whether additional resources are needed. Separate training is provided to the following groups: village volunteers and TBAs, midwives, midwife supervisors, data operators, and heads of health centres.

Transferring from LAM to the LAMAT system will require time, however. Currently, data operators at local health centres and district health offices are required to prepare monthly reports in two formats. Provincial level administrations, which are not yet part of the system require a different format for the monthly results. Budget allocation for implementation is easier if there is already local budget reserved for data collection. LAMAT depends, however, on functioning hardware and software, and maintenance, technical and compatibility problems have been reported. Furthermore, changes of staff in key positions (e.g. head of health centre, midwife coordinator, data operator) can affect the smooth running of the programme, and result in the need to rebuild capacity. A facilitator should be responsible for the successful implementation of the programme in each area. He or she must be easy to reach for solving urgent technical problems.

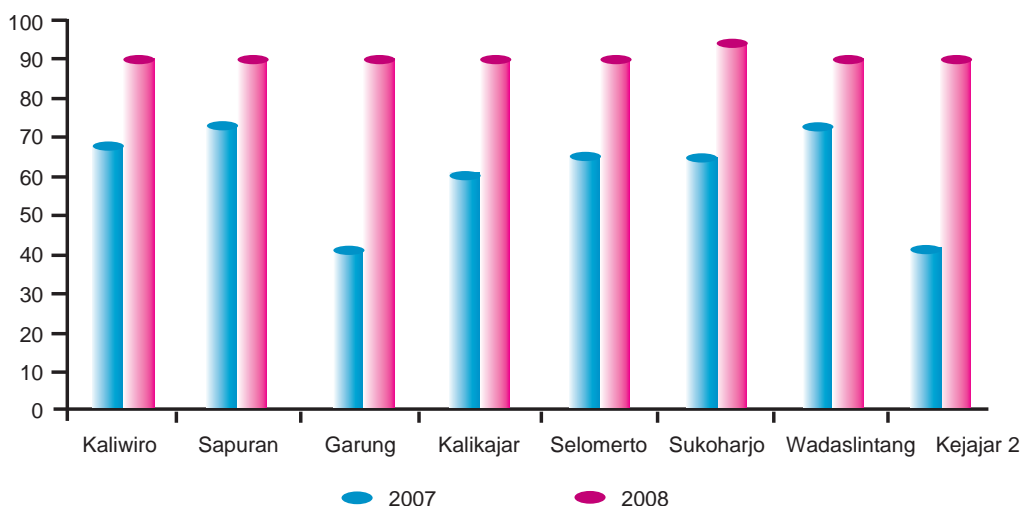
Appropriate use and interpretation of LAMAT system through discussions and questioning were observed by the Independent Monitoring and Evaluation Team in September 2007 in two health centres in *Galesong Selatan*, District Takalar, South Sulawesi, and two health centres in Pandeglang, Banten. In January 2008, a MoH review of the programme revealed that almost all health centres reported a better recording system and an increased coverage of pregnant women since community volunteers and TBAs have been involved in registration. MoH agrees that the previous LAM system needs to be revitalized and improved, and following the review, MoH agreed to support the new LAMAT system and aims to extend it nationally using its own budget. MoH is also working on linking LAMAT with other existing data record systems such as birth preparedness, immunization and hospital records.

Progress and results:

Number of pregnant woman recorded in *Puskesmas* before and during the programme



First antenatal (K1) care by midwife base on actual number in UNICEF focus HC - Wonosobo District



Health officials, however, do not yet generally understand that LAMAT is a complete management tool, and health centre heads and midwife coordinators must be motivated, and capable, to use the database as a tool for coordinating, managing and improving their activities. A further benefit of midwives being familiar with the concept of using data for planning services is that data are more complete if midwives understand that the database can, and should, be used in this way. It is also now understood that each health centre needs to have a data operator dedicated to taking care of the database. Improved data entry and data cleaning skills

greatly reduce the administrative workload of the village midwives. A further future step would be to ensure that data are moved more consistently to higher levels of the health administration where they may be used more strategically, including for financial planning and decision making. It would also be valuable to find a way for the midwives to communicate their observations and the value of the system back to the community. Recently, collaboration with a local university has been proposed. This will further improve the quality of the database and data analysis, and support the university in increasing its academic output.

FA 1 Good practice: Responding to malaria through maternal and child health

Summary:

With pregnant women and families with children under five vulnerable in eastern Indonesia, bed net distribution has been integrated into routine outreach and reporting services. Midwives, nurses and immunization officers distribute bed nets, and midwives provide malaria diagnosis and treatment in remote villages.

Partners:

United States Agency for International Development - CDC (USAID - Centers for Disease Control and Prevention, USA); Indonesia Ministry of Health.

Area:

11 districts in eastern Indonesia, with a total population of 2 million people.

Timeline:

4 years.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

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[Original report courtesy of UNDP]

National malaria authorities recognized pregnant women and families with children under five in malaria-endemic eastern Indonesia as vulnerable populations that needed to be prioritised. As a result, bed net distribution was integrated into routine and outreach antenatal and immunization services and reporting systems. Midwives, nurses and immunization officers distributed bed nets during the first antenatal visit and upon completion of basic childhood vaccinations. In addition, midwives provide malaria diagnosis and treatment for pregnant women and other



UNICEF provides a bednet as part of the maternal and child health programme (UNICEF Indonesia/Susanto)



Mother and child inside the bednet where they know they will be protected from Malaria (UNICEF Indonesia/Susanto)

community members in remote villages. The integration appears to have improved outcomes for all three programmes (malaria, maternal health, immunization) and contributed towards attainment of the Millennium Development Goals. Not only have bed nets been effectively distributed to vulnerable populations, but the provision of bed nets as an incentive seems to have boosted coverage of early antenatal visits and completion of immunization. Working together as a team, UNICEF and the Ministry of Health (MoH) have been able to leverage funds to scale up

this approach from an initial 11 pilot districts to over 200 malaria endemic districts of Indonesia, outside Java. In the context of the decentralized nature of Indonesia's health system, continued facilitation, monitoring and evaluation are required to ensure local ownership and sustain synergies over time in terms of service delivery outcomes and health impact.

Malaria is endemic in eastern Indonesia with variable levels of transmission intensity and is predominantly a mixture of *Plasmodium falciparum* and *Plasmodium vivax* infections. Generally, prevalence is greater in the more rural and remote areas where healthcare services are often insufficient. The main burden of malaria morbidity and mortality is among children under five, but pregnant women are particularly vulnerable. Malaria during pregnancy contributes to maternal mortality, severe anaemia, low birth weight, still births and various deleterious effects for the child. In some areas of eastern Indonesia pregnant women had previously been treated with chloroquine for prevention of malaria, however, this practice has been abandoned due to the development of resistance. The need for an alternative approach to addressing malaria in pregnant women led to the current programme, which supports prevention through bed net distribution and includes rapid diagnostic screening and treatment with artemisinin combination therapy (ACT). With respect to malaria in young children, the need to expand distribution was widely recognized, and distribution of bed nets through the immunization programme, which had achieved relatively high population coverage, was an obvious choice. While programmes providing antenatal care and immunization services have a collaborative history due to their related target populations, the malaria programme had previously focused on broader population-based strategies implemented vertically. Most of these activities had been built around campaigns, but this approach is problematic

for the distribution of bed nets in early pregnancy and for children under five. The antenatal and immunization programmes, by contrast, provide more routine and ongoing services to pregnant women and young children.

Integration of malaria prevention into existing maternal and child health outreach strategies required substantial facilitation by UNICEF to bring together MoH departments at central, provincial and district level. UNICEF, along with key champions within the MoH, played critical roles in facilitating collaboration across these departments to identify mutual goals, draft a national strategy and ensure joint inputs with regards to developing operational guidelines, training materials, staff orientation, logistics systems and reporting formats for their respective programmes. The departments were not required to integrate, but they were encouraged to collaborate to ensure integrated service at the field level.

Fostering the integration of bed nets into routine and outreach services across MoH departments was especially challenging considering the current context of decentralization in Indonesia. Facilitation was required across sectoral departments (malaria, maternal health, immunization), as well as vertically from central to provincial and district levels. Fostering ownership at the provincial and district levels was essential not only due to the vast and diverse nature of Indonesia, which encompasses 33 provinces and nearly 500 districts, but also because districts now have significant budgetary resources and discretion to determine the nature of service delivery. 'Socialisation' through multiple consultations, orientation meetings, field visits by provincial and district personnel to sites that had already benefited from the approach, helped roll out the strategy from central to provincial and district levels. Support from the political authorities (*Bupatis*) was essential not only in securing district level financial

allocations, but also in raising the profile of malaria at the community level and establishing malaria as an issue for local health and development policies and programmes.

Midwives and nurses form the backbone of the healthcare system in Indonesia, particularly in remote areas. They serve as the primary frontline providers of preventive and simple curative care for rural populations. In addition, they coordinate with health centre staff and village level volunteers (*kaders*) in organizing monthly outreach visits that combine antenatal and immunization services. UNICEF supported the development of field level operational guidelines, training materials and job aids to assist these frontline providers and managers to integrate the service. Personnel from all relevant MoH departments and UNICEF were involved in undertaking training of trainers at the provincial level. Within each province, district personnel then trained all service providers at regional and health centre levels, which enabled the training of a greater number of providers. Training was imparted in a participatory fashion encompassing both theoretical and skill-based elements of integrated service delivery. It introduced the providers to malaria in pregnancy, a new area, and provided an opportunity to refresh existing competencies in antenatal care and immunization. Feedback from programme implementation experiences led to the introduction of modules on supervision and reporting responsibilities in the training modules.

A preliminary evaluation suggests that not only were bed nets effectively distributed to a high proportion of pregnant women and families with young children (particularly children under five), but the provision of bed nets as an incentive improved overall coverage of first antenatal visits (in Jayapura, a 20 per cent jump in ANC coverage was observed¹), encouraged earlier presentation for antenatal

care, and increased completion of childhood immunization. Women generally view bed nets as a desired commodity. In addition to prevention of malaria, they cited the reduction in annoyance from mosquito bites sustained by their children as a benefit. Midwives and immunization staff reported minimal additional burden and perceive that the distribution of nets had led to improvements in coverage of their services. In South Halmahera District, survey results carried out in collaboration with the CDC/Atlanta showed a marked decrease in drop-out in the target district, but no change in other districts within the province, which had not yet rolled out the integrated programme. Further, clear increases in DPT3 coverage and proportion of child up-to-date in their immunizations were observed in the survey data². In places where the programme has succeeded the most, substantial district level ownership from the district health office and from the *Bupatis* exists. Collaboration across departments generated integrated guidelines, training and job aids to ensure integrated service delivery and reporting. Integration generated synergies to the benefit of all three programmes (malaria, maternal health and immunization), and addressed priorities highlighted by MDGs 4, 5 and 6.

UNICEF and the MoH have been able to leverage funds to scale up the approach from an initial 11 pilot districts to over 200 malaria endemic districts in Indonesia, where malaria transmission is sufficiently intense to justify this approach. Funds have been raised through grants from the Global Fund totalling US\$ 168 million to support integration of malaria prevention with antenatal care and the Expanded Programme on Immunization.

The strategy increased the number of first antenatal visits and improved their timing. In Jayapura District, reported ANC coverage increased from 80 per cent to close to 100 per cent after inception of the programme. However, no major increases were noted in

additional antenatal visits or in the proportion of deliveries performed by midwives. In addition to optimising the tetanus immunization and the diagnosis and treatment of anaemia and under nutrition through first antenatal visits, further benefits can be obtained through additional visits, including opportunities for detection of other health problems and for counselling on the importance of midwife-assisted deliveries, exclusive breastfeeding, and postnatal visits.

Realizing the full potential of the synergy obtained by bed net distribution will require convincing mothers during the initial visit that they should return for additional visits and be delivered by a midwife rather than a traditional birth attendant. An additional issue is the need to ensure the collection of data to demonstrate the effectiveness of the programme to external groups and donors as well as to use it to advocate for programme expansion. Although high quality administrative data that could be readily used to evaluate and monitor the programme was observed at local level, district-level summaries were incomplete and often inaccurate. A third challenge is maintaining the gains of the programme in the pilot areas. This will require a number of actions at local and district levels including: improved supervision of staff; improved record keeping and data management; careful monitoring of the results to ensure that service delivery is being optimised; focus on specific indicators relevant to the programme objectives; and development of training activities that are flexible to address the frequent turnover of staff.

Political commitment represents a fourth challenge. Scale-up is planned to over 200 malaria endemic districts in Indonesia, outside Java. For Sumatra, Sulawesi, and Kalimantan, the programme is being rolled out only in selected districts. Within some districts, the programme will be rolled out only in selected sub-districts, due to the heterogeneity of

malaria transmission. A final challenge is sustainability. Although money from the Global Fund for AIDS, Tuberculosis and Malaria has made scale-up possible, the pressure to rapidly disburse funds may not permit sufficient time to develop local sharing/ownership of the strategy and thus threaten sustainability. In terms of the health system, bottlenecks that threaten service delivery, such as personnel turnover, represent a threat to sustainability as well.

Integration of bed net distribution as an incentive into existing routine and outreach antenatal and immunization services seems to have enabled better results in terms of improved access and quality of services for pregnant women and children. Integration of bed nets was coherent with the preventive orientation of existing antenatal and immunization services. Integration thus accomplished mutual goals without altering programme identities, leading to greater provider and bureaucratic acceptance. When implementing an integrated programme, efforts are however required to ensure the development of training materials for new and existing staff, plan the logistics of bed net distribution, modify reporting systems, and ensure that the data obtained are fully utilized to further improve the programme.

An additional lesson was the importance of local political support in decentralized countries such as Indonesia. UNICEF field staff played a critical role in obtaining such support, which will be essential for programme sustainability. UNICEF can also play a major catalytic role in convening partners who may have little prior experience working together or for whom collaboration may present political challenges. By creating such coalitions, funding opportunities appear to be greater. For example, US\$ 168 million was raised through grants from the Global Fund to further implement the programme.

FA1 Good practice: Traditional birth attendant and midwife partnerships

Summary:

Traditional birth attendants (TBAs) are much respected in the community, and play an important role at delivery, especially among the poor. However they lack technical skills to deal with complications. This new form of partnership means TBAs and midwives can work better together.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

Banten, West Java, Central Java, East Java, South Sulawesi, West Sulawesi, Maluku, North Maluku, East Nusa Tenggara - total 24 districts.

Timeline:

January 2007 - February 2010.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org



TBA partnership
(UNICEF Indonesia/Widiastuti)



TBAs play an important role in the community
(UNICEF Indonesia/Widiastuti)

Traditional birth attendants (TBAs) are much respected in the community and play an important role at the delivery of babies especially among the poor. partnership has resulted in TBAs and midwives working together. As TBAs impress on pregnant women the importance of timely

referral to midwives, midwives increase their attendance at delivery. Thus, even though the process of delivery has been taken out of the TBAs' hands, their social status has not been damaged, and has even benefited by their role being formally acknowledged within the health system. Young women in Wonosobo

and Takalar report that they now place more trust in the midwives than the TBAs in terms of the technical aspects of delivery. Respecting the work of the TBAs by allowing them to continue and expand their roles, and ensuring their incomes, has proven to be effective. As part of UNICEF Indonesia's programme 'Improving Maternal Health in Indonesia' (IMHI), the programme's objectives of reducing maternal and neonatal mortality fit well with the Government of Indonesia's Making Pregnancy Safer strategy.

With three maternal deaths per 1,000 live births, maternal mortality remains a challenge in Indonesia. TBAs have been, and are, favoured by many women as the primary means of support for their delivery at home. They are much respected in the community, not only as elders and birth attendants, but also as providers of massage, herbal remedies and spiritual support. They are, however, rarely prepared for the management of complications such as eclampsia or haemorrhage, and tragedy often results. For more than 20 years international donor agencies and local organizations have put resources into TBA training programmes, with the expectation that it would contribute to a reduction in the maternal mortality rate. Studies of these programmes' effectiveness however showed that a reduction in maternal mortality only occurred in areas where the TBAs had skilled backup support.

A strategy was required that maintained TBA's participation in delivery and maternal care whilst adding technical skills. The TBA-midwife partnership appears to have found an appropriate solution for all stakeholders, and it can be varied in small but important ways to take account of local cultural norms. Initial elements of implementation involved

introducing the project to district health offices, heads of districts and other local leaders. Partnerships between TBAs and midwives were then formalised in a contract and a financial agreement, and developed through monthly meetings of TBAs and midwives at health centres. TBA's were also offered internships at health centres and in some cases provided with a uniform. The TBAs proceeded to inform pregnant women about the project and explain to them the importance of clinical interventions by midwives. These messages were reinforced through the local media, and community volunteers were recruited to help identify pregnant women. Awareness among men of their role in emergency obstetric preparedness has also increased, and they have been encouraged to establish village ambulances and participate in creating a blood supply system.

Uptake of emergency services may be limited, however, because the costs for transportation and food for accompanying family members have to be covered, even though the health services are free for poor families. The project is however directly relevant to improving maternal and neonatal health among the poor. The TBA-midwife partnership supplements the national public health insurance programme (*JAMKESMAS/Program Jaminan Kesehatan Masyarakat*) by addressing cultural rather than financial barriers to accessing maternal and neonatal care. It draws on the TBA's pride in being part of the health system. The project is an ideal partner for other Maternal and Child Health programmes such as Local Area Monitoring and Tracking (LAMAT) and Birth Preparedness and Complication Readiness (BPCR).

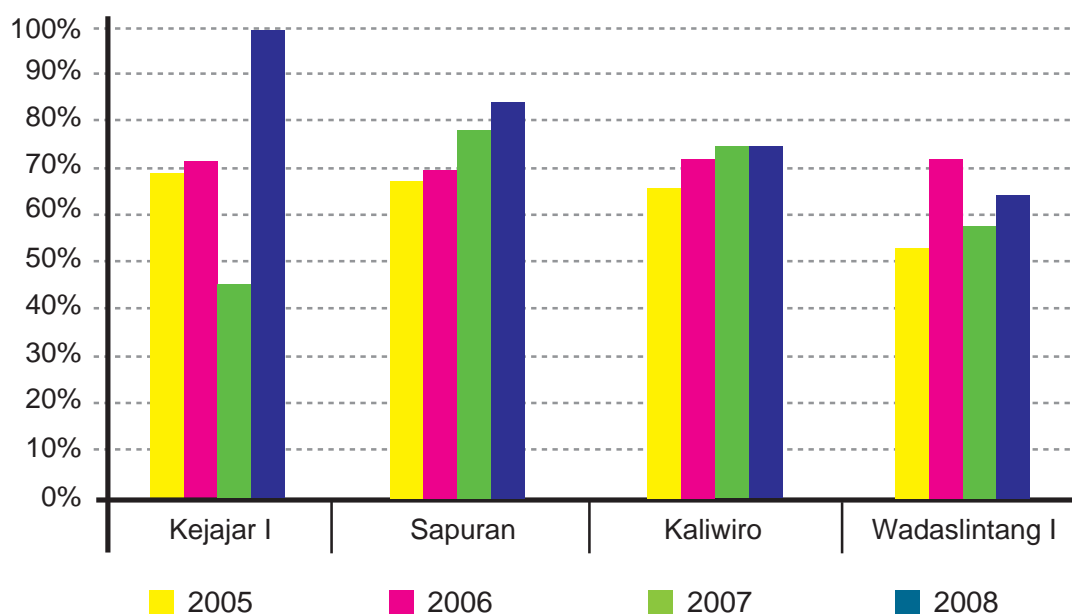
The project's introduction in January 2007 in five health centres of two sub-districts in

Takalar, South Sulawesi, has successfully increased the proportion of deliveries attended by skilled personnel. After three months of the project's start, midwives attended all deliveries in the pilot areas. Health officials have visited Takalar District from other provinces and districts to learn from its success, and to date 10 districts in South Sulawesi, have replicated the programme with the support of the provincial budget. In Takalar the district head is making the TBA-midwife partnership a local law, and implementers there explain that the project's success can be largely attributed to the strong commitment of political, religious and other community leaders, as well as that of the staff of health centres.

programme with their own budget. The village of Plobangan has received an award from the district for the joint activities of the village community to improve maternal and neonatal health. Wealthy families donate a cup of rice each day to a local social organization, which sells it and uses the revenue to support pregnant women in paying for the costs of delivery. The Ministry of Health plans to financially support another 155 districts that cannot afford to replicate the programme using their own funds and have less than 75 per cent of deliveries attended by skilled personnel.

In three sub-districts of Wonosobo, maternal mortality has however stayed high despite

Proportion of deliveries attended by skilled personnel in four pilot sub-districts in Wonosobo



Similarly, in 2008, the proportion of women who delivered with skilled assistance increased in all four pilot sub-districts in Wonosobo district, Central Java, compared to the years before implementation. Also in 2008, 14 sub-districts in Wonosobo district replicated the

the implementation of the partnership. The reasons are not obvious but may be due to the high proportion of poor people in the area (greater than 30 per cent) and the high number of TBAs relative to midwives (more than four TBAs per midwife). More broadly, gender

inequality, linked with socio-economic factors, appears to be related to high maternal mortality. This inequality manifests itself in unequal domestic workloads and women's nutrition during pregnancy and postpartum, as well as in decisions about delivery. Referral to hospital has sometimes been delayed by slow decision-making by the extended family in place of the unemployed husband. Another challenge relates to the fact that midwives often do not want to work in remote areas. Therefore, sometimes only newly graduated and relatively inexperienced midwives are available in these areas, and it can take time before the community accepts them. It will need more time before all partnerships are fully consolidated by midwives and TBAs. In some case external facilitators have been required to solve incidences of mistrust.

The Independent Monitoring and Evaluation team commented favourably on the project's achievement in September 2007, recommending investigating in more detail the underlying mechanisms. For the TBA-

midwife partnership to be successful, it is now recognized that a formal signed agreement, including a specification of shared income, is key. In Takalar, the midwife must pay the TBA IDR 50,000 - IDR 100,000. Formal recognition by health care officials of the distinct roles, and the value of both midwives and TBAs, is also vital, and the involvement of community volunteers is important. They are key in identifying pregnant women and organizing their transport to the hospital in case of emergency. Motivating government authorities to participate is a strategic challenge. Much of the success of the partnership depends on the will of political leaders. Separately, some programme implementers think that the future of the project may be challenged by decreased numbers of TBAs. As many villages now have a resident midwife, the TBA's role may become redundant. Others think that the TBAs will persist because it is an inherited profession and their work profile is being usefully modified. In Takalar, the district head plans to provide a scholarship for the midwifery school to female relatives of TBAs.

FA 1 Lessons learned: Avian influenza community awareness

Summary:

UNICEF field offices developed their own plans for avian influenza community awareness and empowerment activities around a central strategy and centrally produced communications materials. This allowed for contextually sensitive but relatively consistent messaging.

Partners:

Canadian International Development Agency (CIDA); Indonesia Ministry of Health; National Avian and Pandemic Influenza Co-ordinating Agency (*KOMNAS- FBPI*).

Area:

High risk areas in Java, South Sulawesi and Sumatra.

Timeline:

Mid-2006 to mid-2009.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

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With so many Indonesian families³ keeping chickens and other fowl in a 'backyard' setting, community awareness and social mobilization efforts are directly relevant to the avian influenza (AI) response. Aware and active individuals and communities offer a significant means to decrease the incidence of the disease in animals, and to decrease the risk of transmission to humans. As part of the national communications strategy, UNICEF therefore



UNICEF leads in raising awareness on bird flu so that the community can protect themselves from bird flu
(UNICEF Indonesia/Pumomo)



A child looks at birds in the cage at Sasana Kukila bird market as the workers of Animal husbandry Department spray disinfectant to stop the spread of deadly virus in Magelang, Central Java
(UNICEF Indonesia/Pumomo)

initiated and supported a range of community awareness and empowerment activities, including grassroots social mobilization efforts.

These activities varied from district to district, depending on local needs and the wishes of the local authorities. The UNICEF provincial field offices were key in this variegated approach. Indonesia is large and culturally diverse, and each field office knows their local area and has established ties with local

administrators. Each field office therefore developed its own plan within a strategy developed centrally, and many of the communications materials (particularly an 'Avian Influenza Prevention Kit' containing masks, gloves, soap, banners, stickers, an instructional booklet and video compact discs) have been the same. This has ensured relatively consistent approaches and messaging. The localised approach, whereby strategy and materials are produced centrally, but considerable freedom is allowed to regional offices to design and implement specific interventions, was an important factor in maintaining effectiveness and relevance given Indonesia's cultural and geographic variability.

Objectives:

- community empowerment: increasing AI awareness, developing village action plans, rules and policy, enabling and encouraging behaviour change and lifestyle improvements.
- institution strengthening at health centres, district health offices, planning offices, veterinary and animal husbandry operations, and village and sub district offices.
- encouraging AI related information flow through direct inter-personal communications as well as community interaction.

Activities have included:

- participatory learning and community empowerment workshops for village leaders, health workers, religious groups, and government officials.
- sub-district and village level awareness meetings.
- distributing 100,000 AI kits to more than 1,200 villages.
- recruiting and training voluntary cadres for

animal health.

- producing and disseminating locally initiated communication materials such as booklets and flyers.
- NGO and civil society engagement (e.g. community radio).
- private sector engagement (e.g. orientation for factory workers).
- village level outbreak simulations.
- advocacy with regional, district and sub-district level leaders.
- celebrity road shows and social events.

A 2008 study⁴ involving 1,726 respondents in seven provinces (North Sumatra, Jabodetabek - the urban area comprising Jakarta, Bogor, Depok, Tangerang and Bekasi, West Java, Central Java, Yogyakarta, East Java and South Sulawesi) showed significant changes in knowledge and behaviour in several key areas compared with a related study in 2007:

- Washing hands with soap before eating increased from 47 per cent to 56 per cent among adults, from 37 per cent to 68 per cent among school children, and from 23 per cent to 53 per cent among community leaders.
- Among adults, knowledge of the need to burn and bury infected dead poultry increased from 57 per cent to 68 per cent, and to report suspected AI poultry cases increased from 51 per cent to 69 per cent. Knowledge of the need for humans to visit a health centre if they have a high fever increased from 45 per cent to 57 per cent.
- Poultry owners claiming to 'clean the environment from poultry's excess' increased from 15 per cent to 46 per cent, and to wash hands after touching poultry from 17 per cent to 45 per cent.
- Making sure to stay away from poultry increased from 32 per cent to 68 per cent among adults, from 23 per cent to 66 per

cent among school children, and from 12 per cent to 72 per cent among community leaders.

- Eating only well-cooked chicken increased from 69 per cent to 95 per cent among adults, from 53 per cent to 92 per cent among school children, and from 49 per cent to 94 per cent among community leaders.

Lasting change caused by the programme will however vary according to region and the prevalence of AI in poultry, as well as the occurrence of human cases. Some badly affected areas have seen significant changes in poultry raising practices (fewer children now care for poultry, for example) and community norms and regulations. However, whilst outbreaks in poultry or human cases in particular, reportedly provoke and sustain change, a low, or zero, incidence level, appears to reduce the perceived need to sustain change. The increased awareness and capacity among human health and veterinary personnel, and the importance of their communicating AI related information to the community, is more significantly sustainable given the way the new information has been embedded into their professional training and outlook. At both the community and the professional level, the training of facilitators has been of long term value, but continuing funding is required for them to expand the number of communities / professionals that benefit, and regular campaigns / events may be required to maintain AI as a priority at grass-roots level.

The number of new partnerships is extensive. Each field office has its own expanded network. In essence, the one major objective of the programme has been to engage every community, and every individual, as a partner

in countering the spread and threat of AI. Generically, provincial and district health, veterinary and education services have very often been involved, as well as district planning board offices. More specifically, to take just one example, a community meeting and video conference in a remote region of Lampung involved *Bakti Husada* (Lampung Health), Speedy Broadband Access, Darmajaya Informatics and Business Institute, *Suara Petani - 107,7 FM Radio Komunitas*, *JRKL Radio Komunitas Lampung*, as well as provincial, regional and village authorities.

By increasing knowledge and awareness, in regionally and culturally appropriate terms, the programme has enabled families and communities to take action to reduce the spread of avian influenza and to reduce the risk of transmission to humans. Community leaders in particular appear to have benefited significantly from the information and knowledge transfer. The participatory (and in many cases fun and enjoyable) nature of the activities has attracted many segments of the population including adolescents and children. The programme has impressed the threat of AI, and the commitment of UNICEF to countering it, on a large number and wide range of partners, particularly in provincial and regional government departments. Similarly, a large number and wide range of communities, and the individuals within them, particularly in 'high risk' areas, have been engaged with in a participatory manner that leaves considerable scope for the communities to take the action they see as most appropriate. In some areas (such as West Sumatra) provincial funds have been found to extend the animal health side of the programme, and in others (such as Temanggung in Central Java) funds for more general programmes have been made available⁵. The overall

picture, however, is variegated: some regions have been significantly mobilized; others less so.

The design, production and distribution of the 'AI kits' represented significant initial costs to the programme, as did the training of facilitators. More kits will be required if the programme is to be expanded, and whilst a number of facilitators are now trained, further support is required for them to expand their work in communities. As noted above, significant learning has taken place and useful structures have been established at the community level, but both will need to be reinforced, especially in the absence of poultry outbreaks, or human cases.

Instigating and maintaining changes towards healthy behaviours is a recognised challenge everywhere in the world, and in Indonesia there are many competing health priorities. Poultry death is common (through diseases other than AI), and few people see avian influenza as a direct threat to their health. Regular AI 'reminders' are therefore probably necessary, especially in the absence of outbreaks. This might be most efficiently accomplished by incorporating community level AI awareness and empowerment initiatives into broader health-related programming, or expanding AI related initiatives to include other relevant threats, such as rabies. In Indonesia, a regionally specific approach is key.

FA 1 Lessons learned:

Desa SIAGA - reducing maternal and infant mortality

Summary:

Maternal and neonatal mortality rates in central Java project areas are lower than the national level because district governments are using a Participative Learning and Action approach. This encourages people to share experiences, identify problems and implement solutions themselves.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

Wonosobo, Central Java.

Timeline:

2005 - 2009.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org



A midwife in Java paying home visit
(UNICEF Indonesia/Widiastuti)

Maternal (3/1,000), infant (46/1,000), and neonatal (24/1,000) mortality rates in Indonesia are high.

Addressing the issue is challenging because it relates not only to medical services but also to social, economic, cultural and community factors. Purely medical approaches to the problem have been shown to be insufficient. In Central Java province, the *Desa SIAGA* ('Ready, Escorting, Watching') project has been implemented in Wonosobo, Banjarnegara and Rembang districts with UNICEF support, and maternal and neonatal mortality rates are now lower than the national levels. The project uses a Participative

Learning and Action (PLA) approach. As the name implies, PLA encourages people to share experiences, identify their own problems, make their own decisions, and implement solutions themselves. The method is significantly different from 'top down' approaches where a solution is identified outside the community and brought into it for implementation.

The objective of the PLA approach is to empower local inhabitants to improve the health system in their community by increasing their knowledge, their self-esteem, and their ability to collaborate, plan and act. The process

involves local inhabitants, local leaders, local government and village facilitators working together with a common objective. Importantly the facilitator is not a government officer, but is someone trained in PLA methods, who is able to maintain informal and personal relationships with all the local inhabitants. The PLA method is widely appreciated, as it involves games and group work. Sharing experiences is also important as this creates a shared sense of responsibility for the health and safety of pregnant women, women in labour, newborn children, and in supporting local midwives. It has been suggested that the process acts as a community level health education system, identifying local requirements and local abilities, and generating the confidence and enthusiasm needed to build an appropriate and effective local health system in which the local community can have a sense of ownership and pride.

In brief, the process involves specially trained facilitators leading the inhabitants of a village through an enjoyable and informative process that allows them to get to know each other better, and build the trust on which fruitful collaboration depends. Specifically, the *Desa SIAGA* project aims to build understanding and capacity in three areas:

- 1) *SIAP* - identifying pregnant women, and preparing for normal deliveries and emergencies. The latter includes, for example, identifying possible blood donor candidates.
- 2) *ANTAR* - preparing transport for normal deliveries and emergencies.
- 3) *JAGA* - supporting pregnant women at the time of delivery, and follow through activities such as encouraging breast feeding and health checks for mother and their babies after delivery.

PLA is an extensive and detailed process, based around work in groups, and is used in

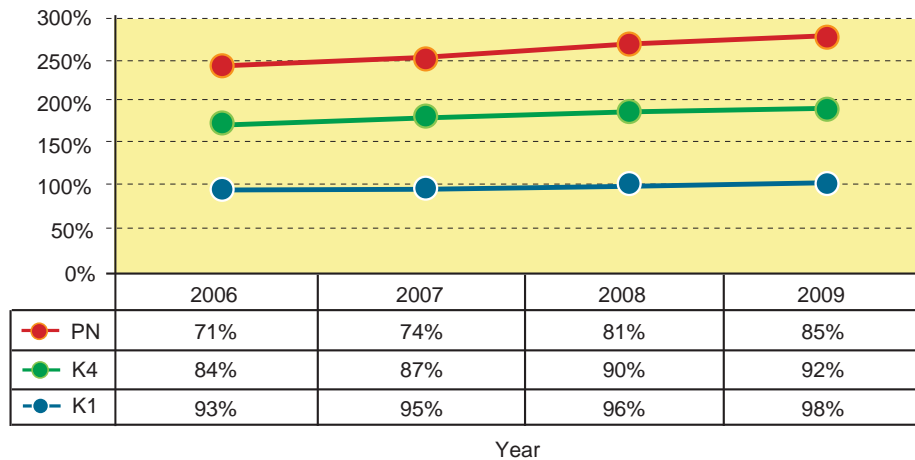
a wide range of situations. It includes activities such as:

- Mapping - participants create and present maps of the village relating to maternal health.
- Transect walks - participants check the map, identifying where pregnant women and midwives live, and where transport is available.
- Body mapping - participants create life-sized drawings of their bodies.
- Group work - participants discuss specific aspects of maternal and child health.
- Calendar - participants create calendars relating to maternal and newborn mortality.
- Stakeholder analysis - participants use diagrams to identify and categorize local organizations which support Maternal and Child Health.
- Focus group discussion - participants discuss symptoms, causes, preventative measures and treatments, and present group results.
- Action planning - participants decide the best way spread health-promoting messages (e.g. posters, dramas, songs).
- Follow-up planning - participants agree to continue the programme.

Through a PLA approach, the *Desa SIAGA* project has been proven to generate community discussion, concern and learning regarding health issues, particularly maternal and infant mortality. Communities demonstrate creativity and pride in their attainments, and there are many concrete positive outcomes. Sempol village, for example, has equipped itself with an ambulance paid for from the Village Fund Allocation (*ADD*). A number of other villages have initiated community social funds supporting basic health services.

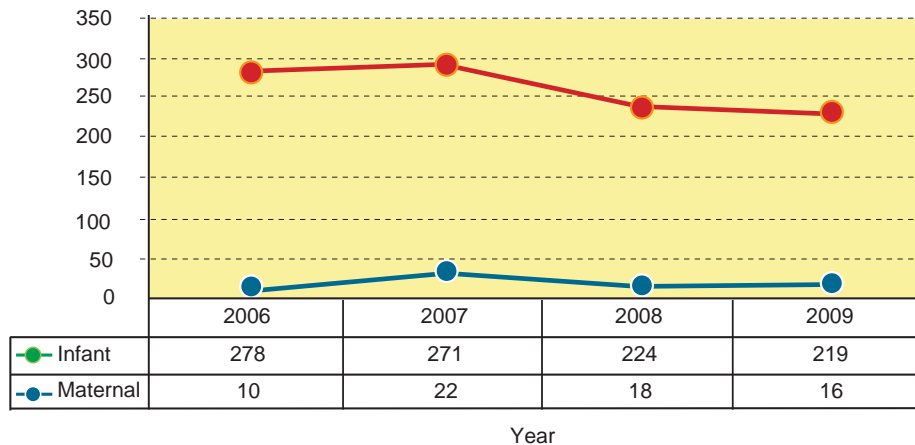
The *Desa SIAGA* project has increased the quality of MCH and community health services in Wonosobo.

Development of maternal health services in Wonosobo 2006-2009



Source: Wonosobo Health Office

Development of maternal and infant mortality cases in Wonosobo 2006-2009



Source: Wonosobo Health Office

The *Desa SIAGA* project has decreased the maternal and infant mortality cases in Wonosobo.

In 2006, Wonosobo as one of the three focus districts (Rembang, Banjarnegara, and Wonosobo) under UNICEF Central Java support, socialized and developed the *Desa SIAGA* project in 50 villages in four sub districts i.e. the Kejajar Sub District (eight villages), Kaliwiro Sub District (eight villages), Wadaslintang Sub District (eight villages), and

Sapuran Sub District (eight villages). In 2007, the Wonosobo local government developed the *Desa SIAGA* project under the *APBD* budget in four other sub districts i.e. the Garung Sub District (five villages), Kalikajar Sub District (five villages), Selomerto Sub District (five villages), and Kalikajar Sub District (five villages). There are currently two development activities in the pilot project village, Sempol: the village ambulance and community financial system.

FA 1 Lessons learned: Developing competency in community midwives

Summary:

In one district in West Java most of the Mother and Child Health budget was spent providing training to almost all community midwives. This did not however necessarily improve the competency of the midwives, or the quality of the service.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

West Java.

Timeline:

2007-2009

MTSP:

Focus area 1 - Young child survival and development.

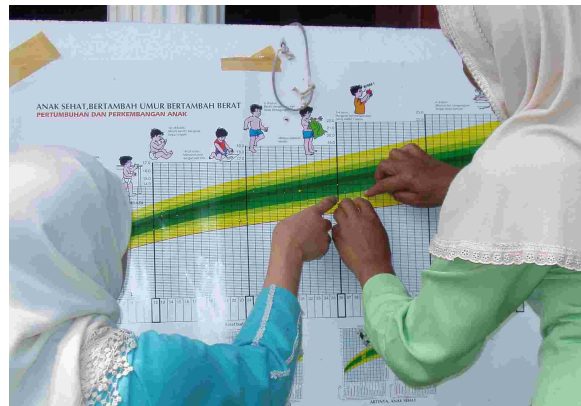
Contact information:

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UNICEF Indonesia, jakarta@unicef.org

In Indramayu, in West Java province, one of four areas where efforts were focused on improving maternal health, most of the Maternal and Child Health (MCH) budget was spent providing training to almost all community midwives. However, this expenditure did not necessarily improve the competence of the midwives, or the quality of the service. Consequently in 2008, Indramayu started to



Community midwives on their way to home visit
(UNICEF Indonesia/Widiastuti)



Midwives practice their skills in monitoring
the child's growth and development using growth chart.
(UNICEF Indonesia/Whoolery)

strengthen the supervision system by combining facilitative and supportive supervision through regional satellite clinics where qualified instructors were available. This programme was supported by UNICEF and the district budget (*APBD*).

The Improving Maternal Health in Indonesia (IMHI) programme was officially launched in

early 2006 in eight provinces in Indonesia. West Java province began the programme later in 2007 after completing district team problem solving (DTPS) planning as recommended by MoH as part of the making pregnancy safer (MPS) strategy. The DTPS planning highlighted the fact that only one provincial and one district centre in West Java were able to provide Basic Normal Delivery (APN) training for midwives. One of the recommendations of DTPS was therefore to develop the District Training System (DTS/P2KP) for midwives in four focus districts - Subang, Sukabumi, Indramayu and Garut - with the intention of developing competency in community midwives. Implementation included the adoption of the MCH programme, replication of UNICEF approaches used successfully elsewhere, and advocacy activities aimed at the local government with a view to obtaining a commitment from the APBD.

In 2007, all four focus districts had a training centre that was recognized by the National Clinical Training Network (NCTN), and an additional four to seven satellite clinics in each focus district provide training that has been standardized by the West Java provincial training centre (PTC/P2KS). As well as supporting the development of the training site, UNICEF supported the preparation of qualified trainers. Now at least four clinical trainers (CT), four clinical instructors (CI) and 40 community midwives have been trained in APN in every DCT. In 2008, UNICEF supported the updating of APN skills integration through five days training covering the early initiation of breast-feeding, newborn care and low birth weight baby management. Experience in implementing this training was shared with MoH as input for the new APN module (2008 edition). This activity has

updated the skills of all APN trainers and 160 APN trained community midwives in all four focus districts. The 2009 DTPS situation analysis identified the success of efforts to decrease maternal death caused by haemorrhage, but suggested that there were still challenges relating to dealing with seizure (eclampsia) in pregnant women. Weaknesses were found in the early detection of hypertension in pregnancy (which is related), the skill of community midwives in administering magnesium sulphate (a therapy), and the availability of magnesium sulphate. Some solutions have been formulated and prioritised to improve the quality of services in 2010-2011.

It is now known that discrete training sessions for community midwives do not necessarily improve their competence, when this is examined for comprehensiveness, or the quality of their service. Qualified instructors should be available to offer support that continues after the discrete training sessions, when midwives are at work in the field. Budget planning should allow for this provision. Monitoring and evaluation should also continue when midwives are at work in the field, to allow gaps in their training and skill-sets to be identified. The low competence of community midwives in assisting complicated deliveries endangers the lives of pregnant women and their babies. Haemorrhage and asphyxia had been identified as the main causes of maternal and newborn death in all four focus districts. Active management of the third phase of labour as outlined in the APN training curriculum has been shown to avoid haemorrhage. APN training is however expensive (averaging IDR 2.5-3.5 million per person plus a lump sum) and there were not enough training places to cover the training requests that were being made.

FA1 Lessons learned: Replicating 'alert' villages

Summary:

'Alert' villages in West Java focus on safe childbirth preparedness. Child health, healthy lifestyles, nutritional awareness are also integrated. Stickers are produced for participating households.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

West Java.

Timeline:

2007-2008.

MTSP:

Focus area 1- Young child survival and development.

Contact information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org

In four focus districts in West Java - Subang, Sukabumi, Indramayu and Garut - the Improving Maternal Health in Indonesia (IMHI) programme has supported the implementation of 'Alert' villages focused on childbirth preparedness, as part of community empowerment relating to Maternal and Child Health (MCH). This initiative emerged from the provincial health office following workshops facilitated by UNICEF. The workshops widened district health planners' perspectives, especially relating to behaviour change strategies, and has led to the development of a set of guidelines, including monitoring instruments, to facilitate replication in sub-districts. Replication to non-focus sub-districts is however challenged due to the high cost of intervention. On average each village is



A baby receiving immunization
(UNICEF Indonesia)



Improving maternal health is one of the important factors in ensuring a healthy child health and development
(UNICEF Indonesia/Suvikaisunthom)

estimated to need IDR100 million to cover 25 health posts (*posyandu*). With 40-60 sub-districts per district, each district is therefore calculated to need more than IDR 5 billion to fully replicate the programme.

The IMHI programme was officially launched in early 2006 in eight provinces in Indonesia. The province of West Java began the programme later in 2007 after completing district team problem solving (DTPS) planning as recommended by Ministry of Health (MoH)

as part of the making pregnancy safer (MPS) strategy. In 2008, UNICEF supported and facilitated a provincial workshop on strategic health communication with discussions focused on increasing uptake of: 1) childbirth assisted by health professionals 2) breast feeding 3) complete immunization of babies. Participants included representatives of the MCH and health promotion sections of the District Health Office (DHO), social mobilization personnel, media development personnel and district Development Planning Board (*Bappeda*) staff from the four focus districts.

The maternal (3/1,000), infant (46/1,000), and neonatal (24/1,000) mortality rate in Indonesia is high. Addressing the issue is challenging because it relates not only to medical services but also to social, economic, cultural and community factors. Purely medical approaches to the problem have been shown to be insufficient. In this context, locally-generated, culturally-sensitive approaches are key.

One initiative that has proved to be successful was the 'Alert' village programme. This included the printing of stickers promoting safe childbirth preparedness, clean and healthy lifestyles (*PHBS*), family nutritional awareness, and child sickness, which were distributed to 200,000 households in the four focus districts. As a follow up, in the second semester of 2008, UNICEF supported eight health centres in the four focus districts to strengthen 117 health posts (*posyandu*). A cascade workshop was designed involving cross-sector organizations with the intention of maximizing the role of sub-district and village secretaries (*sekmat* and *sekdes*). Personnel from the district health office, *Bappeda*, the family planning office, and community representatives also attended. The technical content of the workshop was drawn from the MCH handbook. In 2008, elections in Subang and Garut consumed a significant amount of the district budget (*APBD*). Therefore, the budget

allocation for the IMHI programmes in these two districts that year was minimal. In the 2009 budget, the education programme was prioritised with the intention of allocating 20 per cent of (*APBD*) to it. This implies that the health budget will not increase in the four focus districts. It can also be assumed that elections in Indramayu and Sukabumi in 2010 will also impact adversely on the health budget in those districts.

Should funds be available, it is now understood that sub-district replication is more easily implemented if:

- Sub-district secretaries have roles as programme coordinators at sub-district levels, and village secretaries have similar roles at village levels.
- Heads of villages are perceived as important change agents.
- Pilot villages and health posts (*posyandu*) are available to host study visits.
- Activities are designed within existing mechanisms such as weekly meetings. They therefore strengthen existing planning systems and institutions, rather than disrupt them.
- Activities are designed with consideration for local capacities, including human resources, local institutions and funding resources.
- Health centre and community midwives' roles are limited to providing technical assistance. They should not be expected to be significant change agents.

The importance of district capacity should also be understood. Indramayu, Sukabumi and Subang districts had solid cross-sector facilitator teams with well-developed roles and functions. This solidity was a function of good interpersonal relationships and effective communications that resulted from frequent preparation meetings independent of UNICEF funding support.

FA1 Lessons learned: Accelerating universal salt iodization

Summary:

As iodine deficiency disorders predominantly affect women and children, UNICEF initiated support to achieve universal salt iodization targeting the poor coverage of iodized salt and the widespread 'leakage' of non-iodized salt into consumer markets.

Partners:

United States Agency for International Development (USAID); Indonesia Ministry of Trade and Industry, Indonesia Ministry of National Planning, District Health Office; District Planning and Development Board; District Office of Industry and Trade; Family Welfare and Empowerment; Association of Salt Producer (Central Java).

Area:

Rembang, Central Java.

Timeline:

2003-2009.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org



Iodized salt packet available in
Purworedjo village - Rembang
(UNICEF Indonesia/Foote)



Worker on duty at the iodized salt factory
(UNICEF Indonesia/Foote)

The 2003 National Socio-economic Survey (*SUSENAS*) showed that only 44.3 per cent of households in Rembang District were consuming adequately iodized salt, even though Rembang produces 100 tons of salt every year on average and contributes to the salt supply of other districts. In order to achieve universal salt iodization (USI), Rembang District, supported by UNICEF, has adopted a three-pronged strategy that includes: 1) social enforcement; 2) law enforcement; 3) technical assistance for improving the quality of salt

production. The programme has monitored its success for several years. A National Survey showed that there is a steady trend of improvement from 44.3 per cent in 2003 to 71.4 per cent in 2007.

This innovative approach, combining social enforcement and law enforcement, together with improving the quality of salt production, has proven effective in accelerating the achievement of USI acceleration in the district, and has potential for replication elsewhere.

Local regulations, enforcement, monitoring, local government funds, and broad sectoral participation are all important elements. All salt producing districts need to adopt local regulations that require and facilitate iodized salt at all level (the producer, the market and the household). In addition, such districts should also develop effective mechanisms for monitoring and enforcing implementation of the local regulations.

USI has long been recognized as the most cost-effective and sustainable strategy for improving iodine nutrition of the general population. Iodine deficiency disorders (IDD) are a set of afflictions that predominantly affect women and children, and include goiter, mental retardation and cretinism, as well as increased risk of death. MDGs 1-5, which call for improvements in poverty and hunger, education, gender equality, child health, and maternal health, are all directly or indirectly addressed by salt iodization. The UN Special Session on Children (2002) set a global goal of achieving USI by 2005. Since then, in 2004, the Government of Indonesia (GoI) issued a Presidential Decree, and the ensuing standards require all salt for human and animal consumption to be iodized. While Indonesia achieved rapid gains toward USI in the early 1990s, progress has stagnated over the last decade. One of the main challenges is Indonesia's decentralized governance, which leaves responsibility for health to each of more than 497 districts, now also responsible for specific legislation, enforcement, and public education related to IDD and salt iodization.

In Rembang, one prong of the strategy, social enforcement includes raising community awareness through mass media, interpersonal communication and routine testing of salt at the community level. This is primarily the

responsibility of a group of female volunteers from the community known as Family Welfare Empowerment (*PKK*). These volunteers show high commitment in going door-to-door on a monthly basis with their salt test kit, and in teaching mothers about the benefits of iodized salt during local growth-monitoring sessions for children. *PKK* also started selling iodized salt at market price in certain communities, which helped to fund part of the household monitoring activities in those areas.

Another prong, law enforcement, includes routine testing of salt at production facilities and markets. The confiscation of un-iodized salt, replacement with iodized salt, and a system of warnings and sanctions to market vendors has been effective in blocking sales of un-iodized brands from other districts. Enforcement is conducted by the District Law Enforcement team, coordinated by the District Police, and also includes the District Civil Police, the District Industry, Trade and Cooperation Office, the District Health Office, the District Planning office, and the Legal Department of the Provincial Secretariat. Local legislation serves as the basis for law enforcement efforts to control non-iodized salt distribution. Under decentralization, local-level legislation is required to ensure that national policies and legislation are adequately implemented at the district level. Another significant benefit of this legislation is that it enables local government funds to be allocated for the implementation and monitoring of the salt iodization programme.

The third strategic prong, technical assistance to producers, is provided to improve the quality of iodized salt production. Most producers in Rembang are very small-scale and use low technology, but they export salt to other areas. UNICEF provides technical assistance to improve the Quality Assurance systems among

these small-scale producers to refine the process of iodization so that their salt is neither under- nor over-iodated. More efficient production and QA techniques can save the producers money and limit any health risks of excessive iodine within the population.

The Rembang project has monitored its success for several years, in terms of both coverage and impact on the iodine status of the population. In a representative sample of all sub-districts, the Health Department asked school children aged 6-10 years to bring a sample of their household salt to school for rapid testing in 2008. The results showed that 78.1 per cent of households were using salt containing adequate

levels of iodine. This shows a steady trend of improvement from previous years: 44.3 per cent in 2003, 53.3 per cent in 2005⁶, and 71.4 per cent in 2007⁷. In addition, salt iodization is monitored in Rembang's markets and salt production facilities by the District Law Enforcement Team. In July 2006, the team began testing salt in Rembang's markets using the titration method, the most reliable method for testing iodine content. In 2006, 18 out of 22 brands were below the national standard for iodine content, but by July 2007, 10 out of 10 brands tested all met the national standard, regardless of their district of origin. The following years' results also showed that all salt brands tested were adequately iodised.

FA1 Innovation: Combining social and clinical work for healthy adolescence

Summary:

In East Sumba, one in three babies are born underweight mainly due to nutritional deficiencies and anaemia in the mother. This programme aims to reach young women before they become sexually active and raise their overall levels of health.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

East Sumba.

Timeline:

2006-2009.

MTSP:

Focus area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
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Twenty-five per cent of Indonesian women have had a child or are pregnant before the age of 20⁸ and in the District of East Sumba in eastern Indonesia, 35.7 per cent of babies are born underweight⁹, mainly due to nutritional deficiencies and anaemia in the mother. Low birth weight babies face an increased risk of serious health problems and a higher chance of death. Rather than address the situation when it arises, the adolescent health pilot programme aims to prevent it happening by reaching young women before they become sexually active and by raising their overall levels of health. It is important to raise awareness of health issues that can lead to problems in pregnancy and childbirth while



Waingapu Rematri members discuss leaflets at their local meeting
(UNICEF Indonesia/Rose)



Alethia (left) with fellow peer educators and peer coordinators in Melolo
(UNICEF Indonesia/Rose)

women are still teenagers. Raising awareness about healthy pregnancies should result in fewer pregnancies at a young age, and fewer problems during pregnancy.

The island of Sumba suffers from high rates of poverty and a challenging geography. In some places it is very difficult to travel because of mountains and costly transport. Socially, this is also an area where death can be more highly valued than life, with funerals being the biggest celebrations on the island. For these reasons, health care is not often prioritised, particularly by young people. The broad objective of the programme is “to contribute to a socially, medically and psychosocially healthier woman” and specific objectives

include: 1) to reduce the percentage of young women with severe and moderate anaemia; 2) to postpone first pregnancy until 20 years or older; 3) to strengthen social decision making skills. The strategy combines clinical and social approaches. The social approach is valuable as it leads to awareness being increased in the community as well as in target groups. As a result, community leaders and peer educators have helped to identify increasing numbers of eligible adolescents for clinical intervention. In Waingapu services are provided to up to 80 per cent of all those identified as eligible¹⁰.

This pilot is the only adolescent health programme in Indonesia to successfully combine social activity with clinical contacts and to reach young people out of school. It was developed as a response to the challenges of providing a service to a target group that did not have yet well implemented delivery mechanisms, compared to the well established maternal and child health services. In the past, the government has tried to encourage young people to visit health centres by delivering presentations at school, but with no follow up activity to encourage the young people to actually attend, this was not a great success. Raising awareness is important, but doing something about it is vital. Clinically, a team of health care professionals visits the young people in their villages every six months. They provide a comprehensive service package of ten nutritional and reproductive health interventions by using a clinical algorithm for triage. The services include health promoting, preventative, diagnostic, curative and counselling elements.

Socially, services are provided at peer education group meetings. Young people are selected and trained as peer educators. With support from health care staff and field coordinators/community organizers, they run regular social events among their friends in between the clinical visits. This provides opportunity for informal discussions on a range of health and reproductive health topics, and

is also a useful source of encouragement for attending the clinical sessions. In order to support the twice-yearly clinical contact, a health festival is held in every village. The festival encourages the whole community to get involved with competitions, sports and other health promotion activities. With little social activity for young people in the villages from week to week, the festival has proved to be a popular activity with a high turnout.

In the first year, UNICEF supported various aspects of the festival, providing health-orientated packages for the young women (including items like soap and sanitary towels), as well as sports equipment. As UNICEF has gradually withdrawn financial support, the districts have taken on more responsibility for the interventions. Local government funding began in 2007, and other partners have been encouraged to provide prizes, or get involved in other ways. Since 2006, the number of adolescent women who have received checkups and medication through the programme has increased significantly.

Number of young women attending clinical services:

	First contact	Last contact
Melolo (rural)	56	369
Waingapu (urban)	219	232
Kambira (urban)	128	206

The first contact in Melolo reached mainly out of school pupils, but as the reputation of the clinical activities grew, so did the numbers of both in and out of school females attending. By the fifth contact, in February 2009, a total of 453 young women had been seen with approximately 80 per cent showing moderate to severe anaemia¹¹. Out of the 160 young people who were anaemic during the first, second or third contact, 41 per cent of them were no longer anaemic by the fourth contact, and only 6 per cent had got worse.

Since late 2007, the local government in Kambira District has used its own budget to replicate the programme in three additional

urban villages. This followed recognition that the national Ministry of Health Adolescent Health Friendly Service (*Pelayanan Kesehatan Peduli Remaja/PKPR*) programme lacked outreach services, and made no special provision for promoting healthy lifestyles among young women, postponing early marriage and preventing violence. The enthusiasm of the young people in Melolo and Waingapu for the initiative, and the effectiveness of the programme's peer-to-peer communication, were also recognized.

Ownership by the District Health Office (DHO) is good because support was provided from the outset by local government. There has also been sustained funding from East Sumba district local government since 2007:

Year	Amount of local government funding (IDR)
2007	40,000,000
2008	50,000,000
2009	84,000,500
2010	104,500,000

The social approach has been acknowledged by other organizations as a useful means to reach young people both in and out of school. For example, in December 2008, a representative group of young people, peer educators and health professionals took part in an outbound course run by the forestry commission. The course taught them how to look after their environment, and has encouraged them to spread environmental messages amongst their families. On its own initiative, East Sumba has developed leaflets to inform adolescents and community leaders about the adolescent health and social services. The adolescents were provided with non-medical commodities in an attractive gift pack. In 2008 the first draft of the Rematri diary was created with support from UNICEF and the Ministry of Health (MoH). The booklet was finalised, printed and distributed in 2009 and will be reprinted with local government funding in 2010.

In the pilot districts, the fifth contact took place

in February 2009, when a new guidebook for use by the health care staff was introduced. The guide is a step-by-step flow chart that clearly explains which questions to ask and what advice/medication/referral should be carried out as a next step. The first four contacts used a similar guide but the new publication is more comprehensive and clearer. It also includes questions about domestic violence, and as such could prove to be useful to the Women's Empowerment Bureau. The Adolescent Working Group in the Indonesian Paediatric Association was also actively involved in the 2008 revision of the *PTKR* (*Pelayanan Terpadu Kesehatan Remaja*) algorithm, and has shown interest in a wider application of the tool. UNFPA has shown interest in potential improvements for adolescents' services through the competency based training. It has also supported the *PTKR* training, and will possibly continue support for socialization and baseline data collection in *Sentani Timur/Puskesmas Harapan* in 2010. WHO Jakarta provided technical support in the revision of the algorithm and the development of standards to solidify the *PTKR* services, which applied WHO steps for standard development.

Challenges include that data are currently collected manually, and in some areas there are problems with computerizing the information. These include limited electricity, repeated virus infections and lack of time. A computerized register would allow faster and improved tracking of the service uptake and better analysis of findings related to nutrition and reproductive health more widely. It should also be noted that once a woman becomes pregnant, or of reproductive age at 15 years, she is no longer eligible for the adolescent health programme. Including adolescent women in the Local Area Monitoring and Tracking (LAMAT) programme would make it possible to track pregnancy outcomes, and help identify long-term strategies. There is also an expressed demand that adolescent males should have access to the same kind of services.

FA1 Innovation: Letter from a best friend (*surat dari sahabat*)

Summary:

As midwives had become in short supply in this relatively remote region of north Maluku, pregnant women were sent formal but friendly letters inviting them to attend the antenatal clinic.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

North Maluku.

Timeline:

2008-2010.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org

As midwives had become in short supply in this relatively remote region in north Maluku, pregnant women needed to be encouraged to visit the health centre (*Puskesmas*) for ante-natal care (ANC) rather than more local and convenient facilities. There was also a desire to increase ANC coverage. The solution, which was generated locally, was to write to pregnant women, who were identified by Traditional Birth Attendants (TBAs) and community members, inviting them to attend the ANC clinic. Styled as a 'Letter from a best friend' (*surat dari sahabat*), the letter is formal and friendly, as well as innovative. The formal form is valued in the community, and the friendliness of it makes



A midwife hands over a friendly letter inviting the pregnant mother to attend antenatal clinic
(UNICEF Indonesia/Widiastuti)



A healthy child born of a healthy mother
(UNICEF/Whoolery)

it memorable and unthreatening. Part of it reads (in translation):

Dear Mother, Please don't neglect God's trust. Please take care and always protect your pregnancy. Therefore DON'T HESITATE to check your pregnancy and your baby's condition. We are waiting for your visit. Date: every Monday and Wednesday. Location: Tomalou Health Centre. Time: starting at 09.00. Your Baby will thank you forever because you are giving the best to him or her.

To ensure that pregnant women are identified and that the invitation letters are received, several networks are used. First, TBAs are encouraged to report pregnancies to the health centre, which will then issue them with an addressed letter to be hand-delivered to the pregnant woman. Secondly, pregnant women who are already visiting the health centre, are encouraged to report and deliver the appropriate letter again by hand. This delivery system has no cost and has been found to be accurate and effective.

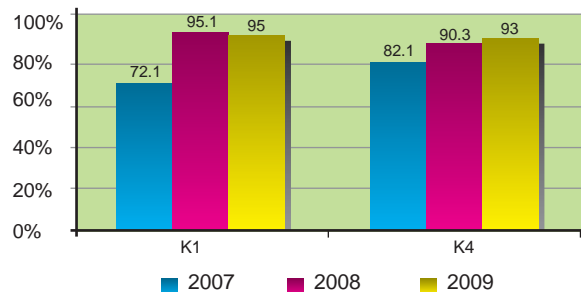
The issue arose because the Government of Indonesia originally appointed midwives with one year of training ('D1' midwives). When this policy changed to require midwives to have three years of training ('D3' midwives), many districts encouraged their midwives to leave the area for further training. This resulted in some villages becoming short of midwives. In the *Puskesmas* in Tomalou, *Kota Tidore Kepulauan*, four out of six midwives left for further training in the regional capital Ternate, leaving just two midwives to serve eight villages. Ante-natal care (ANC) is usually provided by village midwives in health posts (*Posyandus*) or birth stations (*Polindes*). However this was impossible given the reduced number of midwives and a means was required to encourage pregnant women to visit the *Puskesmas* for ANC.

The issue was addressed at a strategic communication workshop that was conducted from 28-29 May 2008. The aim of the event was to explore community participation in support of MCH at the village level and to identify media that might be used to reach the community, in particular to identify and communicate with pregnant women. Participants included the head of the village, religious leaders, midwives and other health

professionals. This mingling of sectors, interests and expertise was fruitful, and when the health promotion (*promkes*) officer understood the requirements she came up with the idea of writing individually to each pregnant woman.

Progress can be seen in the fact that ANC coverage has improved despite a reduction in the number of midwives in the area from six to two.

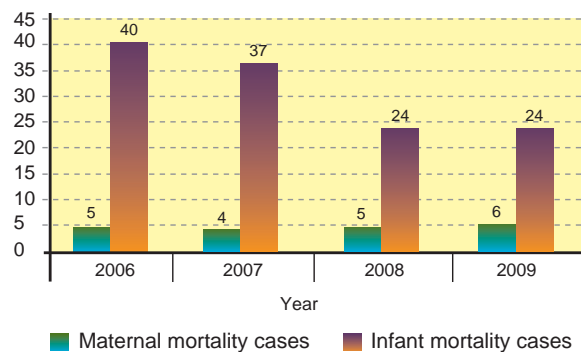
K1 & K4 coverage in the *Puskesmas* in Tomalou 2007-2009



These figures are meeting and surpassing national targets of 95 percent for K1 coverage and 90 percent for K4.

Child mortality has also fallen.

Total cases mother and child mortality *Kota Tidore Kepulauan* 2007-2009



In 2009, a similar approach was replicated in other health centres including the *Puskesmas* in Galala and the *Puskesmas* in Ome.

FA1 Innovation: Micro-analysis & micro-planning

Summary :

Low coverage of health services in Papua was resulting in high maternal and neonatal morbidity and mortality. 'Micro-analysis' and 'Micro-planning' processes help identify appropriate interventions.

Partners :

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

Papua.

Timeline:

2007-2010.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information :

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org



A girl receiving advice from a health worker
(UNICEF Indonesia/Setiawati)



A family enjoy their session with government officials
(UNICEF Indonesia/Susanto)

Low coverage of Maternal and Child Health (MCH) services in Papua was resulting in high maternal and neonatal morbidity and mortality. A 2001 survey showed a Maternal Mortality Rate (MMR) of 832/100,000 live births, significantly above the national figure of 307/100,000, which itself is significantly above the national target of 125/100,000, given in MDGs 5. Almost all other MCH indicators for Jayawijaya District were below target. With national indicator targets for 2015 set at 95 per cent for K1 (first antenatal check up by skilled birth attendants), 90 per cent for K4 (fourth antenatal check up

by skilled birth attendants), 90 per cent for Pn (delivery by skilled birth attendants), 90 per cent for Kn (post natal visit by skilled birth attendants), 90 per cent for TT2 (twice tetanus toxoid) and 90 per cent for Fe3 (number of iron tablets received on the fourth visit by skilled birth attendants), all indicators in Jayawijaya were below 40 per cent, except for Kn, which reached 55 per cent in 2008.

In order to ensure that any proposed solutions were appropriate and effective, it was important to identify the reasons why MCH coverage was low. In a process known as 'micro-

analysis' several villages served by one health centre with low MCH coverage were selected for review. Following the results of this micro-analysis, one village was then selected as an area where new approaches would be discussed with a view to identifying appropriate interventions in a process known as 'micro-planning'. Following two years of implementation, improvements in some MCH indicators have become evident. It is plausible that micro-analysis and micro-planning are effective methods to identify activities that will effectively increase the coverage of MCH services.

The 'micro-analysis' workshop process is deliberately designed to identify specific problems in a specific area. Similarly the subsequent 'micro-planning' workshop process is designed to address the issues identified during the micro-analysis process and involve stakeholders in generating initiatives that are appropriate and effective for local conditions and suit the characteristics of the community. Compared to large-scale programmes that are intended to cover a large number of villages and health centres, micro-analysis and micro-planning workshops have been shown to lead to cost efficient and cost effective interventions, which may then be scaled up.

Micro-analysis and micro-planning workshops can be applied to many situations. The focus is always to identify specific interventions that are appropriate for the local conditions and suit the characteristics of the community. The workshops are not expensive to run, and can often be funded out of the operational costs. Implementation, however, does benefit from close monitoring and supervision, and good teamwork among participants (such as village midwives, midwife coordinators, other health centre staff and the community) is important.

The micro-analysis and micro-planning workshop process only began in Wamena Kota in 2007, and Wouma village was selected for intervention only in 2008. Nevertheless improvements in several MCH indicators in Wouma village can be seen in the table below:

Year	Pregnant mothers target (projection)	K1	K4***	Pn***	Kn	Kf	Fe3	TT2
2006*	46	22	5	11	13	13	13	9
2007	54	45	15	22	26	26	31	40
2008**	54	53	7	17	33	33	27	22

Notes:

- * 2006 is the base line data as the data is best seen compared to the previous years.
- ** Data for 2008 to November
- *** K4 and Pn remain low from year to year. This may be because many Wouma Village inhabitants are originally from Kurima Sub-District in Yahukimo District and Makki Sub District in Lani Jaya District, and that many pregnant women return to their family homes in the third semester to give birth there and return to Wouma Village to receive neonatal visit and PNC visits. However further study is needed to determine the actual causes of low K4 and Pn in Wouma Village.

Even though the workshop costs were not incorporated into the local budget, one specific intervention that resulted from the process - home visits - has been proposed as an item for funding from the local budget in 2010 with the intention of providing them from all health centres in Jayawijaya District. Furthermore, the district government has decided to use funds provided by the provincial government to procure supplies for a birthing facility (*Polindes*). Other activities planned for the future include: continued improvement in health centre staff capacity in order to improve their analytical and problem solving skills; enhanced monitoring mechanisms; and better links with other related interventions.

FA1 From the field: Improving midwife clinical competency

Summary:

UNICEF-supported clinical training in East Sumba has increased the number of trained midwives, encouraged uptake, and improved access to Mother and Child Health Services.

Partners:

United Kingdom Department for International Development (DfID); Australian Agency for International Development (AusAID); Indonesia Ministry of Health.

Area:

East Sumba, NTT Province.

Timeline:

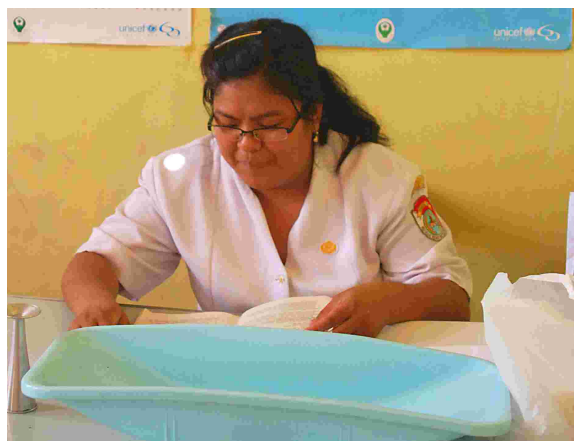
2006-2008.

MTSP:

Focus Area 1 - Young child survival and development.

Contact information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org



Midwife Sherly took part in comprehensive training for normal delivery care recently with UNICEF (UNICEF Indonesia/Rose)



Clinical training center in East Nusa Tenggara Province (UNICEF Indonesia)

In 2006, UNICEF supported the local government in East Sumba, a district in East Nusa Tenggara (NTT) Province, to establish a clinical training centre (P2KP) in Waingapu, the district capital, to improve midwife competency. This has resulted in an increased number of trained midwives, improved access to Maternal and Child Health (MCH) services, and increased uptake of these

services. In 2005, the district had only 4.5 per cent of its 154 midwives certified as being competent in providing Basic Normal Delivery (APN) services. This statistic suggested that few of the region's midwives were D-3 graduates, as APN is included in the three-year D3 curriculum, despite the fact that the government was committed to improving midwife competency through funding for

education, and demand for good quality MCH services was increasing.

Establishing the training centre involved a number of steps: 1) Assessment by national networking group for competency training (*JNPK*) at the tertiary level training centre (*P2KT*); 2) Dissemination of assessment at provincial level; 3) District Health Office and hospital coordination meetings; 4) Multi-sector district workshop; 5) Agreeing a support budget with the government; 6) Identifying human resource requirements - which included the selection of clinical instructors (CI) and clinical trainers (CT) - and procuring equipment; 7) Accreditation of CI/CTs (with parallel *APN* training); 8) Evaluation and further training - which included the accreditation of Advanced Trainers (AT) - and systems strengthening.

From 2006-2008, the centre trained 18 groups of midwives totalling approximately 180 people and subsequently in 2008, 80 per cent of the midwives in East Sumba District were determined to be competent in providing *APN* services. This increased level of competency led to increased demand for midwife services:

- K1 (first trimester) visits increased from 78 per cent in 2005 to 96 per cent in 2008;
- Skilled Birth Attendance (SBA) deliveries increased from 59 per cent in 2005 to 84 per cent in 2008.
- Further benefits include that nine clinical trainers were accredited to *JNPK* standards, and that training services were standardised.

As the centre was also providing training to the neighbouring district of West Sumba, figures there also improved:

- K1 visits increased from 72 per cent in 2006 to 81 per cent in 2008;
- SBA deliveries increased from 51 per cent in 2006 to 68 per cent in 2008.

Challenges included: 1) the limited number and competency of clinical instructors (CI) and clinical trainers (CT); 2) the limited numbers of technical assistance from *JNPK* at the secondary level (*P2KS/P2KT*); 3) the limited number of deliveries to assure practice. As a result of the latter factor, CIs and CTs had to continue to assist and supervise trainees during 'field' delivery sessions in order to fulfil the *APN* certification requirements. The future of the centre, however, looks bright. An allocation for operations has been included within the district hospital's budget, and a specific provision for improving the professional competency of midwives was included in the (revised) 2004-2009 district budget (*RPJMD*). The initiative sits well with Governor's Regulation No. 42 of 2009 (*'Revolusi KIA'*) relating to the acceleration in the reduction of the region's Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). In the draft district regulation (*PERDA*), improving professional (health personnel) competency through pre-service training, clinical training and strengthening training centres is a priority agenda. UNICEF has also recently supported a feasibility assessment for replication in the neighbouring Sumba *Barat Daya* District.

FA 2 Good practice: Avian influenza schools programme

Summary:

UNICEF-assisted schools based programme raised awareness of avian influenza amongst children and encouraged them to transmit messages to their parents and communities. Light-hearted lessons, high-quality teaching materials, and an animated cartoon broadcast on television all contributed.

Partner:

Canadian International Development Agency (CIDA); Indonesia Ministry of National Education; Indonesia Ministry of Health; National Avian and Pandemic Influenza Co-ordinating Agency (KOMNAS- FBPI).

Area:

Aceh, Ambon, Bali, East Nusa Tenggara, Java, Papua, South Sulawesi and Sumatra.

Timeline:

Late 2007 to mid-2009.

MTSP:

Focus Area 2 - Basic education and gender equality.

Contact information:

Child Survival and Development Cluster,
UNICEF Indonesia, jakarta@unicef.org

Indonesia is badly affected by avian influenza (AI), and some 40 per cent of the human victims are children and adolescents. In both urban and rural settings many Indonesian families keep poultry at home, and children are often in contact with them. In November 2007, UNICEF therefore launched a schools-based programme designed to raise awareness of avian influenza amongst children, change their behaviour, and encourage them to transmit messages to their parents and communities. After focus group discussions with school children, three



School-based programme raises awareness of avian influenza among children
(UNICEF Indonesia/Pumomo)



A boy discusses AI activities in school. UNICEF leads in raising awareness on bird flu so that the community can protect themselves from bird flu
(UNICEF Indonesia/Pumomo)

key messages were adopted: wash your hands with soap, don't play with poultry, and report sick poultry to parents and teachers.

Until this programme was implemented, no avian influenza related teaching material was available to schools, and no avian influenza related education took place in schools. A teacher manual, a flip chart, school banners, stickers, and a light-hearted animated cartoon based on known characters, which also aired on television, were consequently developed and distributed. In 2007, 12,000 kits were

provided; in 2008, 38,000; and by May 2009, a further 22,400 had been provided. Additionally, more than 1,400 teachers working in UNICEF assisted CLCC (Creative Learning Communities for Children) schools, who are already familiar with progressive educational approaches, attended workshops to receive orientation and training to deliver avian influenza related training to teachers. Approximately 16,000 teachers attended one-day teacher training workshops in Central Java alone.

A 2008 study¹² showed significant changes in behaviour among school children compared with results from 2007:

- Washing hands with soap before eating rose from 37 per cent to 68 per cent.
- Eating only well-cooked chicken rose from 53 per cent to 92 per cent.
- Washing hands after touching poultry rose from 25 per cent to 61 per cent.
- Staying away from poultry rose from 23 per cent to 66 per cent.

It is however be noted that other communication initiatives such as television announcements and community initiatives may also have had an effect on the school children's knowledge, attitude and behaviour.

More specific to the School Programme, the same study found that:

- 86 per cent of teachers who received a kit used it for teaching.
- 64 per cent of students found the activities 'interesting' and 23 per cent found them 'very interesting'.
- 74 per cent of students tell family / friends what they have learnt about AI.

The programme was implemented under, and embedded into, existing structures of CLCC

teacher training. Once trained to induct teachers into the new material, specialist facilitators are equipped to repeat the process. Once trained, teachers are able to repeat the relevant classes periodically to different year groups. The materials, methods and scheduling of the teaching means that school pupils receive periodic instructions at relevant levels. By inserting messages into children's learning, avian influenza becomes part of a broader, long-lasting 'life skills' education. The classes are popular and enjoyable. How avian influenza related messages are incorporated into lessons is largely left to individual teachers (with instruction and examples given by facilitators). This is particularly important as cultural norms vary widely in Indonesia. With messages transmitted to the household level by children, it is left up to the household to decide how to act. The materials (flip-charts and so on) provided are robust and high quality. The efficiency with which the programme has been shown to transmit avian influenza related messages to the household level is encouraging provincial governments to find the relatively low level of funding required to sustain and expand the programme by enabling already trained facilitators to train further teachers.

Provincial government Health, Education, and Veterinary departments were involved in planning and implementing the programme, particularly the training of facilitators. School teachers and the wider school community, such as management committees were also involved. Whilst UNICEF funded the design, production and distribution of the school material kits at the national level, and the training of facilitators at the provincial and district level, in some cases provincial budgets are now being used for teacher training to clusters of schools. Once the programme is

running in schools there is no further cost to UNICEF, or the province, district or school.

The principle of providing high quality learning material (on almost any subject) to schools is highly replicable. The same is true for the principle of training facilitators to cascade specific knowledge and teaching methods to teachers. It is noteworthy that teachers are trained to integrate avian influenza related material into lessons such as *Bahasa* (children create and enact dramas and write poems about AI), singing (they sing songs about AI) and art (they create AI related pictures). There is considerable flexibility in how avian influenza related messages are incorporated into material developed for individual classes, and how individual classes are conducted. AI related material has been found in a recently published school textbook¹³.

AI related lessons are reportedly fun for the children who sing songs, create and recite poems, enact dramas they have created, play games and paint pictures in them. The teachers also appear to enjoy delivering the classes, and to have a role to play in reducing the incidence of what is widely perceived to be a serious threat to human and poultry health. In some areas particularly, the avian influenza related schools programme integrates well with other programmes such as those related to general hand washing. The AI schools programme, for example, has resulted in new hand-washing facilities being provided at some schools. The programme also provides a means to reach the most remote communities and provides the background knowledge that can serve as a foundation for messaging related to pandemic preparedness and other health issues associated with infectious disease.

FA2 Good practice: Creating learning communities for children

Summary:

Creating Learning Communities for Children (CLCC) is a joint programme of the Government of Indonesia, UNESCO and UNICEF to improve the quality of primary schools. It is one of UNICEF's highest profile activities in Indonesia and widely recognized as a success.

Partner:

New Zealand Agency for International Development (NZAID); Australian Agency for International Development (AusAID); UNESCO; private sectors; Indonesia Ministry of National Education.

Area:

Projects in 78 districts of 15 provinces: NAD, North Sumatra, Banten, West Java, Central Java, DI Yogyakarta, East Java, South Sulawesi, West Sulawesi, NTB, NTT, Maluku, North Maluku, Papua, West Papua.

Timeline:

1999 - 2010.

MTSP:

Focus Area 2 - Basic education and gender equality.

Contact information:

Education and Adolescent Development Cluster,
UNICEF Indonesia, jakarta@unicef.org

Creating Learning Communities for Children (CLCC) is a joint programme of the Government of Indonesia (GoI), UNESCO and UNICEF. It aims to improve the quality of primary schools through the introduction of three 'pillars': effective school-based management (SBM); active, joyful, and effective learning (AJEL); and community participation. The programme is focused on giving schools and communities more responsibility for managing their own resources and helping them to use these resources more effectively. Schools and communities are



A teacher is giving example on how to utilize simple teaching aid to translate theory into practice in Science
(UNICEF/Pumomo)



Students are practicing the theory on 'optic' using simple teaching aid
(UNICEF/Kudus)

trained to develop school plans that integrate all their resources (from the government, the community and the CLCC programme) and to manage these resources in a transparent manner with a focus on improving quality of the teaching-learning process. The programme has also inserted components such as Life-Skills, Inclusive Education, and Child-Abuse Prevention into school education.

The programme has been implemented in two phases: 1999-2006 and 2007-2010. During its first phase, the CLCC programme

aimed at developing a model for primary education quality in 12 provinces through more than 2,000 schools. This successful programme was then followed by a second phase, which focused on advocating the institutionalisation of the programme into government's system. Co-operation programmes with universities and institutions for pre-service teacher training, and the government's education quality assurance body (*LPMP*), were initiated. The programme also moved from supporting individual schools to working at the cluster level and with school supervisors. The programme is widely recognized as successful and is one of UNICEF's highest profile activities in Indonesia. In 2008, 6,880 Indonesian primary schools (including 1,000 schools in Aceh and Nias) were implementing the CLCC model, educating more than 1 million students.

Although Gol is committed to achieve universal education for children aged 7-15 years, and in August 2008 increased the share of education expenditure in the government budget from 17.2 per cent to 20 per cent, the current basic education system has some fundamental problems resulting from under-funding, poor management, lack of leadership, and lack of support from communities. Before political and financial decentralisation, implementation of which began in 2001, central government set rigid guidelines on the administration of schools and the delivery of the curriculum. Local government, acting under the direction of central government, was responsible for building and maintaining school facilities and providing materials and books. This discouraged local initiative and resulted in many schools being in poor condition and short of books and materials.

Many teachers also lacked training, although significant progress was seen in improving access and developing teacher professional support through the cluster system. Now, district governments, which also have

responsibility for the quality of education offered in their areas, allocate most funding for schools, and the proportion of funding being allocated directly to schools has increased substantially. A capacity review, however, conducted between 2007 and 2008 concluded that District Education Offices and District Offices of Religious Affairs (which is responsible for schools with religious foundations) have 'low' capacity in providing basic education, in implementing effective planning, in supporting appropriate teacher allocation and management, in all aspects of data management, and in financial and physical resource management.

The programme's strategy is to work with all stakeholders including NGOs and within existing school structures, including school clusters, teacher working groups, and the government administrative and supervision system. All stakeholders, including teachers, school principals, parents, community members, NGOs, school supervisors and education administrative staff, are trained together in order to create dialogue, mutual understanding and support. Advocacy at national level is intended to establish the principle of equitable 'needs based' education funding for districts, and to gain support for quality improvement through school based management. At district level advocacy is intended to publicise the benefits of SBM, AJEL and CP and to gain commitments from districts to support the programme.

Some important elements of SBM include: comprehensive school plans are made by school staff and communities working together, and are displayed publicly and updated annually; school and cluster meetings are held regularly and are well attended. Important elements of AJEL include: children's work is written using their own words; more practical work takes place; classrooms display children's work and teaching aids; teachers use flexible working groups in their teaching; and children

express their feelings and opinions freely within the classroom. Elements of Community Participation (CP) include: increased parental participation in developing school plans and monitoring their implementation; increased parental participation in supporting children's learning; increased material support for schools (in money or in kind); and increased participation in improving the school environment.

Schools are provided with block grants to supplement funds received from the government and the community in order to encourage transparent school level planning and accountable school management. Teachers and head teachers receive regular training in AJEL to improve the quality of the classroom teaching and learning processes. Parents and community members are trained to support their schools, through helping with their children's learning, providing material support to the school and monitoring the school's use of resources. All activities are undertaken jointly with the Directorate General of Primary and Secondary School Management of the Ministry of National Education (MoNE) and with education offices at sub-national levels. UNICEF and UNESCO have divided responsibilities based on the comparative advantage of each agency. UNESCO is responsible for national-level policy and advocacy activities, and UNICEF is responsible for sub-national level implementation.

Through advocacy at all levels, the SBM programme has emerged as the standard policy in national and sub-nation government planning for primary school improvement. In 2008, advocacy workshops involving 1,200 stakeholders were conducted at national level and in 12 provinces and 52 districts; 24,000 education practitioners, including teachers, school principals, supervisors, and school committee members were trained on newly developed material; and block grants were

provided to around 750 schools as an incentive for school development and to encourage transparent and participatory management. The programme builds on the work of previous projects, including: Active Learning through Professional Support (GoI/ODA, 1980-94), COPLANER: Community Education Support Program, (GoI/UNESCO, 1987-93), Primary Education Quality Improvement Project (GoI/World Bank, 1992-98) and Japan International Cooperation Agency's (JICA) School Based Management Programme.

Through its success and popularity with principals, teachers, students and the community, the programme has strengthened partnerships with local education departments in particular. The introduction of school committees has changed the governance of schools, built partnerships with and among parents and the school community, and has given communities a greater say in the management of schools. AusAID reports that as a result of CLCC, levels of student attendance and participation rates are increasing, and repetition and drop out rates are generally decreasing. Furthermore, as SBM processes are progressively embedded in the governance and management of adopting schools, community commitment to the system rises, parent confidence increases, their interest and understanding of the teaching and learning process improve, and community funding and in-kind support to schools increase.

The model of the programme and its activities are gradually being mainstreamed and institutionalised by district and provincial Education Offices, and by MoNE centrally. It has also been implemented and adapted by similar education improvement projects funded by large donors. AusAID, USAID, PLAN International, the World Bank and a number ADB supported initiatives, for example, have all adopted the CLCC model as a foundation for their work in the basic education sector.

Significant support has also come from the private sector. Commonwealth Life, for example, a savings, investments and insurance company, committed to participate in UNICEF Indonesia's fund raising programme for CLCC for three years from January 2008, and other support has been provided by companies such as Citibank, Exxon Mobil Corporation, and PT Inco, a mining company.

Programme replication is happening via two primary streams: 1) independent national, provincial, and district dissemination of the CLCC programming, and 2) donor supported expansion of the CLCC model into new districts and provinces throughout the country. Within the areas covered by the programme, 39 district governments have replicated the CLCC project in 3,829 other schools. Replicability and sustainability are also ensured through the programme's implementation within the MoNE system and mechanism, its affordability, and its holistic intervention. In 2007, the budget allocated by 51 district governments for SBM was increased, reaching IDR 7,307.6 million or 28 per cent of the total of the education budget reflected in the district budget (*APBD*).

Whilst programme replication continues, it should be recognised that national and regional governments still need support to coordinate, manage and expand the programme, and that there is limited capacity to move from school level activities to institutionalise CLCC at national and sub-national levels. Although the programme has been running for more than ten years, and the relevant regulations are now in place, a major cultural shift is required among national and sub-national legislators if these regulations are to be energetically implemented. One reason for this is the politics associated with decentralisation and regional autonomy. Similarly, CLCC type training materials are available from a number of

sources, but neither the national or sub-national governments are producing clear guidelines for the schools. One reason for this is the confusion associated with the fact that each school can now create its own curriculum, and does not need to respond to central edicts.

The awareness of the importance of education quality is also still relatively low, and national and district governments are inclined to focus education expenditure on buildings and salaries. Continuing advocacy to national and sub-national governments is required to give further and continuing support to the programme. Facilitating study visit to CLCC schools for politicians, civil servants and academics may aid this process, and improved monitoring and evaluation frameworks, and data flow, may enhance evidence-based policy making. It is also necessary to ensure local governments support as important pre-conditions such as providing basic facilities in schools, adequate numbers of teachers, and sufficient learning materials; and continued support needs to be ensured for education boards and school committees as representatives of community participation. Continuing quality training for government officials, school supervisors, school principals, teachers and the community is also required. Schools specifically need more training on indicators so that they might evaluate and manage themselves more effectively. Across the country, only 34 per cent of primary school teachers meet minimum qualification standards, and less-developed regions still experience poor quality learning outcomes. There is still a gap between AJEL teaching-learning methods and the learning output as the AJEL approach is not represented in the curriculum and examination standards. In all areas where the programme is operating, CLCC focus discussions at teachers' meetings at cluster level need to be embedded.

FA2 Lessons learned: Early childhood development

Summary:

The Early Childhood Development programme, also known as *PAUD (Pengembangan Anak Usia Dini)*, aims to develop and implement an integrated and comprehensive approach to early childhood development.

Partners:

Global Girls Education; General Electric (GE) for US Fund; Star TV for Hong Kong National Committee; Indonesia Ministry of National Education; Indonesia National Development Planning Agency; Indonesia Ministry of Health; private sectors.

Area:

Projects in 23 districts in 12 provinces: NAD, North Sumatra, Banten, West Java, Central Java, East Java, West Sulawesi, South Sulawesi, NTB, NTT, Maluku, and Papua.

Timeline:

2006-2011.

MTSP:

Focus Area 2 - Basic education and gender equality.

Contact information:

Education and Adolescent Development Cluster,
UNICEF Indonesia, jakarta@unicef.org

With the early years of a child's life accepted as vitally important, the Early Childhood Development (ECD) programme, also known as *Pengembangan Anak Usia Dini (PAUD)*, aims to develop and implement an integrated and comprehensive approach to early childhood development. The programme focuses on early learning and school readiness for children



An ECD center cadre is helping children to use educational tools
(UNICEF Indonesia)



Children learn to use educational toys with the help of an ECD center cadre
(UNICEF Indonesia)

aged 0-6 years, but extends beyond education to health, nutrition, birth registration, child protection, and water and environmental sanitation in homes and communities. The programme focuses on poor rural areas and involves community-based organizations. Its broad objectives are to promote and protect the rights of young children to survival, growth and development.

ECD is a comprehensive approach to policies and programmes that focus on children from birth to six years old, and their parents and caregivers. It aims to protect children's rights to develop their full cognitive, emotional, social and physical potential. Specific key objectives include: 1) improving children's developmental readiness to start primary school on time, especially marginalised children; 2) reducing gender and other disparities in relation to increased access, participation and completion of quality basic education; 3) improving educational quality and increasing school retention, completion and achievement rates; 4) improving family and community care practices that impact on young children's survival, growth and development.

In Indonesia, the foundation of the strategy involves increasing the capacities of local government authorities and encouraging coordination between different levels of government offices with the intention of improving planning, budgeting, implementation and monitoring of early education programmes. Networks are also developed with relevant bodies including NGOs and other international organizations working in the area as well as with, for example, women's groups, higher education establishments, religious organizations, and existing institutes supporting early childhood development. In the community, potential resources are identified and empowered with a view to delivering services under the principle 'of, by and for' community. Often this involves socializing concepts associated with the importance of early childhood development and education through local level advocacy. A further strand central to strategy is to facilitate the improvement of insight, knowledge and skills among ECD cadres (who work in the ECD posts, often on a volunteer basis) through seminars, workshops, and other training opportunities, and supporting the publication

and dissemination of guidelines and technical references relating to early childhood learning and development. Support, through seed grants, is also made for the establishment of ECD posts, and the development of systems relating to data collection, mapping and the consolidation of programmes and services is encouraged.

ECD is being developed and implemented in close co-operation with the relevant government and non-government institutions, involving dissemination, orientation and counselling, and the direct involvement of communities. The large number of partners involved, however, and the high level of inter-sectoral co-ordination required, makes the completion of policy guidelines a lengthy process. In Wonosobo district, for example, a coordination mechanism among stakeholders from six different ministries has been established, and 15 groups are associated with the programme in one location: 1) *Bappeda*; 2) *Dikpora*; 3) *Dinkes*; 4) *Dinas KB*; 5) *PKK*; 6) *IBI*; 7) *Himpaudi*; 8) *Bapermasdes*; 9) *Dinas Sosial*; 10) *PP dan PA*; 11) *Camat*; 12) *UPTD Dikpora Kec*; 13) *Kades*; 14) *Puskesmas Kalikajar*; 15) *LPP Pos PAUD Mungkung*. A high turnover of government officials responsible for the education programme has also led to a lack of management continuity, repetition of capacity building activities, and a delayed exit. Furthermore, observations in some areas where ECD is being implemented suggest that further socialization of the concept is required, particularly amongst the poorest. Further advocacy among national and sub-national government representatives and civil service counterparts would also benefit the programme, especially if it was based on solid evidence. It is however relatively difficult to quantify the effects of a specific ECD post. Whilst the Government of Indonesia is committed to achieving universal education

for children aged 7-15 years, and in August 2008 increased the share of education expenditure in the government budget from 17.2 per cent to 20 per cent, little formal attention is focused on providing pre-school facilities for children aged 0-6 years. Consequently, the vast majority of children between 3 and 6 years, particularly those from isolated, rural areas, lack access to developmental and early learning activities. According to the 2008 Gol-UNICEF Education Programme Mid-Term Review, there is a 'huge gap' between the small scale of the UNICEF supported ECD programme which targets only up to 13,500 children and the country's needs. According to the Indonesian education statistic 2008, the total children population aged 0-6 years is more than 25 million; and support is given by the Government of Indonesia, other international non-governmental organizations and private sectors. Overall the total coverage of enrolment rate of children aged 0-6 years to ECD centres is 48 per cent or nearly 14 million of children in this age group across the country. Research also shows that problems related to the quality of basic education services in Indonesia include teachers' low qualifications, unfriendly learning environments, weak school management systems (i.e. organizational capacities at local level) and limited community participation. It is also important to address the needs of children in the most vulnerable areas.

To 1 December 2009, 14,500 children aged 2-6 had access to 350 ECD centres in poor rural areas in 23 districts of 12 provinces; and 1,950 cadres were able to implement holistic ECD approaches for children aged 0-6 years and advocate to parents the importance of ECD. According to the UNICEF Central Java Field Office, in 2006 in Wonosobo District there were eight ECD posts, and by mid-2009, there were 116; and a coordination mechanism among stakeholders from six different

ministries had been established.

Every ECD post is reported to be managed by an LPP (a local foundation) with three main targets: 1) maintain the ECD post; 2) empower the community to participate; 3) seek financial resources. In 2009, according to figures produced by the local district Development Planning Board (*Bappeda*) office, in Wonosobo District, 32 villages contributed a total of IDR 3,123 million towards the ECD programme, ranging from IDR 15.9 million from Mangurejo Village (*Kecamatan Kalikajar*) to IDR 249.2 million from Dempel Village (*Kecamatan Kalibawang*). In *Desa Mungkung*, Wonosobo District, with around 640 families, the village has contributed the premises for the ECD post and IDR 6 million in funding, and the majority of families with children served by the post contribute IDR 2,000 monthly. Nevertheless ECD has not reached all young children in Wonosobo. Figures from 2008 show that the service reached 18.91 per cent of the district target of 25 per cent, leaving 81.09 per cent of children aged 0-6 years unserved. It is also recognized that existing services mostly cover children aged 4-6 years.

The low awareness of the importance of early childhood education among some parents suggests that further socialization is required. In some locations, the capacity of the community to provide volunteer cadres, and to enable and encourage those volunteers with appropriate skills and rewards, also requires further investigation. The programme relies on non-formal volunteer labour, and there is a shortage of qualified early childhood education staff both to work in the ECD posts, and to provide training. The number of institutions focusing on training for early childhood education is limited, and they are poorly distributed, of mixed quality, and offer no informal accreditation or training for volunteer ECD cadres.

FA4 Good practice: Birth registration law and national strategy

Summary:

With partners, UNICEF Indonesia has been active in birth registration since 2001. This has involved advocating for the law, raising awareness among national and local policy-makers and citizens, providing technical inputs, and supporting the implementation of innovative birth registration models.

Partners:

Japan National Committee; Indonesia Ministry of Home Affairs.

Area:

Nationwide.

Timeline:

2001-2007.

MTSP:

Focus Area 4 - Child protection from violence, exploitation and abuse.

Contact information:

Social Policy and Protection Cluster
UNICEF Indonesia, jakarta@unicef.org

UNICEF Indonesia has been actively engaged at both the policy and project levels in birth registration in Indonesia since 2001. This has included advocating for the law; raising awareness among key stakeholders, including national and local policy-makers and citizens; providing technical inputs; and supporting the implementation of innovative birth registration models at the district level. In 2006, the Indonesian Parliament approved the Population Administration Law that for the first time in Indonesia established the legal foundations for a civil registration system, including birth



Elizabeth (right) with her mother Maria (left), her landlady Ardiana, and her two week old daughter Magdalen Nona Sindi. Daughter Magdalen has not been registered yet
(UNICEF Indonesia/Rose)



Ibu Meri (left) with her neighbour Ibu Floren (right) and their midwife Ibu Lita. Ibu Meri's son Rivaldo was covered under a local 60 day rule for birth registration
(UNICEF Indonesia/Rose)

registration. This was followed by two main national regulations on civil registration, including birth registration, in 2007 and 2008. The programme is a good example of how strong government commitment, strategic partnerships with local and international organizations, coupled with sustained engagement at national and local policy levels

can be combined with operational project-level support to achieve sustainable and tangible results.

Birth registration is a critical precondition for guaranteeing children's rights. Article 7 of the UN Convention on the Rights of the Child stipulates the right of every child the right to be registered at birth by the State; and birth registration is fundamental for safeguarding other human rights, such as the right to education and health, a family environment, protection against exploitation and abuse and juvenile justice. At the national level, birth registration, as part of an effective civil registration system, is a prerequisite for establishing and maintaining a country's vital statistics, which in turn is essential for accurate planning, budgeting and implementation of development policies and programmes. The adoption of the Population Administration Law in 2006, and the National Strategy for Birth Registration in 2008, present key milestones in Indonesia's efforts towards achieving universal birth registration.

Indonesia has the lowest levels of birth registration in South East Asia (42.4 per cent) even when compared to low-income countries like Laos (72 per cent) and Cambodia (66 per cent). Before the 2006 Law, contributory factors included the lack of a legal and institutional framework for a comprehensive civil registration system, and the lack of a permanent responsible institution. In addition, bureaucratic hurdles and an over-centralized system posed difficulties for people to register their children. Often, registration services were only available in the district capital, making it difficult for people in more remote rural areas to access them. To those with more easy access to registration offices, processing was often long and cumbersome.

Following adoption of the 2006 Law, UNICEF played a key financial and technical role supporting the government in developing the National Strategy on Birth Registration 2011, which was adopted in August 2008. The strategy establishes the goal of achieving universal birth registration in Indonesia by 2011. In parallel, UNICEF continued to provide support to 41 districts in 13 (out of 33) provinces through advocacy efforts. As a result, all UNICEF-supported districts have now adopted district-level laws or regulations on free birth registration. Many of these include measures to simplify the requirements for registration. In most UNICEF-supported districts, services have been decentralised to the sub-district level to reduce time and transportation costs. UNICEF has also continued to support capacity building of local civil registrars and other key stakeholders to ensure more effective birth registration services.

To support the implementation of the law and national strategy throughout Indonesia, UNICEF is continuing to carry out policy and project level work. At the national level, UNICEF is supporting the Ministry of Home Affairs (MoHA) in developing a system for monitoring birth registration rates. It is also supporting MoHA in drafting an inter-ministerial decree to support cross-sector implementation of the National Strategy on Birth Registration. UNICEF is also assisting the government in documenting good practice models of birth registration for replication in other districts. At the sub-national level, UNICEF is assisting pilot districts to implement the national strategy on birth registration through capacity-building and systems development. The pilot districts include Sikka in East Nusa Tenggara (*NTT*) and Surakarta in Central Java.

Success is due to effective collaboration between a wide range of strategic stakeholders, including not only policy-makers in the Government of Indonesia (GoI), but also other international donors (GTZ), international NGOs (Plan International, World Vision) and national NGOs. The national law and strategy were a result of the commitment, technical know-how and collaboration of these various partners. The outcome of the process was richer thanks to the variety of perspectives and expertise brought to the table. The experience demonstrates the importance of forging strategic partnerships both within the government, in civil society and with other international partners to achieve sustainable results.

UNICEF has also supported local governments in mainstreaming and scaling up successful local models for birth registration in rural areas, such as the one developed in Sikka District. The model uses midwives to facilitate the recording of births and the completion of forms, as many parents are illiterate. The midwives also play a key role in raising awareness of the importance of birth registration to families. The district has allocated resources from its local budget (*APBD*) to cover transportation fees and an annual honorarium in the amount of IDR 300,000 per year. Sikka District has also issued a decree to simplify birth registration procedures, and has carried out socialization campaigns over a period of two years to increase citizen awareness. As a result, birth registration rates in Sikka District for newborns up to 60 days have increased from 24.3 per cent in 2005 to 73 per cent in 2007. As of November 2008, the percentage had increased to 80 per cent. On average, it takes only a month to issue a birth certificate in Sikka.

Sikka's success has been the result of local government commitment. This was achieved through intense advocacy efforts from UNICEF and other partners. UNICEF's advocacy work on birth registration included collaborations to advocate for adequate budget allocations for necessary supplies and equipment. Immediately after the parliament's adoption of the law in 2006, UNICEF supported nationwide awareness-raising activities (from December 2006 to February 2007) through a national TV campaign featuring the Indonesian President and the Minister of Home Affairs. Following the national television campaign, the national government allocated IDR 12 billion per year until 2011 to cover the cost of birth certificates for all children in their first two months of life in 100 poor districts throughout the country.

UNICEF's strategy was multi-pronged, focusing on policy-level technical support at national and local levels as well as operational support for implementation of innovative birth registration systems at the local level. Engagement at these four levels (national, local, policy and project levels) is fundamental for ensuring the translation of policy into practice, especially in a decentralized context. In 1999, UNICEF, several government ministries supported by UNICEF, Plan International, GTZ, and local NGOs took the initiative to create the National Consortium on Civil Registration. Its aim was initially to raise awareness and conduct advocacy. In 2001, UNICEF supported the Indonesian Central Bureau of Statistics (*BPS*) to include a module on birth registration in the national household survey (*Susenas*). The survey revealed that 59.3 per cent of Indonesian children under the age of five were not officially registered. With the support of the data generated through the survey, UNICEF played a key role

advocating for the inclusion of birth registration in the Child Protection Law that was approved in November 2002. The Law ended up stipulating free birth registration for all children under 18 years old.

However, as the Law faced difficulties in implementation due to a lack of a comprehensive civil registration system, UNICEF continued advocating for a more comprehensive legal framework, providing technical assistance to the parliamentary team, and bringing in international experts on birth registration to make accessible international good practices on the issue. At the project level, UNICEF also played a key role in making birth registration more accessible by advocating for and supporting the decentralization of services to sub-district and village levels, and supporting the simplification of birth registration procedures. It also built the capacity of relevant personnel at the local level, providing training on guidelines and procedures for registrars, birth delivery attendants, sub-district heads and village heads. UNICEF also supported communication campaigns on television, radio and print materials in over ten provinces to raise awareness about the importance of birth

registration to the general population.

Despite the adoption of the National Strategy on Birth Registration in 2008, many challenges remain for achieving universal birth registration by 2011. These include weak financial, human and technical resources at the district/ municipality level. While the law and the national strategy call for free birth registration for all children under 60 days, in practice, many districts allegedly still charge fees to parents, and as many districts and sub-districts still lack civil registration offices, access can remain difficult for poor people. The marriage certification requirement for having both parents legally recognized on the birth certificate also still constitutes a deterrent for many households, and many people do not see the utility of a birth certificate as they can access many services without having one. There are also challenging inconsistencies between national and local laws. Many district governments have issued their own laws and local ordinances that differ from the national law in substantial ways. Central government funding and donor support, as well as local government resources and political commitment are essential for ensuring an adequate institutional framework.

FA4 From the field: Integrating support for women and children

Summary:

This centre in Ambon provides counselling and support to children and women who have suffered abuse and violence. Services cover medical, social and legal issues, psychological counselling, and support towards obtaining justice in law.

Partners:

Global Thematic Fund, Indonesia Ministry of Health; Provincial Department of Health; Provincial Department of Social Affairs; and provincial police.

Area:

Maluku.

Timeline:

2006-2010.

MTSP:

Focus Area 4 - Child protection from violence, exploitation and abuse.

Contact information:

Social Policy and Protection Cluster
UNICEF Indonesia, jakarta@unicef.org



UNICEF staff comforting a child in child centre
(UNICEF Indonesia)

In 2006, following the initiative of local NGOs and UNICEF, an integrated service centre for women and children (*P2TPA*) was established in Ambon. The objectives of the centre are to provide counselling and support services to children and women who have suffered abuse and violence including domestic violence. These include medical, psychological, social, legal and counselling services, and support towards obtaining justice and legal certainty. The centre itself is small, but collaboration with bodies such as the police, health and legal services, and local NGOs enable the centre's services to be comprehensive. The local social authority

(*Dinas Sosial*) and community and religious groups are also involved providing shelter and rehabilitation. Monitoring continues following return to the community. The centre has also established a referral system, allowing all stakeholders to share information, and UNICEF is further involved in advocacy. UNICEF-trained staff visit communities to promote and explain the service and socialise issues related to domestic abuse and violence. Local radio and newspapers are also used for advocacy and socialisation.

The national law and the criminal code prohibit domestic violence, which is reportedly

prevalent in Maluku province, an area that suffered sectarian violence from 1999-2004. Societal norms, however, mean that women are often reluctant to report domestic violence to their families, and even more so to the police; and communities and law enforcers are not often motivated to support cases being brought to court. Most who suffer abuse therefore do not know what they should do if they experience domestic violence, or to whom they should turn to for help. Furthermore, there is no standardisation in the recording of cases¹⁴. Before the centre opened, several local NGOs supported abused women and children. Cases were however generally dealt with on an individual basis and there was little collaboration between the agencies.

The *P2TPA* centre was initiated by the Maluku child protection forum, consisting of several local NGOs, which was established by Governor's Decree. Consequently the centre, which has a budget from national government, has a strong relationship with local government which is prepared to pay the salary of three staff, and intends to provide IDR 1.5 billion to build new premises. The centre takes important role in early intervention, and helps prevent child abuse and neglect by advocating the child rights and highlighting the problem of violence in communities. The centre was established by adopting a national level Memorandum of Understanding (MOU) between the Ministries of Health, Social affairs, and Women's empowerment. Also at the national level, the centre has partnerships with the Indonesian Commission on Child

Protection (*KPAI*) and the National Commission on Women (*Komnas Perempuan*). These groups have been invited to receive familiarisation and training at the centre. At provincial level, the centre has partnerships with Social Office, Health Office and Labour Office, and many other collaborating groups such as the police, health and legal services, religious and community leaders, and other NGOs. Although the centre is small, it offers a wide range of services by collaborating with many organizations. The determined formation of a network, combined with advocacy efforts and community involvement, set a good example and are replicable. Government officers from other regions (e.g. Papua) have visited the centre to learn how a similar service might work in their region.

The number of reports of sexual violence, violence in school, child neglect, violence in the community and consultations with the centre indicate an increasing awareness of the issues. In 2007, 34 cases were reported to the centre, including 25 cases of sexual violence. Of these, 16 cases were brought to court, four cases were resolved peacefully and five were stuck out. In 2008, 50 cases were reported (44 females and 6 males), including 34 cases of sexual violence. Of these, 22 cases were brought to court, nine cases were resolved peacefully and two were stuck out. In 2009 (up to October 17), 30 cases were reported (17 females and 13 males).

FA4 From the field: *Wadul Bae* - community care for women and children

Summary:

Wadul Bae is a community initiative in Cirebon, West Java. It is building an alert system for children and women at risk of abuse, violence and exploitation. Volunteer forces use their own homes as bases and often fund their own activities.

Partners:

Global Thematic Fund; Provincial Department of Planning, Provincial Department of Social Affairs.

Area:

Cirebon, West Java.

Timeline:

2005-2009.

MTSP:

Focus Area 4 - Child protection from violence, exploitation and abuse.

Contact information:

Social Policy and Protection Cluster
UNICEF Indonesia, jakarta@unicef.org



All children need protection and care
(UNICEF Indonesia)

Wadul Bae is a community-based initiative in Cirebon, West Java, which began in 2005 with support from UNICEF. Its aims are to conduct community surveillance on children and women at risk of abuse, violence and exploitation, and to collect data on such acts. It involves a volunteer force who uses their own homes as operational bases and their own funds for activities. The initiative also provides rehabilitation and legal assistance services in the form of referral mechanisms to the health centres (*Puskesmas*), the police and other agencies. *Wadul Bae* cadres respond to and deal with reports of abuse from individuals and community members. Cadres also socialize women and children as

to their rights and what is considered abuse or violence to their persons. All cadres are trained in the laws and how to promote and use them to inform, intervene and protect. As they are based in the community, cadres are well placed to take the cultural appropriateness of any intervention into consideration.

Wadul Bae stands for *Warga Peduli Bocah Lan Embok'e* ('Community that Cares for Children and their Mothers'). It also means 'Just Complaint'. The organization was set up to support Law 23/2002 on Child Protection, and responds directly to the needs of women and children who are at risk of, or who have experienced, abuse, violence and exploitation. One of the key findings of a 2003 report

compiled by the Government of the City of Cirebon, a fast growing town on the north coast of Java, and UNICEF, was that the city lacked the capacity to adequately establish a protective environment for children. The aims of *Wadul Bae* therefore include to:

- 1) increase the role of the community in creating protective and child-friendly surroundings;
- 2) collect data on children and women at risk;
- 3) document cases of violations against children and women;
- 4) develop a database of violations;
- 5) socialize understanding of the Child Protection Law and domestic violence generally;
- 6) assist survivors.

Wadul Bae is divided into four divisions: public relations, partnerships, assistance and commerce. Each division consists of four to six cadres with two selected from each sub-district to report to the head of the organization, whose house is used as a headquarters. Initially a group of 30 cadres in five sub-districts were trained, followed by a second group of 40. The organization currently operates in five sub-districts with coordination meetings held twice monthly. *Wadul Bae* is an integral part of the multi-sector service system in the city¹⁵. The organization is, however, complimentary to these services, and extends them, because it is locally based. As the cadres work in their own communities, they are aware of the issues, have better contacts, and are better trusted. In particular, the use of the cadres' houses as their bases creates a safe space for people to share confidences and problems, remote from official systems such as the police. This allows for better communication concerning sensitive issues such as domestic violence and child maltreatment. *Wadul Bae* cadres also socialize and disseminate the issues associated with domestic violence and

abuse. This is designed as preventative action, and again it takes place in the community, in a culturally appropriate manner. Informal meetings are held in local health posts (*Posyandu*), family planning clinics, and at social events such as religious reading groups.

Cadres report gaining confidence and becoming better known in their communities. Increasing numbers of men and women are reportedly becoming aware of the law and the issues of domestic violence, and more women are speaking out. As awareness of *Wadul Bae* increases, more people are seeking to become cadres. It has been suggested that the initiative could be scaled up to recruit new volunteers in an expanded number of communities in Cirebon and elsewhere. Training and education could also be extended to health care workers, particularly to include the identification of injuries typically associated with domestic violence.

Two main challenges exist. The first is that volunteers are expected to pay expenses, such as for travel, reporting materials and telephone calls, out of their own pockets. This can inhibit their involvement. The second, which is also related to budgetary constraints, concerns reporting. The initiative's original intention was to collect, analyse and publish data on abuse incidence with a view to better understanding where and when cases were occurring and whether the programme was having any impact over time. A simple mechanism for recording data has been created, but information is often lost as volunteers lose data recorded on pieces of paper. The programme has no computer available and volunteers have to pay for computer rental themselves in order to make reports.

FA5 Good practice: Monitoring MDGs at district level

Summary:

This project, implemented in five pilot districts of South and West Sulawesi, has driven the development of IT systems to monitor progress towards the Millennium Development Goals.

Partner:

Canadian International Development Agency (CIDA); Central Statistics Office of Indonesia (BPS); Indonesia National Development Planning Agency (Bappenas); Indonesia Ministry of Home Affairs (Bangda).

Area:

South Sulawesi - Bantaeng, Bone and Takalar Districts; West Sulawesi - Mamuju and Polman Districts.

Timeline:

Mid-2006 to 2010.

MTSP:

Focus Area 5 - Policy advocacy and partnerships for children's rights.

Contact Information:

Social Policy and Protection Cluster
UNICEF Indonesia, jakarta@unicef.org



Together with the community, we are ready to achieve the MDGs
(UNICEF Indonesia/Nugroho)



Dissemination and advocacy on MDG monitoring programme
(UNICEF Indonesia/Nugroho)

Described as a “revolution” for data collection, processing, analysis and use in Indonesia, the district level Millennium Development Goals (MDGs) monitoring project, which has been implemented in selected areas of South and West Sulawesi, has driven and supported the development of systems to monitor district level progress, or the lack of it, towards the MDGs. In the project areas, district level

authorities now have reliable district and sub-district data, based on MDGs indicators, to help plan and target social services. Before this project, no co-ordinated effort existed in Indonesia towards consistent monitoring of key MDGs indicators at district level and below, or capturing, analysing and managing data related to them. This project significantly contributes to the use of evidence-based planning to improve the quality of social

services for women and children at local levels. The project has also developed valuable expertise, experience and practical guidelines for promoting replicable approaches towards improving and using district level data systems countrywide.

Indonesia's decentralization laws (implementation of which began on 1 January 2001) involved the transfer of power, management authority and funds for the delivery of basic services from the national government to around 440 district (*Kabupaten*) and city / municipality governments (*Kotamadya*). These new authorities had little capacity for planning, management and implementation of social service programmes, lacked participation, transparency and accountability in resources allocation and management, and had no access to reliable data for evidence-based planning. *Susenas* (national socio-economic surveys, implemented yearly by *BPS*-Statistics Indonesia) provided a major source of data for most MDGs indicators, and a mechanism for monitoring many of them at national level, but they did not produce reliable disaggregated data for monitoring at district level, nor any estimates for levels below the district, such as sub-district (*Kecamatan*) or health centre (*puskesmas*). District authorities were therefore unable to track indicators, even if they wished to conduct evidence-based planning and resource allocation in order to improve social services. Similarly, national authorities did not have reliable district level data to guide resource transfers from the centre to districts. Decentralization also, however, offered the opportunity to improve social services by aligning local decision-making service delivery with local needs and affordability, and for implementing local innovations funded by district budgets.

The MDGs are cross-sectoral and this project provides an effective system to monitor the impact of multi-sectoral pro-poor policies and programmes. Before the project, different sectors, and organizations within them, collected data on a range of indicators, which were often not compatible. Common training programmes for different sectors have also led to convergence and co-ordination of attitudes, approaches and action. Now, focused on 60 MDGs indicators (48 at the outset of the project), a wide range of stakeholders have a common set of indicators which provide accurate, timely, commonly-agreed and action-oriented data and information to promote laws, policies, programmes, and informed decision making and resource allocation. Reliable data and information allow stakeholders to argue persuasively for policies and programmes that prioritise the rights of women and children.

In Bone, for example, the largest district in South Sulawesi (with a population of approximately 800,000); the project has significantly contributed to increased district level capacity, and confidence, in evidence-based development planning. Before the project, data were only collected at the district level, and were only analysed and used at national and provincial levels. Now, sub-district level data are available, which are collected, processed and analysed within the district, and used to design and support evidence-based interventions from the village level upwards. In Bone, this led to MDGs data being used in the 2008-2013 District Medium Term Development Plan. The use of data by sectoral institutions has also increased, and standard datasets are now collected across different sectors. The health department used to collect data on one type of child immunisation, for example. Now, using MDGs indicators, data

on all types of child immunisation are captured and analysed to guide future action. The education department now incorporates population data into school enrolment measures. Previously, school records did not capture data on children not attending school. There has also been significant increase in the local use of DevInfo (a UNICEF/UN database system used to compile and disseminate data on human development) and SPSS (commercial data mining and analysis software).

The project has influenced local social services agendas and set basic standards in a relatively poor area of Indonesia. In Takalar, for example, MDGs data used in the District Poverty Reduction Strategy resulted in a budget allocation increase for poverty reduction from 6 per cent in 2007 to 19 per cent in 2008. Similarly, MDGs data have impacted beneficially on strategic planning in Polman, Mamuju and Bantaeng. In Polman they have been used in revising strategic planning for education. In Bantaeng, the use of MDGs data led to district government allocating funds of IDR 1 billion per village for poverty reduction. In principle, it can be seen how policy and decision makers can be motivated by targets, and in Bone this is reported to be the case together with the fact that the MDGs are widely appreciated as worthwhile targets.

Advocacy, and the enrolment of district level stakeholders, has been key from the outset of the project. One widely promoted fundamental idea was that data management systems were being strengthened rather than created. Another was that ownership of the systems resided with local counterparts, and that local funding would be sought to sustain them. A third was that data was not being

collected for its own sake, but in order to provide empirical evidence to support improvements in the quality of social services. From the outset, the project has aimed to increase demand for local level data and analysis, and to develop political commitment to support the project and to use empirical, evidence-based outputs. A detailed and extensive programme of advocacy has been implemented in support of these objectives. One tangible result, to date, is that four out of five pilot districts have made allocations in support of the project from local budgets: Takalar US\$ 85,000 (2007-2008), Bone US\$ 97,100 (2007-2008), Mamuju US\$ 165,175 (2008-2009), and Polman US\$ 135,500 (2007-2008). Specifically it should be noted that the district of Majene, which was not one of the original pilot districts, has contributed US\$ 55,000 from the local budget towards local implementation in 2009-2010.

Institutional cross-sector linkages have also been developed or strengthened in support of enhanced sustainability. At the outset, at the national level, UNICEF had close working relationships with the Central Statistics Office of Indonesia (*BPS*), the National Development Planning Agency (*Bappenas*), the Ministry of Home Affairs (*Bangda* Directorate, UNICEF's direct national level counterpart for district cooperation), and locally, with the district Development Planning Board (*Bappeda*) in particular. The project was implemented in consultation with all these stakeholders with a view to increasing sustainability by creating wide ownership. Similarly, line ministries at all levels have been consulted regularly. At the local level, in Bone, good relations existed between UNICEF, *Bappeda* and *BPS* before the instigation of the project, and that this was one reason why Bone was chosen for early implementation. The project has extended

and deepened these relations. Now, in Bone, a wide set of stakeholders are involved in collecting, analysing and using data, which used to be an exclusive activity of *BPS* operating at national level. This has increased capacity as well extending understanding of the value of data in evidence-based planning. At national level, MDGs monitoring has had further positive effects, notably in UNICEF's access to, and developing relationship with, *BPS* and *Bappenas*. As advocacy for the project is extended nationally, it is anticipated that further positive linkages will be created between different sectors, and between similar sectors in different regions. A small booklet has been produced called "Village in Figures" for distribution among households. This effectively extends partnerships to include civil society, giving everyone access to detailed data analysis on their region annually, and the possibility of greater accountability being required from elected leaders.

The main strategies of the project have included: 1) socialization of the MDGs concept; 2) advocating with and mobilising key actors and decision makers in districts; 3) increasing the demand for disaggregated data at all levels; 4) developing replicable approaches and models, based on results-based evidence; 5) systematically building capacity to implement these new models and approaches; and 6) persuading district decision-makers to commit their own budgets to the initiative. Following initial socialization and advocacy, a core team was built in each district made up of people committed to capturing good data, robust analysis and practical use of the data/analysis. In Bone, for example, these were key staff from the district Development Planning Board (*Bappeda*), the District Health Office (*Dinas Kesehatan*) and the District

Education Office (*Dinas Pendidikan*). This team worked with UNICEF to promote the project to the district parliament (*DPRD*), its leader (*Bupati*), and a variety of approaches were used to popularise the issues, among them arguments relating to child malnutrition. District-specific data flows were then mapped (identifying gaps, bottlenecks and failures) and a range of options were developed and presented that allowed the districts to make technically sound decisions based on their budget limitations. Often, existing survey mechanisms, such as *Susenas*, were adapted to MDGs indicators and local needs. This involved reviewing and simplifying forms, rationalising information flows, and agreeing on calculation and denominator use. Training material was then developed, tuned to local capacities and skills, trainers were trained to train enumerators, and personnel for data entry, processing and analysis, and logistic and mentoring support was offered on the ground. In all more than 5,000 people have been trained in knowledge associated with MDGs data collection; more than 300 district staff trained in IT and database use; and more than 150 district staff trained in database management. As an incentive, computer equipment and intensive follow-up training were provided to districts prepared to commit their own budgets.

Advocacy and mobilization of decision makers, key stakeholders and the public have been vital. Advocacy has focused on three messages: 1) why it is important to take action on issues related to MDGs; 2) what district governments can do to develop data-driven systems and approaches; and 3) success stories. Aside from some determined personal and UNICEF-led advocacy in South Sulawesi and at national level, a sophisticated 'marketing package' made up of five books (covering

study results, data collection, data analysis and local voices) has been developed and will be distributed to all district decision makers in South and West Sulawesi. This is specifically designed to disseminate the approach, and get other partners and local governments across Sulawesi and Indonesia to adopt it, or encourage its adoption. In conjunction with UNICEF Jakarta, the project is being promoted at a national level by way of the *BPS-Bappenas* web sites launched at the UNICEF/ Government of Indonesia Annual Review in December 2009.

In the overall context of decentralization, greater authority has been designated to sub-national governments especially over resource management and basic social service delivery for children and women. National averages and aggregations are acknowledged to be misleading, especially in a country as large and diverse as Indonesia, and cannot be used for development planning or poverty monitoring. Before this project, data for Bone District was based on a set of just 758 samples. Now, a data set totalling around 11,000 samples (300 - 500 samples from each of 27 sub-districts) forms the basis of sub-district household surveys. Before the project, no village-level socio-economic data were collected. Now, socio-economic data are collected from all 372 villages in Bone District. Innovations in IT have also been capitalised on. The health department in Bone for example used to transmit data to Makassar, the provincial capital, on paper by post/courier. Now data can be entered, and accessed, electronically at both provincial and district levels. Beyond MDGs monitoring at district level, this project has also prompted some local uptake of the Community-based Development Information System (CBDIS) and the Community-based Education

Information System (CBEIS).

Steps are being made to promote this approach across South Sulawesi and in other provinces. The ultimate objective is to have district level MDGs-led monitoring running consistently across the country. Practically, in Bone, survey questionnaire design is being strengthened and refined, statistical methodologies are being improved, and sectoral databases and survey data are being further integrated. Many errors from institutional data, for example, have been determined to be linked to unreliable population denominators. Requirements have been identified for additional capacity, enhanced interpretive skills, and the incorporation of qualitative as well as quantitative indicators. The objective of producing village level data has also been voiced, which would open the possibility of accessing funding at village level. The ambition has also been stated of producing household level data.

The project is in the process of being linked with Situation Analysis for Women and Children (*ASIA/Analisis Situasi Ibu & Anak*) at local level, a collaboration between UNICEF and the national government, which promotes a human rights based approach to programming. Further external interest has come from 'Target MDGs', a collaboration between UNDP and *Bappenas* (focusing on pro-poor planning, budgeting and monitoring evaluation at district level), which has asked UNICEF if this project might be used as a model; and the World Bank's SOEI (Support Office for Eastern Indonesia) has contributed US\$ 50,000 to support the project in each of Mamuju and Polman Districts. Furthermore, the Ministry of Home Affairs has circulated a letter to all districts in Indonesia suggesting that they should conduct this analysis as part of the development planning process. For this

to happen, all districts will need to have a district level database based on MDGs indicators.

Challenges reported include: 1) in some cases matching MDGs indicators to local indicators; 2) the difficulties of co-ordinating sectors (including, for example, Health, Education, Social Services, Forestry, Environment, Family Planning and Religion), many of which had separate systems, and diverse perceptions of how a new system should be designed, and what benefits it would bring; 3) generating long-standing commitment from all partners, given the extent of the work required over a relatively long period; 4) co-ordination between *BPS* and *Bappeda* is reported to be remarkably good in Bone, but this does not extend to every location; 5) local politicians and decision-makers, when making budget allocations to routine services, do not always see the importance of good data for evidence-based planning; 6) government policy of zero

growth in civil service staffing means that recruiting new personnel with the relevant expertise can take time.

Strategically however the MDGs monitoring project has increased attention on the need and benefits of strengthening statistical management generally and ensuring that data definitions and disaggregation follow international standards. It has also established well-managed databases in the project areas to support planning and monitoring purposes. Further demand for reliable and disaggregated data must be created from the decision makers and line ministries, however. Continued advocacy appears to be required at this level to introduce the MDGs and the concept of poverty monitoring, to promote their importance, and to advocate the use of data and analysis in evidence-based planning. This is a prerequisite to enable focused attention on addressing the rights of the most vulnerable.

FA5 Good practice: Pandemic preparedness advocacy and media relations

Summary:

As the focal point for UN programme communications for avian influenza and pandemic preparedness, UNICEF supported its main government counterpart, *KOMNAS FBPI*, nationally and regionally, and developed media activities, materials and communication strategies.

Partners:

Canadian International Development Agency (CIDA); WHO and FAO in Indonesia; Indonesia Ministry of Health; Indonesia Ministry for People's Welfare; Indonesia Ministry of Agriculture; National Avian and Pandemic Influenza Co-ordinating Agency (*KOMNAS - FBPI*); provincial and district health, agriculture, education, social welfare, and district coordination bodies.

Area:

Nationwide.

Timeline:

Mid-2006 to mid-2009.

MTSP:

Focus Area 5 - Policy advocacy and partnerships for children's rights.

Contact information:

Communication Cluster
UNICEF Indonesia, jakarta@unicef.org



From left to right, fitness icon Ade Rai, Ron Mullers from the Indonesian Hotel and Restaurant Association, Bayu Krisnamurthi, Chief Executive of (*KOMNAS FBPI*) and Metro TV anchor Dalton Tanonaka, during a press conference to announce "Beat the Bird Flu"
(UNICEF Indonesia/Pumomo)



Children puts their paint splattered hands on white cloth during UNICEF campaign against avian flu at the field of Bontonompo, Gowa, Makassar, South Sulawesi
(UNICEF Indonesia/Pumomo)

Created in March 2006, Indonesia's national avian and pandemic influenza co-ordinating agency (*Komite Nasional Pengendalian Flu Burung dan Kesiapsiagaan Menghadapi Pandemi Influenza/KOMNAS FBPI*) was faced with urgently responding to a widespread epidemic of Highly Pathogenic

Avian Influenza (HPAI). This was affecting the livelihoods of a large number of smallholder farmers particularly, and was closely related to a significant number of human cases and deaths, predominantly among children and young adults¹⁶. One of the committee's responsibilities was coordinating mass

communication and public information. As the focal point for UN programme communications for avian influenza (AI) and pandemic preparedness (PP), UNICEF's programme included advocacy to government and media agents, and other partners. This primarily involved supporting its main government counterpart, *KOMNAS FBPI*, nationally and regionally, and developing media relations activities, materials and communication strategies.

Objectives included:

- maintaining government commitment, and lobbying for increased funding of AI and PP activities.
- building capacity at *KOMNAS FBPI*.
- increasing understanding in government and the media of the dangers of AI and the need for preventative action.
- developing understanding of the role of *KOMNAS FBPI* in the media.

Activities included:

- supporting the government with AI and PP communication materials and strategies.
- initiating and developing the *KOMNAS FBPI* media centre.
- developing and maintaining the websites <http://www.komnasfbpi.go.id> and <http://fluburung-indo.blogspot.com>
- building relationships with government officials and journalists.
- communicating AI and PP related knowledge to key government officials.
- helping to organise media conferences, press releases and informal meetings with journalists.
- creating talking points and guidance on communication activities.
- media monitoring and rumour tracking.
- disseminating reports and data on AI and PP, and related government activities.
- grass-roots level outbreak communications.
- developing PP related communication Standard Operating Procedures.

On 1 September 2006 UNICEF launched a national communications campaign at the *KOMNAS FBPI* offices, which was attended by senior politicians, diplomats and the media. The campaign, which formed the foundation for over two years of subsequent work, received widespread media coverage. Communications is central to the avian influenza response in that it offers routes to decrease the incidence of the disease in animals, and to decrease the risk of transmission to humans. It is also considered a vital element in pandemic planning and preparedness. *KOMNAS FBPI* accepts that it was initially ill equipped to meet the challenges of the extensive communication activities that were required, and is keen to acknowledge UNICEF's response and expertise.

KOMNAS FBPI is also now equipped with the structures, facilities and many of the skills needed to sustain existing communications programmes, and initiate new ones, but in the absence or reduction of UNICEF support, it is an open question whether the Government of Indonesia would increase resources made available to *KOMNAS FBPI* commensurately. It is accepted that further change is required in AI and PP related legislation, policy and institutional frameworks, and whilst *KOMNAS FBPI* is competent, these changes are more likely to be affected with UNICEF support. Changes in media attitudes and practices are likely to be more permanent.

The programme has greatly enthused and enabled *KOMNAS FBPI* staff, if not directly mobilized them, and has led the media towards more extensive, more accurate and more responsible reporting. In turn this may have mobilized support and action at grass-roots level, as well as affecting those responsible for directing resources and funding programmes. The programme has also successfully engaged with, and mobilized, other groups such as students. Similarly, the

media community accepts that it has been well served by UNICEF's interactions with *KOMNAS FBPI*. Advocacy with the media (including district level workshops) has created a nationwide network of over 300 journalists who have produced over 1,500 reports that include AI messaging. According to a media tracking service, which monitored over 3,000 news articles from 31 national and international media, half included positive preventative messages.

In 2009, the Indonesian national response to the 28 April WHO declaration of a Phase Five pandemic threat level (in response to the novel H1N1 virus) was illustrative. In collaboration with *KOMNAS FBPI*, UNICEF was instantly able to: provide daily media updates; participate in high-level government-led coordination meetings; develop public warning messages; prepare and run government press conferences; and support the design, drafting and production of public information materials, including 100,000 fliers and 25,000 posters, which were delivered with ten days of the WHO declaration, and 500,000 fliers and 250,000 posters, which were delivered the following week.

Aside from developing effective partnerships with *KOMNAS FBPI*, and organizations and individuals in the media, UNICEF has also collaborated with the UN Food and Agriculture Organization and the UN World Health Organization in Indonesia. Other partnerships developed at a national level have included those with the Ministry for People's Welfare, the Ministry of Agriculture, and the Ministry of Health. Partnerships developed in provincial

and district government have included those with health, agriculture, education, social welfare, and district coordination bodies.

The principles of this programme are replicable, especially consistent and determined interaction with the media, but the practicalities of advocacy to government bodies in particular depend very much on the receptiveness and competence of the government bodies concerned, and the political climate generally. Good personal relations are also key, as are high levels of expertise, around-the-clock availability, and dedication and determination on the part of those running such a programme in an environment that had many characteristics of an emergency. The programme was also relatively well-resourced, and the fact that UNICEF was able to engage early with a newly formed and influential organization, have been significant elements in the programme's success.

The timely coordination, and sign off, of underlying communication strategies and messages among the complex web of UN system organizations and the manifold national government organizations and departments involved was, reportedly, a challenge to the project. This was solved largely recruiting determined high-level government support. National, international and internal politics also presented challenges. Not every element in government at the national level was fully enthusiastic about the lead coordinating role *KOMNAS FBPI* had in the AI response. These complex politics have required patience and an appreciation of the larger picture.

FA5 Lessons learned: Avian influenza media relations and journalist training

Summary:

Working with media training organisations and Indonesian journalist associations, UNICEF developed and delivered a series of workshops to encourage newspapers, and television and radio stations, to educate and inform the public about the dangers of avian influenza and protection measures.

Partners:

Canadian International Development Agency (CIDA); Indonesia Ministry of Health.

Area:

Nationwide with focus on affected areas.

Timeline:

2006 to 2008.

MTSP:

Focus Area 5 - Policy advocacy and partnerships for children's rights.

Contact information:

Communication Cluster
UNICEF Indonesia, jakarta@unicef.org



Radio broadcast in Bantul on AI
(UNICEF Indonesia/Pumomo)



AI talk show in Cirebon
(UNICEF Indonesia/Pumomo)

Early in the avian influenza (AI) outbreak, many media news reports were sensationalist and offered little in the way of objective information, analysis about outbreaks, or practical steps for prevention. Starting in 2006, UNICEF therefore first worked with the media-training organization Internews (based in Bangkok) and subsequently with On Track Media (based in Jakarta), and Indonesian journalist associations, to develop and deliver district level training workshops covering journalistic techniques and avian

influenza related information. The intention of the programme was to encourage newspapers, television and radio stations to educate and inform the public about the dangers of avian influenza, and measures to protect against it. The media, particularly television¹⁷, is accepted as an important source of information, and by informing and influencing those working in it, the programme aligned well with the objective of preventing avian influenza transmission from animals to humans by increasing awareness and knowledge.

There are further benefits associated with reducing ill informed or sensationalist reporting, and developing relationships of trust with media professionals.

Training workshops ran over two or three days and included presentations by technical experts on avian influenza, presentations on government and partner responses to avian influenza, and training on how to report on avian influenza safely and responsibly. Trainees were also provided with a specially developed manual and contact information, and in some locations made field trips to hospitals, testing laboratories and affected communities. Training was also provided on media ethics, radio and television script development and production techniques. Journalists nominated by their employers to attend were provided with training kits that included a training manual and CD-ROM so that in-house training could be organised.

In 2006, 61 journalists (from radio, TV and the press) were trained to cover avian influenza related stories in Denpasar, Yogyakarta, Cirebon and Malang. In 2008, 68 journalists (again from all media) were trained in Batam, Padang, Medan and Pekanbaru. In addition, in March 2008, 11 journalists from Ambon, which had had only limited outbreaks of avian influenza, and no human cases, were provided with a five day familiarisation visit to Cirebon, Subang and nearby villages in West Java, all areas that had been badly affected by avian influenza. Participants met with *KOMNAS FBPI*, the district Development Planning Board (*Bappeda*), local government and community radio staff, observed community workshops on avian influenza (which included presentations from doctors and veterinarians), visited poultry production facilities, and saw how village communities were responding.

Since training, approximately 300 journalists have produced over 1,500 avian influenza related reports, of which around half included positive preventative messages. The 60-plus print, TV and radio organizations that provided staff for training have aired over 3,000 informational public service announcements and promos, broadcast around 50 hours of phone-in programming and published numerous newspaper and magazine articles. Overall it is estimated that this programme has provided US\$ 849,950 worth of free media coverage for the broad avian influenza programme. An assessment of the programme found that 89 per cent of participants felt the training was effective.

It may be assumed that high-quality training influences a trainee for a considerable period. It may also be the case that trainees influence others in the workplace, especially if they are provided with manuals and other physical material they can share. The introduction of informed and enlightened staff into organization is also likely to raise standards generally. In this sense, the programme is sustainable, and this sustainability is enhanced by journalists' inclusion on an AI email 'Alert List', and involvement with an On Track Media 'alumni' programme. However, some interviewees indicated that their avian influenza related output peaked shortly after training, and refresher or follow-up courses may be of benefit. In news media, the requirement for avian influenza related reporting largely depends on there being outbreaks, or newsworthy events associated with the disease. In the event of widespread endemicity, however, outbreaks may become considered 'normal' and not newsworthy. In these circumstances, the immediate effectiveness of specifically trained journalists would decrease.

Beneficial relationships and partnerships have been developed with the individual media professionals participating in the training workshops, and their organizations. In particular, On Track Media's approach of maintaining on-going contact with programme participants and offering long-term support through an 'alumni' programme merits note. Furthermore, On Track Media's procedure of signing a Memorandum of Understanding with participating media organizations requiring them to print/broadcast a specified minimum number of promotions / public service announcements as part of the training agreement expands the programme beyond the immediate training process and cements relationships with participating organizations.

How avian influenza related messages are incorporated into media reports is left entirely to individual media practitioners (with instruction and examples given by trainers). This gives wide scope for the reporting of events relevant to the audiences of particular media outlets, in terms that are relevant and understandable to their audiences. Training in, and the promotion of, radio phone-ins, as occurs during the training sessions, is a particularly useful means to enable community participation and empowerment, as well as to allow the public to seek the information they require. The media is broadly accepted as one of the most efficient means to generate social and political mobilisation, and influencing the media in an honest and transparent way is an effective means to those ends. Media reports can also reach and have an effect on those responsible for directing resources and funding programmes. These benefits are hard to quantify, especially as they are more likely

to result from persistent reporting around a subject rather than from a single report associated with a single event, but they are real, and should be taken into account.

The principle of training journalists (on almost any subject) is highly replicable. However the success of such programmes depends very much on the quality of the training, and on the existence of a free and plural press. It should be noted that the training organization used more recently (On Track Media) has extensive experience in Indonesia, and has trained journalists on human rights, measles, reporting on children, and washing hands with soap, as well as avian influenza. The organization therefore has considerable experience. Other aspects relevant to the success of the training provided include: careful selection of journalists/media organizations; the involvement of doctors, veterinarians and other qualified professionals; simulated 'live' events; the production of printable / broadcastable material in the course of the training; the presentation of a manual and other permanent training tools; the collection of frequently asked questions; pre- and post-course testing (providing an instant evaluation); and the presentation of certificates to participants and ('for services to their community') to participating media organizations. In particular, the procedure of signing a Memorandum of Understanding with participating media organizations requiring them to print or broadcast a specified minimum number of promotions/public service announcements as part of the training agreement is seen as particularly appropriate and effective.

FA5 Lessons learned: Avian influenza religious leader programme and booklet

Summary:

Collaboration with the *Majelis Ulama Indonesia* in Makassar led to avian influenza health messages being incorporated into Ramadan speeches and Friday sermons, and the publication of a booklet linking Islamic teachings on hygiene with avian influenza.

Partners:

Canadian International Development Agency (CIDA); Indonesia Ministry of Health; Indonesia Ministry of Religious Affairs; District Development Planning Board.

Area:

Initiated in South Sulawesi, the booklet is currently being distributed nationwide.

Timeline:

Mid-2006 to mid-2009.

MTSP:

Focus Area 5 - Policy advocacy and partnerships for children's rights.

Contact Information:

Communication Cluster
UNICEF Indonesia, jakarta@unicef.org

Indonesia has the largest Muslim population of any country in the world and the country is badly affected by avian influenza, which is a relatively new and little understood disease. Some regions, such as South Sulawesi, have particularly high numbers of practising Muslims, and religious leaders are held in considerable esteem. In September 2006, the UNICEF Field Office in Makassar, South Sulawesi, therefore approached the local chapter of the Council of Islamic Scholars (*Majelis Ulama Indonesia/MUI*), Indonesia's top Muslim clerical body, with a view to them incorporating avian



A religious leader spoke at an opening ceremony of Avian flu campaign of the importance of specific changes to behavior
(UNICEF Indonesia/Pumomo)



Crowds raise their hands to sign avian flu response as part of UNICEF campaign against avian flu
(UNICEF Indonesia/Pumomo)

influenza related messages into speeches which are part of evening activities in Ramadan, the fasting month; into sermons which form an important part of prayers on Fridays and other holy days; and to contribute to a booklet which links Islamic teachings on hygiene with avian influenza.

Working through a local NGO, which had previous contact with the *Majelis Ulama*, UNICEF funded a series of workshops where the *Ulamas* were provided with background information on avian influenza and worked on

finding support in the Koran to promote two key messages:

1) wash hands with soap 2) separate poultry from houses. UNICEF also funded the design, production and distribution of the booklet, which was approved by the National *Ulama* Council, and the Ministry of Religious Affairs in May 2009, with nationwide distribution following. In all, over 12,000 religious leaders took part in the workshops and orientations.

The programme aligns with the objective of preventing avian influenza transmission from animals to humans by increasing awareness and knowledge of high-risk behaviour. The fact that messaging is conducted by trusted and respected community leaders, and is linked to such a culturally important determinant of behaviour as religion, is valuable.

It is difficult if not impossible to separate the impact/effectiveness of the Religious Leader Programme from other avian influenza related communication initiatives. Regarding South Sulawesi specifically however, a 2008 study¹⁸ found:

- A rise from 142 to 169 between 2007 and 2008 in urban areas regarding 'Overall Behavioural Change' (i.e. the fourth largest rise in the 16 areas studied).
- The area having the equal highest score (with *Jabodetabek*, the urban area comprising Jakarta, Bogor, Depok, Tangerang and Bekasi) of 41 per cent for 'washing hands with soap after coming into contact with live poultry' in response to enquiries on: 'what actions to prevent AI infection on human do people remember on top of their mind?' This compares with 21 per cent in West Java, 18 per cent in Central Java, 28 per cent in DI Yogyakarta and 37 per cent in East Java, for example;
- The area having the highest score of 90 per cent for 'making sure birds are kept separate from humans' in response to enquiries about people's knowledge on

specific preventative actions. This compares with 60 per cent in *Jabodetabek*, 59 per cent in West Java, 74 per cent in Central Java, 67 per cent in Yogyakarta and 77 per cent in East Java, for example.

The programme has trained a significant number of (religious) leaders in the practicalities and importance of specific changes to behaviour that help reduce the possibility of transmission of the avian influenza virus from poultry to humans. It has also found support for the desired behaviour in an important religious text. Anecdotal evidence suggests that these messages were relayed in the period immediately following the training sessions when there were also a significant number of outbreaks in the area of the disease in poultry. However it remains to be proven whether transmitting the messages will remain a priority for the religious leaders, especially if the number of outbreaks in poultry reduces. Producing and distributing a booklet on the subject designed for religious leaders has encouraged wider and sustained messaging, but it is not certain whether individual religious leaders will preach regularly on the subject without further encouragement, especially in the absence of significant numbers of disease outbreaks.

Provincial animal health services were involved in training the religious leaders, as well as district human health and animal health services, the regional avian influenza commission under the national *KOMNAS FBPI* structure (*KOMDA*) and the district Development Planning Board (*Bappeda*). Although the training sessions and the booklet give specific guidance on how the teachings of the Koran support avian influenza related hygiene messages, how and when these messages are incorporated into preaching is left to individual *Ulamas*. This gives them scope to present themselves as leaders and to tailor messages to their individual congregations. With messages transmitted to

the congregations by a trusted source, in terms that are familiar to them, it is left up to the individuals to decide how to act.

The commitment and sensitivity UNICEF's South Sulawesi Field Office in dealing with religious leaders and their related organizations has demonstrated the importance attached to changing knowledge, attitude and behaviour to respond to the threat of avian influenza and the possibility of transmission of the virus to humans. This has been noticed and appreciated by local government organizations. Involvement with the *MUI*, and individual *Ulamas*, which has taken significant time and effort to cultivate, may also prove to be useful in the future for avian influenza related messaging on different themes, or health messaging on other subjects such as TB, for example. Initiation of this programme was significantly aided by UNICEF's relatively high profile, good reputation and high-level political contacts (particularly in South Sulawesi). It is also relevant to note that UNICEF field officers had established contact with an individual in an appropriate NGO, which was known and trusted by the *MUI*, and in a good position to take the proposition to them. This intermediary organization was described as "invaluable" and realisation of similar projects may be challenged without such an organization or appropriate established contacts with the religious community.

The principle of involving religious leaders who are trusted by the community and in a powerful position to deliver authoritative messages in terms that their congregations can understand and be influenced by is replicable. The specifics and practicalities are, however, more complex. The religion needs to have prescriptive elements that relate to the relevant aspects of health and hygiene, or which can be interpreted to do so, and a priestly class charged with interpretation and dissemination is an advantage if not a

prerequisite. The religion also needs to be relatively widespread, and a force in the lives of its adherents. Islam meets these conditions in many areas in Indonesia, but other religions in other regions may not prove so suitable. In terms of external interest and replicability, it is questionable whether all religions in all regions are as appropriate to avian influenza related health and hygiene messaging as Islam is in some areas of Indonesia. It should also be noted that the programme is unlikely to reach directly, or influence directly, those who are not Muslims.

With production of the booklet commencing in September 2006 and distribution beginning in April 2009, it took considerable time to accomplish publication. This was due to the relatively conservative nature of the organizations that needed to approve and contribute to the project (including the Office of Religious Affairs - *Kantor Urusan Agama*), the number of them, and their complex linkages. The need to agree the translation of some sections of the Koran from Arabic to Indonesian also slowed the process. Whilst the booklet will have a significant shelf life, and the involvement of religious groups and the training of religious leaders are largely seen as one-off activities, it is as yet unproven whether the religious leaders will continue their avian influenza related messaging persistently into the future without further encouragement. The sustainability of the project is therefore unproven.

It was also reported as relevant that the *MUI*, and individual *Ulamas*, could see a "tangible explosion of avian influenza" locally with hundreds of thousands of poultry deaths in a society where many livelihoods at least partially depend on poultry and poultry products. Without such obvious evidence of the need to address the problem, and issues related to human health, it may prove challenging to involve such relatively conservative groups.

FA5 Lessons learned: DevInfo training

Summary:

UNICEF provides training on DevInfo, a database system for monitoring human development. DevInfo training, however, cannot be considered an end result, and training should be preceded with a clear planning process and the acquisition of appropriate data.

Partners:

Central Statistics Office of Indonesia (BPS); Indonesia Ministry of National Development Planning; Indonesia Ministry of Home Affairs; United Nations Development Programme Indonesia.

Area:

Indonesia, various locations.

Timeline:

2006-2007.

MTSP:

Focus Area 5 - Policy advocacy and partnerships for children's rights.

Contact Information:

Social Policy and Protection Cluster
UNICEF Indonesia, jakarta@unicef.org

UNICEF provides training on DevInfo, a database system for monitoring human development, to administrators and users. However many DevInfo training requests are made too early and are not preceded with either a clear planning process or appropriate data. DevInfo training needs to be conducted at an appropriate point in the timeline of the programme process, and monitoring should be part of the after-training technical assistance.

Database development has to be put in the context of data flow and management system improvement. DevInfo training can be used as a tool to encourage and stimulate this



Training on database management using DevInfo in Polman district, West Sulawesi (UNICEF Indonesia/Nugroho)



Training on DevInfo for provincial officer in South Sulawesi (UNICEF Indonesia/Nugroho)

process, but cannot be considered an end result in its own right. Technical training on DevInfo should cover not just the technical aspects database development, but should be conceived and delivered as a more holistic process of consultation and support that starts with planning, runs through development and includes ongoing management. DevInfo training is best delivered in the 'real world' through on-the-job training, continuing coaching and mentoring, and programmes of in-house training.

DevInfo (<http://www.devinform.org>) is designed to organize, store and present data in a uniform way to facilitate data sharing at country level

across government departments, UN agencies and development partners. It can be adapted to different languages, and be used to manage Millennium Development Goals (MDGs) and other indicators such as those relating to, for example, national development goals, programme implementation, and disaster responses. DevInfo is managed by UNICEF on behalf of, and with support from, 20 member agencies of the United Nations Development Group (UNDG), which endorsed the system in 2004. The system is compliant with international statistical standards and operates both as a desktop application and on the web.

Developing a database must be understood to be, and implemented as, part of a process rather than an end-result. Similarly, delivering related activities such as training must not be considered an end-result. Monitoring and support should continue after training has been delivered. These principles apply to initiatives other than database development. Planning for database development, and often other initiatives, should include a clear definition of the indicators, i.e. how the indicators will be measured and calculated so that the data can be understood clearly and rigorously. Planning also includes clarity about the choice of data sources and collection methods so that data meet the indicator criteria. Before developing a database and setting up training, the following should be considered:

- 1) Is the purpose of database clear? Is there a plan for the database structure? Are the indicators clear, rigorous and agreed?
- 2) Are the data for the indicators available regularly and sustainably, and in accordance with expected standards?
- 3) Are there adequate facilities and resources to develop and maintain the database?
- 4) Will the database be utilized and provide optimal benefits to meet the objectives? Is there appropriate capacity to analyse and use the data?

All too often, training participants are given knowledge, skills and equipment, but do not

know what to do with it. In some cases no practice takes place after training, and trainees can consequently forget important aspects of the training.

The lessons learned are drawn from a number of training events:

- 1) The Improving Maternal Health in Indonesia (IMHI) project developed data recording software to help village midwives track and monitor pregnant women. The plan called for the use of DevInfo to process data for monitoring and to produce aggregate data. Consequently DevInfo training was conducted for health centre (*Puskesmas*) and district Development Planning Board (*Bappeda*) staff in Banjarnegara District in July 2006; Health Office, Statistics Office and *Bappeda* staff in Central Java province in September 2006; Health Office and *Bappeda* staff in Wonosobo and Rembang Districts in June 2007; and Health Office, Statistics Office and *Bappeda* staff in East Java in November 2007. Unfortunately, this training was conducted when the tracking and monitoring systems were still being tested, and the data processing software was still under development. Although the purpose of the database development was clear, there was no design plan for the database structure, nor any indicator list or data. The training therefore had to use outcome indicator data from previous surveys. As result, although the training participants' knowledge and skill on DevInfo increased, they were left with no clear vision as to how this knowledge and skill would apply to the programme area. Moreover, by the time the pregnancy tracking and monitoring programme was established, the trainees had moved to other unrelated tasks and positions.
- 2) DevInfo training conducted for MDGs project partners in West Sulawesi in November 2006 and Statistics Office staff in South Sulawesi in February 2007 faced almost the same problem. The training was

conducted before indicator metadata had been agreed and before data collection had started. Consequently, following the collection of survey data in September 2007, the trainees had difficulties applying their training for database development associated with the programme. Only through intensive monitoring and ongoing technical support, including long-distance training from Jakarta supporting database administrators, was a local database eventually established in Polewali Mandar district.

- 3) When DevInfo training was delivered to the Civil Registration Office (CRO) of Surakarta district in East Java in 2007, the forms for recording births, deaths, marriages and divorces had been developed with an appropriate range of stakeholders including the district parliament, and data collection had been in progress by CRO and its partners since 2005, with monthly compilations produced by CRO. Apart from registration purposes, DevInfo was intended to manage data in support of planning and advocacy. In this case, the purpose of the database development was clear and data was available. However, there was no design plan for data processing or for the database structure. Furthermore, the data collection instruments had been developed for registration purpose only, and did not relate to appropriate social indicators. Prior agreement among stakeholders on indicators is required before data processing can take place, and indeed before any meaningful DevInfo training can be accomplished. In this case, DevInfo training therefore had to use existing survey data on indicators related to children under five years old, and on-going technical assistance was required, including a second phase of in-house training for staff involved directly in database maintenance. It was only after this second round of training that a more contextual database was developed together with recommendations to improve

data collection, data entry and data processing. Regrettably there was no further opportunity to monitor implementation, as UNICEF discontinued support to the project due to lack of funds.

Development of a DevInfo database is not a stand-alone activity and development must be seen as just one part of a larger process rather than an end result. Whether or not a database is ultimately useful depends crucially on the 'upstream' planning process. This includes defining the indicators that will be managed in the database, including their unit(s) of measurements, and the level of data aggregation required. The data supply process is also important. Regular, timely and continuous supplies of data are required, and it must be understood that data quality is inevitably related to data collection methods and instruments. The limitations of the data, and the data collection processes must be appreciated. For example, the indicator 'Proportion of households that have access to adequate clean drinking water' begs the questions: What is access? Is it only related to distance, or are time and/or funds relevant? How much is an adequate amount? What is clean? Such criteria will affect how the data collection instrument is developed, how the data collecting method is applied (e.g. are laboratory water tests required?), and how the raw data collected will be processed. A more complex set of criteria will require more indicators to be covered by the data collection instruments, and require more complex data processing calculations and tabulation. These will all have consequences for data flow management and human resources. In many cases, compromises and agreements among stakeholders will need to be reached in advance in order to obtain appropriate indicator definitions with realistic data collection plans. Clear and rigorous definitions of indicators become particularly important when databases are merged. The data of the same indicator from both databases must refer to the same metadata.

FA5 Innovation: Pandemic planning awareness

Summary:

UNICEF's capacity building workshops for non-health sector organisations explored the consequences of pandemic influenza. By formulating and rehearsing the responses, the impact of such an event can be reduced and lives saved.

Partners:

Canadian International Development Agency (CIDA); Indonesia Ministry of Health; National Avian and Pandemic Influenza Co-ordinating Agency (*KOMNAS- FBPI*).

Area:

Nationwide with workshops in Lombok (West Nusa Tenggara), Batam (Riau), Tanah Toraja (Central Sulawesi), Salatiga (Central Java), Brastagi (North Sumatra), Batu (East Java), Ciater (West Java), Cilegon (Banten), and Bali.

Timeline:

January - May 2009.

MTSP:

Focus Area 5 - Policy advocacy and partnerships for children's rights.

Contact Information:

Child Survival and Development Cluster
UNICEF Indonesia, jakarta@unicef.org

All the countries of the world are vulnerable to a pandemic of influenza, which may occur at any time and cause widespread illness, commercial and social disruption, and a significant number of deaths. With a relatively low capacity health system, and endemic Avian Influenza (H5N1), Indonesia is arguably more at risk from being affected early and with little warning. Yet a 2008 study¹⁹ found that only 33 per cent of adults, 56 per cent of community leaders and 74 per cent of communication agents in Indonesia had ever heard the word 'pandemic'. Between January and May 2009, UNICEF



A pandemic planning workshop in Central Java
(UNICEF Indonesia/Pumomo)



Ibu Kartini from Gowa district, Makassar province is the cadre who helps find bird flu in her village
(UNICEF Indonesia/Pumomo)

therefore ran series workshops intended increase the capacity of the non-health sectors to cope with the disruption an influenza pandemic would cause. By exploring the consequences, and formulating and rehearsing the responses, the impact of such an event might be reduced, and lives saved.

Although Indonesia has a draft national pandemic preparedness plan, knowledge of it, and understanding of the consequences of a pandemic at a regional level, is accepted to be low. These workshops, the first to address the issue at a public sector/community level

in Indonesia, were directly relevant to non-health, multi-sector preparedness at regional levels, especially with respect to containment of an outbreak, and the longer term consequences of a sustained event. The workshop delegates were, very largely, precisely the individuals who would be in the front line of the response should a pandemic emerge in Indonesia, or reach the country from another geographic area. Pandemics of infectious disease are radically different events from other natural disasters such as earthquakes or floods. The scale and impact of a pandemic cannot be predicted. Human action plays a role in disease spread, or containment. And, as many areas of the world will be affected simultaneously, external assistance is less likely to be available.

The objective of the workshop series was to increase the capacity of the non-health sectors to cope with the disruption an influenza pandemic would cause. By exploring the consequences, and formulating and rehearsing the responses, the impact of such an event might be reduced, and lives saved. The workshops ran over three days and typically involved around 70 individuals representing non-health sector public, private and community organizations. They were held in hotels large enough to accommodate all the delegates, and provide the four or five rooms required for group breakout sessions. The format of the workshops changed slightly as the series progressed, in response to evaluation and feedback, but can be generically characterised as follows:

Day 1, evening	Welcome speeches (<i>KOMNAS FBPI</i> and others) Pandemic influenza - overview Indonesian national plan - overview Film - fictional account of pandemic outbreak
Day 2, morning	Current global situation
Day 2, late morning and early afternoon	Facilitated discussions of operational responses to an outbreak in groups of 12 - 18 divided into four sectors: 1) security and emergency 2) transport, communications and tourism 3) water, food and energy 4) family, children and religion.
Day 2, late afternoon	Presentations by each of the four sectors of their findings to all delegates, followed by feedback and questions. Personal Protection Equipment (PPE) - familiarisation
Day 3, morning and early afternoon	Functional 'table top simulation'. In early workshops, 12 - 15 individuals were selected to manage a simulated outbreak whilst being watched by the other delegates. The final workshop involved a more complex scenario with delegates in separate rooms, divided according to five regions, managing a nationwide outbreak.
Late afternoon	Expert review and feedback
	Debriefing and evaluation

At the earlier workshops very few delegates professed to have considered the idea, or impact, of a pandemic, personally or professionally. Consequently many of the early reactions of the delegates indicated a low level of comprehension as to the different responses required to a widespread epidemic of an infectious disease, compared with responses to natural disasters such as earthquakes and floods. By the end of each workshop very few, if any, delegates failed to realise that a pandemic was a radically different sort of event, and that it would produce an unusual set of challenges and call for a wide ranging set of responses. The final workshop was of a different character as it brought together in a national context some of those delegates who had been at previous regional workshops. This group's response, at the outset, and through a more complex and challenging set of exercises, was significantly more sophisticated and informed. The workshops were hosted by regional administrations and jointly organised by UNICEF and the national avian and pandemic influenza co-ordinating agency (*Komite Nasional Pengendalian Flu Burung dan Kesiapsiagaan Menghadapi Pandemi Influenza / KOMNAS FBPI*). They proved to

be an example of the close working relationships the two organizations enjoyed. For nearly all of delegates, the workshops proved to be memorable, even dramatic, events, and through the process of 'learning by doing' (i.e. the delegates were expected to produce plans for their sectors, and then play them out through the table top simulation), the delegates' long term knowledge and expertise was enhanced. Many delegates professed the need, and the desire, to take back what they had learned to their offices and professional communities, but without the facilities, expertise, and indeed the drama, of the workshop event, they are unlikely to be able to make such an impression on their colleagues as the event made on them. Nevertheless, as a first step towards driving sustainable change in public policies, institutional frameworks, national and local capacities, attitudes and decision-making processes, the workshops were extremely effective.

The delegates were drawn from a wide range of public, private sector and community organizations. The Batam workshop, for example, was attended by representatives of the following sectors and functional groups:

Sector :	Delegate representation :
Education	<i>Dinas Pendidikan</i> (Education department), <i>PGRI</i> (National Teachers' Association), Media, Scouts
Women & Children	<i>PKK</i> (Civil Service Family Welfare Movement)
Religion	Islamic, Hindu and Christian organizations
Transportation	<i>Organda</i> (National Road Transport Operators Association), <i>Angkasa Pura</i> (Department of Transport), <i>Pelindo</i> (state-owned seaport operator)
Telecommunications	<i>Telkom</i> (commercial network provider), <i>Orari</i> (amateur radio organization), <i>Rapi</i> (citizen band radio)
Banking & Finance	<i>Bank Indonesia</i> , <i>Perbanas</i> (a banking finance and informatics institute)
Tourism	<i>PHRI</i> (Hotel and Restaurant Association), Immigration department
Agriculture & Food Production	<i>Bulog</i> (State Logistics Board)
Energy & Power	<i>PLN</i> (state-owned electricity utility company), <i>Pertamina</i> (state oil company)
Water Supply	<i>PDAM</i> (water utility company)
Security	<i>Kantor SAR</i> (national social service & welfare organization), <i>PMI</i> (Indonesian Red Cross), <i>Tagana</i> (Society for Disaster Management), Police, <i>Kodam</i> (Army group), <i>TNI AU</i> (Air Force), <i>Lantamal</i> (Navy), <i>Satkorlak PBA</i> (disaster management)
Sanitation and Refuse	<i>Dinas Kebersihan</i> (Hygiene department)

The workshops facilitated partnerships among the delegates and their organizations. Few of the delegates had met face-to-face before and in the event of them having to work together (either within their region, or between regions), the joint activities at these workshops is likely to enhance their collaboration. The workshops also led to the empowerment of individual delegates within their professional communities. Very nearly all of them left the workshops with increased knowledge, capabilities and confidence, which they expressed the desire to share with their colleagues and contacts. Consequently the delegates' participation in the process of planning for pandemic preparedness, and, very likely, the participation of their colleagues, has been enhanced.

As noted above, the workshops doubtlessly motivated individual delegates. They also impressed on local government attendees, and other actors, the very real threat and dangers of a pandemic, and the need for planning and preventative action. The final workshop in particular was well covered in the media. Most valuably however, the workshops demonstrated to the national agency, *KOMNAS FBPI*, the value and efficacy of such events, as well as equipping it with a 'template' for future events, and the experience of planning and running such events. The workshops' success made a powerful argument for similar events to be funded and conducted in the future, and following the workshop series plans were made for such activities at the request of local government authorities in West Java, East Nusa Tenggara (*NTT*) and South Sulawesi. Other expressions of interest were made by authorities in Aceh and Papua.

Given the need to transport, accommodate and feed nearly 1,000 delegates, facilitators and support staff (over the course of the series of workshops), as well as to accommodate the workshops themselves, and provide trained facilitators, IT facilities and materials, the

workshop series has to be considered a relatively expensive event. It has been proved however that such events are both necessary and effective, and no stronger case could have been made to national and regional authorities (as well as to the delegates' own organizations) that the programme should be extended. It is also the case that UN System Influenza Coordination (*UNSIC*) recommends continued and expanding work exactly along these lines.

The workshops are particularly valuable if public, private and community groups, especially at regional levels, are starting from a position of relatively low levels of knowledge and preparedness. For the workshops to be replicable and effective, however, a relatively high level of public, private, and community competence and enthusiasm needs to be present, operating within relatively well-formed structures. Earlier workshops, before the novel H1N1 outbreak in April 2009, were challenged by the need for delegates to understand that the pandemic threat was real and significant. Similarly, at the outset, all delegates did not understand how influenza is spread, and the potential severity of the illness. Aside from the actuality introduced by the novel H1N1 event, these challenges were effectively met by presenting authoritative data on historical events, detailed estimates and modelling relating to possible future events, and - most effectively - the screening of a fictional film relating to the mutation and spread of the H5N1 virus from southern China.

It should be noted that the knowledge and ability of the facilitators of such events is crucial. Considerable background knowledge is required in order to answer a wide range of questions accurately and confidently. Subtle skill is required to lead a group to an answer (or to an appropriate question) rather than simply presenting them with it. Over the course of the series of workshops, the facilitators that were observed increased significantly in competence.

Notes:

1. Jayapura District Health Department statistics, 2005-9.
2. Luman, E et al. (2010) unpublished report based upon surveys carried out by Ternate Polytechnic Institute.
3. Some estimates suggest that approximately 30 million Indonesian homes, or 60 percent of all households, keep around 300 million chickens (*ayam kampung*) and/or ducks (*bebek*) and quail (*burung puyu*) in their backyards.
4. 'Study on the Impact of AVI programs in Indonesia', Jakarta 5 Sept 2008, TNS reference: P.AVI2 (JA045).
5. See 'A Central Java district commits \$10,000 to support the war on Bird Flu' http://www.unicef.org/indonesia/media_7104.html.
6. Central Bureau of Statistics, National Socioeconomic Survey (*SUSENAS*) 2003 and 2005.
7. Ministry of Health, Basic Health Research Survey (*RISKESDAS*) 2007.
8. *BPS* 2002.
9. *Riskesdas* survey 2007.
10. Since the first contact, which identified and reached 219 young women, the number eligible has increased, i.e. the third contact reached 228 out of 291.
11. 453 is the total number of young women who have been to at least one contact out of a total of five in Melolo. Dissaggregated data is not currently available for the fifth contact. The fourth contact screened 369 new or continuing adolescent women.
12. 'Study on the Impact of AVI programs in Indonesia', Jakarta 5 Sept 2008, TNS reference: P.AVI2 (JA045).
13. *Bina Bahasa Indonesia SD Kelas V, Semester 2* © 2007 Penerbit Erlangga, Jakarta, pp 16-18.
14. Source: 'Domestic violence in Indonesia' prepared by UNIFEM Jakarta.
15. Responsible, and supporting, agencies include the Office of Community Empowerment for Women and Family Planning (*DPMPKUB*), *Puskesmas* (Health Centres), *Kantor Departemen Agama* (the office of Religious Affairs), the police, *BAPAS*, *Panti Sosial Asuhan Anak*, and *Kantor Kesatuan Bangsa dan Perlindungan Masyarakat*. Also involved are local NGOs and foundations such as *PANDA*, *Insani Global*, *Yayasan Bina Mulia*, *Yayasan Bina Masyarakat Madani*, *Mitra Citra Remana*, and the Lare Grage home shelter for street children and abandoned children.
16. The second quarter of 2006 saw 19 confirmed human cases and 18 deaths.
17. 'Avian Influenza in Indonesia, 2008, Round Two KAP of Backyard Poultry Farmers, Indonesia', 1 September 2008, Prepared by AED, found that only 10 percent of a sample of 1,022 individuals from households with limited incomes and low education levels did not watch television.
18. 'Study on the Impact of AVI programs in Indonesia', Jakarta 5 Sept 2008, TNS reference: P.AVI2 (JA045).
19. 'Study on the Impact of AVI programs in Indonesia', Jakarta 5 Sept 2008, TNS reference: P.AVI2 (JA045).

For an intervention to be described as good practice, it must have had an outstanding impact on the problem it was intended to address. Studies, evaluations or monitoring activities must provide evidence of this impact, which may be direct or indirect. The intervention may be large and complex, or small and simple. Often it will have been replicated in more than one site and in different contexts. good practice documentation should analyze strategic elements that have contributed to the impact. The objective is to outline the methodology so that the intervention may be replicated.

Good practice - Brief operational definition

A good practice is any programme, or elements of one, that meets one or more of the following 'Essential Criteria'. Evidence must be presented that the programme has met the criteria.

1. Impact - evidence can be presented of positive change.
2. Relevance - the programme responds to national development priorities, and national and international partners' policies, as well as the needs of the target population.
3. Replicability - the programme can be replicated in other locations.
4. Sustainability - the programme has resources to continue without UNICEF intervention or funding.
5. Disparity - the programme addresses the special needs of marginalized sections of the community.
6. Gender mainstreaming - the programme takes into account the specific needs of men and women.

'Secondary Criteria' should also be reported:

1. Convergence or multi-sectoral approach - the programme involves more than one sector.
2. Efficiency - the programme uses resources efficiently.
3. Expanded partnerships - the programme involves new partners, or improves links with existing ones.
4. External interest - other groups, including the media, are interested in the programme.
5. Effective management / transparency - all stakeholders are aware of all the elements of, and all the issues associated with, the programme.
6. Innovation - the programme uses novel approaches, methods, systems or tools.
7. Communication and advocacy - the programme successfully utilises Communication for Development (C4D) strategies.

GOOD PRACTICE

Documents well assessed programming practices that have evidence of success/impact. These may be valuable for replication, scaling up and further study.

LESSONS LEARNED

Offers reflections on the implementation of a particular programme or operation. Reports of both successes and failures are encouraged

INNOVATION

News of new thinking in programming and operations. These may be pilot projects or new approaches that demonstrate initial results.

FROM THE FIELD

Flexible short reports for sharing ideas, field experiences, observations, new literature, and so on. Results are not required.

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