National Consultation and Citizen Hearings in Indonesia for Global Strategy for Women’s, Children’s and Adolescents’ Health
NATIONAL CONSULTATION AND CITIZEN HEARING RESULTS
IN INDONESIA:
GLOBAL STRATEGY FOR MATERNAL AND CHILD HEALTH AND
adolescent health

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Jakarta, March, 2015
This report is written based on focus group discussions and national consultation conducted by Indonesia White Ribbon Alliance (Aliansi Pita Putih Indonesia-APPI), Muhammadiyah (USAID grantee), Indonesia Planned Parenthood Federation (Perkumpulan Keluarga Berencana Indonesia-PKBI), Plan International, Save the Children and Wahana Visi Indonesia (partner of World Vision Indonesia), that are members of Maternal and Child Health Movement (Gerakan Kesehatan Ibu dan Anak-GKIA), with funding from The Partnership for Maternal Newborn and Child Health (PMNCH).

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EXECUTIVE SUMMARY

Indonesia has attempted to achieve MDG 4 and 5 targets for reducing maternal mortality rate (MMR) and newborn mortality rate (NMR). IDHS 2012 showed MMR increased to 359/100,000 live births and NMR is stagnant for at 19/1,000 live births. The government needs to hear the voice of the community in order to be accountable to the 2015 Sustainable Development Goals (SDGs). The CSOs need to play a role to facilitate the social accountability mechanism. Citizen hearing involved almost 500 male and female, including youth and consulted at national level on March 13th, 2015, participated by 100 participants from 40 districts in which 30 districts are the focused district of Ministry Health Office and representative of GKIA’s activist at national level.

Citizen views that maternal, infant and young child nutrition; maternal newborn, child and adolescent health; and immunization are still problem in Indonesia. There are some issues identified by citizen including: Breastfeeding mothers do not receive breast milk counseling (77%), capability of health workers in the governance of maternal and newborn mortality clinical causes (61%), premarital sexual intercourse (61%), and that is not all babies are protected with complete basic immunization, including hepatitis, tuberculosis, polio, diphtheria, pertussis, tetanus and measles (29%). There are already good examples of how the accountability mechanism have been built and managed in several districts but again how the public accountability functions is highly dependent to the civil society organization’s facilitation.

Citizen recommends that health services should be provided in a comprehensive service package, along the continuum of care. Cross sector collaboration is necessary to overcome maternal and adolescent health problem, since there are social and economics determinants in the background. The citizen also recommends expanding the scope of Universal Health Coverage (UHC), which is related to equal and non discrimination health and nutrition service coverage. The government has played the role well in preparing norms, standards, regulations and policy, but they are still weak in ensuring the implementation. Therefore a strong, transformative, and reformatory national leader is required for the change in all sectors and levels of administrative area. Although the functions of the regulator, implementer, and finance are in the hands of the government, but the leading actors of this development is the civil society. It is the right of citizens to participate in the planning and program implementation process, so it can be accountable and will be in accordance with the needs of the citizens.

Brian Sriprahastuti
FOREWORD

Maternal and Child Health Movement (Gerakan Kesehatan Ibu dan Anak - GKIA) was jointly initiated by the Government, Civil Society Organizations (CSO), Professional Organizations and Faith Based Organizations, and was launched on June 23, 2010 by the Coordinating Minister for People’s Welfare. GKIA becomes the medium to build more effective communication with the decision makers in Maternal and Child Health (MCH) and Nutrition sectors. Since the launching of the Global Strategy for Women and Child Health “Every Woman, Every Child” by the UN Secretary General in 2011, GKIA has initiated series of cross ministries/institutions and guarded the follow up of recommendation from Commission on Information and Accountability (COIA).

GKIA has been recognized and trusted to represent the Coalition of Indonesian Civil Society in MCH and Nutrition sectors in Asia Pacific regional as well as Global forums. At the end of 2014, GKIA received an information regarding Citizen Hearings (that was initiated in global level by White Ribbon Alliance, International Planned Parenthood Federation, Save the Children, and World Vision) and Global Consultation for Maternal, Child, and Adolescent Health (initiated by The Partnership for Maternal, Newborn, and Child Health). With the agreement through intensive communication with the committee in the global level, GKIA synergized the 2 activities in form of Citizen Discussion (that was conducted in 40 districts/cities) from the end of February 2015 and National level Discussion on March 13, 2015. The result of these whole processes will be submitted to the Delegation of Republic of Indonesia for World Health Assembly (WHA) and other related parties for the development of 2015-2030 Global Strategy for Women’s, and Children’s and Adolescent’s Health.

Asteria T. Aritonang
GKIA Secretariat
CHAPTER 1. INTRODUCTION

1.1. Background

Two of the seven visions of national development for the period of 2015-2019 are creating high, progressing, and prosperous quality of Indonesian people's lives and creating competitive nation with the agenda to improve the quality of the lives of Indonesian people. To meet the agenda, cross sector cooperation with the support of development partners, which are private sectors and civil society organizations, is necessary.

Figure 1.1. Cross-Sector Development Framework, Ministry of National Development Planning (BAPPENAS), 2015

Evaluation towards National Strategic Plan 2010-2015 indicates that the achievement in nutrition and maternal and child health development has not improved significantly with relatively wide gaps among the 33 provinces in
Indonesia.\(^1\) Nationally, Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) are still high. The disparity of health service coverage is obvious from the highest childbirth in health facilities in Daerah Istimewa Yogyakarta (DIY) (99%) and the lowest in Maluku (25.2%); and the highest coverage of complete basic immunization is in DIY (83.1%) while the lowest is in Papua (29.2%) \(2013\) Basic Health Research).

Macro and micro nutrition issues also became unresolved problems. Based on the \(2013\) Basic Health Research, thirty two point nine percent (32.9%) of children under two years old (under-twos) were reported for stunting, 12.1% of children under the age of five (under-fives) were reported for wasting, and 11.9% of under-fives for overweight. 37.1% of pregnant mothers in Indonesia are suffering from anemia. There were only 38% among babies under the age of 6 months who still receive exclusive breastfeeding. Lack of nutrition becomes the underlying disease of sick-under-fives in Indonesia, where pneumonia and diarrhea become the major causes for mortality of under-fives, aside from pre-natal problems. Anemia in pregnant mothers is also known to be contributing to low birth weight infant incidents, where in Indonesia the prevalence is still 10.2%. The information was gathered from \(2012\) Indonesia Demographic Health Survey and \(2013\) Basic Health Research.

Indonesia is facing double burden of increasing incidents of communicable and non-communicable diseases. Several communicable diseases that cause infant mortality have decreased significantly as a result of successful immunization program such as polio; but several other communicable diseases such as measles, tuberculosis, and hepatitis remain unresolved. Thirty percent (30%) of under-fives, and even 40% of under-twos, were

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\(^1\) Currently there are 34 provinces in Indonesia, however, when the National Strategic Plan was being evaluated, there were still 33 provinces
reported for experiencing fever incidents that are linked to malaria incidents for Indonesia’s context, and other acute infectious diseases, such as pneumonia and gastrointestinal infection. Only 40% of under-fives children suffering from diarrhea who received Oral Rehydration Therapy, while in fact the morbidity is still high (14%); similarly, pneumonia that is still known as the hidden killer has not been completely resolved by the government. Malaria prevalence in endemic area (especially in eastern part of Indonesia) and HIV-AIDS tend to increase up to 0.43% in 2013.

Not-optimal health services, especially referral service and hospital standards, as well as challenges in accessibility due to the geographical, financial and social factors are the reasons for the current condition. The gap between health service access in Jawa, Bali and Sumatera with the ones in eastern part of Indonesia such as Nusa Tenggara Timur, Papua, Maluku and some of Kalimantan and Sulawesi becomes clearer because health facilities and workers are still centralized in Jawa, especially Jakarta and the Universal Health Coverage (UHC) strategy is still narrowly understood as National Social Health Insurance (Jaminan Kesehatan Nasional-JKN) Program with the objective to overcome economic barriers.

Global commitment for Millennium Development Goal (MDG) will end this year (2015). The world records various successes but there are also some unfinished tasks left. Indonesia’s ideal to achieve 102 Maternal Mortality Rate is still far from the expectations because 2012 Indonesia Demographic Health Survey indicated 359 per 100,000 live births. There is actually a decrease in the Infant Mortality Rate, which were 23 per 1,000 live births. Neonatal

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2 Maternal Mortality Rate Indonesia, according to the Inter-Agency Report, which is used as the reference during the global level meeting was 150/100,000 live births. The difference of MMR is caused by the different references and it cannot erase the reality that the rate is still very high for a country that was categorized as Middle Income Country like Indonesia.
Mortality Rate (NMR) does not even have any meaningful change in the last fifteen years for only achieving 19 per 1,000 live births.

This situation opens a discourse regarding the importance to explore problems with different methods and to choose more innovative strategy for interventions that can be proven scientifically. Facing the global plan for 2015-2030 sustainable development goals (SDG), Government needs to listen to its citizens’ voices and to improve citizens’ participation, to make the development more accountable, and people’s aspirations can be accommodated in the development plan. Civil Society Organizations are believed to have power to play a significant role in strengthening development accountability mechanism in nutrition and maternal, newborn, child, and adolescent’s health, to make the public services control function works well to support the improvement of service quality, and in the end will contribute to the achievement of development targets.

Approaching World Health Assembly (WHA) in May 2015, GKIA initiated to conduct district/city consultation and national consultation in Jakarta with the representatives of district/city that conduct the consultation and the civil society organizations in the national level. Hearing process was conducted in the research design to be held accountable for the validity of collected information. Based on the above explanation, consultation/Citizen Hearing process that was packed in forms of research will seek for answers of the following questions:

1. What kind of lessons we get from 2010-2015 Millennium Development Goal?
2. What kind of lessons we get from Global Strategy for Maternal and Child Health (2010-2015)?
3. What are the three main priorities of the global strategy proposal that the citizens expect to see for health and nutrition of maternal, children and adolescent after 2015?

4. What are the best ways to build consultation between the communities with the stakeholders?

Collected, processed and analyzed information will be used as the input for recommendation from civil society in Indonesia in the development of 2015-2030 global strategy for women and children. Report of national consultation will be submitted to Ministry of Health of Indonesia as the voice of Indonesia citizen on World Health Assembly in Geneva that is planned to be implemented in May 2015.

1.2. Objective of the Study

This general objective of this study is to understand civil society's opinion regarding the achievement of nutrition, maternal, newborn, and children health, and adolescent health; and the expectations in 2030. Meanwhile, the specific objectives are:

1. To explore information regarding participants’ experiences and observations related to the implementation of nutrition, maternal and child health, and adolescent health programs in the respective district.
2. To explore unresolved problems regarding nutrition of mothers and under-twentos, maternal and newborn health, immunization, and adolescent health, as well as to analyze identified root problems.
3. To explore experiences in developing accountability mechanism of social services in nutrition, maternal and child health, and adolescent health programs.
4. To formulate recommendation for global strategy target regarding nutrition, women’s, children’s, and adolescents’ health.
CHAPTER 2. METHODOLOGY

This study is designed as a combination of qualitative and quantitative study. The information was collected using focus group discussion (FGD) method with informants who represent the elements of the civil society. Instruments in this study include researcher and discussion facilitator, while the measurement tools used were notes and voice recorder. The information was collected using a discussion guide, which was developed from the key questions that appear to answer the objective of this study.

Participants of focus group discussions are the representatives of local and international Non-Governmental Organizations (NGO) working in Indonesia, Empowerment of Family Welfare (Pemberdayaan Kesejahteraan Keluarga-PKK), adolescent groups, faith based organizations, traditional/cultural leaders, non-health professional organizations and other civil society organizations that were considered relevant to provide information as needed. The scope of this study covers four aspects, including 1) nutrition of mother and under-two; 2) maternal and newborn health; 3) immunization; and 4) adolescent health. Study area was determined purposively in 40 districts/cities, where thirty of those areas were selected from Ministry of Health’s 149 priority focus districts/cities. The forty districts/cities are in 15 provinces including: Nanggroe Aceh Darussalam, North Sumatera, Lampung, Banten, DKI Jakarta, West Java, DI Yogyakarta, Central Java, East Java, West Kalimantan, South Sulawesi, Central Sulawesi, East Nusa Tenggara, West Nusa Tenggara, and Papua.

Ten to 12 participants who represent different organizations participated in the focus group discussion, led by a facilitator who was assisted by a note-taker. Focal point NGO selected the facilitator and note-taker by considering
their competences in guiding focus group discussion. Draft for discussion guide was prepared by researchers, then completed based on the input from focal point NGO, while building common perception regarding the expected questions and information expected from the questions.

This study was conducted in 1 (one) month, started in mid of February 2015 until mid of March 2015. Information process and analysis was conducted in Jakarta by the researcher and assistant of researcher. The activity was funded by The Partnership for Maternal, Newborn and Child Health (PMNCH) and additional funding support for discussion implementation in district level and documentation was provided by Indonesia White Ribbon Alliance (Aliansi Pita Putih Indonesia-APPI), Muhammadiyah (USAID grantee), Indonesia Planned Parenthood Federation (Perkumpulan Keluarga Berencana Indonesia-PKBI), Plan International, Save the Children and Wahana Visi Indonesia (partner of World Vision Indonesia).
CHAPTER 3. RESULT AND DISCUSSION

3.1. Information Collection Process

The preliminary meeting was conducted on January 21, 2015, initiated by Save the Children. The next preparation meeting was participated by representatives of focal point Non-Governmental Organizations (NGO) in IPPF/PKBI office on February 11, 2015, with the objective to agree on objectives, analysis method and process, as well as the expected results of the Focus Group Discussion (FGD); also finalization of guideline, mechanism and timeframe of the FGD implementation. The preparation meeting resulted in some important agreements including modification of FGD guideline and addition of individual questionnaire; the method study that was initially designed as pure qualitative study was modified into quantitative-qualitative study with bigger proportion on qualitative side. Individual questionnaire was conducted through self-questionnaire method by all FGD participants with the objective to triangulate information that was also strengthened through secondary data confirmation from 2012 Indonesia Demographic Health Survey, 2013 Basic Health Research, and informants’ explanation.

The meeting resulted in the agreement to implement FGD in district/city and national levels. Discussion in district/city level was in form of a citizen hearing process; while in national level was in form of national consultation process. The number of district/city for study area was increased from 23 to 40, considering the needs for various expected information.

Hearing in District/City Level:

Criteria for FGD participants in district/city level are:
1) Not part of government or legislative elements.
2) Representing civil society, for example: Empowerment of Family Welfare, Professional Organizations, Religious Leaders, Community
Leaders, Non-Governmental Organizations, Academics, and Adolescent Groups.

3) Considering representation of gender and age group aspects
4) Already involved (as practitioner/observer) in Maternal and Child Health program for at least 2 (two) years
5) Experienced direct coordination with Department of Health at least in District/City level for minimum 1 (one) activity.
6) Willing to participate in the whole process of FGD (around 3 hours) in the agreed day in district/city level

Criteria of FGD facilitator in district/city are:
1) Representative of Civil Society Organizations that own nutrition/maternal and child health activity/program in the area where the discussion takes place.
2) Has the capacity to lead discussion, to properly dig for information and to maintain the dynamic of discussion process.
3) At least conducted one focus group discussion.
4) Willing to voluntarily facilitate the whole process (around 3 hours) of focus group discussion on the agreed day.
5) Willing to represent district/city as the participant in national consultation that will be held in Jakarta on the date that will be determined by focal point NGO.

National Consultation:
Criteria of FGD participants in national level are:
1) Facilitator of focus group discussion in district level (40 participants)
2) Representative of CSO (civil society organization) member of Maternal and Child Health Movement-coalition
3) Representative of Government: Department of Health in District/City, Ministry of Health
4) Representatives of adolescent groups: IPPF/PKBI, Independence Youth Alliance (Aliansi Remaja Independen-ARI), etc.

5) Willing to participate in the whole process of FGD (around 3 hours) in the agreed day in district/city level

Criteria of FGD Facilitator in the national level are:
1) Representative of Focal Point NGO
2) Has the capacity to lead discussion, to properly dig for information and to maintain the dynamic of discussion process.
3) At least conducted one focus group discussion.
4) Willing to voluntarily facilitate the whole process (around 3 hours) of focus group discussion on the agreed day.
5) Willing to participate in discussion process from the preparation to reporting

Resource Persons in national level are:
1) Director of Nutrition and MCH of Ministry of National Development Planning (Bappenas) presented the 2015-2020 national strategic plan of nutrition and MCH program
2) Newborn Advisor Save the Children presented Maternal and Newborn Health topic
3) Ministry of Health Official presented National Program of Immunization
4) National Health Research and Development official presented the National Program of Nutrition
5) Indonesia Planned Parenthood Federation official presented Adolescent Health and Reproduction Health Issues in Indonesia

Focus group discussion is conducted for around 3-4 hours, guided by 1 facilitator and 1-2 note-taker(s) through the following discussion steps:
1) Facilitator communicates to participants the objective of conducting focus group discussion
2) Facilitator asks participants to give an informed consent for their participation in focus group discussion.
3) Facilitator communicates to all informants to fill in structured questionnaire in 30 minutes.
4) Facilitator leads FGD using the prepared questions guideline
5) Note-taker records the process and transcript of the group discussion.
6) Transcript and voice recorder of district FGD are sent by email to main researcher within maximum three days after the implementation of discussion and before the national consultation (March 13, 2015).
7) Facilitator brings the independent questionnaire on March 13, 2015 and submits the document to assistant of researcher for data entry, process and statistical analysis.
8) Transcript and voice recorder of national FGD are sent by email to main researcher within maximum three days after the implementation of discussion (March 16, 2015).
9) Main researcher processed the transcript into information format within the period of 13 to 18 March 2015
10) Reduction of information, further analysis and reporting are done by the main researcher on 19 to 20 March 2015
11) Preliminary draft of the report is discussed for clarification with focal point NGO on 21-22 March 2015
12) Main researcher prepares the executive summary and submits it to GKIA coordinator on March 23, 2015.
13) Finalization of report will be done by the main researcher on 24-30 March 2015
14) Focal point NGO submits final input for the final report on 1 April 2015.
15) Final report is expected to be submitted to the delegation of Republic of Indonesia in mid April 2015.
3.2. Data and Information Processing and Analysis
Quantitative and qualitative methods are done to produce comprehensive information regarding maternal, newborn, and adolescent health in 40 districts/cities as the study area. Quantitative data was summarized through data frequency distribution resulted from the self-questionnaire according to part 1 (one) questionnaire, which was completed before focus group discussion (FGD) started. The resulted data formula was in the form of proportion that represents individual characteristic of each FGD member. Characteristic of informants that was seen quantitatively include the age, gender, education background, and individual proportion toward the four discussion topics for maternal and under-two nutrition aspect, maternal and child health, adolescent health and immunization that are also part of the scope of this study.

Qualitative analysis was used to obtain in-depth information regarding the condition of past, current, and future programs in district/city where the discussion participants live. This study uses content analysis with the process stages: Facilitator or note-taker record the discussion process using voice recorder and notes to produce transcript that will be reduced to be presented and to make evidence-based conclusion.

3.3. Characteristic of Discussion Participants
Four hundred and ninety eight people in 42 groups were recorded as FGD participants. The youngest informant was 15 years old and the oldest was 73 years old. The voices of youth were adequately accommodated in the discussion in district/city level, since the age of 11% of the informants were below 24 years. Informants were dominated by female (64%) compared to male. Most of the informants in this study, which is 49.3%, have completed bachelor degree, and 31.6% informants graduated from high school.
3.4. Problem Analysis and Root Problems of Maternal and Child Health

3.4.1. Issues Regarding Maternal and Child Health

Different situations and conditions of community and the environment in Indonesia, as well as the different capacity of regional government in implementing their functions in the state governance, generate quite huge disparity in maternal and child health service. Result of the self-questionnaires and group discussions in district level indicates the different priority of problems between districts in eastern part of Indonesia that still struggle with accessibility due to geographic factor and limitation of infrastructure, with priority in other areas in Indonesia that more likely to bring up issues regarding service quality or the service that cannot reach marginal group.

Generally, maternal mortality, infant mortality, and malnourished on under-fives are still becoming issues that should be resolved optimally. Similarly, adolescent health needs serious attention from all parties because it contributes to the high number of maternal and infant mortality rates. Informants of this study still considered nutrition (98%), Maternal Mortality Rate (89%), Neonatal Health (88%), Adolescents Health (84%), and immunization (43%) as the problems. More detail information regarding those issues is presented in table 3.4.1 below.

<table>
<thead>
<tr>
<th>No</th>
<th>Problems</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clean water source</td>
<td>78%</td>
</tr>
<tr>
<td>2</td>
<td>Breastfeeding mothers do not receive counseling</td>
<td>77.2%</td>
</tr>
<tr>
<td>3</td>
<td>The state has not implement code of conduct regarding marketing of breast milk substitutes</td>
<td>63.7%</td>
</tr>
<tr>
<td>4</td>
<td>Community Health Center and Hospitals are not baby friendly</td>
<td>62.8%</td>
</tr>
<tr>
<td>5</td>
<td>Morbidity and Transmission of HIV</td>
<td>60.9%</td>
</tr>
<tr>
<td>6</td>
<td>Maternity leave</td>
<td>60.3%</td>
</tr>
<tr>
<td>7</td>
<td>Knowledge and management of tuberculosis</td>
<td>58.8%</td>
</tr>
<tr>
<td>8</td>
<td>Access to medicines for sick under-fives</td>
<td>54.4%</td>
</tr>
<tr>
<td>9</td>
<td>Prevention and Management of Malaria Disease</td>
<td>40.2%</td>
</tr>
</tbody>
</table>
3.4.1.a. Issues Regarding Nutrition of Mothers and Children under two years old

As much as 90% of informants stated that nutrition in pregnant mother is still an important matter. It is caused by the lack of mothers’ knowledge regarding nutrition before, during, and after pregnancy; and also social economic issues. According to informants, the nutrition intake of pregnant mothers who have financial barriers and the babies they are carrying will be affected.

Health status of pregnant mother is also indirectly affected by the age during pregnancy. Young-aged mothers tend to suffer from anemia and do not have enough knowledge to maintain the nutrition intake. Misconception regarding dietary pattern as result of ignorance, lower education of females compared to males, low support from father/husband, and the application of myths and cultures that do not support clean and healthy behavior become the basic reason to still consider anemia and protein energy malnutrition on pregnant and breastfeeding mothers a problem. Recommendation for breastfeeding mother to consume a lot of dark green vegetables without the advice to consume adequate sources of animal protein is the example of inappropriate dietary practice, but has been implemented from generation to generation in many places in Indonesia. Furthermore, there is also a belief that forbids pregnant mother from eating a lot in order to avoid having big baby that will complicate the delivery process.

Economic barriers and knowledge limitations are worsen with the fact that health workers are not yet able to provide effective education session to pregnant and breastfeeding mothers. Health workers have not provided counseling service for mothers regarding breastfeeding and feeding practices for children under-two. Most likely, the reason behind this condition is not all
health workers have the skill to conduct counseling, whilst the community based health education intervention does not available in all areas.

“...I think there are 1001 ways to convey messages... That skill should be encouraged and developed. Starting with formal education officers, nutrition and community empowerment officer ... my advice ... create people who are able to convey messages ...”

Aside from nutrition problems on pregnant mothers, most of informants also stated that nutrition on newborn to children aged two (under-twos) is still an issue. Under-twos’ dependency to their nurturer affects mothers’ social economic status and causes mother with anemia or malnutrition; furthermore young-aged mothers become a contributing factor to the newborns and children under-two nutrition issues.

Young-aged mothers tend to have limited knowledge regarding maternal and newborn health, and are likely to just follow the advice from older family members, even when the advices are not appropriate. The condition influences mothers’ attitude and behavior to exclusively breastfeed children up to the age of 6 months; and mothers’ behavior to continue breastfeeding and giving complementary food for children aged 6 months to two years. Breastfeeding behavior in Indonesia is still considered a problem because even though there are government regulations that regulate the obligation to provide lactating facilities in working spaces, the other supporting factors are not yet optimal due to the intensive promotion of formula milk by accessing maternal data, as well as the lack of joint movement to support breastfeeding.

3.4.1.b. Issues Regarding Maternal and Newborn Health
According to the informants, because not all of health workers perform health services according to the pregnancy and childbirth complication (51%) and neonatal complication (64%), the numbers of Maternal Mortality
Rate (MMR) and Neonatal Mortality Rate (NMR) are still high. This condition is also influenced by the weak policy/regulation that has not obligate the use of program management guideline, so there are some of the health workers who do not follow the technical standard case management for maternal health (44.9%) and neonatal health (57%) . Chart 3.4.1.b.1 and 3.4.1.b.2 below present the detail of the situation

<table>
<thead>
<tr>
<th>Accessibility barriers</th>
<th>36%</th>
</tr>
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<tbody>
<tr>
<td>Health providers have not adequate competency on case management of maternal death clinical causes</td>
<td></td>
</tr>
<tr>
<td>Insufficient support of Policy and Regulation</td>
<td></td>
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<tr>
<td>Not adequate maternal health program management</td>
<td></td>
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</tbody>
</table>

Figure 3.4.1.b.1 Analysis of Maternal Mortality Causes according to community, 2015
The discussion also revealed the fact that not all childbirths are done in health facilities, and that it is still common to deliver babies with the assistant of shamans who do not partner with midwives. Aside from the absence of midwives in some villages and the location of primary health facilities that are beyond the community’s reach (48.3%), the other reasons for not having health workers to assist childbirth are the high cost for getting their assistance, inadequate soft skills of health workers such as behaving unfriendly, treating member and non-member of Social Security Administrative Bodies differently, as well as being unresponsive to the needs of patients.

As revealed during the discussion regarding nutrition issues, mothers’ low education is also a contributing factor to the high MMR and NMR. Awareness of pregnant mothers and their families to immediately perform antenatal checkup, the family’s inability to recognize alarms on newborns, and the fact that not all pregnant mothers are aware and able to be responsible for their own safety are also considered as the indirect causes of the high MMR and
NMR. The applied culture and habit in Indonesia considers women (mothers, mother in law, and mother of mother) as the figures around the newborns; therefore women education will be the strategic solution, both formal and informal education.

“...women education will have huge investment, ... education does not have to be formal. ... Have we educate our family for protection because everywhere the families will always be blamed”

3.4.1.c. Issues Regarding Adolescent Health
Informants considered family’s problems, inappropriate reproduction health education method, and the barriers to access adolescent health services, as the factors that caused the premarital sexual intercourse behavior (64.4%) and child marriage (63.1%). On other side, we understand that there are environment pressure toward adolescents (56.8%) that also triggers addiction to drug, psychotropic, and other addictive substances (55.9%), smoking behavior (54.6%), violence in dating relationship and limited counseling for adolescent (41.4%), as well as anemia on female adolescents (24.6%).

Adolescents’ mental condition is unstable and easily influenced. They also have strong curiosity. These encouraged them to try new things without considering the bad results, especially when there are peer pressures involved. Adolescents need the right accountable medium to provide correct information.

“...When I look at the cases, adolescents are more in need for a place for consultation, for asking questions to improve their knowledge because they have high curiosity, they want to try, and then they are trapped in problems.”
Child marriage became an interesting topic in the discussion. Law no. 1 year 1974 regarding marriage set 16 years old as the minimum limit for women to get married. The age limit is contradictive to Law no. 23 Year 2002 in conjunction with Law no. 35 Year 2014 regarding child protection that define children as a person who has not reached the age of 18 years, including the one who is still in the womb. Referring to the two laws, although a marriage that happens to someone who is aged between 16-18 years is considered legal in the face of the marriage law, it is actually considered as violence to Child Protection Law for legalizing child marriage. There are confusions regarding age limit for being called a child and the basic of child grouping.

According to UN agency, youth is someone who is in the age group of 15-24 years; on the other hand, there is another terminology: young people that covers the age of 10-24 years old. Meanwhile, the general understanding claims that adolescents are someone in the aged of 10-19 years, and youth are the ones aged 19-24 years. In Indonesia refers to UU No. 40/2009 about Young People, a person considered as a young person if their age is between 15-30 years old. The age 19 years based on WHO’s definition on adolescent and the scientific consideration where at that specific age, the reproduction organs anatomy are already perfectly developed and optimally functioning.

Based on IDHS 2012, the Age Specific Fertility Rate for 15-19 years old is 48 out of 1,000 female, while the rate for 10-19 years old who gave birth is 2.5%.

Aside from legal basis controversies, incidents of child-age marriage on female in fact are culturally acceptable in Indonesia, as quoted below:

“Early marriage (child age) is not unusual...girls who are taken home at night should be married. The result is mothers are not ready to have children. In my area, if the woman is not the mahram, even when they did nothing, they should get married”

Today’s young generation face a lot of challenges. On one side, the advances in information technology bring negative impact such as misleading information on reproduction health; however, safe and qualified information
and service on reproduction health are limitedly available. Meanwhile, Law Number 36 Year 2009 regarding Health has guaranteed the right of each person to receive safe, qualified and accessible health services, and to receive health information and education. Similarly, Child Protection Law guarantees every child to grow, develop and to receive health services. Still from the same source, PKBI found that around 60% of 270,000 female sexual workers are still in the age of adolescent; 20% of abortion cases are done by teenagers and there are around 900,000 young female deaths for performing unsafe abortion.

Ideally, information and service on adolescent reproduction health can be obtained through sexual education at school, School Health Program (Usaha Kesehatan Sekolah-UKS) counseling, and health service in Adolescent Health Care Service (Pelayanan Kesehatan Peduli Remaja-PKPR). Unfortunately, the implementation of those kinds of activities faced a lot of challenges.

There is no legal basis that obligates schools to share reproduction health material, both integrated with the school curriculum as well as in form of special session. Although reproduction health module is already available and introduced in 2006 and the Government Regulations No. 61 Year 2014 regarding Reproduction Health is applied, the fact is not all schools has adolescents reproduction health program.

"...Department of Education gives the authority to schools, while not all schools have the concern toward adolescent reproduction health education. When we want to give reproduction health information to children, let’s say we want to show images of reproduction organs, we are considered wrong. Legislative also questions the availability of law umbrella."

Discussion participants think that community health center (puskesmas) services are inclusive for only helping physical health, while mental health
service is not available. Although Community Health Center is the frontline of primary health service, but since it has so many main programs with limited health workers, Adolescent Health Care Service is still also not optimal.

“...adolescent friendly service should be more than just a slogan. For instance, when they want to do VCT test...health workers were curious and tease...do you have HIV? Are you sick? Intern doctors and hospitals are also nervous when they see people with HIV...there should be adolescent friendly education during health practices”

Another adolescent health service is done through School Health Program\(^3\), which is managed together between community health center (puskesmas) and the school. School Health Program can also be used as the medium for counseling and it is more easily accessed by adolescents at schools; meanwhile we need to think of other methods, for the adolescents who are outside the school, such as through adolescent reproduction health group.

"...Now the government claims reproduction health service, but usually it is accessed during school hour. Once someone needs it, the officer is not available, going out or whatever. Access is not only about the cost, but also the availability of energy and time"

It is important for adolescents to realize their needs, so when they are in a situation to be married at young age, the decision should be made on their own behalf, and not because they are forced or they feel like they have to. The same things happen with other adolescents needs such as fulfillment of nutrition and treatment although they have not become the routine community health center (puskesmas) program, just as quoted below:

“Adolescents’ health issue has not become a trend like maternal and child health. Additional nutrition for maternal, children and elderly is

\(^3\) School Health Program
available, but not for adolescents. In fact there are so many adolescents who are malnourished and have anemia, etc.”

3.4.1.d. Issues Regarding Immunization Service

As mentioned in the previous section, Indonesia recorded a success in immunization program in reducing mortality of infants and under-fives caused by infectious diseases. After being free from smallpox in the 70s period, and followed by free from polio status, now Indonesia is trying to achieve tetanus free Indonesia and other infectious diseases that are preventable through immunization. The currently applied basic immunization program for children aged 0-9 months includes vaccines for BCG, Hepatitis, Polio, DPT, and measles. Government’s ambition to achieve Universal Child Immunization (UCI) seems to move towards success, but still challenged with the number of under-fives who are not protected from the diseases mentioned above. It happens as result of registration system in Indonesia that still not able to correctly identified babies who have received five complete basic immunizations.

The success of immunization program to reach UCI is the result of mass movement by Empowerment of Family Welfare cadres and internal government from the central to village level. Using posyandu as immunization service post is an important strategy for health service coverage, which was done using National Immunization Week or sweeping when the immunization coverage is below the target. Local Area Monitoring (Pemantauan Wilayah Setempat-PWS) as documentation and reporting method, along with the facility in analyzing the coverage, has become a best practice for tens of years.

“The importance of immunization, the promotion strategy, ability to work through religious leaders and Empowerment of Family Welfare network that reaches the village, playing the role of the lowest level Empowerment of Family
Welfare, which is Ten Houses Grouping or the smallest community group in the sub-village... Through religious leaders who can participate through their own way on the altar or in church...”

The advance of information technology and the freedom to express one’s opinion has triggered anti-immunization campaign using issues such as non-halal vaccine material, doubting efficacy of immunization, etc. Similarly, gender inequality has positioned some of mothers of under-fives to have no freedom to decide the needs for their children’s health. It is visible from the following quote:

“...we breach the male for patriarch policy. Even there are mothers who became aware and secretly get the immunization because they are afraid of their husbands. One side they want their children to be healthy, but afraid of the husband...”

“...They do not want immunization because they are scared of their husbands, that is why immunization became the church’s program and arranged in village regulation, and using the adolescents for socialization, as well as optimizing IT/blog/Facebook facilities...”

3.4.2. Maternal and Child Health Social Determinants

Development in Indonesia indicates the progress in 2015 MDG target achievement, but still left problems in nutrition, MCH, adolescent health, and immunization service coverage that relates to fundamental causes. Culture and beliefs are still applied in many areas and limit mothers, babies, children, and adolescents to receive qualified services. This is obvious from the childbirths that are still assisted by shaman, and myth that says immunization may causes illness on children, etc.

*I see the influence of culture; we say that it is Aceh’s culture that lage zat ngon sifeut or culture and religion mixed together as they are the same*

Low education on female also underlies the lack of mothers’ and adolescents’ knowledge about nutrition and health. It is worsened with the lack of effectiveness of information from the government (health institution) to the
community. The most evident example is the unavailability of sexual education in the education institutions, while the access to information through social media/internet is easier although it may not correctly understood by the adolescents. It creates the tendency of increasing risky sexual behavior, child marriage incidents, and unwanted pregnancy in the teenagers.

“Child marriage is triggered by poverty and low education on women who do not graduate from elementary school. Please encourage scholarship for girls so they can graduate from high school/Vocational High School”

It has been publicly known that the level of family welfare has a great influence to determine the status of maternal and child health. Indonesia Health Demography Survey in 2012 proved that the relationship between the prevalence of underweight and stunting, and wasting with household expense per capita is obvious, where the better the household’s welfare, the lower the stunting and wasting prevalence. The similar thing occurs on maternal mortality and under-fives morbidity where the numbers increase along with decrease of family welfare.

“...there is a correlation between the dreams to increase family’s nutrition with family’s economy”

“...we have no time to think about that, cook for the husband, pick up the children from school and other stuffs. This is so tiring. You don’t feel this, when you go home, you receive your payment, you don’t think about this or that, so economic factor is the most important, so the community are unwilling to get new knowledge for them”.

In many districts/cities in Sumatra, Jawa, and Sulawesi, post-natal bleeding as the direct cause of maternal mortality, and asphyxia as the cause of newborn infant mortality, has started to be addressed, along with the improvement of health service quality and the response of regional
government to allocate funding from Local Revenue and Expenditure Budget (APBD), and the fulfillment of the needs of health workers. Different things occur in the eastern part of Indonesia. Limitations in number and quality of human resources in health sector, and obstacles in the accessibility as results of difficult geographical condition and expensive transportation fee, lead to the issues regarding low community’s attendance to posyandu, while in fact posyandu is the closest media that can provide health information access to the citizens. This is one of the causes for mothers’ ignorance and indifference regarding hygienic behavior (such as regularly washing hands with soap) and healthy life (such as feeding/breastmilk practices for young infant), while the formal education level of girls is still below 6 years.

“There are 6 mothers died in this village, their needs for nutrition were not fulfilled, we also face infant mortality, which was caused by the far distance to Community Health Center; we have to walk for almost 2 hours with difficult geographical condition. The service is bad...especially when there are no officers there...”

“In Posyandu and Supporting Community health center (Pustu) levels, immunization service is not available, but it is centralized in the sub-district community health center (puskesmas) due to the low number of demand/needs. The problem is, the transportation to community health center (puskesmas) is expensive, and when we go down to the sub-district, the vaccine is not available...one sub-district community health center (puskesmas) for 12 villages with up and down geographical locations and only served by one officer...”

Aside from the fundamental causes, there is a tendency of increase of comorbidity contribution (tuberculosis, hepatitis, HIV, and malaria) that cause the mortality of mothers and infants. Furthermore, health programs that are implemented by the government have not optimally addressed the prevention efforts before the problems occur. The future program planning should prioritize on the coverage of family planning that does not only relates to contraception, but more on the pregnancy preparation including financial, nutrition for mothers, family supports, and the preparation of

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comprehensive health services and nutrition in one continuum of care package (Figure 3.4.2).

Figure 3.4.2. Continuum of Care Health & Nutrition Services

3.4.3 Maternal and Child Health Priority Issues

The following is the list of problems identified through the group discussions:

Issues regarding nutrition:

1. Breastfeeding mothers do not receive counseling (77.2%)
2. There is no national law that regulate the code of conduct for breast--milk substitutes marketing (63.7%)
3. Maternity leave (60.3%)

Issues regarding Maternal and newborn health:

1. Capability of health workers in the case management of maternal and newborn mortality clinical causes (61%)
2. Insufficiency supports of policy/regulation (54%)
3. Community barriers to access health facilities and professional health workers (48%)
Issues regarding adolescent’s health:

1. Premarital sexual intercourse (61%)
2. Child marriage (60%)
3. Barrier to access adolescent health service (57.9%)

Issues regarding immunization:

1. Not all babies are protected with complete basic immunization, including hepatitis, tuberculosis, polio, diphtheria, pertussis, and measles (29%)
2. Requirement to have additional/advance immunization for babies and under-fives, for instance for influenza, pneumonia, MMR (28%)
3. Low coverage of immunization against tetanus for women in the reproductive age (28%)

3.5. Indicator and Target

In 2030, it is expected that will be no more families who live in the remote area, islands, and borders, who do not have the ability to fulfill the needs of nutrition for pregnant and breastfeeding mothers, new born babies, under-fives, and female adolescents.

Indicator: Under-fives malnutrition, pregnant mothers and female adolescent.

In 2030, it is expected that qualified, equal, affordable and accessible health service insurances are available for mother, children, and adolescent without any discrimination, and fully supported with the availability of facilities and infrastructure.

Indicator: Maternal Mortality Rate, neonatal mortality rate, handled unwanted pregnancy cases, adolescents receive reproduction health education and access Adolescent Health Care Service (PKPR), coverage of complete basic immunization + pneumonia, screening
pregnant mothers on HIV, TB, malaria, and or other comorbidity according to specific risks in the respective areas.

In 2030 all families will have endurance to fulfill the rights to live, to be protected and to participate, so there will be no more mother and child who died from communicable diseases (tuberculosis, avian flu, swine flu) and diseases related to lifestyle.

Indicator: Healthy house with family toilet and clean water source, hand washing behavior, family access to get protein-source-plant seeds.

In 2030 the state has the commitment to protect mothers, children and adolescents to live healthily and to develop optimally.

Indicator: Minimum 20% of health budget, Law regarding smoke-free public area, strong legal sanction for formula company that violate the code of conduct for supplementary food, provide accessible primary health facilities (less than 2 hours), have health workers who are equipped with medical tools and medicine based on needs; Security assurance from the village government; and own health facility that is equipped with electricity, toilets and clean water source.

3.6. Health System

3.6.1. Health Funding

3.6.1.1. Central and Regional Budget Allocation

Due to the influence of many technical as well as political factors, the size of government’s commitment is highly varied from one area to another. Different forms of legal products had been issued, along with the formulation of various policies both in central as well as regional levels, even up to the village level, with the objective to create program with appropriate target
and supportive cross-sector cooperation in program coordination. Even so, well planned programs still leave not-optimal implementation. One of the indicators to measure commitments of central and regional government in achieving 2015 MDG objectives is obvious from the increase of National Revenue and Expenditure Budget (APBN) and Local Revenue and Expenditure Budget (APBD) for maternal and child health development as well as improvement of nutrition.

One of the districts/cities that are involved in this study indicated the increase of health budget allocation of 2015 up to 13% (1.3 billion) compared to the previous year. This significant change occurred after the civil society organization movement consistently raised issues regarding nutrition, maternal and child health, and spoke the needs to the government. Further assessment regarding budget proportion for MCH program is necessary, to give room for improvements and to gain inputs from the community. Therefore, public accountability becomes stronger and the mechanism for social control functions optimally.

"...Praise Lord, thanks to advocacy of Civil Society Forum, the budget in xxxx District now reaches 21%. It just takes the willingness of Department of Health to arrange their priority...just re-propose the Activity and Budget Plan..."

Aside from national strategy for development, the existence of global strategy is also already known. It indicates the responsibility of international community to create the objective of global development and global target achievement indicators. International cooperation in development funding in forms of financial support as well as technical facilitation to strengthen health system is the form of joint commitment to achieve the global objectives. However, the form of that support should not take over the main function and role of the government, but to support the implementation of
good governance. One of the discussion participants stated the international commitment in the following quote:

“...developed countries save 0.2% or 0.3% of their national income for development programs in countries that need helps...” (national consultation).

3.6.1.2. National Health Insurance/Universal Health Coverage
As explained in the previous sector, economic determinant underlies issues regarding Nutrition, Maternal and Child Health, and Adolescent Health in Indonesia. There are a lot of situations where the citizens do not receive qualified health facilities due to financial barriers, while the government has the responsibility to guarantee the citizens’ health. Universal Health Coverage (UHC) through health insurance by Social Security Administrative Bodies is the form of government’s responsibility in fulfilling the responsibility. This program has started since January 1, 2014, began with the premium fulfillment for citizens who are categorized as poor through National Revenue and Expenditure Budget (Recipient of Contribution Assistance-Penerima Bantuan Iuran-PBI) who is translated as holders of Healthy Indonesia Card (Kartu Indonesia Sehat-KIS) in President Jokowi’s governance.

Although the preparation and socialization of this program has been implemented a year earlier, and even the discourse and hearing to policy makers have been discussed since beginning 2010, the program socialization, however, is considered weak to the grassroots level. The confusion especially relates to issues such as membership, benefit, types and procedure of service as well as collection mechanism issues. The situation caused operational challenges in the field that threats the members’ trusts. This study presented information regarding the lack of information and socialization as the main reason for informants not to have health insurance (40.7%), followed by the
procedure that is considered difficult and complicated (29.4%), and the difficulty to pay the contribution (20.5%).

Health service through health insurance program is also considered not providing protection for adolescent reproduction health. On one side, not all health facilities own the capacity as Adolescent Health Care Service, and on the other side, service for adolescent reproduction health has not been included in health insurance. The impartiality is obvious from the following quote:

“... when talking about health insurance, child insurance is covered, mothers’ insurance is covered. So, how about adolescents’ health? If there are problems related to Unwanted Pregnancy, women usually just accept the condition, for instance the rape victim. But they are surrender... and they are actually the victim”

“...Actually Ministry of Health has their own policy. Consultation included, health insurance available, Healthy Indonesia Card for street children...but community health center (puskesmas) service is conducted during school-hour, how can it be adolescent-friendly? The service is available, but has not been accessed by adolescent”

Changes in Social Security Administrative Bodies service implementation also implies to qualification changes and member registration procedure. Health Insurance Program through Social Security Administrative Bodies should be a family planning strategy in the preparation before the pregnancy; however, in reality it faces a lot of obstacles, due to the interpretation of BPJS membership regulation that only guarantees the mother, and cannot automatically guarantee the newborn unless the family waits until the baby reaches 30 days old. The policy that applies classes according to the premium implies to the different rights on health services, especially in inpatient services, and tends to create different treatment to patients who are members of National Health Insurance/BPJS, when supposedly the service quality should be the same.
The description of the situation above not only creates confusion for the participants, but also creates the risk of preventing the interest of candidates of independent BPJS members, especially healthy community members. Whilst actually, recruiting as many as independent BPJS members is important for the National Health Insurance to be able to optimally implement the cross subsidy mechanism. As the effort to improve BPJS service, it is recommended to have representatives in sub-district level who could facilitate BPJS members; submitting newborn service insurance automatically if the mother is BPJS member, providing service package including adolescent’s reproductive health, no medical treatment and medicine recipes that should be paid independently (out of pocket); and transparency of premium income as well as the use of insurance money to the public. To do those things, better cooperation between central and regional BPJS is required; to socialize the benefit and types of activities, which is guaranteed by BPJS, to make the community and health workers understand correctly to avoid disappointment on the community as the service user (consumer/client) as well as the medical/paramedic as the service provider. If the things mentioned above are implemented, community’s trust toward BPJS service will increase, and there will be more independent BPJS members. In this study, we found that only 24% of independent BPJS members, 38% of subsidized/Healthy Indonesia Card, 30% of Askes (health insurance for civil servants and retired armed force personnel) holder, Jamsostek (social insurance for private sector workers) and Asabri (social insurance for armed force personnel); and the rest is not a member of any health insurance.

With the increasing number of BPJS participants, the needs for health service also increased. Responding to the development, it is important to make improvement on BPJS services that are integrated between different area, so the benefit could be enjoyed when the members are going to and being in
other areas in Indonesia. This should be accompanied with the government efforts to conduct development investment by completing infrastructure such as health service facilities and transportation facilities. If the two things are not implemented, especially with one door financing system, then there will be a risk that BPJS budget proportion will be enjoyed more by the areas that have more health services (Sumatera and Jawa) and supported by better infrastructure. In the meantime, the opportunity of community in eastern part of Indonesia to use BPJS services will be limited, due to the obstacles to access the service and the unavailability of health services. Some of the marginalized community groups also have problems to receive health protection. There are mothers, children, and adolescents who live in the slum area, people with disability, minority group, etc. Generally they are Indonesian citizens whose 'being is not admitted' for not having self-identity (such as Identity Card), or due to other social reason being hidden by their family (such as children with disability). Dissatisfaction in equalization and health service access is expressed as revealed in several quotes below:

“... this BPJS, the people up there enjoy the money from the community, that’s the first thing I see and the decentralized pattern is wrong and related with the technology, so Jawa will again enjoy it, so in Jawa, there are a lot of hospitals with for people with middle up economy…”

“In xxx province, community members complain about a lot of things. Adolescents who live on the road, it is difficult for them to get the ID, how can they get BPJS card? It is even difficult to obtain their rights as Indonesia citizen, how can they get the others?”

Indonesia had the experience of several health insurance models in form of Community Healthcare Insurance Program (Jaminan Pembiayaan Kesehatan Masyarakat-JPKM), Community Health Insurance (Jaminan Kesehatan Masyarakat-Jamkesmas), Regional Health Insurance (Jaminan Kesehatan Daerah-Jamkesda) or health insurance from CSR (Corporate Social Responsibility) funding that are considered better for the convenience provided for the poor family, where the community independently
determines the criteria and identification, facilitated by community health center (puskesmas) and village that can serve all types of complaints, including free of charge childbirth service for rape victims.

“In xxx, we are not really affected by BPJS. All are covered by local government from Freeport. There is one hospital that covers all expenses, anything...”

Considering that JKN program is developed as government's response to fulfill their responsibility in ensuring the sustainability of life and health of its citizens, so civil society’s involvement to perform social control becomes very important. It can only be done when the citizens know their health service rights that they can access and the types and standards of health service that could have been provided by health facilities, as revealed in the following quote:

“accountability mechanism that relates with the National Health Insurance, the simple example is how community health center (puskesmas) can provide chart information regarding health insurance service and facilities where the community can access health service”

3.6.2. Health Information
In the previous section, it was stated that there are challenges for the community to access information regarding health messages and Clean and Healthy Behavior (Perilaku Hidup Bersih dan Sehat-PHBS), ongoing government’s programs on Nutrition, Maternal and Child Health, and Adolescent Health, government's budget for Nutrition, Maternal and Child Health, and Adolescent Health sector development, as well as the transparency in health service and case governance standards.

According to the statistical calculation, in 2015, Indonesia's population will reach 255,461,686 people. Indonesia's populations are spread in more than 500 districts/cities. The diversity of tribes in Indonesia becomes the wealth
as well as challenge. Ideally, local cultures are taken into considerations when conveying community information so it will be easier for the community to receive health messages.

“the other day we have jointly conducted with women alliance and traditional leaders to see how this culture aligns with the issues, so he can share about child marriage because maternal and infant mortality cases in XXX province s still high, because the hips is not ready since the mother is still 16 years old, it’s possible”

“...returning local cultures and write them in form of poems in wedding prosession. There is a culture to bathe the soon to be bride accompanied with the songs that tell stories about when a child was born until she/he grows up, and how to protect her pregnancy until the delivery. ...

“... back to the local wisdom, which is to identify moments where we can squeeze in messages to strengthen the family, which is one of the global strategy.

Aside from that, discussion participants can also raise issues regarding data inaccuracy that was published by the government, and the difference on data issued by the different government instances According to the discussion result, data of the beneficiaries (target group) is not optimally updated, and even if it is exist, often times the results are not optimally utilized during program planning. The situation gets harder because to the problem identification process that involves the closest sources of information does not happen. In the end, the type and amount of the support become target inappropriate and does not satisfy various parties.

“The program exists but the time available is very limited, while there is a lot of community that should be facilitated. The available data are almost incorrect, but we have to update data from the lowest community groups who know exactly the condition of their communities....we really facing invalid data problems”
Community feels that there is no clarity regarding the instances that have the authority to publish data and they do not know the best medium to access and share information. This issue was even raised during the discussion of civil society organization in 2013 to formulize the proposal of 2015-2019 national strategy plan.

"Government should analyze the available data. And the data should be published so there will be more people who know it. Public should now the limited number of health facility and workers. District Department of Health in the area where we stay is not good enough. The existing online data should be repaired because we are still having trouble accessing it. The latest data is hard to find. Results of the government’s works should be demonstrated..."

"...who is responsible and authorized to publish data? .... is it Central Bureau of Statistic or Ministry of Health or other related ministries? So there will be no overlap (gap) of data... like the maternal mortality rate data, some says 346, other say 549..."

3.6.3. Resources and Health Service

Central government has developed an excellent technical instructions and Standard Operating Procedure (SOP) along with the umbrella policy, but faces a lot of obstacles in the implementation. This relates to the work and authority division between central and regional government, and political agenda in district/city, as well as not-optimal capacity transfer from the central to regional level. This situation implies to the inconsistency of program priority and program implementation from the central to the frontline service provider: the village midwives and public health nurse.

Surely this situation creates possibility for not achieving service quality and minimum service standard that can lead to inadequate service provision, and will potentially cause maternal and child mortality as result of management factors. On the other side, not all health facilities, especially government
facilities that owns complaints/feedback mechanism; therefore, the monitoring function toward health services cannot always happen.

Often time the government does not anticipate changing patterns of disease and the causes of mortality as result of development progress. Risky sexual behavior, especially among the teenagers, the use of drugs and prostitution underlie the increase of HIV-AIDS cases, and now has become the third highest disease in several districts/cities. Similarly with death incidents caused by accidents on the road that according to 2013 Basic Health Research has become the first cause of death of the age group 7-15 years.

The government should respond to this situation through program innovation, unusual program plan, and more appropriate program implementation in the region according to the different needs of each region. *Prevention of Mother to Child Transmission* (PMTCT), for instance, should be a priority program for areas with high HIV-AIDS prevalence, to stop infant mortality cases caused by HIV infection from mother or father with HIV. Safety on road promotion program should also become a priority in the districts/cities with high density and busy traffic. Furthermore, reproduction health should be a priority in the big cities due to its high proportion of young-aged population.

Since 2003, The Ministry of Health has declared Adolescent Health Care Service program, and its principle is to be accessible by all adolescent groups, fun, accept the adolescents with open arms, respect them, keep their secrets safe, sensitive with their health-related needs, as well as effective and efficient in providing the needs. Ideally this kind of service should be available in all Community health center (puskesmas), but started with pilots in several Community health center (puskesmas). Unfortunately, not all pilots were implemented optimally. Aside from the community health center
(puskesmas) capacity (or other health facilities), some other factors that prevent adolescents’ access to Adolescent Health Care Service include the attitude of the officers, service that is scheduled during school hours, and also governments’ attitude that has not prioritized adolescents’ health program.

“The government has not consider adolescents’ health important...we do not get support from them. They said there is no budget, no regulation...”

Research and knowledge should be encouraged to find new medicine and vaccine in accordance with the development of new type and strain of bacteria/virus that cause diseases. According to 2013 Basic Health Research, only around 59.2% of under-fives in Indonesia who received complete basic immunization. While in reality, other infectious diseases have also started to threaten. Increasing human mobility opens the opportunity for infectious disease, including avian flu, swine flu, Ebola, etc., to spread. Furthermore, malaria in the endemic area has not been solved. This condition is not only caused by behavioral factor, but also the availability and distribution of medicine, and the availability of simple diagnostic tools, as well as the officers’ governance capacity.

“Immunized children can suffer the same disease. Because the officers only care about achieving the target. So the technique and skills of human resources for the accuracy of treatment should be increased”

"The problem is the low immunization awareness due to the transportation cost to the Community health center (puskesmas), which is expensive...and after you get to the sub-district, the vaccine is not available. What's even funnier, they decided when the community should go to the sub-district, but when the community members came, the officer is not there, and the vaccine is not available”

3.6.4. Governance and Leadership

Both the government and the community are responsible to ensure the achievement of development goals. From the discussion result, it was found...
that good cooperation between the government and civil society organization already exists according to their respective roles. Role of the government is the implementer of development program, while the civil society organizations facilitate civil society to implement social control function. Based on several examples, social control will be successful when the civil society proactively and consistently influences the government through various advocacy methods. This happens as result of the absence of Government of Indonesia’s initiative to develop public accountability mechanism for Nutrition, Maternal and Child Health, and Adolescent Health services that applies nationally.

Even though there are regulations that manage bottom up development program planning and provide rooms for civil society participation, however in practice, the development, specifically in MCH sector, has not optimally answers the problems in the field and tend to develop uniform program, both the type as well as the budget. This is obvious from the health budget proportion that still focus to the curative efforts in the community health center (puskesmas), rather than promotion and preventive efforts, including the construction of ‘luxurious’ community health center (puskesmas), while neglecting the service in the frontline (village), for instance, the unavailability of vehicle (motorbike) for village midwife, no electricity in village health posts, or village with different number of population but receive the same amount of program funding support.

Public service accountability mechanism does not work optimally also due to the lack of socialization of the agreed development plan to the community, and the difficulty to receive the latest information/data regarding program achievement situation as well as morbidity/mortality data. Therefore, civil society cannot optimally implement the monitoring function. The success of civil society organization in influencing regional government to allocate
funding for health does not automatically guarantee the success of the program, if it is not guarded with monitoring by civil society.

"We need transparency regarding budget for nutrition and MCH in the website or other sources of information that are accessible for public. Until now, only a few people who know and have (the information)"

Government, as the duty bearer, has the full responsibility to ensure the fulfillment of its citizens’ rights to live, to receive health services, and to receive appropriate health information. On the other hand, the citizens also have the capacity to speak their needs for the fulfillment of their rights, depending on the ability to be empowered in solving their own, their family’s and their community’s health problems. Therefore, citizen’s participation in development plan process would become important steps to ensure the development programs are designed and implemented for their interests

"Adolescents’ health is not too sexy for policy maker, therefore it is neglected. ..... This is the organization’s role to speak up to formulate good issues, so all policy makers could develop regulations in forms of Law, Government Regulation, etc..."

Various law products are available, but there are problems in the implementation in the field. A strong, transformative, and reformatory national leader is required for the better change in all sectors and levels of the administrative area. On the other hand, political education is also necessary for the citizens, so they can choose the appropriate leader of the country. The quote below represents the question:

“... I see that leadership depends on the leader, where all good areas or regions must be led by leaders who own ..., and what equally important is the issues regarding political education and clear policy, ... how many district that has clear policy?"
3.7. Accountability Mechanism

Law No. 25 year 2009 regarding public services has actually mandated the accountability mechanism; however, it is not optimally implemented. Aside from the fact that not all service providers know the consequence of the policy, confusing reporting flow and the unavailability of communication mechanism between the government and community have made the citizens unable to deliver their complaints.

“reporting and complaint flows are confusing, community cannot find the channel to deliver their complaints...”

“Advocacy starts from the regulations, continue with the service providers and service recipients. The problem is how the officer can read this regulation; when the practice is incorrect, what are the actions in the field; thus the accountability has not been properly developed. Government sets the regulation, but there is no monitoring in the field...”

Considering the previously explained situations, civil society organizations can mobilize the process by proactively supporting the participation of representatives of community’s elements in Development Planning Consultation in sub-village/village, guarding the plan until it is approved in Local Revenue and Expenditure Budget, and monitor the implementation through transparent complaint mechanism. There are several methods that are implemented as results of civil society organization’s facilitation, which in principle is aimed to develop community capacity to know their rights, to think critically for the fulfillment of their rights, to have the power to speak their needs, and in the end will help to encourage the improvement of government’s performance in fulfilling their responsibilities. Social accountability mechanism is applied by several CSO through discussion method, using complaints and suggestion box, SMS gateway, call center, twitter of public officer, satisfaction survey, shadow report, etc.
“We have CVA (Citizen Voice and Action) advocacy program about what to do when there are unfulfilled rights, for instance related to maternal and child health, while talking face to face with policy makers. We provide education regarding public policy...”

“...force the central and regional government to develop SOP regarding transparent immunization, service, what to do when the officers do not serve us, what happen when the community comes and the vaccine is not available, so we advocate community to claim...”

Citizens’ participation should be done from before the implementation of Development Planning Consultation, by giving inputs to the forum based on the data and situation analysis performed by Maternal and Child Health team, consisted of village midwives and health cadres, as the knowledge holder in the community level. Ways and procedures to deliver aspirations and complaints regarding Nutrition, Maternal and Child Health, and Adolescent Health, are conducted by opening accessible information channel regarding regulations, standard and flow of case management of Nutrition, Maternal and Child Health, and Adolescent Health services.

3.7.1. Development Actors
Understanding the condition of maternal, children and adolescent health that are influenced by social and economic determinants, the required government’s role in the development is the cooperation among the development actors. Responsibility to create ideal condition as expected in 2030 is a common responsibility among the state, civil society, and private world.

“...we need to develop everything, to form better life quality; aside from that, private sectors, both profit and non-profit, on how the local government invests and develops toward a better direction...”

The government is the duty bearer and regulator who have the authority to develop policy and provide services accordingly with the rights of its citizens.
Based on this study, the government includes central government, village area, and chief tribes. It was agreed that the main development actor is the government, and government leadership becomes the center to guarantee the rights to health and the fulfillment of nutrition of all citizens.

“...When I look at the leadership... on the leaders, where a good area is certainly led by leaders who have commitment...and what equally important is the political education issues for the citizens, a clear law policy...”

“...Aside from the youth who have clear commitments and directions, I think it is the way to choose leader. Because so far leaders are elected based on the closeness factor, —oh that’s my family, i will choose him/her—there is an influence. Later, the second is the parties that also have commitment and are involved globally for health”

Even so, it does not mean that community members are the development object, but they are the actor who has the responsibility for themselves. As the development subject, it means the community has the role in development process from the planning, implementation and monitoring. Of course, this involvement level is highly dependent to the level of education and support system. It is necessary to have skills so the community can implement their role as development actors, started with the stimulation on willingness, care, and commitment, including the capacity to choose the right leader. Support for joint movement of the civil society organization will encourage community’s participation and develop mechanism that can facilitate community to be actively involved in development process, especially to involve in the regulation development and to guide the regulation implementation to be carried out well.

“...state and community must be able and ready to ensure the families are ready. Preparedness on how prepared a teenager to get marry and ready to be a parent, ready to stop smoking, and ready to stop doing free sex. So when finally she/he gets marry, she/he is ready for everything and in harmony with the marriage...”
“... I will strengthen myself and my family, how the mother can protect the child when she has to work,... so I want to be here, how everybody has the commitment to protect their family, globally this recognizes child rights and able to understand accordingly...”

Although that is what the government is planning, community members positioned themselves as development subject by:
- Getting involved in development planning process through development planning discussion mechanism
- Provide input in policy analysis, regulation development, and guiding the regulation implementation
- Encourage the provision of qualified health service.

Private sector is also expected to contribute in the development by creating enabling environment for the nation’s advancement. Discussion participants even think that the companies have big capacity to overcome transportation barriers in marketing their products to reach the remote villages and the difficult areas. Private company marketing strategy also successful in changing people’s habit and behavior in a relatively short time.

“...private sector, I think we can say it is innovation because they also breakdown local dietary practice with their products, cut through the distribution flow to the remote area; meanwhile why can’t we get to the remote areas with the health products?”

“...private companies can be moved to mobilized CSR funding to fund development programs that have been formulized together between the government and citizens...”

“... there is something about private sector... they are successful in replacing the applied practices in the community, ... foods that are totally not known in the area becomes the kind of food that is accepted in every corner of the country..."
Aside from the potentials owned by private sector to participate in the development, the government needs to play their role to make sure the existence of norms, standards, procedure and criteria that manages CSR fund in developing Nutrition, Maternal and Child Health, and Adolescent Health. This regulation is necessary to reduce the risk of violation towards child rights for the sake of business matter. The companies should follow the existing ethics so the contribution of private sector for development can optimally give positive results and reduce negative impact.

“...Most of the funding used is copying the previous routine (activity). The irregular one is to gather the industry, this is a conflict of interest. Exclusive breastfeeding, but the sponsor is formula milk... We always work together to observe... for example in 2013 and 2014, we almost missed but successfully stopped Danone from sponsoring our national nutrition day...because it’s the Trojan horse”

“Talking about this public private partnership, it should be precise because they prefer the word charity, not CSR, because the impression of CSR is asking to the company, so this is the “proposal language”...” (FGD 2- national consultation)

3.7.2. Civil Society Potential and Role

It is possible for civil society to become development actor, but should work through a partnership with the government with equal power position between the two. It is necessary to strengthen civil society to have control function towards the government achievement in maternal and child health development, therefore social accountability mechanism should be developed, and unnecessary bureaucracy should be cut.

Playing the role as civil society as the main development actor will make government accountability more effective and the information can be more quickly accessed because:

- Making the community the main development actor means involving the community in all development process. Unexpectedly this process
will also improve the people's sensitivity toward Nutrition, Maternal and Child Health, and Adolescent Health issues in the local community, and to critically think for the best solution based on their potentials.

- Community knows the problems they are facing. Community is the source of information about the local situation and condition.
- Making the community the main development actor will shorten the line for information submission/collection, so it will be more valid and up to date.

Community has the potential to become development actor, but in the current context, they still need guidance/facilitation from Civil Society Organization to increase their capacity. Indonesia have had the experiences where Village Consultative Council as the discussion medium for public interests are available. This is the evidence that civil society can be the main development actor when they are given the chance, including skills, to identify problems and formulize solutions for problem solving.

Citizens have an important role to guarantee the sustainability of the development. Although the functions of the regulator, implementer, and finance are in the hands of the government, but the leading actors of this development is the civil society. It has become the right of citizens to be involved in the development planning and program implementation process, so it can be accounted for and accordingly to the needs of the citizens, as quoted below.

"We have mothers’ care for health forum ... it was just yesterday we performed an advocacy to Regional House of Representative related to encouraging efforts so we can be free, or not become Indonesia’s top five contributor of maternal and child mortality rate..."
CONCLUSION AND RECOMMENDATION

A. CONCLUSION

In general, the citizens concluded that issues regarding Mother Mortality Rate, Infant Mortality Rate, and Malnutrition on under-fives in Indonesia should be optimally pursued to overcome. The same thing applies for adolescent health because it contributes to the high number of mother and infant mortality rates. Result of the survey to more than 400 informants from 40 districts/cities stated that nutrition (98%), Maternal Mortality Rate (89%), Neonatal Health (88%), Adolescent Health (84%) and immunization (43%) are still the problems.

In many districts/cities in Sumatra, Jawa, and Sulawesi, post-natal bleeding as the direct cause of maternal mortality, and asphyxia as the cause of newborn infant mortality, has started to be addressed, along with the improvement of health service quality and the response of regional government to allocate funding from Local Revenue and Expenditure Budget (APBD), and fulfillment of the needs for health workers. Different things occur in the eastern part of Indonesia. Limitations in number and quality of human resources in health sector, and obstacles in the accessibility as results of difficult geographical condition and expensive transportation fee lead to the issues regarding low community’s attendance to posyandu, while in fact posyandu is the closest media that can provide health information access to the citizens. This is one of the causes for mothers’ ignorance and indifference regarding hygienic behavior (such as regularly washing hands with soap) and healthy life (such as feeding/breastmilk practices for young infant), while the formal education level of girls is still below 6 years.
Aside from education, economic, and culture, there is a tendency that the fundamental causes of nutrition status and maternal and child health, and adolescent health include the increase of comorbidity contribution (tuberculosis, hepatitis, HIV, and malaria) as the cause of maternal and infants mortality. Furthermore, health programs that are implemented by the government have not optimally address the prevention efforts before the problems occur. The future program planning should prioritize on the coverage of family planning that does not only relates to contraception, but more on the pregnancy preparation including financial, nutrition for mothers, family supports, and the preparation of comprehensive health services and nutrition in one continuum of care package.

Law No. 25 year 2009 regarding public services has actually mandated the accountability mechanism; however, it is not optimally implemented. Based on the results of group discussions in the districts/cities as well as national consultation that involved more than 100 participants, it was informed that there are already good examples of how this accountability mechanism have been built and managed in several districts. Some of the examples of best practices are Citizen Voice and Action (CVA), complaint box, SMS gateway, shadow/alternative report, etc.

How the public accountability functions is highly dependent to the civil society organizations' facilitation, as the facilitator and the capacity as citizens in performing social control toward the development plan process, development programs implementation, and the quality of health services provided by the government. Civil society organizations can mobilize the process by proactively supporting the participation of representatives of community's elements in Development Planning Consultation in sub-village/village, guarding the plan until it is approved in Local Revenue and
Expenditure Budget, and monitor the implementation through transparent complaint mechanism.

Citizens’ participation should be done from before the implementation of Development Planning Consultation, in form of giving inputs to the forum based on the data and situation analysis performed by Maternal and Child Health team consisted of village midwives and health cadres, as the knowledge holder in the community level. Ways and procedures to deliver aspirations and complaints regarding Nutrition, Maternal and Child Health, and Adolescent Health, are conducted by opening accessible information channel regarding regulations, minimum service standard, flow and case management of Nutrition, Maternal and Child Health, and Adolescent Health services. This can only happen when the citizens are aware of and know about their health rights, able to speak their needs and participate in fulfilling those needs, including by supporting the government, as the duty bearer and regulator, to perform their functions and responsibilities.

Based on the joint analysis regarding the existing issues, exploration of the cause of problems, and digging the good experiences that have been implemented in the last fifteen years, the citizens who were involved in the hearing process targeted that: In 2030, it is expected that a qualified, equal, affordable, and accessible as well as without discrimination health service insurance for mothers, children, and adolescents will be available, supported with the state’s commitment to protect mothers, infants, children, and adolescents to live healthily and to develop optimally, with family resistance to fulfill the rights to live for its members, to be protected and to participate, so there will be no more mothers and child who died as result of the direct causes, communicable diseases, and diseases related to lifestyle, fundamental causes (level of education, economic, and culture), and health systems that do not function optimally.
B. RECOMMENDATION

1. Health services should be provided in a comprehensive service package that covers the prevention, promotion, curative, and rehabilitation efforts, as well as meets the *continuum of care*. Cross sector collaboration beyond health sector is strongly necessary to overcome maternal and adolescent health and nutrition issues, since there are so many underlying social and economics determinants. Therefore, the issues regarding high number of Maternal Mortality Rate, Infant Mortality Rate, malnutrition, and adolescents’ health should be solved together with other ministries/departments such as education, public works, industry, creative economy, citizenship, family planning coordination body, etc.

2. *Universal Health Coverage* (UHC) should be understood in a real scope, which is related to equal and without discrimination health and nutrition service coverage. Program plan as well as service delivery should consider community groups that are tend to be neglected due to the limited access toward health facilities and workers. They are mothers, infants, children, and adolescents who live in the difficult geographical area (remote, borders, and islands), with special needs, live in the *slum areas*, and the poor or almost poor.4

3. As the policy owner, the government has played the role well in preparing norms, standards, procedure and criteria related to maternal and child health, but still weak in ensuring the implementation and the compliance of service provider in the front line, which is the village. Various law products are available, but there

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4 According to Statistics Indonesia, the almost poor populations are the ones who have monthly expenses a little above poverty line. The word “almost” quantitatively indicates that their expenses have thin and insignificant differences with the poor population to separate them from the poor population. Day to day, their welfare is not so much different from, even similar with, the poor population. Outside the concept of Statistics Indonesia, people will consider them as “poor”.

GERAKAN KESEHATAN IBU DAN ANAK
are problems in the implementation in the field. A strong, transformative, and reformative national leader is required for the better change in all sectors and levels of the administrative area. On the other hand, political education is also necessary for the citizens, so they can choose the appropriate leader of the country.

4. Development of health sector should be seen in the human rights framework. As the duty bearer, government has the full responsibility to ensure the fulfillment of its citizens’ rights to live, to receive health services, and to receive correct health information. On the other hand, the citizens also have the capacity to speak their needs for the fulfillment of their rights, depending on the ability to be empowered in solving their own, their families’, and their community’s health program. Therefore, the participation of citizens in development plan process would become an important process to make sure that the development programs are designed and implemented for the interests of the citizens.

5. International community can also play their parts in financing the development, as long as they do not take over the functions and main role of the governments, and continuously support good governance. Health financing, supported by various parties, is expected to fasten the achievement of global development objectives.

6. Role of private sector is no less important in ensuring the achievement of development goal by giving the rights of women and child labor of the workers, women, children, and adolescents in the company’s environment, and even as consumers. The real example of role of private sector in Nutrition, Maternal and Child Health, and Adolescent Health development is by providing special room for lactating for female workers who are breastfeeding, ensuring the fulfillment of female reproductive rights, including maternity and menstrual leave.
As well as obeying the marketing code of conduct of breast milk substitution.

7. Citizens have an important role to guarantee the sustainability of the development. Even the functions of the regulator, implementer, and finance are in the hands of the government, but the leading actor of this development is the civil society. Citizens not only have the right to be involved in development plan process and program implementation, but also to perform social control on government responsibility in ensuring access and quality of nutrition and health services for mother, children and adolescents. Therefore, the development result can be accounted for and in accordance with the needs of the citizens.
ANNEX A. MEMBER OF MATERNAL AND CHILD HEALTH MOVEMENT
ANNEX B. FOCUS GROUP DISCUSSION GUIDELINE
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