

REVITALIZING PRIMARY HEALTH CARE

COUNTRY EXPERIENCE:

INDONESIA

CONTENTS

1.	BACKGROUND	1
2.	PRESENT STATUS OF PRIMARY HEALTH CARE.....	2
2.1	Implementation of PHC in Indonesia.....	2
2.1.1	Health Center.....	2
2.1.2	Community Based Health Activities	4
2.2	Eight Elements of PHC.....	11
2.2.1	Health education.....	11
2.2.2	Nutrition.....	13
2.2.3	Maternal and Child Health	14
2.2.4	Water and sanitation	17
2.2.5	Immunization.....	18
2.2.6	Control of locally endemic diseases.....	19
2.2.7	Treatment of common illness and injuries.....	19
2.2.8	Essential drugs.....	20
2.3	Other Elements of PHC.....	20
2.3.1	Occupational health.....	20
2.3.2	Non-communicable diseases	21
3.	TRANSLATING THE VALUES OF PHC INTO POLICY AND ACTIONS. ...	21
3.1	Universal access to care and coverage on the basis of need	22
3.2	Commitment to health equity as part of development oriented to social justice	22
3.3	Community participation	24
3.3.1	Community participation facilitated by health personnel	24
3.3.2	Religion based health activities.....	24
3.3.3	Corporate Social Responsibility	25
3.4	Inter-sectoral actions for health.....	25
4.	LESSONS LEARNT	25
5.	PHC AND THE CURRENT HEALTH ISSUES AND CONTEXT.....	26
6.	THE WAY FORWARD.....	27

1. BACKGROUND

Prior to Declaration of Alma Ata in 1978 regarding Primary Health Care (PHC), Indonesia has developed various forms of PHC in some regions. Based on research in 1976 it is noted that 200 community - based health activities (CBHA) have been implemented and carried out within the community¹. Along the time, PHC has developed rapidly in various forms of CBHA and one of it noted as Posyandu (Integrated Service Post). It's activity covers five major programs, i.e. family planning, maternal and child health, nutrition improvement, immunization and diarrhea prevention. Besides Posyandu, there is village maternity home (VMH) which is managed by village midwife as a way to make maternal and child health services close to the community². CBHA can grow progressively because it is supported by health center. However, the CBHA went into a decline when monetary crisis burst in 1997 which resulted in multi-dimension crisis. The crisis created total reformation in many aspects, including in health sector.

While it is important, decentralization overwhelms most aspect of development, including health sector. It has totally changed the planning model, which formerly was centralization become dependent on each district. It has implication on the priority setting of each district. Many of the local government concern more on curative aspects rather than promotive and preventive measures.

After the democracy euphoria is over, all sectors including health start to revive and revise their priority to a better scale. At central level vision, mission and values of MOH were formulated and described into 4 major strategies³:

- (i) To activate and empower community live a healthy life
- (ii) To improve the access of community toward quality health services,
- (iii) To improve the system of surveillance, monitoring and health information,
- (iv) To increase the health financing.

All of the above strategies related to PHC, the first two strategies no. 1 and 2 are closely related to primary health care (PHC) it indicates the importance role of PHC in health development in Indonesia.

Now a days, many districts and cities implement health programmes respond to the current local situation. However, some of the interventions are not really touch the local needs but many are good and applicable. Some of the interventions will be elaborated in this report.

2. PRESENT STATUS OF PRIMARY HEALTH CARE

2.1 Implementation of PHC in Indonesia

The implementation of PHC in Indonesia mainly through health center and below (including sub-health center, mobile health center) and many type of community based health activities (CBHA) such as village maternity home (VMH) and village health post at village level; integrated service post (ISP or posyandu) at sub-village level. Administratively, Indonesia contains of 33 provinces, 349 districts and 91 municipalities, 5,263 sub-districts and 62,806 villages⁴. The health infrastructure related to the implementation of PHC is stated below (table 1)

Table 1. Health infrastructure related to PHC in Indonesia

Level	Institution	Number
Central	Ministry of Health	1
Province (33)	Provincial Health Office	33
District/municipality (440)	District Health Office	461
Sub-district (5,263)	Health Center	9,746
	▪ Without in patient care	7,669
	▪ With in patient care	2,077
	Sub-Health Center	22,171
Village (62,806)	Mobile Health Center	6,143
	▪ Ambulance	5,552
	▪ Motor boat	591
Village (62,806)	Village Health Post	1,939
	Village Maternity home	25,745
Sub-village	Integrated service post (posyandu)	269,202

2.1.1 Health Center

Health center (HC) is the primary level of health service institution, which led by a doctor and assisted by either medical or non-medical workers. In every sub-district at least there is 1 HC, but some have two or even three HCs depend on the area or the population within the region. HC has responsibility to the health of the community in its area, HC is the first to respond to a disease outbreak, supported and supervised by the District Health Office. Each HC has 3-5 sub-HC and a mobile HC (ambulance or motor boat). Some HC has in patient care department, mostly for birth delivery and diarrhea observation. The number of HC, sub-HC and mobile HC is shown at table 2.

Table 2. Number of HC, sub-HC and mobile HC, 2000 - 2005.

	2000	2001	2002	2003	2004	2005
Health Center	9,022	9,095	9,235	9,337	9,560	9,746
▪ HC without IPD	7,237	7,277	7,309	7,413	7,550	7,669
▪ HC with IPD	1,785	1,818	1,926	1,924	2,010	2,077
Sub HC	21,267	21,687	21,706	21,762	22,002	22,171
Mobile HC	7,502	6,800	5,638	3,113	6,253	6,143
▪ Ambulance	6,661	6,084	4,984	2,796	5,358	5,552
▪ Motor boat	841	716	654	317	895	591

Source: Indonesian Health Profile, 2000 – 2005

Indonesia experienced a political reform following the 1997 monetary crisis. One form of the change in health sector was the issuance of Health Minister Decree number 128/Menkes/SK/II/2004 regarding the basic policy of HC.

There are 3 functions of PHC :

- (i) Center for health development
- (ii) Center of community empowerment
- (iii) Center of health service at primary level which divided into:
 - Individual health service
 - Public health service

Community Health Council

The main change of health reform was decentralization of authority on health development, from central level to district level. Health centers as a front line public health services, are totally managed by local government through district health office. The HC's performance depends on the commitment, and budget capability of the local government.

During the change it was found out that the health centers condition was not good enough to fulfill the public expectations and it had limited budget and capacity, this fact was the background of initiation Community health council (CHC) development. The tasks of CHC are⁵:

- (i) Respond to public grievances of HC
- (ii) Communication of the HC capacity
- (iii) Specific community health promotion using local language.

CHC was first introduced in 5 provinces; North Sumatera, Jambi, Bengkulu, South Kalimantan and Central Kalimantan. Later the concept of CHC was adopted as a new policy of HC policy.

Up to now, there is around 100 CHC in Indonesia, with varies activities⁶:

- (i) Respond to public grievances of HC
- (ii) Mosquito breeding places control coordination
- (iii) Anti narcotics and drug addiction promotion
- (iv) Implement and promotion of community health fund
- (v) Carry out periodic client satisfaction survey for quality assurance improvement of HC
- (vi) Provide inputs for HC regarding the quality of services

Family Friendly Health Center

Another HC reform was Family Friendly Health Center (FFHC) introduction as an implementation of community empowerment, in line to healthy paradigm⁷. The HC should have complete information of all families in the catchments area. A simple indicator was introduced: Healthy Family Potential Index contains of:

- (i) Clean water availability
- (ii) Latrine
- (iii) Current user of Family Planning
- (iv) Regular growth monitoring
- (v) No smoking family

Based on these indicators we classify family into “potentially healthy” and “potentially unhealthy” and create intervention to improve their healthy family potential index. This approach has been done since 2002 in certain provinces and the positive results are:

- (i) Specific intervention can be done for each family or village.
- (ii) Program integration of the program is better led by the village health problem based on the Family Health Potential Index.
- (iii) HC performance improvement with specific health intervention for family and village.

2.1.2 Community Based Health Activities

Another pillar in the implementation of PHC is community based health activities (CBHA), a form of community institution or movement which come from, manage by and also for the community themselves. Usually the community chooses health volunteers and the HC provides training for the health volunteers. CBHA for different community groups are different i.e., for under-five, for elderly people, for students in Islamic school (madrasah).

The community based health activities are varied, and some of them are⁸:

- (i) Posyandu (integrated service post/ISP) which is managed by health volunteers and spread out in all villages. Usually, one posyandu serves 100 under-five years old children.
- (ii) Polindes (village maternity home/VMH) which is managed by midwife. It is expected that every village has one VMH but so far not all villages have it.
- (iii) Poskesdes (village health post/VHP) which is managed by midwife and health volunteers. It is a community institution beyond VMH, to cover other public health services. Each VMH will be improved to be VHP.
- (iv) Posyandu for elderly people (integrated service post for elderly people) which is managed by health volunteers and usually exists in sub-district level. It is a form of health empowerment for elderly people in addressing common diseases for elderly people, especially degenerative diseases.
- (v) Posyandu for non-communicable disease (NCD post) which is managed by health volunteers and it is a form of health empowerment for non-communicable disease risk factor identification such as smoking, sedentary life style, obesity that can manifest as hypertension, cardio-vascular diseases, diabetes mellitus, etc.
- (vi) Village medicine post which is managed by health volunteers and usually is situated in remote area which is far from health service institution.
- (vii) Village malaria post which is managed by health volunteers. Its main role is to help in detecting malaria disease and curing it.
- (viii) Islamic school health post, which is managed by Islamic school student, the main role is to improve the healthy behaviors for Islamic school students.
- (ix) Occupational health post, which is managed by health volunteers who are appointed from the informal workers.
- (x) Saka Bhakti Husada (Health Scout), which is managed by health volunteers and is developed in the scout organization. This organization activity covers various aspects such as nutrition, environment health, maternal and child health, disease prevention and narcotics and drugs.

The participation of inter sector, private and community in every CBHA shown in table 3:

Table 3. Inter sector/private/community participation in each CBHA

Institution	Participation of sector/private/community
ISP (Integrated Service Post)	MOH, MHA, FEW, FPCB, LG, Community
VHP (Village Health Post)	MOH, MHA, FEW, FPCB, LG, Community
VMH (Village Maternity Home)	MOH, MHA, FEW, FPCB, LG, Community
ISP for Elderly People	MOH, FEW, FPCB, LG, Community
OHP (Occupational Health Post)	MOH, LG, informal workers
Islamic College Health Post	MOH, MOR, LG, Islamic College
Health Scout	MOH, LG, Scout Organization
Village Medicine Post	MOH, MHA, LG, Community
Non-Communicable Disease Post	MOH, MHA, LG, Community
Village Malaria Post	MOH, MHA, LG, Community

Note: MOH (Ministry of Health), MHA (Ministry of Home Affair), FEW (Family Empowerment for Welfare), FPCB (Family Planning Coordination Board), LG (Local Government).

Posyandu (Integrated service post)

Integrated service post is the most popular form of community- based health activities in Indonesia. Posyandu is run by health volunteers, open once a month, give health package service including mother & child health (MCH), family planning (FP), nutrition, immunization and diarrhea disease control. Posyandu is the integration of weighing post, health post, family planning post, established in 1984. The number of posyandu increased gradually, from 25.000 posyandu at 1985 and now 269.202 posyandu.

The posyandus' performances varies, from unstable posyandu to self reliant posyandu (regular activities and high coverage of all programmes). The posyandu is categorized into four level of development by using indicators as follows⁹.

- (i) Pratama or first level posyandu. In the unstable posyandu, the activities depend on the presence of health personnel.
- (ii) Madya or second level posyandu. It has regular activities, but the program coverage is still less than < 50%.

- (iii) Purnama or third level posyandu. The activities has run regularly, the programme coverage is high (> 50%), but not yet supported by community health fund.
- (iv) Mandiri or self reliant posyandu. It has a regular activity, high programme coverage and supported by community health fund.

The indicators for posyandu's stratification are stated in table four below.

Table 4. Indicators for posyandu's stratification

Indicator	1 st	2 nd	3 rd	4 th
Number of health volunteers	< 5	> 5		
Weighing frequency/year	< 8	> 8		
Nutrition coverage	< 50%		> 50%	
Family planning coverage	< 50%		> 50%	
MCH coverage	< 50%		> 50%	
Immunization coverage	< 50%		> 50%	
Additional program	(-)		(+)	
Community health fund coverage	< 50%			> 50%

Although the number of posyandu is sufficient, unfortunately the strata of posyandu is still not good as shown in table 5.

Table 5. The strata of posyandu, 2000 – 2006

	2000	2001	2002	2003	2004	2005	2006
Number of posyandu	234526	239288	240828	245154	238699	248358	269202
1 st level posyandu	44.1 %	44.2 %	44.2 %	37.7 %	33.6 %	35.1 %	31.4 %
2 nd level posyandu	34.0 %	34.7 %	34.7 %	36.6 %	39.9 %	36.1 %	38.0 %
3 rd level posyandu	18.3 %	18.0 %	18.0 %	23.1 %	23.6 %	25.2 %	25.7 %
4 th level posyandu	3.6 %	3.1 %	3.1 %	2.6 %	2.9 %	3.6 %	4.9 %

Source: *The Profile of Community Participation on Health Development, 2000 - 2006*

All activities of posyandu are strongly supported by the Family Empowerment for Welfare (FEW), the most popular women organization in Indonesia, which is organized at all levels from central to village level¹⁰.

Using those indicators, all posyandu know their strata it is hoped that they want to increase the strata. MOH give special award to district which has a good performance of posyandu, ie., those achieving service coverage > 60% and performing at 3rd and 4th level. From year of 1997 until now, 29 districts/municipalities accepted the award.

Village Maternity Home

Village maternity home (VMH) is a specific CBHA. The government educates midwives and then posts them to villages and provides equipments and supplies. The community provides or constructs the VMH building and makes consensus for managing and giving MCH services to the people. The midwife is expected to work together with TBA as a partner to help mother in MCH services. The midwife is responsible for professional care like: ANC, delivery of the baby, PNC, Neonatal Care, etc.; and the TBA is responsible for traditional needs such as massage of the mother, caring the baby, etc. Observation from the field shows that the existence of midwife in almost each village has stopped the regeneration of TBA. Several districts have reported that there is no new TBA and the total number of TBA is decreasing naturally.

Similar with posyandu, the VMH also has stratification from 1st to 4th level VMH. The number and strata of VMH can be seen in table.6.

Table 6. Total number and strata of VMH, 2000 – 2006

	2000	2001	2002	2003	2004	2005	2006
Number of VMH	24846	22838	33041	29650	27995	27304	52531
1 st level VMH (%)	83.6	83.6	61.1	76.6	58.8	58.2	25.0
2 nd level VMH (%)	10.6	10.6	17	12.3	27.1	27.5	68.6
3 rd level VMH (%)	4.8	4.8	19.6	8	11.5	11.9	5.4
4 th level VMH (%)	0.9	0.9	2.3	3.1	2.6	2.4	1.0

Source: The Profile of Community Participation on Health Development, 2000 - 2006

MOH also gives award to the district which has high commitment and facilitates the development of VMH. Up to now, 14 districts have accepted this award.

Village Health Post

Village health post (VHP) is an upgrading of the village maternity home (VMH). Beside mother & child health, VHP also give simple treatment of minor illnesses, handled by midwife with additional training. The number of VHP is 1,939 and will increase rapidly as this is the first of 17 priority targets of MOH.

Village Medicine Post

Village Medicine Post (VMP) is a community-based health activity on early detection and prompt treatment, handled by Health Volunteers, usually at the remote area/village. The number of VMP is 12,597 mostly in the 1st level of VMP.

Health Scout

Health scout is a unit which aims to develop health knowledge and skill, to empower the scout members. Health scout was established on 17 July 1985 by the National Quarters of Indonesian Scout movement. Now, scout organization at district level usually has a health scout unit. Based on the substance of health activities, health scout covers 5 groups. i.e.:

- Environmental health
- Family health
- Disease prevention
- Nutrition improvement
- Drugs control

There are 3.607 health scout team, located scattered in municipalities/districts.

Islamic College Health Post.

Islamic college health post (ICHP) is a participation form of Islamic student for improving their health status. The students are trained by HC staff for implementing health program in their college.

Of the 14,748 traditional Islamic colleges; 2,050 have ICHP. The number of CBHA will increase rapidly, as the central government provides special package for establishing the (ICHP).

Another CBHA

We also develop specific community based health activities, for examples:

- (i) Occupational health post for informal workers.
- (ii) Non-communicable disease post for preventing the non-communicable diseases like hypertension, diabetes mellitus, stroke, etc.
- (iii) Community based rehabilitation for empowering the handicapped persons.

The relation between HC, CBHAs and the elements of PHC can be seen in table 6.

Table 6. List of CBHA and its relation to the 8 elements of PHC

Institusi	HE	Nut	W&S	MCH	Imm	CDC	TCI	ED	NCDC	OH
Health Center	V	V	V	V	V	V	V	V	V	V
Sub-Health Center	V	V			V		V	V		
Posyandu (Integrates Service Post)	V	V		V	V	V				
Poskesdes (Village Health Post)	V	V		V	V	V	V	V		
Polindes (Village Maternity Home)	V	V		V	V					
Posyandu for Elderly	V						V		V	
Occupational Health Post	V		V				V		V	V
Islamic College Health Post	V		V				V			
Health Scout	V	V	V	V	V	V				
Village Medicine Post	V						V			
Non-Communicable Disease Post	V	V							V	
Village Malaria Post	V					V	V			

Note: HE (Health Education), Nut (Nutrition), W&S (Water & Sanitation), Imm (Immunization), CDC (Communicable Disease Control), TCI (Treatment of Common Illness) ED (Essential Drugs), NCDC (Non Communicable Disease Control), OH (Occupational Health).

2.2 Eight Elements of PHC

2.2.1 Health education

Health education or health promotion is implemented through

- (i) Mass media, especially electronic media such as television.
- (ii) Group of community education which focuses on healthy and clean behavior, implemented within 5 settings, i.e.: health institution, public places, working environment, schools and household.
- (iii) Individual, health promotion is closely integrated to individual health services.

Health promotion through television is performed through:

- (i) Talk show with Minister of Health: this is shown in one of the private television and presented every Sunday night. The resource persons are the Minister of Health and other related resource persons according to the topic.
- (ii) Serial drama in television with substance of health messages.

Healthy and clean behavior

Health promotion for certain group is directed to develop program of Healthy and clean behavior with the above five settings. This program introduces indicators for each setting, and base on those indicators, each setting may be classified as healthy or not healthy setting. For household setting, the proportion of healthy family setting in a particular locality (village or sub-district) will determine the health status of the locality, and the rank is from healthy setting level 1 (the worst), healthy 2, healthy 3 and 4 (the best).

Community Based Health Education

Community Based Health Education (CBHE) is health education that utilizes the local potential during the process of learning, with community involvement, using local socio culture communication/media along with empowering local community.

These are some models of CBHE:

(a) Posyandu bulletin

Since 1990, MOH has issued “Posyandu Bulletin”, a communication media on Posyandu, which is distributed free to the supervisors of Posyandu. It is a form for sharing field experiences in the field to enable them to learn and exchange knowledge at operational level. There have been direct interactions among the posyandu agents beyond the knowledge of officials at central level.

(b) Poster making

The poster making through CBHE approach follows the steps

- (i) Collaborate with primary/middle school teachers for inclusion of health poster making in drawing lesson. Information on the health topic will be provided by HC staffs to the teachers. Some samples of health slogan will be presented as well. Every student has to absorb the material and understand it before putting their idea in drawing which at the same time would educate the students on the health messages. The idea of involving local students to make poster is that they know their habits better and will use common phrases in local language.
- (ii) The final drawing would be signed by the student’s parents should put before submitting it to the teacher. This, would indirectly expose parents of all students to health information.
- (iii) Grading is made based on the best drawing. The best drawings will get prizes.
- (iv) The best drawing will be printed as a poster.

(c) Competition on making health message

This is a competition for the local teenagers. The prize is prepared for the winner, and the health message will be exhibited along the street in their village. It is expected that the health messages will varies while using local language, and local materials and stimulate the artistic sense of local people. It is then would intensify the absorption of health messages by teenagers. The exhibition of their health messages along the village streets is a form of appreciation of their masterpiece and creation. Moreover the winners will get prizes.

(d) Letter from students

The National Immunization Week (NIW) in 1995 to 1997 aimed to achieve 100% coverage of all children under five. To reach 100% target is not a simple work. Some strategies were made to present all children under - five closest to the NIW post. One of the strategies implemented was to involve student at primary school as they are

present in every village. HC doctor would collaborate with teachers in every primary school in the villages, to do the following:

- (i) Assign students to prepare invitation letters for all the parents who have under fives children to take them to the closest NIW post for polio immunization .
- (ii) Review and make corrections on the language, the invitation are given back to students to be distributed to their neighbors who have under-five children

The involvement of students as health “courier” can increase parents’ motivation to meet the invitation.

Some localities that implement this approach have higher immunization coverage than other localities without such interventions.

2.2.2 Nutrition

The nutrition improvement program is implemented through HC, VMH for pregnant women and posyandu for under-five children. It is hoped that under-five children come to posyandu every month and get their weight monitored. Unfortunately, not all under-five children come to the posyandu regularly therefore underweight children are not detected at early stage. This is one of the reason for persistent prevalence of malnutrition.

Table 7. The coverage of Nutrition program, 2000 - 2006

Indicator	2000	2001	2002	2003	2005
Obesity	3.25	2.7	2.3	2.24	8.8
Under weight	17.1	19.8	18.4	19.6	19.2
Malnourished	7.5	6.3	7.5	8.6	8.8

Source: Indonesian Health Profile, 2000 – 2005

Since 1999 the MOH introduced Nutrition Awareness Family Program. It consists of five actions, i.e.:

- (i) Weigh under-five children regularly
- (ii) Consume iodized salt
- (iii) Promote variety on daily meals
- (iv) Promote exclusive breast feeding
- (v) Supplementary food consumption

The Program has a healthy paradigm that shift the approach from curative to promotive-preventive approach. The family nutrition awareness activities have been implemented in all districts/cities in Indonesia.

2.2.3 Maternal and Child Health

The main causes of maternal mortality are post partum hemorrhage (PPH), infection, eclampsia, and abortion. In general, PPH is the most common cause of maternal mortality in Indonesia, which is estimated around 42% of the total maternal mortality. PPH is unpredictable it may happen to women who do not have any complaints during pregnancy. PPH can be more dangerous for pregnant women who has anemia problem in sudden and will be more dangerous for pregnant woman who has anemia problem.¹¹ Evidences show that those obstetric complications cannot be handled by traditional birth attendants

There are three delays in getting treatment when complication occurred that lead to maternal deaths:

- (i) Delay in recognizing critical sign and in decision to seek care from health facility because of lack of decision making by pregnant woman for her health, socio-cultural factor and ignorance on complications and its implications.
- (ii) Delay in reaching a health facility which may caused by poor distribution of the health facilities, distance and time to reach the health facility, limited transportation and costs.
- (iii) Delay in receiving treatment at health facility which includes referral system, inadequate health equipments and medicines, limited well-trained health providers and the availability of health providers in the health facility.

Aside from the above factors, other factors that contribute to the unfavourable pregnancy are “four too”, i.e.:

- (i) Too young to be pregnant
- (ii) Too often, low spacing between pregnancy
- (iii) Too many children
- (iv) Too old to be pregnant

Mother Friendly Movement (MFM)

In June 1988, The President declared the safe motherhood initiative which propagandized all sectors to promote the decrease of maternal mortality ratio. This movement admitted the importance of the community participation through a strategy namely “strategy 60-60-60”, meaning 60% of districts can provide basic essential maternity service; 60% of the baby birth is assisted by the well trained health workers; and 60% of high risk cases get proper service/treatment in the referral care facility.

Mother Friendly Movement (MFM) was declared by President during the celebration of Mother’s Day on 22 December 1996. As an acknowledgment of the importance of women empowerment in maternal health, the head of this national movement was entrusted to the Minister of Women Empowerment under the mandate to cooperate with Ministry of Health, Family Planning Coordination Board, Ministry of Home Affairs and other related parties.¹²

The implementation of MFM in the field is formulated in 2 program components, Mother Friendly Sub-district and Mother Friendly Hospital.

The key messages of MFM are:

- (i) Every delivery should be assisted by the well trained health provider.
- (ii) Every obstetrics complication and neonatal should get adequate treatment.
- (iii) Every productive woman has access toward prevention of unexpected pregnancy and treatment of abortion complication.

The low coverage of delivery care by health personnel is caused by many factors, which can be simplified by 4 reasons, i.e.:

- (i) Geographical gap
- (ii) Socio cultural gap
- (iii) Information gap
- (iv) Economic gap

Availability of a village maternity home, which headed by mid-wife will decrease such gaps. Posting mid-wife to the village will decrease the geographical gap, because each village has midwife. In every activity, as a member of community, midwife will be able to communicate, educate and give information to the people about health, especially mother and child health. This activity will automatically decrease the

information gap. The partnership between midwife and traditional birth attendants will decrease the socio-cultural gap. The economic gap can be reduced by Community Health Fund or by getting cross subsidy from the rich people to the high-risk pregnant women from low-income community. The latest intervention is to register by listing the high risk pregnant women for seeking cross subsidy from the private sector. The table showed maternal health situation from 2000-2005.

Table 8. MMR, IMR and CMR, 2000 - 2006

Indicators	2000	2001	2002	2003	2004	2005
MMR			307.0			262.0
IMR	47	50	35.0			32.0
CMR	51.4		46.0			
Current user of family planning methods	54.4	52.5	54.2	54.5	56.7	57.9
1 st ANC	88.3	93.0	88.6	87.7	88.1	88.6
4 th ANC	75.0	77.4	73.0	76.3	77.0	77.1
Birth by health personnel	74.5	67.6	69.2	70.6	74.3	72.4

Source: Indonesian Health Profile, 2000 – 2005

Partnership between Midwives and Traditional Birth Attendant in Trenggalek District

In Trenggalek District, child birth is critical situation for mother’s life and the baby because many deliveries are still assisted by traditional birth attendant (TBA). In order to prevent maternal and neonatal deaths, partnership between midwives and TBA is promoted. This approach is expected to gradually change the type of service of TBA, from care during labour and childbirth to domestic help for the mother and her newborn.

Socialization was conducted from district level to village level. The result was:

- (i) Support provided by heads of villages and community leaders towards midwife-TBA partnership activity in each locality
- (ii) Some agreements that covers among others:
 - All TBAs agree to midwife-TBA partnership activity.
 - Every call to TBA for delivery will be referred to midwives in each area.
 - For every referral of pregnant woman to midwife, TBA will get Rp20,000,- (US \$ 2.-)

- TBAs function as domestic help ,providing care for mother and newborn
- When a childbirth is assisted by a midwife, a TBA will be invited to assist the midwife.

After three years of midwife-TBA partnership program, birth delivery assisted by midwife was significantly increased. Even the number of maternal mortality and infant mortality tend to decrease, as seen in the following table¹³.

Tabel.9. The number of mother and infant mortality in Trenggalek District.

Mortality	1999	2000	2001	2002	2003	2004
Mother	12	18	22	11	17	5
Infant	156	128	164	130	110	33

Source: Indonesian Health Profile, 2000 – 2005

Health Insurance for the poor

Since 1998, the Government of the Republic of Indonesia has provided special fund for health services for the poor, including maternal and neonatal health. The fund was previously given directly to facilities such as like HC, VMH and hospitals, but in 2005 health insurance for the poor was launched¹⁴. The insurance has increased the coverage of maternal and child health and shift the pattern of birth delivery care from traditional birth attendant (TBA) to midwife¹⁵.

2.2.4 Water and sanitation

The poor environment degradation caused by deforestation, illegal logging and disasters in many areas has decreased the coverage of clean water and basic sanitation. However, there are some models of community development in environment health, e.g., PHAST (Participatory Hygiene and Sanitation Transformation)¹⁶. Experiences showed that participatory model has been able to motivate the community to generate clean water facilities and basic sanitation. But, because the coverage of the program is still limited, the coverage increase of clean water and basic sanitation in project locations have not been able to increase national coverage significantly.

Table 10. Coverage of Water and Sanitation program, 2000 - 2006

Indicators	2000	2001	2002	2003	2004	2005
Access to improved water source	76.0	75.0	--	79.5	55.3	--
Access to improved sanitation	92.3	93.0	94.0	94.1	77,9	80.1

Source: Indonesian Health Profile, 2000 – 2005

2.2.5 Immunization

The expanded program for immunization began officially in Indonesia in 1977 and then accepted as a cost-effective component of the national preventive health agenda. Immunization is routinely conducted in primary level of care and integrated service post. In 1991 hepatitis B vaccine was introduced into the immunization schedule¹⁷. However, the coverage of immunization has not been satisfying as there were:

- (i) Many polio cases in 2005 so that national immunization week (NIW) was conducted again, created problems to routine immunization.
- (ii) Ongoing outbreak for measles in various localities, forcing measles vaccination to be conducted in the outbreak locations of disaster. This had drained resources resulted in disturbance of routine immunization at primary level of care and integrated service post .

The coverage of immunization is stated at the following table (table 11)

Table 11. Coverage of Immunization Program, 2000 - 2005

	2000	2001	2002	2003	2004	2005
BCG	100.0	96.3	96.6	97.7	97.9	88.2
DTP 3	94.5	91.7	89.6	90.8	91.1	76.2
OPV 4	93.7	89.9	87.5	90.4	90.5	77.6
He B3	78.2	66.7	72.5	79.4	81.2	67.9
Measles	89.7	87.3	90.6	90.4	91.8	86.5
TT2 + PW				84.1	71.8	57.0

Source: Indonesian Health Profile, 2000 – 2005

Student immunization month

Experience showed that it is difficult to increase the coverage of TT2 immunization for pregnant women. To cope with it, student immunization month was launched. In

this program, tetanus immunization is conducted at school. Compulsory schooling program has been launched so that almost all children in their schooling ages go to school. By conducting this program, the recommended frequency of tetanus immunization for adolescents is five times with long life immunity. By conducting this program it is expected that the tetanus immunization for pregnant women later will not be necessary.

2.2.6 Control of locally endemic diseases

The control of locally endemic diseases is conducted through integrated service posts for ARI (Acute Respiratory Infection) and diarrhea. In malaria endemic regions, control is conducted by village malaria post or village medicine post. All those activities are under the supervision of health centers. Some community self-help health activities are promoted, e.g.: cleaning the breeding places of *Aedes aegypti* to control dengue fever, using mosquito bed-net and clothes that cover almost all body to prevent malaria in malaria endemic regions. For malaria, we introduce village malaria post for early detection and prompt treatment to the malaria patients, especially in Java island. It has decreased the annual parasite rate, as stated in the following table (table 12).

Table 12. Annual parasite incidence and annual malaria incidence, 2000 – 2005.

Indicators	2000	2001	2002	2003	2004	2005
API	0.81	0.62	0.47	0.22	0.15	0.15
AMI	31.09	26.2	22.3	21.8	21.2	19.0

Source: Indonesian Health Profile, 2000 – 2005

The prevalence of acute respiratory infection (ARI) especially pneumonia has decreased, from 7.6 % (2003) to 5.2 % (2005) in 2 weeks period, but the coverage of pneumonia still low, at about 24.6 % – 35.9 % of the target. Detection of pneumonia is done by health personnel at HC, sub-HC, or VMH and by health volunteers at posyandu.

2.2.7 Treatment of common illness and injuries

Treatment of common illness and injuries are mainly handled by health center or sub-health center beside hospital. Village medicine post also treats common diseases and occupational health post treats injuries for the informal workers. Some villages

integrate the curative activities done by health personnel into preventive action in posyandu.

2.2.8 Essential drugs

The provision of essential drugs is the government's policy. Since before the economic crisis, around 1995, the policy of generic medicine has been launched. All government facilities are obliged to use generic medicine, with the quality similar to that of patent medicine, but with lower price. Health service for the poor through social health insurance also uses generic medicine.

Beside that, in 2007 the policy of low-cost medicine for the poor was launched. The package of medicine is made in a way that each package costs only Rp1,000,- (US \$ 0.1). The new policy has not been evaluated so that the impact has not known yet.

2.3 Other Elements of PHC

2.3.1 Occupational health

Occupational health is conducted through two approaches, i.e.:

- (i) Insurance for formal workers including health insurance
- (ii) Occupational Health Post for informal workers.

The coverage of insurance for formal workers is quite high because it is compulsory by the law so that every formal worker is insured by worker's insurance, including in health area.

In the rural areas, 77.3% of the working population is informal sector, mostly in agriculture, followed by home-industries, fisheries, etc. They need basic occupational health services like first aid delivery on accidents and diseases, encouraging the utilization of occupational safety equipment, etc. The Occupational Health Post (OHP) has been established since 1980. It is a self-care model in the occupational health, handled by the workers after getting training from Health Center. The total number of Occupational Health post is 8114 OHP, mostly still at the 1st level. The coverage for informal workers is still facing many problems because insurance is not obligatory, while the number of UKK Post is still limited.

2.3.2 Non-communicable diseases

Non-Communicable Disease Post is an integrated health activity of prevention of major NCD risk factors (obesity, hyper cholesterol, hypertension, hyperglycemia, unhealthy diet, lack of physical activity, and smoking). The main activity of NCD Post is to emphasize on active community participation in early detection as well as in enhancing community awareness and skill in of NCD risk factors prevention and control program in community, particularly for population age 25 years and older. The NCD Post was implemented at Depok in 2000, and now has spread out to many districts / municipalities.

Integrated service posts for the elderly also conduct some activities to maintain their own health, by normal living with degenerative diseases.

3. TRANSLATING THE VALUES OF PHC INTO POLICY AND ACTIONS.

Implementing PHC for more than 30 years both in centralization and decentralization eras in Indonesia, we can pick up many values of PHC into health policy, i.e.,:

- (i) In any era, community participation is a key success of the program.
- (ii) The community really has a very strong inner power to work together, the main problem is how to motivate and direct them to achieve the realistic goal.
- (iii) It is impossible for the government to implement program without community involvement. The role of the government is motivating, facilitating and supporting the community to achieve their goal in health development.
- (iv) In the centralization era, the role of central government is very strong, so the main advocacy is at the national level, and has a good result for the national health problem.
- (v) In decentralization era, we should advocate both national and local government. It is more complex and more difficult to implement the health program. Fortunately, for local health problem, each district can create an innovative approach/program which fit into their culture. For example, to improve health access for poor people, there are many innovative program, varies from one district to another district.

- (vi) The health personnel at central level should have high skill in advocacy and motivating the local government for getting their commitment on health development.
- (vii) Community based health activities (CBHA) is a communication forum between health personnel and community, an alternative method to empower the community on health and to reduce the geographical and social gap. CBHA can be established based on geographical area (posyandu, VMH) or based on specific group (Health Scout, Islamic College Health Post).

3.1 Universal access to care and coverage on the basis of need

In an archipelago country like Indonesia, universal health access is a major challenge. Several experiences from many districts reveal some solutions, i.e.:

- (i) Providing health services free of charge for all people or especially for poor people.
- (ii) Establishing the social health insurance for all people or for poor people only
- (iii) Enhancing the mutual self help: introducing “village ambulance” to solve the transportation problem
- (iv) Monitoring the susceptible group through mapping the pregnant women and under-five children.
- (v) Introducing community based health activities which fit into the community (posyandu for under-five, village maternity home for mother, NCD-post for elderly people, Islamic college health post for the student, etc.)
- (vi) Posting doctors and midwives with special incentive in the remote area.
- (vii) Making partnership between midwife and TBA to solve the cultural gap.

3.2 Commitment to health equity as part of development oriented to social justice

More than 20 years we have done the PHC approach to improve health status, and the result has proven the importance of PHC, but health inequity still exist in our country. Health inequity and health inequality are the current issues in Indonesia, based on geographical condition (archipelago versus land, urban versus rural), gender, economic condition and level of education. In line with decentralization, the budget capabilities among districts are vary and bring us into the unfair budget resources which lead to inequity.

The implementation of PHC is directed to the vulnerable group like pregnant women, infant and child, poor people, informal worker, who live in the under developed area, such as rural area, remote area or slum area in the urban. It is hoped that PHC will be able to reduce all kind of gaps (geographical, cultural, economic and information gaps). In several decades of PHC implementation, we conclude that PHC is a method to empower the vulnerable group and reduce the gaps, but it must be supported by other policies which facilitate or strengthen the efforts to empower the vulnerable group.

Health inequity data should be used to plan the priority program. The budget for poor people should be much more than the rich one, rural area should get more empowerment program than urban.

Mapping of poor and rich districts should be made and based on this map the central government will be able to distribute the budget fairly; the poor district will receive more budget than the rich one.

Special programs have been created to protect and empower the poor, like cash transfer aid, conditional cash transfer, distribution rice package for poor, and in health services we have introduced social health insurance for poor people. Since 1998 GOI (Government of Indonesia) provide special budget for health services for poor people. At the first period the budget was given directly to the health facilities (government hospital and HC) but since 2005 the budget has been managed through social health insurance scheme. This program can improve the coverage of health services among poor people especially in out patient care and inpatient care both at hospital and HC. The free of charge maternal health services can shift the delivery process from TBA (traditional birth attendant) to midwife.

Based on this experiences several policies should be done, i.e.:

- (i) PHC must be supported by another pro-vulnerable group's policy, not only in health but also in other sectors.
- (ii) In health sector, social health insurance should be implemented to assurance the health of the poor people
- (iii) Empowerment of the poor both in health sector and other sectors should be the way of thinking of the local government, and become the first priority program in that area.

3.3 Community participation

3.3.1 Community participation facilitated by health personnel

We have many experiences to improve community participation through interaction between health personnel and community, through “community approach” which contains of 5 steps¹⁸:

- (i) Advocacy to the community leader (both formal and informal), to introduce the program and ask their support
- (ii) Community diagnosis through community self survey, to diagnose the community health problems
- (iii) Community prescription through consensus among community including health personnel
- (iv) Community treatment, through the implementation of intervention which has been selected in community prescription
- (v) Strengthening and enrichment the program

3.3.2 Religion based health activities

During monetary crisis, the number poor people were increasing. This condition inspiring many people to help each other directly through several approaches, one of the methods is religion approach. Some Islamic leaders establish “dompet dhuafa” (vulnerable wallet). They get the budget from “zakat” (mandatory Islamic charity fund) and distribute it to vulnerable groups like: poor people, orphan, elderly people, etc) through several programs: education, economic empowerment and also health services.

For health services, in 2001 they established clinic and hospital giving health services free of charge for poor people. More than 50,000 persons become the members of the Islamic charity health activities¹⁹.

The religion based health activities are not only come from Islamic religion, but the other religions (Catholic, Christian, Hindu and Buddhist) also have similar activities.

3.3.3 Corporate Social Responsibility

Another trend of community participation come from private sectors through Corporate Social Responsibility (CSR) program. Each private sector provides certain budget for social activities (mainly education and health) usually managed by NGO. Some private sectors choose the curative actions like giving budget for operations of congenital diseases, the others choose to empower health volunteers, etc.

3.4 Inter-sectoral actions for health

Health status is the end product of bad management by other sectors. If the environment getting worse, the health status also getting worse because the environmental degradation has strong impact on the health status. One of the health reforms is how to increase awareness of other sector to make “healthy public policy”. It means that all policies come from other sector must concern about the health impact of the policy. It is not easy, but other sectors tend to understand those healthy public policies.

4. LESSONS LEARNT

Lessons learnt can be picked up from our experiences in 30 years implementation of PHC, i.e.:

- (i) Establishing CHC is useful for strengthening and improving the quality of services, and preventing the miss-understanding between HC and community.
- (ii) Family friendly HC is an alternative method to implement healthy paradigm in the grass root level.
- (iii) PHC is still important for community empowerment on health.
- (iv) In the decentralization era, the variation of PHC is wider and closer to the local culture and custom.
- (v) Although PHC implementation is prioritized to the vulnerable group, it should be supported by others pro-vulnerable group policies, for example by establishing social health insurance for poor people, empowering vulnerable groups on promotive and preventive actions, etc.
- (vi) The government should facilitate the direct charity program in the community through religion based cross subsidy for health services or health development.

(vii) The government also facilitates the utilization of CSR (Corporate Social Responsibility) program for health development.

(viii) The Government should create the healthy public policies in all sectors of development.

5. PHC AND THE CURRENT HEALTH ISSUES AND CONTEXT

Based on experiences in implementing PHC in Indonesia, several areas of concern need further attention, i.e.:

Community participation	<ol style="list-style-type: none"> 1. Establishing Community Health Council both at sub-district and district level. 2. Introducing level of community participation by using stratification of CBHA. 3. Community participation should be started from planning process until evaluation of the program. 4. The budget of the program should be managed transparently 5. Government should give reward to the people who have high community participation on health development.
Sustaining Health Volunteers	<ol style="list-style-type: none"> 1. The Government should give reward to the long period health volunteers such as: giving health services free of charge including in patient care, comparative study to other district, giving certificate signed by Health Minister, giving discount card for certain products, etc. 2. Establishing Health Volunteers Organization 3. Providing empowerment program for Health Volunteers Organization. 4. Refreshing health volunteers regularly
Ensuring quality services	<ol style="list-style-type: none"> 1. Introducing simple methods of client satisfaction surveys. 2. Periodic client satisfaction survey conducted by Community Health Council 3. Training health personnel on quality assurance
Decentralization	<ol style="list-style-type: none"> 1. Need stronger advocacy not only at central level but also at provincial and district level. 2. Training health personnel how to advocate the program effectively 3. Diversity is better than uniformity

PHC and Public Private Partnership	<ol style="list-style-type: none"> 1. Facilitating the private sector to utilize the CSR (Corporate Social Responsibility) on health development. 2. Giving annual reward to the private sector which good performance in implementing the CSR for health. 3. Facilitating the utilization of religion based charity fund for health development
Health Information System	<ol style="list-style-type: none"> 1. Introducing FFHC (Family Friendly Health Center) which need basic health information of all family in the responsible area of HC. 2. Enhancing the cohort record start from pregnant woman until under-five
Management	<ol style="list-style-type: none"> 1. Introducing bottom up health planning from village to district level 2. Creating simple management tool in the field.

6. THE WAY FORWARD

For the next period the implementation of PHC should be supported by other healthy public policies and pro-vulnerable group policies. Without such support, the implementation of PHC will not run fluently because environmental degradation and bad behavior give big effect on health.

Several healthy public policies are:

- (i) Policies of other sectors which prevent the degradation of environment and promote the green earth.
- (ii) Policies of other sectors which prevent the bad behavior and promote the healthy life behavior.
- (iii) Health policies which protect the vulnerable group like social health insurance for poor, conditional cash transfer for the poor, health assurance for all pregnant women, etc.
- (iv) Health policies which empower the vulnerable group to be self reliant.
- (v) Health policies which guarantee the access of qualified health services for the vulnerable group, such as: giving incentive for medical doctors and midwives who willing to stay at the remote area.

To strengthen the implementation of PHC, the government should:

- (i) Using healthy paradigm to plan and implement health program
- (ii) Train health personnel in advocacy and community empowerment
- (iii) Provide budget for implementation of PHC

References.

1. Ministry of Health. *Primary Health Care in Indonesia. MOH. 1994.*
2. Ministry of Health. *Community Participation on Health, Indonesian Experience. Ministry of Health. Jakarta, 1999.*
3. Departemen Kesehatan RI. *Rencana Strategis Departemen Kesehatan Tahun 2005 – 2009. Departemen Kesehatan RI, 2006.*
4. Departemen Kesehatan RI. *Profil Kesehatan Indonesia 2005. Departemen Kesehatan RI, 2007.*
5. *Proyek kesehatan Keluarga dan Gizi Depkes. Badan Peduli Kesehatan Masyarakat. Departemen Kesehatan, 2002.*
6. Departemen Kesehatan RI. *Kebijakan Dasar Pusat Kesehatan Masyarakat. Departemen Kesehatan, 2004.*
7. Departemen Kesehatan RI. *Dokumentasi dan Cerita Sukses Proyek Kesehatan & Gizi. Departemen Kesehatan RI, 2004.*
8. Ministry of Health. *Community Participation on Health, Indonesian Experience. Ministry of Health. Jakarta, 1999.*
9. Departemen Kesehatan RI. *ARRIF, Pedoman Manajemen Peran Serta Masyarakat. Departemen Kesehatan RI, 1995.*
10. Tim Penggerak PKK Pusat. *Pemberdayaan dan Kesejahteraan Keluarga (PKK). Tim Penggerak PKK Pusat, 2006.*
11. Kementerian Pemberdayaan Perempuan. *Pedoman Gerakan Sayang Ibu. Kementerian Pemberdayaan Perempuan, 2004.*
12. Cholil A, Iskandar MB, Sciortino R. *Penyelamat Kehidupan: Gerakan Sayang Ibu di Indonesia. Galang Communication, Meneg Peranan Wanita, Ford Foundation & UNFPA, 1999.*
13. Departemen Kesehatan RI. *Hikmah Pelaksanaan Proyek Safe Motherhood, a Partnership & Family approach. Departemen Kesehatan, 2005.*
14. Departemen Kesehatan RI. *Pedoman Pelaksanaan Jaminan Pemeliharaan Kesehatan Masyarakat Miskin 2006. Departemen Kesehatan RI, 2006.*
15. Trihono. *Pengaruh Asuransi Kesehatan Masyarakat Miskin terhadap Utilisasi Pelayanan Kesehatan Maternal dan Neonatal (Disertasi). Universitas Indonesia, 2007.*
16. Departemen Kesehatan RI. *PHAST, Pedoman Langkah demi Langkah. Departemen Kesehatan RI, 2001.*
17. Government of the Republic of Indonesia. *Plan of Sustainable Financing for National immunization Program of the Republic of Indonesia. GOI, 2005.*
18. Departemen Kesehatan RI. *Pendekatan Kemasyarakatan. Departemen Kesehatan RI, 1993.*
19. Rohilah E & Nasrullah R. *Mengelola Pelayanan Kesehatan untuk Dhuafa. Layanan Kesehatan Cuma-Cuma. 2006.*

20. Departemen Kesehatan RI. *Profile Kesehatan Indonesia Tahun 2000*. Departemen Kesehatan, 2002
21. Departemen Kesehatan RI. *Profile Kesehatan Indonesia Tahun 2001*. Departemen Kesehatan, 2003
22. Departemen Kesehatan RI. *Profile Kesehatan Indonesia Tahun 2002*. Departemen Kesehatan, 2004
23. Departemen Kesehatan RI. *Profile Kesehatan Indonesia Tahun 2003*. Departemen Kesehatan, 2005
24. Departemen Kesehatan RI. *Profile Kesehatan Indonesia Tahun 2004*. Departemen Kesehatan, 2006
25. Departemen Kesehatan RI. *Profile Peran Serta Masyarakat dalam Pembangunan Kesehatan Tahun 2000*. Departemen Kesehatan, 2001
26. Departemen Kesehatan RI. *Profile Peran Serta Masyarakat dalam Pembangunan Kesehatan Tahun 2001*. Departemen Kesehatan, 2002
27. Departemen Kesehatan RI. *Profile Peran Serta Masyarakat dalam Pembangunan Kesehatan Tahun 2002*. Departemen Kesehatan, 2003
28. Departemen Kesehatan RI. *Profile Peran Serta Masyarakat dalam Pembangunan Kesehatan Tahun 2003*. Departemen Kesehatan, 2004
29. Departemen Kesehatan RI. *Profile Peran Serta Masyarakat dalam Pembangunan Kesehatan Tahun 2004*. Departemen Kesehatan, 2005
30. Departemen Kesehatan RI. *Profile Peran Serta Masyarakat dalam Pembangunan Kesehatan Tahun 2006*. Departemen Kesehatan, 2007

Footnotes

- ¹ Ministry of Health. *Primary Health Care in Indonesia*. MOH, 1994.
- ² Ministry of Health. *Community Participation on Health, Indonesian Experience*. Ministry of Health, Jakarta, 1999.
- ³ Departemen Kesehatan RI. *Rencana Strategis Departemen Kesehatan Tahun 2005 – 2009*. Departemen Kesehatan RI, 2006.
- ⁴ Departemen Kesehatan RI. *Profil Kesehatan Indonesia 2005*. Departemen Kesehatan RI, 2007.
- ⁵ *Proyek kesehatan Keluarga dan Gizi Depkes*. Badan Peduli Kesehatan Masyarakat. Departemen Kesehatan, 2002.
- ⁶ Departemen Kesehatan RI. *Kebijakan Dasar Pusat Kesehatan Masyarakat*. Departemen Kesehatan, 2004.
- ⁷ Departemen Kesehatan RI. *Dokumentasi dan Cerita Sukses Proyek Kesehatan & Gizi*. Departemen Kesehatan RI, 2004.
- ⁸ Ministry of Health. *Community Participation on Health, Indonesian Experience*. Ministry of Health, Jakarta, 1999.
- ⁹ Departemen Kesehatan RI. *ARRIF, Pedoman Manajemen Peran Serta Masyarakat*. Departemen Kesehatan RI, 1995.
- ¹⁰ *Tim Penggerak PKK Pusat. Pemberdayaan dan Kesejahteraan Keluarga (PKK)*. Tim Penggerak PKK Pusat, 2006.
- ¹¹ Kementerian Pemberdayaan Perempuan. *Pedoman Gerakan Sayang Ibu*. Kementerian Pemberdayaan Perempuan, 2004.
- ¹² Cholil A, Iskandar MB, Sciortino R. *Penyelamat Kehidupan: Gerakan Sayang Ibu di Indonesia*. Galang Communication, Meneg Peranan Wanita, Ford Foundation & UNFPA, 1999.
- ¹³ Departemen Kesehatan RI. *Hikmah Pelaksanaan Proyek Safe Motherhood, a Partnership & Family approach*. Departemen Kesehatan, 2005.
- ¹⁴ Departemen Kesehatan RI. *Pedoman Pelaksanaan Jaminan Pemeliharaan Kesehatan Masyarakat Miskin 2006*. Departemen Kesehatan RI, 2006.
- ¹⁵ Trihono. *Pengaruh Asuransi Kesehatan Masyarakat Miskin terhadap Utilisasi Pelayanan Kesehatan Maternal dan Neonatal (Disertasi)*. Universitas Indonesia, 2007.
- ¹⁶ Departemen Kesehatan RI. *PHAST, Pedoman Langkah demi Langkah*. Departemen Kesehatan RI, 2001.
- ¹⁷ Government of the Republic of Indonesia. *Plan of Sustainable Financing for National immunization Program of the Republic of Indonesia*. GOI, 2005.
- ¹⁸ Departemen Kesehatan RI. *Pendekatan Kemasyarakatan*. Departemen Kesehatan RI, 1993.
- ¹⁹ Rohilah E & Nasrullah R. *Mengelola Pelayanan Kesehatan untuk Dhuafa*. Layanan Kesehatan Cuma-Cuma. 2006.

