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EVALUATION

NURTURING THE MOTHER-CHILD DYAD IN AN URBAN SETTING: FINAL EVALUATION OF THE HATI KAMI PROJECT IN JAKARTA, INDONESIA

DECEMBER 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Kathy Tilford, Independent Consultant, with assistance from the Hati Kami team for certain annexes.

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Kathy Tilford
Lead Evaluator

FINAL EVALUATION OF THE HATI KAMI CHILD SURVIVAL PROJECT

RESULTS OF NURTURING THE MOTHER-CHILD DYAD FROM PREGNANCY THROUGH THE FIRST SIX MONTHS OF LIFE: FINAL EVALUATION OF A FOUR-YEAR URBAN HEALTH PROJECT

December 2014

CSHGP Cooperative Agreement No. AID - OAA - A -10 - 00063

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

December 2014

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ACRONYMS AND TERMS

AMSTL	Active Management of the Third Stage of Labor
BCC	Behavior Change Communication
BFC	Breastfeeding Counseling (refers to the WHO standard 40-hour course)
CFW-UI	Center for Family Welfare Research, University of Indonesia
CHV	Community health volunteer, known as Kader (unpaid)
CQI	Continuous Quality Improvement
CSHGP	Child Survival and Health Grants Program
CU2	Children under two years of age
CU5	Children under five years of age
DIP	Detailed Implementation Plan
EBF	Exclusive Breastfeeding
FGD	Focus Group Discussion
IBCLC	International Board Certified Lactation Consultant
IBI	Indonesian Midwives Association (Ikatan Bidan Indonesia)
IR	Intermediate Result
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
KKA	Kedaung Kali Angke (participating sub-district)
KPC	Knowledge, Practice and Coverage Survey
LAMAT	Local Area Monitoring and Tracking
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MCHN	Maternal and Child Health/Nutrition
MHO	Municipality Health Office (for West Jakarta)
MoH	Ministry of Health
m-PWS	Mobile Area Monitoring and Tracking (Sistem Pemantauan Wilayah Setempat secara Mobil)
MSG	Mothers Support Group
OR	Operations Research
PHC	Public Health Center (Puskesmas)
PHO	Provincial Health Office (for Jakarta Province)
PKK	A civil society organization associated with the Ministry of Home Affairs (Pemberdayaan Kesejahteraan Keluarga)
Posyandu	Health Post (Pos Pelayanan Terpadu)
RW	Community consisting of a cluster of 8 to 19 neighborhoods (Rukun Warga)
SBMR	Standards Based Management and Recognition
SOW	Scope of Work
ToT	Training of Trainers



Mother and child participating in a Mothers Support Group in West Jakarta Municipality



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Final Evaluation of the Hati Kami Child Survival Project - Executive Summary

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Evaluation Purpose and Evaluation Questions

The overall purpose of this evaluation was to assess the performance of the project at the end of four years of implementation, documenting results and the reasons for these results. This included testing the assumptions underlying the Results Framework, determining program impact, and identifying lessons learned in order to propose recommendations for future programming. The final evaluation process gave an opportunity for the beneficiaries and key stakeholders – the Ministry of Health structures (MoH), the USAID Mission, project staff, local organizations and other partners – to provide input during the qualitative field work and during the dissemination of the preliminary results of the evaluation in-country.

Evaluation questions: To guide the final evaluation, the Scope of Work (SOW) proposed four key evaluation questions:

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the Detailed Implementation Plan (DIP)?
2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?
3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?
4. What are stakeholder (community members, Municipality Health Office) perspectives on the Operations Research (OR) implementation, and how did the OR study affect capacity, practices, and policy?

In addition to these four questions, the evaluation team also examined four Learning Themes proposed for all 2014 CSHGP Final Evaluations: Community Engagement; Service Delivery, Equity and Continuous Quality Improvement; Scale

Key Findings:

Achieved both project Objectives, exceeding targets for 11 of 13 Key Program Indicators

Successfully adapted a self-assessment tool (SBMR) to improve performance of private midwives delivering MCH services

Set the stage for sustainability of a number of program effects and initiatives by reinforcing solid partnerships with government and private organizations

Promoted strong community engagement through training, BCC activities and identifying “champions” to promote key messages

Tested an approach for using mobile phones for routine data collection, creating high interest within the Ministry of Health for using mobile technology

Scale up of several interventions already being undertaken by key partners, including the PHO

Project Background

Hati Kami, an urban health project located in the West Jakarta Municipality of Jakarta Province in Indonesia, is a four-year Innovation Child Survival and Health Grants Project (CSHGP) implemented by Mercy Corps and its public and private sector partners. The project, whose name means “Our hearts”, was designed to address high rates maternal and neonatal mortality, increased rates of bottle/formula feeding, and limited growth in exclusive breastfeeding (EBF) rates; it successfully built on the results and lessons learned of Healthy Start, Mercy Corps’ previous CSHGP project in Jakarta Province. The overarching goal of the project, implemented from September 2010 through September 2014, was to “promote, support, and protect the mother-child dyad for a healthy start among Jakarta’s poor residents” according to the project proposal. To do this, activities were designed to achieve two interrelated Objectives: 1) Improved maternal child care and nutrition **practices** of mothers from pregnancy through the first 6 months of life and 2) Improved quality of maternal, newborn and infant **services**.

Key interventions included: establishing Mothers Support Groups (MSGs) for reaching mothers with critical information on breastfeeding and maternal and newborn care; integrating counseling on maternal-infant health and nutrition into the 7+ contacts in maternal-newborn care¹; scaling up WHO’s 40-hour Breastfeeding Counseling (BFC) training; implementing a targeted communication strategy; adapting the Standards Based Management and Recognition (SBMR) approach for private midwives; supporting the Municipality Health Office (MHO) and local branch of the Indonesian Midwives Association (Ikatan Bidan Indonesia, IBI) to train providers on the Kangaroo Mother Care method; and replicating the 10 steps to successful breastfeeding model of the previous Healthy Start project.

The **Operations Research (OR) component** was designed to address current shortcomings in the existing implementation of the MoH maternal and child health Local Area Monitoring and Tracking (LAMAT) system. The OR, hereinafter referred to as m-PWS (short for Mobile Area Monitoring and Tracking in Indonesia) was conducted in partnership with the University of Indonesia’s Center for Family Welfare Research (CFW-UI). With m-PWS, Hati Kami and CFW-UI investigated the use of mobile phone technology to improve the quality of MCH-LAMAT data with a cost-effective, efficient and user-friendly mobile-based electronic health record system. The m-PWS tool was tested throughout the data process (from data collection to data analysis) to see if it can be used for inclusive and participatory data monitoring and tracking purposes.

Evaluation Design and Methods

The evaluation team was responsible for collecting and analyzing qualitative primary data using focus group discussions (FGDs), Key Informant Interviews (KIIs) and observation. The team also reviewed and analyzed secondary quantitative data from baseline and endline surveys and assessments. In addition to the qualitative and quantitative data, the lead evaluator also completed a thorough document review including the original proposal narrative, the DIP, annual reports, reports to donors, strategies such as the Behavior Change Communication (BCC) strategy, midterm assessments, and reports sent by external visitors. She also used observation as a technique, especially of interactions among the Hati Kami team, partners and beneficiaries.

At the end of the field work the evaluation team met in a one-day workshop to analyze results, draw preliminary conclusions and propose recommendations. Following the workshop, the lead

¹ 7+ refers to 7 (or more) contacts with a breastfeeding counselor when a woman is: 28 weeks pregnant; 36 weeks pregnant; in labor and delivery; after delivery and still admitted; 7th day post-delivery; 14th day post-delivery; and 39 days post-delivery. The + includes additional contact with counselors after the first 40 days of the baby’s life.

evaluator organized a series of shorter meetings with the Hati Kami team for additional analysis. The lead evaluator triangulated findings from the document review, her observations of interpersonal dynamics and the quantitative data from the endline surveys and assessments. Additional input was provided by the stakeholders when the preliminary results were shared.

Findings and Conclusions

For Objective 1, targets were exceeded for six of the seven Key Program Indicators (all six statistically significant), demonstrating that Intermediate Result 1(IR1) (Increased knowledge and skills of mothers) was accomplished, largely as a result of the MSG approach and the Behavior Change Communication (BCC) strategy. Two of the more notable achievements for improvements in maternal/child care and nutrition practices were 1) the increase in EBF by almost 20 points, from 23.4% to 42.7% and 2) the increase in the percentage of children who did not receive pre-lacteal feeds, from 47% to 76.4%. These changes in practices are traditionally among the more difficult to achieve where Infant and Young Child Feeding (IYCF) are concerned. The one target that was not met was for “Timely Initiation of Breastfeeding”.

Of the six Key Program Indicators for Objective 2, five exceeded the target with statistical significance. What is especially encouraging is that the **quality of health services** for antenatal, delivery and postpartum care all improved, including Active Management of Third Stage Labor (AMTSL). As for the two indicators measuring access to counseling, the percentage of mothers of children under 2 (CU2) who reported receiving counseling during their last pregnancy nearly doubled (from 40% to 79.7%), but there was a disappointing decrease in the percentage of pregnant women who reported receiving counseling during their current pregnancy; this raises concerns about the extent to which providers, especially midwives, are counseling pregnant women.

In evaluating the major activities undertaken by Hati Kami, the most problematic has been the OR. Of the six research questions in the OR design, the first three (accuracy of reporting, timeliness of reports and level of participation) could not be answered due to either a lack of data for certain periods or incomplete data. Sufficient data was available to answer Question 4 – use of maternal and child health (MCH) data for local planning. Utilization was not higher in the m-PWS area for internal planning but was higher in the m-PWS area for the quarterly planning sessions between the Rawa Buaya Public Health Center (PHC) and the community. The last two research questions concerned barriers and enabling factors for the use of the m-PWS and there was useful data generated for these questions. In spite of the problems encountered, the OR initiative has resulted in a number of **positive benefits**. By demonstrating the potential of mobile technology, it raised the awareness of stakeholders and generated widespread interest in replicating mobile approaches for monitoring and tracking.

After reviewing and discussing the quantitative data and corroborating evidence from the qualitative evaluation and a detailed document review, the evaluation team concluded that **Hati Kami has been successful, achieving both of its Objectives and most of the intended results**. In addition, the project team has enhanced the original project proposal design by achieving measurable results with the addition of innovative activities such as adapting SBMR for private midwives and providing financial advocacy training.

The Hati Kami Project in West Jakarta, Indonesia is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Hati Kami Project is managed by Mercy Corps under Cooperative Agreement No. AID - OAA - A -10 – 00063. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about the Hati Kami Project, visit: www.mercycorps.org

EVALUATION PURPOSE AND EVALUATION QUESTIONS

Purpose: The overall purpose of this evaluation was to assess the performance of the project at the end of four years of implementation, documenting results and the reasons for these results. This included testing the assumptions underlying the Results Framework, determining program impact, and identifying lessons learned in order to propose recommendations for future programming. The final evaluation process gave an opportunity for the beneficiaries and key stakeholders – the Municipality Health Office (MHO), the USAID Mission, project staff, local organizations and other partners – to provide input during the qualitative field work and during the dissemination of the preliminary results of the evaluation in-country.

Findings from this evaluation will be disseminated within Mercy Corps and to: the principal stakeholders including organizations and agencies that implemented the project with Mercy Corps; the USAID Mission in Indonesia; the CSHGP office; and other organizations that have expressed an interest in the project. It will also be available to the public once posted on the Maternal and Child Health Integrated Program (MCHIP) and Development Clearinghouse Web sites. It is anticipated that the report will be used within Indonesia to inform forward planning for scaling up project interventions, especially in Jakarta Province; other NGOs and organizations may find it useful for designing similar projects promoting improved maternal care and infant health, especially for breastfeeding and prenatal care initiatives.

A lead evaluator was hired with project funds to guide the evaluation; she had had no previous connection with Mercy Corps/Indonesia or with the Hati Kami project. USAID approved the evaluator and both USAID and EnCompass reviewed the draft Scope of Work (SOW). The lead evaluator submitted the draft report simultaneously to EnCompass and to Mercy Corps Headquarters.

Evaluation questions: To guide the final evaluation, the SOW proposed four key evaluation questions, each of which had a subset of related questions (See Annex VIII for the complete SOW):

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the Detailed Implementation Plan (DIP)?
2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?
3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?
4. What are stakeholder (community members, Municipality Health Office) perspectives on the Operations Research (OR) implementation, and how did the OR study affect capacity, practices, and policy?

In addition to these four questions, the evaluation team also examined four Learning Themes proposed for all 2014 CSHGP Final Evaluations: Community Engagement; Service Delivery, Equity and Continuous Quality Improvement; Scale Up and Sustainability; and Learning and Adaption, including Operations Research. For Service Delivery, Equity and Continuous Quality Improvement (CQI), the team did not make a special effort to look at Equity as access to services is not a major issue in the project area.

PROJECT BACKGROUND

Hati Kami, an urban health project located in the West Jakarta Municipality of Jakarta Province in Indonesia, is a four-year Innovation Child Survival and Health Grants Project implemented by Mercy Corps and its public and private sector partners. It was designed to address a number of maternal/child health issues that the MoH considers high priorities, including:

- Increased rates of bottle/formula feeding and limited growth in exclusive breastfeeding (EBF) rates
- Unacceptably high rate of maternal mortality (The lifetime risk of maternal mortality in Indonesia is one in 150 compared with one in 400 in developed countries².)
- Lack of significant decline in the neonatal mortality rate (The 2007 Indonesia Demographic and Health Survey reported 19/100,000 live births with almost 80% of deaths occurring in the first week of life.)
- With over 50% of Indonesia's population living in urban areas, it is also a priority of the MoH to address the particular health issues among the urban poor that are associated with overcrowding, poor sanitation conditions and lack of the social safety nets one finds in rural communities.³

The project, implemented from September 2010 through September 2014, was designed to improve mothers' practices for their own health when pregnant and the health of their child and to improve the quality of services available for pregnant women and newborns. It successfully built on the results and lessons learned of Healthy Start, Mercy Corps' previous CSHGP project in Jakarta Province. The overarching goal of the project was to "promote, support, and protect the mother-child dyad for a healthy start among Jakarta's poor residents" according to the project proposal. To do this, activities were designed to achieve two interrelated Objectives: 1) Improved maternal child care and nutrition **practices** of mothers from pregnancy through the first 6 months of life and 2) Improved quality of maternal, newborn and infant **services**.

Mercy Corps and the Provincial Health Office (PHO) jointly selected the **project location**, West Jakarta Municipality, for three reasons: its health indicators were among the poorest in Jakarta Province; the Municipality is an important point of entry and exit for new migrants to the city; and Mercy Corps had well-established relationships with the local government and with the PHO, MHO and other actors in the health sector. West Jakarta Municipality is composed of eight Districts and Hati Kami works in the Cengkareng and Kalideres Districts. Based on health statistics, especially anthropometric data, and population density, the West Jakarta MHO and Mercy Corps identified a total of eight sub-districts (out of 56) for project implementation (all six sub-districts in Cengkareng and two sub-districts in Kalideres). The following table shows the levels at which Hati Kami works with the MoH and administrative officials:

² The Lancet, Volume 360, Issue 9858

³ UNICEF Indonesia Issue Brief October 2012

Table 1. Administration and MoH Structures

Administrative Division	MoH Structure
Jakarta Province	Provincial Health Office (PHO); reports to Governor's office
West Jakarta Municipality	Municipality Health Office (MHO); reports to Mayor's office
2 Districts: Cengkareng and Kalideres	2 District Public Health Centers (PHC or <i>Puskesmas</i>); administrative officials and community leaders
8 Sub-districts ⁴	14 Sub-district PHCs; administrative officials and community leaders; community health volunteers (Kaders)
RW (<i>Rukun Warga</i> , a cluster of 8-19 neighborhoods)	<i>Posyandu</i> (Health Post), with support from community health volunteers, administrative officials and community leaders

Over the four years of the project, activities were designed to benefit 221,221 women of reproductive age (WRA) and 65,845 children under 5 (CU5). The beneficiary breakdown by District is provided in the table below. Note that these figures are higher than those reported in the DIP and other project documents as this new table is based on updated 2013 figures provided by the Indonesian government.

Table 2. Beneficiary Population

Beneficiary Population	Cengkareng (6 sub-districts)	Kalideres (2 sub-districts)	Total
Total Population in project area	577,154	160,253	737,407
Total Children 0-59 months	50,275	15,570	65,845
Children 0-11 months	10,695	3,399	14,094
Children 12-23 months	10,177	3,201	13,378
Children 24-59 months	29,403	8,970	38,373
Women of Reproductive Age (WRA)	173,146	48,075	221,221
Total WRA and CU5	223,421	63,645	287,066

(Calculations based on latest population figures from Sub-district Government Offices for 2013)

The following short form of the **Results Framework** shows how the two Objectives would be reached. (For a more detailed Results Framework, see Annex XIX - A.)

Objective 1. Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life

IR1. Increased knowledge and skills of mothers on breastfeeding and essential maternal-newborn care

IR2. Increased access to social support for mothers on breastfeeding and key maternal-newborn care

Objective 2. Improved quality of maternal, newborn and infant services

IR3. Increased skills and compliance of the health providers on MCHN counseling, AMTSL, essential newborn care and the baby friendly protocols.

IR4. Increased use of MCH data for decision making and advocacy.

Key interventions included: establishing Mothers Support Groups (MSGs) for reaching mothers with critical information on breastfeeding and maternal and newborn care; training Motivators to facilitate the MSGs and to conduct outreach; providing Mentors to support the

⁴ Duri Kosambi, Rawa Buaya, Kedaung Kaliangke, Kapuk, Cengkareng Timur and Barat in Cengkareng District; Tegal Alur and Kamal in Kalideres District

Motivators; integrating counseling on maternal-infant health and nutrition into the 7 contacts+⁵ in maternal-newborn care; scaling up WHO's 40-hour Breastfeeding Counseling (BFC) training; implementing a targeted communication strategy; adapting the Standards Based Management and Recognition (SBMR) approach for private midwives; supporting the MHO and local branch of the Indonesian Midwives Association (IBI) to train providers on the Kangaroo Mother Care method; and replicating the 10 steps to successful breastfeeding model of the previous Healthy Start project.

The **Operations Research (OR) component** was designed to address current shortcomings in the existing implementation of the MoH's maternal and child health Local Area Monitoring and Tracking (LAMAT) system. The OR, hereinafter referred to as m-PWS (short for Mobile Area Monitoring and Tracking in Indonesia) was conducted in partnership with the University of Indonesia's Center for Family Welfare Research (CFW-UI). Many of the shortcomings of the current system have roots in the manual data recording and reporting of LAMAT data (i.e. using paper-based health records). Although the Ministry has provided electronic database software for health offices to report data online to the national level since 2008, the data collection at the sub-district level and below remains heavily paper-based, irregular, and of sub-standard fashion. Recording and maintaining physical health records is time consuming and labor intensive.

With m-PWS, Hati Kami and CFW-UI investigated the use of mobile phone technology to improve the quality of MCH-LAMAT data with a cost-effective, efficient and user-friendly mobile-based electronic health record system. The two objectives for the OR were 1) to evaluate whether the m-PWS system can improve collection and use of quality data to inform local health planning and resource allocation and 2) to document enabling factors and barriers to the scale-up of the m-PWS system. The m-PWS tool was tested throughout the data process (from data collection to data analysis) to see if it can be used for inclusive and participatory data monitoring and tracking purposes.

The OR was conducted in two of the eight sub-districts in West Jakarta where the Hati Kami project was located. The two sub-districts have similar estimated population totals (based on government statistics), and each has only one Public Health Center (PHC) in charge of all health reporting. Using a 'flip of a coin' Kedaung Kaliangke (KKA) sub-district was originally randomly selected as the intervention area where m-PWS would be implemented and Rawa Buaya (RB) was originally selected as the control area where the paper-based LAMAT system would continue to be implemented. After the baseline research was completed, the OR team found there was only one private midwife practicing in Kedaung Kaliangke whereas Rawa Buaya had a number of private midwives. Since the OR required greater numbers of private midwives to obtain useful feedback for ongoing m-PWS development, it was decided in Year 3 in consultation with the OR advisory board, to switch these two areas. In both the 'intervention' area (Rawa Buaya) and the 'control' area (KKA), evaluative research consisting of quantitative and qualitative assessments was carried out before and 12 months after the introduction of m-PWS in the 'intervention' area.

One of the defining characteristics of Hati Kami is the extent to which it has been implemented from the beginning with **partners in both the public and private sectors**. The MoH is highly

⁵ 7+ refers to 7 (or more) contacts with a breastfeeding counselor when a woman is: 28 weeks pregnant; 36 weeks pregnant; in labor and delivery; after delivery and still admitted; 7th day post-delivery; 14th day post-delivery; and 39 days post-delivery. The + includes additional contact with counselors after the first 40 days of the baby's life.

decentralized in Indonesia and the project worked most closely with the MHO, which is under the supervision of the West Jakarta Mayor's office; the Provincial Health Office or PHO, which reports to the Governor's office; 16 PHCs; and the Posyandu. In addition to administrative authorities, community leaders and the various levels of the MoH, Hati Kami designed and implemented activities with four other principal groups: private midwives; the Indonesian Midwives Association (IBI); PKK, a civil society organized associated with the Ministry of Home Affairs and consisting mainly of women volunteers; and the Indonesian Moslem Leaders Assembly (West Jakarta branch). The Hati Kami team also collaborated with another USAID-funded project, MCHIP, for the adaptation of the SBMR tool developed by MCHIP.

The Hati Kami project directly supports the priorities outlined in the 2009-2014 **USAID Mission Strategy** for the health sector: improving the quality of services delivered by skilled birth attendants; reinforcing the institutional capacity of IBI; strengthening civil society organizations for improved local efforts to lower maternal and neonatal mortality; collaboration with private health care providers; and a focus on initiatives in urban areas. In addition, the USAID/Indonesia health team expressed great interest in the use of mobile technology for data collection during the final evaluation dissemination meeting September 19, 2014 and made arrangements to observe this aspect of the project the following week.

EVALUATION METHODS AND LIMITATIONS

This section primarily describes the qualitative methods and analysis used during the two-week qualitative evaluation. A brief overview is also provided for the quantitative data used for the final evaluation. This includes the baseline/endline surveys and assessments and the OR data.

The Qualitative Evaluation

The **evaluation team** conducted the qualitative evaluation during a two-week period in September 2014. The team was composed of an external consultant who served as lead evaluator; members of the Hati Kami project team; and four external partners representing the West Jakarta branch of IBI, the MHO, the Kalideres District, and the Cengkareng District. (See Annex XIV for a description of the team.) All four external partners were health professionals and had been involved in various aspects of Hati Kami. In addition to the core team, a second external consultant was hired part-time to conduct some of the Key Informant Interviews (KIIs) with private midwives and PHC staff.

The evaluation team was responsible for collecting and analyzing qualitative primary data using focus group discussions (FGDs), KIIs and observation. The team also reviewed and analyzed quantitative data from baseline and endline surveys and assessments and the OR final report. In addition to the qualitative and quantitative data, the lead evaluator also completed a thorough document review including the original proposal narrative, the DIP, annual reports, reports to donors, strategies such as the BCC strategy, midterm assessments, and reports sent by external visitors. She also used observation as a technique, especially of interactions among the Hati Kami team, partners and beneficiaries.

Qualitative Data Collection: Prior to her arrival in country, the lead evaluator worked with the Hati Kami team to identify potential individuals and groups to interview. Because Hati Kami works through existing structures and organizations and because it has substantial community involvement, the initial list of people to interview was too ambitious for the two-week time period. In consultation with the Health and Nutrition Program Manager and the M&E Specialist, the lead evaluator made the decision to include the following individuals and groups in the

qualitative data collection:

- For FGDs: MSG participants; MSG Motivators; community leaders and Community Health Volunteers (CHVs) involved in m-PWS
- For KIIs: Private midwives; MSG Mentors (primarily PKK members); PHC staff; all Hati Kami staff; MHO; IBI; PKK; the Mercy Corps/Indonesia Country Director; the Mercy Corps/Indonesia Finance Director; the Director of Public Health at Mercy Corps headquarters; and a consultant who had provided substantial technical assistance

Draft **data collection instruments** were developed by the lead evaluator prior to her arrival in country and then revised and translated during a one-day workshop with the Hati Kami team. Each instrument included a set of generic questions to allow for cross-comparison of responses from different groups and individuals. The majority of these generic questions focused on the four Learning Themes: Community Engagement; Service Delivery and CQI; Scale up and Sustainability; and Learning and Adaption. The revised instruments were then shared with the entire evaluation team during a one-day workshop and members of the team had the opportunity to practice using them via role plays. Given time constraints and the number of instruments, it was not possible to conduct a field test but following the first day of field work, the team met to discuss how well the instruments worked and modified both FGD guides to eliminate repetitious questions and questions that yielded little useful information.

The FGDs were conducted by two-person teams, usually a Hati Kami team member paired with one of the external partners. In some cases, however, the interview team was composed of two Hati Kami team members as there were only four external partners available. The lead evaluator conducted all the KIIs with Mercy Corps personnel, including the project staff; she also conducted approximately half of the other KIIs. A part-time consultant conducted some of the KIIs with private midwives and PHC staff. The lead evaluator and the part-time external consultant also observed several of the FGDs with Motivators and MSG participants.

In **selecting sites and participants** for the qualitative data collection, an important criterion was to ensure that all eight sub-districts in the project area were represented. To this end, one FGD with Motivators and one FGD with MSG participants were conducted in each sub-district for a total of 16 FGDs for these two groups. Since these FGDs needed to be scheduled prior to the lead evaluator's arrival in country, the Hati Kami team relied on Mentors, Motivators and PHC staff to ensure that each FGD had 10-12 members.

In choosing the six PHCs for KIIs, it was important to include the two PHCs involved in the OR: Rawa Buaya, the intervention site, and KKA, the control site. For the remaining four, the Hati Kami team prepared a list of potential PHCs and the lead evaluator randomly selected two from each district. The same system was used to select the private midwives, with the lead evaluator randomly selecting four from a list. As for the Mentors who provide support to the MSG Motivators, priority was given to Mentors who were PKK members since this civil society organization plays an important role in the project.

To facilitate the **analysis of the qualitative data**, team members took time at the end of each day of field work to record responses in spreadsheets. At the end of the field work the evaluation team met in a one-day workshop to analyze results, draw preliminary conclusions and propose recommendations. Following the workshop, the lead evaluator organized a series of shorter meetings with the Hati Kami team for additional analysis. The lead evaluator triangulated findings from: the document reviews, her observations of interpersonal dynamics

and the quantitative data from the endline surveys and assessments; and the OR final report. Additional input was provided by the stakeholders when the preliminary results were shared.

Baseline/endline Quantitative Data

Especially useful for triangulation was the data from the **endline quantitative surveys and assessments** conducted from June through August 2014. For Objective 1 endline data was collected for two population-based surveys: a repeat of the baseline **Knowledge, Practice and Coverage (KPC) Survey** with mothers of CU2 and a repeat of the baseline **Maternal Nutrition Survey** with pregnant women. (See Annex VI for detailed report.). The endline instruments omitted some questions used in the baseline that were no longer applicable (e.g., planned activities that were not implemented such as the use of SMS for BCC).

The cluster sampling method was applied for both the KPC and the Maternal Nutrition surveys, with clusters defined as the community neighborhood unit (RW). For the KPC Survey the baseline sample was 300 mothers and the endline sample was 330 mothers⁶. For the Maternal Nutrition Survey 780 pregnant women were interviewed during the baseline survey and 575 during the endline exercise. Enumerators used Smartphones equipped with DataDyne software and once the data had been checked and verified by supervisors, the enumerators sent the data to the DataDyne server. Analysis was conducted using SPSS 17 Trial Version.

For Objective 2, the evaluation team used the results of two endline assessments, which repeated the baseline assessments: an assessment of SBMR with 25 private midwives and an assessment of baby-friendly protocols at 20 health facilities in the project area. (See Annex VI for the report of the two endline assessments for Objective 2.)

OR Data

In comparing m-PWS against a manual, paper-based system, the OR examined six research questions, each of which had its own indicators:

1. Is the discrepancy of MCH indicators between the LAMAT report and the population-based survey significantly smaller in the m-PWS area than in the paper-based LAMAT area? (accuracy)
2. Does the PHC in m-PWS area submit timely LAMAT reports more frequently than the PHC in paper-based LAMAT area? (timeliness)
3. Is the participation in reporting among public and private health providers and community health volunteers (kader) higher in the m-PWS area than in the paper-based LAMAT area?
4. Is the use of data for local planning higher in the m-PWS area than in paper-based LAMAT area?
5. What are the enablers and barriers for health providers and community health volunteers (kader) regarding implementation of the m-PWS system? (considering cost factors, ease of use, feedback, time constraints/ efficiency)
6. What does the government perceive as the barriers and enabling factors for scaling-up the m-PWS system?

Data collection and analysis methods were tailored to each research question. For example, to measure *timeliness of reporting*, the research partner conducted baseline, midterm and endline document reviews at the PHCs. To assess *enabling factors and barriers* to scaling up the m-

⁶ A 10% reserve was added to allow for any errors in data collection.

PWS system, the methodology was different: the research partner conducted in-depth interviews with PCH heads and private health care providers. (For a more detailed description of data collection methods and analysis for each research question, see Annex XV.)

Data Quality and Use

In terms of data available to the evaluation team, the evaluation team did not use data from the MoH or other government agencies as it is not always reliable. Even obtaining current realistic population figures for the two Districts was problematic. The team relied on the qualitative data collected during the September 2014 fieldwork; the baseline and endline surveys and assessments for Objectives 1 and 2; and the OR data.

Possible limitations of the qualitative evaluation methodology include the following:

1. Having Hati Kami team members on the evaluation team: This could introduce bias into the data collection. To mitigate this possibility, Hati Kami team members did not conduct interviews in the areas in which they worked and when possible, they were paired with an external partner. Almost all the KIIs were conducted by the external consultants except for three of the KIIs with Mentors.
2. Time constraints: Conducting the entire qualitative evaluation, including preparatory workshops and dissemination meetings, in two weeks was challenging. One result was that not all groups could be interviewed. If more time had been available, it would have been useful to interview religious leaders, other members of the organizational partners, more government officials and additional community leaders. Even for the groups selected, it would have been helpful to have more interviews, especially with private midwives and the key organizational partners. The time constraint also negated the possibility of using recorders and transcribing the interviews later.
3. Interpreters: Both external consultants relied on interpreters for a number of their interviews. Although the interpreters were competent, it is likely that some key information was missed.
4. Choice of sites and participants: Although a certain amount of randomness was introduced into the selection of sites and participants, the initial lists were prepared by project staff. This was both a factor of time available and the need to set up the FGDs and KIIs in advance.

The **quality of the quantitative data** from the baseline and endline surveys and assessments was good and the M&E Specialist promptly provided explanations and additional data upon request. However, three of the 13 Key Program Indicators needed to be recalculated during the final evaluation. (See Table 3 on the following page for a list of the 13 Key Program Indicators used to evaluate the project.) For the EBF indicator, a child who was exclusively breastfed in the past 24 hours but who had had a prelacteal feed was not counted as exclusively breastfed. The baseline and endline values were recalculated using the Rapid CATCH definition⁷. The other two Indicators that were revised were the Counseling Access for Mothers and the Counseling Access during Pregnancy Indicators. Both indicators state "...received counseling on breastfeeding *or* maternal and infant care messages". However, in the baseline survey respondents had to answer all messages for both breastfeeding *and* maternal and infant care in order to be counted. In recalculating the values, respondents who answered either

⁷ % children 0-5 months who were exclusively breastfed during the last 24 hours

breastfeeding or maternal and infant care messages (or both) were counted.

For the evaluation team, the principal problem in terms of data quality was the OR data. As noted earlier, data for three of the six research questions (accuracy of reporting, timeliness of reports and level of participation) was either missing altogether for certain periods or incomplete. However, the team did find quite useful the OR data on enabling factors and barriers to scaling up m-PWS.

Attribution

Two factors facilitated attribution of results to the project: the project design and the project documentation. First, the clarity of the project design, the logic connecting the two Objectives and the four IRs and the fact that the design, including the number of activities, was not too ambitious made it easier to determine to what extent the project activities and strategies contributed to the results. Second, good documentation, especially for Years 1-3, provided not only descriptions of what activities were implemented but also the constraints encountered and how the project team overcame problems and setbacks. A third factor that facilitated attribution is the fact that no other organizations are carrying out similar activities in the project area.

Table 3. 13 Key Program Indicators

(* = statistically significant. See Annex XIX - B for confidence intervals.)

(NA = Statistical significance not applicable)

INDICATOR	BASELINE	TARGET	ENDLINE
Objective 1: Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life			
1. Timely initiation of breastfeeding: % children 0-23 months who were put on the breast within 1 hour after delivery	62.3%	72%	64.8%
2. Early initiation of breastfeeding: % children 0-23 months who were put on the mother's breast or tummy's skin right after birth for at least 1 hour or until it stopped suckling	23.3%	33%	40.6%*
3. Exclusive breastfeeding: % children 0-5 months who were exclusively breastfed during the last 24 hours	23.4%	38%	42.7%*
4. No pre-lacteal feeds: % children age 0-23 months who did not receive pre-lacteal feeds	47%	55%	76.4%*
5. Having more carbohydrate in pregnancy: % pregnant women who reported having increased portion of staple food during pregnancy	23.7%	25%	64.9%*
6. Iron supplement in pregnancy: % pregnant women who reported taking an iron supplement yesterday	56.4%	60%	67.3%*
7. Folic acid supplement in pregnancy: % pregnant women who reported taking folic acid tablet yesterday	62.1%	65%	81.4%*
Objective 2: Improved quality of maternal, newborn and infant services			
1. Quality antenatal care: % health service providers' compliance in giving standard antenatal care	87%	89%	92.4% (NA)
2. Compliance to standard post-partum and post-natal care: % health service providers' compliance in giving standard post-partum and post-natal care	92.5%	94%	98.3% (NA)
3. Compliance to standard normal delivery and newborn care: % health service providers' compliance in giving standard normal delivery and newborn care	88%	90%	96.8% (NA)
4. Active management of the third stage of labor (AMTSL): % mothers of children age 0-23 months who received AMTSL after the birth of her youngest child	30%	35%	43.6%*
5. Counseling access for mothers: % mothers of children age 0-23 months who received counseling on breastfeeding or maternal and infant care messages	40%	50%	79.7%*
6. Counseling access for pregnant women: % pregnant women who received counseling on breastfeeding or key maternal and infant care messages	71.5%	81.5%	58.1%*

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This section includes discussions of the Evaluation Questions from the SOW and the Learning Themes proposed for all 2014 CSHGP Final Evaluations. Throughout this section references are made to the 13 Key Program Indicators. These are shown in Table 3 on the preceding page and excerpts are included under the “Outcomes” column in Tables 4 and 5. The complete table with confidence intervals for these Key Program Indicators can be found in Annex XIX - B.

FINDINGS

The Findings section is organized into two parts, one for each Objective. Each part includes a Summary Table of the inputs, activities and outputs that contributed to the outcomes for the Objective.

Project Objective 1: Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life

Table 4. Summary of Inputs, Activities and Outputs that Contributed to Key Outcomes for Objective 1

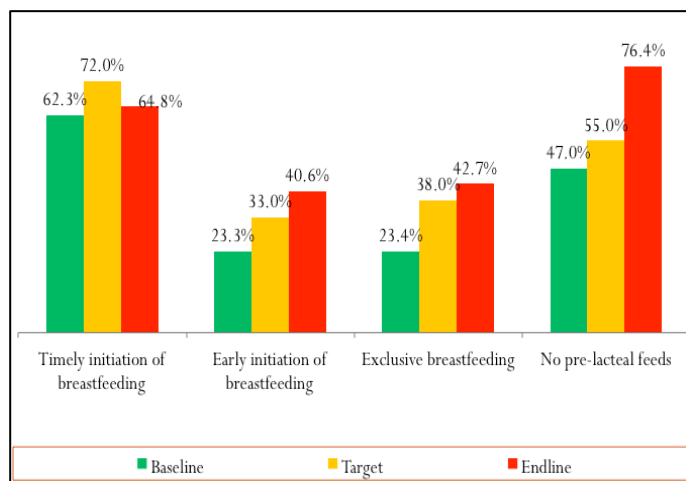
Project Inputs	Activities	Outputs	Outcomes
IR 1. Increased knowledge and skills of mothers on breastfeeding and key maternal-newborn care			Key Program Indicators
MSG Master Trainers	MSG Mentors training	6 MSG ToTs conducted	<p>1. Increase in percentage of children 0-23 months who were put on the mother's breast or abdomen's skin right after birth for at least 1 hour or until it stopped suckling (from 23.3% to 40.6%).</p> <p>2. Increase in percentage children 0-5 months who were exclusively breastfed during the last 24 hours (from 23.4% to 42.7%).</p> <p>3. Increase in percentage of children 0-23 months who <u>did not</u> receive pre-lacteal feeds (from 47% to 76.4%).</p> <p>4. Increase in percentage of pregnant women who reported having increased portion of staple food during pregnancy (from 23.7% to 64.9%)</p> <p>5. Increase in percentage of pregnant women who reported taking an iron supplement in the last 24 hours (from 56.4% to 67.3%)</p>
MSG Motivators and Mentors	MSG Motivators training	96 trained MSG Mentors for West Jakarta	
IEC materials and job aids	Monitoring and evaluation	36 trained MSG Mentors for Jakarta Province	
Cost-share funding from Jakarta PHO, Give2Asia & Johnson & Johnson Indonesia	IYCF Counseling training and ToT using UNICEF's module	512 trained MSG Motivators for 8 sub-districts	
Consultant (IYCF Counseling Master Trainer)	Breastfeeding Counseling	94 RW with functioning MSGs	
IYCF Counseling training kit	Pilot of Blended Learning of Breastfeeding Counseling Course	97 functioning MSGs in 94 RWs conduct meeting at least once/month	
Course Directors and Senior Facilitators	ToT – IYCF Counseling	17 female community volunteers trained and given counseling kit on IYCF	
WHO 40 hours BFC training kit	IYCF training for community counselors/volunteers	16 MSG M&E meetings at sub-district level (9 were cost-shared)	
Episurveyor/Magpi platform for monitoring		6 Breastfeeding Counseling Courses conducted	
Breastfeeding[e]Education by Health[e]Foundation		63 private midwives certified as Breastfeeding Counselors with 40-hour course.	
		27 private midwives in West Jakarta certified as Breastfeeding Counselors via the Blended Learning Course	

Project Inputs	Activities	Outputs	Outcomes
		20 IYCF counseling trainers	6. Increase in percentage of pregnant women who reported taking folic acid tablet in the last 24 hours (from 62.1% to 81.4%)
IR 2. Increased access to social support for mothers on breastfeeding and key maternal-newborn care			
BCC Consultant Mercy Corps Technical Backstop (consultant) Hati Kami: all staff Mercy Corp Indonesia Senior Communication Officer Trainers – Financial Literacy Cash contribution from Prudential USAID: A Toolkit for Religious Leaders Breastfeeding expert-Keynote speaker at Indonesian Moslem Leaders Assembly – West Jakarta branch West Jakarta Mayor’s Office staff	Doer Non-Doer research conducted Team retreat & in-house workshop for BCC ToT for Financial Literacy trainings– bridging onward discussion on savings from breastfeeding at the community level Production, launching, and distribution of “MCH from Islam Perspective” set of materials for religious leaders in West Jakarta.	24 banners, 48 posters and 15 Information Boards produced and placed at PHCs and private midwives’ offices 2 ToT conducted; 30 people (Hati Kami partners and Hati Kami staff) trained as Financial Literacy Trainers 1,998 people from 65 RW in Hati Kami project area trained in Household Financial Literacy Muslim Khutbah Guide, Flyers, and Pocket Book disseminated to religious leaders and public figures	7. No significant increase in percentage of children 0-23 months who were put on the breast within 1 hour after delivery (from 62.3% to 64.8%)

To what extent did the project accomplish and/or contribute to the results stated in the DIP for Objective 1?

For Objective 1 (Improved maternal child care and nutrition practices of mothers), targets were exceeded for six of the seven Key Program Indicators (all six statistically significant), demonstrating that IR1 (Increased knowledge and skills of mothers) was accomplished, largely as a result of the MSG approach and the BCC strategy. Two of the more notable achievements for improvements in maternal/child care and nutrition practices were 1) the increase in EBF by almost 20 points, from 23.4% to 42.7% and 2) the increase in the percentage of children who did not receive pre-lacteal feeds, from 47% to 76.4%. These changes in practices are traditionally among the more difficult to achieve where Infant and Young Child Feeding (IYCF) are concerned. The one target that was not met for this Objective was for “Timely Initiation of Breastfeeding”. Although the result was not statistically significant, it seems that little progress was made for this practice with the endline result being 64.8% compared to a baseline of 62.3%.

Graph 1. Selected results for Objective 1: Infant feeding



To achieve Objective 1, Hati Kami used a variety of strategies for IR1 and IR2, focusing especially on social and behavior change strategies and strategies to enhance the enabling environment. The **cornerstone strategy is the MSG approach**. Building on the previous Healthy Start project, Hati Kami adapted this approach (e.g., adding an IYCF component) and succeeded in establishing 97 functioning MSGs in 94 RWs (neighborhoods). To lead the MSGs, the project trained close to 600 female Motivators drawn from the RWs. The Motivators are in turn supported by Mentors who are volunteers from the PHCs, from IBI and especially from PKK, which is well-established as a civil society organization in the project area.

During the qualitative field work, the evaluation team learned that the MSG meetings not only increase the knowledge of the pregnant women and mothers who participate, leading to changes in practices, but also provide social support for them. This is especially important in an urban environment with a fluid population where new arrivals often lack the critical support of friends and family. Participants interviewed during the FGDs cited making new friends and having Motivators to go to with questions as advantages of the MSGs. Both the document review and the qualitative results indicated that there is some turnover among the Motivators for different reasons: they gain full-time employment, move away, lack motivation or are too busy with other activities.

One of the intended results of Objective 1 was to find ways to help stakeholders **scale up** the MSGs throughout West Jakarta. In addition to giving presentations and advocating for MSGs at health and nutrition fora throughout Jakarta Province, the Hati Kami team developed a set of manuals providing step-by-step instructions and comprehensive tools for those wishing to establish MSGs. In her KII, the Public Health Director for West Jakarta confirmed her desire to replicate MSGs throughout the Municipality.

Although the MSG approach was by and large successful in terms of promoting better practices and providing social support to pregnant women and mothers of young children (based on results from the endline surveys and assessments and the qualitative fieldwork), it could be improved as it is not reaching as many women as anticipated (less than 15% of eligible women participate according to the endline survey results).

Results from the KPC Endline Survey, some of which are shown below in Graphs 1 and 2, were corroborated during the FGDs with MSG participants who cited the key messages they had retained from attending MSG meetings and from other contacts with Motivators, private midwives and PHC staff. The MSG Motivators themselves also consistently cited breastfeeding messages and better nutrition for pregnant women as topics they focus on. The evaluation team also observed high visibility for Hati Kami's key messages via items such as posters, tote bags, and stationery.

BCC was important for the successful implementation of both Objective 1 and Objective 2. Although the definitive **BCC strategy** was not developed until midway through the four-year project cycle, Mercy Corps did devote additional resources to ensuring that it was a comprehensive document that focused on the project's key messages. This included hiring two external BCC specialists, conducting a barrier analysis (Doer-Nondoer Survey), and carrying out Lot Quality Assurance Sampling (LQAS) at the midpoint to gauge the effectiveness of the behavior change activities.

The LQAS and other midterm assessments showed that the project was not systematically including husbands and fathers. As a result, the project team and one of the consultants worked together to include activities for reaching men. Of the activities proposed for men, only one was

implemented fully: involving religious leaders. This was achieved by working with the Indonesian Moslem Leaders Assembly of West Jakarta to develop materials on “MCH from Islam’s Perspective”, using the USAID tool for materials development for religious leaders. Books, brochures and a pocket-sized reference were distributed to religious leaders for use during Koran studies meetings, Friday prayers and other gatherings. (See Annex XIX - C for a description of the materials.) Anecdotal evidence from community members and Hati Kami staff indicate that as a result, there is greater understanding of what Hati Kami is promoting and increased interest on the part of men in the project area, resulting in wider **community engagement**. However, overall there are many missed opportunities to include men in the project, including male community leaders.

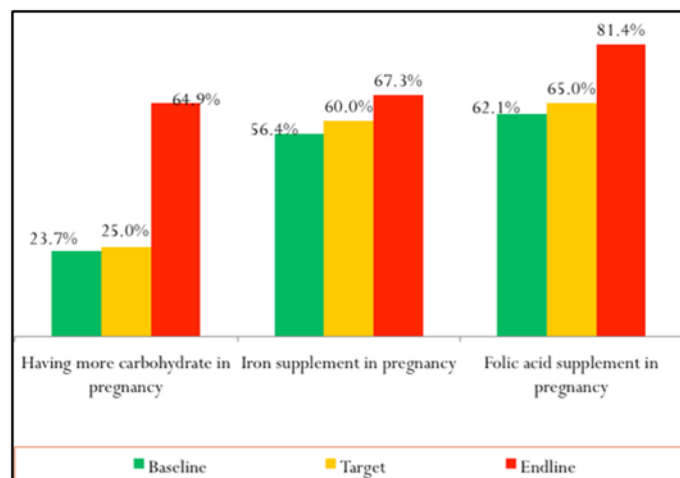
Other BCC activities that reinforced both IRs for Objective 1 and created high visibility for the project included: engaging community leaders and conducting community mobilization sessions, both of which increased **community engagement**; periodic events such as media campaigns around breastfeeding; the production of 68 breastfeeding signboards; and the distribution of motivational materials and items with the key messages (e.g. umbrellas, tote bags, badges, hats and stationery.)

To ensure that messages on the key maternal/child care practices were consistent and that providers integrated counseling into routine contacts for maternal/child care, the project also devoted resources to improving the ability of health care providers to provide **effective counseling** in breastfeeding, Kangaroo Mother Care and IYCF. For example, 90 private midwives were certified as Breastfeeding Counselors after completing either the standard 40-hour WHO course or the self-paced blended learning course. Hati Kami also trained 20 IYCF trainers who in turn trained PHC staff as IYCF counselors throughout Jakarta Province. Note that these activities overlap with and reinforce Objective 2, which focuses on **improving service delivery and the quality of maternal, newborn and infant services**. Improving the technical skills of providers (e.g. breastfeeding counseling and Kangaroo Mother Care) seemed to give them greater confidence and more credibility with the beneficiaries. As one private midwife put it: *“Before Hati Kami I had the correct knowledge about breastfeeding but I didn’t know how to persuade people, how to demonstrate the right positions, or how to answer their questions. Now I do – and I know how to make the learning environment fun!”*

The second IR for Objective 1 (IR2) focuses on increasing social support for mothers as they begin to adopt new practices and behaviors; this IR also depends on an effective BCC strategy to achieve results. The Hati Kami strategy for this IR was two-fold:

1) provide tools to communities for better planning and management of activities to support mothers and 2) increase the capacity of West Jakarta stakeholders to scale up the MSG approach throughout West Jakarta Municipality. Discussions with mothers and KIIs with MHO personnel, project staff, and PHC heads showed that successful techniques included 1) working with religious leaders to develop materials on MCH and Islam, thereby encouraging more men

Graph 2. Selected results for Objective 1: Maternal health



to support the project and 2) training community members in Household Financial Literacy, including the economic advantages of breastfeeding as opposed to buying breast milk substitutes. It is also worth noting here that the achievements for IR2 were also due in no small part to the activities for IR4, which focus on encouraging community members to advocate for local budget support for MCH activities.

Project Objective 2: Improved quality of maternal, newborn and infant services

Table 5. Summary of Inputs, Activities and Outputs that Contributed to Key Outcomes for Objective 2

Project Inputs	Activities	Outputs	Outcomes
IR 3. Increased skills and compliance of the health providers on Standard Based Management of Maternal and Child Health services and the baby friendly protocols			Key Program Indicators
SBMR Facilitators (MCHIP partners) Local Midwives Association (IBI) West Jakarta MHO staff Clinical Practice Facilitators SBMR check list booklet/ IEC materials Budget-share with Municipality and Province Health Offices Give2Asia/Johnson & Johnson Indonesia cost-share	SBMR workshops Participant assessments Evaluation meetings Series of capacity building seminars and workshops World Breastfeeding Week 2013 and 2014 commemoration in Jakarta Support for health providers' participation in seminars and workshops organized by Indonesian IBCLC Association	Practice of 40 participating midwives assessed against SBMR checklist 150 private midwives attended a seminar on Legal Aspects of Breastfeeding Support, Medical Records in Practice, Early initiation and EBF 62 public and private midwives in West Jakarta participated in practice training on Asphyxia Management and Neonatal Resuscitation, Kangaroo Mother Care and Partograph 26 counselors from West Jakarta and partners in the PHO participated in the national event on "Breastfeeding Update in Daily Practice" SBMR full adoption and roll out by Municipality Health Office of West Jakarta	1. Increase in percentage of mothers of children age 0-23 months who received counseling on breastfeeding or key maternal and infant care messages (from 40% to 79.7%) 2. Increase in percentage of mothers of children 0-23 months who received AMTSL after the birth of youngest child (from 30.0% to 43.6%). 3. Increase in percentage of health service providers' compliance in giving standard antenatal care (from 87.0% to 92.4%). 4. Increase in percentage of health service providers' compliance in giving standard normal delivery and newborn care (from 88.0% to 96.8%). 5. Increase in percentage of health care providers who gave standard post- partum and post-natal care (from 92.5% to 98.3%).
IR 4. Increased Use of MCH data for decision making and advocacy			6. Decrease in percentage of pregnant women who received counseling on breastfeeding or key maternal and infant care messages (from 71.5% to 58.1%)
Government's <i>Musrenbang</i> Advisors and Consultant from District and City levels Trained male and female RW leaders Asia Foundation Indonesia's <i>Musrenbang</i> Guidelines MCH profiles in West Jakarta from City Health Office Rawa Buaya MCH population data registered with m-PWS	Training of RW leaders 2012 and 2013 Awareness raising roadshow in 8 RWs in 2012 Community participatory problem listing, analysis and priority rating in 2012 Advocacy and technical coordination (2012 -2014) <i>Musrenbang</i> proposal drafting by RW and sub-district levels	At least 670 male and female leaders and/or community figures were trained on Basic Knowledge on Maternal Child Health and Nutrition; bottom-up development planning facilitation; and MCH-friendly budget proposal and bottom-up advocacy Over USD \$100,000 budget officially allocated for MCH activities for 2013-2014 and	Other Indicator 100% health facilities implemented at least 5 of the 10 steps (range 6-10 steps) to successful breastfeeding protocol by

Project Inputs	Activities	Outputs	Outcomes
(specific to OR intervention area) Stationery supplies for meetings	(2012 and 2013)	2014-2015 in all 8 project sub-districts to conduct and leverage sub-districts' MCH initiatives (e.g. Mothers Support Group, opening up new <i>Posyandu</i> , etc.)	the end of the project.

To what extent did the project accomplish and/or contribute to the results stated in the DIP for Objective 2?

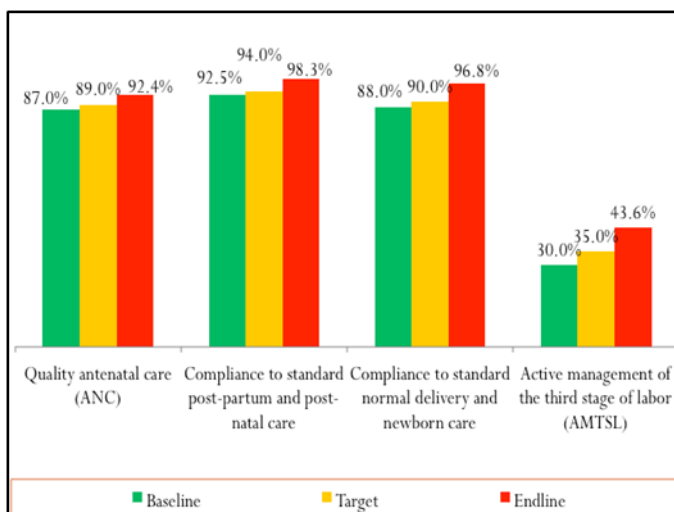
Of the six Key Program Indicators for Objective 2, five exceeded the target with statistical significance. What is especially encouraging is that the **quality of health services** for antenatal, delivery and postpartum care all improved, including Active Management of Third Stage Labor (AMTSL). As for the two indicators measuring access to counseling, the percentage of mothers of CU2 who reported receiving counseling during their last pregnancy nearly doubled (from 40% to 79.7%), but there was a disappointing decrease in the percentage of pregnant women who reported receiving counseling during their current pregnancy. Since the confidence intervals show that this latter result was statistically significant, it raises concerns about the extent to which providers, especially midwives, are counseling pregnant women on the essential maternal and child care messages, including breastfeeding.

To understand the impact of the **IR3 activities** (Increased skills and compliance of the health providers), the evaluation team interviewed providers (private midwives and PHC staff); partners, including IBI, PKK and the MHO; and beneficiaries. Both groups of providers noted the same things about the skills training they had received: it improved their technical skills and their skills in counseling and effective communication, raised their confidence level, and as a result, brought them closer to the communities they serve.

One of the most effective strategies for improving the quality of services was to take the SBMR tool developed by MCHIP and adapt it for use with private midwives. (Adaptation included, for example, removing the checklist for integrated management of childhood illnesses and replacing it with a checklist for exclusive breastfeeding support/counseling.)

Improving the skills of private midwives is crucial in the project area since the majority of women go to them rather than to public facilities. With solid support from the MHO and IBI, this initiative has now been scaled up and the adapted tool is being rolled out throughout West Jakarta, a result that will be one of the lasting legacies of Hati Kami according to the West Jakarta Director of Public Health. This activity was not in the original

Graph 3. Selected results for Objective 2: Quality of health care services



“We had to fight a little the first time but now they know me at the district office and realize that I will be a regular visitor, making sure we receive the allocation for the MSGs.” (Comment from an MSG Mentor who was also trained in Financial Advocacy.)

project proposal design and is a good example of the project team's willingness to adapt, to take risks and to be innovative.

As for IR4 (Increased use of MCH data for decision making and advocacy), the results are mixed due to the fact that OR is included under this IR and the expected OR results have not all been achieved. Leaving OR aside, the qualitative KIs and a review of recent project documents indicate that the project has succeeded in helping communities use data to support MCH activities and to advocate for local budget contributions to these activities, including MSGs. One of the more interesting achievements was getting community leaders and ordinary citizens involved in *Musrenbang*, the bottom-up local budgeting process that provides an opportunity for the community to propose items for the budget. In the past, communities tended to propose infrastructure but as a result of training in advocacy and budgeting, communities in all eight sub-districts succeeded in getting over \$100,000 in allocations for MCH activities for the 2013-2014 and 2014-2015 budget cycles. Those interviewed as Key Informants declared that they were encouraged by their success to date and planned to advocate on a regular basis to ensure that MCH activities such as MSGs and *Posyandu* continue to benefit from the annual *Musrenbang* process.

Factors Contributing to Success

Based on the qualitative results, including observations, and the document review, it is possible to discern some of the factors that contributed to the project achieving its Objectives; these factors can be grouped into three categories: program design; partnerships; and community engagement. Under program **design**, the following points stand out: lessons learned from the previous Jakarta-based breastfeeding project, Healthy Start, were incorporated; the design is relatively simple and tightly focused; there is an inherent logic between the two Objectives (improving practices of mothers and improving the skills of providers); and the design responds directly to the priorities of both the MoH and the USAID Mission.

Strong partnerships were one of the hallmarks of Hati Kami; this included the partnerships within the Hati Kami team and the partnerships between Hati Kami and its partners. The lead evaluator observed that the 11-member Hati Kami team is extremely close-knit and their complementary skill sets (technical, management, leadership, facilitation) enable them to jointly tackle challenges. Although there has been some turnover within the team over the four years of project implementation, the Health and Nutrition Program Manager provided the leadership to maintain the team spirit and drive. Characteristics that define this team include adaptability when confronted with challenges and responsiveness. For example, when some midwives were unable to take a week off to participate in the 40-hour breastfeeding counseling course, Hati Kami found a solution: they submitted a funding proposal to Johnson & Johnson to develop and pilot a blended learning course (self-directed) for breastfeeding counseling skills. When the funding was approved, the team worked with Health[e] Foundation to develop the online course. The team members are responsive to requests for assistance whether they come from the Governor's office, the MHO, a PHC or a community group. At the MHO's request, for example, they developed written guidelines and manuals for MSGs and m-PWS.

During the qualitative field work and the Stakeholders Workshop, the lead evaluator observed the extremely close working relationship between the Hati Kami team and its partners, specifically the MHO, IBI, PKK and the staff at the PHCs. It would appear that the team has paid careful attention to establishing effective working relationships with the result that these organizations provide excellent support, including financial support in the form of sharing budgets for some activities. The Mercy Corps Country Director also commented on this during

the Stakeholders Workshop, saying that the lively interaction between the government representatives and the Hati Kami team was atypical.

Contributing to project achievements is the focus on **involving the community**. This includes incorporating the CHVs and community leaders into project implementation, including the m-PWS and IYCF; using the MSG approach to reach women who might be new to a community and feeling isolated; helping to bridge the gap between health care providers and the community by promoting financial advocacy so that providers and community members make decisions together; employing a variety of social mobilization techniques to reach households with the key messages for improving maternal and child health; and using m-PWS to register mothers and young children so they can more easily be tracked. For this last activity, one PHC head noted that they were able to use the m-PWS data to locate mothers and young children during one of Jakarta's periodic floods.

OR Findings

In evaluating the major activities undertaken by Hati Kami, the most problematic has been the OR. Of the six research questions in the OR design, the first three (accuracy of reporting, timeliness of reports and level of participation) could not be answered due to either a lack of data for certain periods or incomplete data. Sufficient data was available to answer Question 4 – use of MCH data for local planning. Utilization was not higher in the m-PWS area for internal planning but was higher in the m-PWS area for the quarterly planning sessions between the Rawa Buaya PHC and the community.

The last two research questions concerned barriers and enabling factors for the use of the m-PWS and there was useful data generated for these questions. Question 5 concerns enablers and barriers to using m-PWS for health care providers and CHVs. Enabling factors include:

- Data collection and reporting using m-PWS was affordable
- The m-PWS forms were easy to use and reporting was convenient and practical
- The activity encouraged community leaders to participate

Some of the barriers cited by providers and CHVs during the study were:

- Private midwives relied on their own sub-standard registers to complete the forms but were often missing data that they do not routinely collect. This led to delays in submission of their reports.
- Time was a factor for the private midwives, with half of them relying on their assistants to complete the m-PWS forms. As a result, data quality was not always optimal.
- Since the PHC and private midwives in the intervention area still had to complete the paper-based forms, it seemed to some like an extra burden to also use m-PWS.
- The use of mobile technology requires a robust infrastructure to function well. In the absence of such an infrastructure, dedicated technical assistance is needed for the users.

The final OR question concerned the government's perception of enabling factors and barriers for scaling up. An important enabling factor is the government's desire to continue m-PWS as it is more accurate and valid than the paper-based system. It also allows health providers to better track people in their catchment area. According to the MHO, their budget can accommodate the PHC-level expenses for using m-PWS. But the government also has some concerns: need for technical support; turnover of staff who may be trained in m-PWS, resulting in need to train new staff; additional budget needed for the initial training and for ongoing technical assistance; and need for a formal agreement with private providers to ensure that they also participate in m-PWS.

Some of the **obstacles encountered** during OR implementation were beyond the project's control: floods, the departure of the key investigators to pursue graduate studies, a series of elections, and lengthy delays in securing the necessary approvals to move forward. Other obstacles, however, could have been anticipated and/or addressed sooner: the need to switch the intervention area and the control area due to a dearth of private midwives in the original intervention area; the lack of monitoring to ensure that both the intervention and the control areas were submitting complete records on a regular basis; and insufficient oversight of the OR Research Partner to ensure accountability.

In spite of the problems encountered, the OR initiative has resulted in a number of **positive benefits**. By demonstrating the potential of mobile technology, it raised the awareness of stakeholders, including the USAID Mission, of the advantages of this technology and generated widespread interest within the PHO in using mobile technology for monitoring and tracking. In the KIIs conducted as part of the qualitative evaluation, both the head of the Rawa Buaya PHC and the West Jakarta Public Health Director expressed their desire to continue using a mobile system and to eventually replace the paper-driven system. Other PHCs in the project area are also clamoring for the technology. Another positive effect is the increased level of **community engagement**. More than 400 volunteers and community leaders are collecting data and as a result, community leaders say they have a much better idea of who is in their community. The Rawa Buaya staff also noted that this technology allows them to track people better and brings them closer to the people they serve.

CONCLUSIONS

Although the qualitative exercise did show that people hear health and nutrition messages from a variety of sources (e.g. via Hati Kami, from radio and television, and from the Internet), the results described above can largely be attributed to Hati Kami as there are no similar projects in the area that could have produced this combination of results. Overall, after reviewing and discussing the quantitative data and corroborating evidence from the qualitative evaluation and a detailed document review, the evaluation team concluded that **Hati Kami has been successful, achieving both of its Objectives and most of the intended results**. In addition, the project team has enhanced the original design described in the project proposal by achieving measurable results with the addition of innovative activities such as adapting SBMR for private midwives and providing financial advocacy training for community members.

Which elements of the project have been or are likely to be sustained or expanded?

Sustainability includes both ensuring that the positive effects of the program endure and that successful activities and initiatives are continued and scaled up. Among the **positive effects** that seem likely to continue based on discussions with mothers and MSG Motivators and Mentors are the following:

- Many mothers will continue the improved practices they have adopted and some will share what they have learned with friends and relatives.
- The private midwives and other health care providers interviewed stated that they plan to continue practicing what they learned during the trainings.
- Those trained in financial advocacy appear committed to continuing to secure funding for MCH activities in their communities during the annual budget cycle negotiations.
- The trainers trained in breastfeeding counseling and IYCF will continue to train others.

As for activities that are likely to continue, the MHO and IBI are already scaling up SBMR for private midwives throughout West Jakarta. And some MSGs will continue depending on the motivation of the Mentors and Motivators. As for m-PWS, there is strong interest in replicating this system in West Jakarta but a number of hurdles, including budget, need to be resolved.

What were the conclusions reached for the four Learning Themes?

The evaluation team consolidated their conclusions based on the quantitative and qualitative results:

1. Community Engagement

- The MSG is an effective forum for reaching people (especially women) with the right information.
- Hati Kami facilitated access to the community for the PHC staff, leading to higher attendance, better knowledge of population and its problems and greater achievement of PHC targets.
- Hati Kami brought private midwives closer to potential clients. As one midwife said during her KII: “I have become closer to the community.”
- Involving the community, especially RW and other leaders, resulted in increased local funding for maternal and child health activities.
- The CHVs and community leaders were highly visible during activities, lending credibility to the OR and building community capacity for data collection and analysis.
- Effective strategies for community engagement included: networking (e.g., PKK); training and capacity building for CHVs and community leaders; creating MSGs; and reinforcing public/private partnerships by involving private midwives

2. Service Delivery and Quality

- The project helped to increase the use of PHC service (sources: PHC staff and beneficiaries).
- There were quality improvements in services, especially for pregnant women and newborns both at PHCs and from private midwives (endline surveys and assessments)
- Strategies to promote use of services and to improve quality included: BCC via MSGs; use of improved data to locate pregnant women and mothers of children 0-23 months; training in maternal and neonatal care for public and private providers; introduction of SBMR, a self-monitoring tool for midwives; leveraging ongoing funding for maternal and child health services; and reinforcing the partnership with IBI.

3. Scale up and Sustainability

- MSG was scaled up.
- Motivators, Mentors, religious leaders, and community volunteers and leaders were trained to ensure the continuation of MSGs, with oversight and support from PHCs.
- SBMR was introduced to West Jakarta and is now being scaled up by the MHO and IBI for lasting improvements in quality health care.
- The use of mobile technology for LAMAT was piloted and the MHO is very interested in taking it to scale.
- Trained community leaders and other stakeholders plan to continue to lobby for increased local funding for MCH activities.
- Manuals were developed for MSG; m-PWS; and religious leaders.

4. Learning and Adaptation

- Operations Research: The Rawa Buaya PHC and the MHO want a mobile monitoring and tracking system to replace the manual system because it provides real time data, allows for cross-checking, provides more accurate population data and facilitates access to pregnant women and CU2.

RECOMMENDATIONS

Findings	Conclusions	Recommendations	Who is Responsible?
Gender: Project activities focus primarily on women.	There are missed opportunities to involve husbands and fathers in activities that would support their wives.	Develop additional outreach activities for men, using some of the strategies proposed in the midterm review of the BCC strategy.	Stakeholders who plan to scale up the MSG approach; those designing new MSG projects
Community leaders: Although community leaders are involved to some extent in social mobilization and m-PWS, there is no defined strategy to incorporate them for fully into design, implementation and evaluation.	Involving community leaders - elected, appointed, informal - more fully could increase the impact of the project and enhance sustainability.	Develop a series of seminars/trainings specifically for male and female leaders. Include an introduction to adult learning and behavior change at the beginning of the project.	Stakeholders interested in replicating or adapting the project design
Less than 15% of eligible women are members of an MSG.	There are missed opportunities to reach pregnant women and mothers of young children.	Work with health providers, community leaders, CHVs, and current MSG groups to determine why women are not enrolled. (This may include a barrier	Stakeholders who plan to scale up the MSG approach; those designing new MSG projects

Findings	Conclusions	Recommendations	Who is Responsible?
		analysis.) Develop strategies to overcome obstacles to enrollment.	
Motivators drop out for various reasons, often because they find full-time employment, move out of the neighborhood or become bored with the routine of the MSG meetings.	Frequent turnover disrupts the MSG, sometimes resulting in missed sessions and/or participants dropping out.	Identify Motivators with a strong potential for remaining with the program, e.g. the wives of community leaders who are less likely to move and female religious leaders.	Stakeholders who plan to scale up the MSG approach; those designing new MSG projects
The endline KPC survey showed that the majority of pregnant women report that they are not counseled on breastfeeding or maternal and child care during their pregnancies.	These missed opportunities for counseling could have a negative impact on pregnant women and their children.	<p>Conduct an analysis to determine why pregnant women do not receive counseling. Include PHC staff, pregnant women, CHVs, IBI, and private midwives in the analysis and problem-solving.</p> <p>Since the majority of pregnant women receive their care from private midwives, make counseling one of the mandatory competencies for private midwives</p>	<p>MHO, PHC staff, IBI and private midwives</p> <p>PHO, MHO, IBI</p>
Although BCC activities were taking place in the first half of the project, the strategy was not fully developed until Year 3.	A focused, comprehensive BCC strategy would be more effective if available early on in the project.	Ensure that the BCC strategy is developed within the first six months of project start-up and that it is based on formative research. Use LOAS or other cost-effective ways to periodically monitor the effectiveness of the strategy and to make course corrections as necessary.	Those designing new projects
Much of the data needed to answer the OR questions was missing or incomplete.	It was not possible to answer three of the six research questions, undermining the usefulness and applicability of the OR.	Put in place a rigorous system for monitoring and oversight of the OR to ensure that all the necessary data is available and of high enough quality to be useful.	Those designing and implementing future OR activities.