



Bidan Delima Accreditation:

***The Implementation of a Franchise Model in Regulating
Performance of Private Midwives in Indonesia***

A Case Study

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Glossary

List of Acronyms	Definition
<i>Askeskin</i>	Health Insurance Scheme for Poor
BD	Bidan Delima
BPS	Bidan Praktik Swasta
DHO	District Health Office
HSP	Health Services Program
IBI	Indonesian Midwives Association
J&J	Johnson and Johnson
JPS	Social Safety Net
<i>Jamkesmas</i>	Health Insurance for Public
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MCHN	Maternal Child Health and Nutrition
<i>Puskesmas</i>	Community Health Post
<i>Pustu</i>	Health Sub Centers
<i>Posyandu</i>	Integrated Health Post
<i>Program Pendidikan Bidan</i>	Midwifery Education Program
SSM	<i>Sentrong Sigla</i> Management
UPBD	Bidan Delima Implementation Unit
QA	Quality Assurance
QAP	Quality Assurance Project

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1. OVERVIEW OF CHMI

The Center for Health Market Innovations (CHMI) is a global network of partners that seeks to improve the functioning of health markets in developing countries with large numbers of private health care providers. CHMI works to accelerate the diffusion of Health Market Innovations that lead to better health and financial protection for the poor.

CHMI focuses on identifying, analyzing and disseminating information about the vast expanse of Health Market Innovations operating in developing countries. Health Market Innovations are programs and policies—implemented by governments, non-governmental organizations (NGOs), social entrepreneurs or private companies—that have the potential to improve the way health markets operate. These programs and policies enable the transactions that occur in the health care marketplace to lead to better health and financial protection, especially for the poorest and most vulnerable. CHMI categorizes programs according to five distinct program types – organizing delivery, financing care, regulating performance, changing behaviors, and enhancing processes. CHMI’s first level of program documentation consists of a standardized web-based template capturing key data points about each program (such as geographic coverage, target population, health focus, numbers served, etc.) In addition to map the Health Market Innovations globally, CHMI is conducting in-depth case studies designed to give readers a deeper look at the structures, activities, and impact of innovative programs.

In Indonesia, CHMI through **Mercy Corps**, works together with partners from the government, local and intercentral NGOs, for-profit and not-for-profit private sectors, and the community to facilitate knowledge sharing between donors, implementers, policy makers and researchers. The BD program was selected from a scan conducted over three months (Nov 2010-Jan 2011) of more than 100 innovative health programs in Indonesia. The program was selected to assess the adoption of a franchise model in regulating the performance of private midwives.

2. EXECUTIVE SUMMARY

Despite the recent economic growth in the country, maternal mortality in Indonesia remains amongst the highest in the world at 228 per 100,000 live births.¹ In addition to the barriers to free access of care and transportation, unsafe pregnancy and delivery methods also contribute to the high rate of maternal mortality. The high percentage of births assisted by unskilled attendants and insufficient emergency obstetric care are the major contributors to unsafe pregnancy in Indonesia. Overall, there has been an increased percentage (from 75.4% to 82.2%)² of births assisted by skilled birth attendants (SBAs) from 2007 and 2008, with the majority taking place in private facilities or with private midwives. In 2008, there were 68,772 midwives in Indonesia, about half with their own private practices³. By contrast, in the same year, there were 46,926 physicians in Indonesia⁴. The number of private midwives keeps increasing as midwives continue opening private practices as soon as they receive licensure (D'ambruoso, 2009).

2.1. The study

The BD Accreditation study was conducted by the Mercy Corps CHMI Team from January to March 2011 to research the adoption of a franchise model of the BD Program and to uncover how the model affects compliance with standards of care, and improves the quality of services delivered by private midwives. The team conducted interviews and reviewed reports on the program published by USAID-HSP and Johnson & Johnson. The Team conducted a field visit, in-person and phone interviews involving 11 participants consisting of donors, implementers, and the beneficiaries, representing public health, business, and midwifery professionals from BD, Ikatan Bidan Indonesia (IBI), StarH of USAID, HSP-USAID, and Johnson & Johnson.

2.2. The Findings

The decision-making process and types of incentives applied within the BD system are greatly affected by the Indonesian concept of “Organisasi Profesi” or “Professional Organization”. The concept implies that as health professionals, midwives provide quality health services to the public, and that in itself has its own “pride”. Hence, being a public servant should be the key factor driving the midwives’ intrinsic motivations to perform well⁵. BD program is run with the assumptions that the BD midwives have the intrinsic motivations and therefore, the

¹ See <http://www.measuredhs.com/pubs/pdf/FR218/FR218%5B27August2010%5D.pdf> (accessed on 1 March 2011)

² Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan RI (2010) *Riset Kesehatan Dasar*. .

³ See Indonesia Demographic and Health Survey, Badan Pusat Statistik, 2007

⁴ See www.idionline.org (accessed 1 March, 2011)

⁵ Akademi Kebidanan Stikes Cut Nyak Dien Langsa, “Kelompok Etika dan Profesi,” working paper, 2010

program should work with or without the monetary incentives. Currently, most BD implementers remain working on unpaid voluntary basis. The Study Team found that this assumption might have contributed to the reduced motivation amongst BD midwives to perform. The Team indicated the need to find effective monetary incentive schemes for the volunteers amongst the BD midwives management team known as *Bidan Delima* Implementation Unit (UPBD) and implementing facilitators at the province and district level to stimulate active monitoring and reporting.

In addition, the interviewees mentioned the decision-making process within the UPBD at national, provincial and district level is not instructive but rather suggestive⁶. The Study Team indicated that lack of clarity within the 'suggestive' decision-making processes might be a contributing factor to why the dual functional managerial roles at IBI and BD at the province and district levels remain an issue.

The Study Team found the need to revisit the program output in the initial design and assess whether the outputs intended reflect the social and business impacts of the Social Franchise Model. Based on the interviews, the program performance indicators appear to aim solely towards the compliance of the standard of care and not necessarily the number of caseloads. Social Franchise model in health programs is adopted mainly to improve access to quality health services for the public (as the provision of quality health services is argued to be the right for everyone). The adoption of Social Franchise models such as with the BD model has business implications to it because the beneficiaries (the BD midwives) have the potential to increase their income by increasing the number of caseloads after being certified as the BD midwives. Consequently, the BD midwives have the tendencies to associate their satisfaction indicators with the BD program into increased number of their caseloads. Therefore, the program design needs to address whether the output intended should include the number of caseloads in addition to the compliance of standard of care.

The Study Team found a gap between the designed BD program output, which is compliance with standards of care, and the midwives' perceptions about how they would benefit as certified BD midwives. There appears to be 'false expectations' amongst the BD midwives about the assurance of getting more caseloads after becoming BD midwives, although the BD accreditation model performance indicator aims toward compliance with standards of care, not necessarily the increase in the number of caseloads. In the case of BD, there is not yet any mechanism, nor has there been any evaluation, that could prove a direct association between compliance with standards of care and the increase in the number of the midwives' caseloads. For example, the midwives who got more caseloads than others were found to have already been 'popular' even before they became BD midwives; therefore it was unclear whether the pregnant women (end users) especially in the villages, were more driven by

6 Asmilia Makmur. Personal Interview. (March 21, 2011)

the quality (midwives who comply with the standard of care) or popularity of the midwives. Consequently, this gap has significant influence on the decision of BD midwives to pay membership fee and ultimately decide on renewing their memberships. Therefore, the Study Team suggests combining monitoring of compliance with 'word of mouth' marketing strategies to address this gap from both sides.

Based on our study findings, the study team devised the following recommended action plan:

1. Infuse "*Word of Mouth*" sharing of experiences marketing approach into the BD program to increase the visibility of the quality of BD midwives and to improve public recognition of the brand.
2. Conduct assessment on the most effective social media and implementation of media marketing. Despite the use of media to date, BD is not yet highly valued by midwives and pregnant women. There is a possibility that the BD market audience is more sensitive to a certain type of media and the duration of the marketing program exposure. In the Indonesian context, literature suggests a communication strategy that targets the decision makers on pregnancies, including the relatives and husbands.
3. Provide incentives to motivate the facilitators to conduct monitoring of compliance with the standards of care.
4. Conduct routine process and outcome monitoring. At the core of a successful franchise model is regulation and monitoring.⁷ Based on the interviews with key respondents, there is a dire need to ensure the promptness, frequency and accountability of the monitoring and evaluation process of the BD franchise.
5. Develop and improve partnership with private hospitals and doctors for endorsement.

⁷ See <http://www.measuredhs.com/pubs/pdf/FR218/FR218%5B27August2010%5D.pdf> (accessed on 20 March 2011)

3. BACKGROUND AND COUNTRY CONTEXT

3.1. Era of Health Innovation

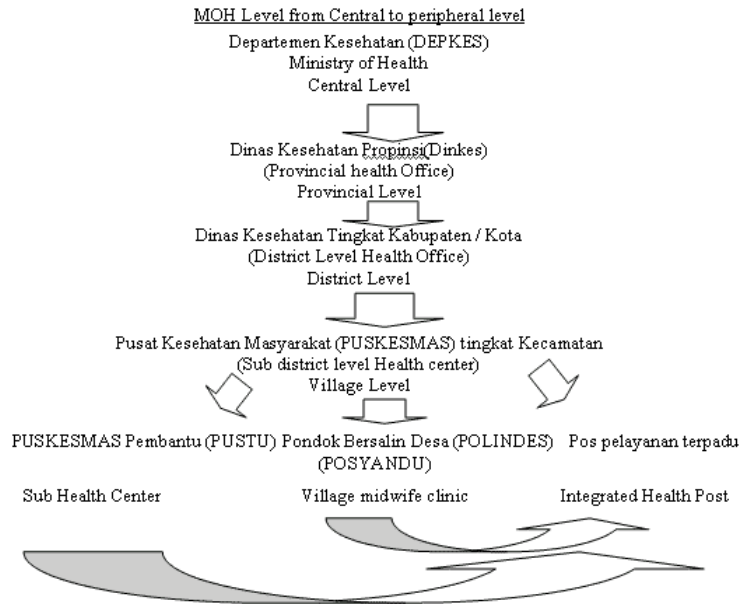
Indonesia, like other developing countries in the region, is on the brink of major health improvements. With constant economic growth and increasing commitment from the government, private sector, and the community to meet the needs of the country's citizens, health care and health programs in Indonesia are poised for a major breakthrough. This is true for many types of interventions - from communicable disease tracking, mobile health insurance, cross-subsidized private hospitals, palliative care for cancer patients, to accreditation for quality midwives.

The term 'Health Innovation' itself is becoming familiar in healthcare circles but it remains ill-defined and unheard of in a broad context, especially by those who remain living below the poverty line and do not have access to health services they need. Stakeholders argue that superior 'Health Innovation' has the potential to enhance operations, regulate performance, change poor behaviors, finance health care, and improve quality of services, namely for the poor.

3.2. Health System

The Indonesian health system became decentralized in 2001 following the passage of the regional (district) autonomy law in 1999 as one of the early products of the governmental reform era. The locus of local health care services are now at the sub-district level where the local community is served by sub-district health posts known as *Puskesmas*, mostly managed by doctors. To further reach local community members, there are usually two or three sub-health centers or *Pustu* at the village level which are administered by nurses. The organizational structure can be seen in the figure below. Private hospitals are also present at the village level, working hand-in-hand with the health providers at *Puskesmas*. These private hospitals are run by various entities such as private clinics owned by physicians and midwives, religious based organizations (*Muhammadiyah* foundation for instance), and local NGOs (such as a low cost, quality clinic run by *Yayasan Kusuma Buana* and HIV/AIDS clinic runs by NGO *Hati-Hati* in Bali).

Figure 1: Organizational Structure of Health System⁸



Source: www.searo.who.int

Networks of private health providers are a promising mechanism to expand the supply of quality health services as they achieve economies of scale in training, procurement and marketing, and allow for rapid expansion to increase coverage, improve financial access by standardized prices, and ensure quality and brand recognition.⁹

3.3. Assuring the quality of midwives in Indonesia

Despite the recent economic growth in the country, maternal mortality in Indonesia remains amongst the highest in Asia, with the central statistic at 228 per 100,000 live births.¹⁰ In addition to the barriers to free access of care and transportation, unsafe pregnancy and delivery methods also contribute to the high rate of maternal mortality. The high percentage of births assisted by unskilled attendants and insufficient emergency obstetric care are the major contributors of unsafe pregnancy in Indonesia. Despite the increased percentage of births assisted by skilled birth attendants (SBAs) from 2007 and 2008, from 75.4 to 82.2, there is a huge gap between the areas with the

⁸ ibid

⁹ USAID, "Private Health Sector in Indonesia: A Desk Review", 2009.

¹⁰ See <http://www.measuredhs.com/pubs/pdf/FR218/FR218%5B27August2010%5D.pdf> (accessed 21 March 2011)

lowest and the highest percentage in Indonesia.¹¹ According to a research study by Riskesdas in 2010, only 8.7 % of live births were assisted by SBAs in Sulawesi Tenggara, compared to 94.5% in Yogyakarta province in Central Java.

In the past years, private midwives keep growing in numbers. By 2008, there are 68,772 midwives in Indonesia and about half of them with their own private practices¹². To regulate quality of services given by private midwives, Indonesian Ministry of Health set up a minimum requirement¹³ for midwifery private practice. However, the government standards were not equipped with a monitoring mechanism and means to improve midwifery skills. This is indicated by inadequate skills in managing complications such as bleeding, infection and eclampsia. In 2004, 60 percent of maternal deaths were caused by these obstetric complications¹⁴.

Perhaps, lack of skills amongst midwives could be associated with inadequate professional training and education. In the early 1980s, midwives only attended a one-year program in midwifery schools or two years training of *Program Pendidikan Bidan* (midwifery education program) between the year of 1989 to 1998¹⁵. Most Indonesian midwives still do not update their knowledge and skills, and fall behind on meeting inter-central technical standards¹⁶ which include three years of training and other care such as infection management, counseling on family planning methods, and post-partum care to avoid post-partum hemorrhage. Thus, the BD program is responding to the need to enhance and certify midwifery competencies.

3.4. Health Financing

There have been a series of attempts to increase health funding, particularly for the poor such as the 2004 "Health Insurance for the Poor" program or *Asuransi Kesehatan Masyarakat Miskin (Askeskin)*. This program was instituted as a new health care system for the poor to replace the former *Kartu Sehat* which was part of the Social Safety Net Program. *Askeskin* included access to in-patient services in private hospitals. This program then evolved into the Community Health Insurance program or *Jaminan Kesehatan Masyarakat (Jamkesmas)* in 2008.

Maternal health services are included in *Jamkesmas* coverage. However, in the coming months of 2011, the services for maternal care will be covered by a specified scheme called *Jampersal (Jaminan Persalinan=Delivery*

¹¹ Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan RI, "*Riset Kesehatan Dasar*", Indonesian Ministry of Health 2010

¹² Indonesia Demographic and Health, Biro Pusat Statistik, 2007

¹³ Government regulation No 900/2002 (22) noted pre-required facilities a midwife should have before opening their private practices. They include examination room, beds, obstetric equipment and standardized documentation using partograph as well as pregnancy monitoring and tracking document.

¹⁴ Peter Heywood, Y. C., "Health System Performance at the District Level in Indonesia after Decentralization." *Intercentral Health and Human Rights*, 10 (3), 2010

¹⁵ Frankenberg, E., Suriastini, W., and Thomas, D, "An expanding access to basic health care improve children's health status? Lessons from Indonesia's 'midwife in the village' program." *Population Studies*, Vol. 59, No. 1, 2005

¹⁶ USAID (2009), p. 34

Insurance) currently under finalization within the ministry of health. Unlike *Jamkesmas* that is only for the poor, *Jampersal* will be available to finance antenatal care, delivery assistance, and postnatal care for all women, regardless of their economic status. *Jampersal* is reimbursement based financing, thus health care providers have to be registered at the respective area health office to be able to reimburse their relevant expenditures. *Jampersal* is available for women from any economic status, but the rates covered in the scheme are equal to the rates in third class service expenditures.

In addition to government sponsored insurance, other forms of financing are provided by intercentral donors. In 1996, the World Bank implemented a pregnancy voucher program in Pemalang district Central Java. The vouchers were distributed by midwives to poor pregnant women. During the project period, the number of district midwives doubled and midwives' coverage of villages reached 95%.¹⁷ Private low-cost health insurance in Indonesia is rare.

4. MODEL OVERVIEW OF BD

INPUT	ACTIVITIES	OUTPUT	MONITORING at Central, Provincial, District level
Midwifery Standard of Care	Enrollment of BD Membership. New members receive modules, apron and pins, decision making tool for family planning, signage.	Compliance with the standard of care	Level of compliance
	Training about the standards	Empowered and proud midwives (midwives who put high value on the brand and accreditation)	Number of private midwives recruited and number of midwives maintain their BD membership
	Monitoring compliance		

¹⁷ World Bank. "Investing in Indonesia's Health: Challenges and Opportunities for Future", *World Bank*, Jakarta, 2008.

5. ACCREDITATION MODEL OF BD

5.1. Background and History

The obligations to provide access to quality health services including the means of safe birth deliveries (attended by Skilled Birth Attendants) have long been argued to be the responsibility of state actors. In reality, the “fulfillment of the right to health is a multi-stakeholder task”¹⁸ namely the task of the government, private sector, NGOs, and the community. The role of the private sector and NGOs is even more apparent in developing countries such as Indonesia, where the obligations to provide quality health services are often shifted from the government to the non-state actors, due to lack of resources, namely funding. BD Accreditation is an example of an innovative program addressing the poor quality of midwifery services, filling the ‘shifting’ gap that is currently unable to be filled by the government.

5.1.1. The Birth of BD

In order to address quality assurance, the Indonesian Midwives Association (IBI) and USAID started a program called BD (BD) in 2003. BD program was started with a franchise model of IBI as a strategy to regulate the performance of private midwives. IBI is the private institution that sets and ensures adherence to standards for safe pregnancy and delivery practices among private midwives in Indonesia.

Franchising has been heralded “one of the best mechanisms in ensuring quality¹⁹” of health services. The franchise model not only specifies “social outcomes that are desired but also forms a partnership with the provider to help them achieve the outcomes by training, overseeing quality, and assisting with media outreach such as trade-marking and branding to mobilize care-seeking by the poor.”²⁰ With accreditation as the product of the franchise model, IBI and USAID aimed to regulate the performance of the BD private midwives with the same standard of practice adopted in IBI. Hence, the BD program adopted the standard of care of IBI.

In 2003, IBI adopted the minimum requirement of the midwifery practices from MOH into its standard of care²¹. To enhance the available standard, USAID-STARH gave technical assistances to IBI on clinical and management standards. USAID-STARH hired the *Jaringan Nasional Pelatihan Klinik Kesehatan Produksi* (JNPK/ central network on obstetric health) to develop modules on clinical standards of competence and to conduct the trainings, focused

¹⁸ K.M. Leisenger, “The right to health: What role for business?” Partnership for women’s health: Striving for best practices within the UN Global Compact, 99, 2009.

¹⁹ Montagu, Dominic, “Franchising of health services in low-income countries”, Health Policy Plan 17 (2): 121-130.2002.

²⁰ See http://www.hcs.harvard.edu/~hhpr/currentissue/184197%20Health%20Highlights_Bishai_edited.pdf (Accessed 21 March 2011)

²¹ For detail information on BD Standard see ch. 3

on twelve areas, including clinical infrastructure and equipment, instrument and essential newborn care, postpartum care, general family planning services for new users, contraceptive services for pill, injectable, IUD and implant methods²². In the following year, BD program adopted the standard of care from IBI.

Additionally, USAID-STARH and the follow-on USAID-HSP initiative assisted IBI to develop the management of BD. Incrementally; both organizations are continuing to develop technical and other pertinent guidelines, particularly on prequalification to support the BD midwife recruitment process.

At its inception in 2003, the program was implemented in six provinces (DKI Jakarta, West Java, Central Java, East Java, North Sumatera, and South Sulawesi). Two years later (2006), the area of coverage was expanded to include new provinces (Bali, Yogyakarta, South Sumatera, Aceh and Banten province). Up to 2009, BD is presence at 15 provinces as Lampung, Bangka Belitung, West Sulawesi and West Kalimantan joined the program.

5.1.2. Management and Scope Reconstructions

In 2005, BD midwife qualifications was expanded from solely reproductive health, such as the completion of APN (normal delivery care) and contraceptive technology, to a broader set of technical qualifications including newborn care, early initiation of breastfeeding, active management of the third stage of labor, and manual removal of the placenta; and supportive supervision skill for monitoring and mentoring. These qualification changes occurred when the donor shifted from USAID-STARH to-USAID HSP April 2005.²³

As a result of a review of BD program supported by USAID in 2010, UPBD was reconstructed and separated from IBI Board Structure.²⁴ The separation was considered necessary as the BD program would require more specific administration procedures in their day-to-day operations. It was expected that UPBD could operate independently and establish its own financial management system in addition to the monitoring and tracking systems, as well as standardized tools and guidance used for assessing candidates' qualification.²⁵ Yet, the separation process proved to be more complicated than expected, particularly in the issue of UPBD's capacity to be independently viable. The interviewees indicated that the financial management currently remains centralized at district, province, and central level while the operations management is centralized only in the central level.

22 USAID-HSP." BD Evaluation Program. " USAID, Washington D.C., 2008

23 USAID. " Evaluation of Health Services Program (HSP) program in Indonesia: Taking Stock and Look Forward". Washington D.C, 2008.

24 USAID-Indonesia, Final Report 2005-2010, page 41.

25 Pola dan Kebijakan Pengurus Untuk Unit Pelaksanaan Bidan Delima,

5.1.3. Franchising Model

In the search to increase membership enrollments and to assure the quality of services delivered, the donor and the primary implementer needed to find a suitable recruitment approach.²⁶ There were two business approaches considered at that time: Multi-Level Marketing (MLM) and Franchise.

The MLM system is known as a sales force where the sales person generates income using their personal relationship to recruit distributors and down-line²⁷. It works through relationships, referrals and word of mouth marketing. If BD were to adopt the MLM, according to Damaryanti, the number of BD candidates could increase but it would be difficult to assure the qualification of the candidates as per BD standard. The MLM strategy could not work to systemize quality assurance and standard of compliance as the recruitment would be based on personal reference.²⁸

Franchising refers to 'a contractual relationship between a franchisee (small business) and a franchisor (usually a larger business) in which the former agrees to produce or market a product or service in accordance with an overall 'blueprint' devised by the franchisor'²⁹. A social franchise is different to business franchise like McDonalds (Montagu, p.122). In a social sector such as health, a franchise is designed as additional services/products to an existing business and using their existing business assets. In the business world, a franchise model is known as the most effective tool to recruit. With well-defined standards followed by continuous training and monitoring; franchising in health services can establish quality assurance³⁰. Additionally, the study also shows that grouping the existing providers under a franchised brand, supported by training, advertising and supplies is a potentially important way of improving access to and assuring quality of medical services³¹.

In the health services, franchises can be adopted to serve 3 ways: assuring the availability of services, the quality of services, and the awareness and use of services³². Damaryanti explained that the BD program provides their clients with guidelines and modules on the quality assurance, brand, mass marketing, trainings and monitoring-evaluation. The guidelines and modules of quality of assurance will give direction for the BD midwives in delivering their care. The quality is then assured through a thorough recruitment and monitoring-evaluation process.

26 Damaryanti, Suryaningsih. Personal interview. (February 21, 2011) .

27 Xardel, Dominique., "The Direct Selling Revolution. Understanding the Growth of the Amway Corporation," Blackwell Publishing. pp. 1–4.1993

28 Ibid, p. 4

29 Stanworth J, Price S, Porter C, Swabe T, Gold M, "Franchising as a source of technology transfer to developing economic." Social Studies Series, No 7, ed. I.F.R. Center. Vol. 7, 1995 , University of Westminster Press.

30 See <http://rru.worldbank.org/documents/publicpolicyjournal/263Ruste-063003.pdf> (Accessed 18 March 2011)

31 Montagu, Dominic, "Franchising of health services in low-income countries" ", Health Policy Plan 17 (2): p. 123. 2002.

32 Ibid, p. 132

5.2. Business Model

BD (BD) is a **branding** program targeting the certified **private midwife practitioners** (proven through a valid midwifery license/SIPB). The program creates demand for quality midwifery services alongside a certification program that recognizes those midwives as BD members³³. The program aims to improve the quality of midwife service delivery according to the **central clinical standards** with respect to **family planning, infection prevention and safe deliveries**³⁴. It also aims to improve the competence of private midwives to have standardized skills, aptitudes, equipment, clinical facility, and management according to Indonesian Ministry of Health regulation on midwifery practices³⁵. The compliance will be assured through a routine and prompt monitoring and evaluation; in this way, BD brand will be recognized for its safety and satisfaction.

In addition to the donors, there are three entities involved in implementation of BD program: (1) Indonesian Midwives' Association (IBI) as the Franchisor (2) BD program as the Franchisee (3) private midwife practitioners (*Bidan Praktek Swasta/BPS*) who become the program beneficiaries.

Ikatan Bidan Indonesia (Indonesian Midwives' Association/IBI) was chosen as the Franchisor by USAID-STARH based on its strategic network and great influence within the Indonesian midwives community³⁶. IBI board consists of retired and semi-retired midwives who oversee their midwives colleagues consisting of those working for the government, practitioners (work for government and open private practices), pure private practitioners (BPS *murni*), and midwife educators at training centers/midwifery schools.

IBI's role can be divided into two (1) regulating midwifery licenses (2) monitoring the standard of operation³⁷. As a professional organization, IBI becomes the sole entity authorized for regulating and awarding midwifery practice licenses in Indonesia³⁸. In order to obtain a midwifery license after graduating from the midwifery schools, a midwife must first be registered as an IBI member. Upon her registration, the midwife should pass an aptitude test on MCHN and Family Planning knowledge as well as on-site inspections if the midwife wishes to open private practitioners (*Bidan Praktek Swasta/BPS*)³⁹. The midwifery license should be renewed every five years. The renewal is contingent upon the midwives' satisfactory to gain enough credit points through series of trainings⁴⁰.

33 See http://www.jsi.com/Managed/Docs/Publications/HealthCareServices/hsp_fy07_annual_report.pdf (accessed 23 March, 2011).

34 See http://www.jsi.com/Managed/Docs/Publications/HealthCareServices/hsp_fy07_annual_report.pdf (accessed 23 March 2011)

35 Panduan Umum BD, p. 33

36 Damaryanti Suryaningsih, Personal Interview. (February 21, 2011).

37 USAID-HSP, "Panduan Umum BD," 2010. p: 1-3

38 Haryani, Nuni & Sanusi, Rossi. "Penegakan Kebijakan Registra Dan Praktek Bidan Swasta Di Kota Jambi," Working Paper Series KMPK Universitas Gadjah Mada, No. 25 Juli 2006, First Draft; p.1-7

39 Ibid, p. 6

40 USAID. "BD Evaluation Program. " Washington D.C., 2008

This is when traditional monitoring mechanism conducted. In 2008, IBI has more than 53,000 members of which about 30,000 are private midwives (pure private and dual practitioners).⁴¹

The decision-making process and types of incentives applied within the BD system are greatly affected by the Indonesian concept of “*Organisasi Profesi*” or “Professional Organization.” The concept implies that as health professionals, midwives provide quality health services to the public, and that in itself produces its own “pride” and values and is the key factor driving the midwives’ intrinsic motivations to perform well. BD program is run with the assumptions the BD midwives have the same intrinsic motivations and therefore, the program should work without monetary incentives. In addition, the interviewees mentioned the decision-making process within the BD system is not instructive but rather suggestive.⁴² Thus, the suggestive nature rather than instructive is reflected in the operation processes as well as the working relationship between IBI and BD.

5.2.1. Accreditation Tools: The Standards

The BD program creates and implements a system for the quality assurance of private midwife practitioners. It adopts the quality and safety standards of Indonesian Ministry of Health which then is combined with clinical management skills that has yet to be regulated by existing standards⁴³.

The MoH regulation no 1464/2010 succinctly explains the minimum standards for private midwives practitioners establishing their practices. It is stated that a private midwife practitioner should provide their own house of birthing, chamber divisions, provision of waiting room, examination room, partum and room for post-partum care, available running water, supply of regulated medications, a complete equipment for preventing infection, a maximum of maternity beds and midwifery care equipment, basic medical equipment, medication and a complete requirement for family planning⁴⁴.

To help meet the clinical management needs of private midwives, BD enhances the existing standards with additional guidelines on clinic management. The management guidelines include financial tracking, compliance on medical record tracking, daily journal, inventory system for medical and non-medical equipment, and archiving the procedural documentations related to informed consent, antenatal and post natal, family planning, registrar, neonatal care, referral, birth certificate, death certificate, maternity leave, and drugs requisitions⁴⁵.

41 Ibid, p. 19

42 Asmilia Makmur. Personal Interview. (February 12, 2011)

43 Indonesian Ministry of Health regulation no.900/ 2002 of midwifery standards focuses on quality and safety in performing maternal and neonatal care, family planning, and public health but has yet touching the issue of clinical management.

44 Haryani, N. and Sanusi, R,” Kebijakan Praktek Bidan. Penegakan Kebijakan Registra dan Praktek Bidan Swasta di Kota Jambi,” Working Paper Series KMPK Universitas Gadjah Mada, Yogyakarta, Indonesia No.25, 2006,

45 Panduan Umum BD. P. 20-23

The modules developed provide detailed information for candidates to conduct self-learning in the clinic management, the use of *partograph*, equipment, tools and medication, guideline to prevent infection, family planning services, antenatal care, normal delivery, neonatal care, antenatal care and follow up. In addition, JNPK also created a validation instrument that will be used by facilitators when conducting assessment to BD candidates and also an instrument to assess compliance.

USAID-STARH and IBI also created the management guideline for program implementation that supports the whole program. The management guideline consist of technical guidance for the BD central management, provincial and district level in facilitating establishment of the BD unit, financial and logistics management, fundraising and advocacy, promotion and marketing of BD program, monitoring the program and lastly Information management system⁴⁶.

As soon as modules and instruments were completed, the BD Implementing Unit (UPBD) was next to being established. The UPBD is the entity in charge of conducting the day to day BD management. Technical guidance of BD for central, provincial and district UPBD consists of pre-qualification forms, self-learning modules for BD candidates, validation instruments for facilitators in assessing the candidates, facilitator guidance for recruitment purposes, and assessor instrument and guidance to validate compliance⁴⁷. Those tools will be used as standard during recruitment, validation and monitoring process⁴⁸.

5.2.2. Activities: Membership, Trainings, and Monitoring of Compliance

BD recruits private midwives. For the recruitment, nine IBI midwives who serve as representatives for the midwives of North Sumatra, South Sumatra, West Java, Jakarta, Yogyakarta, Central Java, East Java, Bali and South Sulawesi were trained as midwife facilitators. Once the training is complete, the next step is to recruit practicing midwives and encourage them to become candidates for BD⁴⁹. Those trained facilitators then inform the private midwife practitioners in each province about the program. Following the dissemination, facilitators engage in an interactive dialog about the BD program. By the end of the dialog, the interested midwives were invited to register as candidates⁵⁰.

BD management trains their members in technical and business administration and also equips their management team with the monitoring system⁵¹. Once the logistic is ready, the BD facilitators at provincial and district level

46 Ibid, p.21

47 Ibid, p.22

48 BD management will be discussed in Human Resources section

49 See <http://www.adb.org/Documents/Books/NGO-Workshop-Studies/NGO-Workshop-Studies.pdf> (accessed 4 March 2011)

50 Ibid

51 Ibid.

received various trainings on standardized clinical management of private midwife practitioners to validate and assess the candidates' skills and capacities⁵².

The recruitment process of a BD midwife is as follows. It starts when a private midwife practitioner proposes her candidacy to be a BD midwife and takes a pre-qualification test. Next the candidate is given self-learning modules on the BD program. Then the facilitators validate the candidate's aptitude and understanding of the BD standards. BD certification is given to those who pass the aptitude test and the facilitators continue their mentoring process until the new BD midwife is ready to work on her own. Those who pass the test pay the first membership fees of IDR 350,000 (USD 40) and in return are certified and authorized to post the BD logo on their name boards. To keep their membership, BD midwives pay as much as IDR 250,000 (USD 28) annually⁵³. The certificate is good for up to five years, at which point they need to renew the certificate.

To maintain their quality assurance, BD has a monitoring and evaluation mechanism to validate and assess the level of compliance of their midwives; the M&E should be conducted every three months by district facilitators⁵⁴. For validity purposes, the M&E is conducted as cross-district monitoring, which is randomly verified by the central BD management.

5.3. Human Resources

5.3.1. Management Team at district, province, and central level

The BD management is comprised of three managerial layers namely unit *pelaksana Bidan Delima* (UPBD): (1) central implementing unit, (2) provincial implementing unit, and (3) district implementing unit. BD activities at each layer should be coordinated with the IBI chairwoman at central, provincial and district level. The coordination structure can be seen on the following page (Figure 3). The central implementing unit, at the top, is chaired by a General Manager who oversees the Quality Assurance Manager, BD System Development Manager, HR Manager, Finance and Accounting Manager, Administration and Logistics Manager. The provincial unit functions as hub between the central and district units; it is chaired by a Province Manager who supervises an Assistant Manager for Quality Assurance and Training, and Assistant Managers for Finance, Accounting, Logistics and Administration. At the lowest level, the District Manager supervises Recruitment, a Monitoring Supervisor, as well as an Administration and Finance Supervisor. The recruitment and monitoring supervisor has several facilitators that are supported by administration staff⁵⁵. The interviewees indicated double-function managerial roles occurred at the

52 USAID-HSP, "Health Service Program, Final Report 2005-2010," Washington D.C. 2010

53 Asmillia Makmur, Personal Interview. (12 February 2011)

54 For detail process of monitoring and evaluation see discussion on performance monitoring (chapter:4).

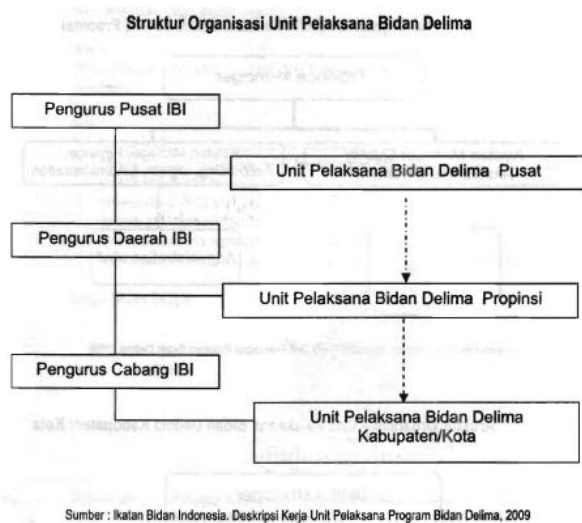
55 Panduan Umum BD. P. 14-16

province and district level as the same individuals serve two positions as the Province Managers and representatives of IBI.

5.3.2. Implementing Facilitators and Assessors

At central level, a Master Assessor is responsible to conduct trainings on the standard of care for the Assessors at the provincial level and reports to the Quality Assurance Manager at the central level. At the provincial level, the Assessor trains the facilitators at the district level and reports to the Province Managers at the province level. At the district level, the facilitators monitor the progress of the implementation and real situation at the district level and report to the Recruitment and Monitoring Supervisor at the district level.

Figure 3: Organogram of BD Management⁵⁶



5.3.3. Volunteering system

In the structure above, all personnel work in voluntary basis except for the UPBD located at the central level.⁵⁷ The management team at the central level was created as a result of the separation decision made in 2010, and includes: a General Manager who supervises a Quality Assurance Manager, HR& BD System Development Manager, Finance & Accounting Manager, and Administration & Logistic Manager.

⁵⁶ Ikatan Bidan Indonesia, "Deskripsi Kerja Unit BD ", Jakarta, Indonesia, 2009. Translated title:

(1) Pengurus Pusat IBI (IBI national management) , (2) Pengurus Daerah IBI (IBI provincial management), (3) Pengurus cabang IBI (IBI district Management). Translation 2: Unit Pelaksana Bidan Delima Pusat (BD National Implementation Unit), Unit Pelaksana Bidan Delima Propinsi (BD provincial implementation unit), Unit Pelaksana Bidan Delima Kabupaten/Kota (BD district implementation unit).

⁵⁷ Asmilia Makmur, Personal Interview (February 12, 2011)

5.4. Target Population

Target population of BD program is defined by area of coverage instead of number of midwives recruited. The selection was based on several criteria such as (1) provinces with the largest private midwife practitioner's presence (2) institutional a readiness to manage the program (3) additionally, USAID-STARH added the population density as other selection criteria. Based on these criteria, BD selected six provinces (West Java, Central Java, East Java, North Sumatra, South Sumatra and DKI Jakarta) to initiate the program.

As of 2010, BD exists in 15 provinces and their target area will expand to an additional six provinces (West Sumatra, Riau, Bengkulu, Jambi, Pekanbaru, Padang, and Southwest Sulawesi, Riau Kepulauan) in 2011.

Figure 4: Distribution of BD 2003- 2011



Source: Indriati, L., 2011. Distribution of BD. Mercy Corps, Jakarta.

5.5. Challenges

Validity of the Monitoring Mechanism

As a part of the activities in the model, facilitators of BD (appointed and received proper facilitator trainings from amongst the BD midwives) conduct the monitoring of compliance of standard of care. This process is done by conducting periodic site visits to the clinics and monitoring the real situation against the monitoring checklists. Monitoring activity by design should be done through a cross district visit to assure its validity. However, such mechanism has never taken place due to facilitators' time conflicts. A facilitator often has so many other activities they have to do: from running their own clinics takes part in the IBI membership as well as BD, and other civic activities. To prepare a cross-district will require more time for coordinating, planning and executing. As a consequence, the monitoring activities have been done through friendly visit to their own mentees. "Taking advantage of a friendly visit as opportunity to conduct monitoring activity is easier and convenient for facilitators and mentees," said one of the interviewee who is a district facilitator for Johar Baru, Central Jakarta.

Such monitoring mechanism raises question about monitoring validity of how can ones assures the objectivity of their judgment.⁵⁸ Our interviewee also stated the needs to do assessment on compliance to know the current program achievement.

Volunteerism based on intrinsic motivation may not be sufficient to stimulate performance

The Team found that the assumption of intrinsic motivations discussed in the earlier sections appear to be insufficient in stimulating the performance of the facilitators at the district level to monitor and report the progress of the implementation and the real situation to the provincial level. Asmilial Makmur stated that there are currently only three out of fifteen provinces (East Java, South Sumatera, and Central Java) that sent their M&E reports to the UPBD at the central level. The facilitators at the district level responsible for monitoring the activities and progress implementation of the BD midwives at the district level are currently unpaid and often have other priorities such as conducting enrichment trainings, board members regenerations and campaign that consume most of their time. This may as well be the case for the UPBD team at the province and district level who may not be stimulated by the intrinsic factors to manage the BD program better.

Weak Market Positioning of the Brand

USAID-HSP evaluation on BD Program (2008) found low brand recognition of BD among the clients of private midwife practitioners. "Only one in five clients they interviewed in Palembang had heard of BD midwives (p.3).

⁵⁸ Asmilial Makmur, Personal Interview, (February 12, 2011)

From overall respondents (n=220), almost half of them did not know how BD midwives are different than other midwives (p.3). Such condition will cause constrain to expand demand of quality midwifery services offered by BD midwives (p.2).

Similarly, Johnson & Johnson (2009) found 33% of respondents out of a total of 200 respondents claim they are unaware of the program. Those who are not aware of the BD program are mostly younger at age (20-35 years). Yet, there is still a chance in penetrating and influencing the unaware to use BD services as the research found of two other clusters of groups of those who are aware but has yet tried (25%) and those who are aware and tried (43%). They suggested that BD program needs to identify clarify its positioning as mostly clients do not use BD service due to (p.35) its high cost and rare availability. Thus, the brand positioning should be clear whether they would like to maximize quality or minimize the cost.

Similarly, five of interviewees in Wonosobo and North Jakarta told that the existence of BD does not affect clients' preferences in choosing midwifery services. Most of the clients prefer going to midwives they familiar with, or recommended by other family members, or a fanatic client. Brand is the least factor they care about when choosing midwives services. The interviewees confirmed they have never experienced increase of case-loads after becoming BD members. It creates doubt whether they will renew the membership once it is expired next year.

Three interviewees confirmed their interests to become BD members due to curiosity and passion in organization. One from the three respondents noted that she is still trying to figure out what could she get from the program as she had only one time of monitoring from her sixth years of membership. Similarly our interview in North Jakarta who has heard of BD program but does not have interest to become a member as her BD colleagues do not experience increase of clients. Additionally, she often saw and heard from others that her BD colleagues do not follow the standard of compliance and did a lot of mistakes. Such thing, according to her, should never happen or at least can be minimized especially with the quality assurance that BD program promoted. When questioned whether or not she feels confident on her midwifery practices, she claimed to be confident enough with her compliance to IBI minimum standard which she can do without being a BD member.

Midwives expectation vs. the designed output

The interviewees indicated that BD midwives expect to be more recognized after becoming the BD midwives and possible increase more caseloads than before. However, there might not be a direct association between having more exposure in the public as a more qualified midwife and the likelihood of getting more caseloads. Furthermore, the direct output of the accreditation model of BD is the compliance of the standard of care and not necessarily in the increase of the number of caseloads. Most of BD midwives who were seeing more clients,

according to The USAID study are already working in busier practices prior to their memberships. Both J&J and USAID studies suggested that unsatisfied midwives are likely to discontinue their memberships and affect the other potential BD midwives become more unenthusiastic to propose their candidacy.

The need for financial support

Our interviewee also suggested that more funding availability and its flexibility for conducting community practices or cross learning, also provision of technical assistance in term of management coaching and M&E, learning about other models, better support from the government can help BD program to overcome those challenges. It is now assessed the possibility to advocate BD program to be sponsored by government⁵⁹. However, Damaryanti noted if the program would have been adopted by government, the franchise model implementation would be changed altogether. Government would prefer to make BD as a central adoption like the one in Philippines. Changing the model, according to her, can potentially add new problems since BD ought to develop a new quality assurance mechanism.

6. IMPACT

Indicators of Performance

The monitoring and evaluation of BD program is conducted by the staff of IBI every three months. The M&E plan focuses on the compliance of the standards in the (1) UPBD at provincial level, UPBD at district level, BPS management, and BD midwives management; (2) **clinical skills** of the BD midwives. The M&E activities at the provincial level are conducted once a year, and at district level randomly every three months in a year. The criteria of monitoring cover clinical equipment, infection prevention, counseling, family planning consultation, ante natal care, normal delivery assistance, post-partum care, follow ups, neonatal care and follow ups, implants, direct observation to client. Since its inception, there had been 1,343 BD candidates, 540 facilitators and 86 assessors who had received clinical and management trainings (HSP, 2010).

Success Stories

Coverage areas of BD have been increasing in the past years. Currently BD midwives are present in all 38 districts in East Java. The comparison study between Malang and Pasuruan conducted by USAID-HSP and BD management Team in 2009-2010, indicated that the implementation of BD in both areas showed improved work quality

⁵⁹ Asmilia Makmur, Personal Interview. (February 12, 2011)

amongst 75% of 95 participants; indicated by the increased level of friendliness, compliance with the standard of care and reports submission, and management skills.

The second success story is derived from USAID study (2008) in Palembang and Bengkulu on clinical management⁶⁰. The study compared baseline data taken at 2004 by USAID-STARH and the follow up at 2008 taken by USAID-HSP. The indicator they used is the level of compliance in recording the log book which will be compared between the two groups. The study team found that number of BD midwives in Palembang who complied to log book recording increased from 86% in 2004 to 91 % in 2008. Through the log book recording system, Bidan Delima facilitator can oversee the fluctuation of caseloads, which are the Bidan Delima clients, and what kind of midwifery services they usually accessed. Such recording will enable UPBD to design marketing strategy, who will be targeted by the strategy and how.

7. GROWTH PLANS

In regards to the future plans for BD, the implementers emphasized the need for expanding the area of coverage to 6 new provinces in 2011. Asmilia believed that demand of the program is high. This is indicated by the rapid growth of BD's area distribution in the past. Since its inception in 2003, the areas of coverage grew from 6 provinces (Jakarta, East Java, West Java, South Sumatra, to North Sumatra) to 15 in 2006 (Banten, Aceh, Lampung, West Kalimantan, Bangka Belitung, Bali, West Sulawesi, South Sulawesi, and Yogyakarta province).

In response to the challenge in monitoring and evaluation, HSP and BD management team at the central level attempted to make a sampled area at Malang and Pasuruan Regency. The aim was to improve management, monitoring, and quality assurance mechanisms in both areas. Once proven to work out, the model will be expanded to other provinces. Additionally, the central BD management team is now conducting a road show to encourage a systematic monitoring to BD board of managements at provincial and district level. To ensure validity, BD management team approaches local *Puskesmas* to conduct a joint monitoring for health professionals. With the involvement of new parties other than mentor/facilitator, BD management hopes that validity of quality assurance can be maintained⁶¹.

60 Panduan Umum BD. P. 14-16

61 Asmilia Makmur, Personal Interview, (February 12, 2011).

8. FINANCIALS

The initial funding installed through STARH program under USAID was USD 150,463.00. In 2010, BD central management received USD206, 075.65 from various sources-Johnson and Johnson (USD 118,893.70), bilateral aid (USD 72, 981.00), and membership fee (USD 14,200.00). To finance the program, BD does not take any kind of loans, or using any kind of risk pooling.

With the bilateral donation came to an end last year followed by J&J that will end at the end of 2011, BD program needs to identify a new source of funding. If they only rely on revenue from membership fees which comes as only 7% of the total funding, the program could not be sustained financially. This is especially true when reviewing trend of new candidacies which rather slow in most provinces. BD also seeks funding from the private sectors through Corporate Social Responsibility (CSR) programs. The new management team just recently developed a working agreement with a private company named The Dewhirst Intercentral- an undergarment company in Pandeglang, West Java. The company agreed to compensate their employees 100% reimbursement if they visit BD midwives for pregnancy care. If more companies are willing to make such cooperation, it would significantly boost the caseloads for BD midwives, as stated by Makmur.

Annex 1: List of Interviewees

Name	Organization/Position
Asmilia Makmur	BD/General Manager
Damaryanti Suryaningsih	USAID-STARH & HSP/ Former Program Manager
Rachmadian	BD/Research & Development Manager
Midwife 1	North Jakarta Private Midwife Practitioner
Midwife 2	Central Jakarta BD midwife practitioner
Midwife 3	North Jakarta BD Private Midwife
Midwife 4	Wonosobo BD Private Midwife practitioner
Midwife 5	Wonosobo Private Midwife Practitioner
Midwife 6	Wonosobo BD Midwife practitioner
Elsa Handayani	Johnson & Johnson / Professional Marketing manager
Harni Koesno	IBI Chairwoman

Annex 2: Secondary Research

Title	Author	Location (e.g., book, journal, website link)
Evaluation of Health Services Program (HSP) program in Indonesia: Taking Stock and Look Forward. Washington D.C	USAID	USAID 2008
Franchising of health services in low-income countries		Health Policy Plan 17 (2): 121-130
Franchising as a source of technology transfer to developing economies.	Stanworth J, Price S, Porter C, Swabe T, Gold M.	Special Studies Series, No 7, ed. I.F.R. Center. Vol. 7 (1995)
Franchising in Health	Jeff Ruster, Chiaki Yamamoto and khamarogo, 2003	http://rru.worldbank.org/documents/publicpolicyjournal/263Ruste-063003.pdf
Health System Performance at the District Level in Indonesia after Decentralization.	Peter Heywood, Y. C.	Intercentral Health and Human Rights, 10 (3).2010
JSI: Promoting and Improving Health	John Snow Inc.	http://www.jsi.com/Managed/Docs/Publications/HealthCareServices/hsp_fy07_annual_report.pdf
Overview of the Indonesian family planning movement: the blue circle and gold circle social marketing policies.	Sihombing, B,.	Planning Coordinating Board, Jakarta, Indonesia, 1994
Private Health Sector in Indonesia: A Desk Review.	USAID. 2009.	www.healthsystems2020.org/.../2356_file_Indo_PSA_Desk_Review_FINAL.pdf
“The Right To Health: What Role For Business?”	K.M Leisinger edited by Martina Timmerman et.al.	UNU (2009)
Strengthening the Impact of Asia’s NGO Community Maternal, Newborn And Child Health (MNCH) Interventions – Immunization	ADB, GSK, Save The Children, 2009	http://www.adb.org/Documents/Books/NGO-Workshop-Studies/NGO-Workshop-Studies.pdf
The Direct Selling Revolution. Understanding the Growth of the Amway Corporation.	Xardel, Dominique (1993).	Harvard Health Policy Review Vol. 9, No. 1, Spring 2008
Social Franchising to Improve Quality and Access in Private Health Care in Developing Countries	Montagu, Adams. Harvard Health Policy Review Vol. 9, No. 1, Spring 2008	http://www.hcs.harvard.edu/~hhpr/currentissue/184197%20Health%20Highlights_Bishai_edited.pdf
Riset Kesehatan Dasar 2010	Ministry of Health Republic of Indonesia	http://www.depkes.go.id/index.php/berita/press-release/1071-kementerian-kesehatan-selenggarakan-lagi-riset-kesehatan-dasar.html

Annex 3: Research Design and Normative Framework

Research Question

“How does the accreditation model of BD affect the regulations of performance of BD private midwives?”

Research Design and Interview Procedures

The data is collected between February and March 2011 through in-person and phone interviews and reviews of existing documentation. Phone interviews were conducted with 3 non-BD private midwives and 3 BD private midwives who live in the rural and urban setting. There are 11 participants representing Public Health and midwifery backgrounds from USAID-HSP, BD, and IBI. Verbal consents were asked prior to the interviews. The sampling method applied was convenience sampling. Participants were selected based on the researcher approaching them and subsequently requesting their willingness to participate.

Annex 4: Lesson Learned

The findings indicated that the bulk of the inefficiencies in the implementation of BD relies on the weak monitoring of the compliance of the standard of care and the market positioning of the program in the mind of the BD midwives and the pregnant women-or the primary and secondary target population.

The ‘undervalued’ brand, coupled with weak implementation of action plans addressing the issue, might affect the assurance of the donors to provide and continue the funding. Furthermore, BD midwives might not see the value of the accreditation because there was no significant change in number of new cases as a result of the brand. The reports reviewed and interviewees indicated there is no strong evidence that BD accreditation stimulates the increase in number of new cases of deliveries. They also indicated that additional cases were coming from the “popular” midwives who were already favored more than the others before they became BD midwives.⁶²

In order to address these points, The Team recommends the following action plans:

Word of Mouth Marketing

With the support of IBI and the donors namely USAID, BD had a strong program design and had developed a strategy to build a stronger branding and increase market positioning within the target population through an accreditation model. However the firm design and strategy were not accompanied by effective action plans or the plans are implemented poorly. Furthermore, BD, with the support of Johnson & Johnson, has identified the customer’s preference for choosing the provider for deliveries as indicated by a market research by an external

62 USAID-HSP, “Bidan Delima Evaluation Report,” USAID, Washington D.C, 2008

research company. The report indicated that word of mouth is the most common public recognition method used by pregnant women in the operational areas of BD. When choosing midwives to assist delivery, pregnant women prefer to use the one who has helped and is recommended by other family members such as mother, aunt, in laws despite of skill or equipment the midwives have (Romans et al, 2008; Sutrisno, 1997, Muis, 1996; Titaley et al, 2010). Thus, women have no power to determine what they can and can't do during pregnancy. Additionally, some community members still hold perception that health services are only if obstetric complications occurred⁶³.

Defined as "The act of consumers providing information to other consumers"⁶⁴, 'word of mouth' is perceived as the most effective of marketing for BD. If the assessments indicate that it is indeed the most effective way to promote the program, the team recommends marketing activities that are based on customer satisfaction and promotes sharing of experiences. This may be done through Mother Support Groups conducted by BD within the community where BD midwives operate and free access to education materials about safe pregnancy prepared by BD midwives, amongst others. Cultural context on pregnancy may impede their market penetration hence a culturally sensitive communication approach needs to be developed. The BD program also needs to identify influencer who has credibility and able to shift the local perspective on maternal health.

Conduct assessments to identify the most effective method of social media

Despite the use of media, BD remained less valued by the midwives and the pregnant women. Thus, there are possibilities that the market of BD's is more sensitive to a certain type of media use and the duration of marketing exposure. Moreover, the market's responds might increase positively when combined with other marketing strategies. A specific communication strategy is also needed in communicating nutrition intake during and post pregnancy.

Engagement with the Private Sectors

Another strategy can be implemented through the endorsement of BD by the private hospitals and clinics to expand brand recognition. As many pregnant women visit hospitals to check their pregnancies or give a newborn care; hospital can be the strategic point to disseminate brand awareness if they can adopt the standard also utilize the BD midwives services. Such kind of efforts can also be done through leveraging with private hospitals and health centers as doctors or OBGYN have credentials to endorse the use of BD standards of care in their institution especially when they got too busy to handle delivery by themselves. Such exposure will help promote the standards and services and spread the word of mouth to potential client. It is an effective marketing strategy

63 Titaley, C., Hunter. C., Heywood. P., Dibley. M, 2010. Why don't some women attend antenatal and Postnatal care services: A qualitative study of community members' perspectives in Garut, Sukabumi and Ciamis districts of West Java Province, Indonesia. *Pregnancy and Childbirth*, 10:61, Sidney, Australia.

64 See <http://www.womma.org/wom101/> (accessed 28 Mar 2011)

through well credited resource person such as doctors can effectively create a credible image on BD midwives and in consequence can stimulate trial and return visit by potential clients.

Improve routine process and outcome monitoring

The core of franchise model is regulation and monitoring.⁶⁵ Based on our interview with key respondents, there is a dire need to ensure the promptness of frequency and accountability of monitoring and evaluation process. M&E is the heart of quality assurance as standardized compliance is their selling point.

The Team recommends conducting assessments to identify the key challenges in the field by getting the information from BD midwives. The WHO guideline on quality assurance as mentioned above proposed the ideal concept on bottom up problem identification. However, BD program did not follow the model and instead designing it from top to be done at the bottom level. Having the midwives forum could help to reverse the unintended impacts caused by top down approach. Besides giving channel and room for the members to express their concern and aspirations, Midwives forum can be used to increase sense of belonging to the program which will be followed by increase of compliance.

Funding

The issue of sustainability that relates to duration and source of external funding is amongst the major problems especially with USAID funding ended in 2010 and J&J funding comes to an end this year. With external funding sources came to an end by the end of 2011, program sustainability would be challenged. The findings suggested a need to identify new source of funding whether it would be from private actors, Indonesian government, or internal source of funding. BD program with their vast distribution and exposure has potential to cooperate with private actors. The cooperation can be done in a various way such as Johnson and Johnson involvement in financing the program's training, Exxon Mobile Oil in financing the expansion of the BD Program in Aceh Province, or through endorsement to use the BD service such as Dewhirst Intercentral-the undergarment company who endorses their female workers to get maternal and child health care services from BD midwives only. With the amount of BD midwives and its vast distribution throughout Indonesian provinces, their cooperation can increase exposure and the Visibility.

The second option is making BD program as part of government sponsored program. However, if government took over the program, there is a possibility the government might suggest all private midwives practitioners to become BD midwives. It would cause a significant change on business model from franchise to moral movement and BD would need to promptly create a new system for quality assurance and brand recognition to adjust to the new model. Creating policy enforcement that involves penalty and social control should be done to ensuring level of

65 <http://www.measuredhs.com/pubs/pdf/FR218/FR218%5B27August2010%5D.pdf>

compliance. The other caveat that BD Program should tackle if funded by government is the red tape. Business sense that was introduced at the beginning of program aimed to create a more liquid situation that match to IBI's environment. For instance, under the current system a BD facilitator can make a friendly visit to their mentees without the need to follow certain complex administrative procedure.

The third alternative is to continue raising funds internally through the membership fees. Besides expanding their geographical exposure and recruiting new members currently, BD needs to encourage members who have yet renewed their memberships since 2008. Up to January 2011, there are 26 percent of members who have not renewed their BD certificate. Internal funding can take over some expenses especially for monitoring and evaluation purpose.

Annex 5: BD Program: Innovation or Adaptation?: Modification of Sentrong Sigla Movement and Blue Circle Family Planning

There are mixed responses as to whether the BD program is replicated from another innovation. One of our interviewees noted the program is actually modified from *Sentrong Sigla* quality assurance movement in the Philippines particularly on the recognition process from nomination to certification⁶⁶. The candidacy/nomination process is somewhat similar, with several differences. The Philippines primary health care unit is nominated by a local government unit; while in the BD program, the recruitment process starts as soon as a midwife proposes her candidacy. The other similarity is in the vetting process. After nomination, the regional team of SSM conducts visits to assess or monitor compliance with the quality standards and award certificate to those facilities that do comply.⁶⁷ It is similar to a validation process where the facilitator conducts on site visit to verify the midwife's clinic and aptitude.

The difference between the programs is methodology and scope; the SSM is intended to work at central scale and is integrated with the decentralization policy. Conversely, BD with their franchise model was designed to create competition between BD and non-BD midwives to stimulate conformity compliance⁶⁸.

In term of marketing strategy, BD's social marketing strategy is similar to the blue circle (*Lingkaran Biru*) of family planning program back in 1980s⁶⁹. The social marketing of blue circle family planning was successful as it is able to be positioned as the brand that provides a well quality and complete family planning.⁷⁰ BD program replicates the

66 Damaryanti Suryaningsih, Personal Interview, (February 21, 2011).

67 M. Palani Natha Raja, S.G. Deshmukh, Subhash Wadhwa, "Quality award dimensions: a strategic instrument for measuring health service quality", *Intercentral Journal of Health Care Quality Assurance*, Vol. 20 Iss: 5, pp.363 – 378(2007)

68 Damaryanti Suryaningsih, Personal Interview, (February 21, 2011).

69 *ibid*

70 Sihombing. B., " Overview of the Indonesian family planning movement: the blue circle and gold circle social marketing policies," Planning Coordinating Board, Jakarta, 1994,

blue circle campaign. It is expected that BD brand can be recognized for its quality of services such as a skilled yet friendly midwife, a clean and homey clinic, affordable with high quality prescription⁷¹.

Annex 6: List of questions

I. MODEL

Program Description

1. Main line of business for organization (if different from or broader than the program to be studied):
2. What is the program's mission/goals? Who had the vision to launch this program/product (i.e., is there a champion or visionary)?
3. Provide a detailed description of the program: Describe in detail the business model, any innovative aspects (eg., use of technology), and distinct components.
 - 3.1. Is this a replication/adaptation of another innovation (e.g., another model that exists), is it a new/proprietary innovation, or a mix? If so, what was it based on?
 - 3.2. Do you have organizations or models that you aspire to be like within your geography, in other geographies, or in other industries?
 - 3.3. How has the program evolved since its launch? (If already answered, skip this question)
 - 3.4. How is your organization structured? Provide a chart of the organization if available.
 - 3.5. Is the government involved in this initiative? If yes, what part of the government? If a partnership between a government and a private entity, how is the partnership structured?
 - 3.6. Do you have partners? If yes, how did you form the partnership(s)?

Human Resources

4. Who is leading the implementation effort for this program/product?
 - 4.1. How large is the team for this program/product?
 - 4.2. What specific roles and responsibilities does each position have? How do you attract qualified personnel and retain current employees (e.g., competitive pay)?
 - 4.3. How do you evaluate staff?
 - 4.4. Do you feel there is a shortage of human resources/technical capacity in the market for the kinds of expertise you require to run this program/product? Which specific skills?
 - 4.5. Were any new Kader created to deliver care? If yes, which ones? What have been the merits of doing this?

Target Population:

5. What is the target population for this program?

If program targets consumers/patients:

- 5.1. Geographic location?

71 USAID-HSP, "Panduan Umum BD" p.87-88

5.2 Income-level? What income quintile do the majority of your consumers fall into? In what ways does your organization interact with the poor? Do you also specifically serve non-poor segments?

5.3. Age/gender group?

5.4. Other (e.g., people with particular disease)?

5.5. What type of provider does the program target?

6. What was the rationale for selecting this target population?

6.1. What is the size of your target population? How big is the population that your current services potentially serve? (e.g., If you target women in 3 Districts, what is the female population of those districts.)

6.2. How many people do you actually provide services to (i.e., numbers actually served)? (If appropriate/available, please provide detail on numbers per month or per year for individual services, E.g, 150 IUD insertions per month and 460 courses of oral contraceptives per month.)What portion (%) of the target population do you actually serve? (Number of people served divided by total target population).

6.3. How long did it take to get to this level of coverage?

6.4. Do you have plans for reaching even more individuals within your current target population?

What are these plans?

7. Do you expect to expand the target population?

7.1. If so, who else do you plan to serve and why?

7.2. How do you plan to expand the population?

8. How do clients/patients find out about the program?

8.1. Do you use any advertising/marketing strategies? How do you communicate to low-income consumers about the value of your product?

9. Is the population that you are currently serving the same as your original target population? To your knowledge, is this what was originally intended or expected?

Challenges:

10. What are the program's key challenges? Please describe the key challenges detail:

10.1.What, if anything, have you done to address these challenges?

10.2.How could you be better supported in meeting these challenges?

Additional Questions

11. Have you received any external technical assistance for this program/product? If so, please describe.

12. Does the program/product have competitors? If so, please describe them (please select all that apply and provide a brief description): Examples: Government program/products, Private non-profit program/products, Private-for-profit, Program/products, other (please specify)

13. Do you work with informal providers (people who delivery health products or services with little or no formal training, e.g., "village doctors", drug sellers, traditional healers)? If so, in what capacity?

II. IMPACT

14. Do you track results? If so, how do you track your results?

14.1. What are your primary indicators?

15. What have been the results thus far?

15.1. Areas where you feel you have achieved success to date

15.1.1. What data illustrates that success?

15.2. Areas for improvement

15.2.1. Is there data that you use to isolate the areas for improvement?

(Try to get actual data, if available.)

16. Have you implemented a monitoring and evaluation plan for your program/product? If you have implemented evaluation(s) of your program/product:

16.1. Who conducts the evaluations?

16.2. What is the methodology?

16.3. Would you be able to share the results with us?

17. Have you documented (qualitatively) your program/product's operational evolution (i.e., a qualitative case study)?

III. GROWTH PLAN

18. In the past year is the demand for the program/product growing, stable, or shrinking?

19. What is the potential demand for this program/product?

20. What are the growth plans for the program/product?

(1) Replicating (i.e., entering new domestic/intercentral markets); (2) Scaling (i.e., expanding market size);

(3) Expanding the scope of services of products offered

IV. FINANCIAL

21. What kind of (if any) external assistance would be useful for you to achieve your growth objectives? Please describe. Ex: Financial, Business, Technical, Clinical, HR, Enabling regulatory environment.

22. What are your annual revenues?

23. What are your current sources of revenues and what percentage of total revenues can you attribute to each source:

1. Out-of-pocket payments

2. Government contracts

3. Insurance or voucher payments

3.1. Government

3.2. Private

4. Donor funding

4.1. Foundations

4.2. Bilateral aid agencies (DFID/UK, KFW/Germany, USAID/US)

4.3. Multilateral aid agencies (e.g., World Bank, Global Fund)

5. Membership/subscription fees

6. Other

24. How much initial funding was required to launch the program/product?

25. What were the sources of your initial funding?

26. Have you taken any loans or equity investments? From what source?

27. Do you subsidize specific populations and/or services?

27.1. Do you cross subsidize any services across populations?

28. Do you use any kind of risk pooling, insurance, or voucher mechanisms? If so, please describe

29. If applicable, please describe how you have priced your services/product.

30. On what basis do you determine your prices?

1. Prices are set to meet operating costs

2. Prices are set to allow the facility to make a profit/surplus

3. Prices are set to be competitive (follow up about competition's pricing)

4. Prices are set to make the services affordable to the market

5. Different prices are charged to consumers/patients with different abilities to pay (follow up with question about how willingness or ability to pay is determined)

6. Mix (please specify)

7. Other (please specify)

31. What are your annual operating costs?

32. Does your program/product generate enough revenue to cover its operating costs?

33. What is the program/product's current financial performance?

1. Earning a profit or surplus over costs

2. About breaking even

3. Losing money

4. Other (please specify)

V. CONTEXTUAL FACTORS

38. Were there any major barriers to program/product implementation? Please describe.

1. Human capital

2. Technology

3. Regulatory

4. Infrastructure

5. Financing

39. Describe the regulatory environment for the program/product you offer?

39.1. Is your product regulated? By what body/regulation/law?

39.2. Are there particular regulations that have been a challenge or barrier for you?

39.3. Are there any regulations that have helped your program/product?

39.4. Which of the following statements best describes your view of regulations as they relate to this program/product?

1. Regulation is a burden

2. Regulation is a support/help

3. Regulation is not relevant

40. Is your program a part of a union, association, or network of private providers? If so, please name and describe these organizations/associations and your affiliation.