Pokja:

Improving collaboration to increase maternal and newborn survival: district-level intersectoral working groups in Indonesia

TECHNICAL REPORT
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EXECUTIVE SUMMARY

The Ministry of Health (MOH) of Indonesia is working to reduce the high levels of maternal and neonatal mortality across the country. In support of these efforts, the United States Agency for International Development-funded Expanding Maternal and Neonatal Survival (EMAS) Program has used an intersectoral governance mechanism, called a *Pokja*, to facilitate collaboration and mutual accountability among various stakeholders for improving maternal and neonatal health services.

In response to the World Health Organization's guidance on intersectoral action for health, the EMAS project facilitated the creation of the *Pokja,* or working group. *Pokjas* were created as a semi-permanent organizational structure intended to facilitate shared governance and enhance collaboration between public officials, service providers, and citizens. In order to improve MNH services, EMAS employed *Pokjas* at the district level to improve cooperation, establish accountability, and help reforms take root among stakeholders. The roles of each *Pokja* consist of advocating for financial resources to strengthen quality emergency MNH service provision, advocating for policy changes to strengthen quality emergency MNH service provision, and to collaborate with civic forums to improve community engagement in maternal-newborn mortality reduction efforts. Each *Pokja* is made of a governing board, a steering committee, and an executive board, which hold quarterly and plenary meetings to review progress on improvements in MNH services, overall performance, and discuss issues and identify solutions.

Although each *Pokja* is unique to its context and specific community, several commonalities influencing their effectiveness have been observed. First, political commitment is key to encouraging action on many maternal-neonatal survival determinants that fall outside the direct influence of the health sector, and strong political support has proven to be a motivator in mobilizing engagement and support from stakeholders. Second, strong leadership in the health sector, especially by senior DHO staff, was demonstrated by high performing *Pokjas* across EMAS districts. Third, clarity of roles and responsibilities among *Pokjas* members helped to complete work plans and achieve results. Finally, continuous communication within the *Pokja* and with communities is key to helping the Pokja's mission function smoothly and achieve positive outcomes as a result of information sharing.

The sustainability of the *Pokjas* has been a focus of their development over the course of the EMAS project. To ensure ongoing political support and commitment, *Pokjas* are designed to directly support the "strengthening districts for good governance" component of the Indonesian government's "National Action Plan for Accelerating Reductions in MMR." Holding districts responsible for establishing and ensuring functional *Pokjas* further ensures ownership at the district level. In addition, costs associated with *Pokjas* are funded by the District Budget (APBD) through DHO, and not through the EMAS project. The capacity of established *Pokjas* to mentor and provide technical assistance to newer *Pokjas*, as well as mentor *Pokjas* starting in new districts is a strong sign of sustainability. The creation of *Pokja* champions to continue advocacy and recognition of *Pokjas* in new districts will also help increase sustainability, as well as motivation and commitment within existing *Pokjas*.

INTRODUCTION

USAID/Indonesia's Expanding Maternal and Neonatal Survival (EMAS) Program is a five-year effort, launched in 2011, that supports the Government of Indonesia to reduce maternal and newborn mortality. EMAS collaborates with Indonesian government agencies (national, provincial and local), civil society organizations, public and private health facilities, hospital and professional associations, and the private sector. EMAS seeks to accelerate reductions in maternal and newborn mortality by improving the quality of EmONC within health facilities and strengthening the referral network to ensure efficient and effective referrals from *puskesmas* to hospitals. EMAS also works to strengthen accountability amongst government, the community and health system by supporting district-level civic forums that engage civil society in MNH issues and *Pokjas* (working groups) that help resolve issues and barriers identified by health facilities and others that impact maternal and newborn survival.

EMAS is a partnership of five organizations—Jhpiego (lead partner), Lembaga Kesehatan Budi Kemuliaan (LKBK), Muhammadiyah, Save the Children, and RTI International. Over five years, EMAS is working with at least 150 hospitals (both public and private) and more than 300 *puskesmas* across the six provinces (North Sumatra, Banten, West Java, Central Java, East Java, and South Sulawesi) where nearly 50% of maternal and neonatal deaths in Indonesia occur.

This technical report examines how EMAS has used an intersectoral governance mechanism to facilitate collaboration among public officials, service providers, and citizens, and to establish mutual accountability for improving maternal and neonatal health (MNH) services.[1] This mechanism, called a *Pokja* in Indonesian, is a working group. The discussion below provides an overview of the *Pokja's* roles, structures, and activities, and details EMAS support to creating and maintaining *Pokjas* in the project's target districts. The report then summarizes the effectiveness of the *Pokja*s in fulfilling their roles, offers observations on sustainability, followed by some concluding remarks.

BACKGROUND

Maternal and neonatal mortality rates in Indonesia have remained stubbornly high. Among the contributing factors are poor quality of MNH services, low proportion of facility-based deliveries, insufficient government spending, and a variety of barriers to access—financial, geographic, and socio-cultural.[2] Addressing these factors requires that health policy makers, managers, and providers develop effective mechanisms, processes, and capacities for collaboration and coordination both within the health sector and across sectoral boundaries. The World Health Organization sought to call attention to the importance of collective action among a wide range of stakeholders to sustainable health outcomes by introducing the term, intersectoral action for health, accompanied by guidance for practitioners.[3] The mechanisms to support such action range from informal, one-off

[1] The report draws on EMAS documents, interviews, direct field observations, and several focus group discussions.

[2] UNICEF Indonesia. *Issue Briefs: Maternal and Child Health*. October 2012. http://www.unicef.org/indonesia/A5-_E_Issue_Brief_Maternal_REV.pdf.

[3] WHO. 2011. Intersectoral Action on Health: A Path for Policy-Makers to Implement Effective and Sustainable Action on Health. WHO Centre for Health Development, Kobe, Japan. http://www.who.int/kobe_centre/publications/ISA-booklet_WKC-AUG2011.pdf. See also Adeleye, O.A. and A.N. Ofili. 2010. Strengthening Intersectoral Collaboration for Primary Health Care in Developing

joint committees or task forces, to full-fledged cross-sectoral agencies with formal recognition and resources within the government. In Indonesia, intermediate between these two poles is the *Pokja*.

A *Pokja*, or working group, is a semi-permanent organizational structure intended to facilitate shared governance and enhance collaboration at the district level.

- Each *Pokja's* procedural details vary according to the needs and desires of its founders
- *Pokjas* establish accountability relationships that help MNH reforms take root
- Membership is comprised of government agency representatives, health providers, health professional associations, and citizens, and its structure features a governing board, steering committee, and executive board.

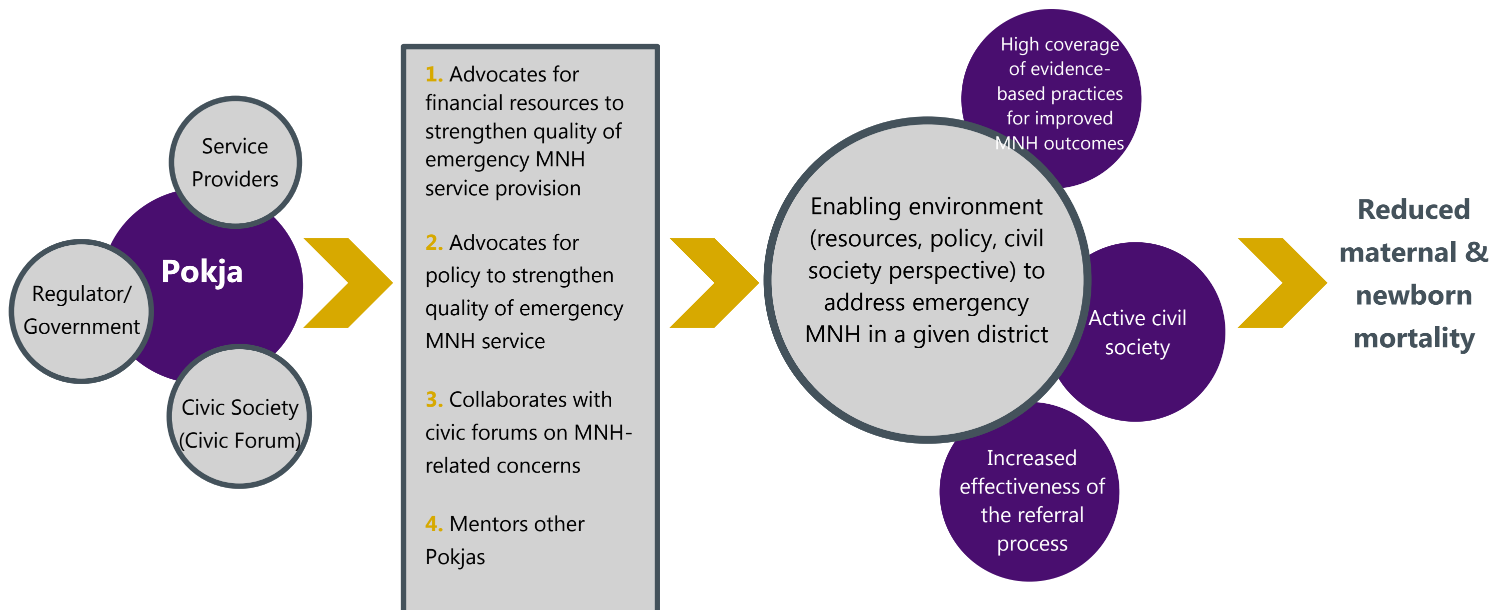
The three roles of a *Pokja*:

1. *Advocate for financial resources to strengthen quality emergency MNH service provision*
2. *Advocate for policy changes to strengthen quality emergency MNH service provision*
3. *Collaborate with civic forums to improve community engagement in maternal-newborn mortality reduction efforts*

To facilitate the kind of intersectoral collaboration likely to support MNH service improvements, EMAS envisioned district-level *Pokjas* that would smooth the pathways to cooperation among government, providers, and citizens while simultaneously establishing accountability relationships that would help reforms to take root and contribute to reduced maternal and newborn mortality. Figure 1 illustrates this causal pathway. EMAS considered *Pokjas* to be major contributors to creating an enabling environment for the project's MNH interventions. Working with their Indonesian government counterparts, EMAS helped put in place new, or strengthen existing, working groups in all of the project's intervention districts. *Pokjas* were established at district level to harnesses the advantages of Indonesia's decentralized governance system where local governments have significant authority to plan, budget, and implement programs tailored to local needs although still subject to national standards for services. The *Pokjas'* membership consists of representatives from government agencies, health providers, health professional associations and civil society entities.

Countries: Can the Health Sector Play Broader Roles? *Journal of Environment and Public Health.* Vol. 2010, Article 272896. http://dx.doi.org/10.1155/2010/272896

Figure 1. Causal pathway: *Pokja* contributions to reducing maternal and newborn mortality



DESCRIPTION

Roles of the *Pokja*

EMAS saw that making progress on this causal pathway called for increased availability of resources, supportive policy changes, and engagement with civil society. These three elements formed the roadmap for the project's portfolio of activities to be undertaken by *Pokjas*. To address MNH issues in a given district, the *Pokja* carries out three roles:

1) Advocates for financial resources to strengthen quality emergency MNH service provision. To fulfill this role, the *Pokja*—with the member from the district health office (DHO) in the lead—prepares a budget proposal for review by the district head (*Bupati*) and inclusion in the annual budget submission to the regional parliament (DPRD) for review and approval. The DHO is usually invited in the budget discussion process in DPRD to explain further the budget plans for MNH.

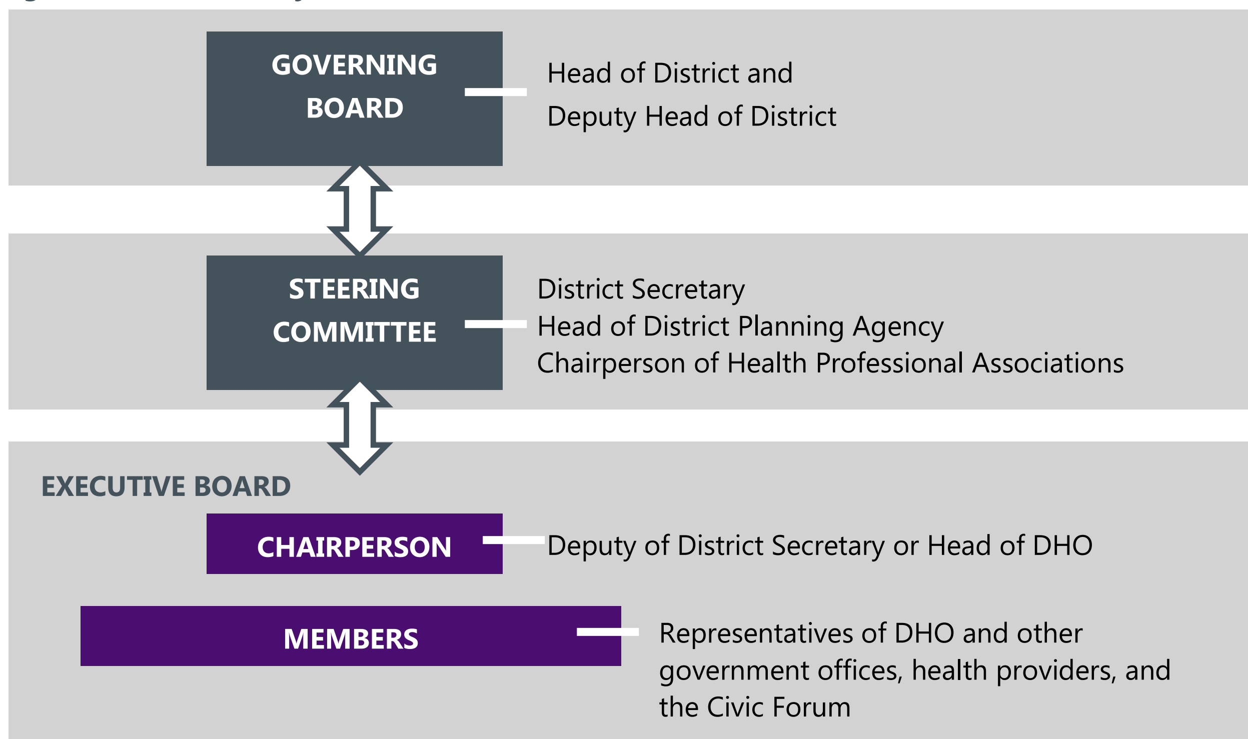
2) Advocates for policy changes to strengthen quality emergency MNH service provision. Here, the *Pokja*, usually with the DHO taking the lead, drafts a policy paper that is submitted to the *Bupati* and district secretariat *(Sekda)* for formalization as a district decree *(Perbup*). Alternatively, the paper can be directed to the DPRD, where it forms the basis for a district parliamentary regulation (*Perda*).

3) Collaborates with civic forums (*Forum Masyarakat Madani*/FMM) to improve community engagement in maternal-newborn mortality reduction efforts. This role involves *Pokja* members in sharing information with civil society through the project's civic forums, another structure intended to facilitate interaction and participation with citizens, and in mobilizing demand for improved MNH services. [4]

Pokja structure

As noted above, the *Pokja* includes members from district government offices with responsibility for various aspects of MNH services, health professional associations, health facilities' management units, and civic organizations with concerns about MNH. The distribution of the *Pokjas* roles are discussed among the members, and the group's decisions are formalized in a decree issued by the *Bupati*. As presented in Figure 2, the standard *Pokja* structure consists of a governing board, a steering committee and an executive board. The head of the district and the deputy sit on the governing board. The steering committee consists of the district secretary, the head of district planning agency, and the chairperson of various health professional associations. At the heart of the *Pokja* is the Executive Board, which is usually chaired by the deputy of the district secretary or the head of the DHO. *Pokja* membership consists of around 15 persons, depending on the specific needs and governance context in each district. Aside from the standard structure, the *Pokja* can also form smaller ad hoc teams to work on specific tasks, such as drafting a memorandum of agreement among health facilities, reviewing service charters, etc.

Figure 2. Standard *Pokja* structure

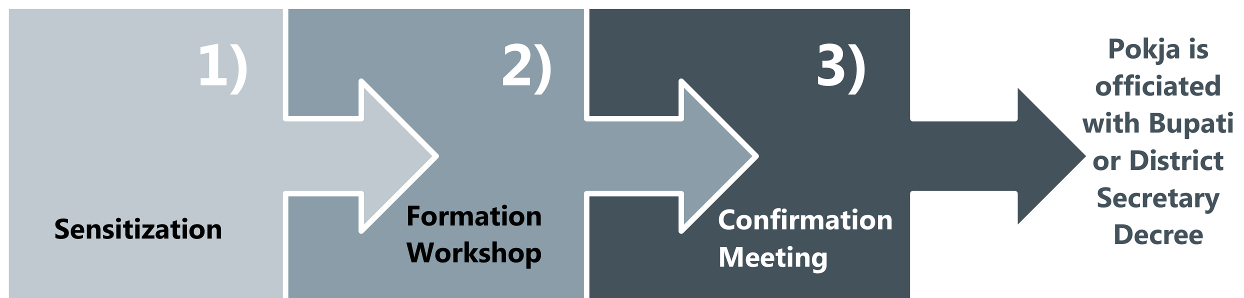


[4] See the EMAS technical report on civic forums.

Pokja formation

To ensure ownership of the *Pokja*, EMAS encouraged the local government to lead the *Pokja* formation process (see Figure 3). For the sensitization step, the EMAS team assists the provincial health office (PHO) to conduct meetings with the DHO and other key stakeholders in the target district. The EMAS teams consist of the district team leader and the district governance specialist. They can draw upon the national technical assistance team as needed, which includes the project's governance advisor, the maternal and neonatal advisors, and the referral system advisor. The purpose of these sensitization meetings is to communicate the importance of addressing high maternal and neonatal mortality in the district and the need for an organizational structure to coordinated efforts. Once this step is completed, the EMAS team works with the DHO to discuss with health service providers on who should be members of the *Pokja* and what their roles will be. Taking into account the input from the DHO and health service providers, the District Secretary (*Sekda*) and the *Bupati* appoint individuals from relevant government offices to the *Pokja*, and invite civil society groups as well. At a formation workshop, with EMAS facilitation, the designated *Pokja* members discuss among themselves how to structure the working group and develop a workplan. Subsequently, the local government issues a decree, making the *Pokja* an officially recognized intersectoral entity.

Figure 3. Steps in the process of *Pokja* formation



Pokja capacity development

Given the importance of intersectoral collaboration to achieving MNH results, EMAS has directed a steady stream of technical support to the project's *Pokjas* to build their capacity. This support has consisted of funding for quarterly meeting expenses in the districts, coaching and advice through regular visits from EMAS governance specialists, organization of an annual gathering in Jakarta for all *Pokjas* to review past experience and plan future activities, and periodic mentoring by strong *Pokjas*. The mentoring approach, used across the EMAS project, is a means of engaging *Pokjas* in peer learning and mentoring, extending the reach of EMAS capacity development resources, and assuring sustainability. The strategy places local actors in the driver's seat to address MNH priorities through their engagement in the *Pokjas*. Mentoring *Pokjas* help EMAS to disseminate best-practices in improving maternal-newborn survival to additional districts and cities. Box 1 summarizes the basic requirements for achieving mentoring status.

Box 1. *Pokja* Mentoring criteria

1. *Pokja* has met the input criteria for effective functioning (membership selected, *Pokja* has a legal basis for operation, has an annual work plan, has a secretariat)

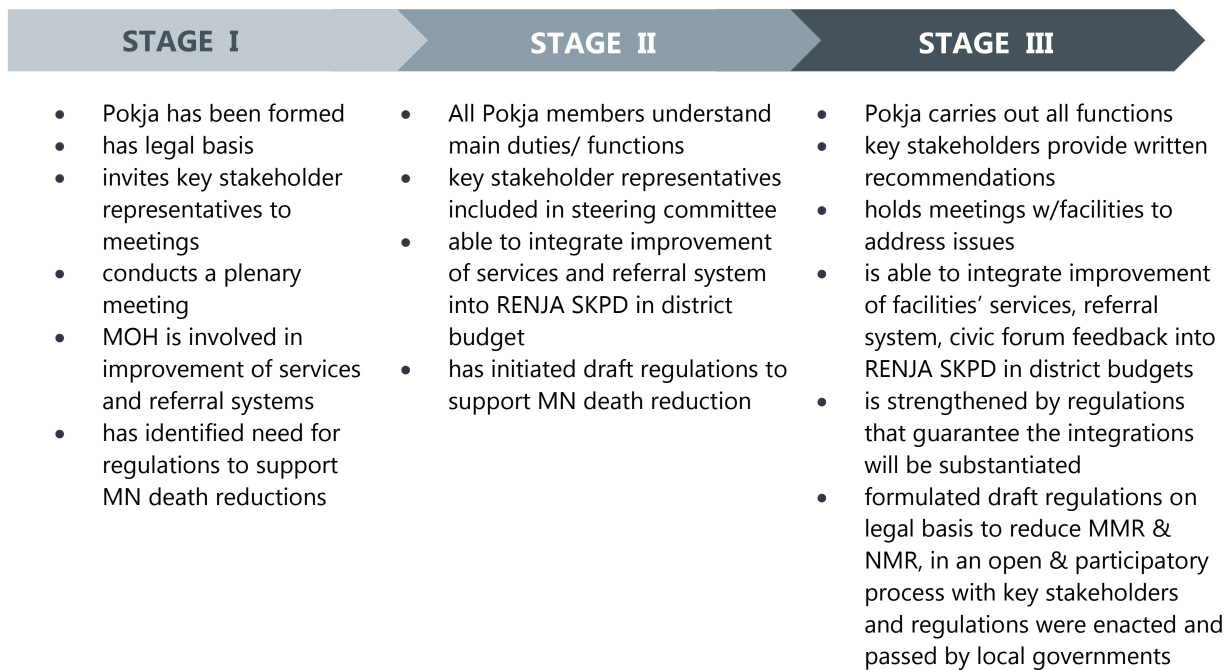
2. Members understand their duties and functions; membership includes representatives of professional organizations, businesses, and civil society

3. *Pokja* holds quarterly meetings that include reviewing progress within health facilities and referral systems and monitoring and completing action plans

4. *Pokja* has prepared work plans and budgets, and has initiated drafting regulations to support reductions in maternal and neonatal mortality rates

EMAS has implemented its activities in phases, expanding coverage to more districts with each phase. EMAS began with 10 districts in Phase 1, from May 2012 through September 2013. Phase 2 expanded the project to 23 districts from October 2013 through September 2014. Phase 3 began in October 2014 and added 7 districts, for a total of 30; it is currently ongoing. EMAS tracked *Pokja* capacity development across these phases and documented three stages of incremental increases in operational capacity. Figure 4 graphically illustrates the growth of *Pokja* capacity from Stage 1 capacity indicators to Stage 3 across the three phases of EMAS implementation.[5]

Figure 4. *Pokja* capacity development stages by district expansion phases



[5] From EMAS. 2015. *Results and Achievements: Year Four Summary*, October 2014-September 2015.

	ACHIEVED STAGE 1	ACHIEVED STAGE 2	ACHIEVED STAGE 3
Phase 1	ALL ACHIEVED	Serang	Asahan, Deli Serdang, Sidoarjo, Banyumas, Tegal, Cirebon, Malang
Phase 2	ALL ACHIEVED	Langkat, Tangerang	Jombang, Labuhan Batu, Pasuruan, Brebes, Cilacap, Kota Semarang, Bogor, Karawang, Bulukumba, Gowa
Phase 3	ALL ACHIEVED	Grobogan, Pekalongan, Madaling Natal, Indramayu, Wajo	Nganjuk, Tuban

Pokja activities

The standard *Pokja* calendar of activities revolves around quarterly meetings of the membership and twice-yearly plenary meetings that expand participation to include the P*okja's* oversight bodies. Slight variations in *Pokja* structure are reflected in adjustments to the standard calendar. For example, in the district of Banyumas, the working group is divided into the "big" and "small" *Pokja*. The big *Pokja* refers to the group that has a regular "coffee morning" with the *Bupati* every three months. Membership is made up of the DHO, senior ob-gyns, head of the district planning agency, and the district secretary. The small *Pokja* consists of representatives of the technical and operational units in the DHO, and it meets on an as-needed basis. In the district of Labuhan Batu, aside from quarterly meetings, the *Pokja* members organize pre-meetings to prepare for the quarterlies, and hold technical cluster meetings at *puskesmas*.

1) **Quarterly Meetings** regularly review progress on the improvements of MNH services and referral performance, discuss problems/issues arises and identify proper solutions. In these meetings, *Pokja* members discuss updates on the performance of MNH emergency services and referral, identify critical stumbling-blocks and develop solutions. Quarterly meetings are also used to conduct regular self-assessment on the *Pokja's* progress on capacity development (see Figure 4).
2) **Plenary Meetings** occur twice a year, and involves all components of the *Pokja* structure, including the Governing Board and Steering Committee. In the plenary meeting, the chairperson reports the overall performance, particularly with regard to the improvement of MNH services and emergency referral, to the Governing Board and Steering Committee. These latter offer commentary and recommendations based on the performance report.

In terms of the content of intersectoral activities in support of EMAS, *Pokjas* have been involved in three main programmatic initiatives. These include developing the referral protocols among facilities, conducting ongoing performance reviews of neonatal emergencies and the referral system, and

supporting the development and implementation of facility service charters. Each of these is described below.

Development of memorandum of agreement (*Perjanjian Kerjasama*/PK)

In the first year of intervention in each target district, the *Pokjas* served as the organizational mechanism through which district-level stakeholders came together with EMAS technical specialists to establish a PK that would delineate a protocol for emergency referrals for maternal and neonatal health emergencies. The PKs define roles, responsibilities, and expectations of the hospitals and health centers (public and private), local government, and civil society forum. The PKs govern the referral network to improve collaboration and coordination among facilities and to integrate private facilities into the referral system.

For development of PK, the *Pokjas* facilitated a series of meetings with management of health facilities in the district, including the first level facilities (*puskesmas* and individual providers' practices) and hospitals (public and private). The first meeting presented the purpose of the referral system and general framework of collaboration among health facilities. The second and third meetings elaborated the details of collaboration down to specific roles of each facility and management of referral among the facilities. These detailed agreements were then formalized in the PK that was signed by the head of the DHO. In subsequent years, the *Pokjas* and the facilities reviewed implementation of PK in the quarterly meetings.

Periodic review of MNH clinical and referral performance

In collaboration with the EMAS clinical mentoring team, *Pokjas* conduct regular visits to health facilities in the catchment area. At times, *Pokja* members participate in mentoring visits and assist in carrying out performance assessments using EMAS's Clinical Performance Standard Assessment modules to identify critical factors hampering the facilities' performance in MNH emergency care and referral. *Pokja* members also participate in the Maternal-Perinatal Audit process in the facilities. The intersectoral nature of the *Pokjas* is key to bridging communication between providers/facilities and district governments, as well as among other stakeholders, in order to take appropriate actions upon the assessment and audit findings. The *Pokjas* bring findings from clinical mentoring, performance assessments and maternal-perinatal audits to the quarterly meeting, develop a comprehensive follow-up action plan and distribute the responsibilities among its member institutions. Progress on the follow-up actions is also reviewed and discussed in the quarterly meetings.

Development of service charters (*Maklumat Pelayanan*)

The Indonesian government's minimum service standards mandate the use of service charters and complaint handling surveys as accountability tools to improve service availability and quality. A service charter is a public announcement issued by both public and private facilities that specifies what services are available, performance measures, and costs. For EMAS, service charters identify certain standardized maternal and newborn care services that should be available at facilities and details how performance related to those services will be assessed. *Pokjas* convened the initial meetings with health facilities to develop draft service charters, and they managed the public consultations to obtain citizen feedback on the drafts. Subsequently, *Pokja*s monitored service

charter implementation in quarterly meetings, and discussed feedback from the community. Feedback information was collected directly from users' reports addressed to the health facility management, or indirectly from the civic forums.

Pokja effectiveness

This section assesses *Pokja* effectiveness in terms of the extent to which *Pokjas* have fulfilled the role statements contained in the causal pathway illustrated in Figure 1. These include results of advocacy for financial resources, passage of legal regulations based on advocacy for policy changes, and increases in citizen collaboration.[6]

Role 1: Advocacy for financial resources

In terms of advocacy for financial resources, the targeted indicator for *Pokjas* is an allocation in the district budget to sustain and expand area coverage of EMAS interventions. By the April-June 2015 period, the majority of *Pokjas* had successfully advocated for allocations in district budgets to match and expand implementation of EMAS interventions. In Karawang District, *Pokja* advocacy secured approximately IDR 400-450 million in the district budget specifically for implementation of EMAS activities (such as installation and implementation of SijariEMAS) in addition to the regular budget allocations for the government's MCH program. Banyumas District reported a significant increase of district budget allocation for MCH resulting from *Pokja* advocacy, from approximately IDR 200 million in 2012 to around IDR 1 billion in 2015. *Pokja* members noted that district officials' (particularly the *Bupati's*) awareness of and support for EMAS activities (and the *Pokja* itself) helped to explain the success of their budget advocacy efforts. Table 1 provides details by EMAS Phase 1 and 2 districts, May 2012-September 2013, and October 2013-September 2014 respectively.

Table 1. *Pokja* achievement in advocacy for financial resources as of April-June 2015

	PROVINCE	DISTRICTS	
Phase 1	North Sumatera	**Asahan**	**Deli Serdang**
		Since 2014, the District Budget has included matching allocations to support EMAS Program activities	Budget to continue supportive supervision, MPA, and clinical mentoring, and to replicate EMAS intervention in other facilities
	Banten	**Serang**	
		Allocated IDR 300million/year to continue supportive supervision, MPA, and clinical mentoring, and to replicate EMAS intervention in other facilities	
	West Java	**Bandung**	**Cirebon**
		Increased district health budget to replicate EMAS intervention in other facilities	Allocated district budget to establish a complaint handling system on MNH services, publication of Service Charter, and implementation of SijariEMAS
	Central Java	**Banyumas**	

[6] The *pokjas*' mentoring role indicated in Figure 1 is not discussed here.

Phase	Province	District	District
		Increased of District Budget allocation for MCH program from approx. IDR 200 million in 2012 to approx. IDR 1 billion in 2015	
		Malang	**Sidoarjo**
	East Java	Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH services	Increased district budget for rehabilitation of health facilities, provision of essential medicine-equipment for emergency MNH services, and to support MKIA activities
		Pinrang	
	South Sulawesi	Budget to replicate EMAS intervention in other facilities	
		Labuhan Batu	**Langkat**
	North Sumatera	Since 2014, the District Budget has included matching allocations to support EMAS interventions	Has not made any notable achievements in advocacy because *pokja* is currently putting most efforts on organizational development
		Tangerang	
	Banten	Increased district budget for MCH program; also received increased supporting budget for MCH program from the provincial level	
		Karawang	
	West Java	District budget has included allocation specific for EMAS implementation and replication in amount around IDR 400-450million/year	
		Kota Semarang	**Cilacap**
Phase 2	**Central Java**	Has not made any notable achievements in advocacy because *Pokja* is currently putting most efforts on organizational development	Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH services
		Pasuruan	**Blitar**
	East Java	Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH services	Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH services
		Jombang	
		Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH services	
		Bulukumba	**Gowa**
	South Sulawesi	Increased district health budget up to 14% of total district budget	Increased district health budget up to 11% of total district budget

Role 2: Advocacy for policy change

The success indicator of *Pokja* policy advocacy is the passage of district-level regulations that have the power to strengthen intersectoral collaboration to improve the quality, access and utilization of emergency MNH services and referrals. District laws (*peraturan daerah/Perda*) and *Bupati* decrees (*peraturan bupati/perbup*) represent examples of such governance reforms, which increase likelihood of success and sustainability of maternal- and newborn-saving interventions in the district.

By April-June 2015, most *Pokjas* in both Phase 1 and Phase 2 districts had made notable achievements in policy advocacy. Some districts have been exceptionally successful since their policy advocacy activities have resulted in the issuance of a district law or a *Bupati* decree that specifically

addresses maternal-newborn life-saving measures. Others have invested in long-term advocacy efforts to pass similar legislation. Table 2 presents the results of *Pokja* advocacy for policy change in these districts.

Table 2. Pokja achievements in advocacy for policy change by April-June 2015

Phase	PROVINCE	DISTRICTS	
Phase 1	North Sumatera	**Asahan**	**Deli Serdang**
		Bupati Decree mandating birth in health facilities	*Pokja* is still advocating for a *Bupati* Decree to support implementation of PK (memorandum of agreement) among health facilities on emergency MNH referral and use of SijariEMAS
	Banten	**Serang**	
		Pokja is still advocating for a *Bupati* Decree on the emergency MNH referral and services	
	West Java	**Bandung**	**Cirebon**
		District Law (*Perda*) on improving maternal, newborn, infant and children health and survival	District Law (*Perda*) on improving maternal, newborn, infant and children health and survival
	Central Java	**Banyumas**	
		District Law (*Perda*) on improving maternal, newborn, infant and children health and survival	
	East Java	**Malang**	**Sidoarjo**
		Pokja is still advocating for a District Law/*Bupati* Decree to support replication and sustainability of EMAS model intervention	*Pokja* is still advocating for a District Law/*Bupati* Decree to support replication and sustainability of EMAS model intervention
	South Sulawesi	**Pinrang**	
		Bupati Decree that mandating standardization of MN services and intersectoral collaboration	
Phase 2	North Sumatera	**Labuhan Batu**	**Langkat**
		Pokja is in process to identify the needs for new or strengthened policy product	Has not made any notable achievements in advocacy because *Pokja* is currently putting most efforts on organizational development
	Banten	**Tangerang**	
		Bupati Decree no.56/2014 on the Guidelines for Emergency MNH services in Tangerang District	
	West Java	**Karawang**	
		Pokja is advocating for a *Bupati* Decree to support implementation of quality emergency MNH services.	
	Central Java	**Kota Semarang**	**Cilacap**
		Has not made any notable achievements in advocacy because *Pokja* is currently putting most efforts on organizational development	*Bupati* Decree on early and exclusive breastfeeding for newborns, and birth in facilities as a mandatory
	East Java	**Pasuruan**	**Blitar**
		Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH	Increased district budget for rehabilitation of health facilities and provision of essential medicine-equipment for emergency MNH

	services	services
	Jombang	
	Before EMAS started, this district already has District Law no. 2/2009 on MNH services. *Pokja's* focus is on fostering the implementation of the law	
South Sulawesi	**Bulukumba**	**Gowa**
	Pokja is advocating for a *Bupati* Decree to support implementation of quality emergency MNH services.	*Pokja* is advocating for a *Bupati* Decree to support implementation of quality emergency MNH services.

Role 3: Collaboration with Civic Forum

Each *Pokja* includes members drawn from the civil society mechanism known as Civic Forum. These representatives of Civic Forum are particularly responsible for *Pokja* activities related to community empowerment and enhancing accountability of government and health providers in provision of MNH services. Besides including Civic Forum representatives as *Pokja* members, the working groups foster collaboration with Civic Forum through regular meetings. By spring of 2015, almost all *Pokjas* had established regular quarterly consultations with Civic Forums in EMAS Districts. In a few districts, *Pokja* and Civic Forum interfaces are conducted in more informal settings on an as-needed basis. In Jombang District (East Java) for example, Civic Forum seeks meetings directly with the DHO, as the lead agency in the *Pokja*, whenever an urgent issue arises.

Examples of Pokja collaborations with the Civic Forum cited in a 2014 evaluation included:

- Joint coordination with the DHO (Pinrang, Asahan)
- Implementation of civil society forums to increase community awareness of MNH issues and national health insurance (Serang, Blitar)
- Planning and budgeting activities (Bulukumba)
- Mapping of potential village-level maternal and child health coordinators (Asahan, Deli Serdang, Malang, Gowa)[7]

Some *Pokjas* also credited collaborations with Civic Forums – in combination with advocacy for financial resources – for concrete improvement in MNH services. In Labuhan Batu, a participant in the FGDs noted that the *Pokja* and Civic Forum collaborated to encourage facility-based deliveries. Whereas in the past, the number of deliveries at the *puskesmas* had been two to three patients per month, it increased to 40-60 patients per month. As a consequence, the *puskesmas* was not able to accommodate all patients and needed to use residents' homes to serve as a delivery facility. Responding to this increase, *Pokja* members advocated for funds to improve *puskesmas* facilities to

[7] Jain, R. 2014. *Expanding Maternal and Neonatal Survival: An Analysis of the Civic Forums and Pokjas*. Jakarta: EMAS.

be able to serve all women who come for childbirth. The proposal was approved by the local government, and the renovation and expansion will start in 2016.[8]

Factors influencing *Pokja* effectiveness

The EMAS experience with *Pokjas* highlights several factors that have contributed to the success of intersectoral collaboration and the effectiveness of the *Pokja* as a governance mechanism. Although the dynamics of individual collaborative efforts are driven by context and the specific social or community problems being addressed, some commonalities can be identified, which are summarized here.

Political commitment

Political support is key to encouraging action on many of the determinants of maternal-neonatal survival that fall outside the direct influence of the health sector. Visible political support and commitment, especially from the *Bupati,* has proven to be a strong motivator to mobilize engagement and support from various stakeholders. In Banyumas District in Central Java, one of the sites where the *Pokja* had developed strong capacity and performed well (see Figure 4), the *Bupati* showed great concern over maternal-neonatal deaths and was very supportive of the *Pokja*. Instead of waiting to receive reports, he held three-monthly health forums inviting various stakeholders relevant to maternal-neonatal health services, including heads of hospitals and *puskesmas*, EMAS mentors, professional organizations and the *Pokja* to discuss cases and monitor deaths.

Another example is the *Bupati* in Pinrang District (South Sulawesi Province), who was very committed to achieving MDGs 4 and 5 related to maternal and child mortality, and has demonstrated consistent support for the *Pokja's* agenda. He signed a regulation concerning maternal and neonatal health that the *Pokja* had proposed, which directs hospitals and the DHO to undertake MNH activities and provide life-saving equipment. Taking the *Pokja's* advice, the *Bupati* directed the head of sub-districts (*camat*) and villages to become actively involved in the identification and monitoring of pregnant women to ensure they can access appropriate MNH services in health facilities. He also signed a decree that the *Pokja* had drafted, which mandates audits of maternal-perinatal death cases.

In some districts, the *Sekda* provided effective political commitment as well, given his operational authority. One FGD participant suggested that the *Pokja's* problem-solving effectiveness was due to the *Sekda's* ability to encourage intersectoral cooperation.

> ***The one that has authority of all the employees is Sekda. Therefore, the Sekda was appointed as the Chairman of the Pokja. The function of Pokja is to coordinate all activities related to MMR and IMR. It is expected that the Sekda who does the activities and other members make the move.***

[8] Martha, E. 2016. *Qualitative Report: EMAS Program Evaluation.* Jakarta: EMAS.

These activities cannot be done solely by the DHO… The function of the Pokja is to settle all the problems that are not successfully solved at the bottom level. For example, there was a problem in a sub-district that involved the Office of Transportation. Who owns the Office of Transportation? The Sekda does (Civic Forum representative in Pokja, Labuhan Batu).[9]

Leadership of health sector

The capacity to carry out intersectoral collaboration is very much dependent on leadership. Leadership is key to instilling collective commitments, developing trust, and fostering good working relationships. High performing *Pokjas* across EMAS districts showed strong leadership by senior DHO staff.

The DHO fulfills two roles in the *Pokja*: leader and facilitator. It assumes leadership roles when addressing issues that relate most directly to its mandate and fall within its realm of expertise, such as maternal-perinatal audits, equipment and health staff capacity readiness in MNH service facilities. The DHO shifts to a facilitation role when the issues extend beyond established health sector capacities, for example, addressing traditional beliefs around MNH care or emergency transportation from households to facilities. This role included crafting a compelling case for actions on the part of other non-DHO stakeholders, suggesting ideas, identifying resources, etc.

Having the right person from a sector or agency—an individual with credibility and the authority to influence and make decisions—was also found to be beneficial for *Pokja* effectiveness. Well-performing *Pokjas* tended to include committed MNH “champions,” prominent and influential leaders, to communicate the issues in terms understood by other sectors beyond health. These champions helped facilitate a shared vision among *Pokja* members and built constituencies for MNH. They used their personal influence and credibility to advocate for widespread adoption of EMAS-supported interventions.

Clarity about roles and responsibilities among members

Intersectoral collaboration calls upon stakeholders to step outside their day-to-day roles and responsibilities and engage with others to achieve a cooperative objective. Therefore, making sure that *Pokja* members had a clear and shared understanding of their roles and responsibilities was important for performance. An internal review conducted by the EMAS team in the third year of implementation revealed that a small subset of *Pokjas* were not reaching their full potential and that most did not proactively address issues as compared to other *Pokjas* that have been established by that time. These underperforming *Pokjas* were found to have large memberships and an absence of clarity around roles and responsibilities among the members. Assisted by EMAS advisors, the *Pokjas*

[9] Martha, E. 2016. *Qualitative Report: EMAS Program Evaluation.* Jakarta: EMAS.

modified their structure by dividing members into smaller working teams with specific tasks and responsibilities, and clear understandings of how their activities contributed to *Pokja* goals. After the restructuring, these *Pokjas* began picking up the pace in accomplishing their work plans and achieving results.

Clearer responsibilities among *Pokja* members, in combination with and support from EMAS clinical mentors, had improved frontline providers' skills and confidence in managing emergencies and referrals. For example, one midwife described her experiences with stabilizing patients presenting with severe pre-eclampsia:

> ***I, as staff in the lowest level of emergency services, with the assistance from EMAS, have received many benefits, especially in performing stabilization. [Before] I did not dare to give MgSO4, I was afraid. I did not dare even to touch it (MgSO4). But with EMAS, Alhamdulillah (Thank God) we are able to handle severe pre-eclampsia, as well as other emergency cases. Before we made a referral to [higher levels], we are able to perform stabilization appropriately. Moreover, as currently each puskesmas has the … tools to monitor the performance of referral process, we can assess whether our referral system has been performed correctly or not…it has indeed benefited us at the primary care level (Pokja, Midwife, Banyumas).[10]***

Continuous communication

Because intersectoral collaboration brings together stakeholders that do not regularly interact with one another, effective communication channels are key to making the collaboration function smoothly. *Pokjas* hold regular meetings, both plenary and ad hoc, routinely meet with health facilities, and regularly discuss MOU's service charters, mentoring, near miss and death audits and relevant policies. *Pokja* meetings, for example, helped improve communication between midwives and facilities staff. *Pokja* meetings also served as support for the establishment of communities of practice among and within mentoring facilities to review use and results of clinical audits and share experiences with use of dashboard indicators. EMAS has seen a variety of positive outcomes as a result of systematically discussing data with *Pokjas*. For example, in high performing districts, relationships among hospitals and *puskesmas* have been noted to be strengthened as a result of *Pokja* meetings.

[10] Martha, E. 2016. *Qualitative Report: EMAS Program Evaluation.* Jakarta: EMAS.

Communication with communities and citizens is important, as well. Interaction with civil society through the Civic Forum enhances public support for district regulations and policy goals, promotes the legitimacy of the *Pokja*, and expedites exchange of information on MNH among the government, health facilities, and communities.

Sustainability

EMAS was designed to put in place systems and processes that contribute to sustainable delivery of maternal and neonatal health services. By working to establish good governance systems, EMAS institutionalizes approaches that are capable of monitoring, improving and sustaining quality over the long-term. EMAS considers sustainability to be related to a set of factors—political support and commitment, capacity, financial resources, owners, and champions. A description of these factors as they relate to *Pokjas*, together with the progress made to date, is provided below.

Political support

Overall, there is strong political support and commitment for *Pokjas*. As a governance forum, the *Pokja* directly support the "strengthening districts for good governance" component of the Indonesian government's "National Action Plan for Accelerating Reductions in MMR." *Pokjas* are established in each district via a *Bupati* decree and are intended to serve the district, not just EMAS. To ensure ownership, districts are responsible for establishing and ensuring functional *Pokjas*. The costs associated with *Pokjas* (primarily meeting costs) are funded by the District Budget (APBD) through DHO as a result of the *Bupati* decree regarding *Pokjas*.

At the national level, EMAS referral strengthening approaches, including use of *Pokjas,* have been incorporated into the "Guidelines for Improving Collaboration within Maternal and Newborn Health Services at Basic and Referral levels" (Collaborative Improvement Guidelines).[11] In 2016, a "Ministerial Decree of BEONC and CEONC and Collaborative Management of Maternal and Newborn Emergency Care from primary level to referral level" (*Permenkes Ponek, Poned, den Manajemen Kolaborasi Pelanyanan Gadar Maternal dan Neonatal Primer Dasar dan Rujukan)* will be issued for these guidelines. This *Permenkes* will provide umbrella policy support for EMAS interventions, including *Pokjas* focused on MNH issues, to be rolled out across Indonesia. It will also provide a legal basis by which provinces and districts can be held accountable for implementing these interventions and through which funding can be allocated.

Capacity and resources

Pokjas in Phase 1 and Phase 2 districts have developed to the point where they have the capacity to mentor *Pokjas* in other districts. To date, they have mentored EMAS Phase 3 districts in establishing *Pokjas* and developing referral network memoranda of understanding. Furthermore, some *Pokjas* have been invited by the government of non-EMAS target districts to share experience and provide technical assistances for *Pokja* development in their districts. The provincial governments in EMAS areas have also issued an official assignment letter (*Surat Keputusan*/SK) of Provincial Mentoring Rosters to ensure that the mentoring role of EMAS districts continues beyond EMAS' completion

[11] Developed by the MOH Directorate for Referral Health Services (*Bina Upaya Kesehatan Rujukan,* BUKR), with EMAS input.

date to mentor *Pokjas* in new districts. This is a strong positive sign that bodes well for sustainability of EMAS interventions, and is recognized by those who have participated in the *Pokja*. As one *Pokja* member noted, the mentoring component differentiated EMAS from other programs and increased the sustainability of the activities it supported:

> ***EMAS actually does not bring a new program, it provided a mentoring process... Others came and brought [another] program...[but] after it finished, nothing was left. But because we are being mentored, even though EMAS is about to end...we will appoint the Civic Forum or the Pokja to serve as the foreman [to continue activities] (Pokja member, District Health Office, Labuhan Batu).***[12]

Mentors and champions

By the end of the project, EMAS intends to have *Pokjas* that are motivated to continue to meet, review clinical and referral data and take action to address gaps related to maternal and newborn survival. These *Pokjas* will continue to serve as models and mentors for other districts and provinces. Despite this progress towards sustainability, ongoing advocacy will be required in some districts regarding the importance of MNH and recognition that a *Pokja* is needed. Having committed MNH champions who will continue to strive for maternal and newborn survival and ensure that the *Pokja* continues to meet, review data, and take action can be a sources of such advocacy.

While the MOH Collaborative Improvement Guidelines mark a major step in ensuring the sustainability of EMAS-supported interventions such as the *Pokja*, their sustained implementation will be strengthened if they are also endorsed at the district level through local laws and regulations. To provide a stronger platform for their role, EMAS will continue to work to include *Pokjas* in local regulations related to MNH services in each district. These regulations will ensure that *Pokjas* will have the authority to monitor and follow up on improvements in emergency maternal/newborn services and referral. In turn, having a *Pokja* in place as a forum for discussing assessment results, MPA results, and SijariEMAS data will also increase the likelihood of these EMAS approaches/interventions.

[12] Martha, E. 2016. *Qualitative Report: EMAS Program Evaluation. Jakarta: EMAS.*

CONCLUSION

The challenges of addressing maternal and neonatal mortality rates cannot be solved by health agencies acting alone. Research and practice recognize that intersectoral collaboration is necessary to engage the resources and capacities of state and non-state actors to co-produce services. Organizational mechanisms that enable co-production, such as the *Pokja*, fill both a governance gap and a logistics gap.[13] Regarding governance, the *Pokja* provided an important decision-making venue that pulled together a variety of stakeholders across local government units, health facilities (public and private), and communities, all of whom had a role in MNH, to come to agreement and to hold each other accountable. Regarding logistics, the *Pokja* enabled joint action to support the cross-facility coordination and the referral system in order to achieve the intended impacts on MNH. EMAS's experience with *Pokjas* confirms the power and promise of intersectoral collaboration as a necessary support to clinical improvements for MNH.

[13] Joshi, A. and M. Moore. 2004. Institutionalised co-production: Unorthodox public service delivery in challenging environments. *Journal of Development Studies* 40(4): 31-49. http://www2.ids.ac.uk/futurestate/pdfs/jds40-4.pdf