

Acronyms

ACCESS	Australia Community Development and Civil Society Strengthening Program
AIPD	Australia-Indonesia Partnership for Decentralisation
AIPHSS	Australia-Indonesia Partnership for Health Systems Strengthening
AIFDR	Australia-Indonesia Facility for Disaster Reduction
AIPMNH	Australia-Indonesia Partnership for Maternal and Newborn Health
ANC	Antenatal care
GOA	Government of Australia
GOI	Government of Indonesia
HRH	Human resources for health
IDHS	Indonesia Demographic and Health Survey
Jamkesmas	Jaminan Kesehatan Masyarakat (Basic Health Insurance for the Poor Program (operated by Ministry of Health)
Jampersal	Jaminan Persalinan (Targeted funding for free maternity care operated by the Ministry of Health)
MAMPU	AusAID's Empowering Indonesian Women for Poverty Reduction Program
MDGs	Millennium Development Goals
MNH	Maternal and newborn health
NMR	Neonatal mortality ratio
NTB	West Nusa Tenggara Province
NTT	East Nusa Tenggara Province
PNPM Generasi	Program Nasional Pemberdayaan Masyarakat Generasi Sehat dan Cerdas (National Program for Community Empowerment)
PERMATA	Primary health care strengthening and Maternal and Newborn Health
PHC	Primary Health Care

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1. Introduction

This paper sets out the gender and equity strategy of DFAT's new primary health care strengthening and maternal and newborn health and nutrition program in Indonesia, PERMATA.

1.1. PERMATA

The overarching development goal of PERMATA is to contribute to reduction maternal and newborn mortality and stunting and improved performance of the primary health care system in Indonesia. The program will operate in three focal provinces, namely Nusa Tenggara Timur (NTT), Nusa Tenggara Barat (NTB), and Jawa

PERMATA: end of program outcomes

- Reduced number of maternal deaths, particularly in poor and disadvantaged populations, in selected provinces and districts.
- Reduced number of newborn deaths, particularly in poor and disadvantaged populations, in selected provinces and districts.
- Reduced stunting in children under five, particularly in poor and disadvantaged populations, in selected provinces and districts.
- Improved detection and management of chronic disease by the PHC system in selected provinces and districts resulting from PHC strengthening
- Effective models and implementation approaches are scaled up and influence policy beyond PERMATA areas.

Timur (Jatim). The program builds on evidence and learning from the Australia-Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) which was implemented in 14 of the 22 districts of NTT and the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) implemented in 8 districts in NTT and Jatim and the national level. PERMATA extends the scope of AIPMNH geographically and expands the technical focus to include nutrition, and family planning and strengthening of the primary health care

system at the sub-national level. The program will support the GOI develop evidence based approaches and solutions to improving access to quality primary health care and raising MNH and nutrition outcomes among the poor and disadvantaged.

The five pathways of PERMATA are:

- Women, families and communities empowered to make healthier decisions
- Increased community access to essential health services
- Improved coverage and quality of essential maternal and newborn health and nutrition services
- Increased availability of essential primary care resources
- Improved primary health care systems management and accountability

PERMATA is an eight year program which will be delivered through a mix of modalities including demonstration models, technical assistance and financial support to the GOI.

1.2. Rationale for a gender and equity strategy

Inequality of maternal and newborn health outcomes in Indonesia by geographical regions, and between socio-economic groups is well documented as are gender based barriers to accessing health care¹. The disparities undermine progress in achieving Indonesia's Millennium Development Goals, and concerns that the gap is widening².

¹ See: Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International. 2008. *Indonesia Demographic and Health Survey 2007*. Calverton, Maryland, USA: BPS and Macro International.

Statistics Indonesia (Badan Pusat Statistik—BPS), National Population and Family Planning Board (BKKBN), and Kementerian Kesehatan (Kemenkes—MOH), and ICF International. 2013. *Indonesia Demographic and Health Survey 2012*. Jakarta, Indonesia: BPS, BKKBN, Kemenkes, and ICF International.

Nguyen K.H., Bauze A.E., Jimenez-Soto E., Muhidin S., 2011, Indonesia Equity Case for Financing Equitable Progress Towards MDGs 4 and 5 in the Asia Pacific Region. Equity Report.

² See Thomas D. and Yusran S., 2013, "Social Development Analysis to Support the Design of AusAID's Future Maternal and Newborn Health Program in Indonesia, PERMATA" AusAID.

National and international experience shows that sustaining policy and program attention to gender and equity requires concerted and systematic effort for them to be translated into action. This strategy provides the framework for how PERMATA can promote gender and equity objectives, and by so doing increase the likelihood of achieving program results.

Issues related to gender and equity of health and nutrition outcomes are spread across the health system. They range from barriers faced in the family and community, along the journey to a health facility, within the health service and the systems that support it, through to policies and regulations. Gender and equity concerns are therefore woven into the full spread of interventions across the demand and supply side, and into governance and accountability.

1.3. How the strategy was developed

This strategy has been developed alongside the design of PERMATA to allow maximum integration and ownership of gender and equity principles and activities. It has been informed by the wide body of literature and evidence on the gender, socio-cultural, geographical, financial, health service and institutional barriers to improving maternal and newborn health in Indonesia and internationally. Analytical work on gender and equity was also commissioned as part of PERMATA design and has informed the design of the program and this strategy³. Experiences and learning from AIPMNH and GoA's other health and demand side programs have played an important part in shaping the strategy, as has consultations with a wide variety of stakeholders from women and members of the community through to health providers, district managers, government policy makers and development partners.

2. Aim of the gender and equity strategy

Gender and equity is a cross-cutting concern which has to be integrated across the PERMATA program and not packaged into a separate component. However, as international experience shows, in addition to integration, it is important that the strategy includes specific gender and equity initiatives which can capture policy and political attention, and profile the strategy.

The aim of PERMATA's gender and equity strategy is therefore twofold: (i) to integrate gender and equity into all areas of the program, and (ii) to demonstrate the effectiveness of specific gender and equity initiatives to increase access to primary health care including MNH services. Through this strategy, starting from planning, through to implementation and monitoring and evaluation, political commitment will be built, technical know-how developed among program partners, and programmatic solutions demonstrated to national and sub-national governments. Implementation of the gender and equity strategy will contribute to closing the gap in health outcomes in focal program areas, and to more gender and socially inclusive health policies.

3. Values and principles of the strategy

This strategy is premised on the value that inclusive development is good development. Social inclusion of women, the poor and vulnerable groups in the benefits of development has both a moral foundation, makes good economic sense, and contributes to a country's social stability and cohesion⁴.

To guide PERMATA in the integration of gender and equity, and drawing on lessons that GOA has learned on aid effectiveness from across its portfolio in Indonesia, the strategy has a number of guiding principles⁵:

³ See Thomas and Yusran 2013. Thomas D and Raintung A, October 2013, Social Development Assessment of PERMATA: Report of Field Visit to Papua, 15-20 September, 2013. Yusran S and Raintung A, September 2013, Social Development Assessment of PERMATA: Report of Field Visit to East Java and Nusa Tenggara Barat.

⁴ Government of Indonesia, 2012, Gender Strategy and Action Plan.

⁵ Powerpoints from Government of Australia's Indonesia's Community of Practice workshop on replication and leveraging; June 2013.

- ‘Closing the gap’ is often more expensive than maintaining the status quo but additional program costs are justifiable to achieve equity and policy objectives, and increase access to services of underserved and marginalised populations.
- Be context specific. Different settings may require different approaches, interventions, partners, pace of implementation, and resource levels. Local solutions and learning what works in different contexts for different population groups is key. Scaling up needs to fit with the socio-economic, geographical and health service context and some interventions to reach very vulnerable groups may not be appropriate for large scale replication.
- Gender and equity has to be integrated across all components and activities of the program and included as a responsibility of all program staff.
- Ownership is central to sustainability and needs to be factored into all program areas and ways of working. Building ownership of gender and equity as a value, objective, activity area and result is a priority for the program.
- Transformational change is needed in the home, community and the health service to make a sustained difference to gender and social inequities in health, particularly MNH, and empowering approaches are more effective at achieving this.
- Gender and equity has to be integrated into the monitoring and evaluation system and may require innovative methods of data collection.

4. Pillars of the gender and equity strategy and areas of activity

There are five pillars through which gender and equity will be integrated into PERMATA as shown below.

Figure 1: Five pillars of the gender and equity strategy



4.1. Evidence for gender and equity in MNH

The Indonesia Demographic and Health Surveys are reliable evidence bases that periodically capture inequalities in MNH outcomes at the national level. Government routine information systems are weak and disaggregated data on *who* is utilising services and *who is left out* are not common at any level of the health system.

Strengthening the evidence base on who is left out of MNH gains at the national and sub-national level and why will contribute to policy development and programming. PERMATA will support research and impact studies in the focal provinces to build the evidence base on inequalities in health and nutrition outcomes, and in access to and utilisation of health services. The evidence portfolio will be defined during the inception phase of the program in partnership with provincial and district governments. It is likely for example, to include the impact of universal health care on financial access to health services of poor and vulnerable populations.

Reproductive health policy in Indonesia limits access to government family planning services to married couples and this places unmarried women at greater risk of unwanted pregnancy. The rising influence of fundamental religious movements has led to a shrinking of moral space around reproductive health including family planning and safe abortion. Evidence of the magnitude of unmarried pregnancies and abortions in Indonesia and their contribution to maternal mortality is a gap. The World Health Organisation estimates that

abortion accounts for 14% of maternal mortality in South East Asia⁶. Filling critical evidence gaps in areas that impact on maternal and neonatal mortality, and uncover and quantify vulnerability to maternal and newborn death is an area of work for PERMATA. Linkages with multi-sectoral learning platforms and civil society coalitions will be developed so that these actors can translate evidence into influential, well-targeted and timely advocacy.

Learning platforms: Sited within government, PERMATA has the opportunity to influence policy makers and program managers at several levels through information dissemination and exchange. Use of learning platforms which bring together Indonesian academics, policy makers, development partners, and civil society organisations has been relatively effective for other GOA-GOI programs, and will be used by PERMATA. Inclusion of gender and equity as core research themes in the learning networks will assist in opening up the acceptability and importance of these research topics. Rights based reproductive health advocacy supported by MAMPU will complement the policy-oriented evidence generation that PERMATA will be better positioned to lead.

Ethnographic research: Quantitative surveys including impact evaluations which can provide robust evidence of the magnitude of inequalities, and assess the impact of program interventions will be part of PERMATA's contribution to the evidence base. Qualitative research which captures the voices of women, men, different ethnic groups and communities, and providers and is able to explain why changes take place or not, will also be important. Ethnographic and peer based qualitative research to monitor changes in social norms and practices will be particularly important given the cultural and gender based barriers that women in the focal provinces face in accessing services.

Innovative ways will be developed to strengthen the influence and use-ability of various data sources on gender and equity. This may include an equity and MNH report card at sub-district, district and provincial level which synthesizes data sources (eg. HMIS (riskesdas), impact studies, qualitative research, community monitoring) and tracks progress for the specified geographical area on an annual basis. A standardised format would allow comparison over time and between geographical areas. Kept simple and reliable, the MNH equity report card could be an advocacy and monitoring tool for parliamentarians, policy makers and leaders at all levels of government.

4.2. Strengthening health systems for more equitable PHC and MNH programming

Information, planning and monitoring for gender and equity

Lack of reliable evidence affects planning, monitoring and decision-making at all levels. From a gender and equity perspective, lack of information on who is left out of service take-up or who is vulnerable to maternal and neonatal death inhibits efforts to reach them as they remain invisible. As PERMATA aims to improve the generation and use of data for decision-making, and create multi-tiered learning platforms, it will be well-placed to assess and identify how evidence can be better collected and used to fill information gaps that are critical to equitable programming and monitoring at district and sub-district level. Sex disaggregated data for child health and mortality is a case in point. Other possibilities include the systematic use of geo-spatial mapping to plan outreach services, identify vulnerable households, and allocate resources.

Various community programs identify vulnerable households for targeting with differing degrees of error. Political influence and patronage often affects who is selected as a beneficiary. World Bank (2012) found that social protection programs have serious weaknesses in their targeting efficiency leading to false inclusions and exclusions⁷. The fragmented approach to identifying program beneficiaries is confusing to users, is known to exclude some vulnerable families, and creates a false sense of covering the very poor. Use of data sets and registers from poverty reduction or social protection programs such as PNPM Generasi or jamkesmas to

⁶ WHO, 2012, Unsafe Abortion Incidence and Mortality.

⁷ World Bank, 2012, *Protecting Poor and Vulnerable Households in Indonesia*.

monitor the reach of health services to poor and vulnerable families may not provide an accurate picture as they cover partial groups of the poor and vulnerable.

Community based mechanisms such as Desa Siaga which collect community wide data on all pregnant women and their newborns could be a more accurate way of collecting inclusive data at the community level to identify vulnerable households than relying on registers from other government programs. PERMATA will give attention to how reliable data can be collected at the community level to identify vulnerable women and families and target health services to them. Collaboration with AIFDR and related geospatial mapping of vulnerable households can be pursued to synergise effort and resources.

Linkages between the different registers and databases within the health system (posyandu, polindes, pustu, puskesmas, Jaminan Kesehatan Nasional) are not connected for planning and monitoring purposes. Better joined-up use of this information by service providers and managers could improve reach to poor and remote women and children, and strengthen the monitoring of access and equity at the primary health care level. Similarly, PERMATA has a role to play in strengthening inclusion of gender and equity concerns in district level planning and monitoring. This will include strengthening the availability and quality of health service utilisation data so that it incorporates equity dimensions and can be used to track progress in reaching poor, remote and vulnerable groups. In addition, PERMATA will leverage existing opportunities for community engagement in district planning and monitoring as well as cross-sectoral involvement, thus promoting greater accountability.

The vital registration system is weak and while institutional strengthening falls outside of the program's boundaries, given the increasing numbers of facility based deliveries it is expected that PERMATA will work within the Frontline framework to support improving of the timely and inclusive issuance of birth certificates.

[Funding and incentivising pro-poor service delivery](#)

At the national level, health financing reforms will be supported by AIPHSS. AIPMNH has had some success at improving fund management at puskesmas level which receives over ten different sources of financing to manage. As fund availability and flexibility is a major constraint at the primary health care level, PERMATA plans to test out the effectiveness of performance based grants to districts against primary care indicators. While recognising that performance based grants work best where the targets or indicators are small in number and achievable and the need to resist overloading them, this mechanism could be a way of encouraging health managers to use flexible funding to target underserved populations such as remote villages or hamlets. Opportunity to integrate an equity perspective into PERMATA's performance based grants needs to be assessed and maximised as appropriate.

[Human resources for health \(HRH\) to improve the equity gap](#)

Demand for primary health care and maternal and child health services in some areas, such as NTT, lie unmet because of the non-availability of services. Uneven distribution of health personnel is one of the underlying causes of poor health service coverage. In addition, high rates of absenteeism and the challenge of retaining staff in rural and remote areas is a systemic problem that impacts most on the poor and poorest. In some areas in NTT, language and the cultural background of many health workers hinder their posting to rural areas and further obstruct workforce placement. While AIPHSS leads GOA's support on HRH policy and workforce planning issues, PERMATA is well placed to offer contextual and programmatic insight and incubate HRH solutions linked to MNH and PHC provision in the focal provinces. This could for example involve evidence generation around HRH availability and skills, and collaborative streams of work on testing out solutions to staffing remote health facilities, such as rotational placement of midwives between remote areas and district hospitals or high patient load puskesmas to retain competencies and mentoring. PERMATA's focus and comparative strength on gender and health equity will be an added-value to feed into HRH policy research. Mechanisms to involve PERMATA's gender and equity specialists in HRH policy and planning development networks at provincial and district level will be guided by AIPHSS experience.

Locating services to be accessible

The location of primary level health facilities and outreach services currently gives inadequate consideration to accessibility by the poorest and remote, and to women's needs and voices. Posyandu clinics are held in rooms and spaces provided on a voluntary basis. Donated land is often in undesirable locations such as near the cemetery where women and families do not like to go, or in areas away from remoter hamlets where poorer families live. PERMATA will support districts and sub-districts to improve the synergy between where services are provided and who needs to receive them. This could include guidelines for the equitable location of new primary level facilities. For community level service centres, such as posyandu, which are moveable, consensus and buy-in of local government budget holders and communities will need to be forged to identify accessible locations, mobilise the necessary resources, and if necessary purchase land. Improved physical planning and locating of services to be more accessible, along with improved human resourcing of them, could increase utilisation by poor and remote populations.

4.3. Making PHC and MNH services more gender sensitive and inclusive

Outreach and community based health service delivery are currently weak. The posyandu is struggling and midwives are overstretched to deliver outreach services in their catchment areas along with facility based clinical and administrative duties. The ratio of villages to midwives is high generally, and in remote areas midwives are often not available. PERMATA will develop and test outreach and community based PHC and MNH service delivery strategies tailored to context to increase access of the poor, difficult to reach, and remote communities. This will include clinical service delivery and the provision of information and counselling; and very importantly an enhanced focus on home visits to postpartum women and babies. Linkages with AIPHSS and DFAT-supported civil society strengthening programs to address HRH management issues and strengthen community monitoring and accountability will aim to increase the incentives and pressures on health providers to undertake outreach.

Respectful care: Quality deficits in puskesmas and outreach health services are well documented vis-a-vis clinical competence, interpersonal communication, and respect. Respectful care is an important but often overlooked element of quality of care which impacts on the confidence and trust users have in services and consequently affects demand. This includes providing information to clients so that they can make informed decisions and understand the benefits and risks of procedures and services they receive, and be aware of their entitlements. PERMATA will integrate attention to respectful care into HRH capacity building programs, and systems of supervision and management, to foster a culture for practicing and rewarding respectful care.

Vulnerable women: PERMATA's emphasis on empowering women and girls means that it will give particular attention to reaching socially vulnerable pregnant women and their infants, who are also the most at risk. Unmarried pregnant women are particularly at risk as they transgress social norms and may find themselves outcast from the family and community; this in turn places their children at risk. Other vulnerable women and their children, include women living with disability, sex workers, women living with HIV/AIDS, and returning migrant workers. PERMATA will pilot targeted approaches to reaching socially vulnerable pregnant women and their children, possibly in collaboration with civil society organisations. This will include outreach and communication efforts to help vulnerable women overcome social and physical barriers to access, as well as training and skill development of midwives and health workers so that they are better equipped to provide respectful services to them, and improvements in infrastructure to make facilities more physically accessible.

4.4. Voice and accountability for PHC and MNH

In NTT where political commitment to maternal health is strong and local regulations for institutional deliveries have been passed, public demand and voice for quality maternal health services has grown. In this context, there is opportunity to leverage the space that maternal and neonatal death audits have created and promote community monitoring of maternal and newborn births, deaths and services. Strengthening social

capital so that communities lead and own health development, and are empowered to work with providers and policy makers and also hold them to account, can make a difference.

Voice and demand side accountability approaches in the health sector can take various forms. Under PERMATA, voice efforts will focus at the community and facility level where gains in improved service delivery and utilisation seem most likely to result, and accountability interventions can work synergistically with support provided to strengthen services. International experience shows that community monitoring of health services can have a significant impact on health outcomes and functioning of health services⁸.

Community monitoring: In Indonesia where community structures and leadership are respected and have authority and influence, the enabling environment for community monitoring of health services, particularly MNH, is encouraging. This is further supported by the fact that maternal and neonatal death audits have fostered a willingness of the health department to share information with the public, and to take a no blame approach. Building on AIPMNH's Desa Siaga experience, and community involvement in Puskesmas Reformasi, as well as community monitoring approaches developed by previous Australian support in civil society strengthening (ACCESS), PERMATA will experiment with the introduction of community monitoring of health outcomes with the aim of improving the availability and quality of local health service delivery and influencing district policymakers and officials. Scoping and design work during inception and implementation phases will determine the nature of the community monitoring. Various approaches need to be considered, including social audit, community scorecard, public gatherings, the adaptation of Desa Siaga, and using customary institutions and tools. Mechanisms and partnerships to advocate towards policy makers will need to be factored into the design. Community monitoring will provide another vehicle for mobilising the community for MNH and other health problems and may be an alternative to Desa Siaga in some contexts, such as peri-urban areas.

Puskesmas Reformasi is a multi-dimensional intervention that is enabling community participation in health facility management and reform, encouraging community contributions to the functioning of the puskesmas, and increasing information dissemination and transparency. It is therefore an important vehicle through which to strengthen responsiveness to the community. This will embrace attention to the needs of the local community and the barriers they face in accessing services, how services can be made more gender responsive, and the constraints that poor and vulnerable population groups face in availing services, including for example unmarried pregnant women, remote communities, and the very poor.

Through Puskesmas Reformasi, PERMATA will bring a stronger gender and equity lens into the management of primary health care services. Under AIPMNH, Puskesmas Reformasi led to changes in the physical infrastructure of facilities which increased women's accessibility, including for example labour wards on the ground floor, ramps rather than stairs, separate toilets for women, waiting areas for accompanying family members. Maternity waiting rooms are another example of a local solution. Under PERMATA, gender responsive approaches and ways to reach underserved populations through demand and supply side solutions will be stimulated through Puskesmas Reformasi, and potentially linked to performance based grants.

Attention to gender and social inclusion in the functioning of Puskesmas Reformasi itself will also be strengthened. This will include attention to the gender balance of committees, the orientation and facilitation necessary to support a stronger gender and equity focus, and how Puskesmas Reformasi can embed inclusive community engagement in the reform process.

4.5. Informed and empowered demand

Costs, remote and difficult terrain, gendered decision-making, cultural norms and traditional practices, and poor knowledge of healthy practices are some of the key barriers that inhibit use of health services in the focal

⁸ See Thomas and Yasrun 2013.

provinces. It is well recognised that strengthening health services without addressing demand for care and the barriers that restrict access especially in poor and geographically challenging contexts will have limited results. AIPMNH provides valuable experience and lessons of what has worked to mobilise communities, and what additional interventions are needed. PERMATA builds on this learning and expands the range of demand side initiatives to more effectively empower women and communities to improve health practices and use of services; increase access to care, and affect the underlying determinants of maternal and newborn health.

Information and empowering communication is key to improving health and nutrition practices including early and exclusive breastfeeding, care of the pregnant woman, hand washing and sanitation. Given women's lack of decision making authority in the family, and patriarchal power structures in the community, information needs to be provided in a way that informs and empowers women and their mothers-in-law to trade traditional practices for healthier and more modern ones, and empowers women to decide when to seek health care. Male involvement and participation will be essential for success.

At the international level, community based approaches have demonstrated their effectiveness in raising awareness, changing family practices, and impacting on neonatal and maternal health outcomes^{9,10}.

In Indonesia, midwives are expected to provide community based ANC and post natal home visits, though this is often compromised. PERMATA will strengthen and complement this community delivery platform with empowering education and support to the mother and family. PERMATA will assess, design and test communication approaches for empowering women and families to adopt healthier practices in selected sites. The opportunity to build on existing women's groups will need to be explored. The emphasis will be on empowering communication to mobilise for change rather than product based information to raise awareness.

The socio-cultural diversity of the focal provinces and differences in the capacity and coverage of the health service, means that different approaches are likely to be relevant in different contexts, and in some situations such as peri-urban areas, well designed information products may be the most appropriate response. Linkages with PNPM Generasi's planned community based nutrition facilitator model will need to be explored, and factored into intervention design. One possibility is that PERMATA will test out the nutrition facilitator model in selected focal areas where PNPM Generasi is not present.

Raising awareness of entitlements: Lack of awareness of health entitlements such as jamkesmas and jampersal continue with the launch of the national health insurance. This affects demand for services, and how much poor people benefit from government subsidies. Raising awareness of entitlements that poor, vulnerable, and near poor women have for primary health care including maternal and newborn health will enable them to reduce the financial barriers they face in accessing services, particularly delivery care. PERMATA will work with other Frontline programs to develop and test different information delivery approaches such as radio listening groups, SMS texting, and packaged combinations for raising awareness and claiming entitlements.

Desa Siaga has proven its ability to mobilise men and community leaders behind MNH and put in place structures and networks to support birth preparedness, emergency responses, and monitor individual actions. These are positive attributes that need scaling up. However, as currently designed Desa Siaga is not a vehicle for informing and empowering women to lead changes in family health seeking behaviour. Potential expansion of Desa Siaga to have a stronger focus on empowering women to lead change and the concomitant trade-off of diluting what Desa Siaga does well, will be considered during inception and factored in to Desa Siaga expansion. PERMATA will assist focal provinces with the roll-out of Desa Siaga including tailoring implementation to context, and learning how Desa Siaga can be sustained. Support to Desa Siaga will support

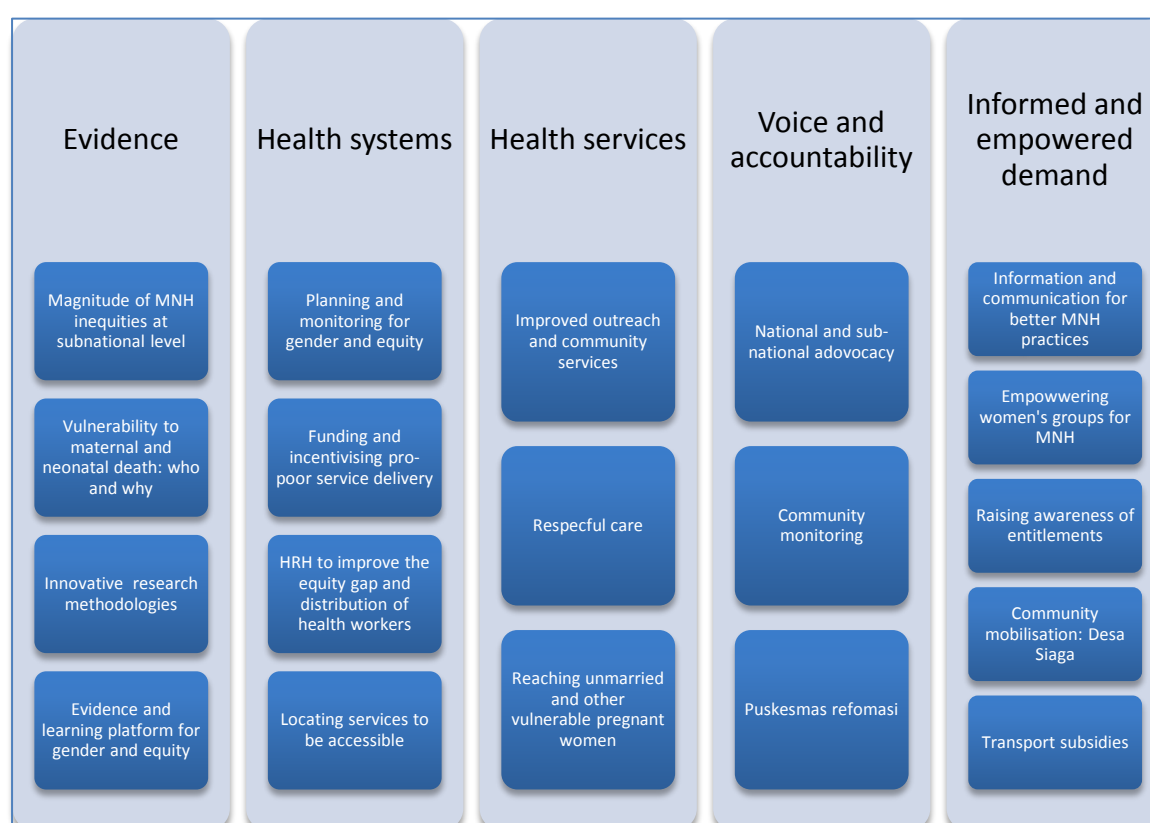
⁹ Lassi ZS, Haider BA, Bhutta ZA, 2010, "Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes (Review)", *The Cochrane Library* 2010, Issue 11.

¹⁰ Prost A., et. al., 2013, "Women's groups practising participatory and learning action to improve maternal and newborn health in low resource settings: a systematic review and meta analysis", *The Lancet*, 381:1736-46.

other community based planning and management programs, including disaster risk management, as well as voice and accountability efforts.

Transportation: The cost of transportation is generally reported to be the most expensive out of pocket expense related to seeking health care. Social protection programs do not cover the cost of transportation. Where Desa Siaga is active, transport costs are covered, but this is in a minority of areas. To tackle transportation costs to the user, PERMATA will assess and design a menu of options available to local government. This may include transport vouchers, subsidies for ambulance services, contracted transport providers, and community solutions as in Desa Siaga. An international review of emergency obstetric referral interventions by Hussein et. al. (2012) found that interventions focusing on improved referral of women with complications usually reduced newborn mortality but not maternal mortality, while community based emergency transport funds have a direct positive effect on maternal and newborn deaths¹¹.

Figure 2: PERMATA Gender and Equity Strategy and Key Areas of Activity



5. Implementation of the strategy

The strategy aims to mainstream gender and equity into all areas of PERMATA including its design, and demonstrate the effectiveness of a small number of specific gender and equity initiatives. The process for operationalizing the strategy will include the following:

District selection

Within each of the program provinces focal districts will be selected where activities will be implemented; the remaining districts in the province will participate in learning and exchange. The criteria for district selection will include gender and equity indicators as well as health and nutrition, and governance related criteria. This

¹¹ Hussein J et al (2012) The Effectiveness of Emergency Obstetric Referral Interventions in Developing Country Settings: A Systematic Review. PLoS Med 9(7): e1001264. [doi:10.1371/journal.pmed.1001264](https://doi.org/10.1371/journal.pmed.1001264)

will ensure that districts with the poorest socio-economic and geographical conditions such as poverty and remoteness are prioritised.

Program planning at the district level

In line with the context specific planning principle underlying PERMATA, each focal district government will develop annual workplans based on a situational analysis and needs assessment which includes attention to gender and social inclusion. Through this planning process gender and equity will be mainstreamed in district TA workplans and budgets, and targeted gender and equity activities included.

Monitoring and evaluation of PERMATA

Gender and equity will be mainstreamed into the monitoring and evaluation framework. This will include the collection and analysis of data disaggregated by socio-economic and geographical factors to identify trends in equitable coverage and outcomes; including for example by sex, poverty, faith, tribal group, remoteness, and social vulnerability. The program will also include evaluation of targeted gender and equity initiatives to inform government replication.

Learning and policy development

Gender and social inclusion are core principles of Government of Indonesia policy, and PERMATA's learning platform will contribute to strengthening the evidence base on which policies for achieving gender and equity in health are developed and operationalized.

Ways of working

Gender and social inclusion are played out in the way people, organisations and governments work. Gender-sensitive and inclusive ways of working have to be mainstreamed across the technical teams supporting government in each of the districts and provinces, and upheld as good practice through the management of the program.

Monitoring and development of the strategy

Implementation of the strategy will be monitored by the Australian Government during its periodic monitoring of the program. As the program and development context evolves, the gender and equity strategy will be adapted for relevance.

6. Coordination with other Government of Australia development programs

PERMATA is designed to work in coordination and synergy with other Australian Government programs at national and sub-national levels. The primary areas of coordination are set out below. The details, and the mechanisms by which programs will coordinate and be held to account on this, will be developed during PERMATA's inception phase.

- *AIPD*: At the district and provincial planning level, PERMATA's work on gender and equity will be supported by Australia's governance strengthening program which is well placed to support the mainstreaming of gender and equity into local government systems including public financial management systems. Communication and coordination at the district level will be forged by the implementing teams and through government partnerships.
- *AIPHSS* support to health financing and human resources for health and workforce planning will be the prime vehicle by which the Australian Government supports GOI integrate gender and social inclusion into these core building blocks of the health system. PERMATA will channel learning and advocacy around gender and equity into common health policy networks. Coordination and synergies will need to be managed by the respective implementing teams and defined during inception phase.
- *MAMPU* policy influencing and women leadership development will support the enabling environment for gender responsive and socially inclusive health systems and services. MAMPU

support for civil society-led advocacy is expected to be a means of amplifying learning and evidence from PERMATA. At the community level, MAMPU's plans to work with women networks and groups will open the opportunity for the two programs to develop reproductive, maternal and newborn health communication packages. In provinces and districts where MAMPU is not operational, PERMATA may adapt and roll out the communication package. The programmatic areas and means of coordination will need to be developed by the implementing teams at the national level during PERMATA's inception.

- *PNPM Generasi's* stunting initiative will be a key area of collaboration with PERMATA. Details of the scope of collaboration will be developed during the inception phase once there is clarity on its geographical scope.
- *AIFDR* development of geospatial mapping systems will provide health service providers, local government, and communities a platform for mapping health service availability, identifying areas with poor access, and vulnerable households; and contribute to community mobilisation. PERMATA supported *Desa Siaga* will support AIFDR's community mobilisation and preparedness planning.
- Complaint centres and demand side accountability initiatives previously developed by ACCESS and AIPD have, and are expected to continue to provide learning to PERMATA's community monitoring and advocacy work. DFAT health team will continue to communicate with the decentralisation program on how the PERMATA program can work with the next iteration of ACCES and AIPD.

Figure 3: Areas of coordination between PERMATA and other Australian Government Programs

