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Playbook

Adoption, Contextualization, and Adaptation of the Integrated and Champion Puskesmas (PUSPA) Program

Center for Indonesia's Strategic Development Initiatives (CISDI)

Collaborate with

DINKES JABAR

PUSPA
Puskesmas Terpadu dan Juara

Playbook

Adoption, Contextualization, and Adaptation of the Integrated and Champion Puskesmas (PUSPA) Program

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Introduction from the CEO of CISDI

The *Puskesmas Terpadu dan Juara* or Integrated and Champion Puskesmas (PUSPA) is a collaborative program between the West Java Provincial Government and the Center for Indonesia's Strategic Development Initiatives (CISDI), which focuses on strengthening primary health care services in West Java. This program was designed to respond the COVID-19 pandemic in 2020. As the COVID-19 pandemic progresses, marked by an increase in COVID-19 vaccination coverage and the beginning of the control of COVID-19 cases, the PUSPA program has expanded the scope of intervention to essential health care services: nutrition and non-communicable diseases (hypertension and diabetes mellitus) programs.

Primary health care services, with community health center or *pusat kesehatan masyarakat* (puskesmas) as the core of basic services, serves as the backbone of the national health care system. The significant role of *puskesmas* has become even more apparent as the world faces the COVID-19 pandemic. The PUSPA program aims to transform *puskesmas* into an optimal and responsive service provider through human resources capacity building, implementation of innovative programs, and cross-sector collaboration.

With the spirit of sharing and relentless learning, CISDI has developed a guideline or PUSPA playbook after three years working in West Java. CISDI hopes that this playbook can serve as a source of knowledge and inspiration for other institutions that also aspire to make Indonesia's *puskesmas* into integrated and champion health care service.

Happy reading.

Founder and CEO of CISDI

Diah S. Saminarsih

Introduction from the Head of the West Java Province of Health Office

The *Puskesmas Terpadu dan Juara* or Integrated and Champion Puskesmas (PUSPA) program is initiated through a collaboration between the West Java Provincial Government and the Centre for Indonesia's Strategic Development Initiatives (CISDI). We share the same goal of strengthening primary health care services, which is the spearhead of the national health care system. The PUSPA program was specifically launched on February 1, 2021, to assist the COVID-19 pandemic response, in line with the vision of the West Java Governor at that time. The PUSPA program supports the COVID-19 Pandemic response at the first line of defense, focusing on the 3M (wearing masks, washing hands, and maintaining distance) and strengthening of the 3T (Tracing, Testing, and Treatment-Isolation). With CISDI's experience and expertise in community empowerment, community-based surveillance in PUSPA Puskesmas differentiates them from other *puskesmas*. The community is involved in not only promoting 3M but also tracing cases and managing self-isolation as a follow-up to the case tracing results.

In 2022, the focus shifted to accelerate COVID-19 vaccination efforts and restore essential health care services for non-communicable diseases (NCDs) and nutrition that were affected during the COVID-19 pandemic. In addition, there was an increase in the Minimum Service Standards (MSS) or *Standar Pelayanan Minimum* (SPM) achievements for hypertension, diabetes mellitus, and productive age screening in 100 PUSPA locus *puskesmas*. In 2023, the PUSPA Program aimed to strengthen *puskesmas* in West Java, focusing its interventions in 8 districts/cities with the lowest Urban Health Index (UHI). Equipped with two years of learning, the PUSPA program has produced many innovations at the district/city and *puskesmas* levels in 2023 in the efforts to address and prevent stunting, immunization, and NCDs.

Over the course of 3 years in West Java, the PUSPA Program, with its various learnings and best practices, indeed needs to be materialized into a knowledge product as a guideline for all regional governments, especially province and district/city of health offices in West Java, and generally in Indonesia. Reflecting on the success of the primary health care service strengthening program, we support CISDI in creating this Playbook for Strengthening Integrated Primary Health Care Service. We encourage agencies and regions with similar aspirations to prioritize good governance, collaboration, and innovation. Finally, please enjoy reading this playbook and continue the work to improve public health.

Head of the West Java Province of Health Office

dr. Raden Vini Adiani Dewi

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Abbreviations

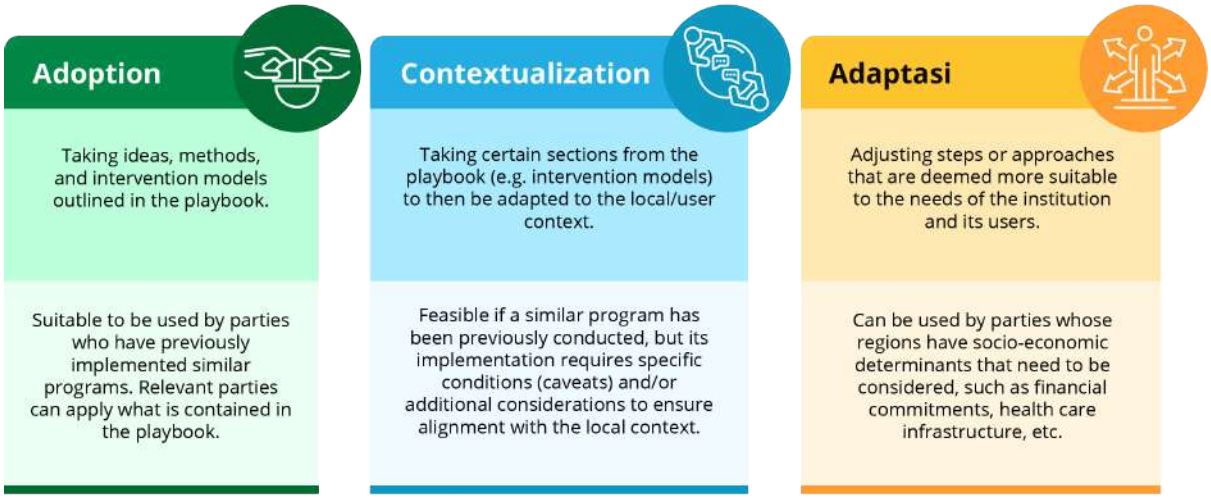
3M	Memakai Masker, Menjaga Jarak, Mencuci Tangan (Wearing Mask, Washing Hands, and Maintaining Distance)
3T	Tracing, Treatment, and Treatment-Isolation
APD	Alat Pelindung Diri (Personal Protective Equipment – PPE)
ASIK	Aplikasi Sehat IndonesiaKu
Bappeda	Badan Perencanaan Pembangunan Daerah (Regional Development Planning Agency)
BKKBN	Badan Kependudukan dan Keluarga Berencana Nasional (Family Planning and Population Control Agency)
BPS	Badan Pusat Statistik (Statistics Indonesia)
CHW	Community Health Workers
CISDI	Center for Indonesia's Strategic Development Initiatives
COVID	Corona Virus Disease
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
Dinkes	Dinas Kesehatan (Health Office)
DPMD	Departemen Pemberdayaan Masyarakat dan Desa (Department of Village and Community Empowerment)
FGD	Focus Group Discussion
GWB	Gubernur, Walikota, Bupati (Governor, Mayor, District Heads)
HDI	Human Development Index
IEC	Information, Education, and Communication
ITT	Indicator Tracking Table
NAR	National All Record
NCD	Non-Communicable Diseases
P2P	Pencegahan dan Penanggulangan Penyakit (Disease Prevention and Control)
PFA	Psychological First Aid
PHC	Primary Health Care
Posyandu	Pos Pelayanan Terpadu (Integrated Health Post)
PP	Peraturan Pemerintah (Government Regulation)
PPPK	Pegawai Pemerintah dengan Perjanjian Kerja (Contract Government Officer)
Puskesmas	Pusat Kesehatan Masyarakat (Community Health Center)
PUSPA	Puskesmas Terpadu dan Juara (Integrated and Champion Puskesmas)
RAO	Regional Apparatus Organizations
Riskesdas	Riset Kesehatan Dasar (Basic Health Research)

RPJMD	Rencana Pembangunan Jangka Menengah Daerah (Regional Medium-Term Development Plan
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goals
SIPTM	Sistem Informasi Surveilans Penyakit Tidak Menular (Non-Communicable Diseases Surveillance Information System)
SPM	Standar Pelayanan Minimum (Minimum Service Standard, MSS)
UHI	Urban Health Index
UKBM	Upaya Kesehatan Berbasis Masyarakat (Community-Based Health Efforts)

How to Use This Playbook

This guideline was developed based on CISDI's experience in developing and implementing the PUSPA Program throughout 2021-2023 in West Java Province, as a response to the health crisis (COVID-19 pandemic). It can be utilized by various parties, especially program implementers and health observers, whether previously involved or interested in initiating similar programs. For stakeholders who are directly or indirectly related to the health sector, this playbook can serve as a supportive reference in decision-making considerations. In addition, civil society and development partners can also adopt best practices from this playbook to strengthen primary health care services in districts/cities or provinces according to their respective domains of contribution.

Parties planning to replicate the program are advised to first consider whether to adopt, adapt, or contextualize the stages outlined in this guideline[1].



[1] Dizon, J.M., Machingaidze, S. & Grimmer, K. To adopt, to adapt, or to contextualize? The big question in clinical practice guideline development. BMC Res Notes 9, 442 (2016). https://doi.org/10.1186/s13104-016-2244-7

SECTION 1

Initiation and Planning Stage

Legal Basis

- Law No. 17 of 2023 on Health
- Minister of Health Regulation No. 44 of 2016 on Management Guidelines for Community Health Center (Puskesmas)
- Government Regulation No. 2 of 2018 on Minimum Service Standards
- Minister of Health Regulation No. 4 of 2019 on Basic Service Technicalities in the Health Sector Minimum Service Standard.
- Minister of Health Regulation No. 26 of 2017 on Guidelines for Health Human Resources Procurement in Supporting the Healthy Indonesia Program with Family Approach
- Government Regulation (PP) Number 49 of 2018 on Contract Government Officer Management (PPPK)
- Minister of Health Regulation number 10 of 2020 on Technical Competency Standard for Health Regional Apparatus Officer
- Minister of Health Regulation number 48 of 2017 on Health Planning and Budgetting Guidelines

CHAPTER I
BUILDING COMMITMENT

1.1. Commitment of the Head of Regional Government

The regional heads commitment to strengthen primary health care services are crucial in the initial stages. The concrete form of the regional head commitment is evidenced through:

a. Regulatory support provided through regional head (Governor or head of the provincial government, and Regent/Mayor or head of the district/city government);
b. Budgetary commitment for the strengthening of primary health care services and community health center (puskesmas);
c. Monitoring of the implementation of the program to strengthen the primary health care services, and directives to resolve issues by the regional head and regional government;

1.2. Conducting Coordination Meetings to Build Commitment

Coordination meetings are conducted to discuss essential matters, including ensuring the program core components. These meetings provide an opportunity to explore the needs and initiate programs inclusively and strategically. Participation of key stakeholders is crucial at this stage.

Coordination meetings may be conducted both before and after the development of the program logical framework. A recommended best practice is to analyze priority issues beforehand, and then discuss them to obtain support and commitment from all key stakeholders.

Examples of coordination meeting implementation

- Participants: representatives from the province, district/city, and locus *puskesmas*.
- Method: group discussions with a facilitator. Discussions can be grouped based on location or administrative level.
- Intended outcomes: establishment of secretariat/task force, role distribution, targets for each indicator, budget allocation for the program, and other essential aspects for the program.

1.3. Establishing a Joint Secretariat

The Joint Secretariat is a group of individuals responsible for managing the program, consisting of the health office and collaborating partners (CSOs and academics). There is no standardized organizational structure for the Joint Secretariat. Thus, each region is authorized to create an organizational structure according to the program's needs. The secretariat should include program managers, monitoring and evaluation staff, administrative and financial staff, and human resources managers. The PUSPA program organizational structure in 2022-2023 is shown in Figure 1.

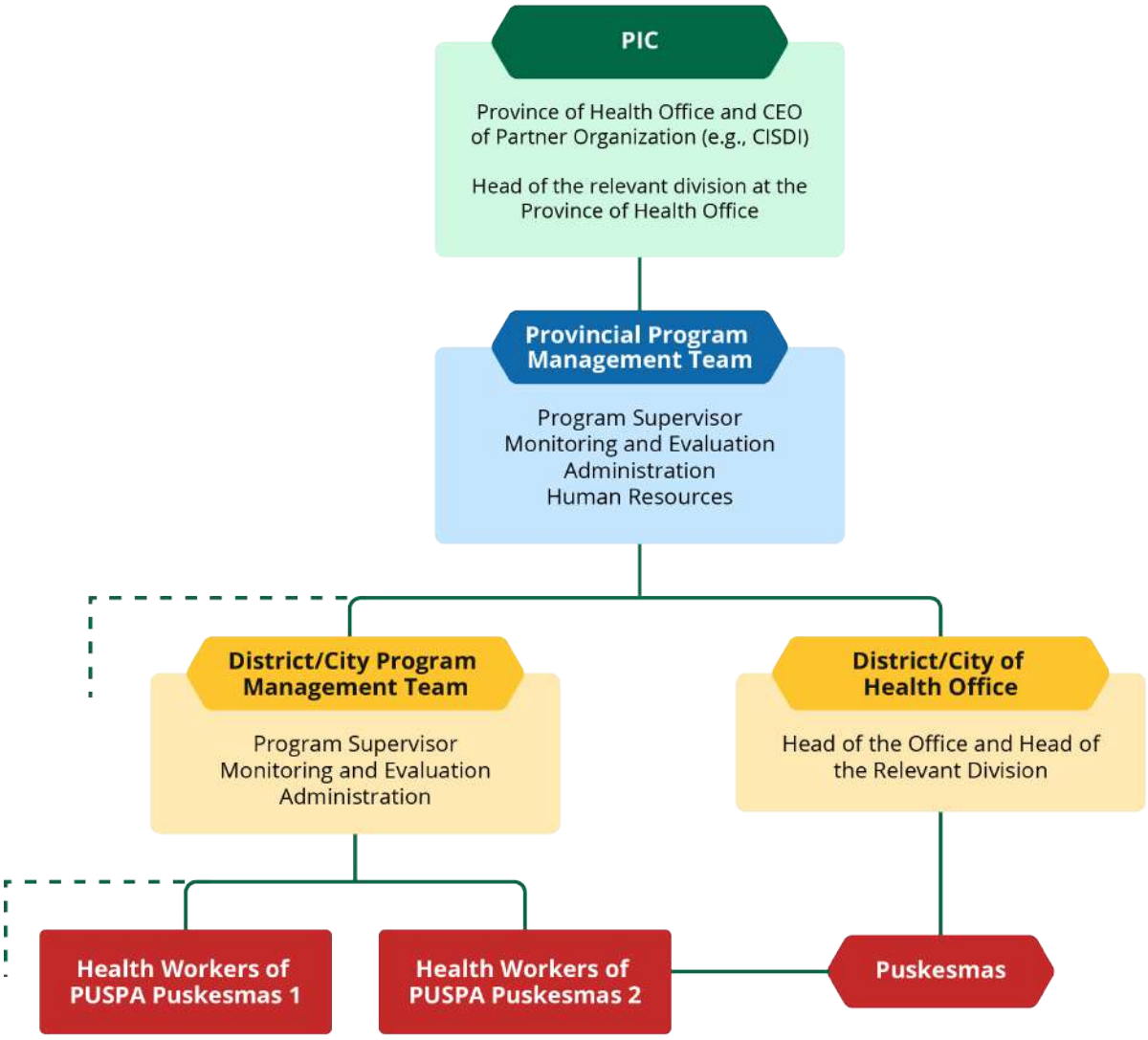


Figure 1. PUSPA Organizational Structure (dashed lines indicate a similar chart that can be multiplied as needed)

1.4. Budgetary Commitment

The budget plan demonstrates a commitment to provide sufficient financial resources for program needs. Several aspects to consider in budget commitment include allocating budget resources towards the expected impact of the program, followed by monitoring the absorption and impact of the budget. The expenditure component of the program to strengthen health care services include human resources (HR), HR capacity building, program implementation, monitoring and evaluation, and logistics.

See Appendix L1.1 and L1.2 for the expenditure components and budget menu in the program to strengthen primary health care services.

⚠ Avoid!

1. Preparing budgets based on annual routines.
2. Allocating too much budget for meeting activities.
3. Drafting budget plans before designing the program objectives and activities. The budget is at risk of being wasted on non-impactful activities.

Appendix Chapter 1:

L1.1 Program Expenditure Components

L1.2 The Example of Program Budget Menu

CHAPTER II
INTERNAL CO-CREATION

2.1. Conducting Problem Analysis and Determining Program Concept

In conducting problem analysis, managers can review issues within their respective regions and utilize national programs as considerations and foundations. Reviewing local issues can be conducted by analyzing Health Minimum Service Standards (MSS) or *Standar Pelayanan Minimum* (SPM) and other health data to identify the root of the problem. Root cause analysis can be performed using methods such as causal-effect loop analysis, fishbone framework, etc. This stage is useful for identifying root causes and appropriate interventions, as well as designing program concepts.

Prioritizing program analysis is the first step underlying ideas in logical framework development. At this stage, the health office can determine 1-3 priority health issues or diseases with the most significant impact.

Example of program concept design based on problem analysis
Context: PUSPA Program Experience in 2021

Figure 2. PUSPA Intervention Model in 2021

The analysis found that the root causes in the Covid-19 pandemic response were limited community empowerment, quantity and quality of health human resources, and inadequate commitment and cross-sector collaboration. These aspects needed to be targeted in addition to direct interventions on three main indicators, namely testing, tracing, and follow-up (isolation and referral).

Health promotion and community empowerment served as both tools and supporting indicators that strengthen the achievement of these three main indicators. In practice, community empowerment was conducted through community-based surveillance activities by mobilizing community health workers (CHWs) for tracing activities, monitoring

isolation, and securing suspects in their respective environments for subsequent referral to *puskesmas* and tested for COVID-19.

2.2. Stakeholder Mapping

Stakeholder mapping, both internal and external, is typically conducted using the Power-Interest matrix. The power of a party is mapped vertically, i.e. the higher the power level of the party towards the program success, the higher its position in the matrix. Interest in the proposed program is mapped horizontally, i.e. the greater the interest in the program, the position in the matrix is further to the right.

Stakeholders in the implementation of primary health care service strengthening program consist of both governmental and non-governmental sectors. The non-government sector includes educational institutions, non-profit organizations or NGOs, industry, media, and the private sector. Details of positions and functions in the government sector are presented in Table 1.

Table 1. Details of Names, Positions, and Functions of Stakeholders in the Governmental Sector

Bureaucracy Role	No.	Positions	Functions
Strategic - Policy Makers	1	Governor/Mayor/ District Head (GMD)	To provide regulatory support within their authority as the basis for program implementation. The regulatory support may include Governor/Mayor/District Head Regulations on program implementation or the designation of intervention locations.
	2	Regional Secretary	To provide strategic support for coordination across Regional Apparatus Organizations (RAO), budget provision, and synchronization with the Governor/Mayor/District Head's vision-mission.
	3	Regional Assistant for People's Welfare Affairs	To provide strategic commitment in providing substantial support to the Governor/Mayor/District Head in terms of program implementation that supports health development and provides budget strengthening.

Bureaucracy Role	No.	Positions	Functions
	4	Head of the Province of and District/City of Health Offices	To have the authority as budget users as well as the main planners and implementers of health programs. Provide inter-division coordination support in material preparation, quality control, and budgeting.
	5	Head of the Regional Development Planning Agency (Bappeda)	To provide support for budgetary commitments and synchronization with the Regional Medium-Term Development Plan (*Rencana Pembangunan Jangka Menengah Daerah - RPJMD*) and the vision and mission of the Governor/Mayor/District Head.
Planning	6	Head of Health Services Division of the Health Office	To conduct program planning related to the *puskesmas* management, which includes planning, implementation, and evaluation.
	7	Head of the Public Health Division of the Health Office	To conduct planning and mentoring related to the implementation of Community-Based Health Efforts (*Upaya Kesehatan Berbasis Masyarakat - UKBM*) activities, nutrition, health promotion, and management of non-communicable diseases (NCDs). The community health workers (CHWs) development program is also under this division.
	8	Head of the Health Resources Division	To conduct planning related to the procurement of human resources, the provision of personal protective equipment (PPE), and consumables that are essential in supporting the PUSPA program. The largest financing components in health programs is generally within this division.
	9	Head of the Disease Prevention and Control Division	To conduct planning and mentoring related to the surveillance of communicable and non-communicable diseases as well as immunization/vaccination.
Leverage	10	Family Planning and Population Control Agency	It has a role to support the achievement of programs related to stunting issues, and has a program for strengthening at-risk families.

Bureaucracy Role	No.	Positions	Functions
	11	The Department of Village and Community Empowerment (*Departemen Pemberdayaan Masyarakat dan Desa - DPMD*)	It has a role in providing guidance and monitoring village planning, has instruments that can be used to increase village government commitment to health programs, especially incentives for CHWs and Integrated Health Posts or *pos pelayanan terpadu* (posyandu).
	12	Education Office	It has an important role in the supplementation of iron folic acid tablets. The education office is essential to involve if national health programs target indicators such as stunting and education.
	13	Regional Leaders	Sub-district head, village head, and urban-village head play a crucial role in mobilizing resources to support programs involving CHWs, posyandu, and local bureaucracy at the village/sub-district level.
Technical Implementers	14	Head of Puskesmas	The Head of Puskesmas plays a crucial role in ensuring that health services activities are aligned with *puskesmas* planning and budget allocations, including the division of roles between Puspa personnel and *puskesmas* staff.
	15	Program's Person in charge (PIC)	The PIC at each *puskesmas* should be involved in program implementation and monitoring, as well as training activities, as they will impact the program's long-term sustainability and data availability in the field.

2.3. Designing Selection and Competency of Health Workers

Health workers for PUSPA can be selected from existing health workers at the *puskesmas* or by recruiting new health workers. The selection stage is a crucial factor in ensuring that both sets of health workers have competencies aligned with the program's needs (Figure 2). However, the implementation of this selection process can be adjusted according to institutional and regional regulations. Transparency and accountability need to be maintained at every stage, including partnering with external parties to serve as secondary assessors.

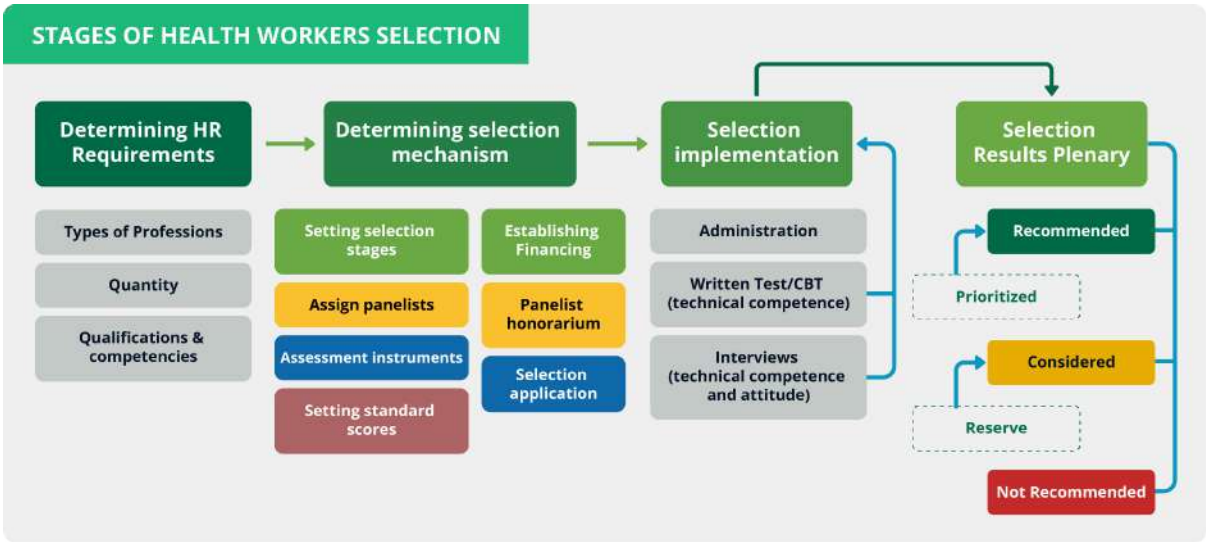


Figure 2. Stages of Health Workers Selection

Health workers competencies in the primary health care service strengthening program are developed based on the demands of the position and the challenges experienced in the field. These competencies are divided into three categories: core, behavioral, and technical competencies. Core competencies are derived from institutional values as the primary requirements that must be possessed by health workers. Technical competencies consist of knowledge, skills, and attitudes related to specific technical aspects according to the program's focus. Behavioral competencies are standard behavior expected to be consistent and supportive of good work attitudes.

See Appendix L2.1 for the recommended qualifications for program managers and health workers

Tips

For recruitment and selection processes, the health office may partner with a human resource management agency or a psychology center. Based on experience, recruitment and selection partners should have the following requirements:

1. The bureau or agency has a license to operate from the government;
2. Experienced in conducting HR Consultation (HR assessment and recruitment) in both government and private sectors.

2.4. Determining Site Selection

The selection of intervention sites begins with determining needs-based indicators or health issue priorities. These indicators are determined through discussions with key stakeholders of PUSPA (Figure 3), taking into account both the biological determinants and the socio-economic determinants of health, for example:

- **Puskesmas Health Minimum Service Standards (SPM) Coverage**
  Health MSS coverage represents the achievement of minimum service standards at *puskesmas*. Through this data, the program management team can observe the coverage of health indicator data within MSS with low achievement and health urgency.
- **Basic Health Research or *Riset Kesehatan Dasar* (Riskesdas)**
  Riskesdas data can serve as validation to assess the urgency of selected indicators, and adjusted according to the achievement of *puskesmas'* MSS and the needs of the intervention area.
- **Case Reports**
  Case reports can utilize reporting data from platforms used by the government, such as Si Lacak and NAR for COVID-19, ASIK, e-PPBGM, or health reporting platforms in regional governments.
- **Population Density**
  Population density can indicate the regional burden of a region or *puskesmas*. Regions with high population density have a higher risk of rapid and massive transmission of communicable diseases. In other words, *puskesmas* in areas with high population density bear a greater responsibility for reaching communities with preventive and promotive services for non-communicable diseases. Data sources for calculating population density can refer to the Statistics Indonesia or *Badan Pusat Statistik* (BPS) data.
- **Poverty Percentage**
  Poverty is the root cause of poor housing sanitation and limited access to health services. This affects health issues such as stunting, communicable diseases, non-

communicable diseases, and reproductive health issues. Areas with the highest poverty percentages should be considered priorities in inclusive health interventions. Data sources that can be used include Human Development Index (HDI) data or economic survey results.

Figure 3. Priority in Determining Site Selection Indicators

Once the indicators for site assessment are agreed upon, the next step is mapping and measurement. These measurements weigh the selected indicators to determine the intervention sites. Calculation of indicators can be performed using various methods, such as the Urban Health Index (UHI)[2] method and weighting methods. *See Appendix L2.2 for several options of intervention area selection methods along with the steps and examples.*

The UHI method has advantages over the weighting method. The UHI formula refer to the entire dataset, taking into account the maximum and minimum values, making the determination steps objective and reliable. *See Appendix L2.3 for the template for determining indicators using the Urban Health Index (UHI).*

⚠ Avoid!

1. Selecting intervention sites based on assumptions and subjective assessments.
2. Not considering the commitment aspects of the area to be intervened.

[2] Urban Health Index, WHO, 2014

Appendix Chapter 2:

L2.1 Qualifications of PUSPA Program Managers and Health Workers

L2.2 Options for Program Site Selection

L2.3 UHI Calculation Tool from WHO

CHAPTER III
DISTRICT/CITY CO-CREATIONS

3.1. Building a Logical Framework and Program Indicators

A logical framework is an overview of a program implementation process that contains targets and indicators. It shows the objectives of a program and the steps to be taken to achieve those objectives. In its development, key stakeholders need to be involved, for example, through coordination meetings. The logical framework includes outcomes, immediate outcomes, outputs, processes/activities, and inputs (Table 2). Each component should be monitored and measured. *See Appendix 3.1 for the example of the logical framework of the primary health care service strengthening program.*

Table 2. Logical Framework Components and Their Definitions

Component	Definition	Example
Outcome/Main Objectives	Represents the impact, change, or desired result. The main objectives show how the outcome affects the desired situation or condition.	Improved condition of hypertensive patients with controlled blood pressure.
Output	Output refers to tangible results of a process or activity. These are products or services that resulted from a specific effort. Output shows what has been produced or accomplished.	Standardized hypertension services, with a target indicator of 80% of intervention *puskesmas* successfully achieving a 60% coverage of hypertensive patients receiving standardized services.
Process/Activity Indicator	A set of activities that drive toward achieving outputs. Process indicators are quantitative and can be directly calculated.	- Health workers conduct screening for NCD risk factors (hypertension) in patients aged >15 years - Community health workers (CHWs) monitor hypertensive patients (treatment

Component	Definition	Example
		regularity and routine check-ups)
Input	Resources, budget, personnel, time, materials, and other factors needed to implement the program.	- Hypertension diagnostic tools at *puskesmas* - Guidebook for CHWs - Report recording templates

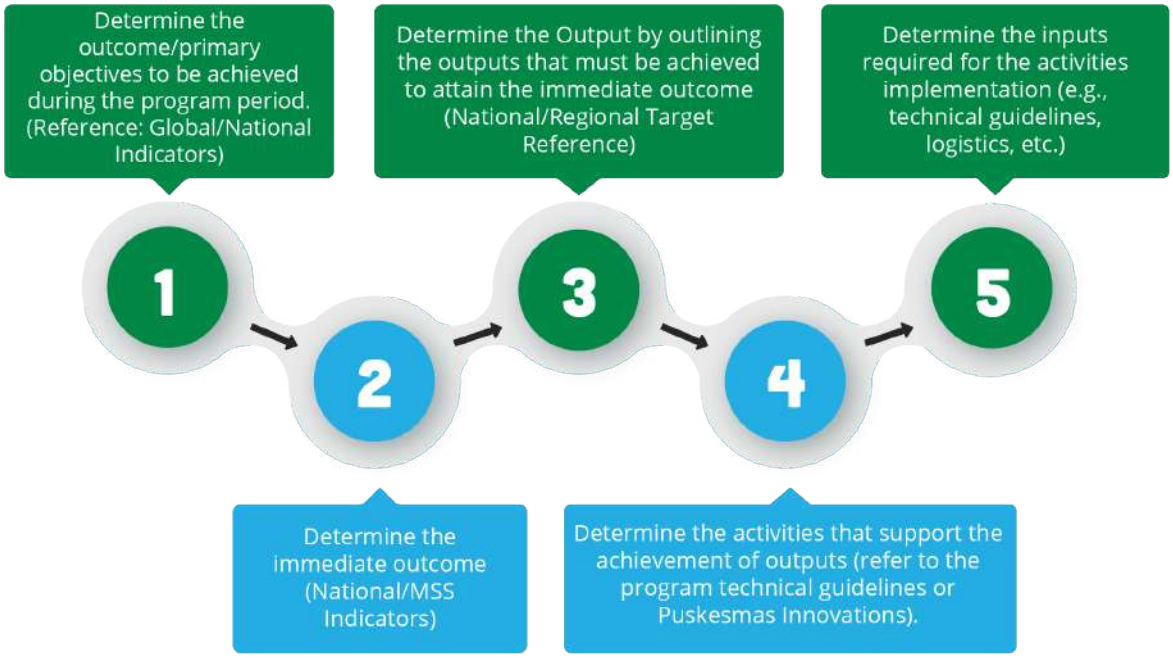


Figure 4. Summary of Stages in Developing the Program's Logical Framework and Indicators

⚠ Avoid!

1. Creating indicators that cannot be measured (qualitative monitoring can be conducted to provide a holistic overview, complementing measurable monitoring).
2. Creating output and process indicators that are not aligned with the indicators of the main objectives.
3. Not involving the field team *(puskesmas)* in the development process of indicators.

3.2. Developing Program Technical Guidelines

The technical guidelines for program implementation are essential for both program managers and field implementers. The program guidelines should contain illustrations of pre-implementation, implementation, and monitoring/evaluation stages. The recommended structure for manual book of primary health care service strengthening program is as follows.

Table 3. Outline and Explanation of Content in the Program Manual Book

Outline	Explanation
Chapter I Introduction 1. Background 2. Legal Basis 3. Principles of Program Implementation	The background contains a least 3 paragraphs covering the current situation, the ideal condition, and an explanation of the program as a solution to address the current problem. The legal basis is adjusted to the legal basis for program implementation, which includes laws, presidential regulations, government regulations, ministerial regulations, regional regulations, and regional head regulations. It is sorted according to the legal hierarchy. The principles of program implementation explain the logical framework of the program.
Chapter II Scope 1. Definition 2. Implementation Team at *puskesmas* 3. Objectives 4. Program Implementation Areas 5. Target Beneficiaries	Definition refers to the operational definition of the program.
Chapter III Program Implementation Mechanism 1. Selection of Intervention Areas 2. HR Recruitment 3. HR Capacity Building 4. Program Protocols	Selection of intervention areas explains the method of selecting and determining intervention areas, which include indicators, calculation techniques, and finalizing the determination of areas. HR recruitment covers HR competencies, registration, and selection.

Outline	Explanation
	Capacity building explains the capacity building curriculum and various HR capacity building activities. Program protocols explains the program indicators, mechanism of each program indicator, and program coordination mechanism.
Chapter IV Control and Supervision 1. Monitoring and Evaluation 2. Reporting 3. Digital Instruments	Monitoring and Evaluation covers both the components and implementation of monitoring and evaluation. Reporting includes routine program, financial, and HR administration reporting. Digital Instruments refer to digital platforms used according to the program's needs, such as SIPTM and ASIK for non-communicable diseases.

See Appendix 3.2 for the PUSPA 2021 manual book as an example of a playbook for integrated primary health care service strengthening program.

Appendix Chapter 3:

L3.2 The Example of a Playbook for Integrated Primary Health Care Service Strengthening Program

SECTION 2

Implementation, Monitoring, and Evaluation

Legal Basis

- Ministry of Health Regulation No. 50 of 2020 on the Organization and Work Procedures of Technical Implementation Units for Health Training within the Ministry of Health.
- Ministry of Health Regulation No. 8 of 2019 on Community Empowerment in the Health Sector.
- Ministry of Health Regulation No. 25 of 2019 on Clarification.
- Republic of Indonesia Government Regulation No. 39 of 2006 on the Procedures for Controlling and Evaluating the Implementation of Development Plans.
- Minister of Health Decree No. 656 of 2007 on Guidelines for Controlling and Evaluating the Implementation of Health Development Plans.
- Guidelines for Public Health Program Indicators in the National Medium-Term Development Plan (RPJMN) and Ministry of Health Strategic Plan (RENSTRA) 2020-2024.
- Guidelines for Integrated Development of Community Health Center by the Health Office of the Directorate General of Public Health Services in 2021.
- Minister of Health Decree No. 7 of 2021 on Guidelines for Implementing Competency Innovation for Civil Servants within the Ministry of Health.

CHAPTER IV
CAPACITY BUILDING OF HEALTH WORKERS

The capacity building framework was conducted using the ADDIE framework, which stands for Analyze, Design, Develop, Implement, and Evaluate. Table 4 and Figure 5 summarize the process on each stage.

Table 4. Stages and Forms of Capacity Building Activities

Stages	Activity
Analysis (Training Needs Analysis)	This stage collects information about the types and topics of capacity building that align with the needs, serving as input for the design stage. The methods chosen are tailored to the characteristics of potential participants and resource availability, for example: 1. PUSPA Secretariat: Capacity building needs interviews, 2. PUSPA health workers: Competency tests or self-assessment questionnaires. *See Appendix 4.1 for a more detailed explanation and example of Training Needs Analysis document.*
Design	In this process, the training committee will determine the capacity building and training evaluation design according to the analysis process recommendations. Several points to be determined in this stage include: 1. Training materials • Basic material: national policy and strategic direction, basic concepts of primary health care services and program concepts, • Core material: covers thematic issues of the program, such as immunization, nutrition for children under five, etc., • Supporting material: tailored to program needs, such as Psychological First Aid (PFA) or sexual violence prevention; 2. Capacity building format, for example: pre-placement orientation, incidental program information, and routine mentoring with district/city supervisors; 3. Types of evaluation and their instruments • Assessing participants' reactions during training, for instance via feedback forms, • Assessing participants' knowledge, for example, through pre-test and post-test questions.

Stages	Activity
	See Appendix 4.2 for the example of Training Curriculum document.
Develop	What is carried out in this stage 1. Developing capacity building materials with the trainer, 2. Adjusting the content and media to the learning objectives, 3. Paying attention to the technical preparation.
Implement	Implementing the capacity building/training on the appointed day. Making sure that there are briefing and debriefing sessions with the committee and trainer in the implementation. *See Appendix 4.3 for the example of training guideline document.*
Evaluation	Evaluate the program using the instrument and method that had been designed on the Design stage. For example: distributing feedback form and conducting pre-test and post-test to the participants. After the data were collected, the committee can analyze the data and prepare the report. The points of analysis that must be included are 1. How the capacity building sessions are going? The analysis might use the SWOT framework; 2. Does the training achieve its intended objectives? The analysis might refer to the participants' feedback and pre-test and post-test results. 3. What are future recommendations for the participants and committee? Is there a need for retraining in specific materials? *See Appendix 4.4 for the example of capacity building evaluation instrument, and Appendix 4.5 for the example of capacity building report.*

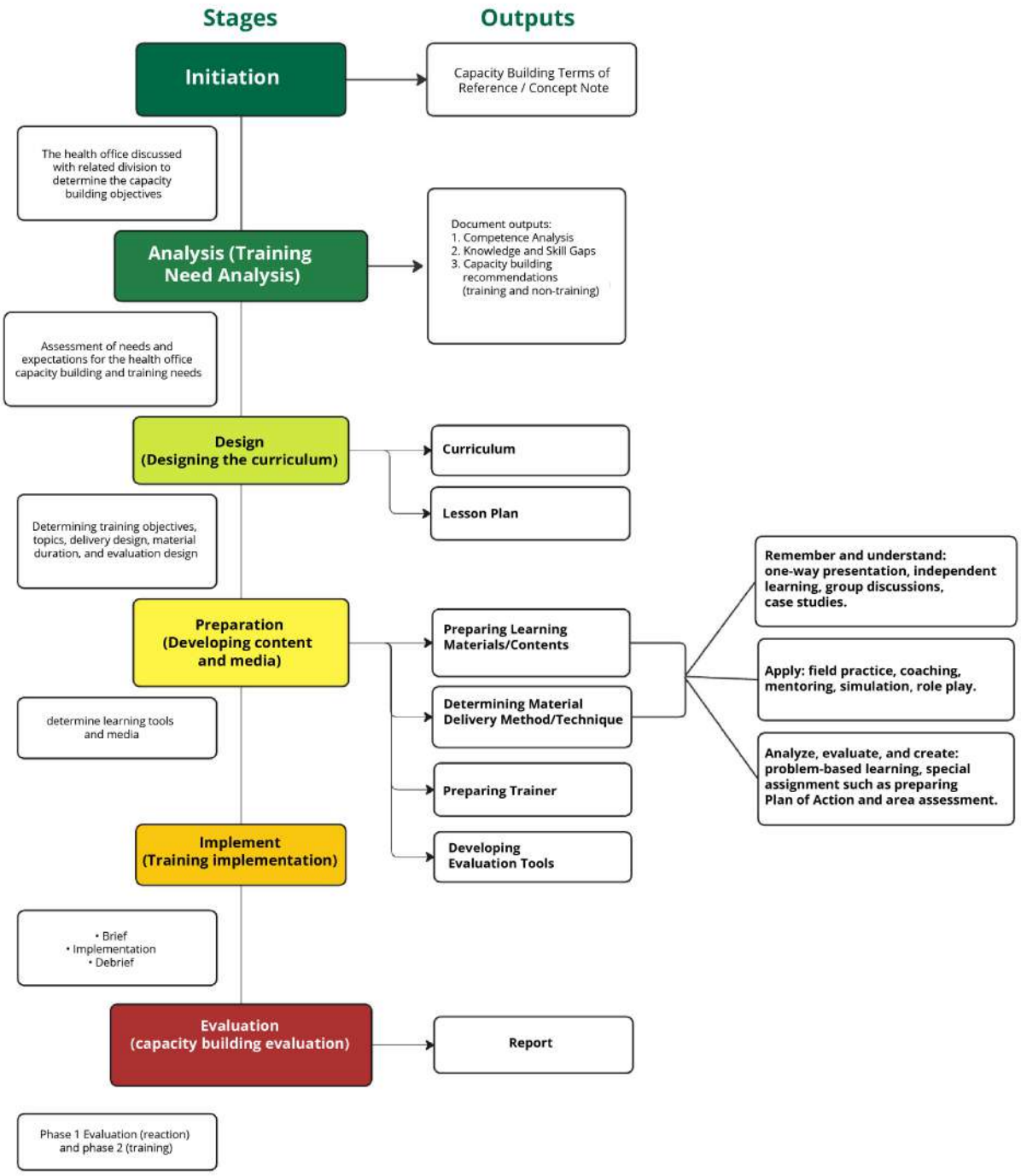


Figure 5. Flowchart of Stages in Human Resources Capacity Building

Appendix Chapter 4:

L4.1 The Example of Capacity Building/Training Need Analysis Document

L4.2 The Example of Capacity Building/Training Curriculum Document

L4.3 The Example of Capacity Building/Training Guideline (*online*)

L4.4 The Example of Capacity Building/Training Evaluation Instrument

L4.5 The Example of Capacity Building/Training Report

CHAPTER V
MONITORING

5.1. Designing Monitoring Method and Schedule

In designing program monitoring procedure, program manager is recommended to create a monitoring/evaluation framework plan document. This framework is created in a table containing program indicators. In this stage, the managers have to make sure that program indicators have been designed in the planning stage. *See Appendix 5.1 for monitoring/evaluation plan template, and Appendix 5.2 for monitoring and evaluation framework.*

Next, the following items need to be identified on each indicator

1. What is the operational definition of each indicator?
2. What is the basic guideline before the program implementation?
3. How many targets will be set?
4. Where the source data indicator will be obtained?
5. How often the indicators will be measured?
6. Who will collect the data?
7. When and how the information based on the analyzed data will be disseminated?

	Indikator	Definisi *Bagaimana cara perhitungannya*	Baseline *Nilai saat ini*	Target	Sumber Data	Frekuensi *Seberapa sering indikator ini akan diukur*	Responsibel *Siapa yang akan mengukurnya*	Reporting *Siapa yang akan melaporkan*
Outcome								
Output								
Aktivitas								

Figure 6. The Example of Monitoring and Evaluation Plan

Data collection procedures can make it easier to identify the data source of the indicators up to the analysis stage by the monitoring and evaluation team. The steps in creating a data collection procedure are:

1. **Data Type Identification**
   Determine the type of required data. The data can be in the form of number, text, picture, sound, or a combination of various types of data. Make sure that the data you choose are relevant with the project objectives.

2. **Developing Data Collection Plan**
   Make a detailed plan of how you will collect the data. Determine whether you will use secondary data, survey, interview, observation, or other data source. If you use secondary data, choose relevant and validated data source.
3. **Designing Data Collection Instrument**
   If you use instrument such as *puskesmas* program report, survey, interview, or other instruments, make sure that the questions or instruction in the instrument are clear, unambiguous, and relevant.

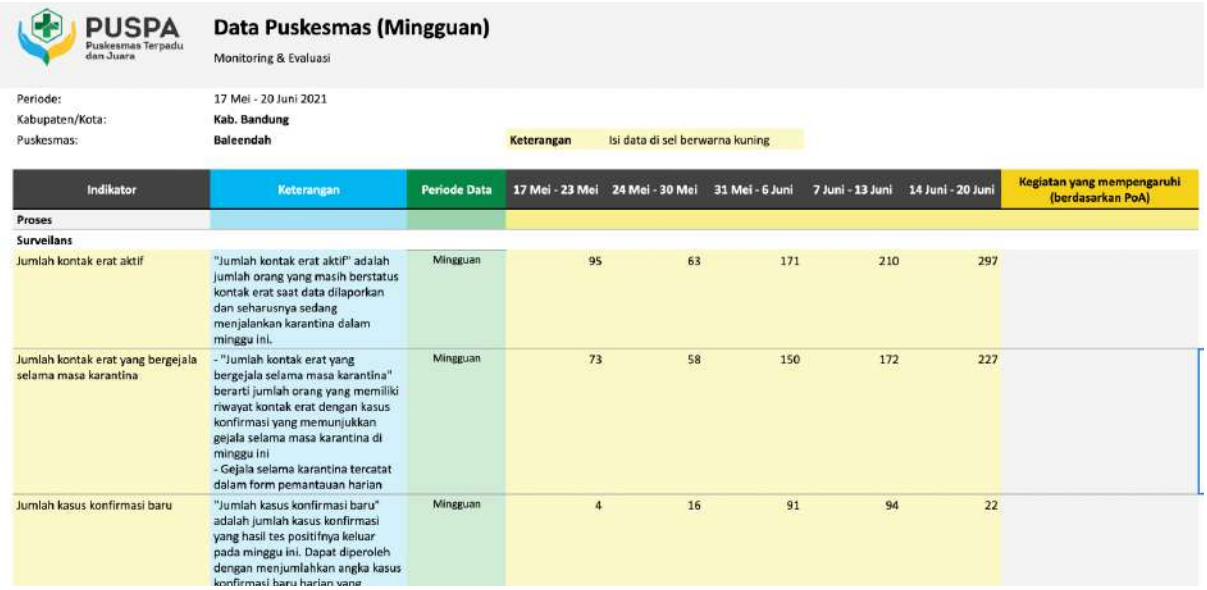
Tips

1. Use documents that can be edited by several people at the same time or living document, such as Google Docs, Spreadsheet, or Notion. It makes the access easier for all parties when there are changes in the indicators;
2. Complete the monitoring design at least 3 months since the beginning of the program implementation. Monitoring design will make it easier for the program manager and implementer to implement all program activities.

5.2. Creating Reporting Instrument and Achievement Monitoring Instrument

A. Reporting instrument

1. Definition: a reporting instrument used to collect achievement data or performance data in the field.
2. Objectives: Reporting instrument functions to collect indicators data in the same document to make it easier for monitoring and evaluation officers to measure achievements.
   Examples of recording instruments developed in PUSPA program are as follow:
   a. Reporting Calendar
      Reporting calendar used to provide time information for data reporting. Data reporting calendar designed by the monitoring and evaluation team by adjusting the intervention time. *See Appendix 5.3 for the example of reporting calendar.*
   b. *Puskesmas* Data
      Data collection instrument can be designed using Spreadsheet, by categorizing the sheet based on data collection time to make it easier for the team that must input the data. Indicators can be written vertically and the data collection period can be written horizontally (Figure 7).



PUSPA
Puskesmas Terpadu dan Juara

Data Puskesmas (Mingguan)

Monitoring & Evaluasi

Periode: 17 Mei - 20 Juni 2021
Kabupaten/Kota: Kab. Bandung
Puskesmas: Baleendah

Keterangan: Isi data di sel berwarna kuning

Indikator	Keterangan	Periode Data	17 Mei - 23 Mei	24 Mei - 30 Mei	31 Mei - 6 Juni	7 Juni - 13 Juni	14 Juni - 20 Juni	Kegiatan yang mempengaruhi (berdasarkan PoA)
Proses								
Surveilans								
Jumlah kontak erat aktif	"Jumlah kontak erat aktif" adalah jumlah orang yang masih berstatus kontak erat saat data dilaporkan dan seharusnya sedang menjalankan karantina dalam minggu ini.	Mingguan	95	63	171	210	297	
Jumlah kontak erat yang bergejala selama masa karantina	- "Jumlah kontak erat yang bergejala selama masa karantina" berarti jumlah orang yang memiliki riwayat kontak erat dengan kasus konfirmasi yang memunjukkan gejala selama masa karantina di minggu ini - Gejala selama karantina tercatat dalam form pemantauan harian	Mingguan	73	58	150	172	227	
Jumlah kasus konfirmasi baru	"Jumlah kasus konfirmasi baru" adalah jumlah kasus konfirmasi yang hasil tes positifnya keluar pada minggu ini. Dapat diperoleh dengan menjumlahkan angka kasus konfirmasi baru harian yang	Mingguan	4	16	91	94	22	

Figure 7. The Interface of *Puskesmas* Data Collection Instrument

B. Achievement Monitoring Instrument

1. Definition: monitoring process or program achievement measurement based on specific period.
2. Objectives: it functions to measure the progress of determined indicators on program logical framework (logframe). Indicators, data collection time, and data source to see the program achievement can be adjusted to the monitoring and evaluation plan document that has been designed.
3. Types and format of Achievement Monitoring.
   a. **Indicator Tracking Table (ITT)**

      The program to strengthen primary health care services or other health innovation programs sometimes has many indicators from various data source. Therefore, to make it easier for the monitoring officers to manage and present data, Indicator Tracking Table (abbreviated as ITT) can be created. It is a table that contains a set of indicators.

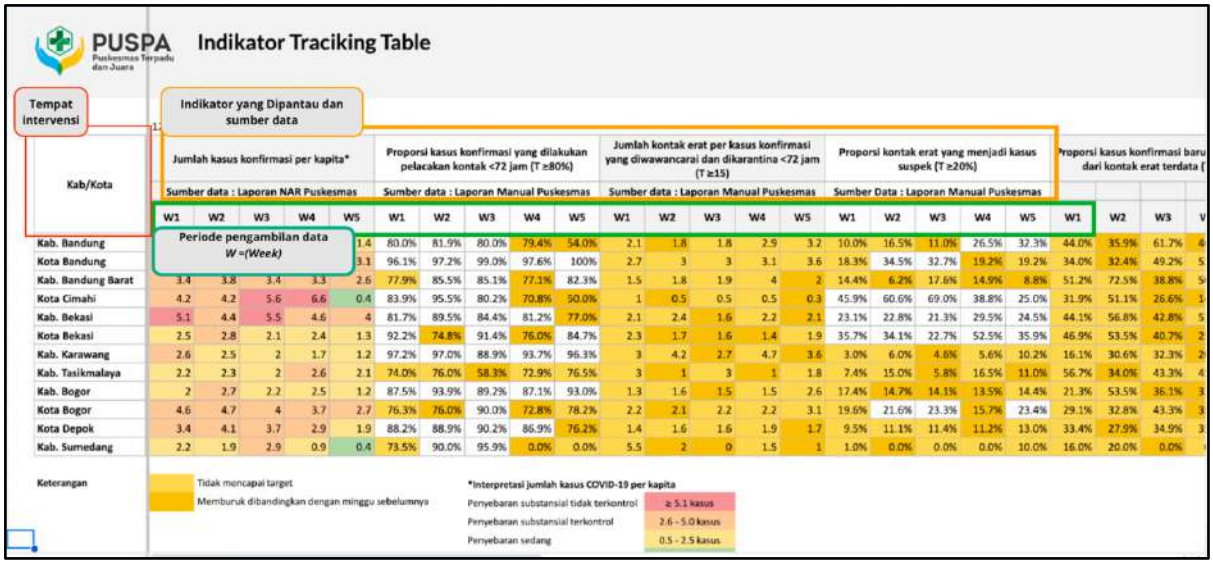


Figure 8. The Example Indicator Tracking Table (ITT)

If the figure is unclear when edited: the soft file can be accessed on: LINK

The ITT is periodically updated by the monitoring and evaluation team. On Figure 8, column A and B (on the left) contain intervention location variables, which are the name of intervened districts/cities. Column C and so on contains the indicators being monitored, complemented by information on the origin of the data source and the data collection period. The monitoring and evaluation team can use the "IMPORTRANGE" formula on ITT column to automatically filling data from regional team reports into the ITT column. *See Appendix 5.4 for the example of ITT column and its formula.*

b. Achievement Dashboard

Dashboard (visual interface) is an information system application or visual interface that presents information related to main indicators and activities of an organization or a project in one screen. Some advantages of visual interface are interactive features that give users the freedom to search for information according to their needs. Moreover, the data are always updated to make it easier for the users to understand the current situation. In the program to strengthen integrated primary health care services, visual interface can be used to monitor and evaluate the ongoing process, monitor the program performance, and predict future conditions. In building a dashboard, there are three aspects that need to be considered[3], namely:

[3] Hariyanti, Eva. 2008. "Methodology in Building Dashboard as a Tool to Monitor the Bandung Technological Institute Organization Performance". ITB.

1. Data/information that will be presented and personal data confidentiality.
   Presented data/information can be in the form of achievement progress based on the predetermined logical framework. Visualization of information should be straightforward and can be directly understood by the users without having to calculate the data themselves. Publicly accessible dashboard can present aggregate data and use encryption technique if it presents individual level data.
2. Visual interface personalization
   The visual interface should be adjustable according to the required analysis and user preferences. For instance, the users can select different data to display, set filters, select data collection time/duration, and so on.
3. Collaboration between users of the visual interface
   Collaboration between users of the visual interface is a practice in which multiple individuals or team members work together using a dashboard to access, analyze, and share information. General aspects that need to be considered in general collaboration between users are:
   - Different users can be granted access to the same dashboard to view information that are relevant to their responsibilities.
   - Users can share their analysis results or dashboard interface with other team members, either in the form of links or other formats.
   - The dashboard platform enables real-time collaboration, in which the users can directly see the changes made by other users.
   - The team can use the dashboard to monitor organizational or project performance together. Therefore, they can support better decision making.

   Recommended tools that can be used to build a dashboard are:
   1. Spreadsheet,
   2. Power BI,
   3. Tableau.

The Example of PUSPA Dashboard in 2021: https://s.id/DashboardPUSPA2021
The Example of PUSPA Dashboard in 2023: https://app-diskes.jabarprov.go.id/puspa/

Tips

1. "Data Validation" feature can be used to perform system validation. For example, the value for the indicator of "the number of posyandu providing services" cannot be greater than the indicator of "the number of *posyandu* in the *puskesmas*".
2. "Conditional Formatting" feature can be used to distinguish between cells that have or have not been filled, and between achievements that have or have not met the targets.
3. The use of Power BI to develop a dashboard is very easily integrated with Microsoft services such as Excel, Azure, and SQL Server. Thus, data collection instruments in the field can use these Excel/Spreadsheet services.
4. Power BI also has powerful data modeling and analysis tools, such as DAX (Data Analysis Expressions), Power Query, and Power Pivot. However, it may take longer to learn and understand advanced features like DAX.
5. Tableau is known for its intuitive user interface, making it easier for novice developers and offering various types of more interesting visualizations. However, Tableau licenses for businesses are typically more expensive than Power BI, and have limited integration with Microsoft products.

5.3 Monitoring Process during the Implementation

Program implementation monitoring focuses on the development process of intervention, output, and impact of health programs that have been designed and launched. Considering the intervention scale, the monitoring process can be executed in stages between the PUSPA secretariat team, province of health office, district/city supervisor, and district/city of health office.

Best Practices of PUSPA Implementation

PUSPA program developed daily, weekly, and monthly reporting instruments based on types of the indicator. Recording instruments can be developed with several data retrieval tools such as online Spreadsheet, Microsoft Excel, Kobo Toolbox, or Jotform. Spreadsheet is the easiest instrument to use and have minimal errors.

Table 5. The example of data reporting time based on indicators:

Indicators	Data Reporting Frequency
The number of COVID-19 confirmed cases	Daily
The number of antigen-tested people	Daily

The number of PCR-tested people	Daily
The number of active close contact	Weekly
The number of symptomatic close contact during quarantine period	Weekly
The number of children under five that are weighed at *posyandu*	Monthly
The number of NCD-screened productive age	Monthly

A. Weekly Monitoring

Weekly monitoring is performed between district/city program management staff (district/city supervisors) and health workers at *puskesmas*. Apart from monitoring needs, this meeting is also used to build connection between the supervisor and the health worker team. The monitoring is carried out both online and offline with the following discussion topics:

1. Monitoring the development of indicators achievement;
2. Exploring implementation process at each location in the past week;
3. Exploring the encountered obstacles and look for the solutions;
4. Sharing best practice between intervention location; and
5. Planning activities to be executed in the next week.

B. Biweekly Monitoring

Biweekly monitoring is performed by the program manager or provincial secretariat. The meetings can be held online (via Zoom meeting). The meetings contain more strategic discussions and are a forum for coordination between regional and provincial supervisors. At the bi-weekly meetings, a progress reporting template for each intervention area is provided to make it easier for the provincial secretariat team to explore problems during the online meeting. *See Appendix 5.5. for the supervisor's biweekly report template.*

Duration of the meeting is around 60–90 minutes with the following discussion topics:

A. Delivering feedback from the monitoring and evaluation team regarding achievement data for each district/city;
B. Exploring the ongoing intervention process;
C. Presenting the obstacles encountered by the PUSPA team;
D. Formulating the solution for the encountered obstacles; and
E. Sharing best practices implemented on each area

1. Monthly Monitoring

The monthly monitoring is attended by all parties involved in the program development such as representatives of the province of health office, district/city of health office, district/city secretariat and supervisors. The duration of the meeting is around 90–120 minutes.

Apart from being a monitoring forum, this monthly meeting aims to foster active participation by the district/city of health office in PUSPA activities. Monthly monitoring can also be carried out thematically, for instance the theme for this month is the progress on immunization achievements, and for next month is the NCD achievements. *See Appendix 5.6 for the supervisor's monthly report template, and 5.7 for the example of thematic report.*

The monthly monitoring is held by the PUSPA secretariat and discusses the following topics:

1. Delivering the progress of PUSPA achievement in the past month;
2. Presenting encountered obstacles;
3. Sharing existing best practices; and
4. Presenting strategic direction, if needed.

Tips

1. For the sake of time efficiency in online meetings, prepare a list of meeting agendas that will be discussed and their duration, and make a time agreement at the start of the meeting.
2. Use additional applications that make the meetings more interactive, such as Mentimeter, Slido, Jamboard, Miro, or similar applications.

D. Site Visit

Apart from remote monitoring, the monitoring can be carried out by site visits[4]. This activity is generally held twice a year. Monitoring visit is an opportunity to explore systemic or contextual factors that may influence the activity implementation. *See Appendix 5.8 for the example of site visit instrument.*

The following is several data collection technique during site visit.

[4] USAID. 2022. How - To Note: Planning and Conducting Site Visits

In carrying out site visits, the program secretariat can collaborate with partners and other stakeholders, including the district/city of health office and *puskesmas*. The implementation of monitoring activities is executed in the following stages.

Pre- (before) monitoring

- Reading program planning document, obtaining an overview of the situation;
- Coordinating with the field team and stakeholders to implement the monitoring;
- Finalizing the instrument (and logistics if there are visits);
- If the monitoring format is site visit, pre-visit briefing can be held.

During monitoring

- Asking open-ended questions to obtain greater insight into activity performance;
- Exploring opinions from the implementation team and other stakeholders to generate new learning;
- Documenting the activities for reporting purposes.

Post- (after) monitoring

- If the monitoring is site visit, debriefing can be held to discuss findings, provide feedback, and design follow-up plan;
- Organizing documentation and summarizing findings and lessons learned;
- Monitoring agreed follow-up plans.

Appendix Chapter 5:

L5.1 Monitoring/evaluation Plan Template
L5.2 Monitoring and evaluation Framework
L5.3 The Example of Reporting Calendar
L5.4 Indicator Tracking Table (ITT) Template
L5.5 Supervisor's Biweekly Matrix Template
L5.6 Supervisor's Monthly Monitoring Template
L5.7 The Example of Supervisor's Thematic Report
L5.8 The Example of Site Visit Instrument

CHAPTER VI
MANAGING INNOVATION

6.1 Driving and Managing Innovation

Driving innovation is one of the aspects that differentiates PUSPA with other health programs. PUSPA's health workers are equipped with the knowledge and motivation to be able to find creative and clever solutions based on existing gaps in the field. In designing innovation, *puskesmas* can modify the delivery method or related health program environment. *See Appendix 6.1 for a collection of PUSPA's Innovations in Nutritional and NCD Programs*

In designing program innovation, the stages taken by the *puskesmas* and PUSPA health workers are summarized in Figure 9:

Figure 9: Managing Innovation Process

To support the emergence of innovation in the *puskesmas* level, health offices and partners can facilitate several additional activities, namely:

- **PUSPA Health Worker Mentoring Sessions**
  Mentoring sessions are held in the form of discussions on a particular theme, for instance NCD, immunization, and etc. After the PUSPA team in the *puskesmas* collected ideas, the mentor will explore the progress of innovation that has been made and then discuss obstacles and opportunities in developing innovation. These meetings can be held weekly or biweekly. *See Appendix 6.2 for the thematic monitoring template.*
- **Meet the Expert Sessions**
  After the mentoring is held by the program management team, field staff will meet experts whose knowledge is in line with the innovation needs and themes of each

puskesmas. The experts were brought in from internal and external parties of the health office and partners, such as provincial nutrition program managers, food security experts, communication and advocacy experts, and so on.

6.2 Community Empowerment through Community Health Workers Mobilization

The previous program to strengthen primary health care services includes community health worker activities to perform preventive and promotional aspects (Figure 10). Empowering the community to become community health workers has been proven to be effective and impactful, especially for health problems that have a wide impact[5]. To hold those activities, cadres who understand program activities and have appropriate competencies are needed. Community health worker competencies can refer to cadre competency standards from the Ministry of Health, and its development procedures can be adapted to the stages on Chapter IV.

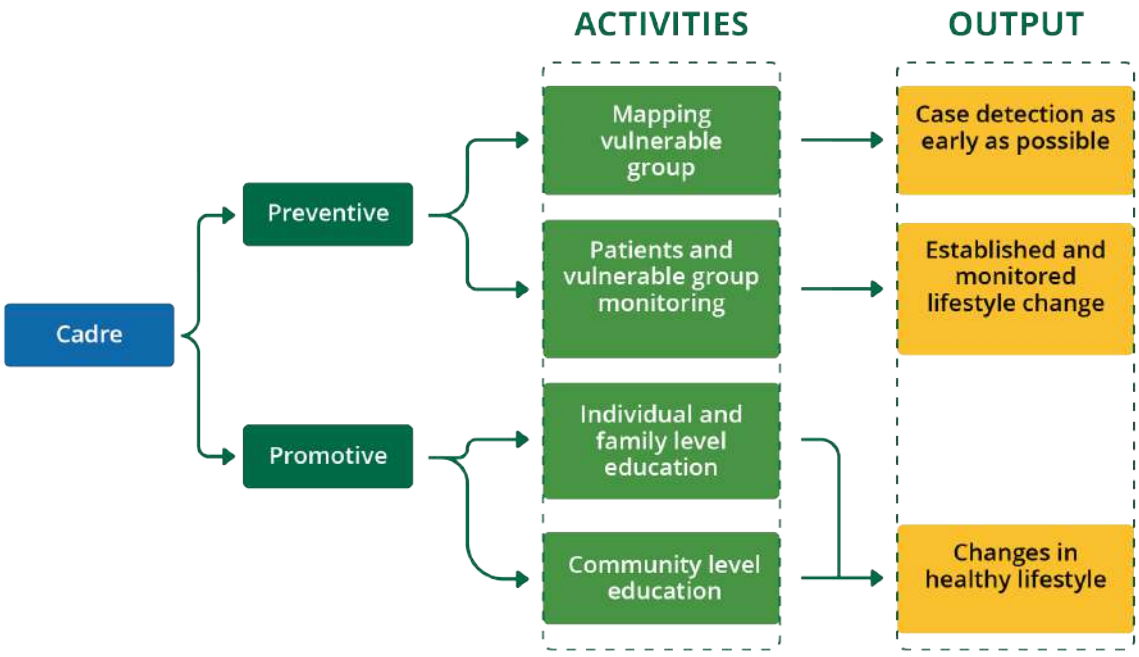


Figure 10. Opportunities to Involve Community Health Workers in the Program to Strengthen Integrated Primary Health Care Services

[5] Economic Evaluation Report of West Java's PUSPA Program in 2021

Appendix Chapter 6:

L6.1 The Collection of PUSPA's Innovations in Nutritional and NCD Programs in 2022

L6.2 Thematic Monitoring Template

CHAPTER VII
EVALUATION

Program evaluation is an assessment process which is performed systematically to determine the extent to which instructional objectives are achieved by the program. The evaluation aims to check achievements, challenges, and learning that has occurred from the beginning of the program to the evaluation time (checkpoint). In the best practices for the primary health care services strengthening program, program managers conduct mid-term and final program evaluations.

1. **Mid-term Program Evaluation**

   Mid-term program evaluation is generally conducted in the middle of program implementation, for example in the 6th month of 12th months of program implementation. The learning outcomes and recommendations from the mid-term program evaluation will determine implementation in the remainder of the program.[6] The output of this evaluation can be a plan for corrective steps or follow-up from the district/city management team as well as policies and directions from the provincial program management team. *See Appendix 7.1 for the example of mid-term evaluation results for integrated primary health care services strengthening program*

2. **Final Program Evaluation**

   Final program evaluation aims to explore opportunities and achievements of program that has been running. The recommendations in final program evaluation determine the design of subsequent programs in the future. The output of final evaluation can be a final report and other publications according to the needs of the PUSPA management. *See Appendix 7.2 for the example of final program report.*

It is recommended that the preparation of an evaluation document include at least the following elements:

A. Introduction: Objectives, Scope, and Methodology
B. Project Description and Background Context
   - B.1 Development Context: project description and objectives;
   - B.2 The problems to be solved by the project;
   - B.3 Project description and strategy: objectives, and expected results, description of field location;
   - B.4 Project Implementer: description of the project implementer; and
   - B.5 Key partners and stakeholders involved in the project implementation.

[6] UNDP. 2014."GUIDANCE FOR CONDUCTING MIDTERM REVIEWS OF UNDP-SUPPORTED, GEF-FINANCED PROJECTS"

C. Results

C.1 All achievements are described per indicator. Besides quantitative data, qualitative information can also be reported;

Figure 11. The Example of Data Recapitulation Table

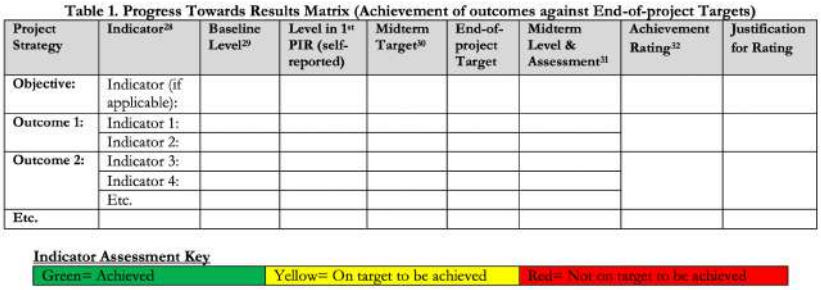


Table 1. Progress Towards Results Matrix (Achievement of outcomes against End-of-project Targets)

Project Strategy	Indicator[28]	Baseline Level[29]	Level in 1st PIR (self-reported)	Midterm Target[30]	End-of-project Target	Midterm Level & Assessment[31]	Achievement Rating[32]	Justification for Rating
Objective:	Indicator (if applicable):							
Outcome 1:	Indicator 1:							
	Indicator 2:							
Outcome 2:	Indicator 3:							
	Indicator 4:							
	Etc.							
Etc.								

Indicator Assessment Key

Green= Achieved | Yellow= On target to be achieved | Red= Not on target to be achieved

C.2 The progress of indicators can be presented in a data recapitulation table that contains indicator achievements based on logical framework/logframe;

C.3 Project Implementation Process;

C.4 Sustainability.

D. Conclusions and Recommendations

Appendix Chapter 7:

L7.1 The Example of Mid-term Program Evaluation Result

L7.2 The Example of Final Program Report

SECTION 3

Partnership and Communication

Legal Basis

- The Minister of Health Regulation Number 27 of 2022 on Guidelines for Public Private Partnerships in the Non-Infrastructure Health Sector
- The Minister of Health Regulation Number 1787 on Advertisement and Publication of Health Services
- The Minister of Health Regulation Number 74 of 2015 on Health Improvement and Disease Prevention Efforts

CHAPTER VIII
BUILDING AND NURTURING PARTNERSHIPS

Multi-party collaboration is beneficial to see what problems can be solved together, and encourage new breakthroughs that can accelerate the achievement of health targets in the intervention area. Collaboration can be initiated in the level of province of health office, district/city of health office, as well as *puskesmas.*

The program to strengthen integrated primary health care services can open up opportunities for sectors/institutions to partner in the scope of health care services according to the priority topics (for example NCDs, Nutrition, and etc.), youth empowerment, sustainable development goals, and so on. The types of partnerships that should be avoided are with industries or institutions with products that pose a health risk for example the tobacco/cigarette industry, the alcohol industry and the sharp weapons industry.

The partnership, which is not only in the form of Corporate Social Responsibility, can be a reference for the potential collaboration between the health office and development partners at various levels, from the private sector to the student community.

8.1 Performing Partnership Assessment through Due Diligence Process

Due diligence is conducted internally by the Partnership Team or related bureau at the *puskesmas*/health office to ensure:

a. Potential partners should not be affiliated with 3 (three) industries whose products pose a health risk, such as the tobacco/cigarette, alcohol, and sharp weapons industries;
b. Potential partners should not enter the partnerships in order to promote health risk products that conflict with the preventive function of the *puskesmas*, such as flavored drinks and foods high in salt and fat;
c. Potential partners should not have a track record of violating the equality values, such as cases of sexual harassment and violence against children; and
d. Potential partners should not involve in corruption cases.

8.2 Determining Types of Partnership and Collaborative Benefits

Several partnership schemes that can be initiated and developed in the program to strengthen integrated primary health care services can be seen on Table 6. Further information regarding collaborative benefits needs to be included in a partnership proposal. *See Appendix 8.1 for the example of a partnership proposal for fundraising purposes, and Appendix 8.2 for a reference on partnership experience in the program to strengthen integrated primary health care services.*

Table 6. The Example of Partnership Types and Collaborative Benefits Potential

Partnership Types	Potential Collaborative Benefits (can be discussed with partners)
Implementing Partners (Including Impact Evaluation Partners) • In the form of goods (non-cash) • Funding for overall activities (including impact evaluation) • Ensure the availability of isolation shelter	• Strategic position as a member of PUSPA Collaborative Center • Access to partner program outreach and communications to 10,000 beneficiary cadres • Promotion of partners on program communication and promotion materials (e-posters and banners in 100 *puskesmas*) • Exclusive invitation for thematic/partnership discussions with West Java Governor and CISDI Founders • Acknowledgment for volunteer partners. • Story-telling package that depicts health issues. • Access to the PUSPA Program Impact Evaluation Report
Knowledge Partners (Including Impact Evaluation Partners) • Training • Workshop • Funding for impact evaluation	• Strategic position as a member of PUSPA Collaborative Center • Promotion of partners on program communication and promotion materials related to training and workshop (e-posters, communication products, and banners) • Acknowledgment for volunteer partners. • Story-telling package that depicts health issues. • Access to the PUSPA Program Impact Evaluation Report

8.3 Partnership Formalization

After holding discussions and reaching a partnership agreement, the parties can create a cooperation agreement. The agreement document may contain the following details:

a. **Controlling the Ownership of Partnership Products**
   All products produced from the program partnership scheme will become the property of the West Java Provincial Government which is managed by the Secretariat and West Java Province of Health Office. The use of the products by potential partners can be discussed.

b. **Promotion**
   The program to strengthen integrated primary health care services is fully managed by the West Java Provincial Government. All potential partners who support the PUSPA program will receive recognition in the form of the inclusion of partner's logo on the program's communication and publication materials (program posters, banners, displays, and presentations).

c. **Monitoring and evaluation mechanism**
   Monitoring of activities that are the output of the partnership should be conducted regularly. In addition, the parties can jointly make activity and impact reports at the end of the program.

Appendix Chapter 8:

L8.1 The Example of Partnership Proposal for Fundraising

L8.2 The Example of Partnership Experience Reference in the Program to Strengthen Integrated Primary Health Care Services

CHAPTER IX
COMMUNICATIONS, PUBLICATIONS, AND MEDIA

9.1 Communication Activities

Communication activities are activities to promote the program to the general public, either to disseminate information to gather movements to support the program, or to influence people to do something.

a. **Program Launching and Closing**
   This activity marks the start and the end of the program. It is not meaningful if the event only consists of document ratification or submission. It needs to be discussion or sharing sessions that encourage the public to participate. Ideally, there should be open activities so that the public can watch. In addition, it is better if the activity is also broadcasted live via YouTube. This is to anticipate obstacles experienced by participants who join via Zoom, or if the activity is only held offline.
b. **Joint Campaign**
   One of the intervention activities that involve large (mass) groups is a joint campaign, either directly in the field or through social media. The campaign aims to invite more residents to be screened, get educational exposure, and promote *puskesmas* routine activities to residents who don't know about them.

An effective communication strategy is developed through Social and Behavior Change Communication (SBCC) approach. The SBCC approach identifies and analyzes situations, determines target groups, and formulates messages into relevant and convincing arguments to shape desired attitudes and practices. Important things that can be detailed in the SBCC are as follows.

- Preparation of key messages for specific target groups;
- Preparation of communication indicators is conducted by health workers, community health workers, or field workers who perform the interventions;
- Formulation of materials for information, education, and communication (IEC) activities following the key messages;
- Implementation of training concerning communication as needed;
- Planning campaign activities to increase screening coverage; and
- Regular monitoring and evaluation of the implementation of SBCC activities.

A strategy that can be executed to expand information about *puskesmas* efforts and education for local residents is a digital campaign via social media. The team can work together with the *puskesmas* health workers who are assigned to manage social

media by establishing a WhatsApp group for coordination and creating joint digital campaigns.

9.2 Communication Products for Education or Campaign

Various communication products are created by the program organizers as supporting instruments for the implementers to execute education or health campaigns to the public. The aim is to make it easier for the public to understand the health message being conveyed. Some communication materials that can be made include flashcards, videos, posters, and banners. *See Appendix 9.1 for communication activity and IEC products ideas.*

9.3 Publication in Social Media and Website

Various social media platforms such as Twitter, Facebook, Instagram, TikTok, LinkedIn, Blogs, and YouTube has become a means of publishing and bridging information to get closer to the public. Moreover, the current existence of social media is very necessary to build reputation and networks so that information dissemination is easier. Publication and information access which is conveyed through social media are assumed to reach the target group faster.

Implementation of social media utilization as a publication space can be started by informing about the sustainability of program activities, existing partnerships, and important moments during program implementation. The format of social media and website publications that can be used include: Instagram and Instastory posts, Instagram Live, call centers, or posts on other social media owned. Meanwhile, various products can be published on the website, for instance articles and bulletins. *See Appendix 9.2 for detail that must be prepared in creating press release and newsletter.*

Some ideas for publication theme that can be produced are as follows:

1. Various health innovations
2. Community figures or local heroes who have an influence on the health sector
3. Best practices in the field to handle health problems.
4. Health program achievements.

A press release is a written document prepared by an organization, group or company to provide information to the mass media. The main purpose of writing a press release is to get the attention of the media and the general public on that media. The commonly used press release structure consists of:

1. **Title or headline:** The main information that become the main objective for audience to read further.

2. **Date and place:** Date and place where the press release was broadcasted. The date and place are usually written in the introduction.
3. **Foreword or Lead:** One initial paragraph that summarizes the issue or main problem being discussed.
4. **Content or body of press release:** Detailed and supporting information regarding the topics discussed in the press release.
5. **Citation from spokesperson:** Quotes from organization representatives and trusted sources regarding the issues discussed in the press release.
6. **Contact information** Contact information of the organization's contact person who can be asked for further information.
7. **Closing:** Conclusions from the information presented in the press release.
8. **Boilerplate:** Summary of information about the organization and implemented programs.

Siaran Pers

Memperingati Hari Obesitas, CISDI, UNICEF, dan P2PTM Menyerukan Pentingnya Membangun Sistem yang Menciptakan Lingkungan Lebih Sehat

Ardiani Hanifa Audwina • 4 Mar 2023

Center for Indonesia's Strategic Development Initiatives (CISDI) bekerja sama dengan UNICEF Indonesia dan Direktorat Pencegahan dan Pengendalian Penyakit Tidak Menular (P2PTM), Kementerian Kesehatan Indonesia, mengadakan rangkaian acara "Gerak Bersama, Ubah Sudut Pandang" sebagai bagian peringatan Hari Obesitas Dunia 4 Maret 2023.

Rangkaian acara ini dimulai melalui diskusi publik bertema *"The Hidden Crisis of Obesity"* di Perpustakaan Taman Literasi Martha Tiahahu, Jakarta (4/3). ***Chief of Policy and Research*** **CISDI, Olivia Herlinda,** memaparkan peran penting cukai minuman berpemanis dalam kemasan (MBDK) sebagai salah satu regulasi menciptakan lingkungan yang tidak obesogenik. Lingkungan obesogenik adalah lingkungan yang mendukung terjadinya obesitas atau kenaikan berat badan berlebih.

Figure 11 : The example of press release broadcasted by CISDI and published on cisdi.org (CISDI, 2023)

9.5 Documentation

Documentation is assets for storing information as evidence and explanation that can strengthen activities that have been carried out in the field. Moreover, it provides an overview of activities that will be carried out in the future. The process of providing various documentation, such as taking photos and videos and other supporting aspects that will be published via social media, needs to be equipped with metadata and approval sheets.

Metadata is standard information stored in a photo, such as file name, dimensions, and camera EXIF (exposure, focal length, ISO speed rating, flash, and GPS). Furthermore, IPTC (International Press Telecommunications Council) metadata can also be added, such as the name of the photographer, the location where the image was taken, telephone number of the object in the image, website address, copyright status including photo captions.

Informed consent is an agreement form that contains a statement or agreement from the relevant party regarding taking a photo or video as a form of respecting human dignity and guaranteeing the rights, safety, and welfare of every person in the photo or video. This informed consent can be in the form of a printed sheet with a wet signature or online form in the form of a Google Form. *See Appendix 9.3 for the example of informed consent in performing documentation.* Figure 11 describes situations that need or do not need informed consent.

Situations that do not need informed consent	Situations that need informed consent	
	General	Requires special treatment – highly requires informed consent
1. Individual who is unrecognized in public space (their face and other physical characteristics are unrecognizable). 2. Public figure in public space (for example: public official, celebrity in ceremonial events. 3. Crowd in public space (for example: concert crowd). 4. People who pose and are aware of the presence of the photographer or videographer. fotografer atau videografer	All individuals who can be recognized in every situation.	1. Health worker and patients whose faces can be recognized and situated at clinical environment. 2. Documentation that portrays children's photos. 3. Individuals both recognizable and unrecognizable in a condition whose personal and private information are exposed through photos or documented in the caption such as: - Health status (for example: sex workers, sexual orientation, illicit drug and alcohol users, specific drug users, victims of genital mutilation, and etc.) - Criminal acts (for example: perpetrator or victim of gender violence, and etc.)

Figure 12. The Use of Informed Consent in Documentation.

Appendix Chapter 9:

L9.1 Communication Activity and IEC Products Ideas

L9.2 Details that Must be Prepared in Creating Press Release and Newsletter

L9.3 The Example of Informed Consent in Documentation

Further Discussions

Please contact CISDI for further discussion related to information and the use of this playbook.

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All Appendices in This Book