Code/Field of Science:
351/Kesehatan Masyarakat

RESEARCH REPORT
INTERNATIONAL REASEARCH COLLABORATION AND SCIENTIFIC PUBLICATION

IMPROVING MATERNAL HEALTHSERVICES IN REMOTE RURAL THROUGH SHELTER MODEL AND MID- PROVIDERS INVOLVEMENT

Rersearch Team :

Principal Researcher : Dr.dr. Arlina Dewi, M.Kes.,AAK (NIDN: 0531106801)

Members :

1. Dr. Sri Sundari, M.Kes (NIDN : 0513046702)
2. dr. Supriyatiningsih, SpOG, M.Kes (NIDN:0518027203)

UNIVERSITAS MUHAMMADIYAH YOGYAKARTA

SEPTEMBER, 2018

HALAMAN PENGESAHAN

Judul	: Improving Maternal Health Services in Remote Rural Areas through a Shelter Model As Well As Mid-Level Providers Involvement
Peneliti/Pelaksana	
Nama Lengkap	: Dr. dr. ARLINA DEWI, S.Ked, M.Kes
Perguruan Tinggi	: Universitas Muhammadiyah Yogyakarta
NIDN	: 0531106801
Jabatan Fungsional	: Lektor
Program Studi	: Manajemen Rumah sakit
Nomor HP	: 08122972576
Alamat surel (e-mail)	: dewikoen@yahoo.com
Anggota (1)	
Nama Lengkap	: Dr. Dr SRI SUNDARI M.Kes
NIDN	: 0513046701
Perguruan Tinggi	: Universitas Muhammadiyah Yogyakarta
Anggota (2)	
Nama Lengkap	: Dr SUPRIYATININGSIH S.Ked, Sp.O.G, M.Kes
NIDN	: 0518027203
Perguruan Tinggi	: Universitas Muhammadiyah Yogyakarta
Institusi Mitra (jika ada)	
Nama Institusi Mitra	: University of Muenster, Germany
Alamat	: Frauenklinik des Universitaetsklinikums Muenster Albert Schweitzer Campus 1 48149 Muenster
Penanggung Jawab	: Prof. Dr. med. Ralph J. Lellé, MD, PhD, MIAC
Tahun Pelaksanaan	: Tahun ke 2 dari rencana 3 tahun
Biaya Tahun Berjalan	: Rp 150,000,000
Biaya Keseluruhan	: Rp 576,000,000

Mengetahui,
Kepala LP3M UMY

(Dr.Ir.Gatot Supangat, MP)
NIP/NIK 196210231991031003

Kab. Bantul, 25 - 9 - 2018
Ketua,

(Dr. dr. ARLINA DEWI, S.Ked, M.Kes)
NIP/NIK 19681031200310173060

TABLE OF CONTENS

ABSTRACT

One of the objectives in Milennium Deveopment Goals (MDGs) is decreasing maternal mortality rate (MMR). Currently, by the end of MDGs in 2015, MMR in Indonesia is recorded at 359, out of the target that it should be decreased to 102. This resarch is a multy years program, aiming at reducing maternal death by providing sheltes services in rural areas.

There are many methodologies will be used during the period of research. The methodology of an action research approach will be implemented. In the first year, a qualitative study already conducted and designed need assessment tools before developing the program further. The researcher from Germany and Indonesia developed a training modul to be used in an experimental study for the Mid-Level Providers (MLP). In the second year, the researchers team from Indonesia will visit Germany to develop shelter model with expert from Germany. An qualytative research will be planned by conducting a shelter model pilot project and training of trainer for midwifes. The result of this trial will be evaluated and discussed qualitatively with stakeholders. The evaluation from the second year then will be a concern to conduct a qualitative study in the final year for model redevelopment and national conference dissemination.

The output in second year were international reputated publications (Scopus Index Q4 accepted in Global Health Action), invited speaker in scientific international forum 2 Times in Yogyakarta and Surabaya (Proceeding Scopus), Two monograph books : Panduan Kader Bagi Kesehatan Ibu Hamil and Scalling Up Nutrition The future of Indonesia, Copyright : Panduan Deteksi Kebutuhan Ibu Hamil Bagi Kader Kesehatan

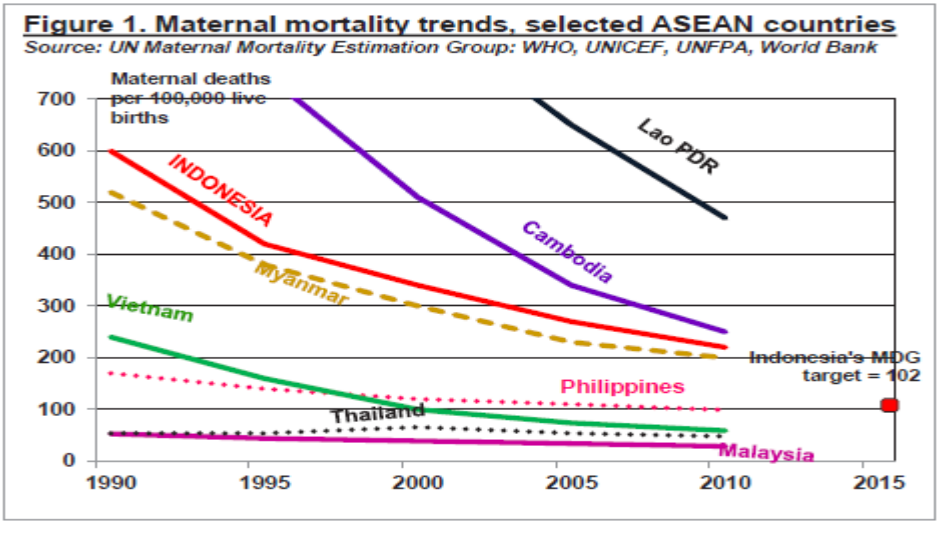
Key words: maternal health, maternal mortality, shelters, rural areas, mid-level providers

Chapter I
INTRODUCTION

Background of this research is distribution of health workforces between rural and remote areas became main topic in many developing countries. Another hand are the unequally distribution of health infrastructures and facilities as the cause of the big disparities of healthcare services' distributions between Islands in Indonesia. Healthcare services should be equal everywhere to reduce health outcomes disparities in one country. The limitation of health infrastructures and human resources in underserved areas in Indonesia leads to high mortality rate especially for mother and children.

Indonesia's progress on maternal health, the fifth Millennium Development Goal (MDG), has slowed in recent years. Its maternal mortality ratio, estimated at around 228 per 100,000 live births, has remained stubbornly above 200 over the past decade, despite efforts to improve maternal health services. Poorer countries in the region show greater progress in this regard (Figure 1) (UNICEF, 2013).

Figure 1. Maternal mortality trends, selected ASEAN countries
Source: UN Maternal Mortality Estimation Group: WHO, UNICEF, UNFPA, World Bank



Urgency of this research is regarding the fact that until the end of Millennium Development Goals in 2000-2015, maternal mortality rate in Indonesia is still very high at 359. The figures 1 indicate that the target is not reached during the 15 years of development. Target post-Millennium Development Goals on maternal mortality rate

in Indonesia is 102 (WHO,.2013). It means that Indonesia is even worse than the poorest countries in ASEAN, such as East Timor, Myanmar and Cambodia.

Indonesia has now been predicated underdeveloped in Asia in protecting maternal health. Emergency maternal mortality should be terminated with the seriousness of improved policies, budgets and immediate action (BKKBN, 2013). Supratikto *et.al* (2002) showed between 1995 and 1999 the audit reviewed 130 maternal deaths. The leading causes of death were haemorrhage (41%) and hypertensive diseases (32%). Delays in decision-making and poor quality of care in health facilities were seen as contributory factors in 77% and 60% of the deaths, respectively. Indonesia has a long history of unequal infrastructure development, physician shortage und uneven distribution of medical personal between urban and rural area. The side effect of huge disparities of distribution is assumed to contribute to the persistently high neonatal and maternal mortality rates (MoH, 2014).

Adressing those recent problems, preliminary research has been conducted to find solution constraints faced in the utilization of shelter at South Sulawesi. Qualitative study will be designed as a need assessment tool before developing the program further. The method of data collecting used FGD and in-depth interview. Research respondents were stakeholders; consisting of provincial policy makers, Head of the District Health Department and midwifes from Bulukumba, Bantaeng and Makasar.

The results of the study reported that the shelter is a residential house with facilities of beds and household appliances. During the wait of the birth, pregnant mothers were given the opportunity to stay at the shelter. Rental fees for housing and meals are provided free of charge. All fees are charged to government-by Jampersal (a local health coverage). A pregnant woman does not have any activities and without any companion from health personnel when living in a shelter. Besides, pregnant women feel more comfortable living near their family during waiting for delivery.

Another quantitative data was processed descriptively and analyzed with conjoint analysis. A total of 51 pregnant women and 49 families were participated in the study as two group's respondent. Most pregnant women and families had never

heard of maternal waiting homes. The number of families permitting mother to stay in the shelters is lower compared to pregnant women itself. More than 70% of both groups respondent were agree for the assistance of mid-level provider/MLP during their stay at the shelters. Conjoint analysis described the preference of staying at maternal waiting homes which is determined by living expense during stay (all expenses are covered) and skills of mid-level provider (MLP can apply a simple management before being referred).

During the year 2 of the program, the research process followed by pilot project a shelter model and training modul for MLP. The result of this trial will be evaluated and discussed qualitatively with policy makers, communities, and users (MLP and maternal). Output in year 2 is the result of evaluation program and the reduction in the number of maternal death in this trial.

The models of shelters with mid-level providers could be one of the solutions to improve primary healthcare services in underserved areas and improve community based healthcare in those areas. We wish to introduce a model of maternity waiting shelter and mid-level providers to solve of the urgent problem. The limitation of health professionals in remote rural areas are big issues that must be solved. The MLP's programme are the type of programme that improves the quality and quantity of human resources in remote rural areas (WHO, 2015). The MLP's programmes are planned to be a sustainable programmes that improve the local communities to participate in the healthcare system. Those model can reduce the facilities barriers and in healthcare services and improve the health outcomes for mother and children. The contribution of researchers in solving the problems:

1. For researchers Indonesia (UMY): expected to do need assessment, develop and test entrepreneurial models with quality standard for maternity shelter that are responsive to community needs, operationally and financially sustainable and effective in increasing access to quality facility delivery among the most vulnerable women.

2. For German researchers (Muenster University): expected to develop strengthening the workforce with mid-level health providers (MLP). Design of MLP will be the responsibility of Germany researchers. MLP design will be involved in shelters.

The aim of research is to reduce the gap of healthcare services disparities which contribute to the Maternal Mortality Rate.

The potential results to be obtained by the end of this study are:

1. To design a suit and sustainable programmes with Mid-Level Health Provides that will be arranged for underserved area with high maternal and infant mortality rate.
2. The model of a shelter with MLP aim to improve both access and quality of healthcare services especially for mother and children in underserved or remote areas.
3. To empower the community health of rural or remote areas through the model of shelter with MLP

The importance to conduct the research with foreign partners because of maternal mortality rate is one of the global indicators which very important in the era of Millennium Development Goals that ended in 2015 and will be implemented a Sustainable Development Goals starting in 2016-2031. On the basis of these reasons, we need to learn from country that has successfully built on maternal health that has number very low maternal mortality. Countries that have the concept of a comprehensive maternal care are United Kingdom, Germany, Australia, Netherlands and United States. They can reduce the maternal mortality rate to less than 25 (WHO, 2013).

We choose Germany because we have cooperation with the Center for Parents, Children, and Youth Medicine, Muenster University Hospital, Germany. We have conducted cooperative research and community services in 2016 with the title: "A comprehensif approach of maternal health : reducing maternal mortality rate by developing health resources, access, and management" (Germany experts : Prof. Jorg Haier and Evelyn Reinke).

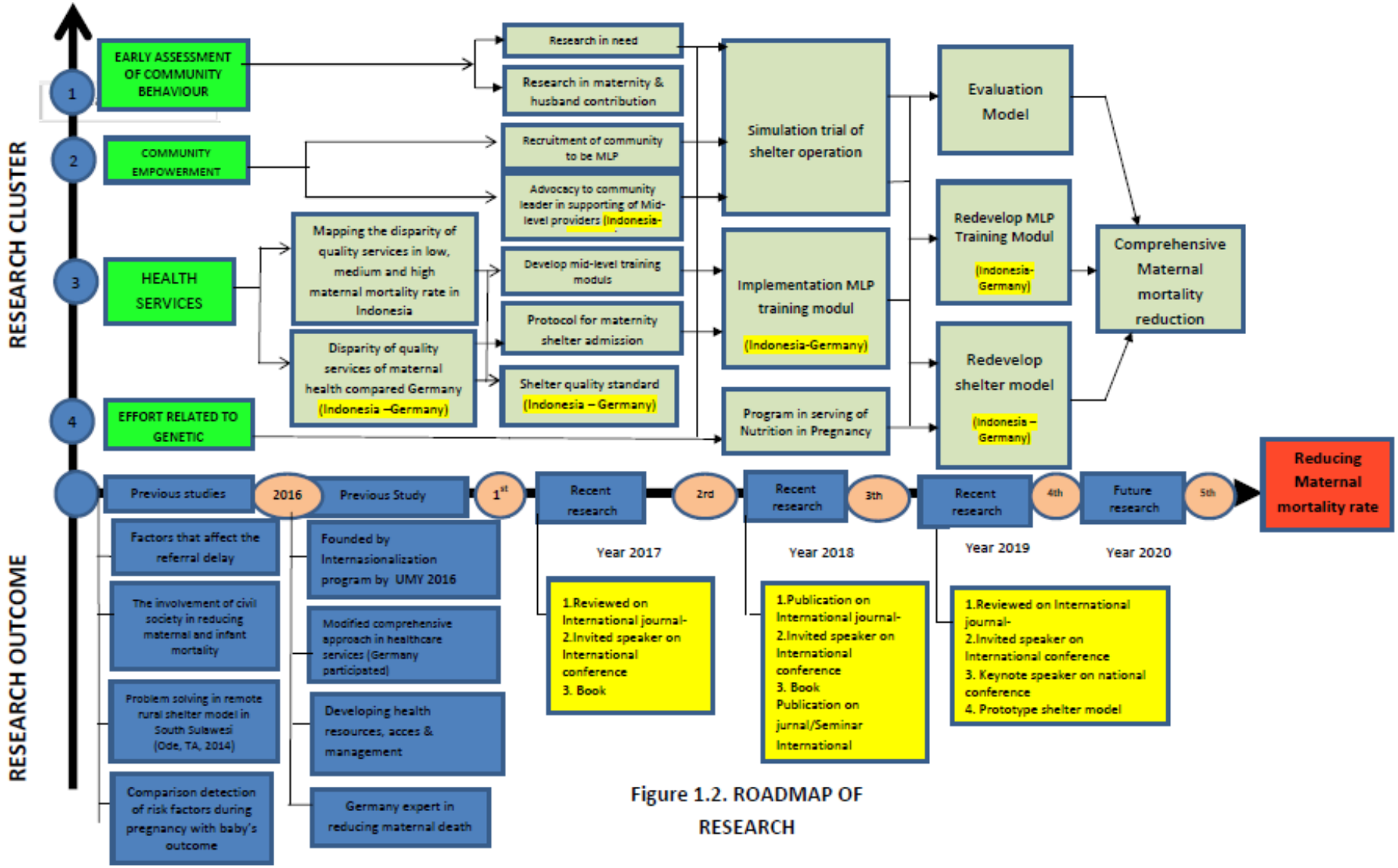


Figure 1.2. ROADMAP OF RESEARCH

Table 1.1. Outcome Planning

No	Type of Outcome		Indicator		
			CY	CY+1	CY+2
1.	Scientific Publication	International	1(reviewed)	1(accepted) 1 (reviewed)	1(published)
		National-Accredited			
2.	Invited speaker in scientific forum	International	1	1	1
		National			
3.	Keynote speaker in scientific forum	International			
		National			1
4.	Visiting lecturer	International		1	
5.	Intellectual Property Right	Patent			1
		Simple Patent			
		Copy Right	1	1	
		Trade Mark			
		Trade Secret			
		Industrial Product Design			
		Geographical Indication			
		Plant Variety Conservation			
		Integrated Circuit Topography Conservation			
6.	Intermediate Technology				
7.	Model/Prototype/Design/Art/Social Engineering		-	-	-
8.	Book (ISBN)		Edited	published	
9.	Technological Readiness Level (TRL)		2	4	5-

Chapter II

LITERATURE REVIEW

Scarcity and uneven distribution of health workforces between rural and remote areas became main topic in many developing countries (WHO 2015). Another hand are the unequally distribution of health infrastructures and facilities as the cause of the big disparities of healthcare services' distributions between Islands in Indonesia (MoH 2014). The limitation of health infrastructures and human resources in underserved areas in Indonesia leads to high mortality rate especially for mother and children (ibid). That bad outcomes can be avoided with the development of health facilities and human resources in selected areas. The models of shelters with mid-level providers could be one of the solutions to improve primary healthcare services in underserved areas and improve community based healthcare in those areas.

Figure 2.1: Indonesian Healthcare System Challenges

Rising Population	**Shortage und unequal distribution of medical personal between cities and remote areas**	**Highly centralized advanced healthcare in the main cities**
Double Burden Diseases (communicable and non-communicable diseases)	**Geographical Barriers**	**Growing demand of hospital beds**
High neonatal and maternal mortality rate	**Uneven distribution of quality healthcare**	**Increase health expenditures**

(Source: own presentation original source from MoH, 2014)

The model shelters with mid-level health providers can be used as a bridging to reduce the gap of healthcare services disparities. The most of mother and children mortality rate in underserved areas are happened because of the late of interventions. The complication of pregnancies can be helped with the quick and right intervention from health professionals. The limitation of health professionals in underserved areas are big issues that must be solved. The MLP's programme are the type of programme

that improves the quality and quantity of human resources in underserved areas (WHO 2013). The MLP's programmes are planned to be a sustainable programmes that improve the local communities to participate in the healthcare system. The local people will be selected and trained as MLP and they will be a key person of the communities to improve communication between health professional and communities in remote areas. The local person as MLP has many advantages because they know better the cultural sensitive issues, and how to communicate and get the trust from the local communities. The trust can be used to transfer the knowledge of health issues especially in primary health care to the communities.

2.1. Mid-Level Providers (MLP)

According to the WHO, there are several working definitions of Mid-Level Providers (MLP) that will be used. MLP are health workers

a. Who are trained, authorized and regulated to work autonomously;
b. Who have received pre-service training at a higher education institution for at least 2-3 years;
c. Whose scope of practice includes (but is not restricted to) being able to diagnose, manage and treat illness, disease and impairments (including perform surgeries, where appropriately trained), prescribe medicines as well as engage in preventive and promotive care (WHO 2010, S. 8).

Another definition is from Lehmann (2008) : "*Mid-level practioners are front-line health workers in the community who are not doctors, but who have been trained to diagnose and treat common health problem, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injures for further care*" (WHO/WPRO 2001 in Lehmann 2008:1). From those definitions can be summarized that MLP have big influence of healthcare services in developing countries especially in underserved areas. MLP can work as community health workers in the communities. They will be members of the communities their work and would be selected by the communities. They should be answerable to the communities for their activities and should be supported by health system but they are not necessarily be part of its

organization and get shorter training than professional workers. (Lehmann, Uta 2008; Eco,Umberto, 2010; Sanberg, e al 2012).

Figure 2.2 Worldwide physician deficit and uneven distribution of medical personals between remote/Rural and city

No	country	Population vs. physicians
1.	Bangladesh	30% of nurses in four metropolitan districts where 15% of population lives
2.	South-Africa	17% doctors; 27% general practitioners; 25% medical specialists; 7% dentists; 6% phycologists in rural area where 46% of population lives
3.	Kenya	64% of psychologist in Nairobi where only 7,5% of population lives
4.	USA	9% of registered physicians in rural areas where 20% of population lives
5.	Canada	9,3% of physician workforce in rural areas where 24% of population lives

(Source: WHO 2010: 11)

Several benefits that can be got with the implementation of MLP's programmes, such as (Egger, et al, 2012) :

- MLP improves Access to Healthcare services (overcome the geographical barriers)
- MLP improves equity and equality in Healthcare services
- MLP improves the health outcome for the communities
- MLP reduces mother and child mortality and morbidity rate
- MLP is a key for primary healthcare services
- MLP can reduce cost in healthcare system

With MLP's programmes should improve the accessibility, affordability and quality of healthcare services and bring improvement in healthcare management.

Death of women from complications of childbirth remains a major global health problem. In 2010, nearly 300,000 women died in childbirth, the vast majority in developing countries. The maternal mortality ratio—deaths associated with pregnancy or childbirth per 100,000 live births—has proven to be one of the most intractable

health indicators in the developing world. Few resource-limited countries have made significant progress toward the Millennium Development Goal 5 target to reduce the maternal mortality ratio by 75% between 1990 and 2015. Lesotho, for example, has one of the highest maternal mortality ratios in the world—in fact, the maternal mortality ratio increased from 237 to 1155 per 100,000 live births between 1990 and 2009 (Hogan *et al*, 2010; MOHSW, 2010). In contrast, almost all resource-rich countries have less than 10 maternal deaths per 100,000 live births.

Common causes of maternal death in resource-limited settings include obstetrical hemorrhage, peripartum infections, eclampsia, and obstructed labor (WHO, 2005). The majority of these deaths can be prevented with timely access to emergency obstetrical care. However, in resource-limited settings, many deliveries occur at home, often aided by a traditional birth attendant or family member without the skills or the equipment to respond effectively to obstetric emergencies. The geographic distance between women's homes and the nearest health facility can also magnify the problem. In a setting like rural, where women must traverse mountainous terrain to reach a facility with obstetric services, the delay can be significant. If a woman experiences a complication with rapid onset, even a delay of several hours can be fatal. Such emergencies often cannot be easily predicted.

Maternity waiting homes (shelters) are built near a facility with essential obstetric services and allow pregnant women to travel there several weeks before delivery, wait for the onset of labor, and be quickly transferred to the facility for safe delivery. Waiting homes have been introduced in many developing countries, but their efficacy in decreasing maternal mortality remains controversial. In our experience, maternity waiting homes can be an extremely effective intervention, but only if they are part of a larger, comprehensive strategy to increase access to maternal health services. This strategy requires decentralizing primary health care services to bring skilled obstetric care closer to women in rural areas as well as the use of community health workers to identify pregnant women and accompany them to the facility for care (Satti H, *et al*, 2012)

2.2 A HISTORY OF MATERNITY WAITING HOMES (SHELTERS)

Maternity waiting homes/shelters are not a new idea. Since the early 20th century, waiting homes have existed in the United States and Europe, particularly in remote rural areas where women have limited access to an obstetric facility. Maternity waiting homes began to be introduced into developing countries in the 1960s. Though the World Health Organization has provided broad guidelines of what should be included in maternity waiting homes, significant variation exists in how they have been implemented. Waiting homes have also differed in terms of whether food, water, and other necessities are supplied, and whether family members are also accommodated (Wild K, 2012).

Historically, maternity waiting homes have been part of a maternal mortality reduction strategy focused on risk screening to identify women who should receive facility-based intrapartum care. In this model, women at high risk for complications (e.g. previous postpartum hemorrhage, previous cesarean section, age > 35 years) are encouraged to stay in a waiting home built near a hospital with emergency obstetric care several weeks before the onset of labor (WHO, 2005). One rationale for risk screening is that it prevents hospitals from being overwhelmed with patients who could safely be managed at the health center level. In most settings, maternity waiting homes have been constructed near rural hospitals rather than health centers.

The high-risk screening strategy, however, has proven to be largely ineffective because complications are difficult to predict (Campbell OM, 2001; Graham W, 2000). The majority of complications arise in pregnancies initially identified as low-risk. Even in a low-risk population, an estimated 15-20% of pregnancies will result in complications requiring treatment at a facility with comprehensive essential obstetric care (WHO, 2005). Maternity waiting home programs that focus on risk screening fail to account for women with low-risk pregnancies who end up facing an obstetric emergency at home far from facility-based delivery care.

Chapter III
RESEARCH METHODOLOGY

Currently, the team is investigating maternal health service quality ini collaboration with Muenster University, Germany. The study consist of health infrastructure, human resources, the areas whih are overed by the services and funding resources. The result with giving emphasize on the real condition of maternal health status within that area. Furthermore, there are many shelters in South Sulawesi, such as Gowa, Wajo, Bulukumba district. It is served by the local government and had run for about several months. The currents shelters would be a starting point assest in conducting need assessment before proceeding to the next step of the program.

During the first year, an early assessment will be conducted to explore the socio cultural that might be affected the use of the shelters. These socio cultural aspect are covering women and husband views of benefiting the maternity shelters. The study will also examine the health providers views during the services. To support a successfull services, the team will develop a MLP training modul. This basicly contains any skills the MLP should be trained, such as identifying when they should contact the hospital for a maternal emergency. During the first year period, an experimental study was designed aiming for model trial before applicated in the districts.

In second year, the research process followed by pilot project a shelter model. Stage 1 in this year are prepare tutor from midwifes in shelter location (TOT from Germany).. The result of this trial will be evaluated and discussed qualitatively with policy makers, communites, and users (MLP and maternal). Output in year 2 are shelter quality standard and optimalisation the use of shelter and the role of midwife and MLP

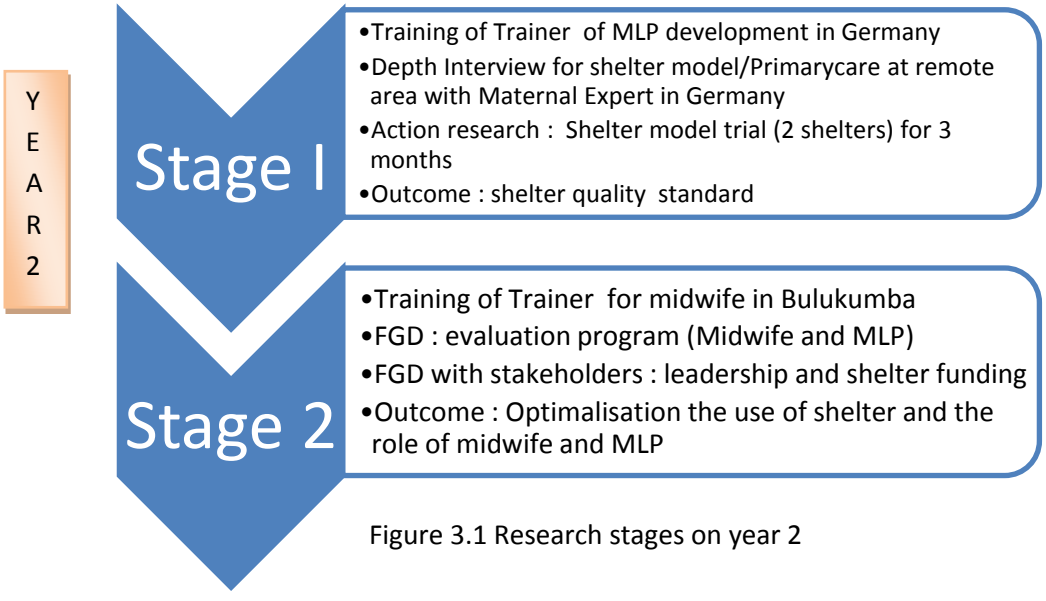


Figure 3.1 Research stages on year 2

In the 3rd year, will be carried out a qualitative study on the evaluation model for redevelopment shelter dan MLP training modul. Output in this stage is suistanable program, especially operational and financing issues. Thus, it is designed for a capacity building program for shelter management training for the local governments, particularly those who worked under the local health offices.

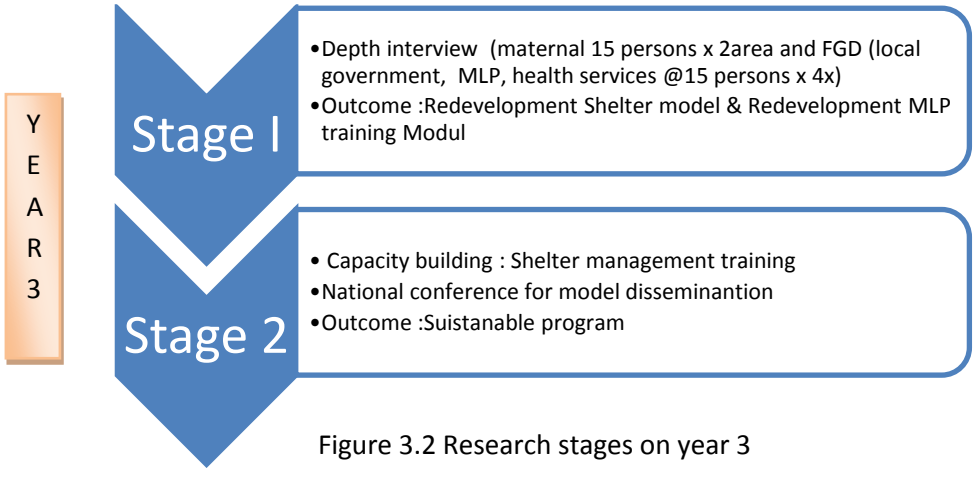
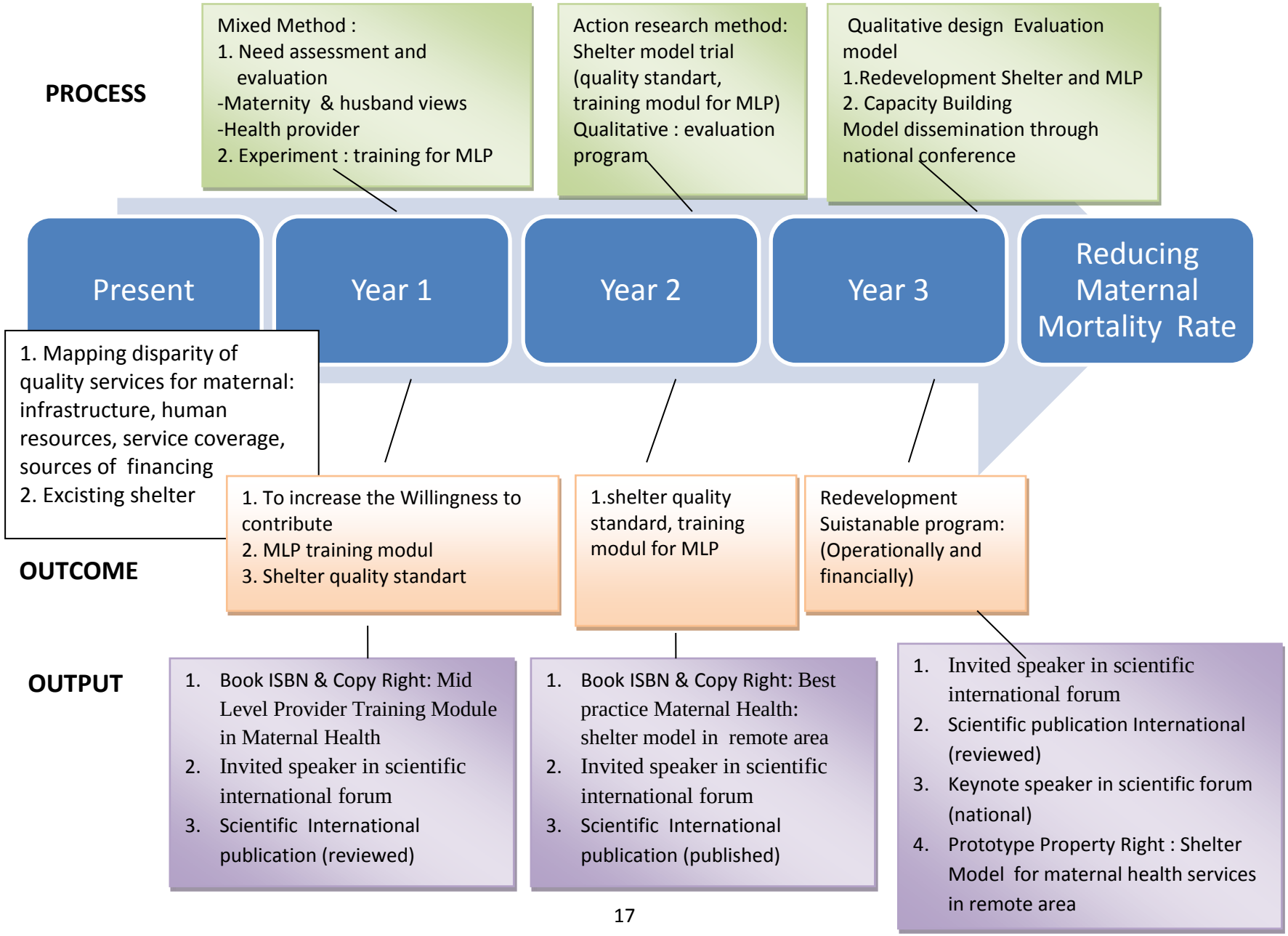


Figure 3.2 Research stages on year 3

Figure 3.4 Research Process, Outcome and Output



Chapter IV

RESULT AND DISCUSSION

1. INTRODUCTION

Maternal deaths currently arise in worldwide countries because lack of human resources for the pregnant women is not supplied by government and medical providers. Besides, most of pregnant women do not utilize the maternity waiting homes even though those have been provided well. One of the crucial matters comes out that the pregnant women prefer to stay at home during their pregnancy until getting birth. Anyhow, there are 830 women who die regarding the pregnancy and childbirth causes every day and many births still occur at home in the low and middle countries (Alkema et al., 2016 & Johnson et al., 2013). Therefore, to reduce the maternal mortality, the pregnant women should stay at MWHs in their pregnancy process.

Moreover, MWHs are places where pregnant women can stay there before having birth to fend off high risk of pregnancy. Manava et al., (2015) argued that maternity waiting homes are residential facilities located near with qualified medical facility. Also, the pregnant women with high risk of pregnancy can await their delivery and be transferred to a nearby medical facility early before the compilations arise. Likewise, staying at MWHs can help the pregnant women to avoid from maternal mortality. Thus, MWHs are not used by the pregnant women as the solution to reduce maternal mortality in Indonesia.

Indonesia is recorded as country with increased rate of maternal mortality as the highest in Southeast Asia. Additionally, in south Sulawesi, Bulukumba, it is one of the regencies which include high maternal deaths, but many remote areas have been provided several MHWs which are not utilized by the pregnant women. From the statements mentioned previously, the utilization rate of MWHs is insufficiently adequate to decrease the maternal mortality. Furthermore, to increase the utilization rate of MWHs, it should include some acceptance requirements for Bulukumba pregnant women's perception which can be applied in the use of MWHs. The objective of this study to investigate the pregnant women's Willingness to Pay (WTP) toward the maternity waiting homes (MWH).

2. METHOD

This study was descriptive quantitative design. The data were taken from the field surveys. From the research samples, there were found 100 people consisted of 51 pregnant women and 49 families especially their own husbands based on simple random sampling. This research took place in Bulukumba (n=67) and Bantaeng (n=33) regency, South Sulawesi, Indonesia with the number of respondents determined proportionally.

3. RESULTS

3.1 Demographic Characteristics

The average age of pregnancy of respondents is 6 months (median). Twenty eight years old was the average of pregnant women, and thirty two years old was the average of the families. Twenty seven percent of pregnant women finished their own study in Senior High School, and fifty one percent of families' education background was bachelor degree. For their own professions, a number of house wife were 92.2 % for the pregnant women largely, and 50.2 % of families got involved to work in informal sector. Thus, most of pregnant women and families had good education backgrounds and professions.

3.2 The Acceptance of MWH

From the acceptance of MWH, it showed that 62% of pregnant women and 67,3% the families had not heard about the MWHs, and presented that the pregnant women gave 62% and the families gave 67.3% for not yet answers to MWH information. Also, the pregnant women with 66.7% and the families with 47.8% strongly agreed and agreed if the pregnant women should stay at MWH when they were in 7th of the pregnancy. Additionally, the pregnant women with 70.6% and the families with 80.5% strongly agreed and agreed with if the trained non-medical providers (or Community Health Workers/CHW) accompanied them at MWH.

3.3 Willingness to Pay for MWH

Regarding the willingness to pay MWH, the pregnant women's and family's answer showed that 37.3% average of pregnant women and 32.6% average of families who agreed to pay during staying at MWH. The amount of the willingness to pay for a group of pregnant women was 100.000 IDR in a month (median) with the minimum amount of 5.000 IDR, and the maximum amount was 500.000 IDR. Moreover, for the amount of a family group's willingness to pay, it was 200.000 IDR in a month (median) with the minimum amount of 20.000 IDR, and for the maximum amount, it spent 1.000.000 IDR. Thus, the willingness of pregnant women and families was very low which spent about 3.500 IDR to 7.000 IDR per day. For more information of maternity waiting home, it would be mentioned and explained in the following table.

Table 1: The acceptance of maternity waiting home

Questions	Pregnant women (answer)	Family (answer)
Have you ever heard about MWH?	62% (not yet)	67.3 % (not yet)
Do you agree if high risk of pregnant women stay in MWH when they are in 7th month of pregnancy to ease the access to the health service facility?	66.7% **(s**trongly agree and agree)	47.8 % (strongly agree and agree)

Do you agree if MWH is accompanied by community health worker, but they have been trained before?	70.6% (strongly agree and agree)	80.5 % (strongly agree and agree)
If you, pregnant women's family have to stay in maternal waiting home (MWH), do you agree to pay the payment for your daily life needs during staying at MWH?	37.3% (trongly agree and agree)	32.6% (strongly agree and agree)
If agree, how much the maximum amount which you give during staying in MWH per month?	IDR 100,000 *	IDR 200,000 *

*Median rate

4. DISCUSSION

The pregnant women and their families in average did not recognize about the MWH since there were not any information which they got from the government or even from medical providers. According to Lori et al., (2013), conveying the MWH is one of the ways to deliver what social communities are needed to know about in order the information to be known by the social communities around. Doing socialization is an effective way to define whole context of maternal waiting homes, so social

communities or the people who are related to it especially for the pregnant women and their family will know what the maternal waiting home is and what the kind of regulations used are (Ekunwe, 2017). Giving information about MWHs to pregnant women was one of the ways to introduce what MWH is used for.

Pregnant women should stay in maternal waiting home when they have been in 7th month of their pregnancy to avoid from the serious risk which they face (Tiruneh et al., 2016). Hence, pregnant women needed to live in MWH due to their health pregnancy. Of course, there were mid wife health providers who always stayed in MWH to fulfil what pregnant women wanted to be helped in any kind of activities related to their activities. Consequently, the pregnant women should really know when they had to come to MWHs to ward off the high risk of pregnancy.

To conduct MWH, it should include community health workers (CHW) who can accompany pregnant women during at MWH. Also, the community health workers (CHW) had been trained in order to have skilful to serve their own pregnant patients. The statements mentioned previously was in line with El Shiekh and van der Kwaak (2015) who argued that to achieve great goals in conducting maternal waiting homes, it should provide skilled medical providers in order to achieve good treatment to be applied to their own pregnant women. Besides, skilful medical providers have various ways to handle pregnant women (Gaym et al., 2012). Consequently, skilled mid- medical providers are needed in maternal waiting homes to accompany pregnant women during staying at maternal waiting home. To avoid from unnecessary services, it should include non-medical providers to help CHW and their own patients, pregnant women.

Living cost at MWHs was the important aspect for the pregnant women or community who lived in remote area especially in South Sulawesi, Bulukumba. Besides, not most of them came from high economical level, and they might be from low economical level. Then, MWH should have the solution to overcome previous problems mentioned. Lori et al., (2017) declared that the living cost during staying at maternal waiting home is covered only for the patients who cannot afford to pay the registration and services, and at MWH, it should provide good services. Again, those ways mentioned are to make the patients feel satisfied with the services at MWHs.

Additionally, if MWH could not provide as statements mentioned previously, it should be the solution to solve the problems at MWH. Satti, McLaughkin, and Seung (2013) said that to decrease the cost of

maternal waiting home; it should be some options such as the provision of food to reduce indirect cost and the presence of midwife health providers in order to help and prevent the pregnant women not to stay at maternal waiting home which come as the solution. Also, they maintained that pregnant women who stay at MWHs should have free operational financing for staying at MWHs regarding the low economical level, or it should be option for the middle and high economical level to provide the appropriate operational financing. For instance, if the pregnant women are from low economical level, the payment for the daily life needs during staying at the shelter should be free for them in any kind of services (Penn-Kekana et al., 2017). Therefore, the living cost for staying at maternal waiting home should be implemented in order to attract the pregnant women to stay on it.

5. CONCLUSIONS

For a group of pregnant women, the amount of WTP which was capable to be paid was 100.000 IDR in a month. Moreover, for a group of family, the amount of WTP which they could pay for staying at MWH was 200.000 IDR in a month. The pregnant women's acceptance to stay in MWH is good, but their willingness to pay is still very low.

In Indonesia, as in many other international jurisdictions, demands for improvements in health service delivery have highlighted the need for system-wide health reform (Dickson and Lindstrom, 2010; Lewis, 2009). One aspect of this reform is the growing importance of professional health care management overall, and specifically, managers who are able to lead change (Heading, 2009; McGrath *et al*., 2008; Snowdon *et al*., 2010).

Successful reform requires sophisticated, modern leadership (Ford, 2009; Institute for Health Improvement, 2010; Institute for Innovation and Improvement, 2010). But who will these leaders be and how will they be developed? Nearly all health organisations share leadership capacity issues that pose a number of obstacles to successfully implementing health reform imperatives (Institute for Health Improvement, 2010; Institute for Innovation and Improvement, 2010).

As previously reported Indonesian maternal mortality rate is still high at 359/ 100.000 live birth (SKDI, 2012). It is identified maternal mortality as the highest priority. Accordingly the Uganda's experiences there are three interventions were identified as the most effective: scaling up of Emergency Obstetric Care (EmOC), strengthening family planning services and increasing deliveries at health units (Uganda Ministry of Health/UNICEF, 2003). This article describes the impact of implementing these decisions. Maternal mortality has declined only slightly in the last 10 years; and is currently estimated at 505/100,000 live births (WHO, 1999). Factors related to maternal and infant mortality have been documented and classified into direct and indirect causes. The direct causes of maternal mortality in Asia are widely known (Bailey *et al*., 2006). A recent government multi-sectoral task force to analyze maternal mortality and recommend strategies concluded investing in social services such as health, education, nutrition and safe water would improve maternal health. It also recommended specific programs addressing the health of adolescents, family planning and emergency care (UNICEF, 1997). Efforts to redefine current interventions and develop a road map to reduce maternal mortality followed the realization that many countries are unlikely to achieve the millennium development goals (MDGs) especially on child and maternal mortality.

The models of shelters with mid-level providers could be one of the solutions to improve primary healthcare services in underserved areas and improve community based healthcare in those areas. We wish to introduce a model of maternity waiting shelter and mid-level providers to solve of the urgent problem. The limitation of health professionals in remote rural areas are big issues that must be solved. The MLP's programme are the type of programme that improves the quality and quantity of human resources in remote rural areas (WHO, 2015). The MLP's programmes are planned to be a sustainable programmes that improve the local communities to participate in the healthcare system.

Those model can reduce the facilities barriers and in healthcare services and improve the health outcomes for mother and children.

However, one of the problems met indeveloping countries is the lack of readily available data. This limits the capacity of programs to make evidence-based decisions in resource allocation and management of programs. To address this constraint, a needs assessment was carried out in Indonesia where South Sulawesi to provide baseline data useful for scale-up of maternal mortality program.

Material and method

As research on strategic alliances gains depth. The key success factors and the challenges of managing this under-explored cadre of cross-sector alliances may be dissimilar from conventional inter-firm alliances.We performed in-depth interviews (n= 49 pregnant women, 52 pregnant women families) and focus group discussions from public (15 people), private (5 midwifes) and civil sectors (2 people). This evaluation study used in-depth semi-structured interviews including the topics: maternal health, community support, maternal shelthers. Key stake holders in strategic position in the public and private sectors as well as key persons in the local community were included (response rate: 100 %). Evaluation of the interview results was done using N Vivo 11 starter for window ®.

Given that little is known about the practice along with the benefits and challenges of such cross-sector alliances this study examined the use of alliances for first step implementing maternity shelter as pilot study in rural Indonesia. In this article two cases, which involve a large number of organisations including universities, governments, professional associations, businesses, and health authorities in South Sulawesi are used to investigate cross-sector alliances as a strategy for large-scale leadership development initiatives with the aim of improving health leadership capacity and capability. Lessons drawn from the cases and the literature are discussed so as to better understand the benefits and challenges of enacting an alliance strategy with organisations from different sectors for implementing the maternity shelter as pilot model in Indonesia. Finally, implications for practitioners and future research along with conclusions follow in the last section.

Two cases of large-scale health leadership development in this section, the two case studies are presented and show how the large-scale health leadership development initiatives formed and operated. The lessons learned from the cases are then set out to figure out the situation of the leadership in the first step implementing.

Table 1.

Two models health leadership development initiative

Sector	Case 1: District Scale	Case 2: CHLNet
Civil		
- Association	1	10
- Pregnant women	49	0
- Pregnant women's family	52	0
Public		
- Federal/ Country goverment	0	3
- Health authority	7	1
- District goverment	4	0
- University	4	2
- Mid level provider group	1	0
Private		
- High tech	0	0
- Membership based association civil sector	2	4
- Research	1	1
TOTAL	**121**	**21**

Case 1: district large-scale health leadership development initiative

During the time frame of the study it included a total of nine parties. It involved seven health authorities which are the backbone for service delivery, provincial-level government, local ministry of health, a not-for-profit health association, Universitas Muhammadiyah Yogyakarta and mid level provider group (see Table I). The aim of the alliance was to strengthen the district's health leadership capacity by diagnosing, identifying, assessing, and developing the leadership capabilities of individuals in health organisations. At the outset of this large-scale health leadership development initiative, there was a deep sense of inertia. This initial indifference was tempered by the insight of some that new approaches to overlooked opportunities for managerial leadership development could

be built. The project conducted research on the model of mid level provider in shelter (maternity waiting home/maternity shelter) and the leadership capacity and capabilities critical for health service delivery. These factors were then translated into the envisioned future state attributes of a large-scale health leadership development initiative, i.e. it should provide succession planning for all health authorities to prepare senior leaders to move into large, complex organisations; and it should stimulate leadership development as a priority for all managers within the health system (Leaders for Life, 2008). Following a gap analysis, these attributes provided the basis for the vision and the core strategy pursued in this case (i.e. systems-wide collaboration with other organisations from health, education, government, and community). System-wide collaboration required extensive participation among the allying organisations to develop an integrated model that included the identification of talent, the use of workplace based experience, coaches, custom courses and programs for the whole district or province, and self-directed learning experiences among others that collectively combined to create the Leaders the Life program (Leaders for Life, 2006). Once the strategy of large-scale health leadership development through collaborating with others was endorsed, the organisations began to create the sets of systems and routines of how they would work with each other (Leaders for Life, 2007a).

This led to Universitas Muhammadiyah Yogyakarta (UMY) team adopting a hub or network captain role (Provan et al., 2007). set out to coordinate the day-to-day operations, oversee the relationships, and monitor performance. UMY formed a "leadership panel" to serve as an advisory council, a program directorate, project-level working committees, an operations unit, research teams, and a communications arm (Leaders for Life, 2007b). These entities were constituted from the participating organisations and conducted services.

This model its role of hub/network captain, managed the alliance activities and communications among internal partners and to external audiences. Key to aligning initial efforts was the creation of the province's first leadershipcapability framework (Dickson, 2008). This gave an opportunity for partners toaccumulate collaborative experience in a low-risk manner. It was labelled as a "pilot" and did not directly impact health service delivery. Using the leadership capability framework as a springboard, efforts were undertaken to build an integrated model for large-scale leadership development. This involved a comprehensive suite of leadership learning program and services suited for the senior executive, upper management, middle-management, and supervisory levels while simultaneously including health professions (Leaders for Life, 2008). For instance, selection processes geared to identify and target those aspiring leaders were implemented as part of a piloting scheme. The suite of leadership development products and services coupled with perceived high value provided an indicator of success at one level. However, the hurdle of integrating and

institutionalising the large-scale health leadership development initiative as an integral part of the overall strategic and business planning process in Indonesia has yet to be overcome. Efforts continue on this side.

Case 2: country-wide large-scale health leadership development initiative

This cross-sector alliance –one as global model from the Canadian Health Leadership Network – was created in 2006 in support of identifying, developing, supporting, and celebrating excellence throughout the lifecycle of health leaders across Canada. The goal of the Canadian Health Leadership Network (CHLNet) is to provide organisations and individuals interested in leadership with access to applied leadership development tools, collaborative dialogue and networking opportunities, and access to research in leadership and leadership development.

CHLNet set out to a build large-scale leadership development support system that spanned the country. At the outset one of the biggest hurdles involved framing awareness of leadership development capacity deficiencies so that they:

- resonated with the experiences of senior leaders in a non-threatening manner
- revealed the scope of health leadership reform
- posed joint action as a viable strategy

Following the endorsement of this integrative approach, efforts shifted to creating the sets of systems and processes that would allow the collaborating organisations to take full advantage of their collective assets. CHLNet was an early adopter and judicious user of technology-enabled communication methods. Driven in part by the sheer volume of organisations involved , a lack of geographic proximity to each other, and a span of five time zones compelled a variety of methods for communication among the internal members and to external audiences. In tandem with the emerging coordination and governance mechanisms CHLNet engaged in a low-risk, low cost, high impact opportunity to adapt the original provincially-based leadership capability framework developed in case 1 for the country.

This approval spurred the creation of assets. These resources included the first Canadian inventory of leadership programs and tools for leaders (e.g. primers for fine-tuning on-the-job abilities and recommended readings to develop skills) (Canadian Health Leadership Network, 2011). Efforts to institutionalise and integrate a "for health, by health" leadership framework across the health industry were undertaken (Tholl, 2010). The Canadian College of Health Leaders endorsed the framework to guide its renewed certification process. Similarly, Accreditation Canada opted to refresh its governance and leadership guides to align with the framework. CHLNet has sought to position

itself as a "network of networks" (Canadian Health Leadership Network, 2010). Each member organisation is one of many with an influence on the structure and operations, and efforts have focused on generating an enduring set of principles that are encoded in how responses to change are met rather than enforcing a rules-based governance model. In practice, this has translated into minimal formal documentation of roles and responsibilities. While the risks involved in this governance approach are evident, continuity is maintained by two external co-chairs, direction is set by the board, and implementation is managed by an executive director and secretariat co-located with the Canadian College of Health Leaders. Having expanded its membership to 22, CHLNet continues as a "coalition of the willing" that initiates and responds to large-scale health leadership development opportunities country-wide.

Discussion: lessons learned

The two cases illustrate five main benefits that alliance partners can derive from large-scale health leadership development initiatives (see Figure 1 for a summary). A discussion of the mindsets, operations, and governance needed to overcome challenges.

Benefits

Benefit 1: gaining access to new and different resource combinations.

To be a strategically valuable partner, both cases demonstrated that benefits are produced through the pooling of assets (Gulati, 1998; Kale et al., 2000; Todeva and Knoke, 2005). This collective pool of assets enabled repurposing of programs and services, and creating new ones where needed. This included filling in gaps for under-serviced geographies and managerial levels, and setting new standards for health leadership capabilities. In case 2 (CHLNet), the adaptation of the LEADS in a Caring Environment leadership capability framework gave health leadership a credible research foundation, a common language for health leadership, and a set of standards for its participating organisations which led to a broader uptake and its institutionalisation. In case 1 the creation of a customised 360 degree assessment and an aspiring executive program filled in gaps in the leadership development system. To gain access to the assets of partners, thereby gaining the advantages of scale and scope while reducing the risk meant that partnering organisations needed to hone their abilities to conduct internal scanning to identify and evaluate their own organisation's assets in term of strengths and weaknesses

Benefit 2: demonstrating the differential value of affiliation.

Large-scale leadership development initiatives enacted through alliances involve many people and groups often pursuing dissimilar aims (London et al., 2005; Selsky and Parker, 2005). In both cases, the decision to ally with other health organisations, universities, professional associations, and business required the identification and measurement of value

generated for each partner so that they were able to make an informed decision not only to join, but also to stay affiliated. This meant that they needed to understand each partner's objective (whether it be altruistic, revenue generation, political, or other); demonstrate through various measures that the relationship generated value that would be difficult for each one to achieve moving independently, that this value is produced both in the short term and over the longer time horizon; and show that the relationship produced value to the "end user/client" (i.e. individual health leadership candidate) as well as other internal and external audiences. Both cases demonstrated that the collective value generated needed to exceed individual costs. This needed to be demonstrated at both the organisational and individual level. At the organisational level, this involved identifying the savings realised through the more efficient development of leaders (organisational level). In both cases this involved a common framework with a shared language that identified the health leadership capabilities. This, in turn, strengthened the ability of organisations to seek system-wide solutions and reduce the frequency of costly mistakes in recruiting from other jurisdictions or internally. Similarly, at the individual level, managers needed emerge from the leadership development process with the skills and knowledge necessary to move into positions with greater responsibilities.

Benefit 3: providing tools for dialogue among decision makers to inform strategy.

One of the primary drivers of the two-profiled large-scale health leadership initiatives was improved access to an integrated health leadership development system by the participating organisations. In both cases, governance issues and operational projects required dialogue among the partnering organisations. For example, capability framework provided alliance partners with the research foundation for leadership that had not previously been available, and spurred dialogue across organisations about how the framework represented the challenges of leadership. In practice both cases utilised a suite of decision making tools at the organisational level that encouraged dialogue among decision-makers that had not typically worked across organisational boundaries in the field of leadership development. It provided individual organisations with a framework to assess needs in view of health care reform, and to plan with a longer time horizon as well as sudden managerial needs such as unanticipated vacancies (McCall, 1998).

Benefit 4: creating a more efficient and transparent decision process for selection.

In the depth interviews (n= 49 pregnant woemn, 52 pregnant women families) and focus group discussions with some other parties at Bulukumba district, previous practices within health authorities employing nebulous or non-existent criteria for the decision making process to identify prospective candidates for leadership development and the attendant people as mid level provider at shelter in their growth and development contributed to low morale and a negative message through the respective organisational workforces. This process was tailored for the career lifecycle of a supervisor, a mid level manager, a senior level manager, and aspiring executive level. It gave greater ability to identify and support candidates' leadership growth (McCall, 1998), thereby reducing gaps in capacity and capability shortcomings. The CHLNet case provided an ancillary benefit to the decision process: the first online database for individuals and organisations to identify professional leadership development opportunities keyed to the leadership capability framework by province, credit, granting status, and instructional approach.

Benefit 5: exercising a relationship-oriented management approach

As the collaborative model is comprised of voluntary relations (Gulati, 1998), both cases were able to adapt their management approach (albeit differently) to meet the aim of the collective rather than a single person or an individual organisation.

Challenges

In spite of the benefits identified above, there are also some difficulties experienced in enacting a collaborative approach. The two case studies highlight several ways in which large-scale leadership development initiatives can be improved. Mindsets and behaviours. The resolve and determination (i.e. will) of those participating in collaborative relations influence the ability to envision and implement large-scale leadership development initiatives. Those with a collaborative-oriented images of the future and move collectively towards the aim even when it seems out of reach (Kouzes and Posner, 1987). In the absence of a collaborative-oriented mindset and corresponding complementary actions (e.g. focus, stamina, perseverance, patience, consideration of others' needs), the initiative can flounder (Arino and de la Torre, 1998; Ring and Van de Ven, 1994). The potential for misalignment was evidenced in the two cases by the emergence of sub-groups (e.g. "us versus them"), and assertions of individual over collective benefits (e.g. "we're different because . . . ").

Implementation issues, facilitating communication, exchanging resources, and coordinating the day-to-day operational aspects of collective activities are critical activities in terms of achieving results collaboratively (Kale and Singh, 2009; Schreiner et al., 2009). In both cases, the hub organisations lacked the infrastructure needed to carry out many activities once the alliances were up and running. They defaulted to working through the existing infrastructure and resources in the affiliated

organisations. To do so requires that leaders have a sophisticated set of skills to align aims and assets in order to produce collective value among the partners. It also demands dedicated time, energy, and financial resources on behalf of the participating organisations. It is not enough to have these skill sets at the CEO level (local ministry of health of Bulukumba). Given the need to utilise infrastructure across organisations, these skills are required of many individuals exercising leadership at different levels of the typical organisation chart.

These cases contribute to a better understanding of the challenges of synchronising activities in cross-sector alliances. The challenges were evidenced in the cases by: a pattern of starting many projects and finishing few; situations whereby personal/political interests superseded client/collective interests; examples of absent, contradictory, and vague communication; and circumstances where dedicated resources were incommensurate with agreed upon goals Governance. Governing collaborative relationships is complicated and complex, particularly among organisations from different sectors (Gulati, 1998; Selsky and Parker, 2005). These cases further an understanding of how to structure and oversee relationships between "strange bedfellows" (London et al., 2005). They also suggest the potential limits of these relationships. While both cases established formal associations to further their collective activities, differences were displayed. One way for the collaborating organisations to manage their relationships is through the formation of a dedicated alliance function designed to oversee and monitor performance (Kale and Singh, 2009). In case 1, this "hub" role was played by th e local government and the local wisdom.. Another way for the organisations to structure and manage their efforts is through enacting a "relational approach" (Kale et al., 2000) in which trust and respect create the basis for cooperative behaviour while curbing opportunism. This approach was adopted by CHLNet (case 2). Health organisations – like most others – have constraints on time, energy, and financial resources. Given the preponderance of organisation and profession-centric leadership development initiatives, there is a tendency to default to this familiar approach even in instances where an alternative is being implemented. The more strategically driven collaborative approach, as investigated through the two cases, demands time,energy and financial resources along with the will (i.e. collaborative-oriented mindset), enabling behaviours, and supporting structures to achieve the benefits envisioned through large-scale health leadership development initiatives.

Conclusion

By examining the emergence and operation of large-scale health leadership initiatives informed by a collaborative model, this study responds to the repeated calls for strategy research to extend the scope of its inquiries to address cross-sector relationships, and to provide support and motivation to practitioners. The findings suggest large-scale health leadership development enacted through the

collaborative approach of strategic alliances informs a set of practices and structures as well as a way of thinking about leadership development that creates beneficial synergies. Like the exercise of leadership itself, collaboration only exists in the context of a relationship; effective collaborations achieve results only when they work in relationship with others.

Those organisations de velopingcapacity for leadership through large-scale leadership development initiatives have realised that key to their success is a prominently articulated differential description of the benefits accrued to organisations through alliances from the public, private, civil sector coupled with enabling mindsets supported by appropriate structures and processes for coordination and governance. The findings also suggest that identifying the inhibitors for the reconfiguration of resources and capabilities across individual organisational activities should enable better performance by making managers aware of them. Developing and supporting a collaborative mindset may, however, prove the most difficult challenge in a context where conventional mindsets are deeply ingrained.

While these findings are an important step along the journey in furthering an understanding of large-scale leadership development initiatives through collaborative efforts, future research might go beyond the limitations of this study. Future research is needed to establish whether there are additional factors that affect health leadership capacity and capability gaps. Second, the choice of two case studies may invite questions of generalisability. It would be useful to examine other health jurisdictions and how cross-sector alliances influence large-scale leadership development initiatives in the context of the universal access model. The cases are predicated on the premise that tomorrow's health leaders will come from today's managers. Key to overcoming one of the barriers to improved service delivery through health reform resides in developing a new kind of leadership that can build partnerships within the health and the non-health providers and across sectors in the achieving of the goal to reduce maternal mortality in rural area in the country like Indonesia.

References

Alkema, L., Chou, D., Hogan, D., Zhang, S., Moller, A.-B., Gemmill, A., … Say, L. (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *The Lancet*, *387*(10017), 462–474. https://doi.org/10.1016/S0140-6736(15)00838-7.

Andemichael, G., Haile, B., Kosia, A., & Mufunda, J. (2010). Maternity waiting homes: A panacea for maternal/neonatal conundrums in Eritrea. *Journal of the Eritrean Medical Association*, *4*(1), 18–21. https://doi.org/10.4314/jema.v4i1.52112.

Borghi, J. O., Ensor, T., Somanathan, A., Lissner, C., Mills, A., & group, L. M. S. S. steering. (2006). Mobilising financial resources for maternal health. *The Lancet*, *368*(9545), 1457–1465.

Callister, L. C. (2012). Mothers Without Borders: *MCN, The American Journal of Maternal/Child Nursing*, *37*(3), 203. https://doi.org/10.1097/NMC.0b013e31824b3a9d.

Ekunwe, A. B. (2017). The Efficacy of Maternity Waiting Homes in Decreasing Maternal and Perinatal Mortality in Low-Income Countries – A Systematic Review.

El Shiekh, B., & van der Kwaak, A. (2015). Factors influencing the utilization of maternal health care services by nomads in Sudan. *Pastoralism*, *5*(1). https://doi.org/10.1186/s13570-015-0041-x.

Gaym, A., Pearson, L., & Soe, K. W. W. (2012). Maternity waiting homes in Ethiopia--three decades experience. *Ethiopian Medical Journal*, *50*(3), 209–219.

Hussein, J., Kanguru, L., Astin, M., & Munjanja, S. (2012). The effectiveness of emergency obstetric referral interventions in developing country settings: A systematic review. *PLoS Medicine*, *9*(7). https://doi.org/10.1371/journal.pmed.1001264.

Johnson, F. A., Padmadas, S. S., & Matthews, Z. (2013). Are Women Deciding against Home Births in Low and Middle Income Countries? *PLOS ONE*, *8*(6), e65527. https://doi.org/10.1371/journal.pone.0065527.

Lori, J. R., Munro-Kramer, M. L., Shifman, J., Amarah, P. N. M., & Williams, G. (2017). Patient Satisfaction With Maternity Waiting Homes in Liberia: A Case Study During the Ebola Outbreak. *Journal of Midwifery and Women's Health*, *62*(2), 163–171. https://doi.org/10.1111/jmwh.12600.

Lori, J. R., Wadsworth, A. C., Munro, M. L., & Rominski, S. (2013). Promoting access: The use of maternity waiting homes to achieve safe motherhood. *Midwifery*, *29*(10), 1095–1102. https://doi.org/10.1016/j.midw.2013.07.020.

Luckow, P. W., Kenny, A., White, E., Ballard, M., Dorr, L., Erlandson, K., … Panjabi, R. (2017). Implementation research on community health workers' provision of maternal and child health services in rural Liberia. *Bulletin of the World Health Organization*, *95*(2), 113–120. https://doi.org/10.2471/BLT.16.175513.

Lundine, J., Hadikusumah, R. Y., & Sudrajat, T. (2013). Indonesia's progress on the 2015 Millennium Development Goals. *Strategic View Indonesia. July-September*, *3*.

Mannava, P., Durrant, K., Fisher, J., Chersich, M., & Luchters, S. (2015). Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Globalization and Health*, *11*(1). https://doi.org/10.1186/s12992-015-0117-9.

Penn-Kekana, L., Pereira, S., Hussein, J., Bontogon, H., Chersich, M., Munjanja, S., & Portela, A. (2017). Understanding the implementation of maternity waiting homes in low- and middle-income countries: a qualitative thematic synthesis. *BMC Pregnancy and Childbirth*, *17*(1), 269–269. https://doi.org/10.1186/s12884-017-1444-z.

Satti, H., McLaughlin, M. M., & Seung, K. J. (n.d.). The role of maternity waiting homes as part of a comprehensive maternal mortality reduction strategy in Lesotho. PIH Reports 2013; 1 (1). Partners In Health is a 501 (c)(3) nonprofit corporation and a Massachusetts public charity.\copyright Partners In Health, 2013. This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivs 3.0 Unported License. Publication of this report was made possible by flagrant from the Greif Packaging Charitable Trust. *Right: Women Enjoying the Sun Outside the Maternity Waiting Home at Nohana*, 3.

Sialubanje, C., Massar, K., Kirch, E. M., Van Der Pijl, M. S. G., Hamer, D. H., & Ruiter, R. A. C. (2016). Husbands' experiences and perceptions regarding the use of maternity waiting homes in rural Zambia. *International Journal of Gynecology and Obstetrics*, *133*(1), 108–111. https://doi.org/10.1016/j.ijgo.2015.08.023.

Singh, K., Speizer, I., Kim, E. T., Lemani, C., & Phoya, A. (2017). Reaching vulnerable women through maternity waiting homes in Malawi. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics*, *136*(1), 91–97. https://doi.org/10.1002/ijgo.12013.

Suplee, P. D., Bingham, D., & Kleppel, L. (2017). Nurses' Knowledge and Teaching of Possible Postpartum Complications. *MCN: The American Journal of Maternal/Child Nursing*, *42*(6), 338–344.

Tiruneh, G. T., Taye, B. W., Karim, A. M., Betemariam, W. A., Zemichael, F., Wereta, T. G., & Lemango, E. T. (2016). Maternity waiting homes in Rural Health Centers of Ethiopia: The situation, women's experiences and challenges. *Ethiopian Journal of Health Development*, *30*(1), 19–28.

Titaley, C. R., Hunter, C. L., Dibley, M. J., & Heywood, P. (2010). Why do some women still prefer traditional birth attendants and home delivery?: a qualitative study on delivery care services in West Java Province, Indonesia. *BMC Pregnancy and Childbirth*, *10*(1), 43.

Badan Koordinasi Keluarga Berencana Nasional (BKKBN). 2013. Survey Demografi dan Kesehatan Indonesia (SDKI) 2012. Jakarta: BKKBN

Campbell OM. What are maternal health policies in developing countries and who drives them? A review of the last half-century. In: De Brouwere V, Van Lerberghe W, eds. Safe Motherhood Strategies: A Review of the Evidence. Studies in Health Services Organisation & Policy, 17. Antwerp: ITG Press; 2001: 412-442.

Eco, Umberto (2010): Wie man einewissenschaftlicheAbschlussarbeitschreibt. 13. Auflage. Facultaswuv: Wien.

Egger, Matthias; Razum, Oliver (Hrsg.) (2012): Public Health. Sozial- und PräventivmedizinKompakt. Walter de Gruyter GmbH: Berlin

Graham W. Every pregnancy faces risks. Plan Parent Chall. 2000:13-4.

Hogan MC, Foreman KJ, Naghavi M, et al. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. Lancet. 2010;375:1609-23.

Lehmann,Uta; Sanders, David (2007): Community Health Workers: What did we know about them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of Using Community Health Workers. WHO: Geneva

Lehmann, Uta (2008): Mid-Level health workers. The state of evidence on programmes, activities, cost and impact on health outcomes. A literature review. WHO, Geneva.

Ministry of Health and Social Welfare (MOHSW) [Lesotho] and ICF Macro. 2010. Lesotho Demographic and Health Survey 2009. Maseru, Lesotho: MOHSW and ICF Macro.

Ministry of Health Republic of Indonesien (2014): Indonesia Health Profile 2013. Ministry of Health Republic of Indonesien: Jakarta.

Sanberg, Berit (2012): WissenschaftlichArbeiten von AbbildungbisZitat. Lehr-und ÜbungsbuchfürBachelor, Master und Promotion. OldenbourgVerlag: München.

Satti H, Motsamai S, Chetane P, et al. Comprehensive approach to improving maternal health and achieving MDG 5: report from the mountains of Lesotho. PLOS One. 2012;7(8):e42700.

Supratikto, G, Wirth, M.E., Achadi, E., Cohen, S. and Ronsmans, C. (2002), A district-based audit of the causes and circumstances of maternal deaths in South Kalimantan, Indonesia. Bulletin of the World Health Organization, 80(3):228-34.

Unicef Indonesia (2012): Issue Briefs: Maternal and Child health. Unicef

UNICEF Indonesia. October 2013. Issue Briefs: Maternal and Child Health.

World Health Organization. 2005. The World Health Report 2005: Make every mother and child count. Geneva: World Health Organization.

World Health Organization, UNICEF, UNFPA, The World Bank. 2010. Trends in maternal mortality: 1990-2008. Geneva: World Health Organization

WHO (2010): Mid-level health providers. A promising resource to achieve the health Millennium Development Goals. WHO, Geneva.

World Health Organization (WHO). 2013. Maternal Mortality Database in World

WHO (2015): Health Workforce and Services: Draft global strategy on human resources for health: workforce 2030. WHO Executive Board 138th session Provisional agenda item 10.8. EB 138/36. 11 December 2015.

Wild K, Barclay L, Kelly P, Martins N. The tyranny of distance: maternity waiting homes and access to birthing facilities in rural Timor-Leste. Bull World Health Organ. 2012 Feb 1;90: 97-103.

Anderson, L., Malby, B., Mervyn, K. and Thorpe, R. (2009), "The Health Foundation's position statement on effective leadership development interventions", research report, University of Leeds, Leeds.

Arino, A. and de la Torre, J. (1998), "Learning from failure: towards an evolutionary model of collaborative adventures", Organization Science, Vol. 9, pp. 306-25.

Bowerman, J. (2010), "Editorial", Leadership in Health Services, Vol. 22 No. 4, pp. 291-3.

Bailey P, Paxton E, Lobis S, Fry D. (2006), The availability of life-saving obstetric services in developing countries: an in-depth look at the signal functions for emergency obstetric care. Int J Gynecol Obstet 2006;93:285–91

Caldwell, D.F., Chatman, J., O'Reilly, C.A. III, Ormiston, M. and Lapiz, M. (2008), "Implementing strategic change in a health care system: the importance of leadership and change readiness", Health Care Management Review, April-June, pp. 124-33.

Canadian Health Leadership Network (2010), "CHLNet governance review of issues and options", discussion paper, September, CHLNet, Ottawa, available at: www.chlnet.ca (accessedApril 26, 2010).

Canadian Health Leadership Network (2011), "Resources", available at: www.chlnet.ca/resources, (accessed January 1, 2011).

Cikaliuk, M. (2010), Develop Coalitions: Leads in a Caring Environment, Canadian Health Leadership Network, Leaders for Life, Canadian College of Health Service Executives, Victoria. Downloaded by Florida Atlantic University At 00:29 26 February 2015 (PT)

Conference Board of Canada (2007), "The Canadian Health Leadership Network learning and development outlook: a report on the leadership development practices in the Canadian health sector", Canadian Health Leadership Network, Ottawa.

Corbin, J. and Strauss, A. (2008), Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory, 3rd ed., Sage, London.

Dickson, G. (2008), Branches of Knowledge: Genesis of the Leaders for Life framework, Leaders for Life, Victoria.

Dickson, G. and Lindstrom, R. (2010), Systems Transformation: Leads in a Caring Environment, Canadian Health Leadership Network, Leaders for Life, Canadian College of Health Service Executives, Victoria.

Dickson, G., Briscoe, D. and Rowlands, G. (2005), "Leadership without ownership: developing strategic leadership for health reform", a white paper for discussion in the BC health system, Royal Roads University, Victoria.

Dickson, G., Briscoe, D., Fenwick, S., Romilly, L. and MacLeod, Z. (2007), "The pan-Canadian health leadership capability framework project: a collaborative research initiative to develop a leadership capability framework for healthcare in Canada", Canadian Health Services Research Foundation, Ottawa.

Dyer, J. and Singh, H. (1998), "The relational view: cooperative strategy and sources of interorganizational competitive advantage", The Academy of Management Review, Vol. 23 No. 4, pp. 660-79.

Eisenhardt, K.M. (1989), "Building theories from case study research", Academy of Management Review, Vol. 14, pp. 532-50.

Ford, R. (2009), "Complex leadership competency in health care: towards framing a theory of practice", Health Services Management Research, Vol. 22, pp. 101-14.

Gulati, R. (1998), "Alliances and networks", Strategic Management Journal, Vol. 19, pp. 293-317.

Heading, G. (2009), "Strategic leadership, culture and change in health services", discussion paper, The Cancer Institute of New South Wales, Alexandria.

Institute for Health Improvement (2010), available at: www.ihi.org/IHI/Topics/ LeadingSystemImprovement/Leadership/ (accessed April 26, 2010).

Institute for Innovation and Improvement (2010), available at: www.institute.nhs.uk (accessed April 25, 2010).

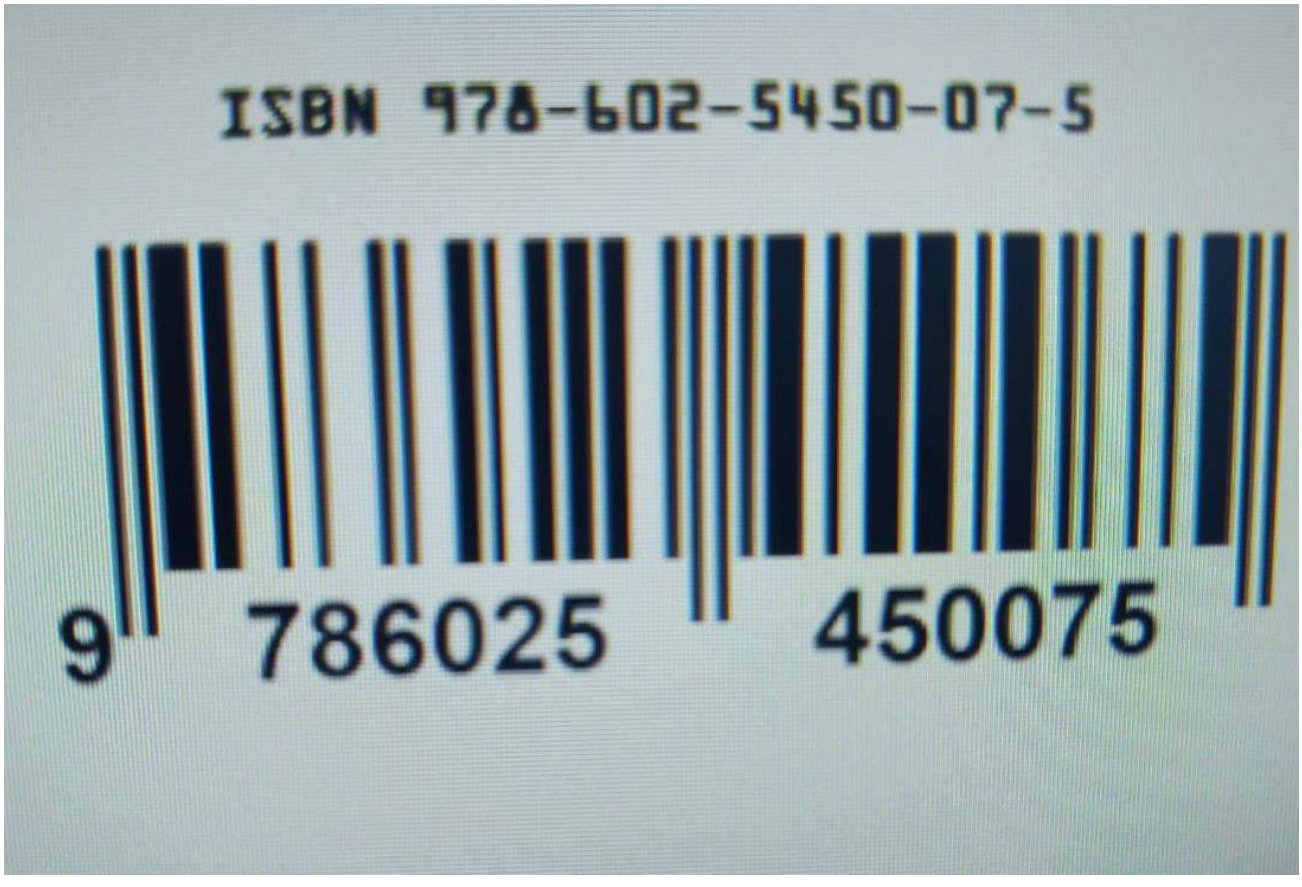
Kale, P. and Singh, H. (2009), "Managing strategic alliances: what do we know now, and where do we go from here?", Academy of Management Perspective, August, pp. 45-62.

Kale, P., Singh, H. and Perlmutter, H. (2000), "Learning and protection of proprietary assets in strategic alliances: building relational capital", Strategic Management Journal, Vol. 21 No. 3, pp. 217-37.
Kouzes, J.M. and Posner, B.Z. (1987), The Leadership Challenge, Jossey-Bass, San Francisco, CA. Langley, A. (1999), "Strategies for theorizing from process data", Academy of Management Review, Vol. 24 No. 4, pp. 691-710.
Leaders for Life (2006), "Moving forward on the vision", working document, October 2, Leaders for Life, Victoria.
Leaders for Life (2007a), "Leaders for Life program management and governance structure", working document, January, Leaders for Life, Victoria.
Leaders for Life (2007b), "Leadership panel terms of reference", working document, January, Leaders for Life, Victoria. Downloaded by Florida Atlantic University At 00:29 26 February 2015 (PT)
Leaders for Life (2008), "Leaders for life business plan", working document, March, Leaders for Life, Victoria.
Leaders for Life (2010), available at: www.leadersforlife.ca (accessed April 25, 2010).
Leidtka, J.M. (2005), "Strategy formulation: the role of conversation and design", in Hitt, M.A., Freeman, R.E. and Harrison, J.S. (Eds), The Blackwell Handbook of Strategic Management, Blackwell, Oxford, pp. 70-93.
Lewis, S. (2009), "Patient-centered care: an introduction to what it is and how to achieve it", discussion paper, Saskatchewan Ministry of Health, Regina. London, T., Rondinelli, D.A. and O'Neill, H. (2005), "Strange bedfellows: alliances between corporations and nonprofits", in Shenkar, O. and Reuer, J.J. (Eds), Handbook of Strategic Alliances, Sage, Thousand Oaks, CA, pp. 353-68.
McCall, M.W. (1998), High Flyers: Developing the Next Generation of Leaders, Harvard Business School Press, Boston, MA.
McGrath, K., Bennett, D.M., Ben-Tovim, D., Boyages, S.C., Lyons, N.J. and O'Connell, T.J. (2008), "Implementing and sustaining transformational change in health care: lessons learnt about clinical process redesign", Medical Journal of Australia, Vol. 188 No. 6, pp. S32-5.
Provan, K.G., Fish, A. and Sydow, J. (2007), "Interorganizational networks at the network level: a review of the empirical literature on whole networks", Journal of Management, Vol. 33, pp. 479-516.
Ring, P.S. and Van de Ven, A.H. (1994), "Developmental processes of cooperative interorganizational relationships", Academy of Management Review, Vol. 19 No. 1, pp. 90-118.
Rowlands, G. (2006), personal communication. Schreiner, M., Kale, P. and Corsten, D. (2009), "What really is alliance management capability and how does it impact alliance outcomes and success?", Strategic Management Journal, Vol. 30, pp. 1395-419.
Selsky, J.W. and Parker, B. (2005), "Cross-sector partnerships to address social issues: challenges to theory and practice", Journal of Management, Vol. 31 No. 6, pp. 849-73.
Senge, P. (1990), The Fifth Discipline, Doubleday, New York, NY.
SKDI (2012), Survei Demografi Kesehatan Indonesia. Jakarta.
Snowdon, A., Shell, J. and Leitch, K. (2010), Innovation Takes Leadership: Opportunities and Challenges for Canada's Health Care System, Ivey School, Toronto.
Stake, R.E. (1995), The Art of Case Study Research, Sage, London.
Tholl, W. (2010), personal communication.
Todeva, E. and Knoke, D. (2005), "Strategic alliances and models of collaboration", Management Decision, Vol. 43 No. 1, pp. 123-48.
Uganda Ministry of Health/UNICEF. Status of emergency obstetric care in Uganda. A national needs assessment of EmOC process indicators. New York: UNICEF; 2003.

UNICEF/WHO/UNFPA. (1997), Guidelines for monitoring and availability and use of obstetric services. New York: UNICEF
WHO. (1999), Reduction of maternal mortality. A joint WHO/UNICEF/ World Bank statement. Geneva: WHO. ISBN 9241561955
World Health Organization. (2005), The World Health Report 2005: Make every mother and child count. Geneva: World Health Organization.

Appendix

ISBN Buku : Scalling Up Nutrition The future of Indonesia



Global Health Action

2017 Impact Factor

1.906

11th September, 2018

Dear Supriyatiningsih,

After several revisions and based on peer reviewers analysis we accepted your research article with title:

Key success factors in leadership at the first step implementing mid-level model in shelter: a pilot study in rural Indonesia

Supriyatiningsih[1], Jörg Haier[2], Ralph J. Lelle[3], Arlina Dewi[4], Sri Sundari[5], Dianita Sugiyo[6]

Because of the long queues of research articles received, your article will be published on volume 15, 2018. Ope access will be done in January 2019.

This journal is published by Taylor and Francis in cooperation with Umea University Sweden.

Best regards,

Markus Grant

Editor-in-chief

FGD Bulukumba (1) 2 Juli 2018

FGD Bulukumba (2) 15,16,17 Juli 2018

FGD Bulukumba 3, 15 Agustus 2018

24 Agustus 2018

REPUBLIK INDONESIA
KEMENTERIAN HUKUM DAN HAK ASASI MANUSIA

SURAT PENCATATAN
CIPTAAN

Dalam rangka pelindungan ciptaan di bidang ilmu pengetahuan, seni dan sastra berdasarkan Undang-Undang Nomor 28 Tahun 2014 tentang Hak Cipta, dengan ini menerangkan:

Nomor dan tanggal permohonan	:	EC00201826324, 4 September 2018
Pencipta		
Nama	:	**Dr. Dr.Arlina Dewi, M.Kes, Dr. Supriyatingingsih, M.Kes, Sp.OG, , dkk**
Alamat	:	Griya Alvita C.15, Kasihan Bantul, Daerah Istimewa Yogyakarta , Bantul, Di Yogyakarta, 55182
Kewarganegaraan	:	Indonesia
Pemegang Hak Cipta		
Nama	:	**Universitas Muhammadiyah Yogyakarta**
Alamat	:	Jalan Brawijaya, Kasihan, Geblagan, Tamantirto, Kasihan, Bantul, Daerah Istimewa Yogyakarta, Bantul, Di Yogyakarta, 55183
Kewarganegaraan	:	Indonesia
Jenis Ciptaan	:	**Buku Panduan/Petunjuk**
Judul Ciptaan	:	**Panduan Deteksi Kebutuhan Edukasi Ibu Hamil Bagi Kader Kesehatan**
Tanggal dan tempat diumumkan untuk pertama kali di wilayah Indonesia atau di luar wilayah Indonesia	:	31 Agustus 2018, di Yogyakarta
Jangka waktu pelindungan	:	Berlaku selama 50 (lima puluh) tahun sejak Ciptaan tersebut pertama kali dilakukan Pengumuman.
Nomor pencatatan	:	000116457

adalah benar berdasarkan keterangan yang diberikan oleh Pemohon.
Surat Pencatatan Hak Cipta atau produk Hak terkait ini sesuai dengan Pasal 72 Undang-Undang Nomor 28 Tahun 2014 tentang Hak Cipta.

a.n. MENTERI HUKUM DAN HAK ASASI MANUSIA
DIREKTUR JENDERAL KEKAYAAN INTELEKTUAL

Dr. Freddy Harris, S.H., LL.M., ACCS.
NIP. 196611181994031001

LAMPIRAN PENCIPTA

No	Nama	Alamat
1	Dr. Dr.Arlina Dewi, M.Kes	Griya Alvita C.15, Kasihan Bantul, Daerah Istimewa Yogyakarta
2	Dr. Supriyatingingsih, M.Kes, Sp.OG	Miliran Baru Gg Delima No.9, Muja Muju, Umbulharjo Yogyakarta
3	Dr. Dr. Sri Sundari, M.Kes	Tegal Mulyo WB I No.1, Pakuncen, Wirobrajan, Yogyakarta
4	Dianita Sugiyo, S.Kep, Ns, MHID	Perumahan Alam Citra K 64 DK Cabean, Panggungharjo, Sewon Bantul

Committee of 1st ICoHAP
1st International Conference on Health Administration and Policy
Department of Health Policy and Administration
Faculty of Public Health, Airlangga University, Campus C Mulyorejo 60115
Secretariat of the committee – Scientific Team:
Phone Number: (+62) 82245554162, email: icohap@fkm.unair.ac.id.

LETTER OF ACCEPTANCE

Dear Sir/ Madam**, Arlina Dewi,, Supriyatiningsih, Sri Sundari, Dianita Sugiyo, Ralph. J. Lellee**

Congratulation! Your abstract entitled

"Willingness to Pay for Maternity Waiting Homes in Rural Indonesia"

has been approved as **Oral Presentation** for the 1st International Conference on Health Administration and Policy 2018 (1st ICoHAP) on 1st – 2nd September 2018 in Hotel Wyndham, Surabaya.

Please make the payment and upload the payment proof through our online system (NOT EMAIL) http://icohap.fkm.conference.unair.ac.id/account-invoice/upload?id=51 and upload your fullpaper before 7th September, 2018.

With best regards,

The 1st ICOHAP Committee

1st ICoHAP

UNIVERSITAS AIRLANGGA
Excellence with Morality

CERTIFICATE

This is to certify that

Dr. dr. Arlina Dewi, M.Kes

as

ORAL PRESENTER

have participated in the event

THE 1st INTERNATIONAL CONFERENCE ON HEALTH ADMINISTRATION AND POLICY

(1st ICoHAP)

"RISK MANAGEMENT IN HEALTHCARE"

1 - 2 SEPTEMBER 2018, SURABAYA - INDONESIA

• 12 SKP IDI • 4 SKP PPNI • 3 SKP IAKMI • 6 SKP PERSAKMI •

PERSAKMI

1st ICoHAP

Prof.Dr. Tri Martiana dr.,MS.
Dean of UNAIR PUBLIC HEALTH FACULTY

Colonel drg.Bima Pramundita Sp.Prostho
Chairman of the commiitee

CERTIFICATE

2018 ICHAA

International Conference on Health
Alma Ata University 2018

Given to

Dr. dr. Arlina Dewi, M.Kes, AKK

as

Oral Presentator

"OPTIMIZING THE ROLE OF HEALTH PROFESSIONALS TO IMPROVE MATERNAL AND CHILD HEALTH IN SUPPORTING SUSTAINABLE DEVELOPMENT GOALS (SDGS)"

SKP PPNI	: *Participant 1 SKP, Committee 2 SKP, Moderator 2 SKP, Keynote Speaker 3 SKP, Oral Presentation 3 SKP, Poster Presentation 3 SKP* ***No. 0194/DPW.PPNI-DIY/Tap/K.S/II/2018***
SKP IBI	: Participant 4 SKP, Committee 4 SKP, Moderator 4 SKP, Speaker 5 SKP, Oral / Poster Presentation 5 SKP **No. 0394/B/SM/UAA/IX/2017**
SKP IAKMI	: Participant (5 SKP), Oral Presentation (3 SKP), Poster Presentation (2 SKP), Speaker (6 SKP), Moderator (3 SKP),Committee (4 SKP) **No. 0394/B/SM/UAA/IX/2017**
SKP PERSAGI	: Participant , Committee, Moderator, Speaker, Oral / Poster Presentation 1 SKP **No. 0394/B/SM/UAA/IX/2017**
SKP PPNI	: Participant 1 SKP, Commitee 2 SKP, Moderator 2 SKP, Keynote Speaker 3 SKP, Oral / Poster Presentation 3 SKP **No. 0194/DPW.PPNI-DIY/Tap/K.S/II/2018**
SKP IAI	: Participant 7,5 SKP, Committee 3 SKP, Moderator 1,5 SKP, Judge 3 SKP, Presenter 3 SKP, Keynote Speaker 4,5 SKP **No. 255/SK-SKP/PP.IAI/I/2018**

Prof. Dr.H. Hamam Hadi, MS., Sc.D.,Sp.GK
Rector
Alma Ata University

Dr. Sri Werdati, SKM., M.Kes
DEAN of Medical Faculty
Alma Ata University

ISBN : 978-602- 5714 -08-5

PROCEEDING

THE I[st] INTERNATIONAL CONFERENCE ON HEALTH ALMA ATA UNIVERSITY 2018

...ING THE ROLE OF
...SSIONALS TO IMPROVE
HEA... ...D CHILD HEALTH IN
MA... ...SUS...BLE
DE...

...Speakers
...Nila Djuwita Farid Moeloek
...inistry ... ...blic of Indonesia

Invited Speakers

Prof. Dr. H. Hamam Hadi, M.S., Sc.D., Sp. GK
Rector of Alma Ata University

Dr Hasto Wardoyo, SP.OG
Mayor of Kulon Progo

Prof Betty Ya- Wen Chiu, Ph.D
Taipe Medical University

Susheewa Wichaikull, RN. MSN, PhD.
Boromarajonani Nopparat Vajira College of Nursing

Elsi Dwi Hapsari, S.Kp., MS, DS
Maternity Lecturer Master of Nursing UGM

Rina Mutiara M.Pharm, Apt
Pharmacist RSCM

ICHAA 2018

Alma Ata University
Address :Jl. Brawijaya 99, Yogyakarta 55183
Telp : (0274) 434 2288,(0274) 434 2270
Email : uaa@almaata.ac.id

CONTENTS

SURAT PERNYATAAN TANGGUNG JAWAB BELANJA

Yang bertanda tangan di bawah ini :
Nama : Dr. dr. ARLINA DEWI S.Ked, M.Kes
Alamat : Perum. Griya Alvita C.15 Kasihan Bantul
berdasarkan Surat Keputusan Nomor 3/E/KPT/2018 dan Perjanjian / Kontrak Nomor 109/SP2H/LT/DRPM/2018 mendapatkan Anggaran Penelitian Improving Maternal Health Services in Remote Rural Areas through a Shelter Model As Well As Mid-Level Providers Involvement sebesar 149,732,750 .
Dengan ini menyatakan bahwa :
1. Biaya kegiatan penelitian di bawah ini meliputi :

No	Uraian	Jumlah
01	**Honorarium** Petugas Survey, Pengolah data, Koordinator Lapangan, Narasumber Dinas Kesehatan Bulukumba	16,920,000
02	**Peralatan Penunjang** Stampel, Alat pengambilan data lapangan	8,370,000
03	**Bahan Habis Pakai** akomodasi peneliti jerman, konsumsi peserta penelitian (FGD 1,2,3)	34,159,730
04	**Perjalanan** tiket Jogja -Bulukumba (3kali) dan akomodasi , sewa mobil, Tiket Jogja -Jerman dan akomodasi	85,183,245
05	**Lain-lain** Pajak, Design Buku, Pendaftaran Haki,	5,099,775
	Jumlah	**149,732,750**

2. Jumlah uang tersebut pada angka 1, benar-benar dikeluarkan untuk pelaksanaan kegiatan penelitian dimaksud.
3. Bersedia menyimpan dengan baik seluruh bukti pengeluaran belanja yang telah dilaksanakan.
4. Bersedia untuk dilakukan pemeriksaan terhadap bukti-bukti pengeluaran oleh aparat pengawas fungsional Pemerintah
5. Apabila di kemudian hari, pernyataan yang saya buat ini mengakibatkan kerugian Negara maka saya bersedia dituntut penggantian kerugian negara dimaksud sesuai dengan ketentuan peraturan perundang-undangan.
Demikian surat pernyataan ini dibuat dengan sebenarnya.

Kab. Bantul, 25 - 9 - 2018
Ketua,

LEMBAGA PENELITIAN, PUBLIKASI DAN PENGABDIAN MASYARAKAT UNIVERSITAS MUHAMMADIYAH YOGYAKARTA

LPPM 25/9/18

Dr. Eko Supardi

(Dr. dr. ARLINA DEWI, S.Ked, M.Kes)
NIP/NIK 19681031200310173060