

# Quadrant of Usefulness-easiness With Weighting (QUE-We) as a New Method for Prioritizing Maternal and Child Health Under the Indonesia Healthy Program With Family Approach

Heni Puji Wahyuningsih<sup>1\*</sup>, Heru Santoso Wahito Nugroho<sup>2</sup>,  
Desy Nuryunarsih<sup>3</sup>, Diani Fadmi Putri<sup>4</sup>, Belandina Oyaitou<sup>5</sup>

<sup>1</sup>Department of Midwifery, Poltekkes Kemenkes Yogyakarta, Yogyakarta, Indonesia, <sup>2</sup>Department of Midwifery, Poltekkes Kemenkes Surabaya, Surabaya, Indonesia, <sup>3</sup>Faculty of Medical Sciences, Population Health Science Institute, Newcastle University, Newcastle Upon Tyne, England, United Kingdom, <sup>4</sup>Faculty of Psychology and Health, UIN Walisongo, Semarang, Indonesia, <sup>5</sup>Puskesmas Kentuk, Jayapura, Indonesia. \*Corresponding Author's Email: heni.pujiw@poltekkesjogja.ac.id

## Abstract

The implementation of the Indonesia Healthy Program with Family Approach faces challenges in prioritizing interventions and optimizing training for health workers. A systematic, participatory and evidence-based approach is needed. This study introduces the Quadrant of Usefulness-Easiness with Weighting (QUE-We), a modified prioritization model that reframes the traditional difficulty dimension as easiness and enables strategic prioritization. This mixed-method study involved a Focus Group Discussion (FGD) with health experts and practitioners to determine indicator weights, followed by a national online survey with 1,000 respondents. Each indicator was scored for perceived usefulness and easiness. Indicator weights were determined during FGD before the survey. Six Maternal and Child Health indicators were evaluated, namely: family planning participation, childbirth in health facilities, basic immunization, exclusive breastfeeding, toddler growth monitoring and national health insurance membership. Weighted scores were plotted into the QUE-We quadrant. Family planning and national health insurance membership were placed in the upper-left priority quadrant. Childbirth in health facilities was positioned in the high usefulness-high easiness quadrant. Basic immunization, exclusive breastfeeding and toddler growth monitoring fell into quadrants with lower usefulness but higher easiness. QUE-We effectively classified priorities by integrating stakeholder perception and expert weighting. QUE-We is a practical and innovative tool for prioritizing maternal and child health programs. By emphasizing easiness and incorporating expert-derived weights, this model supports more accurate decision-making and strengthens implementation of the Indonesia Healthy Program with a Family Approach.

**Keywords:** Health Prioritization, Maternal and Child Health, Quadrant with Weighting, Usefulness and Easiness.

## Introduction

Maternal and Child Health (MCH) remains a cornerstone of global public health and is widely recognized as a key indicator of a nation's socio-economic development and the effectiveness of its healthcare system. Numerous studies have addressed different dimensions of MCH, including pregnancy care (1), postpartum services (2) and child health outcomes (3). Improving maternal and child health is therefore not only a clinical priority but also a strategic component of sustainable development and health equity.

In Indonesia, efforts to improve family health are implemented through the Indonesia Healthy Program with Family Approach (Program Indonesia Sehat dengan Pendekatan Keluarga – PIS-PK).

This initiative aligns with global evidence emphasizing family-centered and people-centered primary health care, which promotes comprehensive promotive and preventive services delivered at the household level (4). The program emphasizes evidence-based decision-making in which primary healthcare facilities collect and utilize family health data during home visits to design and implement targeted interventions (5). Compared with traditional health service models that focus primarily on curative care, the PIS-PK approach prioritizes preventive and promotive strategies within the family environment. This paradigm shift aligns with global best practices that emphasize strengthening primary healthcare

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systems, community participation and data-driven decision-making to improve population health outcomes (6).

Despite its strategic importance, the implementation of PIS-PK since 2016 has not fully eliminated disparities in maternal and child health outcomes across Indonesia. Significant differences persist among the country's 38 provinces, particularly in remote and border areas where geographical barriers, limited infrastructure and uneven distribution of health resources constrain access to essential health services (7). These disparities highlight the need for more effective program planning and prioritization mechanisms to ensure that limited resources are allocated to the most impactful interventions.

In practice, the implementation of the Indonesia Healthy Program with Family Approach often encounters operational challenges, including limited resources, diverse community health needs and the complexity of coordinating multiple health interventions simultaneously (8). These conditions make it difficult for health managers at the primary healthcare level to determine which program components should receive immediate attention. Traditional prioritization methods used in public health planning may also lack transparency, objectivity and adaptability to local contexts, thereby limiting their effectiveness in guiding strategic decision-making (9).

Beyond these methodological limitations, several systemic barriers further complicate the implementation of PIS-PK. Previous studies have reported challenges related to inconsistent utilization of health data, limited digital infrastructure, insufficient health workforce capacity and the absence of a standardized framework to determine program priorities (5,10). In a decentralized health system such as Indonesia's, where decision-making authority is distributed across multiple administrative levels, determining which health indicators should be prioritized requires more than policy directives. It requires practical and context-sensitive decision-support tools that can assist health managers in allocating resources efficiently and designing targeted interventions (11).

Existing empirical studies on PIS-PK have mainly focused on program implementation and policy evaluation rather than developing systematic prioritization frameworks. For example,

implementation at the Kwoor Health Center in Tambrauw Regency faced challenges such as limited human resources, inadequate funding and unstable internet connectivity that hindered family health data reporting (12). Similarly, early policy implementation was influenced by human resources, documentation systems and health management practices, while monitoring and evaluation were constrained by network limitations (7). Although these studies highlight important implementation barriers, they do not provide structured approaches for prioritizing maternal and child health indicators within the PIS-PK program.

Moreover, methodological reviews indicate that traditional public health prioritization approaches often lack consistency and transparency. A systematic review reported substantial variability and suboptimal reporting in prioritization processes, suggesting the absence of standardized frameworks for evidence-based decision-making (13). These limitations are particularly critical in programs such as PIS-PK, where diverse health needs and limited resources require more structured prioritization tools.

Historically, prioritization frameworks in health have relied on matrix-based approaches such as the Eisenhower Matrix and the Impact-Effort Matrix. More recently, models such as the Quadrant of Difficulty-Usefulness (QoDU) have been applied to classify health interventions based on their perceived usefulness and implementation difficulty (14). In the context of health program prioritization, several related models have been developed to support decision-makers in evaluating interventions, including the Quadrant of Difficulty-Usefulness (QoDU), the Difficulty-Usefulness Pyramid (DUP) and the Difficulty-Usefulness Pyramid with Weighting (DUP-We), which have been applied in digital learning and public health contexts (15–18).

Studies in implementation science indicate that the adoption of health interventions is influenced by multiple determinants, including intervention characteristics, organizational context and healthcare professionals' acceptance, which can act as barriers or facilitators to successful program implementation (19). In many prioritization approaches, implementation challenges are framed primarily in terms of "difficulty," which tends to emphasize barriers rather than practical

feasibility for implementers, particularly at the community level where structural constraints are common (20).

To address this limitation, this study introduces the Quadrant of Usefulness–Easiness with Weighting (QUE-We), a prioritization framework that reframes difficulty as easiness and integrates expert-driven weighting derived from Focus Group Discussions (FGDs). By combining expert consensus with national perception data, the model provides a context-sensitive decision-support tool for prioritizing maternal and child health indicators within the Indonesia Healthy Program with Family Approach.

This study aims to develop and apply the QUE-We framework by determining indicator weights through expert consensus, analyzing perceptions of usefulness and easiness and mapping indicators into strategic quadrants to support evidence-based decision-making in maternal and child health programs.

## Methodology

### Time, Location and Type of Research

This study employed a sequential exploratory mixed-methods design, integrating qualitative and quantitative approaches to develop and apply the Quadrant of Usefulness–Easiness with Weighting (QUE-We) framework (21). The qualitative phase was conducted first through an expert Focus Group Discussion (FGD) to determine the relative weights of maternal and child health indicators across usefulness and easiness dimensions. The results of this phase informed the development of the survey instrument used in the quantitative phase.

The study was conducted over a two-month period from April to May 2025 across Indonesia using an online data collection approach through Google Forms. The quantitative phase involved a nationwide survey targeting individuals involved in or familiar with the implementation of the Indonesia Healthy Program with Family Approach, including midwives, public health workers, community health volunteers, students in health-related fields and members of the general public. Respondents assessed six maternal and child health indicators using a semantic differential scale ranging from 0 to 10 to evaluate their perceived usefulness and easiness. The collected data were subsequently analyzed using descriptive statistical methods and visualized through the

QUE-We quadrant framework to identify strategic priority indicators.

### Population and Sample

The study employed a non-probability purposive sampling strategy to recruit respondents with relevant knowledge or experience related to the implementation of the Indonesia Healthy Program with Family Approach (PIS-PK) (22). The target population consisted of individuals who were directly or indirectly involved in or affected by maternal and child health services. These groups were selected to capture diverse perspectives from professional, community-based and academic contexts. The population included midwives working in primary health care facilities or community health posts, community health cadres involved in health promotion activities, health workers such as health promotion officers, members of the general public who were familiar with local health services, students particularly those enrolled in public health or health sciences programs and individuals working in maternal and child health services.

The inclusion criteria were individuals aged 15 years and above, belonging to one of the predefined respondent categories, willing to participate voluntarily and able to independently access and complete the online questionnaire.

Data were collected using an online questionnaire developed in Google Forms. The survey link was distributed nationwide through professional networks, academic forums, WhatsApp groups and community-based health communication networks to reach respondents across different regions of Indonesia. Participants were also encouraged to share the survey within their networks to expand the reach of the study. Responses were screened for completeness and eligibility before analysis. After data cleaning, a total of 1,000 valid responses were included in the final analysis.

### Research Stage

This research was conducted in several structured stages to ensure the systematic development and application of the QUE-We method (Figure 1). The stages are as follows:

#### Stage 1: Focus Group Discussion (FGD) with Experts

The qualitative phase involved a Focus Group Discussion with 15 experts, consisting of midwives, public health practitioners, maternal

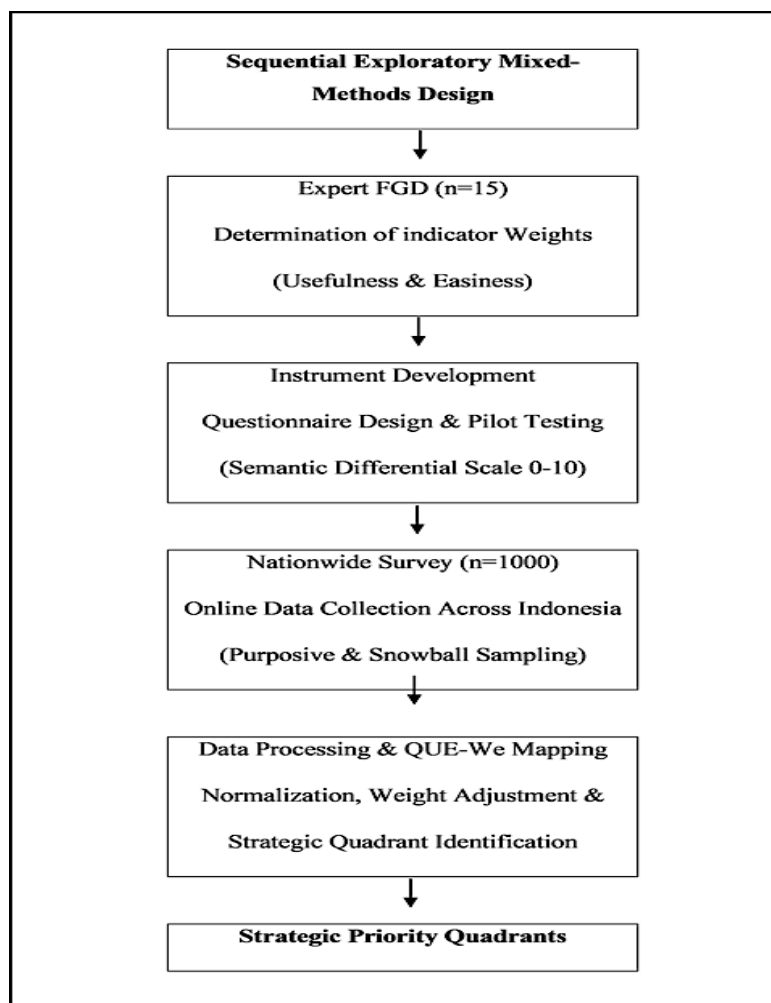
and child health program managers and academics with experience in maternal and child health programs. The purpose of this stage was to determine the relative weights of six maternal and child health indicators across two dimensions: usefulness and easiness. Through structured discussion and consensus-building activities, participants assigned importance scores to each indicator. The resulting weighted matrix ensured that the total weight for each dimension equaled 100%. These weights were later used to adjust the perception scores obtained from the survey data.

**Stage 2: Instrument Development and Validation**

Based on the results of the FGD, a structured questionnaire was developed to measure respondents' perceptions of the usefulness and easiness of each maternal and child health indicator. The instrument used a semantic differential scale ranging from 0 to 10. Content validity was reviewed by public health experts and practitioners. A pilot test was conducted with a small group of respondents to evaluate clarity, comprehension and usability of the questionnaire before the nationwide survey was implemented. These elements are presented in Table 1.

**Table 1:** Questionnaires As Instruments for Selecting Prioritizing Maternal and Child Health Elements Based on Priorities

Easiness	Elements	Usefulness
High 0 1 2 3 4 5 6 7 8 9 10 Low	Family Planning	Low 0 1 2 3 4 5 6 7 8 9 10 High
High 0 1 2 3 4 5 6 7 8 9 10 Low	Childbirth Facility	Low 0 1 2 3 4 5 6 7 8 9 10 High
High 0 1 2 3 4 5 6 7 8 9 10 Low	Basic Immunization	Low 0 1 2 3 4 5 6 7 8 9 10 High
High 0 1 2 3 4 5 6 7 8 9 10 Low	Exclusive Breastfeeding	Low 0 1 2 3 4 5 6 7 8 9 10 High
High 0 1 2 3 4 5 6 7 8 9 10 Low	Toddler Growth Monitoring	Low 0 1 2 3 4 5 6 7 8 9 10 High
High 0 1 2 3 4 5 6 7 8 9 10 Low	National Health Insurance Membership	Low 0 1 2 3 4 5 6 7 8 9 10 High



**Figure 1:** Flowchart of the Research Methodology

**Stage 3: Quantitative Survey Administration**

The questionnaire was distributed online across Indonesia using Google Forms from April to May 2025. Respondents were recruited using purposive and snowball sampling techniques through professional networks, academic forums, community health communication groups and social media platforms. Eligible participants were individuals aged 15 years and above who had prior exposure to maternal and child health services or programs. After data screening and validation to remove incomplete responses, a total of 1,000 valid responses were included in the final analysis.

**Stage 4: Data Processing and QUE-We Mapping**

The collected data were cleaned, coded and analyzed using descriptive statistical analysis. Mean scores for usefulness and easiness were calculated for each indicator. These scores were then normalized and adjusted using the expert-derived weights obtained from the FGD stage. The weighted values were plotted in the Quadrant of Usefulness–Easiness with Weighting (QUE-We) matrix, where the X-axis represents usefulness and the Y-axis represents easiness. Based on their positions within the matrix, indicators were categorized into four strategic quadrants

representing different levels of implementation priority.

**Results**

This study applied the QUE-We approach to prioritize program components under the Indonesia Healthy Program with Family Approach. A structured questionnaire was administered to 1000 respondents of health practitioners, health students, health volunteers and the general public. Each participant rated six program elements based on their perceived usefulness and implementation easiness, using a semantic differential.

The dataset consists of survey responses evaluating the usefulness and easiness of various maternal and child health program elements. Each element was assessed using a semantic differential scale across two dimensions. In this study, usefulness reflects the perceived value of a health-related practice, while easiness represents the perceived level of feasibility or ease in implementing the practice.

The following are the results of the Focus Group Discussion (FGD) with Experts in Table 2.

The usefulness and easiness scores for each element are presented in Table 3.

**Table 2:** Expert Assigned Weights (From FGD)

Indicator	Usefulness Weight (%)	Easiness Weight (%)
Family Planning	56	44
Childbirth Facility	52	48
Basic Immunization	50	50
Exclusive Breastfeeding	51	49
Toddler Growth Monitoring	53	47
National Health Insurance Membership	59	41

**Table 3:** Score of Each Element

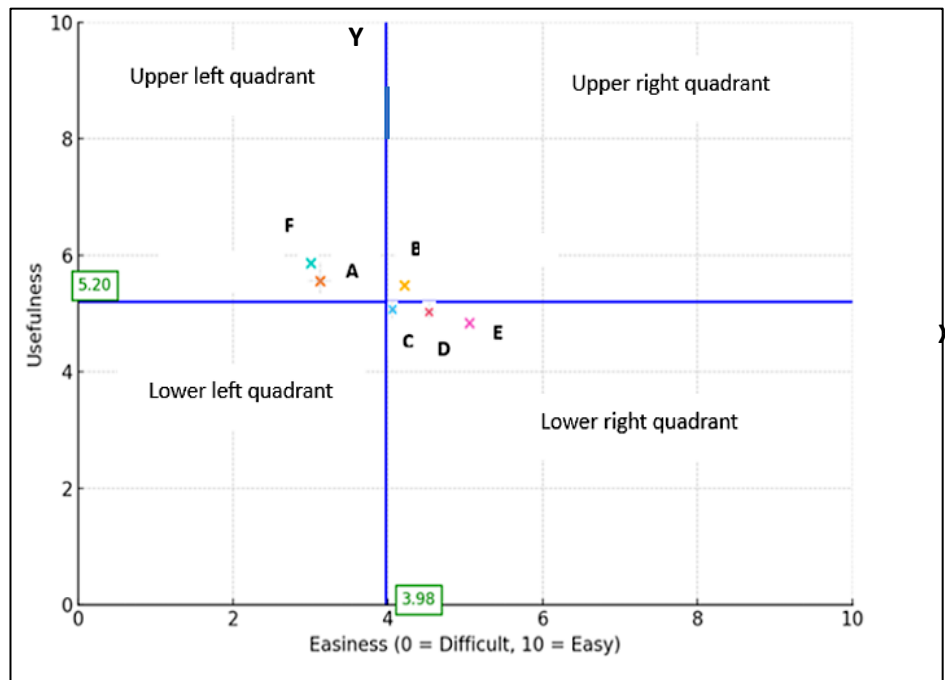
Score of Usefulness	Indicator	Score of Easiness
5.35	Family Planning	3.56
5.06	Childbirth Facility	4.35
4.89	Basic Immunization	4.44
5.00	Exclusive Breastfeeding	4.09
5.18	Toddler Growth Monitoring	4.00
5.67	National Health Insurance Membership	3.41

Furthermore, the average usefulness and easiness scores were 5.20 and 3.98, respectively, which were used as the threshold values for defining the X-axis (usefulness) and Y-axis (easiness) in the QUE-We quadrant. Each indicator was then positioned in the matrix based on its mean usefulness and easiness scores. Based on Figure 2, the distribution of PIS-PK indicators across the four quadrants shows different levels of strategic priority. The highest priority (Upper Right Quadrant) is childbirth in health facilities, which

demonstrates both high usefulness and high easiness. The second priority (Upper Left Quadrant) includes family planning participation and national health insurance membership, which have high usefulness but relatively lower easiness of implementation. The third priority (Lower Right Quadrant) consists of basic immunization, exclusive breastfeeding and toddler growth monitoring, which are relatively easy to implement but perceived as having lower usefulness. No indicators were located in the lowest priority

quadrant (Lower Left Quadrant), indicating that all evaluated elements were perceived as having at

least moderate usefulness or implementation feasibility.



**Notes:** X-axis= Usefulness score (0-10), Y-axis= Easiness score (0-10), A= family planning, B= Childbirth facility, C= Basic immunization, D= Exclusive breastfeeding, E= Toddler Growth Monitoring, F= National Health Insurance Membership

**Figure 2:** Analysis of the Position of Each Element of Prioritizing Maternal and Child Health in the Four Quadrants with QUE-We

## Discussion

The application of the QUE-We method in this study demonstrates its usefulness as a structured framework for categorizing and prioritizing maternal and child health program components within the Indonesia Healthy Program with Family Approach (18). Unlike conventional descriptive program evaluations, this approach supports data-driven prioritization by simultaneously considering the perceived usefulness and the feasibility of implementation (19). The QUE-We method is a data-driven prioritization framework that evaluates health indicators across two main dimensions: usefulness and easiness (9). Usefulness refers to the perceived contribution of an indicator to improving maternal and child health outcomes (16), while easiness reflects the feasibility of implementation considering local resources, infrastructure, cultural acceptance and operational constraints (23, 24).

The findings suggest that integrating usefulness and easiness in a single analytical framework allows health planners to better identify strategic program priorities in complex health systems. In many public health settings, interventions that are

theoretically beneficial may face substantial implementation barriers, particularly in decentralized systems where resource distribution and health service capacity vary across regions (25). Therefore, combining perceived benefit with implementation feasibility provides a more realistic basis for prioritizing health interventions. A key conceptual contribution of this study lies in the prioritization logic used in the QUE-We framework. Traditionally, prioritization of health programs has been conducted by comparing the perceived usefulness and the level of implementation difficulty of each indicator. However, such approaches generally assume equal importance across indicators and rarely incorporate systematic weighting in the decision-making process. In contrast, the QUE-We framework introduced in this study determines program priorities by comparing usefulness and easiness while simultaneously applying expert-derived weights to each indicator. This approach enables a more balanced prioritization process, where perceived program benefits, implementation feasibility and the relative importance of each

indicator are considered simultaneously. As a result, the prioritization process becomes more strategic and context-sensitive, particularly for maternal and child health programs implemented within complex health systems.

The Indonesia Healthy Program with Family Approach emphasizes evidence-based family health profiling as a foundation for improving health outcomes at the household level. Key indicators used for maternal and child health evaluation include participation in family planning, births in health facilities, complete basic immunization, exclusive breastfeeding, growth and development monitoring for children under five and national health insurance membership. These indicators represent essential components of primary healthcare strategies aimed at reducing maternal and child morbidity and mortality.

The implementation of the QUE-We method reflects the growing need for context-sensitive decision-support tools in public health planning (26). Through its dual-lens evaluation, assessing both usefulness and easiness, the QUE-We model encourages a more pragmatic allocation of limited health resources in maternal and child health (MCH) programs (27). One of the key conceptual contributions of this framework is its ability to identify interventions that are both highly beneficial and relatively easy to implement, often referred to as “low-hanging fruit” strategies in program planning (28). These interventions allow health systems to generate measurable improvements in program performance within a relatively short period of time.

For instance, the distribution and utilization of maternal and child health handbooks and antenatal education programs have consistently been associated with improved maternal knowledge, better care-seeking behavior and stronger engagement with health services (29). Because these interventions require relatively limited infrastructure and financial resources, they can be rapidly scaled at the community level, making them effective entry points for strengthening maternal and child health programs (20).

However, the analytical value of the QUE-We framework becomes more apparent when examining interventions located in the High Usefulness–Low Easiness quadrant. Programs in this category are recognized as highly beneficial

but face significant operational challenges. Examples include family planning programs and national health insurance participation, both of which are strategically important for improving maternal and child health outcomes but may encounter sociocultural, administrative and logistical barriers. Such findings highlight the importance of strengthening institutional capacity, improving community engagement and addressing systemic barriers to program implementation (30).

Family planning programs, for example, are widely acknowledged for their role in reducing maternal mortality, improving birth spacing and supporting women’s reproductive autonomy (31). Nevertheless, the FGD findings indicate that several barriers continue to affect program uptake, including limited male involvement, sociocultural norms, and misinformation regarding contraceptive methods. These challenges are consistent with previous studies showing that sociocultural norms and community perceptions can significantly influence contraceptive utilization in many communities (32).

Similarly, participation in national health insurance programs is perceived as highly beneficial for expanding access to maternal and child health services. However, the implementation of such schemes often involves administrative complexities, limited digital accessibility and bureaucratic procedures that may discourage participation among vulnerable populations. These findings indicate that improving health financing mechanisms requires not only policy expansion but also operational simplification to ensure equitable access to healthcare services (33).

The findings from the High Usefulness–High Easiness quadrant further highlight the importance of strengthening interventions that already demonstrate both strong impact and high feasibility. Access to childbirth services in health facilities, for instance, has become increasingly feasible due to the expanded availability of trained midwives, improved referral systems and broader community acceptance of facility-based deliveries. These improvements reflect the positive effects of national health system strengthening initiatives that aim to improve maternal care quality and accessibility (34).

In contrast, interventions located in the Low Usefulness–High Easiness quadrant present a different strategic challenge. Although programs such as basic immunization, exclusive breastfeeding promotion and toddler growth monitoring are relatively easy to implement, their perceived usefulness appears lower among some community members. This finding suggests that implementation success alone does not guarantee strong community engagement or perceived value. Public health programs must therefore be accompanied by continuous health education and community awareness efforts to ensure sustained participation (35).

For example, vaccine hesitancy remains a growing concern in several regions despite the proven effectiveness of immunization programs. Misinformation, cultural beliefs and limited trust in health information sources can reduce vaccination acceptance and threaten long-term disease prevention efforts. Similarly, exclusive breastfeeding practices are often influenced by social norms, employment conditions and family support systems, which may limit sustained breastfeeding practices even when mothers are aware of its benefits (36, 37).

Overall, the findings highlight the potential of the QUE-We framework as a practical analytical tool for supporting strategic decision-making in maternal and child health programs. By integrating perceived usefulness, implementation feasibility and expert-based weighting, the framework offers a more nuanced understanding of program priorities within complex health systems. This approach is particularly relevant in decentralized health systems such as Indonesia, where program effectiveness depends not only on policy design but also on local implementation capacity and community engagement.

## Conclusion

This study demonstrates the applicability of the Quadrant of Usefulness–Easiness with Weighting (QUE-We) framework as a practical tool for prioritizing maternal and child health interventions within the Indonesia Healthy Program with Family Approach. By integrating survey-based perception data with expert insights from Focus Group Discussions (FGDs), the framework enables program components to be evaluated based on both their perceived

usefulness and implementation feasibility. The analysis shows that childbirth facility access falls within the High Usefulness–High Easiness quadrant, indicating a strategic intervention that should be maintained and strengthened. Family planning and national health insurance membership are categorized as High Usefulness–Low Easiness, suggesting that although they are highly beneficial, additional efforts are needed to address sociocultural and operational barriers. Meanwhile, basic immunization, exclusive breastfeeding and toddler growth monitoring are positioned in the Low Usefulness–High Easiness quadrant, highlighting the need to strengthen community awareness and perceived value of these programs.

Conceptually, this study contributes by introducing a prioritization framework that integrates usefulness, easiness and expert-derived weighting into a single analytical model, providing a more context-sensitive approach to health program prioritization compared with traditional usefulness–difficulty frameworks. Practically, the QUE-We method can support policymakers and health program managers in identifying priority interventions and allocating resources more strategically within decentralized health systems. However, the study relies on perception-based assessments and online survey sampling, which may limit representativeness and introduce subjective bias. Future research should expand the application of the QUE-We framework to other health programs, incorporate objective performance indicators and explore longitudinal analyses to better understand how program priorities evolve across different regional contexts.

## Abbreviations

FGD: Focus Group Discussion, MCH: Maternal and Child Health, QUE-We: Quadrant of Usefulness–Easiness with Weighting.

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## Author Contributions

All authors contributed equally to the manuscript.

## Conflict of Interest

The authors declare no conflict of interest.

## Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

## Declaration of Artificial Intelligence (AI) Assistance

During the preparation of this manuscript, the authors used AI-assisted language editing tools to improve grammar and clarity. The authors take full responsibility for the content of the manuscript.

## Ethics Approval

Information about opinion from the Ethics Committee was taken to perform the study. This study has fulfilled the principles of (1) respecting autonomy, (2) justice, (3) beneficence and (4) non-maleficence.

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