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**INDONESIA TRIP REPORT
JAKARTA, YOGYAKARTA,
AND BANDUNG, INDONESIA**

September 16-October 8, 1996

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TABLE OF CONTENTS

ACRONYMS

EXECUTIVE SUMMARY	1
I. PURPOSE OF TRIP	3
II. TRIP ACTIVITIES	3
A. BASICS—HP-IV Collaboration on Decentralization and Private Sector	3
B. BASICS—UGM Studies on the Private Sector in Purworejo District, Central Java	6
C. Medical Education in IMCI	9
D. USAID Meeting	12

APPENDICES

A	Workshop Training Guide
B	Work Group Guide
C	Workshop Agenda
D	Memorandum to the HP-IV Team—Workshop Review and Recommendations
E	Transparencies
E1	Models of Analysis
E2	Private Sector
F	Behavioral Objectives Description (Purworejo District)
G	Improving Provider Case Management Practices for Child Illness in a Rural Indonesian District
H	Pilot Project Proposal
I	Facilitators Guide: General Outline

ACRONYMS

ABS	Audit Balita Sakit
BASICS	Basic Support for Institutionalizing Child Survival Project
CHN-III	Community Health and Nutrition III–World Bank Project
HMO	Health Maintenance Organization
HP-III	Health Plan III
HP-IV	Health Plan IV
IBI	Ikatan Bidan Indonesia (Indonesian Midwives Association)
IDAI	Indonesian Pediatric Association
IDI	Ikatan Dokter Indonesia (Indonesian Medical Association)
ijin	word meaning license (permission) in Indonesian
IMCI	Integrated Management of Childhood Illness
JHU	Johns Hopkins University
MCH	Maternal and Child Health
MH	Maternal Health
MSH	Management Sciences for Health
NTB	Nusa Tenggara Barat (Province)
PDE	Project Development Expenditure
PKK	Persatuan Kesejahteraan Keluarga
PVO	Private Voluntary Organization
UGM	University of Gadjah Mada
UMS	Utilization Monitoring System
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Robert Northrup of the BASICS Technical Division traveled to Indonesia September 16-October 8, 1996, to plan and conduct a planning and management workshop; to help plan and negotiate district-level quality of service interventions; and to participate in the third meeting of the national committee for curriculum on the integrated management of childhood illnesses (IMCI).

The World Bank loan-based HP-IV project of the Planning Bureau of the Indonesian Department of Health held a four-day workshop from Sept 23 to 26 for three persons from each of the 11 districts from five provinces participating in the first year of the project. The workshop covered the methods used to collect data regarding basic health services and analyze it for management and planning of public and private sector basic health services. BASICS supported the workshop substantially, with Jean Jacques Frère supporting preliminary preparation of the workshop schedule and preparing models for analysis of district data; Rob Northrup preparing the detailed activity descriptions and working group activity guide, working with the facilitator team to prepare them for the workshop, presenting the models for analysis and an introduction to the private sector, and serving as a facilitator to the small working groups from each district; and Annette Bongiovanni, a short-term consultant, presenting on maternal health data and serving as a working group facilitator. The workshop is a useful tool for BASICS' work in other countries in assisting in the process of decentralization of planning and management for child survival activities, including increasing government involvement of the private sector.

Following the HP-IV work, I worked in Yogyakarta with Dr. Djauhar and Ibu Siwi (Gadjah Mada University) to prepare plans for the intervention activities in the Purworejo private sector study, based on the results of the baseline survey. We met twice with Dr. Lina, the MCH Director for the Purworejo District Department of Health, initially to engage her in selecting overall strategic approaches, subsequently in reviewing the actual proposed plans, which she strongly supported. The proposed intervention activities include meeting with public and private sector doctors and midwives and private drug sellers including small convenience shop owners to inform them of the key examination, treatment, and counseling actions of the national integrated management of childhood illness protocol and to obtain their contract to perform those specific actions from this overall list which they can agree to do immediately. Their compliance will be monitored by ongoing "sick child audits" in which mothers from community mothers groups will interview mothers whose children have been sick in the last two weeks regarding their home case management and the actions performed in diagnosis, treatment, and counseling by practitioners consulted for that illness. The results of that monitoring will be fed back to the practitioners by the Department of Health, who is the employer of the doctors and midwives in their public sector roles, and who provides the license for the drug sellers. Gadjah Mada and BASICS will provide ongoing assistance in the whole process and manage the data needed to evaluate the effectiveness and the cost of the effort. The intervention proposed would be initiated by a pilot intervention in a single subdistrict to develop materials and methods using BASICS/USAID funds, followed by a scaled up intervention in eight subdistricts, the four subdistricts already assessed for baseline quality of care, followed by four new subdistricts, all taking place from approximately January

1997 through completion of evaluation in August 1998. Recent inputs from central level to the province and district make it highly likely that approval for funding from CHN-III through PDE funds will be available for the scaled up intervention.

I then participated in a three-day workshop in Bandung October 4-6 for the national team of the Indonesian Pediatric Association responsible for modifying the existing WHO training materials for IMCI to use in training medical students in pre-service medical education. Also attending were the IMCI leaders from the national Department of Health and the two health directors from UNICEF who will be providing support to the government in implementing IMCI throughout the country in every district hospital, health center, and satellite health center by 2001. The workshop reviewed intensively the detailed proposals, and in some cases pilot initial studies, of seven protocols for research studies on various aspects of the use of IMCI for medical education and in various geographic and cultural environments in the country. It then examined in detail each of the modules of the WHO course, and identified needed adaptations, changes, additions of technical material and use of more sophisticated referral actions, and teaching approaches, assigning tasks to each of the members for preparation prior to the next meeting in February. The national program has already completed translation of the modules and preparation of an adapted algorithm, which will be modified by the team to become more suitable for medical education. The meeting concluded with an intensive interaction between the UNICEF Health Director (Dr. Samhari) and the team to bring the IMCI medical education activities into synchronism with national program efforts to implement IMCI in every health center and satellite health center, with the implication that the medical education effort would need to intensify the preparation of medical school staff to serve as facilitators for the immense amount of training which will be needed in the national program. BASICS has completely supported this effort technically and financially so far, and will play a critical role in the next 12 months in completing the materials, planning the actual teaching, and developing the workshops and promotional approaches needed to introduce the new methods to the country's 35 medical schools.

A meeting was held with Barbara Spaid of USAID. She informed me of the Mission's decision to discontinue work in child survival by October 1997, and requested BASICS to conclude its Mission-supported efforts, including those with Field Support funding, by that time with the possible exception of visits without intervention activities to monitor progress in areas of previous Mission-supported intervention. Activities supported by Global funds can continue after that date.

I. PURPOSE OF TRIP

Robert Northrup of the BASICS Technical Division traveled to Indonesia September 16-October 8, 1996, to do the following:

1. Plan and carry out a workshop for HP-IV project districts on data-based district level planning and management of public and private basic health services.
2. Plan and negotiate interventions to improve the quality of services provided by private and public sector practitioners to sick children in Purworedjo District, Central Java, to be carried out through the District Health Department and Gadjah Mada University (GMU).
3. Participate in the third meeting of the national committee to develop curriculum materials and methods for teaching the integrated management of childhood illness (IMCI) to medical students in Indonesia.

II. TRIP ACTIVITIES

A. BASICS—HP-IV Collaboration on Decentralization and Private Sector

On arrival September 18, I met with Jean Jacques Frère to review progress in planning the workshop and obtain charts he had prepared from Lombok Barat (NTB) showing data regarding the relationship of available manpower to coverage and utilization achievements in maternal health, and showing various analysis approaches and potential uses in management and planning of data from the new utilization monitoring system, a key methodology to be conveyed to the HP-IV districts during the workshop. These materials were subsequently used in the presentation by Annette Bongiovanni on material health and manpower and in my own presentation on models of analysis.

At the HP-IV offices at the Department of Health, I found that specific activities had not yet been planned by the HP-IV team, although a general schedule was available. Discussions that day and over the next four days provided the basis for preparing a detailed training guide (only partially completed) and work group guide to assist in defining the activities of the participants and the facilitators (see Appendices A and B). These were used in the meeting of facilitators on the first day of the workshop (September 23, 1996), leading to revisions in the agenda as well as these documents, and were then used during the workshop. I also began the preparation of the individual presentations I would be giving, two on the private sector and one regarding models of analysis of the UMS data.

An introductory meeting with facilitators was held September 20 and 21, and on September 22, I met individually with Dr. Faried (Kalimantan Timor) formerly the Provincial Secretary of the HP-III project, who became the "course director", and on Sept 23, the facilitators met in earnest

to finalize the plans for the workshop prior to the opening activities in the evening. In addition to Mark Brooks, A. Bongiovanni, and myself, facilitators included Dr. Faried, Dr. Mala Suguni, formerly the HPIII Secretary for NTB, and Dr. Birlean from Litbangkes, who specializes in health care financing and HMO development. Dr. Mamman and Dr. Bambang from the Planning Bureau also participated substantively in the workshop, and Ibu Ira, the HP-IV director, was present for nearly all of the workshop, playing an important role, particularly in the initial introductory and final planning sessions.

The workshop began the evening of September 23, and ran until mid-afternoon of September 26. The planned workshop agenda is attached (Appendix C). There were 43 participants overall: three district and puskesmas staff from each of the 11 districts and two provincial level staff from each of the five provinces. Various central level staff attended the workshop from time to time as resource persons, presenters, and observers. The planned workshop schedule consisted of eight modules as follows (see Training Guide, Appendix A, for more details).

1. Opening and Introduction
 Welcome, summary of HP-IV, workshop terms of reference, HP-IV performance indicators and district management and planning, private sector perspective, review of workshop agenda
2. Facility Physical Status
 Presentation of principles of planning based on data; district working group analysis of pre-workshop facility physical status survey data using data worksheet, standard setting for availability of running water, problem identification, priority setting, and preparation of district action plan for running water availability improvement
3. Coverage Target Setting
 Presentation on coverage target setting methods and population data; district working group recalculation of puskesmas coverage targets based on 1990 census and actual district population growth data, using worksheet
4. Maternal Health Coverage and Manpower
 Presentation on potential relationships between maternal health (MH) performance deficiencies and available manpower; district working group analysis using worksheet of MH coverage relative to available puskesmas and pustu manpower based on routine monthly reported MH data and pre-workshop manpower capacity survey; identification of performance problems; preparation of action plan for improvement in MH coverage
5. Immunization Coverage and Manpower
 Same as MH but for immunization coverage

6. Utilization Monitoring System

Introduction to new facility utilization recording and analysis system, experience with UMS in NTB and Kalimantan Timur during HP-III, models for analysis of UMS data to reveal potential problems, working group exercise in analysis, management, and planning using actual data from one NTB district, preparation of district UMS implementation plan

7. Private Sector

Introduction to private sector components, role, and activities, and potential health department role and activities; district working group inventory and assessment of current private sector components and preparation of potential district action plan for private sector activities

8. Action Plan, Follow-up and Evaluation

Working group preparation of coordinated short-term district action plan based on the MH, immunization, UMS, and private sector action plans previously prepared, preparation of provincial follow-up and support action plan, preparation of recommendations for the next data workshop for these districts, evaluation and recommendations for improvement of this workshop.

Dr. Faried was the overall moderator for all the workshop sessions and module leader for the UMS module, while other resource persons took leadership responsibility or made presentations for individual modules. There were five working group facilitators: Mark Brooks, Faried, Birlian, Annette, and myself.

In actual performance, the time needed for data analysis and planning was more than had been planned. Accordingly, the module on immunization had to be dropped. There was much more discussion on the UMS than had been anticipated, with many of the participants initially opposing the imposition of a new data recording and collection instrument. This extended the time needed for that module compared to that shown in the agenda.

Evaluations of the workshop by the participants were generally positive, with a number of useful suggestions for improvement. Those comments as well as my own observations and recommendations are summarized in a memorandum to the HP-IV team which I prepared after the workshop (Appendix D). Transparencies used in various presentations are provided in Appendix E.1 and E.2, related to the Models of Analysis and Private Sector presentations respectively.

The follow-up workshop for this group of districts is planned for May 1997, while the first workshop for the Year 2 HP-IV districts (15) is planned for February 1997. The HP-IV team is anxious for BASICS to play an active and leading role in both the planning and actual running of both of these workshops, if possible. I indicated that we were less likely to be able to help in running the February workshop although we would contribute to its planning based on the

experience with this workshop. We would be more actively involved in the May workshop, both in the planning and actual running of the sessions.

The workshop just conducted is a useful tool for BASICS' work in other countries in assisting in the process of decentralization of planning and management for child survival activities, including involvement of the private sector. With only minor adaptation it should prove useful in assisting governments in the important tasks of shifting operational and managerial responsibility of child survival efforts from central to provincial and district levels.

In other interactions related to the BASICS—HP-IV collaboration, discussions regarding the proposed contract between BASICS and HP-IV with Dr. Nasirah Bauddin indicated that she had no objection to separating the contract for payment of travel costs for myself and Dr. Frère from a contract for both the services and travel costs of Steve Solter in assisting efforts in training decentralization. I indicated that BASICS would convey this information to MSH, and seek to revise proposals and present them to HP-IV in October. I also conveyed to Dr. Ira the limitations on USAID funds from the Jakarta Mission and their insistence that all Mission-supported work be terminated by October 1, 1997 (see comments on meeting with Barbara Spaid, below). We agreed to schedule further BASICS involvement with those limitations in mind.

B. BASICS—UGM Studies on the Private Sector in Purworejo District, Central Java

Following the HP-IV workshop, I went on September 28 to Yogyakarta to work with Dr. Djauhar and Ibu Siwi (Gadjah Mada University) and the staff of the Purworejo District Department of Health to prepare plans for the intervention activities to be carried out in the Purworejo private sector study, based on the results of the baseline survey.

An environment of receptiveness surrounded these planning and negotiation activities. Dr. Kumara Rai, formerly the Director General of the DepKes Bureau of Planning in Jakarta, had been to Central Java twice in the context of reviewing the CHN-III project. His initial meeting, in Semarang in August, had exposed the resistance of the provincial staff to any funding for Gadjah Mada, and had provoked a strong request from him to the province to both submit some proposals for CHN-III project development expenditure (PDE) funding and to more actively engage and collaborate with UGM to take advantage of what had been concluded was very useful data gathering and activities by Gadjah Mada in their Purworedjo longitudinal work. This meeting had been followed by Dr. Kumara's visit to Purworedjo and UGM on September 27-28, the day I arrived in Yogyakarta. He was again impressed with the work of the Gadjah Mada surveillance team and pleased with what he saw in Purworejo, leading to reiteration of his request to increase the level of activities being carried out by UGM in support of the district's health services. These specifically included the private sector study. In short, it appears very likely at this point that funds from CHN-III will be available for the proposed private sector intervention studies, although the planning, review, and financial administrative process would not make funds available until approximately July 1997.

Since my previous visit, a one-day workshop with district health office staff and a number of public/private doctors, nurses, and midwives was held on August 28. UGM organized the agenda, and made presentations of the results of the baseline assessments of home case management and private and public practitioner case management, as well as the basic philosophy and methods of IMCI. Six small working groups of the participants prepared recommendations for responding to these inputs. It was clear from the workshop that interest was high in the effort, and that at least initial cooperation from the practitioners could be expected. The workshop also conveyed to the practitioner groups the key elements of IMCI.

A strategy planning session on Saturday, September 28 led to preparation of a behavioral objectives description (Appendix F), to facilitate strategic discussions. On Monday, September 30, we met in Purworejo with Dr. Lina, the MCH Director for the Purworejo District Department of Health, to engage her in selecting overall strategic approaches. These were used in preparing draft proposals for a pilot and a full-scale intervention over the next two days. On Thursday, October 3, we met with Dr. Lina again to review these proposed plans, and obtained her strong verbal approval and her promise to introduce them to Dr. Harun, the District Health Officer. The UGM group will complete the drafts and budget in the next few days and finalize the proposals with the district, after which the district will submit the proposal for the full-scale intervention to the CHN-III program for funding. The timing for the review process requires that the proposal must be submitted immediately. The BASICS role in the full-scale intervention is limited to technical assistance to UGM and to the district.

The proposed intervention activities include meeting with public and private sector doctors and midwives and private drug sellers including small convenience shop owners, to inform them of the key examination, treatment, and counseling actions of the national integrated management of childhood illness (IMCI) protocol and to obtain their contract to perform those specific actions from this overall list which they can agree to do immediately. UGM and the Dinas will collaborate with the district doctors and midwives professional organizations (IDI and IBI) in organizing these sessions and in continuing communication with the practitioners subsequently during the monitoring and feedback phases of the project.

Compliance of the practitioners with their agreed-to behavioral contracts will be monitored by ongoing verbal case reviews (Audit Balita Sakit = ABS) in which mothers from community mothers organizations, most likely PKK, will interview mothers whose children have been sick in the last two weeks regarding their own home case management and the actions performed in diagnosis, treatment, and counseling by practitioners consulted for that illness. The results of that monitoring will be reported to the District Department of Health on a quarterly basis by the women's organization, and then fed back to the practitioners by the district. It is important to note that the district is the employer of almost all of the doctors and midwives in their public sector roles, provides the license (ijin) for their private practice in the afternoons, and licenses the drug sellers to sell food as well as drugs.

Gadjah Mada will provide ongoing technical as well as managerial assistance in the whole process and will manage the data needed to evaluate the effectiveness and the cost of the effort. BASICS' role is limited to providing technical assistance to UGM and to the district, as well as providing financial support to the pilot intervention effort in one district.

The proposed intervention would be initiated by a pilot intervention in a single subdistrict to develop materials and methods while awaiting CHN-III funds for the larger effort. It is anticipated that this would start approximately January 1997, and proceed for about one year through evaluation. The full-scale CHN-III funded intervention in the four subdistricts already assessed for baseline quality of care and in a second set of four new subdistricts which would require both baseline data collection and terminal evaluation would begin approximately July 1997. It is highly likely that approval for funding from CHN-III through PDE funds will be available for the scaled-up intervention.

The drafts presented to Dr. Lina on October 3 are attached as Appendices G and H. The Gadjah Mada team will forward the budget and Indonesian language versions of these to BASICS as soon as they are available, most likely by mid-October.

The most important task for BASICS is to obtain funding approval as soon as possible for the pilot effort in one district, in order to allow it to be initiated by the end of calendar year 1996, if possible. The importance of the pilot is to enable development of the methods and materials, allow appointment and on-the-job training of Department of Health staff who will run the project and the field manager for the UGM inputs, and provide opportunity for adjustment of the methods based on experience, so that when the CHN-III funding is made available, activity will be able to start immediately and with greater efficiency. This in turn will allow completion and evaluation of the interventions prior to the end of BASICS, and will also allow the most critical technical inputs from BASICS to be made prior to the September 1997 deadline for stopping all technical and financial inputs funded by Mission-controlled Field Support funds.

Relative to completion of the current BASICS contract with UGM, Dr. Djauhar reviewed with me the characteristics of the reports which will need to be prepared and submitted to BASICS prior to payment of the final installment of funds on the contract to UGM. He anticipates that these can be completed by the end of calendar year 1996. I also raised the question of the provision of assistance from BASICS to help in more detailed analysis of the baseline assessment data, specifically the possibility of using a JHU graduate student with experience in this sort of data analysis to carry out more in-depth analyses and to prepare appropriate reports. Dr. Djauhar indicated that such support would be welcome, with the proviso that any publications of data including reports or theses must obtain the approval of the UGM team before release. BASICS needs to determine if this sort of assistance can be made available.

C. Medical Education in IMCI

The national team of the Indonesian Pediatric Association (IDAI) responsible for modifying the existing WHO training materials for IMCI to use in training medical students during their pre-service medical education met for the third time, in Bandung on October 4-6, 1996. Also attending were the IMCI leaders from the national Department of Health, and the two health directors from UNICEF (Dr. Hanna and Dr. Samhari), who will be providing support to the government in their program to implement IMCI in every district hospital, health center, and satellite health center throughout the country by 2001.

Following a brief initial review of the overall committee's work, the workshop reviewed intensively the detailed proposals and in some cases pilot initial studies of seven protocols for research studies on various aspects of the use of IMCI for medical education. The topics covered in these seven protocols, along with commentary regarding the relevance of the topic to adaptation of IMCI to Indonesia and to medical education in Indonesia, are as follows:

1. *Epidemiologic pattern of diseases related to IMCI in teaching health facilities* (Dr. Rusdi, Palembang) To determine the likely proportion of diseases needing basic health services in various levels of health services, from teaching hospital to district hospital to primary health care facilities; this will help to shape the teaching activities for which adequate numbers of patients will be available in different levels of health facility.
2. *Patterns of feeding by mothers during childhood illness* (Dr. Moersintowati, Surabaya) This study will contribute to the definition of the "food basket" for IMCI feeding recommendations for various parts of Indonesia, and will also provide the basis for the teaching of medical students regarding counseling for feeding during illness and prevention of malnutrition (feeding during healthy periods).
3. *Patterns of management of infectious diseases in Indonesian Health Services relative to the IMCI protocol* (Dr. Irawan, Semarang) Determination of the proportion of specific diagnoses causing fever among patients of different ages at different levels of health facilities; comparison of diagnoses and treatments determined by use of the IMCI with those carried out by the routine methods used by regular facility staff; determination of the breadth and difficulty of behavioral changes in management of acute infections needing to be brought about by IMCI teaching.
4. *The use of clinical signs for the diagnosis of anemia in Indonesian children* (Prof Dr. Suryono, Yogyakarta): This will entail a comparative determination of the accuracy, reliability, sensitivity and specificity of the use of palmar paleness, nailbed paleness, and conjunctival paleness compared to actual hemoglobin

determination in the identification of anemia in Indonesian children; adapting IMCI diagnostic methods for use in Indonesian people with lighter skin than the African models for these methods.

5. *Mothers' reasons for taking children for treatment* (Dr. Cissy, Bandung)
Developing messages for use in counseling mothers regarding self-referral for childhood illness; having messages on hand appropriate to various Indonesian localities and cultural environments, along with actual data documenting their effectiveness, for use in teaching medical students regarding how to counsel mothers on when to return.
6. *The influence of malnutrition on the methods for identifying pneumonia in under-fives using simple clinical signs* (Dr. Irawan, Semarang) Confirming the applicability of the findings in the Gambia regarding the need to use lower respiratory frequencies as the threshold for pneumonia definition in children with severe and moderate malnutrition; documenting the proportion of children with pneumonia among those with rapid respirations compared with signs detectable by use of the stethoscope and radiologic examination, at various levels of the health system; confirming for Indonesian medical students the effectiveness of respiratory rate as a sensitive and specific indicator of the presence of pneumonia in under fives.
7. *The effectiveness of different methods of providing counseling to mothers during IMCI in different cultural and linguistic settings* (Dr. Yati, Yogyakarta)
Adaptation of the standard methodology for counseling using a mother's card to the Indonesian setting, where mother's cards may not be cost-effective compared to other methods, and where specific local terms may be critical to producing understanding of the mothers; assessment of the effectiveness of student doctors at various stages of their training in counseling mothers; developing methods for training students in counseling skills.

Only one of the studies, the first one by Dr. Rusdi, had collected significant amounts of data; other investigators had done only a few patients or none at all. All of the protocols were judged to need modification; Dr. Rusdi's general disease epidemiology study and Dr. Suryono's anemia study needed only very minor changes, the others needed more substantial changes. Revised protocols will be submitted to BASICS for review as soon as available.

In addition to the purposes noted above, a major purpose of these studies is to involve a widening proportion of the faculty at each medical school in IMCI-related activities, as a well-recognized approach to "marketing" the new method. By investing their own time and attention on research in the various IMCI topic areas of the protocols, medical faculty members will take ownership of the effort, and be much more likely to welcome the new teaching methods and topics when they are offered to the departments. This makes the proposed multi-center approach to each of the

protocols even more important, as the investments have a critical role in convincing the currently uninvolved members of the teaching staff at the six participating universities of the importance and desirability of the IMCI protocol as a clinical approach and of the proposed IMCI medical student curriculum as a road worthy of being taken.

It should be noted, thus, that the committee proposes that BASICS or other donor sources will be able to fund studies on each of the topics at each of the six participating medical schools, i.e., seven multi-center studies. The PMPT committee hopes to have a decision by mid-November at the latest on the ability of BASICS to support these protocols.

Having completed the discussions on research cum marketing activities on Friday, October 4, the committee used the following day first to examine in detail each of the modules of the WHO course (Assess and Classify, Identify Treatment, etc). Discussion led to proposals for needed adaptations, changes, additions of technical background material needed by medical students in contrast to already graduated doctors, additions of more sophisticated diagnostic or treatment actions related to the fact that medical students would be caring for patients at the referral level with availability of more sophisticated equipment and procedures as well as at the primary care-low technology level, and additions or modifications of teaching approaches. These will be incorporated into revisions of the modules by the committee members assigned to the particular module prior to the next meeting in February. The national program has already completed translation of the modules and preparation of an adapted algorithm. These will be use in the next four months as the basis for the proposed changes by the committee members.

The committee also considered the Facilitators Guide, a volume not yet dealt with by the committee prior to this meeting other than having prepared a general outline of the contents (see Appendix I). The committee assigned chapters of that volume to various members of the committee. Some of those chapters can be merely translations from the existing Facilitators Guide; others will require original writing or use of source documents other than the current WHO course documents. For example, the committee recognizes the need for a detailed explanation of the scientific background and rationale for the integrated approach to care itself, and assigned the task of preparing that material to one of the members, assisted by BASICS.

During the Saturday discussions, the committee at one point had a prolonged debate over whether to make available an adapted version of the whole set of WHO materials, including all the case studies and other exercises used by trainees in the original WHO course, versus developing a severely shortened set of materials concentrating primarily on presenting the protocol and omitting most of the student exercises. Concern was expressed that the bulk of the WHO materials would cause many faculty members as well as students to be disinterested in even opening them, and to be reluctant to make the effort to select a package of activities from them which could be effectively employed in limited time periods in various settings (teaching hospital ward, polyclinic, district hospital, health center, community) and in various stages of the medical education process (premedical, preclinical, introduction to physical examination, clerkship, public health teaching, etc). The debate concluded with a decision to produce adapted

versions of the modules in their entirety, and to prepare possible sequences of selected activities from the modules which could be used in the various settings and stages. These would serve as models or examples for faculty members, hopefully thereby helping to convince faculty members of the practicality and feasibility of using the translated materials without substantial additional investment of time. Assignments for producing such examples were divided among all of the faculty members of the committee. The results will be reviewed in February and incorporated into the adapted Facilitator's Guide.

The meeting concluded on Sunday, October 6, with a presentation and subsequent intensive discussion between the UNICEF Health Director (Dr. Samhari) and the team regarding the steps needed to bring the IMCI medical education efforts into synchrony and support of the national program to implement IMCI in every puskesmas and pustu by the year 2001. Dr. Samhari recognizes the critical need for skilled trainers if the national program is to reach its goals in the targeted time period. To have these trainers available, the most likely source is the medical schools and their involved faculty members. With this in mind, he proposed that the committee speed up and intensify its schedule, so that all the medical schools would be covered and competent in IMCI by as much as a year earlier than the schedule previously in mind. The committee members responded positively to this appeal. Although there was not time to reach agreement on a specific set of revised dates, the group agreed in principle to speed up the process, asking the committee chairperson Dr. Suryono and myself to work out an appropriate and feasible schedule.

BASICS has almost solely supported this effort technically and financially so far, and will play a critical role in the next 12 months in completing the materials, planning the actual teaching, and developing the workshops and promotional approaches needed to introduce the new methods to the country's 35 medical schools. The new UNICEF collaboration will ensure that the BASICS effort will reach the whole country in a very short time. It will be important, therefore, for us to maintain our full involvement with this effort despite the lack of support from the USAID/Jakarta Mission.

Tasks to be done include:

- ▶ revise, negotiate, and finalize the budget and schedule as soon as possible
- ▶ prepare sections of modules and the facilitator's guide on IMCI technical background
- ▶ obtain certain technical references from WHO

D. USAID Meeting

A meeting was held with Barbara Spaid of USAID. She informed me of the Mission's decision to discontinue work in child survival by September 30, 1997, and requested BASICS to conclude

its Mission-supported efforts including those with Field Support funding by that time, with the possible exception of visits without intervention activities to monitor progress in areas of previous mission-supported intervention. She indicated specifically that activities supported by Global funds can continue after that date. She requested that BASICS supply her with a revised workplan showing how it will conclude its activities. The plan should

- ▶ show what will have been accomplished with the 1995 Field Support funds
- ▶ show what will continue with other funds, e.g., World Bank funds or government funds
- ▶ illustrate how “what we were able to start with Field Support dollars was able to be picked up by other sources”

Further discussion revealed that the Mission’s difficulty is not lack of money, but lack of manpower for purposes of monitoring funded activities. The Mission has withdrawn Indonesia from the list of countries eligible for child survival PVO grants for this reason, for example. They are not comfortable with a less active management style, and with the cutbacks in manpower they are not able to maintain the number of activities possible previously with more manpower.

Tasks to be done

- ▶ submit revised description and workplan.

APPENDICES

APPENDIX A
WORKSHOP TRAINING GUIDE

WORKSHOP TRAINING GUIDE

MODULE

1. PEMBUKAAN

A. TUJUAN

B. HASIL KERJA (OUTPUT)

C. PROSES DAN KEGIATAN

0. Sebelum sidang mulai: registrasi peserta dgn mengisi formulir registrasi dan pembagian materi Raker (agenda, notulen, tas, dll) kepada peserta

Sidang Pembukaan: Moderator ??

Jam	Acara
19:30	Acara sambutan dan pembukaan yang resmi
20:00	Acara ilmu mulai
20:00 - 20:15	1. Presentasi: Use of data in planning -- Pak Mark
20:15 - 20:30	2. Presentasi: HP-IV dan Pemakaian Dana SAF -- Ibu Ira
20:30 - 20:45	3. Presentasi: Perkenalan ttg Peranan Sektor Swasta dalam manajemen pemanfaatan dan cakupan pelayanan -- Pak Rob
20:45 - 21:00	4. Perkenalan Tim Fasilitator
21:00 - 21:30	5. Perkenalan Tim2 Kabupaten dan Propinsi - diskusi pendek dalam masing2 tim, kemudian perkenalan oleh masing2 orang disertai dgn presentasi singkat dari setiap tim ttg harapan mereka dari Raker dan satu contoh kegiatan yg berkaitan dgn tujuan Raker yg pernah dikerjakan di tempat kerja tim tsb (kabupaten atau propinsi)
21:30 - 22:00	6. Presentasi Agenda Raker dengan tanya-jawab -- Pak Rob
22:00 - 22:10	7. Perkenalan Module #2 dan pemberian tugas PR -- mengisi Lembar Rekap Data Fisik Puskesmas & Pustu untuk 5 puskesmas, sebelum sidang pertama hari ke2 jam 08:00 -- Ibu Erry

D. BAHAN RUJUKAN

1. Gambaran ttg latar balakang dan tujuan umum raker dgn agendanya
2. Daftar performance indicators untuk proyek HP-IV
3. Keterangan dan petunjuk ttg pemakaian dana SAF
4. Problem-solving cycle, private sector structure diagram
5. Petunjuk untuk Module 2 - Keadaan fisik puskesmas/pustu

E. ISI PRESENTASI-PRESENTASI

F. PETUNJUK FASILITATOR

2. INDIKATOR FISIK PUSKESMAS/PUSTU - AIR MENGALIR

A. TUJUAN

B. HASIL KERJA (OUTPUT)

C. PROSES DAN KEGIATAN

Jam	Agenda
08:00	1. Presentasi: Agenda hari ini -- Pak Faried
08:05	2. Presentasi: Memperingatkan tujuan dan kegiatan Module 2, kemudian memberi petunjuk untuk kerja kelompok -- Ibu Ery

- 08:15 - 10:00 3. Kerja Kelompok
- menentukan keadaan standard/target masa lama untuk fasilitas fisik khususnya sumber air dan adanya air mengalir, juga apakah standard akan bervariasi menurut keadaan setempat atau faktor2 lainnya
 - meninjau keadaan sekarang dari data di Lembar Rekap, dan tunjukkan kekurangan2nya
 - menafsirkan faktor2 yg mempengaruhi adanya kekurangan2nya
 - menentukan beberapa tindakan alternatif (teknik), termasuk penentuan fase2 tindakannya
 - menentukan cara dan kriteria untuk menentukan prioritas bagi fasilitas mana akan menerima tindakan lebih dulu.
 - membuat rencana satu tahun untuk kegiatan tsb termasuk anggaran yg terinci, ketenagaan, penjadwalan, cara monitoring, dll. (proposal SAF)
- 10:15 - 11:00 4. Presentasi hasil kerja kelompok oleh 2 kelompok (sidang pleno)

D. BAHAN RUJUKAN

- Lembar rekapitulasi data fisik puskesmas dan pustu Lingkup kabupaten
- Data dari masing2 puskesmas dan pustu dari survei keadaan fisik (perlu dibawa ke raker oleh peserta)

E. ISI PRESENTASI-PRESENTASI

F. PETUNJUK FASILITATOR

3. INDIKATOR CAKUPAN DAN SASARAN PUSKESMAS

A. TUJUAN

B. HASIL KERJA (OUTPUT)

C. PROSES DAN KEGIATAN

Jam	Kegiatan
11:00 - 11:45	1. Penjelasan & presentasi mengenai indikator cakupan dan pentingnya pemakaian target yg benar untuk manajemen pelayanan kesehatan dasar, disertai diskusi pleno -- Pak Mark
11:45 - 12:00	2. Penjelasan mengenai kerja kelompok
13:00 - 14:30	3. Kerja sebagai kelompok kabupaten <ul style="list-style-type: none"> -- berdasarkan data dari sensus 1990, dan tafsiran perkembangan per tahun sesudah 1990 menurut Biro Sensus sampai 1996, menghitung jumlah/target yg berikut: <ul style="list-style-type: none"> -- jumlah penduduk -- jumlah ibu hamil, -- jumlah balita -- jumlah bayi berumur 0 - 11 bulan, untuk tahun 1996, untuk setiap wilayah puskesmas di kabupaten yg bersangkutan -- membandingkan angka2 baru ini dgn target2 yg dipakai biasanya, dan membuat tabel perbedaan diantaranya dalam persen. Membikin grafik ttg perbedaan2 tsb pada transparan -- memasukkan angka2 di tempat2 yg sesuai pada Lembar perhitungan cakupan KIA dan Lembar perhitungan cakupan imunisasi
14:30 - 15:00	4. Diskusi pleno untuk mencari kesepakatan -- Pak Mark

d) Materi/petunjuk kerja/worksheet/dll

- Petunjuk kerja kelompok
- Data dari sensus 1990 untuk masing2 wilayah
- Tafsiran angka kecepatan berkembang dari Biro Sensus
- Lembar perhitungan cakupan KIA dan Immunisasi
- Kertas grafik dan transparan

E. ISI PRESENTASI-PRESENTASI

F. PETUNJUK FASILITATOR

4. TENAGA KESEHATAN DAN CAKUPAN KIA

A. TUJUAN

B. HASIL KERJA (OUTPUT)

C. PROSES DAN KEGIATAN

Jam	Kegiatan
15:15 - 16:00	1. Presentasi dgn diskusi pleno: Hubungan antara adanya dan efisiensi kerja tenaga dgn cakupan ibu hamil dan kehamilan -- Ibu Annette
16:00 - 16:10	2. Penugasan kerja kelompok -- Pak Rob
16:10 - 21:30	3. Kerja kelompok <ul style="list-style-type: none">-- mengisi Lembar Perhitungan Cakupan KIA dengan data dari Laporan KIA 6 bulan.-- mengisi Lembar Rekapitulasi Tenaga Kesehatan, khususnya jalur2 ttg dokter, bidan dan perawat dgn data yg dikumpulkan dengan survei.. Membuat grafik untuk memamerkan perbedaan2 antara puskesmas2 dan pustu2 di wilayah anda untuk beberapa hal : proporsi tenaga yang tidak tetap, proporsi tenaga yg baru, proporsi tenaga yg dapat melayani ibu hamil yang merupakan bidan, yg merupakan dokter, dan yg merupakan perawat.-- menghitung jumlah penduduk, jumlah ibu hamil dan jumlah persalinan per bidan untuk masing2 puskesmas dan pustu, juga per semua tenaga yg dapat melayani ibu hamil (dokter + perawat + bidan). Menghitung lagi angka2 tsb dengan memakai "Hari kerja efektif" sebagai denominator. Membikin grafik untuk mengemukakan data itu. Berapa besar bedanya antara yg paling besar dan yg paling sedikit, untuk angka2 yang dihitung?-- melaksanakan brainstorming tentang sebab2 yang mungkin merupakan sebab untuk perbedaan2 yg ditemukan. dan mencatat hasil brainstorming pada suatu daftar.-- mendiskusikan tindakan apa saja yang mungkin dapat dikerjakan untuk meningkatkan instansi2 yg kelihatannya ada di belakang daripada yg lain. Membikin daftar tindakan2 pada transparan.-- menentukan puskesmas/pustu dgn cakupan ibu hamil dan persalinan yg baik dan kurang baik: persen K1 dan K4 menurut puskesmas dan pustu, persen persalinan yg dibantu oleh tenaga profesional menurut puskes/pustu-- menghitung angka2 yg mencerminkan hubungan antara adanya dan efisiensi tenaga bidan/perawat dgn cakupan ibu hamil dan persalinan: ratio % K1 dan K4 per bidan, ratio % persalinan yg dibantu per bidan menurut puskes/pustu-- melaksanakan brainstorming ttg faktor2 yg mempengaruhi perbedaan cakupan antara puskesmas/pustu --> daftar sebab2 yg mungkin-- menentukan langkah2 untuk mendiagnosa sebab2 yg nyata (mengumpulkan

data lebih lanjut tentang apa? wawancara tentang apa dgn tokoh2 tertentu, dll)

- menafsirkan tindakan2 yg mungkin untuk mengatasi faktor2 yg mungkin
- membuat POA/rencana kabupaten untuk 3 - 5 tahun secara kasar, dan untuk satu tahun secara terinci, untuk meningkatkan cakupan KIA, baik dengan menaikkan jumlah tenaga, maupun dengan menaikkan efisiensi tenaga yang ada.
- mencatat analisa, kesimpulan, dan langkah2 diagnostik dan therapeutic pada transparan supaya jalan pikiran kelompok dapat diperlihatkan kepada peserta2 lainnya.

Hari Rabu

08:00 - 08:15 Presentasi agenda hari ke2 - Pak Faried

08:15 - 09:15 4. Presentasi hasil analisa dan POA dari 2-3 kabupaten (sidang pleno)

D. BAHAN RUJUKAN

E. ISI PRESENTASI-PRESENTASI

F. PETUNJUK FASILITATOR

5. CAKUPAN IMUNISASI

A. TUJUAN

B. HASIL KERJA (OUTPUT)

C. PROSES DAN KEGIATAN

Jam	Kegiatan
09:15 - 09:25	1. Presentasi singkat ttg cakupan immunisasi, adanya dan efisiensi tenaga, dan faktor2 lain yg mempengaruhi cakupan immunisasi, kemudian penjelasan ttg proses kerja kelompok - Pak Mala & Pak Rob
09:25 - 12:00	2. Kerja Kelompok <ul style="list-style-type: none">-- mengisi Lembar Perhitungan Cakupan Immunisasi dengan data dari PWS Immunisasi selama 6 bulan untuk 5 puskesmas bersama dgn pustunya-- menghitung jumlah persalinan, jumlah anak 0-11 bulan dan 0 - 4 tahun per bidan untuk masing2 puskesmas dan pustu, juga per semua tenaga yg dapat melayani anak yg membutuhkan immunisasi (dokter + perawat + bidan). Menghitung lagi angka2 tsb dengan memakai "Hari kerja efektif" sebagai denominator. Membikin grafik untuk mengemukakan data itu. Berapa besar bedanya antara yg paling besar dan yg paling sedikit, untuk angka2 yang dihitung?-- menentukan puskesmas/pustu dgn cakupan immunisasi yg baik dan yang kurang baik, khususnya cakupan untuk masing2 antigen (DPT 1, polio 4, dan campak) menurut puskesmas dan pustu-- menghitung angka2 yg mencerminkan hubungan antara adanya tenaga dan efisiensi tenaga bidan/perawat dgn cakupan immunisasi, maka jumlah masing2 immunisasi dibagi jumlah tenaga (bidan sendiri, kemudian bidan + dokter + perawat), cakupan (dalam %) dibagi jumlah tenaga. Membandingkan efisiensi bidan, dokter, dan perawat. Membuat tabel dengan hasil perhitungan, juga grafik pada transparan.-- melaksanakan brainstorming ttg faktor2 yg mempengaruhi perbedaan cakupan antara puskesmas/pustu --> daftar sebab2 yg mungkin Jangan lupa faktor2 di masyarakat selain faktor2 di sistem kesehatan.

- memikirkan, mendiskusikan, dan menentukan langkah apa saja yg dibutuhkan untuk mendiagnosa sebab2 yg sebenarnya (mengumpulkan data lebih lanjut tentang apa? wawancara tentang apa dgn tokoh2 tertentu, dll)
- memikirkan, mendiskusikan, dan menentukan tindakan2 yg mungkin untuk mengatasi faktor2 yg dianggap paling mungkin
- membuat POA/rencana kabupaten untuk 3 - 5 tahun secara kasar, dan untuk satu tahun secara terinci, untuk meningkatkan cakupan KIA, baik dengan menaikkan jumlah tenaga, maupun dengan menaikkan efisiensi tenaga yang ada. POAnya perlu ada tindakan diagnostik untuk membuktikan sebab2 yg ada, dan tindakan terapi (intervensi) terhadap sebab2 yang kemungkinan besar akan ternyata ada.
- mencatat analisa, kesimpulan, dan langkah2 diagnostik dan terapi pada transparan supaya jalan pikiran kelompok dapat diperlihatkan kepada peserta2 lainnya.
- memilih salah seorang untuk mempresentasikan proses kerja dari grup

13:00 - 14:00 3. Presentasi hasil kerja kelompok dgn POA dari 2 kelompok (moderator Pak Mala & Pak Rob)

D. BAHAN RUJUKAN

-- Lembar perhitungan cakupan imunisasi lingkup kabupaten

E. ISI PRESENTASI-PRESENTASI

F. PETUNJUK FASILITATOR

6. SISTEM MONITORING PEMANFAATAN FASILITAS KESEHATAN (SMPFK)/ UTILISATION MONITORING SYSTEM (UMS)

A. TUJUAN

1. TUJUAN UMUM.

Setelah sesi ini berakhir peserta memperoleh kejelasan tentang sistem monitoring pemanfaatan fasilitas kesehatan (UMS) serta terdapat kesepakatan dan akan menerapkannya di daerah masing-masing.

2. TUJUAN KHUSUS.

1. Peserta memahami secara benar konsep UMS:

- Tujuan UMS
- UMS dapat dilakukan tanpa melakukan banyak perubahan dari sistem pencatatan dan pelaporan Puskesmas (SP2TP) yang dewasa ini sudah berjalan.
- Data yang direkam dapat digunakan untuk evaluasi kinerja fasilitas kesehatan tersebut.
- Hal-hal yang perlu diperhatikan agar UMS dapat terlaksana secara mantap dan berkesinambungan.

2. Peserta menyepakati bentuk formulir yang dipergunakan dalam UMS.

3. Peserta dapat menganalisa data UMS.

4. Peserta dapat menggunakan hasil analisa tersebut untuk merencanakan tindakan/pendekatan yang diperlukan untuk perbaikan yang diinginkan.

5. Peserta membuat rencana tindak lanjut (back home plan) dalam rangka menerapkan UMS di daerahnya masing-masing.

B) HASIL KERJA (OUTPUT)

1. Instrumen UMS yang disepakati untuk dipergunakan.

2. Model analisa data yang dipergunakan.

3. Bentuk Rencana tindak lanjut didasarkan analisa data dikaitkan dengan penggunaan SAF.
4. Rencana tindak lanjut penerapan UMS (Back home plan).

C. PROSES DAN KEGIATAN

- | | |
|---------------------------------|---|
| 14:00 - 16:15 | 1. Presentasi ² dengan diskusi pleno (Moderator - Ibu Erry) |
| 14:00 - 14:30 | 1. Presentasi secara umum tentang konsep UMS yang akan diterapkan. (Pak Mark - 30menit) |
| 14:30 - 14:45 | 2. Presentasi pengalamam NTB (dr.Mala Saguni , 15 menit) |
| 14:45 - 15:00 | 3. Presentrasi pengalamam Kaltim (HM Faried SA, 15 menit) |
| 15:15 - 16:00 | 4. Model-model analisa -- (Rob N., 45 menit) |
| 16:00 - 16.15 | 5. Penjelasan ttg kegiatan kerja kelompok (HM Faried SA, 15 menit) |
| | 2. Kerja Kelompok dan Diskusi Pleno |
| 16:15 - 17:00,
19:30 - 20:00 | 1. Diskusi kelompok melakukan analisa terhadap data puskesmas (75 menit). |
| 20:00 - 21:00 | 2. Penyajian kelompok (Moderator Faried SA, 60 menit). |
| 21:00 - 21:45 | 3. Diskusi pleno tentang kesepakatan UMS (Moderator Pak Faried, 45 menit). |
| Hari Kamis | |
| 08:00 - 08:45 | 4. Penyusunan rencana tindak lanjut (Back home plan UMS) (Penugasan Ibu Erry, 45 menit pada pagi hari berikut). |
| 08:45 - 10:00 | 5. Penyajian rencana tindak lanjut bersama diskusi pleno (Moderator Pak Faried, 75 menit) |

d) BAHAN RUJUKAN

1. Lembar harian Pemanfaatan Pelayanan Kesehatan Lingkup Puskesmas/Pustu.
2. Lembar rekapitulasi harian Pemanfaatan Pelayanan Kesehatan Lingkup Puskesmas/Pustu.
3. Lembar rekapitulasi bulanan Pemanfaatan Pelayanan Kesehatan Lingkup Puskesmas/Pustu.
4. Lembar rekapitulasi Pemanfaatan Pelayanan Kesehatan Lingkup Kabupaten.
5. Data UMS dari 4 puskesmas

E. ISI PRESENTASI-PRESENTASI

F) PETUNJUK UNTUK FASILITATOR

Mengikuti diskusi kelompok dengan waspada. Apabila kelompok kesasar atau agak kering, pertanyaan² seperti yg berikut dapat diusulkan kepadanya untuk membantu diskusinya

- Berapakah angka kunjungan per tahun per orang menurut masing² golongan umur untuk masing² tipe pelayanan yg disediakan (pengobatan, KIA, gigi, dll)? Apakah angka itu sesuai dengan harapan? Kalau belum, apa sebabnya?
- Berapakah "visit rate" (angka kunjungan = jumlah kunjungan / jumlah penduduk) untuk masing² instansi? Ratenya cukup atau tidak? Bagaimana trendnya? (data lebih banyak diperlukan?) Apa saja faktor² yg mungkin menyebabkan visit rate yang tidak memuaskan?
- Apakah ada variasi jumlah kunjungan menurut golongan umur atau tipe pelayanan pada hari² tertentu dalam seminggu? Apakah hal itu terjadi di semua puskesmas/pustu dengan variasi yg mirip, atautkah instansi² tertentu? Apa faktor²nya yang mungkin dapat menyebabkan hal itu? Apakah cara pemberian pelayanan (misalnya jam buka, tenaga yg ditugaskan didalam fasilitas, macam pelayanan yg diberikan (imunisasi, KB, pelayanan antenatal) dapat di buat variasi juga untuk menyesuaikan pelayanan dgn adanya

pemakainya? Usulan kelompok apa saja?

- Apakah proporsi status bayar sama di semua fasilitas? Mengapa ada perbedaan? Apakah status bayarnya sesuai dgn tafsiran? Kalau yg membayar dianggap belum cukup (utilisasi kurang), apa sarasannya? Bagaimana mereka dapat ditarik ke puskes/pustu?

Pada waktu kelompok sudah mulai membuat POA untuk mengimplementasi SMPFK/UMS di wilayah kabupaten, dengarlah unsur2 yang akan mereka gunakan dalam rencana. Kalau kelihatannya tidak akan cukup lengkap, hal2 yang berikut dapat diusulkan kepadanya: usaha untuk meyakinkan dan melatih tenaga puskesmas dan pustu, menentukan kolom tambahan pada formulir2 kalau ada masalah yang membutuhkan data yang belum ada di formulir asli, menyediakan formulir2, menentukan analisa2 apa saja yg akan dilaksanakan secara rutin, menentukan siapa saja yang akan bertanggung jawab, penjadwalan implementasi sistem baru (apakah akan dikerjakan di semua instansi sekaligus? Kriteria apa saja akan dipakai untuk memilih pelopornya? gelombang keduanya?)

7. SEKTOR SWASTA

A. TUJUAN

- mengerti komponen2 sektor kesehatan swasta dan peranannya masing2 berkaitan dgn jalan ke child survival (Pathway to child survival)
- mengerti hubungan antara kegiatan sektor swasta dgn usaha2 dinas dan pencapaian target/indikator performance
- menyadari beberapa pendekatan dan metoda yang bisa dipakai oleh dinas untuk mendiagnosa peranan komponen2 sektor swasta dan mutu kegiatan/perilaku daripada tenaga dan lembaga sektor swasta, termasuk metoda survai Verbal Case Review (VCR) [*diagnostic methods*]
- menyadari beberapa pendekatan dan metoda yang bisa dipakai oleh dinas untuk bertindak supaya peranan/perilaku komponen2 sektor swasta ditingkatkan [*intervention methods*]
- beberapa kabupaten HP-IV (2 atau 3) merasa mampu dan sudah membuat rencana untuk melakukan survei diagnostik (verbal case review) tentang peranan dan mutu pelayanan tenaga swasta, dan akan melaksanakannya sebelum Raker #2

B. HASIL KERJA (OUTPUT)

Diskusi pleno:

- daftar tenaga sektor swasta
- daftar organisasi/lembaga2 swasta dan peranannya di bidang kesehatan
- daftar tipe dan kegiatan wakil perusahaan obat dan distributor item konsumen misalnya sabun
- daftar tindakan2 terhadap sektor swasta yg sudah diusahakan di tingkat kabupaten dan propinsi

Kerja kelompok:

- rencana dari masing2 kabupaten untuk kegiatan2 yg berhubungan dgn sektor swasta; rencananya termasuk keterangan ttg kegiatan apa, mengapa, siapa yang akan mengerjakannya, bagaimana, dimana, kepada apa/siapa, dan kapan, juga termasuk anggaran kalau perlu, cara monitoring pelaksanaannya, dan cara melaporkannya (sesuai dgn format proposal SAF)

C. PROSES DAN KEGIATAN

- 10:15 - 11:15
1. Presentasi tentang unsur2 sektor swasta dan
 2. Diskusi pleno dgn brainstorming tentang faktor2 swasta yang ada hubungan dengan angka cakupan dan angka pemanfaatan basic health services (visit rate) (Rob N., 60 menit)
- 11:15 - 11:30
3. Penugasan untuk kerja kelompok (Dr Rob, 15 menit)
- 11:30 - 12:00
4. Kerja Kelompok (75 menit)

13:00 - 13:45 Makan siang

13:45 - 15:00 5. Presentasi pleno hasil kerja kelompok dgn diskusi pleno (Moderator Rob N. 75 menit)

D. BAHAN RUJUKAN

1. Pathway dan Struktur Sektor Swasta transparan dan handouts
2. Transparan2 lainnya untuk presentasi
3. Petunjuk untuk peserta ttg kerja kelompok
4. Petunjuk untuk fasilitator ttg kerja kelompok

E. ISI PRESENTASI-PRESENTASI

[akan di gambarkan]

F. PETUNJUK FASILITATOR

- berpartisipasi secara aktif seperti peserta waktu presentasi/diskusi pleno, dgn menyumbang pengalaman dan usul-usulan lainnya
- merangsang peserta/kelompok untuk menyumbang pengalaman atau bayangan untuk ke-tiga unsur sektor swasta (tenaga praktek swasta, pertokoan dan pabrik2 obat dan lain2 barang yg terkait dgn kesehatan, lembaga sosial masyarakat) Supaya semua komponen dipikirkan, sebaiknya mulai diskusi dgn brainstorming ttg masing2 komponen secara berurut-urut

Sesudah ada daftar dari brainstorming, kemudian ditentukan prioritas dgn cara "ranking" atas suatu skoring yg dikerjakan secara individu. Masing2 peserta memberi skor antara 0 s/d 4 ttg kepentingan topik atau kegiatan tsb, juga ttg feasibility kegiatan2nya, termasuk besarnya anggaran, adanya tenaga di tempat yg mampu untuk melaksanakan kegiatan tsb, dll. Kemudian skor2 dijumlahkan, dan jumlah2 yang paling tinggi dipilih.

Sesudah metoda ranking ini dipakai untuk memilih topik2 dan kegiatan2 yang paling feasible dan penting, daftar usaha yang sekarang pendek dipertimbangkan lagi untuk menilai apakah kegiatannya dapat dikerjakan sekaligus pada waktu yg sama oleh kabupaten/puskesmas/pustu atau oleh propinsi, atau perlu diprioritaskan dan dikerjakan secara bertahap.

Fasilitator supaya menilai kelancaran diskusi kelompok juga kreativitas dan sesuainya (appropriateness) kegiatan2 yg akhirnya keluar dari proses. Kemudian atas penilaian tsb usulkanlah kepada ketua modul kelompok2 yang dapat memberi laporan yang menarik ttg hasil kerja kelompok waktu kembali untuk sidang pleno lagi.

8. PERENCANAAN LANGKAH LANJUTAN DAN EVALUASI

A. TUJUAN

B. HASIL KERJA (OUTPUT)

C. PROSES DAN KEGIATAN

15:15 - 15:30 1. Penugasan kerja kelompok (Ibu Ira. 15 menit)

15:30 - 16:15 2. Kerja kelompok2 kabupaten dan kelompok2 propinsi (45 menit)

- Untuk tim kabupaten: membuat rencana/jadwal/penentuan tanggung jawab yang menyimpulkan kegiatan untuk usaha2 kelima topik: air mengalir, perobahan target, cakupan KIA, cakupan Imunisasi, pengikut-sertaan sektor swasta
- untuk tim propinsi: membuat rencana pemberian bantuan untuk menyelesaikan proposal2 SAF, monitoring dan pemberian bantuan untuk usaha2 kabupaten, dan persiapan untuk pelatihan2 dan bimbingan2 untuk kabupaten2 baru (gelombang HP-IV ke2).
- untuk semua kelompok:
 - menentukan keperluan2 lainnya untuk melaksanakan kegiatan2 ini (mis. tambah komputer, melaksanakan pelatihan lanjut ttg topik tertentu (termasuk

EPI-INFO, computerisasi, dll), dan membuat proposal SAF

- melaksanakan brainstorming ttg harapan/isi Raker ke2 bulan Februari
- melaksanakan brainstorming ttg Raker #1 ini: apa yg dapat dikerjakan untuk membuat Rakernya lebih efektif dan berguna (untuk gelombang yg berikut); membuat daftar usul untuk disajikan dan diserahkan ke moderator.
- mengisi formulir evaluasi secara individu

- 16:15 - 16:45 -- Presentasi hasil kerja kelompok oleh masing2 propinsi secara singkat (Moderator Ibu Ira, 30 menit)
- 16:45 - 17:15 -- Diskusi pleno (Moderator Ibu Ira, 30 menit)
- 17:15 - 17:30 -- Penutupan (15 menit)

D. BAHAN RUJUKAN

- formulir evaluasi

E. ISI PRESENTASI-PRESENTASI

- penugasan kelompok menurut proses dan kegiatan yg diharapkan

F. PETUNJUK FASILITATOR

- berusaha menjamin lengkapnya rencana baik kabupaten maupun propinsi - siapa, dimana, kapan, kepada siapa, bagaimana, dengan anggaran yg cukup terinci, juga mengenai macam2 langkah (supervisi, latihan, dll)
- merangsang komentar yg kritik dengan usul2 ttg pelaksanaan raker ini.
- menjamin pengisian formulir evaluasi oleh masing2 peserta
- merangsang supaya rencana lanjutan dibuat dalam bentuk yg dapat diberikan kepada panitia sebagai petunjuk untuk followup di kabupaten dan di propinsi tsb oleh tim HP-IV pusat.

**APPENDIX B
WORK GROUP GUIDE**

PETUNJUK UNTUK KERJA KELOMPOK

MODULE

2. INDIKATOR FISIK PUSKESMAS/PUSTU - PENGALIRAN AIR

- menentukan keadaan standard/target masa lama untuk fasilitas fisik khususnya sumber air dan adanya air mengalir, juga menentukan apakah standard boleh bervariasi menurut keadaan setempat atau faktor2 lainnya, atau harus sama dimana-mana. Kalau boleh bervariasi, batasannya apa, dan faktor apa saja akan dipakai untuk menentukan standard mana yg akan laku untuk tempat tertentu. Hasil diskusi ini supaya dicatat pada daftar untuk kemudian dipresentasikan.
- meninjau keadaan sekarang dari data di Lembar Rekap, dan tunjukkan kekurangan2nya yang ada; daftarkanlah kekurangannya
- dengan cara brainstorming, menafsirkan faktor2 yg mempengaruhi adanya kekurangan2nya untuk masing2 instansi yang keadaannya belum sesuai dengan standar, dan membikin daftar sebab untuk masing2 instansi
- berdasarkan daftar sebab2 dan juga lain2 alasan, melaksanakan brainstorming untuk mengusulkan beberapa tindakan alternatif (pendekatan tehnik) untuk mengatasi macam2 kekurangannya yg ada. Untuk masing2 alternatif mencatat pendapat kelompok ttg mudah/sulitnya alternatif tsb menurut keadaan setempat, besarnya dana yang diperlukan, waktu yg diperlukan sampai selesai, tenaga atau sumber lainya yg akan diperlukan, dan usaha apa saja lagi yang harus menyertai alternatifnya kalau akan berhasil (mis promosi kepada masyarakat, motivasi tenaga puskesmas, dll)
- menentukan cara dan kriteria untuk menentukan prioritas diantara fasilitas2. Memakai cara/kriteria tswb untuk menentukan fasilitas mana yang akan menerima tindakan lebih dulu.
- membuat rencana kasar untuk tiga tahun berdasarkan faktor2 yang dipikirkan tadi. Kemudian membuat rencana satu tahun yang terinci untuk kegiatan tsb. Rencana tsb sebaiknya termasuk langkah2, siapa2, pembagian tugas dan tanggung jawab, anggaran yg terinci, penjadwalan, cara monitoring, dll. seperti untuk proposal SAF.
- mempersiapkan presentasi hasil daripada masing2 langkah kerja kelompok; membuat transparan yang dapat dipresentasi di sidang pleno dgn hasil2 tsb.

3. INDIKATOR CAKUPAN DAN SASARAN PUSKESMAS

- berdasarkan data dari sensus 1990, dan tafsiran pertumbuhan penduduk per tahun sesudah 1990 menurut Biro Sensus sampai 1996, menghitung jumlah/target yg berikut:
 - penduduk,
 - jumlah ibu hamil,
 - jumlah bayi berumur 0 - 11 bulan,
 - jumlah balitauntuk tahun 1996, untuk setiap wilayah puskesmas di kabupaten yg bersangkutan
- membandingkan angka2 baru ini dgn target2 yg dipakai biasanya, dan membuat tabel perbedaan diantaranya dalam persen. Membikin grafik ttg perbedaan2 tsb pada transparan yg dapat dipresentasikan. Berapa proporsi puskesmas yang akan harus kerja lebih keras (atau lebih cerdas) pada masa depan untuk mencapai target baru?

4. TENAGA KESEHATAN DAN CAKUPAN KIA

- mengisi Lembar Perhitungan Cakupan KIA dengan data dari Laporan KIA 6 bulan.
- mengisi Lembar Rekapitulasi Tenaga Kesehatan, khususnya jalur2 ttg dokter, bidan dan perawat dgn data yg dikumpulkan dari survei.. Membuat grafik untuk memamerkan perbedaan2 antara puskesmas2 dan pustu2 di wilayah anda untuk beberapa hal : proporsi tenaga yang tidak tetap, proporsi tenaga yg baru, proporsi tenaga yg dapat melayani ibu hamil yang merupakan bidan, yg merupakan dokter, dan yg merupakan perawat.

Apakah jumlah tenaga yang ada merupakan faktor yang terpenting?

- menghitung jumlah penduduk, jumlah ibu hamil dan jumlah persalinan per bidan untuk masing2 puskesmas dan pustu, juga per semua tenaga yg dapat melayani ibu hamil (dokter + perawat + bidan). Menghitung lagi angka2 tsb dengan memakai "Hari kerja efektif" sebagai denominator. Membikin grafik untuk mengemukakan data itu. Berapa besar bedanya antara yg paling besar dan yg paling sedikit, untuk angka2 yang dihitung?
- melaksanakan brainstorming tentang sebab2 yang mungkin merupakan sebab perbedaan2 jumlah tenaga yg ditemukan, dan mencatat hasil brainstorming pada suatu daftar.
- mendiskusikan tindakan apa saja yang mungkin dapat dikerjakan untuk meningkatkan jumlah tenaga di instansi2 dengan kekurangannya. Membikin daftar tindakan2 yang mungkin pada transparan.

Bagaimana performance tenaga yg ada?

- menentukan puskesmas/pustu dgn cakupan ibu hamil dan persalinan yg baik dan kurang baik (*performance*): persen K1 dan K4 menurut puskesmas dan pustu, persen persalinan yg dibantu oleh tenaga profesional menurut puskes/pustu
- menghitung angka2 yg mencerminkan hubungan antara tenaga dan cakupan: adanya dan efisiensi tenaga bidan/perawat dikaitkan dengan cakupan ibu hamil dan persalinan dengan menghitung ratio % K1 dan K4 per bidan, ratio % persalinan yg dibantu per bidan menurut puskes/pustu
- melaksanakan brainstorming ttg faktor2 yg mempengaruhi perbedaan cakupan antara puskesmas/pustu, baik faktor ketenagaan dan efisiensi, maupun faktor2 lain misalnya faktor lingkungan, pengetahuan masyarakat, dll. Mencatat hasil brainstorming pada suatu daftar sebab2 yg mungkin
- menentukan langkah2 untuk mendiagnosa sebab2 yg sebenarnya (mengumpulkan data lebih lanjut tentang apa? wawancara tentang apa dgn tokoh2 tertentu? lain2 cara?)
- mengemukakan tindakan2 apa saja yg mungkin berguna untuk mengatasi faktor2 yang diassumsi penting (brainstorming)

Perencanaan tindakan:

- membuat POA/rencana kabupaten untuk 3 - 5 tahun secara kasar, dan untuk satu tahun secara terinci, untuk meningkatkan cakupan KIA, baik dengan menaikkan jumlah tenaga, maupun/atau dengan menaikkan efisiensi tenaga yang sudah ada dan bertindak terhadap faktor2 lain yang dianggap penting.
- mencatat analisa, kesimpulan2, dan tindakan diagnostik dan "kuratif" pada transparan supaya jalan pikiran kelompok dapat disajikan kepada peserta2 lainnya.
- memilih salah seorang untuk mempresentasikan hasil kerja tsb itu

5. CAKUPAN IMUNISASI

- mengisi Lembar Perhitungan Cakupan Imunisasi dengan data dari PWS Imunisasi selama 6 bulan untuk 5 puskesmas bersama dgn pustunya
- menghitung jumlah persalinan, jumlah anak 0-11 bulan dan 0 - 4 tahun per bidan untuk masing2 puskesmas dan pustu, juga per semua tenaga yg dapat melayani anak yg membutuhkan imunisasi (dokter + perawat + bidan). Menghitung lagi angka2 tsb dengan memakai "Hari kerja efektif" sebagai denominator. Membikin grafik untuk mengemukakan data itu. Berapa besar bedanya antara yg paling besar dan yg paling sedikit, untuk angka2 yang dihitung?
- dengan memakai model analisa yang hampir sama dengan model analisa untuk cakupan KIA, menilai hubungan antara cakupan imunisasi (3 antigen) dengan tenaga, mengusulkan faktor2 yang dapat mempengaruhi angka cakupan, dan dan mengusulkan dan menetapkan tindakan therhdap faktor2 tsb. Hasil diskusi dibuat dalam bentuk daftar dan transparan dan dipresentasikan.

6. SISTEM MONITORING PEMANFAATAN FASILITAS KESEHATAN / MONITORING SYSTEM (UMS)

UTILISATION

1. Peserta dibagi dalam kelompok kabupaten.
2. Peserta kabupaten mendiskusikan data 4 puskesmas (data akan diberikan kepada kelompok):
 - a) melakukan penilaian terhadap kebenaran pengisian form termasuk melakukan uji kebenarannya
 - b) Apa bila terdapat kesalahan, tindakan apa yg perlu dilakukan; bagaimana dan siapa yang harus berbuat?
 - c) Anggaphlah butir b) telah dilakukan, dan untuk itu kelompok boleh melakukan asumsi untuk memperbaiki data laporan Puskesmas tersebut.
 - d) Kelompok melakukan analisa terhadap data tsb:
 - kesimpulan masalah2 yang ditemukan
 - menetapkan prioritas masalah
 - menetapkan tujuan tindakan
 - membuat alternatif dan memilih alternatif pendekatan yg akan dilakukan
 - menyusun rencana kerja (bila mungkin termasuk pembiayaanya, dalam hal ini anggaphlah 4 puskesmas tersebut di kabupaten anda)
3. Hasil kerja kelompok dipresentasikan (masing-masing propinsi 1 kelompok kabupaten), dilanjutkan dengan diskusi pleno sampai ada kesepakatan UMS
4. Menyusun rencana tindak lanjut (back home plan UMS) dalam kelompok kabupaten. Menyusun bahan penyajian supaya rencananya dapat dipresentasikan
5. Presentasi pleno rencana tindak lanjut oleh beberapa kelompok kabupaten, bersama dengan diskusi pleno

7. SEKTOR SWASTA

1. *Apa yang sekarang dilakukan?*

Diskusi kelompok kabupaten bersama dgn tenaga dari propinsi. Menginventarisasi apa yang ada di kabupaten dari ke3 unsur sektor swasta: tenaga yg berpraktek swasta (private practitioner), sektor swasta yg komersial (pabrik, penyalur, wakil2 pabrik, dll). lembaga2 sosial masyarakat), dan kegiatannya yg ada hubungan dengan utilisation/pemanfaatan pelayanan (visit rate secara umum), cakupan termasuk pelayanan preventif dan kuratif, pelayanan kepada yg miskin, penyuluhan kesehatan, promosi, dll. Dari diskusi/brainstorming ini dihasilkan daftar dgn 3 kolom - instansi yg ada, kegiatannya sekarang, dan klasifikasi kegiatannya (macam kegiatannya)
2. *Apa yang dapat dilakukan?*

Diskusi dilanjutkan dengan mengusulkan apa lagi yang unsur2 itu dapat melakukan untuk mencapai tujuan sistem kesehatan yaitu meningkatkan status kesehatan di masyarakat dan jumlah dan mutu pelayanan dasar. Tambahan kegiatan itu dapat merupakan peningkatan kegiatan yg sudah berjalan, atau memulai kegiatan baru. Diskusi ini juga dilaksanakan dengan cara brainstorming, dan hasil dibuat daftar tertulis
3. *Apa saja usaha dinas?*

Kemudian tindakan2 dinas untuk merangsang atau membantu kegiatan swasta diusulkan. Bisa tindakan diagnostik misalnya melaksanakan pertemuan, wawancara, kunjungan ke tempat prakteknya atau waktu kegiatannya di masyarakat, observasi, survei, dll. untuk diagnosa kuantitatif dan juga kualitatif (mis mutu pelayanan). Bisa juga tindakan intervensi, misalnya motivasi dgn insentif, melakukan latihan, memonitor kegiatannya, memberi umpan balik, dll. Hasil diskusi usulan ini juga dicatat pada daftar.
4. *Priority setting dan planning*

Kriteria untuk menentukan prioritas ditetapkan. Kemudian usaha2 dinas yang mungkin dinilai menurut kriteria tsb, dan diranking. Kemudian dibuat rencana terinci untuk yang dapat dilaksanakan pada tahun yang akan datang, dan rencana kasar untuk 2 tahun kemudian.(OUTPUT)
Buat presentasi kemudian kelompok membuat beberapa transparan atau flipchart dari seluruh proses tadi, langkah 1 s/d 4.
5. *Presentasi*

Wakil kelompok mempresentasi proses dan output kepada pleno secara singkat

8. PERENCANAAN FOLLOW-UP DAN RAKER #2 YAD, DAN EVALUASI RAKER #1 DGN SARAN/KOMENTAR

- Untuk tim kabupaten: membuat rencana/jadwal/penentuan tanggung jawab yang menyimpulkan kegiatan untuk usaha2 kelima topik: air mengalir, perubahan target, cakupan KIA, cakupan Immunisasi, pengikut-sertaan sektor swasta
- untuk tim propinsi: membuat rencana pemberian bantuan untuk menyelesaikan proposal2 SAF, monitoring dan pemberian bantuan untuk usaha2 kabupaten, dan persiapan untuk pelatihan2 dan bimbingan2 untuk kabupaten2 baru (gelombang HP-IV ke2).
- untuk semua kelompok:
 - menentukan keperluan2 lainnya untuk melaksanakan kegiatan2 ini (mis. tambah komputer, melaksanakan pelatihan lanjut ttg topik tertentu (termasuk EPI-INFO, computerisasi, dll), dan membuat proposal SAF
 - melaksanakan brainstorming ttg harapan/isi Raker ke2 bulan Februari
 - melaksanakan brainstorming ttg Raker #1 ini: apa yg dapat dikerjakan untuk membuat Rakernya lebih efektif dan berguna (untuk gelombang yg berikut)
 - mengisi formulir evaluasi secara individu
- Presentasi hasil kerja kelompok oleh masing2 propinsi secara singkat

**APPENDIX C
WORKSHOP AGENDA**

Jadwal Rapat Kerja (revisi)

Hari/tgl	Jam	Acara	Metode	Moderator	Pembicara
Senin 23 Sept	18.30-19.30	Makan malam			
	19.30-20.00	- Protokol - Laporan Ketua Panitia Penyelenggara - Sambutan Basics/USAID - Sambutan Karo Perenc.			Nasirah B
	20.00-20.15	Presentasi perencanaan penggunaan data	Presentasi		Rob N Karo Ren Mark Brooks
	20.15-20.30	Presentasi performance indicators & pemakaian dana SAF			Nasirah B
	20.30-20.45	Perkenalan mengenai perencanaan & manajemen berdasarkan data di Kab & peranan sektor swasta	Presentasi	Nasirah B	Rob N
	20.45-21.00	Perkenalan tim fasilitator		Nasirah B	
	21.00-21.30	Perkenalan tim2 kabupaten dan propinsi		Nasirah B	
	21.30-21.45	Agenda workshops	Presentasi		Rob N
	21.45-22.00	Tanya jawab			Rob N
	22.00-22.10	Pemberian tugas rekap data fisik			Erry
Selasa 24 Sept	08.00-08.05	Agenda hari ini			M. Faried
	08.05-08.15	Petunjuk kerja kelompok	Presentasi		M. Faried

34

Hari/tgl	Jam	Acara	Metode	Moderator	Pembicara
	08.15-10.00	<ul style="list-style-type: none"> - Menentukan keadaan standar - Meninjau keadaan sekarang dari data rekap - Menafsirkan faktor2 yg mempengaruhi - Menentukan tindakan alternatif - Menentukan cara dan kriteria menentukan prioritas 	Kerja kelompok	M. Faried	M. Faried/ Erry
	10.00-10.15	Rehat kopi			
	10.15-11.00	Hasil kerja kelompok	Pleno	M. Faried/ Erry	
	11.00-11.45	Indikator Cakupan - Penjelasan & presentasi mengenai indikator cakupan	Presentasi		Mark Brooks
	11.45-12.00	Penjelasan kerja kelompok			Mark Brooks
	12.00-13.00	Makan siang			
	13.00-14.30	Kerja kelompok	Kerja kelompok		
	14.30-15.00	Diskusi pleno	Pleno	Mark Brooks	
	15.00-15.15	Rehat kopi			
	15.15-16.00	Presentasi hubungan antara efisiensi kerja tenaga dgn cakupan ibu hamil & kehamilan	Presentasi		Annette
	16.00-16.10	Penugasan kerja kelompok			Rob N
	16.00-17.00	Kerja kelompok			

25

Hari/tgl	Jam	Acara	Metode	Moderator	Pembicara
	17.00-19.30	Istirahat & makan malam			
	19.30-21.00	Kerja kelompok (lanjutan)	Kerja kelompok		
Rabu 25 Sept	08.00-08.15	Agenda hari ini		M. Faried	
	08.15-09.15	Hasil Plan of Actions data KIA	Pleno	Mala	
	09.15-09.25	Penjelasan kerja kelompok data cakupan imunisasi			Mala/Rob
	09.25-10.15	Kerja kelompok			
	10.15-10.30	Rehat kopi			
	10.30-12.00	Kerja kelompok (lanjutan)	Kerja kelompok		
	12.00-13.00	Makan siang			
	13.00-14.00	Presentasi Hasil Plan of Actions imunisasi (2 kelompok)	Presentasi/ diskusi	Mala	
	14.00-14.20	Sistem Monitoring Pemanfaatan Fasilitas Kesehatan/Utilisation Monitoring System (UMS) - Pengenalan/penjelasan - Presentasi pengalaman di NTB/ Kaltim	Presentasi	Erry	Mark Brooks
	14.20-14.40	Presentasi pengalaman NTB		Erry	Mala
	14.40-15.00	Presentasi pengalaman Kaltim		Erry	M. Faried

Hari/tgl	Jam	Acara	Metode	Moderator	Pembicara
	15.00-15.15	Rehat kopi			
	15.15-16.00	Model-model analisa yang dapat dilakukan	Presentasi/ diskusi		Rob N
	16.00-16.15	Penjelasan kerja kelompok	Kerja kelompok		M. Faried
	16.15-17.00	Kerja kelompok	kerja kelompok	M. Faried/ Erry	
	17.00-19.00	Istirahat & makan malam			
	19.00-20.00	Kerja kelompok (lanjutan)	Kerja kelompok	M. Faried/ Erry	
	20.00-21.00	Penyajian kelompok		M. Faried Erry	
	21.00-21.45	Kesepakatan UMS	Diskusi pleno	M. Faried/ Erry	
Kamis 26 Sept	08.00-09.00	Penyusunan rencana tindak lanjut UMS	Kerja kelompok	Mala	
	09.00-10.00	Penyajian rencana tindak lanjut UMS	Kerja kelompok	Mal	
	10.00-10.15	Rehat kopi			
	10.15-11.15	Sektor swasta	Presentasi/ diskusi		Rob N
	11.15-12.00	Kerja kelompok	Kerja kelompok	Rob N	
	12.00-13.00	Makan siang			

27

Hari/tgl	Jam	Acara	Metode	Moderator	Pembicara
	13.00-13.45	Kerja kelompok (lanjutan)	Kerja kelompok	Rob N	
	13.45-15.00	Presentasi kerja kelompok		Rob N	
	15.00-15.15	Rehat kopi			
	15.15-17.30	<ul style="list-style-type: none"> - Follow up actions - Agenda untuk Rapat Kerja yad. - Saran/komentar - DII. 	Kerja kelompok/ diskusi	Nasirah B Mark Brooks	

APPENDIX D
MEMORANDUM TO THE HP-IV TEAM
WORKSHOP REVIEW AND RECOMMENDATIONS

BASICS

BASIC SUPPORT FOR INSTITUTIONALIZING CHILD SURVIVAL

1600 Wilson Boulevard Suite 300, Arlington, Virginia 22209 U.S.A. Tel: (1) 703 312-6800 Fax: (1) 703 312-6900
Robert S. Northrup, M.D., Technical Officer Email: RNORTHRU@BASICS.ORG

MEMORANDUM

Date: September 30, 1996
To: Health Project IV Management Team, Departmen Kesehatan, Jakarta
From: Robert Northrup, M.D.
Subject: Review and Recommendations: District Workshop #1

The document which follows offers observations and comments on the first workshop on Data Based District Level Management and Planning, held September 23-26, 1996 in Cilandak, and recommendations for improving its effectiveness in future implementations of the workshop for Year 2 and Year 3 districts. These observations, comments, and recommendations come from three sources, the writer himself based on personal observations and conclusions, the written evaluations of participants submitted at the end of the workshop, and conversations with participants and other facilitators during and after the workshop, including the discussions held in the HP-IV office on September 27.

1. The workshop was successful overall.

There is substantial evidence, objective as well as subjective, that the workshop was a success, both functionally and psychologically. The evidence includes the following:

- Many of the general objectives of the workshop which the planners had in mind were achieved. These included
 - giving the participants the methods needed to analyze data related to a number of the HP-IV Performance Indicators in new ways and skill in using those methods from actual practice,
 - giving them clear encouragement to plan for and initiate themselves activities in response to deficiencies exposed by such analyses of district and puskesmas data, that is, encouragement to move aggressively from Performance Indicator assessment and analysis to use of the analyses for management and planning
 - opening the door to the use of SAF funds to support such activities
 - providing guided practice in using this approach with two of the most critical and important aspects of basic health services, maternal health and facility utilization

The plenary reports of working group activities were generally on target and illustrated that the participants had acquired the desired understanding and skills.

- The participants worked diligently to complete the tasks given to the working groups, both late into the night and through the last topic on the last day, the private sector. Even the dokabus continued to participate fully to the end.
- The participants retained a spirit of good humor and mutual support. Participation in both plenary and working group discussions was both general -- no-one seemed to be left out -- and active, with plenty of fresh suggestions and ideas. Hierarchy (e.g. the presence of dokabus) did not seem to play an important role in stifling participation by the less senior participants.
- The general comments on the workshop overall given by the participants in the Evaluasi Lokakarya, even the specific comments on the various modules of the workshop, were overwhelmingly positive, with criticisms and recommendations largely aimed at smaller details rather than at the general approach or overall workshop methodology and choice of topics.

With this evidence in hand, it seems appropriate to conclude that any changes suggested should be

considered as inputs aimed at improving an already effective approach, rather than redoing an approach which had not worked well from the beginning.

2. Preparation for the workshop needs improvement

Participants expressed frustration with not bringing the most useful data, in part because of lack of understanding of what the goals of the workshop were. The time to pull together data in a useful fashion was minimal and inadequate for some. One participant requested the Working Group Guide to be distributed to participants in advance. At the level of the facilitator and presenter team, the delay in appointing persons to be in charge of certain modules, to lead the workshop overall, and to do particular presentations, the lack of clear information about who would be able to participate on which days, and the delay in finalization of the details of the plenary and working group sessions until the day of the workshop, all led to confusion and lack of a shared understanding of what should be happening.

Recommendations:

- *Finalize Training Guide, Agenda, and Petunjuk Kerja Kelompok at least 6 weeks in advance if possible.*
- *Assign responsibilities for each module and presentation well in advance*
- *Obtain firm commitment from a facilitator team of adequate size in advance*
- *Invite participants at least 6 weeks in advance.*
- *Inform participants of both what data they should bring, and what it will be used for*

3. The educational objectives, products from workshop activities, and determination of how the methods learned in the workshop should be applied at home (behavioral objectives) were unclear.

While the stated goal of the workshop was stated to be an increase in district planning and management activities based on data, many came away with an understanding that the workshop had been about learning to report on Performance Indicators. Clear expression in well-stated objectives, both for the workshop as a whole and for individual modules, of both the educational and behavioral objectives of the workshop would have helped in planning the presentations and working group activities to better achieve those objectives. Participants expressed confusion about how they were to apply some of the modules when they returned home. When, for example, should they carry out the analyses regarding performance relative to workload - every month? quarterly? annually? How should they deal with the organizational pressures to use targets given from the province or national levels? Should they seek to argue formally against targets assigned to individual kabupatens by provincial statistics units using similar but possibly different methods than recommended by the HP-IV workshop?

Regarding workshop products, the wide variation among the results of the working groups, ranging from well-organized meaningful tables and charts to scattered, disorganized, and incomplete presentations, illustrates that the guidance given in the Petunjuk Kerja Kelompok was inadequate. The format of the workshop limits the opportunity for detailed commentary and efforts to improve such products. There is limited time for both working group activities and for the presentation of their results, there are unclear roles for the facilitators in supporting the work groups based in part on tension between the desire to steer and direct their working with the desire to allow and encourage independent thinking on their part, and the large and unwieldy plenary working group presentations make directive and educational inputs by facilitators in response to poor products from some working groups difficult (Dr Maman's inputs when he was chairing the plenary sessions were an example of such constructive inputs relative to the WG presentations, and an exception to the usual chair's behavior and comments).

Recommendations:

- *Provide formats and detailed outlines of working group products*
- *Allow time for WGs to present their results in smaller sessions, 1-4 WGs at a time, with an emphasis on providing opportunity for facilitator input into correcting or upgrading products*
- *Prepare a carefully considered list of workshop objectives, in particular focusing on the specific*

activities which will be needed if the participants are to implement the new methods at home (the behavioral objectives) , in which they proceed beyond the analysis of data to managerial or planning actions on a regular or periodic basis.

4. The facilitators' roles and expected interactions with their assigned working groups were undefined, and they did not make the contributions to improving the quality of WG products which they might have.

While the Training Guide had a category for facilitator activities, the last-minute preparation of the activities did not allow this area to be considered and characterized in the planning. Moreover there was no formal facilitator "training", nor even opportunity to discuss potential problems which the WGs might face and how to deal with them, specific technical points needing extra stress to the WGs by the facilitators, or specific types of encouragement or guidance which the facilitators could usefully make. As a result, the role of the facilitators was generally that of observer, rather than facilitator or teacher.

A related point is the lack of participation by Pusdiklat in this workshop. It is possible that some of the handicaps of the workshop could have been avoided had persons in addition to Dr Faried been available both in advance and during the workshop to bring a stronger training perspective and set of skills to the leadership team. Such a person would be a real help in planning for appropriate and active facilitator activities in the working groups, and could help to organize the facilitator training prior to the workshop.

Recommendations:

- Based on this experience, the instructions to the facilitators characterizing their roles and indicating likely problems and useful inputs in response to them should be completed prior to the next running of this workshop, and for future workshops in the sequence.*
- A one-day session prior to the workshop to "train" the facilitators and allow them to experience themselves the processes being asked of the participants should be arranged*
- Use of flip-charts rather than notes on ordinary paper during WG discussions should be specified, as flip-charts would make the deliberations of the WG more readily visible to a facilitator.*
- Make early efforts to enlist a dynamic trainer from Pusdiklat for the workshop leadership team.*

5. Some participants of functional importance were not invited to the workshop

Including more puskesmas staff would have allowed much more reliable discussions of actual processes taking place at that level. Participants requested inclusion of other kabupaten section heads, notably KIA and P2M heads, also PKM. Only one HP-IV secretariat staff member attended (Dr Yahya from Jatim), and no provincial Bapelkes staff attended, making both followup and support by provincial staff of the new procedures to be carried out at district and puskesmas levels and the planning and carrying out of this Performance Indicator workshop at provincial level difficult or impossible.

If it were possible to engage the facilitator and presentation team for 2 weeks instead of 1 week, allowing the workshop to be presented in 2 sessions rather than one, it would be possible to include both increased kabupaten staff and the provincial staff needed to facilitate local repetition of the workshop as well as post-workshop support of planned activities.

Recommendations:

- Consider running the workshop in two sessions, with 4-5 persons from each kabuten and with a HP-IV Secretariat and a Bapelkes representative from each province.*

6. The workshop schedule was very demanding and fatiguing, going from early morning to late at night

The use of evening hours for WG work time appeared to work well, with good participation by most of the members until late into the night. Surprisingly there was a notable lack of complaining in the evaluation sheets about this late night work - only one or two persons mentioned it. The tightness of the schedule,

42

however, caused in part by the reduction from four days to three days (1/4 + 1 + 1 + 3/4 days), did make it difficult to allow enough time for the working groups to complete actual plans, even when an important topic -- immunization coverage -- was eliminated. The result was superficial work and possibly superficial learning, which may not well support putting the new methods into action upon returning home. The limits on time were made worse by the large number of groups wanting to present their results in plenary sessions, leading to extending those sessions in time, and by the prolonged discussion of the UMS forms, which eliminated WG activity for that evening.

Recommendations:

- *Every effort should be made to obtain additional time for the workshop, either by extending the number of days, or by reducing the number of groups participating and needing to present.*

7. The handouts provided to the participants had limited use.

Participants complained that many of the handouts were in English, particularly the critical Performance Indicators list. Almost no handouts were prepared as support of the presentations -- the participants were expected to get the point from the verbal presentations. The verbal presentations were not recorded, nor were even outlines provided to allow for detailed critique of them in advance, to ensure that they were consistent with what was being targeted. At the same time, the participants used many of the presentations directly in their work, as if the presentation had defined the sequence of activities to be used: a good example is the Model-model analisa presentation, from which participants directly used the sequence of analysis and the approach of presentation in their own subsequent analyses of UMS data.

Recommendations:

- *Translate all handouts into Indonesian language.*
- *Provide a handout for each scientific presentation giving the key points and some useful examples.*
- *Ensure that both presentations and handouts are reviewed in advance if possible, to ensure consistency with the objectives and processes of the workshop as planned.*

8. The facilities at the Bapelkes did not maximally support the group processes needed by the workshop.

The very large room was comfortable and well air-conditioned, but the location of the screen in the front right corner rather than in the middle, and the size of the group, made it difficult to get speakers and participants close to each other for the intensive types of plenary discussions which were planned. The rooms used by the working groups in two cases had no air conditioning. Flip charts did not seem to be available in adequate numbers to have one per working group.

Recommendations:

- *Efforts to identify a facility with a seating arrangement which would allow participants and speakers to be close for easy plenary discussion, would have air conditioned WG rooms, and would provide adequate numbers of flip charts -- one for each working group -- should be made soon, to ensure having a more effective functional space available.*

9. The lack of case studies as examples made it difficult for participants to translate presentations of principles into operational steps.

A repeated concern expressed by participants in their evaluations of the workshop was their inability to determine just what was required of them. Concrete examples with tables, sequential products, etc could help substantially in overcoming that problem.

Recommendations:

- *Workshop leaders and presenters should prepare concrete case studies which illustrate in detail what participants should be doing after they return home, and if possible during the workshop as well.*

10. Many participants were frustrated by the lack of availability of computers.

Most of the teams had more than one participant who used computers frequently or daily in manipulating data. Having to enter data manually into tables during the workshop, and having to draw by hand graphs and charts which could be much more efficiently prepared by computer and would be more accurate as well, takes time which could be better spent in discussions on the topics characterized by the data. Although making the workshop computer based would require time to set up the computers, eliminate viruses, load programs, etc, the time saved, as well as the opportunity to practice the actual methods which would be used at home with computers, justifies the use of resources for that purpose.

Recommendations:

- *Provide a computer in some fashion for each working group, either through asking participants to bring one or arranging for rental.*
- *Ensure that participants have their data available in computer files when they come to the workshop.*
- *Choose between Lotus and EPI INFO as the basic software for the project, and provide some training as needed to ensure competency in using the program of final choice.*

11. Participants did not propose “diagnostic activities” – efforts to gather further data prospectively to identify and clarify more objectively the causes of a problem exposed by analysis of routinely reported data.

Despite recurrent urging to plan for additional data collection of various sorts using surveys, interviews, focus groups, or other methods prior to planning problem solving activities, participants did not put such activities into their workplans. Such data gathering activities are at the heart of decentralization of planning and management to district level. As such, the workshop must be much more successful at convincing the participants that diagnostic activities should be a constant part of the problem solving process.

Recognizing that developing the details of such data-gathering activities, for example preparing a survey instrument or interview outline, may be beyond the skills of many workshop attendees, it would be useful for the HP-IV team to develop some models of such methods or instruments. These could be used by participants prior to workshop activities, to give them a concrete idea of the nature and use of diagnostic activities.

Recommendations:

- *Plan activities for the workshop which will give participants a clear idea of the range and use of diagnostic activities (additional data collection) in problem solving, and will provide them some experience (through exercises) in the thinking process regarding the choice of diagnostic activity -- which type of diagnostic activity focused on which critical questions would be useful -- in problem solving for some of the most common problems.*
- *Sponsor the preparation of diagnostic approaches including instrument preparation for 2 to 5 of the most common problems, for example, low utilization (visit rates) of puskesmas or pustu facilities, low coverage of pregnant women with antenatal care, lack of information regarding the quality of care being provided by the private sector, etc. Include applications to the most important puskesmas or kabupaten problems of the rapid data collection approaches currently being developed in a range of topic areas.*

12. The plans developed by kabupaten working groups as part of their discussions of KIA, utilization, and the private sector were vague, lacking in detail, and largely useless as either workplans or proposals for SAF funds. Moreover no specific plans were made for the processes needed at kabupaten level to implement the lessons learned at the workshop after returning home, nor for the activities to be carried out by provincial HP-IV or other staff to support such implementation plans.

Despite the comments on what a satisfactory plan ought to consist of which were included in the Petunjuk Kerja Kelompok, and the expectations on the part of Pak Faried and myself that the participants ought to know how to prepare a satisfactory project proposal already, the plans presented by the working groups were almost all inadequate. In their evaluation sheets a few of the participants commented on this, noting that they felt the time made available had not been adequate to do serious project plan or workplan preparation. This implies that, given adequate time, participants would be able to prepare satisfactory plans. I suspect that this is not generally true, and that many of the participants do not know how to prepare a satisfactory plan. If this is in fact the case, the provision of adequate time alone, without providing materials or exercises characterizing an appropriate planning process and product, would not improve the quality of the plans produced. More extensive efforts are likely to be needed, including the preparation of a guide to planning which characterizes the steps and the format and content of an adequate plan, and the provision of one or more exercises on plan preparation as part of the workshop activities.

Recommendations:

- *Develop a guide for kabupaten planning in the context of HP-IV and SAF and PDE proposal preparation, which includes a description of the planning process, a description in detail of the format and contents of a satisfactory plan, the criteria to be used to judge and rank such plans in considering them for funding (for use in self-assessment of draft plans), and several examples or case studies illustrating both an appropriate planning process and an actual satisfactory plan.*
- *Add to the workshop agenda, preferably early in the course of the workshop, a module on how to prepare a satisfactory plan.*
- *Revise the time allocations in the current workshop agenda to ensure that participants have adequate time in their small group working sessions to prepare at least one actual plan for a problem-solving response to a common problem.*
- *Revise the timing of the final sessions of the workshop so that three different activities can occur: 1) kabupaten level participants will have adequate time to prepare detailed draft workplans for implementation of the workshop procedures after returning home and provincial participants will have time to prepare draft plans for their support of those implementation activities, 2) facilitators (and possibly other participants) will have time to review these draft plans critically using the criteria in the planning guide and to provide critical feedback and direction to the planners regarding needed revisions of the plans, and 3) participants will have time to revise the plans and submit them to the workshop committee in final form prior to departing for actual consideration for support. This will probably require having this workplan preparation on the afternoon of the day before the final day, critical review of the plans and constructive and directive feedback by facilitators (and other participants?) at the end of the afternoon, and preparation of final plans that evening, for presentation and submission the following day. By combining these presentations with an activity that does not require preparation of an implementation plan (eg a technical presentation on the new approach to integrated Management of Childhood Illness, or a presentation on the basic aspects of survey planning or statistical analysis), the agenda can thus ensure both that adequate attention is given to the implementation planning and that the final day, when participants are paying more attention to their impending departure than to the workshop's activities, is not wasted in hasty but useless planning efforts.*

13. No concrete followup activities to be carried out by the HP-IV pusat team were planned prior to the workshop

Given the lack of followup planning by both the kabupaten and the provincial teams, followup activities by the pusat HP-IV team will be even more important to the implementation of the lessons and procedures of the workshop at kabupaten and puskesmas level. The following is a list of possible followup activities, some of which have already been discussed and agreed upon by the pusat team. Some of these are followup to this workshop's activities and plans, others are preparation for the "followup" workshop #2 now planned tentatively for May 1997 for the same participants from the 11 Year 1 HP-IV districts.

Recommendations:

- *Prepare program in EPI INFO for data entry and standard report and graphics production using the data related to Performance Indicators, the special forms distributed in preparation for this workshop and during this workshop, and other related routinely collected data (Ibu Roberta)*
- *Translate the Performance Indicators list, the descriptions of SAF and PDE procedures, and other necessary handouts and distribute to all peserta as well as provincial HP-IV offices.*
- *Prepare an official letter summarizing the expectations of HP-IV for each kabupaten as followup to the workshop, including procedures to be initiated, plans to be prepared in more detail, data analyses to be done, and reports to be submitted either to provincial or pusat HP-IV offices, each with a target date for completion or initiation. Send this letter while the workshop is still fresh, ideally in the next 10 days. Send a copy of this letter and a separate letter indicating suggested followup activities to be carried out by the provincial HP-IV secretariat or a designated provincial staff member in support of the kabupatens doing what they need to do, particularly training of other staff in the new PI related data collection, management, and analysis procedures.*
- *Prepare an official letter to each KaKanwil in the 5 provinces describing the actions taken in the workshop with regard to target setting for coverage activities, and requesting that he/she direct the appropriate persons on his staff and in the Biro Statistik of the province to come together and prepare mutually agreeable coverage targets, either those prepared by the working groups, or another set using a similar type of approach to deal with population growth and movements.*
- *Have Annette Bongiovanni or another consultant prepare an instrument for doing "diagnostic" interviews on a puskesmas visit to examine the reasons for low coverage of K1 and K4 examinations. A draft of the instrument is to be completed by the end of January or earlier, a field test of the draft instrument in late February or March, revisions of the instrument shortly afterwards, and sending the final revised instrument with instructions for use and analysis of data to each kabupaten by April 1 with instructions to use it and be prepared to report on the resulting data, analysis and interpretation of the data, and plans for intervention at the followup workshop (#2) in May 1997.*
- *Inform kabupatens that they should be prepared to have all necessary data for performance indicator analysis and reporting for both 1995 and 1996 in computer files using software to be provided by pusat by the time of the followup workshop in May 1997.*
- *RSN to do a TOR for involving Litbangkes in the Sektor Swasta area as a counterpart to his own activities*
- *RSN to do a TOR for a counterpart team including persons from Perencanaan with whom to interact with regard to the kabupaten planning and management activities and related training efforts.*
- *RSN to visit in early 1997 or possibly in Dec 1996 to assist in finalizing activities and documents for the improved Workshop #1 for the second group of HP-IV kabupatens, to collaborate with Sidoarjo to prepare a PDE proposal for a private sector assessment study, to followup on field implementation of procedures discussed at Workshop #1 in a few additional kabupatens, and to explore and help to design a private sector inventory for use in 2-3 kabupatens in addition to Sidoarjo.*

13. Strengths and weaknesses of specific workshop sessions or modules

a) Pembukaan

The substantive talks given by Ibu Ira, Pak Mark, and myself following the ceremonial opening were brief, perhaps too brief to be meaningful. In retrospect, it may be desirable to make those talks more than just introductions. It would also be desirable to more effectively communicate to the peserta that the workshop is both about the performance indicators and about district management and planning, using those performance indicators and other data as tools to improve the effectiveness and efficiency of basic health services. Given the fact that many among the participants have not been intensively involved with HP-IV in the past, it may be desirable to review the components of the HP-IV project as a whole, re-emphasizing the focus on basic health services, the emphasis on quality improvement, and the role of the private sector.

Recommendations:

- Give a detailed review of the basic goals, objectives, and activities of the HP-IV project as a whole.
- Give a detailed review of the educational objectives of the workshop, session by session, at this time. Clarify the activities expected to be carried out by the participants after they return home.
- Present the Performance Indicators in detail, including the reporting requirements of the Bank, and the consequent reporting requirements of each district and puskesmas. Include a clear presentation of the Performance Indicators related to the Private Sector

b) Status fisik puskesmas dan status air mengalir

Review of the reports and presentations of the working groups indicates that only a few groups interpreted the meaning of "standards" properly -- a number confused standards with the means to provide water, eg PDAM, sumur, etc. The plans prepared by the WGs, as was the case in the other modules, were superficial and inadequate. It is likely that this was caused both by a lack of time, and a lack of knowledge about what a satisfactory plan should include, and how to organize and format a satisfactory plan. The process of priority setting was not followed. Some groups indicated that, since the money needed to complete the job for all puskesmas was not large, they could do all at once. Few recognized, however, that they had not dealt with the Puskes Pembantu in that single first round, in essence giving priority to the puskesmas without defining reasons for doing so. In short, while the data manipulation needed was minimal, the module required the participants to use a number of new concepts, for which the preparations and instructions did not prepare them adequately. By strengthening the teaching of each of these new concepts and procedures in this session, they could inform the similar activities in the modules which follow this one. This may be a situation in which the facilitators could do some clearly defined teaching at the level of the working groups (perhaps with 2-3 WGs combined), and could take a more active role in defining the style of group interaction and group dynamics (eg using flip charts, using a facilitator, following standard brainstorming rules) rather than the leaderless and informal discussion style used by the groups during this workshop. The workshop could by doing so help to improve skills in working in groups efficiently and in using group work tools, in this manner helping to reinforce the training in these same areas which will be a part of the QA activities of the project in the third phase of QA, the team building phase. This could be made a specific educational objective of this workshop.

Recommendations:

- Provide more detailed materials on priority setting and planning, and schedule specific activities to ensure that the concepts and skills in doing priority setting and planning are acquired by the participants. By providing more detailed descriptions, criteria, and one or more examples, characterize more clearly the differences between standards themselves VS methods for reaching standards.
- Divide the teaching between plenary sessions and sessions in the working groups run by the facilitators
- Set as an educational objective for the workshop the enhancement of skills in working productively in groups, and use this module to provide teaching and practice in those skills, specifically learning the rules and methods of brainstorming and priority setting.
- Make this module the place where the format and content of an adequate plan is learned, and allow adequate time for this module so that adequate plans are in fact prepared by each WG. To do this, have one intermediate presentation (perhaps in a session with 2-3 other WGs) of the results of reviewing data, setting standards, and identifying current deficiencies, followed by a work session(s) to do priority setting and preparation of a specific plan, followed by another presentation. .

c) Targets and target setting

While the groups successfully calculated new targets using the worksheet provided, both the participant comments on the evaluation sheets and my own observations during the small group work suggested that there was substantial confusion about this activity. In addition to confusion about the operational aspects of the activity being carried out by the WGs, there was also substantial concern expressed by many that, to

be able to use the newly calculated targets, they would have to negotiate with various groups at provincial level, and in at least the case of Jatim, similar recalculation of targets for individual kabupatens had already been done by provincial statistics units.

Recommendations:

- *Provide a detailed handout with examples of problems with the current targets and the approach to recalculating targets as well as description of what participants will have to do to be allowed to use these new targets. If necessary, workshop committee should negotiate in advance with the involved persons in each province to clarify the current methods in use in each province to establish kabupaten-specific targets and what would have to be done to use modified targets prepared by the participants.*
- *Review the Petunjuk for this module, and reconsider the usefulness of the preparation of graphs etc asked of the participants as a means to convince participants of the importance of this activity.*

d) Tenaga & KIA

This module was uniformly rated as helpful by the participants in their evaluations, and the worksheets were easy to use. No useful plans were produced, however, and the connection between the analyses and potential interventions to improve the situation were unclear, with only vague interventions being proposed. This was one of the areas where the lack of attention to the need for further data gathering (diagnostic studies) was particularly severe. While the presentation by Annette Bongiovanni emphasized the need for such explorations rather than preparing to act immediately as the most appropriate response to deficiencies made apparent by data analysis, it did not provide a model for an appropriate sequence of actions -- data review and analysis, useful models of analysis, types of deficiencies to be detected, further diagnostic steps which should be taken to determine causes and direct potential interventions to particular causative factors, and finally potential interventions.

Recommendations:

- *Review the Petunjuk Kerja Kelompok and consider reorganization and alternative approaches to this topic, including separating the steps in working with this data from each other in a more explicit fashion (eg intermediate presentations in sessions with 1 or 2 additional kabupaten teams).*
- *Consider a role play in which a participant uses a prepared interview guide (such as will be prepared by Annette) to explore possible causes of coverage deficiencies or low productivity of specific employees detected by data analysis in an interview at puskesmas or pustu level. Including such a role play would give needed emphasis to the importance of diagnostic activities as followup to data analysis prior to planning interventions*
- *Prepare a handout with examples of data analysis procedures and case examples of analyses followed by actions of various sorts. This could form the basis for a presentation which would more directly model the sequence of behaviors desired of the participants.*

e) Immunization & tenaga

While this module was eliminated due to lack of time, immunization is an area in which current data analysis procedures are already advanced due to the use of local area monitoring and analysis techniques, and where both diagnostic and intervention actions are well defined. Given that this is the case, it may be more useful in future workshops to let this topic precede KIA, but confine it to a presentation illustrating the desired sequence of steps from data identifying deficiencies in coverage to intervention planning and possible specific interventions, with examples of tools and instruments and procedures provided and actually looked at during the presentation.

Recommendations:

- *Use immunization as an example of effective working approaches to data-based management by performance. Use it to precede KIA or as part of an integrated presentation in which immunization related actions provide an example for similar KIA related actions.*

f) Utilization Monitoring System

The prolonged discussions aimed at achieving consensus on the introduction of a new form for data collection will probably not be needed in the future presentations of this workshop, as the system will already be in place in the districts attending this workshop. This should allow increased time to work with the data. While the presentation I made of Models of analysis did provide a sequence of steps in analysis and a number of examples of styles of presentation of data with graphs, the presentation was not organized specifically to document each and every step in the analysis sequence, and the conceptual thinking behind the analysis sequence was not effectively conveyed to the participants by the presentation alone. Despite these deficiencies, the sequence of analysis presented in the Models presentation was directly applied by some of the participants, according to information passed on to me by one of the facilitators. Hence it would be desirable to revise the presentation to include the majority of hoped for analyses (eg analysis of the proportion of patients in various age groups was not included), or to provide a handout which spells out concretely the basic steps to be carried out in analysis of this data and use the presentation to emphasize further more imaginative analyses which bring in data from other data sources. This would be aided by the availability of software with programmed analyses and report/graph preparation, as will be prepared by Ibu Roberta

The use of real data for this module made the participants feel the actual problems of trying to manage on the basis of somewhat unreliable data, and should be continued. Here too the emphasis should be on determining approaches to more in-depth assessment of potential causes of deficiencies in utilization identified through the data analyses, rather than on developing intervention plans

Recommendations:

- *Provide participants with a handout characterizing an appropriate sequence of basic analysis steps of utilization data, and with software incorporating those steps. Give working groups the data both in raw form (paper reports) as was done this time and as electronic files already entered into the computer, most likely in EPI INFO. Revise the presentation to both touch on the basic analysis steps, and to give examples of more complex analyses which bring in other data beyond that provided by the UMS.*
- *Modify the directions for small group work to emphasize the importance of additional data gathering to clarify the causes of observed deficiencies, for example, by asking participants to prepare an interview guide to explore a specific problem identified through the data analysis.*
- *Include in the small group work formal brainstorming as in QA activities to suggest possible causes of certain deficiencies (Ishikawa diagram)*

g) Private Sector

This module needs significant modification for the next performance of this workshop. Participants noted in their evaluations that the topic was important and should be given more time. At the same time, many commented that the presentation did not make it clear what they were expected to do in this area, and some noted that the conditions at kabupaten level did not seem to allow interventions such as some of those mentioned in the presentation or discussion (working with drug manufacturers, for example). While the Performance Indicators related to the Private Sector make clear a focus on the quality of health services provided by private practitioners and organizations, this was not emphasized in the presentation. Examples of potential activities were given in the presentation, but apparently not in sufficient detail to allow participants to appreciate their relevance to their own situations, and the handouts provided for the module were more conceptual than operational (eg the structure of the private sector with its 3 components). It will be important in planning the next performance of this workshop for Feb/Mar 1997 to reach a decision as to just what actions are to be expected of the participating kabupatens in this area, even if they will not be carried out immediately but planned for some months into the future. Among the decisions needed here is a clear decision as to whether HP-IV will seek to ensure the availability of the capacity to design and carry out simple data gathering (management level surveys) at kabupaten level. In my judgment, effective decentralized kabupaten management and planning in the future will depend on having this capacity at hand;

without it managers are doomed to dependence on intuition rather than objective data as the basis for decision making. Effective efforts in improving the quality of private sector services will particularly require having this capacity available.

Recommendations:

- *Revise the presentation to focus on improving the quality of basic health services by the private sector, decreasing the emphasis on the overall structure of the private sector.*
- *Provide a general handout which includes basic descriptive and practical information, a description of activities expected to be performed by most kabupatens, and useful case study examples.*
- *Provide adequate time for participants to prepare a concrete plan to carry out a single activities or no more than two activities in this area, emphasizing the diagnostic rather than the interventional side of potential efforts which could be implemented.*
- *Consider and reach a decision prior to the next performance of this workshop as to whether some sort of inventory and survey of private practitioners will be expected to be carried out by each kabupaten at some point during HP-IV. Let this decision influence the content of the module.*

14. Planning for workshop #2

Potential activities for workshop #2 include the following:

- practice in analysis of Performance Indicator related data for two years - 1995 baseline and 1996 - using a manual and software as a guide.
- preparation and critique of actual detailed plans based on those data and analyses
- planning for active private sector activities, including presentation of the experience in Purworejo and in 1-3 HP-IV districts with the Verbal Case Review methodology and related interventions to improve the quality of private health services
- review of experiences and data from using diagnostic instrument for exploring possible likely causes of KIA or UMS deficiencies; instrument to be prepared and field tested by Annette Bongiovanni in early 1997
- use of GIS as a planning and management tool

APPENDIX E
TRANSPARENCIES

**APPENDIX E1
TRANSPARENCIES FOR PRESENTATION OF THE
MODEL OF ANALYSIS**

MODEL-MODEL ANALISA

1. Angka-angka saja
2. Proporsi2 yg sederhana
3. Variasi menurut waktu (trend analysis)
4. Perbandingan antar fasilitas
5. Levels of aggregation
 - puskes/pustu
 - kabupaten
 - propinsi
6. Kenyataan VS harapan (sasaran, rencana)
7. Performance VS investment
 - kinerja -- sumber

PERENCANAAN ANALISA DATA

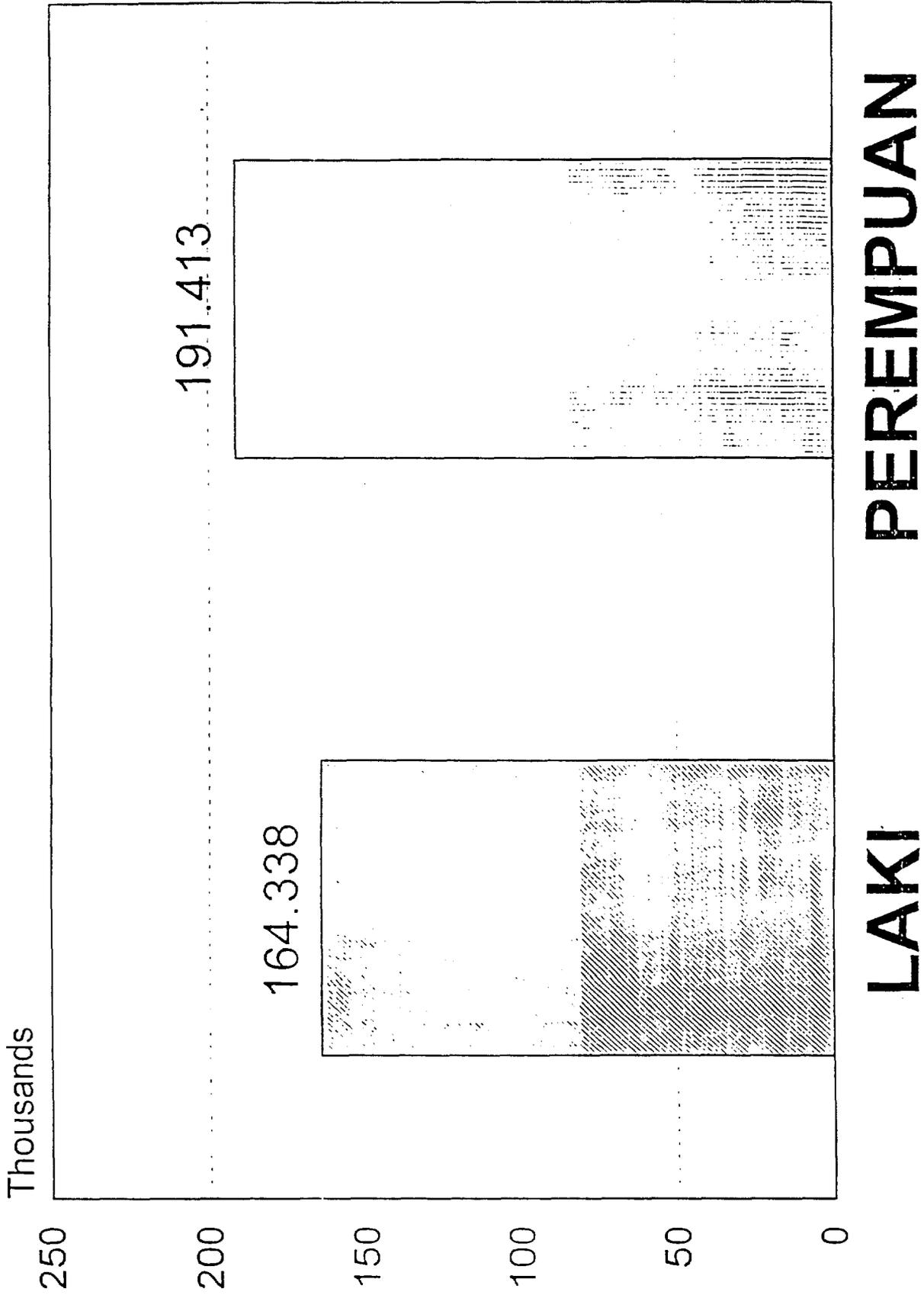
Tujuan:

Kabupaten menetapkan pola dan langkah-langkah analisa data yang akan menghasilkan angka-angka bulanan dan tahunan yang langsung dapat digunakan dalam manajemen dan perencanaan

PENENTUAN POLA ANALISA

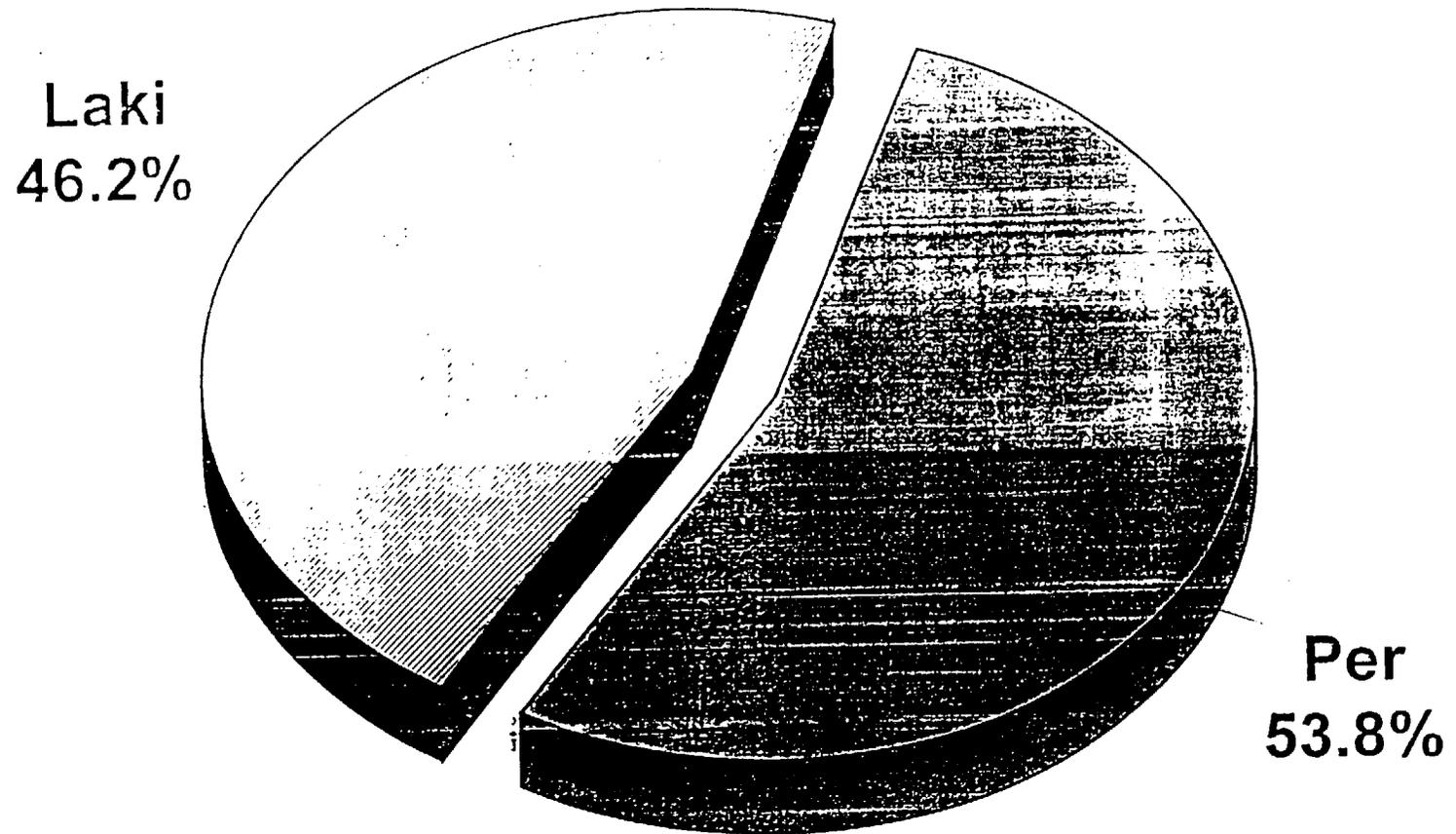
1. Management by objectives
 - kesehatan (hasil)
 - pelayanan (proses, operasionil)
2. Management by performance
3. Management by resource allocation
4. Management by finances
 - income VS costs
 - cost centers

Dr. Rob Northrup
25 Sep 1996



54

KUNJUNGAN 6 B



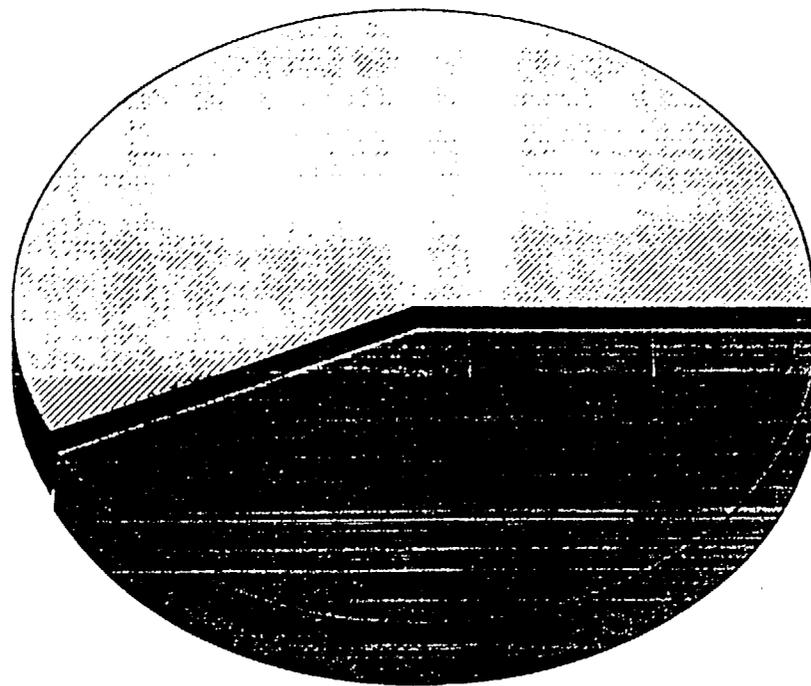
Laki
46.2%

Per
53.8%

5

KUNJUNGAN 6 B

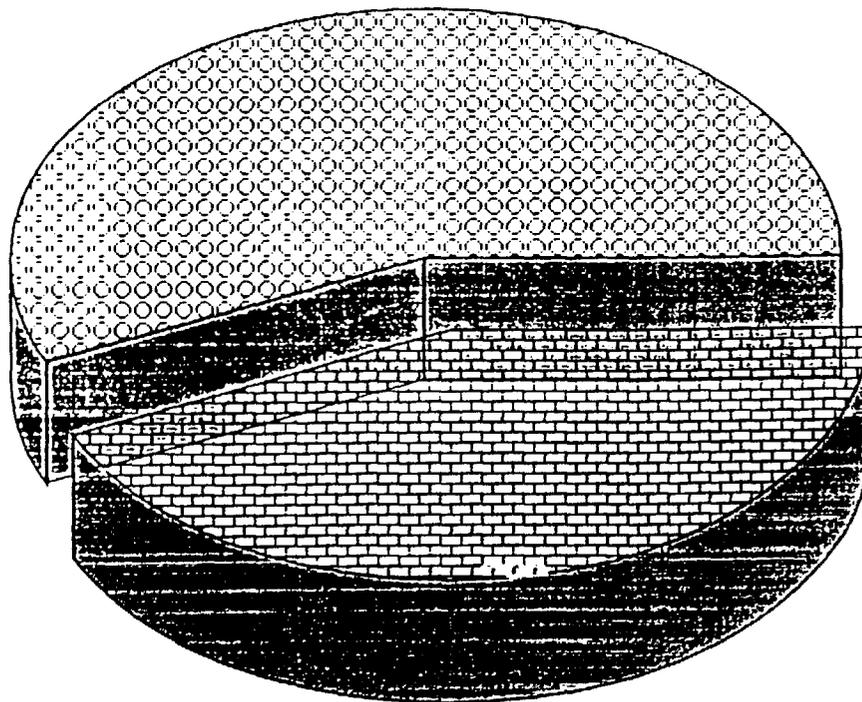
puskesmas
56.9%



pustu
43.1%

VISITS TO PUSKESMAS/PUSK PEMBANTU 1991

PUSKESMAS 56.7%
379325

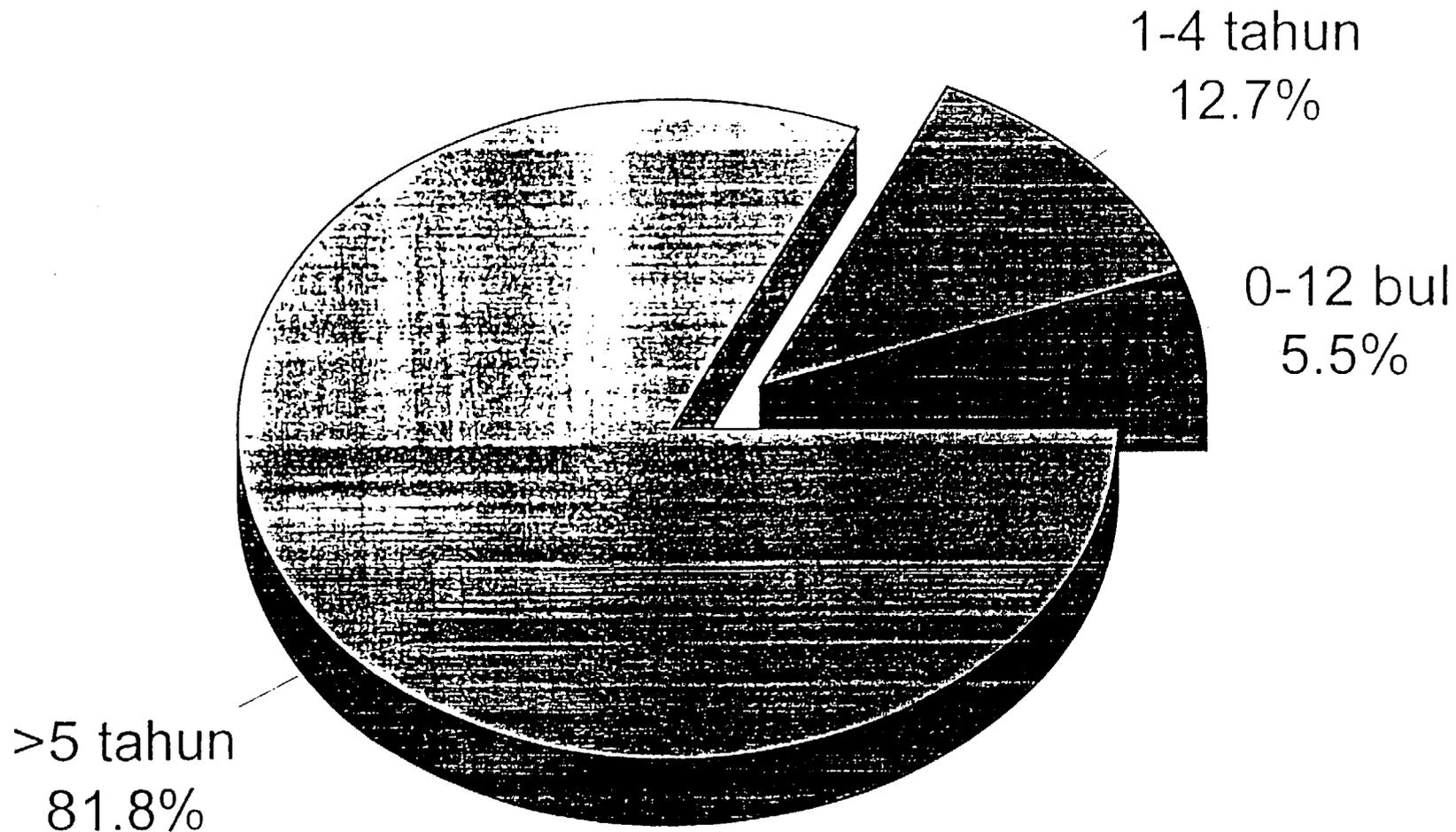


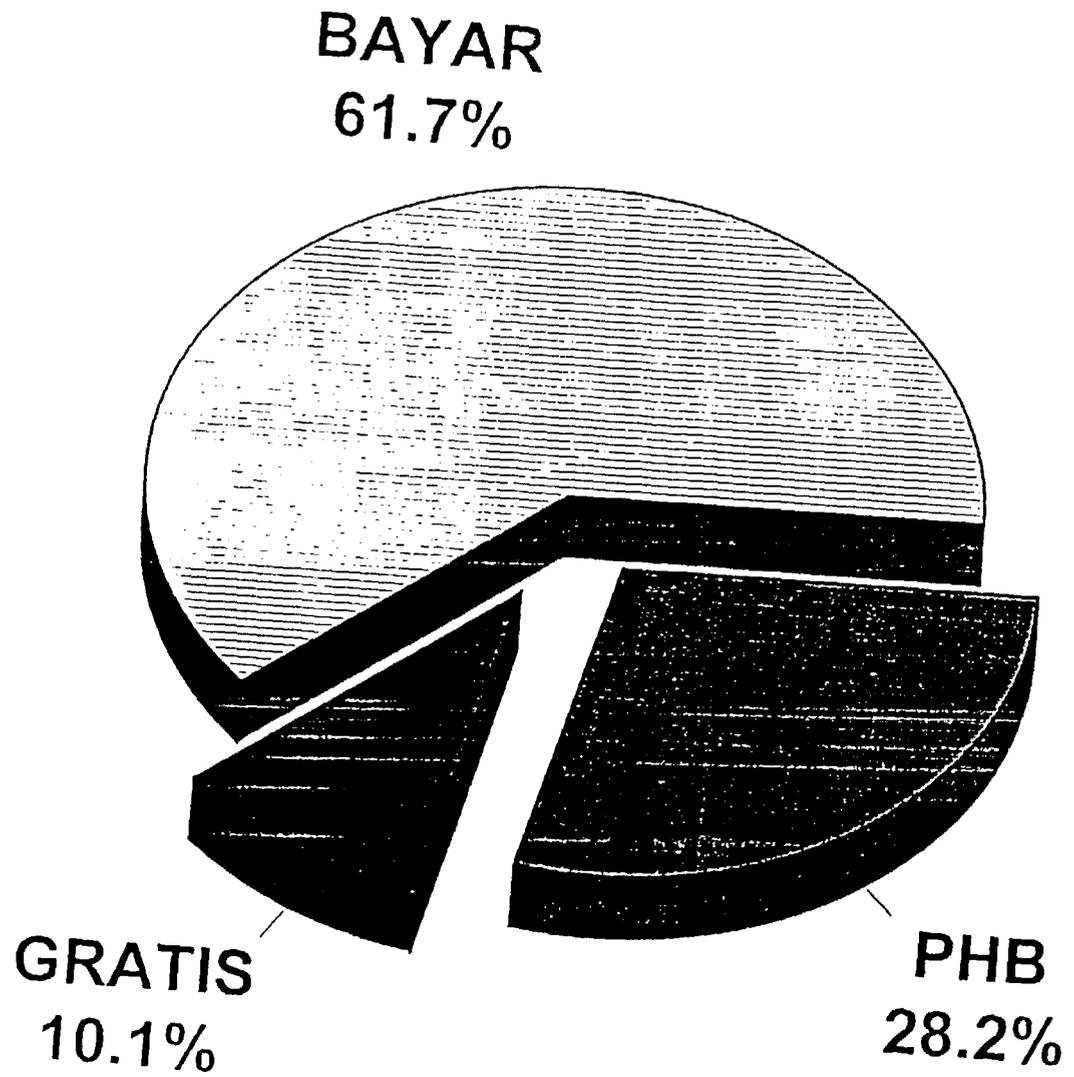
PUSK PEMBANTU 43.3%
289918

51

distribusi kelompok umur

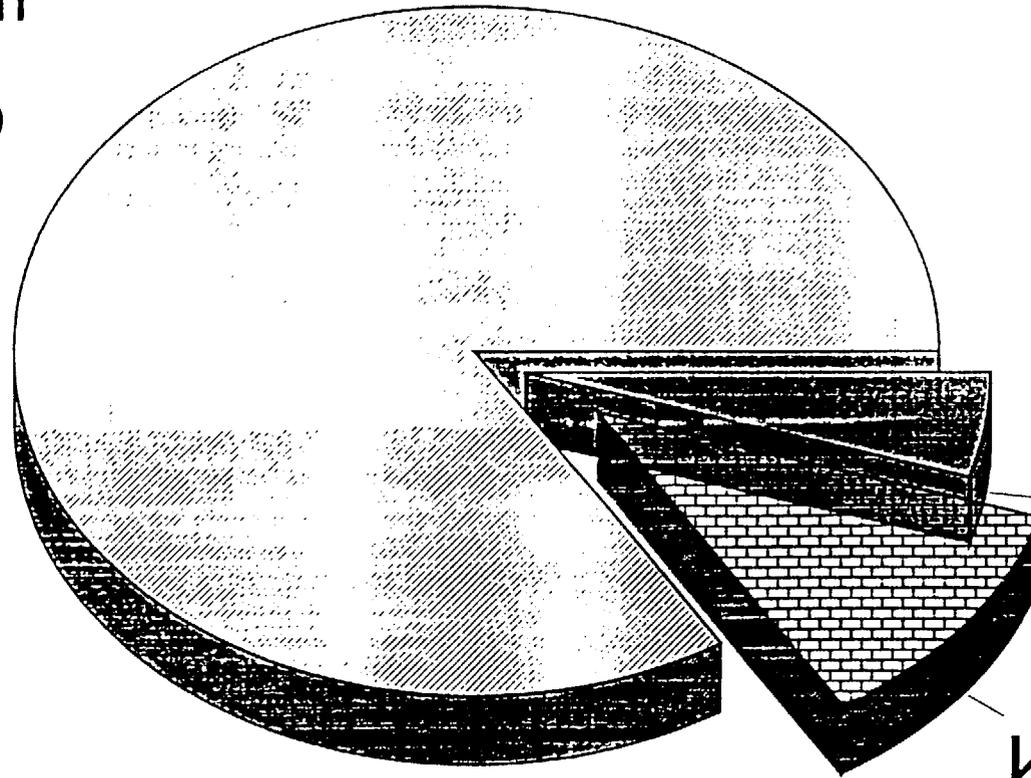
note: 0-1 bul = 0.4%





Distribusi Kunjungan

poliklini
83.8%

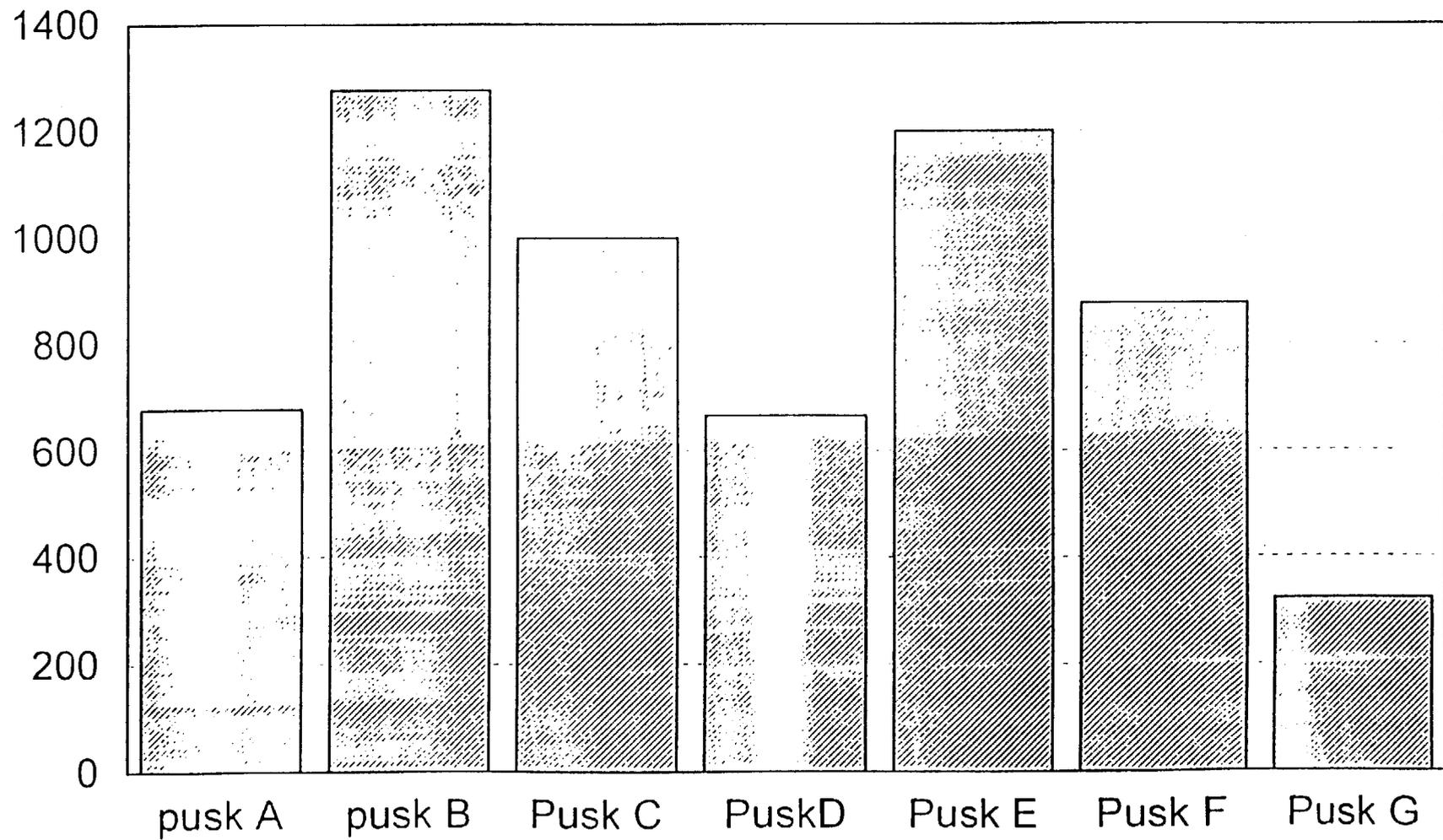


GIGI
4.8%

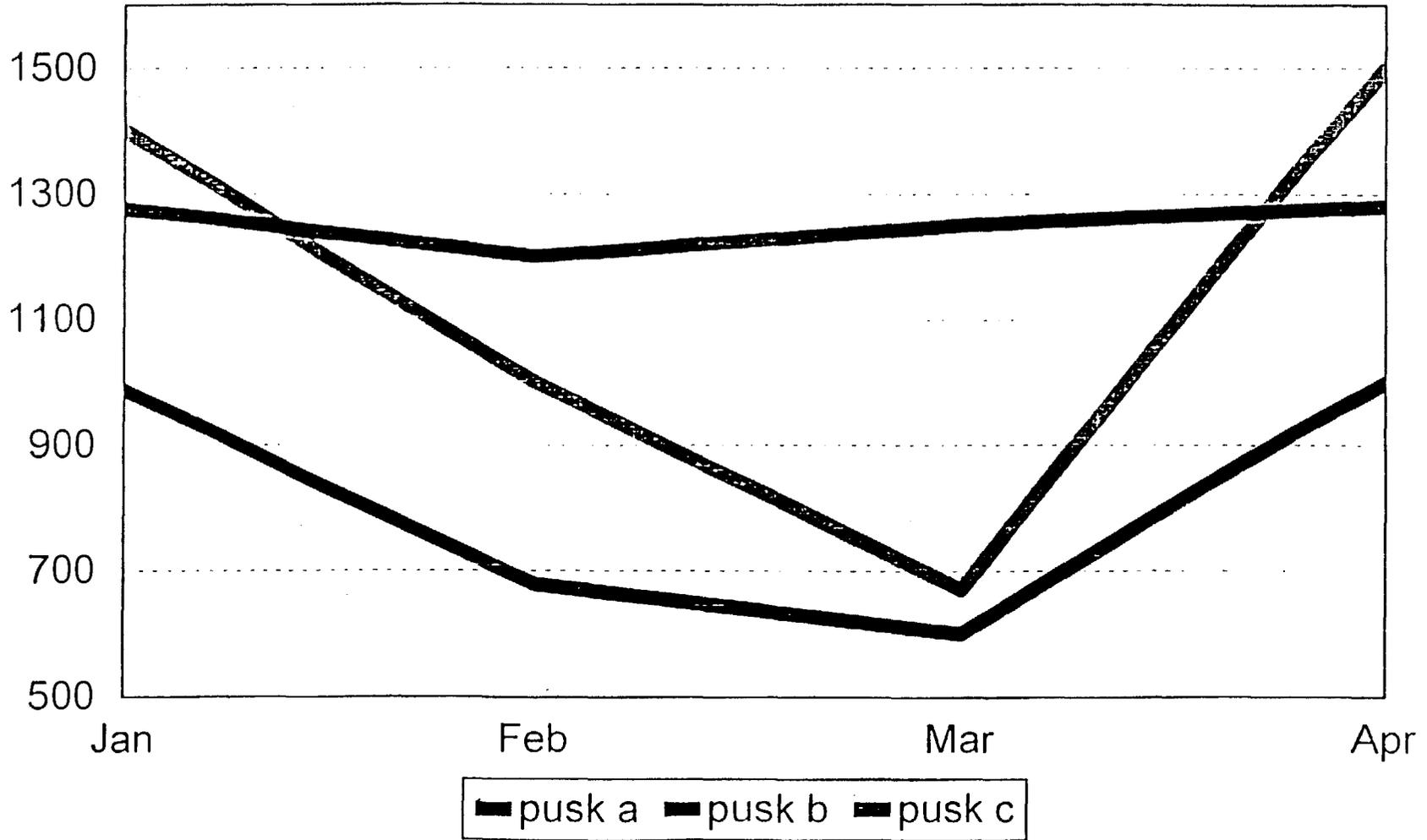
KIA/KB
11.3%

kunjungan per puskesmas

Bulan September

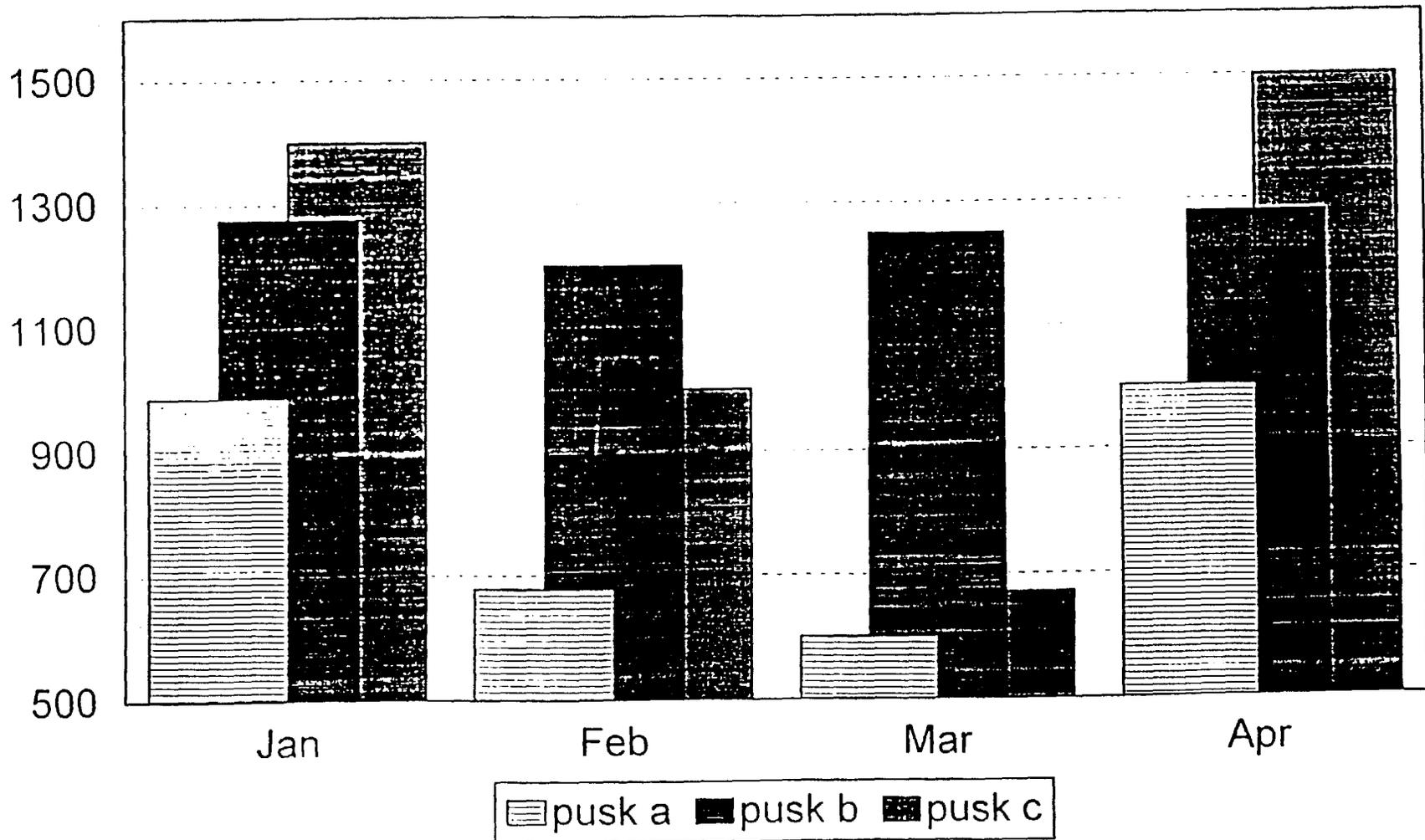


kunjungan



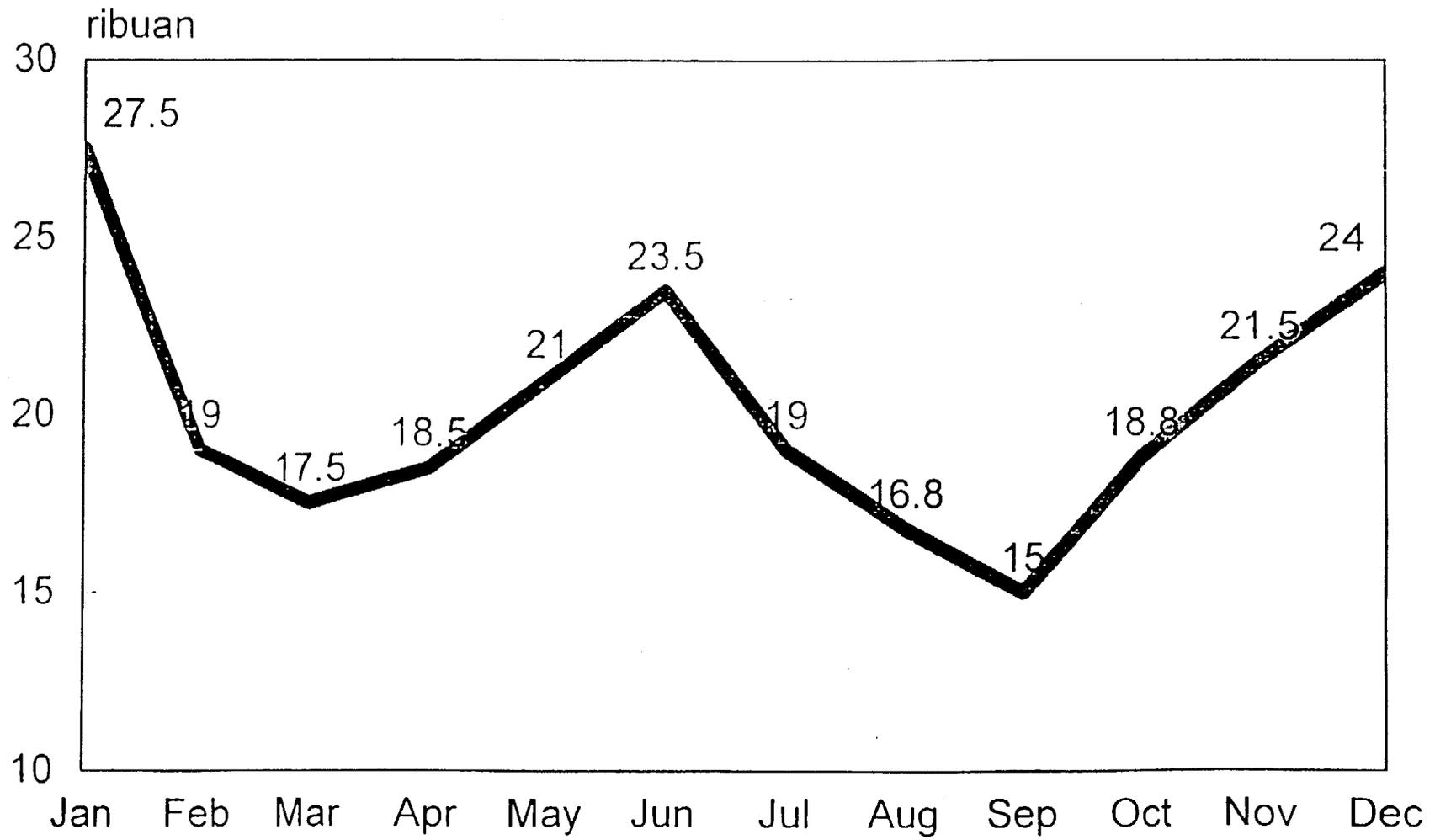
20

kunjungan



Jumlah Kunjungan

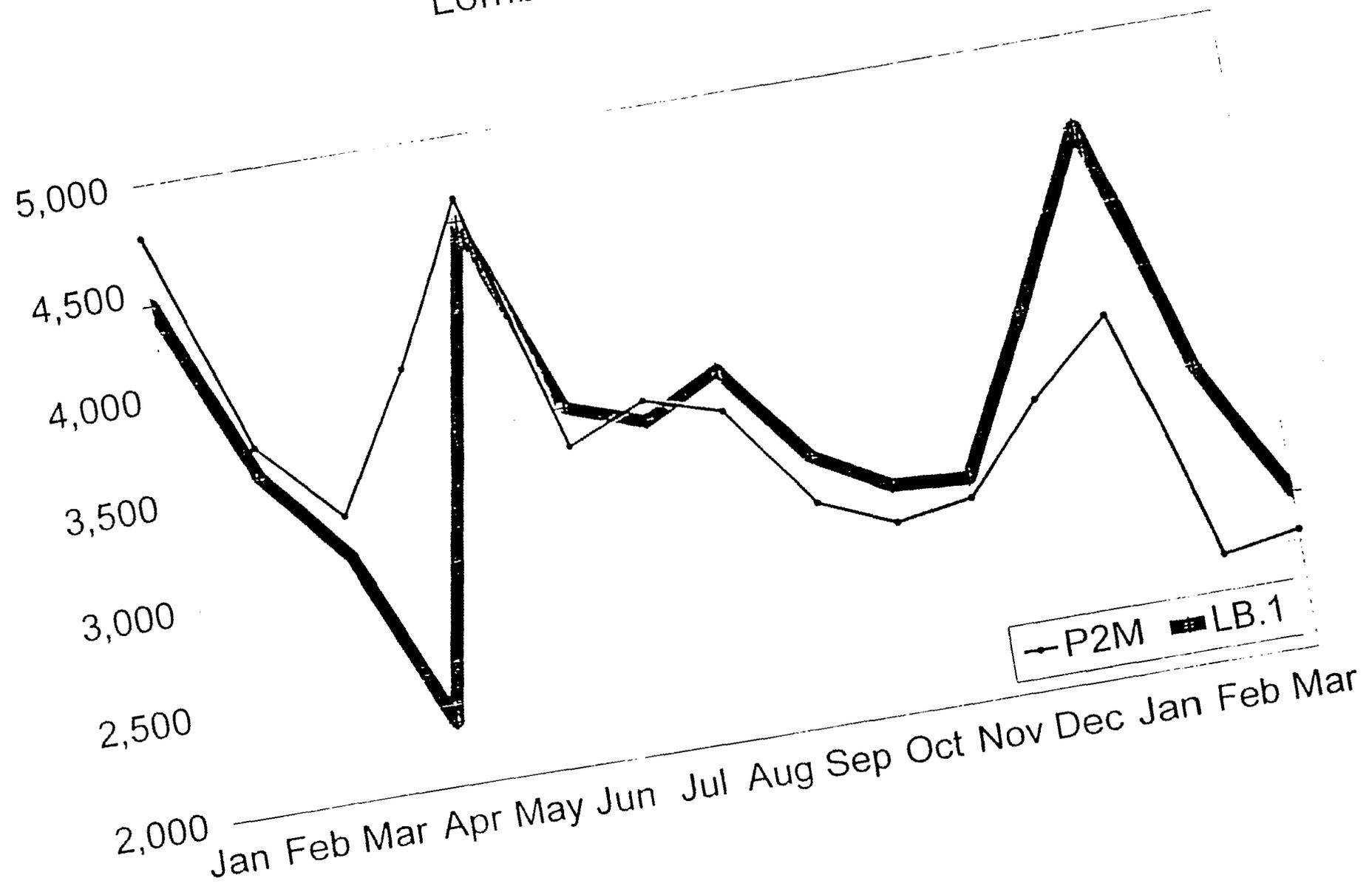
Kabupaten....



54

MALARIA KLINIS

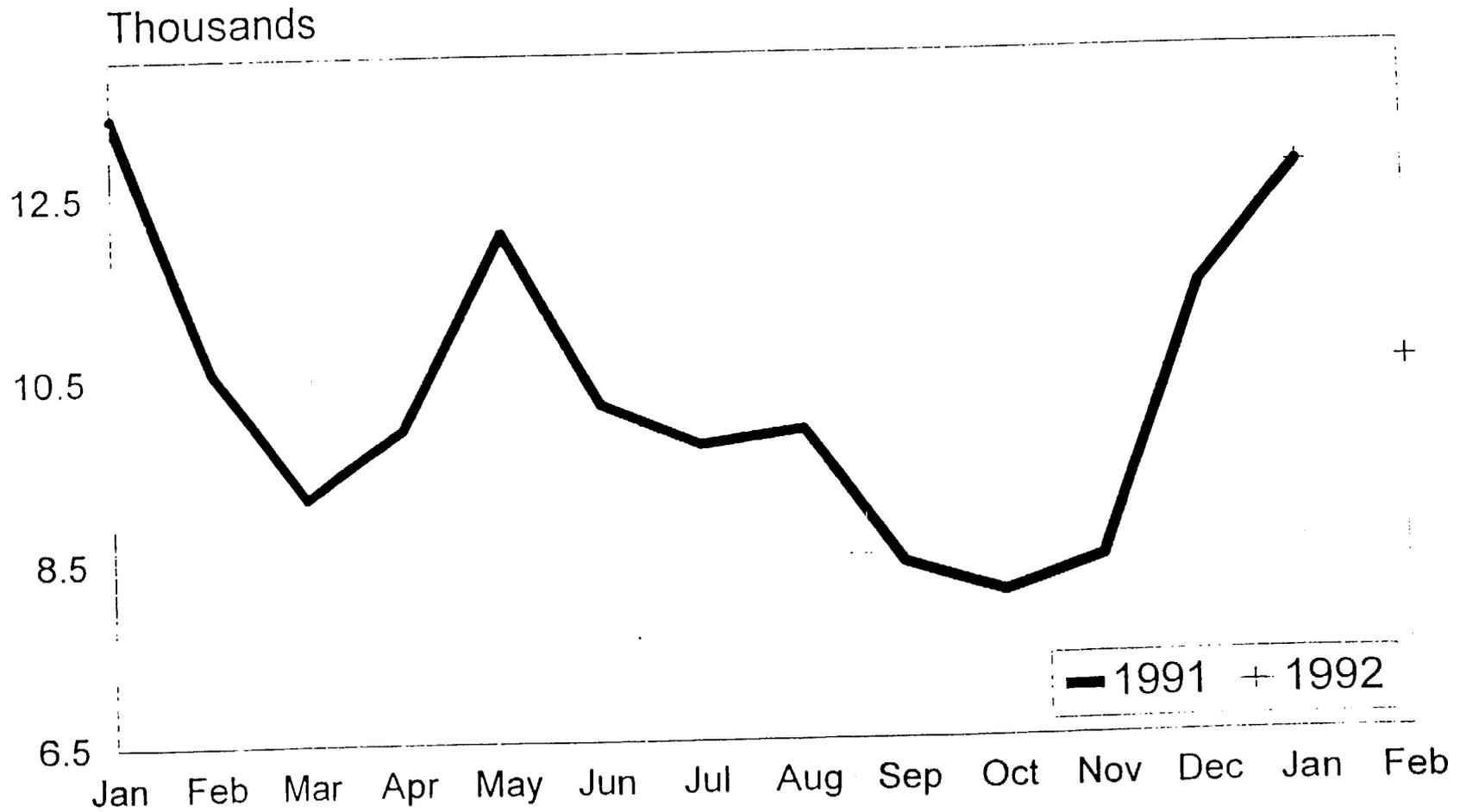
Lombok Barat 1991-92



5

MALARIA

NTB 1991-92

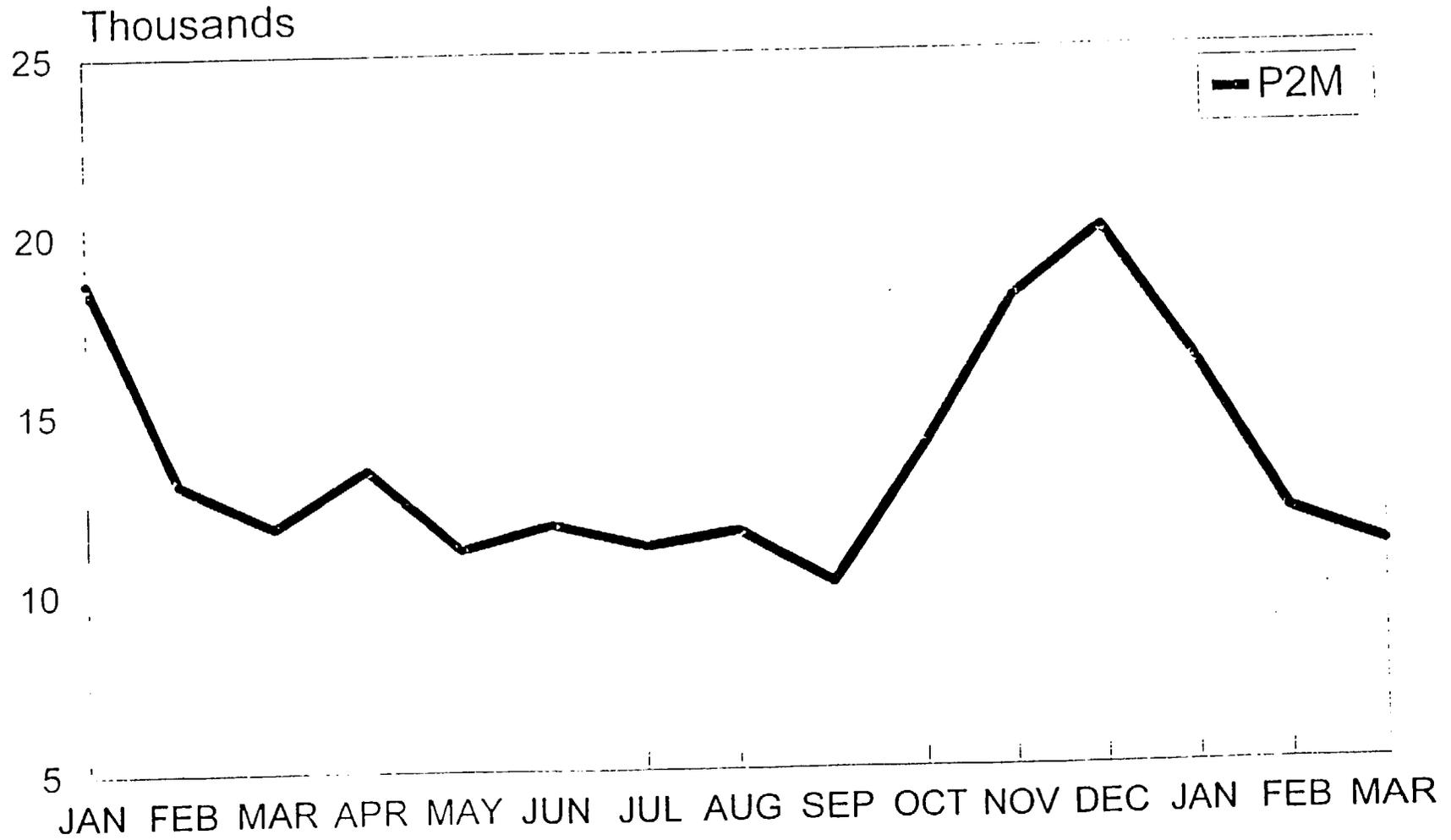


klinis

1992

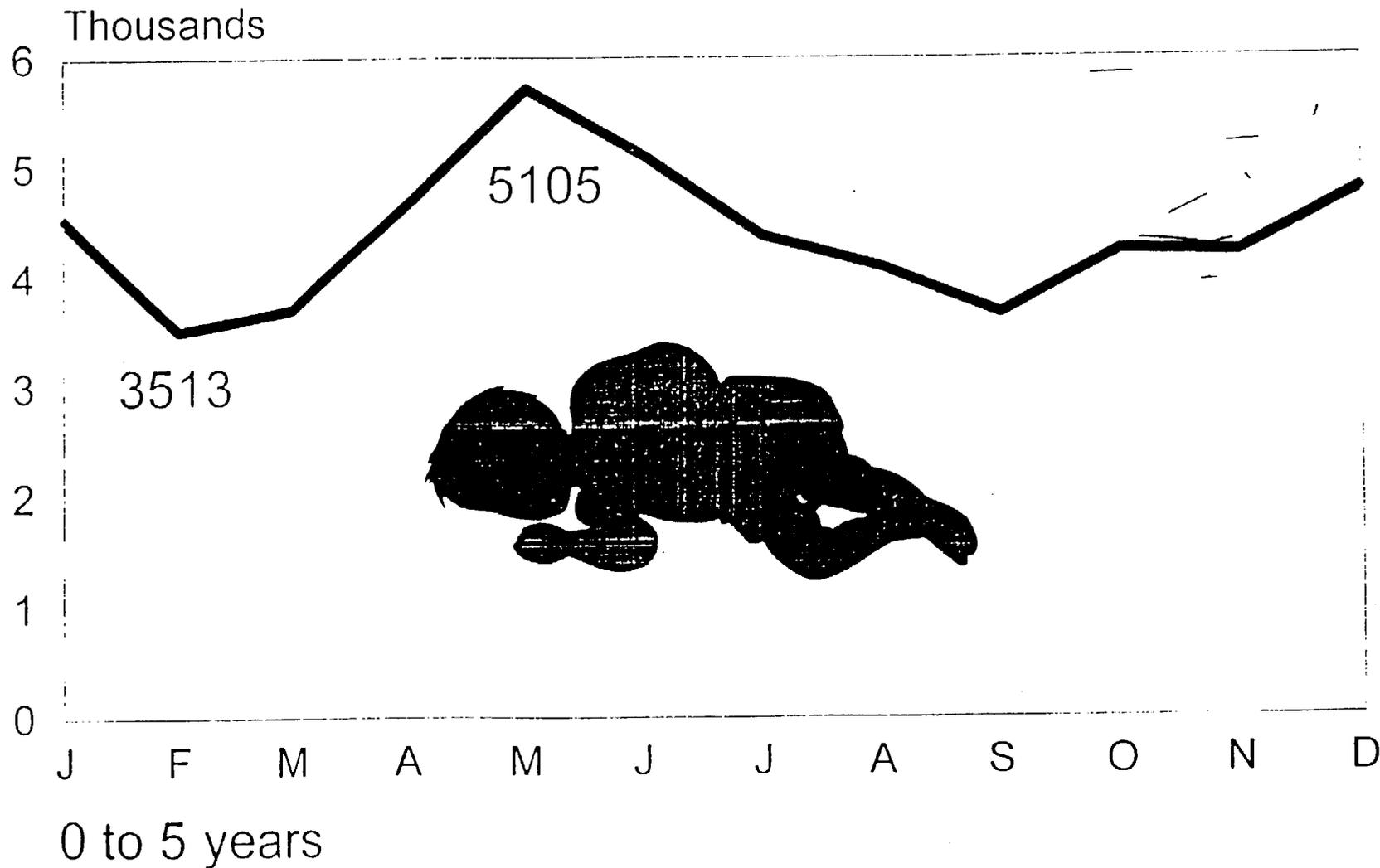
DIARE, P2M

NTB 91-92

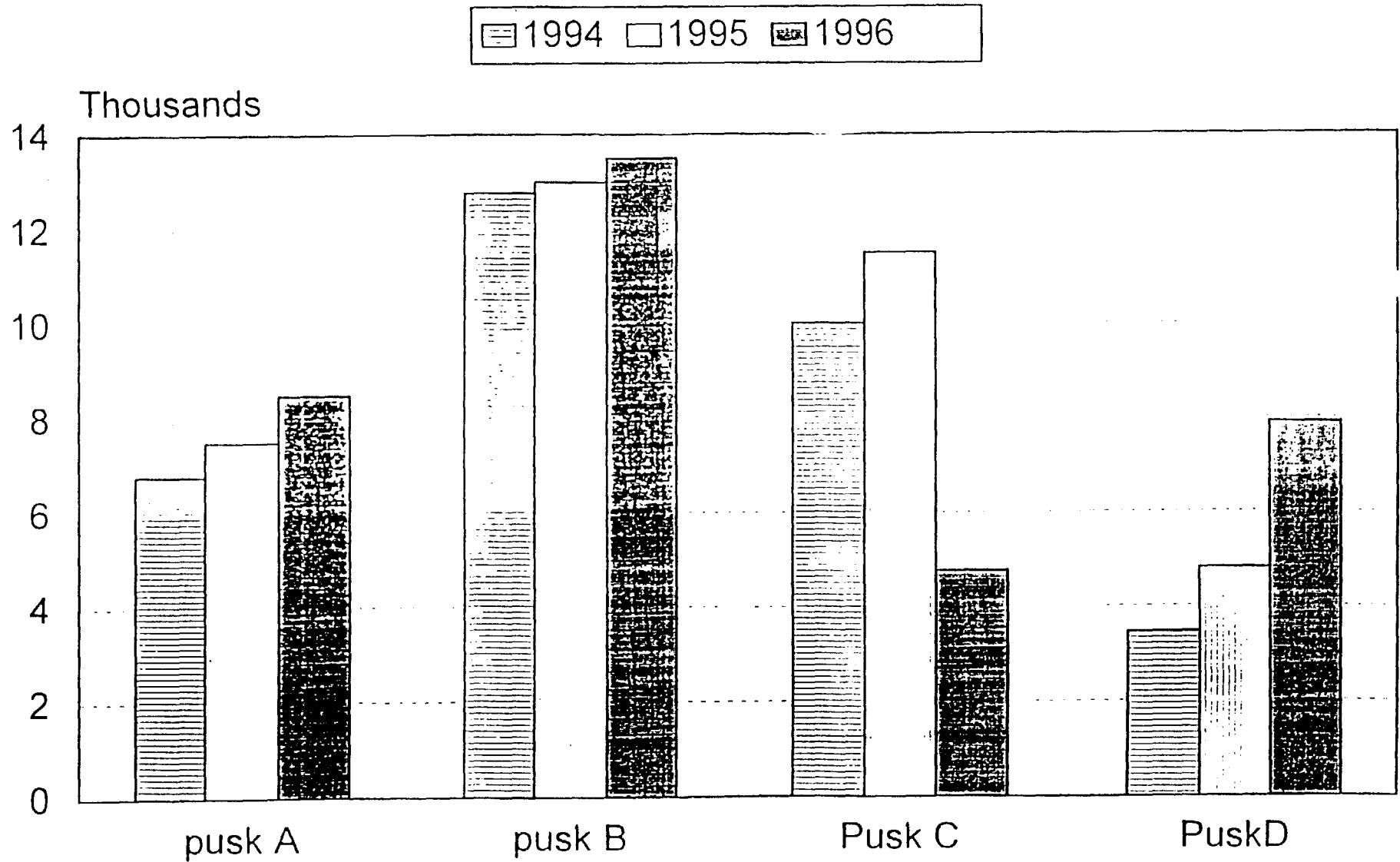


Upper Respiratory Infect

Lombok Barat 1991

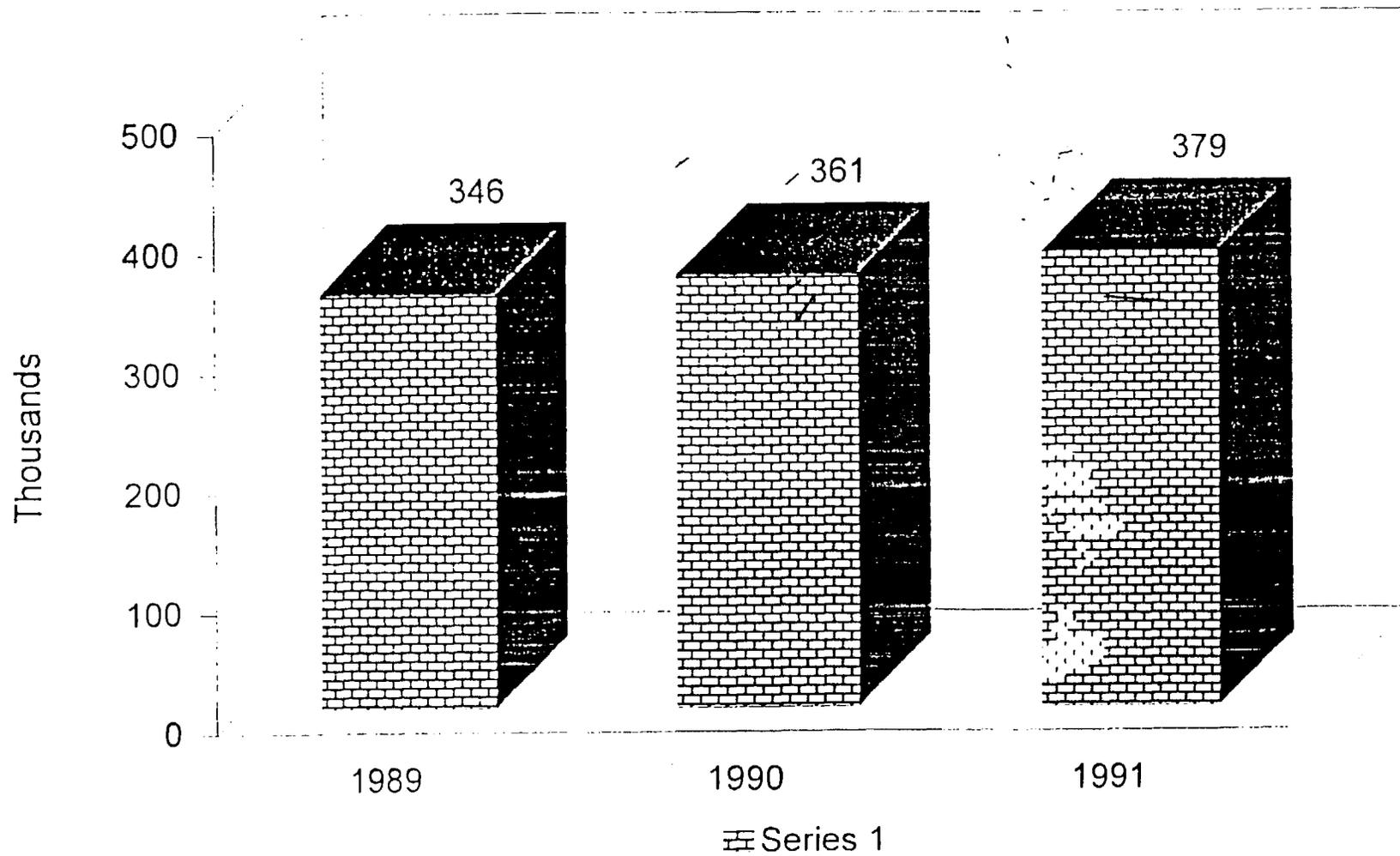


kunjungan per puskesmas

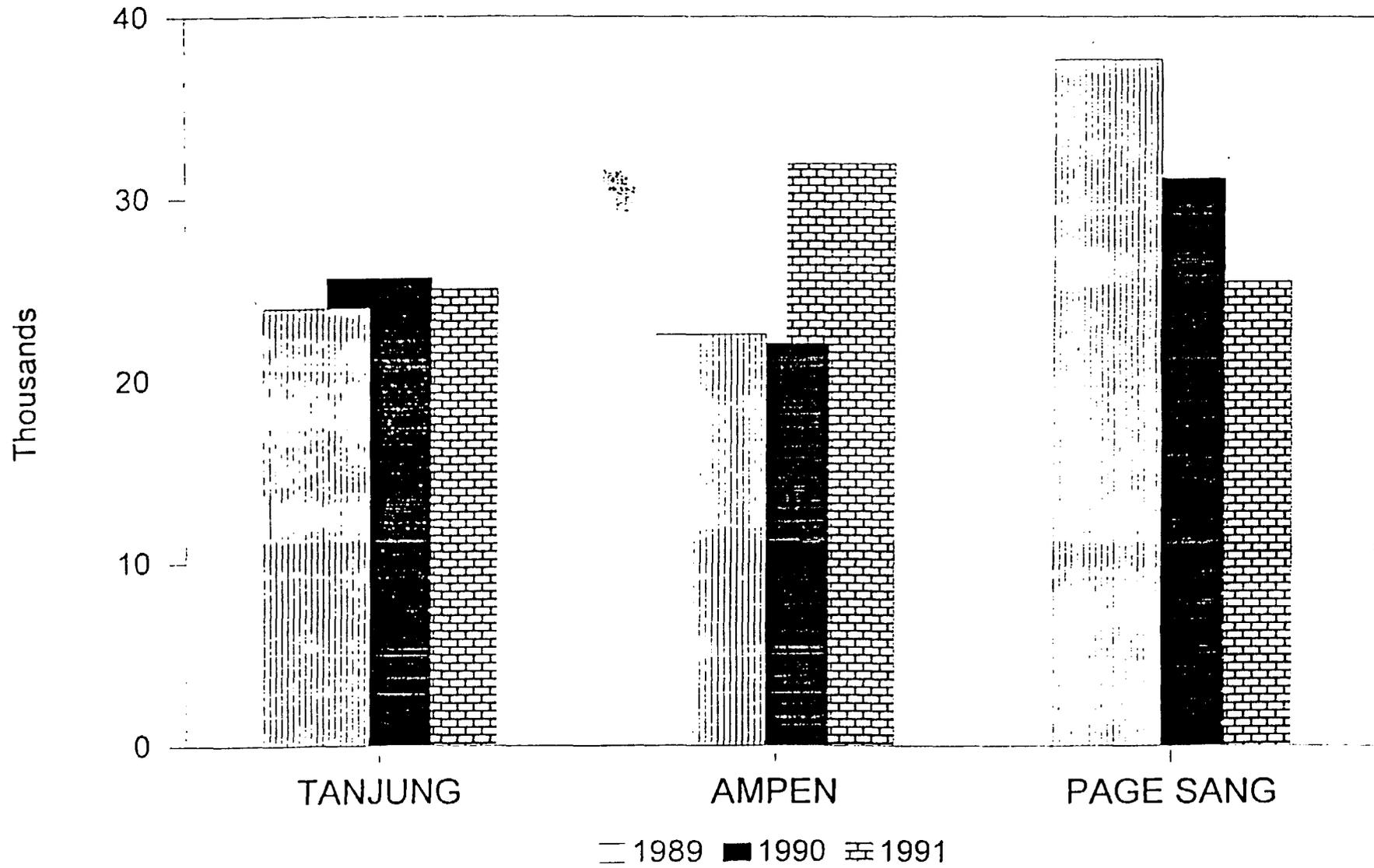


VISITS TO PUSKESMAS

1989-1990-1991 LO.BAR



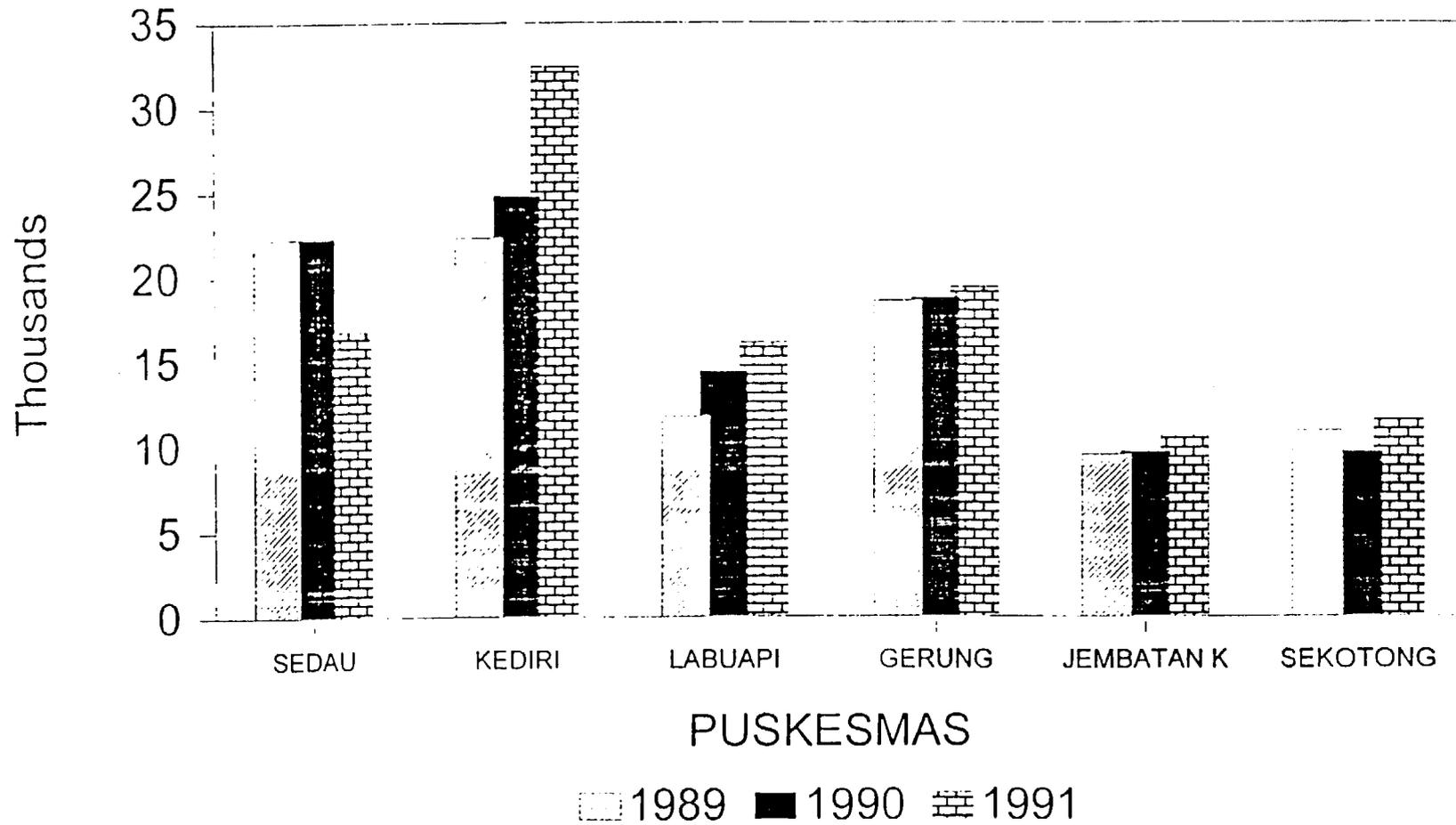
VISITS TO PUSK 89-90-91



11

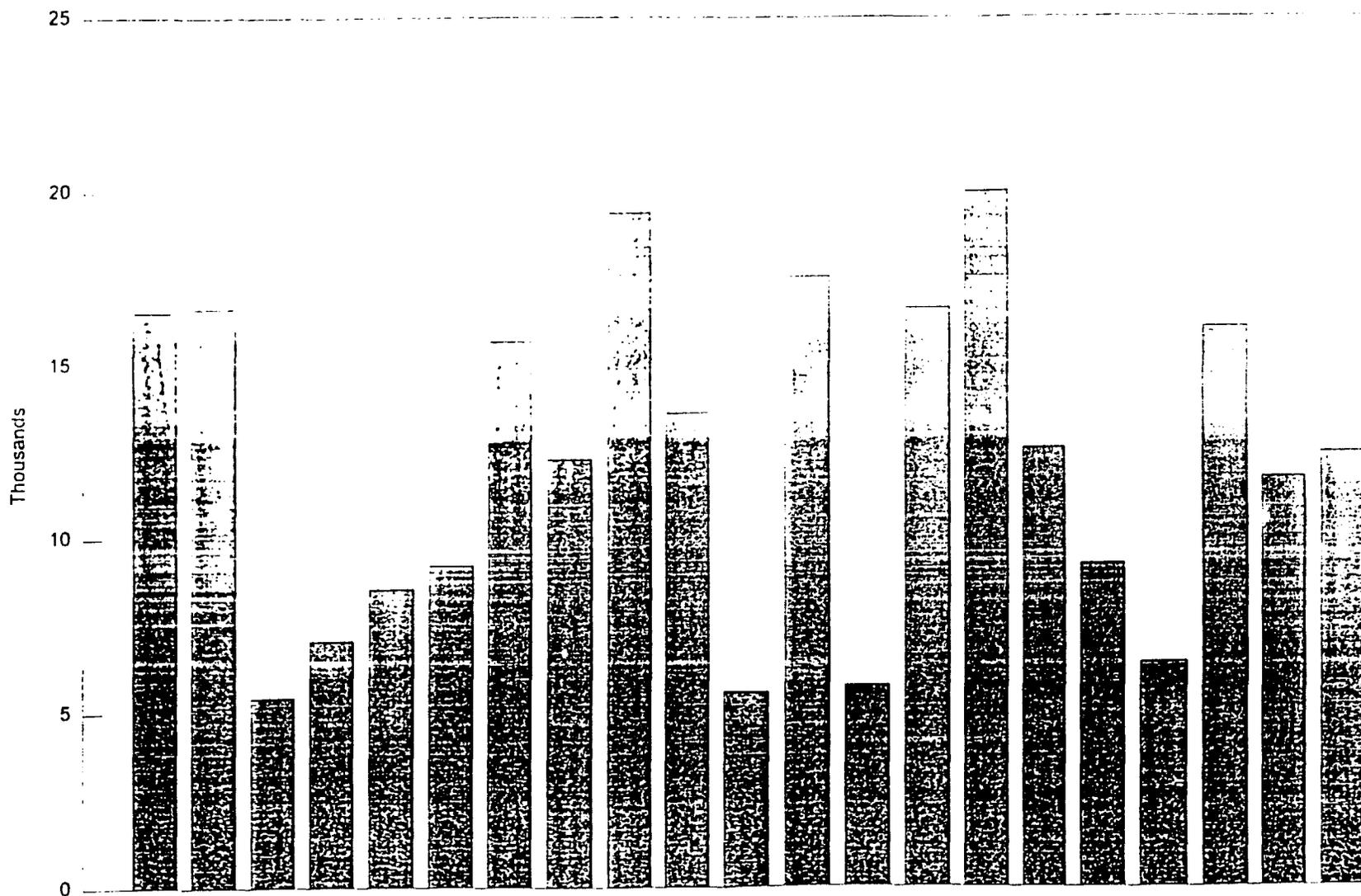
SELECTED PUSKESMAS, LoBar

VISITS 1989-1990-1991



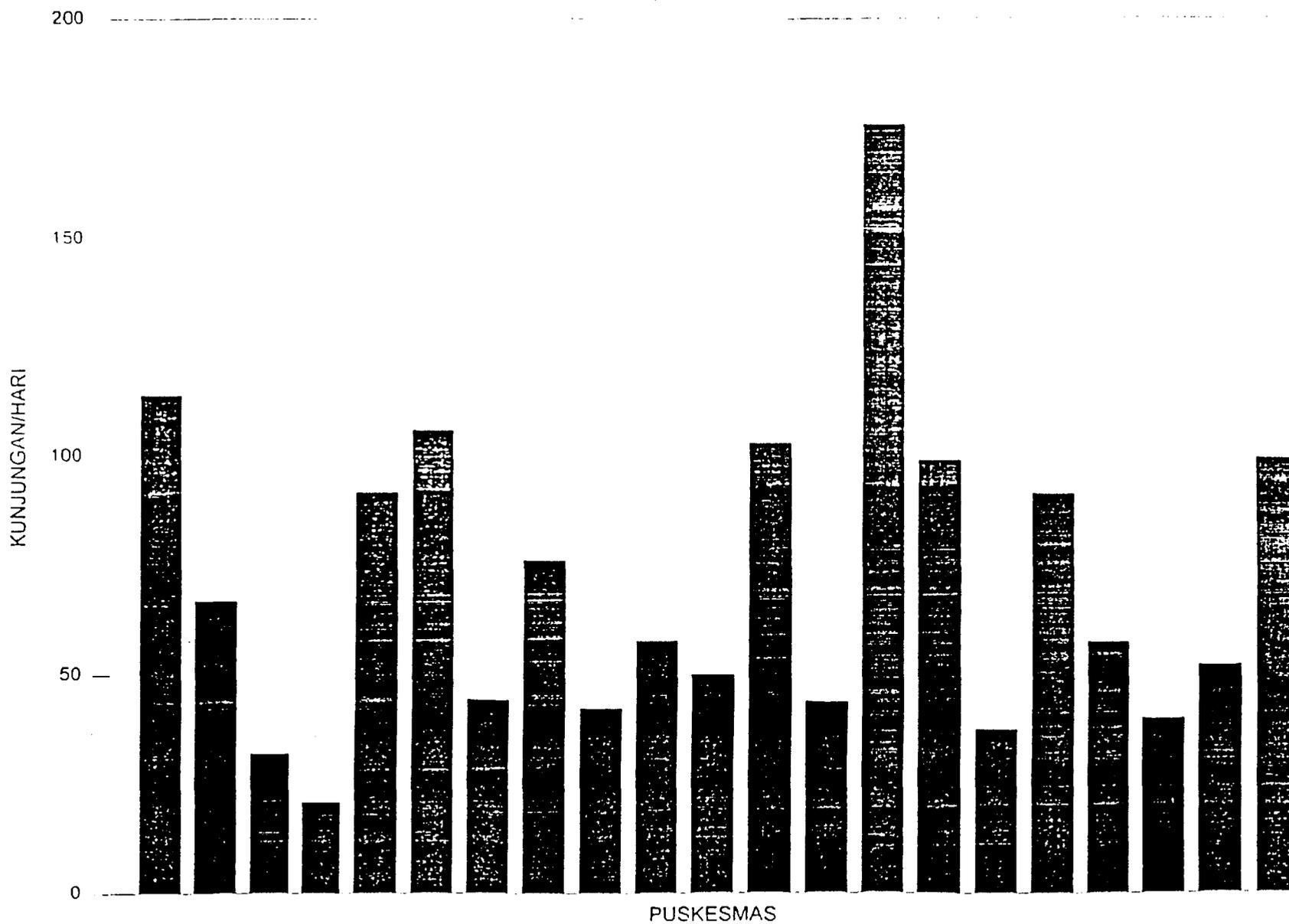
22

PENDUDUK/PUSKESMAS



13

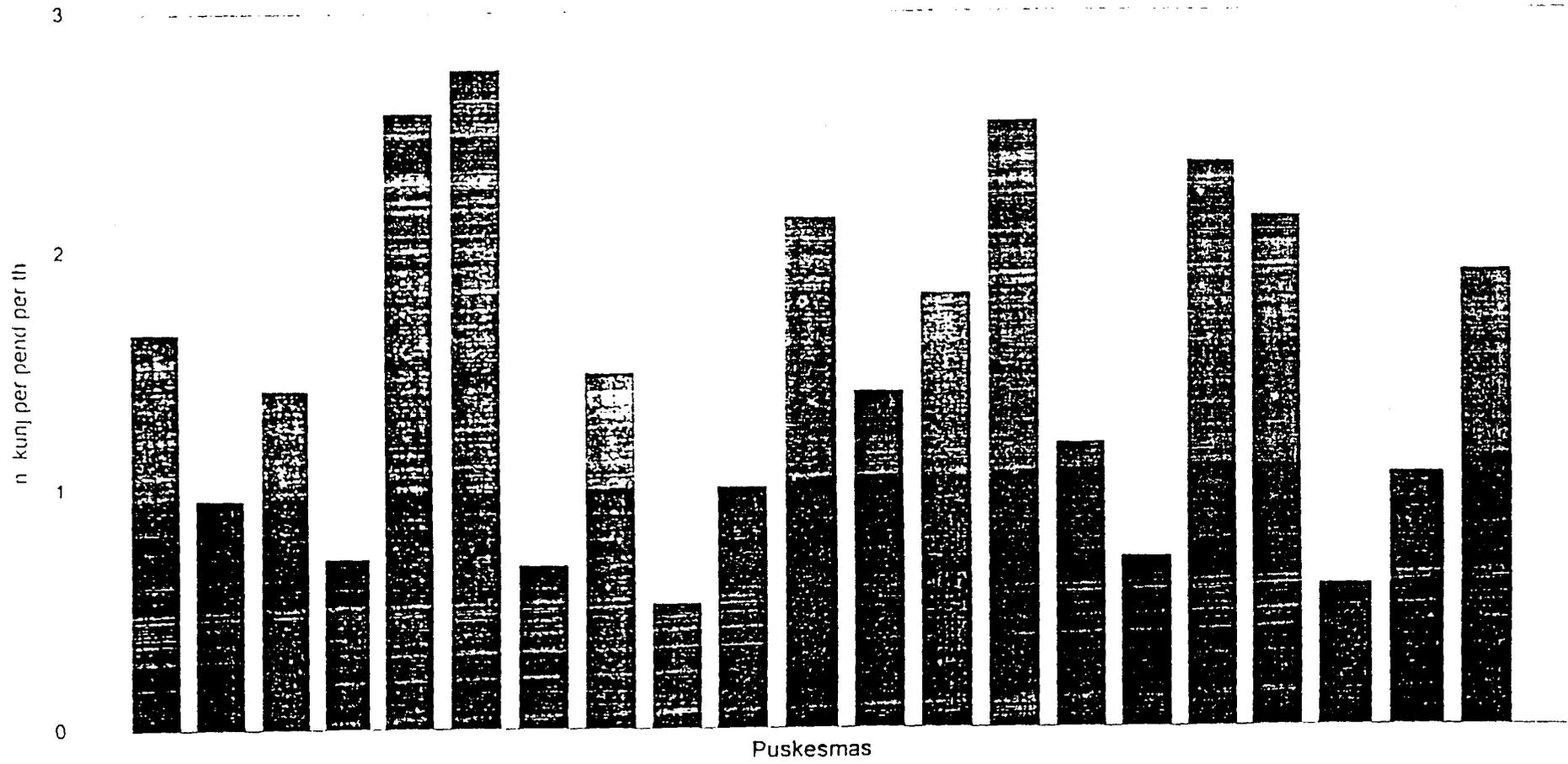
KUNJUNG/HARI/PUSK



74

		PEND			KUNJ	
	mini	average	maxi	mini	average	maxi
PUSK	5423	12308	20011	20.9	71.4	176
PUST	2875	7196	20101	4.1	15	31.7

VISIT RATE



MODEL-MODEL ANALISA

- 1. Angka-angka saja**
- 2. Proporsi yg sederhana**
- 3. Variasi menurut waktu
(trend analysis)**
- 4. Perbandingan antar
fasilitas**
- 5. Levels of aggregation**
 - puskes/pustu**
 - kabupaten**
 - propinsi**
- 6. Kenyataan VS harapan
sasaran, rencana**
- 7. Performance VS investment
kinerja -- sumber**

PERENCANAAN ANALISA DATA

Tujuan:

Kabupaten menetapkan pola dan langkah-langkah analisa data yang akan menghasilkan angka-angka bulanan dan tahunan yang langsung dapat digunakan dalam manajemen dan perencanaan

PENENTUAN POLA ANALISA

- 1. Management by objectives**
 - kesehatan (hasil)**
 - pelayanan (proses, operasional)**
- 2. Management by performance**
- 3. Management by resource allocation**
- 4. Management by finances**
 - income VS costs**
 - cost centers**

APPENDIX E2
TRANSPARENCIES FOR PRESENTATION ON THE
PRIVATE SECTOR

Sektor Swasta yg ada
hubungan dengan kesehatan
adalah apa?

Apakah pemerintah
bisa kerjasama dgn

Sek Swa secara praktis?

- efektif
- efisien (cost-effective)

Sektor Swasta

1. Usaha² ke arah sektor swasta sangat pentinglah untuk mencapai tujuan H.P. IV + tujuan Depkes
 - kecenderungan ke swasta
 - keterbatasan kemampuan pemerintah
 - cakupan, utilization (visit rate), mutu pelayanan tak bisa lepas dari swasta.
 - pemerintah bertanggung-jawab

Yang belum ada -
INFORMASI

District-Level Data-Based
Planning + Management

Kabupaten membutuhkan
data tentang utilitas,
cakupan, dan biaya
pelanggan + kegiatan
lain sebagainya untuk
perencanaan + management
yang benar.

Medical Model

Keluhan ← Sakit
gejala
(subyektif)

Monitoring

Pemeriksaan
diagnostik
fisik/lab/riswayat

Pengobatan
Tindakan

Diagnosa analisa
tepat interpretasi
obyektif
benar/valid

BEST AVAILABLE

HEALTH SISTEM MGT

SEHAT

Monitoring

Gejala
(utiliz
sedikit)

(sakit)

Pengumpulan
data

Tindakan
(menjamin
access)

Diagnosa
tepat
obyektif
(mis. Trend
ke swasta)

analisa
interpretasi

planning

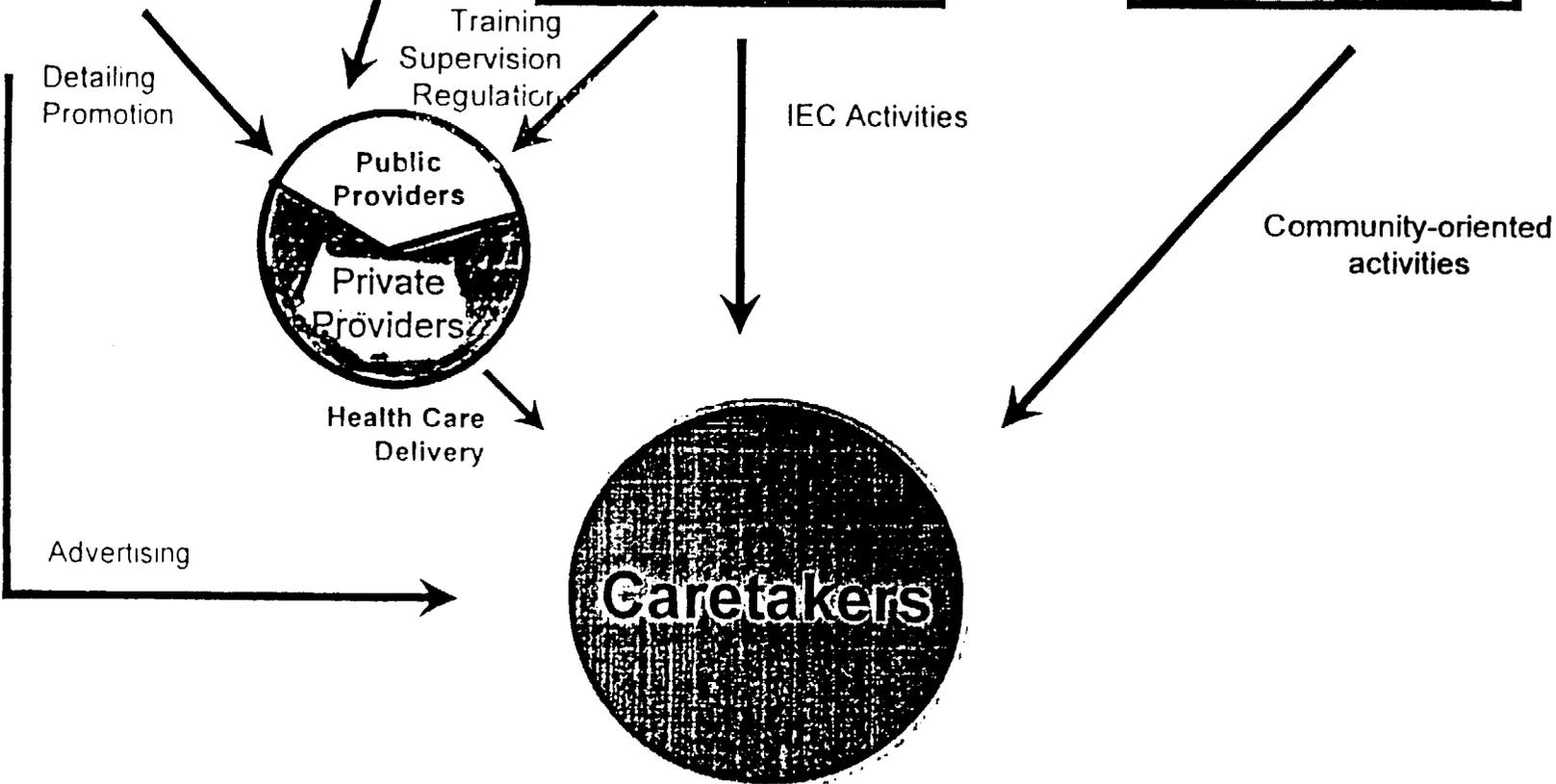
BASICS

BASICS



Public Sector Leadership
Policy/Program/Mngmnt

NGO/PVOs



BEST AVAILABLE COPY

86

KOMPONEN SEKTOR SWASTA

1. PRIVATE PRACTITIONERS

Sektor Formal

<i>Tenaga</i>	<i>Institusi</i>
-- dokter	praktek, rumah sakit
-- bidan	praktek, masyarakat
-- perawat, mantri	praktek
-- apoteker	apotik
-- pemilik toko obat	toko obat

Sektor Informal

Tenaga

Institusi

-- dokter/mantri
tak berijin

praktek

-- dukun

rumah, masyarakat

-- pemilik
warung

warung

-- penjual
jamu

masyarakat

-- pengobat
tradisi

praktek, rumah

-- juru pijit

masyarakat

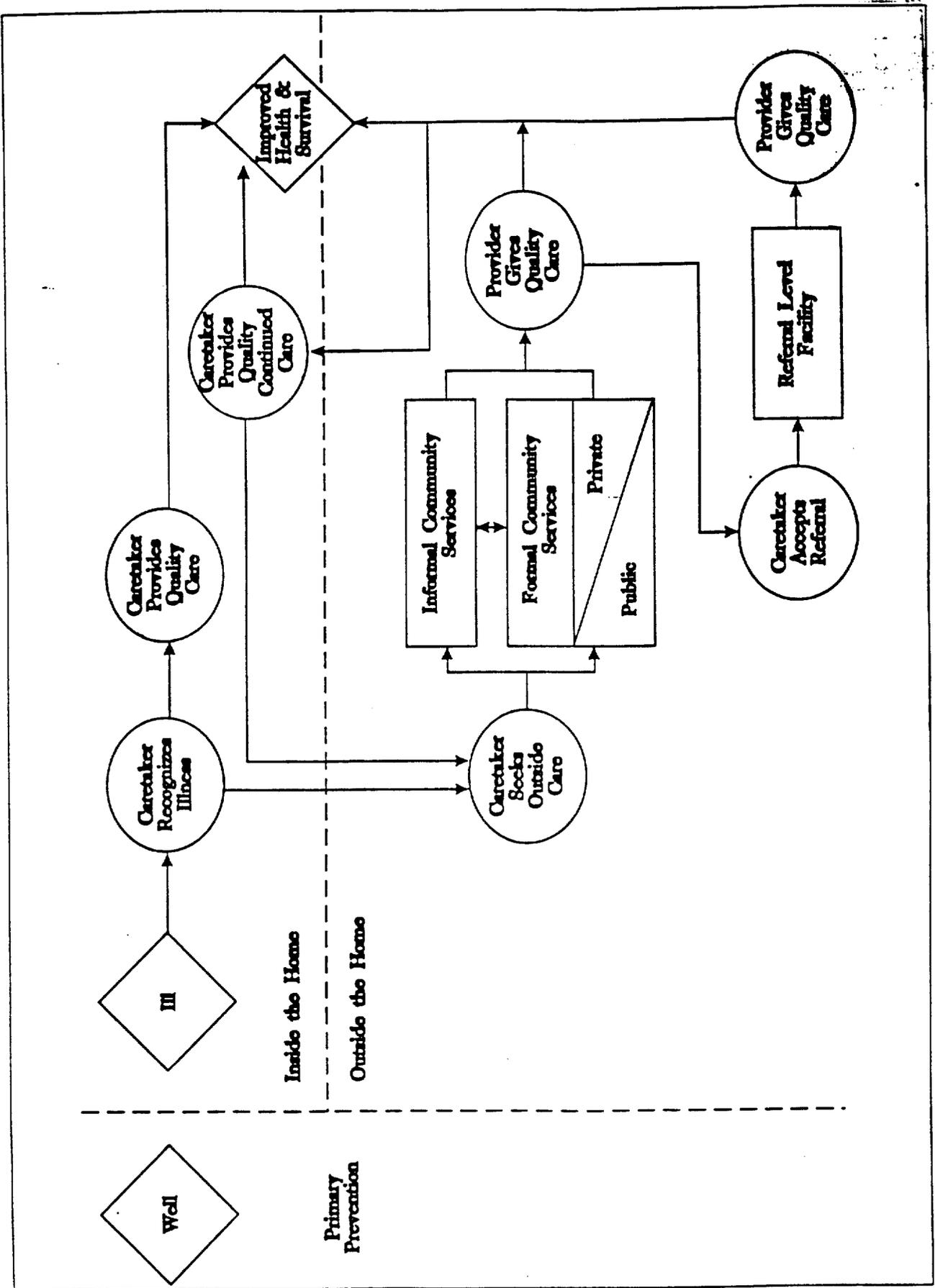
2. NON-GOVERNMENT ORGANIZATION (NGO)

<i>Type</i>	<i>Contoh</i>
Lembaga sosial	PKK Fatayat Mohammadiyah Care, Plan International Pramuka
Organisasi profesi	IDI IBI
Perusahaan besar	pabrik kain pabrik besi pabrik elektronik perkebunan

3. COMMERCIAL MANUFACTURERS, MARKETERS, AND DISTRIBUTERS (CMMDs)

<i>TYPE</i>	<i>CONTOH</i>
Pabrik obat	Pabrik oralit Pabrik vitamin A Pabrik antibiotika
Pabrik barang rumah tangga	Pabrik sabun Pabrik jaring nyamuk
Pabrik makanan	Pabrik susu Pabrik garam dgn iodium

Pathway to Survival



SEKTOR
KOMERSIAL



ab

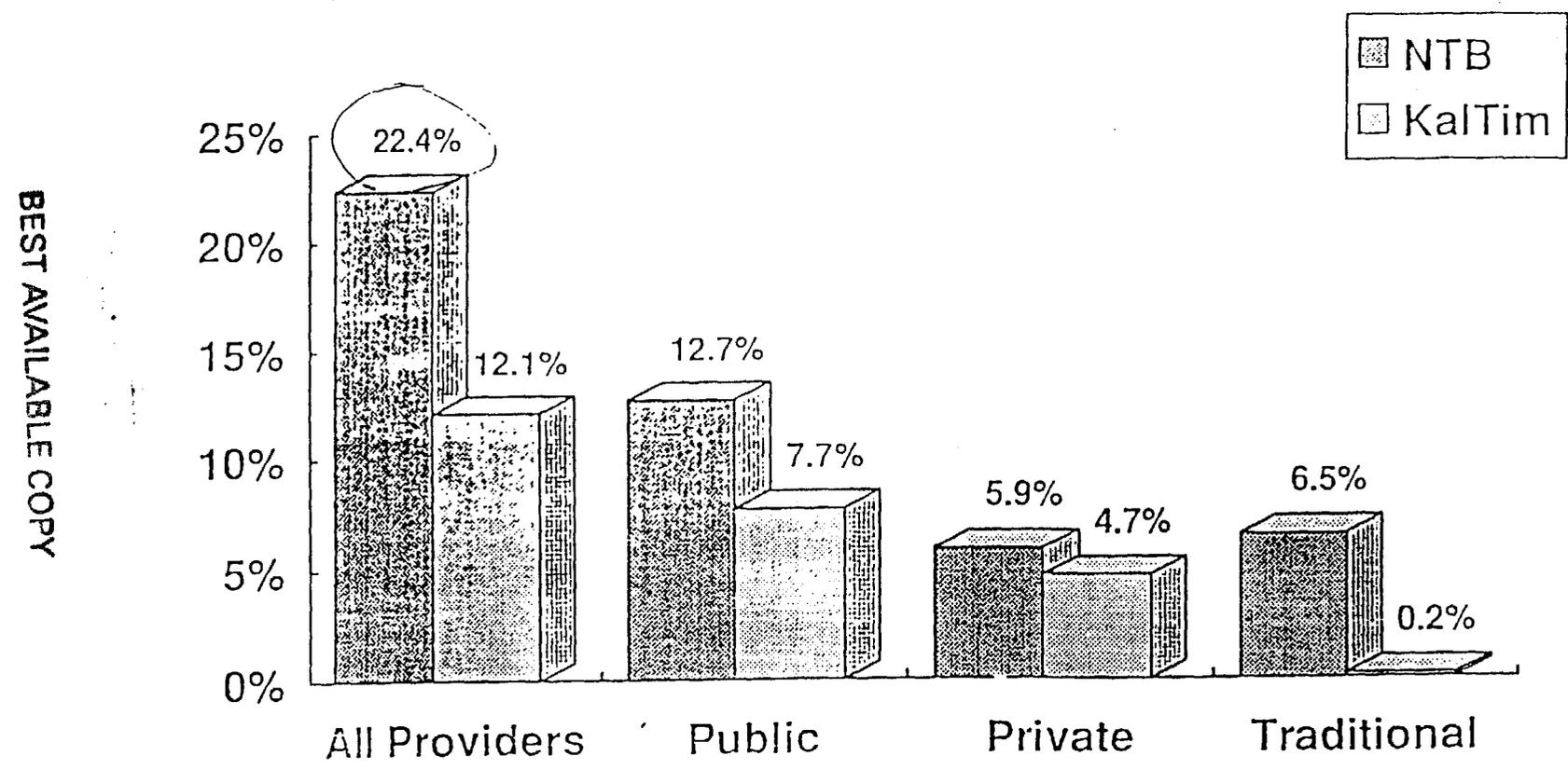
Annual Visit Rates by Provider

Provider	KalTim	NTB
All	2.08	4.74
Public	1.28	2.29
Private	0.74	1.03
Traditional	0.05	1.42

RAND

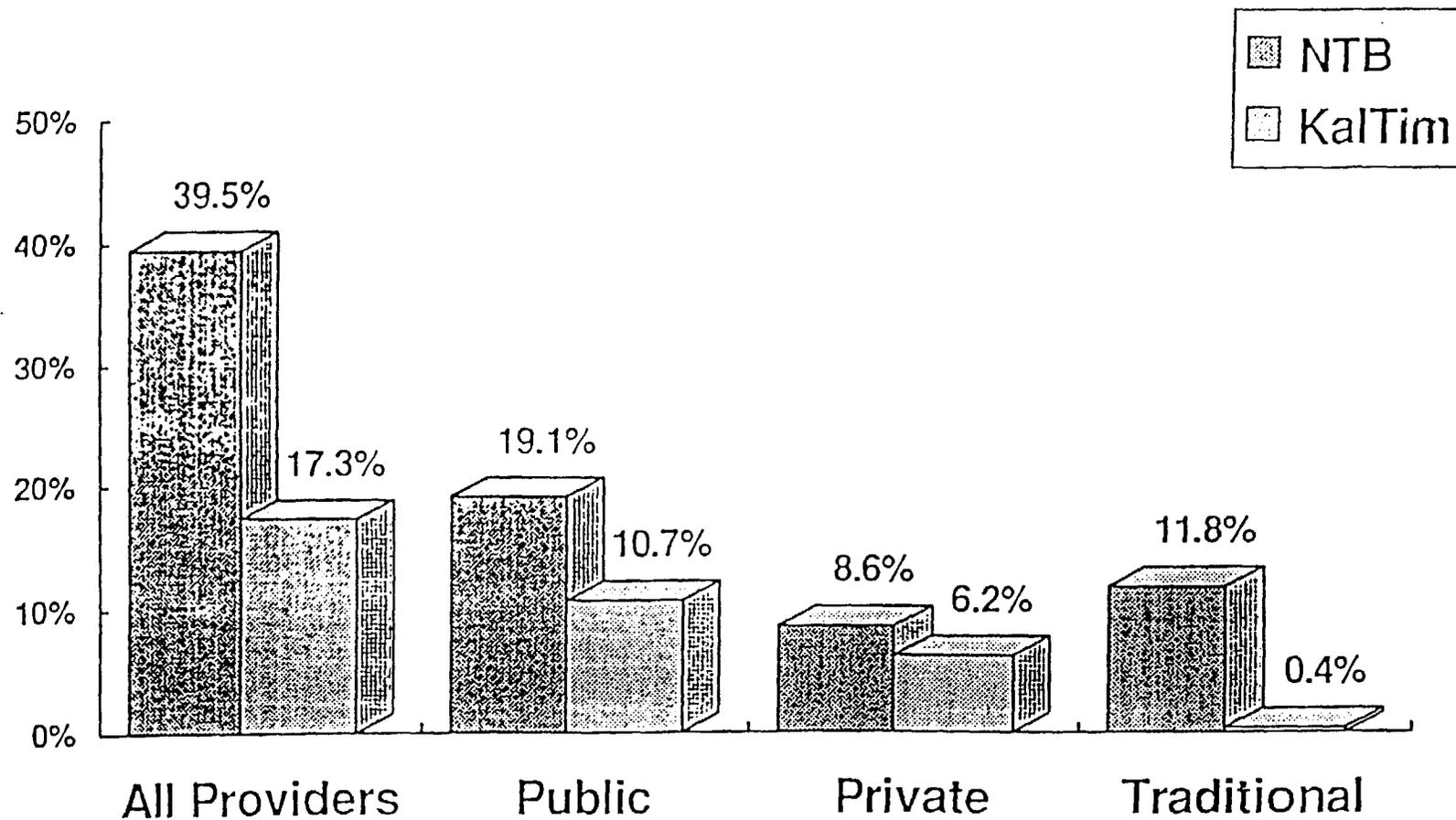
1991 IRMS Household Results

CONTACT RATES TO ALL HEALTH PROVIDERS

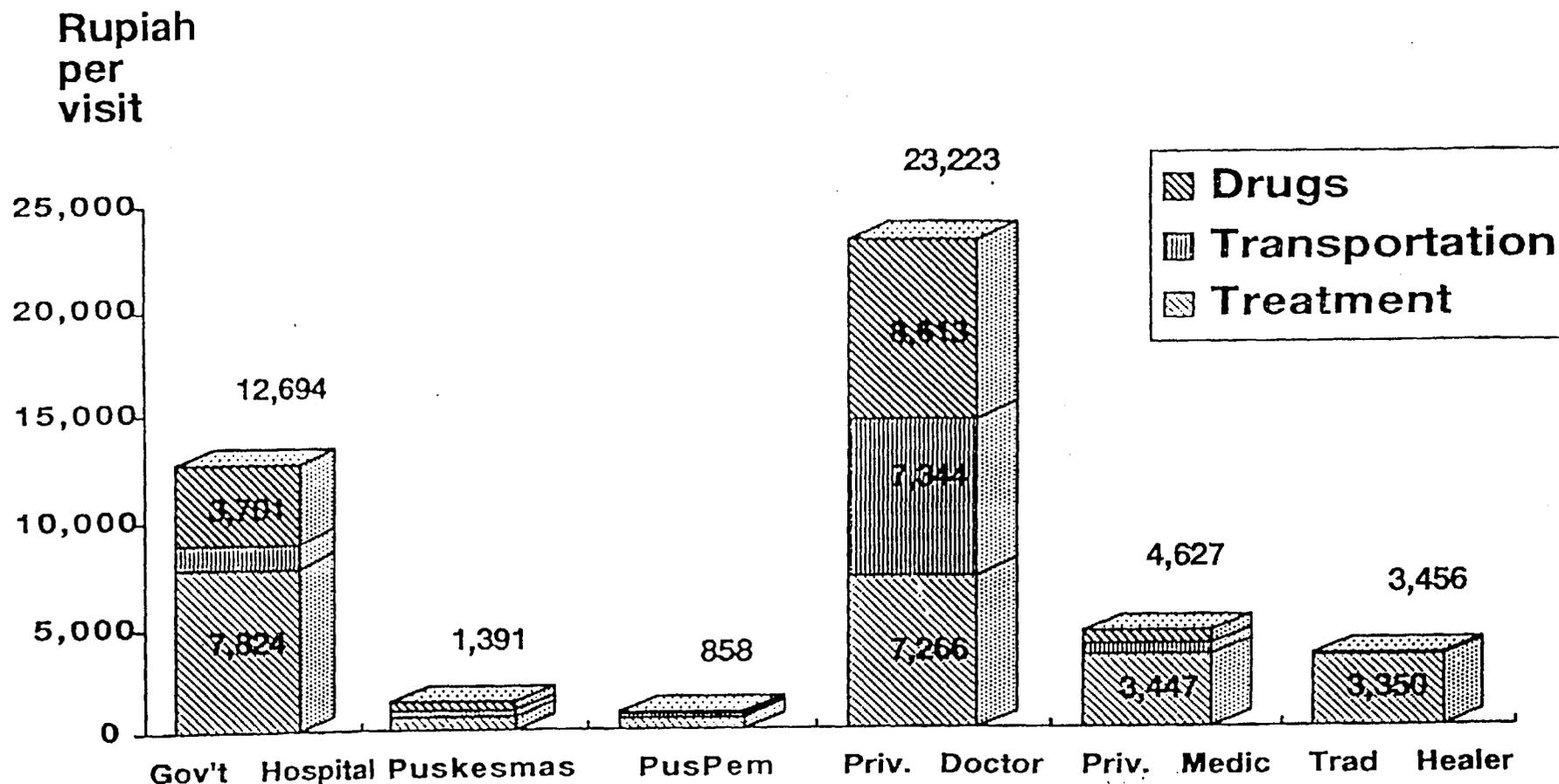


of

VISIT RATES TO ALL HEALTH PROVIDERS

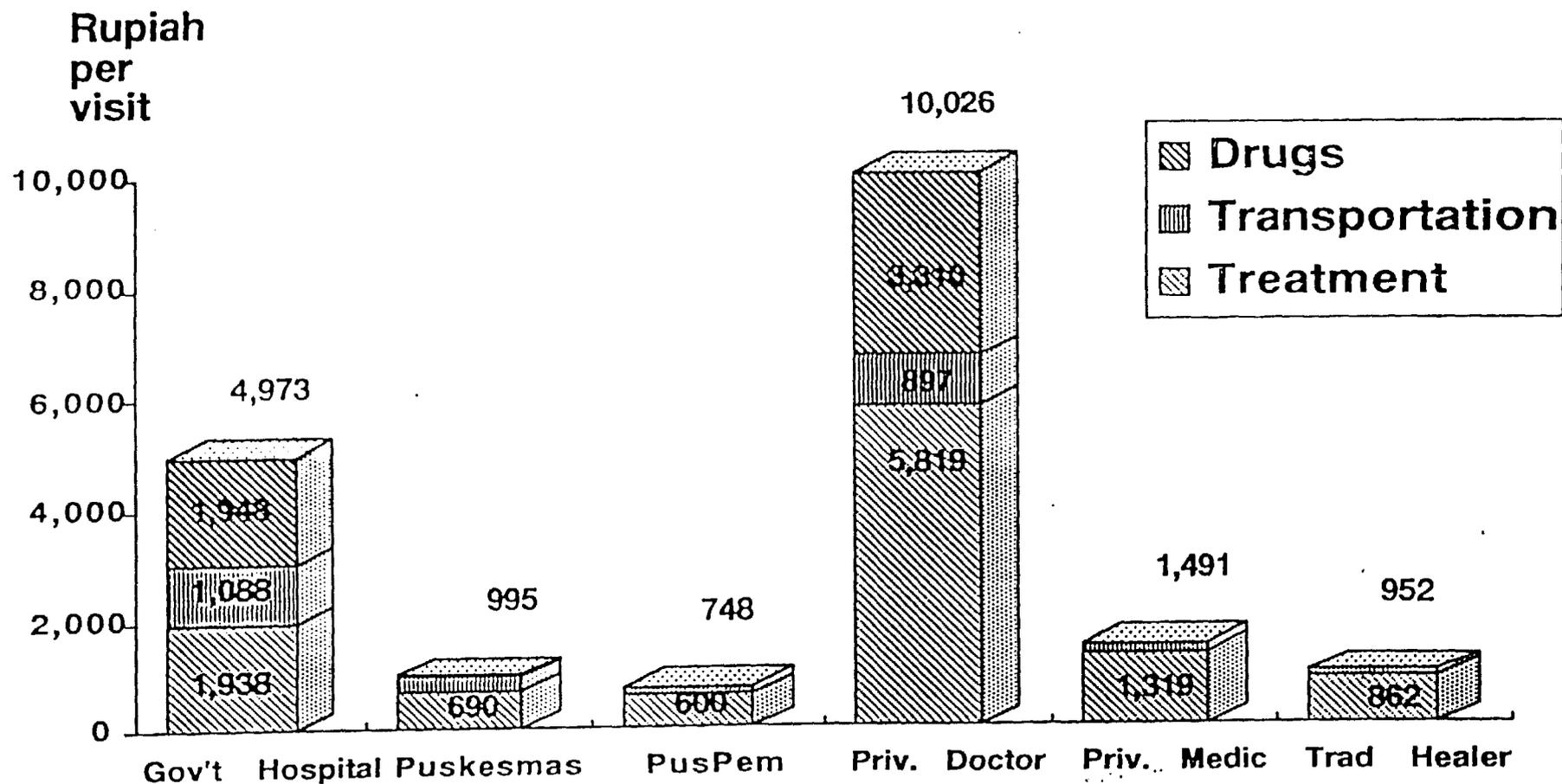


COMPONENTS AND TOTAL AVERAGE EXPENDITURE PER VISIT TO PROVIDERS (KaITim)



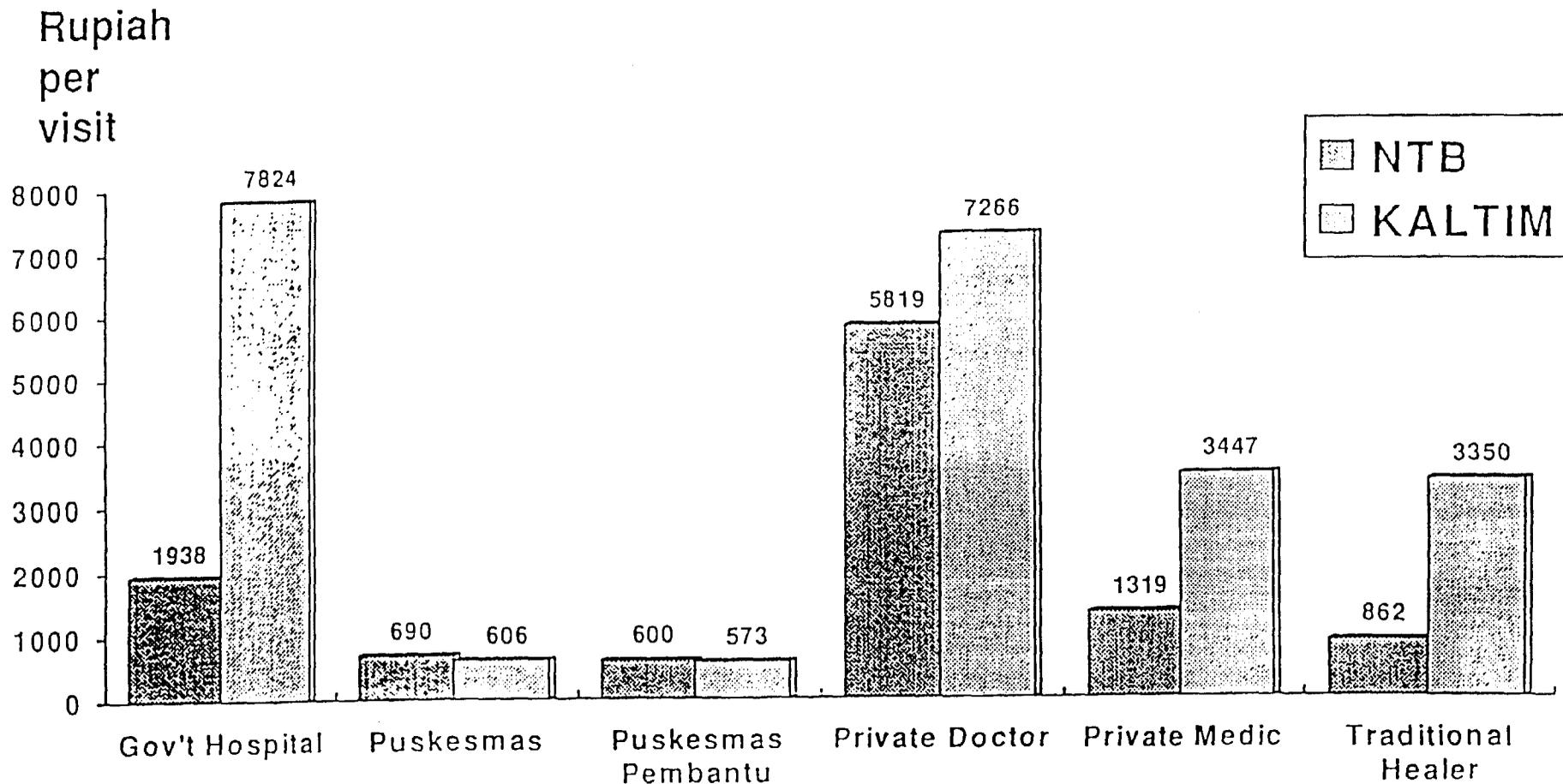
ofo

COMPONENTS AND TOTAL AVERAGE EXPENDITURE PER VISIT TO PROVIDERS (NTB)

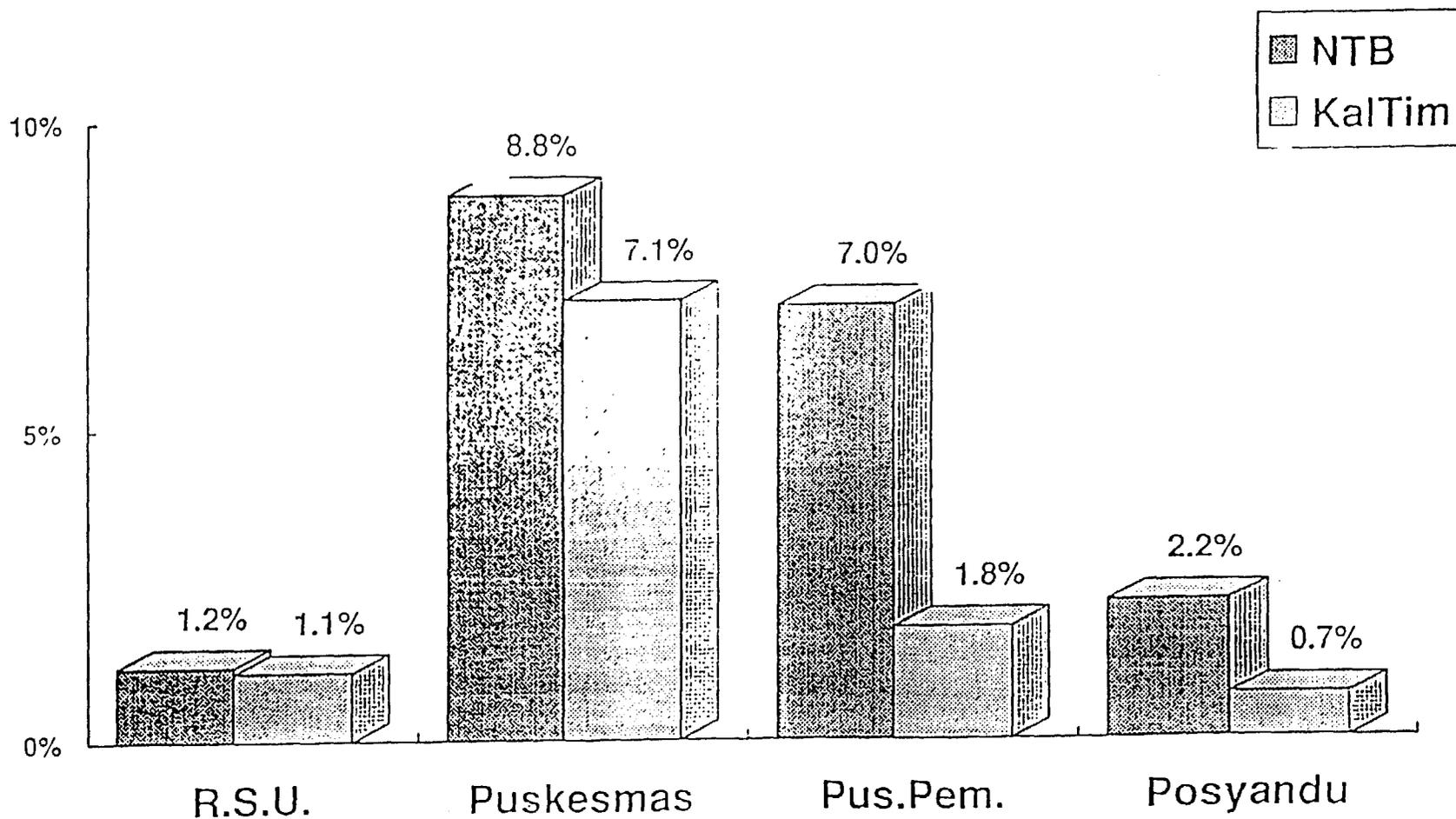


69

AVERAGE FEE PER OUTPATIENT VISIT

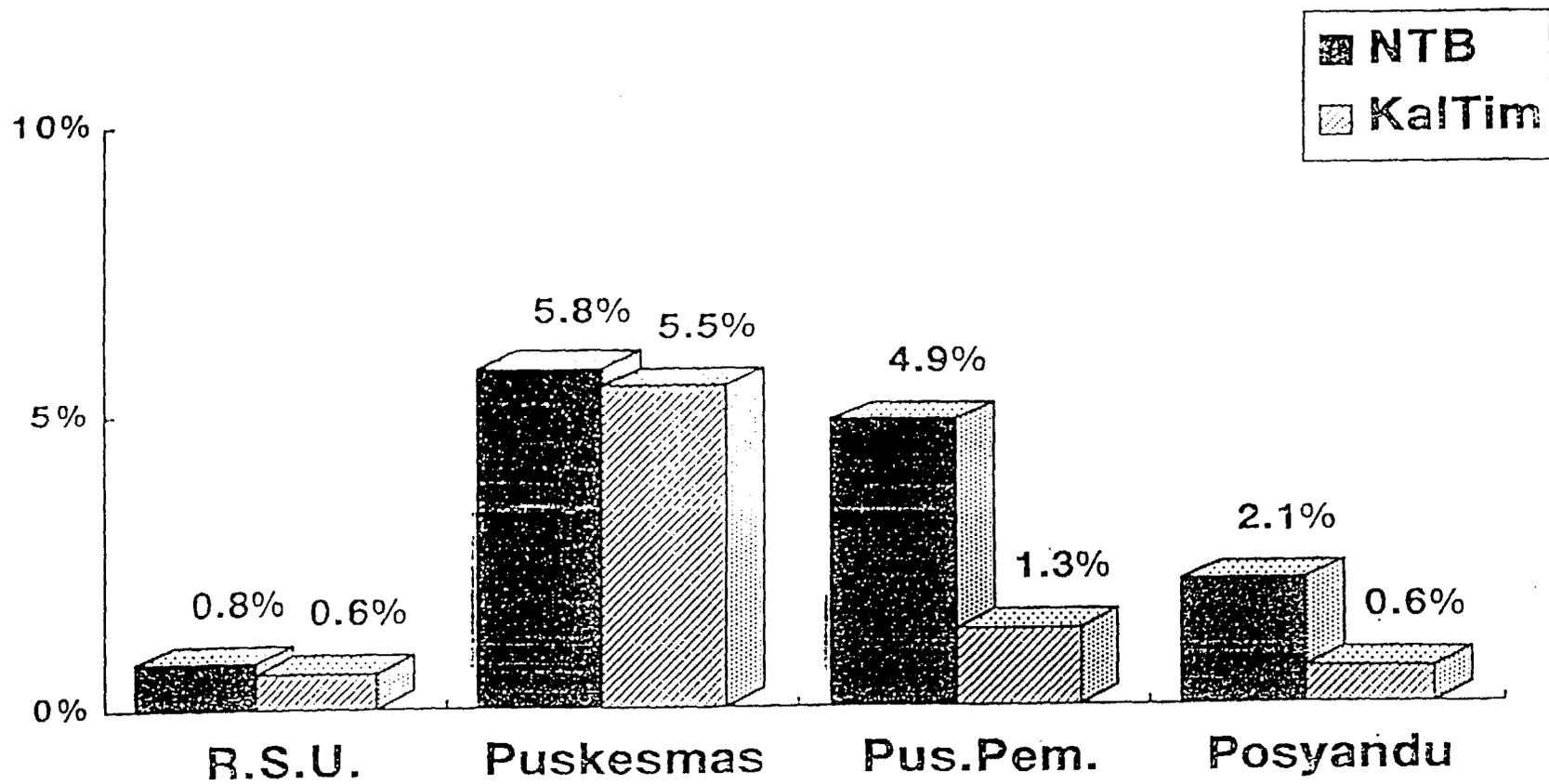


VISIT RATES TO GOVERNMENT HEALTH PROVIDERS



69

CONTACT RATES TO GOVERNMENT HEALTH PROVIDERS



100

POTENSIAL SEKTOR SWASTA: PENGALAMAN YANG ADA

1. Meningkatkan mutu dan efektivitas pelayanan praktisi swasta

- Melatih pengobat tradisional untuk menangani kasus2 kolera dengan memakai oralit (Bangladesh)
- Menyokong toko2 obat dan apotik untuk mempromosi oralit dan memberi penyuluhan kepada ibu2 tentang pemakaiannya secara benar untuk kasus2 diare pada anak (Jawa Barat)
- Melatih kader untuk mengobati kasus2 ISPA (India)
- Menyokong partnership antara organisasi2 masyarakat dan praktisi2 swasta (Nigeria)

- Membantu untuk pendirian organisasi “profesional” dokter2 liar di desa dan memberi latihan dan monitoring mutu pelayanan (India)
- Melatih dukun2 untuk meningkatkan mutu pelayanan pada persalinan termasuk rujukan pada indikasi2 tertentu (banyak negara)
- Meningkatkan pengetahuan dan perilaku dokter praktek swasta melalui organisasi profesi (Filipina, India, Pakistan, negara2 lain)

2. Menyokong praktisi2 swasta untuk melayani pasien2 yang kurang mampu

- Proyek Initiatives (USAID - beberapa negara)

3. Memakai organisasi2 masyarakat untuk memberi penyuluhan dan motivasi kepada masyarakat

- Organisasi ibu (Fatayat) memberi penyuluhan dan mendistribusi Vit A (Jakarta)
- Organisasi ibu rumah tangga melaksanakan penimbangan bayi (Indonesia, banyak negara lain)
- Perusahaan meningkatkan mutu pelayanan kesehatan dasar dan mengikutsertakan keluarga pegawai (Malaysia, Malawi, Bangladesh, dll)
- Cooperative susu menciptakan asuransi kesehatan untuk anggotanya (India)

4. Meyakinkan produsen barang kesehatan untuk menjadi partner dengan pemerintah untuk promosi obat atau barang tsb kepada practitioner atau kepada masyarakat

- Pabrik2 oralit secara aktif bersama pemerintah mempromosi oralit kepada dokter2 dan penjual2 obat (apotik, toko obat) (Indonesia, Pakistan, Kenya, Bolivia, Salvador, India, Filipina)
- Pabrik2 sabun merubah kampanye promosi sabun untuk menekankan cuci tangan sebagai tindakan preventif terhadap diare (Amerika Tengah)
- Pabrik2 kondom dibantu dalam promosi kondomnya dengan iklan2 umum pemerintah dan bantuan dalam perencanaan marketing campaign (India, Morocco, lain2 negara)

- Pabrik dan penyalur jaring nyamuk dibantu melalui kerja sama dengan pemerintah untuk meningkatkan promosi barang jaring dan obatnya sebagai tindakan preventif malaria (Africa)
- Organisasi profesi advertising agency bersama pemerintah menciptakan kampanye oralit melalui televisi (Pakistan, Indonesia)

USAHA BASICS DENGAN PRIVATE PRACTITIONER (PP)

Tujuan:

Meningkatkan mutu dan efektivitas pelayanan medis PP dan pelayanan ibu di rumah kepada anak sakit

Langkah 1:

Menentukan peranan PP untuk penyakit² tertentu dan mutu pelayanannya sekaligus menentukan perilaku ibu kepada anaknya

Alat diagnostik -- Verbal Case Review

Wawancara dgn ibu2 tentang apa yang dilakukan di rumah, keputusan untuk mencari nasehat, obat, atau pelayanan diluar rumah, dan perilaku dan tindakan PP yang dikunjungi (dalam maximal 2 minggu yang lalu)

Tindakan --

- Latihan kepada PP tentang langkah pemeriksaan, penentuan diagnosa, pengobatan, dan counselling kepada anak & ibu
- Pelaksanaan Verbal Case Review yang disederhanakan secara kontinu oleh organisasi ibu. Hasilnya dilaporkan kepada organisasi (LSM di India, Dinas Kes kabupaten di Jawa Tengah), kemudian kekurangan² dalam penanganan kasus oleh PP dikomunikasikan kepada PP kalau belum memenuhi syarat

PERANAN PEMERINTAH DALAM USAHA SEKTOR SWASTA

(tekanan pada private practitioner)

1. Mengetahui apa yang sedang terjadi -- DATA
 - diagnostik
 - monitoring
2. Menentukan dan menetapkan kebijakan
3. Bertindak secara aktif untuk menjamin mutu dan efektivitas pelayanan swasta, atas data yang ada
4. Memonitor secara kontinu proses dan dampak tindakannya

KEGIATAN:

- pengumpulan data diagnostik
- pemberian informasi
- motivasi
- insentif2
- pendidikan
- kerja sama dengan organisasi
- monitoring
- management
- perencanaan
- pelaporan

PERFORMANCE INDICATORS

- assessment of PPs & NGOs
- steps taken to promote service delivery
- Quality assurance activities
- Number of PPs trained by type
- Activities of health professional organizations in promoting better health services

APPENDIX F
BEHAVIORAL OBJECTIVES DESCRIPTION
PURWOREJO DISTRICT

TUJUAN-TUJUAN PERILAKU INTERVENSI

Komunikasi dengan ibu

- tentang cara penanganan kasus di rumah
- tentang imunisasi
- tentang tanda2 bahaya
- tentang diagnosa
- tentang pengobatan
- tentang makanan/minuman/ASI

Tindakan preventif yang umum

- menimbang anak, menilai pertumbuhan, memberi nasehat
- imunisasi anak dan ibu

Pemeriksaan anak berkaitan dgn gejala

UNTUK PANAS:

- mengukur suhu dgn termometer
- melihat tenggorokan
- melepas baju
- memeriksa perut dengan tangan

Penanganan anak berkaitan dgn gejala

- memberi anjuran untuk memandikan dalam air hangat
- memberi obat anti-panas
- menganjurkan untuk minum banyak
- memberitahu tanda2 berbahaya

UNTUK DIARE

- menyentuh anak
- memeriksa perut dengan tangan
- mencubit tebal lipatan kulit

- memberi oralit
- tidak memberi suntikan
- memberitahu bagaimana mencampur dan memberi oralit
- menganjurkan untuk minum banyak
- menganjurkan untuk melanjutkan makan dgn frekwensi lebih tinggi
- memberitahu tanda2 berbahaya

UNTUK ISPA

- mengukur suhu dengan termometer
- melepas baju sampai dada terlihat
- menggunakan jam/timer untuk mengukur frekwensi pernafasan

- menganjurkan untuk minum banyak
- memberi antibiotik sesuai dengan kriteria adanya pneumonia atau tidak
- memberitahu tanda2 berbahaya

Pemberitahuan nasehat untuk semua kasus

- diagnosanya apa
- tentang makanan yg perlu diberikan
- tentang penyusuan anak
- tentang kapan perlu datang lagi atau rujukan
- tentang cara mencegah penyakitnya di kemudian hari
- memberi kesempatan kepada ibu untuk menanyakan sesuatu
- bagaimana memberi obat/sirop
- tentang cairan yg harus diminum
- tentang tanda2 berbahaya

APPENDIX G
IMPROVING PROVIDER CASE MANAGEMENT PRACTICES
FOR CHILD ILLNESS IN A RURAL INDONESIAN DISTRICT

IMPROVING PROVIDER
CASE MANAGEMENT PRACTICES FOR CHILD ILLNESS
IN A RURAL INDONESIAN DISTRICT

SUMMARY

A targeted demonstration intervention project using an experimental design is proposed. The project will assess the quality of care given by private and public providers to sick under-five children in Purworedjo District in Central Java, comparing current practices with those recommended by the WHO algorithm for Integrated Management of Child Illness (MTBS) and will also assess the home case management behaviors of mothers, including care seeking behavior. An innovative assessment and monitoring method (Sick Child Audit (ABS - Audit Balita Sakit) using mother recall of home case management behaviors and provider behaviors will be used in addition to other data collection methods.

Interventions will be aimed at the most critical specific provider behaviors found deficient by the assessment. Doctors and midwives from both the public and private sectors as well as warung and toko drug sellers will be informed about expected management methods through professional organizations (IDI, IBI) or directly by Dinas Kesehatan staff, and asked to agree formally (contract) to adopt specific desired case management behaviors. Mothers who are members of community mothers' organizations will be trained in the use of a simplified ABS instrument, and will collect continually information on provider and maternal behaviors through interviews with neighbors whose children have been sick. When the ABS shows that providers have failed to use the methods they agreed to use, a report will be submitted by the mothers' organization to Dinas Kesehatan health officials in Purworedjo who will inform the specific practitioner that further improvement is needed. Deficiencies in maternal home case management detected by the ABS will be targeted by the mothers' organizations as the basis for education and promotion efforts aimed at their members and other women in the community. Improved counseling of mothers of sick children by practitioners as a result of the project's interventions will reinforce the educational and promotion activities by the mothers' groups in improving home case management of sick children.

An end-of-project cross-sectional ABS survey combined with other data collection methods will allow assessment of the intervention processes and costs, assessment of changes in home and practitioner behaviors in comparison to the baseline pre-project data, and assessment of the validity and reliability of the ongoing ABS data from the mothers' organization monitoring activities.

The first phase of the study will be in four subdistricts in Purworedjo in which a baseline assessment has already been carried out in an earlier study. Two subdistricts will have interventions and the remaining two will serve as a control area. Both the intervention and control subdistricts will have monitoring of behaviors by the mothers' organization, but only in the intervention subdistricts will the results of that monitoring be fed back to the practitioners. In the second phase of the study four additional subdistricts will be covered using simplified methods suitable for use by district or subdistrict staff at low cost, again with two intervention and two control subdistricts. In the third phase of the study the four control subdistricts will receive the intervention and continuing monitoring and feedback, while monitoring and feedback will continue in the four subdistricts which received the interventions in phases 1 and 2.

OBJECTIVES

1. To assess the quantitative proportion and quality of care being provided by private and public sector providers to children for their most important health problems, including both curative services and preventive care and health education.
2. To carry out an educational and motivational intervention aimed at improving the quality of services being provided by those practitioners which provide the majority of care to sick children, with the standard of quality being the newly adopted algorithm for integrated management of sick children (MTBS -- Manajemen Terpadu Balita Sakit)
3. To involve local mothers' groups in assessing and monitoring the quality of provider care using a simple audit approach (ABS -- Audit Balita Sakit), the results of the audit being fed back to practitioners through the Department of Health
4. To improve home case management and health seeking behaviors of families in response to child illness, through improved practitioner counseling of mothers during case management and through educational and motivational activities of the mothers' groups to their members in response to the information on inadequate home practices from the ABS monitoring activities.
5. To monitor and assess the process, quality, and cost of the implementation of the interventions, and to evaluate their impact on the quality of care provided by targeted private providers and on the case management and health seeking behaviors of community households.

BACKGROUND & RELEVANCE

Studies in a number of countries have indicated the remarkably high proportion of cases of common childhood diseases which are treated by private sector providers. In India, a nationwide study showed that, of children with diarrhea taken outside the home for treatment, fully 93% were treated by private practitioners, and only 7% by government facilities and providers (Rohde et al, 1988) These private practitioners included a wide range of types, from the unregistered and often untrained "village doctor" often practicing largely Western style medicine, to sellers of drugs at shops specializing in drugs or shops dealing with general household goods, to practitioners of formal systems of indigenous medicine (Ayurvedic, homeopathic) as well as traditional healers, to local herbalists and birth attendants.

Surveillance data collected by the CHNRL in the Purworedjo study population have documented that a large proportion of children with the major health problems of that age group obtain their care from private sources. Table 1 shows that doctors and bidans in private practice as well as drug shops provide more than half the care for these problems. These figures most likely represent an underestimate, as the questions used to elicit this data did not probe aggressively for the full sequence of actions taken by the family, and may have been biased by expectations on the part of respondents that the interviewer was seeking information primarily about consultations with formal health sector practitioners and facilities.

TABLE 1

CARE SEEKING FOR UNDER 5s
IN PURWOREDJO, CENTRAL JAVA
(figures in percent)

	fever	cough	cold	diarrhea
govt hosp	1.6	0.2	0.3	1.4
priv hosp	0.7	0.2	0.3	
HC/HC satell	27	24	20	31
priv clinic	0.2	0.2		
posyandu	0.4	0.6	0.4	6.8
docter priv pract	7.2	8.2	5.2	7.5
bidan priv pract	8.5	7.1	5.8	10.9
drug shop	27	29	35	11
dukun	2.4	0.9	0.4	
sinshe	0.2		0.3	
self Rx	15	13	14	21
ignored, no Rx	8	13	16	6
other	3	3	3	4

[Source: Laporan Penelitian Tahun 1, 5/95]

More recent data from a baseline household survey in 4 Purworejo districts (TABLE 2) indicates that an even larger percentage of illness episodes are treated with medicines obtained from

TABLE 2 SOURCE OF OUTSIDE CARE FOR CHILD ILLNESS EPISODES
(figures in percent)

Drug sellers	53.4
-- warung	44.0
-- toko obat	7.6
-- apotek	1.8
Midwife (bidan)	27.1
-- puskesmas*	11.8
-- bidan	8.1
-- pustu*	3.7
-- polindes*	2.0
-- puskesmas*	1.5
Dokter	6.0
Mantri praktek swasta	2.2
Dukun bayi atau lain	1.9
Other (no source > 1%)	9.4

TOTAL	100.0

Ddata from 1996 Sick Child Audit Household Survey

* presumed to be care by bidans

small shops selling general household items (warungs) or other drug sellers, while midwives (bidans) provided the majority of practitioner care, either in government facilities or private settings.

Data demonstrating the widespread inconsistency of case management practices with standard protocols for these illnesses is also abundant, in Indonesia as well as in nearly every country in which such studies have been done. Studies of drug prescriptions in Indonesia have shown a high use of unnecessary tetracycline and other antibiotics and a low use of ORS (oral rehydration solution) by practitioners of various sorts (Bates, *Where Has The Tetracycline Gone?*, 1987), for example, and a recent assessment of case management practices of public sector practitioners for ARI cases showed nearly universal absence of the critical practice of counting respiratory rates and observing for chest indrawing as the basis for a diagnosis of pneumonia, and the use of ineffective antibiotics in treatment of that group of illnesses. (Haryoko, HP-IV baseline study, 1994 unpubl)

A recent household survey in 4 Purworejo subdistricts which asked mothers about the actions of the practitioners consulted for specific episodes of childhood illness occurring in the previous 2 weeks compared current practitioner behaviors with those specified by the WHO algorithm for Integrated Management of Childhood Illness (MTBS -- Manajemen Terpadu Balita Sakit). The results of this survey are attached as Appendix I pages 4-8. Both government and private practice practitioners showed substantial deviation from the behaviors specified in the MTBS protocol.

While a quantitative estimate of the contribution of these ineffective practices to excess childhood mortality and unnecessary morbidity from these illnesses is difficult, it may be estimated that as much as 50% of deaths among children brought to careseekers could be avoided by effective case management practices even in such simple low-tech environments as a rural solo practitioner's practice site or satellite health center (Pustu) in Central Java.

Maternal knowledge and beliefs and careseeking practices contribute to the excess deaths caused by inadequate case management of sick children, in particular where they lead to failure to seek essential medical care. Recent work in Indramayu, West Java has shown failure on the part of mothers to recognize critical signs of pneumonia, reluctance to take sick infants out of the house for care, and problematic behaviors such as the mother taking the medication designated for the infant (Sudart B et al, 1993; Sutrisna B et al, 1993). For the 139 infants and children in the Indramayu cohort who died during the study period, the likelihood that Western-style medical care would be sought at any time during the eventually fatal illness was strongly and independently associated with indicators of maternal beliefs, knowledge, and attitudes related to health, disease, and care-seeking. (Reingold, 1993 unpubl)

Data on home case management practices for specific childhood illnesses (diarrhea, fever, respiratory illness) from the 1996 household survey in 4 Purworejo subdistricts already referred to showed substantial deviations from desired home case management practices. (Appendix I pages 1-3)

A major challenge to those who would reduce excess child mortality from such preventable causes is thus to determine how to influence maternal beliefs, knowledge, and attitudes so that home management of child illness is improved and barriers to appropriate care-seeking for serious episodes are overcome or eliminated.

Community organizations, particularly women's organizations (mothers' groups) can play an active and important role in child health. Motivation of members or other community women to participate in monthly weighing activities, support and motivation for participation in routine and special immunization activities, education regarding care of diarrhea or other child illnesses, actual distribution of important health products such as oralit, condoms, contraceptive pills, or vitamin A supplements are all activities of women's organizations which support healthy children.

A recent survey in 4 Purworejo subdistricts identified 53 community organizations, of which 22 were women's organizations, and 8 were organizations to carry out Pos Yandus. 46 of the 53 organizations already are involved in health related activities, as shown in Appendix II. Of the 36

organizations involved in immunization, 9 (25%) actually gave immunizations (the Pos Yandu organizations plus one additional organization) while all 36 were involved in promotion and assistance with immunization campaigns.

The Working Women's Forum, a women's organization in Madras, India, played an active role in improving the care being provided to their children by government health facilities, pushing facility staff members to provide services which they were supposed to provide but were not. (personal observation) It seems reasonable to assume that women's organizations in Purworejo would be interested in participating in efforts to improve the effectiveness and quality of the care being given to their children when they are sick, as well as the effectiveness of their own home care.

Professional organizations of health workers have been active participants in efforts to improve the quality of care being provided by their members. A major effort by the Indian Medical Association resulted in training of 37,000 doctor members nationally in modern diarrhea case management. The Badan Koordinasi Gastroenterologi Anak Indonesia, a committee of the Indonesian Pediatric Association (IDAI) has been a leader in activities to improve the care of Indonesian children. IDI for doctors and IBI for bidans as well as PPNI for perawats are all strong and active in Purworejo area, and could play an important role in coordinating training and motivational activities for their members in collaboration with the Dinas Kesehatan.

DESIGN AND METHODOLOGY

STUDY AREA:

Phase 1:

- 4 subdistricts in Purworedjo District, as follows: Gobang and Pituruh, both rural kecamatans with intensive CHNRL sampling, and Purworedjo and Kutohardjo, both urban with non-intensive CHNRL sampling. Only a single puskesmas and its area will be covered in kabupatens which have more than one puskesmas (Purwo. and Kuto)
- Baseline data collection from all four subdistricts has already been carried out (see Appendices I and II)
- Interventions (provider training and behavior contracting, ABS monitoring by mother members of mother's organization and behavior feedback to practitioners by Dinas Kes) in 2 subdistricts (one intensive, one non-intensive), 2 subdistricts as control area (no training, ABS monitoring by mothers' organizations done but without behavioral feedback to practitioners)

Phase 2:

- 4 additional subdistricts in Purworedjo District, to be determined.
- baseline data collection by puskesmas staff in all 4 subdistricts
- interventions as in Phase 1 -- 2 intervention subdistricts, 2 control subdistricts

Phase 3:

- interventions in the 4 subdistricts which had been control districts in Phase 1 and 2.

STUDY TOPICS:

- home/maternal behavior: response to diarrhea, cough/fever, fever
- private provider behavior: response to diarrhea, cough/fever, fever
- NGO activities in support of community health concerns

BASELINE DATA

Baseline studies in 4 Purworejo subdistricts have already carried out the following data collection activities:

- household survey of mothers of sick children (Audit Balita Sakit) including review of actual case management and care seeking behavior in the recent illness, and recalled provider case management practices during a consultation for the recent child illness
- semi-structured interviews with health officials and staff, regarding attitudes, policies, and activities relative to the private sector.
- interviews with selected private providers and community organizations, characterizing nature and size, facilities, health related activities, and knowledge and projected response to case scenarios regarding standard case management of the target child illnesses, as appropriate.
- exit interviews of mothers leaving a practice site or drug shop regarding the case management practices of the private provider she has just consulted for her child's illness.
- observation studies of actual case management practices of private providers (very limited numbers due to unwillingness of practitioners to be observed)

Intervention planning has been based on the results of these studies

For Phase 2 subdistricts, the instruments used for the ABS in phase 1 will be simplified, and the interviews carried out by puskesmas staff. The other data collections will be carried out by interviewers under the direction of CHNRL/UGM.

INTERVENTION

Dinas staff, supported by UGM CHNRL staff, will carry out the following series of intervention related activities:

1. Informing and obtaining agreement from medical practitioners about expected case management behaviors, providing feedback, and adjusting agreements as appropriate

- Meet with IDI and IBI, obtain agreement to collaborate in this project
- Develop plan for Information meeting with doctors
- Develop plan for Information meeting with bidans
- Develop forms for recording agreement/contract of individual practitioners regarding each individual behavior targeted; forms for recording patient interactions to remind practitioners of desired behaviors as well as using in return visit
- Hold initial meeting for doctors, sponsored jointly by IDI and Dinas; inform practitioners of desired algorithm/behaviors; give scientific background as necessary; discuss and negotiate regarding specific behaviors relative to difficulties in carrying them out. obtain individual contracts for those specific behaviors agreed to by each doctor; plan followup meeting for 1 month later to discuss difficulties in carrying out desired behaviors. (one meeting probably sufficient for doctors (3 to 5 serving each of the 2 intervention kecamatans)
- Hold initial meetings for bidans, sponsored jointly by IBI and Dinas; inform bidans of desired algorithm/behaviors; give scientific background as necessary; discuss and negotiate regarding specific behaviors relative to difficulties in carrying them out. obtain individual contracts for those specific behaviors agreed to by each bidan; plan followup meeting for 1 month later to discuss difficulties in carrying out desired behaviors (2 meetings of \pm 10-15 bidans each to cover 2 kecamatans)
- Followup meeting with doctors; revise contracts as necessary (1 meeting)
- Followup meetings with bidans; revise contracts as necessary (2 meetings)
- Give individual feedback to doctors and bidans on quarterly basis from ABS results provided by

women's organization (Alternative #1: feedback to be given by kabupaten (dr Lina) to doctors (call them in to the Dinas for a personal meeting) , by dokter puskesmas to bidans (personal meeting at puskesmas); Alternative #2: feedback given by Dinas to IDI and IBI, then those organizations communicate the results to individual practitioners)

- Plan and implement followup meetings with doctors and bidans \pm 7 months after the initial contracting of behaviors and after two rounds of feedback, to discuss in a group the difficulties in carrying out the behaviors and plan actions or changes as necessary (3 meetings needed)
- Repeat followup meetings at \pm 13 months from initial information/contracting meetings, to again discuss progress and make adjustments as needed.

2. Informing warungs and drug sellers about expected behaviors, obtaining contracts, providing followup feedback, and adjusting agreements as appropriate

- Develop list of expected behaviors consistent with available products (ORS, drugs, soap, etc) at warungs, toko obats, and apoteks. This will require some additional data collection and focus group meetings
- Hold planning meeting at kabupaten with puskesmas staff to plan contacts with retailers, develop specific plan for each intervention puskesmas
- Puskesmas staff meet with retailers according to plan -- individually, meetings of retailers from 2-3 desas together, larger meetings, or other approaches. -- retailers informed of expected behaviors, negotiation carried out, agreement/contract obtained for those behaviors which the retailers accept to perform.
- Followup contact one month later, as with doctors and bidans
- Feedback from results of ABS provided to each retailer quarterly, using channel set at retailer meeting
- Followup meetings \pm 7 and 13 months after initial information/negotiation meetings (after two ABS feedbacks) to discuss progress together, make adjustments as needed

3. Collaboration with community women's organizations to carry out ABS monitoring of practitioner and retailer behaviors and to provide education to members and other community women regarding effective home case management of child illnesses and appropriate care seeking behaviors for more serious cases

- Prepare, with UGM support, plans for meetings with kecamatan women's organizations and assessments of interest and capability; prepare forms for recording process of meeting and for objective assessment of indicators of capability of the potential organizations.
- Conduct meetings/training with puskesmas staff from the 4 phase 1 kecamatans to conduct the meetings with organizations
- Dinas (probably puskesmas staff) with support from UGM staff carries out preliminary meetings with PKK, Fatayat, Asiyah, Darma Wanita, religious organizations, or other appropriate community organizations in the four Phase 1 kecamatans to assess their interest in collaboration in these activities, their capability in managing the data collection and reporting activities, and their capability in carrying out health education on these topics to other village women. On the basis of these meetings select 1 or 2 organizations for each kecamatan
- Prepare simplified version of ABS forms consistent with agreed upon behaviors of practitioners and retailers. Prepare materials for teaching about MTBS, home case management, and appropriate care seeking behaviors. Prepare plans and needed materials for training sessions with chosen community organizations.
- Hold meetings/conduct training of puskesmas or other selected staff on training methods for training community organizations in desired skills and activities

121

- Puskesmas staff or other selected staff conducts meetings/trainings of community organizations members in ABS and case management topics
- Members of organizations begin to carry out ABS with neighbors, submit forms to organizations, organizations in turn analyze results, identify deficient maternal and practitioner behaviors, submit reports to Dinas on quarterly or more frequent basis (whether to puskesmas or to kabupaten to be determined)
- Organizations conduct meetings or group health educations sessions with community women regarding good case management and health seeking behaviors, also on what behaviors to expect of practitioners and how to ask questions of practitioners
- Meetings between organizations and designated Dinas counterpart on quarterly basis to assess progress and problems and to arrange for modifications of procedures as needed.
- New materials for new or evolving topics developed on quarterly basis, for use in quarterly meetings between Dinas and community organizations to provide new input and upgrade levels of understanding in ongoing topic areas (diarrhea, fever, respiratory infection, malnutrition, immunization)

4. Phase 2: Extension of activities to 4 new kecamatans, including baseline assessments

The Phase 2 activities will begin at the same time as the Phase 1 Intervention activities with a series of pre-intervention activities including a baseline assessment, as follows:

- Select four Purworejo kecamatans and obtain agreement from Puskesmas and local government officials
- Initial meetings with puskesmas doctors and selected staff along with UGM team to define activities, identify potential collaborating women's organizations, identify puskesmas and kabupaten participating staff for baseline data collection activities, define job descriptions, and prepare overall Phase 2 workplans and schedules
- Prepare focused and simplified ABS instrument based on EPI INFO, for use by puskesmas staff and community organization members
- Train puskesmas staff and organization members in using ABS instrument
- Carry out baseline assessment of mother and practitioner behaviors (puskesmas staff)
- Identify practitioners serving kecamatans, including warungs and other drug sellers, bidans, doctors through key informant interviews (District and puskesmas staff) using standardized forms.
- Identify problem and deficiencies in home case management and practitioner case management through analysis of baseline ABS and other assessments.
- Hold separate meetings with IB1, ID1, and selected community women's organizations, present information on case management behaviors to them, and obtain their agreement to participate in the project

Following these preintervention activities, the intervention activities will proceed as described in Intervention Steps 1 through 3 above.

5. Phase 3: Intervention in the 4 control kecamatans from Phase 1 and Phase 2.

Phase 3 activities will be initiated following the completion of the evaluation of both Phase 1 and Phase 2 activities, that is, approximately 18 months after the initiation of Phase 1. As baseline assessments will have already been carried out in these kecamatans, the intervention activities can be initiated immediately, following the sequence of activities described in Steps 1 through 3 above. Only monitoring will be carried out; no formal evaluation will be performed. The project supported intervention activities will cease after the submission of 2 ABS monitoring reports from the mothers' organizations involved and the 7 month review meeting with the practitioners.

122

Further activities of the involved puskesmas in collaboration with the community and professional organizations in the kecamatans in all three phases will continue as part of routine Dinas activities or as a separate PDE activity for which a subsequent proposal will be submitted.

6. Monitoring, management, and evaluation of provider and community activities

MANAGEMENT

The planned interventions in Phase 1 will be implemented over approximately a 13 month period, from July 1997 through June 1998. Phase 2 will begin 3 months later and run a similar time course. Phase 3 will begin only after the completion of phases 1 and 2.

The Project Director will be the Head of the Maternal and Child Health unit of the District health department (Dinas Kesehatan). The Dinas will designate a senior staff member to be the Project Coordinator, who will manage the project from Kabupaten level on a day-to-day basis. In each involved subdistrict (kecamatan) the physician head of the puskesmas will be the Subdistrict Project Director, and a staff member will be designated as the active Subdistrict Project Coordinator to take similar day-to-day responsibility for the activities. Staff members at District and Subdistrict levels will be engaged for data collection, training, and other activities on an intermittent basis.

The UGM CHNRL program will support these activities through preparation of needed forms, management and analysis of data collected, and preparation of training and information materials, as well as providing assistance in identification and solution of problems as they arise. CHNRL staff will include a Project Director, a Project Coordinator, and a Senior Consultant in Yogyakarta along with data management and analysis assistants and secretarial and administrative support on an as-needed basis. CHNRL will also appoint a Field Manager stationed in Purworejo who will participate in many of the project's activities as observer and recorder as well as providing assistance in problem solving, maintain regular communication with the project team in Yogyakarta as well as the District and Subdistrict project directors and coordinators, the community organizations, and the professional organizations, and pursue intermittent contact with local government officials as well as health workers and community leaders. The USAID BASICS Project (BASic Support for Institutionalizing Child Survival) based in Washington will provide intermittent technical support to the Dinas and UGM teams at no expense to the project.

Dinas staff will actively manage and monitor the activities of the project through **weekly meetings** with the CHNRL Field Manager, **monthly meetings** with the Yogya-based CHNRL study team, with participating puskesmas staff, and with professional organizations, and **quarterly meetings** with participating community women's organizations. Data monitoring the progress of the implementation will be obtained through **regular written reports** prepared by the Project Director in collaboration with the Project Coordinator and CHNRL Field Manager, through brief **event reports** documenting meetings on a simple standardized form completed by the Dinas, community organization, or professional organization person responsible for the event, through **verbal reports at meetings** recorded in meeting minutes, and through village level **field visits** and random **interviews** with target providers and mothers by the CHNRL Field Manager and CHNRL Project Director and Project Coordinator recorded on a standardized form for efficient data management..

MONITORING

Data monitoring the impact of the interventions on behaviors of mothers and providers will be obtained from ongoing **ABS interviews** performed by community organizations and by puskesmas staff. This information will be augmented by questions added to the routine **CHNRL longitudinal cohort 3-monthly household health and demographic data gathering** activities. The CHNRL Field Manager will be responsible for **documenting the costs of the intervention**, in particular the time

spent by various staff members. Data will be collected using standardized instruments from implementing organizations and staff regarding the **time spent** on intervention activities. Six-monthly reports prepared by the Project Director in collaboration with the Project Coordinator and the CHNRL Field Manager will summarize implementation progress and problems, data collected, management and problem-solving activities, and cost estimates for the interventions during that period..

EVALUATION

Evaluation studies will be carried out at the end of the 13 month implementation period for each phase. The evaluation studies will repeat the baseline household studies regarding actual case management practices and knowledge and projected response to case scenarios of the target health problems, also the exit interviews, observation studies of practitioners, and interviews with practitioners regarding knowledge and projected response to case scenarios.

SIGNIFICANCE AND DISSEMINATION OF THE EXPECTED PROJECT FINDINGS

The assessment activities of this project will provide a significant increase in understanding about the exact role of private sector providers of health care in the case management of the most critical illnesses of children. The specific approaches to information gathering will allow more detailed knowledge of the process leading from disease onset to home care provision by mothers or other caretakers, to seeking care outside the home, and to the provision of care by practitioners of various sorts. This detailed description of the "Pathway to Child Survival" in a specific locality will provide the basis for targeted interventions to facilitate behaviors which will support improved child health and reduced child mortality. It will at the same time, it is expected, be an important component of efforts to convince health officials of the importance of private sector activities (for example poor quality case management by private providers) as part of their responsibility, and of the potential for the private sector to contribute to the solution of community health problems through such educational efforts led by local branches of national professional organizations such as IDI and IBI or by community women's organizations as are part of this project.

At a broader national and international level, the data from the assessments and intervention activities will contribute to a strengthening tide of recognition among governments and donors that efforts to improve basic health services and improve health in developing populations must include the private sector in planning and assessing both prevention and curative care. This project will demonstrate both the challenges and the rewards of facilitating the private sector in making a positive contribution to better health.

The task of the project is to develop practical and effective methodologies suitable for use by the public sector to assess the private sector and to intervene in improving its functioning. The Purworedjo effort is timed to coordinate with activities planned under the new World Bank funded Health Project IV (HP-IV). The methodologies developed in Purworedjo will be immediately introduced to provincial, district, and kecamatan health officials involved in HP-IV at workshops to be held in 1996 and 1997, with the expectation that they will be implemented in a number of districts in 5 provinces (Jawa Timur, NTB, Sumatra Barat, Kalimantan Timur, Kalimantan Barat) over the 5 years of HP-IV.

In addition, the collaborating BASICS project has activities in some 30 countries. It is the policy of BASICS to encourage each of its country projects to assess the role of the private sector in child health and to take action to improve that role as appropriate. The experience in Purworedjo will be directly applied in other BASICS countries through the involvement of the BASICS consultant to the Purworedjo investigations.

The CHNRL and BASICS collaborators will also assist the Project Director in preparing reports suitable for publication in national and international literature, for the widest possible dissemination of the results of the activities.

BUDGET

124

**PRIVATE SECTOR INVENTORY & QUALITY ASSESSMENT
UNIVERSITAS GADJAH MADA CHNRL
HOUSEHOLD SURVEY REPORT
24 JUNE 1996**

FROM FORM BV – HOME CASE MANAGEMENT & CARE SEEKING

- Rate of each illness in last 2 weeks, and annual # of episodes of each illness in an average child under 5 years of age (based on 1 week duration of illness)

TYPE OF ILLNESS	PREVIOUS 2 WEEKS	ANNUAL EPISODES PER AVERAGE CHILD
Fever	575 (65 %)	8.5
Diarrhea	60 (7 %)	1.4
Respiratory infection	774 (88 %)	11.4

- Rates of inadequate or inappropriate home case management practices regarding fever

HOME MANAGEMENT PRACTICES - FEVER	PERFORMANCE RATE
gave less or no fluids	13 %
gave breastmilk less often	3 %
gave food less often	39 %
did not bathe with tepid water	36 %
did not take off clothing	72 %
did not give aspirin or paracetamol	84 %
gave antibiotics prior to consulting provider	1 %
did not give chloroquine	99 %

-- Rates of inadequate or inappropriate home case management practices regarding **diarrhea**

HOME MANAGEMENT PRACTICES - DIARRHEA	PERFORMANCE RATE
Gave less or no fluid	10 %
did not give ORS	80 %
did not give SSS	87 %
gave food less often	35 %
gave anti-diarrheal meds	8 %
gave antibiotic	3 %

-- Rates of inadequate or inappropriate home case management practices regarding **ARI**

HOME MANAGEMENT PRACTICES - ARI	PERFORMANCE RATE
gave traditional herb med	5 %
used other traditional measures	31 %

-- Rate of seeking advice for **each illness** and for **all cases**

SOUGHT ADVICE FOR	NUMBER AND RATE
Fever	39 (7 %)
Diarrhea	11 (18 %)
ARI	41 (5 %)
All cases	52 (6 %)

-- Rate of seeking medicine for **each illness** and for **all cases**

SOUGHT MEDICINE	NUMBER AND RATE
Fever	475 (83 %)
Diarrhea	45 (75 %)
ARI	609 (79 %)
All cases	678 (77 %)

-- Rate of seeking care for each illness and for all cases

SOUGHT TREATMENT	NUMBER AND RATE
Fever	282 (49%)
Diarrhea	32 (53%)
ARI	312 (40%)
All cases	355 (40%)

-- Rate of using each of the 6 most frequently used types of practitioner for each illness and for all cases that sought treatment outside the home:

PRACTITIONER TYPE	FEVER	DIARRHEA	ARI	ALL CASES
Health Center or Post	120 (37.7%)	7 (19.4%)	130 (37.8%)	147 (38%)
Private Midwife	56 (17.6%)	8 (22.2%)	59 (17.2)	64 (16%)
Private doctor	36 (11.3%)	7 (19.4%)	43 (17.2%)	49 (13%)
Village maternity post	16 (5%)	2 (5.6%)	18 (12.5%)	19 (5%)
Govt. hospital	10 (3.1%)	2 (5.6%)	8 (2.3%)	11 (3%)
Other	75 (23.6%)	9 (25%)	81 (23.5%)	95 (24%)

FROM FORM BK – QUALITY OF PRACTITIONER CASE MANAGEMENT

The following tables are based on a comparison of the three most frequently used public providers (healthcenter, health post, and village maternity post) and the three most frequently used private providers (private doctors, midwives, and nurses)

For **all cases**, rates of critical practitioner behaviors :

HISTORY TAKING:

for the most frequently used types of providers (n=787)

PROVIDER BEHAVIOR	YES	NO
asks about illness or about immunization	134 (17 %)	653 (83 %)
asks the mother about what she had done at home for the child's illness	84 (63 %)	50 (37 %)
asks about or asks for the child's immunization card	29 (22 %)	105 (78 %)
asks about immunization of the mother herself	4 (0.5 %)	134 (99 %)
advises mother to get immunizations for the child	21 (16 %)	113 (84 %)
advises the mother to get herself immunized	4 (3 %)	130 (97 %)

EXAMINATION:

For the most frequently used types of providers, for **all cases**
(DEPKES = Dept of Health, SWASTA = Private)

PROVIDER BEHAVIOR	DEPKES (n=136)	SWASTA (n=126)
weighs the child	26 %	35 %
takes temperature of child using thermometer	18 %	34 %
touches the child	67 %	88 %
looks at the throat	32 %	54 %
takes off the child's clothing to examine the child	74 %	79 %
examines the abdomen with his/her hand	43 %	69 %

- for cases of **fever**, rates of critical practitioner behaviors for the most frequently used types of providers

PROVIDER BEHAVIOR	DEPKES (n=81)	SWASTA(n=74)
takes temperature using thermometer	21 %	31 %
touches the child	85 %	95 %
looks at the throat	32 %	58 %
takes off the child's clothing to examine it	72 %	89 %
examines the abdomen with hand	44 %	74 %

- for cases of **diarrhea**, rates of critical practitioner behaviors for the most frequently used types of providers

PROVIDER BEHAVIOR	DEPKES (n=7)	SWASTA(n=11)
asks about what was done at home (eg gave ORS or SSS, gave special diet, etc)	14 %	36 %
weighs the child	0 %	18 %
examines the abdomen with hand	43 %	91 %
touches the child	86 %	91 %
pinches the skin to check for dehydration	0 %	18 %

- for cases of **ARI**, rates of critical practitioner behaviors for the most frequently used types of providers

PROVIDER BEHAVIOR	DEPKES (n=77)	SWASTA (n=74)
measures temperature with a thermometer	18 %	28 %
uses a watch or timer to measure the frequency of respiration	8 %	16 %
takes off the child's shirt so that the chest can be seen	71 %	82 %
uses a stethoscope	82 %	88 %

CASE MANAGEMENT:

for the most frequently used types of providers

-- for **all cases**, rates of behavior which is not consistent with standard practices:

PROVIDER BEHAVIOR	YES	NO
giving injection	12 (3.2%)	364 (96.8%)
giving more than one injection	1 (8.3%)	11 (91.7%)
giving pill/tablet/powder	373 (98.7%)	5 (11.3%)
giving more than 2 types of pill/tab/powder	53 (14.3%)	318 (85.2%)

-- for cases of **fever**, rates of behavior which are inconsistent with standard practices:

PROVIDER BEHAVIOR	DEPKES (n=81)	SWASTA (n=80)
gave injection	1 %	4 %
gave antibiotic	0 %	1 %
did not recommend to bathe the child with tepid water	84 %	76 %
did not give anti-fever medicine	42 % - 58 % *	68 % *
did not recommend to give lots of fluid	91 %	85 %
did not speak of fluid at all	80 %	
did not inform the mother about danger signs to look for to know when to come for care	100 %	100 %

* = includes respondents that did not know or did not remember what was given

-- for cases of **diarrhea**, rates of behavior inconsistent with standard practices

PROVIDER BEHAVIOR	DEPKES (n=7)	SWASTA(n=11)
tidak memberi oralit	100 %	100 %
gave antidiarrhea medicine	100 %	100 %
gave antibiotic	0 %	0 %
did not recommend increasing fluids, or did not speak of fluids at all	71 % 57 %	82 % 46 %
did not recommend giving diet as usual, or more often than usual.	86 %	63 % 0 %
recommended reducing the intake of foods	0 %	9 %
did not speak about diet or foods at all	71 %	55 %
did not give information about how to mix ORS	100 %	100 %
did not give information about danger signs to watch for to know when to seek care	100 %	100 %

-- for cases of **ARI**, rates of behavior inconsistent with standard practices:

PROVIDER BEHAVIOR	DEPKES (n=77)	SWASTA (n=74)
gave injection	0 %	7 %
did not recommend increasing fluid intake, or did not speak at all about fluid intake	71 % 60 %	84 % 72 %
did not give information about danger signs to look for to know when to seek care	100 %	100 %

INFORMATION GIVING

For the most frequently used types of providers

— for all cases, rates of information giving:

PROVIDER BEHAVIOR	YES	NO
how to give the medicine or syrup	327 (42 %)	460 (58 %)
about food/diet, or how and what to give for diet while child is sick	57 (7 %)	730 (93 %)
about fluids which the child should take	33 (4 %)	753 (96 %)
about breastfeeding the child	5 (0.6 %)	782 (99 %)
about when the child should be brought back to be checked, or about referral to another provider	31 (4 %)	756 (96 %)
about danger signs which tell when the child is getting worse, and needs to get help again	-----	787 (100 %)
gave the mother a chance to ask any questions	65 (8 %)	721 (92 %)
about how to prevent the illness in the future	12 (2 %)	774 (98 %)

APPENDIX II

ORGANISASI MASYARAKAT (53 FORM)

NAMA ORGANISASI	JUMLAH	NAMA ORGANISASI	JUMLAH
Aisyah, Fatayat	2	Kelompok Tani	2
AMPI	3	Klompencapir	1
Dasawisma	7	KPD	1
Darma Pertiwi	1	Kumpulan RT	1
Darma Wanita	2	NU, Muhmdy, muslimat	3
PPNI	1	KB	1
FKPPI	2	PEPABRI	1
HWK	1	PKK	11
Karang taruna	2	Posyandu	8
PWRI	1	Tatwamasi	1

Keanggotaan Organisasi

Wanita	22
Pemuda/Pemudi	7
Umum	8
Profesi	1
Keagamaan	5
Ibu&balita	8
Lainnya	7

Aktivitas kesehatan

Ya	46
Tidak	7

Imunisasi :Promosi dan vaksinasi	36	78%
Pembagian Vitamin A	18	39%
Penyuluhan Gizi	21	46%
Penyuluhan Kesehatan	40	87%
Sanitasi lingkungan	44	96%
Pembagian Oralit	19	41%
Promosi KB	38	78%
Pos Pengobatan	1	2%
Lainnya	24	52%

Telah aktif dalam imunisasi selama lima tahun terakhir

Ya	36	78%
Tidak	10	22%

Promosi Imunisasi	36	100%
Membawa anak ke tempat imunisasi	-	-
Menemani Ibu dan anak ke tempat imunisasi	-	-
Memberikan Imunisasi	9	25%
Membantu kampanye imunisasi	36	100%
Lainnya	1	3%

**APPENDIX H
PILOT PROJECT PROPOSAL**

PILOT PROJECT PROPOSAL

ACTIVITIES

1. Preliminary pre-intervention activities including baseline assessment

- Select one kecamatan - criteria: interested puskesmas doctor and staff, relatively easy to reach
- Initial meetings with Dinas kabupaten project director and project coordinator, puskesmas doctor and selected staff, UGM team: define activities, identify potential collaborating women's organizations, identify puskesmas and kabupaten participating staff and define job descriptions, modify overall pilot plans as needed based on discussions,
- Prepare focused ABS instrument based on EPI INFO, for use by puskesmas staff and/or community organization members
- Train puskesmas staff or organization members in using ABS instrument
- Carry out baseline assessment of mother and practitioner behaviors
- Identify practitioners serving kecamatan, including warungs and other drug sellers, bidans, doctors through key informant interviews
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2. Informing and obtaining agreement from medical practitioners about expected case management behaviors, providing feedback, and adjusting agreements as appropriate

- Meet with IDI and IBI, obtain agreement to collaborate in this project
- Develop plan for Information meeting with doctors
- Develop plan for Information meeting with bidans
- Develop forms for recording agreement/contract of individual practitioners regarding each individual behavior targeted; forms for recording patient interactions to remind practitioners of desired behaviors as well as using in return visit
- Hold initial meeting for doctors, sponsored jointly by IDI and Dinas; inform practitioners of desired algorithm/behaviors; give scientific background as necessary; discuss and negotiate regarding specific behaviors relative to difficulties in carrying them out, obtain individual contracts for those specific behaviors agreed to by each doctor; plan followup meeting for 1 month later to discuss difficulties in carrying out desired behaviors. (one meeting with 3-5 doctors)
- Hold initial meeting for bidans, sponsored jointly by IBI and Dinas; inform bidans of desired algorithm/behaviors; give scientific background as necessary; discuss and negotiate regarding specific behaviors relative to difficulties in carrying them out, obtain individual contracts for those specific behaviors agreed to by each bidan; plan followup meeting for 1 month later to discuss difficulties in carrying out desired behaviors (1 meeting of \pm 10-15 bidans from the target kecamatan)
- Followup meeting with doctors; revise contracts as necessary (1 meeting)
- Followup meetings with bidans; revise contracts as necessary (1 meeting)
- Give individual feedback to doctors and bidans on quarterly basis from ABS results provided by women's organization (Alternative #1: feedback to be given by kabupaten (dr Lina) to doctors (call them in to the Dinas for a personal meeting) . by dokter puskesmas to bidans (personal meeting at puskesmas); Alternative #2: feedback given by Dinas to IDI and IBI, then those organizations communicate the results to individual practitioners)
- Plan and implement separate followup meetings with doctors and bidans \pm 7 months after the initial contracting of behaviors and after two rounds of feedback, to discuss in a group the difficulties in carrying out the behaviors and plan actions or changes as necessary (2 meetings needed)
- Repeat followup meetings at \pm 13 months from initial information/contracting meetings, to again discuss progress and make adjustments as needed.

2. Informing warungs and drug sellers about expected behaviors, obtaining contracts, providing followup feedback, and adjusting agreements as appropriate

- Develop list of expected behaviors consistent with available products (ORS, drugs, soap, etc) at

135

warungs, toko obats, and apoteks. This will require some additional data collection and focus group meetings

- Hold planning meeting at kabupaten with puskesmas staff to plan contacts with retailers, develop specific plan for the selected kecamatan and puskesmas
- Puskesmas staff meet with retailers according to plan -- individually, meetings of retailers from 2-3 desas together, larger meetings, or other approaches. -- retailers informed of expected behaviors, negotiation carried out, agreement/contract obtained for those behaviors which the retailers accept to perform.
- Followup contact one month later, as with doctors and bidans
- Feedback from results of ABS provided to each retailer quarterly, using channel set at retailer meeting
- Followup meetings \pm 7 and 13 months after initial information/negotiation meetings (after two ABS feedbacks) to discuss progress together, make adjustments as needed

3. Collaboration with community women's organizations to carry out ABS monitoring of practitioner and retailer behaviors and to provide education to members and other community women regarding effective home case management of child illnesses and appropriate care seeking behaviors for more serious cases

- Prepare, with UGM support, plans for meetings with kecamatan women's organizations and assessments of interest and capability; prepare forms for recording process of meeting and for objective assessment of indicators of capability of the potential organizations.
- Conduct meetings/training with Dinas and/or puskesmas staff from the selected kecamatan to conduct the meetings with organizations
- Dinas (probably puskesmas staff) with support from UGM staff carries out preliminary meetings with PKK, Fatayat, Asiyah, Darma Wanita, religious organizations, or other appropriate community organizations in the selected Pilot kecamatan to assess their interest in collaboration in these activities, their capability in managing the data collection and reporting activities, and their capability in carrying out health education on these topics to other village women. On the basis of these meetings select 1 or 2 organizations for the pilot kecamatan
- Prepare simplified version of ABS forms consistent with agreed upon behaviors of practitioners and retailers. Prepare materials for teaching about MTBS, home case management, and appropriate care seeking behaviors. Prepare plans and needed materials for training sessions with chosen community organizations.
- Hold meetings/conduct training of puskesmas or other selected staff on training methods for training community organizations in desired skills and activities
- Puskesmas staff or other selected staff conducts meetings/trainings of community organizations' members in ABS and case management topics
- Members of organizations begin to carry out ABS with neighbors, submit forms to organizations, organizations in turn analyze results, identify deficient maternal and practitioner behaviors, submit reports to Dinas on quarterly or more frequent basis (whether to puskesmas or to kabupaten to be determined)
- Organizations conduct meetings or group health educations sessions with community women regarding good case management and health seeking behaviors, also on what behaviors to expect of practitioners and how to ask questions of practitioners

APPENDIX I
FACILITATORS GUIDE: GENERAL OUTLINE

USUL-USUL KERANGKA BUKU-BUKU PMPT

I. BUKU PANDUAN MAHASISWA

- Pendahuluan
- Tujuan2 umum

Ilmu dasar protokol MTBS

- Tujuan2 spesifik
- Latar Belakang perkembangan protokol MTBS
- ilmu priority setting
 - protokol2 dan program2 vertikal - diare, ISPA, imunisasi
 - epidemiologi penyakit2 anak angka mortalitas dan morbiditas, kemudian penentuan penyakit2 prioritas; tambahan penyakit yg perlu di-protokol-kan
 - malaria
 - gizi
 - sakit telinga
 - pentingnya usaha untuk mengkaitkan kuratif dgn preventif - konsep "missed opportunity" dan dampak usaha2 preventif pada kesehatan anak
- ilmu decision making - mengapa memakai protokol/algorithm
- ilmu cost-benefit dan faktor2 ekonomi; faktor2 efficiency dan cost-effectiveness - justifikasi untuk kegiatan yg terintegrasi secara umum, dan protokol MTBS yg mengintegrasikan protokol2 lainnya
- proses perkembangan protokol MTBS, dgn penelitian2 ilmu sbg bukti, hasil ujicoba2 protokolnya
- proses adaptasi protokolnya untuk lingkungan epidemiologis tertentu, termasuk musim
- pertanyaan2 dan self-drill atas contoh2
- referensi

Protokol MTBS - tekanan untuk masing2 unurnya - anak yg berumur 2 bulan sampai 5 th

- Panduan penerapan/petunjuk pelaksanaan protokol MTBS
 - pemakaian status pasien
 - kapan protokol perlu dipakai
 - hubungan dgn program DepKes
 - program MTBS
 - Posyandu
 - KB dan kesehatan wanita, termasuk immunisasi TT pada ibu
 - MTBS di lapisan2 sistem kesehatan - pustu, puskesmas, RS kabupaten, RS C, B, A, fasilitas2 swasta dan peranan petugas2 kes.. swasta. Peranan dokter dan paramedis di lapisan2 rujukan dan pemakaian sistem dan mekanisme rujukan dlm pelaksanaan MTBS

- ASSESSMENT DAN KLASSIFIKASI *[isi dari yg berikut hanya meliputi isi protokol dan pemakaiannya, tidak termasuk ilmu dasar masing2 topiknya]*
 - Tujuan2 spesifik
 - Komunikasi dgn ibu
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
 - Tanda2 bahaya
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
 - Panas
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
 - topik berikutnya (batuk/sesak nafas; diare, sakit telinga, malnutrisi dan anemia, imunisasi)
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2

- IDENTIFIKASI TERAPI DAN RUJUKAN

- PEMBERIAN TERAPI
 - panas
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
 - diare
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
 - dll
 - dll

- PEMBERIAN COUNSELING KEPADA IBU
 - subtopik
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
 - dll

-- MANAJEMEN ANAK SAKIT BERUMUR 1 MG SAMPAI 2 BULAN

- subtopik
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
- dll
- dll

-- FOLLOWUP

- subtopik
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
- subtopik
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2
- subtopik
 - keterangan2
 - contoh2
 - pertanyaan2
 - referensi2

II. BUKU PEGANGAN PEMBIMBING

- Pendahuluan (tujuan dan pemakaian isi bukunya, hubungan dgn Buku Panduan Mahasiswa ttg MTBS dan Buku Ajar dari UKK-UKK)
- Metoda2 mengajar/belajar: bagaimana membimbing metoda2 m/b masing2 (active vs passive learning, diskusi kelompok, kuliah yg lebih aktif, role play, debat, drill, membimbing di bangsal/klinik, bimbingan problem-based learning, dll)
- Problem-Based Learning ttg MTBS dan bimbingannya - Kegiatan Mengajar-Belajar (KMB) ttg MTBS dlm format PBL (di kelas)
- Kegiatan Mengajar-Belajar (KMB) ttg ilmu dasar protokol MTBS - epidemiologi dan priority setting, decision making, cost-benefit, integrasi - di kelas
- Kegiatan Mengajar-Belajar (KMB) ttg Assessment dan Klasiifikasi - di kelas
 - self-study dari Buku Ajar - bimbingan pada kelompok studi, atas studi2 kasus dgn drillnya
 - diskusi kelompok ttg komunikasi dgn ibu, dgn pertanyaan2 dan jawabannya
 - main peran ttg komunikasi dgn ibu
 - diskusi kelompok ttg tanda2 bahaya dgn pertanyaan2 dan jawabannya
 - diskusi kel ttg panas
 - diskusi kel ttg dll...
 - " " " "

- kuliah ttg A & K
- KMB dgn video dan foto2
- KMB lainnya ttg A & K
- “ ” “ ”
- KMB ttg Identifikasi Terapi dan rujukannya - di kelas
-
- KMB ttg Pemberian Terapi
-
- KMB ttg Counseling - di kelas
 - diskusi kel
 - main peran
 - KMB lainnya
 -
- KMB ttg Manajemen Anak sakit berumur 2 mg sampai 2 bulan - di kelas
-
- KMB ttg Follow-up

Contoh Pola KMB di fasilitas-fasilitas pendidikan dan di fase-fase pendidikan

FASILITAS

- KMB di poliklinik pendidikan (intensif)
 - observasi dan umpan-balik, pemakaian ceklis
 - OSCE -- bimbingan atas logbook mhs
- KMB di bangsal anak
 - mencari kasus dgn tanda2 tertentu; metoda demonstrasi dan tanya-jawab dgn kasus2 demonstrasi
- KMB di puskesmas - bimbingan non-intensif
- KMB di RS kabupaten - bimbingan non-intensif

FASE PENDIDIKAN

- KMB di Problem-Based Learning -- KMB di PBL (Pengalaman Belajar Lapangan)
- KMB di Panum -- KMB di Clerkship -- KMB di Public Health
- KMB di lain kegiatan pendidikan

-- EVALUASI

- ilmu dan pendekatan2 evaluasi untuk pendidikan medis
 - konsep kompetensi dan pendekatan2 evaluasinya
 - evaluasi pengetahuan -- evaluasi ketrampilan -- evaluasi sikap dan motivasi
- pemakaian metoda2 evaluasi (ME) untuk pendidikan medis MTBS
 - ujian tertulis, dgn pertanyaan2 (sebagai lampiran)
 - observasi langsung dgn ceklis
 - penilaian status pasien
 - pemakaian kesan dan penilaian pasien ttg performance mhs
 - OSCE
 - logbook mhs
 - penentuan nilai mhs, keputusan lulus atau tidak