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HEALTH PROJECT IV WORKSHOP
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TABLE OF CONTENTS

ACRONYMS v

PURPOSE OF VISIT 1

BACKGROUND 1

TRIP ACTIVITIES 1

RESULTS AND CONCLUSIONS 2

RECOMMENDATIONS 4

SUGGESTED FOLLOW-UP ACTIONS 5

ACRONYMS

HP-IV	Health Project Four funded by World Bank
MCH	Maternal and Child Health
MOH	Ministry of Health
POA	Plan of Action
Posyandu	Integrated health post in Indonesia
TBA	Traditional Birth Attendant

PURPOSE OF VISIT

The purpose of this visit was to participate in the design and implementation of workshops for Health Project IV districts regarding utilizing data toward other Health Project IV performance indicators for district management, planning, and preparation for private sector studies.

BACKGROUND

HP-IV is a project implemented with World Bank funds in five provinces: East Java, Nusa Tengarra Barat, West Kalimatan, East Kalimatan, and West Sumatra. One of the stated aims of HP-IV is to increase the capability of district managers to independently allocate resources for basic health services. The project supports institutional development vis à vis the central, provincial, and district health offices. HP-IV expects to have an impact on health policy, supervision, and support institutions at each level. One of the central level roles is to develop health policy, provide technical guidance and oversight, and manage the national budget programming. The provincial health offices are expected to improve supervision and monitoring and demonstrate increased independence in health budgeting. At the district level, the officers are expected to independently manage programs, supervise health facilities, and become more actively involved in health budgeting. [1]

The HP-IV workshop objectives directly related to the author's input included the following[2]:

1) To improve district capacity to assess utilization and coverage and other HP-IV performance indicators through routine recording and monitoring and coverage surveys; and,

2) To enhance district capacity to design and implement surveys and other targeted collection methodologies to identify, diagnose, and plan solutions to problems in basic health services.

TRIP ACTIVITIES

The following is a listing of the author's activities during this trip:

September 23	Briefing at Ministry of Health with Robert Northrup, Mark Brooks, Nasirah Bahuadin, Eri, Faried, and other project secretariat staff. Opening ceremony and presentations began in the evening.
September 24-26	Workshop lectures, discussions, presentations and small group exercises.
September 27	Debriefing with Robert Northrup, Mark Brooks, Nasirah Bahuadin, and Eri. Prepared trip report.

RESULTS AND CONCLUSIONS

The four-day workshop was conducted smoothly without incident. The logistics were well managed by MOH staff. Computers and a printer were set up in a central location and available to all participants and facilitators. Nonetheless, none of the workshop activities required the use of a computer.

The author's key role was as a facilitator during the workshop. She rotated throughout the various small groups and provided insights and suggestions. In addition, she made a presentation entitled "Efficient Utilization of Manpower to Achieve MCH Targets." Data collected by JJ Frere in Lombok and data the author collected in Maluku provided the basis for discussion during this presentation. The questions put forth to guide the small group exercises were: 1) Do the total number of health center staff make an important difference in the achievement of MCH targets? and 2) What is the performance level of existing staff?

The graphic representations of total staff per health centers in Lombok and Maluku provinces revealed a great degree of variation. The Maluku data further described the number of staff in relation to their availability to the community. Detailed data from 47 health centers displayed the total number of midwives per fertile couple and total midwives per infant among other ratios of staff to catchment populations. Discussions in two of the small groups quickly determined that a more significant ratio should be the number of midwives per pregnant women. The former denominator "per fertile couple" is dependent upon the contraceptive prevalence in a particular district or catchment population. On the other hand, the denominator "per infant" is dependent upon the number of live births and infant mortality rate. The target emphasized during this module was first and fourth antenatal visits which is why the number of pregnant women is a better denominator.

The staff per population was also related to the total catchment population for each *posyandu*. Four examples from Maluku were portrayed -- two strong health centers and two weak health centers. In an effort to minimize demographic and geographic biases, a strong center was juxtaposed with a weak center of a similar makeup.

Another slide presented demographic data for four health centers, again rated strong and weak as noted above. The number of children under one and under five years of age as a percentage of the total population was provided. The strongest clinic has percentages close to the national averages while the weakest center had a very high proportion of infants that might be suggestive of poor contraceptive prevalence. This center also had an extremely low percentage of children under five years of age, which could be suggestive of a high mortality rate. Conversely, another weak health center had an extremely low percentage of infants that might suggest a high infant mortality rate or a high contraceptive prevalence. Since the percentage of children was also significantly lower than average it could suggest there are fewer children overall, perhaps because they are dying or contraception is indeed quite good.

Other data considered the ratio of staff per population (e.g., the number of vehicles available per population and per village; the number of sporadic *posyandus*; the number of first antenatal visits per midwife; and, the percentage of births attended by a midwife).

The purpose of presenting all of these data was to emphasize the need to examine data collectively rather than as vertical pieces of information. It does not suffice to look just at the number of midwives per pregnant women. Perhaps the midwives need to reach the *posyandus* or maybe the vehicles are available but the *posyandus* are sporadically held. The manager would need to examine the cause of the sporadic *posyandus* since that could help them discern the nature of their weaknesses. The antenatal visits could be low because the *posyandus* are not being held due to a shortage of funds, a shortage of staff, geographic conditions, poor staff performance, etc. Thus, the point was to encourage the managers to be creative in the way they view the data and to combine pieces of information to rule out possible causes for poor target achievements.

Another topic covered during the author's presentation concerned the rationale for the high drop-out rates between the first antenatal visits and the fourth (K1 and K4). An open discussion pursued among the participants and their feedback concurred with the author's findings in Maluku. This was again reconfirmed during the small group discussions. Some of the reasons for high antenatal visit drop-out were:

1) The first antenatal visit is often late into the pregnancy (e.g., after the fifth or sixth month); therefore, there is not enough time remaining in the pregnancy to achieve a fourth antenatal visit.

2) Women perceive the need for a health center midwife only if there is a problem. For many women, a TBA is the appropriate caregiver during a normal pregnancy.

3) Women are more comfortable with the TBA because she spends more quality time with them (e.g., home visits, bathing the mother and child every day, massage, barter system for payment, etc.).

4) Women fear they cannot afford to pay the cost of the health center midwives.

5) Women do not have confidence in the new village midwives (*bidan di desa*) because they are often young, unmarried, and inexperienced.

Finally, factors which influence the reliability of MCH data were described during the author's presentation. The intent was again to encourage the managers not to rely heavily on single pieces of information, especially if they do not coincide with other inputs. The managers need to question incongruous data and troubleshoot for the etiology behind unreliable data. The data may need to be verified or could be subject to double counting or missing inputs. Hence, it is important to reinforce the message to review the data in light of the entire health center picture

to determine the possible causes for failing MCH indicators. Poor staff performance is one of many possible explanations. The module on performance indicators went into greater detail for the variables indicative of general staff performance.

Lastly, the author designed, piloted, and implemented a course evaluation form. There were several open-ended questions concerning the content and delivery for the modules, in addition to the overall utility of the workshop. Copies of these evaluations were given to Dr. Northrup. The author also assisted in the preliminary review and discussion of these results.

RECOMMENDATIONS

The following are the author's recommendations:

1) The expected outputs of the small group exercises need to be more explicit. It may be beneficial to focus on a few critical outputs and place more emphasis on the plans of actions. The POAs presented by the participants were often quite generic and nonspecific.

2) The managers clearly need more assistance with POA development. This could be a defined role for the facilitators as they assist with the working groups. More attention should be devoted to the diagnosis of problems rather than listing standard activities.

3) The immunization model was dropped during the implementation of this workshop due to time constraints. This module might be eliminated from future workshops since there is some redundancy with the MCH module exercises.

4) Not all of the districts need to present their work after each small group session. The district groups could be selected to present for each module, with every district having an opportunity to present once during the week. However, this might discourage non-presenters from becoming actively involved at each session. Another option would be to have each province present a synthesis from their districts' results. This would entail representatives from each district working together to provide a provincial profile after they completed their work in the small groups. The group would be too large if all the participants from the province met at once and some participants might be left out of the discussion. Thus, the initial meeting should be broken into district groups as before. Selected representatives from each district in a province would reconvene and present the provincial results.

5) Inform the participants well in advance about what specific information they need to prepare and bring to the workshop.

6) The linkages between the modules could be developed.

SUGGESTED FOLLOW-UP ACTIONS

During the debriefing, the potential need for developing a diagnostic tool for district managers to use at the health center level was discussed. This diagnostic tool would be used to assist in determining the cause of poor MOH target coverage (e.g., antenatal visits and births attended by professional staff). According to resident staff, a draft of the tool should be available by the end of January. This draft tool could be piloted after the Muslim holiday at the end of February. The finalized instrument should be available in early April to allow at least six weeks for implementation before the next workshop offered in May 1997. The districts that attended the first workshop will be using the diagnostic tool. The new districts added to HP-IV would use this diagnostic tool after they have attended the first workshop.

[1] Staff Appraisal Report: Indonesia Fourth Health Project -- Improving Equity and Quality of Care. May 22, 1995, East Asia and Pacific Regional Office, Country Dept. III, Population and Human Resources Division.

[2] Memorandum to Ms. Eri, HP-IV Domestic Consultant from Dr. R. Northrup, BASICS on 15 August 1996.