

The Enterprise Program

NAHDLATUL ULAMA MUSLIMAT Hospital and Clinic Assessment

September 20 - 28, 1988



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ENTERPRISE PROGRAM

NAHDLATUL ULAMA MUSLIMAT

Hospital and Clinic Assessment

September 20-28, 1988

Assessment Team:

**Lyn Russell
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ENTERPRISE PROGRAM

NAHDLATUL ULAMA MUSLIMAT HOSPITAL AND CLINIC ASSESSMENT

EXECUTIVE SUMMARY

I. PURPOSE

The purpose of this consultation was to provide assistance to the LKKNU in its survey of Muslimat health facilities. The LKKNU is undertaking a quantitatively oriented survey over the next several weeks to profile its thirty or more clinics and hospitals. This team collected qualitative information relating to the facilities' quality of care, organizational structure, and managerial effectiveness. A primary objective of the effort was to develop a general statement regarding overall strengths and weaknesses within the system, and initiatives that should be considered to enhance organizational viability, self reliance, service to the community, and quality of care.

The team consisted of an American nurse midwife (Lynette Russell, C.N.M., M.S.) and David Speltz, President of Speltz Associates, a health care consulting company in Cleveland which specializes in strategic planning, business development, and financial turnarounds. Dates of the visits were 20 September through 28 September, 1988.

II. Description of Activities

The team made assessment visits to seven health facilities of the NU. Five sites were located in East Java, one in Central Java, and one in Jakarta (see page 7). In general, these facilities, ranging from a tertiary urban hospital to an urban storefront clinic, were sponsored and managed by local foundations established by the Muslimat. Six of the seven facilities were hospitals, although only the Islamic Hospital in Surabaya provided comprehensive inpatient services. The other five sites were small women's hospitals providing both inpatient obstetrics as well as MCH-FP and general outpatient services.

Two of the hospitals provided inpatient pediatric care. Only one of the seven provided outpatient clinic services exclusively.

The team was warmly welcomed in each facility with visits generally lasting three to four

hours. Foundation members as well as clinical and administrative staff participated in the interviews and tours. Interpreters were used when necessary.

III. GENERAL OBSERVATIONS

1. All facilities were sponsored by and responsible to a local foundation established by the local Muslimat, except for the Islamic Hospital in Surabaya which was under an NU foundation. Foundation members, in general, managed the clinics as well as providing governance.
2. Facilities were open to all members of the community, regardless of religious, cultural or racial background. Access to the facilities was generally easy due to convenient locations. All facilities visited were in high density urban or town environs.
3. Most of the facilities made an effort at outreach through mobil clinics, school visits, or other health education efforts.
4. Most were financially viable, operating at or close to patient revenue levels. Inpatient services appeared to be important to determining financial success and the ability to reach out into the community with money losing outreach services.
5. Most offered family planning services, some more effectively and aggressively than others.
6. The clinical and administrative staff, and foundation members were clearly dedicated to the facilities and community they served.
7. There was a universal thirst for training, new ideas, and help in improving their services. In particular, assistance in upgrading their skills in management, family planning services, maternal and child health, and high risk maternity care was high in priority.

8. Most have hopes for major improvements in facility and services, generally with the addition of pediatric and maternity beds.

9. The strongest programs were under the direction of a dedicated and enthusiastic physician.

10. Acceptance for family planning services and demand for private maternity and pediatric care seems to be generally high.

This is a loosely organized system of 30 or so hospitals. Each is unique in its strengths but exhibit common weaknesses. Because of the relative financial viability of these facilities, and the generally sound quality of care, investment in these facilities may have excellent returns in terms of family planning and child survival programs. Recommendations detailed in the body of this report suggest the following:

1. The governing bodies -- the foundations and Central foundation in Jakarta, be assisted in developing a more cohesive organization through which a health care system can be truly developed and through which assistance can flow;

2. A few strong programs be identified among the clinics and be developed as "franchise" models for the full system. These models would include clinical methods and standards, business operation, marketing, record keeping, and all other aspects of operation that can be duplicated throughout the system as a facility is able to support it.

3. Training, especially certain clinical and management training be the focus of any assistance;

4. Certain minimal equipment, such as autoclaves, be provided to those clinics that do not have them.

FACILITIES VISITED

Siti Hadjar
RB/BKIA/Poliklinik Muslimat N.U.
Sidoarjo, East Java

Polyclinic Islam Masyitoh
RB/BKIA/Poliklinik MASYITTOH
Bangil, East Java

Islamic Hospital
Rumah Sakit Islam
Jl. Karah 89 B
Wonocolo
Surabaya, East Java

Ralai Kesehatan Masyarakat
(Communitih Health Center)
RB/BKIA/Poliklinik Muslimat N.U.
Jl. Sawunggaling 12
Kepanjen, East Java

RB/BKIA/Poliklinik Muslimat N.U.
Ranggolawa II
Singosari, East Java

Poliklinik Islam
Gandhekan Pathu
Jl. Pajekson
Yogyakarta, Central Java

RB/BKIA/Poliklinik Kb Muslimat
Jl. Hang Tuah I/6
Keb. Baru
Jakarta, West Java

BACKGROUND INFORMATION

Preliminary Contacts

In August, 1987, the BKKBN requested the Enterprise Program to explore the possibility of assisting with the development and improvement of family planning programs provided by Islamic organizations. After obtaining USAID and American Embassy concurrence, Enterprise made a preliminary assessment visit in April, 1988 to the central headquarters of the Nahdlatul-Ulama, to two N.U. pesantren and to two N.U. Muslimat clinics.

This trip was made by Joel Montague, Enterprise Project Director and Jerry Russell, Asian Regional Representative of Enterprise, to explore collaboration with family planning and health programs of Muslim organizations. (See Trip Report, Indonesia April 24-May 3, 1988). One of the outcomes of this trip was an identified need to assist the Muslimat in improving and strengthening its health services, including family planning. Visits to two maternal child health family planning Muslimat clinics revealed that the Muslimat appeared to have high quality clinics and maternity hospitals, with staff and volunteer boards dedicated to providing the best possible care to the women and children of their communities. However, it was discovered that documented information about many aspects of the health institutions was not known. Therefore, it was determined that an assessment by Enterprise consultants and a survey by LKKNU would be undertaken. The purpose of the assessment was to profile the facilities organizational structures, management systems, locations, services, strengths and weaknesses in order to obtain information needed for any subsequent project proposal and assistance.

A concept paper was written which proposed a two-phased institutional development activity. (See Concept Paper, Institutional Collaboration for the Further Development of the Muslimat Nahdlatul-Ulama Management and Clinical System, The Enterprise Program, May 3, 1988). The first phase consists of a survey assessment of existing Muslimat MCH-FP facilities to ascertain how they, in cooperation with BKKBN can improve their self sufficiency, management and clinical services.

The results of this survey will provide a basis for development of a project proposal. The second phase will implement and support the activities described in the proposal.

During a later trip, on May 2, 1988, Jerry Russell, Enterprise Asian Regional Representative, met with Rozy Munir of LKKNU and a representative of the Muslimat to present and discuss the major objectives of the survey. At that time, an outline, tentative timetable, budget and the scope of survey was defined.

The overall objectives of the two phased project are:

- 1) Strengthening the management and clinical capacity of the Muslimat;
- 2) Encouraging the expansion and self-sufficiency of the N.U. preventive and public health systems;
- 3) Supporting the objectives of the BKKBN; and
- 4) Collaborating on new and potentially replicable management and preventive health service approaches, including family welfare planning services, through Islamic PVO's.

While the pesantren visited had good examples of programs in education, community development, agricultural production and general community involvement in development activities, they did not have clinics and hospitals open to the surrounding communities. However, the Muslimat womens' organization has over 30 clinics and maternity hospitals are open to the community. A number of these facilities are already providing family planning services, and interest appears strong for increasing their involvement. It was also found that the leadership of the N.U. and the Muslimat desires to cooperate with the Enterprise Program in project development.

The first phase of project development consists of a qualitatively oriented assessment of seven representative Muslimat hospitals and clinics by an American team consisting of a management specialist and a nurse midwife; this is to be followed by a quantitatively oriented survey conducted by the LKKNU designed to locate all the institutions, examine their staffing and activities, and determine their strengths and weaknesses. Discussions will then be held with the leadership of the N.U., the Muslimat and the BKKBN to ascertain how they wish to proceed with institutional strengthening so as to improve the Muslimat clinics' self-sufficiency, management and clinical capability.

The second phase could involve support to a variety of Muslimat activities. It would no doubt emphasize the improvement of management, clinical systems and techniques which, in the N.U. context, are essential if maternal and child health and family planning services are to be strengthened and the Muslimat clinical system expanded.

Demographics

Indonesia is the fifth most populous country in the world with a population of 175 million. The serious problem of imbalance between population growth and natural resource in the country was recognized in 1967 when President Suharto signed the World Leaders' Declaration on Population. That was the first step in implementing a population policy which is now lauded as being among the most successful in the world. Indonesia's National Family Planning Coordinating Board (BKKBN) was founded in 1970, and services has been extended to the entire country by 1979. Population policy has received strong government support from its inception and government funds for the support of family planning in Indonesia have consistently increased.

More recently, support for the private sector as a vehicle for implementing national population policy has gained increased prominence, partly as a result of the drop in world oil prices and subsequent reluctance of Government supported family planning activities.

Enterprise Activities in Indonesia

In response to the increased demand for private sector family planning activities, the Enterprise Program initiated activities in Indonesia in 1986. To date, three projects have been carried out or are underway with YKB, PKMI, and P.T. Gamay Djaya. The project with YKB, an Indonesian PVO, involved Enterprise Program assistance formulating a business management plan and the establishment of a profit-making clinic. PKMI is a group of local AVSC clinicians who are seeking ways to become financially self-sustaining. The project with P.T. Gamay Djaya follows the work-based model by providing family planning services through an on-site clinic.

All of these projects are successful and represent models which could be replicated in the Indonesian private sector. Because of this, and at the request of the BKKBN and the Mission in Indonesia, the Enterprise Program has now given priority to assisting family planning programs of Islamic organizations.

Islam and Family Planning in Indonesia

Ninety percent of Indonesians are Muslims, making Indonesia the largest Muslim population group in the world. Although many Muslims believe their religion proscribes family planning, there are some who maintain that the Quran leaves ample room for individuals to determine their own fertility. There are no specific Quranic references which prohibit contraceptive use, but certain practices are still debated. The use of the IUD, for example, is still contested among some religious leaders because some believe it may act as an abortifacient and it can cause additional bleeding, thus interfering with a women's ability to pray.

Those who approve family planning stress the Quran's emphasis on ensuring family welfare as a justification for limiting family size. Taking good care of one's children, including providing for their spiritual welfare, education, and general well-being, is one of the most commendable deeds in Islam. The BKKBN, which emphasizes the government's objective of achieving a small, happy and prosperous family, has cultivated the support of top level Islamic leaders from the early stages of the program and thus avoided most opposition from religious groups. Among the Islamic groups with the BKKBN has worked is the Nahdlatul-Ulama.

Nahdlatul-Ulama

The Natdlatul-Ulama (N.U.) was founded in Indonesia in 1926 and has grown to thirteen million members. N.U. was formed as a conservative reaction to an Islamic reform movement which was gaining popularity in Indonesia. It is perceived to be an organization which is particularly religious in nature, traditional and close to grass roots village life, doing much of its work through pesantren, the traditional Islamic schools.

The organization has changed its identity and mission several times since it was founded and became politically active in the 1950's. In 1984 the N.U. withdrew from politics and is now a non-partisan organization, placing a greater emphasis on village level development projects. The N.U. membership consists of a wide variety of individuals including scholars and lawyers as well as religious leaders. The organization purports to be the largest Islamic (social) organization in the world and as such has members and influence in all geographic, social and economic areas of Indonesia. Because of its leadership among the Muslim community, the organization has the potential for effecting change in the attitudes and behavior of an enormous number of Indonesians.

The BKKBN has had a formal relationship with the N.U. since 1970 as a supplier of contraceptives. The leadership of the N.U. has not been opposed to pills, condoms, injectables or implants. This is not necessarily true of its membership, which has traditionally been conservative toward contraceptives of any kind. Sterilization was a problem until 1981 when a conference sponsored by N.U. in Jakarta appeared to clarify the issue. N.U.'s recent emphasis has been on family planning as part of the broader objective of supporting community development.

Muslimat Health Services

The Muslimat N.U. is the women's organization of the N.U., hereafter referred to as the Muslimat. It is an autonomous organization with 1152 branches throughout the country. The Muslimat seeks to carry out the objectives of the N.U. by making Muslim women conscious of their rights and duties based on Islamic lessons. The Muslimat operates 3250 kindergartens, at least 30 hospitals and clinics, 5 dormitories, and 11 orphanages. These activities are supported by a number of government organizations and donor agencies. Although the membership of the Muslimat is

unknown, it is estimated to be between three and a half and four million, with registrations between 1978 and 1986 totally 477,100.

Very little information has been available on the health and family planning services which are currently offered by the Muslimat. In a recent interview with Enterprise Program staff, one Muslimat clinic volunteer-chairwomen said that she believed that only six clinics, of an unverifiable total, were providing family planning services. This report will suggest the number far exceeds that estimate. One reason for the lack of information regarding health services is that there is no central office coordinating the work of those locally owned and operated facilities. A bi-monthly meeting of twenty-three of the hospitals and clinics in East Java serves some small coordinating function.

Health service delivery activities of the Muslimat have been poorly documented and little information has been available on management issues. The Muslimat is highly decentralized, with no central body responsible for any major component of health and family planning work. Leaders are women activists who are appointed because of their adherence to traditional religious values.

FINDINGS

Summary

The NU and Muslimat health facilities provide for the Enterprise Program the opportunity to strengthen, throughout Java, fertility reduction and child survival programs in a financially viable, emerging private health care system. Enterprise involvement is coincident with what appears to be an important step forward by the NU to develop a linkage between local governing bodies (the local Muslimat foundations) under the umbrella of the Central Foundation. Assuming this organizational groundwork is developed, a health facility network is a natural next step.

The team found the system in various stages of development. Governance is generally well developed at the local level but as noted is only in its early stages at the national level. Financially, the health facilities are viable, requiring management training to insure their success in a competitive market place and to improve their use of resources. Clinically, the facilities range from satisfactory to excellent, requiring training assistance and some basic inexpensive equipment to build on existing strengths.

Governance Issues

In general, the Muslimat facilities visited were sponsored and controlled by local foundations, small groups of Muslimat women, often ten to twelve in number. Exceptions to this rule are the two Muslimat facilities in Jakarta which are sponsored by the Central Foundation, and the Islamic Hospital in Surabaya, sponsored by the Surabaya branch of the NU.

Foundations have historically been developed as an "executive committee" of a local Muslimat to oversee certain health and welfare projects. The foundations have no formal affiliation with each other or with the Central Foundation in Jakarta. During our visit, the Central Foundation (Jakarta) sponsored a national conference that brought together foundations from other parts of Java for the first time. A description of this conference is in Exhibit 2. The importance of this conference was its underlying agenda to develop unity and organization. Because the local foundations control most of the health facilities, the importance of this institution building effort among the foundations

should not be underestimated.

The main issue facing the foundations as a group is finding the formula and process to enable themselves to organize into a cohesive national body. This formula will balance the need for unified direction and local autonomy. If accomplished, the opportunities for developing national Muslimat health programs, clinical standards, and marketing approaches are significantly enhanced.

At each site, persons interviewed were asked to list the four most important training programs they needed. Foundation members, with the exception of the small clinic in Yogyakarta, asked for management training as one of the four. When asked to explain what they meant by management training their response invariably included strategic planning as well as operations issues; for example, they were concerned with how to properly determine what services should be developed, where to find new revenues, and how to organize fund raising efforts. Concern about how to organize the foundations as a group was cited as high priority.

The foundation members showed a high level of sophistication in articulating their governance related training needs, possibly as a result of the national foundation conference earlier in the month. A full description of each clinic's governance can be found in the site reports in Exhibit 1, page 23.

Management Issues

Foundations are not only governance bodies for the health facilities but also provide management services. In Kepanjen, the foundation members have developed a system of "assistant administrators" rivaling the hierarchy and organization of larger hospitals. The assistant administrators are unpaid foundation members. Yet in Sidoarjo, the foundation plays the role of the board, leaving the management to the physicians and employees of the hospital. At this point in their development, neither approach has an advantage over another.

When describing management training, foundation members and employees defined it as only implied strategic planning, governance, accounting, personnel management, scheduling, and other operations issues. Operations training was identified by foundation members and employees alike as a top priority.

The main management (operations) issues facing the facilities include the following:

- 1. understanding how to analyze the external environment and developing responses to it through selected program development, marketing, and financial planning;**
- 2. scheduling business hours and personnel.**
- 3. improving financial systems, price structures, negotiating discounts.**
- 4. developing relationships with other providers to enhance referral patterns.**
- 5. Facility and equipment maintenance.**

If management training is to be implemented, consideration should be given to joint training for both foundation members as well as management employees and key physicians. Several advantages would be realized by a combined effort:

- 1) those who manage the facilities (be they foundation members or facility personnel) would be trained, as would their (foundation) supervisors;**
- 2) the foundation members have indicated a desire for management training that can be used to improve foundation organization itself;**
- 3) having both foundation and clinic personnel receiving training together should result in improved communications and discussions between employees and employers regarding organizational and longer term planning issues.**

Financial Issues

Of the seven sites visited, four were profitable, one close to breakeven, and two were unprofitable. The two that were losing money (Jakarta and Yogyakarta) were losing money because of location. The others were well located, were more or less well managed and consumer responsive. Our visits indicated that if basic issues such as location, service profile, quality, hours, and money management were attended to, facilities could be financially viable.

The Jakarta facility is experiencing neighborhood gentrification in the past few years which has resulted in the replacement of young, middle class families with upper income older adults that have no need for maternity services. The foundation is considering a reconfiguration of services at this site and the development of a new site in a younger neighborhood. The Yogyakarta clinic was specifically placed in a slum of the city and can not be expected to operate profitably. The foundation is seeking alternative sources of revenue to fund it in the future.

Sidoarjo, Bangil, Kepanjen, and Surabaya are vibrant, community oriented hospitals that are strong financially, dominate their market, and seek to develop new programs and facilities. Each of these facilities have at least one unique strength that, if developed, can serve as a model for other NU health facilities to emulate. Each hospital provides inpatient care, including VIP accommodations which probably subsidize the clinic services (including the family planning activities). Singosari, which operates close to the breakeven point, is similar to Kepanjen but is not as profitable because of a lower income clientele and more intense competition.

It appears that an important key to financial viability is a service profile that includes inpatient beds (maternity or pediatric) and clinic programs that attract expectant mothers and provide followup services to mother and child. A minimum 40% occupancy level appears to be the breakeven point for bed utilization. It is not clear that polyclinic or family planning services pay for themselves. This suggests that the most viable configuration is one which includes an inpatient service supported by comprehensive MCH-FP services in a location where demand is strong enough to maintain a 40% or higher occupancy.

A full description of the financial status of each of the sites is included in the facility narratives, Exhibit 1, page 23.

Clinical Findings

The quality of clinical care ranges from good to excellent, based on observations of patient/clinician contact as well as a review of medical records, tour of the facilities, and interviews with clinicians. Where weaknesses existed, they were a result of old or non-existent medical equipment (autoclaves were in short supply) and a lack of access to clinical inservice training for nursing staff.

Medical records were generally in good order and reflected adequate care plans. Staffing was at acceptable levels, including night staffing. Facilities often had dormitories and night rooms for staff. In general, all facilities were doing a commendable job for the level of service they had defined for themselves.

Family planning advocacy was generally passive, except for Kepanjen where the physician in charge had developed an excellent, well managed program with a well trained staff. Training and program management technical assistance could significantly enhance the family planning services at most of the facilities.

Injection and IUD appeared to be the preferred method of contraception with approval from the religious leaders and husbands being a significant factor in determining the number of acceptors. The team found that acceptance of family planning was at a relatively high level and did not seem to be a controversial topic. Males rarely sought vasectomy and females rarely sought methods other than injection or IUD as noted above, probably due to religious reasons.

Most facilities were involved in outreach activities at a modest level. Often it was through the government sponsored POSYANDU, or Post Integrated Services in which government brings together either government or private clinic health services in local schools or other facilities to reach local populations. In general, this effort is directed to providing health education. Some facilities provided outreach services outside this program, however it clearly cost more than it brought back in revenue or patients. The facilities appear to have found levels of service they can afford to subsidize. Additional outreach should not be encouraged without careful thought and planning.

The team noticed that the facilities that appeared to be most sophisticated and dynamic had working with them a head physician who provided the time and dynamic leadership that not only

maintained quality at a high level, but also stimulated program development and attracted middle and higher income patients. Where there was no strong physician leadership, the foundation and clinic appeared to be struggling with direction. This may suggest that for those facilities that do not have access to strong local physician leadership a substitute through affiliation with another Muslimat facility or access to a Central Foundation physician consultant may be important to further development for them.

In summary, the provision of certain minor equipment, especially autoclaves, and access to a continued education program will build on the clinical strengths that already exist within the part of the Muslimat system we observed. In the opinion of the assessment team, a moderately strong organizational and clinical base exists upon which Enterprise can overlay, with moderate risk, family planning and child survival programs. This risk can be reduced through additional technical assistance that helps organize the foundations and their facilities nationally as well as focuses on the development of model clinical programs and their implementation in those sites that are prepared to implement them.

RECOMMENDATIONS

Recommendations focus on institution building within the foundation system, and the development of model clinical programs taking advantage of existing strengths found in the various facilities.

Ideally, Enterprise support would be administered through an effective national NU organization that would work with each of the thirty or more facilities to develop their programs. The assistance would be both designed to strengthen them clinically and managerially as well as to further strengthen family planning and child survival programs, the focus of the charge to Enterprise by USAID.

The Muslimat foundations appear to recognize the need for direction, integration, and closer relationships. The recent national meeting in Jakarta and the views expressed in the site visits confirm this. Yet there is a strong desire to remain autonomous, borne of the fear of losing control over programs that are extraordinarily close and personal to foundations members. The development of trust between the Central foundation and local foundations, the sharing of ideas between local foundations, the development of dependence on one another, and the recognition that participation in such a relationship can serve local needs and enhance local pride at the same time is of key importance.

Enterprise can be of assistance in this process by assisting with the talent needed to help the foundations work through this organization process. Although there are other organizations (e.g. LKKNU) who could be called on to administer technical assistance to the facilities, the emotional ties to the Central Foundation and to each other are strong enough that every effort should be made to nurture the national development of this organization. If the institution building process is successful, one could imagine a health facility system similar to the Catholic system in which local autonomy exists but program development, resources and direction are coordinated through a highly effective umbrella organization.

At the same time the foundations are developing the formula for their relationship, Enterprise should consider providing, through Central Foundation sponsorship, programs designed to strengthen

clinical services that have a high potential to be successfully duplicated in other parts of the system. Many of the sites visited exhibited at least one unusually strong and innovative program. Kepanjen's family planning program was exemplary as was Sidoarjo's pediatric program. With assistance, these sites could further develop these programs, improving standards, protocols, staff training, marketing and organizational functions to the point where they could be packaged and placed in other facilities with appropriate modification where necessary.

The advantages to this approach are numerous:

1. Facilities selected to receive assistance to develop a model program through Central Foundation sponsorship will learn quickly the benefits of working with the Central Foundation. Local pride, enhanced service capacity, and financial returns will accrue.
2. Once programs are ready to be implemented in other sites, these sites will also enjoy the benefits of local pride, improved quality and financial returns. The advantage of working with a national foundation will be apparent.
3. Duplication of startup effort among the facilities is eliminated, reducing expenses and risk.
4. Enterprise can concentrate its efforts on specific sites through the Central Foundation, focusing its resources on the development of a fully developed, transportable program, relying on the foundations to regenerate it system wide.
5. The improved clinical and managerial programs should enhance the financial viability of the facilities, providing support for more aggressive family planning and child survival services, both on site and through outreach.

The assessment team further recommends that once the LKGNU survey has been completed, a matrix be developed that identifies facilities and their programs that are clinically strong and merit further development, identifies market demand and potential financial returns, takes into account geographic and rural/urban location, and provides a guide to selecting demonstration models. In addition, a careful examination of the survey results should be done to confirm the assumption in this analysis that the provision of inpatient maternity, gynecological and pediatric services can provide the revenue needed to subsidize less profitable clinic services.

Exhibit 1

Site Visit Narratives

Sidoarjo	p. 25
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COMPARATIVE PROFILE OF MUSLIMAT FACILITIES

Facility Site:	Sidoarjo	Bangil	Surabaya	Kepanjen	Singosari	Yogyakarta	Jakarta
Hospital/Clinic	OB/Ped hospital	OB/Ped hospital	Tertiary Hospital	OB hospital	OB hospital	Clinic	OB hospital
Control	Local foundation	Local foundation	MU	Local foundation	Local Foundation	Local foundation	Central foundation
Location	Rural-agricultural	Rural-agricultural	Urban-mixed income	Rural-agricultural	Rural-agricultural	Urban-low income	Urban-gentrified
Service area pop.	1 million	75,000	2 million	250,000	100,000	100,000	250,000
Financial Performance	Profitable	Profitable	Profitable	Profitable	Small Losses	Unprofitable	Unprofitable
Competition	Low	Low		Moderate	Intense	Intense	Intense
Services:							
OB Beds	6	12	This is a full	10	10	0	12
Ped Beds	14	3	service referral	0	0	0	0
MCH-FP	X	X	hospital for the	X	X		X
Polyclinic	X	X	region.	X	X	X	
Outreach	X	X		X			
Pvt Doctor Offices		X			X		
Lab	X						
Drugstore	X	X		X			
Radiology							X
Training Requested:			Community medicine	Elder care		None	
MCH		X	X		X		
Family Planning	X	X	X				
High Risk Delivery	X	X		X	X		
Polyclinic	X	X			X		
Pediatrics	X			X			
Nutrition	X	X					
Management	X	X	X	X	X		X
Possible Opportunities	Higher risk OB. Private/semiprivate rooms.	Higher risk OB. Mini-lab.	Training center for Muslimat facilities.	Mini-lab. Podiatric beds.	Mini-lab. Pediatric beds.	Create new facility in middle class area with OB/Ped beds.	Create new facility in middle class area and reconfigure this site for mixed adult
Needs	Training as requested above.	Modernize equipment including autoclave. Training as requested above.	*	Modernize equipment including autoclave. Training as request- ed above.	Training as requested above. Modernize equipment.	Linkages with other foundations. Mgmt training. Funds for development. Basic supplies & minor equipment.	

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RB/BKIA/PoliKlinik Muslimat NU

Location: Sidoarjo

Visit Date: 20 September 1988

I. COMMUNITY

The hospital is located about 25 km south of Surabaya in Sidoarjo, East Java. It is a masonry building built in 1962 and is due for extensive rehabilitation because of age and limited capacity. The facility serves an area of a 10 km radius and 1 million people. Some 95,000 of these people are NU members, 50,000 of which are children. Of the total patient population served by the clinic, 60% are NU.

II. SERVICES

The main outpatient services are polyclinic (general medicine), prenatal, postpartum, well and sick child, immunizations, family planning and dental. Some minor emergency service are offered, but most are referred to the hospital. Inpatient services include labor and delivery, immediate postpartum and pediatrics. The major problems for hospital admissions of children are diarrhea and respiratory tract infections.

Laboratory tests performed in the clinic are urinalysis, CBS, stool exam, and typhoid. There are no x-ray services at the present time. The "drug store" in the clinic stocks a few commonly used medicines and is staffed by a person trained on-the-job, not a pharmacist.

Patient Care

Direct patient care and performance of procedures were not observed in the outpatient clinic. The medical records are kept separately for each clinic and reflect good care and treatment plans. In the hospital, nurses were attentive and busy providing direct care to sick children. Mothers and children were roomed together, with a pull-out bed provided for the mother.

IEC and Community Outreach Programs

The outreach program consists of staff visits to the local elementary school where general health education is given. There is no planned home visiting program. Occasionally, a home visit is made after hospital discharge of a problem case. This visit depends on staff time and is decided on a case by case basis.

Once a year a child health fair is held at the clinic. Maternal-child health is promoted and a "health-baby" award is given.

Family Planning Program

The family planning clinic offers IUD's, injectables, pills and condoms. Women requesting implants are referred to the local hospital. The staff reports there is little or no request for oral contraceptives, natural family planning, foam or jellies. Tubal ligation requests are few and are referred. There were no vasectomy requests.

The staff interviewed stated that family planning methods are accepted in the community. In general, family planning is first accepted by the local religious and community leaders, then by the families in the area. There is both a doctor and nurse-midwife that provide these services. There does not seem to be a large demand nor an active, educational program. There are no classes or group instruction given. Some individual counseling takes place during postpartum visits according to one staff nurse-midwife.

Inpatient Service Statistics

Deliveries	18-20/month with ALOS 3 days
Pediatric Admissions	70/month with ALOS 4 days

Outpatient Service Statistics

Polyclinic visits	30-40/month
Prenatal visits	30-40/month
Postnatal	90/month
Infant visits	90/month
< 5 yrs old	50/month
5-7 yrs old	20/month
Dental	40-80/month

Family Planning Statistics

Counseling	12-15/month
Injection	5 month
Pills	None
Norplant	5 requests/month

The reason that postnatal visits are high along with infant visits is that most women deliver at home but come to the clinic at time the first immunization is due for their baby. At the time, they are also seen in the postpartum clinic. Service statistics are recorded on bar graphs and posted in each clinic area.

This medical facility serves primarily women and children, providing both inpatient as well as outpatient and private practice specialist care. It includes six obstetrics beds and fourteen pediatric beds.

Although not certified by the government as a hospital, it would fall into a class D level because of the availability of two specialists (pediatrics and OB/GYN), inpatient beds and 24 hour service.

Inpatient care includes labor and delivery (about 18 per month) and pediatric care. The

pediatric wards housed, during our visit, ten children with problems ranging from diarrhea and respiratory problems to three cases of typhoid.

Outpatient services are both clinic as well as private practice based. The clinic, with its employed doctors and nurse-midwives provide family planning, prenatal and postnatal services, well-baby care, immunizations, a sick-baby clinic, and some minor surgery services. Patients seen in the clinic are about thirty per day, generally in the morning. Another thirty per day are seen in the afternoon by private specialists who use the facility to see their patients (rent free). These include a dentist, obstetrician, and pediatrician. The facility, according to the staff and Foundation is running near capacity.

The family planning program is passive in that it is provided to patients at the clinic but not aggressively encouraged in the community.

There is a growing demand for inpatient gynecological care and emergency services due, it appears, to a growing impatience with government healthcare services at the district hospital. The demand is felt through requests from patients and through Muslimat meetings where the issue is discussed. No formal market analysis has been done, nor do they feel the need for it. There are plans to begin construction shortly of new space that would provide sixteen new GYN beds (semi-private and private), an emergency room with an operating room, and new clinic space. Existing space will be renovated. Government approvals appear to have been received. Upon completion, the physical facility should have the capacity to receive nearly double the patients it now serves. Surpluses and Muslimat fund raising will pay for the construction, although it appears the money is not yet available at this time.

There is a small laboratory and pharmacy in the clinic. There are six pharmacies in the community to which patients are referred for medicines that are not available in the clinic. There is a limited community outreach program.

III. RELATIONSHIP TO OTHER PROVIDERS

There are no formal networks with either the other Muslimat clinics, the NU Islamic Hospital in Surabaya (about 45 minutes) or with the District Hospital. The clinic does refer cases it cannot handle to these hospitals.

IV. STAFFING

The staff for the clinic includes the following:

Position	Full/Part Time	Quantity
Head physician	part time	1
General Practitioner	full time	1
Watch doctors	part time	4
Head mid-wife	full time	1
Nurse-midwives	full time	3
Nurse-midwives	part time	7
Lab tech	full time	2
Cashier	full time	1
Bookkeeper	full time	1
Planner	full time	1
Administrator	full time	1

In addition to the twenty three employees identified above, there are an additional seven responsible for clerical, maintenance laundry, cooking and other support services. The watch doctors (night doctors) and seven part time midwives are receiving experience before government assignment.

Recruitment and retention is not a problem. It is not clear how salaries relate to government salaries, although the head physician stated they were trying to rationalize the salary system.

V. TRAINING

Training is a major concern and priority for the clinic and foundation. In the last twelve months, two mid-wives were sent to Surabaya for family planning training. The priority, however, is management training. Both the foundation members and clinicians felt that training in accounting, overall management, and planning was needed to improve the administration of the clinic. This need appears to be motivated by a perception of a lack of efficiency, thefts ("leaks"), accounting and financial report inadequacies, planning for the expansion of the clinic into a hospital, and a desire to enhance skills in motivation.

VI. COMPETITION

There are nearly forty private physicians and one other maternity clinic in the area, as well as the district hospital. It is not clear how competitive the area is. The District hospital has a reputation for inconvenient hours and long waits. The staff feels that additional beds and clinic space would attract private physicians gynecologists and their referrals to the clinic.

VII. MARKETING

Promotion of the clinic is done through meetings of the NU and Muslimat, through an annual well baby competition, by word of mouth and through the facility sign.

VIII. ORGANIZATIONAL STRUCTURE

The local Foundation controls the clinic, meeting once a month to receive reports and deal with policy issues. It, in effect, serves as the clinic's Board of Directors. The local Muslimat could be considered the Corporate membership, with policies determined by the Foundation, but the Muslimat being informed of progress and important issues. The 1st Vice-Chair of the Foundation is the Chair of the Muslimat, so coordination is close, with overlapping boards.

There is a practical division of responsibility between the role of the Foundation and the role of the management (head Doctor) at the clinic. Day to day activities are within the realm of decision making by the staff. Reports are sent to the Foundation on a monthly basis, and the head Doctor attends to the monthly Foundation meeting, bringing along staff as needed. The Foundation deals with issues related to new programs, taxes and fiscal matters, fund development and planning for the new facility. The Treasurer of the Foundation oversees the finances of the clinic.

IX. GOVERNMENT RELATIONSHIPS

Government relationships are limited. The clinic is obligated to submit periodic reports to both the government Health Center in the area as well as the Ministry of Health. The clinic receives family planning supplies and equipment from the government, as well as vaccines.

X. FINANCIALS

The clinic began to break even in 1984. It expends Rp32.4M per month and earns a Rp2M surplus (\$1,250 profit on \$20,000 income).

At least 20% of care is free (a government requirement). Profits are not seen as such, but as surpluses that can be used for facility improvement, hiring personnel, and program development.

XI. NEEDS

1) The Foundation and staff have plans to build for additional inpatient services, expanding to 36 beds and adding gynecological, high-risk obstetrics and emergency care. This will be done in steps as funds become available.

2) Families in the community have requested more private and semi-private rooms, as opposed to ward rooms when the expansion is completed.

3) The head doctor indicated a need for better staff utilization with improvement of general clinical management.

4) The nursing staff would like training to up-date their skills in family planning, maternal-child health, nutrition and pediatric care.

In addition to the above, training in comprehensive family planning programs would be beneficial. This training should have a strong I.E. & C. and community outreach component, i.e., how to manage their own program and strengthen their services. Expansion of the clinic pharmacy may generate additional income.

POLIKLINIK ISLAM "MASYITHOH"

BANGIL

Visit date 9/21/88

I. THE COMMUNITY

Bangil is about 45 km south of Surabaya, an agricultural center of 75,000 - 100,000 population. It is generally lower income, with a family earning an average Rp 150,000 per month. It is accessible to Surabaya, a one hour drive, via a busy, slow rural road. According to the Foundation chairman, 80% of the population in the area is NU.

II. THE FACILITY

The facility, located in the center of Bangil, is of masonry circa 1966 in excellent repair. It is attractive, clean, and the staff presented extremely well with simple but attractive uniforms. The most complicated equipment are the two vehicles, one an ambulance used for transfers to the District Hospital or to the Islamic Hospital in Surabaya, the other a minivan for outreach services and taking mother and infant home after being discharged from their inpatient stay.

The hospital is built around a core that houses 15 beds, including three pediatric and twelve obstetrics. There are six ward beds in a central hall, four first class beds, and two VIP beds. The difference between the first class and VIP are in room size and decoration. The first class and VIP beds are popular and provide important revenue to the facility. The three pediatric beds are first class. There are plans to build pediatric ward for lower income pediatric patients. There is discussion of developing the facility to undertake C sections and pathological obstetrics.

The pediatric beds were full when we visited. There were two patients in the OB ward, the VIP beds were empty, and two of the four first class rooms were occupied. Occupancy was 45%. Bed income clearly supports the clinic. A complete L&D package, including an average 3 day stay post partum is Rp 110,000 for a VIP room, Rp 66,000 first class, and Rp 33,000 ward bed. The price includes drugs, meals, and all services including transport home at the end of the stay. The poor are given discounts ranging from 50% to free care. No one is turned away.

There is an attractive and well maintained polyclinic with a small and simple pharmacy and medical records room adjacent. We found a well maintained private practitioner office and a not so clean exam room for GYN exams. Dormitories house the staff in the rear of the hospital. Patients usually arrive via bejaj, horse drawn cart, or mini-bus. Access does not appear to be a problem.

III. SERVICES

Inpatient services are maternity and pediatrics. There are 12 maternity beds; a 6-bed ward room, 2 VIP rooming-in private rooms with TV, small refrigerator and private bath; and 4 1st class rooming-in private rooms. The staff are proud of their VIP and private maternity rooms. There are 6 pediatric crib-beds; 2 beds in each of 3 rooms. Gastro-intestinal and respiratory infections constitute the majority of admissions for pediatrics.

Outpatient services consist of polyclinic for both men and women, a MCH and family planning clinic, and an ambulance service. Minor emergencies can be treated at the polyclinic. The ambulance is used to transport referrals and to take discharged patients to their homes.

There are no laboratory facilities. The pharmacy is well-stocked and organized. Most of the medications used for treatment in the clinics are stocked and patients obtain their medications at this pharmacy. It is maintained by an "on-the-job" trained staff member. There is an operating room that is now empty and not used.

Patient care

Performance of procedures was not observed, but inpatient care was obvious and seemed attentive and good. There were mothers with newborns being assisted in breast feeding and newborn care. Two pediatric cases, one with burns and an asthmatic, were observed.

Medical records and charts are short, but contain essential information and a treatment plan. They are organized and filed systematically. The patient waiting areas are roomy and pleasant, both inside the building and outside on open porches with benches.

Instruments are boiled for 20 minutes for infection control. Various antiseptics are used. There is no autoclave. City water supply is sometimes limited, but the clinic has a reservoir so that they can be assured of water.

I.E.C. and Community Outreach

The clinic staff visit the local school (pesantran) for health education and promotion. They refer sick children to the clinic for treatment and charge half fee.

The staff also visits different areas of the subdistrict (mobile clinic) to offer general treatment and immunization. They promote their clinic services. Once a week they staff a medical post 1 kilometer away for general treatment. They report 50-60 patients per week and charge Rp. 600 per visit. They lose about Rp. 200,000 per month this service.

Six branches of the Muslimat meet weekly for prayer. The staff reports that information about family planning is given. Every 3 months a meeting with other Muslimat clinics is held at various locations to discuss problems, issues and expansion needs.

Community Facilities and Resources

The general district hospital located 15 kms. away is used for referrals as well as the Islamic Hospital and others in Surabaya. A local, private laboratory is used for laboratory tests. This lab is nearby and able to perform urinalysis, CBC, stool exam, typhoid and hepatitis tests. Patients are sent from the clinic to this lab.

Family Planning Program

For the past 4 years, there have been an increased awareness and acceptance of family planning. Women come to the clinic to request a method because the provider is a woman which they prefer. There are no outreach programs nor classes in the clinic.

The most frequently used methods are injection and IUD, but numbers are low. The staff reports that pills and condoms are available but not used. They also report that Depoprovera injection is preferred over Noristat.

The family planning clinic is scheduled one day a week, but service can be provided every evening 5-10 P.M. The nursing staff feel that family planning is good for spacing of children. One nurse-midwife stated that after the first baby, an IUD is recommended.

Service Statistics and Records

Deliveries	40-50/month with ALOS 3 days
Antenatal	110/month
Postpartum	40-50/month
Child health	varies, over 100/month

Family Planning:

Injections	3-7/ month
IUD	2-3 per month
Condom, pills	none

Total clinics outpatient 20-25 per day

There were 3 inpatient pediatric cases at the time of our visit, and 8 mothers recently delivered. Most of the child health visits are for immunizations.

The clinic sends reports of service statistics to the local government health center administrations and to the district government (MOH). In addition, they send reports to the provincial and central (Jakarta) level (MOH). These are submitted every 3 months. The clinic submits monthly, quarterly, and annual reports to the government Health Center and to the Ministry of Health. A bi-annual report goes to the Central Foundation (see exhibit 3, page 71).

IV. STAFFING STRUCTURE

The medical staff includes a part time physician director who teaches and works at the university. There is a full time female physician who is responsible for the day to day operation of the hospital. Two part time OB/GYN's and one part time pediatrician round out the staff.

Working under the supervision of a midwife director are four nurse midwives who live in the dormitories and eight other midwives who live in the community.

In addition to the five physicians and thirteen midwives, support staff includes:

Pharmacy aides	3
Kitchen helpers	2
Laundry	1
Security	1
Cashier	1
Drivers	2
Clerical	1
Messenger	1
Gardeners	2

Total staff, including full and part time doctors numbers thirty two persons.

Staff recruitment is not a problem at any level. Staff salaries are maintained at levels 60% higher than government salaries.

At the time of our visit, the staff seemed under utilized. However, our visit was not a typical occurrence in the clinical work day, so was stopped to accommodate us.

V. TRAINING ISSUES

Training, as in the other clinics, was of special interest to the hospital staff. The last training program anyone attended was in 1972. Shortage of money was not cited as the primary reason ... programs simply are not available.

When asked to state the four training courses that would be of most importance to the facility in the next year, in order of importance, the interviewees agreed on the following:

1. Management training
2. Nutrition training
3. Family planning training
4. Emergency treatment skills

The nurse-midwives report that they have not had an opportunity for additional training in the past year or two. In fact, they stated that in 1972 some Foundation member received training in family planning, but the staff did not. The district government does not have training programs or courses.

The nurse-midwives would like to receive training in nutrition, general health education, and family planning skills. They would prefer training in a center with good facilities.

VI. GOVERNANCE

The governance and management structure includes the local foundation as the sponsoring organization, board of trustees, and to some extent, the senior management. The foundation has an executive committee of 10-12 persons who meet monthly to consider clinic issues such as staffing and programs. Extraordinary meetings are held when there is a loss or circumstances require it. There is a liaison member who spends a great deal of time at the clinic attending to day to day non-clinical issues.

The local foundation is legally autonomous and has no representation on the central foundation. It was stated that in 1963 the Central Foundation tried to embrace all local foundations

but was not successful. An "emotional" link to the Central foundation was acknowledged although the lack of communication has not strengthened that tie. The foundation conference held the past weekend in Jakarta was a start in the right direction.

VII. NETWORKS AND COMPETITION

Patients who cannot be treated at the hospital are transferred via hospital ambulance to the government General Hospital in the district (15 km) or to the Islamic Hospital in Subaraya. There is a fee for transport. There is no formal relationships with the hospitals, however there are meetings once every three months at the Islamic Hospital where Muslimat Clinics meet to discuss various issues.

The Hospital seems to have a monopoly on inpatient obstetric care. Neither the nearby Mohammedia Clinic nor the General hospital provide obstetrical care. Complications are referred to Subaraya.

VIII. MARKETING

Marketing and promotion are limited to providing information to NU members at religious ceremonies. Because 80% of the area is NU, this is "their" facility. Outreach programs are to the poor and cause some financial hardship to the clinic. Hours tend to be limited, with the polyclinic and MCH-FP clinics open 8-12am and 7-9pm. When asked what can be done to expand volume, the answer was to offer quality services, smile, and provide information at religious ceremonies.

An important status change is taking place for the town of Bangil that has encouraged the Foundation to begin rethinking the role of the clinic, although it is only in its formative stages. The government is expected to upgrade the classification of the town to a higher level which means new government services and growth. Perhaps the desire for management training is to help in thinking through how the hospital should respond to this expected growth.

IX. FINANCES

The hospital operates on a breakeven budget of Rp 1.5M/month. The clinic itself is self

supporting, the outreach programs are not. The Foundation donates Rp 1M/month to cover those costs.

X. NEEDS ASSESSMENT

The facility plans to increase the pediatrics and obstetric inpatient capacity, to include high-risk obstetrics and possibly C-sections. Some equipment, such as an autoclave, is needed now, with additional equipment as expansion proceeds.

The staff could benefit from additional training in management, both at the administrative and clinical level. The nurse-midwives need continuing education courses in MCH, family planning and nutrition with strong I.E. and C. components. Skills such as how to conduct informal classes in the clinic or community, how to manage an outreach program, and techniques of counseling would be helpful.

NOTE:

The foundation and clinic staff at Kepanjen Malang was visited the following day. They reported that the clinic at Bangil was able to receive income from bird's nest (the major ingredient for bird's nest soup). Evidently a bird(s) came accidentally to the clinic and built nests in one of the VIP maternity rooms. The clinic recently "harvested" 6 kilogram of bird nests which were sold. According to our interpreter, 1 kg. of bird's nest sells for 1-1/2 million Rupiya. So the clinic has sacrificed one VIP room to allow the bird(s) to continue building nests. The proceeds go to the clinic. This is one of the most unusual and innovative examples of promoting self-reliance that we have encountered!

RUMAH SAKIT ISLAM

ISLAMIC HOSPITAL - SURABAYA

Visit Date 9/22/88

I. DESCRIPTION OF THE COMMUNITY

The hospital is located in the southern section of Surabaya, a city of three million in East Java. The city is second in size to Jakarta with major industry, hotels, and agriculture in and around the city limits.

Because of its inner-city location, a high proportion of nearby residents are poor. The hospital's free mobil clinic programs which reach into other sections of the city to serve the poor further extend the service area for the hospital. The hospital is also a referral center for the twenty four Muslimat clinics in the region.

II. THE FACILITY

This 130 bed private hospital is a collection of approximately 20 masonry and wood buildings in good repair which appear to be twenty to thirty years old. Most are connected with covered walkways with attractive gardens throughout. The hospital is considered a "B level" facility, that is, a comprehensive specialist hospital with a full range of inpatient, outpatient, and diagnostic services (an "A level" hospital must be 1500 beds and provide medical training. There are only two in Indonesia --one in Jakarta, the other in Surabaya, both government owned).

III. DESCRIPTION OF SERVICES

This 130-bed hospital complex has both inpatient and outpatient services. Inpatient services include obstetrics-gynecology, pediatrics, internal medicine, surgery, emergency care, psychiatry, radiology and physical therapy.

The outpatient services include a polyclinic, maternal-child health clinics, family planning clinics and emergency. The maternal-child health and family planning clinics operate at different

times, but are administered together.

We were unable to tour the hospital complex, but we visited the MCH-FP clinic and the polyclinic. Medical records, equipment, supplies and examination rooms were adequate and well-maintained. The outpatient area had patients waiting to be seen outside each of the clinics.

The occupancy rate of the inpatient hospital is 80-90%, with an average 5-day stay per patient. Forty-five percent of inpatient admissions are charity cases. The hospital serves all members of the community.

The hospital "supervises" the 24 Muslimat clinics in East Java, and receives many referrals from these clinics. Interviews in the clinics did not acknowledge this supervision, however.

Service Statistics and Records

Because of the limited time available to us due to Dr. Achmad's busy schedule, we limited our tour to the Polyclinic and MCH-FP clinics. The family planning clinic has approximately 400 visits a month. This includes new and return acceptors. We were not able to obtain the number of acceptors by method (due to lack of time and Dr. Achmad's busy schedule). The most frequently used contraceptives are injection (depoprovera) and IUD (copper T). Oral contraceptives are available, but seldom used. Implants are not performed. The Dr. reports that female tubal ligations are done only for the health of the mother.

Outreach Activities

The hospital staff provides some health education in the schools. In addition, the hospital participates in a joint venture with the local government health centers by offering "medical posts" or mobile clinics in remote areas. The local health center decides which area to send the mobile clinic. The services offered through the mobile clinics are called "integrated post services" and include family planning, nutrition, immunizations, diarrhea treatment, maternal-child health care, health education including use of traditional herbs and general medical care. These services are located in areas for the poor and are free. At present, this service is only temporary because of lack of funds.

IV. TRAINING ISSUES

The hospital has a 3-year nursing school. Students are admitted to the school from Junior High School. The present enrollment is 200 students. Upon graduation, many of the nurses work in the N.U. Muslimat clinics-hospitals.

Training programs are offered by the hospital for health personnel of the N.U. Muslimat clinic-hospitals. In the past year, a nutrition program was conducted for nurses. There has also been child health programs. Training programs for nurses are usually conducted by the faculty of the nursing school. There are no set fees for the training courses, but rather "whatever the people can pay."

As with the other clinics, both the Foundation representative and the hospital director were asked to state and rank the top training priorities for the hospital in the next year. These were:

1. Management (planning, organizational motivation, financial and marketing systems).
2. Administration (Bookkeeping, accounting inventory control).
3. Maternal and child health and family planning.
4. Preventive and community medicine.

The training issue was of special interest to both the Foundation Secretary and the Hospital Director. It led to a discussion of the relationship between the regional hospitals and clinics and their respective foundations, and the Islamic Hospital and sponsoring foundation. There is dissatisfaction with the lack of organization, process and management methods that exist at the foundation level. Both agreed that the local foundation should first receive management training as a first step in a re-organization of Muslimat health care in the region. The priority stated above is thus directed at the Foundation.

It appears that the foundation sponsoring this hospital and the foundations sponsoring the regional hospitals and clinics serve not only as the "Board of Trustees, but also as the "senior management team." Thus, the training priority stated above would not only benefit the rationalization of the foundation structure and operation, but would also benefit the hospital through improved planning, marketing, supervisory, and financial systems.

Their preferred re-organization would include parallel vertical governance structures - one with the foundation at the top providing non-clinical policy and management direction to the hospital and clinics in the region, the other structure the Islamic Hospital medical establishment at the top providing clinical leadership throughout the region.

V. FINANCIAL ISSUES

The hospital breaks even in spite of 45% charity care. This is accomplished volunteerism, including physicians turning all private practice income over the hospital to subsidize running costs. The outreach programs into low income areas appear to be taxing the bottom line to the extent that they are termed "pilot projects" suggesting they may be temporary unless outside funding is obtained.

VI. Needs Assessment

The Director and Secretary of the Hospital report that there is a need for improved management capability within the Foundation, so that the Foundation can then manage the hospital and clinics better. They also identified general administration, maternal-child health/family planning and community health/outreach as areas needing strengthening in both program management and training.

The community hospital and major referral center for Muslimat clinic-hospitals has the potential for developing excellent skill training and continuing education programs for health personnel.

BALAI KESEHATAN MASYARAKAT

Kepanjen

Visit Date 9/23/88

I. THE COMMUNITY

The clinic is located in the center of Kepanjen, a town of 250,000 population located about 15 km west of Malang in East Java. Income levels in this area are low to middle, averaging Rp 150,000/month, derived from agriculture as well as industry (sugar, cigarettes) found in Malang. 60% of the surrounding population is NU. The surrounding area is hilly, and at times mountainous, rainy and cool. It is densely populated, with no shortage of public transport (bejaj and mini-bus).

II. THE FACILITY

The clinic, built of masonry materials in 1973, is in good repair having undergone some rehabilitation recently. There are 10 beds for maternity patients -- 6 ward and 4 first class, a delivery room with two tables, two sleeping rooms, one of which doubled as a prayer room, a rudimentary kitchen, three baths and toilets, an exam rooms for MCH and FP and a room for the polyclinic.

The Foundation has developed plans for a major expansion of the facility. They feel they must diversify beyond maternity care because of the success of family planning in the area (Malang is reputed to be a model for family planning success in Java). The town is growing quickly and the government has identified it as a new administrative center, thus opening new government offices. The clinic plans to take advantage of this growth and has developed three and five year plans (attached). These call for the development of 20 pediatric beds, a minor surgery operating room, a second delivery room, a dental facility, the acquisition of a vehicle for transfers and outreach, and a laboratory. Patients must now go to Malang for these services. They are also in need of a generator, according to the doctor in charge.

The development of pediatric beds would provide them with a new "product line," one that

has proven to be successful in Sidoarjo. Community need for the beds as expressed in prayer meetings, observing Sidoarjo's experience, and the influence of Dr. B very likely accounts for the decision to open this service. The number of beds, 20, seems to be related to the number of beds that will fit in the room they are planning to use.

III. DESCRIPTION OF SERVICES

The outpatient services are polyclinic maternal-child health and family planning. The MCH services include prenatal, postnatal well and sick child and immunizations. Inpatient services are labor, delivery and postpartum (8 beds). There are no laboratory facilities. The small apotik (drug store) stocks commonly used medications and supplies. Medicines are dispensed by the staff.

Patient Care

Patient care and performance of procedures were not observed. At the time of our visit there were not maternity patients no clinic visits (Friday afternoon). Medical records reflect essential information and a treatment plan. There is a separate family planning record.

The patient waiting room is pleasant with colorful health posters on the wall concerning MCH. The facility is open 24 hours a day for maternity patients.

Instruments are boiled for infection control. Various antiseptics are used. There is no autoclave.

I.E.C. and Community Outreach

The staff visit local schools for health education and promotion. Family planning, immunization, and other health-related information is given to women in the community at religious meetings. The staff reports that they also give health information to youth organizations. The chief Dr. (Dr. Bambang) promotes information about family planning men's meetings.

Every year a health baby contest is sponsored by the clinic, during which child health is promoted.

Every 3 months the Foundation members and some staff meet with other Muslimat clinics at

different places to discuss plans, needs and problems. There is a local Association of Midwives that meet to share problems and health issues.

Community Facilities and Resources

The district general hospital at Kepanjen (1 km.) is used for referrals and for laboratory services. Referrals are also sent to the district hospital at Malang. One other polyclinic in the area offers delivery, but there are several private midwife operated delivery clinics (at least 3).

Family Planning Program

This facility has a separate family planning room and a family planning administrator. The room contains separate family planning records filed by year since 1983, a supply cabinet, desk and counseling area. This program was organized by the chief doctor, Dr. Bambang, who is the director of PKBI (an association for "family planning experts and information"). We were not able to meet with Dr. Bambang, who comes to the clinic once a month.

The staff reports that family planning activities are increasing and important. The most commonly used method is the pill, followed by IUD, condom, and injection. Usually women obtain the condoms for their husbands. Both the doctor and midwife can insert IUD's. A very clean operating room is used for IUD insertions. This room is not used for any other purpose. Implantations and sterilization requests are referred to the district hospital.

Service Statistics

The staff have posted graphs in the administrative office depicting service statistics. In addition, we were given a 3 year (1983-1985) report on their activities and a written health plan.

Approximate figures for 1987 to date:

Total outpatient visits	450/month
Well baby and child	75/month
Prenatal	60/month
Polyclinic	70/month (men & women)
Immunizations/breast feeding	1000/month
Family planning	100-150/month (new & return visits)

Figures for number of acceptors by method for 1987 was not obtained, but 1985 figures were:

	Total	Total
	New Patients	Return Visits
Oral Pill	410	58
IUD	75	28
Condom	27	14
Injection	12	-

Reports are sent to the local government health center administration, the Islamic Hospital in Surabaya, local BKKBN, Department of Manpower and the local district government (MOH).

IV. STAFFING STRUCTURE

The staff consists of a full time doctor who works 8AM to 8PM six days a week. The Head Doctor, Dr. Bambang, is a lecturer at the university. Although he is not on site often, he appears to have had a profound influence on the success of the family planning program in the clinic. He is the chairman of the SPKBI, the association of family planning experts in Indonesia.

The secretary of the foundation runs the clinic on a day to day basis with a visit once a week from the chairman. There are two nurse-midwives, four assistant midwives (3 months training each), and a full time administrator for the family planning clinic (reflecting Dr. Bambang's influence) and the usual support staff of laundry and kitchen. There is physician backup under an arrangement with the local university. There is no problem with recruitment and a surplus of physicians available, according to the foundation representatives.

The physician director is Dr. Bambang who visits the clinic monthly. Another Dr. works at the clinic 6 days a week from 8 A.M. to 8 P.M. There are 2 midwives, one who works days and one who works nights and 4 assistant midwives. The assistant midwives have graduated from senior high school and have taken a 3-4 month course in health given by the Ministry of Health. They receive certificates for passing this course.

There is also a family planning administrator responsible for records, suppliers, and statistics of the f.p. program. The Foundation members also function as administrative staff.

V. TRAINING ISSUES

As in other clinics, discussion regarding training were especially lively and of interest to the clinic staff and foundation. Except for the BKKBN training of the family planning administrator, no other training has been undertaken in the recent past. When asked to rank the four most important training programs of interest to them, they, as the other clinics have, listed the following:

1. Management training
2. High risk obstetrics
3. Sterilization procedures
4. Pediatric and elderly care

When asked to explain what problems management training would help solve, the answer was financial management, how to handle money, and fund raising. Planning, marketing, organizational structure and service delivery was not mentioned as an issue in this clinic.

The staff noted that they have had no opportunity to obtain additional training or attend educational courses on health and commented they needed more training in obstetrical complications and problems, child care, elderly care, and sterilization of equipment.

The assistant midwives were very eager to learn new skills in any area of clinical operation. They have limited training (3-4 months) and would like this expanded.

VI. GOVERNANCE

The local foundation, as in other clinics sponsors and governs the clinic. In addition, they manage the clinic on a day to day basis through an unusual arrangement of "assistant administrators", under the direction of the secretary, who are foundation volunteers. They have, in effect, divided the management of the clinic into five divisions with a foundation member responsible for each function -- dietary, finance, laundry, drugs, facility, on a day to day basis. The foundation clearly has a firm grip on both policy making and management, very likely in concert with Dr. Bambang. The full time doctor and head nurse-midwife appear to have less authority than we have found in other clinics.

VII. RELATIONSHIPS WITH OTHER PROVIDERS

A foundation representative attends the tri-monthly regional clinic meetings sponsored by the Islamic Hospital in Surabaya. These meetings rotate through the region, being hosted by member clinics. There appears to be no affiliation with any other providers in the area.

Referrals are sent to the District Hospital in Malang (a class C hospital), as are lab tests. Patients are referred out to drugstores for anything but basic medicines.

There are other midwives in the area who do home deliveries as well as deliveries in their own home. Except for the government health center, there are no other clinics in the area.

VIII. MARKETING

There are four groups of prayer meetings for the NU, one for women, one for men, one for girls, and one for boys. Efforts are made to seek input and provide information about the clinic at the women's prayer meetings.

One a year there is a family planning contest during which celebrations are held. BKKBN sends a representative to this event.

IX. FINANCES

Running costs for this clinic average Rp 750,000/month with a profit averaging Rp 150,000, most of which is donated to the pre-school daycare program, orphanage, and school.

Funds for their long range plan needs, namely a generator, dental clinic equipment, a minor surgery room, a van for mobil outreach and emergency transfers, and pediatric beds are expected to be donated and not be paid for from patient surplus which is earmarked for other Muslimat activities:

Charges tend to be higher than the other clinics visited. A delivery with a 5 day stay in a second class bed is Rp 60,000 and Rp 75,000 for a first class beds. The foundation representatives stated that the average cost in the area was Rp 100,000, high for a low to middle income area. A maximum of 20% free care is provided.

X. NEEDS ASSESSMENT

Training courses for the staff and especially for the assistant midwives would contribute to strengthening the clinical services. Since the family planning program in this clinic is very active, programs in community outreach, home visiting and information dissemination would be beneficial.

The clinic requests sterilizing equipment for instruments. An autoclave would help in sterilizing IUD packs and delivery kits.

The Foundation members and staff have prepared excellent written reports and plans for their facility. They could benefit from training in financial management and fund raising.

The staff of the clinic have a closet full of baby clothes, blankets, booties and other items that new mother and baby may need or want. These are sold at a 30% mark-up and generates a small

amount of income for the clinic.

A laboratory that could perform basic tests such as HCT/HGB, and urinalysis might generate additional income.

BKIA/RB MUSLIMAT SIGOSARI

SINGOSARI

Visit Date 9/24/88

I. THE COMMUNITY

Information about Singosari is scant since foundation members could not address local population issues. We estimate the population of the clinic to serve about 100,000 persons. The area appears to be agricultural and low income. Estimates of NU membership in the area made by the foundation secretary (the chairman was ill) was 50% of the residents, consistent with Kepanjan's estimates which is in the Malang area. The town itself is located about 15 km north of Malang and a drive of 2 1/2 hours from Subaraya.

II. THE FACILITY

The facility, built in masonry materials in 1972, is in good repair. During our visit, about half the facility was in renovation, including most support service facilities. The gardens and wide open spaces were especially attractive and the combination waiting room/administrative office was large, well lit and welcoming. The clinic is located on a side street in the town, out of the way of general commerce and traffic.

There are ten maternity beds, four of which are first class and six in a general ward. There are two exams rooms, one for the polyclinic, and one for the doctor during his daily visit. There is a labor and delivery room that is need of repair. Renovations will provide a rehabilitated delivery room. A new doctor's exam is under construction as well.

The foundation plans to build on vacant land next to he clinic (for which they are negotiating purchase) ten more maternity beds. Deliveries during the month tend to come in peaks often resulting in patients being referred out or being discharged "prematurely." The average length of stay is 4 days post partum.

III. SERVICES

Outpatient services consist of a polyclinic, maternal-child health and family planning. Maternal services include antenatal and postnatal. Child services include growth monitoring, acute illness and immunizations. Inpatient services are maternity patients only (10 beds).

All of the outpatient services are provided by the chief-midwife in the mornings. The midwife registers the patient, obtains the medical record, provides care and treatment and dispenses medications if they are needed. All patients are seen in one examination room which also contains the medical records and a few medications. Sick children constitute the largest member of the clinic visits.

In the afternoon a Dr. sees the patients (2-5 P.M.) The clinic is open from 7:30 A.M. - 6 P.M., and patients are seen by the Dr., midwife or nurse. The maternity-delivery unit is open 24 hours and staffed during evening and night by midwife assistants. They call the nurse who lives nearby if there is a problem.

Immunizations are scheduled and given once a month. Vaccines are obtained from the local government health center and transported to the clinic by cold box.

There are no laboratory facilities nor pharmacy. Medicines used are ordered from the local pharmacy monthly by the nurse-midwives. These are obtained at a 10% discount.

Patient Care

The chief-midwife was busy during our visit seeing patients. Observation of the examination and treatment of a child with a cold and low fever revealed a good care plan. At one time, about 12 mothers with children were waiting to be seen.

The health record is a 2 page chart with essential data, diagnosis and treatment. They are filed systematically. The patient waiting area is a large room with benches and chairs. No appointments are given, but waiting time is short.

Instruments used are reported to be boiled for infection control. There is no autoclave. The clinic has a well in its central courtyard which is used for laundering, washing, etc.

I.E. & C. and Community Outreach Programs

There is no outreach program that provides services. Health issues including family planning are discussed at women's prayer meetings and social groups.

Community Facilities and Resources

The local government general hospital located in Lawang, about 15 minutes by car, is used for referrals. Lawang also has a larger apotik (pharmacy) and laboratory services which are utilized by the clinic as needed. It appears that very few laboratory tests are used in patient care.

Family Planning Program

There is an acceptance of family planning within the community. However, the Foundation secretary and chief-midwife report that the IUD method is not acceptable because of religious beliefs. Injection, pill, condom and implants are used by patients. The few requests for tubal ligation are referred to the general hospital. The staff reports that the Dr. does implants at the clinic, although no number was given.

The most frequently used method is injection, followed by pills and condoms. The staff seem supportive of responding to requests for a method from a patient. There is no outreach program other than information given at women's prayer meetings.

Service Statistics and Records

Deliveries	25-30 per month (4 day stay)
Total Outpatients	25-30 per day

Family Planning

Pill and Condom	10-12/month; of these, 1 or 2 are new acceptors
Injections	13 per month

Service statistics and reports are submitted to the local government health center and to the government hospital in Malang. A report is also submitted to the Islamic Hospital in Surabaya.

IV. STAFFING

The medical staff consists of one half-time general practitioner who works in the afternoon from 2-5PM six days/week. The other staff include:

Head midwife	1
Nurse midwives	1
Nurse	1
Midwife assts.	3
Cook	1
Laundry	1
Gardener	1
security	1

The midwife assistants have a junior high or high school education and work on a voluntary basis at night in the maternity unit. The midwife does the bookkeeping.

Foundation members provide administrative and supervisory support.

The administration staff is the Foundation members. The midwife does the bookkeeping. Foundation members report that recruitment of staff is not a problem, as many are interested in working at the clinic.

V. TRAINING ISSUES

Neither staff nor foundation members are aware of any training programs in recent memory, nor are they aware of any programs available locally. The chief-midwife reports that nurses and assistant midwives need courses in all areas of health work, polyclinic, MCH, and delivery. Family planning was not mentioned specifically. Foundation members would like management training, specifically help on finances, improving services, and fund raising.

There have not been training programs for the staff. They are not available locally. The chief-midwife reports that nurses and assistant midwives need extra courses in all areas of health work, polyclinic, MCH and delivery. Family planning was not mentioned specifically.

The Foundation members state that management training is needed, described as "how to raise funds and how to improve service".

VI. GOVERNANCE

The clinic is under the sponsorship of the local foundation which clearly manages the clinic as well. It appears that the chairman and secretary share management responsibilities. Policy decision are made by the foundation and they are energetic in caring for the facility and its welfare.

VII. RELATIONSHIPS WITH OTHER PROVIDERS

There are three delivery centers in the area providing, it seems, stiff competition. Patient the clinic cannot care for are referred to the district hospital in Malang, including sterilizations which this clinic does not do. Lab services and drugs are obtained in Lawang, about 10 km from the clinic.

VIII. MARKETING

Prayer and social meetings are the means by which the clinic remains in touch with women in the community. The foundation members report that these meetings are mixed NU and non-NU. There appears to be no other means to promote the clinic or learn the communities needs.

IX. FINANCES

Charges at this clinic are relatively low compared to the others we have visited. A delivery with a length of stay of four days in a second class (ward) bed is Rp 20,000 complete, and for a first class (semi-private) bed it is Rp 30,000. Over the past four years, the clinic has moved from requiring a 50% subsidy from the foundation to 2% today. Running costs are Rp 1,000,000/month. There is relatively little charity care (one or two patients/month). Patients who have trouble paying are put on an extended payment plan. Clinics patients pay on a sliding scale, with poor patients paying Rp 500 per visit and middle income and wealthy paying Rp 1000/visit.

X. NEEDS ASSESSMENT

The clinic and maternity hospital have plans for expansion which are being implemented now. Work on renovation and adding beds and rooms is done as money becomes available. The Foundation members and staff could benefit from financial planning as well as administrative training. Continuing education courses or training programs would help strengthen the staff's ability to provide extended services in the clinic and outreach programs.

Counseling and patient education should be an integral part of any training. A laboratory that could provide the tests need for expanded inpatient services as well as present outpatient needs might generate additional income. There is a possibility that other community members would use this laboratory, although we were unable to determine what degree.

POLYCLINIC YAYASAN KESEJAHTERAAN KELUARGA

Yogyakarta

Visit date 9/26/88

I. THE COMMUNITY

Yogyakarta is a city of one million persons located in Central Java. The town is an academic center of Indonesia with 50 colleges and universities and 25% of the population students. The governor of the specially designated region is a sultan who also holds a ministry post in national government. The center of the city appears affluent. The clinic, however, is located in a low income, if not slum, area of the city serving the poor.

II. THE FACILITY

The clinic is a storefront, two room clinic with a total of 150 square feet of space. Its sliding door opens directly to the sidewalk and its adjacent neighbor shops are a Chinese traditional medicine store, a hairdresser, and a tiny shop selling scout badges. A few doors down is the open public bath, in full swing during our visit. The clinic is open from 5PM to 8PM in the evening.

Patients wait on benches that are placed on the sidewalk, or in the front room where a small table sits with 5x7" medical record forms and a volunteer nurse. There appears to be a shared toilet facility in the back hallway. A small TV, donated by the doctor, sits in the waiting area, switched off during our visit. Some ten patients, both Chinese and Javanese, patiently waited while we interviewed the staff.

The doctor perches behind a miniscule desk in front of which stand two stools for patients. Behind a curtain adjacent to him is an exam table. The only ventilation is the front door which, in fact, spans the width of the clinic itself.

The clinic was established in 1959 by the local foundation. The facility is rented from a landlord who collects in rent whatever the foundation can afford to pay that month.

III. DESCRIPTION OF SERVICES

In contrast to other clinics visited, this small 3-room storefront polyclinic offers only general outpatient care from 5-8 P.M. 5 days a week. The Dr. sees 15-20 patients each evening. The most common health problems treated is upper respiratory infections. Also 1/3 of patients are women.

There are no maternal-child health or family planning services. There are no medicines stocked in the clinic except a few samples given by drug companies. Laboratory tests are generally not used. There are no outreach services, the clinic itself is an outreach-type service. Equipment and supplies are minimal.

Community Facilities and Resources

The women in the community deliver at home or at the Mohammidah Hospital. The clinic Dr. refers patients to this hospital 1/2 km. away or to the University Hospital. There is a government health center nearby and a private Dr. about 50 meters away. There is also a herbalist shop on the same street close to the clinic. The Dr. reports that there are many physicians in the city, about 278 with 30-40 who have specialties.

The University has a medical school and nursing school (nursing and midwifery). The medical school has about 200 residents and many specialties.

IV. STAFF STRUCTURE

A doctor, 2 nurses and a carekeeper are the staff. The Dr. sees patients assisted by one nurse, while the other nurse registers patients, locates clinic card, and keeps records. All work at government jobs during the day. The work of the two nurses could actually be performed by non-nursing staff or volunteers.

V. TRAINING ISSUES

The nurses state that they do not need any training for this type of polyclinic. They have many years of experience working in a government hospital.

VI. GOVERNANCE

The foundation consists of 10 leading members of the NU community. They define their role as both policy makers as well as managers, although there is little to manage, and the doctor appears to have that under his control. There are two important policy issues with which the foundation is now concerned.

The first is fund development that will allow them to build a new clinic. They report that US\$ 100,000 is needed to purchase land across the street from the existing clinic and to construct a building. Their concern is where to find the money. Little thought has gone into whether it is the ideal location, whether it would be financially viable, or how to staff it. This clinic is, in fact, an outreach post without a base. We briefly discussed establishing a clinic in a middle income neighborhood that could develop the cash surpluses required to fund a the clinic in the low income district.

Their second concern is establishing stronger ties with other foundations and with the central foundation in Jakarta. The "retreat" two weeks before in Jakarta seems to have influenced their thinking in this regard. They see strong ties meaning an inflow of donations from other foundations, however -- not very realistic. When asked how they would feel if programs (with reporting strings attached) were provided from the central foundation they reported that it would be welcome, however, the strings would represent intervention.

VII. RELATIONSHIPS WITH OTHER PROVIDERS

Because the doctor and nurses work during the day at the local government hospital, referrals seem to be straightforward and appropriate. When asked if it would make sense for the foundation to establish another clinic in a higher income area he responded negatively, stating there were plenty of doctors in Yogyakarta because of the presence of the university faculty.

Yogyakarta appears to be dominated by Muhammadiyah, rather than NU. It was not known how many clinics they have established.

VIII. MARKETING

In terms of understanding the community it serves, no formal planning or evaluation has been undertaken by the foundation. When asked how the foundation assesses the needs of the community, the response was "the treasurer lives in the neighborhood and has the pulse of the people." There is clearly no shortage of patients seeking help, based on the people lined up to see the doctor when we were there.

IX. FINANCIAL ASSESSMENT

The clinic runs on a shoestring, paying no wages except to the caretaker. The doctors and nurses receive a travel allowance, although the amount varies according to how much is earned each month. Often, the doctor gives money to patients who need medicine and do not have the means to pay for them. Fees, when they are charged, are Rp. 2000 for a doctor visit.

X. NEEDS ASSESSMENT

The nursing staff state that there is some difficulty in volunteers to work in the clinic. The clinic staff felt that first aid supplies, a small bed for sick children or adults while waiting to be seen, and some commonly used medicines would be very helpful.

In general, the equipment and supplies in the examination/Dr.'s room were few and old. Stainless steel canisters, glass jars with lids, and a hand-washing basin are needed.

KLINIK K/B MUSLIMAT

Jakarta

Visit date 9/27/88

I. THE COMMUNITY

This is a fascinating case of a Muslimat maternity hospital in its dying stages because, ironically, the neighborhood has evolved from a lower/middle income area which once required maternity services to an upper class community that has few children, and when they do, go elsewhere for care.

Located in the southern section of Jakarta, this facility was started in 1966 by the Central Foundation (one of two in Jakarta sponsored by this group). In 1975, demand for maternal care resulted in 75-80 deliveries per month using 18 beds. Gentrification has now reduced volume to 20 deliveries using twelve beds. The mothers who use the service are generally the daughters of the older generation who once lived in the area, traveling to the hospital from outside the area for services.

II. DESCRIPTION OF THE FACILITY

The facility, built of masonry materials in 1966, is in excellent repair. There are twelve inpatient maternity beds including one VIP, four 1st class, 4 second class, and three third class. The VIP room includes a television, patio, private bath, and air conditioner. Third class beds were combined in one room of about 200 square feet. All rooms had air conditioning except for 3rd class.

No polyclinic exists in this facility. There is a daycare room for children of mothers who are overnighting (the father care for the child at night). There were three exam rooms, and an XRay room with a basic portable Toshiba camera. Apotik, or drugstore services were not available, nor were lab services. There was a dormitory on the second floor for nursing.

III. SERVICES

Outpatient services are antenatal, postpartal family planning, child health and X-rays. Inpatient services are maternity only (12 beds). Immunization services are generally limited to babies who were delivered at the clinic as part of continuing care.

The X-ray services are used as a means to generate income. General practitioners in the area refer their patients for X-rays. It is used very seldom for the clinic's patients. There is no laboratory or apotik (pharmacy). A few medicine are stocked and are dispensed by the staff.

There is a day-care room for older children of mothers who deliver in the clinic. It is open from 8 A.M. - 5 P.M. It was established so that the mother and new baby could stay 4-6 days postpartum and not worry about child care for other children in the family, nor leave the clinic early because of lack of child care at home. The working father can bring the children in the morning and pick them up after work if needed. Mothers who deliver at the clinic came from the south part of Jakarta, some from a long distance. Many are daughters of patients who delivered at the clinic in earlier years.

Patient Care

There were no patients at the clinic during our visits (in the afternoon before evening clinic hours). However, the clinic is attractive and clean. The delivery room is exceptionally well-maintained and equipped. There is both a stainless steel electric broiler and an autoclave for sterilizing instruments and delivery kits.

Medical records are filed in the reception area. They appear adequate and complete. The two patient waiting areas are pleasant and can accommodate patients and their families comfortably.

I.E.C and Community Outreach

The clinic participation in "POSYANDU", or Pos Pelayanan Teopadu which is Post Integrated Services. This is a cooperative venture with the local health centers whereby a group "cadre" of people are trained in health care and visit homes in the community. Follow-up after delivery is one

example of their work. Direct services are not provided; it is mostly health education.

Community Facilities and Resources

There are many other private polyclinics in the area. Referrals are sent to the area (south Jakarta) general government hospital, which also has laboratory facilities. There are also private laboratories and many apotik in the general area.

Family Planning Program

Family planning services are available in the morning and evening clinics and are provided by both midwives and the gynecologist. The most commonly used method is the IUD, followed by injection and pill.

The Foundation chairperson states that the national family planning program is one factor that contributed to the decrease in number of deliveries in the past several years, from 70-80 per month prior to 1975 to about 20 per month presently.

Service Statistics

Deliveries	20/month	
Antenatal	125/month	
Postpartal	50/month	
Family Planning	New acceptors	return
Jan-Aug 1988		visits
Pill	1	107
IUD	54	300
Injection	5	58

There were also 2 requests for tubal ligation which were referred to the general hospital, and 2 requests for tubal ligation after a previous ligation and reversal.

IV. STAFFING STRUCTURE

A well known Jakarta OB/GYN is the day to day director of the facility, although he practices at the clinic only in the late afternoon. Two other OB/GYNs practice there as well. There are four midwives, six nurses, two XRay technicians and two support staff. A foundation member oversees the clinic although it was not clear to what extent.

There are two XRay technicians, although their role in a maternity hospital is unclear. Probing revealed that very few XRays were done on pregnant women. It seems to be used more for diagnostic referrals from neighborhood practitioners and possibly for industrial exams (although this is a high income residential neighborhood).

There are 4 midwives, 6 nurses, 3 consulting physicians with specialties in obstetrics and gynecology, 2 x-ray technicians and support staff for a total of 17. The daily bookkeeper is the head midwife who reports to the Foundation monthly.

V. TRAINING ISSUES

The midwives of the clinic have received training in IUD insertion at the area general hospital. They have also attended a seminar on abnormal newborn care. The staff are able to receive continuing education and training about twice a year from seminars offered by the University, or other programs.

VI. NEEDS ASSESSMENT

The foundation members report a need for management training. They feel that the services provided to patients are good, but coordination of all of the Muslimat clinics is difficult. They need to establish a more efficient network for communication, cooperation, sharing ideas and resources. They would like some degree of standardization.

Exhibit 2

Muslimat Conference

September 17-19, 1988

Jakarta, Indonesia

MUSLIMAT FOUNDATION CONFERENCE

The assessment team was invited to attend the first National Conference of Muslimat Foundations in Jakarta. This conference was held the weekend of September 17-19, 1988.

BACKGROUND

Mrs. Wahid Hasjim is the founder and chairwoman of the central Foundation of Social Welfare. She is the mother of Abdurahman Wahid, the chairman of the N.U. The foundations were established to focus on social welfare programs. Orphanages, kindergartens and girls dormitories were the original work of the of the foundations. Health facilities were added later.

There are forty two local foundations and one central foundation located in Jakarta. Each local foundation, consisting of generally 8-12 members, is sponsored by a local Muslimat. There is no direct authority over the local foundations by the national foundation, although there is clearly a degree of leadership and influence exhibited by the central foundation.

PURPOSE

The purpose of the conference was "institution building." For the first time, under sponsorship by the central foundation, members were able to meet together, share ideas, discuss problems and begin to explore ways to standardize their programs and operations. On one afternoon of the conference, the health services group met to discuss problems that included strategic planning, management issues, equipment shortages, fundraising, family planning, and other issues. The assessment team joined the discussions at their invitation.

The opening addresses on Saturday by key members of government, the NU, and of the central foundation established the agenda for the weekend. Government, NU, and central foundation policy were described and were the basis for the discussions of the weekend.

Mrs. Wahid Hasjim, Chairwomen, in her opening address to the conference, stated that the goal of the foundations is to increase health and welfare at the grassroots level. She suggested foundations should concentrate on health services, including family planning and the reduction of infant and maternal mortality, services for orphans and the elderly, student dormitories for girls, and the development of a close relationship between LKKNNU and the Muslimat.

Abdurahman Wahid, Chairman of the NU, stated in his opening remarks that the NU accepted the Pansacila as a operating policy and that the goals of the NU were to pursue social welfare efforts.

Other keynote speakers were the chairwomen of the Muslimat, Asmah Syahroni, Minister for Religious Affairs, Munawir Sadsali, the Deputy Governor of Jakarta, Dr. Anwar Ilman, and the director of the BKKBN, Dr. Haryono.

The importance of this conference should not be underestimated. It was a well planned effort to develop a national agenda for the foundations, build trust and communications between them, and begin creating a foundation organization that can integrate the direction, leadership, and resources that will be required to develop the Muslimat health services into consistently high quality, well managed organizations.

Exhibit 3

Translation of Hospital Report Form Quarterly Report to Ministry of Health

NAME OF HOSPITAL

- 01 Admission Date
- 02 Surgical Date
- 03 Finishing Date
- 04 Type of Care 05 Class
- 06 Admission Procedure
- 07 Referred From
 - 01 General Hospital/District Hospital/Maternity Clinic
 - 02 Health Centre
 - 03 General Practitioner/Dentist
 - 04 Paramedic Resource
 - 05 Police Cases
 - 06 Trained Traditional Practitioner
(TBA, Bonesetter, Herbalist)
 - 07 Direct from Home
- 08 Place of Residence
 - Province District Subdistrict
- 09 Date of Birth
- 10 Level of Education
 - 01 Never go to school 02 Not finish elementary school
 - 03 Finish elementary school 04 Finish junior high school
 - 05 Finish senior high school 06 Graduate from college
- 11 Occupation
- 12 Marital status
 - 01 Children 02 Not yet married 03 Married
 - 04 Widow 05 Widower
- 13 Gender/Sex
 - 01 Male 02 Female
- 14 Diagnosis
- 14a Trauma/Positioning
- 14b Morphology Neoplasm
- 15 Survey/Operation

- 16 Nosocomial Infection (NI)
- 01 NI Unsymptomatic Urinary Tract
 - 02 NI Symptomatic
 - 03 NI Gastro-intestinal Tract
 - 04 NI Lower Respiratory Tract
 - 05 NI Upper
 - 06 NI Skin wounded operation
 - 07 NI Combustio (skin burned)
 - 08 NI Other skin
 - 09 NI Reproductive organ
 - 10 NI Bacterotomia
 - 11 NI Others
 - 12 Unknown
- 17 Causes of NI: -----> see form
- 18 Disability
- 19 Immunization Histories
- BCG, DPT, Polio, TT, DT, Measle
- 20 Blood Transfusion
- No Yes ----- CC
- 21 Radiotherapy Treatment
- No Yes
- 22 Status of Leaving the Hospital
- 01 Recover 03 Not Recover
 - 02 Recovering 04 Dead before 48 hours of being inpatient
 - 05 Dead after " " " " "
- 23 Condition on Leaving the Hospital
- 01 Permitted to go home
 - 02 Referred to other hospitals
 - 03 Unpermitted to go home
 - 04 Escape from caring
- 24 Temporary permission on leaving the hospital _____ days

Doctor in Charge _____

Signature _____

Name

Tanggal 1 - 10 bulan 19

Jenis Formulir

1

(1)

Kode R.S.

(2-8)

No. Dok. Medik :

(9-14)

Nama Rumah Sakit : No. Dokumen Medik :

01. Tanggal Masuk Rumah Sakit :	/	/ 19	Tgl. Masuk (15-20)	<input type="text"/>
02. Tanggal Operasi/Tindakan :	/	/ 19	Tgl. Operasi (21-26)	<input type="text"/>
03. Tanggal Keluar Rumah Sakit :	/	/ 19	Tgl. Keluar (27-32)	<input type="text"/>
04. Jenis Pelayanan Rawat Nginap :	05. Kelas :		Jns. Pelayanan (33-34)	<input type="text"/> Kelas (35) <input type="text"/>
06. Prosedur masuk RS : <input type="checkbox"/> 1. Melalui Unit Darurat <input type="checkbox"/> 2. Melalui Unit Rawat Jalan <input type="checkbox"/> 3. Langsung Rawat Nginap			Prosedur masuk RS (36)	<input type="checkbox"/>
07. Cara masuk RS / Rujukan <input type="checkbox"/> 1. RSU/RSK/RB <input type="checkbox"/> 2. Puskesmas <input type="checkbox"/> 3. Dokter/Dokter Gigi <input type="checkbox"/> 4. Tenaga Paramedik <input type="checkbox"/> 5. Kasus Polisi <input type="checkbox"/> 6. Dukun terlatih <input type="checkbox"/> 7. Datang sendiri			Cara masuk RS (37)	<input type="checkbox"/>
08. Tempat Tinggal : Propinsi Kab/Kodya Kecamatan			Prop (38-39) <input type="text"/> Kab (40-41) <input type="text"/> Kec (42-43) <input type="text"/>	
09. Tanggal Lahir :	/	/ 19	Umur (44-49)	Thn <input type="text"/> Bin <input type="text"/> Hr <input type="text"/>
10. Pendidikan yang diselesaikan <input type="checkbox"/> 1. Tidak sekolah <input type="checkbox"/> 2. Belum/tidak tamat SD <input type="checkbox"/> 3. Tamat SD <input type="checkbox"/> 4. Tamat SMTP <input type="checkbox"/> 5. Tamat SMTA. <input type="checkbox"/> 6. Tamat Universitas/Akademi			Pendidikan (50)	<input type="checkbox"/>
11. Pekerjaan / Jabatan			Pekerjaan (51-53)	<input type="text"/>
12. Status kawin <input type="checkbox"/> 1. Dibawah Umur <input type="checkbox"/> 2. Belum Kawin <input type="checkbox"/> 3. Kawin <input type="checkbox"/> 4. Janda <input type="checkbox"/> 5. Duda			Status kawin (54)	<input type="checkbox"/>
13. Jenis kel. Kelamin <input type="checkbox"/> 1. Laki-laki <input type="checkbox"/> 2. Perempuan			Jenis Kelamin (55)	<input type="checkbox"/>
14. Diagnosis Utama			Diagnosis Utama (56-59)	<input type="text"/>
14 a. Penyebab luar cedera & koracunan			Kode Sangkur/Kode E/Morfologi *)	<input type="text"/>
14 b. Morfologi Neoplasma :			(60-63) <input type="text"/> (64) <input type="text"/>	
15. Operasi / Tindakan			Operasi/Tindakan (65-68)	<input type="text"/>
16. Infeksi Nosokomial <input type="checkbox"/> 1. IN Sal Kencing tak bergejala <input type="checkbox"/> 2. IN Sal Kencing bergejala <input type="checkbox"/> 3. IN Sal Cerna <input type="checkbox"/> 4. IN Sal nafas bawah <input type="checkbox"/> 5. IN Sal Nafas Atas <input type="checkbox"/> 6. IN Luka Operasi pada kulit <input type="checkbox"/> 7. IN Luka Bakar <input type="checkbox"/> 8. IN Lain pada Kulit <input type="checkbox"/> 9. IN Organ reproduksi <input type="checkbox"/> 10. IN Bakteriemia <input type="checkbox"/> 11. IN Lainnya <input type="checkbox"/> 99. Tidak tahu			Jenis IN (69-70)	<input type="text"/>
17. Penyebab Infeksi Nosokomial <input type="checkbox"/> 1. Staphylococcus <input type="checkbox"/> 2. Streptococcus <input type="checkbox"/> 3. Pneumococcus <input type="checkbox"/> 4. E. Coll <input type="checkbox"/> 5. Klebsiella <input type="checkbox"/> 6. Pseudomonas <input type="checkbox"/> 7. Proteus <input type="checkbox"/> 8. Lain-lain <i>OTHERS</i> <input type="checkbox"/> 9. Tidak tahu <i>(if any)</i>			Sebab IN (71)	<input type="checkbox"/>
18. Ketunaan, ketidak mampuan dan kelainan :			Ketunaan (72-76)	<input type="text"/>
19. Sejarah Immunisasi <input type="checkbox"/> BCG <input type="checkbox"/> D.P.T <input type="checkbox"/> Poliomelitis <input type="checkbox"/> Tetanus formal toxoid <input type="checkbox"/> D.T <input type="checkbox"/> Campak			Immunisasi (76-77)	<input type="text"/>
20. Transfusi Darah <input type="checkbox"/> Tidak <input type="checkbox"/> Ya, cc	21. Pengobatan dengan Radioterapi/kedokteran nuklir <input type="checkbox"/> Tidak <input type="checkbox"/> Ya,		Transfusi (78)	<input type="checkbox"/> Radioterapi (79) <input type="checkbox"/>
22. Keadaan Keluar Rumah Sakit <input type="checkbox"/> 1. Sembuh <input type="checkbox"/> 2. Mulai Sembuh <input type="checkbox"/> 3. Belum Sembuh <input type="checkbox"/> 4. Meninggal sebelum 48 jam dalam operasi <input type="checkbox"/> 5. Meninggal dalam 48 jam dan lebih dalam operasi			Keadaan Keluar (80)	<input type="checkbox"/>
23. Izin Keluar (Jika Pasien Keluar Rumah) <input type="checkbox"/> 1. Dipulangkan <input type="checkbox"/> 2. Dirujuk <input type="checkbox"/> 3. Pulang Paksa <input type="checkbox"/> 4. Lari			Izin Keluar (81)	<input type="checkbox"/>
24. Cuti Sakit :	Har		Cuti Sakit (82-83)	<input type="text"/>

Kolom 60 - 63/64 diisi dengan Kode Sangkur jika Klasifikasi Kode Rangkap atau Kode E jika Kecelakaan atau Kode M jika Neoplasma

Dokter yang bertugas :

Tanda tangan :

1. Nomor kode RS :

2. Nama RS :

3. Jenis RS : *Type of Hospital*

4. Kelas RS : *Class of Hospital*

5. Nama Direktur RS : *Director's Name*

6. Alamat/Lokasi RS : *Address*

8. Surat Izin/Penetapan :

a. Nomor :

b. Tanggal :

c. Oleh :

d. Sifat : 1. Sementara 2. Tetap

9. Penyelenggara RS :

a. Nama :

b. Status :

Telepon :

7. Kegiatan dimulai Tgl. Bln. Thn.

Khusus untuk Swasta berilah tanda (V) :

Islam Hindu Perorangan

Katolik Budha Perusahaan

Protestan Organisasi Sosial

11. Fasilitas Tempat Tidur Menurut Rawat Nginap.

10. Fasilitas Kesehatan Gigi : a. Kursi Gigi : b. Unit Gigi

No.	Jenis Pelayanan/ Ruang Rawat Nginap	Alokasi TT	Perincian Tempat Tidur Per Kelas					Luas Ruangan (M2)	No
			Kelas Utama/VIP	Kelas I	Kelas II	Kelas III	Kelas IV		
1	2	3	4	5	6	7	8	9	10
1	Penyakit Dalam	INTERNAL							1
2	Bedah	SURGICAL							2
3	Kesehatan Anak	PEDIATRIC							3
4	Obstetri	OBSTETRIC							4
5	Ginekologi	GYNCOLOGY							5
6	Bedah Saraf	NEURO SURGICAL							6
7	Saraf	NEUROLOGICAL							7
8	Jiwa	MENTAL							8
9	THT								9
10	Mata	EYE							10
11	Kulit & Kelamin	SKIN							11
12	Gigi & Mulut	DENTISTRY							12
13	Kardiologi	CARDIOLOGICAL							13
14	Radioterapi/Kedokteran Nuklir	RADIOLOGICAL							14
15	Bedah Orthopedi	ORTHOPEDIC							15
16	Paru-Paru	LUNGS							16
17	Kusta	LEPROSY							17
18	Umum *)	POLYCLINIC							18
19	Unit Darurat	EMERGENCY							19
20	Rehabilitasi Medik	REHABILITATION							20
21	Isolasi	ISOLATION ROOM							21
22	Luka Bakar	BURN / WOUND UNIT							22
23	ICU	INTENSIVE CARE UNIT							23
24	ICCU	INTENSIVE CARDIAC CARE							24
77	SUB TOTAL								77
88	Perinatologi./Bayi	PERINATOLOGY / INFANT CARE							88
99	TOTAL								99

Exhibit 4

Itinerary and Schedule

Date	Location	Activities
Sept. 15	Jakarta	Arrival in Jakarta Team meeting
Sept. 16	Jakarta	Team meeting, scheduling, travel plans Briefing at USAID with Carol Carpenter Meeting with staff of YKB clinic and tour of facility Meeting with Does Sampoerno, Pathfinder
Sept. 17	Jakarta	Attended opening ceremony of Muslimat Foundation Conference Meeting with Rosy Munir of LKKNU; arranging interpreters, discussing visit schedule
Sept. 18	Jakarta	Arrangements for travel Meeting with Health Facilities Group of Muslimat Foundation Conference Meeting with Rosy Munir, LKKNU Final selection of clinics
Sept. 19	Jakarta	Team meeting, preparing travel arrangements for interpreters Meeting with Firman Lubis YKB to discuss financing, establishing clinics, self--reliance
Sept. 20	Surabaya	P.M. - Travel to Surabaya, East Java
Sept. 20	Surabaya	Team meeting Business meeting with interpreters Sidoarjo Travel to and assessment visit of clinic at Sidoarjo
Sept. 21	Surabaya	Travel to and assessment visit of Bangil clinic at Bangil Team meeting Writing reports, assessment
Sept. 22	Surabaya	Travel to and assessment visit of Islamic Hospital Meeting with Chairman of Hospital Foundation Business meeting with interpreters Planning logistics of visits, contacts

Date	Location	Activities
Sept. 23	Kepanjen	Travel to Kepanjen, Malang Assessment visit to Kepanjen Clinic Orientation for new interpreter Team meeting
Sept. 24	Singosari	Travel from Malang to Singosari Assessment visit of Singosari Clinic
	Surabaya	Travel to Surabaya by car Evening flight to Yogyakarta YogyakartaSolo, Travel by car to Yogyakarta
Sept. 26	Yogyakarta	Meeting at Muslimat Foundation office (chairwoman's home) Assessment visit to Yogyakarta Clinic Writing reports, organizing material
Sept. 27	Yogyakarta	A.M. flight to Jakarta
	Jakarta	Assessment visit to Jakarta Clinic Business meeting with interpreter Team meeting, writing
Sept. 28	Jakarta	USAID debriefing with Carol Carpenter LKKNU meeting and report of visits with Rosy Munir Team meeting Writing reports
Sept. 29	Jakarta	Writing(Lyn)

Exhibit 5

Contact List

ORGANIZATION

RB/BKIA/PoliKlinik Muslimat NU
Location: Sidoarjo

NAME

Mrs. Nur Zainab
Foundation Chairman

Mrs. Mursintowati Narindra
Physician-in Charge

Mrs. Fatmah Assegaf
2nd Chairman and Chairman of local
Muslimat

Mr. Machfudz
Treasurer of Hospital and Foundation

Mrs. Soedarman
Nursing Coordinator and Midwife

Mr. I. Kimawan
Engineer and Planner

POLIKLINIK ISLAM "MASYITHOH"
BANGIL

Mrs. Abdul Rahman
Foundation Chairman

Mrs. Chodidyah
Vice Chairman

Mrs. Musrifah
1st Secretary of the Foundation

Mrs. Salamah Kadir
2nd Secretary of the Foundation

Mrs. Wiwik, M.D.
Physician-in-Charge

BALAI KESEHATAN MASYARAKAT
Kepanjen

Mrs. Istigomal
Foundation Chairman

Mrs. Sholichas
Foundation Secretary

Oemar Soemary, M.D.
Physician-in-Charge

**RUMAH SAKIT ISLAM
ISLAMIC HOSPITAL
SURABAYA**

**Mr. H. Achmad, M.D.
Physician-in-Charge**

**Mr. M. Oja'far
Foundation Secretary**

**BKIA/RB MUSLIMAT SIGOSARI
SINGOSARI**

**Mrs. Tbolcha
Foundation Secretary**

**Mrs. Hartati
Nurse-Midwife**

**Mrs. Suliha
Foundation member**

**Mrs. Kusmida
Foundation member**

**Mrs. Suharti
Foundation member**

**Mrs. Robawa
Foundation member**

**Mrs. Solibra
Foundation member**

**POLYCLINIC YAYASAN
KESEJAHTERAAN KELUARGA
Yogyakarta**

**Mohammad Fajrul Falaakh
Foundation Representative**

**Professor dr. R.M. Tedjo Baskoro
Physician-in-Charge**

**Mrs. Surasih
Nurse**

**KLINIK K/B MUSLIMAT
Jakarta**

**Mrs. Soeparman
Clinic Foundation Chairman**

**Dr. Falmui, MPH
Physician-in-Charge**

**Miss. Nilmah
Midwife**

**Mrs. Hastini
Nurse**