

**Achievements of the National Clinical  
Training Network in Indonesia (1997–2000):  
A Review**

**JHP-20**

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## ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
BDC	Basic delivery care
BKKBN	National Family Planning Coordinating Board
CBT	Competency-based training
DinKes	Dinas Kesehatan: health office in a province or district (under the local government)
DTC	District training center
FGD	Focus group discussion
FP	Family planning
IBI	Indonesian Midwifery Association
IDI	Indonesian Medical Association
Implanon <sup>®</sup>	Single-rod etonogestrel implant
JICA	Japan International Cooperation Agency
MMR	Maternal mortality rate
MNH	Maternal and Neonatal Health
MOH	Ministry of Health (Departemen Kesehatan [DepKes])
NCTN	National Clinical Training Network (Jaringan Nasional Pelatihan Klinik [JNPK])
NRC	National resource center
Ob/gyn	Obstetrics/gynecology
PKBI	Indonesian Family Planning Association
PKMI	Indonesian Association for Surgical Contraception
POGI	Indonesian Society for Obstetrics and Gynecology (Perkumpulan Obstetri dan Ginekologi Indonesia)
PTC	Provincial training center
RH	Reproductive health
SDES	Service Delivery Expansion Support
STARH	Sustaining Technical Achievements in Reproductive Health
SWOT	Strengths, weaknesses, opportunities and threats
TIMS <sup>®</sup>	Training Information Monitoring System
TQA	Training Quality Assurance
TRH	Training in Reproductive Health
UNFPA	United Nations Population Fund

## EXECUTIVE SUMMARY

In 1991, a partnership between the Indonesian Society for Obstetrics and Gynecology (POGI), National Family Planning Coordinating Board (BKKBN), Ministry of Health (MOH), and JHPIEGO was created to conduct a nationwide clinical training needs assessment. The assessment was the basis of a strategy to improve clinical training, which included the formation of a clinical training network, the National Clinical Training Network (NCTN). This network grew to incorporate other professional organizations and nongovernmental organizations with a stake in reproductive health (RH) service provision and clinical training. The NCTN was officially established in 1994 as a means to ensure high-quality RH services in Indonesia.

A mid-project assessment was conducted at the end of 1996 and early 1997 to review the management, technical effectiveness, and efficiency of the network. In addition, there was an evaluation in 1998 of the United States Agency for International Development's Service Delivery Expansion Support (SDES) Project, which had funded NCTN development, both through field support to JHPIEGO's global Training in Reproductive Health (TRH) Project and through the institutional contractor Pathfinder International. The evaluation included an assessment of providers' knowledge and skills in family planning service delivery. Both of these assessments provided valuable insights and recommendations to continue strengthening the NCTN. In the past 3 years, the NCTN devoted much energy and effort to defining and disseminating standards for high-quality clinical training. This review sought to document the experience and accomplishments of the NCTN, focusing on the years since the mid-project assessment to identify lessons learned to help guide NCTN initiatives in the future.

A mixed method approach was used for this review and data collection consisted of self-administered questionnaires with a mixture of closed and open ended questions, in-depth interviews with key informants, and focus group discussions (FGDs) with providers who had attended clinical skills training courses. NCTN and JHPIEGO representatives identified six main areas of focus for the review:

- ◆ NCTN's capacity to plan, manage, implement, and evaluate training
- ◆ Qualification of trainers and providers
- ◆ Quality assurance and monitoring of standards for training quality (provincial training centers [PTCs], district training centers [DTCs])
- ◆ DTC's role in sustaining provider performance
- ◆ NCTN collaboration and partnerships
- ◆ Expansion of NCTN capacity (additional content areas, wider geographic coverage)

The self-administered questionnaires were mailed to all NCTN training center managers and trainers. A team composed of University of Indonesia researchers, NCTN representatives from the coordination unit, the two national resource centers (the BKKBN and the MOH), and JHPIEGO staff was recruited to conduct the interviews and facilitate the FGDs. They traveled to six provinces and eight districts during the months of February and April 2001. A subset of the team conducted interviews in Jakarta with central level stakeholders. Completed questionnaires were received from 104 trainers and 9 NCTN managers. In total, 117 interviews and 13 FGDs were conducted.

Overall, results in the area of the NCTN's capacity suggested the PTCs and DTCs are responding to the needs of their clients, at least in active training centers. In some provinces,

training may still be done at the provincial level (e.g., Bali, North Sumatra), which may be an appropriate model if the level of activity is not too burdensome for the PTC.

In the management domain, many but not all training centers realized the need for annual planning in addition to preparation for each course. Before a course, PTCs and DTCs conducted coordination meetings and covered a broad area of training related issues such as participant selection, clients for practice, and supplies and materials. Thanks to good cooperation between the training center and the sponsoring government agency, more often than not, logistical issues were raised and some solution was found to shortfalls or problems in those meetings. Finances were also managed in varying ways by each site. The use of reports or other documentation to record training activities was less prevalent and probably warrants more emphasis. Similarly, although NCTN trainers conducted supervisory or evaluation activities for other trainers, documentation of these efforts may be lacking.

The majority of respondents within the NCTN were comfortable with the current management and leadership structure as described in the “Ortala” (*Organisasi Tata Laksana*, a document that details NCTN rules and procedures). They also agreed that stakeholders other than POGI should be represented in that structure and be present in coordination meetings. There was less agreement, however, as to the type of representation, by which of the stakeholders, and whether it needs to exist in the same fashion at the district and provincial level as it does at the central level. The roles of the professional organizations (POGI, Indonesian Midwifery Association [IBI], and Indonesian Medical Association [IDI]) need to be made explicit. These could be distinguished from roles of other member organizations, such as the Indonesian Association for Surgical Contraception, Indonesian Family Planning Association, and Muhammadiyah (an Islamic nongovernmental organization). Similarly, respondents recommended that the NCTN look into clarifying the linkages between training centers and the hospitals that house them.

As for the sustainability of the NCTN as a whole and the DTCs in particular, respondents provided some concrete proposals, particularly in the areas of advocacy and marketing that target local governments. One proposed strategy was to participate actively in district level planning to integrate ongoing health activities. Respondents expressed that the DTCs need the entire network to support them in continually improving the quality of training, applying common standards for training, and providing ongoing guidance and support.

As for the qualification of trainers, NCTN interview respondents generally reported applying the trainer development pathway (see **Appendix B** for the pathway). In terms of participant qualification, the review team noted the majority of NCTN respondents were unable or unwilling to estimate the percentage of past participants who were deemed competent. In addition, members of the review team observed that Training Quality Assurance (TQA) forms submitted after a course were often missing data on provider competency. On the contrary, trainers reported that if there were not enough cases for a participant to reach competency, they sought ways to correct the problem. Only 6% of trainers reported qualifying a participant in a case where competency could not be established with clients.

Many participants in clinical skills courses recommended more practice time with clients as well as sufficient caseloads for the number of participants being trained. In FGDs, providers often raised issues about course certificates. By not distributing a certificate, trainers may create uncertainty about whether they had deemed the participant competent.

In recent years, the NCTN has put a great deal of effort into the painstaking process of developing standards for training. This review revealed that not all of these standards were yet

fully known, either by training coordinators or by stakeholders outside the PTCs and DTCs. The fact that a forum exists and has worked to develop these standards was also not known at lower levels. Although the TQA documents had been distributed in coordination meetings, more needs to be done to disseminate these documents in provincial and district level meetings.

Although TQA and Training Information Monitoring System (TIMS<sup>®</sup>) were still not yet implemented throughout the network at the time of this review, feedback on their applicability and effectiveness in tracking training activities was generally positive. In particular, NCTN managers expressed an interest in using TIMS to monitor training activities. These responses illustrated the fact that these systems need further development and should be well received.

Most respondents felt that training in and of itself was central to improving provider performance and judged the DTCs as having contributed to improved performance. Providers attested to their own improved confidence and competence. Although followup with participants after training is a time and resource intensive activity, it is important to note that 49% of trainers responding to the self-administered questionnaire reported conducting followup. Some providers who participated in the focus groups also mentioned having been “followed up” by their trainers, particularly those from the district level.

In the area of collaboration, the primary NCTN partners in the field are two government institutions—the BKKBN and the MOH. Even though many training centers reported collaborating with IBI, some IBI respondents felt that they could and should play a greater role in the NCTN activities. IDI respondents sought more information about the NCTN, not a greater role. Not surprising, POGI branch respondents—who were often the trainers—felt the collaboration with the training centers was good. Collaboration leads to improvements in the quality of training (e.g., through problem solving to identify needed resources), but may also lead to compromises that affect quality (e.g., changing the length of the course or the selection of participants). Some government respondents felt the NCTN was too rigid or expensive. Others recognized that the NCTN represents high standards in training and thus high-quality service provision.

With regard to expansion, there has already been steady growth in the NCTN. The number of training packages continued to grow steadily and geographic expansion has occurred. Finally, NCTN trainers who were also faculty reported using competency-based training methodologies in their work with medical and midwifery school students.

The results of this review formed the basis of an NCTN strategic planning effort that engaged the participation and commitment of all NCTN stakeholders to determine how it could best function under decentralization. Components of this process included election of an NCTN chairperson, discussion of the findings of this review, national NCTN strategic planning workshops to develop a strategic plan and action plan, and systematic implementation of the action plan over the subsequent 18 months.

In sum, the NCTN has survived the end of the SDES Project and has maintained and expanded the investments made under the TRH Project. It is continuing to provide training in nearly 90 sites around Indonesia. Given the great diversity in the country and the variety in funding sources and mechanisms required for training, this is no small feat. Challenges remain to be addressed in the future, but there is a strong foundation upon which to build a more sustainable and cohesive organization for as long as RH clinical training is needed in Indonesia.



# **Achievements of the National Clinical Training Network in Indonesia (1997–2000): A Review**

## **INTRODUCTION**

The partnership between JHPIEGO, the National Family Planning Coordinating Board (BKKBN), the Ministry of Health (MOH), and the Indonesian Society for Obstetrics and Gynecology (POGI) began in 1991 with a request from the BKKBN to assist with a nationwide clinical training needs assessment. As a result of the assessment, a two-phase strategy was developed to address the weaknesses of the clinical training program at that time. In the first phase of the strategy, a “refresher training” program was initiated; in the second phase (1995–1999), a unified, standardized, and supervised training network was established through POGI: the National Clinical Training Network (NCTN) for reproductive health (RH). Since the inception of the NCTN in 1994, one of the goals of the collaboration was NCTN institutionalization and capacity building as a means to ensure high-quality RH services in Indonesia. Although the NCTN initially focused on family planning (FP), it grew to include maternal health under a separate project—the Maternal Health Training Project—in collaboration with both JHPIEGO and PRIME. As the environment for RH services changes, this development and other examples of the NCTN’s ability to expand the content and complexity of its activities will be key to its continued relevance and sustainability in Indonesia.

This review was conducted at JHPIEGO’s request to document the current status of the NCTN when the Training in Reproductive Health (TRH) Project ended its activities in Indonesia and two other awards—Sustaining Technical Achievements in Reproductive Health (STARH) and Maternal and Neonatal Health (MNH)—were beginning or expanding (FY2001). Until the award of the MNH Program in 1998, all JHPIEGO support to the NCTN had been funded under the global TRH Project. In August 2000, the United States Agency for International Development/Indonesia also awarded a new FP cooperative agreement for STARH. This review describes the experiences and accomplishments of past efforts and documents lessons learned in an effort to guide future NCTN initiatives and improve quality and choice through existing institutions.

To review the management and technical effectiveness and efficiency of the network, a mid-project assessment of the NCTN was conducted between October 1996 and March 1997. Subsequently, a Service Delivery Expansion Support (SDES) Project evaluation in 1998 examined the knowledge and skills of providers after training. As a result of both of these assessments, the NCTN leadership put energy and effort into developing and establishing training standards. A comprehensive review of the experience since these assessments was deemed useful to identify lessons learned and to make recommendations for implementation under the STARH and MNH programs. Moreover, the documented experience of the partnership between JHPIEGO and the NCTN will become a reference for similar future JHPIEGO program efforts worldwide. Finally, Indonesia is going through the initial phases of decentralization and it was thought that an assessment of the NCTN’s experience under TRH could generate pathways for innovative strategies for NCTN operation in a decentralized system. This review looks back as well as forward to form the basis for future planning and development of the NCTN.

## METHODOLOGY

### Objectives

Focusing on the past 3 years since the mid-project assessment, the overall objective of this evaluation is to review and document the various collaborations and achievements in establishing and building the capacity of the NCTN, as well as to look forward to its ability to adapt to and function within a decentralized system.

The review focused on the following specific objectives:

- ◆ Documenting the development and establishment of the NCTN in Indonesia
- ◆ Describing the key initiatives supporting the national clinical training system, including Training Information Monitoring System (TIMS<sup>®</sup>) and Training Quality Assurance (TQA)
- ◆ Determining the capacity of the NCTN to respond to expansion (additional content areas, wider geographic coverage) and adapt to pressures such as decentralization
- ◆ Describing the partnerships and collaboration between POGI, the NCTN, the BKKBN, the MOH, Indonesian Midwifery Association (IBI), and Indonesian Medical Association (IDI), and their contributions to the achievements of the NCTN
- ◆ Identifying lessons learned and categorizing recommendations for implementation of the MNH, STARH, and other donor funded projects in Indonesia, as well as for JHPIEGO country programming initiatives worldwide

A series of meetings with the NCTN and JHPIEGO staff were held to clarify the purpose of the review and identify broad areas of inquiry. Six main areas were identified as the focus of the review:

- ◆ NCTN's capacity to plan, manage, implement, and evaluate training
- ◆ Qualification of trainers and providers
- ◆ Quality assurance and monitoring of standards for training quality (provincial training centers [PTCs], district training centers [DTCs])
- ◆ DTC role in sustaining provider performance
- ◆ NCTN collaboration and partnerships
- ◆ Expansion of NCTN capacity (additional content areas, wider geographic coverage)

The design applied for this NCTN review was a cross sectional descriptive study largely composed of assessing how the NCTN functioned in providing clinical training, accomplishments of the network, and analysis of future directions based on the lessons learned from past experience. A mixed method approach was applied in the conceptual framework and in gathering and analyzing both quantitative and qualitative data.

### Sampling Frame

The review team sent a self-administered questionnaire to all the national resource centers (NRCs), PTCs, and DTCs of the NCTN to give all NCTN trainers and managers an opportunity to contribute to this review. In addition, the review team stratified a sample of provinces and districts geographically by the two NRCs in Indonesia (Jakarta and Surabaya) for in-depth interviews and focus group discussions (FGDs). All PTCs were listed and six were purposively selected and clustered into the following three broad categories:

- ◆ Those established with support from the SDES Project
- ◆ Those established with support from the Asian Development Bank (ADB)/United Nations Population Fund (UNFPA)
- ◆ Those initiated by their own provinces

PTCs established through SDES were divided into pairs—one that was deemed to be performing very well with one that had encountered greater difficulty—and selected to represent each of the NRCs. One of each of the nonSDES-supported provinces was selected to ascertain whether there were differences in how these PTCs and DTCs functioned. Among the SDES-supported PTCs associated with NRC Jakarta, the team selected North Sumatra and West Java. For those associated with NRC Surabaya, the team chose South Sulawesi and Central Java. And lastly, Riau was selected for the review among the PTCs supported by ADB/UNFPA. Bali was selected as a province where the PTC had been developed by the province itself (**Table 1**).

**Table 1. National Resource Center/Provincial Training Center Sites**

Training Center	Support	Classification
NRC Jakarta		NRC
• PTC North Sumatra	SDES	Greater challenges
• PTC West Java	SDES	High performer
PTC Riau	ADB/UNFPA	NonSDES funds
NCR Surabaya		NRC
• PTC South Sulawesi	SDES	Greater challenges
• PTC Central Java	SDES	High performer
PTC Bali	Own	NonSDES funds

The review team then selected seven DTCs (two DTCs for the two PTCs classified as high performers, and one DTC from each of the other study provinces). A random selection was made using two lists of DTCs—active and nonactive—to obtain an equal number of active and inactive DTCs.<sup>1</sup> **Table 2** summarizes the districts selected for in-depth interviews and FGDs, as well as the criteria for selection.

<sup>1</sup> Bali does not yet have any DTC, so it was excluded from DTC selection. Deli Serdang was selected for being active, but when the interview team went to the district, they found that this DTC was not active because all training in North Sumatra still occurred at the PTC.

**Table 2. District Training Center Sites**

<b>DTC</b>	<b>Province</b>	<b>Selection Criteria</b>
1. Brebes	Central Java	Not active
2. Pati	Central Java	Active (and involved in basic delivery care training)
3. Deli Serdang	North Sumatra	Active (when selected, in fact not)
4. Sukabumi	West Java	Not active
5. Garut	West Java	Active
6. Pare Pare	South Sulawesi	Least active (all South Sulawesi DTCs are active)
7. None	Bali	No DTC functioning at time of assessment
8. Dumai*	Riau	Active
*Dumai was in fact not active, so Kampar was included in the end.		

### Data Collection Instruments

Three types of instruments were used to collect data for the review:

- ◆ **Self-administered questionnaires** for training center respondents: The questionnaires contained information about respondent background characteristics, including completed clinical training courses, training qualification level attained, skills qualifications acquired, and information about the six broad areas of focus in the review.
- ◆ **Interview guides** designed for each type of key informant (from NCTN training centers, professional organizations, government agencies, hospitals where training centers are housed): The review team developed five interview guides for specific central, provincial, and district key informants—namely NCTN managers, training coordinators, professional organizations (POGI, IBI and IDI), government institutions (the BKKBN and the MOH), and district hospital directors. The guides were used to elicit information about respondents' characteristics, involvement in RH clinical training, training management, partnerships in planning and implementation of training activities, quality assurance, and supervision and reporting systems. During the interviews, special attention was given to respondents' perspectives, including experiences, views, and judgments about the central issues and aspects of interest in the review.
- ◆ **FGD guides** to gather information from providers who had attended clinical skills training courses: A similar structure to that of the interview guides was used in the design of FGD guides for providers who had recently undergone clinical training. The discussions allowed providers to describe their experiences and views regarding the training they had recently undertaken and the application of skills they had acquired in their profession.

A document review was also conducted to examine and complement information obtained from the questionnaires and guides. The review was used especially to verify historical understanding of the NCTN, to track trends of capacity building and management of clinical training, and to explore other issues of interest in the review best captured in documents.

**Table 3** outlines the organizing framework for developing the data collection instruments. The remainder of the report is organized around each of the key questions listed in **Table 3**.

**Table 3. Areas of Focus and Key Questions to Be Answered by the Review**

Area of Focus	Key Questions	Instruments	Respondents
NCTN's capacity to plan, manage, implement, and evaluate training	<ul style="list-style-type: none"> <li>To what extent has the NCTN successfully demonstrated its capacity in planning, managing, implementing, and evaluating training at the PTC or DTC level, including responding to district level training needs?</li> </ul>	Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers
	<ul style="list-style-type: none"> <li>How has the NCTN specifically managed the financial and logistical implementation of training at the PTC/DTC level?</li> </ul>	Interview Guides, Focus Group	BKKBN, MOH, NCTN Mgrs, Hosp Admin, Providers
	<ul style="list-style-type: none"> <li>What kind of management structure and leadership might help in improving the operations/ effectiveness of PTCs and DTCs? How can the sustainability of the DTCs be enhanced under decentralization?</li> </ul>	Self-Admin'd Qs, Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Hosp Admin
	<ul style="list-style-type: none"> <li>What specific areas need additional technical assistance at the DTC level?</li> </ul>	Self-Admin'd Qs, Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Hosp Admin
	<ul style="list-style-type: none"> <li>What support will DTCs need to continue sustaining/enhancing provider performance?</li> </ul>	Self-Admin'd Qs, Interview Guides, Focus Group	Prof Orgs, BKK-BN, MOH, Trainers, Providers
Qualification of trainers and providers	<ul style="list-style-type: none"> <li>How well are trainer and provider selection and qualification criteria being applied and adhered to?</li> </ul>	Interview Guides, Focus Group, Document Review	Prof Orgs, BKK-BN, MOH, Trainers, Providers
	<ul style="list-style-type: none"> <li>How are qualification criteria determined and reinforced?</li> </ul>	Interview Guides	Prof Orgs, BKK-BN, MOH, Trainers
Quality assurance and monitoring of standards for training quality (PTCs, DTCs)	<ul style="list-style-type: none"> <li>To what extent has the NCTN successfully demonstrated its capacity to establish standards for training and to ensure adherence to the standards?</li> </ul>	Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers
	<ul style="list-style-type: none"> <li>How have PTCs and DTCs maintained minimum standards for training performance (selection criteria, caseload, length/content)?</li> </ul>	Self-Admin'd Qs, Interview Guides, Focus Group	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Providers
	<ul style="list-style-type: none"> <li>How have PTCs and DTCs ensured that training sites are meeting the standards established by the NCTN and the Trainer Task Force?</li> </ul>	Interview Guides	BKKBN, MOH, NCTN Mgrs, Trainers, Hosp Admin
	<ul style="list-style-type: none"> <li>How has the NCTN used tools such as TIMS and TQA to ensure ongoing monitoring of training implementation?</li> </ul>	Self-Admin'd Qs, Interview Guides	NCTN Mgrs, Trainers
DTC's role in sustaining provider performance	<ul style="list-style-type: none"> <li>How has the DTC supported providers' ability to use the skills acquired during training and how has service delivery improved, in the opinion of district leaders, managers, providers, and trainers?</li> </ul>	Interview Guides, Focus Group	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Providers

Area of Focus	Key Questions	Instruments	Respondents
NCTN collaboration and partnerships	<ul style="list-style-type: none"> <li>What do models of successful partnerships and collaboration among POGI, NCTN, BKKBN, MOH, IBI, and IDI look like?</li> </ul>	Self-Admin'd Qs, Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Hosp Admin
	<ul style="list-style-type: none"> <li>How has collaboration enhanced the quality of training at the district level and what has it supported?</li> </ul>	Self-Admin'd Qs, Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Hosp Admin
	<ul style="list-style-type: none"> <li>How can collaboration be improved at different levels (NRC, PTC, DTC)? <i>Various collaborations to explore:</i> <ul style="list-style-type: none"> <li>PTC/DTC with BKKBN</li> <li>PTC/DTC with Kanwil* or Dinas Kesehatan</li> <li>PTC/DTC with IBI or POGI</li> <li>PTC and DTC directors with hospital management</li> </ul> </li> </ul>	Self-Admin'd Qs, Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers, Hosp Admin
Expansion of NCTN capacity (additional content areas, wider geographic coverage)	<ul style="list-style-type: none"> <li>How has the NCTN successfully built on a solid base to cover additional content areas?</li> </ul>	Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers
	<ul style="list-style-type: none"> <li>In what way has the NCTN expanded to new sites for wider geographic coverage?</li> </ul>	Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs
	<ul style="list-style-type: none"> <li>How has creation of the NCTN enhanced competency-based training at medical/midwifery schools?</li> </ul>	Self-Admin'd Qs, Interview Guides	Prof Orgs, BKK-BN, MOH, NCTN Mgrs, Trainers
<p>Notes:  Hosp Admin=Hospital Administration; Mgrs=Managers; Prof Orgs=Professional Organizations; Self-Admin'd Qs=Self-Administered Questionnaires  *Kanwil=Kantor Wilayah, the MOH office in the province (under decentralization, this type of office does not exist anymore)</p>			

Data collection was conducted over 4 weeks (from February to April 2001). There were three teams of interviewers representing the NCTN, University of Indonesia, the BKKBN, the MOH, and JHPIEGO. To ensure effective data collection, a team of experienced interviewers was recruited and trained in using each of the review instruments. Key stakeholders from the NCTN coordination unit, two NRCs (Jakarta and Surabaya), the BKKBN, the MOH, representatives from JHPIEGO/Jakarta, and evaluation experts from the University of Indonesia comprised the team. JHPIEGO staff and University of Indonesia evaluation experts interviewed the selected key informants from the NCTN and BKKBN senior staff in central offices. All the interview guides were pretested during training and reviewed to ensure the instruments adequately captured the information of interest to the review. Experiences during pretesting were discussed and relevant changes were incorporated into the final versions of the instruments.

Data collection commenced immediately after the training and pretesting. Two data collectors conducted each interview; one of them interviewed the respondent while the other took notes on the responses. In addition to the interviews, the data collectors focused on the aspects of interest in the review that could not be captured through the interviews (e.g., nonverbal communication during interviews or issues of importance in data analysis). Unless the respondents themselves specifically invited their colleagues, each respondent was interviewed in a private room to ensure privacy and confidentiality. Moreover, before conducting the interviews, the data collectors explained the purpose of the interviews to the respondents and assured them of the confidentiality of the information they provided. In an attempt to increase

confidence and honest responses, the respondents were informed that giving their names was optional in the interview.

Self-administered questionnaires were sent to 2 NRCs, 18 PTCs, and 72 DTCs. Included in the same mailing was information on the purpose of the review, confidentiality of the information obtained, and instructions for how to complete and return the form.

## Data Analysis

The data were analyzed using both quantitative and qualitative methods of analysis, including grouping the data according to the emerging key themes and identifying recurrent voices. Information from records and reports were tabulated using SPSS<sup>®</sup> data analysis software.

## RESULTS

### General

The NCTN Coordination Office received completed questionnaires from 104 trainers and 9 NCTN managers (NRC, PTC, or DTC directors). In-depth interviews were completed with 107 respondents. Overall, 13 FGDs were held with 106 participants.

As planned, the review team conducted in-depth interviews in Jakarta and in six provinces—North Sumatra, Riau, West Java, Central Java, Bali, and South Sulawesi. In-depth interviews were completed in eight districts rather than seven, because both the Sukabumi municipality and district prepared themselves for the review team and, thus, both were included.<sup>2</sup> Also, in Riau, the district originally chosen (Dumai) was found not to have an active DTC, therefore the team was steered toward Kampar instead. As expected, Bali province was not included because it did not have a DTC at the time of the interview.<sup>3</sup>

The NCTN managers were interviewed themselves (rather than delegating to someone else), with the exception of one district in which the DTC director was out of town and was replaced. From the professional organizations, all but one POGI and IBI chairpersons were interviewed themselves—in one province IDI chairmen mostly delegated the interviews.

All focus groups were conducted as planned in the districts. An additional focus group was held in Sukabumi, because both the district and the municipality had prepared participants. In all districts, midwives had attended clinical skills courses, whereas doctors had been trained in only some districts. In the districts where doctors attended these courses, the review team held separate FGDs with each professional group.

### Characteristics of Respondents

Not all respondents from IBI, IDI, and government institutions had previous knowledge of the NCTN; therefore, specific questions about the NCTN were excluded. The characteristics of the respondents and their knowledge about the NCTN are presented in **Table 4**.

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<sup>2</sup> Most respondents were interviewed as planned, except for one head of a BKKBN provincial office who was not present at the time of visit and who failed to delegate someone to represent him.

<sup>3</sup> See **Appendix A** for the distribution of the respondents for in-depth interviews and FGDs.

**Table 4. Characteristics of In-Depth Interview Respondents According to Type of Respondents**

Characteristics	NCTN Manager	Training Coordinator	Professional Organizations			Government Institutions		Hospital Directors
			POGI	IBI	IDI	BKKBN	MOH	
Director/ Chairman:								
- Yes	14	15	6	15	6	15	9	4
- No (delegated)	1	0	1	--	8	--	8	3
Sex:								
- Male	14	9	7	--	12	14	11	5
- Female	1	6	--	15	2	1	6	2
Knows NCTN:								
- Yes	15	14	7	10	8	13	13	N/A
- No	--	1	--	5	6	2	4	

Note: N/A=not applicable

Additional information on characteristics of trainers who answered the self-administered questionnaire is presented in **Tables 5, 6, and 7** below.

**Table 5. Distribution of Trainers by Courses Completed (from Self-Administered Questionnaires)**

Type of Course (n=104)	Attended (%)	Certificate Received (%)
1. CSS IUD	67.3	89.1
2. CSS Norplant® Implants	53.8	90.9
3. CSS Basic Delivery Care	25.0	100
4. CSS Postabortion Care	7.7	80.0
5. CSS Vasectomy	3.8	75.0
6. CSS Tubectomy	5.8	88.9
7. CTS Course	44.2	71.4
8. CTS Practica	28.8	75.0
9. ATS Course	22.1	50.0
10. ATS Practica	20.2	29.4
11. Instructional Design Course	3.0	66.7
12. Other	4.8	80.0
CSS=Clinical skills standardization CTS=Clinical training skills ATS=Advanced training skills		

**Table 6. Distribution of Trainers by Training Qualification Level (from Self-Administered Questionnaires)**

Training Qualification Level	Number	Percentage
Master Trainer	3	2.9
Candidate Master Trainer	2	1.9
Advanced Trainer	20	15.0
Candidate Advanced Trainer	19	15.0
Clinical Trainer	60	46.0
Candidate Clinical Trainer	26	20.0
<b>Total</b>	<b>130</b>	<b>100</b>

Note: Percentages do not always add up to exactly 100% due to rounding.

**Table 7. Distribution of Trainers by Types of Courses for Which They Currently Train (From Self-Administered Questionnaires)**

Type of Course	Currently Train in (%)
1. CSS IUD	73.1
2. CSS Norplant® Implants	54.8
3. CSS Basic Delivery Care	34.6
4. CSS Postabortion Care	10.6
5. CSS Vasectomy	13.5
6. CSS Tubectomy	16.3
7. CTS Course	29.8
8. Coaching Clinical Trainers/CTS Practicum	25.0
9. ATS Course	9.6
10. Coaching Advanced Trainers/ATS Practicum	6.7
11. Instructional Design Course	3.8
12. Other	3.8
CSS=Clinical skills standardization CTS=Clinical training skills ATS=Advanced training skills	

### ***General Knowledge and Opinion of Respondents about the NCTN***

**Table 4** indicates that a number of respondents had no knowledge about the NCTN and therefore could not be asked about it. The following data reflect answers from the other 80 respondents who knew about the NCTN only.

The main functions of the NCTN for RH, according to responses from NCTN managers, trainers, and professional organizations, are detailed in **Table 8**.

**Table 8. Main Functions of National Clinical Training Network According to National Clinical Training Network Respondents and Professional Organizations**

Function	NCTN	Professional Organizations			Total
		POGI	IBI	IDI	
1. Training center	5	4	1	5	15
2. Monitoring/supervision of training	--	2	1	--	3
3. Development of training standards	2	1	1	--	4
4. TQA	--	1	--	--	1
5. Improve quality of provider/services	10	--	5	2	17
6. Provide training funds	--	--	1	--	1
7. Train trainers	1	--	--	1	2
8. Do not know	1	--	1	--	2
9. No answer	--	1	--	--	1
10. Increase coverage of RH services	1	--	--	--	1
11. Decrease maternal mortality rate (MMR)/infant mortality rate	1	--	--	--	1

The NCTN had been active in conducting training for approximately 5 years prior to this review. Respondents were asked their opinion of the strength of the NCTN and its contributions to RH thus far, and specific questions about the NCTN's capacity in managing training. Overall, respondents cited three main strengths of the NCTN: it has qualified trainers (24 respondents), it is using competency-based training (CBT) (23 respondents), and the training is standardized (20 respondents). Moreover, 9 respondents felt the NCTN is a network and therefore has coordination throughout, and 4 respondents thought it had government support (**Table 9**).

**Table 9. Strengths of the National Clinical Training Network by Type of Respondents**

Strengths	NCTN	Professional Organization	Government Institution	Total
1. Use CBT	14	7	2	23
2. Qualified trainers	5	10	9	24
3. Standard training	3	5	12	20
4. As a network	2	3	4	9
5. Updated technology/knowledge	3	--	--	3
6. Government policy support	1	2	1	4
7. Has funds/equipment	--	5	--	5
8. Support from JHPIEGO	--	--	3	3
9. Certified training	--	1	--	1
10. Improve quality of services	--	1	--	1
11. Training by BKKBN not hospital	1	--	--	1
12. Do not know	1	3	2	6

Since its establishment in 1995, the NCTN has conducted training for trainers as well as for providers, and has developed training packages and standards for training. According to all respondents, the most frequently mentioned contribution to the RH program was the NCTN's well conducted training courses that improve providers' skills. However, 4 respondents (3 from DTC and 1 BKKBN) believed there was no evident contribution by the NCTN yet, either because the DTC was new or not active. There were 3 respondents (2 DTC, 1 MOH) who said they did not know (Table 10).

**Table 10. National Clinical Training Network's Contributions to the Reproductive Health Program According to Respondents from the National Clinical Training Network and Government Institutions**

NCTN Contributions	NCTN	Government Institutions	Total
1. Good training/coordination of training	7	16	23
2. Improvement of providers' skills	11	5	16
3. Improvement in quality of services	--	7	7
4. Development of standard training packages	3	4	7
5. Development of training standards	2	2	4
6. Decrease in complications/side effects	3	1	4
7. Provision of qualified trainers	1	--	1
8. Decrease in MMR	1	--	1
9. Answering to a need	1	--	1
10. Support program of professional organization	1	--	1
11. Do not know	2	1	3
12. No contribution yet (because new or not active)	3	1	4

**Focus Area I: National Clinical Training Network's Capacity to Plan, Manage, Implement, and Evaluate Training**

**KEY QUESTION:** To what extent has the NCTN successfully demonstrated its capacity in planning, managing, implementing, and evaluating training at the PTC or DTC level, including responding to district level training needs?

Overall, BKKBN respondents' view of training management at the NRCs and PTCs was positive, but most believed it needed improvement at the DTC level. MOH respondents were more mixed—3 found the NCTN effective at coordinating and conducting training, 1 felt only some of the DTCs were effective, and 1 central level respondent said more should be done.

***The NCTN Capacity in Planning***

Annual plans for training activities were developed by both NRCs, 3 PTCs, and 1 DTC, while 3 other PTCs and 6 DTCs were not yet developing annual plans. At the NRC level, the annual plan was developed for the whole network. At the other training centers, the plan was developed for the individual center, with the exception of 1 PTC that developed an annual plan for the entire province. Planning within the NCTN was the responsibility of the training centers' directors (7 respondents) or the training coordinator (4 respondents), or, in the case of other responses, by an education coordinator—IBI or Japan International Cooperation Agency (JICA).

Some of the reasons given by those centers that did not develop an annual plan were:

- ◆ Their activities depend on requests (3 respondents)
- ◆ They depend on funds from the province (2 DTCs)<sup>4</sup>
- ◆ The demand is too high (PTC Riau)
- ◆ Only 1 to 2 trainers are active (PTC Bali)
- ◆ All training is done at the province (1 DTC)

When the review team asked MOH interviewees about the NCTN's planning and conducting of training courses, positive points cited were good coordination (3 respondents), and MOH involvement in planning courses (4 respondents from 2 districts and 2 provinces) or in the development of clinical training standards (Directorate of Family Health). Other respondents, however, stated that the MOH is only involved in providing participants for the training courses (1 province; 2 districts) or that the MOH is not involved yet (Pusdiklat [the MOH's Education and Training Center]).

When BKKBN representatives were asked about their role in planning and conducting training courses, most reported active collaboration with the NCTN. Areas of collaboration included: good coordination (6 respondents), planning (5 respondents), developing budgets, setting selection criteria for participants and ensuring caseload and equipment for training, as well as implementing training courses. In 5 districts and 1 province, however, BKKBN representatives felt they were uninvolved in the planning and implementation of NCTN training courses. On the other hand, 3 respondents from the Central BKKBN, 5 provinces, and 2 districts mentioned NCTN involvement in the development of the BKKBN training workplan. The BKKBN reported asking for NCTN input in the development of training standards (5 respondents), decisions on criteria for participants (2 respondents), preparation of trainers (2 respondents), and in the development of materials (1 respondent).

### ***The NCTN Trainers' Meetings***

Most respondents mentioned that the NCTN held periodic meetings specifically for trainers, although respondents from 2 DTCs were not aware of these meetings. According to 10 respondents (5 PTCs, 5 DTCs), the PTC meetings with DTCs were held 2 times a year; 7 respondents each said that NCTN trainers' and internal trainers' meetings were held on a yearly basis. Master trainers' meetings were also held yearly, 5 respondents said. According to 4 respondents, meetings with other institutions (the BKKBN, the MOH) were held as needed, and NRC meetings with PTCs were held 2 times a year, according to 4 respondents.

The topics most often discussed in these meetings, in order of response frequency, were:

- ◆ Training materials (4 DTCs, 3 PTCs, 1 NRC)
- ◆ Upcoming training events (4 PTCs, 1 NRC)
- ◆ Selection of participants (3 PTCs)
- ◆ Number of clients needed (1 DTC, 1 PTC)
- ◆ Training facility (1 DTC, 1 PTC)
- ◆ Certification (2 PTCs) preparation of trainers (1 DTC)
- ◆ Management aspect of courses (NRC)

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<sup>4</sup> This response and the previous one point to opportunities under Indonesia's decentralization initiative.

## **Coordination Meetings with Stakeholders**

At all levels of the NCTN, with the exception of PTC Riau and DTC Pati, the respondents agreed there were periodic meetings of NCTN managers. The respondents were not consistent about the frequency of these meetings, but agreed that internal meetings were held more often and usually before every course (**Table 11**).

**Table 11. National Clinical Training Network Coordination Meetings According to National Clinical Training Network Respondents**

<b>Respondent</b>	<b>Level of Meetings</b>	<b>Frequency</b>
NRC	National NRC with PTC Internal	1 time/year 1 time/year (NRC Surabaya) 1 to 2 times/year or every course
PTC	National NRC with PTC PTC with DTCs Internal	1, 2, 4 times/year (4 PTCs) 1, 2 times/year (3 PTCs) 2 to 4 times/year (4 PTCs) 12 times/year or every course (4 PTCs)
DTC	Internal	1 to 3 times/year or every course

At these meetings, participants were typically from various NCTN stakeholder institutions, including the BKKBN, trainers/trainer coordinators, and the NCTN itself (9 respondents). In addition, 8 respondents mentioned POGI, IBI, and the MOH/Dinas Kesehatan (DinKes). Other participants included IDI, JHIEGO, Indonesian Association of Pediatricians, and JICA.

The most common agenda items at these meetings, in order of frequency, were:

- ◆ Planning/preparation of courses
- ◆ Training evaluation
- ◆ New information on training methods
- ◆ Supervision
- ◆ Certification

## **Use of NCTN Reports for Evaluation**

When asked about the types of reports prepared or used by the NCTN, most NCTN respondents mentioned financial reports and reports on participants. Only 4 PTCs reported using training reports for planning or evaluation purposes. Almost all respondents from the MOH (central, provincial, and district levels) said training reports were used for information only and not for planning purposes. Some said they needed the reports just for the donors. Only 2 BKKBN respondents (1 central and 1 province) said they used NCTN training reports for purposes of planning, evaluation, monitoring, and analysis of training; the rest used the reports solely for information.

## ***Financial Management and Logistics for Training***

<b>KEY QUESTION:</b> How has the NCTN specifically managed the financial and logistical implementation of training at the PTC/DTC level?
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In the provinces and districts visited, the BKKBN, the MOH offices, and foreign donors (JHPIEGO, JICA) were the main sources of funds for NCTN training. Other financial support came from the hospital, the ADB-funded Social Safety Net for Health, obstetrics/gynecology (ob/gyn) residents, and participants (Riau and Central Java).

Two training centers had developed a standard budget for their training courses, but approximately 50% of NCTN respondents mentioned they did not develop their own standard budget. This happened either because the BKKBN and the MOH already had a standard budget, or because respondents followed a budget from donor agencies. Nevertheless, the training centers tried to establish a standardized trainer's fee, but could not always apply it. According to 30% of NCTN managers, the training budgets met only the minimal costs of the courses; 40% said the budget from the BKKBN/MOH did not meet their requirements at all. Others did not comment on budgets, but accepted whatever was provided.

Training centers themselves managed training funds at the NRCs—3 PTCs and 2 DTCs. The BKKBN/MOH managed funds for the other centers. When centers managed the funds, they provided reports to donors and the BKKBN/MOH; 1 DTC also sent reports to the PTC.

When MOH respondents were asked whether their budgets included allocations intended for NCTN training, only 1 district had a positive answer. The MOH's Pusdiklat, however, had asked the NCTN for its trainers' assistance and had paid for the trainers' time. With the exception of South Sulawesi (where the PTC had developed a standard budget for training by the MOH), thus far MOH respondents had not reported NCTN involvement nor asked for NCTN input in developing budgets for training.

When BKKBN officials were asked whether their budgets included allocations intended for NCTN training, all responses from the central level were positive.

The logistical needs for each course were mostly met by the BKKBN, or were included in the training budget. Only some courses received logistical support from the MOH or the hospital (2 DTCs). Logistical problems—in this case meaning there was a need to reallocate funds for training—had been experienced by the NRCs, 2 PTCs, and 1 DTC. Logistical problems were handled differently at each level of the NCTN. NRC respondents mentioned they had used funds from the institutional fee. PTCs reported using funds for equipment, while the DTCs used funds for office supplies.

The institution where the clinical practice was conducted (e.g., the hospital or Puskesmas [community health center]) handled logistics, according to the majority of responses from the BKKBN and MOH. From their perspective, they did not have any problems with logistics because they had good cooperation with the aforementioned facilities.

In most cases, the allocation for distribution of materials and equipment by the BKKBN/MOH was based on the results of coordination meetings at the planning stage. However, if needed, the training centers could always make requests to those institutions. The procedure to request supplies and equipment was based on previous reports of training or by submitting a formal

request. According to BKKBN respondents, the interval of time of such a request response varied from 1 to 2 days to approximately 21 days.

The self-administered questionnaire asked trainers to report how they felt about the availability of supplies (**Table 12**). The majority of trainers seemed to feel that, for those courses offered throughout the network (IUD, Norplant® implants, and infection prevention), supplies were adequate. Lower agreement scores are more difficult to interpret, because not all training centers may have been offering courses that required those supplies.

**Table 12. Level of Agreement of Trainers to Specific Statements Regarding Supplies and Facilities**

Statements	Items	Agree	Disagree	No Answer
There are sufficient training modules for each participant and trainer	IUD	78.8	8.7	12.5
	Norplant® implants	68.3	10.6	21.2
	Basic delivery care	30.8	10.6	58.7
	Postabortion care	10.6	11.5	77.9
	Vasectomy	28.8	7.7	63.5
	Tubectomy	33.7	9.6	56.7
	Infection prevention	69.2	9.6	21.2
	PocketGuide	41.3	12.5	46.2
The training facilities (e.g., classroom, space in clinical area) are adequate		68.3	10.6	21.2
There are sufficient anatomic models for use in training	ZOE®	62.5	15.4	22.1
	Arm	69.2	14.4	16.3
	Obstetric model	71.2	17.3	11.5
There are sufficient instrument kits for use in training	IUD	72.1	11.5	16.3
	Norplant® implants	63.5	12.5	24.0
	Minilaparotomy	37.5	8.7	53.8
	Vasectomy	31.7	9.6	58.7
	Partus set	52.9	12.5	34.6

Note: Percentages do not always add up to exactly 100% due to rounding.

### **Management Structure, Leadership, and Response to Decentralization**

**KEY QUESTION:** What kind of management structure and leadership might help in improving the operations/effectiveness of PTCs and DTCs?

The NCTN management structure was documented in the “Ortala” (*Organisasi Tata Laksana*, a document that details NCTN rules and procedures) (Kodim 1999), and the majority of NCTN respondents agreed that the current structure met their needs for conducting training. However, 3 people found the current structure rather confusing, and 2 respondents said it did not meet their current needs. In 1 DTC, they had chosen not to follow the organizational structure specified in the “Ortala”. An NRC respondent suggested there should be a separate structure for the management of courses from the management of the training center. *“It would be preferable for stakeholders to be on a ‘Board of Coordination’ whereas the role of the NCTN is more to*

manage and to make decisions about planning,” the respondent said.<sup>5</sup> A few DTC respondents mentioned the structure of the relationship with the hospital should be clearer. Some PTC respondents suggested there should be a technical team in the structure of the network.

NCTN managers interviewed named POGI, IBI, IDI, the BKKBN, and the MOH as NCTN stakeholders. Of these respondents, 80% said all stakeholders named should be represented in the organization’s structure and attend coordination meetings held at each level. However, some respondents maintained that POGI was the major stakeholder. As 1 NCTN manager said, “All need to be represented in the organization. There should be a meeting to discuss this.” Another said, “[We] need to socialize [the NCTN] to the professional organizations and the DTCs so that it functions as a unit.”<sup>6</sup> In 1 DTC, the only stakeholders mentioned were POGI, IBI, and IDI, but in that same district, the IDI respondents did not know about the existence of the NCTN. In addition, 1 PTC said the stakeholder institutions did not need to be represented in the organizational structure, because they were already integrated in the NCTN coordination body.<sup>7</sup>

The selection process for directors was another element of leadership. In the self-administered questionnaires, trainers were asked how their center’s director was named (see **Table 13**).

**Table 13. Distribution of Methods for Selecting the Director of a Training Center**

Method of Selection	Number	Percentage
1. Through a selection process in the NCTN	11	10.6
2. Through a selection process within this center	11	10.6
3. Direct appointment	41	39.4
4. Volunteered	2	1.9
5. No others available or qualified to do it	10	9.6
6. Others	15	14.4
7. No answer (missing)	14	13.5
<b>Total</b>	<b>104</b>	<b>100</b>

These responses suggest that the process is either not uniform or not transparent.

**Response to Decentralization**

KEY QUESTION: How can the sustainability of the DTCs be enhanced under decentralization?

As is well known in Indonesia, many government functions have devolved to the district level since January 2001. NCTN respondents believe the main challenge of decentralization for the NCTN is meeting the demand for RH training. NCTN respondents proposed the following strategies to meet these challenges (listed in **Table 14**).

<sup>5</sup> “Stakeholder sebaiknya sebagai ‘Board of Coordination’ sedangkan peranan JNPK lebih kepada manajemen, dan decision perencanaan.”  
<sup>6</sup> “Semua harus terwakili dalam organisasi, perlu pertemuan untuk bahas hal ini”  
 “Perlu sosialisasi ke organisasi profesi dan P2KP berfungsi sebagai unit.”  
<sup>7</sup> “...tidak perlu, stakeholder telah terintegrasi dalam struktur yang ada saat ini...”

**Table 14. Challenges of Decentralization of the National Clinical Training Network and Strategies to Meet These Challenges**

Challenges	Strategies
<ul style="list-style-type: none"> <li>NCTN remains centralized</li> </ul>	Improve collaboration with stakeholders and other potential institutions; empower DTCs
<ul style="list-style-type: none"> <li>The need to develop new PTCs</li> </ul>	Optimize resources; increase social marketing activities
<ul style="list-style-type: none"> <li>The need to develop more district hospitals as training centers</li> </ul>	Respond to local needs
<ul style="list-style-type: none"> <li>Dependence on policies of the local government</li> </ul>	Advocate for training with the local government
<ul style="list-style-type: none"> <li>Funding: training centers need to be self-sufficient</li> </ul>	Find its own funding; conduct trainings that are paid for by participants; improve managerial skills of the training centers

To respond to the challenges within the NCTN, important adjustments need to be made to increase the NCTN’s capacity. Adjustments suggested by respondents from the BKKBN/MOH were related to training content, standards, management and planning, implementation, and monitoring and evaluation:

- ◆ Improve the quality of training
- ◆ Apply NCTN’s standards for training
- ◆ Conduct needs assessments
- ◆ Conduct integrated planning
- ◆ Coordinate with service facilities
- ◆ Do monitoring and supervision
- ◆ Provide guidance to training centers at lower levels
- ◆ Establish clearer certification criteria
- ◆ Present a clearer and simpler organizational structure of the NCTN
- ◆ Improve lobbying skills

Overall, the PTCs and DTCs need to be more proactive and, according to respondents from the central levels of the BKKBN and the MOH, especially in the areas of developing advocacy skills at the district level, increasing partnerships, and developing training packages according to local needs.

***Future Technical Assistance Needs at the DTC Level***

KEY QUESTIONS:

- What specific areas need additional technical assistance support at the DTC level?
- What support will DTCs need to continue sustaining/enhancing provider performance?

Most respondents, especially from the NCTN itself, agreed the PTCs and DTCs still need technical assistance in the area of management—“*especially in the area of increasing communication and socialization of the DTC,*” said one respondent.<sup>8</sup> Only 6 respondents (of the

<sup>8</sup> “*terutama peningkatan komunikasi dan sosialisasi P2KP*”

40 respondents who thought the DTC needed technical assistance) felt the DTCs already had adequate management skills. **Table 15** includes suggestions of needed management skills and specific technical assistance. The opinion on DTCs in general was that overall management skills needed to improve and they should have committed trainers, add new trainers, and improve the training facilities.

**Table 15. Management Skills and Specific Technical Assistance Needed**

Level	Management Skills Needed	Specific Technical Assistance Needed
NRC	Supervision Management information systems	Management support Funds
PTC	Management Monitoring More trainers Presentation skills	Management support Training equipment Funds Facility
DTC	Management Marketing Clinical skills Training quality assurance	Support from PTC Management Advocacy Trainer meetings Equipment Materials Supervision

Aside from technical assistance, respondents listed other factors that could help support the NCTN to become sustainable. POGI respondents suggested the NCTN become a nongovernmental organization by selling training packages as well as improving its human resources. Respondents from the MOH suggested improving expertise, establishing a clearer legal framework, and creating a permanent office, facility, and staff. In addition, MOH and BKKBN respondents suggested partnership/coordination (as did the NCTN and IBI) and monthly meetings (as did IDI). BKKBN and IBI respondents listed commitment, including government commitment, as a way to become sustainable. IBI respondents cited expansion as a factor that would contribute to NCTN sustainability, along with involving hospital directors (a factor mentioned by IDI as well). NCTN respondents suggested fulltime staff would help the NCTN make the transition.

**Focus Area II: Qualification of Trainers and Providers**

- KEY QUESTIONS:
- How well are trainer and provider selection and qualification criteria being applied and adhered to?
  - How are qualification criteria determined and reinforced?

**Trainers**

Approximately 60% of respondents from the NCTN (2 NRCs, 4 PTCs, and 4 DTCs) felt they had enough trainers. In the case of 1 DTC, there were enough trainers for participants who were midwives, but more trainers were needed for courses for doctors—“*There are not yet enough, [we] need to have more advanced trainers, midwives and ob/gyns,*” a respondent said.<sup>9</sup> For 6 centers that reported insufficient numbers of trainers (2 PTCs and 4 DTCs), 2 centers needed

<sup>9</sup> “*Belum cukup, harus ditambah advanced trainer, bidan, SpOG*”

more midwife and ob/gyn trainers, 3 centers needed only additional midwife trainers, and 1 center needed more general practitioners as trainers.

A respondent from NRC Jakarta suggested refresher training for trainers in the future. Other respondents from the NCTN thought the selection of trainers should be done by the training center where the director or manager is a POGI member.

NCTN managers cited the following criteria for selecting a clinical trainer:

- ◆ Must be a clinician (doctors/midwives)
- ◆ Is experienced in providing RH services
- ◆ Has already attended a skills standardization
- ◆ Is likely to stay in the same unit for more than 2 years after training
- ◆ Is on staff in the hospital
- ◆ Is currently practicing
- ◆ Has extra time available
- ◆ Has expressed desire to be a trainer
- ◆ Other (e.g., commitment)

Once a trainer is qualified, selection takes place again for each course. **Table 16** lists the methods of trainer selection reported by trainers in the self-administered questionnaires. Nearly one-third of trainers reported no selection system; another one-third reported that selection was based on their experience and skills.

**Table 16. Distribution of Methods for Selecting Trainers for Each Specific Course**

Methods of Selection	Number	Percentage
1. Does not have a selection system	32	30.8
2. Based on their certification	21	20.2
3. Based on their experience and skills	32	30.8
4. Based on their availability of time	1	1.0
5. Periodic time	1	1.0
6. Those who volunteer	8	7.7
7. Others	9	8.7
<b>Total</b>	<b>104</b>	<b>100</b>

Note: Percentages do not always add up to exactly 100% due to rounding.

## Providers

According to interviewees, all entities decided on the selection criteria for participants of a training course. The main criterion required by the NCTN was that the participant should be providing clinical services. The selection of participants was mainly the responsibility of the MOH or health offices, or of the BKKBN and the MOH together, based on the qualifications of the participant. When respondents were asked what criteria were used in the past, 11 types of criteria were cited (see **Table 17**). The three most commonly mentioned selection criteria were:

- ◆ Is a clinical provider
- ◆ Has never been trained in this skill
- ◆ Has permission from supervisor (MOH office)

**Table 17. Participant Selection Criteria with Number and Type of Respondents**

Criteria	Number and Type of Respondent
According to the NCTN standard	Trainer coordinator (1 DTC, 3 PTCs, NRC), 2 provincial MOH offices
Selected by the local MOH office	Trainer coordinator (2 DTCs)
Depends on needs in the geographical area	Trainer coordinator (DTC), 3 provincial health offices, 1 district health office
Depends on caseload	Trainer coordinator (MOH)
Depends on quality of inservice and preservice training they had before	1 PTC and 1 DTC
Motivation; has permission from supervisor; will stay at least 2 years after training	NRC
Is a provider	NRC, MOH
Not pregnant and not bringing children	MOH South Sulawesi
Has never had this training	1 DTC

From FGDs conducted with participants from previous courses, the suggested criteria for selecting participants were:

- ◆ Is Puskesmas midwife or registered private midwife
- ◆ Sees many clients in her practice/work
- ◆ Has high failure rate or complication rate when assisting childbirths
- ◆ Has never been trained in the skill before or is not skilled
- ◆ Is healthy
- ◆ Is senior midwife from the MOH

These participants were not informed when a course participant did not meet the criteria and therefore did not know what would happen if it did occur. Responses to the self-administered questionnaires (shown in **Table 18**) also reveal the trainers' understanding of what criteria were applied for selecting participants.

**Table 18. Criteria in Selecting Participants According to Trainers (from Self-Administered Questionnaires)**

Criteria for Participants in Clinical Skills Course	Yes	No	Do Not Know	No Answer
1. Is provider of RH services	92.3	--	--	7.7
2. Is likely to stay in the same unit for at least 2 years	81.7	1.9	1.0	15.4
3. Needs the skill for his/her job	93.3	1.0	1.0	4.8
4. Has not been trained in the skills before	85.6	3.8	1.0	9.6
5. Is recommended by supervisor	86.5	4.8	1.0	7.7
6. Other	25.0	--	--	75.0

Note: Respondents could choose more than one option.

Note: Percentages do not always add up to exactly 100% due to rounding.

The self-administered questionnaire also inquired about trainers' reactions to cases in which participants did not meet the selection criteria (see **Table 19**).

**Table 19. Distribution of Trainer Responses When a Participant Does Not Meet the Criteria**

Trainer Response	Number	Percentage
1. Let the participant attend the course anyway	17	16.3
2. Do not accept the participant	21	20.2
3. Complain to the institution that sent the participant	42	40.4
4. Other	6	5.8
5. No answer	18	17.3
<b>Total</b>	104	100

According to NCTN respondents, the percentage of training participants who reached competency at the end of training was:

- ◆ 100% (2 DTCs, 1 PTC, and 1 NRC)
- ◆ 80% (1 PTC and 1 NRC)

The remaining respondents could not say what percentage of participants reached competency at the end of training. According to trainers, if a participant was not competent at the end of training, the trainers gave more time to practice, provided more coaching, or asked a participant to practice with the next training course participants. Moreover, 1 PTC respondent also reported doing followup supervision to providers at their work site.

The training feedback mechanism is apparent in the responses from 4 DTCs, 5 PTCs, and 2 NRCs who said they prepared reports on participant competency and sent them to:

- ◆ Donor agency (2 DTCs)
- ◆ BKKBN (3 PTCs and 1 NRC)
- ◆ MOH/health office (1 DTC, 1 PTC, and 1 NRC)
- ◆ PTC/NRC (1 DTC, 1 PTC)

It is heartening that 9 NCTN managers confirmed receipt of such reports.

## Results from FGDs with Participants from Previous Courses

Not all focus group participants attended the same training course. As far as they remembered, the IUD insertion and removal course lasted anywhere from 3 to 5 days in most districts, with the exception of 1 district where it lasted 7 days with practice with clients. The training for Norplant implants lasted 3 days and Implanon® training lasted 1 day. The basic delivery care (BDC) course lasted 10 days.

Opinion on the length of the course varied; most of the respondents thought the length of the course was good. Most physicians thought the course was too long, because they already knew the course material or had practiced it in their work. According to 1 of the doctors: *“If the course is too long, we cannot concentrate. We always think of the work that we left behind, also our private practice.”*<sup>10</sup> The majority of participants in the BDC course thought 10 days was too long. The reasons given were logistical and not related to training content or quality—they had families and they had to leave their families and work.

The focus group participants confirmed trainer reports in cases where a participant did not reach competency at the end of training. They said they were given time to practice more at their Puskesmas or private practice. In their own words, *“[The person] will be entrusted to [his/her] respective Puskesmas, then the relevant people will report to the DTC and be given their certificates.”* Another person said, *“[The person] has to apprentice at the hospital or join the next class to come only for the practice sessions.”*<sup>11</sup> For many participants, the receipt of a certificate was linked to competency in the course. According to 1 provider, she had not yet received a certificate *“because the number of cases was too low for certificates to be given.”*<sup>12</sup>

General comments from the participants about the training were:

- ◆ All participants stated they felt qualified to provide the skill acquired during training and that the trainers qualified them as well.
- ◆ Training helped boost self-confidence. This is best portrayed by direct statements:
  - A midwife spoke of having *“more self-confidence. [I] already have better means if there is a new patient.”*<sup>13</sup>
  - A doctor said, *“There is added value [to attending the course], especially if we are consulted by a midwife.”*<sup>14</sup>
  - Another midwife said, *“[My] ability has increased, patient complaints have decreased... it’s like having an SIM [driver’s license] to take care of patients.”*<sup>15</sup>
  - Another said, *“Yes, [I am] more self-confident. Side effects can be overcome, especially bleeding. It is [now] easier to take action.”*<sup>16</sup>
- ◆ Not all participants received their certificates at the end of training. Some mentioned that they received their certificate for the IUD course after they practiced with a certain number of clients (e.g., 10 clients). Another group mentioned that they received their certificate 1 week after the training ended. Participants of Norplant implants, Implanon, and BDC courses had

<sup>10</sup> *“...bila pelatihan dilaksanakan terlalu lama, kita tidak bisa konsentrasi, karena memikirkan pekerjaan yang ditinggalkan, dan juga praktek kita.”*

<sup>11</sup> *“...akan dititipkan ke puskesmas masing-masing, kemudian yang bersangkutan lapor ke P2KP dan diberi sertifikat” and “harus magang di rumah sakit atau ikut angkatan yang akan datang tapi prakteknya saja.”*

<sup>12</sup> *“Belum, karena jumlah kasus kurang maka sertifikat belum diberikan”*

<sup>13</sup> *“Lebih percaya diri, sudah ada bekal bila ada pasien baru”*

<sup>14</sup> *“Ada nilai tambahnya, terutama bila ada konsul dari bidan”*

<sup>15</sup> *“Ya, karena kemampuan meningkat, keluhan pasien berkurang... seperti orang punya SIM untuk melayani pasien”*

<sup>16</sup> *“Ya, makin percaya diri, risiko bisa diatasi, terutama perdarahan. Lebih mudah mengambil tindakan”*

not received any certificates yet. Similarly, 1 provider said, “[I] still haven’t received a certificate. I was only told that I was qualified.”<sup>17</sup> These responses show that there are management practices in need of attention.

- ◆ All the participants were satisfied with the training course, because the methodology was different from other courses they had attended.
- ◆ Some participants were less satisfied with the practice with clients, because there were too few clients (in the case of an Implanon course, there were approximately 40 participants).

Another outcome of training was the dissemination by participants of the new knowledge or clinical skills to their colleagues in the workplace.

Recommendations made by the focus group participants were:

- ◆ Preparation for practice with clients should be improved. If possible, the area for practicing with clients during training should be separated from the general service area.
- ◆ The number of clients should be sufficient to reach competency, but not by conducting an “FP Safari.”
- ◆ More than one session should be set aside for practice with clients and more trainers should observe the practice.
- ◆ The certificate should be given at the end of training, if possible.

### **Focus Area III: Quality Assurance and Monitoring of Standards for Training Quality**

<p>KEY QUESTION: To what extent has the NCTN successfully demonstrated its capacity to establish standards for training and to ensure adherence to the standards?</p>
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### ***NCTN Capacity to Establish Standards for Training and Ensure Adherence to the Standards***

#### *Development of Standards for Training*

One of the functions of the NCTN is to provide high-quality clinical training that is standardized. The NCTN has standards for trainers, participants, ratio of trainers to participants, facilities/equipment, and standard training packages.

The required standards for NCTN trainers have been developed in the form of a trainer development pathway (see **Appendix B**). Standards for ratio of trainers to participants, facilities, and the training process are mentioned in the TQA guidelines and forms and “Ortala”. Several standard training packages have been developed by the NCTN, and others are in the process of being adopted by the NCTN. This review sought to determine whether all NCTN managers, trainers, and stakeholders know these established standards.

Of the 15 NCTN managers interviewed, 12 felt that all trainers should follow the trainer development pathway to conduct NCTN courses, although 3 DTC directors did not mention this spontaneously. The need for trainers to be trained first was mentioned, as was the ratio of

<sup>17</sup> “Belum menerima sertifikat, hanya dikatakan memenuhi kualifikasi”

trainers to participants. A trainer should have motivation, 1 NRC director said. All NCTN managers and training coordinators mentioned that the training method used in the NCTN is CBT. All but 1 NCTN manager were able to list the existing standard training packages that have been developed by the NCTN. Not all training coordinators, however, could do so.

Not all of the NCTN managers knew the standard ratio of trainers to participants as written in the TQA guidelines. According to 1 respondent, the ratio should be 1:5–7, another respondent said 1:1, while other respondents only mentioned that there was a standard ratio without citing the ratio. For qualification of participants, all the NCTN managers (with the exception of 1 manager who did not think there was a standard yet) and all training coordinators answered that there was a standard.

The committee responsible for developing standards is the Trainers' Forum, which consists of master trainers and some advanced trainers. The existence of the Trainers' Forum was not known by all NCTN managers and training coordinators. All NRC managers and training coordinators knew about the existence of the forum, but only 3 PTCs and none of the DTCs knew who was responsible for developing the standards.

NRC respondents mentioned being involved in the development of standards for services by the MOH, thus linking standards for services to standards for training. Only 1 DTC respondent mentioned the need to integrate standards for services into standard training packages. Others could not think of any linkages. Given the role of the NCTN in improving service quality, it is cause for concern that trainers do not perceive their role as a means to model and disseminate service delivery standards in response to such a question.

### *Stakeholder Knowledge of Standards*

Standards for training developed by the NCTN were not well known by the professional organizations. Generally, POGI and IBI members were more aware of standards than the IDI respondents. Overall, 3 POGI, 3 IBI, and 1 IDI respondent mentioned all the various standards that exist, while 1 POGI, 1 IBI, and 6 IDI respondents did not know about these standards at all.

Most MOH respondents could not name the standards that are applied to NCTN training courses, but respondents from 5 districts and 3 provinces knew that standards are implemented in NCTN training courses. *"They exist and are already applied in accordance to the pilot that was done,"* one respondent said.<sup>18</sup> While most BKKBN respondents knew about standards for training, only respondents from 3 districts mentioned all existing standards.

Most respondents from professional organizations (4 POGI, 9 IBI, and 7 IDI respondents) reported the development of standards for training and standards for services were linked by following/reviewing the existing standards for services, working together with the MOH, or by periodic meetings or supervision. *"Yes, there are meetings between maternal and child health [MCH] section chiefs at the district level, which are a forum for discussing any problem and to seek solutions,"* one respondent said.<sup>19</sup> In total, 4 respondents (1 POGI, 2 IBIs, 1 IDI) thought there was no link, while others did not know.

In discussing service delivery standards, interviewers asked the representatives of professional organizations about their own role in the development of standards. About half of the respondents (5 POGI chairmen, 6 IBI chairwomen, and 2 IDI chairmen) said their organization

<sup>18</sup> "...ada dan sudah diaplikasikan sesuai dengan panduan yang ada..." — MOH respondent

<sup>19</sup> "ya...ada pertemuan antara kasie KIA di tingkat kabupaten, tempat untuk membicarakan masalah-masalah yang ada dan mencari solusinya." — MOH respondent, provincial level

had played a role in developing standards for services as well as for training, and that they also should enforce compliance with those standards: “*When invited, [we] engage in discussions to determine standards and are given the right/authority to delete or to add [to the standards].*”<sup>20</sup>

This scenario was especially true in the case of standards for RH, according to 6 POGI, 6 IBI, and 7 IDI members. Most thought standards development should be done at the central level or, for site specific protocols, in coordination with the local hospitals. According to 3 IDI respondents, developing standards for RH services should be the role of independent organizations (from the university and government). Almost all respondents agreed that the NCTN should be involved in developing these standards (all POGI chairmen, 11 IBI chairwomen, and 5 IDI chairmen), because the NCTN is responsible for disseminating or socializing these standards through training (POGI and IDI) and because the NCTN has experts to provide input and give their approval (IBI).

KEY QUESTION: How have PTCs and DTCs maintained minimum standards for training performance (selection criteria, caseload, length/content)?
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The NCTN tries to ensure that standards are followed by monitoring or supervising training courses (7 respondents), disseminating standards (2 NCTN respondents), asking for the commitment of trainers (2 respondents), and by developing written standards such as the TQA guidelines (1 respondent). Of 8 MOH respondents who knew of the existence of standards, 7 reported that the NCTN made efforts to ensure standards were adhered to, but 1 district level respondent thought that no effort had yet been made.

Most of the BKKBN representatives (12 respondents) agreed that the NCTN made some effort to ensure standards were followed—either by improving the equipment of the training center or through coordination. According to 1 BKKBN respondent from a province, ensuring standards was hard for the NCTN to do, and 2 respondents (1 from a province and 1 from central) did not think any monitoring was done by the NCTN. The 3 BKKBN respondents who were not aware of standards could not respond.

The PTCs and DTCs themselves reported trying to maintain minimum standards of training performance by developing job descriptions for each trainer, ensuring coordination, conducting direct observation with feedback, and by selecting appropriate trainers for each specific course.

**Tables 20** and **21** present results from the trainer self-administered questionnaires. The questions sought to assess how trainers deal with deviation from established standards. Only 6% of the 104 trainers qualified participants when there were not enough cases, indicating that few trainers lowered their standards of quality. In addition, 39% asked for clients from other service facilities, a self-impetus mechanism (**Table 20**).

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<sup>20</sup> “...dengan diajak berdiskusi untuk menentukan standard dan diberi hak/wewenang untuk mengurangi atau menambah.”

**Table 20. Trainers' Opinions on the Caseload Availability for All Participants to Become Competent and Confident in the Skill Taught**

Description	Number	Percentage
Enough cases	27	26.0
Not enough cases	77	74.0
<ul style="list-style-type: none"> <li>• Qualify participants anyway</li> <li>• Ask for clients from other service facilities in the middle of the course</li> <li>• Postpone qualification/give more practice time after end of course</li> <li>• Others</li> </ul>	6 41 28 2	5.8 39.4 26.9 1.9
<b>Total</b>	104	100

More than half of the trainers said the reason the standard course length was changed was because of a request from another institution (e.g., the BKKBN, the MOH, IBI, IDI) or due to insufficient funds. Of trainers, 10–15% said they adjusted the course length to meet an identified need (participants' capabilities, agreement between participants and trainers) (**Table 21**).

**Table 21. Standard Course Length and Reasons for Changes According to Trainers**

Variable	Yes	No	No Answer
There is a standard number of days for each training course	83.7	3.8	12.5
Ever changed the standard of number of days of training	45.2	35.6	19.2
Reasons why the standard number of days was changed:*			
<ul style="list-style-type: none"> <li>• Requested by another institution (the MOH, the BKKBN, IBI, IDI, etc.)</li> <li>• Not enough funds</li> <li>• The trainer did not have the time</li> <li>• According to the participants' capabilities</li> <li>• Agreement between participants and trainers</li> <li>• Other</li> </ul>	44.7 19.1 4.3 10.6 14.9 6.4		
* Based on answer to ever changed the standard number of days of training (n=47)			

Similar to feedback from the participants, 61% of trainers felt that certificates were always given to participants at the end of the course (**Table 22**).

**Table 22. Level of Agreement of Trainers to Specific Statements Regarding Compliance to Training Standards**

Statements	Agree	Disagree	No Answer
1. Clinical practice is performed according to standard	88.5	5.8	5.8
2. The appropriate ratio of trainers to participants is respected	84.6	6.7	8.7
3. Suitable participant accommodations exist near the center	81.7	9.6	8.7
4. Certificates are always given to participants at the end of course	60.6	30.8	8.7
5. Trainers are committed to time for training	92.3	2.9	4.8

Note: Percentages do not always add up to exactly 100% due to rounding.

The trainers reported trying to stay competent and update their knowledge by reading and participating in seminars or refresher courses. From the self-administered questionnaires, additional information on the efforts of trainers to update their knowledge and skills was obtained and is presented in **Tables 23, 24, and 25**.

It is notable that 62% of the trainers (or 64 out of 68 who used the trainer self-assessment tools at least once) reported using these tools at least annually (**Table 23**).

**Table 23. Distribution of Trainers Who Ever Used the Trainer Self-Assessment Tools**

Frequency of Tool Use	Number	Percentage
1. Every time the trainer conducts a training course	42	40.4
2. Sometimes (at least once a year)	22	21.2
3. Only once since clinical training skills training	4	3.8
4. No answer (missing)	36	34.6
<b>Total</b>	104	100

More than half of all trainers reported using the self-assessment guide checklists to update their knowledge and skills (**Table 24**).

**Table 24. Percentage of Trainers who Reported Using the Different Types of Self-Assessment Guide Checklists (n=104)**

Self-Assessment Guide Checklists	Yes	No	No Answer
Presentation skills	64.4	6.7	28.8
Coaching for clinical skills	59.6	7.7	32.7
Clinical demonstration skills	61.5	7.7	30.8

Note: Percentages do not always add up to exactly 100% due to rounding.

Trainers were asked whether they conduct training improvement activities with their colleagues. Their responses show that 10–20% of the trainers never do peer trainer work (**Table 25**).

**Table 25. Distribution of Trainers who Conduct Training Improvement Activities with Their Colleagues (n=104)**

Training Improvement Activities	Always	Sometimes	Never	No Answer
1. Assess each other’s clinical skills	32.7	29.8	23.1	14.4
2. Assess each other’s training skills	32.7	29.8	20.2	17.3
3. Provide feedback to each other regarding skills	35.6	27.9	20.2	16.3
4. Make team decisions about how to implement a course	45.2	16.3	20.0	18.3
5. Assess the overall training course for lessons learned	47.1	21.2	10.6	21.2
6. Identify, as a team, mechanisms for problem solving in training	47.1	20.2	10.6	22.1
7. Others	8.7	3.8	5.8	81.7

Note: Percentages do not always add up to exactly 100% due to rounding.

**KEY QUESTION:** How have PTCs and DTCs ensured that training sites are meeting the standards established by the NCTN and the Trainer Task Force?

*Training Center Standards*

The review asked hospital directors to recall the criteria for the establishment of existing training centers when examining these criteria and past experiences. Among the 5 hospital directors who knew that their hospital was an NCTN training center, 3 answered that their facility was chosen in part because they had an ob/gyn specialist, the location of the hospital was strategic, it was a referral hospital, and because they had sufficient facilities and equipment. The directors of 2 hospitals could not recall the reasons why their hospital was selected.

According to NCTN managers (n=15), the criteria for developing training centers were:

- ◆ It is a teaching hospital or attached to a medical school (1 NRC, 1 PTC)
- ◆ It is a hospital/supervised by a hospital doctor (3 PTCs)
- ◆ It fulfills a standard mentioned in the “Ortala” (1 NRC)
- ◆ It has the required number of trainers/ob/gyns (2)
- ◆ It has enough caseload (1)
- ◆ It has the required facility (2)
- ◆ A DTC should be near a PTC (1)
- ◆ Do not know (6)

NCTN management had made efforts to verify whether a training center was still meeting the established standards (supervision and monitoring [4 respondents] and review of training reports [2 respondents]). According to 4 respondents, no effort had been made yet because there were no funds for it, while the other respondents did not know.

## Training Supervision System within the NCTN

All but 1 NCTN manager agreed that a training supervision system existed within the NCTN. The respondent who disagreed mentioned that the system did not exist because of lack of funds; therefore, the supervision was done by either the BKKBN or the MOH.

According to 5 NCTN managers, supervision was done either with the BKKBN and the MOH (“*there is supervision, conducted as a team with funds for facilitative supervision from the BKKBN-MOH*”<sup>21</sup>) or only with the MOH (1 respondent). According to 1 respondent, only training supervision was conducted by either the BKKBN or the MOH. But among training coordinators, 6 out of 15 respondents did not know about the existence of a training supervision system. The training coordinators from the NRCs and 1 DTC mentioned that a team did supervision. The 4 PTC respondents said the PTC supervised training conducted by DTCs.

Results from the trainer self-administered questionnaires show nearly 70% of trainers had been supervised, 60% had been supervised during a course that s/he was conducting, and 57% had received feedback from their supervisor (**Table 26**).

**Table 26. Distribution of Trainers Who Had Ever Been Supervised by a More Experienced Trainer**

Response from Trainers on Experience Being Supervised	Yes	No	No Answer
Ever been supervised by a more experienced trainer	68.3	17.3	14.4
Supervision done during a course respondent was conducting	59.6	13.5	26.9
The supervisor gave feedback on respondent’s performance	56.7	16.3	26.9

Note: Percentages do not always add up to exactly 100% due to rounding.

Only 4 NCTN managers said they received written supervision reports (used for information purposes only and copied to the MOH). NCTN managers did not have to give feedback because there were no problems. NRC and PTC level training coordinators used the reports for evaluation and feedback. An NRC training coordinator said there was no standard report form.

Problems encountered in supervision, according to NCTN managers, were mostly time constraints (8 respondents), lack of funds (5 respondents), availability of human resources to do supervision (2 provinces), lack of supervision tools (2 respondents), and geographic problems (PTC Riau). Three respondents (1 PTC, 2 DTCs) did not report any problems.

**KEY QUESTION:** How has the NCTN used tools such as TIMS and TQA to ensure ongoing monitoring of training implementation?

## TIMS and TQA

Because maintaining high-quality training was important for the NCTN, a TQA system was developed in 1998 and documented in writing (Kodim 2000). This system was pilot-tested in two provinces and four districts, and subsequently revised. JHPIEGO also developed a computer-

<sup>21</sup> “*ada...secara tim dengan dana fasilitatif supervisi BKKBN-Depkes*”—NCTN manager

based program (Training Information Monitoring System [TIMS]) to monitor information on training conducted within the NCTN. The TQA system included TIMS data collection forms.

The review team was interested in knowledge about these tools and their use. Of the NCTN managers interviewed, only 2 had used the TQA tools and none had used TIMS. According to 2 other respondents, the TQA system would be very useful in the future and TIMS could help the NCTN director in monitoring training achievements. In self-administered questionnaires, 18% of trainers said they had used the TQA tools and 21% had used information from TIMS.

**Tables 27** and **28** show trainer responses on the usefulness of TIMS and TQA.

**Table 27. Trainer Opinions (n=21) on TIMS (among Trainers Who Had Used It)**

Statement About TIMS	Agree	Disagree
1. User friendly	95.5	4.5
2. Effective in monitoring implemented clinical training course	100.0	--
3. Effective in monitoring trainer activities	100.0	--
4. Effective in monitoring trainer qualifications	86.4	13.6
5. Effective in monitoring provider qualifications	86.4	13.6
6. Others	4.5	95.5

**Table 28. Trainer Opinions (n=104) on the TQA (among Trainers Who Had Used It)**

Statement About TQA	Agree	Disagree
1. Is user friendly	78.3	21.7
2. Is effective in monitoring process of planning clinical training courses	95.7	4.3
3. Is effective in monitoring preparations for clinical courses	95.7	4.3
4. Tracks detailed information about how courses are conducted	91.3	8.7
5. Provides information about numbers of evaluations of training courses conducted	91.3	8.7
6. Provides detailed information about training evaluation and feedback	95.7	4.3
7. Is effective in assuring the quality of training	73.9	26.1
8. Is effective in monitoring participant qualifications	73.9	26.1

### *Training Quality Monitoring by NCTN Stakeholders*

Most MOH offices reported being involved in monitoring of training standards (6 districts, 3 provinces, and 2 central level respondents) through direct monitoring, coordination, and supervision. According to the MOH Director General, however, this monitoring happens only in some provinces and districts. In 1 district, for instance, monitoring is done only by the provincial level MOH office.

Out of 12 respondents, 7 (3 district, 3 province, and 1 central level) said they were involved in training supervision with the NCTN, while the other 5 said they were not involved. The main objective of the supervision was to make sure that training standards were followed. Other objectives were to qualify providers, to provide support/assistance, and to make sure that clients were satisfied.

In supervising training courses, most BKKBN respondents from the central level, 2 provinces, and 1 district reported being involved by doing field visits. However, 1 respondent from the Central BKKBN mentioned the BKKBN only facilitates supervision of training. The objectives of training supervision were to ensure training standards were followed (4 respondents), to help solve problems (3 respondents), and to monitor provider activity during the training (2 respondents).

All respondents from IBI and IDI said they had never been involved in supervision done by the NCTN, while 3 POGI respondents remembered having been involved.

**Focus Area IV. District Training Center’s Role in Sustaining Provider Performance**

***NCTN Managers and Trainer Coordinators***

Two-thirds of NCTN managers (n=10) and over half of the training coordinators (n=9) agreed that DTCs have already contributed to improving the performance of providers, even though not all DTCs were active. The contributions were provided through conducting training (6 respondents), by decreasing complications and improving the quality of services (6 respondents), through disseminating training standards (1 respondent), and by improving provider self-confidence (1 respondent). These contributions resulted in increases in numbers of contraceptive users (1 respondent). There were 2 NCTN managers who felt they could not comment on the DTCs’ contribution to providers’ performance, and 3 respondents from new and inactive DTCs thought the DTCs had not yet provided any contribution.

***Government Institutions***

Most MOH respondents acknowledged the DTCs had contributed to improving providers’ performance (the Central MOH, 3 provinces, and 5 districts). Only 1 respondent from a provincial health office did not know, and respondents from Riau province and district said “not yet,” because their DTC was still new. BKKBN respondents acknowledged the contribution provided by the DTCs (2 Central BKKBN, 4 provinces, and 4 districts). Only 1 Central BKKBN respondent said there had not been any contribution yet, and 2 district respondents did not know. The specific contributions cited in interviews are listed in **Table 29** below.

**Table 29. Types of Contributions Made by the District Training Centers According to Government Respondents**

<b>Types of DTC Contributions Cited</b>	<b>MOH</b>	<b>BKKBN</b>
1. Improvement in quality of services	1 central, 1 province, 1 district	2 districts
2. Improvement in skills of providers	2 provinces, 3 districts	
3. Providing training	1 central, 1 province	1 district
4. Dissemination of standards	1 province	
5. Monitoring		1 province

Citing the fact that training led to improved quality of services, 5 of 7 POGI respondents, 6 IBI respondents, and 3 IDI respondents agreed the DTCs had already contributed to improving providers’ performance. Some POGI respondents, however, felt the contribution was still small and not optimal. At the provincial level, 2 IBI respondents felt the DTCs had yet to make any contribution. All other respondents did not have an opinion.

Nevertheless, many respondents from the 3 professional organizations who knew about the NCTN (n=17) saw opportunities for the DTCs to improve performance and improve the quality of training and services. They cited the demand for high-quality services and the fact that the DTCs had professional trainers and could meet the need for training, especially in BDC. They felt the DTCs needed to develop or improve their monitoring and supervision system, however, and the NCTN should develop new training modules. Only 2 respondents (1 IBI and 1 IDI) were of the opinion that the DTCs were not able to improve providers' performance. In the case of the IBI respondent, this was because the DTC had not involved IBI; the IDI respondent did not provide any reason.

In addition to training, effective supervision and followup can benefit providers' performance. To apply new skills, many participants require additional reinforcement after successful training. The review team gathered information about followup activities of participants in training courses through the self-administered questionnaires from NCTN managers and trainers. Few NCTN managers knew the training centers had a followup system for participants. Nearly 50% of trainers had done followup or supervised participants after training. Of trainers who did followup, 45 of 51 said providers were followed up after training, while only 12% saw this followup as solely for trainers. Of 51 respondents, 39 identified all the key purposes of the standard form, and 37 (73%) said they used a standard form for the followup visit (**Table 30**).

**Table 30. Distribution of Target, Purpose, and Use of a Standard Form During Supervision of Participants after Training (n=51)**

Variable	Number	Percentage
1. Target:		
• Providers who attended a clinical skills course	16	31.4
• Trainers	6	11.8
• Both	29	56.9
2. Purpose:		
• To evaluate participants performing the skill acquired at training	8	15.7
• To reinforce the skills they learned	1	2.0
• To identify and help solve problems	2	3.9
• To see the facilities and equipment	1	2.0
• All of the above	39	76.5
3. Use a standard form for followup visit:		
• Yes	37	72.5
• No	14	27.5

Note: Percentages do not always add up to exactly 100% due to rounding.

Providers in the FGDs reported they had received followup from trainers verifying the trainers' reports. The following are some of their comments:

- ◆ *“There hasn't been any supervision yet, but a DTC trainer came to the healthcare center afterwards so he could monitor [me] directly.”<sup>22</sup>*

<sup>22</sup> *“Belum ada supervisi, tetapi ada pelatih DTC ke Puskesmas sehingga langsung dapat memonitor (yang dimaksud pada pernyataan ini sistim Dinas Kesehatan Kabupaten yang ada: sebulan sekali Puskesmas mendapat kunjungan dokter ahli, termasuk dokter kebidanan)”*

- ◆ “Only for BDC [training], the trainer asked questions and looked at the records.”<sup>23</sup>

As background to exploring a potential new DTC role in improving provider performance after training, the review also asked collaborating institutions about existing systems for supervising providers. MOH respondents in 4 districts, 2 provinces, and the central level reported that a supervision system for providers already existed. Other respondents (4 districts, 4 provinces, 2 from central level) said no such system existed. Supervision of providers was described as done in the district supervision program (1 province and 1 central), as integrated supervision (1 district and 2 provinces), as a routine activity (2 districts), and as done by using a checklist (1 district). The NCTN has not yet been involved in any MOH supervision activities.

BKKBN officials from 2 districts and 4 provinces, and 2 respondents from the central level reported the existence of supervision, but only at the district level by direct field visits or through the FP field workers. The NCTN trainers had been involved in BKKBN supervision of providers in 2 districts and 3 provinces.

Most respondents from professional organizations stated that a supervision system that could support providers did not yet exist at the district level, or that they did not know about the existence of such a system.

#### **Focus Area V: National Clinical Training Network Collaboration and Partnerships**

- |  |
|--|
| <p>KEY QUESTIONS:</p> <ul style="list-style-type: none"><li>• What do models of successful partnerships and collaboration among POGI, NCTN, BKKBN, MOH, IBI, and IDI look like?</li><li>• How has collaboration enhanced the quality of training at the district level and what has it supported?</li><li>• How can collaboration be improved at different levels (NRC, PTC, DTC)?</li></ul> |
|--|

During this review, good partnership and collaboration models among stakeholders were identified and are described below. Some respondents from the NRCs and the Central BKKBN mentioned that the collaboration and partnership between RH stakeholders was best in South Sumatra and East Java, provinces that were not selected for this review.

#### ***NCTN Managers***

The NCTN managers who were interviewed reported their training centers had collaborated with the following institutions/organizations:

- ◆ BKKBN (14 of 15 managers)
- ◆ MOH/DinKes (14 of 15 managers)
- ◆ IBI (10 centers)
- ◆ POGI (5 centers)
- ◆ IDI (4 centers)
- ◆ The affiliated hospital and university (NRC Surabaya and PTC North Sumatra) for internal training programs
- ◆ Indonesian Family Planning Association (PKBI) (PTC Central Java)

<sup>23</sup> “Pernah untuk APD, pelatih tanya jawab dan melihat sarana”

- ◆ JICA (PTC South Sulawesi)
- ◆ Muhammadiyah (an Islamic nongovernmental organization) (PTC South Sulawesi)

Managers reported 2 centers were working only with either the BKKBN or the MOH, because those institutions had projects for training in RH. Only 1 DTC was not actively collaborating with any other institution, but this DTC was not very active.

NCTN managers described the roles of the partner organizations in collaboration as detailed below (**Table 31**). According to several respondents, the BKKBN was involved in all the roles of the organization, including planning. According to at least 1 respondent, the MOH/DinKes was also involved in all the roles. Several respondents mentioned that the MOH/DinKes was involved in providing clients, and at least 1 respondent said the MOH/DinKes was involved in selecting participants. At least 1 respondent said POGI, the PTCs, and DTCs were involved in providing trainers.

**Table 31. Distribution of Roles of Partnering Organizations**

Organization	All Roles	Planning	Select Participants	Provide Trainers	Provide Clients	Provide Funds	Supervision and Evaluation
BKKBN	TT	TT			T		
MOH/DinKes	T		T		TT		
POGI				T			T
IBI			T		T		
IDI			T				
NRC				T		T	
PTC		T		T			
DTC			T	T			T
PKMI*		T	T				
PKBI			T				
Other organizations					T	T	
T=Involved according to at least one respondent    TT=Involved according to a greater number of respondents *Indonesian Association for Surgical Contraception							

The institutions that most closely worked with the NCTN centers were the BKKBN and the MOH/DinKes. Of 14 NCTN managers, 9 felt the cooperation with all other institutions worked very well and that they had not encountered any problems thus far. However, 4 NCTN respondents felt the relationship with the MOH could be improved, especially in regard to bureaucracy and the agreement on training standards.

To improve collaboration with these organizations, NCTN managers made the following recommendations:

- ◆ A common vision/goals should be developed
- ◆ A detailed annual workplan should be developed jointly
- ◆ There should be a clear division of roles and responsibilities
- ◆ PTCs should be more proactive in coordinating activities with other institutions

According to the POGI president, POGI is the major stakeholder of the NCTN. Chairmen of the POGI branches in the provinces, however, stated that the involvement of POGI was mainly as trainers in the NCTN. The role of POGI was stated as leader or facilitator of the NCTN, or as provider of trainers and inputs. Cooperation between POGI and the NCTN was said to be very close, because the NCTN is integrated in POGI. Only 1 out of 7 POGI chairmen stated that the coordination between the NCTN and POGI should be improved, and 2 respondents recommended a clearer organizational structure be developed.

Overall, IBI felt it was not optimally involved or not involved at all in the NCTN. Only 3 out of 15 respondents mentioned IBI's role as board member in the NCTN or as being involved in planning for courses. Some felt that IBI has only a minor role in the NCTN—“*not so much... because [we've got] only a maternity, so they don't contact IBI,*” one respondent said.<sup>24</sup> Most IBI leaders also felt that IBI's role in the NCTN was not clear. Only 1 IBI respondent stated that IBI's role was to provide trainers and 2 respondents mentioned providing participants for the training courses. “*They recruit IBI members for training and give information to IBI members about training,*” the respondent said.<sup>25</sup>

Although 4 IBI respondents said they had good cooperation or were partners with the NCTN (national level, the Central Java province and district, Kampar district), 8 respondents felt there was no cooperation between the NCTN and their organization. Most IBI respondents still felt that IBI should be more involved in the NCTN through socialization, improving coordination, and by increasing the use of midwives as trainers. Also, 2 respondents recommended that there should be equity between the trainers from IBI and trainers from other professions.

The president of IDI stated that IDI's involvement was represented through POGI. On the contrary, the IDI chairmen in the provinces and districts either felt they were not involved in the NCTN, or did not know about the NCTN at all. The role of IDI in the NCTN was also not clear to most of them; only 1 respondent said that IDI was providing trainers and another mentioned the role of facilitator. Most of the IDI leaders recommended that more socialization of the NCTN was needed for their organization, a clearer organizational structure should be developed, and there should be transparency. “*With socialization of the NCTN, even in future training, JNPK could involve IDI, maybe also PKBI [the Indonesian Family Planning Association],*” one respondent said.<sup>26</sup>

### *Parallel Training Courses*

In addition to the training organized by the NCTN, some respondents from each of the 3 professional organizations (1 from POGI, 7 from IBI, and 2 from IDI) said their organization conducted clinical training in RH. IBI generally worked together with the BKKBN/MOH and POGI, and its courses were partially funded by the participants or from sponsors. Some, but not

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<sup>24</sup> “*kurang karena hanya rumah sakit bersalin, tidak menghubungi IBI...*”

<sup>25</sup> “*merekruit anggota IBI untuk pelatihan, memberikan info kepada anggota IBI tentang pelatihan.*”

<sup>26</sup> “*...dengan sosialisasi JNPK, hingga dalam pelatihan selanjutnya, JNPK dapat melibatkan IDI maupun juga PKBI.*”

all, of these courses were coordinated with the NCTN. POGI used the training standards from the NCTN and offered courses to its members. For example, 1 IDI branch coordinated with the NCTN through the BKKBN, but 3 IBI chapters and 1 IDI branch said they did not coordinate with the NCTN. In 2 of the 3 IBI chapters, however, respondents said they used PTC/DTC trainers for their courses.

### *Provider Qualification*

POGI and IDI usually qualified their members to provide certain RH services if the provider had completed a formal education in this field through specialization. Only some skills required qualification through training courses (such as Norplant implants and voluntary sterilization), as did general practitioners. For midwives, IBI required more inservice training courses to qualify to provide specific services, because of the variation in their preservice education.

Most POGI chairmen felt their members benefited from participating in the courses offered by the NCTN—whether clinical or training skills courses—by acquiring more standardized skills in certain RH services or infection prevention, or by participating as trainers. With the exception of 1 of the IBI respondents, all felt their members had benefited from the courses offered by the NCTN. They felt the midwives had clearly improved their skills and the quality of their services and had become more confident. They had acquired legitimacy in providing services and had been able to increase their clientele. In total, 7 IDI respondents agreed their members had improved their skills and the quality of their services, and were now legitimate in providing those services. As expressed by 1 IDI chair, *“Clearly, if they have had a course, their skills have increased and they have the competence to provide services.”*<sup>27</sup> On the other hand, 7 other IDI respondents could not say whether their members had benefited or not.

### *Monitoring and Supervision*

In the interviews, the review team asked respondents about their roles in monitoring and supervision to gain a better sense of whether the NCTN had a role to play in broadening its position beyond training to the performance of providers on the job. At that time, most professional organizations did not have mechanisms for monitoring the performance of their members. Only IBI stated that these mechanisms existed through peer review, field visits, supervision, midwife coordinators, and meetings (3 IBI chairwomen at district levels stated there is no mechanism yet). Almost all respondents from POGI (5) and IDI (10) stated that they only learned about their members’ performance if there were complaints of malpractice. According to 2 POGI respondents, a form of monitoring exists through meetings or seminars, and 1 IDI respondent said a mechanism to monitor their members exists through coordination with the MOH. The MOH monitored providers in their work place, and IDI then received information on the results if there were any problems.

According to 9 of 12 IBI respondents, written reports of the monitoring/supervision results existed and were used for evaluation, followup, feedback, and determining future needs and materials in the IBI National Coordination Meetings. For the other organizations, 1 POGI chairman (out of the 2 above) and the IDI respondent stated that a written report existed and was used as documentation only.

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<sup>27</sup> *“Jelas, bila telah mengikuti akan meningkatkan ketrampilan, dan mempunyai wewenang untuk memberikan pelayanan”*

## ***Government Institutions' (the BKKBN and MOH) Role and Involvement with the NCTN***

### *The BKKBN*

Most BKKBN respondents (14 of 18 respondents) felt their organization shared common goals with the NCTN, such as:

- ◆ Improving the quality of services (11 respondents)
- ◆ Improving provider skills and professionalism (5 respondents)
- ◆ Improving training quality (1 respondent)
- ◆ Developing standards (1 respondent)

All BKKBN respondents from the central and provincial levels were able to speak about the collaboration with the NCTN. Respondents from only 3 districts (2 with inactive DTCs, 1 with an active DTC) could not recall any collaboration. At the district level, 2 BKKBN respondents did not know about the NCTN at all. In 2 other districts, BKKBN respondents knew of the existence of a training center, but did not recognize it as part of a network. Finally, in 1 district, the BKKBN was not involved with activities of the NCTN, because the DTC mostly conducted BDC training rather than FP. The role of the BKKBN within the NCTN was described as a partner in the development of training standards, the planning of training courses, certification, and in the provision of training materials, funding, facilities, and clients for practice. In 3 provinces, the BKKBN was also involved in the organization of training and, in 1 province, the BKKBN helped in marketing the NCTN.

BKKBN officials from 5 provinces and 3 districts were satisfied with the NCTN's ability to meet their needs in training. They felt the NCTN had provided effective training, improved quality of services, and developed standard training packages. Those respondents who expressed dissatisfaction with the NCTN's capacity to meet their needs (1 central, 1 province, and 4 districts) mentioned the need for increased coverage of providers trained and for improved coordination with the BKKBN in developing standards and in budgeting. In 1 district, the BKKBN reported that the DTC had not conducted any training and therefore they could not comment.

When asked about activities other than training in which the BKKBN and the NCTN collaborated, respondents mentioned:

- ◆ BKKBN planning process (8 respondents)
- ◆ Research (2 respondents)
- ◆ Quality assurance program (1 respondent)
- ◆ Supervision (1 respondent)
- ◆ Seminars (1 respondent)
- ◆ Management of client complications (1 respondent)

### *The MOH*

According to respondents from the MOH at the central level, the MOH collaborated with the NCTN through its role as a member of the steering committee and as a source of funding for training courses. From the MOH's Pusdiklat, 1 respondent claimed to not have been involved in the NCTN. With the exception of 1 province and 1 district, all MOH respondents from province and district levels felt they were involved with the NCTN. Their role was mostly in selecting participants for training (7 respondents), which coincides with the responses of NCTN managers

who also said the MOH was involved in selecting participants (see **Table 31**). Other roles mentioned were as a member of the team/organization (2 respondents), as a provider of facility or technical assistance (1 respondent each), and as a participant in planning, supervision, and budgeting (1 respondent each). It was summarized thus by 1 respondent: “*Arranging for training funds, calling the training participants, being involved in supervising, and providing guidance to participants who have been trained...*”<sup>28</sup> At the central level, the MOH was also involved in developing standards for services and, together with the NCTN, in assessing training needs.

With the exception of 1 province and 1 district, all respondents thought the NCTN and the MOH shared the following common goals:

- ◆ Provide/improve quality of services/providers (8 respondents)
- ◆ Provide/improve quality of training (2 respondents)
- ◆ Decrease maternal mortality (2 respondents)
- ◆ Support the maternal and child health program through coordination (2 respondents)

Respondents from 3 districts and 1 province, and 1 respondent from the Central MOH, reported being satisfied with the NCTN’s ability to meet their needs in the area of training. They said this was due to good coordination with their office, improved skills of the providers, and the training courses being standardized. However, 6 respondents expressed that the NCTN still did not meet all their needs for training, because the NCTN covered only limited topics in RH. Respondents also mentioned:

- ◆ Training courses were not coordinated with the MOH
- ◆ The NCTN needed more materials
- ◆ The NCTN did not yet have sufficient coverage for BDC training
- ◆ The standard NCTN budget was too high

Some of these statements may have been made by respondents who were not aware of the full range of training materials available or who were in a geographical area where a certain type of training was not yet available. For example, 1 respondent said, “*We still need other skills, such as training for postabortion care.*”<sup>29</sup> Another said, “*For standard FP courses, demand has been met, whereas this is not yet the case for maternal healthcare.*”<sup>30</sup>

At the central level, the MOH and NCTN have had other opportunities to work together aside from training. For example, they collaborated on training needs assessments and on developing standards for services in RH. At lower levels, MOH respondents did not mention other areas of collaboration.

When asked about problems encountered in collaborating with the NCTN, responses most often referred to poor coordination, not enough socialization, and low commitment of NCTN trainers. Less frequently, respondents mentioned lack of equipment and facilities in the training centers, no clear criteria for training centers, and budgeting for training courses. In 1 district, the MOH office mentioned problems in working with the hospital rather than the NCTN.

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<sup>28</sup> “...menyusun dana pelatihan, memanggil peserta pelatihan, terlibat dalam supervisi dan pembinaan peserta yang dilatih...”

<sup>29</sup> “...tapi masih perlu ketrampilan-ketrampilan yang lain, misalnya pelatihan pasca abortus.”

<sup>30</sup> “...untuk standar KB sudah terpenuhi untuk standar persalinan belum ada...”

Recommendations to overcome these problems were mostly to improve communication, coordination, and facilities and equipment of training centers, and to develop a clearer organizational structure within the DTCs.

### ***District Hospitals' Role and Involvement in the NCTN***

The directors of 7 district hospitals were interviewed about the DTC located in their hospital. Of those interviewed, 2 directors did not know of the existence of a DTC in their hospital, and 1 said she knew of “a place for RH services where RH training is done, yes, but I do not know the NCTN.”<sup>31</sup>

The status of the DTC in the hospital varied from an independent organization under the hospital linked to or part of the hospital's training unit, to an institution under POGI, which collaborated with the hospital's training unit. In the case of 1 hospital director, the status of the DTC in the hospital could not be defined.

In conducting training, 3 DTCs were working together with the hospital's training unit; the other 2 were not. When asked whether they had to make special accommodations for the DTC in their hospital, 3 directors mentioned having to provide space and equipment for those centers. None of the 5 hospital directors complained about the activity of their staff as trainers, nor did they feel the training activities hindered the provision of services to hospital patients.

### **Focus Area VI: Expansion of National Clinical Training Network Capacity**

**KEY QUESTION:** How has the NCTN successfully built on a solid base to cover additional content areas?

### ***Additional Content Areas***

The first training packages for Norplant implants and IUD were developed in 1993. When Implanon implants were approved in Indonesia, the NCTN developed a new training package in 1995. Subsequently, Jadena (two rod implant containing levonorgestrel, also called Jadelle<sup>®</sup>) trials began and further adaptations were made for that method in 1996. Both the BDC and the postabortion care training packages began development in 1997 and were officially approved in 1999.

Managers from both NRCs have received requests for training in other RH topics, and they have tried to meet the requests by developing new training packages. Among PTCs, 4 reported being asked to do so, whereas no DTC had received such requests. This finding was confirmed in interviews with both the BKKBN (1 district, 3 provinces) and the MOH (central, 1 province, 1 district).

When the review team asked other agencies about the need for the NCTN to develop new training materials in RH, the following suggestions were given (listed in **Table 32**).

<sup>31</sup> “...tempat pelayanan kesehatan reproduksi, melakukan pelatihan kesehatan reproduksi, tapi tak tahu JNPK.”

**Table 32. Distribution of Responses Regarding Requests for New Training Packages**

New Training Packages Requested	POGI	IBI	IDI	MOH	BKKBN	Already Exists
Basic Surgical Skills	T		T			
Forceps	T					
Vacuum Extraction	T					
Basic Emergency Obstetric and Neonatal Care		T	T			
Life Saving Skills		T				
BDC				T		T
Postabortion Care		T				T
Management			T			
Adolescent RH				T		
Geriatric RH				T		
Vasectomy					T	T(PKMI*)
Tubectomy					T	T(PKMI)
Interpersonal Communication					T	T(draft)
*PKMI=Indonesian Association for Surgical Contraception						

There were already training packages for some of the needs expressed (e.g., postabortion care and vasectomy). It is unclear whether respondents were not aware of the existence of these packages, or were reporting that they requested these packages for their particular geographical area.

Focus group participants also listed types of maternal and neonatal health training courses they were interested in, such as: BDC, antenatal and postnatal care, neonatal care (asphyxia), management of retained placenta, basic emergency obstetric and neonatal care, and Implanon. The doctors also wanted to participate in diagnostic courses: ultrasonogram, electrocardiogram, and management of obstetric emergency.

### ***Wider Geographic Coverage***

KEY QUESTION: In what way has the NCTN expanded to new sites for wider geographic coverage?

**Table 33** shows the gradual expansion of the NCTN over time, as well as the source of funding for the initial establishment of specific training centers.

**Table 33. Chronological Development and Expansion of the National Clinical Training Network**

Year	Official Letter	Donor/Funding	NCTN Level	Location
1994	POGI	Pathfinder/SDES	NRC	Jakarta and Surabaya
1995	POGI	Pathfinder/SDES	PTC	North Sumatra, South Sumatra, Lampung, West Java, Central Java, East Java, South Sulawesi
1995	POGI	JHPIEGO	NCTN Coordinator	Jakarta
1997	POGI	Pathfinder/SDES	PTC	Aceh, West Kalimantan, South Kalimantan, West Nusatenggara
1997	POGI	Local	PTC	North Sulawesi and Bali
1999	POGI	ADB	PTC	Riau
1999	POGI	UNFPA	PTC	Jambi
2000	POGI	World Health Organization	PTC	West Sumatra and Yogyakarta
2000	POGI	JHPIEGO	PTC	Jakarta

Generally, people interviewed felt the NCTN should expand further in the future. All NCTN managers felt similarly and almost all training coordinators and professional organizations agreed that the NCTN should expand to new provinces and districts. However, 2 MOH respondents argued that the existing centers should be activated first.

The main reasons given for geographic expansion were related to decentralization and training needs. Manager and trainer respondents, as well as those from professional organizations and the MOH, felt geographic expansion was necessary in decentralization, and that every district should have a training center. Respondents from these 3 entities also felt expansion was necessary to standardize training everywhere or to expand training capacity. In addition, managers, trainers, and members of professional organizations said expansion would decrease the burden of the PTCs. Respondents from the BKKBN and the MOH felt the quality of services and providers would improve with expansion. BKKBN respondents also said expansion would help to improve coverage.

According to 2 NCTN managers, however, expansion should only be to those districts that have an ob/gyn specialist<sup>32</sup>. Moreover, expansion should not be in all districts, but should be developed regionally. Some IDI respondents suggested that expansion be done in all provinces, but only up to the PTC level.

<sup>32</sup> "...diusahakan ke setiap kabupaten yang ada ob/gyn"

Respondent criteria for development of new training centers are listed in **Table 34**.

**Table 34. Criteria for Development of New Training Centers According to Respondents**

Criteria	NCTN n=30	MOH n=17	BKKBN n=17
1. Enough human resources/trainers	25	5	7
2. Facility/equipment/funds	18	9	14
3. Need (high MMR, low performance, demand)	18	7	7
4. Geographic criteria	10	2	3
5. Ob/gyn specialist available	7	2	1
6. Sufficient caseload	4	3	1
7. Commitment of local government/human resources	2	4	3
8. Use existing criteria in "Ortala"	2	2	3

**Enhancement of CBT in Medical and Midwifery Schools**

KEY QUESTION: How has creation of the NCTN enhanced CBT at medical/midwifery schools?

According to 13 respondents from professional organizations, the training skills acquired by NCTN trainers were also used in preservice education. Those NCTN trainers who were also lecturers/instructors in medical and midwifery schools used CBT methods when conducting training at these institutions. Infection prevention was the topic most widely seen as having been strengthened in preservice education through the NCTN. Information on expansion of CBT in medical and midwifery schools, collected from the self-administered questionnaires completed by trainers, is shown in **Table 35**. Of trainers, 77% (n=80) said they used CBT techniques in preservice education—44% of these trainers used CBT in medical schools and 31% used CBT in midwifery schools. Notable is that 16% of trainers said they used CBT in other areas (e.g., courses, friends).

**Table 35. Distribution of Trainers Who Have Ever Used Competency-Based Training Techniques in Preservice Education**

Variable	Number (n=104)	Percentage
1. Ever used CBT techniques in preservice education:		
• Yes	80	76.9
• No	24	23.1
<b>Total</b>	104	100
2. If yes, place of preservice education:		
• Medical school	35	43.8
• Midwifery school	25	31.3
• School of nursing	7	8.8
• Others (e.g., courses, friends)	13	16.3

Note: Percentages do not always add up to exactly 100% due to rounding.

## DISCUSSION AND RECOMMENDATIONS

This section reviews the findings and discusses the implications and lessons learned. The focus areas and key questions provide the organizing framework for this section.

### Focus Area I: National Clinical Training Network's Capacity to Plan, Manage, Implement, and Evaluate Training

- |   |
|---|
| <p>KEY QUESTIONS:</p> <ul style="list-style-type: none"><li>• To what extent has the NCTN successfully demonstrated its capacity in planning, managing, implementing, and evaluating training at the PTC or DTC level, including responding to district level training needs?</li><li>• How has the NCTN specifically managed the financial and logistical implementation of training at the PTC/DTC level?</li></ul> |
|---|

Overall, the PTCs and DTCs are responding to the needs of their clients in those training centers that are active. In some provinces, training may still be done at the provincial level (e.g., Bali, North Sumatra), which may be an appropriate model if the level of activity is not too burdensome for the PTC.

In fact, North Sumatra provides a good example of a province where the PTC is meeting district level training needs. The fact that past participants could be identified from the North Sumatra district selected for the FGD suggests that coverage may be adequate. Focus group participants in the Deli Serdang district had attended an array of training courses at different locations: at the PTC in Pirngadi Hospital (3 FGD participants), at the BKKBN Province Training Center (3 FGD participants), and at a clinical training skills practicum at the DTC level (3 FGD participants).<sup>33</sup>

Those participants trained in the district hospital complained that classroom space was too small, the accommodations were inconvenient, and there was not enough lighting. According to the DTC manager, "*The DTC is only a linking point at the district level for those providers from the district who are trained at the provincial level.*"<sup>34</sup> The BKKBN and the MOH, which fund most training activities for that district, were not even aware of any DTC activities.

Many centers saw the need for annual planning in addition to preparation for each individual training course. Others probably could be encouraged to be more proactive in approaching their partners at the BKKBN and the MOH to inquire about annual plans; however, the latter still provide training when a request is made.

Before a course, PTCs and DTCs conduct coordination meetings and cover a broad area of training related issues, such as participant selection, client caseload for clinical training, and supplies and materials. In those meetings, logistical issues are raised and, more often than not, a solution is found to shortfalls or problems, thanks to good cooperation between the training center and the sponsoring government agency.

Finances are managed in varying ways by each site. This review was not able to identify the reasons why, in some provinces or districts, financial management was delegated to the NCTN, while in others, control was maintained by the BKKBN or the MOH. It is unclear whether the

<sup>33</sup> The TRH Project directly funded the clinical training skills practicum in an effort to qualify trainers after the NCTN adopted a trainer development pathway and stricter criteria for trainer qualification.

<sup>34</sup> "*P2KP hanya sebagai penyambung di tingkat Kabupaten jika ada tenaga Kabupaten dilatih di propinsi*"

decision is based on the perceived capacity of the NCTN or the preferences or wishes of the government institution. During the 1995 mid-project assessment, the review team found the government (the BKKBN/MOH) managed all finances under the SDES Project and, at that time, NCTN managers complained about this arrangement. The findings of the 1995 assessment were disseminated in each SDES province. Perhaps the fact that some NRCs or PTCs were currently managing the funds themselves is in part a result of NCTN requests being well received by government counterparts in those areas. In terms of NCTN capacity, greater leadership in managing finances is desirable, because it allows for better control over the quality of training. However, this is probably not essential if the collaboration between partners is good.

The use of reports or other documentation (such as TQA forms or the use of TIMS to record the training activities) is less prevalent and warrants more emphasis. Similarly, although NCTN trainers conduct supervisory or evaluation activities for other trainers and providers, documentation of these efforts is often lacking. The TIMS database does include an optional section where information collected in followup assessments can be recorded and analyzed. Standard followup forms, however, are needed to make good use of this feature.

**Recommendations**

- ◆ The NCTN coordination unit and the NRCs should encourage the PTCs and DTCs to develop annual plans. Some attention should be given to the planning cycle. Plans should be received at the national level in time for dissemination with government and donor agencies prior to finalization of their own annual budgets and plans.
- ◆ Knowledge of standards and activities of the NCTN seemed to be weakest at the district level. Findings indicate that many NCTN coordination meetings were being conducted, with the exception of those involving both PTCs and DTCs. If DTC managers and trainers come to the provincial level for other reasons, PTCs should consider coordination meetings with the DTCs in their province. They could use these meetings as occasions to disseminate information from national or regional meetings and to give DTCs the opportunity to update them on training activities. Such meetings could also be used to enhance data collection for TIMS.
- ◆ Training center management of funds was still uneven, with some managing their own budgets and others only attempting to collect trainers’ fees. Those centers that do manage their own funds might come together to discuss standard line items (trainers’ fees and supplies) and nonstandard items (transportation and accommodation). They could then share these budget items with other centers to encourage uniformity and better advocacy with sponsoring agencies.
- ◆ Training events and followup or training supervision activities should be better documented, using standardized forms or reports whenever possible.

<p>KEY QUESTION:      What kind of management structure and leadership might help in improving the operations/effectiveness of PTCs and DTCs? How can the sustainability of the DTCs be enhanced under decentralization?</p>
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The majority of respondents within the NCTN were comfortable with the current management structure as described in the “Ortala.” There was also agreement that stakeholders other than POGI need to be represented in that structure and be present in coordination meetings. There

was less agreement, however, as to the type of representation by different stakeholders and whether it needed to exist in the same fashion at the district and provincial level as at the central level. It might be helpful for the leadership of the NCTN to examine potential models for incorporating IBI and IDI into the management structure more clearly. Questions to be answered include whether representation of the professional organizations in the coordinating forum is sufficient, or whether a more precise role for IBI, IDI, and POGI exists at PTC and DTC levels.

As for the sustainability of the NCTN as a whole and the DTCs in particular, respondents provided some concrete proposals, particularly in the areas of advocacy and marketing that target local governments. A proposed strategy was participating actively in district level planning to integrate with ongoing health activities. Additionally, respondents said the DTCs need the entire network to support them in continually improving the quality of training, applying common standards for training, and providing ongoing guidance and support.

The MOH raised the question of legality of the NCTN as an entity. They encouraged the NCTN to seek a clearer legal framework. Even if this is not a priority in the short term, strengthening the legal basis for the network could become a long term goal.

### **Recommendations**

- ◆ NCTN managers recommended that a common vision for the NCTN be developed along with long term goals, and that the roles of the various stakeholder organizations within the NCTN should be more clearly defined. In particular, the roles of the professional organizations—POGI, IBI, and IDI—need to be made explicit, they said, especially as they relate to the management structure of the organization. These functions could be distinguished from the roles of other member organizations, such as the Indonesian Association for Surgical Contraception, PKBI, and Muhammadiyah.
- ◆ To be truly effective, DTCs will need additional technical assistance. For this assistance to be well coordinated and to have an impact, DTCs need to consider assigning clear roles for advocacy, coordination, planning, and quality assurance within the team at the center. Also, whatever structure is adopted at the DTC level needs to be transparent and well communicated to counterparts within the BKKBN and the local health office.
- ◆ Similarly, respondents recommended the NCTN clarify the linkage with the hospital. Whether this can be done for all hospitals using a standard memorandum of understanding, or whether each PTC or DTC needs to document their own system is something to discuss in an upcoming national meeting.

### **Focus Area II: Qualification of Trainers and Providers**

- KEY QUESTIONS:
- How well are trainer and provider selection and qualification criteria being applied and adhered to?
  - How are qualification criteria determined and reinforced?

From the results, we might infer that trainer qualification (in both clinical skills standardization and training level) is not the primary determinant for the selection of trainers for individual courses (as seen in **Table 16**). Indeed, the review team received some self-administered questionnaires from trainers who were not in the TIMS database but who had been participants in a training skills course. This finding may indicate that the training database is incomplete (a

real possibility, because it was still new at the time of the review) or that some individuals acting as trainers had not been qualified using the NCTN's own standards. The review team's questions, however, were not pointed enough to gauge whether this potential lack of qualification was true or not. On the whole, NCTN interview respondents reported applying the trainer development pathway.

Many stakeholders commented on participant selection. Although they provided varying selection criteria, all seemed reasonable and in the correct spirit for ensuring that training investments are not lost.

As for participant qualification, the review team noted that the majority of NCTN respondents were unable or unwilling to estimate the percentage of past participants who were deemed competent. Apart from this review, members of the review team had observed that TQA forms submitted after a course were often missing the data on provider competency. More reassuring were the trainers' responses to questions about their action when there were not enough cases for a participant to reach competency. Only a small percentage (6%) reported qualifying a participant anyway. This is important as well, because it shows that the trainers sought other mechanisms to ensure that a participant could reach competency (see **Table 20**).

Nevertheless, for the NCTN to be able to vouch for the high-quality of its training, trainers need to pay greater attention to establishing clearly whether participants are competent to provide services. In FGDs, providers emphasized the issue of course certificates. Not receiving a certificate may give rise to uncertainty about whether the trainers deemed the participants competent. Greater NCTN uniformity in the handling of certificates would help alleviate the vagueness surrounding the issue of competency and ensure appropriate data entry into TIMS.

**Recommendations**

- ◆ Although NCTN trainers and managers are well sensitized to the requirements of the trainer development pathway, there should be continued emphasis on ensuring that trainers meet the qualification levels prescribed when conducting courses.
- ◆ A central element of high-quality training is ensuring that participants can reach competency by the end of the course. Many participants in clinical skills courses recommended more practice time with clients and sufficient caseload compared to the number of participants. More attention needs to be paid to clinical practice, especially caseload. Alternatives such as self-paced learning approaches should be explored, especially when caseload or trainer availability is an issue.

**Focus Area III: Quality Assurance and Monitoring of Standards for Training Quality**

KEY QUESTION: To what extent has the NCTN successfully demonstrated its capacity to establish standards for training and to ensure adherence to the standards?

In recent years, the NCTN has put a great deal of effort into the painstaking process of developing standards for training. However, the review team documented that not all these standards were fully known by either training coordinators or stakeholders outside the PTCs and DTCs. The fact that a forum exists that has worked to develop these standards is also not known at lower levels. Although the TQA documents have been distributed in coordination

meetings, more needs to be done to circulate these documents in provincial and district level meetings.

### **Recommendation**

- ◆ Although the Trainers' Forum is responsible for setting standards within the NCTN, many trainers are not even aware the forum exists. More needs to be done to define the role and disseminate the work of the Trainers' Forum.

KEY QUESTIONS:

- How have PTCs and DTCs maintained minimum standards for training performance (selection criteria, caseload, length/content)?
- How have PTCs and DTCs ensured that training sites are meeting the standards established by the NCTN and the Trainer Task Force?

Even though interview respondents could not immediately cite what the training standards were, other data showed positive findings. In addition to the issue of qualifying participants when caseload was insufficient (as mentioned above), also encouraging is the number of trainers who reported using trainer self-assessment tools to maintain their skills and who asked their colleagues to provide feedback. Of trainers, 68% reported having been supervised by a more experienced trainer.

The NCTN managers and trainers had inconsistent answers about the length of a course. Almost half reported that the standard number of days for a course had been changed. In the majority of cases (64%), the reasons given could have resulted from factors external to the training site (the request of a collaborating agency or insufficiency in funds). The other cases (36%) were for reasons that trainers could and should control (e.g., adjustments to the participants' capabilities, trainer time constraints, or agreements between participants and trainers). This review was not structured to assess the impact of these changes on participant skill attainment.<sup>35</sup> Changes in course length are not inherently a problem as long as provider competency can be reached before the course ends and those aspects important to quality of care—such as interpersonal communication, counseling, or infection prevention—are not given short shrift.

From interview responses, there does not seem to be a clear, established mechanism to review whether an existing training center still meets the NCTN requirements as a training center. Currently, the system relies on the professionalism of trainers and occasional supervision to ensure that training centers continue to meet standards.

### **Recommendations**

- ◆ There should be continued updating and dissemination of training standards and TQA tools to maintain an emphasis on high quality.
- ◆ The NCTN should review the standards that define a training center as a first step to further defining the status of various training sites within the NCTN. For example, if a Muhammadiyah hospital is conducting training, does it do so in conjunction with a DTC or

<sup>35</sup> The SDES evaluation did show some deficiencies in the skills of providers who had been trained and it has been hypothesized that this result was due to shortcuts taken during training courses.

does it become a DTC? Part of the standard review should also identify and publicize the frequency with which the Training Center Assessment Form in the TQA tool set needs to be applied and where the results are sent.

- ◆ Once the above training center standards are reviewed, the NCTN should identify the steps needed to “activate” DTCs in districts where they are not yet active and where the BKKBN or the local MOH sees a need and has resources for training. The role of the PTC in this process should also be clarified.

KEY QUESTION:      How has the NCTN used tools such as TIMS and TQA to ensure ongoing monitoring of training implementation?
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Although TIMS and TQA are still not implemented throughout the network, feedback on their applicability and effectiveness in tracking training activities was generally positive. These responses point to the fact that these systems need further development and can expect to be well received.

### ***Recommendation***

- ◆ NCTN managers have expressed an interest in using TIMS to monitor training activities. At the current time, TIMS software is still undergoing development to be used in multiple sites. More can be done to exploit the information available in the TIMS database. STARH should help the NCTN disseminate quarterly reports using TIMS, some of which can be tailored to each PTC. Under decentralization, the relevant TIMS information should be distributed to each PTC and DTC and used to coordinate and review training achievements on a regular basis.

### **Focus Area IV: District Training Center Role in Sustaining Provider Performance**

KEY QUESTION:      How has the DTC supported providers’ ability to use the skills acquired during training, and how has service delivery improved in the opinion of district leaders, managers, providers, and trainers?
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Most respondents felt that training itself was central to improving provider performance and they judged the DTCs to have contributed to improved performance. Providers themselves also attested to their own improved confidence and competence.

Whether the DTCs have a role to play beyond providing training was of interest in this review. Given that follow up with participants after training is a time and resource intensive activity, it was interesting (and admirable) to note that 49% of trainers reported having conducted followup of providers. Some providers who participated in the FGDs also mentioned having been followed up by their trainers, particularly those from the district level.

Some of these positive answers may relate to the IBI peer review system, an established mechanism for following up trained midwives for either FP or BDC. Peer review should continue to receive support from the NCTN as an effective means of sustaining the retention of skills after training.

Government respondents were least likely to mention the monitoring of provider performance as one of the means by which the DTC has had an impact on quality. This finding suggests the

DTC is not yet perceived as an active player in a broader definition of provider performance improvement. It should also be noted, however, that MOH supervision in general seems to be weak, or at least inconsistent, from one district to another. Although trainers may not be the right entity to remedy this situation, they can perhaps play an advocacy role so the investments made in training are not wasted. Also, trainers can seek ways to facilitate the transfer of skills learned to the job setting by spending time in each course encouraging participants to reflect on the potential constraints to skill transfer and developing strategies to overcome them.

### **Recommendations**

- ◆ Under decentralization, decisions about training will increasingly be made at the district level. For DTCs to be able to advocate for and justify training budgets, they must be able to guarantee high-quality training and apply the uniform NCTN standards. Also, training will be more appropriate in cases where the DTCs have been involved in training needs assessments and participated in district level planning exercises. Mechanisms need to be identified and implemented to ensure the coordination and consistency in the DTCs' application of NCTN standards.
- ◆ Trainers should be encouraged to add a session at the end of each clinical skills course to help participants plan for the transfer of their new capabilities to their work setting, including preparing to overcome predictable, early obstacles to their good performance. In addition, increasing trainer follow up of participants should be discussed with participants before the end of a training course.

### **Focus Area V: National Clinical Training Network Collaboration and Partnerships**

- KEY QUESTIONS:
- What do models of successful partnerships and collaboration among POGI, NCTN, BKKBN, MOH, IBI, and IDI look like?
  - How has collaboration enhanced the quality of training at the district level and what has it supported?
  - How can collaboration be improved at different levels (NRC, PTC, DTC)?

In the field, the primary NCTN collaboration is with two government institutions: the BKKBN and the MOH. In districts where BDC is the main activity (such as Pati), the MOH may have the lead role, while the BKKBN has the role elsewhere. Many training centers reported collaborating with IBI; however, some IBI respondents felt they should and could play a greater role in NCTN activities. IDI respondents only sought more information about the NCTN, not a greater role. POGI respondents, because they are often the trainers, felt the collaboration with the training centers was good.

Collaboration leads to improvements in the quality of training (such as problem solving to identify needed resources), but it may also lead to compromises that affect quality (e.g., changing the length of the course or the selection of participants). Even though some government respondents felt the NCTN was too rigid or expensive, others recognized the NCTN represented high standards in training and thus high-quality service provision.

## **Recommendations**

- ◆ Recommendations from respondents for improving collaboration are worth repeating here:
  - A common vision/goals should be developed
  - A detailed annual workplan should be developed jointly
  - There should be a clear division of roles and responsibilities
  - PTCs should be more proactive in coordinating activities with other institutions

The NCTN's coordination unit can provide some leadership in supporting these recommendations, but the DTCs and PTCs are in a better position to implement them for their own geographical area and stakeholders.

- ◆ NCTN members at all levels need to advocate for the network whenever the opportunity presents itself. The NCTN has demonstrated an impressive ability to maintain collaboration and partnership over the years. Nonetheless, the work to keep such partnerships alive is never finished, because the relationships need ongoing care. The staff in one or more of the organizations may change and therefore need to be reminded of what the NCTN represents.

## **Focus Area VI: Expansion of National Clinical Training Network Capacity**

- KEY QUESTIONS:
- How has the NCTN successfully built on a solid base to cover additional content areas?
  - In what way has the NCTN expanded to new sites for wider geographic coverage?

There already has been steady growth in the NCTN, both in terms of content and geographic coverage. The number of training/learning packages covering a variety of topics continues to grow steadily. In fact, the NCTN might do better not to rush the process of developing new packages to maintain high quality. Indeed, designing effective CBT is a complex and time consuming endeavor.

Geographic expansion has successfully occurred, but it is likely that growth will remain dependent on identifying donors who are willing to invest new resources in specific locations. District level expansion should be guided by the PTCs and be consistent with ensuring that the PTC can provide ongoing support to the DTCs that are created. The East Java model of four districts for each DTC might be one that other provinces should study.

## **Recommendations**

- ◆ Expansion should be progressive, with careful planning and implementation to maintain the NCTN's strengths as a network that provides high-quality CBT, and with consideration given to various successful models already implemented. The responses to this last question point to the synergistic effect of investing in the NCTN. NCTN trainers who are also faculty reported using CBT methodologies in their work with medical and midwifery school students. Donors often fund training to meet short term benefits, but doing so through the network may also have longer term impact on future generations of providers. This impact depends on students spending clinical training time in healthcare facilities where services are provided according to national standards. Training centers have a responsibility to implement service delivery standards as well as training quality standards.

- ◆ Future assessments of NCTN capacity should explore how service delivery standards are applied within DTCs and PTCs.

## **CONCLUSION**

The results of this review formed the basis of an NCTN strategic planning effort designed to engage the participation and commitment of all NCTN stakeholders to determine how it can best function under decentralization. As a first step in this process, a July 2000 national meeting hosted the first election of a chairperson by NCTN stakeholders. Between May and August 2001, meetings were held among central level NCTN stakeholders and among PTC/DTC representatives to discuss the findings and recommendations of the review, and to identify challenges and propose approaches to meeting them. In September 2001, strategic planning workshops were conducted to develop both a 5-year strategic plan and a 12- to 18-month action plan. These workshops brought together trainers and managers from PTCs and DTCs, as well as stakeholders from the BKKBN, IBI, POGI, and PKBI. All participants were very engaged in the discussion of strengths, weaknesses, opportunities, and threats (SWOT) analysis, and put considerable effort into completing questionnaires with recommendations for the contents and process of the strategic plan. The systematic implementation of the action plan began in October 2001 and will continue through March 2003.

The NCTN has survived the end of the SDES Project and has maintained and expanded the investments made under the TRH Project. It is continuing to provide training in nearly 90 sites around Indonesia—no small feat given the great diversity in the country and the variety of funding sources and mechanisms for training. The NCTN, in reaction to the findings in this review, has already implemented a strategic planning process that is constructive and participatory, involving the district level as well as providing for coordination between provinces and districts. Challenges remain to be addressed in the future, yet there is a strong foundation upon which to build a more sustainable and cohesive organization for as long as the need for RH clinical training exists in Indonesia.

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## APPENDIX A

### Distribution of Interview and Focus Group Discussion Respondents

**Table A-1. Distribution of In-Depth Interview Respondents by Level**

Level	NCTN Managers	Trainer Coordinator	Professional Organizations			Government Institutions		Hospital Directors	Total
			POGI	IBI	IDI	BKKBN	MOH		
- Central	2	2	1	1	1	3	3	--	13
- Province	6	6	6	6	6	6	6	--	42
- District	7	7	--	8	7	8	8	7	52
<b>Total</b>	15	15	7	15	14	17	17	7	107

**Table A-2** details the number of participants to FGDs.

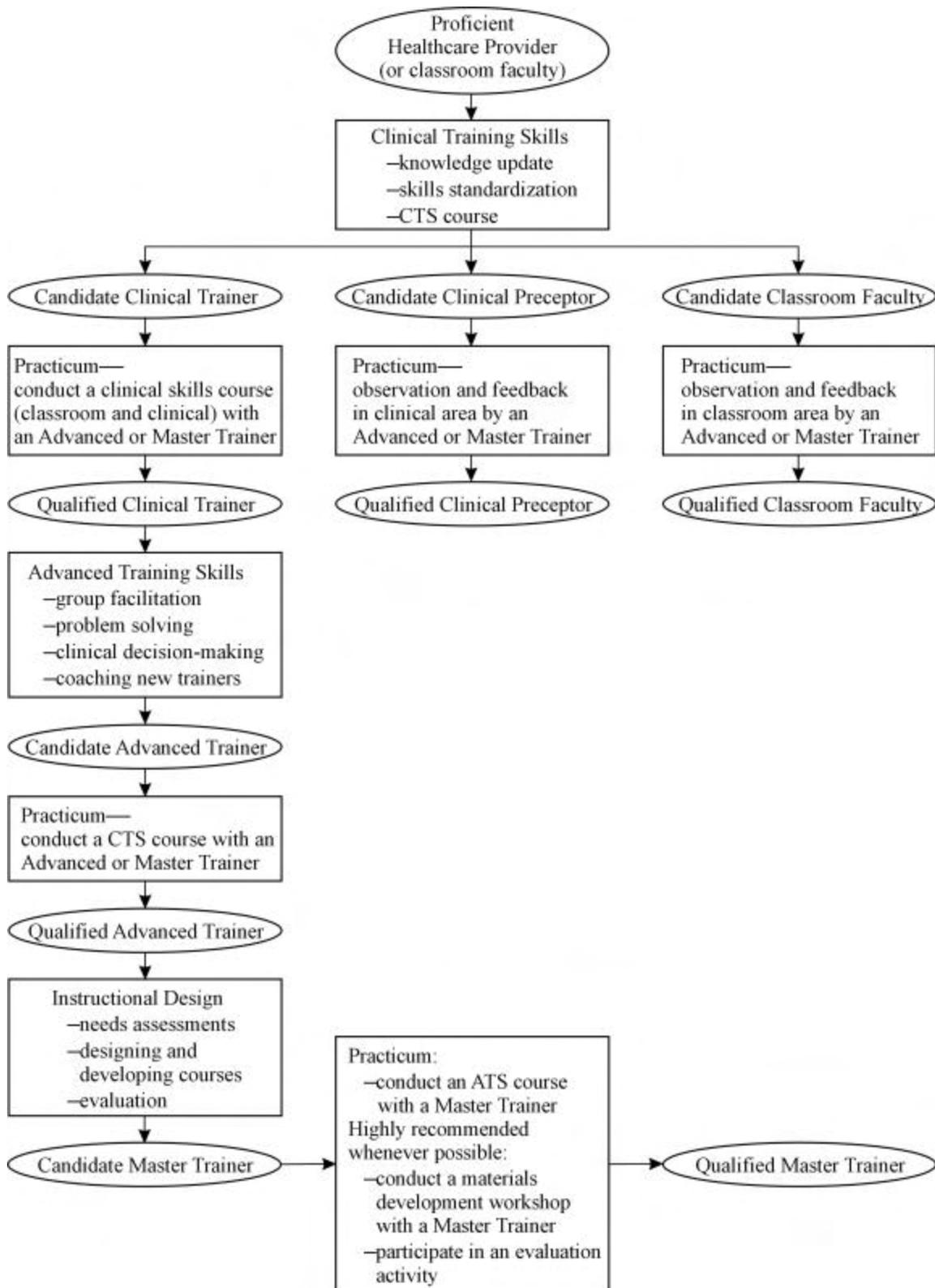
**Table A-2. Number of Focus Group Discussion Respondents by Profession**

FGD Respondents	Doctors	Midwives	Total
Number of groups	4	9	13
Number of participants per group:			
- Deli Serdang	--	10	10
- Kampar	--	6	6
- Garut	4	6	10
- Sukabumi City	--	12	12
- Sukabumi District	--	6	6
- Pati	10	8	18
- Brebes	10	8	18
- Bali (PTC)	6	6	12
- Pare-Pare	--	14	14
<b>Total</b>	30	76	106



# APPENDIX B

## Faculty and Trainer Development Pathway



Notes: CTS=Clinical training skills; ATS=Advanced training skills

# ALUR PENGEMBANGAN PELATIH DAN DOSEN

