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## **Final Report**

# **Evaluation of the External Quality Assurance System for Voluntary Sterilization and Other Long-term Contraceptive Services in 12 Provinces of Java, Sumatera and Sulawesi**

**Prepared by**

**Sasa Djuarsa S., Ph.D.\***

**Pinkey Triputra, Msc.\***

**Jack Reynolds, Ph.D.\*\***

**\*Lembaga Penelitian dan Pengembangan Komunikasi Massa**

**\*\* University Research Corporation**

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# Executive Summary

## 1. Background

This evaluation was conducted as part of an overall assessment of Voluntary Sterilization (VS) in Indonesia. It is part of a sub-assessment of family planning quality assurance (QA) systems that have been developed and tested in Indonesia over the past 5-10 years. The results were to be used by a QA Design Team that was formed to recommend an appropriate and sustainable QA system for family planning services in Indonesia.

The External Quality Assurance system (XQA) consists of two major activities at the field level: 1) periodic meetings to review monthly activity reports submitted by the clinics in the province; and 2) site visits to clinics that are having problems to conduct a comprehensive review of facilities, equipment, clinic staff and clinical procedures.

This evaluation was designed and organized in March and April of 1995 and field work got underway in late April. Data were collected from 51 kabupatens in 12 provinces in Java, Sumatera and Sulawesi. Interviews were held with BKKBN, Depkes and PKMI provincial chiefs, the chiefs of hospitals and clinics where services were provided, with 58 provider teams, and with the team leaders and members of the XQA provincial teams. Field work was completed in three weeks. A preliminary report was presented in mid-June, about two weeks prior to the arrival of the QA Design Team.

## 2. Findings

The current XQA program is designed to cover 732 of the 3,848 service sites in Indonesia. The program comes very close to conducting most of the meetings and all of the clinic visits planned in the XQA coverage area. In 1993/1994 that meant that 26 percent of the 732 clinics in the XQA system were visited. But from a national perspective, coverage and visits are quite modest. The system currently covers only about 19 percent of the 3,848 LTM/VS clinics, and only 5 percent of those are visited each year. Only 205 clinic visits were reported for 1993/1994, which averages out to about one visit per province every two months. At this rate it would take 18 years to visit each clinic just once.

There is a great deal of variation among provinces. The program is larger and more active the more populous the island (i.e., Java is first, then Sumatera, then Sulawesi). Bali, East Java and Central Java are the most active provinces, in that order. Bali, for example, a LTM province, has 52 clinics, of which 32 are in the XQA system (62 percent). In 1993-1994 the provincial XQA team made 42 visits. That is 131 percent of the clinics in the XQA system and 81 percent of all LTM/VS (long-term method/voluntary sterilization) clinics in the province. But, at the other extreme, some provinces conduct few or no visits.

Funding limitations and delays account for some of this. With additional funds many provinces could make additional visits. However, the data indicate that this is not the only limiting factor. Just as important is the lack of time XQA members have to make visits. Also, there is no paid staff to administer the system. Even if the members had more time and the administration of the system could be strengthened, it is expensive as it stands. At Rp. 710,000 per visit on average, it would be extremely expensive to expand coverage and increase the frequency of visits. Roughly, one visit to each of the 3,848 clinics each year would cost Rp 2.7 billion.

On the positive side, the XQA team leaders and team members appear to be well-qualified and experienced in both quality assurance and supervision. The majority have spent several years working in the XQA system. The fact that they are volunteers and that most have not even thought about dropping out of the system is a good indication of their commitment and dedication to quality assurance.

The XQA system seems to be well-designed, and most of the members follow the procedures carefully. The periodic meetings are held every two months on average and are thought to be valuable. The topics that are supposed to be discussed (results of clinic visits and results emerging from monthly clinic reports) are discussed. The clinic visit protocol is comprehensive. It covers structural items (facilities, equipment, etc.) as well as procedures (counseling, operations, etc.). Direct observation of key procedures is reported to be conducted quite often.

It seems clear that the system has the potential to make a significant contribution to quality improvement. There are a few limitations that were identified which could easily be corrected. Some improvements in indicators could be made so that the teams could better identify clinics that need attention and also compare clinic performance with standards of clinical practice and quality of care. The feedback component needs to be strengthened and a follow-up mechanism added to make sure that recommendations for improving quality are implemented by the providers.

### **3. Recommendations**

The most serious constraints, however, are that the system is very time-consuming and expensive. It is unlikely that it can be replicated in its present form so that all LTM and VS clinics are covered and visited at least once each year. That would seem to be the minimal requirement if this system were to become the primary mechanism for quality assurance throughout the country. Even if the funds were available to upgrade the system, add support for administrative costs, and expand coverage to all clinics, which is unlikely, there are not enough XQA team members to conduct the minimum number of visits that would be required (around 4,000 per year). And the pool of potential candidates who could serve as members is very small.

The best use of the XQA system may be as a complement to an alternative national system. For example, the QA Design Team has recommended a simple and inexpensive QA system that could be an extension of the clinical training that is now getting way under the National Resource Centers and the National Clinical Training Network. Commitment to quality would be built into the curricula, and require no extra training time. Trainees would develop action plans at the end of their clinical training session. Those plans would be complemented by a self-assessment form that the trainees would send back to the trainers at 6 weeks, 6 months and 1 year. The trainer would check performance, provide feedback, and arrange for a site visit, if required. A limited number of "spot checks" or "random visits" would be made by the trainer to the providers who were trained to observe and assess their performance.

The XQA clinic visit form could be modified to be used for these spot checks and follow-up visits. The results of these visits could be fed back to the NRCs, PKMI, Depkes, BKKBN and others for consideration and action at local, provincial and national levels.

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## Acronyms and Abbreviations

AVSC	Association for Voluntary Surgical Contraception
BISEP	Bureau of Contraception (BKKBN)
BKKBN	National Family Planning Coordinating Board
Depkes	Department of Health
HC	Health center
IBI	Indonesian Midwives Association
IDI	Indonesian Medical Association
IEC	Information, education, communication
IFY	Indonesian Fiscal Year
LPPKM	Institute for Mass Communication Research and Development
LTM	Long-term methods
MKET	Most effective contraceptive methods
NRC	National Resource Centers
PIL	Project Implementation Letter
PKMI	Indonesian Association for Secure Contraception
POGI	Indonesian Obstetrics and Gynecology Association
PSFP	Private Sector Family Planning project
PUBIO	Biomedical Research Center (BKKBN)
QA	Quality assurance
RAM	Repair and maintenance (of VS equipment)
Rp	Rupiah
SDES	Service Delivery Expansion Support project
URC	University Research Corporation
USAID	U.S. Agency for International Development
VS	Voluntary sterilization
XQA	External quality assurance

# I. Introduction

## 1. Background

In 1984 PKMI with assistance from AVSC and Pathfinder, undertook a special pilot program called "*Quality Maintenance of VSC*". The program began in East Java and later expanded to Bali, North Sumatera and West Java.

Quality Assurance teams were established in each province. They consist of members from PKMI, BKKBN and Depkes. The teams agreed to use PKMI's service standards and to assess provider performance on the basis of those standards. Usually the provincial teams met each month to review monthly service statistics and other indicators of quality. Among the key indicators were deaths and complications from vasectomy and tubectomy operations carried out at the VS service sites. The teams made two visits to each VS clinic each year, used checklists to determine if standards were being followed, and followed up on problems identified.

An evaluation was conducted in 1986 that looked at the sustainability, replicability and cost-effectiveness of the system. As a result, a number of changes were made. The most significant was that only those clinics that had problems (defined as high complication rates) would be visited. The teams would review service statistics at their monthly meetings and select the clinics that needed to be visited.

In 1987/1988, with the help of BKKBN and Depkes and with USAID funding, this program was refined and expanded to 7 provinces and then to 13. Over the next five years it was established in all 27 provinces.

By 1989/1990 it was clear that the program was having an impact. Supervision had improved in the VS hospitals, operational problems were better understood, the requirements for facilities and equipment were better understood, both BKKBN and Depkes began to understand the importance of quality in the delivery of services, and BKKBN started holding an annual review where findings from the supervision visits were presented, discussed and solutions identified.

But some problems were also identified. A 1992 proposal from PKMI summarized them :

The *internal quality assurance (QA)* activities do not get appropriate attention and have not been properly implemented in most service delivery sites. The situation is not promising one because the *external QA* activity has some weaknesses: (1) needs considerable funds, (2) too much focus on outcome indicators, (3) lack of "self-reliance", (4) external QA team weak and (5) no link to community-based activities.

PKMI, BKKBN and USAID agreed to develop and test an **internal QA system** to complement the **external** one and to deal with the problems identified in the assessments. That got underway in 1993. In addition, they agreed to pilot test an expanded **external QA system** to cover all long-term methods. This two-year test was conducted in East Java,

West Java, Bali and North Sumatera. The external QA (XQA) system was continued in the remaining 23 provinces without change

## 2. Objectives

The main purpose of this study is to carry out an evaluation of the XQA system. This information is needed by BKKBN, PKMI and USAID, who are planning a general review of the various quality assurance systems that have been tested and/or implemented in family planning. The end product of that review will be the design of an appropriate and sustainable quality assurance system for clinical family planning services in Indonesia. The information will also be of interest to Depkes, POGI, IBI, IDI, and other organization involved in the direct provision of family planning services. One of the main questions to be addressed is whether this system should be expanded nationwide, revised or just used selectively.

### Specific objectives

1. Describe the activities undertaken by XQA teams over the past year. Describe both the quantitative achievements (number of meetings held, number of visits made, proportion of clinics covered, number of problems identified, percent of problems resolved, etc.) and the processes used in external supervision.
2. Identify the strengths and weakness of the XQA system in respect to inputs, processes, and outcomes, in particular impact on quality. Identify factors that account for the principal strengths and weaknesses.
3. Identify potential solutions to problems identified.
4. Estimate the costs of the system, including non-monetary costs (for example, time contributed).
5. Make recommendations as to future courses of action that should be considered, including appropriate alternatives to this system.

## 3. Methodology

### 3.1 Study design

The initial terms of Reference for this study were requested by USAID as a follow-up to an agreement by USAID to fund an assessment of the External Quality Assurance system through AVSC. URC agreed to prepare the TOR and act as the lead technical assistance agency for the study. The draft TOR was reviewed by the chiefs of PUBIO, BISEP and BIREN in early March 1995. An updated version was reviewed by PKMI, AVSC and the Population Council in mid-March. A final version was formally submitted by USAID to BKKBN (PUBIO) in early April. The Population Council agreed to fund local costs, and URC agreed to use PSFP funds to provide technical assistance and monitoring. PKMI also offered to cooperate in the development of the instruments, data collection and administrative arrangements.

*"Lembaga Penelitian dan Pengembangan Komunikasi Massa" (Institute of Mass Communication Research and Development) or LPPKM, was contracted by the Population*

Council to collect, tabulate and analyze the data as well as prepare the final report. URC drafted the instruments and selected the sample, which were reviewed by BKKBN, USAID, PKMI, and AVSC and then finalized by mid-April. LPPKM conducted pretests of the instruments, conducted orientation sessions for field investigators, who were recruited from each of the 12 provinces selected, and data collection got underway in late April 1995. URC staff accompanied LPPKM to four provinces to provide assistance as needed. At the same time, PKMI provided URC with activity and financial records so that an analysis could be done of QA activities funded through PILs 14 and 17,<sup>1</sup> as well as to draw the specific samples of clinic sites to be visited by the field investigators.

## 3.2 Sample

### 3.2.1 Target locations of the study

In accordance with the TOR, this study covered 12 provinces and 51 "kabupaten/kotamadya" as follows:

1. West Java (Jabar): Bandung, Garut, Ciamis, Cianjur and Cirebon.
2. Central Java (Jateng): Klaten, Blora, Kudus, Muntilan and Magelang.
3. D.I. Yogyakarta (Yogya): Yogyakarta, Kulonprogo, Wates, Bantul and Wonosari.
4. East Java (Jatim): Situbondo, Tulungagung, Mojokerto, Madiun, Pacitan, Sumenep, Sampang and Bangkalan.
5. North Sumatera (Sumut): Tanjung Balai, Sidikalang, Balige, Tapanuli Utara and Karo.
6. West Sumatera (Sumbar): Padang, Padang Panjang, Lubuk Basung and Lubuk Sikaping.
7. South Sumatera (Sumsel): Palembang, Lahat, Belitang, OKI and Musirawas.
8. Riau: Bangkinang, Dumai, Lirik, Bagan Siapi-api and Bengkalis.
9. North Sulawesi (Sulut): Manado, Minahasa, Bolaang M, Gorontalo and Bitung.
10. South-East Sulawesi (Sultra): Kendari and Kolaka.
11. Central Sulawesi (Sulteng): Parigi, Kolonedale and Luwuk.
12. South Sulawesi (Sulsel): Enrekang, Bulukumba and Pinrang.

The above provinces and "kabupaten/kotamadya" were selected to be representative of the XQA activities conducted in the 27 provinces. The sample was purposively selected to make up a cross-section of provinces that represent the most significant differences among the QA sites. This include type of service covered (LTM or VS only); the three most populous islands (Java, Sumatera and Sulawesi); large, medium and small-sized provinces (e.g. West Java, South Sumatera and Central Sulawesi); provinces with large,

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<sup>1</sup> PILs are Project Implementation Letters that USAID uses to both approve and commit funds for project activities.

medium and small numbers of clinics (e.g. Central Java, North Sumatera and Southeast Sulawesi); and different types of provider sites (hospitals and health centers).

Together the twelve provinces selected account for 75% of the total population of Indonesia. They also include 75% of the 3,848 VS clinics in Indonesia and 75% of the 732 clinics in the XQA system. As the following chart shows, the sample is also representative of all of the dimensions mentioned above.

Province	Major island	Area (km <sup>2</sup> )	Population (million)	# Clinics (S,M,L)	# XQA Clinics	LTM/VS	Hospital & Hlth Cntr
West Java	Java	44,176	35.4	1,011	97	LTM	Yes
Central Java	Java	34,503	28.5	567	118	VS	Yes
Yogyakarta	Java	3,142	2.9	70	7	VS	Yes
East Java	Java	47,921	32.5	87	27	LTM	Yes
N. Sumatera	Sumatra	71,680	10.2	310	52	LTM	Yes
W. Sumatera	Sumatra	42,297	4.0	38	28	VS	Yes
S. Sumatera	Sumatra	109,254	6.3	206	25	VS	Yes
Riau	Sumatra	94,561	3.3	62	10	VS	Yes
N. Sulawesi	Sulawesi	25,786	2.5	48	20	VS	Yes
C. Sulawesi	Sulawesi	68,033	1.7	31	4	VS	Yes
S. Sulawesi	Sulawesi	62,482	7.0	132	57	VS	Yes
SE Sulawesi	Sulawesi	38,140	1.3	37	5	VS	Yes

Clinics were selected from lists prepared by PSG from records provided by PKMI. All meetings and clinic visits made under PILs 14 and 17 were listed for each of the 12 provinces. The calendar years 1993 and 1994 (January 1, 1993 through December 31, 1994) were selected as the sample period for two reasons. Calendar year 1994 was the most recent 12-month period for which complete data were available, and 1993 was selected because some of the sampled provinces had no activity in 1994.

Five of the most recently visited clinics were selected from each province. This was to increase the likelihood that the QA teams and the provider teams would still be available for interview and would still recall the clinic visits that were made by the QA teams. In some cases not enough visits had been made in the two-year period and sites visited in 1992 had to be selected. In a few cases (South, Central and Southeast Sulawesi) there were still not enough sites (five) visited in a province for the entire period. In those cases, only three sites could be visited. East Java was oversampled (10 sites) because it was said to have a unique system that warranted special study.

In most cases two hospitals and one health center were selected, and an attempt was made to select sites from different districts so that all three sites would not be clustered in the capital city.

### 3.2.2 *Sample respondents*

The target respondents of this study were selected to represent policymakers (provincial BKKBN, Depkes, & PKMI) service institutions (hospitals, health centers, clinics), XQA teams (XQA team leaders & members), and providers (VS/LTM doctors and nurses). Thus in each province the field investigators were to interview the following

group of respondents : (1) Kepala/Wakil BKKBN and Kepala/Wakil Depkes, (2) Kepala PKMI Propinsi, (3) Ketua Tim QA Propinsi, (4) 2-3 Anggauta Tim QA, (5) "Kepala Rumah Sakit/Klinik/PKM" and (6) "Tim Pelaksana MKET/KONTAP" (providers).

Overall the sample size of this study was 245 respondents. Description concerning the number of respondents for each group is as follows :

Province	Number of respondents for each group						Total
	(1)	(2)	(3)	(4)	(5)	(6)	
1. West Java	2	1	1	2	10	5	21
2. Central Java	2	1	1	3	10	5	22
3. Yogyakarta	2	1	1	2	8	5	19
4. East Java	2	1	1	2	19	10	35
5. North Sumatera	2	1	-	3	10	5	21
6. West Sumatera	2	-	-	-	10	5	17
7. South Sumatera	2	1	1	2	9	5	20
8. Riau	2	1	1	1	8	5	18
9. North Sulawesi	2	1	1	3	10	5	22
10. South-East Sulawesi	2	1	1	3	4	2	13
11. Central Sulawesi	2	1	1	3	5	3	15
12. South Sulawesi	2	1	1	3	6	3	16
<b>Total</b>	<b>24</b>	<b>11</b>	<b>10</b>	<b>27</b>	<b>109</b>	<b>58</b>	<b>239</b>

The total number of respondents who were interviewed was 239. However, 6 (six) of them, namely: 1 PKMI chief, 1 XQA team leader and 2 team members in West Sumatera; 1 XQA team leader in North Sumatera; and 1 XQA team member in Riau could not be interviewed for several reasons. Some of them were not willing to be interviewed, others were not available during the two-weeks of field data collection.

### 3.2.3 Field data gathering

The field data gathering was carried out through individual interview technique using questionnaires. Twelve types of questionnaires (six LTM questionnaires and six VS questionnaires) were prepared for this study.

The field data gathering activity was conducted simultaneously from the fourth week of April to the second week of May 1995. Eight data collection teams were formed, one each for East Java, West Java, Central Java and DI Yogyakarta, North Sumatera and West Sumatera, South Sumatera, Riau, North Sulawesi and Central Sulawesi, and South Sulawesi and South-East Sulawesi. each team consisted of one field coordinator from Jakarta (LPPKM) and 3 to 5 local interviewers (mostly lecturers and senior students of the local University). As mentioned previously, URC staff (Dr. Jack Reynolds and Ms. Nurfina Bachtiar) accompanied LPPKM to four provinces in Sulawesi. Almost all of the interviews were held by appointment in the respondents' office.

Simultaneously, PSG staff compiled the data on XQA team meetings, clinic visits and expenditures for the 12 provinces from PKMI central office records and receipts. This information was compiled for a 24-month period, from 1 January 1993 through 31 December 1994.

### **3.2.4 Data processing and draft report presentation**

The data processing (coding, data entry, tabulation and analyses) was conducted from the third week of May to the second week of June 1995. URC provided LPPKM with a plan of data analysis. The first draft report was completed and presented in a seminar held in BKKBN on June 16, 1995.

## **4. Limitations**

The evaluation focused on the XQA system as it functions in the field. There was no examination or evaluation of activities undertaken at the central level in support of these field activities, or in reaction to findings from the field. For example, training by PKMI central staff of team members in quality assurance was not examined. However, statistical data for all 27 provinces were provided by PKMI and were analyzed to develop an overall picture of field activities. This information was in addition to the 24-month sample of data on meetings, visits and costs that was also provided by PKMI.

The sample was purposively selected, as described in the methodology. That means that the provinces east of Java (Bali, NTB, etc.) were not included, nor were any provinces from Kalimantan included. These provinces are generally weaker, but there are exceptions, in Bali and NTB, for example.

BKKBN and Department of Health officials at the Kabupaten level were not interviewed. This was an oversight that should be corrected if an assessment of this kind is done again. That is because these officials feedback forms from the XQA teams and are in a more immediate position to take action and follow-up on team recommendations.

Quite a bit of supplementary and complementary data from the clinics are available, but were not compiled and analyzed. This includes, for example, information on the characteristics and experience of the team members, data on the number of VS acceptors, complications, failures, and so forth, which would provide a broader picture of VS activities in each province.

Cost estimates are only for the sampled provinces and only for field activities. Central and provincial administrative costs in support of the XQA program were not included. An upcoming study of the costs of VS, including PKMI activities, will provide an opportunity to estimate the overall monetary costs of the QA system.

In reviewing a draft of this report, PKMI identified a number of discrepancies between the survey findings and PKMI records, such as the number of team members in a province. These discrepancies were examined and explained to the extent that this was possible, given the limitations of the data. A few could not be resolved, for example, 60 percent of the team members said they always sent feedback to the providers, but only 27 percent of the providers said they had received feedback from the teams. These items can only be resolved through another survey or follow-up by PKMI. In general, however, these remaining discrepancies do not seem to be serious or significant enough to affect the general conclusions of the report.

## II. The External Quality Assurance System

The External Quality Assurance (XQA) system has been described in several PKMI publications, the most recent of which (1994) describes how both the internal and XQA systems are supposed to be carried out for the assessment of long-term method services.<sup>2</sup> The external system for VS is described in a 1992 PKMI publication and is identical.<sup>3</sup>

A special Provincial QA Team is supposed to be formed in each province, made up of representatives of agencies that are responsible for LTM or VS services. The target groups are all LTM or VS facilities in the province, including private practice doctors and midwives, hospitals and health centers. When the team is first formed it organizes itself and then an orientation program is set up by PKMI to familiarize the team members with the XQA process. Next, the team is supposed to conduct an inventory of all LTM or VS facilities in the province.

The team has three primary functions. The first is **monitoring**. The team members review monthly reports compiled by BKKBN which summarize any medical problems that occurred in the clinics, in particular, contraceptive side-effects, complications, failures, incomplete procedures and deaths. This information is reported for each contraceptive method as well as each clinic. Thus, the VS clinics report on vasectomies and tubectomies and the LTM clinics also report on IUD and implant problems.

**Evaluation** is the second function. The team holds periodic meetings to review the problems identified from the reports and to discuss recent visits made to clinics. Thus, the meetings provide an opportunity to identify specific clinics that need to be visited and to make an overall assessment of quality in the province.

**Improvement** is the third function. This might involve recommending a policy change or a procedure to be implemented throughout the province to deal with a common problem. But the major activity is a visit by one or more members of the team to clinics that have been identified as needing attention.

A special form has been designed to be used during these visits to make sure that all equipment, procedures, etc. are checked and reported (form F-III/Kontap for VS and F-IV/MKET for long-term methods). The form is 17 pages long and is divided into the following 11 sections:

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<sup>2</sup> Azrul Azwar. *Panduan program menjaga mutu pelayanan metoda kontrasepsi efektif terpilih*. PKMI, Jakarta, Januari 1994.

<sup>3</sup> Azrul Azwar. *Panduan program menjaga mutu pelayanan kontrasepsi mantap*. PKMI, Jakarta, Juli 1992

Figure 1: Summary of the clinic visit reporting form	
1. Clinic identifying information	Name, address, type clinic, type services offered, etc.
2. Personnel	Type of medical and non-medical staff, whether trained in VS/LTM, counseling, administration, etc.
3. Reception and registration	Condition of room/area and furniture, IEC material, registration cards, etc.
4. Counseling	Special room/area, condition, IEC materials, models, forms, etc.
5. Pre-service/Pre-operation	Examination room, condition, furnishings, equipment, history taking, physical exam, laboratory setup and equipment, etc.
6. Preparation	Changing room, condition, use of sterilizer/autoclave, etc.
7. Service/Operation	Operating room/service area, furnishings and equipment, anesthesia procedure, type anesthesia used, etc.; operating procedures (incision, sutures etc.), complications, deaths, number of procedures in last six months, etc.
8. Post-service/Post-operation	Recovery room/area, furnishings and equipment, record keeping, leaflet for client, recovery time, problems, etc.
9. Revisits	Number of revisits, time since operation/procedure, record keeping, etc.
10. Referrals	Referral facility in area, referrals made in last six months, etc.
11. Payment	Payment received, amount by type contraceptive, reimbursement from BKKBN, etc.

The team members are supposed to check medical records to make sure they are complete, check consent forms, observe how the counselor interacts with the client, how the doctor makes incisions, and so forth. The forms are written in checklist format and there is a space at the end of each section for listing of problems and suggestions. An example of one section, this one for LTM counseling, is reproduced on the next page.

**Figure 2: LTM counseling checklist**

IV. COUNSELING SERVICES		
	YES	NO
1. Is there a special room/area for counseling?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a model or visual aid that can be used for LTM counseling?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe: Counseling kit	<input type="checkbox"/>	<input type="checkbox"/>
Poster	<input type="checkbox"/>	<input type="checkbox"/>
Leaflet	<input type="checkbox"/>	<input type="checkbox"/>
Flipchart	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
3. Is LTM counseling given to all candidates and acceptors?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is LTM counseling given	<input type="checkbox"/>	<input type="checkbox"/>
Before the operation?	<input type="checkbox"/>	<input type="checkbox"/>
After the operation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the request and consent form for LTM services		
Filled out completely?	<input type="checkbox"/>	<input type="checkbox"/>
Stored properly?	<input type="checkbox"/>	<input type="checkbox"/>
6. Within the past six months has there been a problem in providing LTM counseling?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, clarify in the following space. .		
<b>PROBLEMS AND SUGGESTIONS REGARDING COUNSELING SERVICES</b>		

The team is also supposed to complete a feedback form and send it back to the clinic and to the local BKKBN and Health Department offices where the clinic is located. The form is used primarily to summarize problems identified during the clinic visit and to make recommendations for solving or preventing them in the future. An abbreviated version of the form is shown on the following page.

Finally, the XQA system also includes monthly reporting forms that the QA team is to send to the PKMI provincial and central offices. These reports summarize the status of LTM/VS activities in the province. The following information is to be provided:

1. Total number of LTM/VS facilities in the province
2. Total facilities reporting
3. Total facilities providing services
4. Total clients served by method
5. Total incomplete cases by method

6. Total side effects/complications
  - a) Minor complications by method
  - b) Major complications by method
7. Follow-up of side-effects/complications
  - a) Resolved by the client
  - b) Referred
8. Total failures
9. Total deaths (attach case fatality report)
10. Monitoring activities conducted (facility visited, date of visit, problems found, causes, prevention strategies)
11. Periodic meetings held (date, problems discussed, results discussed and suggestions for follow-up).

Figure 3: XQA feedback form

FEEDBACK FORM LTM QUALITY ASSURANCE		
ASPECT	PROBLEM	PREVENTION
1. Service Quality		
a) Minor Complications		
b) Major Complications		
c) Failures		
d) Incomplete Cases		
e) Deaths		
2. New Acceptors		
3. Facilities and Equipment		
4. Reporting and Recording		
5. Other		

### III. Findings of the Study

#### 1. Coverage of facilities<sup>4</sup>

According to the most recent figures from PKMI and BKKBN, there are 3,848 clinics in Indonesia that provide voluntary sterilization (VS) services. About 46 percent are in the four LTM experimental provinces. The other 54 percent are in the 23 "VS only" provinces.

Province	Total clinics	Total XQA clinics	Percent XQA clinics
LTM (4)	1,760	308	18%
VS (23)	2,088	424	20%
<b>Total (27)</b>	<b>3,848</b>	<b>732</b>	<b>19%</b>

As mentioned in the Background section, the XQA system originally covered all VS clinics, but was revised to cover only those with significant problems. Although the present system is not designed to cover all clinics, it is important to know how much of the service network is being covered by the XQA system at the moment. Table 1 shows the total number of clinics by category (LTM or VS only) and the number in the XQA system in Indonesian fiscal year (IFY) 1993/94 (April 1, 1993 through March 31, 1994). The Appendix provides the same data for each province. (See Table A 1.)

This table shows that the XQA system covers about 19 percent of the clinics, in both categories. However, coverage varies by province, from 74 percent in Sumbar and 62 percent in Bali to 7 percent in Maluku and Bengkulu. See Appendix A for details.

There is no obvious pattern for these differences. Coverage in the LTM provinces, for example, ranges from 17 to 62 percent. Coverage in the 8 largest provinces ranges from 9 to 62 percent. However, a regression analysis (see Table A-4 in the Appendix) shows that population size is a good predictor. In general, the larger the population of a province, the more clinics, coverage, clinic visits and costs. When the provinces are grouped by island the relationship is even stronger. That is, Java (with the largest total population) has significantly more clinics, XQA clinics and clinic visits than Sumatera, which has more than Sulawesi.

Table 2 shows the same data for the sample of 12 provinces. The total number of clinics in the sample provinces and the number of XQA clinics are in about the same

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<sup>4</sup> Please note that because these data come from different sources, they cover different time periods of 12, 17 and 24 months. The data for the 12-month period (4/93-3/94) for 27 provinces was compiled by Russel Vogel from BKKBN and PKMI data; the 17-month data (4/93-8/94) is taken from PKMI. "Laporan Hasil Pertemuan Evaluasi Program Menjaga Mutu Pelayanan VS dan LTM di 27 Province di Indonesia." Cisarua, 14-17 Oktober 1994; and the 24-month data (1/93-12/94) was compiled by PSG staff from receipts submitted to PKMI by the provincial teams.

proportion. That is, 19 percent of the clinics in the sample are in the XQA system. (See Tables A 2 - A 3 for basic statistics on the sample by province and island.)

Province	Total clinics	Total XQA clinics	Percent XQA clinics
LTM (3)	1,708	276	16%
VS (9)	1,191	274	23%
<b>Total (12)</b>	<b>2,899</b>	<b>550</b>	<b>19%</b>

## 2. Characteristics of the XQA team members

### 2.1. XQA team leader

#### a. Number of team members<sup>5</sup>

The survey data indicate that the majority of XQA teams (60 percent) have between 6 to 10 individual members. The rest had between 1 to 5 (20 percent), and 11-15 (20 percent). See Table A 3 for more comprehensive data.

Total members	LTM				VS										Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12			
1 - 5	-	-	X	0	-	1	X	-	-	-	1	-	-	25%	20%	
6 - 10	1	1	X	100%	-	-	X	-	1	1	-	1	1	50%	60%	
11-15	-	-	X	0	1	-	X	1	-	-	-	-	-	25%	20%	
X = No interview		1. Jabar			4. Jateng			7. Riau			10. Sulteng			N=10		
		2. Jatim			5. Yogya			8. Sumsel			11. Sulsel					
		3. Sumut			6. Sumbar			9. Sulut			12. Sultra					

#### b. The length of time served as XQA team leader

On the average, XQA team leader respondents have been in office for almost 4 years. However, one-fifth of them have already been in office for more than 4 years, and another one-fifth for less than 4 years (see Appendix Table A 5 for details).

#### c. Time expected to remain as XQA team leader

Team leaders are appointed for an indefinite period, and most (7 of 9 who responded) said that they did not know when they would be replaced or decide to retire from the position. One said that he expected to continue for another 1 to 3 months. Another said that his time as XQA team leader was finished (see Appendix Table A 6 for details.)

#### d. Training received in QA and/or supervision

Most XQA team leaders (80 percent) mentioned that they had received training on the XQA system, and 70 percent of them had also undertaken training on supervision (see Appendix Table A 7 for details).

<sup>5</sup> PKMI central records show somewhat higher numbers of members. This may be because the respondents reported on currently active members.

*e. Prior experience in XQA and/or supervision*

More than half (55 percent) of the XQA team leader respondents in these 12 provinces indicated that they had prior experience in QA and/or supervision (see Appendix Table A 8).

*f. Criteria for XQA team members*

According to XQA team leader respondents, there are several criteria that should be sought in a good XQA team member. The criteria most frequently mentioned by them are: 1) should be concerned with LTM/VS program services, 2) have an interest in the field of QA, 3) possess adequate capability (i.e., has undertaken QA and/or supervision program training), 4) have enough time to carry out the QA's work, 5) be expert in the field of ob/gyn, family planning and contraceptives, 6) be willing to cooperate with others, 7) be knowledgeable of socio-cultural issues and problems, 8) have a strong personality and 9) be highly dedicated.

**2.2 Members of XQA teams**

*a. The length of time served as members of the XQA team*

The largest percentage of the XQA team members (24 percent) had been on the team for 3 years. Those who have served as members for 2 to 4 years accounted for 20 percent of the respondents. Of the rest 12 percent have been members for less than 2 years and 12 percent have been on the team for more than 6 years (12 percent). See Table A 9 for more details on this.

*b. Time expected to remain as a member of the XQA team*

Most of the current members of the XQA teams (18, or 66.7 percent) had no idea how long they would remain a member. Three said from 1-12 months longer, three others said between 13-48 more months, and three said their time was already up (Table A 10).

*c. Training received in QA and/or supervision*

Training in QA had been received by 70 percent of the team members interviewed, while training on supervision had been received by 63 percent of them (see Table A 11).

Type training	LTM				VS										Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12			
QA	1	1	1	71%	3	1	X	1	1	1	2	3	2	70%	70%	
Super- vision	1	1	1	71%	2	1	X	-	2	2	2	3	-	60%	63%	
X = No interview		1. Jabar 2. Jatim 3. Sumut			4. Jateng 5. Yogya 6. Sumbar			7. Riau 8. Sumsel 9. Sulut			10. Sulteng 11. Sulsel 12. Sultra			N=27		

*d. Experience in QA and/or supervision*

Slightly over half of the team members said that they had prior experience in XQA and supervision (see Table A 12).

### 2.3 Conclusions

The XQA team leaders and team members appear to be well-qualified and experienced in both quality assurance and supervision. The majority have spent several years working in the XQA system. The fact that they are volunteers and that most have not even thought about dropping out of the system is a good indication of their commitment and dedication to quality assurance.

## 3. VS/LTM service statistic reports

As noted previously, the teams are supposed to review monthly reports of VS/LTM clinic activities. They need these reports to: 1) keep track of problems and trends in complications, failures, etc.; and 2) to identify clinics that should be visited.

### 3.1 Types of reports received

About 70-90 percent of the PKMI chiefs and XQA team leaders in the 12 sample provinces said that they received three types of reports. They were: (1) F-II/KB (monthly VS clinic report), (2) F-II/MKET-KONTAP (LTM medical case problem report), and (3) F-III/MKET-KONTAP (summary of LTM achievement and problems encountered).

Out of 11 PKMI chiefs interviewed:

- 8 received FII/KB reports<sup>6</sup>
- 7 received FII medical case problem reports
- 8 received FIII/MKET-KONTAP reports

Out of 10 XQA team leaders interviewed:

- 9 received FII/KB reports
- 8 received both FII medical case problem reports and FIII/MKET-KONTAP reports. See Tables A 13 and A 14 for more details.

### 3.2 Clinics not reporting

About 90 percent of the PKMI chief and XQA team leaders reported that some of the clinics have never made nor submitted any of these reports. Only one province reported that all clinics submitted such reports (Tables A 15 and 16). Although the exact number of non-reporting clinics is not known, the 1994 PKMI evaluation indicated that reporting was

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<sup>6</sup> PKMI believes that this may be in error because the procedures call for these reports to be sent to BKKBN, where they are summarized in FIII/MKET-KONTAP reports and then sent to PKMI. However, it is possible that some PKMI provincial have made arrangements to obtain the reports directly. This discrepancy was not followed up and remains unresolved.

quite high for LTM clinics (about 84 percent) but quite low (about 36 percent) for VS clinics.<sup>7</sup>

### 3.3 Reasons for failing to report

“Terlalu sibuk” (too busy) was the most frequently mentioned reason for failing to submit QA activity reports. Between 40 to 45 percent of PKMI chief and XQA team leaders mentioned this as the reason why the clinics failed to make such reports. “Waktu terlalu sempit” (the time was too short) and “tidak lagi menawarkan MKET-KONTAP” (did not offer MKET-KONTAP services anymore) were the second most mentioned reasons (9 to 10 percent).

### 3.4 Evaluation of the accuracy and completeness of the reports

The XQA team leaders were asked to rate the F-II/KB reports in terms of accuracy and completeness. Forty percent found the reports satisfactory on both criteria. Only 10 percent thought the reports unsatisfactory in terms of accuracy, and 30 percent thought them unsatisfactory in terms of completeness. A large number of respondents didn't answer (40 percent and 30 percent respectively). The responses were practically the same for the assessment of the FIII/MKET-KONTAP report.

A different picture appeared when they were asked about their evaluation of the FII/MKET-KONTAP reports. Only 16 percent and 27 percent said the reports were satisfactory in terms of accuracy and completeness, respectively. The figures were 11 percent and 5 percent unsatisfactory. Again, 33 percent did not answer the accuracy question and 23 percent did not answer the completeness question. (See Tables A 17, 18, and 19).

The respondents had a variety of suggestions for improving the reporting: increase supervision, add personnel, conduct the clinic visits at the same time as monitoring, simplify the reporting forms provide an incentive, increase the funds, provide orientation/training for the workers, provide informal QA, and increase coordination.

### 3.5 Conclusions

Although reporting is high for the LTM clinics and fairly high for the VS clinics, only a minority of the QA team leaders (16-40 percent) were willing to say that they thought the reports were satisfactory in terms of accuracy and completeness. Although a large proportion (23-40 percent) did not respond, that includes those who were not familiar enough with the report to have an opinion. That in itself is an indicator of the low value some of these respondents place on the reports. In addition, the information provided in the reports is limited to summaries of activities (especially new acceptors) and “outcome”

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<sup>7</sup> PKMI. “Laporan Hasil Pertemuan Evaluasi Program Menjaga Mutu Pelayanan VS dan LTM di 27 Province di Indonesia.” Cisarua, 14-17 Oktober 1994.

problems (complications, incomplete procedures, failures, etc.). The reports do not provide any information on the qualitative aspects of the service program (for example, the counseling process, the procedures followed in performing an operation, post-op recovery, and so forth).

This assessment of the value of the reports may reflect clinic values as well. It appears that many of the clinics do not view the reports as particularly important, especially given all of the other tasks they have to carry out. Clinics that do not provide VS services probably see no reason to spend the time on these reports.

#### 4. Periodic meetings

Ideally, the periodic meetings are supposed to be held every month. During these meetings the teams are supposed to review the reports mentioned above (F-II, F-III), discuss trends and problems identified in the reports, identify possible solutions to common problems that emerge, and identify clinics that seem to be having serious problems (high IUD complication rates, for example) and which may need to be visited by the team.

##### 4.1 Meetings planned and held nationwide

Each year PKMI prepares a budget that finances periodic meetings, clinic visits and operational costs. That budget identifies the number of meetings and visits planned for each province for the year. Although we do not have data on the plans for IFY 93/94, we do have a 1994 evaluation report covering a 17-month period (April 1993 - August 1994).<sup>8</sup> This report shows that 10 meetings were planned during that period for each province, but as Table 5 shows, only about 2/3 of the meetings planned were held. The LTM provinces held proportionately more meetings than the VS provinces. There were significant variations by province, ranging from a high of 18 in Bali and NTB to 0 in Riau, TimTim, Maluku and Irian Jaya (see Appendix, Table A 1).

Province	Planned	Conducted	Percent
LTM(4)	40	53	132.5%
VS (23)	230	120	52.2%
Total (27)	270	173	64.1%

##### 4.2 Meetings held in the 12 sample provinces

The data from our sample of 12 clinics show that 165 meetings were held over the two-year period under study and that again, the LTM provinces held proportionately more meetings. Although we do not have data on the number of meetings planned, the pattern is similar. The LTM provinces averaged 18 meetings each and the VS provinces 12. North Sumatera (23) and South Sumatera (22) had the most meetings, and Central Sulawesi (3) the least.

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<sup>8</sup> Ibid.

Province	Total	Percent	Meetings/mo.
LTM (4)	54	32.7%	0.8
VS (9)	111	67.3%	0.5
Total (12)	165	100.0%	0.6

Please recall that this data is for a two-year period. The frequency of the meetings ranged from 0.1 (Central Sulawesi) to 1.0 per month (North Sumatera). On the average, each province held about one

meeting every two months.

#### **4.3 Meetings attended by XQA team leaders and members in the last 12 months**

Almost all PKMI chief and XQA team leaders attended the periodic meetings held within the last twelve months. Only one out of the 11 PKMI chiefs mentioned that he had never attended a periodic meeting. Two of the respondents reported that they had attended between 11 to 12 meetings within the last 12 months. On the average, however, the respondents had attended 6.7 meetings (see Table A 20).

Similar attendance is also found among the XQA team leaders. Out of the 10 XQA team leaders, only one said that he had not attended any of the periodic meetings during the last 12 months, whereas two had attended 11 to 12 meetings. The average frequency of attendance among XQA team leaders was six (Table A 21).

The frequency of attendance among members of the XQA team was slightly lower than that of PKMI chiefs and of XQA team leaders. On the average, members of the XQA team only attended four of the meetings which were held within the last 12 months (Table A 22).

The reasons most frequently mentioned by those who were unable to attend the meeting were 'too busy' or they were 'not at the site.'

#### **4.4 The perceived benefits of the periodic meetings**

The majority (51 percent) of PKMI chief, XQA team leader and XQA team member respondents perceived the periodic meetings as being highly beneficial for them. About 40 percent of them regarded the meeting as being somewhat beneficial ("lumayan bermanfaat"), whereas the remaining 9 percent did not answer (Table A 25). No one said the meetings were of little value. The LTM province respondents were especially positive about the meetings. Eight out of 11 (73 percent) said the meetings were highly beneficial (see Table A-23). The XQA team leaders and members said that the meetings helped them to identify problems, find solutions, plan their activities and strengthen relations among the team members. The meetings also provided a chance to get feedback on clinic visits that had been made, and to gain experience. However, sometimes the reports weren't available or all of the members couldn't attend. And not all of the problems raised at the meetings could be discussed and solved. That affected the value of the meetings.

#### **4.5 The perceived purposes of the meeting**

'To discuss the visit results' was the most frequently mentioned purpose of the periodic meetings; about 60 percent of PKMI chief, XQA team leader and member respondents said so. 'To select which clinics to be visited' was mentioned by 54 percent

of the respondents, followed by “to improve activities,” that was mentioned by approximately 31 percent of the respondents. The least frequently mentioned purpose of the meeting was ‘to solve problems’ and ‘to plan program activities;’ both reasons were mentioned by only 18.7 percent and 8.3 percent of the respondents respectively (Table A 24).

#### 4.6 Strengths, weaknesses and suggestions

The respondents were asked to identify the strengths and weaknesses of the meetings and for their suggestions for improving them. Among the strengths:

1. Increases the control team members have, since many activities are still not being carried out as they should be
2. Several institutions are involved in the XQA system (improves coordination and increases mutual understanding)
3. Increases knowledge about the problems in the field, as well as monitoring of VS/LTM activities and problems
4. Helps the team anticipate problems or possible ones that might come up, such as contracting AIDS
5. It's a good vehicle for consolidating the special expertise of the different members
6. It's a means for making contacts and learning about different capabilities
7. Good for providing a complete understanding of the elements and framework of QA

Among the weaknesses:

1. There's no follow-up
2. The major problems that patients have aren't discussed
3. The team members are too busy (to attend)
4. There's no medical specialist to talk to about the medical problems found in the clinics/field so the results of the meetings are less than optimal
5. Intersectoral coordination is unsatisfactory
6. It just becomes an arena for chatting
7. Often staff are delegated to attend the meetings who don't understand QA problems
8. The meetings aren't held routinely
9. The meetings just deal with routine activities
10. The same things are discussed over and over

There were a number of suggestions made by the respondents.

1. Objectives of the meetings: focus again on improving service quality; the general and specific objectives need to be periodically reordered clearly; the meetings should improve the quality of the team; discuss subjects that are important and necessary for the QA program; discuss items and feedback

that come from the central level; find a way to ensure that the clinics report and are kept under control.

2. Frequency of meetings: suggestions varied from holding them monthly, bimonthly, trimonthly, semiannually, to annually.
3. Procedures: Need written authorization (mandate) from the various institutions; better control of the schedule; each member should bring things from the field so that the priority problems can be identified and discussed in depth.
4. Results: Be able to tackle the most pressing problems and improve weaknesses; need an effort to reach the same perception/agreement on the problems that are identified.
5. Other: Need financial support; eventually have a meeting of all the clinics that have problems; involve the important outside (views) in the meetings.

#### 4.6 Conclusions

The available data indicate that most of the LTM provinces in the XQA system conducted more meetings than planned and that most of the VS provinces conducted fewer. On average the LTM provinces in our sample held one meeting every month and one-half. The VS provinces held one every two months. Interviews with the PKMI and XQA team leaders supported this figure. Team members only averaged one meeting every three months. As expected, the reasons were that they were too busy or were out of town at the time.

### 5. Clinic visits

#### 5.1 Awareness of the XQA team

Most (75 percent) of the 133 BKKBN chiefs and clinic/hospital chiefs in the 12 provinces studied were aware of the existence of the XQA Teams. Awareness was 100 percent in North Sumatera, Central Java, Yogya and North Sulawesi. Awareness was also 100 percent among BKKBN officials, and only one Depkes official did not know about the teams. Awareness was lowest among the hospital and clinic chiefs, but still relatively high. About 15-20 percent did not know about the teams.

Answer	LTM				VS										Sub-total	Total
	1	2	3	Sub Total	4	5	6	7	8	9	10	11	12			
Yes	7	8	12	60%	12	10	11	7	6	12	3	7	5	83%	75%	
No	2	3	-	11%	-	-	1	3	3	-	4	-	1	14%	13%	
No answer	3	10	-	29%	-	-	-	-	2	-	-	1	-	3.5%	12%	
1. Jabar                      4. Jateng                      7. Riau                      10. Sulteng                      N=133 2. Jatim                      5. Yogya                      8. Sumsel                      11. Sulsel 3. Sumut                      6. Sumbar                      9. Sulut                      12. Sultra																

## 5.2 Awareness of the XQA team visits to clinics

Awareness of the clinic visits was somewhat lower (65 percent), but 100 percent in the four provinces mentioned above. Awareness was notably low in three provinces: West Java, South Sumatera and Central Sulawesi. It should be noted that 22 percent did not respond, which could reflect additional lack of awareness. Again, awareness varied by position, with BKKBN and Depkes officials more aware than the facility chiefs.

Answer	LTM				VS										Sub-total	Total
	1	2	3	Sub total	4	5	6	7	8	9	10	11	12			
Yes	2	4	12	40%	12	10	9	7	4	12	2	7	5	77%	65%	
No	5	2	-	16%	-	-	2	-	4	-	4	-	1	13%	14%	
No answer	5	15	-	44%	-	-	1	3	3	-	1	1	-	10%	22%	
X = No response		1 Jabar			4. Jateng			7. Riau			10. Sulteng			N=133		
		2. Jatim			5. Yogya			8. Sumsel			11. Sulsel					
		3. Sumut			6. Sumbar			9. Sulut			12. Sultra					

## 5.3 Knowledge of the purpose of clinic visits

All of the respondents were asked about the purpose of clinic visits. Most of the 239 respondents mentioned that they knew the purposes of the clinic visits. The majority (55 percent) said the main purpose was to improve services, and the rest (36 percent) said it was to identify the cause of side-effects.

Purpose	LTM				VS										Sub Total	Total
	1	2	3	Sub Total	4	5	6	7	8	9	10	11	12			
Improve services	1	3	17	27%	19	19	11	9	6	20	9	9	9	69%	55%	
Detect cause of side-effects	6	4	14	31%	7	8	6	4	5	14	7	4	8	39%	36%	
		1. Jabar			4. Jateng			7. Riau			10. Sulteng			N=239		
		2. Jatim			5. Yogya			8. Sumsel			11. Sulsel					
		3. Sumut			6. Sumbar			9. Sulut			12. Sultra					

Some of the team leaders admitted that they sometimes made visits to clinics for additional purposes: 1) if there is a serious problem, such as a failure or major complication; 2) when there is a training program to be carried out in the area; 3) when the clinic hasn't submitted reports and needs to be followed-up; 4) to check the data reported if there is an indication that it may be seriously wrong; and 5) when they have heard about a complaint and need to find a way to deal with it.

#### 5.4 Clinics visited by XQA teams

The 1994 evaluation report cited above also listed the number of clinic visits planned for the 17-month period covered by the report. As Table 10 shows, practically all of the 212 visits planned were carried out. But the LTM provinces conducted proportionately more than the VS provinces, averaging 23 compared to 12. East Java and Central Java had the highest targets (25 visits each) and the highest achievement (35 and 28 respectively). At the other extreme, Malukus and Irian Jaya had no visits planned and didn't carry any out. On average, each province carried out 7.5 visits during the 17-month period, or a little over 5 per year. LTM provinces averaged almost 16 per year and VS provinces a little over 3.

Province	Planned	Conducted	Percent
LTM (4)	59	90	152.5
VS (23)	153	112	73.2
Total (27)	212	202	95.3

As we saw from Table 1, 19 percent of the clinics are theoretically "covered" by the XQA system. But only a portion of those clinics are visited by XQA teams each year. Again, the program as designed does not expect all clinics to be visited, but since this system is a candidate for expansion nationwide, it is important to know the proportion of the total currently being visited. Table 11 shows data for IFY 1993/1994. Only 26 percent of the clinics in the XQA system were visited during the year. Overall, only 5 percent of all of the 3,848 clinics were visited.

There was also a significant variation by province. The percent of XQA clinics visited in the four LTM provinces was 131 percent (Bali), 28 percent (East Java), 19 percent (North Sumatera), and 3 percent (West Java). Bali's figure of 131 percent means that XQA teams there actually visited about 1/3 of the XQA clinics twice in the year.

Province	Total visits	Percent of all clinics visited	Percent of XQA visited
LTM (4)	90	5%	29%
VS (23)	115	6%	25%
Total (27)	205	5%	26%

In the VS provinces the percent of XQA clinics visited ranged from 0 percent in four provinces (Riau, Maluku, Irian Jaya and TimTim) to 80 percent in Southeast Sulawesi and around 60 percent in four other provinces (South Sumatera, NTB, NTT, and

Jambi). See the appendix, Table A 1 for details on all provinces.

The sample data from the 12 provinces are summarized in Table 12. They show that over a two-year period the teams had only been able to visit about 1/3 of the XQA clinics (34.5 percent). Proportionately more visits were made to VS clinics than LTM clinics in these 12 provinces during this two-year period. Again, there were significant differences by province. The largest number of visits were made by Central Java (40) and East Java (38), and the lowest by Central Sulawesi (1),

Province	Total visits	Percent of all clinics visited	Percent of XQA visited
LTM (3)	75	4.4%	27.2%
VS (9)	115	9.7%	42.0%
Total (12)	190	6.6%	34.5%

Southeast Sulawesi (2), South Sulawesi (3) and Riau (4).

In terms of the proportion of clinics visited, Yogya (186 percent) and North Sulawesi (115 percent) were the highest. South Sulawesi (5 percent) was the lowest (see Table A 2).

### 5.5 Frequency of visits

This leads to a question about the frequency of the clinic visits. The national level data for all 27 provinces for 1993/1994 show that there were only 205 visits made throughout the year. That averages out to 8 per province, 17 per month, and less than 1 (0.6) visits per province per month. The frequency was much higher in the LTM provinces, averaging over 22 visits per year for the each of four provinces and almost 2 visits per month per province. In contrast, the other 23 provinces averaged one visit every 2 ½ months.

Province	Total visits	Visits per province	Visits per month	Visits per month/province
LTM (4)	90	22.5	7.5	1.9
VS (23)	115	5	9.6	0.4
Total (27)	205	7.6	17	0.6

The XQA evaluation sample of 12 provinces covered two years, as mentioned above. Table 14 shows that the overall frequency of visits per province per month is similar to the national level data for one year (0.7 vs. 0.6). The frequency for VS clinics is about the same as well (0.5 vs. 0.4). However, the frequency of visits in the LTM provinces is about half of what it was nationally for one year (0.8 vs. 1.9). See Table A 2 for details.

Province	Total visits	Visits per province	Visits per month	Visits per month/province
LTM (4)	75	25	3.1	0.8
VS (23)	115	12.8	4.8	0.5
Total (27)	190	15.8	7.9	0.7

Although some provinces are much more active than others (Bali, East Java and Central Java, in that order), most of the provinces are making very few clinic visits. If the top three provinces are left out, only 100 visits were made in IFY 1993/1994 by the other 24 provinces. That's about one visit every three months by each provincial team. At this rate, it would take these teams 4.5 years to visit each XQA clinic just once, and 28 years to visit all of the VS clinics in their provinces once.

### 5.6 Clinic visits made within the last 12 months by XQA teams surveyed

On average, XQA team leaders interviewed said that they had made three clinic visits during the last 12 months. Those who visited clinics one to three times accounted for 40 percent, those who made clinic visits four to six times also 40 percent. Those who never

made a visit was only 10 percent. The most frequent traveler was from South Sumatera, with 8 visits in 12 months.

Frequency	LTM				VS										Total
	1	2	3	sub-total	4	5	6	7	8	9	10	11	12	sub-total	
Never	-	-	X	0	-	-	X	-	-	-	-	1	-	13%	10%
1 time	-	-	X	0	-	-	X	-	-	-	-	-	-	0	0
2 times	-	-	X	0	-	1	X	-	-	1	1	-	-	38%	30%
3 times	-	-	X	0	-	-	X	1	-	-	-	-	-	13%	10%
4 times	1	1	X	100	-	-	X	-	-	-	-	-	1	13%	30%
5 times	-	-	X	0	-	-	X	-	-	-	-	-	-	0	0
6 times	-	-	X	0	-	-	X	-	1	-	-	-	-	13%	10%
DK/NR	-	-	X	0	1	-	X	-	-	-	-	-	-	13%	10%
X = No interview		1. Jabar		4. Jateng		7. Riau		10. Sulteng		N=10					
DK = Don't know		2. Jatim		5. Yogya		8. Sumsel		11. Sulsel							
NR = No response		3. Sumut		6. Sumbar		9. Sulut		12. Sultra							

On average, the XQA team members visited clinics only twice. About one-fifth of them (22 percent) admitted that they had never made a visit. Those who made visits one to three times accounted for 45 percent, while those who made four to six made up 26 percent.

Frequency	LTM				VS										Total
	1	2	3	sub-total	4	5	6	7	8	9	10	11	12	sub-total	
Never	-	1	1	29%	-	1	X	-	-	-	-	2	1	20%	22%
1 time	1	-	-	14%	-	-	X	-	-	1	1	-	-	10%	11%
2 times	-	-	-	0	1	1	X	-	2	1	1	-	1	35%	26%
3 times	-	-	-	0	-	-	X	1	-	1	-	-	-	10%	7%
4 times	-	-	-	0	-	-	X	-	-	-	1	-	1	10%	7%
5 times	1	1	1	42%	-	-	X	-	-	-	-	-	-	0	11%
6 times	-	-	1	14%	1	-	X	-	-	-	-	-	-	5%	7%
DK/NR	-	-	-	0	1	-	X	-	-	-	-	1	-	5%	4%
X = No interview		1. Jabar		4. Jateng		7. Riau		10. Sulteng		N=19					
DK = Don't know		2. Jatim		5. Yogya		8. Sumsel		11. Sulsel							
NR = No response		3. Sumut		6. Sumbar		9. Sulut		12. Sultra							

The providers and service institution chiefs were asked the same question. More than one-third of the providers reported that they were never visited by the XQA team during the last 12 months. Please recall that all of the clinics in the sample had been reported as having been visited within the past 24 months. Some had not been visited in the past year. So these provider perceptions are consistent with the data reported by the XQA teams and the service statistics. Some 34 percent said they were visited once, another 31 percent were visited 2-3 times. The overall average for all the clinics sampled was 1 visit made by the team during the previous 12 months. One MKET clinic in North Sumatera claims to have been visited 6 times over the past year. This could be a

**Table 17: Provider recollection of the frequency of visits by the XQA team to clinics within the past 12 months**

Frequency	LTM				VS										Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12	Sub-total	
Never	5	9	-	70%	-	-	1	2	2	-	2	-	-	18%	36%
1 time	-	1	1	10%	3	5	-	2	2	3	-	3	-	47%	34%
2 times	-	-	3	15%	2	-	1	1	-	1	1	-	-	15%	15%
3 times	-	-	-	0	-	-	1	-	1	1	-	-	1	10%	6%
4 times	-	-	-	0	-	-	-	-	-	-	-	-	1	2%	1%
5 times	-	-	-	0	-	-	2	-	-	-	-	-	-	5%	3%
6 times	-	-	1	5%	-	-	-	-	-	-	-	-	-	0%	1%
DK/NR				0		-								0	0
				1. Jabar	4. Jateng			7. Riau			10. Sulteng			N=37	
DK = Don't know				2. Jatim	5. Yogya			8. Sumsel			11. Sulsel				
X = No response				3. Sumut	6. Sumbar			9. Sulut			12. Sultra				

misunderstanding since this provider didn't distinguish between an XQA visit and PKMI visits for other purposes (e.g., in connection with the SDES project, the RAM center, and so forth).

Among the service institution chiefs, about 60 percent said that there had been a team visit within the last 12 months, 16 percent said there had not and the rest (26 percent) didn't know. That is consistent with the provider perspectives.

The XQA team leaders were asked if they made their visits alone or with other team members. Only 26 percent of the visits were made alone, another 22 percent were made with one other member, and the majority (66 percent) were made by a full team of three. The team members tended to make more visits alone (40 percent), as many with two other members (43 percent) and few with just one other member (8 percent).

Two of the respondents explained that it is easier to get access to the clinics when a full team goes because the team usually includes members from BKKBN and Depkes, who have the contacts in the local area. Another respondent noted that the visit is more productive, more complete when there are two or three members. If there is only one team member and that person is not a physician, then all of the medical aspects cannot be assessed. In addition, the providers are more likely to pay attention if a physician is present, and especially if more than one team member is there. Having representatives from all three institutions also ensures that all three have input to the assessment and that the same findings are taken back to their institutions.

It isn't always possible for a full team to go out, however, because sometimes the money for travel hasn't been received or there isn't enough in the budget for a full team. Sometimes the team leader doesn't go because he or she wants to give another member an opportunity to get some experience, or limits his or her visits to clinics that have serious problems, such as a failure or major complication.

### 5.7 Reporting form used during the clinic visits

Almost all XQA team leaders (7 out of 9, or 78 percent) said that they had used all 11 sections of the Clinic Visit Report Form when they made XQA visits. The chief from South Sumatera didn't use one of the sections, on payment. The respondent from Riau province said that only two sections were used (Counseling and Post-operation). (See Table A 25).

Most of the XQA team members (14 out of 20, or 70 percent) also said they used all of the sections. Usage of individual sections varied, but ranged from 79-95 percent. The section used least (79 percent) was pre-operation/pre-service. See Table A 26 for details.

Providers who reported that they had been visited by an XQA team in the last 12 months were asked which sections the team used. Again, most of the teams were seen to use most of the sections. The least used section was the one dealing with payment. Overall, usage ranged from 65-86 percent. (Table A 27)

The respondents were asked to evaluate each section of the form that was used during the clinic visit, especially whether they were appropriate/precise enough and complete enough. The team leaders who responded generally thought the sections were fine. There were some complaints that they were unnecessarily repetitive in parts (e.g., the same questions about equipment in several sections) and too detailed. One noted that it was not possible to fill out a number of the sections that involve patients until after they had left, which made them inefficient.

The team members had roughly the same assessments. The majority of the team members who made visits thought the form was adequate. Although, they were less satisfied with the appropriateness (average 60 percent) than the completeness (83 percent) of the form.

Respondent	Appropriate	Complete
Team leaders (N=8)	50%	97%
Team members (N=19)	60%	83%
Providers (N=37)	44%	39%

The providers were less impressed with both the appropriateness and the completeness of the assessment procedures (44 and 39 percent, respectively). See Table 18.

### 5.8 Data collection methods used in clinic visits

The evaluation was especially interested in whether the XQA teams were able to observe the providers actually carrying out their services. The XQA team leaders and

members who made clinic visits and the providers they visited were asked to identify the data collection methods used for five key service tasks. The results are shown in Table 19.

Interviews with the providers was the most common data collection procedure in most cases, followed by review of documents and records, and then direct observation. Still, the degree to which

Method	Interview	Observation	Documents
Counseling	85%	48%	61%
Preservice/operation	73%	57%	60%
Preparation	78%	67%	61%
Service/operation	76%	70%	63%
Postservice/operation	73%	55%	79%

observation could be used, especially in preparation of the patient and the actual operation, was very high (67 percent and 70 percent respectively (see Tables A 28-32).

### 5.9 Strengths, weaknesses and suggestions

Many of the people interviewed didn't respond to the questions about the strengths and weaknesses of the visits, and had no suggestions. In quite a few cases this was because they were generally satisfied with the clinic visits as they are. However, the providers and chiefs of hospitals and health centers appear to have a different perspective. Very few of them had any comments, which may reflect a lack of interest in the system. The few who did respond said that the visits can help improve services, but they are too infrequent and communication is unsatisfactory.

The team leaders and members had some thoughts about the strengths and weaknesses of the clinic visits. Being able to visit the operational units to see for themselves the reality of the condition of the clinics, how they operated, and to be able to discuss such things with the providers directly was the most valuable characteristic of the system. Having the opportunity to provide advice, be creative in problem-solving, and to help to improve the quality of services was also a strength mentioned. Getting accurate, valid information was another strength ("the providers can't lie"). The visits make the clinic staff pay attention and encourage them to make improvements in services. The intersectoral composition of the team was often mentioned as a strength.

Among the weaknesses mentioned were the burden the visits place on the clinic staff, who are forced to accommodate the team, the lack of interest in the visits at some clinics visited, and the inability at times of the team to help the clinic staff solve some of their problems. Other weaknesses mentioned: sometimes the clinic doctor isn't there or is too busy and can't be interviewed; if visits are made too frequently it tires out the clinic staff; the team visit can disrupt clinic activities and services. One provider pointed out a common problem, which is that they do not always know when the teams are coming. Several team members and leaders pointed out that there is not enough time to do a thorough job, and that sometimes there are no patients, so it is not possible to observe service procedures. Another typical weakness is that the monthly reports are not always sent to the team beforehand, and when the team arrives at the clinic it is sometimes difficult to find the data they need to examine.

Many of the respondents said that the system is fine as it is, and had no suggestions. However, there were a few worthy of mentioning:

1. Objectives. "Focus on improving the quality of services," was mentioned several times, implying that the current focus was on something else in their provinces. Several respondents suggested a different focus, to improve the skills of the clinic staff, often through on-the-spot training.
2. Frequency of visits. There was no consensus on this. In fact there was a split between those who thought there were too few visits (make one every 1, 2, 3, 4 months, and "the more the better") and those who felt there were too many visits (once per year, only when urgent).
3. Schedule. Several members believe that there should be fixed schedules for visits, rather than the current approach, which they saw as ad hoc, episodic, and/or reactive.
4. Content. A few suggested other tasks for the teams: look into patient complaints; provide training; look into broken VS equipment.

## 5.10 Conclusions

Most of the provincial family planning leaders are aware of the XQA teams and their purpose of the clinic visits. They are not as well informed about their current activities, however, possibly because most of them do not receive reports of XQA activities. The number of clinic visits made by the teams is modest, averaging about one visit every two months. Over the two-year study period only about one-quarter of the XQA clinics were visited once, and only 5 percent of all VS clinics in the country were visited once. But there are wide variations by province, with some, like Central Java, making a large number of visits (20/year) and others like Central Sulawesi, making very few (1 in two years). Lack of funds and slow disbursement procedures are two reasons for the low number of visits. But just as important is the lack of time on the part of the XQA team members.

When they do visit the clinics most of the teams do a thorough job. Most use all 11 sections of the clinic visit form and do not rely only on records and interviews, but they also observe clinical procedures. Many of the respondents think that the clinic visits are really valuable. The lack of time and money to make more visits was the major constraint identified. However, the XQA team leaders and members seem to see more value in the visits than the providers who are visited.

## 6. Feedback

### 6.1 Submission of feedback reports by XQA team

After the clinic visit is completed, the XQA team is supposed to fill out and submit copies of the feedback form to the clinic and the district BKKBN and Health Department offices. In some provinces the forms may also be sent to other offices. The XQA team leader and members were asked if feedback reports were sent to the clinics, and if so to whom and when.

Six of the 10 team leaders responded that feedback was always sent, and 4 said it was sometimes sent. Feedback was usually sent immediately after the visit was completed or within four weeks. Of the 23 team members who responded, 14 (61 percent) said

feedback was always sent, 4 (17 percent) said sometimes, and 5 (22 percent) said it was not sent. Another four respondents didn't answer. Of the 18 who did send feedback, 7 (39 percent) sent it immediately, 9 (50 percent) sent it within 2-4 weeks, and 2 (11 percent) didn't respond.

Several of the team leaders didn't see any need to send feedback to the clinics: "not our job, no instructions to do that." Some said that there's no need to send a written report if feedback is given on the spot. Another said it's not necessary if there are no problems. A number of the members agreed. Several thought it was PKMI's job to provide feedback to the clinics. Only one, by the way, said that feedback wasn't given because it was too sensitive.

The reports seem to be sent to a variety of offices, and not always to the provider teams. Also, the team members and team leaders do not always agree on where the reports are (or should be) sent. Only three of the team leaders said the reports went to the providers. West Java said it sent the report to the PKMI chapter; East Java sent copies to the hospital/clinic and BKKBN provincial office; Central Java sent copies to the provider, the hospital/clinic, PKMI province and BKKBN province. North Sulawesi sent one copy out only, to PKMI central. The XQA team members said that the reports were sent to the chief of the hospital/clinic (56 percent) or to the provider team directly (44 percent). Some sent the report to both. The North Sumatera team members did not send their reports to the clinic directly, but to the PKMI chapter or the district BKKBN office. North Sulawesi sent its report to the provider team and the BKKBN district office. Three other members from South Sulawesi and Southeast Sulawesi sent copies to the PKMI office (see Tables A 33-36).

Only 1/2 of the team leaders said that they used the feedback forms. A few said it wasn't part of their packet. Several thought it would be better to provide feedback right away, while still at the clinic, so the form wasn't necessary in that case. The team members were more likely to use the form and to be satisfied with it.

They were also more positive about the reactions of the clinic staff to the feedback. All but one who provided feedback said that it was well-received. Only one of the team leaders thought that the feedback was well-received. Others thought it varied, depending on the clinic personnel and the situation. Sometimes there wasn't enough time to go into enough detail with the staff. Some clinic staff don't pay attention to the team and aren't interested or motivated to listen to them.

## **6.2 Receipt of the feedback reports by BKKBN, Depkes, PKMI and hospital/health center chiefs**

The chiefs (BKKBN, Depkes, PKMI, hospital, health center and clinics) were asked if they knew if feedback reports were sent by the XQA teams to the clinics. They were also asked if they received copies, and if so, whether they found the forms accurate, complete and clear.

Almost  $\frac{2}{3}$  (64 percent) of the PKMI chiefs thought that the reports were sent to the clinics, but only a minority of the other chiefs thought that: BKKBN/Depkes = 38 percent and hospital/health center = 17 percent. Most of the respondents did not receive copies of

the feedback (BKKBN/Depkes = 33 percent, and hospital/health center = 15 percent), except for the PKMI chiefs (67 percent). Some didn't even know that there was supposed to be feedback. (See Table A 37.)

Those who did receive feedback were evenly split about their assessment of its value. As Table 20 shows, most said the feedback was highly valuable or adequate, with the hospital/health center chiefs much more positive about the feedback than the others.

Response	BKKBN, Depkes	PKMI	Hospital, health cntr	Total
N =	9	7	18	34
High value	11%	29%	72%	47%
Adequate	56%	71%	28%	44%
Low value	22%	14%		9%

Their assessment of the appropriateness, completeness, and clarity of the feedback forms was mixed. Roughly, six out of ten of the 34

respondents said the form fit those criteria (see Table A 38).

### 6.3 Receipt of the feedback reports by providers

All of the providers who said they had been visited in the past 12 months were asked if they had received a feedback form from the XQA team, and if so when. Only 10 of the 37 (27 percent) clinics said that they received the report. That's much less than what the team leader and members said (about 60 percent). Practically all of the providers who did not receive feedback did not know why. Of those who did get feedback, six thought it was well received, three thought it was just adequate, and one said it was not well-received. About the same number thought that the feedback form was appropriate and complete (Tables A 37-38).

### 6.4 Strengths, weaknesses and suggestions

The strengths and weaknesses of the feedback and suggestions for improving it were asked of the XQA team leader, the team members, and the providers.

As before, many respondents did not have anything to say, and many of the comments that were made were similar to those already mentioned. The most common response was that feedback is very useful because it helps to identify problems, suggest solutions, anticipate potential problems and take preventive measures. All of this contributes to improvements in the quality of services. One chief said that the feedback enables them to compare clinics with one another. But another said that the clinics can't be compared, which is a weakness of the current system.

One of the most common complaints about feedback was that it either wasn't done, or wasn't done soon enough after the visits to be of use. Other weaknesses identified were: there often isn't any follow-up; the follow-up form itself is too general and open-ended; the providers don't always have the resources to do anything about the suggestions; and the team's findings and recommendations are not always accurate or appropriate. In some cases the written ones are different from those given during the clinic visit.

Among the suggestions that pertain to feedback itself were the following:

1. Really focus on improving quality (again implying that this wasn't being done in some places);
2. Don't make the feedback too complex or the recommendations too difficult for the provider to implement, keep it simple
3. Prepare feedback for all visits, send it out promptly, and send it to all parties concerned

## 6.5 Conclusions

The feedback system, which is emphasized as one of the most important components, is not functioning as well as planned. There is clearly confusion about who should receive the feedback and whether it is even required. The key target group, the providers who were just assessed, usually do not get any formal feedback, and those who do are not especially impressed with it. Only half said that feedback was well-received by the clinic staff.

The majority of the principal policymakers are not receiving the feedback, either. It is important to recall that the system was designed to send the feedback only to the clinic and the local (kabupaten) PKMI and BKKBN offices. The provincial offices are not identified as recipients. Nevertheless, some teams submit copies of the reports to these offices, and most of these offices seem to want to have the reports sent to them so that they can monitor quality.

Finally, the feedback form itself is not designed to provide specific information. It is up to the XQA team to decide what to feed back. The quality and specificity of the feedback is not standardized and its utility to the providers, in particular, is quite varied.

## 7. Clinic revisits

All of the XQA team leaders and members were asked if the clinics were always revisited. The purpose of the revisit would be to see if there had been any improvement in quality, especially in areas where problems had been found and suggestions made for resolving them. . The providers who were visited were asked the same question.

Half of the XQA team leaders and 62 percent of the members stated that the clinics were "always" revisited, while the rest said they were not. Of the providers who were visited only about 1/3 of them reported

Response	XQA team leader	XQA team members	Providers
N =	10	27	37
Yes, always	50%	62%	32%
No, not always	50%	48%	68%

that their clinics were "always" revisited. Two-thirds said they weren't "always revisited" (see Tables A 41-43). As Table 22 shows, most of the respondents said that there was no set time for revisits. It depended on the case.

Response	XQA team leader	XQA team members	Providers
N=	5	15	12
No set time	60%	33%	42%
1-4 weeks	20%	13%	33%
5-12 weeks		13%	
13-24 weeks		13%	
25-52 weeks	20%	20%	
DK/NR		7%	25%

Otherwise, it may not be worthwhile, especially if there were no significant problems identified, if the clinic doesn't have very many new acceptors, or if follow-up can be done in another way (by telephone, for example).

Besides that, there are the familiar problems of time and money. Revisits take time, and the team members do not have much time for initial visits, let alone revisits. And the funds for such visits would have to come out of the budget for initial visits. Thus, there are serious tradeoffs to consider when deciding whether to make a revisit to a clinic or use the money instead to visit a different clinic.

There were several interesting recommendations made, mostly by XQA team leaders. One was to make only one revisit to any given clinic, not only to conserve resources, but to avoid bothering the clinic staff too much and/or making them overly dependent on outsiders to improve the quality of services. Another

was to use a less detailed visit form to make the visit more efficient and to concentrate on key problems that were identified during the first visit. This would also take less of the clinic staff's time. A third was to allow sufficient time between visits to enable the clinic staff to implement changes. That time interval will vary, depending on the nature of the changes. A fourth recommendation was to concentrate on clinics that have the most serious problems, and to respond to their requests for assistance as soon as possible.

## 8. Administration

Reports	PKMI Chief	XQA team leader
Activity report used	100%	100%
Accuracy	46%	44%
Completeness	73%	11%
Financial report used	91%	67%
Accuracy	36%	22%
Completeness	64%	22%

### 8.1 Reporting

All 11 of the PKMI chiefs and team leaders interviewed said that they used the monthly activity report ("Formulir Laporan Kegiatan Program Pemantauan"). However, only about half (46 and 56 percent) thought the report format was

Most of the team leaders and members agree that revisits would enable the team to see if their recommendations were carried out, but they also think that they are not necessary. If anything, they should be done selectively. If a clinic is having serious problems, for example, then it should be revisited.

appropriate and about 7 out of 10 (73-67 percent) thought it was complete.

All but one of the PKMI chiefs and 6 of 9 of the team leaders said they used the monthly financial report ("Laporan Keuangan). A little over a third (36 percent) of the PKMI chiefs thought it was appropriate and about two-thirds (64 percent) thought it was complete. The team leaders were more positive - 60 and 100 percent respectively (see Tables A 44-46).

## 8.2 Strengths, weaknesses and suggestions

The respondents were also asked to identify the strengths and weaknesses of the management of the XQA system, the composition of the teams, and the financial system.

Management: The most often mentioned strength is the ability to go directly to the field, observe what is really going on and provide guidance and suggestions on the spot that fit the needs of the clinic. Other strengths mentioned are that experts can be brought in as needed and continuous monitoring of VS services is possible.

Among the weaknesses are the lack of time that professionals have to go to the field, to coordinate their activities among themselves, and to devote to carry out their tasks as designed (because of lack of time). There is also some subjectivity in the assessments, and some inconsistencies when others (not part of the XQA team) make visits and assess quality.

Team composition: The greatest strength is the ability to involve experts, experienced people, and those who represent different specialties and institutions. One respondent said that a "hot line" has developed informally among the team members.

The major problems are that these people are very busy and have limited time to devote to the XQA system. When key members are transferred or promoted to other jobs they are usually lost to the team, which, of course means a loss of experienced and skilled members.

Financial system: Several respondents thought there was enough money, that the system was flexible and that one of the strengths is that it provides funds specifically for field visits. Most felt that the money was insufficient, especially for field visits, and particularly to reach clinics far away. Another common complaint was that the money comes too late, and that it only is sent after the reports are sent in.

The respondents had several suggestions for improving administration.

1. It would be best to hire full-time, professional staff; need full-time secretary; better not to mix the XQA tasks with those of the hospitals
2. Special training is needed on administration (various reports)
3. Standardize the QA administrative system; simplify the forms to make the system more efficient; delegate XQA tasks to the districts to increase efficiency and reduce reliance on the provincial teams

4. Increase the funds; send the funds more quickly/on time so as not to impede the clinic visits; send the forms and funds according to the schedule and not late; provide feedback from the central office more quickly

## 9. Results of the visits

All of the respondents were asked to identify the main problems that the teams found, and whether the XQA system had led to improvements in the quality of services in their provinces. The chiefs and providers were asked whether any changes had been made in activities or services as a result of the suggestions made by the teams and if so what they were.

### 9.1 Main problems found by the teams

Tables A 47-52 in the Appendix provide the detailed responses by each group of respondents. The following table summarizes the top three problems that the respondents thought the XQA teams were finding. The number one problem for each group is shaded.

While there was no consensus on the most important problem being identified by the XQA teams, five of the six groups identified the low number of new VS acceptors as the second most important problem. Three groups each identified minor complications, clinic personnel, and finances as major problems that were being found by the teams.

What stands out is the lack of agreement as to what the teams are identifying as major problems. Even the XQA team leaders and their members do not agree on the most important problem they are finding. The members identified minor complications as the most common problem, and the team leaders identified administration, especially the lack of adequate funds, which was also said to be the cause of other problems, such as the low number of acceptors and the inability to attract medical specialists (obgyn). Both groups did agree on new acceptors and clinic personnel as the other major problems, however.

**Table 25: Top three problems found by the teams according to the respondents**

Type problem	BKKBN Depkes chiefs	PKMI chief	XQA team chief	XQA members	Hospital, HC, clinic chief	Provider
1. Minor complications	12 (50%)	8 (73%)		17 (63%)		
2. Major complications						
3. Failures (pregnancy)						
4. Incomplete cases						
5. Fatalities					50 (46%)*	
6. Counseling						
7. Lack of new acceptors	11 (46%)	8 (73%)	6 (60%)	13 (48%)		16 (28%)
8. Lack of clinic personnel		10 (90%)	6 (60%)	13 (48%)		
9. VS infrastructure poor	12 (50%)				30 (28%)	16 (28%)
10. Medical procedures						
11. Referral facilities						
12. Administration			7 (70%)			
13. Inadequate financing			6 (60%)		32 (29%)	22 (38%)

\* Question possibly misunderstood to be "what would be the worst problem the team could find."

Just as interesting are the areas that were not rated as main problems (major complications, failures, incomplete cases, counseling, medical procedures, and referral facilities. Most were mentioned by some respondents in each group, but they were not among the most frequently mentioned. The first three are the key indicators that are used to select the clinics to be visited. This reinforces the finding mentioned previously that the routine reports do not provide the information needed by the XQA teams on key quality problems.

It is possible that at least some of the respondents misunderstood the question, although it was asked twice and seems clear (“What are the main problems that have been identified from the investigations of the QA team?” - followed by the list shown in Table 25; and “What do you think is the main problem from those you identified and what is the cause?”). The hospital, health center and clinic chiefs thought fatalities was the major problem being identified, even though fatalities are rare and none were known to have occurred in these provinces during the study period. PKMI chiefs and team leaders tended to identify personnel as a major problem (lack of training, low salaries). One respondent identified the lack of mass media to promote VS as a major problem. While these may all be problems, they apparently reflect the problems the respondents feel are important, rather than problems that the teams have been identifying. (See Tables A 47-52.)

## 9.2 Changes in program activities and services as a result of the XQA team suggestions

Except for the PKMI chiefs, few of the “client groups” of the XQA system said that changes had been made as a result of suggestions from the XQA team. Table 26 shows the positive responses were only 33, 10 and 12 percent respectively for BKKBN/Depkes chiefs, the hospital/health center/clinic chiefs, and the providers. The low

**Table 26: Changes made as result of XQA team suggestions according to respondents**

Changes made?	BKKBN, Depkes chiefs	PKMI chief	Hospital, HC, clinic chief	Provider
N=	24	11	109	58
Yes	8 (33%)	6 (54%)	11 (10%)	7 (12%)
No	8 (33%)	4 (36%)	44 (40%)	26 (45%)
DK/NR	8 (33%)		54 (50%)	25 (43%)

positive response from the main target group, the providers, is especially noteworthy.

**Table 27: Services/activities changed according to the respondents**

Service/activity changed	BKKBN, Depkes chiefs	PKMI chiefs	Hospital, HC, clinic chiefs	Providers
N=	8	6	11	7
Counseling	2 (25%)	4 (67%)	4 (36%)	2 (29%)
New acceptors	2 (25%)		1 (9%)	1 (14%)
Clinic personnel	1 (13%)	1 (17%)	1 (9%)	
Clinic infrastructure	4 (50%)		2 (18%)	3 (43%)
Medical procedures	4 (50%)	1 (17%)	2 (18%)	2 (29%)
Referral facilities	1 (13%)		2 (18%)	1 (14%)
Administration	7 (88%)			3 (43%)
Other		2 (33%)	2 (18%)	

The respondents who answered “yes” were asked to identify the activities or services that had been changed. The program activities and services changed

were mostly concerned with “counseling,” “administration,” “facilities and equipment” and “medical techniques.”

### 9.3 Improvement in quality as a result of the XQA system

The non-team respondents were asked if they thought that the XQA system had improved LTM/VS service quality in their provinces. Table 28 shows that the BKKBN/Depkes and PKMI chiefs were very positive. Some 83 percent of the former and 55 percent of the latter said “yes.” The more immediate client groups, the providers and the chiefs of their institutions, were less certain. There is a fairly even split between those who said they didn’t know and those who said yes: 53/44 percent for the chiefs and 41/52 percent for the providers.

Changes made?	BKKBN, Depkes chiefs	PKMI chief	Hospital, HC, clinic chief	Provider
N=	24	11	109	58
Yes, a lot	18 (75%)	6 (55%)	34 (31%)	20 (35%)
Yes, a little bit	2 (8%)	3(27%)	14 (13%)	10 (17%)
No		1(9%)	3 (3%)	4 (7%)
Don’t know/no response	4 (17%)	1(9%)	58 (53%)	24 (41%)

When asked to explain this, most of the providers and hospital chiefs didn’t respond, again indicating a fragile involvement with the system. The BKKBN, Depkes and PKMI chiefs were more responsive, but even they qualified their impressions. Many said that the system is a positive influence, on the right track, and so forth, but there are other programmatic activities that are going on as well, and they could have just as much, perhaps more, to do with improvements in quality as the XQA teams. These activities include provider training, refurbishment of facilities, better IEC, broader distribution of services, increased promotion, and so forth. Thus, even if it is true that complications are decreasing and quality is improving, it may not be due to the XQA teams.

Quality improved	XQA team chiefs	XQA team members
N=	9	27
In clinics visited	9 (100%)	24 (89%)
In other clinics in province	6 (67%)	16 (59%)
Nationally	6 (67%)	20 (74%)
Don’t know/no response		3 (11%)

The XQA teams were asked a slightly different question, which is summarized in Table 29. Almost all of them thought that quality had improved in the clinics that the teams visited. And quite a few also thought that what they had done had also had “spin-off” effects to their provinces, and to the nation as a whole.

In general, the assessment of the impact or value of the XQA system seems to vary according to involvement in the system. Those who actually implement the XQA system are the most convinced it is having an impact on quality. Next are those who supervise and coordinate services at the

provincial level, and who see the system as being able to identify and deal with problems on their behalf, province-wide. Last are the targets of the system, the providers and their supervisors, who are less sure that the system is doing anything significant for them.

## **10. The strengths and weaknesses of the XQA system**

All of the respondents were asked to identify the strengths and weaknesses of the XQA system and to make suggestions for improving it.

According to the respondents the QA external system has the following general strengths:

1. Helps to understand the reality of field service operations and problems
2. Helps to identify and solve existing problems in the field
3. Useful in monitoring the actual implementation of program services
4. Objective and scientific approach
5. Good vehicle for transferring knowledge to the field
6. Helps to improve the quality of LTM/VS services
7. Involves other related/authorized organization's or institutions
8. Involves people with various areas of knowledge, experience and perspectives

The respondents also mentioned several general weaknesses of the XQA system:

1. There is a lack of information and communication concerning the XQA program
2. The system requires a lot of money and a lot of time
3. The funds provided are "very limited" and often "delayed"
4. There is no "fixed" honorarium for those involved in the program, no incentive for this work
5. There is a lack of permanent personnel in charge of administration of the program
6. Most of the XQA team members are not able to carry out their work well since they are "too busy"
7. The teams lack experience and training
8. The local internal QA teams are not involved in the assessments
9. Often the QA team members are transferred, resulting in incomplete teams
10. Most of the program activities are carried out "unprogrammed," on an ad hoc basis
11. The selection of XQA activities is very unsatisfactory
12. The clinic visits are most often conducted "incidentally," i.e. only when there is a medical case or problem reported by the clinic

## **11. Suggestions for improving the XQA system**

The following are general suggestions made by the respondents

1. Realize that it will take 1-2 years to improve the quality of services
2. Need clear guidelines about the QA program
3. Funding needs to be increased
4. Local governments and local QA teams (internal) need to be involved
5. Coordination between BKKBN and Depkes needs to be improved
6. Need to renew and regenerate the team membership
7. The teams should be made up of various relevant disciplines
8. Need organized training, education and supervision (or the teams)
9. QA team members should be selected carefully
10. QA team members should be selected in consultation with BKKBN and Depkes
11. Full-time professional administrative and secretarial staff are needed
12. Need an official decree (surat keputusan) about the status and continuity of the QA team within their normal duties
13. Clinic facilities and equipment need to be improved
14. The forms need to be simplified
15. The activities shouldn't be just incidental. Each activity needs to be programmed and scheduled
16. Need to have follow-up that is consistent with the findings of the QA teams field visits or the needs of the clinics

The team members also had a number of suggestions

1. Need education & training on QA
2. Disseminate information about QA
3. Need XQA standards and procedures
4. Need monitoring by the central team
5. Involve the professional organizations
6. Tie in with education, skills and responsibilities
7. Need to perfect the system
8. The meetings and clinic visits need to be improved
9. Need to set up QA teams in the kabupaten
10. Need to improve the data and reporting system
11. Need a good communication system

## **12. Costs**

The costs of the overall program include BKKBN, Depkes and PKMI central and provincial management, training, supervision and related costs. None of those have been included in this cost estimate. The costs gathered only cover five categories, all directly related to the operation of the XQA teams in the field. These are transportation to the periodic provincial meetings (rapat berkala), transportation and per diem for the team members to make the clinic visits, and operational costs for communications and supplies. The data for these costs were compiled from invoices submitted to PKMI for

reimbursement, and they were collected only for the 12 sample provinces. Thus, the total costs of the program are much higher than the total shown. In addition, no salaries or fees are paid to the team or to BKKBN, Depkes, PKMI and other staff who are involved in the program. None of those "opportunity costs" were calculated, either.

Province	Meetings	Visits	Operational	Total
LTM (3)	6,610,000	72,649,000	2,609,000	81,686,000
VS (9)	10,370,000	37,176,000	5,514,000	53,060,000
Total (12)	16,980,000	109,825,000	8,123,000	134,928,000
Annual	8,490,000	549,125,000	4,061,500	67,464,000
Percent	12.6%	81.4%	6.0%	100.0%

The overall costs are for two years, so the table also includes the estimated annual costs of the program in these 12 provinces. This amounts to Rp 67 million or about Rp 5.6 million per province per year. The LTM provinces have the highest costs at Rp 10.2 million each. The VS provinces are about 1/3 of that at Rp 2.9 million each per year. As the table shows, the bulk of the money (81 percent) is used for travel and per diem for the team visits. See Table A-2 for a breakdown by province.

The cost per visit was used as the key "cost-effectiveness" indicator. This is because the clinic visit is the most important activity of the program. This is when and where the quality assessment and quality assurance take place. All other activities are either inputs to those visits or examinations of the results of the visits. Thus, the more visits made the more effective the system should be in both assessing quality more accurately and in helping to ensure that problems are identified and resolved.

There were 190 clinic visits made over the two-year period in the 12 provinces. The total billed by the teams was Rp. 134,928,000. Which makes the cost per visit Rp 710,000. As Table 24 shows, this varied significantly by province, depending both on the number of visits made and the amount of costs incurred, The highest cost was in West Java, followed by East Java and North Sumatera. The highest cost per visit was North Sumatera, which had less than half of the number of visits as East Java, but relatively high cost. Similarly, Riau had a modest cost but a small number of visits, making the cost per visit relatively high.

Province	Visits	Cost (Rp 000)	Cost per Visit (Rp 000)
Jatim	38	20,348	799
Jabar	27	31,646	1,172
Sumut	10	19,874	1,987
LTM	75	81,868	1,092
Yogya	13	8,238	634
Jateng	40	15,203	380
Riau	4	6,195	1,549
Sumbar	11	5,510	501
Sulut	18	7,635	424
Sulteng	23	6,835	297
Sultra	1	944	944
Sumsel	2	1,000	500
Sulsel	3	1,500	500
VS	115	53,060	461
Total	190	134,928	710

In general, the cost per visit for LTM provinces was more than double the cost in the VS provinces, over Rp 1 million per visit compared to Rp 461 thousand.

It is important to remember that these costs are underestimates of actual and total costs, possibly by a factor of two or three. When BKKBN, PKMI and Depkes costs are added in for central and provincial administration and support, the unit cost would be much higher, to at least Rp 1 million per visit and most likely much more than that.

## IV. Conclusions and Recommendations

### 1. Findings

The current program, which is designed only to cover a portion of the service sites, comes very close to conducting all of the clinic visits planned. But there is a great deal of variation among provinces. Most of the LTM provinces exceed their targets for meetings and clinic visits. Most of the VS provinces do not reach their targets. The program is larger and more active the more populous the island (i.e., Java, the most populous island, is first, then Sumatera, then Sulawesi). Delays in getting funds to the provinces have accounted for some of the variation in activity, but as the sample data show, for quite a few provinces there has been only modest, or little activity over a two-year period.

Looking at the XQA system from a larger perspective, coverage and clinic visits are quite modest. The system currently covers only about 19 percent of the 3,848 LTM/VS clinics in Indonesia, and only 5 percent of those are visited each year. The figures are higher for the 732 clinics that are "in the XQA system." Around 26 percent of them are visited each year. Still, the number and frequency of visits is far from adequate if this were to become the main mechanism for quality assurance. Only 205 clinic visits were reported for 1993/1994, which averages out to about one visit per province every two months. At this rate it would take 18 years to visit each clinic just once.

With additional funds many provinces could make additional visits. However, the data indicate that this is not the only limiting factor. Just as important is the lack of time on the part of the XQA members to make visits. Most, probably all members, are very busy medical professionals. This affects scheduling, and results in an *ad hoc* approach to clinic visits. It is difficult for the teams to meet regularly and carry out their visits in a scheduled, systematic way. It is difficult for most of the team members to take time away from their jobs, so the visits often have to be scheduled on weekends or on days when one team member can take time off to make a visit. This also makes it difficult for the team to go as a group, to visit clinics that are far from town, and to make return visits.

Although there is a team leader in each province, there is no provision for administrative support for planning, scheduling and follow-up. This puts an added workload on the volunteer team leader and members, and cuts into the time they have available for technical work.

Even if the members had more time and the administration of the system could be strengthened, the system is expensive as it stands. At Rp. 710,000 per visit on the average, it would be extremely expensive to expand coverage and increase the frequency of visits.

On the positive side, the XQA team leaders and team members appear to be well-qualified and experienced in both quality assurance and supervision. The majority have spent several years working in the XQA system. The fact that they are volunteers and that most have not even thought about dropping out of the system is a good indication of their commitment and dedication to quality assurance.

## 2. Conclusions

The XQA system seems to be well-designed, and most of the members follow the system carefully. The periodic meetings are held every two months on average and they are thought to be valuable. The topics that are supposed to be discussed (results of clinic visits and results emerging from monthly clinic reports) are discussed. As the description of the system showed (see Section II) it is decentralized, comprehensive and the clinic visit protocol covers structural items (facilities, equipment, etc.) as well as procedures (counseling, operations, etc.). Direct observation of key procedures is reported to be conducted quite often.

There are a few limitations in the design that have been identified. The first is the limited amount of data on service quality that is provided in the monthly reports. Evaluation and selection of sites to be visited is dependent on that information, which is limited to statistics on complications, failures, incomplete procedures and fatalities. More process indicators are needed if the teams are to be able to monitor and evaluate the quality of services. And some way must be found to get the clinics to submit their reports, regularly and on time.

Second, the clinic visit instruments consist largely of general questions about whether a particular piece of equipment is available or a procedure is conducted "properly." Specific indicators based on standards of practice need to be added to the instruments to make them more precise and comparable, such as "Does the counselor verify that the client understands that the implant must be removed after five years?"

One of the most important parts of the system is feedback to the clinics. Although the majority of the XQA teams say they do send the feedback form to the clinics, a significant percentage of the team members (22 percent) said that no feedback was sent. More importantly, most of the providers said they did not get any feedback.

It also seems clear that the feedback mechanism isn't standardized. Some reports are being sent to PKMI, some go to BKKBN, some go to the hospital chiefs. This may reflect provincial preferences, as some offices, such as the provincial PKMI and BKKBN offices, very much want to be kept informed about quality issues in their provinces. But there does not seem to be any reason to send the reports to these administrative offices and not to the providers. As the XQA manual states, "The external quality assurance program doesn't have much meaning without feedback."<sup>9</sup>

Finally, there was no consensus from the respondents as to the main problems that the system is identifying and few of them said that any changes had been made as a result of the clinic visits. The providers, in particular, do not seem to see that the system is contributing much to them, probably because of the limited feedback, but also because many of them do not feel involved in the assessment. The overall assessment was that the

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<sup>9</sup> Azwar, op. cit., p. 39 (MKET) and p. 47 (Kontap).

XQA system is not contributing very much to the improvement of service quality in their provinces. That is not surprising given the limited coverage, visits and feedback.

One strength of this system that was not examined in the evaluation, but which should be mentioned, is the feedback of findings to PKMI and BKKBN central offices. This is done primarily through an annual Review Meeting where representatives from the provinces gather together with representatives from BKKBN, PKMI, POGI, Depkes and other interested groups to discuss the VS program's strengths and weaknesses. Input from the XQA team reports and clinical visits is usually incorporated into these meetings. Common problems are identified at these meetings and discussions held that lead to recommendations for changes. There is no doubt that the field experience generated by the XQA teams is a very important input to this process.

It seems clear that the system has the potential to make a significant contribution to quality improvement. The system is well-designed and the procedures and forms that make it up are followed in the field. Some improvements in indicators could be made so that the teams could better identify clinics that need attention and also compare clinic performance with standards of practice. The feedback component needs to be strengthened and a follow-up mechanism added to make sure that recommendations for improving quality are implemented by the providers.

The most serious constraints, however, are that the system is very time-consuming and expensive. It is unlikely that it can be replicated in its present form so that all LTM and VS clinics are covered and visited at least once each year. That would seem to be the minimal requirement if this system were to become the primary mechanism for quality assurance throughout the country. Clinics that are inactive or which don't offer the VS services anymore probably should be dropped. But every clinic that is in the system, even if it provides services only rarely, needs to be included. Otherwise, the reputation of the program could be seriously damaged by providers who don't follow clinical procedures correctly. Even if the funds were available to upgrade the system, add support for administrative costs, and expand coverage to all clinics, which is unlikely, there are not enough XQA team members to conduct the necessary number of visits. And the pool of potential candidates who could serve as members is very small. The recommended criteria for selection of XQA team members include being "expert in obgyn, family planning and contraceptives." There are only 770 obgyns in the whole country, and 240 of them are in Jakarta. Half of the district hospitals do not have an obgyn.

### **3. Recommendations**

The best use of the XQA system may be as a complement to an alternative national system. For example, the QA Design Team has recommended a simple and inexpensive QA system that could be an extension of the new clinical training that is being implemented

through the NRCs and the National Clinical Training Network.<sup>10</sup> The proposal suggests a simple way to incorporate commitment to quality into the curricula in a way that would not increase training time. Trainees would develop action plans at the end of their clinical training (refresher or in-service) that would describe what they would do differently when they got home, and how they would overcome potential barriers that they identify. Those plans would be complemented by a self-assessment form that includes a short list of key indicators that the trainees and trainers would check to make sure that the trainee is able to conform to the standards of practice that were taught. The trainee would send the self-evaluation back to the trainer at 6 weeks, 6 months and 1 year. The trainer would review it and provide feedback and suggestions for dealing with any problems that the trainee raises. Finally, the trainers would supplement that system with a limited number of "spot checks" or "random visits" to the providers who were trained to observe and assess their performance. The current XQA clinic visit form could be modified for this purpose. The results of these visits could be fed back to the NRCs, PKMI, Depkes, BKKBN and others for consideration and action.

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<sup>10</sup> Presentation of QA strategy, July 14, 1995. The draft report of the team is expected to be available in early August.

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BASIC DATA

Table A 1: Total long-term method and sterilization clinics, Indonesia, 4/93-3/94 (12 months)						
Province	Total clinics	Total XQA clinics	Percent XQA clinics	Total visits 1993/94 12 months	Percent of all clinics visited	Percent XQA visited
1. Jatim	387	127	33%	35	9%	28%
2. Jabar	1011	97	10%	3	0%	3%
3. Sumut	310	52	17%	10	3%	19%
4. Bali	52	32	62%	42	81%	131%
<b>Total LTM</b>	<b>1760</b>	<b>308</b>	<b>18%</b>	<b>90</b>	<b>5%</b>	<b>29%</b>
1. Jateng	567	118	21%	28	5%	26%
2. Sulsel	132	57	43%	3	2%	5%
3. DKI	93	27	29%	6	6%	16%
4. Sumbar	38	28	74%	3	8%	11%
5. Sumsel	206	25	12%	16	8%	64%
6. Kalbar	79	22	28%	4	5%	18%
7. Sulut	48	20	42%	7	15%	35%
8. Lampung	179	16	9%	3	2%	8%
9. NTB	41	16	39%	10	24%	63%
10. NTT	84	11	13%	3	4%	60%
11. Kalsel	73	10	14%	4	5%	40%
12. Kaltim	65	10	15%	3	5%	30%
13. Riau	62	10	16%	0	0%	0%
14. Aceh	56	8	14%	2	4%	17%
15. Jogja	70	7	10%	8	11%	50%
16. Maluku	92	6	7%	0	0%	0%
17. Irian Jaya	34	6	18%	0	0%	0%
18. Kalteng	23	6	26%	2	9%	33%
19. Sultra	37	5	14%	4	11%	80%
20. Jambi	36	5	14%	6	8%	60%
21. TimTim	15	5	33%	0	0%	0%
22. Sulteng	31	4	13%	4	13%	57%
23. Bengkulu	27	2	7%	2	7%	50%
<b>Total VS</b>	<b>2088</b>	<b>424</b>	<b>20%</b>	<b>115</b>	<b>6%</b>	<b>25%</b>
<b>Grand Total</b>	<b>3848</b>	<b>732</b>	<b>19%</b>	<b>205</b>	<b>5%</b>	<b>26%</b>

Source: PKMI and BKKBN, compiled by Russel Vogel (file: mutuperc), undated.

Table A-2: Basic statistics, 12 province sample, by province and island

Total clinics				Total Meetings		Total clinic visits			
Province	VS clinics	XQA clinics	Percent XQA clinics	Total meeting	Meeting per month	Clinic visits	Percent of clinics visited	Percent XQA clinics visited	Visits per month
Jatim	387	127	32.8%	21	0.9	38	9.8%	29.9%	1.6
Jabar	1011	97	9.6%	10	0.4	27	2.7%	27.8%	1.1
Jateng	567	118	20.8%	16	0.7	40	7.1%	33.9%	1.7
Jogya	70	7	10.0%	18	0.8	13	18.6%	185.7%	0.5
JAVA	2035	349	17.1%	65	2.7	118	5.8%	33.8%	4.9
Sumut	310	52	16.8%	23	1.0	10	3.2%	19.2%	0.4
Riau	62	10	16.1%	15	0.6	4	6.5%	40.0%	0.2
Sumbar	38	28	73.7%	13	0.5	11	28.9%	39.3%	0.5
Sumsel	206	25	12.1%	22	0.9	18	8.7%	72.0%	0.8
SUMATERA	616	115	18.7%	73	3.0	43	7.0%	37.4%	1.8
Sulut	48	20	41.7%	12	0.5	23	47.9%	115.0%	1.0
Sulteng	31	4	12.9%	3	0.1	1	3.2%	25.0%	0.0
Sultra	37	5	13.5%	6	0.3	2	5.4%	40.0%	0.1
Sulsel	132	57	43.2%	6	0.3	3	2.3%	5.3%	0.1
SULAWESI	248	86	34.7%	27	1.1	29	11.7%	33.7%	1.2
Total	2,899	550	19.0%	165	6.9	190	6.6%	34.5%	7.9

Table A-3: Basic statistics, 12 province sample, by province and island

Province	Total XQA members/visits			Costs (two years)					Cost per visit (Rp 000)	
	Total membe	Membe per visit	Visits per year membe	Meeting Transp (Rp. 00)	Visits (Rp. 000)		Operational costs (Rp. 000)			Total (Rp. 000)
					Trans.	Per Die	Communi	Supplies		
Jatim	95	2.5	4.0	2,375	2,838	24,310	416	409	30,348	799
Jabar	58	2.1	2.4	1,952	2,730	26,290	300	374	31,646	1,172
Jateng	103	0.2	4.3	1,480	1,733	11,330	329	331	15,203	30
Jogya	42	1.1	1.8	1,960	698	4,620	510	450	8,238	206
JAVA	298	2.5	12.4	7,767	7,999	66,550	1,555	1,564	85,435	724
Sumut	23	2.3	1.0	2,283	2,786	13,695	565	545	19,874	1,987
Riau	17	4.3	0.7	1,400	1,725	2,530	240	300	6,195	1,549
Sumbar	26	2.4	1.1	1,480	420	2,860	360	390	5,510	501
Sumsel	31	1.7	1.3	1,960	1,335	3,380	480	480	7,635	424
SUMATERA	97	2.3	4.0	7,123	6,266	22,465	1,645	1,715	39,214	912
Sulut	25	1.1	1.0	890	1,960	3,025	443	517	6,835	297
Sulteng	2	2.0	0.1	240	220	220	163	101	944	944
Sultra	2	1.0	0.1	480	90	220	120	90	1,000	500
Sulsel	6	2.0	0.3	480	150	660	48	162	1,500	500
SULAWESI	35	1.2	1.5	2,090	2,420	4,125	774	870	10,279	354
Total	430	2.3	17.9	16,980	16,685	93,140	3,974	4,149	134,928	710
			Percent	12.6%	12.4%	69.0%	2.9%	3.1%	100.0%	

Table A 4: Regression analysis, 12 province sample

Province	Population (1990)	Area Km2	VS clinics	XQA clinics	Total meetings	Clinic visits	Visits per month	Team members	Total cost (Rp. 000)	Cost per visit (Rp 000)	Province
Jatim	32,503,815	47,921	387	127	21	38	1.6	95	30,348	799	Jatim
Jabar	35,381,153	44,176	1011	97	10	27	1.1	58	31,646	1,172	Jabar
Jateng	28,521,692	34,503	567	118	16	40	1.7	42	8,238	206	Jateng
Jogya	2,913,054	3,142	70	7	18	13	0.5	103	15,203	1,169	Jogya
Sumut	10,256,027	71,680	310	52	23	10	0.4	23	19,874	1,987	Sumut
Riau	3,306,215	94,561	62	10	15	4	0.2	17	6,195	1,549	Riau
Sumbar	3,999,120	42,297	38	28	13	11	0.5	26	5,510	501	Sumbar
Sumsei	6,276,947	109,254	206	25	22	18	0.8	31	7,635	424	Sumsei
Sulut	2,478,793	25,786	48	20	12	23	1.0	25	6,835	297	Sulut
Sulteng	1,711,327	68,033	31	4	3	1	0.0	2	944	944	Sulteng
Sultra	1,349,609	38,140	37	5	6	2	0.1	2	1,000	500	Sultra
Sulsel	6,981,646	62,482	132	57	6	3	0.1	6	1,500	500	Sulsel
Jumlah	135,679,398	641,975	2,899	550	165	190	7.9	430	134,928	710	Jumlah
Indonesia	179,321,641	1,948,732	3,848	732							
Percent	75.7%	32.9%	75.3%	75.1%							

Regressions: the effect of the Independent variable (X) on the Dependent variable (Y), e.g. the effect of family planning (x) on fertility (y).

r<sup>2</sup> values: the higher the number the greater the effect of the independent variable on the dependent variable

Effect of X > On Y:	Population	Area Km2	Island Population	Total clinics	XQA clinics	Visits
Total clinics	0.815	0.005	0.994	xxx	xxx	xxx
XQA clinics	0.894	0.016	1.000	0.602	xxx	xxx
Total meetings	0.065	0.029	0.214	0.026	0.088	0.221
Total visits	0.667	0.084	0.999	0.421	0.671	xxx
Visits/month	0.667	0.084	0.999	0.421	0.671	1.000
Cost	0.601	0.028	0.928	0.429	0.250	0.373
Cost per visit	0.000	0.056	0.091	0.014	0.011	0.088

Shading = significant relationship

Most significant relationships:

- 1 Visits on visits/month
- 2 Island population on XQA clinics, visits, visits/month total clinics, cost
- 3 Population on XQA clinics, total clinics

**TEAM LEADERS**

Table A 5: Time spent as XQA team leader															
Times	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
<12 months	-	-	X	0	-	X	X	-	1	-	1	-	-	29%	22%
13-24 mo.	-	-	X	0	-	X	X	-	-	-	-	-	-	-	-
25-36 mo.	-	-	X	0	-	X	X	-	-	-	-	-	1	14%	11%
37-48 mo.	-	1	X	50%	-	X	X	1	-	-	-	-	-	14%	22%
49-60 bn	1	-	X	50%	-	X	X	-	-	-	-	1	-	14%	22%
>60 months	-	-	X	0	1	X	X	-	-	1	-	-	-	29%	22%

Table A 6: Time will remain as XQA team leader															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Don't know	1	1	X	100	1	X	X	1	1	-	1	-	1	71%	78%
1 - 3 mo.	-	-	X	0	-	X	X	-	-	-	-	1	-	14%	11%
Finished	-	-	X	0	-	X	X	-	-	1	-	-	-	14%	11%

Table A 7: Training received - XQA team leader															
Training	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
QA	-	1	X	50%	1	1	X	1	1	-	1	1	1	88%	80%
Supervision	-	1	X	50%	1	-	X	-	1	1	1	1	1	75%	70%

Table A 8: QA and supervision experience															
Training	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
QA	1	1	X	100	1	X	X	1	1	-	-	1	-	57%	55%
Supervision	1	1	X	100	1	X	X	-	1	1	-	1	-	57%	55%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

**TEAM MEMBERS**

Table A 9: Time spent as XQA team member																
Times	LTM				VS											
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12	Sub-total	Total	
<12 months	-	-	1	17%	-	-	X	-	-	-	1	-	1	11%	12%	
13-24 mo.	1	-	-	17	1	1	X	-	-	1	-	1	-	21%	20%	
25-36 mo.	-	-	-	0	1	1	X	-	1	-	2	-	-	26%	20%	
37-48 mo.	-	-	-	0	-	-	X	1	-	-	-	-	-	5%	4%	
49-60 bn	1	1	-	33%	-	-	X	-	1	-	-	2	-	16%	20%	
61 - 72 mo.	-	-	-	0	-	-	X	-	-	1	-	-	2	16%	12%	
>60 months	-	1	1	33%	1	-	X	-	-	-	-	-	-	5%	12%	

Table A 10: Time will remain as XQA team member																
	LTM				VS											
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12	Sub-total	Total	
Don't know	2	1	2	71%	-	2	X	1	1	3	3	-	3	65%	67%	
1 - 12 mo.	-	-	-	0	-	-	X	-	-	-	-	3	-	15%	11%	
13 - 24 mo.	-	1	-	14%	1	-	X	-	-	-	-	-	-	5%	7%	
25 - 36 mo.	-	-	-	0	-	-	X	-	-	-	-	-	-	0	0	
37 - 48 mo.	-	-	1	14%	-	-	X	-	-	-	-	-	-	0	4%	
Sudah habis	-	-	-	0	2	-	X	-	1	-	-	-	-	15%	11%	

Table A 11: Training received - XQA team member																
Training	LTM				VS											
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12	Sub-total	Total	
QA	1	1	3	71%	3	1	X	1	1	1	2	3	2	70%	70%	
Supervision	1	1	3	71%	2	1	X	-	2	2	2	3	-	60%	63%	

Table A 12: QA and supervision experience - XQA team member																
Experience	LTM				VS											
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12	Sub-total	Total	
QA	2	1	-	43%	3	1	X	-	1	1	1	2	2	55%	52%	
Supervision	2	1	-	43%	3	1	X	-	2	2	1	2	-	55%	52%	

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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## REPORTS

Type report	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
F II/KB	1	-	-	33%	-	1	X	1	1	1	1	1	1	88%	73%
F II/Kasus Medis	1	-	-	33%	1	-	X	1	-	1	1	1	1	75%	64%
F III/MKET	1	-	1	67%	1	1	X	-	1	1	1	1	-	75%	73%
Other	-	-	-	0	1	1	X	1	1	1	-	-	-	63%	46%

Type report	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
F II/KB	1	-	X	50%	1	1	X	1	1	1	1	1	1	100%	90%
F II/Kasus Medis	1	-	X	50%	1	-	X	1	1	1	1	1	1	86%	80%
F III/MKET	1	1	X	100	1	1	X	-	1	1	1	1	-	75%	80%
Other	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Yes	1	1	X	100	1	1	X	1	1	1	-	1	1	88%	90%
No	-	-	-	0	-	-	X	-	-	-	1	-	-	13%	10%

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Yes	1	1	1	100	1	1	X	1	1	1	-	1	1	88%	91%
No	-	-	-	0	-	-	X	-	-	-	1	-	-	13%	9%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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**Table A 17: Assessment by the XQA team leaders of the appropriateness and completeness of the FII/KB report**

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Appropriate															
Satisfactory	-	-	X	0	1	1	X	-	1	-	-	1	-	50%	40%
Unsatisfactory	1	-	X	50%	-	-	X	-	-	-	-	-	-	0	10%
No response	-	-	X	0	-	-	X	1	-	1	1	-	1	50%	40%
Complete															
Satisfactory	-	-	X	0	1	-	X	-	1	-	1	-	1	50%	40%
Unsatisfactory	1	-	X	50%	-	1	X	-	-	-	-	1	-	25%	30%
No response	-	1	X	50%	-	-	X	1	-	1	-	-	-	35%	30%

**Table A 18: Assessment by the XQA team leaders of the appropriateness and completeness of the F II/MKET/Kontap Report**

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Appropriate															
Satisfactory	-	-	X	0	1	-	X	-	1	-	-	1	-	37%	16%
Unsatisfactory	1	-	X	50%	-	-	X	-	-	-	-	-	-	12%	11%
No response	-	1	X	50%	-	1	X	1	-	1	1	-	1	62%	33%
Complete															
Satisfactory	1	-	X	50%	1	-	X	-	1	-	1	-	1	50%	27%
Unsatisfactory	-	-	X	0	-	-	X	-	-	-	-	1	-	12%	5%
No response	-	1	X	50%	-	1	X	1	-	1	-	-	-	37%	23%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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Table A 19: Assessment by the XQA team leader of the appropriateness and completeness of the F III/MKET/Kontap Report															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Appropriate															
Satisfactory	-	1	X	50%	1	1	X	-	1	-	-	-	-	27%	40%
Unsatisfactory	1	-	X	50%	-	-	X	-	-	-	-	1	-	12%	20%
No response	-	-	X	0	-	-	X	1	-	1	1	-	1	50%	40%
Complete															
Satisfactory	1	-	X	50%	1	-	X	-	1	-	1	-	-	37%	40%
Unsatisfactory	-	1	X	50%	-	1	X	-	-	-	-	1	-	25%	30%
No response	-	-	X	0	-	-	X	1	-	1	-	-	1	27%	30%

#### PERIODIC MEETINGS

Table A 20: Number of times the PKMI chiefs attended the periodic XQA meetings in the last 12 months															
Frequency of meetings	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Never	-	-	-	0	-	-	X	-	-	-	-	1	-	13%	9%
1-2 times	-	-	-	0	-	-	X	-	-	-	-	-	1	13%	9%
3-4 times	1	-	-	33%	-	1	X	-	-	-	-	-	-	13%	18%
5-6 times	-	-	-	0	-	-	X	-	-	1	-	-	-	13%	9%
7-8 times	-	-	-	0	-	-	X	-	-	-	-	-	-	0	0
9-10 times	-	-	-	0	1	-	X	1	-	-	-	-	-	25%	18%
11-12 times	-	1	1	67%	-	-	X	-	-	-	-	-	-	0	18%
No response	-	-	-	0	-	-	X	-	1	-	1	-	-	25%	18%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

**Table A 21: Number of times the XQA team leaders attended the periodic XQA meetings in the last 12 months**

Frequency of meetings	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Never	-	-	X	0	-	-	X	-	-	-	-	1	-	13%	10%
1-2 times	-	-	X	0	-	-	X	-	1	-	-	-	1	25%	20%
3-4 times	1	-	X	50%	-	-	X	-	-	-	-	-	-	0	10%
5-6 times	-	-	X	0	-	1	X	-	-	1	-	-	-	25%	20%
7-8 times	-	-	X	0	-	-	X	-	-	-	-	-	-	0	0
9-10 times	-	-	X	0	1	-	X	1	-	-	-	-	-	25%	20%
11-12 times	-	1	X	50%	-	-	X	-	-	-	1	-	-	13%	20%
No response	-	-	X	0	-	-	X	-	-	-	-	-	-	0	0

**Table A 22: Number of times the XQA team members attended the periodic XQA meetings in the last 12 months:**

Frequency of meetings	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Never				0			X				1	3		20%	15%
1-2 times				0			X		1		1		1	15%	11%
3-4 times	1	1		29%	1	2	X		1				1	25%	63%
5-6 times	1	1	1	43%			X			2			1	15%	22%
7-8 times				0			X							0	0
9-10 times			1	14%	1		X	1			1			15%	15%
11-12 times				0			X			1				5%	4%
No response			1	14%	1		X							5%	7%

**Table A 23: Assessment by the PKMI chiefs, XQA team leaders and members of the value of the meetings**

Value	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
High	1	4	3	73%	5	1	X	3	1	2	2	1		44%	51%
Satisfactory	2		1	17%		2	X		3	3	2		5	44%	40%
Low				0										0	0
DK/NR				0			X			1	3			0	9%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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**Table A 24: Purpose of the meetings according to the PKMI chief,s XQA team leaders and members**

	LTM				VS												Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12					
To select the clinics to visit		1	3	33%	4	4	X	2	2	4	4	1	3	61%	54%			
To discuss the results of the clinic visits	1	1	1	25%	2	4	X	3	3	5	4	1	4	72%	60%			
To improve the activities	2	1	3	50%	3	2	X		3		1			25%	31%			
To psolve problems	1	1		17%	2		X			4			1	19%	19%			
To plan the program	2			17%			X	1			1			6%	8%			

## CLINIC VISITS

**Table A 25: Sections of the clinic visit form used according to the XQA team leaders**

Form	LTM				VS												Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12					
N (team ldr)	1	1	X	2	1	1	X	1	1	1	1	0	1	6	8			
Identification	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Personnel	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Reception & registration	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Counseling	1	1	X	100	1	1	X	1	1	1	1		1	88%	90%			
Pre-op	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Preparation	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Operation	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Post-op	1	1	X	100	1	1	X	1	1	1	1		1	88%	90%			
Revisits	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Referrals	1	1	X	100	1	1	X		1	1	1		1	75%	80%			
Payment	1	1	X	100	1	1	X			1	1		1	63%	70%			

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

Form	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N (team members)	2	1	2	5	2	1	X	1	2	3	3	0	2	14	19
Identification	2	1	1	80%	3	2		1	2	3	1		2	100%	95%
Personnel	2	1	1	80%	3	2		2	1	3	1		2	100%	95%
Reception & registration	2	1	1	80%	3	2		2	1	3	1		2	100%	95%
Counseling	2	1		60%	3	2		2		3	1		2	93%	84%
Pre-op	2	1		60%	3	2		1		3	1		2	86%	79%
Preparation	2	1		60%	3	2		2		3	1		2	93%	84%
Operation	2	1		60%	3	2		2		3	1		2	93%	84%
Post-op	2	1		60%	3	2		1		3	1		2	93%	84%
Revisits	2	1		60%	2	2		1		3	1		2	93%	84%
Referrals	2	1		60%	2	2		1		3	1		2	93%	84%
Payment	2	1	1	80%	2	2		1		3	1		2	93%	89%

Form	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N (providers)	0	1	5	6	5	5	4	3	3	5	1	3	2	31%	37
Identification	-	1	5	100%	4	5	3	2	2	4	1	2	1	77%	81%
Personnel	-	1	4	83%	4	5	2	3	2	4	1	2	1	77%	78%
Reception & registration	-	1	5	100%	5	5	1	3	2	4	1	3	2	84%	86%
Counseling	-	1	4	83%	4	5	3	3	1	4	1	2	2	81%	81%
Pre-op	-	1	5	100%	4	5	4	2	1	4	1	-	-	68%	73%
Preparation	-	1	5	100%	4	5	3	2	1	4	1	2	2	77%	81%
Operation	-	1	5	100%	4	5	3	2	1	4	1	2	2	77%	81%
Post-op	-	1	5	100%	3	5	2	2	1	3	1	1	2	65%	70%
Revisits	-	-	5	83%	4	5	3	2	1	3	1	1	2	71%	73%
Referrals	-	-	4	67%	5	5	2	2	1	3	1	2	2	74%	73%
Payment	-	-	4	67%	5	5	2	2	1	3	1	-	1	65%	65%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

Table A 28: Data collection methods used for counseling section according to the XQA team leaders, members and providers																		
Method	LTM				VS												Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12					
Interview	3	1	6	34%	9	8	4	3	4	9	4	2	4	71%	60%			
Observation	2	1	2	17%	5	6	2		2	5	4		3	40%	33%			
Documents	3		2	17%	6	7	1	2	4	8	4	1	3	54%	43%			

Table A 29: Data collection methods used for pre-op section according to the XQA team leaders, members and providers																		
Method	LTM				VS												Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12					
Interview	3	2	6	37%	8	7	3	3	4	8	4	1	2	60%	53%			
Observation	3	3	2	27%	5	6	4	3	3	7	3	2	2	53%	45%			
Documents	3		3	20%	7	7	3	3	4	6	4			51%	42%			

Table A 30: Data collection methods used for preparation section according to the XQA team leaders, members and providers																		
Method	LTM				VS												Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12					
Interview	3	2	6	37%	8	6	4	4	4	6	4	2	3	62%	54%			
Observation	3	3	3	31%	5	5	3	7	2	7	3	2	2	54%	47%			
Documents	3		3	20%	7	6	3	2	3	6	3	1	4	53%	43%			

Table A 31: Data collection methods used for the operation section according to the XQA team leaders, members and providers																		
Method	LTM				VS												Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12					
Interview	3	2	6	37%	8	6	4	4	4	5	4	2	3	59%	52%			
Observation	2	3	3	27%	6	6	3	3	3	9	3	2	4	60%	50%			
Documents	3		2	17%	7	6	3	3	3	5	4	1	5	56%	44%			

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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Table A 32: Data collection methods used for the post-op section according to the XQA team leaders, members and providers																
Method	LTM				VS										Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12			
Interview	3	2	5	34%	8	6	3	2	4	6	4	1	5	59%	51%	
Observation	2	3	3	27%	5	5	3	2	3	4	2		5	43%	38%	
Documents	3		3	20%	7	8	3	4	2	9	4	1	4	65%	61%	

## FEEDBACK REPORTS

Table A 33: Feedback reports sent to providers, according to the XQA team leaders																
	LTM				VS										Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12			
Yes, always		1	X	50%	1	1	X		1			1	1	63%	60%	
Not always, sometimes	1		X	50%			X	1		1	1			38%	40%	

Table A 34: Promptness of sending feedback reports to the providers, according to the XQA team leaders																
	LTM				VS										Sub-total	Total
	1	2	3	Sub-total	4	5	6	7	8	9	10	11	12			
Immediately after visit		1	X	50%		1	X		1			1		38%	40%	
Within 4 weeks	1		X	50%	1		X						1	25%	20%	

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

**Table A 35: Who feedback report is sent to, according to the XQA team leaders**

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
XQA team			X	0	1		X					1	1	38%	30%
Chief hospital/clinic		1	X	50%	1		X		1			1	1	50%	50%
PKMI prov.	1		X	50%	1		X		1					25%	30%
PKMI Central			X	0			X			1				13%	10%
BKKBN Prov.		1	X	50%	1		X		1					25%	30%
Depkes Prov.			X	0			X		1					13%	10%

**Table A 36: Feedback reports sent to providers, according to XQA team members**

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Yes		1	3	57%	3		X		1	1		3	2	50%	52%
No		1		14%			X	1		2	1			20%	19%
Sometimes	1			14%		1	X		1		1			15%	15%
DK/NR	1			14%		1	X				1		1	15%	15%

**Table A 37: Total number of respondents who received feedback reports**

Respondent	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
BKKBN/ Depkes chiefs	1		2	50%	1			2	1			1		63%	33%
PKMI chief			1	33%	1	1	X	1	1	1		1	1	88%	67%
Chiefs of hospital/HC/ Clinic			6	15%	2	1	5	2						14%	15%
Providers			3	60%	1	1	1	1	1		1		1	22%	27%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

**Table A 38: Assessment of the appropriateness, completeness and clarity of the feedback reports by the BKKBN/Depkes, PKMI, hospital/health center and clinic chiefs**

N = 23	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Appropriate		1	7	73%	3	1	4	2	1			1	1	57%	59%
Complete	1	1	3	45%	1		4	2	2			2	1	52%	50%
Clear	1	1	9	100%	1	2	4	1	2			2	1	57%	65%

**Table A 39: Promptness of sending feedback reports to the providers, according to XQA team members**

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
DK/NR							X		1		1			15	11
Immediately after visit		1		20%	3	1	X			1		1		46	39
Within 2 wk	1		3	80%			X								22
Within 4 wk				0			X		1			2	2	39	28

**Table A 40: Who feedback report is sent to, according to XQA team members**

	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
XQA team			1	20%			X			1		3	2	46%	39%
Chief hospital/clinic	1	1	2	80%		1	X					2	2	39%	50%
PKMI chapter				0	2		X					1	2	46%	33%
BKKBN district				0	1		X			1				15%	11%
QA team, district				0			X		1					8%	6%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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## RETURN VISITS

Table A 41: Return visits made to the clinics, according to the XQA team leaders															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Yes, always		1	X	50%		1	X	1	1				1	50%	50%
Not always	1		X	50%	1		X			1	1	1		50%	50%
DK/NR			X	0			X							0	0

Table A 42: Whether the clinics are always revisited according to the XQA team members															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Yes, always		1	3	57%	3	1	X	1		1	1	2	2	55%	56%
Not always	2	1		43%		1	X		2	2	2	1		40%	41%
DK/NR				0			X						1	5%	4%

Table A 43: Whether the clinics are always revisited, according to the providers															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Yes, always			5	25%	1		1	1	1	1	1		1	18%	21%
Not always		1		5%	4	5	3	2	2	4		3	1	63%	43%
DK/NR	5	9		70%			1	2	2		2			12%	36%

## ACTIVITY AND FINANCIAL REPORTS

Table A 44: Whether the VS/LTM activity and financial reports are submitted															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Activity report	1	1	1	100	1	1	X	1	1	1	1	1	1	100%	100%
Financial report	1	1	1	100		1	X	1	1	1	1	1	1	88%	91%

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

Table A 45: Appropriateness and completeness of the VS/LTM activity report forms															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Appropriate	1	1		67%	1	1	X	1				1		38%	46%
Complete	1	1		67%	1	1	X			1	1	1	1	75%	73%

Table A 46: Appropriateness and completeness of the VS/LTM financial report form.															
	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
Appropriate	1	1		67%		1	X					1		25%	36%
Complete	1	1		67%		1	X		1	1	1			63%	64%

#### MAIN PROBLEMS FOUND BY XQA TEAM

Table A 47: Main problems identified by XQA team, according to the BKKBN/Depkes chiefs															
Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	2	2	2	6	2	2	2	2	2	2	2	2	2	18	24
Minor complication	2	2	1	5(83%)	1		2	2			1		1	7(39%)	12(50)
Major complications	2	1	1	5(83%)	1		2							3(17%)	8(33)
Failures	2		1	3(50%)		1	1						1	3(17%)	6(25)
Incompleted cases	1		1	2(33%)	1									1(6%)	2(18)
Deaths				0										0%	0
Counseling			1	1(17%)	1		2			2	1		1	6(33%)	6(25)
New acceptors			2	2(33%)	1	1	2			2	2			9(50%)	11(46)
Personnel	2	1	2	5(83%)	1	1	2			1		1		4(22%)	9(38)
Facilities & equipment	1	1	1	3(50%)	2	1	2		1	1	1	1	1	9(50%)	12(50)
Medical procedures	1	1	2	4(67%)	1		2							3(17%)	7(29)
Referral services			1	1(17%)	1		1							3(17%)	4(17)
Administration	2	1	1	4(60%)	1									3(17%)	7(29)
Finance			2	2(33%)						1	1			2(11%)	4(17)

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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**Table A 48: Main problems identified by XQA team, according to the PKMI chiefs**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	1	1	1	3	1	1	X	1	1	1	1	1	1	8	11
Minor complication	1	1	1	3(100%)	1	1	X	1		1	1			5(63%)	8(73%)
Major complications	1	1	1	3(100%)	1	1	X	1						3(38%)	6(55%)
Failures		1		1(33%)	1		X			1	1			6(38%)	4(36%)
Incompleted cases				0	1		X			1				2(25%)	2(18%)
Deaths			1	1(33%)	1		X							1(15%)	2(18%)
Counseling	1	1	1	3(100%)	1	1	X		1					3(38%)	6(55%)
New acceptors		1	1	2(67%)	1	1	X		1	1	1	1		6(75%)	8(73%)
Personnel	1	1	1	3(100%)	1	1	X	1	1		1	1	1	7(88%)	10(90%)
Facilities & equipment			1	1(33%)	1	1	X		1		1			4(60%)	5(46%)
Medical procedures	1			1(33%)	1		X		1	1				3(38%)	4(36%)
Referral services			1	1(33%)	1	1	X							2(25%)	3(72%)
Administration			1	1(33%)		1	X	1		1			1	4(60%)	5(46%)
Finance			1	1(33%)			X	1		1		1	1	4(60%)	5(46%)

**Table A 49: Main problems identified by XQA team, according to XQA team leaders**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	1	1	X	2	1	1	X	1	1	1	1	1	1	8	10
Minor complication	1	1	X	2(100%)			X			1	1			2(25)	4(10%)
Major complications	1	1	X	2(100%)			X					1		1(13%)	3(30%)
Failures		1	X	1(50%)			X			1	1			2(25%)	3(30%)
Incompleted cases			X	0			X			1				1(13%)	1(10%)
Deaths			X	0			X							0	0
Counseling	1		X	1(50%)			X							0	0
New acceptors			X	0	1	1	X	1		1	1	1		6(75%)	6(60%)
Personnel	1		X	1(50%)	1	1	X	1				1	1	5(63%)	6(60%)
Facilities & equipment		1	X	1(50%)	1		X	1	1					3(38%)	4(40%)
Medical procedures	1		X	1(50%)			X			1				1(13%)	2(20%)
Referral services			X	0			X		1					1(13%)	1(10%)
Administration	1	1	X	2(100%)	1	1	X	1		1			1	5(63%)	7(70%)
Finance	1		X	1(50%)			X	1		1	1	1	1	5(63%)	6(60%)

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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**Table A 50: Main problems identified by XQA team, according to XQA team members**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	2	2	3	7	3	2	X	1	2	3	3	3	3	20	27
Minor complication	2	2	3	7(100%)	1	1	X	1	1	2	2		2	10(50%)	17(63%)
Major complications	2	2		4(57%)			X	1						1(5%)	5(19%)
Failures	1	2		3(43%)			X		1	1			2	4(20%)	7(26%)
Incompleted cases	1	1		2(29%)			X			2				2(10%)	7(15%)
Deaths		1		1(14%)			X							0	1(4%)
Counseling		1		1(14%)			X		1	3	1	1		6(30%)	7(26%)
New acceptors			1	1(14%)	1		X			3	2	3	1	10(50%)	11(41%)
Personnel	2		1	3(43%)	1		X	1	2		2	3	1	10(50%)	13(48%)
Facilities & equipment		1	2	3(43%)	2	2	X	1	1		1			7(35%)	10(37%)
Medical procedures				0	1	1	X	1	1	3				7(35%)	7(26%)
Referral services	1		1	2(29%)	1		X				1			2(10%)	4(15%)
Administration	1	1	1	3(43%)	1		X	1	1	3		1		7(35%)	10(37%)
Finance	1		1	2(29%)	1		X	1		1		3		6(30%)	8(20%)

**Table A 51: Main problems identified by XQA team, according to the hospital/health center chiefs**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	10	19	10	39	10	8	10	8	9	10	5	6	4	70	109
Minor complication			3	3(8%)	2		6		2			3		13(19%)	16(15%)
Major complications				0		1	2					1		4(6%)	4(4%)
Failures			2	2(5%)	1	1	1					1	3	7(10%)	9(8%)
Incompleted cases			2	2(5%)			1							1(1%)	1(1%)
Deaths		1	8	9(23%)	8	4	8	2	3	7		5	3	41(59%)	50(46%)
Counseling			4	4(10%)	3	2	6		2	4		3	2	22(31%)	26(24%)
New acceptors			5	5(13%)	3	1	7	1	2	4		4		22(31%)	27(25%)
Personnel			4	4(10%)	1	1	3		1	1		1		8(11%)	12(11%)
Facilities & equipment		1	6	7(18%)	4	3	5	1	2	6		1	1	23(33%)	30(28%)
Medical procedures			4	4(10%)		1	4		1				1	7(10%)	11(10%)
Referral services			2	2(5%)	1	2	1		1	3				8(11%)	10(9%)
Administration			5	5(13%)	1	3	1		1	2		1		9(13%)	14(13%)
Finance			8	8(21%)		2	3	2	3	6		5	3	24(34%)	32(29%)

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

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**Table A 52: Main problems identified by XQA team, according to the providers**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	5	10	5	20	5	5	5	5	5	5	3	3	2	38	58
Minor complication			3	3(15%)	1	3	2		1	1	1	1	1	11(%)	17(63%)
Major complications			1	1(5%)	1	1	1					1		4(%)	5(9%)
Failures			1	1(5%)	1	4	2				1	1	2	11(%)	12(21%)
Incompleted cases			1	1(5%)	1	1	1			1			2	5(%)	6(10%)
Deaths				0										0	0
Counseling			1	1(5%)	2	3	3		1					9(%)	10(17%)
New acceptors			2	2(10%)	1	1	3	2	1	2	1	2	2	14(%)	16(28%)
Personnel			2	2(10%)	1	2	1					1	1	7(%)	9(16%)
Facilities & equipment			3	3(15%)	1	3	1		2	3		1	2	13(%)	16(28%)
Medical procedures		1	1	2(10%)		1	3						1	5(%)	7(12%)
Referral services				0	1	1	1			3				6(%)	6(10%)
Administration			1	1(5%)		1	2		1				2	6(%)	7(12%)
Finance			2	2(10%)	1	1	4	3	2	4		3	2	20(%)	22(38%)

**CHANGES MADE BASED ON XQA TEAM RECOMMENDATIONS**

**Table A 53: Activities or services changed in accordance with XQA team suggestions, according to the BKKBN/Depkes chiefs**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N+	2	2	2	6	2	2	2	2	2	2	2	2	2	18	24
Yes	1	1		2(33%)	1		1		1		1	2		6(33%)	8(33%)
No	1	1	2	4(67%)	1		1	2						4(22%)	8(33%)
DK/NR				0		2			1	2	1		2	8(44%)	8(33%)

**Table A 54: Activities or services changed in accordance with XQA team suggestions, according to the PKMI chiefs**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N=	1	1	1	3	1	1	X	1	1	1	1	1	1	8	11
Yes	1	1		2		1	X		1		1	1		4	6(54%)
No			1	1	1		X	1		1			1	4	5(45%)

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra

**Table A 55: Activities or services changed in accordance with XQA team suggestions, according to the hospital/health center chiefs**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	10	19	10	39	10	8	10	8	9	10	5	6	4	70	109
Yes		1	3	4(10%)		2	2	1		2				7(10%)	11(10%)
No		1	5	6(15%)	10	5	3	2	3	6	1	5	3	38(54%)	44(40%)
DK/NR	15	12	2	29(74%)		1	5	5	6	2	4	1	1	25(36%)	54(50%)

**Table A 56: Activities or services changed in accordance with XQA team suggestions, according to the providers**

Problem	LTM				VS								Sub-total	Total	
	1	2	3	Sub-total	4	5	6	7	8	9	10	11			12
N =	5	10	5	20	5	5	5	5	5	5	3	3	2	38	58
Yes		1	2	3(15%)	1		1			1	1			4(11%)	7(12%)
No			3	3(15%)	4	5	2	3	2	4		2	1	3(61%)	26(45%)
DK/NR	5	9		14(70%)			2	2	3		2	1	1	11(29%)	25(43%)

X = No interview	1. Jabar	4. Jateng	7. Riau	10. Sulteng
DK = Don't know	2. Jatim	5. Yogya	8. Sumsel	11. Sulsel
NR = No response	3. Sumut	6. Sumbar	9. Sulut	12. Sultra