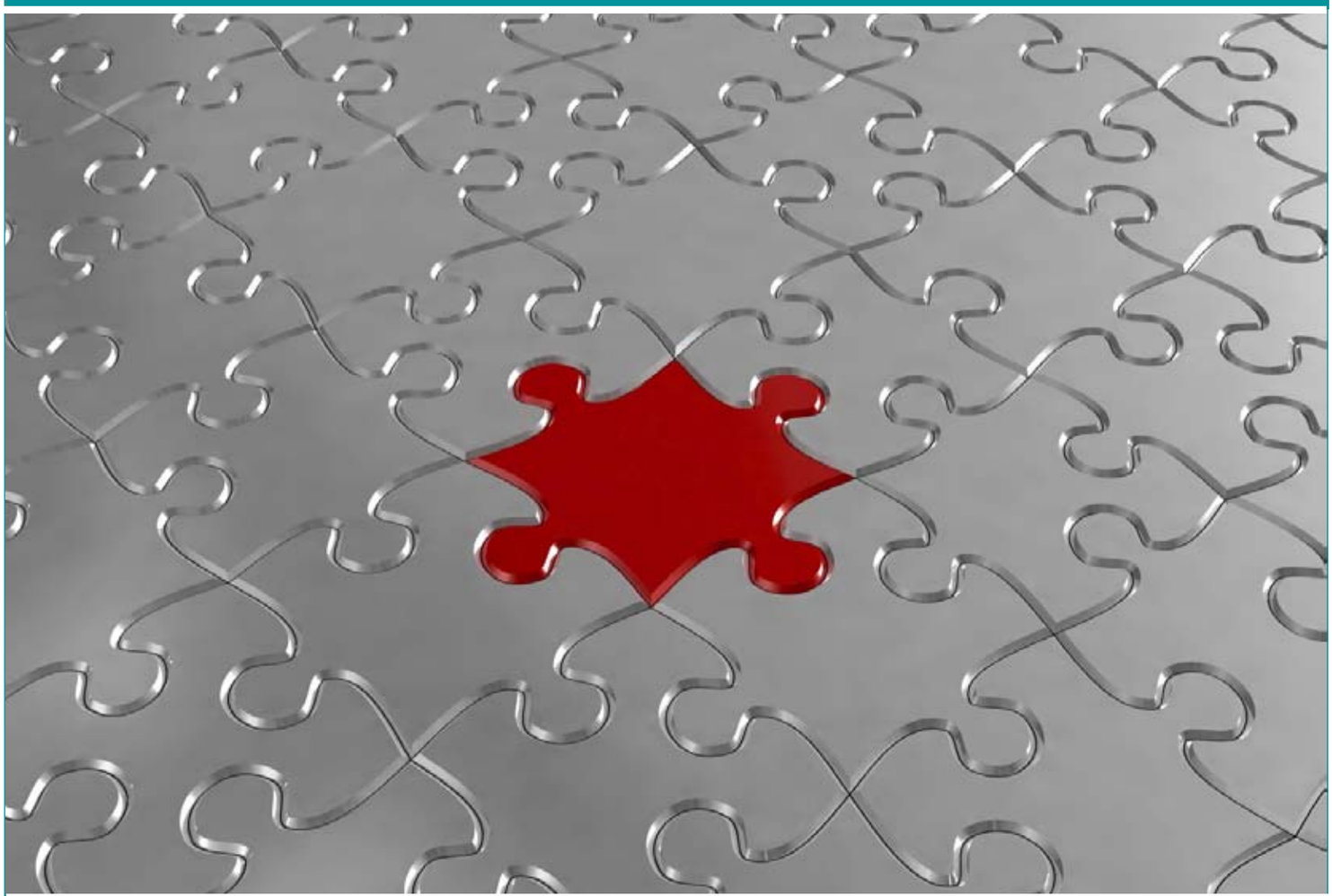
GTZ SISKES & HRD in Nusa Tenggara, 2006 - 2009



The lessons learnt working in the Indonesian Health Sector
in the West and East Nusa Tenggara Provinces

gtz

COOPERATION
REPUBLIC OF INDONESIA
FEDERAL REPUBLIC
OF GERMANY

BAKTI HUSADA

In loving memory of our dear
friends and colleagues:

Janette Margaret O'Neill (14 May 1955 - 16 November 2009)
James Darmawan (9 June 1950 - 11 December 2009)

Deutsche Gesellschaft fuer Technische Zusammenarbeit (GTZ) GmbH
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Lessons Learnt working in the Indonesian Health Sector in the West & East Nusa Tenggara Provinces, Indonesia

Editor:

James Carl Sonnemann

Principal Advisor:

Gertrud Schmidt-Ehry

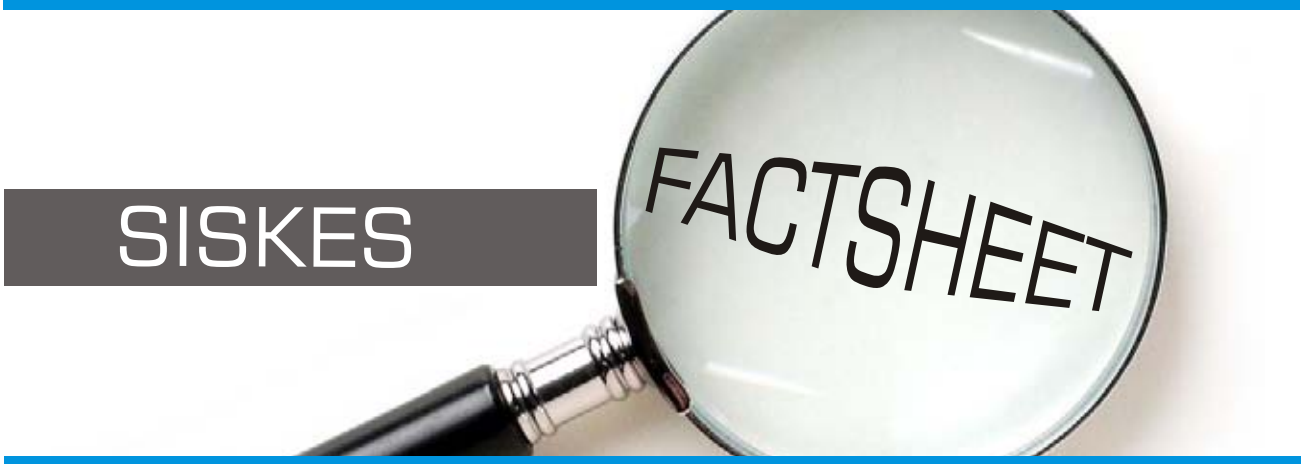
Layout & Design

Karsten van der Oord

Funded by:

Table of contents

SISKES



SISKES Improvement of the District health System in East & West Nusa Tenggara Provinces

The German Government has provided support to Indonesia's Health Sector in East Nusa Tenggara Province (NTT) since 1999 and in West Nusa Tenggara Province (NTB) since 2006. Implemented by GTZ and partners, the SISKES Project addresses District Health System improvement, focusing since 2006 also on Maternal and Neonatal Health with co-funding from the British Government (DFID).

A central principle of the technical cooperation is sustainable capacity building, working with Indonesian Government partners to link all levels and to focus strongly on improving the quality of health systems management. Central level policy and guidelines combine with local priorities as a basis for cooperation and harmonization between stakeholders. Collaboration with professional associations, local NGOs, and others provides additional opportunities for implementation. Organizing Project support through subsidies to be managed by local program officials wherever possible establishes stronger, sustainable program ownership. Clear steering mechanisms have been installed with MoH and at local level to cover three German-supported projects: Human Resources Development, SISKES, and Sector Program Health addressing health facility equipment (through KfW).

An ongoing process of learning from experience was initiated in late 2008.

Three phases of the SISKES project

Phase	Province	Districts	Period	Funding
SISKES I	NTT	East Sumba, Alor	1999 - 2002	2.452.000 Euro
SISKES II	NTT	East Sumba, Alor, Belu, Kupang, Maumere, Timor Tengah Selatan (TTS), Rote Ndao, Ende	2003-2005	2.345.000 Euro
SISKES III	NTT & NTB	NTT: Health System Development: 16 districts Making Pregnancy Safer (MPS): 6 districts: Kota Kupang, Kupang, Timor Tengah Utara (TTU), TTS, Belu, Rote Ndao	2006-2009	10.150.000 Euro (4.000.000 Euro BMZ funding, 4.200.000 £ DFID

Primary Areas of Cooperation

1. Health System Management Strengthening

- Working within the Indonesian Government planning and budgeting cycle, the Project improves the health system by linking the various levels through planning based on local data and priorities in conformity with national policies and standards.

This process of Integrated Health Planning and Budgeting (IHPB) is implemented through the Provincial and District Health Offices (PHO, DHO). A monitoring and evaluation (Monev) toolkit provides integrated review before each new planning cycle. Sixteen districts in NTT and all ten in NTB are involved in IHPB, and all of their health centers (Puskesmas) (272 in NTT and 142 in NTB) are part of the process as a first step of IHPB.

- Analysis of district and province health account expenditures (DHA and PHA) has been introduced in all ten NTB districts as an important component of improved planning and budgeting and to promote public expenditure transparency. Local budgeting will sustain the DHA process beyond 2009. In collaboration with the GTZ Good Local Governance (GLG) and policy (PAF) projects, GTZ SISKES supports development of a health financing model in NTB for the poor who are not yet covered under the Ministry of Health's JAMKESMAS plan. In NTT, SISKES II supported expenditure analysis in East Sumba (2001-2003), and DHA is currently supported by AusAID in nine districts.

- SISKES has supported improvement of the Health Management Information System (HMIS) through local HIS (SIKDA) teams within the PHO and DHOs in both provinces. A simplified manual HMIS format and software version developed in Belu District of NTT has been approved by the PHO for roll-out to all other districts of the province. In NTB, a computerized, semi-computerized and manual system introduced and used in 98 selected Puskesmas is scheduled for review and expansion at the end of 2009. One NTB hospital has also developed a computerized HMIS.

- Forums for coordination of donors at province level, developed in both NTT and NTB, are fully owned by Indonesian partners through the PHO in NTT and the Provincial Planning Board (BAPPEDA) in NTB.

2. Health Services Management

- A comprehensive Puskesmas management training toolkit was developed and used in both provinces. In NTT, evaluation of 79 of the 103 Puskesmas involved demonstrated improved performance and client satisfaction. In NTB, 31 of the 60 Puskesmas receiving the training also showed better performance and client satisfaction. The toolkit was later adapted to accommodate a new Ministry of Health curriculum.

- Beginning in 1999, hospitals in NTT received significant support to improve their management and infrastructure through GTZ and KfW/EPOS. KfW provided 14 hospitals with equipment and related support for performance monitoring, procurement and maintenance of equipment and nursing management, GTZ supported business planning during SISKES I and GTZ/Saniplan (SISKES II) supported seven hospitals (East Sumba, Alor, Belu, Ende, Kupang District, Maumere, and TTS) to help them qualify for hospital management autonomy. All were oriented in quality management using the European Foundation for Quality Management model, and a pool of trainers was created. Four of the hospitals (East Sumba, Alor, Belu, Ende) also received intensive training in accountancy and human resources management. Three were assisted to focus their quality improvement process in 2009 (SISKES III) on patient safety (Kupang, Belu, TTS). Hospital management training in NTB has been introduced in all seven hospitals in collaboration with Universitas Gajah Mada/Yogyakarta (UGM), and the process of continuous quality improvement has started.

- After assessing referral systems in the five Making Pregnancy Safer program (MPS) focus districts, a guideline integrating the MOH's 2004 MPS

guidelines with its 1972 referral guidelines was pilot tested in Lombok Barat for referral and back referral (feedback to the referring agency). The new guidelines were adapted and tested in Belu District in NTT. The new forms are now in use in both provinces and the system is ready for roll out.

3. Clinical Services Improvement

- SISKES supported MoH-initiated APN (normal delivery care) training of 347 of NTT's 1058 midwives (240 fully financed and supported by GTZ) and of 432 of NTB's 553 midwives (60 supported by GTZ). Evaluation by SISKES in NTB showed that performance had improved. SISKES supported training in Basic Emergency Obstetric and Neonatal Care (BEONC/PONED) for 18 teams in NTB (4 financed by GTZ) and for 12 teams in six districts of NTT (fully funded by GTZ). Training impact evaluation, an integral part of all Project-supported training activities, used the findings from maternal audits in the five supported MPS districts in NTB to show that delays in provider decision making and delays in obtaining appropriate care have been reduced at Polindes and Puskesmas levels, but not yet at hospital level.

- In NTB training was also supported and assessed for basic neonatal care training of 26 participants from five district hospitals, for emergency neonatal care for five doctors in Kota Mataram, and for special 3-month training in emergency pediatrics for one pediatric nurse from Mataram Hospital. Assessment showed improved case management. In NTT, training in neonatal resuscitation was carried out in five hospitals (79 participants), training in management of low birth weight deliveries in four districts hospitals, and contraceptive technical update training in Kota Kupang (20 midwives).

- The Project assisted the implementation by PHO of MoH Decree No. 836/2005 on 'Management of clinical performance of the midwife and nurse'. SISKES implementation in NTT began in 2007 in two pilot districts (Rote Ndau and Belu) with situation assessment, training in midwife clinical performance management (PMKK), and development of job descriptions and maternal and neonatal care SOPs, thus supporting the five requirements of the decree: a) availability of Standard Operating Procedures (SOPs), b) defined job descriptions, c) defined and agreed performance Indicators, d) discussion case reflection, and e) monitoring and evaluation (MonEv). Socialization of national guidelines for clinical performance management was carried out in NTT's other four MPS focus districts. The PHO approved the newly developed SOPs (based on 17 existing reference documents) and these were further disseminated and introduced to all MPS focus districts in NTT with support from UNFPA, UNICEF, and AIPMNH.

- Using a checklist developed by SISKES and revised together with PHO and other external agencies, evaluation of the use of and compliance with the SOPs found encouraging results. All 31 Puskesmas and two district hospitals assessed were found to have the midwifery SOPs posted prominently on the wall of the MCH ward or the delivery room. In NTB the availability and use of clinical algorithms whose dissemination and introduction had been supported by SISKES were evaluated in all five MPS focus districts, also with satisfactory results.

• SISKES provided support for IEC strategy design, and CDs of IEC materials have been produced and disseminated in both provinces. IEC improvement and implementation in NTT Province, carried out by VSO volunteers (under grant agreement contract with GTZ), has been completed successfully in TTS District.

• The WHO human rights research tool implemented by SISKES is available and has been disseminated to NTT and NTB Health Offices and external agencies with a final report and partner recommendations. NTB followed up some of the recommendations, integrating them in their operational plans.

• In 2005 a Lymphatic Filariasis elimination strategy and guidebook were introduced in NTT Alor District. Its LF rate reached < 1% in 2008 (five consecutive years < 1% are required to declare elimination). Belu District (2008 LF rate 2.6%) introduced an elimination strategy with its own budget in 2009.

4. Community Empowerment

• Five 'alert village' (Desa Siap Antar Jaga) networks focusing on maternal and neonatal health have been established and are functioning in 90 villages (5 districts) of NTB and in 50 villages (6 districts) of NTT. A toolkit for establishing Desa Siaga has been developed for NTB, and evaluation shows encouraging results. Cost analysis done (both NTT and NTB) will be useful for rolling out the approach.

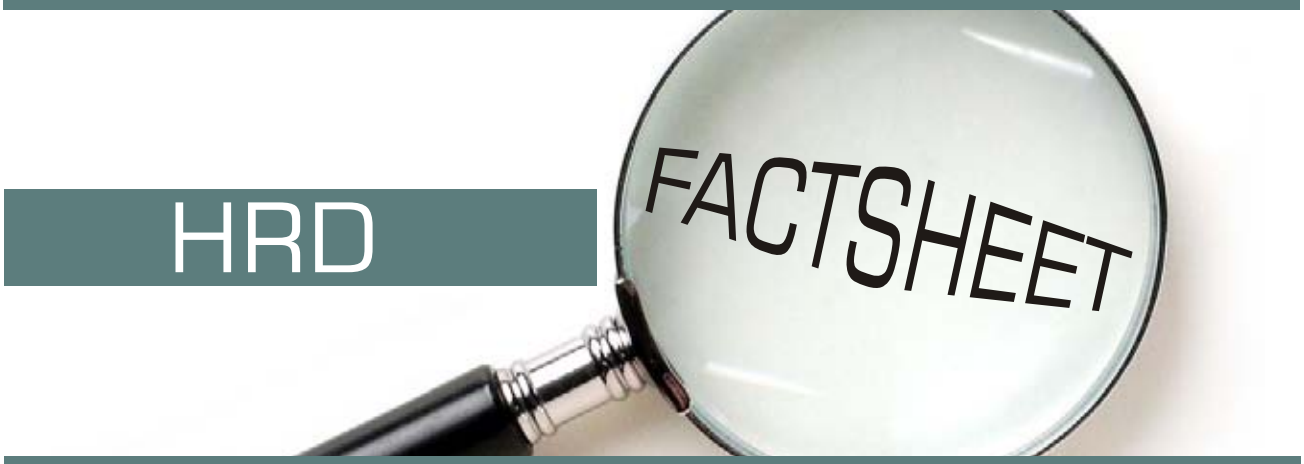
• In NTB, a module for adolescent reproductive health classes has been made available and tested in three classes in Kota Mataram and Lombok Barat.

• A small Project grant supported promotion and follow-up evaluation of hand washing with soap and trimming fingernails. Its effectiveness in reducing infant diarrhea cases in one West Lombok Puskesmas was shown to the population in a strategy to convince people to adopt healthy behaviors. Mothers could understand that washing their hands with soap keeps their children healthier, and this is becoming routine behavior.

Project Contact:

Dr. Gertrud Schmidt-Ehry (Principal Advisor)
Jl. Swara Mahardika No. 16
Mataram - Lombok (NTB)
Tel: +62 (0)370 647 848 (Hunting)
Fax: +62(0)370 637 676
Email: health.mataram@gmail.com

HRD



HRD: Human Resources Development in Indonesia's Health Sector

At the request of the Indonesian Government, the German Government has collaborated with the Board of Development and Empowerment of Health Human Resources (BDEHHR) of the Ministry of Health since the end of 2005 to support Nusa Tenggara Timur (NTT) and Nusa Tenggara Barat (NTB) Provinces in the field of human resources development in the health sector.

The HRD Project was designed to continue parts of the SISKES Phase II activities promoting human resources development and management as well as systematic institutional strengthening the project's main office is in Jakarta to be able to link implementation at province and district levels to policy and strategy development at the central level. The project has focused strongly on human resources (HR) system strengthening including HR planning, HR management, and quality improvement of training systems and institutions. In a related activity, the Provincial Hospital in Aceh was assisted to carry out a Workload Indicator of Staffing Needs (WISN) study.

Project	Areas	Partner Organizations	Period	Funding
HRD	National NTB&NTT	BDEHHR, Bappelkes & Poltekes in NTB & NTT, all hospitals in NTB, 3 hospitals in NTT in close collaboration with SISKES; WISN intervention in NAD (Aceh)	10/2005 12/2009	4.000.000 Euro

Main areas of cooperation and achievements:

1. Strengthening Health Human Resources Planning and Management

- A Health Human Resources Management Information System (HR-MIS) was introduced in 6 districts and 4 government hospitals of NTT Province. Expansion to NTB is in the final stages to cover the Provincial Health Office (PHO), 10 District Health Offices (DHO), and all government hospitals.
- An HR-MIS Toolkit was developed.
- Health Workforce Planning Development Methodology (Dewdney Method) was introduced at national, provincial, and district level.
- A WISN Tool Kit was completed.
- The Responsibility and Authority Mapping Process (RAMP) was introduced in NTT and NTB and implemented in NTB. Local governments in NTB

have requested expansion of the tool to other sectors of government.

- Facility based planning using the Workload Indicator of Staffing Need (WISN) methodology was implemented in 12 NTT and all NTB districts. Local governments in NTB have requested application of the tool to other sectors of government, and trainers have been trained to help ensure sustainability. The NTT counterpart team also assisted the Nanggroe Aceh Darussalam (NAD) Provincial Hospital to implement WISN.

2. Quality of Health Workforce:

- The pre-service training systems of NTT and NTB Province were studied in cooperation with AusAID. Areas requiring strengthening were identified, and follow up measures continue through twinning collaboration of Poltekkes 3 in Jakarta and Poltekkes NTT.

- Training of 30 provincial accreditation surveyors and 30 assessors was completed to strengthen in-service training in NTT and NTB. This training included staff from pre-service education to strengthen links between pre-service and in –service. PHO HRD staff in NTB is now working to establish a provincial accreditation body to monitor quality of training.

- Bapelkes in NTT and NTB have completed development and implementation of roadmaps to improve in-service training accreditation status. NTB has achieved improvement of its accreditation score from 3.7 to 3.9. NTT is awaiting official central level accreditation assessment, but the provincial process indicates an improvement from 3.2 to 4.35.

3. Strengthening Hospital Management:

- Hospital management training has been jointly supported by the HRD and SISKES Projects. Technical advisors from both projects have been involved in preparations and coaching together with contracted universities.

- Hospital Management Training (HMT) and Quality Improvement Action was completed in NTB. Eight government hospitals, including the mental health hospital, are now using the HR-MIS.

- Human Resources Management was strengthened in 10 hospitals of NTT through application of WISN, and the training of hospital trainers has been completed. HR-MIS has been introduced to 4 hospitals and is now being used routinely.

- Training in Patient Safety and Quality Improvement actions was completed in 3 hospitals in NTT to complete interventions originally initiated by SISKES I and II and KfW/EPOS support.

1. Dr. Gertrud Schmidt-Ehry (Principal Advisor) 2. Joyce Smith (Team Leader)
Badan Pengembangan dan Pemberdayaan SDM Kesehatan
Pusat Perencanaan dan Pendayagunaan SDM Kesehatan
Jl. Hang Jebat III Blok F3
Kebayoran Baru
Jakarta 12120
T +62 (0)21 720 7806, 7279 7446
F +62 (0)21 720 7806
E gtzeposhrd@cbn.net.id

Authors:
Dr. Lieve Goeman, MD, MPH
Dr. Yustina Yudha Nita

Linking IHPB and DTPS-MNCH methodologies for program planning: A case study from the Kupang Municipality Health Office NTT Province, 2007-2009

Decentralisation in the health sector aims at improving health care services in pursuit of better performance and equity. In bringing decision making for health services closer to the people, it is believed that service delivery will better fit local needs and be more efficient and effective than in a centralised system. Planning ranks among the most important decisions to be made, ideally based on local needs identified through participation of the community, all levels of the health system, and stakeholders of various sectors.

Two methods to facilitate local planning and budgeting have been developed to systematise the process in the interests of efficiency, efficacy, and equity. During the period of GTZ SISKES assistance to NTT and NTB Provinces, both the District Team Problem Solving approach and Integrated Health Planning and Budgeting were employed in NTT. This paper describes the GTZ SISKES contributions in the context of one local government area, the municipality of Kupang, NTT Province.

I. Background

The Maternal and Child Health division of the Indonesian Ministry of Health (MoH) has promoted the use of District Team Problem Solving (DTPS) since 2003 for planning and budgeting the Maternal, Neonatal, and Child Health program (MNCH). This method uses a multi-sector problem solving approach to involve all stakeholders that results in a list of priority interventions needed to address the most important problems.

As part of its support to the health services of NTT and NTB Provinces, GTZ SISKES assisted their Provincial Health Offices (PHO) to develop an Integrated Health Planning and Budgeting (IHPB) mechanism as approved by the two provinces and by central level. The planning teams and IHPB facilitators of the two PHOs developed a practical guideline on how to implement the IHBP methodology in logical chronological steps from the health centre to the DHO and PHO levels. IHPB is intended to contribute to the effective and efficient management of the health sector, improving synergies from all levels for development planning as mandated by Law 25 of 2004 on the national development planning system.

Inasmuch as the MNCH program is part of the overall health development programme, the results of DTPS-MNCH should be integrated and accommodated in the wider IHPB process.

This document illustrates this link between DTPS and IHPB by describing the planning processes that took place in Kupang City during 2007-2009.

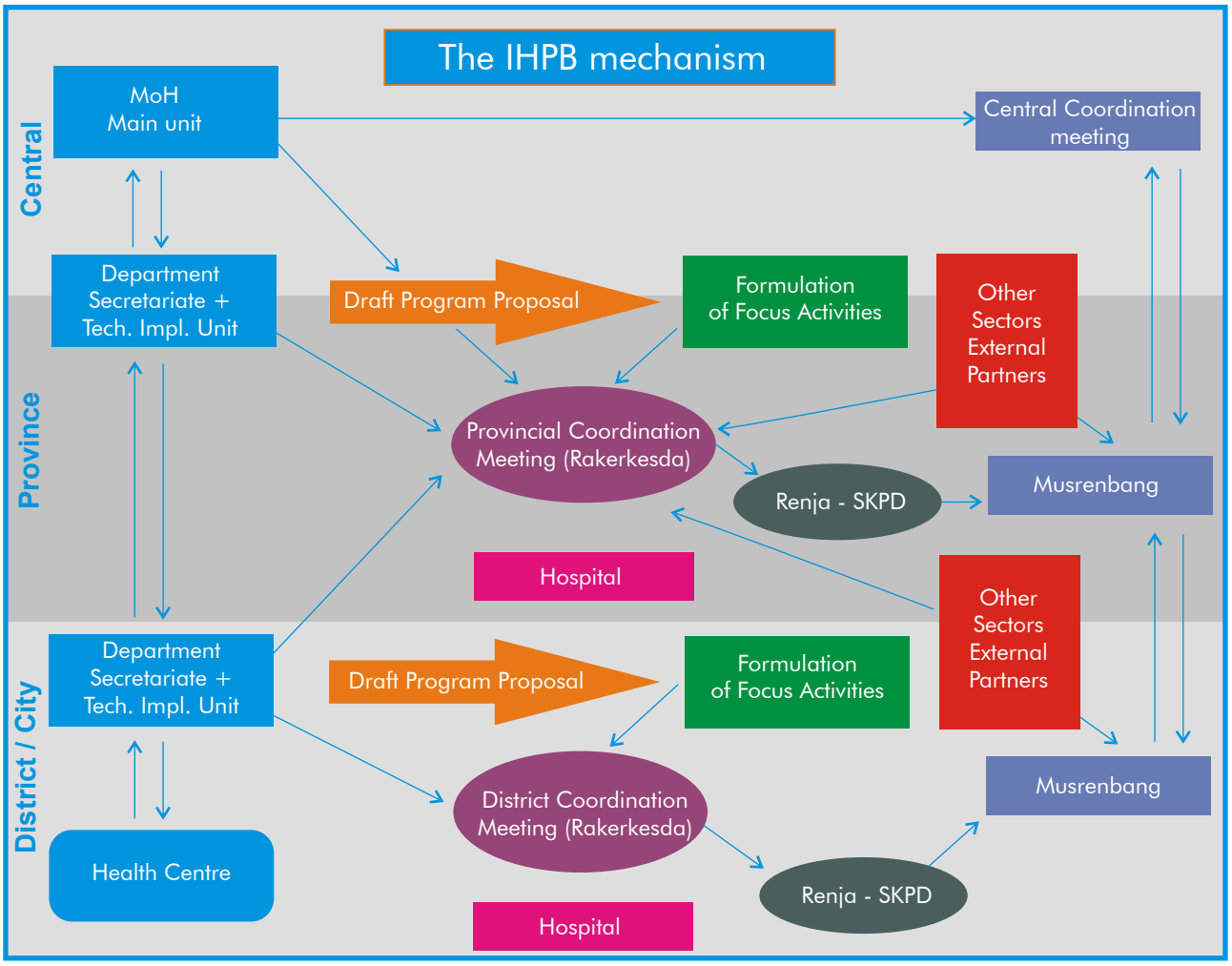
2. Integrated Health Planning & Budgeting (IHBP)

IHPB is a mechanism to facilitate more appropriate health planning and budgeting in order to achieve better health outcomes. Based on existing laws and government regulations[1], it is not a new mechanism but an effort to improve the existing process of developing integrated annual plans from health centre to DHO and PHO to MOH level.

3. District Team Problem Solving in Maternal, Neonatal, and Child Health (DTPS – MNCH)

DTPS is a planning tool developed by WHO for use by district/city teams for all types of health programs. In Indonesia the method has been used by the MNCH program since 2003 as a health planning method. Originally used for planning of the Making Pregnancy Safer (MPS) strategy, "DTPS-MPS" was later expanded to consider all elements of the MNCH program. The aim of the tool is to involve all stakeholders and use evidence for better planning and budgeting of the MNCH program. Evidence is obtained from a situation analysis using MNCH data from the district/city, problem analysis, and priority orientation. The 3-step process starts with multi-stakeholder orientation and consultation, followed by planning meetings and follow-up advocacy to the local government for appropriate budgets.

The pink boxes labelled "Formulation of Focus Activities" in the figure below indicate where DTPS can be integrated into the IHPB mechanism.



[1] Guideline on Law 25/2004 on National Planning system; Governmental Regulation 39/2001 on Decentralisation; Guidelines for Musrenbang as in Governmental Regulation 58/2008; Guideline for planning at health centres; Guideline for P2KS, PROSPEK, DTPS.

4. Planning processes at Kupang City DHO 2007-2009

The use and coordination of IHPB and DTPS for developing integrated annual work plans (Renja Terpadu) by health officials of Kupang City developed gradually through three years of GTZ SISKES support:4.

2007 - Development of annual plan / Renja Terpadu for 2008

- IHBP: Kupang City DHO began to implement the IHPB mechanism in 2007 with support from the GTZ SISKES Project. The process started in March with a joint planning meeting of the heads of all health centres and the Kupang City DHO. Although IHPB normally expects the health centres to make their plans prior to that of the DHO, that could not start before an IHBP guideline had been developed and the mechanism socialised.

- DTPS: Delayed release from central level of the Dekon budget to conduct the workshop delayed the first DTPS workshop until April 2007. By that time the annual plans of the health centres and the DHO had already been completed, but integration of the DTPS results was still possible because the Musrenbang[2] had not yet been conducted.

- PHO response: Because the Dekon budget for DTPS will always be released later than the start of the IHBPS mechanism, the NTT Province MPS team decided to conduct the DTPS meetings only once every 2 years and to use the results for 2 consecutive years of planning. Thus the results of the 2007 DTPS would be used for the annual plans for 2008 and 2009.

2008 - Development of the annual plan/ Renja Terpadu for 2009

- IHPB: This year the health centres started the IHPB process in January by making their plans (RUK), facilitated by the Kota Kupang DHO in March. Based on these plans, the Kota Kupang DHO developed their plan (Renja). The Rakerkesda[3] was conducted in April, followed by the Musrenbang.

- DTPS: The findings from the DTPS 2007 were integrated with the MNCH program as part of the health plan for 2009.

2009 - Development of the annual plan/ Renja Terpadu for 2010

- IHPB: Implementation of the IHPB mechanism started in January at the health centre level, facilitated by Kupang City DHO. The annual DHO plan followed, and the Rakerkesda was held in April.

- DTPS: As expected, the dekon budget to conduct the DTPS meeting had not yet been released at the time of the planning, so the results of DTPS 2007 were once again used for MNCH program planning. The results of the DTPS workshop that took place in July were used to update the MNCH annual plan.

The results of DTPS 2009 are/will be used for the 2010 and 2011 annual plans. The next DTPS meetings will be conducted in 2011.

5. Integration of DTPS-MNCH Recommendations into IHPB

Table 1 shows the results of the 2007 DTPS process. The DTPS team recommended 21 interventions to address the priority problems identified. Not all 21 were taken up in the annual plan for 2008. Based on these priorities but limited by available budget, nine interventions of the recommended interventions were actually integrated in the annual plan.

These are bolded in the table on the following page.

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1. Musrenbang: A process to harmonise all sector plans with district development policies and priorities.
2. Rakerkesda: District meeting involving PHO, local government, and the planning board to discuss the priorities and plans of the DHO and health centres.

Table 1: Results of DTPS – MNCH 2007 DTPS – MNCH 2007

DTPS – MNCH 2007

1. Training in APN[4] , PPGDON[5] , APK[6] , PONED[7]
2. Development of SOPs[8]
3. Procurement of the MCH book
4. Procurement of drug and health equipment
5. Provision of houses for health staffs completed with facilities
6. Health education by health personnel on childbirth and delivery.
7. AMP[9] at health centre level
8. Regular meetings on MCH surveillance at health centre level (PWS KIA)
9. Regular meetings between health personnel and trained Traditional Birth Attendants (midwife-TBA partnership)
10. Referral transport, especially for in-patients
11. Provision of drivers for in-patients
12. Training in Health promotion
13. Provision of free Family Planning services
14. Establishment of alert village systems
15. Training in Asphyxia management
16. SOP on child abuse (KPA) services
17. Health promotion for parents on child education using humane approaches
18. Health promotion at schools on Reproductive Health and against child abuse
19. Establishment of facilities providing Reproductive Health and child abuse services (room, equipment, materials, budget)
20. Health education in schools: Peer and little doctor training for children
21. Cross-sectoral socialisation of Child abuse and Reproductive Health

Table 2: Results of DTPS – MNCH 2009

DTPS – MNCH 2009

1. APN and PONED training including post-training evaluation
2. Training on supportive supervision and post-training evaluation
3. Training on the use of MCH book and post-training evaluation
4. Training on the use of ABPK KB[10] tool and post-training evaluation
5. Training on the use of P4K[11] and post-training evaluation
6. Training on Modern Contraceptive Techniques (CTU) training and post-training evaluation
7. Training on use of Partogram and post-training evaluation.
8. Conduct of AMP at health centre and community level
9. Use of Social AMP at sub-district level
10. Training on the use of MCH book for volunteers at the integrated hamlet health post
11. Training on asphyxia and post-training evaluation
12. Training on ANC and post-training evaluation
13. Training on Low Birth Weight and post-training evaluation
14. Conduct on the job training at Provincial Hospital in PONEK[12]
15. Procurement of the health cards for children under five.
16. Conduct of Focus Group Discussion at neighbourhood level on MCH and , early detection of child development problems.
17. 3 monthly meeting between DHO and health centre level
18. Provision of Reproductive Health services at each village
19. IMCI[13] training
20. Water quality control
21. Conduct of participatory health promotion on diarrhoea

4. APN: Normal Delivery Care
5. PPGDON: Emergency Obstetric Neonatal Delivery services
6. APK: Complicated Delivery Care
7. PONED: Basic Emergency Obstetric and Neonatal Care
8. SOP: Standard Operation Procedures
9. AMP: Maternal and Perinatal audit

10. ABPK KB: a decision making toolkit for family planning
11. P4K: Strategy for delivery and emergency preparedness
12. PONEK: Comprehensive Emergency Obstetric and Neonatal Care
13. IMCI: Integrated Management of Childhood Illness

6. Conclusion

DTPS is a tool to produce results that can be used for MNCH planning as part of overall health program planning. The results of the DTPS meetings are being used and integrated in the IHPB process as illustrated by this case study of Kupang City. Although linked, not all the recommendations of the DTPS are accommodated in the annual plans (cfr. table 1 and 2) because of MNCH program budget constraints.

Unless appropriate budget for DTPS could be allocated from the province or district budget (APBD) to ensure that DTPS can be conducted early in the year (Jan - April) before the DHO planning, it must be assumed that the release of the budget from the central level for DTPS meetings may be delayed beyond the time needed for the IHPB process. In that case, the decision of NTT Province planners to conduct the DTPS only once every 2 years is reasonable.

A
lesson
learnt

Author: Ir. Zubaebah, MA

Introducing District and Provincial Health Accounts in NTB Province: **Public Expenditure Review**

Health account monitoring incorporates all expenditures for health in a given area. The widest used international system, and the one used for National Health Accounts (NHA) in Indonesia, is the system of national accounts and International Classification for Health Accounts (ICHA) developed by the Organisation for Economic Co-operation and Development (OECD) in collaboration with the World Bank, WHO, and USAID. According to the ICHA system, national health accounts, and by extension, health accounts at province and district level "can help in understanding the roles of government, industry, households, and external organizations in the purchase of health care. Because of their reliance on standardized classifications of providers and functions, NHA illustrate the linkages between financing and delivery and outcomes of health services and goods."[1]

The ICHA Guide "urges the health accounts team to understand the policy issues of the health system so that the health accounts can be structured to be of maximum value to decision-makers."[2] As health accounts systems are developed locally, it encourages first-time accountants to "select those aspects that are most relevant to their customers and focus their resources and energies on those aspects. Even the accounts of countries with decades of experience in doing such work are in a state of continuous improvement."[3]

Decentralization and Health Accounts

Until the introduction of decentralization in 2001, Indonesia financed its health sector as in many formerly centrally-planned economies. 85% percent of the public funds were administered from the central Ministry of Health (MoH). International agencies encouraged countries to use the National Health Accounts (NHA) tool to track health sector expenditures, and Indonesia developed its NHA in the 1980s for application at national level. With decentralization, however, most expenditure authority and responsibility for health and other social services was devolved to the district level, and local government decision makers were suddenly in need of health accounts information to be able to monitor and allocate public resources for the health sector, comparing what is spent with what is needed and with what is allocated. Decentralization took place quite rapidly, and a complex system of intergovernmental fiscal transfers emerged that largely bypasses the central MOH to support the decentralized administrations. This resulted in considerable difficulties, including disruption of the

[1]. Guide to producing national health accounts, With special applications for low – income and middle – income countries, 2003, World Health Organisation, World Bank, USAID, Canada, (p.2).
[2]. Ibid (p. 7)
[3]. Ibid (p. 9)

flow of information within the public sector. One consequence was that monitoring of government health spending was largely neglected.

As in other countries that have decentralized, a number of Indonesian provinces and districts have attempted to develop Province and District Health Accounts, generally with donor funding. And, as elsewhere, assessing the private side is always difficult, so the process begins with review of the more accessible public expenditures.

Decentralization should facilitate better, more efficient allocation of resources for health because local government health officials have superior knowledge of local needs, resources, and opportunities. Without adequate local information on health sector needs and performance, local decision makers are left with little guidance, however, and NHA data does not help much for local decisions. In NTB Province the results include district budgets that are insufficient to ensure effective health services, fragmentation and inefficiency in the use of the funds available, inadequate operational funding that directly undermines health services performance, increased capital costs, delayed release of annual funding that results in activities implemented too hastily for good quality, and budget allocations that are not in line with priorities as defined by Minimum Service Standards (SPMs), National Midterm Plans (RPJM), Ministry of Home Affairs (Permendagri) regulations, the Millennium Development Goals (MDGs), etc.

Local government officials and the public urgently need transparent and accessible information on health financing within the Province. Local parliaments, politicians, and policy makers have asked repeatedly about the size of problems in NTB's districts. They have asked where the health sector money goes, who benefits, and how much is needed to reduce the rates of infant and maternal death that still rank NTB among the worst in Indonesia. Such questions can only be answered by recording actual health expenditures for analysis at district and province levels using a tool such as District Health Accounts (DHA) and Provincial Health Accounts (PHA) that can demonstrate financial performance at specific administrative levels. DHA and PHA use standard tables to record data for analysis on expenditure sources, agents, providers, resource costs, and beneficiaries. They can also show the pattern of health financing for a particular district in comparison with health priorities and past trends.

As part of its objective to strengthen health sector management in NTB Province through development of methods to provide reliable evidence to guide appropriate decisions and facilitate integrated health planning and budgeting (IHPB), SISKES supported the development of District Health Account (DHA) and Provincial Health Account (PHA) capacity throughout the Province. This document reports on the process of Local Health Account development in NTB Province, the findings and lessons learned to date.

GTZ support for DHA and PHA in NTB Province

Through the SISKES Project, GTZ supported the development of DHA and PHA in NTB Province as part of its broader commitment to strengthen an integrated health management information system (HMIS) to provide reliable evidence for improved health sector management, and for integrated health planning and budgeting (IHPB) in particular. The province was assisted to assess the adequacy of current district health funding and to produce good data to improve health planning and policy-making, especially using the government budget. A public health financing map at district level cast light on fund flow and allocations. It also allows comparison among districts and with the national NHA framework.

SISKES identified the following objectives for PHA and DHA development in NTB Province:

- to improve understanding of heath financing and its problems at various levels of the districts and province
- to improve understanding of the "Health Accounts" concept (NHA, PHA, and DHA) at district and province levels

- to develop the skills of district and province officials to develop DHA and PHA using the WHO standard international classifications for health accounts (ICHA) so that the findings can be used for comparisons among districts within the province and the country
- to improve knowledge and skills for analysis and interpretation of DHA and PHA data in order to strengthen IHPB, integrated monitoring and evaluation (Monev), and policy reform
- to develop tools for transparency and accountability at district and province levels
- to institutionalize DHA and PHA methods
- to support NHA development

SISKES identified several key indicators to monitor its DHA / PHA activities:

- Serial data for 2006, 2007, and 2008 that are accurate, reliable, and comparable
- Annual sets of DHA data for IHPB, Integrated Monev, and policy reform at district and province levels for each of the three years
- Skilled and professional human resources capacity to develop DHA using ICHA standards
- Incorporation of DHA and PHA as part of the HMIS and for formal presentation in annual health reports at district and province levels
- Routine use of DHA and PHA within the planning divisions.

Strategies, methods, and activities to develop DHA and PHA

In general terms, expenditures for health accounts classification can be grouped as expenditures from public or private sources, organisations as well as individuals. Public sector funding for health comes from two principal sources – government agencies and foreign donor assistance. Because Government funding is always insufficient and donor support is often overestimated and poorly integrated with government funding, coordinated planning and monitoring is essential to address local priorities and avoid financing overlaps. Reliable information and analysis of expenditure are also essential for public transparency and to able to advocate effectively to district governments to allocate sufficient, appropriate funding for health.

Private expenditures include health insurance by employers and out-of-pocket payments by individuals. The former are very small in NTB Province, but they should be available for the province as a whole, if not by district, and this is one reason to do PHA as well as DHA. More important are private payments by individuals that can be accessed through periodic surveys. Recent surveys in Indonesia include the annual National Socio-economic Survey (SUSENAS) of approximately 200,000 households, and the Riset Kesehatan Dasar (Riskesdas) of 2008. Results from these surveys have not been available in a timely fashion for recent years, but even an analysis of public expenditures alone can be valuable for monitoring the fit between priority needs and expenditures to evaluate and improve local budget allocation decisions. When sufficiently robust private expenditures are available, they will be added to the local accounts analysis.

SISKES consultants used workshops, health accounts teams, and coaching to introduce and develop DHA / PHA methods throughout NTB Province using a Local Health Account method limited in scope to expenditures that are either public (government) or provided by external "rest of the world" donors. Workshops introduced tools, built commitment, and explained the use of the tools with exercises for data entry, cleaning, interpretation, and dissemination. Detailed information on public expenditures using standard international definitions and classifications as set out in the WHO Producers' Guide (WHO, 2002) was used. Following introduction of the basic methods, with assistance from an international consultant, coaching continued via email, telephone contacts, and consultant support from the University of Indonesia.

Steps to develop DHA and PHA in NTB Province

Orientation

The preparation process began with a first workshop for decision makers from Bapeda, the PHO, nine DHOs, and the province and district hospitals to introduce the concept, need, and

importance of Health Accounts using OECD standards. The aims were to secure interest and commitment to produce DHAs, identify responsible staff, gain access to finance data, and come to common agreement that both cash and 'in-kind' expenditures are to be included in the calculations.

At province level, a PHA team of 12 persons was formed with representatives from each division of the Provincial Health Office (PHO), the public hospital, the regional planning body (Bapeda), the bureau of statistics (BPS), and health training bodies. At district level each DHA team was made up of one person from Bapeda (cultural/social division), two from the District Health Office (DHO) planning unit, and one from the public hospital (planning/finance). Bapeda was included as a key member to facilitate data collection from related health sector institutions.

At a second workshop attended by representatives from all districts, the 4-person DHA teams were joined by the PHO planning division to develop a "roadmap" to guide the process. The next step would be to find or develop tools and training materials.

Development of tools and teaching materials
SISKES contracted the NHA team from the University of Indonesia to identify or develop essential tools and teaching materials for DHA / PHA use:

- teaching materials on the concept and theory of Health Accounts
- a database template in spreadsheet format with Pivot Table
- guidelines on filling in the DHA database template
- a Code of Accounts based on the ICHA (International Classification of Health Accounts) classifications of WHO and Permendagri No. 59/ 2007

The third workshop introduced the tools and identified budget resources and the flow of funds. The workshop also reviewed the concept and theory of DHA using ICHA-WHO criteria because some of the original participants had been shifted to new posts and replaced by new personnel.

Data collection

With PHO support, the DHA teams then began to collect the data needed. The scope of data expanded from year to year in all districts as the limited data and DHA team members' time permitted. For 2006 the DHA recorded only DHO and public hospital expenditures. The 2007 DHA added other public expenditures related to the health sector and donor agencies, and the 2008 DHA data included almost all public expenditures in health sectors. Data from the Central Bureau of Statistics on "out-of-pocket" expenditures are still awaited. The following table lists the major budgets analyzed.

Source of funds	Title of document
Province Budget (APBD I) District Budget (APBD II)	2006-2007: DASK (list of work to be executed) 2008: DPA (budget execution document)
Deconcentration Budget (DEKON) from Center	DIPA (list of budget allocations)
Special Allocated Funds (DAK) Capital investment budget (TA)	Part of DPA within APBD for 2008 DIPA (list of budget allocations)
Temporary personnel salaries (Gaji PTT)	Gaji PTT (salaries for temporary personnel

In 2008, because data from the private sector and donors or international organisations was not available by district but generally available at province level, SISKES supported development of PHA as well in order to obtain a more complete overall picture of health expenditures from all sources, not only government. However, international organisations' data, including that from GTZ during 2006-2007, were found to be difficult to disaggregate by district.

Data collection poses a major challenge in developing DHA and PHA, and the teams faced numerous problems of limited data, anxiousness regarding transparency, and resistance to the

sharing of data, particularly from higher level officials. DHA team members who quit the DHA teams did so largely in response to such difficulties.

Producing actual District Health Accounts

The fourth workshop convened the participants by large island group (Sumbawa and Lombok) for increased effectiveness. Participants were required to bring laptops for sharing their knowledge, skills, and data with other participants. Previous exercises on data entry in DHA 2006 and 2007 had used OECD standard formats, but for 2008 the ICHA format was used and participants entered their own data by district with close coaching from consultants to ensure that all participants could use the formats, classifications, and boundaries of ICHA. The ICHA requirements were also harmonized with Permendagri No. 59/2007 during these workshops.

Data cleaning

At the request of the participants, a fifth workshop was organized on the subject of data cleaning, a process to be carried out within each district, primarily by DHO personnel with PHO coordination using telephone and email for consultation and feedback. Incomplete data and consistency with classification standards were proving to be challenging, and data cleaning with coaching via email and telephone was not proving satisfactory.

DHA team members were distracted by their primary duties from following up on feedback from consultants, and their supervisors did not always feel that their DHA duties deserved priority. In addition, some DHA team members still lacked skills. The workshop was therefore devoted to data cleaning where the DHA teams could concentrate full time on the task.

Data Analysis and Interpretation

Data processing and analysis were done jointly by the DHA and PHA team with close coaching by consultants. Analysis used ICHA classifications with some modifications for the local context. Data were transformed into information describing resources, agents, providers, functions, resource costs, and beneficiaries. The information was analyzed by criteria of sufficiency, sustainability, efficiency, effectiveness, and equity to be used to guide Integrated Health Planning and Budgeting and for Integrated Monitoring and Evaluation.

Dissemination and use of findings

The results of DHA and PHA were presented to the DHOs, PHO, and then National and International levels. Presenters strongly advocated the institutionalization of NHA, PHA, and DHA within existing systems and for the use of DHA and PHA data to disaggregate NHA data to improve planning, management, and policy at all levels.

DHA / PHA methods applied

The public expenditures portion of DHA was carried out in the nine districts of NTB Province[4]. All nine districts developed local health accounts using their actual staff who would need to be able to do so. During the process it was apparent that, in general, the district level staff have the skills and the motivation to classify and analyse public expenditure data.

To produce good quality public expenditure data, clear definitions and boundaries are employed to classify all direct government expenditures for activities whose primary purpose is to restore, improve, and maintain health for the public during a defined period of time.

The fundamental health accounts activity is to classify health expenditures using the standard international definitions set out in the WHO Producers' Guide that sorts data into standard tabulations according to categories of financing agent, provider, resource input, function, or beneficiary. Training materials and standard templates were developed and used as guidelines for local teams to construct their database in line with the National Health Accounts framework. In 2008, a revised local health account template brought cost item classification in line with the National Health Accounts system.

[4]. The tenth, North Lombok (Lombok Utara), had not been created yet

Tracking public expenditures for health developed step by step in NTB Province. Analysis of 2006 data was limited to the District Health Office services and hospitals. More comprehensive expenditures were included in 2007 to cover government spending by non-health agencies as well, and donor and "rest of the world" expenditures were also included. Further extension in 2008 included additional non-health agencies. Thus, by 2008, the scope included data from public expenditures on health from health and non health sectors such as social health insurance (Askes, Jamsostek) and several donors.

The Provincial Health Office also tracked expenditures for health in 2008. More complete assessment of the private sector, to be added as data are available, may prove more difficult to collect and to measure. Data from Central Statistics on out-of-pocket expenditures are awaited. An initial focus on public expenditures is valuable in itself, however, because it directly reflects public policy and performance and can guide policy and management decisions.

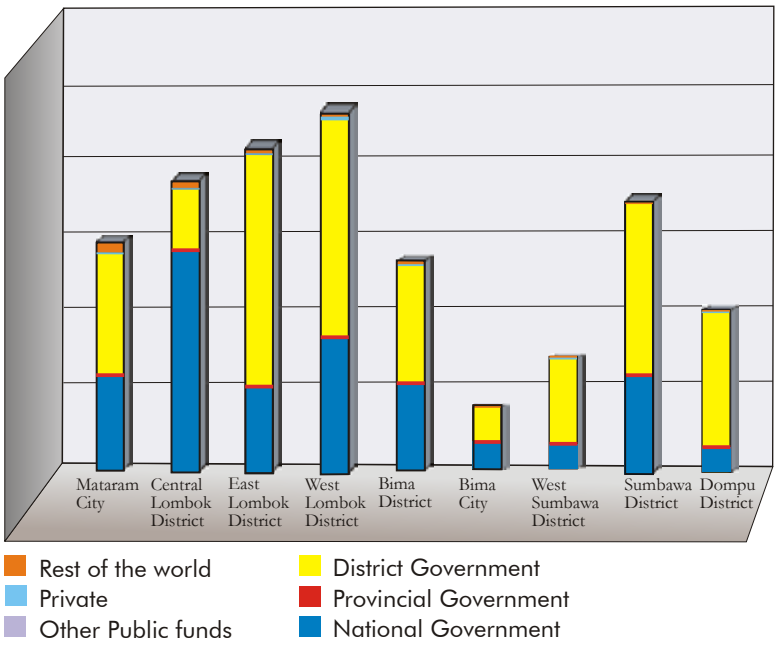
Data sources included in PHA and DHA of NTB Province in fiscal year 2008:

Health agencies	Non-Health agencies	Not yet included
1. Health services 2. Public hospitals 3. Police hospital	1. Family Planning Body 2. Education services 3. Infrastructure department 4. Harbor 5. Social Welfare 6. Planning Bureau 7. Prisons 8. Worker's health insurance (PT. ASKES, JAMSOSTEK)	1. Army hospital 2. Out-of-pocket (data not available at province and district levels)

Findings from DHA

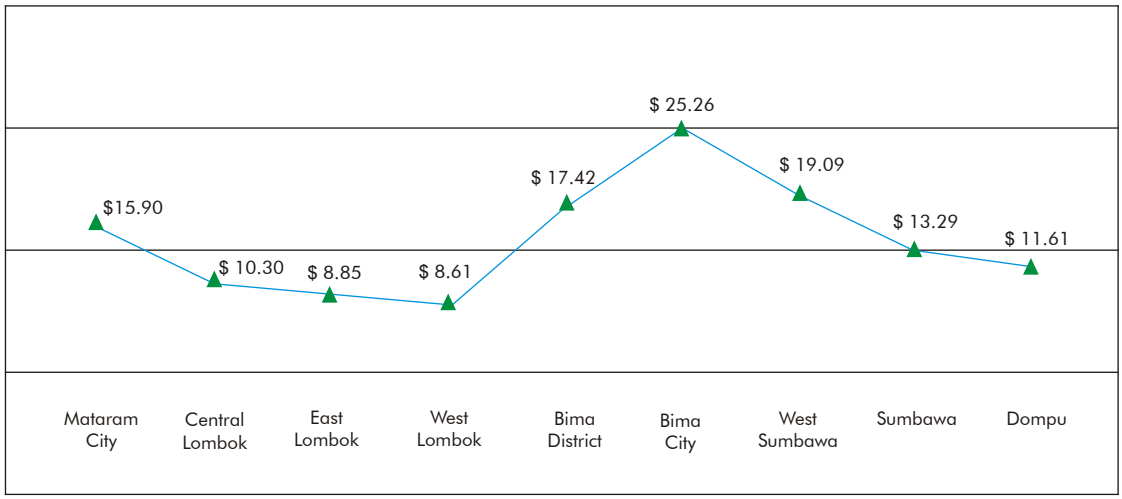
The following graphs present findings from the nine districts according to several health accounts categories. Additional manipulation of the data can focus in other ways as well.

Public Health Expenditure by sources of funds - NTB 2008



It is immediately clear in Figure 1 that the most significant sources of funds for health in the 9 districts of NTB in 2008 were the district budgets (APBD II) and central government contributions. The proportions contributed by donor agencies and others are quite minor. While this reflects the importance of local government decision-makers, and supports hopes that innovations initiated with the help of international organisations such as GTZ can be affordably sustained, it should be noted that much of the district funding must first cover salaries and other fixed expenses that absorb from 56% of the total local budget in Bima City to 80% in West Sumbawa. The proportion remaining for allocation to program operations is considerably less. This also demonstrates the importance of the institutions at district level, particularly the District Health Office, that manage the great majority of funds. With districts having the authority/power to manage and allocate funds, their need for reliable DHA data is clear.

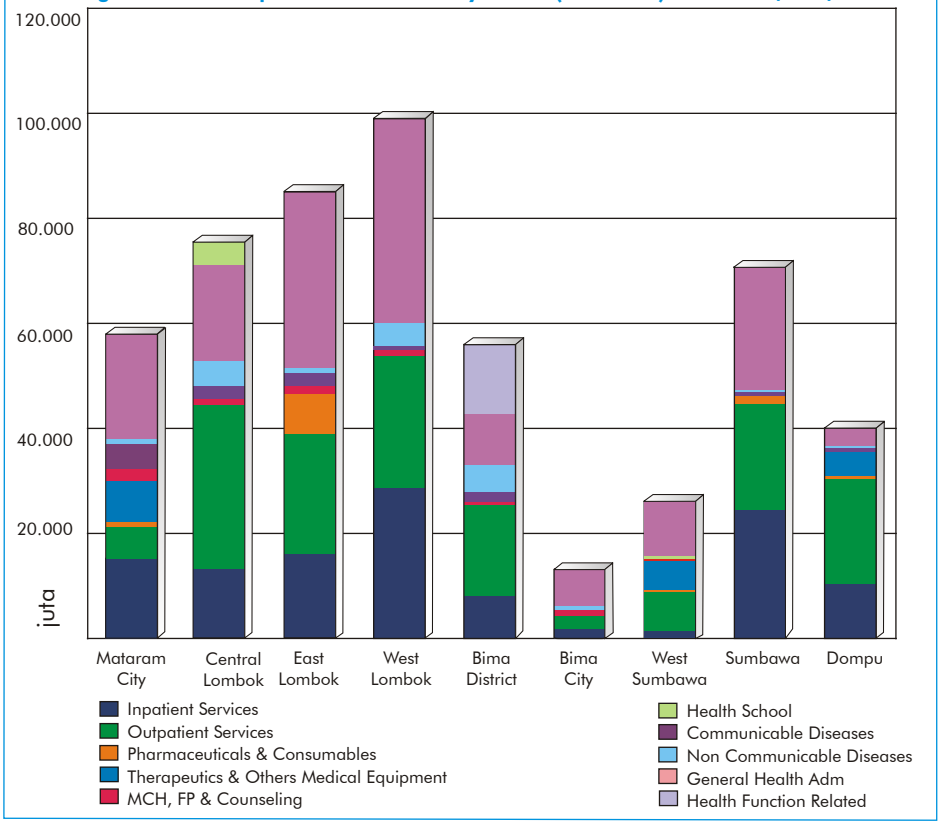
Figure 2. Public expenditure on health per capita by district, NTB, 2008



The districts of NTB vary in funding per capita for health. To understand what this means, however, it is necessary to consider that some are engaged in hospital construction or other capital-intensive projects, that the districts vary considerably by wealth, and that the proportion of the total local budget allocated to health can vary greatly, subject to decisions by local government.

Sorting expenditures by function (Fig. 3) highlights two predominant functions – curative services (outpatient and inpatient) and general health administration. Spending for curative care, ranging from 35% to 70%, probably reflects the availability of additional funds from the central government's pro-poor health financing program over the past two years.

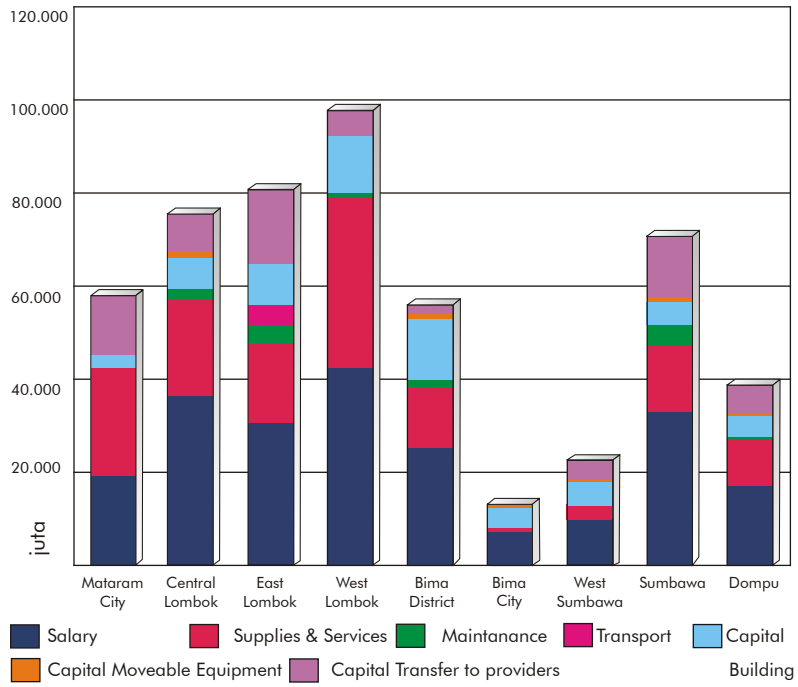
Figure 3. Public expenditure for health by service ("function") and district, NTB, 2008



The graph shows that the providers that provide most of the health care functions are hospitals and the health centers (Puskesmas).

Financing is relatively low for the province's priority programs and Millennium Development Goals (MDGs) focus areas such as maternal and child health (MCH), family planning and counseling, communicable disease control, and health promotion. It is hoped that the limited attention to promotive and preventive activities will not result in stagnant disease patterns.

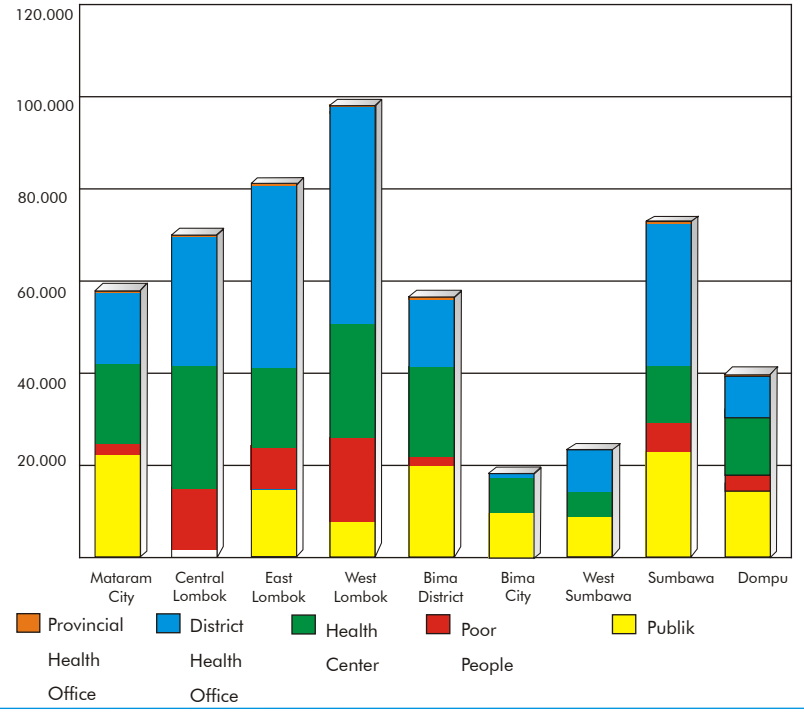
Figure 4. Public expenditure for health by type of Resource Cost and district, NTB, 2008



Sorting by "resource cost" aggregates expenditures by type as investment (capital construction, capital transfer to providers, and moveable capital equipment) or operational costs (salaries, maintenance, supplies, and services).

In 2008, expenditure in the nine districts averaged 28% for investment and 72% for operational costs. Expenditure for salaries and honoraria averaged 60% of total operational expenses, and the second largest proportion after salaries and honoraria was capital transfer to providers of medical equipment, stationery, etc. Operational funds remaining to support priority programs were small.

Figure 5. Public expenditure for health by Beneficiary and district, NTB, 2008



Sorting by beneficiary (Figure 5, below) shows that government officials in Puskesmas, DHO, and PHO received about 80% of the expenditures in each district. The public (general public and the poor) benefitted from only about 20% of expenditures (highly variable) in each district.

On average, about 7.5% of health financing was spent to benefit the poor in the nine districts. West Sumbawa does not show a budget for the poor because it provides total free health care coverage.

Use of the DHA / PHA findings

To date, seven of the nine districts have used DHA data for budgeting and advocacy during the Integrated Health Planning and Budgeting process at district level. At province level PHA 2008 data were utilized by the Dewan Peduli Anggaran (DPA) network of NGOs to advocate to parliament during the APBD 2010 budgeting revision process. Dompu District used DHA data to compare with malnutrition cases to improve the equity of its budget allocations for remote Puskesmas area.

The DHA and PHA methods and findings have been presented internally to DHO, PHO, and NGOs in NTB Province, and to the MOH and health planning staff throughout Indonesia through the NGO forum, donors, universities, at the IHEA symposium in Beijing in July 2009.

Personnel from NAD (Aceh) Province and Kudus District of Central Java joined at least two of the sessions organized by SISKES. Kudus District has now initiated the process, and NAD has rolled out DHA to two additional districts.

The process begun with SISKES Project support shows signs of sustainability. The PHO and DHOs have committed in RAKERKESDA 09 to continue DHA and PHA in the future. The PHO has already incorporated a budget line of its central budget for PHA, and West Lombok and Bima Districts have included it in their local budgets.

Conclusions

The large majority of public funding for health services in NTB Province is allocated and managed by the districts and central levels in Jakarta, and the district level is most critical for management of public health programs. Pertinent health account information is therefore most needed at those two levels for appropriate decision making. The health accounts process provides information on public expenditure that facilitates rational decisions for allocating the limited resources available. Private expenditures to complete the picture will be incorporated when data are available.

Building local capacity to carry out the Local Health Account process is feasible, but it requires a significant initial investment to prepare teams to do and local governments to look at what they produce. District level staff, once properly trained and supported, can produce appropriate health accounts, with appropriate analysis. The most difficult aspects of the process are gaining access to actual expenditure data and classifying data in conformity with international usage. Classification of out-of-pocket expenses may prove difficult as well.

Review of the findings for 2006-2008 demonstrates that curative health services receive a far larger proportion of available public resources than are spent for preventive and promotive services that are essential to achieve goals such as the Millennium Development Goals and those of Health Indonesia 2010.

The DHA / PHA process initiated in NTB Province now produces such information on expenditure of public funds for health in formats compatible with NHA data. There are encouraging signs of district level interest in the process, and the information gathered is increasingly used to improve planning and budgeting at local levels. Support from the Bupati and the Governor's office for continued annual health accounts analysis can sustain the efforts initiated with SISKES Project support.

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Health Sector Development in the Era of Decentralization:

The "Think Tank" Approach

Author: Laksmi Zahara

A Lesson Learnt

During the implementation of GTZ-SISKES Project in NTB Province, informal discussions with Provincial Health Office personnel gradually became an informal working group that became known as the "Think Tank" to the Project and its counterparts.

The meetings provided a forum for creative discussion of problems and potential approaches that are not constrained by bureaucratic boundaries or formal meetings with defined expectations. The "Think Tank" has become a special, facilitating feature of health system development in NTB Province.

The fairly abrupt implementation of far-reaching "regional autonomy" or decentralization of most Indonesian social services in January 2001, with authority transferred to provinces and districts to manage resources according to their own priorities, offered local government new possibilities to define local health policy that fit local needs, interests, and capacities. Nevertheless, several problems arose during implementation:

- The priorities and timing of policy implementation differ from national to local (province and regency/city) level. Even though a process for coordination and planning was outlined in UU (Public Law) No. 25 of 2004, many operational factors differ from place to place, with the result that the focus and locus of programs and activities differs too.
- Institutional and organization structures vary from region to region, causing problems in health program coordination and implementation.
- Formal leaders of specific programs of the PHO often displayed narrow perspectives that were not easy to combine with the stated objectives of the SISKES Project.
- Frequent and unpredictable rotation of government officials and transfer to new posts
- delayed and undermined program implementation and coordination as staff were repeatedly in the situation of trying to assimilate a new situation and to implement policies and programs that have not been fully communicated or understood.

The GTZ-SISKES Project encountered this situation upon start-up in NTB Province in 2006. In response to the problem, informal discussions began with three contact persons interested in the Project and familiar with the PHO programs. From these discussions, the idea emerged to engage additional PHO personnel to discuss problems and possible solutions in order to coordinate policies and accelerate implementation the GTZ-SISKES Project in the framework of health sector development in the province.

The informal discussions identified activities for Project support which could to accelerate achieve of national targets (RPJMN and MoH strategic plans) within the context of local development (local strategic Renstrada plans – RPJMD).

institutions and regions (regency/city) until the Deputy Director of the Provincial Health Office named the informal forum the "Think Tank". The results of its discussions were brought to the leadership forum for consideration, and the process was finally approved as part of the agenda of health development by both the Health Services and GTZ-SISKES.

Role of the Think Tank

The role of the Think Tank was to start as an informal forum involving a few staff to start communicating development ideas that might later develop into technical policy. The special characteristics of the Think Tank are that:

- It applies informal, open procedures in which participants are free to give their opinion without representing or committing their organization.
- Anyone interested can participate: there are no formal boundaries.
- Individuals can continue as members even after transfer to a new position.
- Designing policies is approached as problem solving.
- Information is disseminated to others regarding important current issues.

The intense informal meetings often ran beyond formal work hours, but reports of the meeting results to structural officers (management) were found to activate and accelerate program activities of the PHO's yearly and 5-year strategic plans.

Advantages of the Think Tank approach

- The Think Tank approach can give everyone the opportunity to participate in health development without getting involved in bureaucratic structural boundaries.
- The potential of individual staff can be recognized and used maximally, highlighting the skills and real commitment of Health Office personnel. It pushes aside claims that the region does not have enough competent human resources.
- Activities can be initiated and managed locally, without other resources from other regions.
- It can accelerate communications and coordination, both inside and outside of the Health Services.
- To counter the problems caused by high staff rotation, the Think Tank can be very important in providing information and advocacy to new officers in decision-making.
- When an active member of the Think Tank is rotated to another department, he/she can apply his/her knowledge to the new work site, benefiting both that Institution and the Health Office. For example, BAPPEDA adoption of the Integrated Health Planning and Budgeting (IHPB) approach for application to the whole sector was initiated following advocacy by a Think Tank member moved from the Provincial Health Office to BAPPEDA.
- Think Tank members can continue to contribute ideas and knowledge actively to the Health Office even after moving to a different department.

Continuing concerns

- The legality of the Think Tank can be questioned because it does not fit within the strong bureaucratic boundaries of the Government's system of duties and functions (TUPOKSI).
- Misunderstandings can occur when a Think Tank participant is considered to do something that it is not within his/her authority.

Conclusions and recommendations

The Think Tank grew into an informal working group of about 20 members from the Governor's Office, the PHO, and even districts. As a non-formal group, it is relatively independent of staff transfers and people remain members because of personal interest and commitment. Because its members come from different sections, it has proven to be a dynamic, comprehensive forum to work on integrated planning, budgeting, monitoring, and evaluation. It has become the most important partner group for ongoing health system development work in NTB and provides hope for sustainability and committed ownership.

- Considering the positive results achieved by the Think Tank approach for the NTB Provincial Health Office, efforts should be made to maintain it by ensuring its legality.
- From the perspective of the institution, the Think Tank should be equipped with a complete database to continue to analyze policy and provide technical advice.

A LESSON LEARNT

Author: Dr. Lieve Goeman, MD, MPH
Contributions: Dr. Lau Fabianus
Dr. Idawati Trisno, Mkes

Project flexibility

can overcome differing or changing partner agency priorities

What happens when an external agency wants to achieve an output which is not of particular interest to the partner either because it is not a priority or there is no budget?

What happens if the partner agency suddenly identifies an important health problem that was not foreseen in the plan of operation of the external agency?

SISKES Project experience in NTT shows that when the priorities of the external agency and the host agency differ, solutions to consider should include NGO collaboration to enable the external agency to achieve its outputs and support its partner. If new priorities arise for partner agencies that were not foreseen in the external agency's plans, the external agency should be flexible in adapting its plan, budget, and activities to meet the partner's changing priority needs.

IEC in TTS

Two examples from SISKES in NTT Province illustrate these lessons:

1. The SISKES plan of operations included output 3.3: "IEC strategy renewed" as reflected in indicators;
a) revision, approval, and dissemination of the revised strategy;
b) production of a CD with health promotion materials to used by DHO and PHO to develop IEC strategies; and
c) IEC activities strengthened, based on the IEC strategy.

The first 2 indicators were easily reached and with success in the early stage of the Project, but strengthened IEC activities were not a stated priority for the PHO and proved difficult to implement the activity and to demonstrate the relevance and usefulness of the IEC strategy.

Through partnership with VSO, collaboration with the DHO of TTS District was established, facilitated by the VSO volunteer placed in the health promotion division of the DHO.

The IEC strategy was adapted to the local context of TTS, activities were planned during 2008 and approved in the budget for 2009 and implementation as soon the budget was released with SISKES and VSO support.

The Project thereby achieved its outputs and indicators and could convince the district partner of its importance as well.

H1N1 Flu in Belu

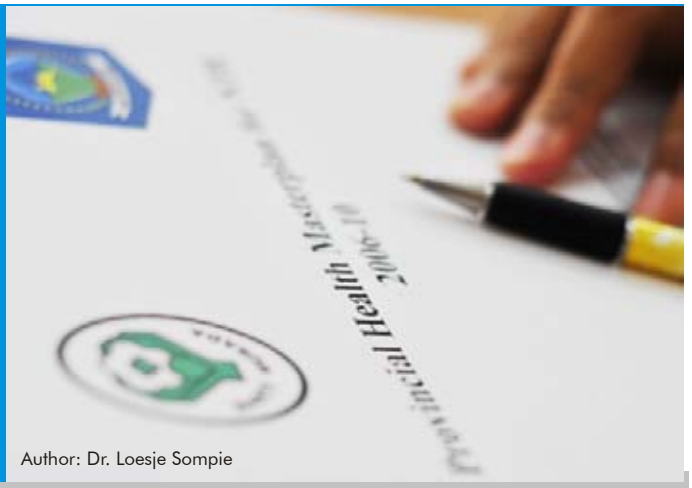
H1N1 The spread of H1N1 flu throughout Indonesia and Timor-Leste in 2009 created anxiety among the community and health stakeholders in Belu District, neighboring Timor-Leste.

The DHO recognized an urgent need to convene all stakeholders to disseminate correct health information and develop an appropriate action plan for prevention and disease control. The DHO requested resource persons from the PHO and support from SISKES to facilitate the event.

Flexibility within the SISKES plans and budget, and the willingness to address emerging health problems, made it possible to respond adequately to the changing and sudden priority of its district partner.

Reproductive Health
Program Donor Coordination Meetings:

Were they useful?



Author: Dr. Loesje Sompie

From 2006 through 2009 the SISKES Project seconded a senior national expert to MoH to assist in coordination, working closely with the directorate of Maternal health and WHO. GTZ-SISKES participated in numerous meetings with other donor organizations to coordinate activities to promote the Ministry of Health Making Pregnancy Safer (MPS) program. This paper reviews that coordination from the perspective of the Project.

Background

The MoH initiated the Safe Motherhood Program in 1988, and the first meeting to coordinate the donors, NGOs, and Government agencies working to accelerate the reduction of maternal/perinatal morbidity and mortality in Indonesia took place in July 1994. Thereafter, coordination meetings, sponsored by WHO, took place on a quarterly basis. From July 1994 through November 2001, 24 meetings were held to discuss many issues and share lessons learned and recommendations. Success stories from one donor or one place were reported, but could rarely be sustained. Any commitments agreed were never monitored, and after projects closed, their programs also disappeared. The legacy of this series of 24 quarterly meetings is not apparent. Meanwhile, Indonesia's maternal mortality rate (MMR) remained high and the Government failed to achieve its goal of reducing the MMR from the 1985 level of 450 deaths per 100,000 live births to 225 or less by the end of the Repelita VI.

In 2000 the Government renewed its commitment to Safe Motherhood by launching the Making Pregnancy Safer (MPS) program with three main messages and four key strategies.

The three main Main messages:

1) all deliveries should be done by skilled birth attendants,
2) all complications of pregnancy should be referred and treated properly,
3) and all pregnancies should be wanted.

The four key strategies identified were:

1) to increase coverage of reproductive health services,
2) to increase the quality of reproductive health services,
3) to empower communities to improve their reproductive health, and
4) to improve the management of the reproductive health care system.

The 2002-2003 Indonesia Demographic and Health Survey (IDHS) estimated MMR to have decreased to 307 per 100,000 live births, still far from the national target of 226 per 100,000 live births by 2009. To achieve the target, the MoH committed improving coordination with and between donors, not merely to share information, but to institute joint planning of activities in order to use resources effectively and avoid duplication.

In 2006, when the SISKES Project initiated its special focus on MPS, a donors' workshop on 8 February in Jakarta identified eight recommendations:

1) The MoH should set policies, strategies, standards and be responsible to disseminate them to provincial/district level. Additionally, the MoH should coordinate all donor support by establishing a coordination unit/body to act as a clearing house and provide support and direction in planning and the use of best practices when rolling out programs of related MoH technical departments and to donors.

2) Maternal / Neonatal and Child Health Care should be addressed with a systems approach, implementing all programs in a coordinated, harmonious, and integrated way to avoid overlapping and contradictions between programs and donor support.

3) The province should go beyond just providing information and supervision but also fulfill its role to coordination with districts. It should also bring districts together to learn from each other and needs technical and managerial assistance to do so.

4) The MoH should develop a "task force" to work on 2-3 critical issues in 2006 to support improved planning and implementation of the reproductive health program.

5) Two coordination meetings should be held every year, the first at the beginning of the year (March in 2006) and the second at mid-year to accommodate interventions as needed. In following years the first meeting should be conducted before March to allow the donors time to adjust their support to the district plans and budget allocations.

6) Implementation of the 2006 program should be rescheduled according to the funding and activities of local government, and budget distribution should be linked to performance and degree of implementation reached by the province/district.

7) A roadmap should be developed to identify 1-2 topics at a time to focus the coordination. One topic suggested was Desa Siaga as a model of community participation that could addressed MPS as well as non-medical issues.

8) A small team should be established to develop a follow-up plans of practical activities.

Based on these recommendations, GTZ and WHO took the initiative to assist MoH by providing accurate data on donors activities through a updated donor data mapping mechanism.

Table 1 that follows is an inventory of donor activities and projections in 2006.

Donor activities and projections in 2006

Agency	Project Name	Funding & Duration	Geographic focus
AusAID	Women's Health and Family Welfare Project. Project components includes: assistance to GoI to improve the quality and access to health care for women and newborn infants; promotion of FP and safe motherhood; promotion of community responses to safe motherhood.	A$27.8 million grant over 4 years (Jul 02 – Jun 06)	NTT: Sikka, Ende, Ngada, East Flores, Manggarai, Lembata NTB: East Lombok, Central Lombok, Bima, Dompu
UNICEF / AusAID	Improving Maternal Health in Eastern Indonesia. Program includes: support to policy, district planning, and problem solving; health system strengthening and quality control; improved delivery of health services; improved community participation	US$4,16 million grant over 3 years (Jan 04 – Dec 06)	NTT: Kota Kupang, Alor, West Sumba, East Sumba Papua: Jayapura, Jayawijaya, Sorong, Bi: Manokwari

UNICEF / DFID	Improving Maternal Health in Indonesia. Program includes: support to policy, district planning, and problem solving; health system strengthening and quality control; improved health services delivery; improved community participation	US$14.9 million grant over 3 years (Feb 06 – Feb 09)	Banten (3 districts) W. Java (3 districts) Central Java (3 dist.) E. Java (3 districts) S. Sulawesi (3 dist.) W. Sulawesi Maluku (3 districts) N. Maluku (2 districts)
GTZ / BMZ / DFID	GTZ Siskes Plus Making Pregnancy Safer. Program includes: support to effective management of health services; functioning referral system; availability of appropriate technical skills for health professionals; informed, alert and supportive communities and political leaders; improved sector coordination	€10.15 million grant over 4 years (Jan 06 – Dec 09)	NTT: Kab. Kupang, Kota Kupang, TTS, TTU, Belu, Rote Ndau. NTB: West Lombok, Kota Mataram, Kota Bima, Sumbawa, West Sumbawa
UNICEF / AusAID	Women and Children Health Program in Papua. Program will focus on: increasing community awareness of and initiative in adopting good health practices; strengthening decentralized health system; strengthening human capacity for health system management and delivery	A$6.2 million grant (subject to approval). Expected commencement July 06 – Jun 09	Papua: Jayapura, Jayawijaya, Sorong, BI: Manokwari
USAID	Health Services Program. Program includes technical assistance to reduce maternal, newborn and child mortality. Focus on improving District Health Office performance in planning and budgeting; increasing skilled attendance at delivery; mobilizing communities: Desa Siaga, advocacy, and bcc interventions at community level. HSP works with GOI, NGOs, and private sector organizations.	US$38 million grant over 4 ½ years (Apr 05 – Oct 09)	NAD North Sumatra Banten West Java East Java DKI Jakarta
European Union	Support to Community Health Services. Program includes: improved skills and capacity of districts to plan and manage community health care system; define and operate quantitative and qualitative performance standards for community health care services; develop district capacities and systems to carry out new roles in health financing with particular emphasis on financing for the poor and socially deprived.	€35 million grant over 4.5 years (Sep 03 – Mar 08)	South Sumatera Jambi Papua

World Bank	Provincial Health Project. The project aims to bring about effective health sector decentralization in two provinces; and help the central ministry carry out its new role in a decentralized system.	US$38.3 million loan over 6 years (Jun 00 – Jun 06)	Lampung DI Yogyakarta
World Bank	Second Provincial Health Project.	US$63.2 milion loan over 6 years (Jun 01 – Jun 07)	North Sumatera Banten West Java
ADB	Decentralised Health System (DHS) – 1 -Effort to improve province & district capacity to provide local specific & needs driven health services planning & implementation activities. -Accessible & affordable health services. -Focus on the poor and vulnerable, including women & children.	US$65 million loan. Initially over 5 years (Jun 01 – Sep 06, extended to Dec. 2008)	NAD Bengkulu Riau Kepuluan Riau North Sulawesi Central Sulawesi SE Sulawesi Bali
ADB	DHS – 2 -Improved health status of the population, especially the poor and vulnerable groups	US$100 million loan over 5 years. Began in 2005.	South Sumatera Bangka-Belitung Central Kalimantan South Kalimantan South Sulawesi West Sulawesi Gorontalo NTT NTB
ADB / AusAID	TA 3579-INO: Strengthening Health Reforms. Provide advice to 1) Assist MOH and selected local governments identify, implement, and evaluate health sector reforms in the context of decentralisation and 2) support DHS in meeting its objectives for: a) improved health and family planning services b) guaranteed access of the poor to essential health and family planning services.	A$2 million grant 2005 – 2008	Selected districts receiving DHS1 or DHS2 funding
UNFPA	7th Country Program. Main program focus includes: integration of RH in Devt. Framework; awareness and advocacy for RH / Adolescent RH / RR / Gender; Improved maternal care and EOC; Youth friendly RH information / services; Linking population / RH / Gender to poverty	US$23 million core grant over 5 years + US$2 million other grants (2006 – 2010)	NAD (4 districts) S. Sumatera (OKI) W. Java (2 districts) W. Kalimantan (5 dist) NTT (5 districts)

JICA	Ensuring the Quality of MCH Services through MCH Handbook. -Started a pilot project in Central Java, collaboration with Central Java Health Office, in one district (1994) -Adopted at the national level (2001), Continuous printing support by JICA MCH office -Strong commitment and ownership by MoH: SK Menkes no 248/Menkes/SK/III/2004 on Using MCH Handbook	1994 - present	NAD (with UNICEF and USAID) N. Sumatra (w/ USAID) Central Java E. Java (w/ UNICEF) W. Java (w/ UNICEF) Banten (w/ USAID) DKI Jkt (w/ UNICEF) NTT (w/ UNICEF) Papua (w/ UNICEF)
WHO	Making Pregnancy Safer Project. Project provided technical assistance in: policy and strategy, program / model development, adaptation guidelines / tools in the areas of: technical/clinical; management of MNH services, advocacy and community empowerment, coordination, and partnership with other donors and GoI		Bangka-Belitung Banten NTT N. Maluku Papua
WHO/GTZ/DFID and all RH Donors	RH Donor Coordination Improve coordination among all partners in health linked to RH with a focus on MPS under stewardship of the GoI at central, provincial, and district level in order to contribute to an effective, harmonized, and scaled-up response to maternal mortality in Indonesia, aligned to the MPS strategy.		(national level)
IMMPACT / DFID	IMMPACT Indonesia Aims to provide rigorous evidence of the effectiveness and cost-effectiveness of safe motherhood intervention strategies and their implications for equity and sustainability.		Banten (Serang, Pandeglang)

GTZ coodination with donors and Government health teams

The IDHS of 2007 found MMR to have decreased to 248 per 100,000 live births, not far from the 2009 target of 226, but far from the MDG 2015 target of 102 per 100,000 live birth. It was apparent that to achieve the MDG target, the MoH cannot work alone: it needs to work closely with other programs, other sectors, and all external donors including UN agencies and NGOs. A small team was therefore organized under WHO leadership during 2007-2008 to promote harmonization among MoH, external donors, and the UN bodies. This team met as needed to respond to conditions requiring discussion or further action from the MoH. These meetings ended because of personnel changes in WHO, AusAID, and UNICEF, but collaboration among the key leaders of the external donors continued, and, as several external donors neared the final phase of their project (e.g., USAID's Health Services Project,

JICA, UNICEF, GTZ's SISKES and HRD Projects), efforts were made to involve other external donors to continue the coordination meetings with the Director of Maternal Health.

GTZ adopted as an objective increased coordination and harmonization between donors and MoH in order to avoid duplication of effort and improved direction from the Ministry's Directorate of Maternal Health on policy and strategies to guide external donor program implementation in their individual geographic areas of work. An early step in organizing the twice-a-year donors meetings was for related donors to meet in advance of the meeting with the Directorate of Maternal Health to select the most important topic(s) for the next meeting.

The draft ToR for the meeting could take a long time when counterparts were particularly busy, but announcements of the tentative plans and schedules were sent to donors, related NGOs, and the programs / sectors. The coordination meetings which were held can be seen in the box below.

It can be seen that the meetings were held later than intended, the first usually in March, the second in November. About 85% of the invitees attended, and most MPS donors sent their top or second officer. The GoI generally sent echelon IV or even staff. The donors preferred half day seminars inasmuch as higher ranking program officers tended to vanish after the lunch break.

No.	Date, Venue	Topic(s)	Participants	Budget
1	02.08.2006, Bali	Tuning RH coordination effort between partners, GoI, and partners	~ 67	GoJ Rp 244.4 million
2	09.17.2006, Depkes	Desa Siaga socialization and mechanisms of planning and budgeting	~ 65	GTZ SISKES
3	02.08.2007, Depkes	MPS advocacy	~ 60	GTZ SISKES
4	08.13-14.2007, Depkes	Mainstreaming gender by external donors	~ 65	GTZ SISKES Rp 41.2 million
5	11.14-15.2007, Depkes	Socialization and action plan, Reproductive Rights Survey	~ 50	GTZ SISKES Rp 91.9 million
6	03.18.2008, Depkes	New maternal and neonatal health program policy and strategies		GTZ SISKES Rp 12.5 million
7	11.19.2008, Depkes	Challenges and Opportunities to accelerate Health Development to achieve the MDG's target 2015	~ 70	GTZ SISKES Rp 7.1 million

In small meetings led by WHO small teams identified topic(s) to be suggested to the MoH for the donors meeting. Once the topic or topics were agreed, preparations for the donors meetings could begin.

Although only responsible for technical support and some budget, the GTZ reproductive health coordinator usually had to see to most of the preparations (draft ToR, venue, invitations, meeting package, agenda, logistics, meals, etc).

The Director of the HSSP Project (SISKES + SPH + HRD) usually opened the meetings, provided direction and turned the meeting over to the SISKES team. The HSSP's Central Project Coordinating Unit (central secretariat responsible for coordination) always attended the meeting. Depending on the topic, GTZ SISKES from NTT or NTB would be invited. Appendix 1 presents a summary of many of the coordinationg meetings in which GTZ-SISKES participated.

What was achieved by donor coordination meetings?

Did they improve donor and GoI harmonization and alignment?

Yes, RH/MSP donor program activities were jointly developed or revised, and guidelines, SOPs, and manuals were reviewed, developed, and revised. Agreed policy and directions were clarified for distribution to province and district level for implementation, and GTZ SISKES was authorized to socialize approaches, distribute materials, and support training sessions.

What difficulties were encountered?

To arrange donors meeting required patience, especially to find counterparts' time after the APBN budget was released each year. Because of the high volume of counterparts' activities, time even to discuss the topic for next donors meeting would have to be re-scheduled several times. The SISKES Project also found it difficult to find a suitable time acceptible to both the Director General of Community Health, as Director of the HSSP Project, and the Director of Maternal Health, as Coordinator of SISKES. The presence of both was important for effective donor coordination meetings, and donor coordinators would leave the meetings if these two were seen to leave, leaving one to wonder about the shared ownership and commitment to coordination of others.

Were the donor coordination meetings relevant?

They proved relevant primarily in ensuring that program objectives and implementation were linked to national policies at province and district levels.

Is there ownership of the donor coordination meeting process?

Although this function should be assumed by MoH, committed ownership was not always apparent, as when implementation of activities was delayed almost every year by delay in convening the second donors meeting of the year. The second meeting should occur September, as agreed in Bali, but if the central budget is released during this period, the counterparts focus first on how to use the new budget for their program and activities.

Are the donor coordination meetings sustainable?

Even if the MoH realizes the importance of coordination with and among donors to avoid overlapping and collaborate in decreasing the MMR, it is not clear that MoH ownership is sufficient to continue the meetings when needed without the support of donors.

Conclusions

The objective of Donors meetings is to increase harmonization and collaboration among donors and between donors and GoI. Donors coordination meetings are essential for both donors and the GoI as a forum to share experience and plans and discuss new GOI policies and strategies, problems faced by donors in implementation, and problems faced by the donors. Harmonization and collaboration can result if there is trust, mutual respect, and openness.

The MNH donors coordination meetings in the period 2006-2009 increased harmonization and collaboration among donors and net-working developed. Facilitation did not only occur from donors to Government counterparts, but also among the donors.

The quality of donors meetings depends not only on the topic(s) but also on whether or not high ranking counterparts attend. The presence of the DG and or a Director from MoH encourages high rankking donor officers to attend as well. Half day meetings are preferred over one day meeting. Preparation for the meetings can be a long process because of the large number of competing responsibilities of counterparts, especially within the Directorate of Maternal Health.

Recommendations

Based on GTZ experience in organizing donor meetings from 2006-2009, some recommendation can be suggested:

1. Although donors coordination meetings are important for sharing information, discussion, and decision making to improve collaboration, harmonization, and alignment of donors and the

MoH, the difficulties encountered in organizing meetings between 2006 and 2009 suggests that this alternative mechanisms be considered. Are these meetings twice a year really the most effective way to achieve harmonization?

2. Because many new GoI policies that are not directly related to RH/MPS will indirectly affect the implementation of the program's activities, donors meetings should also address non-RH/MPS issues (e.g., Ministry of Finance decree on grants/loans).

3. The many other Reproductive Health programs (i.e., Family Planning, IMS, including HIV/AIDS), Adolescent Reproductive Health, and Reproductive Health of the Elderly) as well as the child health programs could broaden the topics/issues addressed in the meetings.

4. Funding for coordination meetings should be shared among donors/NGOs, with contributions from the MoH as well if at all possible, to improve ownership.

5. Holding meetings as scheduled needs attention from one GoI staff member in addition to the RH/MPS coordinator.

6. The meeting should always ensure attendance by the DG of Community Medicine or at least the Director of Maternal Health to motivate donors to send their decision makers to the meetings.

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A LESSON LEARNT

Author: Dr. Lieve Goeman, MD, MPH
Contributions: Dr. Stefanus Bria Seran, MD, MPH
Gabriel Kennenbudi

CHOOSING THE RIGHT INTRODUCTION STRATEGY

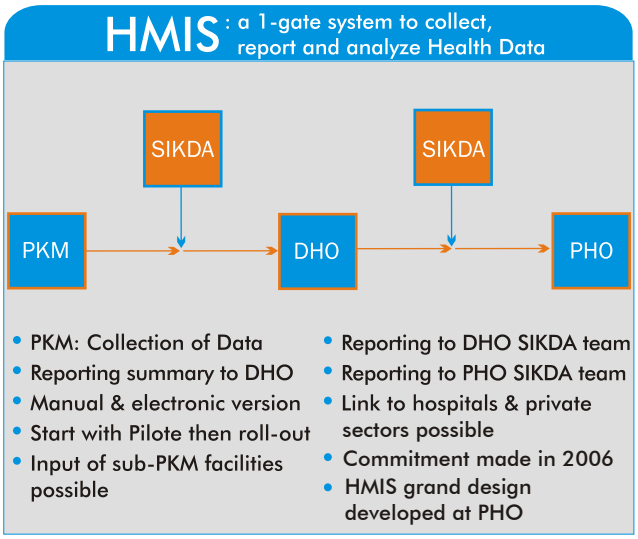
SCATTERED PILOT AREAS vs. FULL COVERAGE OF ONE AREA

The SISKES Project in NTT Province found that using the appropriate pilot strategy is important for success when implementing a new concept or strategy. SISKES Project experience in NTT in piloting a revised HMIS (Health Management Information System) strategy and in introducing the Desa Siaga concept is instructive.

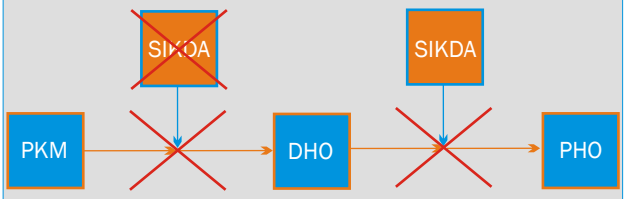
Introduction of a revised HMIS in NTT Province

The new HMIS system that started under the previous phase SISKES II was adapted, proposed, and approved by the central level (MOH/ PUSDATIN) and by the NTT PHO (Provincial Health Office). The plan was to pilot it in two Puskesmas in each of five districts. Each DHO (District Health Office) would have a SIKDA (HMIS) team established. The HMIS manual would be implemented at Puskesmas and DHO level.The assumption was that this strategy would be rolled out by each DHO to all Puskesmas within its district, followed by roll-out to all districts of NTT under the commitment and responsibility of the PHO.

In fact, the roll out to other Puskesmas within the five districts did not occur, partly because of limited partner resources, but also because the presence of two different methods of data collection and reporting to the DHO and PHO confused the health offices. The two parallel systems led to a high administrative burden for the staff and interfered with the existing system. The DHO refused to accept the data from the two pilot Puskesmas as long as all the other Puskesmas still reported the old way, and the PHO refused to accept the new data from the five pilot districts because they was not harmonized with the other districts. Evaluation found disappointing results: the chosen pilot strategy was not successful, even though the pilot Puskesmas recognized the benefits of the new system.



CONSTRAINTS & CHALLENGES



- 2 pilote PKM per D use new format
- All others old format
- ICD 9 vs.10, age categories
- DHO refuses new format
- Some PKM double recording and reporting
- 5 DHO report in new format, vs. 11 DHO in old format
- No acceptance of new format by PHO
- SIKDA teams not operational
- No operational 1-gate system
- Budget constraints for printing formats

The HMIS introduction strategy was then revised in close collaboration with the head of the PHO. The new HMIS would be piloted through full coverage of all Puskesmas in only one, strongly committed district, Belu. All Belu District Puskesmas and the DHO would collect and report data using the new system. The revised strategy was closely monitored and evaluated by PHO itself. This time the strategy was successful, and the benefits, relevance, and impact of the new system were clearly evident.

The PHO and all districts approved the new HMIS system and committed themselves to adopt it and to roll it out to the entire province of NTT.

Introduction of Desa Siaga[1] in NTT Province

To introduce Desa Siaga, a strategy similar to the initial HMIS pilot strategy was chosen. The 50 villages in which SISKES would facilitate the implementation of the alert system and the five networks were selected by the DHO with equal geographic distribution, a minimum four villages per district, and in six districts in total. The scattered implementation assumed that neighboring villages would learn from the established Desa Siaga concept and recognize its benefits, leading to further roll out of Desa Siaga to surrounding villages and the entire district under DHO coordination.

This scattered support did not interfere with the system nor created an additional administrative burden, and it fit the Desa Siaga concept promoted by the central Ministry of Health.

In Belu District roll out to 31 additional villages occurred with DHO and BPMD (the community empowerment Board) support. Kota Kupang saw roll out to 13 more villages, TTS District to four villages, and TTU District to three villages.

Conclusion:

Selecting the appropriate pilot strategy is important for success when implementing a new concept or strategy. Revising and correcting an unsuccessful pilot strategy, based on monitoring and evaluation results, should be done immediately if the expected outcomes do not occur.

[1] "Desa Siaga" describes the concept of community members owning their own resources and capacities for preventing and overcoming their own health problems, health emergencies and disasters based on mutual support and in a spirit of togetherness. GTZ SISKES facilitated the objectives of Desa Siaga regarding reducing maternal and neonatal death in 90 villages in NTB and 50 villages in NTT by supporting the establishment of their own alert system and networks, which cover notification of pregnant women, provision of transport for medical emergencies, financial support, provision of blood donors and a Family Planning Information post.

A LESSON LEARNT

Authors: Dr. Rahmi Sofiarini, Dr. Lieve Goeman, MD MPH
Contributions: Dr. Nyoman Wijaya Kusuma, Dra. Yohana Maxi, MDM

DIFFERENT PARTNERS REQUIRE DIFFERENT APPROACHES

INTRODUCTION OF DESA SIAGA IN NTB AND NTT

SISKES facilitated to introduce Desa Siaga in both NTB and NTT Provinces, but the process employed differed. NTB defined clear responsibilities for each of the stakeholders and believes time and money were saved. NTT used the District Health Office (DHO) for each stage of the process and believes it achieved stronger ownership for the long term. Each approach may be correct for its context.

Which approach is better is not yet clear.

The NTB approach

NTB defined clear roles, tasks, and responsibilities for each of the stakeholders involved before beginning Desa Siaga implementation. Agreements were reached as to which activities would take place at which level and organized by whom. This approach of 'the right stakeholder for the right activity at the right time' facilitated implementation and reduced costs, confusion, and delay in waiting for approval to continue with the next step of the activity.

In NTB the PHO and DHO are the main coordinators responsible for activities taking place at province and district level. NGOs play a prominent role in linking the stakeholders and providing technical support in the village during the establishment of Desa Siaga. In functioning as an extension of GTZ for administrative matters and facilitating all activities, they serve as a catalyst.The role of the NGO is temporary, however, and after establishment the Desa Siaga is owned by the community and the health system.

Together with the Village Facilitator, the Puskesmas is the other critical element for village activities because of its responsibility within the health system for any village activities.

The Puskesmas staff member responsible for community empowerment is strengthened in his/her role as Desa Siaga facilitator, ensuring sustainability and ownership of the concept as well as roll out and potential coordination with other community level outreach services of the Puskesmas.

Thanks to the clear definition of roles from the beginning, the Desa Siaga system is quickly functional.

The NTT approach

NTT chose to work directly through the DHO for the entire process. The DHO coordinates and organizes all activities, even at village level, in close collaboration with a District Facilitator from an NGO or other district agency such as BKKBN or BPMD. This approach was selected in order to ensure ownership and sustainability of Desa Siaga system inasmuch as the DHO is the main coordinator in assembling all stakeholders to plan, budget, and implement all Desa Siaga related activities.
By requiring each DHO to focus on the process, each district can pursue the district specific process that best fits its local conditions and preferences. Some implementation steps may even be combined or omitted. In Kabupaten Kupang, for example, the last district in NTT to begin Desa Siaga implementation, a district orientation workshop was unnecessary as the concept was already known, and there was no need to select District Facilitators because they were already available for other village activities.

Depending on the choice of the district, socialization of the Desa Siaga concept, election of a Village Facilitator, and collection of secondary data can be done as three separate activities or combined.

The disadvantages of the 'DHO focus' employed in NTT are higher total costs, a slower and more cumbersome process because DHO staff have many competing responsibilities, and disruptions caused by high staff turn-over without proper handover of existing programs. Desa Siaga requires strong coordination, however, and NTT believes it is worthwhile to invest extra money, time, and effort to involve the DHO throughout the entire process and thereby strengthen their ownership and commitment to sustaining a functioning Desa Siaga system.

Conclusion:

Different approaches can be employed to support the establishment of Desa Siaga depending on the specific context and partner's preferences. Future evaluation will tell which approach is better.

If you involve government staff in every step, the process of community mobilization gets slower and is more expensive, but time and money may not be all to judge on this:

- There is not only one way to start the development of Desa Siaga
- The involvement of Government employees can cover different steps within the process:
  - Based on task distribution in the beginning
    OR
  - Accompany every single step
- Ownership is with the community; government supports the process
- Both think that their way is the best to reach sustainability
- Each approach may be correct for its context
- Only the long term assessment will prove if there is right or wrong, or that both are right.

A LESSON LEARNT

NTB stakeholders pool resources to respond to local politics:

A lesson in collaboration

Author: Ir. Zubaedah, MA
Contribution: Nurhandini Eka Dewi Sp.A

Political calls for free health services

Leading politicians in NTB have begun to rally to the Governor's call for publicly funded "total coverage for health care and education". Donor agencies, university, and NGOs active in NTB have long pressed for greater public funding for health promotion, disease prevention, and treatment, and Islamic leaders, decision makers at various levels of government, and the general community have eagerly welcomed the Governor's call. Free health care would improve access to health services, particularly for the 87% of the population who are poor or middle class and cannot afford the high costs of hospital treatment.

The new call for total public coverage could prove to be a double-edged sword, however, if the limited resources are allocated to curative services at the expense of a balanced health program. Recent experience with the JAMKESMAS program illustrated the moral hazard risk posed by free services: demand for curative services paid by the program far exceeded the resources available.

External agencies respond

GTZ and other NTB health sector stakeholders recognized both the dangers and the opportunity. The growing political interest could provide considerable public sentiment for expanded public funding if the new funding can be properly designed in a professional manner using comprehensive analysis based on accurate data.

The Governor's call was in line with the "financing model for the poor" included in the GTZ SISKES objectives for NTB. Although not included in the Project's current plans and budget, the Project decided to include such support as an urgent new activity.

To amplify its effectiveness, SISKES approached ten other institutions and stakeholders with a similar vision, mission, interest, or concern and convened a meeting to create a working group that came to include representatives of 14 donor agencies, local NGOs, activists, individuals, and university as well as local government and the Provincial Health Office (PHO).

The working group attempted to include people who were both interested in the health system and had important connections or the capacity to influence political decisions.

A second meeting produced a simple work plan and roadmap, defined a common mission, objectives, and roles, and secured resource commitments (knowledge, funding, skills, lobbying capacity, other support as needed) from the working group. All decisions were made in a participative manner among the working group, with the leader and secretary serving only to initiate and facilitate. The next step was to develop the group's concept of "total coverage health care for NTB province". With analysis of data provided by working group members, a concept and draft plan was developed in three days. Support was soon obtained from the Governor's Office, the planning bureau, the PHO, the provincial hospital, PT ASKES, and representatives of five Districts Health Officers.

When the concept was next presented to representatives from the ten district governments in a meeting chaired by the Governor and Vice-Governor, it was agreed that 50% of the budget required should be provided by the province and 50% by the districts. It was also decided by the forum that the program would start by serving only the poor the first year, gradually expanding to total coverage over five years.

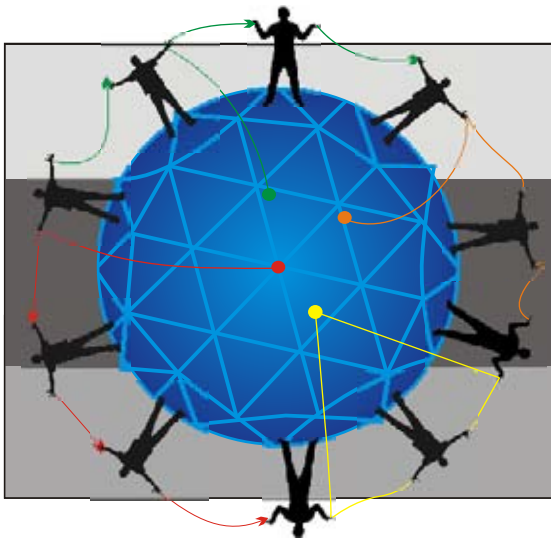
Expanding the model to calculate the health care package required to cover the middle class and rich as well, the new Bupati of Lombok Barat District decided that his district would also subsidize the middle class as well as the poor. He followed the working group's suggestion to let the rich pay their own insurance for better use of scarce resources.

Conclusions

The pooled strategy that was pursued helped to align political sentiment with priority needs through professional analysis and collaboration. The highly motivated people who volunteered to support the program of political leaders will ensure sustainability and local ownership into the future. This experience demonstrated that support for a political statement responsive to community needs can lead to collaborative planning and broadly shared commitment. Pooling the resources of various institutions and individuals was made possible by responding urgently when a situation arose that the Project had not planned or budgeted for. The donor agencies were also able to overcome the tendency of donors and International NGOs to concentrate on their own plans with limited concern for changes in the policy environment and local needs, a tendency that has often resulted in unsustainable programs lacking local government ownership.

As a result of this pooled effort, the donor organizations find themselves closer to the decision makers and in a position that can facilitate other programs. Meanwhile, a program responsive to community needs has been initiated with political will to sustain it.

If there is a strong political commitment for new strategic approaches to go and if there is a good cooperation between different actors, then pooling resources can help to speed up the process and make a quick start possible.



GUIDELINES FOR REFERRAL IMPROVE THE HANDLING OF PREGNANCIES WITH COMPLICATION IN WEST-LOMBOK

A LESSON LEARNT

By: Dr. Husin Fahmi, MPH; Dr. H.L. Thamrin Hijaz; Gusti Bagus Kertayasa, SKM,MARS; Dr. IB Jelantik; Soetarno, Apt; Dr. Nyoman Wijaya Kusuma

A guidebook for medical referrals was piloted with SISKES support in Lombok Barat District and its impact assessed. The referral system was found to have improved, and the system strengthened, with harmonized handling of cases referred between the different levels of the health system.

Summary

The NTB Province PHO Master Plan and annual plans for 2006-2010 target reduction of maternal and neonatal deaths, but decline has been very slow as 99 maternal deaths were recorded for 2006, 95 for 2007, and 92 for 2008 whereas registered live births increased (90.436 - 93.688) during the same period. Many of the deaths occurring in hospital are due to delays in intervention by trained health workers. The number of neonatal death reported actually increased from 920 in 2007 to 946 in 2008. The myriad reasons for lack of progress suggested by various health workers had a common theme: weaknesses of the referral system.

The referral system occupies a strategic position as an essential part of the health system. Primary health care in peripheral health facilities requires hospital back-up at district and province levels to ensure the best possible handling of emergency, complicated, and high risk cases. To prevent avoidable deaths, patients with maternal complications recognized at Polindes or Puskesmas must be referred to a hospital or to a Puskesmas upgraded to BEONC (Basic Emergency Obstetric and Neonatal Care) capacity. Too many maternal deaths occur in hospital due to delays in treatment by trained doctors (obstetricians) or due to weakness in the system to refer the patient to hospital or Puskesmas. To overcome these problems and improve chances for safe pregnancy and childbirth, the referral system must be strengthened, and an essential step is to ensure that clear technical guidelines (SOPs) are available and in use, and that monitoring and evaluation are being conducted appropriately.

Assessment of the existing referral system in five SISKES MPS ("Making Pregnancy Safer" program) focus districts of NTB in 2007 found the referral guidelines to be out-of-date and not even available in many health facilities. Only one copy of the general referral guidelines could be found, and that at province level, and the 2005 MOH

guidelines for maternal and neonatal cases was only available at some facilities for limited use by midwives and doctors only. The health referral system was running on its own, with no comprehensive guideline or SOPs. A new comprehensive technical guideline with SOPs was needed.

If the MDGs are to be achieved and health indicators improved, the guidelines must define a health referral system with clear guidance on how each part of the system is interlinked.

As part of its commitment to strengthen the referral system, GTZ SISKES supported the development and publication of comprehensive technical guidelines for referral based on the general MOH guidelines of 1972 and the 2003 and 2005 guidelines for maternal and neonatal health. The guideline was piloted in West Lombok District during about 8 months from November 2008 through June 2009. Assessment of the pilot found the guidelines to be properly disseminated and in use at all levels of health service providers, including village maternity clinics, village health posts, primary health centres, district hospitals, and the provincial hospital. The guidelines had been accepted by all health workers.

Two specific indicators with targets were defined to assess the pilot study:

- the appropriate register was completed for at least 60% of unanticipated obstetric referral cases
- "back-referral" documentation was sent to the referring level for at least 60% of MPS referrals

Referral to hospital of a greater proportion of those pregnancies having complications saves mothers' lives. Evaluation of the pilot study showed that the number of pregnancies with complications referred to hospital increased in Gerung from 31% (2007) to 61% (2008) of the estimated total number of pregnancies with complications (20% of all pregnancies), and in Mataram from 81% (2007) to 90.7% (2008).

The evaluation also found that during the pilot period, proportion of referred patients for whom "back referral" letters were sent to the referring facility improved in 37% to 92.3% at the District Hospital in Gerung and from 18.5% to 83.7% at the Province Hospital in Mataram.

Piloting the guideline also had positive effects on the patients referred. Patient exit surveys showed that patient satisfaction before and after the pilot improved from 76.6% to 89.8%.

A Provincial Health Office team on strengthening the referral system was established, and the team has developed a "road map" to roll out the new guideline and related activities to all DHOs, hospitals, and Puskesmas throughout NTB Province. In order to have the optimal impact, it is planned that key persons at community level and Kader from Desa Siaga "alert villages" promote referral at community level so that any complications during pregnancy or delivery are referred promptly to the nearest BEONC Puskesmas or hospital. Budget support for the plan has been put incorporated in the NTB annual plan and budget for 2010.

GTZ SISKES warmly welcomes and supports the development and publication of these technical guidelines for the health referral system in NTB Province.

Their dissemination and use by health service providers at all levels, including village maternity clinics, village health posts, primary health centres,

district hospitals, and the provincial hospital will strengthen the local health system and expedite the reduction of maternal and neonatal mortality.

Design and implementation of the pilot study

The SISKES intervention was aimed at strengthening the handling of referral between health facilities, including administrative and managerial actions, in order to avoid maternal and neonatal deaths due to delays and too late intervention at health facilities. The objective defined by SISKES was to strengthen the referral system by disseminating a new guideline for referral that would;

a) educate health facility staff to use standard referral and back-referral letters and document medical record accordingly and
b) to create an environment dedicated to reducing inappropriate medical care of referred patients.

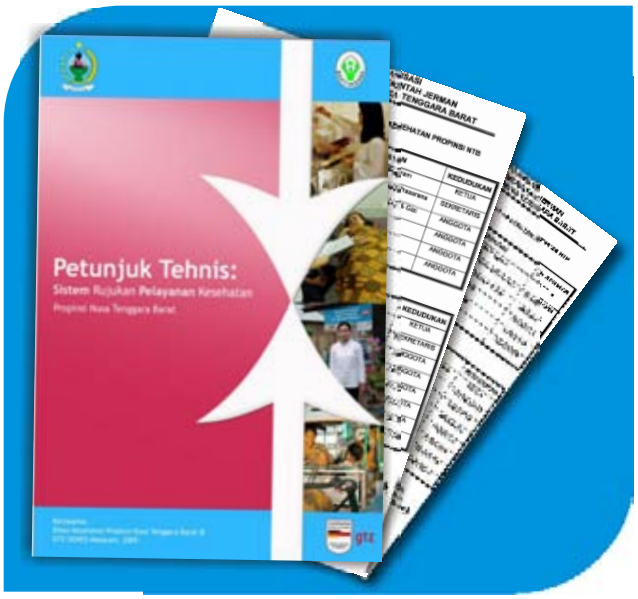
Two indicators with targets for success were defined:

1. Appropriate register completed for at least 60% of unanticipated obstetric referral cases
2. Appropriate counter-referral documentation for at least 60% of referrals linked to MPS.

The first step was assessment of the current referral system. Focal group discussion with counterparts at PHO, DHO, Puskesmas, midwife villages, and hospitals levels found that they implement referral however they like, based on past experience and different formats at puskesmas and hospital. Counterparts agreed to conduct field assessment of the referral system, and a local consultant from the University of NTB assessed the functioning of the referral system in 5 MPS districts in April 2007, finding that the main problem was that none of the health service facilities, including hospitals in 5 MPS districts, had a referral system guideline. Only midwives at puskesmas and villages were found to have a 2005 MOH guidebook for maternal and neonatal referral. The counterparts committed to strengthening the referral system by establishing a provincial working group by PHO director decree.

In 2008 the working group produced a technical guideline with standard operation procedures (SOPs) for health workers on referring patients, laboratory specimens, and medical information. The guideline was developed using references from the 1978 edition of the Guidebook for Referral, the 2005 edition of the MOH Guidebook for Maternal and Neonatal Referral, the 2003 version of the MOH Hospital information system, and the 2007 assessment of five MPS focus districts of NTB. The new guideline was discussed, revised, and launched in workshops attended by MOH representatives on primary health care, PHO, DHOs, puskesmas, midwifery, and advisors. With forewords from the NTB PHO Director and Principal Advisor SISKES, the team hopes for a foreword by the Governor after piloting.

It was agreed to pilot the guidebook in West Lombok District by involving all 19 puskesmas and 77 sub-puskesmas, 121 midwives villages, and 1 district and 1 provincial hospital.



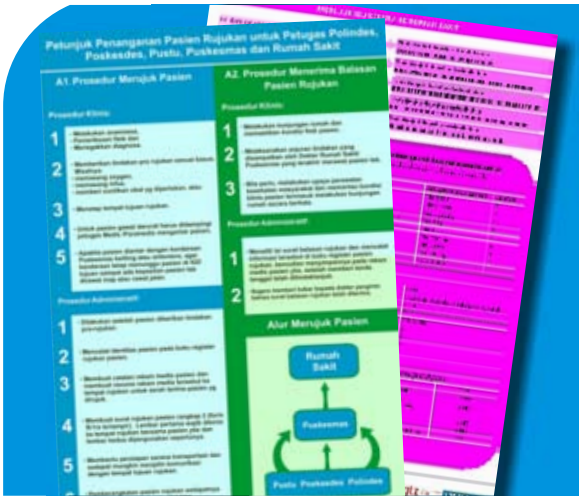
West Lombok was selected as being close to the provincial hospital and having its own district hospital and four BEONC puskesmas. Persons involved included PHO staff, West and North Lombok DHO staff, staff of 19 puskesmas, 121 village midwives, staff of 2 hospitals, Primary and Secondary Health Care divisions of the MoH, the

National Health Insurance Agency (ASKES), and the Labor Health Insurance Agency (JAMSOSTEK). The pilot involved four phases - socialization (orientation), implementation, monitoring, and evaluation.

PHO and DHO teams facilitated meetings at district and each puskesmas to introduce the Guidelines for the referral system to all health staff in the pilot area. The staff were asked to follow the SOPs, to use the forms, and to document all referral cases handled, referred, or received.

A socialization meeting was also held in the province capital, Mataram. Each of 19 puskesmas then organized orientation meetings for its staff including sub-puskesmas and midwife villages. PHO and DHO team member attended the puskesmas meetings where each doctor, puskesmas or sub-puskesmas nurse, and village midwife was given one set of the guideline book, SOPs posters, referral patient forms, and report forms. The participants committed to begin to use the guideline, SOPs, and forms following the meeting.

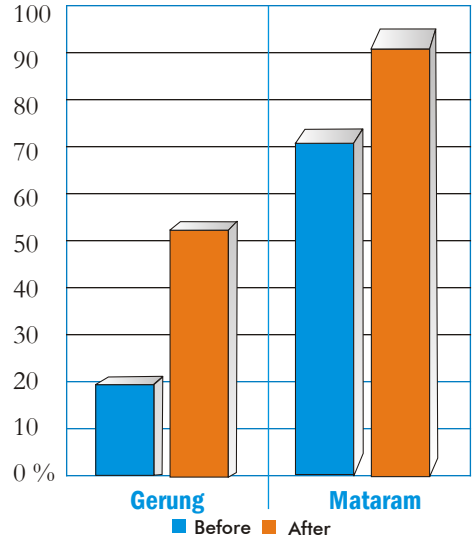
Monitoring was conducted regularly every 2 or 3 months. PHO and DHO teams visited each puskesmas at least three times to collect data and discuss how to overcome any problems encountered. Each Head of Puskesmas appointed one nurse in charge as administrator of the referral system, with the task of monitoring and documenting patients referred from puskesmas to



hospital and checking the register book and stock of forms. Previously, at least two or three referral registers were used in each puskesmas (e.g., for the emergency ward, maternal ward, in-patient ward, or out-patient ward). Now only one register book would be used for all wards, permitting "one gate" recording and reporting and the use of a uniform referral letter. Most puskesmas staff have been happy to use the SOPs and referral letter form, explaining that they are no longer confused as to how to refer a patient to hospital or BEONC puskesmas even if the doctor is not available.

Monitoring in hospital used exit interviews with patients discharged from inpatient wards. Data were analyzed after about 50 patient interviews and presented in internal staff and review meetings. Hospital directors appointed one nurse to a new position in charge of referral system administration. Back referral letters gradually improved as hospital coordinators gradually overcame resistant from specialists other than obstetricians, pediatricians and internists. Some doctors rejected the term "back referral", preferring the term "counter referral." The change was accepted. After the eight months, the pilot was evaluated by MOH staff from the Primary and Secondary Health Services divisions, the PHO Director and staff, DHOs of pilot and non-pilot districts, puskesmas representatives, and hospital representatives. The results showed that all of the 19 puskesmas and 2 hospitals had applied the guideline and SOPs and used uniform referral and counter referral letters.

Fig. 1: Referred obstetric cases handled at Gerung District Hospital & at the Province Hospital in Mataram

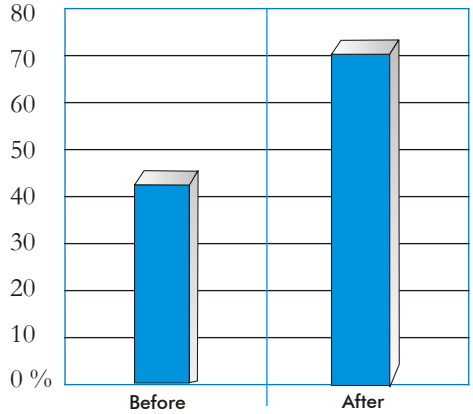


Each hospital registered all obstetric cases referred to obstetric and emergency wards from puskesmas.

The number of cases handled was then compared with the estimated 20% of pregnancies expected to have complications.

The proportion referred had improved in both hospitals, from 31% (2007) to 61% (2008) in Gerung, and from 81% (2007) to 90.7% (2008) in Mataram. The chances for safe pregnancy and delivery had increased.

Fig. 2: Referred obstetric cases handled at the pilot puskesmas

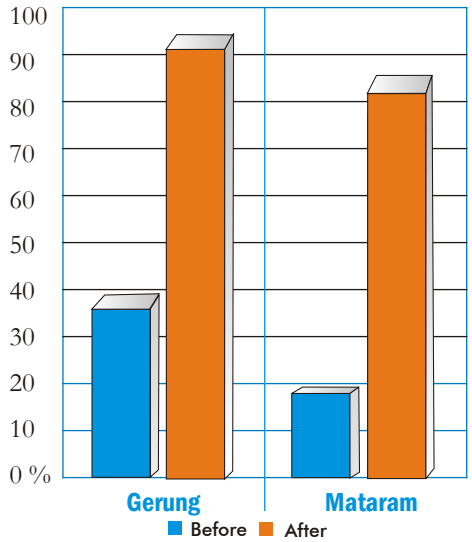


All maternity cases with complications handled in puskesmas were registered and reported to DHO monthly by PWS KIA (Local Area Monitoring report).

The DHO compared the total with the estimated 20% of pregnancies expected to have complications and found that the proportion improved from 45.8% (2007) to 72% (2008).

That too means the chances for safe pregnancy and delivery increased.

Fig. 3: Counter referral letter provided by Gerung and Mataram Hospitals



Each hospital registered all MPS-related cases referred from puskesmas and provided a counter referral letter to the referred patients upon discharge.

Hospital teams conducted exit patient interviews with 50 patients every two months.

The results showed that during the pilot period, the proportion of referred patients given counter referral letters improved in both hospitals, from 37% to 92.3% in Gerung and from 18.5% to 83.7% in Mataram.

Piloting the new referral system guidelines in West Lombok enabled counterparts, stakeholders, and health workers at all health facility levels to realize that the referral system had been neglected and errors not detected. Piloting the guideline was also seen as positive by the referred patients. Based on the patient exit survey, patient satisfaction before and after piloting improved from 76.6% to 89.8%.

The pilot showed that strengthening of the referral system required commitment of the personal involved and support from health facility management. Individually, each of the health staff agreed that the referral system should work, but they could not make any change without management support. Although staff may not feel they can advocate to management, but such advocacy can provide useful information of actual conditions. In this case the PHO, DHO, and hospital management only realized after the assessment that no technical guideline for referral existed and that their assumption that referral was functioning well was not true.

Looking ahead: sustainability and replication

This intervention could be replicated in other districts or provinces. The first requirement is commitment of the management level, demonstrated by the establishment of a working group or internal team charged with strengthening the referral system. At this stage, careful socialization is essential: the pilot found that socialization from higher to lower levels and intensive monitoring was critical to secure commitments and its implementation. A second requirement is budget support for printed materials (guideline books, forms) and meetings. The varying perceptions of the Guideline and SOPs that would have occurred if the socialization meetings during the pilot study had been very short were clarified through several rounds of socialization meetings and monitoring in the field. Key community leaders and Kader of Desa Siaga villages should be involved to socialize the hospital with BEONC capacity. Developing a realistic road map and involving as many different health workers and stakeholders as possible in implementation of the revitalized referral system are strong recommended.

In the pilot areas, because a comprehensive guideline had been missing, the new referral guideline was seen to be in line with central and local health policy, and SOPs for what should be done were included, it is expected that facilities will continue to use the new guideline, SOPs, and forms.

A PHO team established to focus on strengthening the referral system has developed a road map to roll out the new guideline and related activities to all DHOs, hospitals, and puskesmas in province. This, and the inclusion of a budget for the activity in the annual plan for 2010, suggests that both replication and sustainability can be expected in NTB Province.

If you provide clear guidelines and standard operation procedures covering all aspects of the different service providers and it is developed together with a team being part of the referral system, you can expect that the system can act faster and better in case of emergencies. This will act on the fatal delays regarding maternal death.

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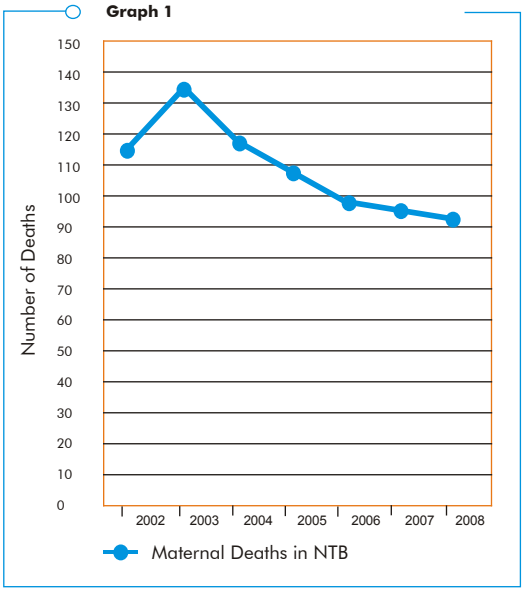
A LESSON LEARNT

Author:
Dr. Karina Widowati

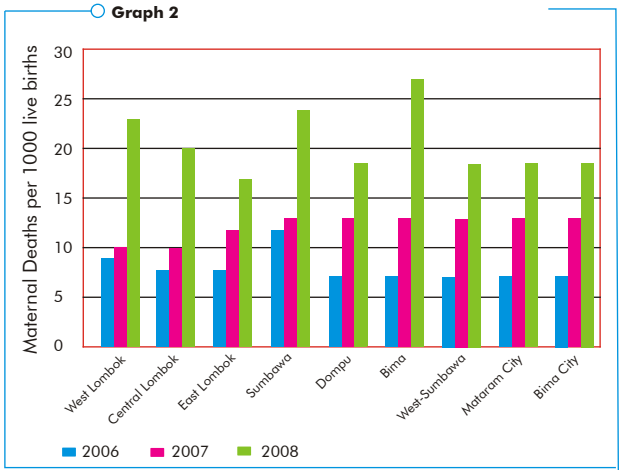
Basic Emergency Obstetric and Neonatal Care Training: SISKES Experience in NTB Province

NTB Province has long ranked as one of Indonesia's provinces with the highest maternal and infant mortality. Over the past decade, however, concerted efforts have been made to improve the situation, and NTB has begun to reduce maternal mortality as illustrated in Graph No. 1 below.

The decrease after 2003 seen in the graph has been attributed largely to increases in skilled birth assistance[1] in high population areas, to greater access to social health insurance, and to increased use of family planning.



Beginning in 2006, MOH provided additional funding to accelerate the trend to decrease mortality rates by strengthening the Maternal and Neonatal Health (MNH) program. The slow decline has continued, but the need was also recognized for an improved network of accessible facilities ready to provide emergency obstetric and neonatal care in district hospitals and selected health centers to serve women in less populous areas who still give birth without skilled assistance.



In 2006 and 2007, the neonatal deaths reported by NTB showed a neonatal mortality rate (NMR) of only 8 and 10 deaths per 1,000 live births, far below the national average of 23 and far from the findings of surveys. It was highly unlikely that a province with the highest Infant Mortality Rate (IMR)

[1] During this time there was increased momentum in normal delivery training (APN) with the result that at least 75% of all community midwives have undertaken the training since the early 2000s.

in Indonesia would have an NMR much less than the country's average. Quite simply, few neonatal deaths were being reported. This has changed, however, and by the end of 2008, a number of districts were reporting rates of over 20 per 1,000 live births (Graph 2). This most likely indicates that communities have increased access to the health system and that staff have improved their data collection.

Among the programs launched to accelerate maternal and neonatal health improvement were education and training for skilled delivery assistance and establishment of Basic and Comprehensive Emergency Obstetric Neonatal Care (BEONC and CEONC) at the first referral level – the health center with beds – and at the district hospital respectively. There is no disagreement that delivery with skilled attendance and timely emergency obstetric care when required are best practices to avoid unnecessary deaths of both women and newborns[2].

This paper will describe the collaboration of the GTZ SISKES program with the NTB Health Office to establish BEONC in five districts to improve first referral level care, reduce unnecessary referrals, and improve the preparation of referred cases to reach emergency care for prompt care by skilled providers in a facility ready for emergencies.

A. Brief description of the program

GTZ/SISKES focuses on a District Health System Improvement with a specific focus on maternal and neonatal health from four main perspectives[3]:

- Management of the health system: integrated planning, budgeting, and monitoring, including HMIS (Health Management Information System) and health financing
- Management of the health services and their linkages within the health system
- Quality of clinical services
- Community empowerment and participation in health related actions

In NTB the program is implemented between January 2006 and December 2009 with BMZ (the German Ministry of Economic Cooperation) as the primary donor and important co-funding for the additional Maternal and Neonatal Health program by the British DFID (British Department for International Development). The program operates within the Making Pregnancy Safer (MPS) program of the Ministry of Health (MoH), implementing the nationwide program with specific attention to improved management of health facilities, the health system at the district level, and improved clinical services through better staff skills.

A major focus for change and improvement has been the systematic evaluation of clinical and management skills after training, an aspect of services management that has been neglected in spite of the development of comprehensive checklists for such activities the USAID-funded HSP program. The SISKES approach focuses strongly on comprehensive technical assistance to develop considerable capacity to manage processes more effectively and efficiently while providing better quality service delivery[4].

B. Objectives and key indicators

1. Availability and functioning of BEONC services

A short list of signal BEONC functions is used to monitor health facility progress in advancing from being only partially functioning to becoming fully functional over a period of six months to one year after training.

2. BEONC facility performance

Facility performance is also judged by collecting routine secondary data from health facilities on emergency cases handled and referred. Inputs are noted as one indicator of District Health Office (DHO) commitment to support the facilities in performing BEONC services. Two main types cases are followed -- post partum bleeding due to atonic uterus, placental retention, or retained products of

[2]. Marger Berer "Maternal Mortality and Morbidity: Is Pregnancy Getting Safer for Women?", RHM journal, 2007
[3]. SISKES & HRD Annual Report 2008
[4]. Program Progress Review SISKES 2009

conception and newborn asphyxia or low birth weight – because proper treatment of these cases at a health center with BEONC capability could reduce unnecessary referrals and improve preparations for severe cases which do need referral to hospital.

C. Program implementation

An integrated approach to improve clinical emergency obstetric and neonatal care services was divided into 3 major steps:

1. Planning
2. Implementation
3. Monitoring and evaluation

The Training Concept for MPS prepared by a SISKES consultant concluded that NTB was ready to move toward BEONC training because there are districts with more than 75% of midwives trained in APN[5]. With more than 80% coverage of skilled attendance at delivery, the establishment of BEONC and a functioning referral system completes the maternal and neonatal intervention package envisioned.

To assess current state of MPS clinical services, a short survey was conducted with the MCH officer of the Provincial Health Office (PHO) in all nine districts of NTB in November 2006. Increased attention to the five MPS focus districts after January 2007 aimed to ensure sustainability of BEONC services by assuring the availability of a permanent medical officer, midwives who have attended the 10 days APN normal delivery care training course, infrastructure, and equipment. Additional criteria for BEONC health center selection were developed with the DHO to take advantage of the Alert Village (Desa SIAGA) movement and health center management training supported by the program. Final selection was done by the DHO with an emphasis on team rather than individual training.

The BEONC implementation process varied between districts. Written requests from partners were required, and the capacity of districts to write proper proposals varied. BEONC training for ten teams of health centers was conducted in three districts in 2007, followed by seven other health centers from two districts in 2008. The 6-day training at P2KS included a maternal component (60%) and a newborn component (40%). Thirteen teams were trained with full support from GTZ and four Lombok Barat District teams were trained using central budget. Only Lombok Barat had the budget needed to complete the recommended 14 days of internship in the training sites. To partially overcome this problem, the trainees from the other districts took internship shifts at night during the training period.

The next implementation step was dissemination by the DHO of standard equipment, drugs, and supplies needed by BEONC facilities as defined by MoH guidelines[6]. This required intensive meetings with the pharmacy department because the drug request list from the pharmacy has not been updated for many years and emergency drugs for obstetric and neonatal care were not on the list.

Strong advocacy was also needed with the planning department in order to have sufficient budget to complete the supporting environment. The availability of the standard equipment was important because the functioning of BEONC services is very much dependant on the enabling environment, and training by itself may not necessarily improve service performance. When the essential drugs and equipment are available, related clinical actions are more likely to be performed[7].

Another important activity to improve the service performance was to ensure that providers, once trained, always follows the standard operational procedures developed by central level. Clinical algorithms were developed by professional organizations[8] for three obstetric emergencies – antepartum bleeding, post partum hemorrhage, and pre-eclampsia – and two neonatal emergencies – low birth weight and newborn asphyxia.

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[5]. Training Concept for Making Pregnancy Safer, Janette O'Neill, Oct 2006 – the assumption was based on a critical mass of skilled birth attendants with basic competencies to support movement to the next skill level.
[6]. Pedoman Pengembangan Pelayanan Obstetrik dan Neonatal Dasar di Puskesmas, Depkes RI.
[7]. The Skilled Attendant Index: Proposal for a New Measure of Skilled Attendant at Delivery. Hussein et al, Reproductive Health Matters, 2004
[8]. IBI= Indonesian Midwifery Association, POGI = Indonesian Obstetrics Association, IDAI= Indonesian Pediatrics Association

The availability of these five clinical algorithms is important to ensure the quality of clinical standards and minimize variation among clinical services as they may try to save resources[9]. The availability of the five algorithms was added to the current MCH supervision check list.

The first evaluation of compliance judged the availability of standard inputs – human resources, the physical environment, supporting care, equipment, organizational system, and financial resources[10]. The second evaluation used a process standard (what we do) to monitor performance of activities meeting a standard – service procedures, documentation, and the use of resources as judged by direct observation and the completeness of the WHO partograph[11].

In order to ensure that trainees are supported in their job by their home institution, their work environment, and their supervisor, training was followed by an assessment visit to the trainee's workplace within 6 months to 1 year after the training.

This visit evaluated the competence of the newly trained clinicians in providing high quality maternal and newborn health care services and gaining the support and commitment of on site supervisors for the newly strengthened service[12]. The visit was made by a trainer and also involved a representative of IBI (the Indonesian Association of Midwives) and the program manager at the DHO as the offsite supervisor responsible for improved health service performance after training.

Post training evaluation could only be done in three districts – Lombok Barat, Kota Mataram, and Sumbawa Barat, but regular monitoring of overall BEONC performance was done using a short list of "signal functions". It was considered important to distinguish between how facilities are supposed to function and how they are actually functioning, and six signal functions of maternal care plus 2 signal functions of emergency neonatal care were selected to serve for classification and monitoring to recognize BEONC services that should be provided at a Basic EONC facility. The six signal functions are shown below (Table 1).

Table 1

SIGNAL FUNCTION PONED		yes	no
1	Administration of parental antibiotic (by injection or IV drip)		
2	Administration of parental oxytocic drugs		
3	Administration of parental anticonvulsant for pre-eclampsia & eclampsia		
4	Perform manual removal of placenta		
5	Perform removal of retained products (manual vacuum aspiration)		
6	Perform assisted vaginal delivery		
7	Low birth weight care		
8	Initial resuscitation for newborn asphyxia		

[9] Block 2 module of Hospital Management Training
[10] Check List Facilitative Supervision of Care Delivery at Puskesmas level, MoH 2008
[11] Similiar with clinical pathway for the progress of delivery
[12] HPIEGO/Maternal & Neonatal Health Program: Guideline for Assessment of Skilled Provider After Training in Maternal And Newborn Healthcare. 2004
[13] Guideline for Monitoring the Availability and the Use of Obstetric Service. UNICEF, WHO, UNFPA, August 1997

Additional supervision to ensure adequacy of the enabling environment was also done twice a year by the DHO and IBI to supplement the monitoring process. This assessment of the supporting environment included availability of, and compliance with, SOPs.

For newborn care, the records of the health centers that are not fully functioning show that they referred high numbers of newborns for low birth weight and newborn asphyxia.

Table 2

District	Health centre trained in BEONC	6 months after training	1 year after training
Mataram City	4	2 fully function 2 partially function	3 fully function 1 partially function
West Lombok	4	1 fully function 3 partially function	1 fully function 3 partially function
West Sumbawa	3	1 fully function 2 partially function	2 fully function 1 partially function
Sumbawa	4	1 fully function 3 partially function	3 fully function 1 partially function
Bima City	3	3 partially function	3 partially function

D. Results

1. Availability and functioning of BEONC services

Provincial data show that 74 of the 146 health center in 9 districts (a tenth district was split off in early 2009) have completed training in BEONC, but no assessment has been conducted to date to evaluate their performance on emergency obstetric and newborn care. Evaluation has been done only for the training supported by GTZ in 5 MPS districts.

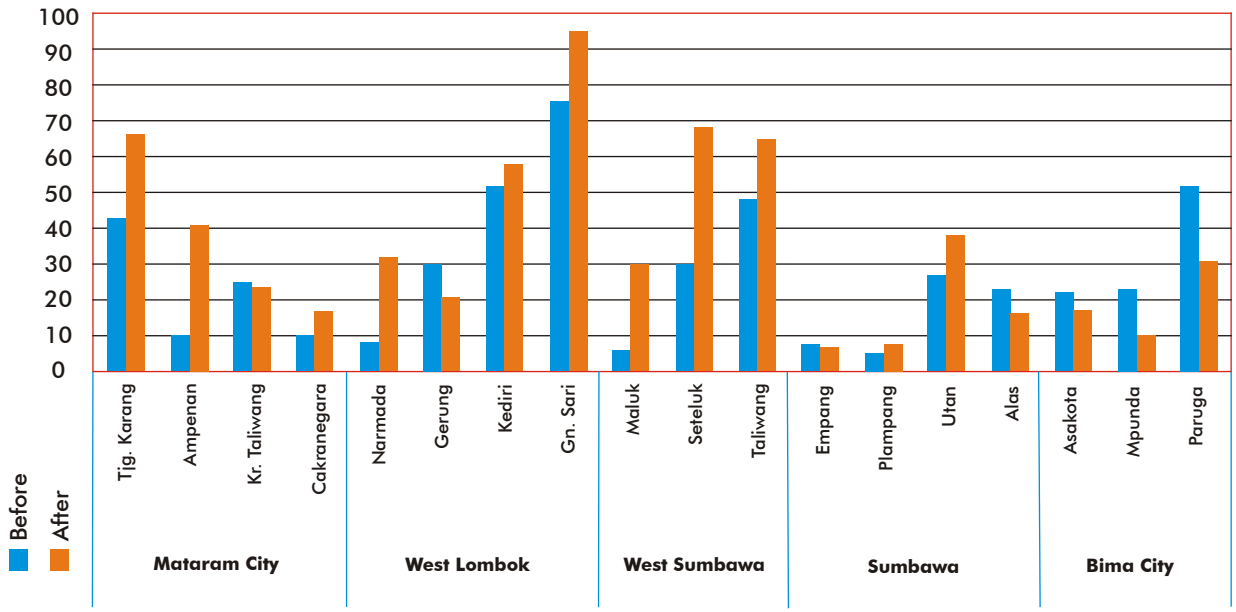
Using the check list in Table 1, evaluation of the SISKES-supported found the results reported in Table 2 based on routine data and direct observation on the completeness of standard equipment, drugs, and supplies. Signal function 6 (assisted vaginal delivery) was usually not performed due to lack of confidence on the part of the team to do so. Three health centers claim to have tried but failed in two cases, discouraging them from performing that function.

In this case, the lack of competency, particularly for newborn asphyxia, was the main factor found by the trainer's assessment.

Table 3 shows the pattern in cases handled themselves by the BEONC health centers in the SISKES-supported districts.

SOPs were only available for post partum bleeding, management of pre-eclampsia, and low birth weight care for the newborn. The clinical algorithms for ante partum bleeding and initial assessment for newborn asphyxia were still missing.

Graph 3: No. of Emergency Maternal Cases Handled



2. BEONC facility performance

The results for the availability of the standard inputs ranged from 88% - 100%, meaning that most BEONC facilities had adequate inputs to provide the services. To monitor performance, the availability of the SOPs and actual referrals were then used.

SOPs for the five types of obstetric and two types of neonatal emergency are crucial for clinical performance. The program helped to disseminate the "Practical Guideline for Maternal and Neonatal Care" published in 2002 by the MoH in collaboration with the National Network of Reproductive Health Training (JNPK) to all health centers and midwifery clinics in 2007, and during an initial visit one month after training the team found that all health centers had a copy. However, the clinical algorithm translating portions of this into

The DHO in collaboration with IBI therefore took the initiative to draft two algorithms using the training module and the MoH guideline as references.

With assistance from SISKES, the DHO presented the draft to the Pediatrics and Obstetrics Associations for final content and design, and a simple printing was disseminated during monitoring visits. In the 6-month post training evaluation, 10 of the 18 health centers had complete algorithms for all five emergency cases. The final visit in early 2009 showed that 12 out of 18 had all five algorithms displayed in the labor room within one year after training.

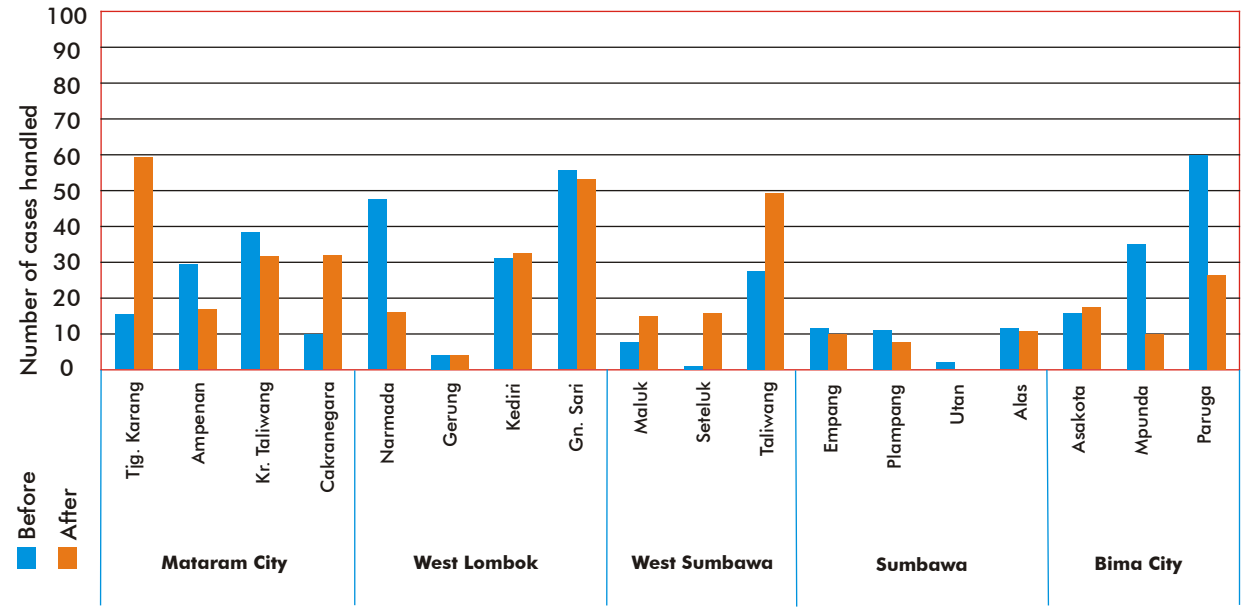
BEONC functioning was influenced by many factors, but primarily by the leadership of doctors within the trained teams. Without their active involvement, the

confidence of other members drops dramatically, and willingness to perform the BEONC services is very low. This is part of the reason that three health centers in Kota Bima and Sumbawa Barat are only partially functioning one year after training.

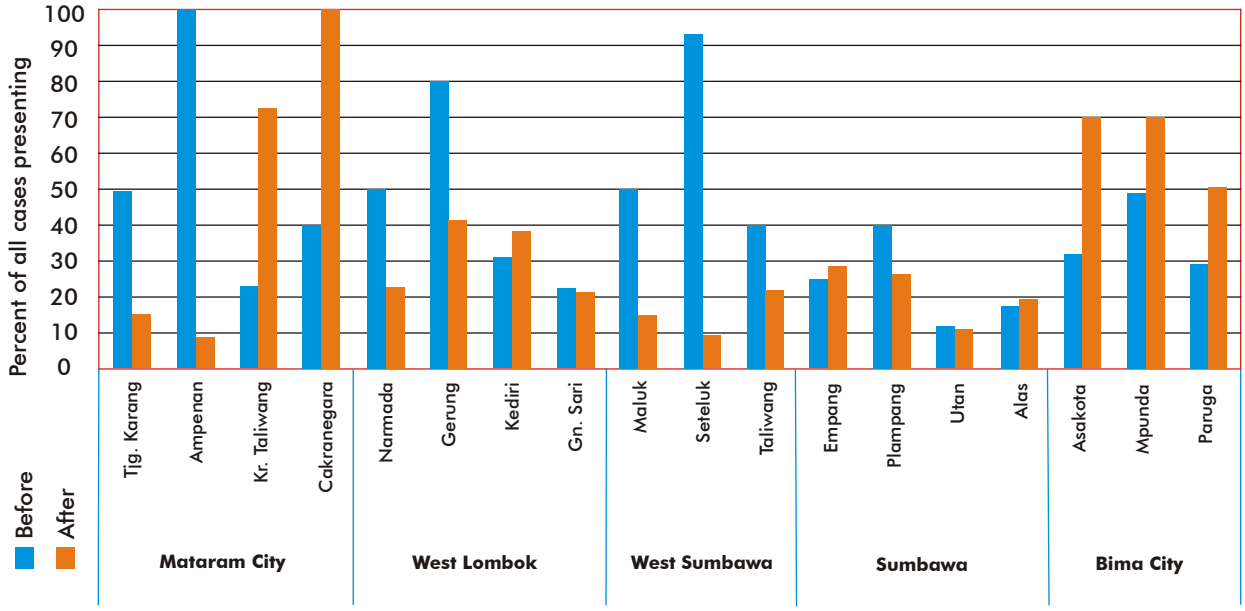
Commitment from the head of the health center is also important to ensure the enabling factors and support from other staff since BEONC services require 24 hours availability.

One health center in Mataram lacked this commitment. Another problem observed is that almost all districts in NTB suffer from high turnover of staff, and this seriously hampers the functioning of health center services. This affected the BEONC services in five health centers (Lombok Barat, Kota Bima, and Sumbawa).

Graph 4: No. of Emergency New Born Cases Handled



Graph 5: No. of Maternal Cases Referred



[14] The MOH indicator is 15% of all women ought to be referred to the next level of care.

Overall, the rate of maternal referrals has decreased from 39% to 28% in the 18 health centers. Prior to the BEONC intervention, all but two of the 18 health centers were referring at least 20% of women with complications to hospital[14]. Afterwards, ten of the 18 were referring fewer obstetric complications (Graph 5). For neonatal emergencies, however, only two health centers decreased their referrals, and three health centers referred no cases at all (Graph 6).

The type of referral cases has shifted. Before the training, all pre-eclampsia and prolonged labor cases were sent to hospital for final treatment, and most cases of newborn asphyxia were directly sent to the hospital without proper preparation.

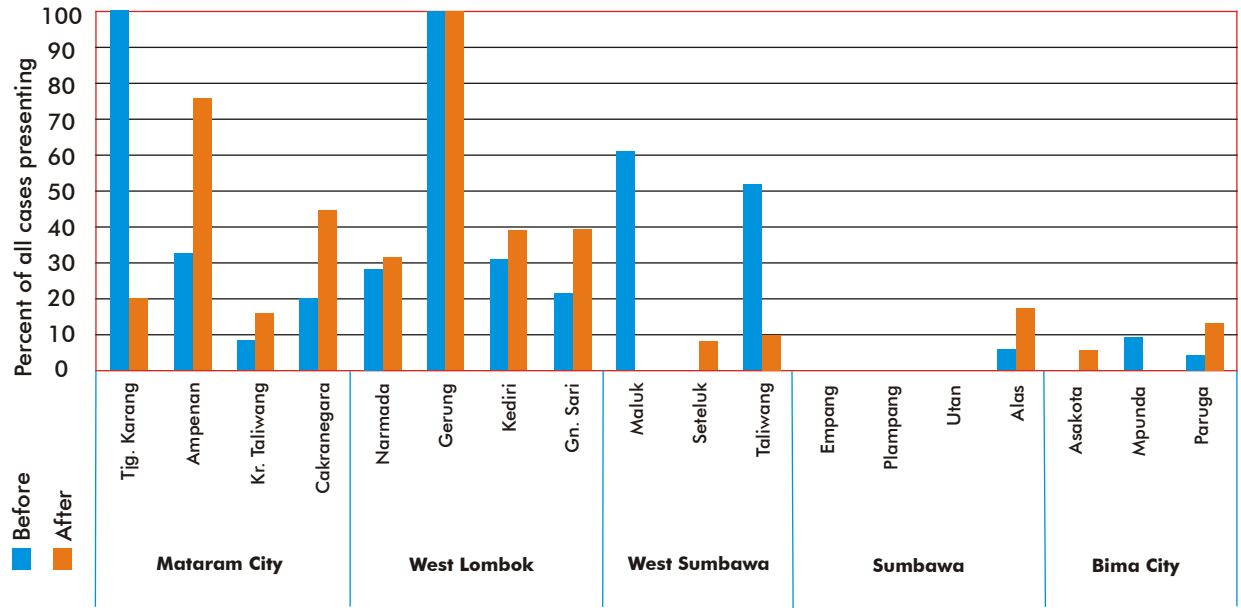
As a result, the condition of some patients had worsened by the time they arrived in the hospital, resulting in permanent disability and sometimes even death in less than 1 hour after arriving in the hospital. After the training, the health centers prepare cases better that need to be referred since they are now able to predict the patient condition when they arrive in hospital[15].

These shifts are often not evident in secondary data and are best explored in staff interviews as the narrative shows.

One week after training, we had a woman that came to us with pre eclampsia. Her blood pressure was 190/120 and she was about to deliver (fully dilatated). We were aware that if we referred to the hospital, she will probably develope a full eclampsia status since it needs at least 1.5 hours drive to the nearest hospital, so we decided to give Magnesium Sulfate drip, assist her for delivery with telephone guidance from one trainer, thank God the baby was delivered safely and the mother was also healthy when we discharged her 2 days later. One month ago we had a similar case and referred her directly to hospital, she survived but the baby died.

Table 3 on the next page is a listing of emergency cases presenting to a selection of BEONC health centers in the first year following the training. The PHO report, however, that new born cases have increased in most facilities, whether or not they BEONC facilities. This is reflected as well by the increase in neonatal mortality reported.

Graph 6: No. of New Born Cases Referred



[15]. Maternal Audit: Lombok Barat and Sumbawa Barat, 2007

Table 3. Numbers of obstetric cases handled in health center in 2008

Cases handled in 2008	Tanjung Karang			Kediri			Taliwang			Alas			Paruga		
	No of cases	*Refer*	*Out-come*	*No of cases*	*Refer*	*Out-come*	*No of cases*	*Refer*	*Out-come*	*No of cases*	*Refer*	*Out-come*	*No of cases*	*Refer*	*Out-come*
Severe Pre-eclampsia	17	11		16	13		5	4		3	-		10	-	
Eclampsia	-	-		-	-		-	-		1	1		-	-	
Uterus Atoni	14	-		19	5		1	1		3	1		3	2	† (2)
Placenta Retention	13	3		2	0		9	3		6	1		4	4	
Retained Product of Uterus	4	-		2	0		42	3		-	-		-	-	
Low Birth Weight	7	3	† (3)	8	4		22	3	† (3)	10	-	† (2)	14	2	† (2)
Newborn Asphyxia	31	-	† (2)	3	1	† (1)	21	5	† (1)	1	1	† (1)	11	1	† (1)
Maternal Death	0			0			1 – infection post CS			0			2		
Newborn Death	5			1			6 – congenital (2)			9 – still birth (5)			9 – stillbirth (5) and infection (1)		

These BEONC facilities claimed no maternal death in 2008 (except for Kota Bima), and data from Kota Mataram show that none of the five maternal deaths recorded in 2008 came from a BEONC health center. Anecdotal evidence suggests that most death cases were due to a late response at hospital rather than a late referral from these health centers (Confidential Enquiry of Maternal Death report, Lombok Barat, 2009). The capacity of health centers to handle cases that were previously referred has improved after training. For newborn emergencies, by contrast, it was found that late referral from a BEONC health center to hospital was sometimes delayed by family members slow to agree to the referral.

It may be that BEONC intervention has improved case management of obstetric emergencies but not necessarily the management of newborn emergency cases. There is the possibility that through the training, health center personnel have lost confidence in handling newborn cases and are more aware so they prefer to refer to the hospital.

The results of cases referred found no difference between the teams who received the full training package (6 days training with 14 days of internship) and the team who only attended class training.

E. Program costs

There are differences in the overall unit costs for each health center of training, internship, and monitoring activities. JNPK emphasizes team work rather than individual training, and each health center sent 3 or 4 staff to training for a total of 12 participants per training and 3 to 4 health centers per training batch.

Direct costs include the expenses paid directly to the training center in the provincial capital to cover trainer's fee, stationery, modules, room rent, and meals for participants and trainers. Accommodations are also direct costs for those coming from Sumbawa Island (Sumbawa Barat, Sumbawa and Kota Bima) to Lombok for training. Indirect costs include participant travel costs from district to province and all related expenses for the DHO committee (i.e., transportation from the district, accommodations, and meals during training). Daily allowances are also an indirect cost. The internship costs for Mataram and Kota Bima included only local transport for the mentor in the evening during 6 days of training, but in Lombok Barat included 14 full days of internship at the provincial hospital.

All expenses related to training were fully covered by GTZ funds with the exception of Lombok Barat where GTZ covered only 31% of the total cost for training and central government financed the other 69%. The other four districts contributed to local transport costs during training for participants and to the transport costs from sub-district to district. For the post training evaluation, the major costs are for evaluator fees from the provincial training center, transportation, meals, and additional accommodations when evaluation takes place in a district located in Sumbawa Island. Due to the tight schedule of trainers, for Sumbawa and Kota Bima the evaluation was directly supervised by GTZ and the DHO partner using the checklist in Table 1 to evaluate the appropriateness of the services provided and direct observation of the completeness of drugs, supplies and data.

The expenses for regular supervision were also supported by GTZ and the partner for one year after training (mostly for meals) while transportation was covered by district budgets.

Table 4 below shows unit cost per intervention in Indonesian Rupiah per district, except for Sumbawa and Kota Bima where the expenses for supervision were fully covered by local government budget.

Table 4

*1€ = 14,000 IDR

No.	Cost Variable	Mataram	West Lombok	West Sumbawa	Sumbawa	Bima City
1	Training					
	Direct Cost	24.100.000	32.797.500	27.523.000	27.885.000	25.563.000
	Indirect Cost	1.050.000	1.350.000	6.040.000	4.581.000	6.744.000
	Internship	1.050.000	29.470.000	Not done	Not done	1.050.000
2	Monitoring					
	Post Training Evaluation	4.530.000	2.025.000	2.253.000	1.785.000	Not done
	Supervision / year	1.130.000	2.809.211	339.000	909.167	659.000
TOTAL:		31.860.000	66.451.711	36.155.000	35.160.167	34.016.000

To answer the question whether unnecessary referral has decreased through this intervention, we have focused on post partum hemorrhage due to atonic uterus and retained products of conception and the management of newborn asphyxia because the training emphasized early detection and proper local management of these cases which should reduce need for referral.

Comparing one year before with cases after training completion, the data show a decrease of 17% for post partum hemorrhage referral and 12% for newborn asphyxia. It is assumed that this means that those cases no longer referred were effectively handled directly at the BEONC health center. The length of stay in hospital decreased by an average of 2 to 4 days for the maternal patients and 3 to 6 days for the newborns[17].

As a result, the costs for hospitalization were saved both for hospital insurance of patients covered under Jamkesmas (social health insurance for the poor) and for related expenses of the caretaker during a stay in the hospital averaging Rp. 1,232,000 (88€) in total cost.

The following table (5) on the next page shows the cost deferred by avoiding hospitalization.

[17]. Verbal estimates by hospital and provincial health staff.

Table 5

No.	Cost Variable	Min	Max	Average
1	Direct cost in hospital	149.000	400.000	274.500
2	Indirect Cost			
	Patient transport to hospital	40.000	1.125.000	582.500
	Family transport (has to be recalculated on roundtrip cost	0	150.000	150.000(?)
	Meals for family (50 IDR/day for 1 caretaker)	200.000	300.000	250.000
TOTAL		580.000	1.975.000	1.232.000

It can be concluded that the improvement of emergency services in health centers can contribute to efficiencies through the reduced length of stay in hospital and reduced hospitalization costs.

F. Lessons learned

The full package of training that includes internship and monitoring has shown no clear trend to decrease referred cases after one year of evaluation. There is a need for continued investigation, up to 3 years after the training, to watch for this trend.

The combination of training followed by post training evaluation and regular monitoring shows more positive results in terms of clinical performance than a single training intervention only.

Additional days for internship at the training venue (provincial hospital) did not provide the expected result of decreasing referrals, perhaps because the internship experience depends on the availability of emergency cases during the 14 days of internship.

Compared with individual training, the team based approach as suggested by the program shows more positive results in increasing the confidence of health centers to handle maternal and newborn emergency cases.

Emphasis on monitoring six months to a year after training could improve the functioning of the health center to perform basic emergency care since scheduled monitoring revealed real efforts to improve performance.

G. Recommendations

There is a need to modify the internship program to improve team confidence in handling emergency obstetric and newborn cases through continuous coordination between trainees and trainers through regular visits for on-the-job training at the work place or by follow up of the cases referred by the team so as to be able to perform the treatment in hospital under direct supervision from the trainer.

This approach could reduce internship costs and days and ensure the availability of proper cases to improve competence.

To ensure the functioning of basic emergency maternal and newborn care services, a monitoring system to measure service performance needs to be

developed by analyzing the six basic obstetric care functions and two additional basic functions for the newborn through routine data collection and regular supervision (using the MoH format).
It is absolutely necessary that staff rotation be permitted only among the BEONC facilities.

The BEONC health center could function optimally (24 hours per day, 7 days a week) if there is more than one team available. Therefore, an additional team consisting of one medical doctor, a competent midwife, and a nurse should be considered for BEONC health centers. While waiting for the training budget to be approved, the current team could do on-the-job training of the selected candidates.

Uninterrupted availability of essential equipment, drugs, and medical supplies must be ensured for functioning of the BEONC services. It is essential to avoid delayed proposals and procurement at DHO level since facility completeness is important for the services to function.

This intervention that focused largely on service level showed little result in terms of improvement of newborn health. For that, it should be combined with a community empowerment program to minimize treatment delay from the community side.

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Report

Author: Dr. Nyoman Wijaya Kusuma
Rahmi Sofiarini, Ph.D

Empowerment from Within:

What moves communities to reduce maternal and neonatal deaths ?

A key approach in the broad range of SISKES interventions to improve district health systems while focusing on maternal and neonatal health is community empowerment. This component was developed most fully in empowerment of the community to develop the "alert system" known as Desa Siaga to respond to maternal and neonatal emergencies and to increase the access of women and adolescents to health services including information and education on Sexual Reproductive and Health Rights. This document describes Project experience from NTB Province in determining what makes the community move in reducing maternal and neonatal deaths.

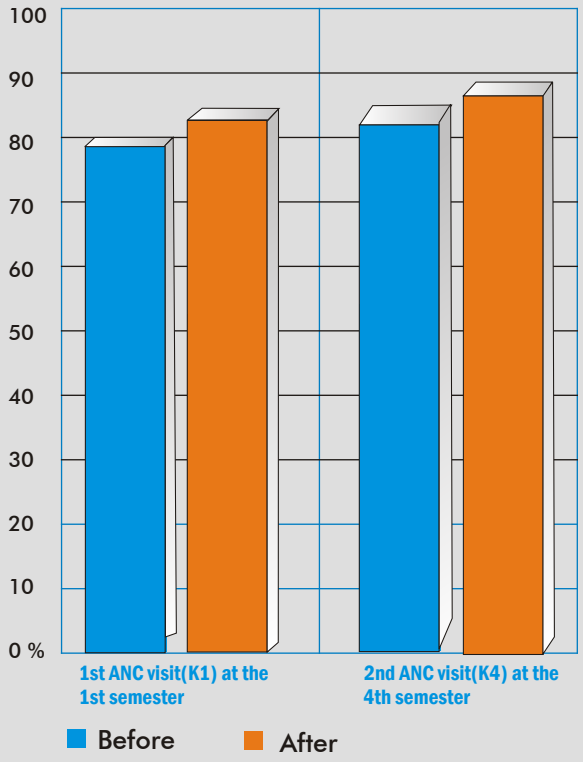
1. Summary

Building on the social tradition of mutual assistance of the peoples of NTB, SISKES assisted communities in participatory consensus building to establish "Community-based Alert System" by which villagers support each other in responding to maternal health emergencies. The alert system includes notification of urgent health issues and emergency cases, means of transport and communication to the local health , financial support, and voluntary blood donation.

Quantitative and qualitative information from routine data and specific evaluation demonstrate that the community based alert system is used and benefits mothers as its main beneficiaries. The program has significantly changed women's and men's behavior health seeking behavior related to pregnancy and delivery care. Evaluation shows improvement in many indicators:

- the first antenatal care visit: 4.5 % improvement ($p<0.05$)
- fourth antenatal care visit during the final trimester: 3.3 % improvement ($p<0,05$)
- skilled birth attendant delivery assistance (SBA): 3.5 % improvement ($p<0,01$)
- deliveries at health facilities: 16.3 % improvement ($p<0,01$)
- family planning knowledge as compared to 2007 baseline data
- family planning current users
- client satisfaction with health services at village level
- men accompaying women to antenatal care visit: 31.8 % improvement ($p<0.01$)
- men present at delivery: 15.8 % improvement ($p<0.01$)

1st (K1) & 4th (K4) ANC visit, from secondary data before & after alert systems).



One of the objectives of the notification system is to identify pregnant women, remind then of antenatal visits, and monitor and assist them for antenatal care by professional health personnel. A central message of the village facilitator in every meeting is that "every pregnancy and delivery is a risk", so every pregnant women is motivated to follow antenatal care during her pregnancy.

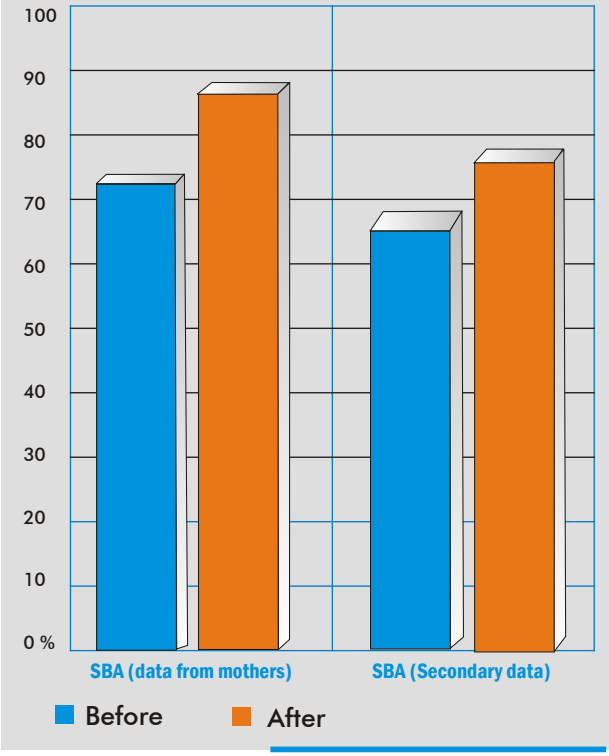
To monitor the effect of this notification, the study looked at proportion of mothers who had made antenatal care visits in the first and fourth trimesters of pregnancy for their second last child and their last child in order to determine whether the likelihood of antenatal care visits improved after establishment of the notification system. The study found a significant increase on both measures.

Similar trend is shown by secondary data as well.

- Indicator SBA: Skilled Birth Attendant delivery assistance: 3.5 % improvement ($p<0,01$)

One of the objectives to empower the community through the DS approach is to enable pregnant women to be assisted by skilled birth attendants when giving birth. The evaluation shows a significant increase of SBA of 3.5% after the establishment of alert system. A similar trend is demonstrated by secondary data.

SBA primary & secondary data, before & after Alert System



The program efforts have combined with the tradition to trigger a new tradition of people helping each other to save lives.

The sustainability of the program is ensured by the benefits of the system itself and the avaibility of a toolkit that includes cost analysis of the system and evidence of its impact. The toolkit[1] also enables other districts/provinces to adopt this approach and adapt it to specific local conditions.

The essential element that makes the community move is the value of its own traditions that are used to raise awareness of the need to assist each other to save lives. The high level of local ownership confronting real needs and benefits will help sustain the program.

2. Background

Maternal and infant mortality are still high in Indonesia, and NTB Province consistently ranks among the worst rates in the country. The province is also among the lower third for the Human Development Index (HDI)[2].

Life expectancy is 60.5 years, compared with 68.1 nationally. Adult literacy is 78.8 %, compared with 90.9 nationally. Improvements in the public health sector in recent times have improved these indicators, but the decline has been slow, partially because minimal attention was given to the role of the community itself in reducing these key indicators.

Maternal mortality has ascribed to **3 'delays'**:
Delay in decision-making;
Delay in finding transport to refer the woman for emergency care;
Delay in receiving proper treatment at the health facility)
and the four 'too's of pregnancy:
Too old; **T**oo young; **T**oo many; **T**oo closely spaced pregnancies).

One of the solutions most often offered to overcome those problems is increased community participation to reduce maternal deaths and improve child survival by ensuring exclusive breast feeding by the mother.

1. Toolkit is a complete information box containing technical guidelines, case studies, training modules etc to support advocacy and implementation of DS.
2. Based on data through the current decade produced by various departments of the Government of Indonesia.

4. Key indicators

Output level:
- Coverage of Desa Siaga village by GTZ SISKES
- Knowledge, understanding, and use of DS and its network
- Opinion of usefulness of DS
- Outcome level:
- Behavior change: men assisting women (gender impact) and helping each other to save lives
- Development Assistance Committee (DAC) meeting OECD criteria of relevance, effectiveness, impact, efficiency, and sustainability.
- RH services indicators: antenatal care visits, delivery by skilled birth attendants, place of delivery, family planning, and client satisfaction with health services.

2. Main Activities

The community empowerment program was implemented through a 6-step facilitation process:

1. **Orientation meetings** :
- Provincial orientation for relevant stakeholders
- District orientation with stakeholders including sub-district and village levels.
- Selection of village facilitator

2. **First training on the DS concept and Participatory Learning and Action Approach for village facilitator and health facilitator**

3. **Self-assessment survey by the communities**
- Self-assessment by community members to analyze their own health conditions and their own potential to solve their own health problems

4. **Second training on organizing the community to establish an alert system**

5. **Meetings to establish five alert systems**
1) Meeting for reaching consensus on a notification system
2) Meeting for reaching consensus on provision of transportation/communication system
3) Meeting for reaching consensus on providing social financial support
4) Meeting for reaching consensus on provision of blood donation
5) Training for Kader of the Family Planning (FP) Information Post

6. **Monitoring and evaluation**
- Monitoring and evaluation (M&E) during the process – input and process indicators during the process of DS establishment
- M&E of maintenance of a functioning Alert System (DS)

Steps 1 through the first part of step 6 can be viewed as investment activities, and the second part of step 6 as a maintenance activity for a functioning DS alert system once established.

The key questions are:
What sort of concrete action should be taken by the community?
How can the community be assisted to increase its role in reducing maternal and neonatal deaths?
What is the contribution of community empowerment to the overall objectives of the Project?

This paper describes the program community empowerment using the Desa Siaga (DS) approach to move the community and contribute to solving its own health problems.

3. Objective and strategy

The overall objective of the Project is for the population, especially the poor, women, and children, to use quality health services. The impact will be seen in improvement of the health status of the population. As part of the District Health System Improvement Project, the objective of community empowerment component is that communities establish and maintain a supportive environment that enables their members to access appropriate Reproductive Health (RH) services.

The strategy selected to reach the objectives is the Desa Siaga (DS) strategy which empowers the community in reducing maternal and neonatal deaths and maintains access to appropriate RH services. The DS strategy is underpinned by the existing NTB social traditions of helping each other. The Project strategy is to assist communities in a participatory process to reach consensus on helping each other to respond to health emergency situations by establishing a "Community-base Alert System" known as Desa Siaga.

The Desa Siaga system incorporates notification in the community in times of urgent health issues, provision of means of transportation and communication to access the local health , provision of financial support, and voluntary blood donation.

The entry point to improve maternal and infant health is the assumption that improved behavior and community support will reduce vulnerability, yield positive results, and be more likely to be applied to wider health issues in the community.

All villages selected for the Project's community empowerment component are in the catchment area of a health facility equipped to provide Basic Emergency Obstetric and Neonatal Care (BEONC)3 and trained in Health Management.

Each village has a midwife trained in normal delivery care (APN[4]) and a village health post (POSKESDES[5]). These criteria of selection were established to ensure that improved community action from the demand side will be met by improvement on the supply side as well.

[3] HC with BEONC: a health that is capable to handle basic obstetric and neonatal emergencies
[4] APN training: enables the midwife to do normal delivery care
[5] POSKESDES: health post in the village, providing basic health care. Women can go to deliver there.

In conclusion, evaluation shows that the empowerment of community through the DS approach has demonstrated increased engagement of the community in reducing maternal and neonatal deaths, especially due to delays at community level, by monitoring proximate indicators of ease of handling emergency cases on the part of village providers after the establishment of the transportation system (76 %) and Blood donor supply the systems (71 %).

8. The Village Midwife perspective

A village midwife in Tanjung Village of Kota Bima explained how community empowerment has affected her responsibilities in providing health services.

"This past year became an enjoyable time for me as a midwife working at the village level. This is because the things that formerly worried me when assisting a delivery do not happen anymore, and there have been no maternal or neonatal deaths.

Of course fatigue always occurs because I assisted 162 pregnant women to deliver their babies safely in the last year. My exhaustion disappears, though, when I see the lovely babies that are born safely from their mothers who have just passed a critical period.

I must recognize that this is happening because my village has become an Alert Village facilitated by GTZ which has brought an innovative approach to the village.

It is still fresh in my mind that a few years ago I managed one case of maternal death and others with haemorrhage that shocked and frustrated me as midwife. Nowadays, these old stories are no longer bother me because I feel more confident as a midwife, seeing a lot of change in the community after they developed their alert system.

Maybe as an outsider you will not believe a lot of the changes that have occurred within just one year, but for me, as one who is involved and has experienced these changes,

I can tell you that when I need to refer a woman, it is very easy to find transportation: just by calling the coordinator of the transportation system, the transport is ready.

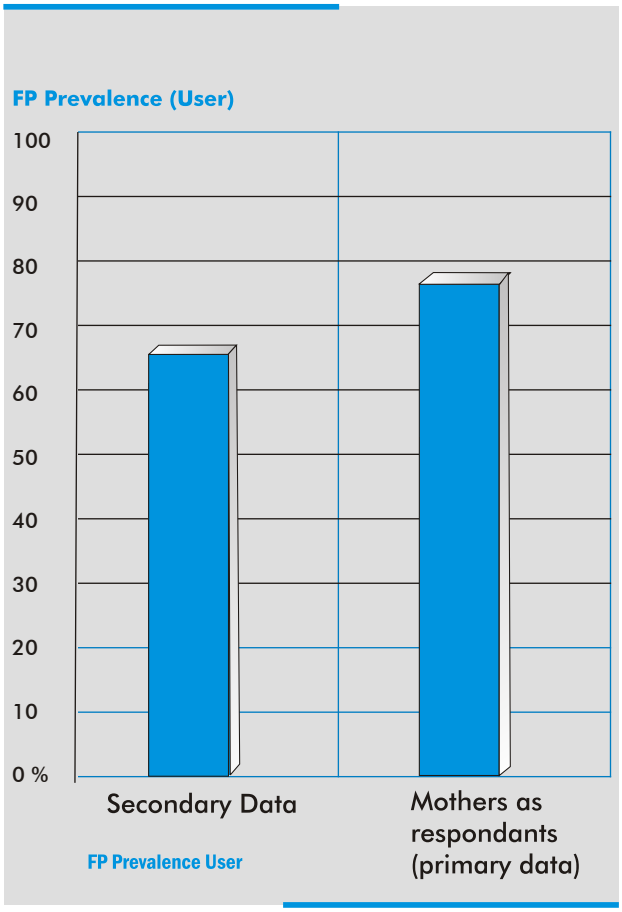
Before it was very difficult to ask the pregnant women to give birth at the village maternity post (Polindes), but nowadays even if they are just about to deliver, they come to the Polindes. In 2008, 100% of pregnant women delivered in the Polindes.

The Kaders are very active in notifying pregnant women and disseminating family planning information. I now realise this has happened because of the increased understanding by the people and their willingness to change to help each other. At the early stages of the facilitation process, I felt doubts –

Can it make a change? -- but now after one year there is broad change. Pregnant women can receive treatment and the babies who are our future are born safely".

The following graph on this page shows that knowledge of family planning methods is increasing when compared to the results of the baseline household survey of 2007. Thus, having more knowledge of FP is enabling women to make choices and to join FP.

- Indicator: FP current users



The new family planning Information Post of the DS system has brought family planning information closer to women and, by providing more information, has enabled them to use FP methods. Both primary and secondary data shows similar trends of increased family planning users.

- Indicator: Client satisfaction with health services at the village level

Although community empowerment deals primarily with the non-medical approaches to reducing maternal mortality, the efforts to save the lives of women and infants is inseparable from the medical based interventions. Improved community action from the demand side requires improvement as well on the supply side so that both complement each other with better collaboration and networking. This collaboration and networking as an impact of the community empowerment program is reflected by the satisfaction of mothers with the maternal and neonatal health services provided at village level. The mothers were questioned on ten aspects of services and each item valued from 1 to 10. The questions used in this study are similar to those in the baseline household survey in 2007.

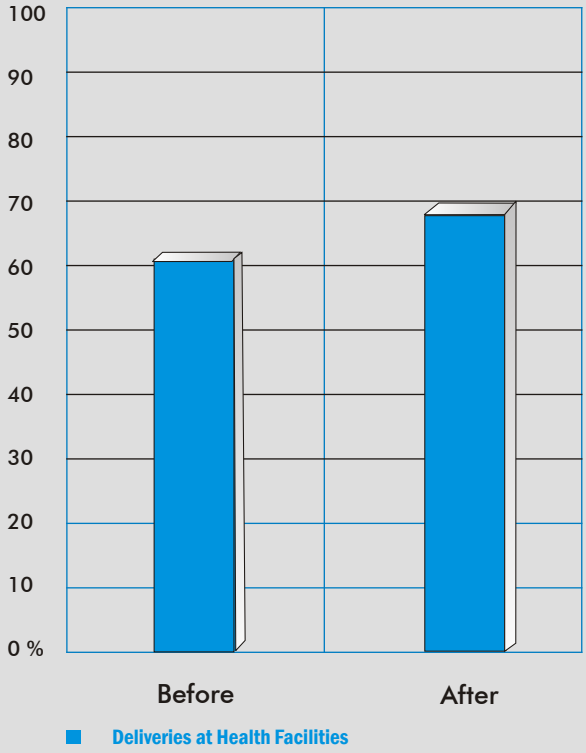
This table shows the results:
The table shows that satisfaction of mothers with the MNH services provided in Polindes has improved as compared with the 2007 survey, suggesting that there is improvement on the supply side as well as the demand side.
These results cannot be claimed as a result of the DS program only, but they reflect the Project's efforts to improve the demand side in parallel with improvement on the supply side.

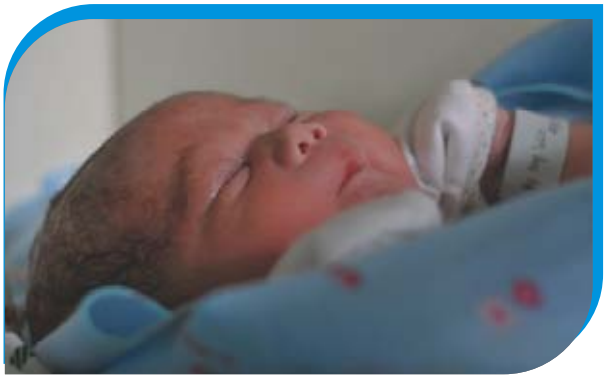
Client Satisfaction with MNH services at Polindes (Rating 1-10)	Mean (2000)	Mean (BLS
A. Friendliness of Health Personnel in delivering the health services	9.0	7.9
B. Skills of the health personnel in providing treatment to patient	9.0	7.8
C.Completeness of equipment provided	8.9	7.6
D. Cleanness of health facilities	9.0	7.8
E. Waiting time before receiving the services	9.1	7.4
F. Provision of privacy services	8.9	7.4
G. Feeling convenient to herself	8.9	7.7
H. Inform the results of diagnoses to the patient	8.9	7.8
I. Accessibilities to health services	9.0	7.8
K. Relatively low cost	9.1	7.9

- Indicator: Delivery at health facility: 4.0 % improvement ($p<0,01$)

Due to increased awareness of the risk of every pregnancy and delivery, women prefer to be assisted by skilled birth attendants and to give birth at health facilities. The evaluation shows a significant increase in the proportion of deliveries at facilities (4.0 %) after establishment of the alert system.

1st (K1) & 4th (K4) ANC visit, from secondary data before & after alert systems).

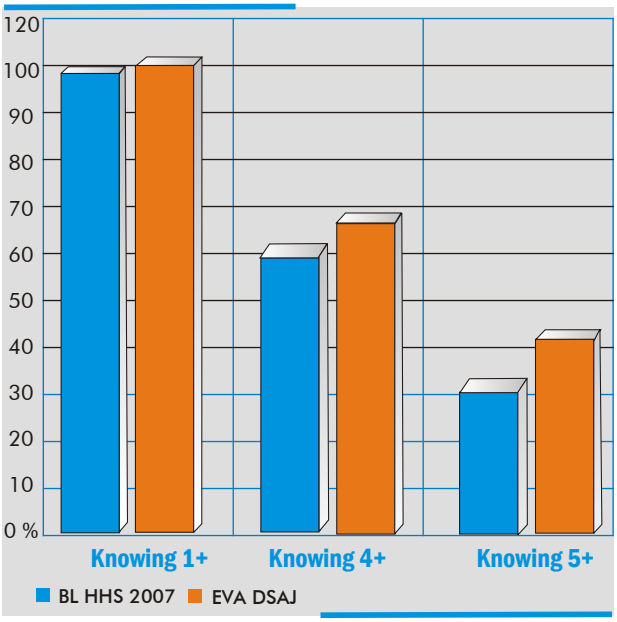




A midwife of Sambinae village in Bima confirmed these changes in the following story:

"Before having a village birthing post (Polindes) building and establishing the Alert Systems only 20% of deliveries were assisted by health personnel. After having the Polindes building, the number of deliveries assisted by health personnel increased to 40%, and after establishment of the Alert System, the deliveries became 100% assisted by health personnel, and all take place in the health facilities."

The implementation of DS Approach in empowering communities can be seen to have contributed to behavior change of pregnant women in seeking health services: more women's deliveries are assisted by skilled birth attendants and are taking place at health facilities.

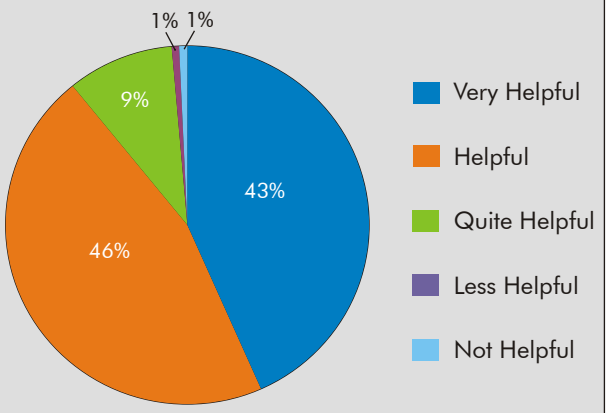


- **Indicator: FP knowledge compared with baseline data (2007)**

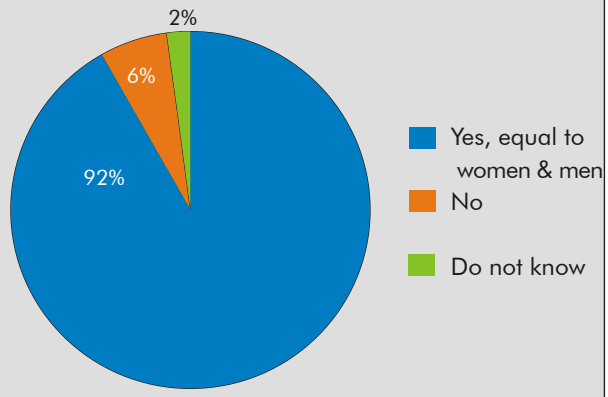
Maternal deaths are reduced by planning pregnancies and avoiding unwanted pregnancies. In order to do so, women need to be empowered to choose what method will be used to avoid unwanted pregnancies. In this context, the justification for having a family planning information post is to bring family planning

89% of mothers believe that the alert system has provided better access to the poor in accessing health services and has given equal opportunity both to women and men in using the the existing alert system.

Opinion of mothers on helpfulness of the existence of the alert system for the poor to access health services (n=280)



Opinion of mothers on equall access of men and women in getting assistance from the existing Alert System (n=280)



- Assessment of the DS program using DAC criteria

Various stakeholders involved in DS implementation have been queried about its relevance, effectiveness, impact, efficiency, and sustainability. At village level 490 persons were questioned (70 village heads, 70 Village Facilitators, 70 Midwives, 280 mothers).

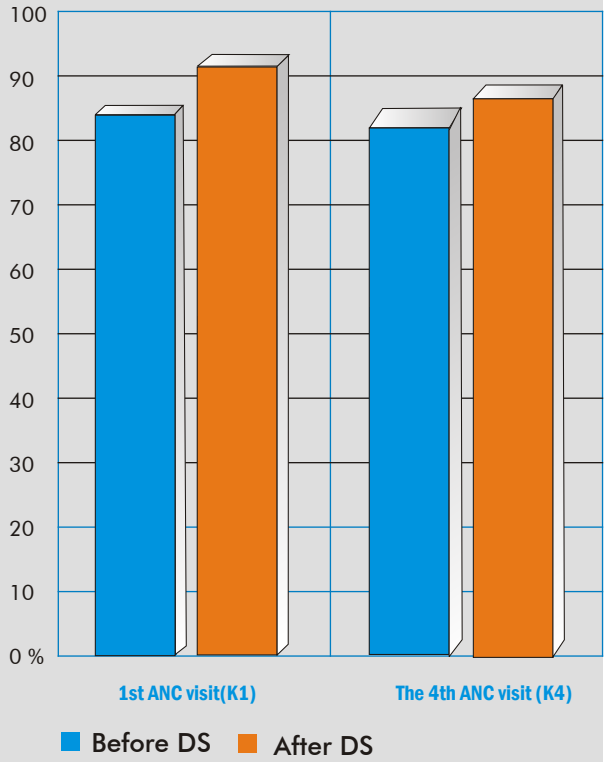
At district level those questioned were DHO staffs (10), Family Planning personnel (5), District Facilitator (4), and Health Center Facilitator (31). And at province level two PHO staff were queried. The final rating, after calculating scores[6] was a 2 ("good, fully in line with expectations, no significant defects").

- **Use of RH services indicators**

The survey of the 280 mothers permitted a determination of improvement after the establishment of DS in the community:

- **Indicator K1: First antenatal care visit (K1) during the first trimester of pregnancy: 4.5% improvement ($p<0.05$)**
- **Indicator K4: Fourth antenatal care visit (K4) during the third trimester of pregnancy: 3.3% improvement ($p<0,05$)).**

1st & 4th ANC visit, data from the mothers/primary data



[6] The scores from each stakeholder were weighted according to DAC guidelines and then multiplied by the weight of each criterion divided by the total weight. The result is the overall rating.

6. Persons involved

Desa Siaga (DS) was implemented by various stakeholders at various levels, with the role, tasks, and responsibilities for each stakeholder clearly defined before implementation. An agreement was reached as to which activities would take place at which level and organized by whom. The Provincial Health Office (PHO) and District Health Office (DHO) are the main coordinators and are responsible for activities taking place at province and district level. PHO is responsible for organizing the provincial orientation meeting, the first training on DS concept and PLA approach, and the second training on organizing the community to establish the alert System. The DHO is responsible for organizing the activities of district orientation and monitoring and evaluation. FP training is organized by the district's FP institution.

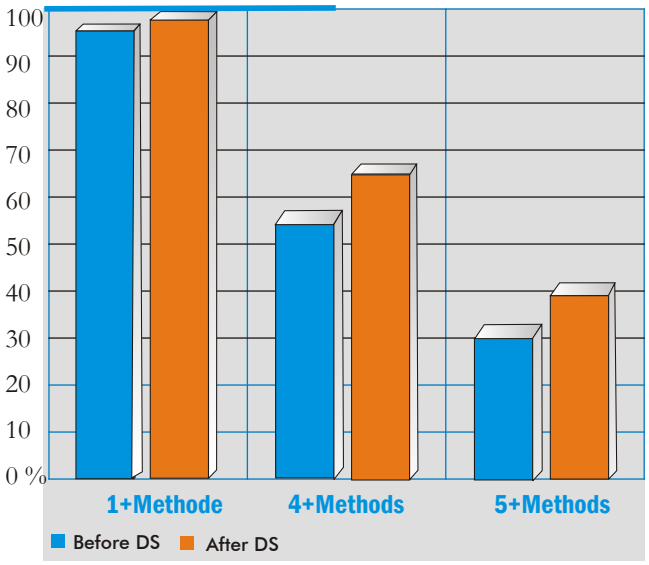
For village activities the Health Center facilitator and Village Facilitator are the most critical roles because in NTB the health center is the responsible structure within the health system for village activities. The local NGOs, as district facilitator, plays a key role in linking stakeholders with each other and providing technical support within the village during the establishment of DS. They function as the extension of GTZ for administrative matters and facilitate all activities (catalyst role). The role of NGOs is temporary, inasmuch as the DS, once established, is owned by the community

7. Evidence of program impact

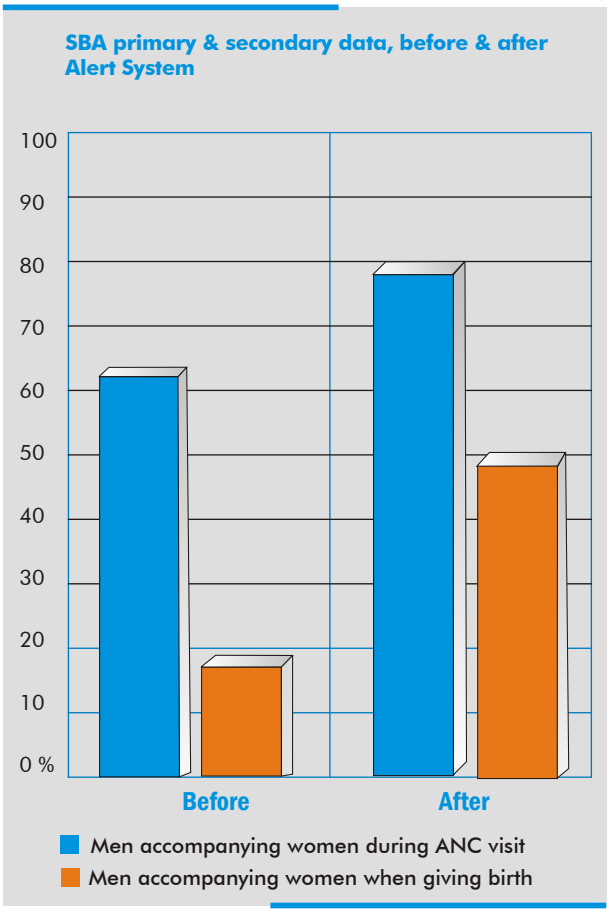
Evaluation of DS was carried out in 70 of the 90 villages supported by SISKES-GTZ in NTB by interviewing mothers (N=280) who had given both before and after establishment of DS in their village (whether or not the child lived). The results show difference between the time of their previous pregnancy to their recent pregnancy after establishment of DS in the community.

- **Understanding and use of DS**

Awareness and some understanding of the Desa Siaga alert system is essential if it is to be used when needed. 83 % of mothers interviewed were found to have a good awareness of DS alert system, and most of them have used it.



9. Impact on poverty and gender equity



The DS program has been categorised as "pro-poor" to the extent that the alert system has provided better access to health services for the poor. It also has provided equal access for men and women in using the system. In fact it has changed the behavior of men in accompanying their wives to antenatal care visits (31.8% increase ($p<0.01$) and when giving birth (15.8% increase ($p<0.01$), a significant increase as can be seen in the graph .

10. Efficiency

A cost analysis that can be found in a separate document shows that the total cost per village to implement this program was Rp. 43,481,900 (3,345 €) for all activities once, and Rp. 53,414,400 (4,109 €) for one year of implementation. 80% of that total unit cost is for establishing the alert systems and 20% is for operational activities.

Considering this cost in the light of the impact described above, the program is worth funding because it serves not only for the current generation of pregnant women, but will remain for the next generation as what has been established in the community system will be passed to the next generation because helping each other has become a new tradition that benefits them all.

10. Looking to the future

This community mobilization program requires intensive process facilitation, and as long as the facilitation process is followed properly step by step as explained in the toolkit, it will produce successful results. Due to its intended process, the program must be supported with adequate budgeting. It should be noted that the facilitation process does not only deal with establishment of the Alert System. It is in itself a process of empowering the community from within, involving its soul and its values. Thus, it should be borne in mind that implementation does not consist only of reaching coverage, but one impact of the implementation process is to change the behavior of the community.

Sustainability of the DS established will depend upon maintaining the established systems from both community and provider sides and encouraging and motivating them. The health center staff member responsible for community empowerment has been strengthened in his/her role as DS facilitator. This will facilitate sustainability and ownership of the concept as well as roll out because this person is close to the community and DS activities can be combined with other outpatient services and health center activities. In addition, the toolkit (a complete information box containing technical guidelines, case studies, training modules, and film to support advocacy and implementation of DS) will also contribute to sustainability because the concept, guidelines for implementation, and modules for training, evaluation, and cost analysis are documented and available for rolling out and scaling up. For NTB in particular, this community empowerment is a part of AKINO ("No maternal death in the village") strategy, the NTB Province government's program for reducing maternal and neonatal mortality.

Community consensus developed "from, by, and for themselves" has made coping with emergencies easier and saved lives, not only for maternal emergencies but also for road accidents and other emergency health problems such as, dengue, and malaria. Indeed, it appears as though community action to deal with emergencies is becoming a new tradition of helping one another in the community. The community action has also affected the continuum of care by revitalizing the network of the Family Planning Commission (BKKBN) and increasing the number of active contraception users. The role of the district Red Cross Society has similarly become more visible. And finally, the program has resulted in greater advocacy to local government to provide adequate budget for the health sector at village level.

All these community actions contribute to the vision of health development in Indonesia, "to make people healthy", by increasing surveillance, monitoring, health information and health financing so that access to better quality health services is achieved. Thus, community empowerment in the health sector can go hand in hand with the global effort of health development toward the Millennium Development Goals and is implicit in the overarching mission of the Ministry of Health in providing Primary Health Care to its people.

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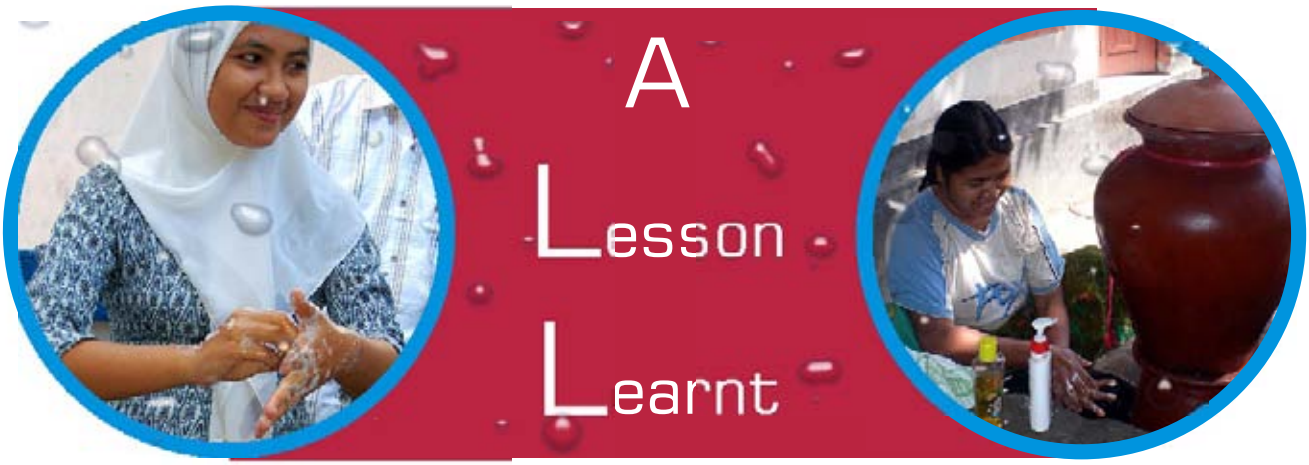


A Community Study to Change Behavior:
Clean hands and fingernails reduce infant diarrhea

Background

Potable water, hygiene, and sanitation remain significant problems in Indonesia. A study by the Indonesian Sanitation Sector Development Program[1] in 2006 showed that 47% of Indonesians still defecate in rivers, agricultural fields, ponds, backyard gardens, and other open spaces.

According to the 2006 Basic Human Services Study[2], only 12% of Indonesians wash their hands after defecating, 9% after cleaning the feces of infants and children under five, 14% before eating, 7% before feeding infants, and 6% before preparing meals. National figures from 2006 showed 423 diarrhea cases per 1,000 persons, and diarrhea outbreaks occurred in 16 provinces with a 2.5% Case Fatality Rate.

The Riskesdas survey of 2007 (Depkes 2008)[3] found diarrhea prevalence of more than 10% in all NTB districts except Mataram City and East Lombok. Riskesdas reported handwashing at 11.2% in NTB, compared with 43.3% nationally. The effectiveness of handwashing in reducing diarrhea has been demonstrated in the health literature and promoted in Indonesia by international donors and health promotion teams, and promotion of handwashing with soap to prevent communicable disease is especially important in communities where the practice is so infrequent.

The question is how to convince people to change their behavior to clean their hands and nails. The most common strategy has been to target students in schools with handwashing demonstrations, but there is little evidence of its impact. As part of the community mobilization component of SISKES in NTB Province, a small study in 2009 by Kediri Puskesmas in West Lombok tried to use research targeting mothers with infants to promote behavior change.

Riskesdas reported handwashing at 11.2% in NTB, compared with 43.3% nationally.

[1] WSP/EAP-Bappenas, 2007. National Sanitation Awareness Campaign, Handwashing with Soap, ISSDP program pengembangan Sanitasi, Nov.2007.
[2] USAID, 2006. Basic Human Services, Baseline Household Survey 2005.2006 in 30 districts of 6 Provinces in Indonesia: Report of Results Health Services Program, Jakarta.
[3] Depkes 2008.Laporan Riset Kesehatan Dasar NTB. 2007.

The promotional research study

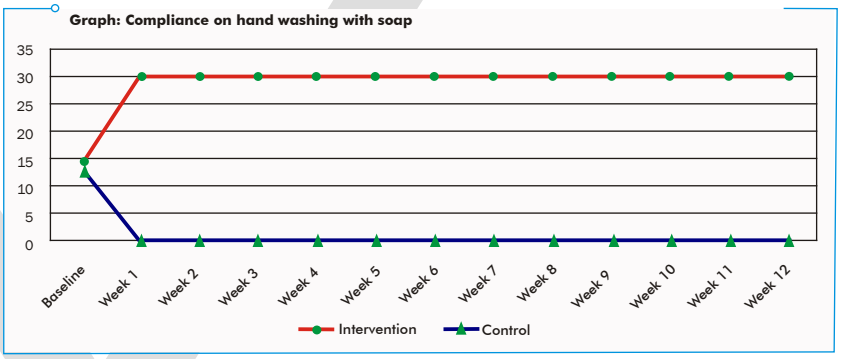
This "promotional study" was conducted in Banyu Mulek Village during April-June 2009. A team composed of the Communicable Diseases Division of the West Lombok DHO, the sanitarian of the Kediri Health Center, village government, village midwives, the heads of sub-villages, and six local Kader health facilitators followed 60 mothers with an infant less than 12 months of age by July 2009 for a period of 12 weeks to monitor handwashing with soap, nail-cutting, and incidence of diarrhea in their infants.

As first step, baseline data were collected on hand-washing and nail-cutting practices, possession of the materials needed, and diarrhea among the infants during the previous week. IEC materials and a leaflet on handwashing were printed, and a short training was held for Kader, heads of sub villages, village midwives, and sanitarians on how to complete the weekly observation form.

In a meeting at Posyandu with the target group of mothers, the 6 steps of handwashing with soap were demonstrated, the leaflets were distributed for each household, and the mothers demonstrated handwashing.

The mothers for the study were divided into two groups of 30 mothers each from separate sub-villages. The intervention group was provided with advice, a demonstration how to wash hands properly with soap, and the materials needed (water container, soap, hand towel, nail cutter).

The control group received only an advice on the importance of nail cutting and handwashing with soap to prevent infant diarrhea. They were not given any materials to reinforce and facilitate the behavior.

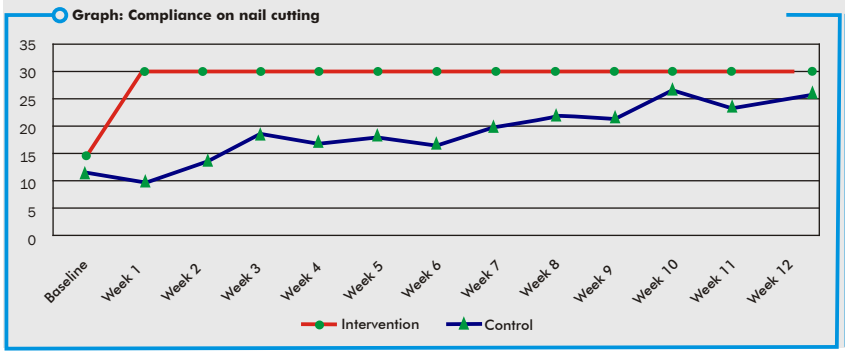


Weekly home visit interviews by six Kader monitored compliance in both groups with handwashing with soap, cutting nails, and diarrhea among the infants. Data were analysed by the PHO/DHO/ health center team with feedback to the mothers.

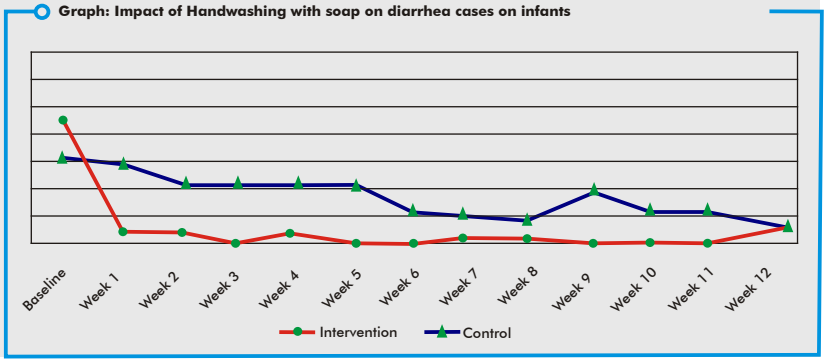
Results of the intervention

Compliance of mothers with handwashing with soap is depicted in the following graph. All 30 mothers in the intervention group regularly washed their hands with soap; the mothers in the control group were not observed to do so. Although the Kader were not convinced of what they were told, the mothers claimed that they did not wash.

The results regarding nail cutting are shown in the graph below. The graph shows that there is increased compliance with nail cutting both groups, but much more in the intervention group.



The incidence of diarrhea among the infants of the mothers can be seen in the following graph. The impact of handwashing with soap and cutting nails on diarrhea among their infants can be seen.



Community discussion

After the three months of observation, a meeting was held with the mothers to explain what had been found, followed by group discussion of feelings about handwashing and challenges to be overcome in adopting the practice routinely. Mothers were convinced that handwashing with soap can reduce diarrhea in their infants. They reported that after washing their hands with soap, they felt cleaner and more confident in touching their babies. They also observed that handwashing is easier than caring for an infant with diarrhea, and comparing the cost of soap with that of care for diarrhea, soap and water are much cheaper.

It was reported as well that handwashing with soap by mothers has spread to others in many families.

When members of the family want to touch the infant, the mother reminds them, "Please wash your hands first if you want to touch the baby." This also reduced women's burden in fetching water because others in the family shared more of the task of fetching water for handwashing by all family members.

Finally, the mothers added that cleaning their hands and nails helped them to practice their religion. The Quran says, "For Allah loves those who turn to Him constantly and He loves those who keep themselves pure and clean" and "cleanliness is half of faith".

They felt that handwashing with soap makes them cleaner for praying.

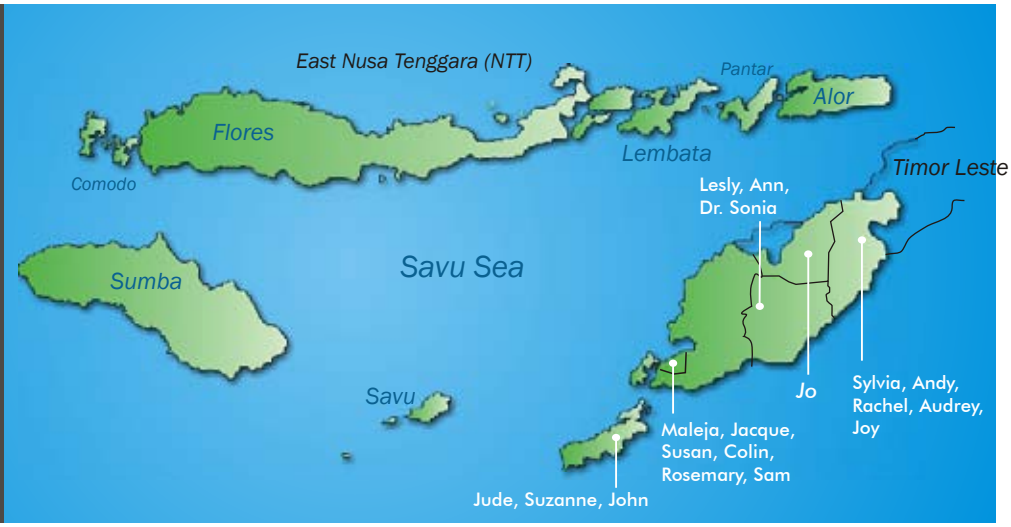
Conclusions

The local health officials who carried out this study concluded that promoting behavior change through a community study is an effective strategy for changing behavior. Mothers can make handwashing with soap a daily practice and thereby protect the health of their infant.

The results of this study were used widely for promotion by the Puskesmas, the District Health Office, and the NTB Provincial Health Office. In addition, such a study can help to train staff to develop skills in research that can be applied in many ways. The PHO included the strategy in its promotion activities in 16 health centers of East Lombok when those areas faced a diarhea outbreak.

A LESSON LEARNT

Author: Dr. Lieve Goeman, MD, MPH
Contributor: Dinnia Joedadibrata



SISKES partnership with VSO's skilled volunteers led to greater achievements by the SISKES Project

Partnership (grant agreement) between GTZ and VSO and was made possible through co-financing by DFID of part of the project. The GTZ budget of up to EUR 666,454 was matched with EUR 512,635 from VSO to cover the period 1 May 2006 through 31 December 2009.

The partnership contributed to the achievements of the SISKES project

The first volunteer arrived in June 2007, and since then 18 short and long term volunteers have worked at three different levels of the health system in all six of the districts targeted by SISKES for Making Pregnancy Safer (MPS) program support.

The primary aim of the partnership was volunteer placements that contribute to the SISKES Project goal that the people of NTT and NTB Provinces, especially the poor, women, and children, use accessible and affordable quality health care services. These services include assurance of professional support during pregnancy, delivery, and postpartum as well as family planning and neonatal care.

The activities of the volunteers included capacity building of the partner agency, provision of small funding, organization of trainings and workshops, written publications, and the sharing of mechanisms and networks.

The partnership had a synergetic effect on the positive impacts of Project activities. The most important features that made the partnership effective were the combination of highly qualified VSO volunteers with the technical expertise of the GTZ staff, concrete collaborations on particular activities and outputs, and a linking of policy level with "grass root" implementation.

VSO Sharing skills Changing lives

The collaboration was built on regular meetings and consultations, exchange, and provision of information and feedback of M&E results between both parties.

Concrete examples of successful partnership include collaborations on HMIS, Desa Siaga,and the IEC strategy.

To contribute to the improvement of HMIS in NTT, VSO recruited highly competent experts for the implementation of the information system in the Johannes hospital in Kupang. Collaboration between the technical advisor and the VSO expert facilitated implementation by providing updated information on the existing data collection and reporting requirements & by ensuring a possible link with the HMIS system of the Province in the

future.

The VSO expert provided the PHO with technical feedback and advice on HMIS development. Another VSO expert facilitated establishment of an HMIS team in the DHO of Sikka District and roll out of the manual HMIS to all Puskesmas in the district.

The achievements of the IEC health promotion strategy were made possible through the partnership by combining policy work at provincial level with implementation of the health promotion strategy at district level. After the strategy for the province was revised and an inventory of all existing health promotion material was made by GTZ staff and the provincial health partner, implementation in the district was facilitated by the VSO volunteer health promotion expert placed within the DHO of TTS District.

The partnership had also a synergetic effect on Desa Siaga implementation, with the SISKES strategy supported by many VSO volunteers in their placements. Sharing resources in terms of time, money, and expertise, regular meetings, joined trainings, activities, and M&E visits led to greater achievements.

Challenges and constraints of the partnership.

Even though concrete collaboration, regular meetings, bottom up feedback, and dissemination of policies and guidelines to the grass roots level occurred, some opportunities were missed. Possibilities for more concrete and closer collaboration developed slowly over the 2½ years of the partnership, and some were discovered too late. These could have been avoided by establishing joint planning at early stages of the partnership, more institutional flexibility, better exchange of information, and clear definition of operational roles and framework. The establishment of an optimal functioning partnership takes time. Socio-cultural barriers need to be overcome, and mutual recognition of each other's technical skills and expertise needs to be developed.

The partnership added value for both GTZ SISKES and VSO in the achievement of their objectives.

The presence of highly skilled VSO volunteers within health offices, health facilities, NGOs, and communities facilitated the work of the GTZ technical advisors. VSO contributed to the implementation of policies and strategies in the field, especially for Desa Siaga which needed a

huge input of resources and where VSO could complement and overcome the limitations of implementing activities through GTZ SISKES staff alone. They provided continuous capacity building of counterparts, accelerated implementation, and ensured progress on specific objectives.

Their feedback and additional information of what was happening on the ground provided useful input to policy development and strengthened the linkages. All these features had a synergetic effect on the achievements of SISKES, and through volunteer networking and communications, experience and ideas were spread wider than the target areas.

The VSO–GTZ partnership with a well established SISKES program shortened the time needed for volunteer orientation and understanding of the wider perspective of their work. The technical experience and expertise available through the GTZ advisers facilitated the work of the VSO volunteers through the provision of information, reports, material, and resources as well as through sharing the existing network and introduction to the partners. VSO experts were thus more efficient.

The work was facilitated both by additional funding for program implementation and training and by the presence of more volunteers in the same area focussing on the same objectives.

Some of their experiences were taken to a policy level by GTZ SISKES to advocate and influence existing policies and strengthen their impact on the ground.

Conclusions

SISKES–VSO partnership led to higher achievements of the SISKES's Project. Conditions to optimize the positive potential of such a partnership include a well established communication mechanism, clear definition of roles, recognition of each other's expertise, mutual exchange of information and experiences, linkage of implementation with the policy level, and a willingness to look for concrete ways to collaborate.

Fulfilling these conditions was a challenging learning process for both parties, and progress was made during the partnership. Both parties perceived this partnership as an added value in reaching their objectives.

BEST PRACTICE

Use of "WISN - Workload Indicator Staffing Needs" methodology at decentralized levels of the health system:

Experience in Nusa Tenggara Timur Province, Indonesia

The Workload Indicator of Staffing Needs (WISN) process has been widely advocated by WHO for national level workforce planning. The application described here to planning at decentralized levels represents an innovation singularly well-suited to current needs of Indonesia's decentralized system.

By: Dr. James Darmawan, MPH, Dr. Ketut Mendra, Joyce Smith,RN,HV,M,PHIL, Pardjono Kromoredjo, MPH, Dr. Riitta-Liisa Kolehmainen-Aitken, MD, DrPH

Workforce planning at decentralized levels has traditionally been based solely on staff-to-population ratios. Whilst this method can provide global numbers, it is imprecise, unable to take into account geographic and workload factors, and it results in a mal-distribution of health personnel. The Human Resources in the Health Sector (HRD) Project in Indonesia, financed by the German government BMZ, through GTZ and contracted to EPOS worked with counterparts in NTT to equip staff in health facilities with evidence based tool to more precisely identify their staffing needs. The HRD Project collaborated closely with the GTZ SISKES project..

Background and rationale

The Indonesian Ministry of Health (MOH) has used various methodologies to plan human resources for health. In the 1980s, the MOH issued Decree No. 262/1979, stating that bed ratios would be the basis for calculating staff requirements for hospital wards, and fixed standard staffing patterns were also defined for district hospitals and health centres. Difficulties were encountered, however, in attempting to develop a method to plan the appropriate health workforce for different facilities.

The Indonesian decentralisation and autonomy laws were passed in 1999 and came into effect abruptly on 1 January 2001 with unsatisfactory transition. How about 'little' or 'limited' attention to the transition process?t transition. Powers were decentralised directly to the district/municipal level with only limited authority given to provinces, even after amendment in 2004 provided the provinces with slightly more authority.

The central government retains the authority for new personnel allocations and the setting of civil service regulations, but responsibility for health human resources is decentralised to the district level. Payment of salaries, development of career paths, recruitment and placement into civil service positions are now the responsibility of each district government. The province has almost no function in human resources except for coordination, monitoring and evaluation, and the transfer of personnel among districts and provinces.

Provincial health workforce planning functions are almost meaningless, and districts decide their own human resource matters except for new staff allocations that require central authorisation by the National Personnel Board under the State Ministry for Administrative Reforms (MENPAN).

The Board for Health Human Resources Development and Utilization (BPPSDMK) was established by the Ministry of Health (DEPKES) in 2001. Its four centresDifferent functions or to cover four geographic areas? Or what? Or maybe it is not important to know how many centres they have? cover all aspects of health human resources aspects, from planning to utilization, to pre-service education and in-service training to professional empowerment and foreign work affairs. The Board has accreditation power for educational and training institutions but oversees only DEPKES-owned health polytechnics. There is almost no direct connection between the BPPSDMK and district health offices and governments.

MOH Decree No.1202/2003 that defined indicators for Healthy Indonesia 2010 used population ratios for calculating staff requirements (e.g. 100 midwives for 100,000 population). In 2004 an additional MOH Decree (No. 81/2004) on staffing was issued. Called the "Guideline on Health Workforce Planning for District Health Offices, District Hospitals, and Health Centres", the decree promoted the use of three methodologies for determining required staffing: population per staff ratios, facility-based staffing standards, and WISN (Workshop Indicator of Staffing Needs). BPPSDMK organised a series of training courses in Jakarta on the three methodologies for representatives from Indonesia's 33 provinces. The impact of the training was limited, however, for a number of reasons:

- The BPPSDMK specified who the trainees should be, but it had no control over who was actually sent to the course by the provinces.

- Many provincial trainees were administrative staff who were neither sufficiently senior in status nor appropriately placed to be able to persuade province and district leaders to adopt new workforce planning methods.

- The training was short, with WISN covered in only one day. This proved inadequate to achieve any level of competence in the use of WISN methodology, and training was focused narrowly on doing calculations, not on interpreting results.

The training response varied greatly, depending upon the interest, ability, and seniority of individual trainees. On return to their provinces, some merely reported on the training. Others began to implement WISN, but they quickly encountered problems. Senior managers at the central level changed frequently, and there was neither strong encouragement to use WISN nor adequate funding to follow-up trainees. Decentralised decision makers and politicians who did not know or understand the WISN methodology on which they were based were unwilling to accept WISN recommendations on staffing levels. Provinces (and districts) found it easier to continue to use the ratio method, already in use, that had also been included in MOH Decree 81/2004. Employment and deployment of health personnel continued to be subject to political pressures. The "top down" approach to introducing WISN had been too centralised for effective implementation at local level.

The HRD in the Health Sector Project, is working with BPPSKMK to support human resource planning and management improvement at central level and in Nusa Tenggara Timur (NTT) and Nusa Tenggara Barat (NTB) Provinces. The Project agreed to support the application of WISN methodology in particular in the two provinces. Because the Project's two HRD national experts were not familiar with WISN, they joined provincial health staff for centrally organised WISN training before assisting their Provincial Health Office (PHO) colleagues to implement WISN. They encountered a number of problems, however, and have had only limited success.

Objective and Strategy

The objective was to support the successful implementation of WISN at decentralized levels as a more effective workforce planning method than reliance on ratio methodology alone. To facilitate the introduction of WISN in NTT and NTB Provinces, a short-term international consultant was engaged to work with three long-term national experts.

Key indicators

- Staff in health facilities confidently apply WISN methodology to their work loads,

- Decision makers accept the methodology as an alternative to ratio methods.

- Decision makers accept the WISN results and apply the results in staffing health facilities.

Main Activities

Beginning with a review of the WISN training materials used by the central level, the international consultant noted that certain methodological steps had not been included or explained correctly. The complex language of the 1998 WHO WISN Manual and its lack of "user friendliness" appear to have resulted in difficulties in translation and consequent misinterpretation. It was also observed that MOH Decree 81/2004 included Activity Standards from countries other than Indonesia.

The provincial representatives trained at the central level had attempted to use these foreign standards without considering their applicability to their own provinces.

After intense discussions, the GTZ/EPOS HRD team agreed with the NTT and NTB Provinces that a new approach was required to introduce WISN within the decentralised health system. It was decided that in NTT province the new WISN approach would initially address only one category of staff, midwives at the health centre level. In NTB, the focus would be on hospital nurses, the largest category of hospital staff.

The first step in the WISN process was to identify and orient key decision makers and stakeholders to WISN methodology and its advantages. In NTT, discussions were held with the Provincial Health Director to select members of a Steering Committee of influential officials at provincial and district level.

The final list included heads of District Health Offices, Provincial and District Personnel Bureaus, and the Provincial Planning Board; senior officers from the Provincial Health Office (including its human resource division); representatives from the Midwifery Association; and representatives from the midwifery pre-service and in-service training institutions in the province. Gaining the interest and understanding of the Steering Committee would be necessary for successful WISN implementation.

A one-day orientation organized by international consultant and Project experts for the Steering Committee informed its members of the WISN methodology and its advantages and encouraged questions. Strong support for the WISN methodology from the Provincial Health Director was crucially important to gaining Steering Committee support. When the members recognised that WISN, as a workload based tool, could provide more accurate and appropriate staffing guidance than the old ratio method, they enthusiastically supported WISN application in their jurisdictions.

A Task Force of 23 members from nine districts was given responsibility for the actual WISN development. Besides experienced midwives working at health centre level, the Task Force included midwifery educators, representatives from the IBI midwifery association, and midwives from the Provincial Health Office. The Task Force was trained in a 3 day workshop following orientation of the Steering Committee. The GTZ/EPOS HRD Project funded participation of Task Force members from six districts, and an AusAID project supported three more districts. The Provincial Health Director and senior members of the Provincial HRD division again showed support by being present during most of the training. Despite the fact that the province no longer ranks higher in the hierarchy than the district, this was a strong signal of the importance of WISN. It also strongly encouraged a spirit of "working together" for more effective human resource planning.

During the training, the Task Force members jointly estimated a health centre midwife's available working time, defined her workload components, developed Service and Allowance Standards, and calculated Standard Workloads. The final part of

the workshop was spent using their own workload data to calculate required midwifery staffing for health centres at district level for comparison with current staffing levels. Where workload statistics were incomplete or their data not entirely clear, the midwives decided to clarify the data before completing the calculations. Furthermore, they next committed themselves to calculating WISN for individual health centres in their districts.

Expanding WISN in NTT Province

Following the enthusiastic response of the original nine districts, the Provincial Health Director requested support from GTZ and AusAID to expand WISN training to the remaining districts in the NTT province. GTZ supported this initiative and the same approach of orienting decision makers (Steering Committee) and training midwife representatives (Task Force) was used with eleven further districts. The training was done by the GTZ/EPOS Project National Experts, supported by the international consultant.

Both the first and second Task Forces worked enthusiastically long after normal work hours to identify and agree on the core midwifery workload components and Activity Standards for their districts. Intense discussions with provincial representatives led eventually to common agreement on both workload components and Activity Standards at the provincial level. The participants in the second WISN training suggested that a group of WISN trainers be trained locally so that the WISN process could be carried forward without needing outside support.

Following the Task Force workshops, several trained midwives organised informal sessions at their work sites to share the WISN methodology with their peers. They explained that they found WISN extremely useful because it helped them to better focus their working time on key activities. They also appreciated being empowered to analyse their own work situation in their own health facilities. This allowed them to send evidence based recommendations upwards to the district level, where staffing had frequently been based on political, rather than technical considerations.

GTZ agreed to support the TOT training. It was provided to 14 WISN trainers, selected from the most motivated, previously trained midwives. The trainers included personnel from the HRD and Community Health Service divisions of the Provincial Health Office, from pre- and in-service training of the provincial health polytechnic, from the midwifery association, and from nine district health offices. Because these midwives already knew and were confident with the WISN methodology, training focused on communication, motivation and interpretation of WISN results. The training was conducted by the three GTZ/EPOS Project national experts. Since then, GTZ Project input to WISN has been purely supportive. The NTT based national expert continued to provide some technical assistance and advice to trainers, but the districts are now funding WISN from their own budgets.

NTT Assistance to Other Provinces

The German funded health project in Aceh province (implemented through GTZ heard about the success of WISN in NTT. The project managers requested support from the GTZ/EPOS HRD Project for using WISN in that province. The focus was staffing of the newly reconstructed hospital in Banda Aceh, the provincial capital. Two WISN trainers from NTT together with one project Expert from EPOS went together to Aceh. They jointly implemented a WISN training workshop for seven different categories, including medical specialists. The NTT trainers were midwives, who previously had only applied WISN at the health centre level. They were initially nervous about applying it in the more complex hospital environment with many competing professional interests. The Jakarta based Expert who accompanied them was an experienced former hospital director. With his support, the trainers performed extremely well and have been invited back for a follow up workshop.

For the NTT WISN trainers, their role in introducing WISN to Aceh Province is a source of immense pride. Their experience and understanding of the methodology allowed them to apply WISN successfully in a much more complex environment than a health centre.

They are now confident in applying their expertise to hospitals in NTT as well.

In neighbouring NTB Province WISN introduction started with nurses in two hospitals, but progress was slow due to competing professional self interests and other issues. Following NTT's at the health centre level, the NTB focus was changed from hospital to health centre as well, and the response from districts has been enthusiastic. WISN trainers have now been trained, and a number of districts have allocated budget for WISN application in 2009.

Findings and Policy Implications

Table 1. **Time spent on main service activities and allowance activities. What are allowance activities?**

Determining the workload components of a health centre midwife revealed that midwives frequently perform "non-midwifery work" such as school health, care of the elderly, TB and malaria surveillance and control, and other such activities.

No.	District	Proportion of time (%)	
		Main services	Allowance activities
1	TTS	49.97	50.03
2	TTU	49.95	50.05
3	Belu.	49.95	59.80
4	Kupang City	42.17	57.83
5	Kupang	39.30	60.30
6	Rote Ndao	46.25	53.75
7	Sikka	38.03	61.97
8	Ende	42.78	57.27
9	Sumba Timur	28.80	71.20
10	Range	28.80 - 59.97	50.03 - 71.20
11	Average	43.02	58.02

It is not clear whether this is due to a shortage of nurses or other personnel categories, but the finding has policy implications for defining the expected roles and responsibilities of the various categories of staff if the staff mix at the facility level is to be appropriate and efficient and the competence of health workers to carry out their work is to be ensured.

Another important WISN finding was the considerable time spent on activities such as handover reports, meetings and collection of salary which are not direct midwifery tasks.

Table 1 below presents the findings from the nine original districts in the proportion of midwives' time used for their main service activities and "allowance" activities.

The WISN calculations for health centres in one district identified clearly which facilities were relatively over- and under-staffed. Table 2 provides an example from TTS District.

Table 2. WISN calculation of midwife requirements for all health centres, TTS District, 2008

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Table 2. WISN calculation of midwife requirements for all health centres, TTS District, 2008

No	Health centre (HC)	Current midwives (a)	Required midwives (b)	Difference (a-b)	Problem	WISN ratio (a/b)	Workload pressure
1	Boking	4	4	0	Adequate	1.0	Perfect match
2	Batu Putih	8	7	+1	Overstaffed	1.1	No
3	Kuanfatu	6	8	-2	Understaffed	0.75	Low
4	Polen	6	9	-3	Understaffed	0.67	High
5	Siso	9	11	-2	Understaffed	0.81	Low
6	Manufui	3	2	+1	Overstaffed	1.5	No
7	Noemuke	4	4	0	Adequate	1.0	Perfect match
8	Hauhasi	3	8	-5	Understaffed	0.38	Extremely high
9	Kualin	6	5	+1	Overstaffed	1.20	No
10	Hoibeti	2	4	-2	Understaffed	0.5	Very high
11	Oe'ekam	6	9	-3	Understaffed	0.66	High
12	Kie	7	10	-3	Understaffed	0.70	High
13	Panite	12	10	+2	Overstaffed	1.20	No
14	Lilana	2	3	-1	Understaffed	0.66	High
15	Oinlasi	6	10	-4	Understaffed	0.60	High
16	Se'i	5	7	-2	Understaffed	0.70	High
17	Fatumnasi	5	5	0	Adequate	1.00	Perfect match
18	Nulle	16	10	+6	Overstaffed	1.60	No
19	Nunkolo	4	3	+1	Overstaffed	1.33	No
20	Niki-niki	13	16	-3	Understaffed	0.81	Low
21	Kota	16	12	+4	Overstaffed	1.33	No
22	Kapan	10	17	-7	Understaffed	0.58	Very high
23	Ayotupas	2	5	-3	Understaffed	0.40	Very high
TTS District totals		155	179	-24	Understaffed	0.86	Low

The importance of interpreting the data before formulating new policies or taking management action was emphasised to the WISN trainees. An important question in the NTT context, for example, is whether the calculations include "non-midwifery" activities or only midwifery tasks. Thus a policy decision to increase midwife staffing in response to WISN results that include non-midwifery activities would incorrect. This is important in Indonesia because midwives are now trained only for midwifery functions but often expected to do much more and find themselves untrained for their non midwifery activities.

Most NTT health centres in the first WISN exercise applied the methodology only to midwives. In Kupang city, however, both district and health centre level staff decided to apply WISN for all health centre categories (i.e., midwives, nurses, a nutritionist, and a sanitarian). Representatives of each category were brought together as groups in a workshop to develop WISN for their own cadres. The joint activity with different groups working side by side identified areas of overlap and duplication, particularly in the area of nutrition. Such findings highlight the need to re-examine the roles, functions, and job description of each category and, if necessary, to adjust policies as a consequence.

Policy and decision makers at decentralised levels have found WISN very useful because it provides technical, evidence-based justification for staffing decisions that were previously often made on grounds such as political criteria or simple reliance on staff/ population ratios alone. The strategy of introducing WISN first at the health centre level also facilitates real collaboration between health centre and district and provincial staff to identify actual health workforce needs and optimal distribution. Sharing with provincial and central levels data that identify understaffed facilities allows the adoption of appropriate recruitment strategies such as targeting potential students from underserved communities for pre-service training. The WISN methodology also leads to clearer policies on Activity Standards and professional roles in health facilities at different levels and, where necessary, re-profiling of jobs. These, in turn, affect policies relating to job descriptions and performance assessment.

Persons involved

The NTT experience suggests that the methodology is more effective if used by the staff who actually do the work rather than by administrators remote from the facilities and not fully conversant with the real workloads of the individual health facilities or work units. The approach employed in NTT involved staff from all workforce categories actually working in the health facilities. The health facility staff themselves feel empowered to analyse their own workloads and provide the results as evidence to decision makers. They become highly motivated when the decision makers act on the evidence they produce.

Decision makers oriented to WISN methodology in NTT Province include personnel from the HRD and Personnel divisions of PHO and DHO, in-service Health Training Centres, Pre-service Health Training Institutes; District and Province Personnel Boards, Organisational Boards, Planning Boards, Parliamentarians, and the Indonesian Midwives Association. Decision makers who previously relied on the ratio method were able to see evidence demonstrating the adjustments to previous staffing patterns that are needed for individual facilities.

Impact recognized to date

- Five districts accepted the WISN findings and are now acting on the results.

- Four districts have used the results to advocate to their district parliaments for appropriate changes.

- Four health centres that presented WISN results as evidence of changes needed and received staffing adjustments with unexpected improvement in motivation for performance have initiated performance motivation/improvement programmes.

- The WISN results at those four health centres has motivated 17 other health centres to commence motivation/improvement programmes of their own.

- One district has programmed all health centres to implement WISN and performance motivation

with funding from its own 2010 district budget.

- Based on the results of the health centre experience, three hospitals have commenced utilising the WISN health workforce planning method as part of hospital management training, and six other hospitals have begun to implement WISN with their own budgets.

- Training of a large core group of WISN trainers has been completed in anticipation of increasing demand for WISN training.
The PHO and five DHOs have included WISN activities in their upcoming 2010 budgets.

Conclusion

The introduction of WISN methodology at decentralised levels has been an exciting experience. The response at the province and district levels far exceeded the expectations of the HRD Project staff, and a number of important lessons were learned in the process:

- Use of WISN Methodology is more effective than the ratio method, particularly at decentralized levels.

- A bottom-up approach is more effective than top-down for introducing WISN in a decentralised government system. The NTT experiences shows that once local decision and policy makers understand the WISN methodology and its benefits, they are willing to accept and act on the results. Moreover, they take ownership of the WISN process as demonstrated by including funding for WISN in their district and province budgets.

- Engaging the local senior decision and policy makers in understanding the method is essential for success. Gaining the support of this group in NTT Province sent a clear signal to health workers at the health facility level that WISN is an approved method, and district health and local government authorities are now taking into account the demonstrated workforce requirements of individual facilities.

- The NTT Provincial Health Director's role in advocating and supporting the WISN methodology was particularly important both for the success of WISN and for the empowerment of staff of various categories. He demonstrated that he trusted the ability of the midwives to apply WISN to analyse and provide evidence of staffing needs. As women who are frequently based in the most isolated parts of the province, the midwives had previously felt that they had no voice in staffing decisions. The Provincial Health Director's strong support was extremely empowering both for the midwives at the health centre level and the midwifery profession in the province as a whole.

- The complexity of the 1998 WHO WISN manual led the central level to implement WISN through a "top-down" approach using translated parts of the manual. In applying a "bottom-up" approach, however, the translated WHO manual was not provided to either the Steering Committees or the Task Forces. Key points of WISN and steps for its implementation were instead provided to trainees through PowerPoint presentations. Calculations using the participants' own local data provided WISN examples, and the members of the Steering Committees and Task Forces were encouraged to ask questions and receive clarification of each point and step.

- Health workers even at the basic service level can use and take ownership of the WISN methodology if the training is clear, simple, and to the point. Training health centre midwives in NTT Province to implement WISN in their health facilities has been a huge success. They demonstrated that once they thoroughly understand the methodology, and are confident in using it in their health centres, only supportive supervision is needed for them to apply it in a more complex environment such as a provincial hospital. They rapidly gained confidence in sharing the WISN methodology with other categories, including medical specialists.

- Conversion of a Category Allowance Standard through a mathematical formula into the Category Allowance Factor was the most difficult WISN step for the trainees to grasp. To address this challenge, GTZ/EPOS HRD Project staff has developed a

simplified WISN Manual. It includes a clearer way of explaining this step.

- Developing local self-reliance and ownership of the WISN process is very important as Project support ends. After introduction of the new WISN approach by the GTZ/EPOS HRD Project, and subsequently support from both GTZ and AusAID, the Task Force members who saw the value of the WISN methodology lobbied for training of their own group of WISN trainers. The enthusiastic response to WISN from senior district health and government officials led them to lobby local parliamentarians to accept WISN as the official workforce planning method in NTT Province, and they allocated local budget funds for continued implementation. The GTZ/EPOS Project has now taken a back seat in the WISN process. Up to the end of the Project (end of 2009), its support still focused on two activities: technical assistance, as needed, by the Project's National Expert based in NTT and refresher training for the WISN trainers. The refresher training was aimed at extending WISN to hospitals and other staff cadres.

- The WISN process has been an important force for bringing together the various stakeholders involved in health workforce decision making in a complex decentralised health system. In NTT, the provincial and district authorities, professional cadres, and professional associations are beginning to address in a systematic manner the difficult issues of health workforce roles and distribution in districts and the province as a whole.

- WISN results can help to clarify health professional roles and professional categories. The application of WISN at the health centre level demonstrated clearly that health centre midwives in NTT were spending more than 50% of their working time on "non midwifery" activities for which they have not been trained. Many of these activities, in fact, belong more appropriately to nurses. This was a very important finding in light of the prevailing assumption up to that point that the number of midwives is insufficient for their midwifery workload. Without the clarification that WISN provided, this may have resulted in employing more midwives, rather than nurses, to cover the "non-midwifery" activities. The transfer of these activities to nurses will allow midwives to concentrate on their dedicated midwifery functions.

- Applying WISN at the same time to a number of health professional categories who work together contributed more to role definition than application to a single category at a time. The Task Force members had never been exposed to WISN methodology prior to their training, and application to the single category of the health centre midwives allowed them to become comfortable with the methodology. When their competence had increased, and Kupang City decided to train all four health centre cadres together, discussion between categories made it easier to identify overlapping roles and provided important information for the review and revision of job descriptions.

- The WISN process has highlighted inconsistency and lack of clarity in data definition. Decentralisation carries the risk of fragmenting the health information system, including the way data are defined. The application of WISN in both NTT and the NTB Provinces revealed inconsistencies and lack of clarity in data definitions. In some cases these could be resolved through discussion among the Task Force members. In the case of NTB hospitals, the nurses in the Task Force were unable to complete the WISN calculations during the training workshop, however, when they found that "inpatient admission" is not defined uniformly in the two hospitals.

Impact on poverty and gender equity

The WISN findings highlighted the fact that midwives were spending less than 50 % of their time on their main midwifery duties. Appropriate staffing adjustments in the individual health facilities allows reallocation of duties, thereby releasing the midwife to spend most of her working time in providing services to pregnant women in a province with one of the highest maternal mortality rates in the country. It also empowers health centres to respond to Governor of NTT Decree No. 42/2009 -- the "NTT Mother and Child Health Revolution".

Efficiency

Once the staff in the facilities apply the methodology, they are able to apply WISN routinely on an annual basis or as and when changes occur in their individual health facilities. This does not require extra budget or time.

Sustainability

The key to sustainability is decision makers who continue to accept and act on the results of WISN. Several districts are advocating to decision makers that WISN become the official workforce planning methodology. This would help to offset the problem of the frequent reassignment of senior staff. Fifty-two WISN trainers have been trained to date in the PHO, In-service and Pre-service Training Institutions, eleven DHOs, and nine hospitals. They constitute an important resource for continued use of the WISN methodology and ongoing support to all health facilities.

Considerations

WISN is not a "stand alone" methodology. It is one of three methods for overall district and provincial workforce planning, and the HRD Project staff has collaborated with counterparts to establish as well a Human Resources Management Information System (HR-MIS) and an overall Workforce Planning Method (Dewdney Method). WISN feeds into the other two methods by providing evidence of specific staffing needs of individual health facilities, thus facilitating more precise workforce planning and contributing to more effective budgeting for HRD.

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