

Title of the project	The Essential Reproductive Health Baseline Survey in South Sumatra, West Java, West Kalimantan, and East Nusa Tenggara
Conducted by	Center for Health Research, University of Indonesia
Supported/funded by	UNFPA
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Sample size	2121 Household, 250 CHC, 434 health providers, 605 clients, 32 FGDs
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BACKGROUND

In order to implement the integrated Essential Reproductive Health (ERH) Package, as one of the objectives of the Sixth Country Project in four provinces of Indonesia, the UNFPA required a relevant baseline survey for planning and evaluation purposes. As stated in the terms of reference, the baseline RH survey will need to assess various information on: the political commitment to prioritize RH program in the project areas; the level of implementation of the ERH Package components at district and Service Delivery Point (SDP) levels; the existing reproductive health services and facilities/ infrastructure at the district and SDP levels; the level of quality of care, skills, and performance of health personnel at the district and selected sub-district levels; and the training needs for health personnel. Center to Health Research-University of Indonesia was appointed to implement the baseline survey for ERH package in selected 43 target areas in South Sumatra, West Java, West Kalimantan, and East Nusa Tenggara.

METHODOLOGY

To obtain the objectives of this baseline survey, CHR-UI conducted several types of research activities, deploying both quantitative and qualitative approaches, as well as using the conceptual framework from Kumar et al. for situation analysis of Family Planning and Reproductive Health Services (Miller R. et al, 1997). There are five types of activities that will provide the necessary data: identification of operational levels of description, identifying levels of commitments (policy and budget), identifying service readiness of the providers (infrastructure, services, resources, training), identifying service received by the clients (knowledge, satisfaction), and identifying the impact of the services.

CONCLUSION

Although most of health related institutions in Indonesia had already committed with the ICPD 1994, the RH components are still conducted by government institutions separately. The National Commission for RH, although politically supported by a Ministerial Decree, has been for sometime inactive and limited in terms of resources. Most of its members are busy government officials, thus further limiting its function. This means that in order for the NCRH to operate, it will need investments in capacity strengthening. The NCRH will better serve if it is more streamlined: a group of a small number of experts and some government officials would be better than an NCRG with large number of officials. At the operational levels, RH task forces can be developed at the district levels to at least raise the awareness of the local governments of the importance of RH.

With the decentralization process still in the transition phase, it seems that budget allocation was already in the hands of local government. However, local policy development, planning, and implementation plans are mostly still following the central level. This includes policies and

programming in the health sector. Capacity building for the heads of district health services need to be strengthened, since budget for health was low compared to other component. Comparing ERH support with the other health program it is obvious that the allocated budget for ERH is very low. There is limited number of trained ERH staff that can be deployed to advocate the importance of ERH. This means that transformational leadership also need to be strengthened at the local health leader.

The results of the survey indicate some components of the ERH, especially the FP and ANC programs, are already integrated and functioning as expected. However, issues relating to STI and ARH services are either not recognized, or not available. The paragraphs below describe in detail comparison between the 6th Country Program Indonesia objectively verifiable indicators (OVI) with the results of the baseline survey, and its relevant recommendations.

In terms of number, the human resource level for MCH and FP services in most CHCs are adequate. Lack of doctors was faced by 16% of all the CHCs, especially for East Nusa Tenggara and West Kalimantan. The gap between poor and rich provinces will be more obvious if contracted doctors are to be directly managed by the local government. Village midwives face the same issues as the contracting doctors, but this study excluded the village midwives as the unit of analysis. Nevertheless, this issue will need to be considered seriously.

It was reported that 79% of the CHCs acknowledged that they have laboratory that can functioning well, but 29% of the total CHCs reported that they have no laboratory personnel. Only 7% of all CHCs have STI testing facilities. Since the service available is far below the laboratory equipment available, it is suggested to conduct the more detailed survey on the laboratory to check the availability of STI services and facilities as well as the supply of reagents should UNFPA decide to implement the laboratory approach to prevent STIs. If the approach was to use the syndromic approach we can see that the antibiotics supply was good enough, but STI services are still limited as many of the existing MCH and FP providers are not skilled in STIs and case handling. In general, both STI laboratory facilities as well as trained staff in syndromic management of STIs are lacking in most CHCs.

Out of stock of contraception at time the survey was reported by between 13% to 52% of CHCs, with East Nusa Tenggara as the worst province facing this problem. It was suggested to improve the contraceptive supply systems. Drugs availability for the emergency of delivery such as magnesium sulphate and oxytocin were frequently reported as not available in the last six month. These drugs are essential for emergency delivery services. It is suggested that this two emergency drugs be on the list of the essential drugs and under the monitoring of the MOH.

Quality of service was not a major concern in this survey since the patient relatively satisfied by the service. But the skills of providers in counselling are still weak since the giving information and answering client's questions were the least item that we observed. It is recommended to improve the counselling skills especially for STI management.

Training in MCH and FP were the most frequent topics that the provider received. Although the provider's knowledge are still low. The most training needed to implement the integrated ERH package was STI case management, since most of the MCH and FP provider rarely received training on the topic.

The other important issue in this survey is integrating the ERH package into the CHC. The planning and budgeting the ERH components are still fully vertical and there was little coordination except if the project was from the same donor agency. FP and MCH programs are

better coordinated since the policies for FP and Health have already been implemented in the CHC.

Integrating STI within FP and MCH services will be much more difficult since although the implementing agency was MOH, they have completely separate reporting and planning structure. Coordination only happened infrequently. This can be seen by the fact that many MCH and FP providers are rarely exposed to STI cases and management training. Although they are not yet integrated, all of the ERH components are already operational at the CHC, albeit separately. Only MCH and FP services have already been integrated since they both share the same clinic site for the services. ARH should be developed by the CHC. Providers can be trained as resource person in the community for adolescent reproductive health services. Other alternative institutions for ARH are available, for example the school system and the Scouts. If boy/girl scouts or high school students are trained and more knowledgeable about ARH, then they can function as better resource-person for their peers. NGOs that work with youth must be supported for ARH activities.

Gender bias in FP was found from this survey, with the male respondent knowledge and participation in FP indicating lower levels compared to females. However female respondents reported higher level of self-decision making in FP.

In MCH it was stated in the variable objective that at least 50% of married men in program areas should be able to identify selected risk factors and dangerous sign in pregnancy. From the baseline survey, only 8% of male respondents are able to identify 3 dangerous signs of pregnancy, and only 16% among female respondents. Further survey is suggested to find out the man involvement in emergency delivery.