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TOOLKIT: COMMUNITY EMPOWERMENT IN MNH



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Toolkit: Community Empowerment in MNH

ALAT BANTU DESA SIAGA

ALERT VILLAGE TOOLKIT

FOREWORD FROM THE DIRECTOR OF MATERNAL HEALTH, MINISTRY OF HEALTH OF REPUBLIC OF INDONESIA

Assalammualaikum. Wr.Wb.

Greetings to all,

Based on the Making Pregnancy Safer (MPS) Strategy and in line with the efforts of accelerating the reduction of maternal death towards achievement of MGDs 2015, the Ministry of Health has launched the “ National Program on Birth Preparedness and Complication Readiness” (P4K=Program Perencanaan Persalinan dan Pencegahan Komplikasi) using identification stickers. The implementation of this program will reduce maternal death and influence a reduction in newborn death. By implementing the P4K using identification stickers, the condition of the pregnant woman can be monitored intensively so that they can deliver their babies safely and have healthy babies. Furthermore, through the P4K using sticker, the pregnant woman, her husband, family members and the community will be empowered through increasing their knowledge about pregnancy, dangerous signs of pregnancy as well as signs of complications and the importance of give birth assisted by skilled health personnel and post partum care including selection of family planning methods. In another words, through P4K the community has important roles in the efforts of saving the life of mothers and their newborn.

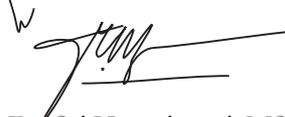
In order to perform the important role of community members in saving the lives of mothers and their newborn especially in emergency situations, the community needs to be facilitated to organize themselves in forming their own alert system in MNH, which covers notification, provision of means of transportation and communication, social financial support, blood donors and family planning information. By forming their own alert system, their alertness on identifying and overcoming emergency situations will increased and in the early stages will focus on maternal and newborn health, family planning and reproductive health for adolescents. Furthermore, in the next step the alertness system will be developed to cover child health, community nutrition and will be extended to cover other health issues such as an alert system for overcoming outbreaks including avian flu. Thus, the implementation of P4K using identification stickers becomes the starting point on community empowerment in the alertness of holistic health towards the achievement of Desa Siaga.

I am very grateful about the development of this toolkit for community empowerment in MNH which is developed based on the experiences of West and East Nusa Tenggara Provinces in facilitating their communities in forming their alert system in MNH. I hope this toolkit can be used by all parties that are committed to increase participation of people in reducing maternal and neonatel death in Indonesia.

Jakarta, August, 2008

The Director of Maternal Health

Directorate of Community Health, Ministry of Health of Republic of Indonesia,



Dr. Sri Hermiyanti, MSc.



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 MATARAM

**FOREWORD FROM THE HEAD OF THE WEST NUSA
 TENGGARA PROVINCIAL HEALTH OFFICE**

Assalamualaikum Warahmatullahi Wabarakatuh .

Maternal and infant death, especially neonate death and poor nutrition are complex problems faced by the NTB province. These problems need to be handled together by multi stakeholders, including community, and by utilizing and mobilizing resources that are our own.

In order to overcome those problems, the Provincial Government of West Nusa Tenggara, through the Provincial Health Office, have implemented the National Programs of Desa Siaga and Birth Planning and Complication Prevention (P4K) using the "sticker", which is part of the Making Pregnancy Safer (MPS) Program. The implementation of these two programs especially in NTB, refer to the Making Pregnancy Safer (MPS) Strategy and have been integrated into the effort of increasing community participation through a program called "Community Empowerment in Maternal and Neonatal Health".

By implementing this community empowerment program, the community members organize themselves to establish their own Alert System in order to prepare themselves when faced with health emergencies. It is intertwined with the P4K Program using the "sticker" and forges a path in achieving the goal of the Desa Siaga National program.

I am fully supportive of the development of this Guideline that can be used as a guidance in the efforts to increase community participation in the health sector.

Mataram, July 2008

The Head of Provincial Health Office
 West Nusa Tenggara Province



Dr. Baiq Magdalena

FOREWORD FROM THE TEAM

Thanks to God, a guideline on the implementation of Community Empowerment in Maternal and Neonate Health (MNH) together with a trainer's manual, guidelines on conducting Self Assessment by the community and guidelines on conducting village meetings in establishing the "Siaga System" have been developed. This guideline was developed based on the experiences of the implementation in West Nusa Tenggara Province in 5 districts/municipalities.

The program of community empowerment in Maternal and Neonatal Health is part of the Ministry of Health's (MOH) "Desa Siaga" National Program which aims to increase the capacity and independence of people to help themselves in the health sector. It is part of the MOH's National program of Birth Preparedness and Complication Prevention using the "sticker". Thus, this community empowerment in MNH is one of the components in the development of the program.

In this guideline you will find the following topics : the concept of the MOH's Desa Siaga; the concept of Community Empowerment in MNH, the process of empowering the community in MNH and the indicators to see the results.

I thank all who have been involved and have supported the development of these guidelines and other products included in this toolkit. I hope that this toolkit can be used by all organizations that are committed to reduce the Maternal Mortality Rate and will generate fruitful results in the region of West Nusa Tenggara Province and other regions of Indonesia with potential adaptation in the wider international community.

Mataram, May 2008.

DEVELOPMENT OF TOOLKIT ON COMMUNITY EMPOWERMENT IN MATERNAL AND NEONATAL HEALTH TEAM

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LAY-OUT AND DESIGN OF THE TOOLKIT

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LIST OF ABBREVIATION AND TERM USED

Abbreviation and Terms In Bahasa Indonesia		Abbreviation and Terms in English	
	Sistem Siaga		Alert System
	Desa Siaga		Alert Village
	Kader		Volunteer Health Worker
MPS	Menuju Persalinan Selamat	MPS	Making Pregnancy Safer
	<i>Same as English</i>	AIDS	Acquired Immune Deficiency Syndrome
	Pemeriksaan Kehamilan	ANC	Ante Natal Care
POSKESDES	Pos Kesehatan Desa		Health services facility at village level
	Kesehatan Reproduksi Remaja	ARH	Adolescent Reproductive Health
PMI	Palang Merah Indonesia		Indonesian Red Cross
UTD	Unit Transfusi Darah	BTU	Blood Transfusion Unit
	<i>Same term as English</i>	CD	Compact Disc
Dikes Kabupaten	Dinas Kesehatan Kabupaten	DHO	District Health Office
	Pemerintah Indonesia	GOI	Government of Indonesia
	Kerjasama Tekhnis Pemerintah Jerman	GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
Dikes Propinsi	Dinas Kesehatan Propinsi	PHO	Provincial Health Office
KB	Keluarga Berencana	FP	Family Planning
	Dukun Melahirkan	TBA	Traditional birth attendant
Askeskin	Asuransi Kesehatan untuk Masyarakat Miskin		Community Health insurance for the poor
BAPPEDA	Badan Perencanaan Pembangunan Daerah		Regional Development Planning board
BKBKS	Badan Keluarga Berencana dan Keluarga Sejahtera		Family planning & welfare board at district level
BKKBN	Badan koordinasi keluarga berencana nasional		National Family Planning Coordination Board
Depkes	Departemen Kesehatan	MOH	Ministry of Health
Dinkes	Dinas Kesehatan		District Health Office
Polindes	Pondok Persalinan Desa		Birthing village House
DPR RI	Dewan Perwakilan Rakyat Republik Indonesia		National Parliament
DPRD	Dewan Perwakilan Rakyat Daerah		Local Parliament
IBI	Ikatan Bidan Indonesia		Indonesia Midwives Association
Kespro	Kesehatan Reproduksi	RH	Reproductive Health
KB	Keluarga Berencana	FP	Family Planning
KBKS	Keluarga Berencana dan Keluarga Sejahtera		Family planning and family welfare association
KIA	Kesehatan Ibu & Anak	MCH	Maternal & Child Health

KIE	Komunikasi, Informasi edukasi	IEC	Information, education & Communication
LSM	Lembaga Swadaya Masyarakat	NGO	Non Governmental Organization
M&E	Monitoring dan evaluasi	M & E	Monitoring & Evaluation
NTB	Nusa Tenggara Barat		West Nusa Tenggara
NTT	Nusa Tenggara Timur		East Nusa Tenggara
NU	Nahdatul Ulama		Islamic Women's NGO
PKK	Pemberdayaan Kesejahteraan Keluarga		Family Welfare Development Organization
Posyandu	Pos Pelayanan Terpadu		integrated maternal and child health service post
P4K dengan Stiker	Program Perencanaan Persalinan dan Persiapan Komplikasi dengan stiker		Birth Preparedness and Complication Readiness using sticker
Puskesmas	Pusat Kesehatan Masyarakat		Community health clinic
RSUD	Rumah Sakit Umum Daerah		Hospital at District Level
SISKES	Sistem Kesehatan		Health System

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INTRODUCTION

Maternal and infant deaths are still a problem in Indonesia, especially in West Nusa Tenggara Province. While the province does not have the highest MMR or NMR in the country, the province is amongst the lower third. The province does have the worst IMR behind Papua, this impacts on the Human development Index (HDI) which, again, is almost the lowest in Indonesia, barely behind Papua. The improvements in the public health sector in recent times have had an influence on decreasing these key rates but similar to other provinces and indeed many Asian countries, the decline in the rates has been slow. This slow decline could be attributed to the minimal attention given in the past to the role of the community themselves in contributing to a reduction in these key indicators that contribute to attainment of healthy and prosperous communities.

From a non medical aspect point of view, causes of maternal death commonly identified are related to:

- The three delays
 - Delay on making decision
 - Delay on providing transportation means in referring the mother
 - Delay in gaining proper treatment at the health center

- The four too's
 - Too old
 - Too young
 - Too often
 - Too close pregnancies

One of the solutions most often offered to overcome those problems is increasing community participation in reducing maternal death, thus also influencing child survival.

The questions are:

- What's sort of concrete action should be taken by the community?
- How could the community be facilitated in increasing their role in reducing maternal and neonatal deaths?

There is little documentation on programs and best practice regarding efforts of increasing people's participation in successfully reducing maternal and neonatal deaths. An article in the British Medical Journal in 2004 called for the need for large scale effectiveness trials but to date little has been published. More recently, Rosato et al reviewed various community participation initiatives from the mid 1970s and concluded that overall community mobilisation is an effective strategy and can contribute to improving MNH. This article though pointed out the many large scale programs do not include community mobilisation due to various controversies that include community mobilisation versus facility based interventions, what are the mechanisms in community mobilisation that bring about health outcomes and how pilot interventions could be scaled up?

This toolkit is a resource for everyone who is committed to reducing maternal and neonatal

death. It is designed to help program managers of MNH and community empowerment programs in general. It can be used for advocacy to decision makers in raising awareness on reducing maternal death. It will also help the practitioner who works in increasing community participation such as those working in NGOs.

Although this program is dealing with the non medical aspects of reducing maternal death, the action of saving lives of women and infants is inseparable from the medical aspects, such as the interventions recommended in the Lancet Series published in 2006. This program is improving community action from the demand side and it requires improvement also in the supply side so that the both sides will complement each other for better collaboration and networking.

1. WHAT IS THE TOOLKIT?

This toolkit is called “Community empowerment in MNH towards the Alert Village (Desa Siaga)”. Thus, it consists of the concept of community empowerment in MNH, the concepts of an alert system in MNH and links to the national concept of the Alert Village of Ministry of Health.

The toolkit also describes a process of implementing the concept of community empowerment in MNH and each step of the process is equipped with guidelines and training manuals in the implementation process. Thus, for those who are interested to implement community empowerment especially facilitating communities in establishing their own alert system in MNH, this toolkit can be followed comprehensively. For those looking for materials for single activities such as advocacy to decision makers or for raising awareness amongst health personnel in performing their roles parts of the toolkit such as the video can be used. In addition, the manual training for family planning can also be used separately from the package of the community empowerment in MNH.

Systematically the toolkit has 5 parts:

- Guidelines consisting of:
 - the concept of the National Alert Village
 - the concept of the Community Alert System
 - the process of facilitating the community in establishing their own alert system, in which each step is equipped with training manual, guidelines and materials used (such as a video) and the budget calculation needed in running the community empowerment program.
- Training Manual I for the facilitator, including the guideline for conducting Self Assessment Survey on analysing the MNH conditions and potential and resources owned by people.
- Training Manual II for the facilitator, including the guideline for conducting a meeting in facilitating people in establishing their own alert system step by step, monitoring forms for various levels on the functioning of the established alert systems.
- Training Manual for the facilitator on Family Planning for Cadres of the FP Information Post
- Multimedia used in the trainings: Siaga Film, Reproductive Health Film.

As the process of community empowerment in MNH is a sequential activity, the toolkit should be read from the concept to the implementation process as a whole, while the guidelines and manual trainings are tools for supporting the implementation of the process.

2. WHY WAS THIS TOOLKIT DEVELOPED?

The effort of increasing people's participation in reducing maternal and neonatal death has been conducted by many institutions in NTB province with many stories on the successes and the challenges, but little has been documented. Based on the experiences of implementing this program over a number of years through a number of initiatives, this toolkit was developed. In addition, documentation of this experience on multimedia such as the film has become a part of the toolkit itself. The film does not only show the experience of implementation but also is able to demonstrate the concept so that the film is an essential part of the toolkit.

Thus, the aim of the development of this toolkit is to provide an example of possible best practice in community mobilisation to compliment medical based initiatives to reduce maternal death such as those recommended in the Lancet Maternal Survival Series. The toolkit consists of the concept and the process of implementation including guidelines and training manuals for each step. The development toolkit is intended to be used to roll out this program in a broad range of areas facing worrying levels of maternal death by a broad range of institutions responsible for reducing maternal death and community development.

3. WHO IS THE TOOLKIT FOR?

This toolkit is developed mainly for the program manager of MNH and community empowerment from any institution working to reduce maternal and neonatal death through increasing community participation in non medical aspects. This toolkit, especially the film, can be used as a reference for broad audiences. It is intended to raise peoples' awareness that maternal death is a responsible of everyone to save lives of women, who could be our own mother or sister or daughter or granddaughter or could be our neighbor.

4. HOW WAS THE TOOLKIT DEVELOPED?

The toolkit was developed through a long term consultancy process provided through technical assistance of the GTZ managed, SISKES Program. The program focused on Health System Support to NTB and NTT Provinces, counterparts being the provincial and district health offices in collaboration with the Ministry of Health of Republic of Indonesia. The process of development of the concepts and implementation also involved the family planning institutions, local government, local health centres, village government and local non-governmental organization (NGOs). The program was carried out with all these institutions in ninety (90) villages in five (5) districts in NTB province in the full two (2) year period of 2007-2008.

The materials were compiled throughout the process of consultancy, reviewed and linked to existing references and literature. A team was formed for the development of the toolkit and consisted of representatives of the PHO, training institutions, representatives of local NGOs, representatives of family planning institutions and the technical adviser of GTZ-SISKES.

The draft was discussed in a seminar involving a large audience, from the MOH, PHO of various sub-programs, DHO, local NGOs, training institutions and community members. Feedback and input from the seminar was accommodated by the toolkit development team and then released as the official toolkit by the PHO with acknowledgement from MOH.

5. HOW TO USE THIS TOOLKIT

The toolkit consists of the concept and implementation process as well as tools including the budget to run the program. Thus, for those who have the intention to provide support to this program or to run this program, all the materials in the guidelines should be read and the film viewed in order to gain a comprehensive understanding of this program including the end results that are intended.

While the training manual and guidelines for each step can be studied and used easily by the professional trainer/facilitator that could be hired to facilitate the training. The trainer/facilitator of the training, however, should read the concept before facilitating and using this training manual in order to get the whole concept of the community empowerment program. In addition, people who have joined the training program can use this toolkit for replication of the program to other sites easily. Especially the film, it can be used independently as media for conducting advocacy or in raising peoples' awareness on the reduction of maternal death as everyone's responsibility.

GUIDELINES FOR IMPLEMENTATION

COMMUNITY EMPOWERMENT IN MATERNAL AND
NEO-NATAL HEALTH TOWARDS THE ALERT VILLAGE



MATARAM, 2009



gtz

GUIDELINES FOR IMPLEMENTATION

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I. INTRODUCTION

In order to accelerate the achievement of the targets of Indonesian Health Development, that is, Healthy Indonesia 2010, the Health Department of Indonesian Government has developed the National Program of Desa Siaga (Ministry of MOH decree: 564/Menkes/SK/VIII/2006) as a strategy that is believed to contribute to improving health status of all Indonesians.

The Development of the Desa Siaga Program involves efforts to improve access of people to primary health care services, to prepare people to be alert to overcome their health problems and to educate people to be independent in developing their healthy life styles through empowerment strategies.

Looking at the objectives and scope of the development of Desa Siaga concepts, the implementation and development of community empowerment in Maternal and Neonatal Health (MNH) is a crucial strategy in achieving the objectives of Desa Siaga in reducing maternal and neonatal death.

Regarding the effort on acceleration of reduction maternal and neonatal death, the MOH of Indonesian Government has also launched a National Birth Planning and Prevention of Complication (Perencanaan Persalinan dan Pencegahan Komplikasi - P4K) incorporating a “sticker” Program. Through the implementation of “P4K using Sticker”, the condition of pregnant women could be monitored intensively so that women can have a safe birthing process as well as having a healthy baby.

In NTB Province, many efforts have been conducted regarding the reduction of maternal and neonatal death, however, until now the maternal and neonatal death rate still remains a problem. The causes that are identified nationally, known as “three delays” (delay on making decision to refer the pregnant women, delay on providing means of transportation, and delay on getting appropriate medical treatment), and “Four T's” (too young, too old, too often, too closely spaced pregnancies).

Looking at the identified causes of the maternal and neonatal death above, it is very crucial to increase involvement of people to overcome the problems, by empowering them to be alert in terms of the non clinical aspects when emergencies of maternal and neonatal conditions happen. This community based-Alert System can also support the implementation of the Program of Birth Planning and Complication Prevention (P4K) using the “sticker”. Therefore, this guideline on the implementation of community empowerment in MNH has been developed. This is an inseparable effort in the development of the National Desa Siaga Program.

II. DESA SIAGA CONCEPTS

”Indonesians are independent for having a healthy life” and ”To make healthy people” are the Vision and Mission of the MOH of the Indonesian Government. The vision and mission will be achieved through the following strategies:

- Mobilizing and empowering people to have a healthy life.
- Improving access of people to better health services.
- Improving surveillance, monitoring and health information systems.
- Improving health financing/budgeting.

Regarding the above strategies, one of the targets which is crucial to be achieved by the end of 2008 is that all villages in Indonesia become Desa Siaga. Through the development of the Desa Siaga Program it is hoped that the following targets of Health Development in Indonesia can be achieved between 2004-2009:

- Increase life expectancy from 66.2 years to 70.6 years.
- Reduce neonatal deaths from 45 to 26 per 1000 live births.
- Reduce maternal death from 307 to 226 per 100,000 live births.
- Reduced prevalence of poor nutrition on child under five years old from 25.8% to 20%.

By achieving these targets, it is hoped that by 2010 Indonesians can live in a healthy environment, having a healthy life style and able to access quality health services equally with equity so that Indonesians can have a higher health status.

Desa Siaga describes people who live in a village or municipal area who are aware of, have intention and capability to prevent and overcome many threats of vulnerability to their health condition such as poor nutrition, communicable diseases, and potential outbreaks by using their own local resources mutually and by gathering a togetherness spirit amongst themselves.

Besides being an effort to bring primary health care services closer to the people, the development of Desa Siaga involves an effort to increase people's readiness and to be alert to overcome health problems, and to make people more independent in developing their own healthy lifestyles. Thus, the main activity of development of Desa Siaga is to empower communities in order to have intention and capability in having healthy lifestyles.

Therefore, in its development, Desa Siaga requires an educative approach, which is to facilitate people to learn through their own learning process based on problem solving approaches.

The development of the Desa Siaga Program covers the following aspects :

- Maternal and neonatal health
- Improvement of people's nutrition
- Promoting healthy life styles
- Improving sanitation and healthy environments
- Simple epidemiology
- Supporting the Poskesdes – community health center as primary health care services for the people

A. DEFINITION

Desa Siaga is a term used to describe community members who live in villages who own resources and capacities for preventing and overcoming their own health problems, disasters and health emergencies based on mutual support and in a spirit of togetherness.

B. OBJECTIVES

General Objectives:

Villagers will have healthy lifestyles and are aware of and alert to their own health problems in their area.

Specific Objectives:

- Increased knowledge and awareness of the villagers about the importance of health.
- Increased preparedness and readiness of the villagers to overcome risk and dangers that cause health problems (such as a disasters, an epidemic, emergencies).
- Increased number of families that practice healthy lifestyles, having good nutrition and healthy status.
- Increased healthy environment in the village
- Increased intentions and capabilities of the villagers on mutual support amongst themselves towards the health sector.

C. THE TARGETS OF DESA SIAGA DEVELOPMENT

The targets of Desa SIAGA development are categorised as follows :

- Individuals and families who live in the village will be able to practice healthy lifestyles and are aware of and alert to their own health problems in their area.
- Parties that have an influence on the behaviors change of individuals and families or those who are able to create support for behaviors change, such as community/religious leaders, female leaders, youth, cadres, and health personnel. In other words, parties who have influence in the community.
- Parties that are able to provide support on policy, law, regulation, budget, labor, resources, and infrastructure, such as the village head, sub-district head, relevant policy makers, donors, and other stakeholders.

D. CRITERIA of DESA SIAGA

A village will be called Desa Siaga, if the village has at least a Pos Kesehatan Desa (POSKESDES), which is a community based health service established in the village in order to bring primary health care services closer to the villagers.

The personnel of POSKESDES are: a minimum one midwife assisted by two cadre.

III. CONCEPT ON COMMUNITY EMPOWERMENT in MATERNAL AND NEONATAL HEALTH (MNH)

As described previously, one of the objectives of the National Desa Siaga Development Program is to increase people's intentions and capabilities for helping each other in

overcoming their health problems. Included in the program are emergencies related to pregnancy and delivery. The community empowerment linked to MNH is a crucial part in achieving the objectives of Desa Siaga.

A. BACKGROUND

Conceptually, the community empowerment linked to MNH is developed based on the cultural practices of mutual assistance across the societies in NTB.

In all of the cultures in NTB, there is a practice through tradition of mutually helping each other in many aspects of life using community resources. The people help each other when someone dies, when a couple gets married, or when celebrating religious ceremonies. This tradition of mutual help does not exist by itself, but it is developed through the centuries by people organizing themselves to overcome their own problems by raising consensus to help each other. The unwritten consensus becomes a local custom that the majority of the community abides by. The consensus is practiced by the people and it is passed on from one generation to the next producing tangible benefits of practice, leading to development of traditions in the society.

The tradition of helping each other, when a couple gets married or when a person passes away, exists in all cultural groups in NTB province but with different terms. These terms include “Banjar Kawin” and “Banjar Kematian” for Sasak Society, “Mboloweki” for Bima, Dompu and Sumbawa ethnic groups in Sumbawa Society.

The tradition of mutually helping each other are applied not only when marriages take place or when death occurs but are applied in other activities. For example, when someone builds a new house it is called “Banjar Rumah”, when working farmland it is called “Banjar Kerja” and when building a mosque. Thus, it can be said that the tradition of helping each other occurs because people find it is important for them to share the burdens and joys of life using their own resources.

However, this tradition of helping each other, unfortunately, is rarely applied for saving people's lives, when someone is facing health problems or an emergency health situation. One such emergency is related to pregnancy and delivery, and we know in reality, the high mortality and neonatal death rate is a big problem faced by the province of NTB.

The concept of community empowerment in MNH is developed as a strategy to reduce maternal and neonatal health through increasing people's participation in helping each other on the non clinical aspects related to pregnancy and delivery emergencies. The concept has been developed through learning from the existing traditions of mutual assistance and combined with lessons learnt from the previous Maternal and Neonatal Health (MNH) Project in West Java and the AusAID Project support of Women's Health and Family Welfare (WHFWP) in NTB.

Specifically, the community empowerment in MNH is developed in order to respond to following facts:

- High percentage of maternal deaths happen within 2 hours during and following the process of delivery.

- Most of the maternal deaths have a correlation to the “three delays “– delay in making the decision to refer the woman, delay to provide a means of transportation and delay to obtain adequate medical treatment.
- A high percentage of maternal death is caused by hemorrhage.
- Pregnancy and delivery is assumed as a natural occurrences that happens to every woman.
- Pregnancy is associated as women's affairs.

In fact, 85 % of maternal deaths could be avoided because:

- The ”three delay” problem is a problem that is largely related to social and cultural behaviors within the community.
- There are still many myths/taboo that are related to pregnancy and delivery that need to be well explained.
- Pregnancy and delivery is not only women's affairs but it is also affair of the family and it should become a public affair.

Considering those facts, every one: husband of the pregnant woman, her neighbor, her neighborhood (community leader), midwives, health facilities (health center and hospitals), could help the pregnant woman by realizing their roles. However, we did not know what we can do to reduce maternal death and what role we can take to save a life of a pregnant woman. Therefore, in principle, we can take a role to save the life of a pregnant woman by promoting Birth Preparedness and Readiness to face complications through the following actions (Kusyunarti, 2004):

- Increasing the awareness of people that each pregnancy is our responsibility, it is not only women's responsibility.
- Each pregnancy and delivery has a risk and each pregnancy is unique to each woman.
- Revitalizing the values of helping each other in saving a life of pregnant woman from the non clinical aspects.
- Involving all stakeholders in dealing with this issue.

By implementing these actions it is hoped that access of people towards the birth planning mechanism and readiness to face any complication at the community level is improved. This improvement is through establishing a Community Based Alert System that is developed ”from, by and for” people in terms of notifying the condition of the pregnant woman, provision of the means of transportation, communication, provision of blood donation, and financial support.

B. DEFINITION

The community empowerment within MNH is an effort to facilitate people to establish a Community Based-Alert System in order to manage the non clinical aspects of emergency situations related to pregnancy and delivery.

The Community Based Alert System is defined as a system of people helping each other developed ”from, by, for themselves” in the provision of the means of transportation, communication (phone, mobile phone), financial support, voluntary blood donation, notification, and Family Planning (FP) Information Post.

The Community based Alert System at the community level consists of:

1. Notification system.
 2. Means of transportation/communication systems.
 3. Financial support system.
 4. Blood donation system.
 5. Dissemination of FP Information.
- A process of community empowerment in MNH is not only facilitating people in establishing their own Community Based Alert System but it is also a process of facilitation for behavior change, that is: (Kusyunarti, 2004)
 - Social mobilization to prepare people to be ready to respond to an emergency situation, especially related to pregnancy and delivery.
 - Increasing people's participation in reducing maternal death.
 - Using resources owned by people in helping women during pregnancy and delivery.
 - Achieving all deliveries assisted by Skilled irth Attendants (SBA).
 - Empowering the community so that they are able to solve their own problems.
 - Involving men in solving maternal health problems.
 - Involving all stakeholders in overcoming health problems.
 - Thus, community empowerment in MNH is from the following philosophical thoughts:
 - Revitalizing values of social togetherness and mutual assistance for the woman during her pregnancy and delivery.
 - Shifting the paradigm: delivery is a public affair, it is not only women's affairs.
 - Shifting the mind set: health problems are not only the responsibility of government but they are a shared problem of people and the responsibility of people to overcome.
 - Involving all stakeholders in the community.
 - Applying participative approaches.
 - Doing in action and advocacy.

C. OBJECTIVES

General Objectives:

To increase people alertness in facing maternal and neonatal problems and emergencies in order to accelerate reductions in maternal and neonatal deaths.

Specific Objectives:

- Established of Community Based Alert System: notification, provision of means of transportation, communication, financial support, blood donation, and dissemination of FP Information.
- Increased visits of pregnant women to the health center.
- Increased deliveries attended by SBA.
- Increased number of active FP users.

D. SCOPE

The community empowerment in MNH is facilitating people to establish a Community Based Alert System in MNH, that is, an Alert System developed from, for and by people that covers the following content:

Community Based Notification System

- In order to be able to help someone who is in an emergency situation, people need to have information on what is happening in their community. They need to have a recording, monitoring and reporting system aimed at notifying themselves.
- This recording-monitoring-reporting system is participatory system that is done from, by and for themselves and focused on health issues.
- Information will be recorded and monitored but it is up for consensus to decide what is going to be monitored. For instance, information on the number of pregnant women, maternal deaths, neonatal deaths, number of population and kept up date. In other words, the health problem that will be recorded depends on what is agreed by the community members.
- Under this system, those who are having a health problem or condition go to the volunteer recorder who is agreed by the community.
- The volunteer recorder is a community member who has the spare time and wants to use her/his spare time to record what is happening in their area on health that is reported to her/him by those who are facing the problem. The voluntary recorder should exist in each neighborhood in order to encourage people to record.
- Agreement on establishing this system is done through holding a meeting with community members that represent the population of the sub-village. However, the consensus raised in the meeting will rule all people who live in the sub-village.
- The consensus belongs to the people who developed them so they are implemented and become the responsibility of the people who live in the sub-village.
- The functioning of this system will be very worthwhile for neighborhood, sub-village, village office, therefore, the consensus is not only to be agreed but it is important that it should be applied by all people and the gathered information will be used to monitor the health problems in the area.
- This system is developed using forms that are agreed upon by the people.

Community Based: Means of transportation/communication systems

- Mutually assisting each other for the provision of the means of transportation and communication when health emergency situations and disasters occur.
- In order to run this system, people need to raise a consensus on helping each other with the provision of the means of transportation and communication with rulings on: who the owners are of transportation and communication means that are listed in the system, how to ask for help, how to give help (provide the means of transportation and communication), what costs (pay or free of charge) and who will coordinate this effort, etc.
- The consensus is developed from, for and by the people through holding a meeting at the sub-village level that is attended by the representative of the neighborhoods.
- The consensus could be raised and agreed by people who attend the meeting but it will concern all people who stay in the sub-village, so the consensus itself has to be informed to others who do not join the meeting.
- The consensus owned by the people needs to be applied by them continuously so that they take responsibility.

Community Based Financial Support System

- An emergency situation often happens when someone does not have any cash money and this often causes delay in efforts to save a life. People need to support each other in

these emergency situations by establishing financial support, similar to the support when someone dies or gets married.

- The financial support system is an effort to help each other, developed from, by and for the people for finance matters when emergency situations or disasters happen.
- In order to manage this financial support, people need to raise a consensus amongst themselves by holding a meeting at the sub-village level that is attended by representatives of the neighborhood or all families who live there.
- Using consensus the representatives will be guided on where the source of the fund will be raised, how much of the fund will be raised, what the fund will be used for, who will be eligible to receive, who will manage the fund, how much support will be given, in what conditions someone is eligible to receive funds and how the usage of the fund will be reported back to the people who formed the financial support.
- The consensus reached will belong to the people and it has to be applied by these people. So it is not only raising consensus but it should be an applicable consensus that supports each other financially.

Community Based Blood Donation System

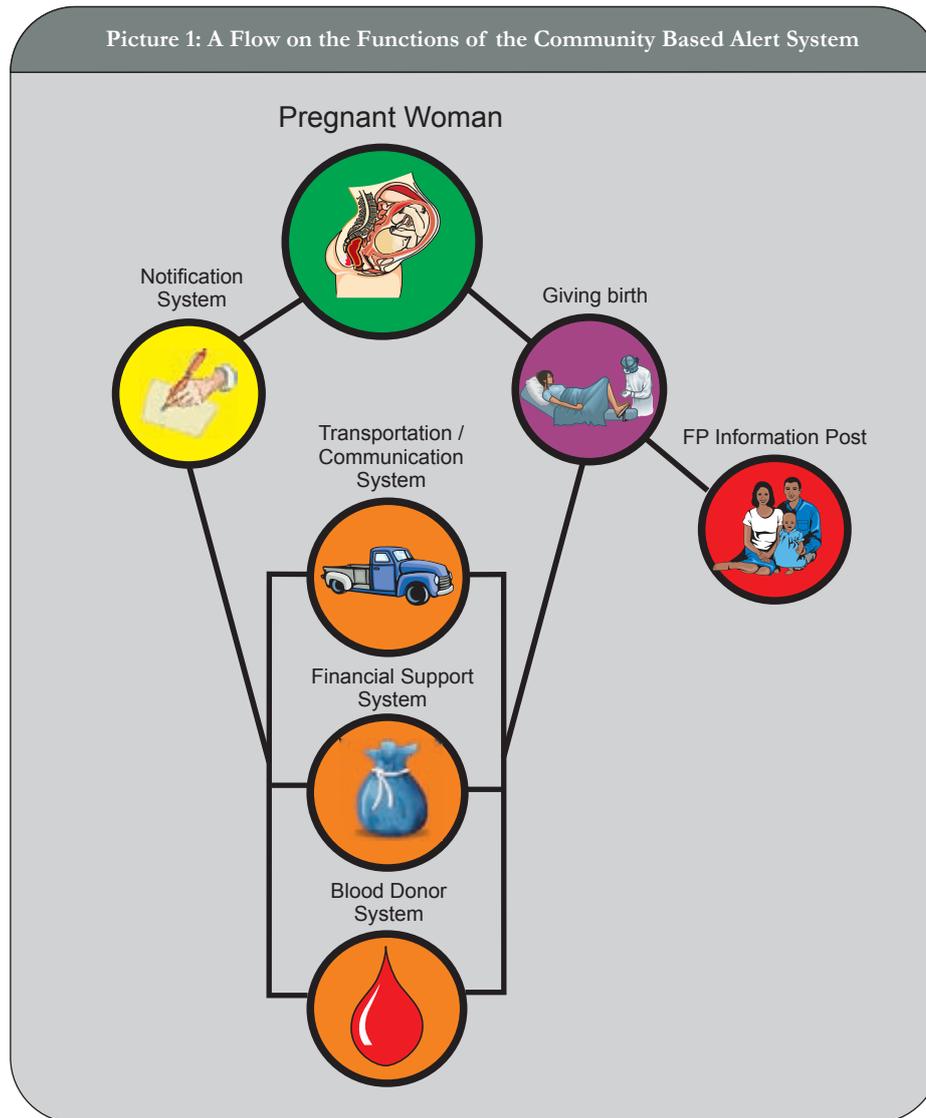
- It is an effort to help each other, “from, by and for themselves”, regarding the provision of a blood donor system when emergencies require blood transfusion.
- In order to establish this system, people need to have a list of potential blood donors with blood types, and how to provide the blood donors. People who are eligible to be the blood donor will be checked for their blood type in order to make them ready to donate their blood when needed.
- The meeting to establish this system is held at the village level.
- The meeting is attended by the potential blood donors and representatives of the villagers from all sub-villages, people from the health center, the village midwives and Red Cross blood transfusion unit.
- The decisions raised through consensus in the meeting belong to the villagers and are implemented by them.

Family Planning (FP) Information Post

- An effort to help each other on the dissemination of FP information amongst the villagers, especially to males and females of reproductive age, in order to bring closer access of FP Information.
- To increase the capacity of the villagers to disseminate FP information, one of the community members from each sub-village is trained in Reproductive Health, FP, communication skills and equipped with IEC material on the topics so they will be able to disseminate the information to the rest of the people in their village.
- This sharing of information on FP will be sustainable because each sub-village has its own resource person who will act as a bridge between the villagers and the health services.

How the Community Based Alert System works is illustrated on the next page.

Picture 1: A Flow on the Functions of the Community Based Alert System



The process of community empowerment in MNH through facilitation of people in establishing their own Alert System involves the following activities:

- Developing the partnership between midwives and the traditional birth attendant
- Supporting the National Program of Birth Planning and Prevention of Complication (P4K) using the "sticker"
- Revitalizing an Integrated Services Post at the sub-village level (Posyandu).

The establishment of the Alert System: notification, provision of transportation and communication means, financial support, and blood donation as well as FP Information Post combined will support the birth planning program that is planned by the pregnant woman together with her family. In addition, the functioning of the Alert System will be discussed in the community based primary health care services (Poskesdes) once a month, so all these activities will compliment each other in order to achieve better health for the villagers.

This cyclical process that allows people to comprehend their condition and take action in solving their problems is called Participatory Learning and Action (PLA). This approach facilitates people to explore and manage various components, strengths and differences, so that everyone has the same view on solving problems. It is also a process of organizing people so that they are able to think, to analyze and to take action to solve their future problems. This is the process of empowering people so that they are able to carry out actions to improve their condition. Thus, this is a process in which people transform themselves personally and collectively and they drive their power from their energy and strengths (Hartstock, 1981)³.

Regarding the establishment of the Community Based Alert System, people at the beginning need to understand and analyze their current health condition, such as maternal health, neonatal health, services available, power relationships that affect these conditions so that they are able to take action to improve the conditions based on their analysis of resources they have. In order to facilitate them to think, to analyze and to take action, the process of facilitation and who facilitates this process is important. In addition, the facilitator requires understanding both on community empowerment concepts in MNH and knowledge and skills on the application of participatory approaches, techniques and tools. Thus, the approach applied into this community empowerment process will determine the next and further processes and activities in the entire process community empowerment in MNH.

IV. IMPLEMENTATION STAGE IN THE PROCESS OF COMMUNITY EMPOWERMENT IN MNH

The main process in the implementation of community empowerment in MNH is the provision of facilitation on the establishment of the Community Alert System because the system itself does not exist as yet in the community. Once it is established, the functioning of the system will depend on the people themselves. In this context, the process of community empowerment in MNH could be described as like putting an electricity installation into a house. Relevant institutions will help the villagers to install the installation which is establishment of the Alert System but when it was installed the villagers should take care, maintain the work and provide the operational resources of the system. Like electricity, after the installation of the hard ware, it is up to the owner or those who stay in the house, to keep the light on. It is up to the villagers to maintain the activities of each system to better their health.

Within the facilitation process, the main actor in the development of the Alert Systems in the village is one of the community members having a role to do facilitation. In order to be able to perform his/her roles, the selected villager requires knowledge and skills on facilitation, how to organize people and how to mobilize people using a participative approach. In other words, they need training and guidelines to perform facilitation works with people as well as coordinating skills with relevant institutions in developing a network for each system.

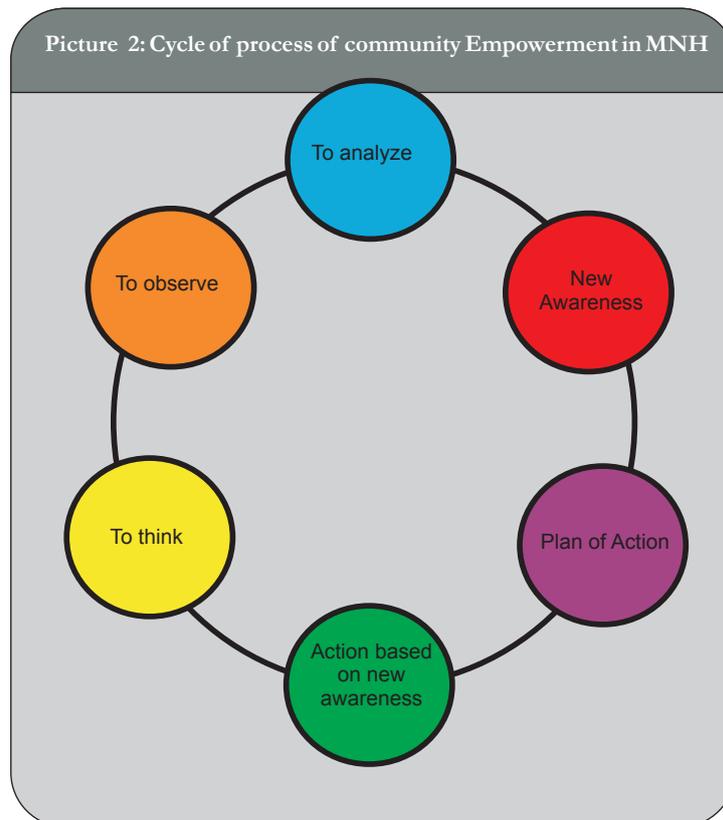
³ Hartock, N.1981, "Political change: two perspective on power" in *Building Feminist Theory: Essays from Quest*, ed. Chalotte Bunch et.all., Longman Press, New York.

E. AN APPROACH APPLIED TO COMMUNITY EMPOWERMENT IN MNH: PARTICIPATORY LEARNING AND ACTION

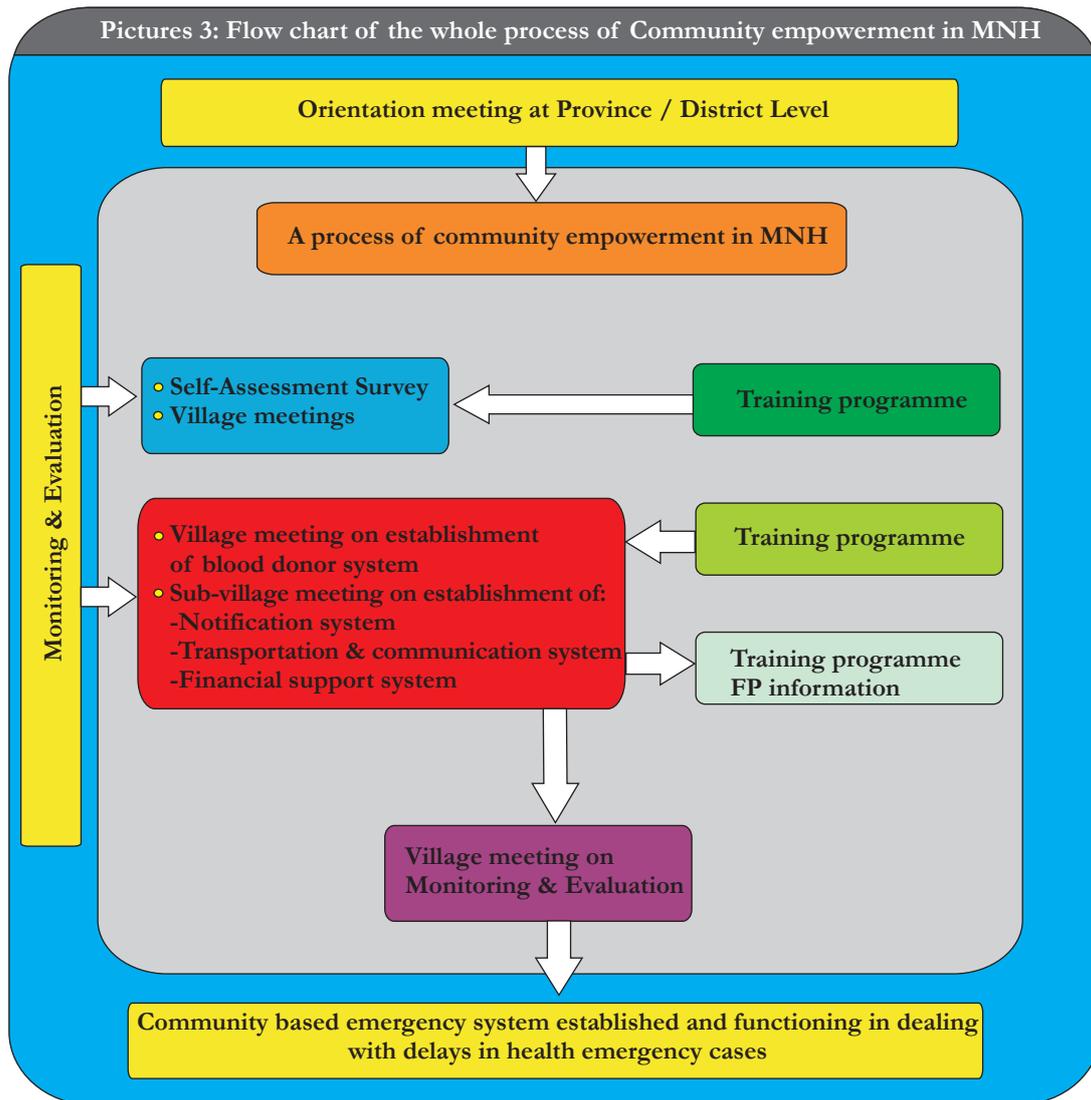
A process of community empowerment in MNH is very much dependant on gender balanced community participation. To do so, it is necessary to put the community as the subject of their own development (Chamber, 1997)¹. Thus, how is the community made the subject?

To be able to be the subject, the community will need to be aware that they have problems that affect their lives; they have to be aware that they have their own resources to overcome these problems, so that they carry out the actions to solve the problems. This principle is supported by Paulo Freire's theory on conscientisation (1973)², development roots come by educating both disadvantaged and advantaged people. By raising awareness through self-reflection, people are able to assert their voices and stimulate their own self-driven collective actions to transform their reality.

In order to raise people's awareness it is important to facilitate them to think and to analyze their own condition and problems critically. By facilitating them to think, re-think and analyze their own health condition and problems, people will be able to have sensitivity and a new awareness that triggers them to have intention to act in order to change their current condition. Their new emerging action then will be observed, re-thought and re-analyzed in order to have further awareness based on lessons learnt from previous actions and used for forging new actions. The cycle of this process can be illustrated as follows:



1. Chambers, R. 1997, 'Paradigm shifts and the practice of participatory research and development' in Power and Participatory Development, Theory and Practice, ed.N.Nelson and S.Wright, Intermediate Technology Publication, London.
2. Freire, P.1973, Pedagogy of the Oppressed, Penguin Books, London.



Briefly the process of community empowerment in MNH can be divided into two main

B. ORIENTATION MEETING AT DISTRICT LEVEL

1. Aims of the meeting include dissemination of the concept of community empowerment in MNH, including its approach, process and discussion on criteria of selecting members of the community who will take roles as village facilitators in the process of the empowerment of the community in MNH.
2. Participants:
 - From the district level: Planning Board, District Health Office, District Family Planning Institution, District Parliament, District Hospital, District Midwife's Association, District Red Cross, Blood Transfusion Unit, MNH Clinic, District Women's organization.
 - From the sub-district level: the head of the sub-district, head of the health center, midwifery coordinator, sub-village women's organization, sub-village FP coordinator.
 - From the village level (the nomination of the site of the program): the village head, the village parliament, the village midwives and the village women's organization.
3. Implementation: this is a one day meeting and it could be organized by the relevant institutions that will lead the delivery of this program.
4. Output of the meeting:
 - The concept of the Community Empowerment in MNH is understood.
 - The selection site where the program will be run is agreed.
 - Commitment of the district/sub-district/village government and relevant institutions on the provision of budget and support of the process and the functioning of the established Alert System is agreed.
 - Criteria on selection for the village facilitator is agreed.
 - Commitment from the selected village government to implement this program and maintain the sustainability of the established Alert System gathered.

C. TRAINING PROGRAM I OF COMMUNITY EMPOWERMENT IN MNH: CONCEPT AND ITS APPROACH

Regarding the principle of community empowerment in MNH, which is, “from, by and for the villagers themselves”, the facilitation process requires a facilitator from the selected village. To be able to facilitate the process, one of the community members is invited to a joint two training programs. Training activities within the process of community empowerment in MNH is a process of enabling one member of the village to be able to facilitate her/his community members for organizing themselves in overcoming their health emergencies or disasters by developing a consensus to help each other in saving the lives of people. The first training covers the program of increasing the capacity of the participant in understanding MNH problems. The emphasis is on the MNH problems from the villager's point of view including the village facilitator and how everyone could take a role to overcome the problems by looking at their own capacities, resources available in the village. These include the existing

village organization or institutions, knowledge and technology owned by the villagers including their traditions of helping each other that can be used in saving lives of the people, especially the lives of pregnant women during pregnancy and giving birth. The village facilitators are equipped with knowledge on how to approach and involve those who have influence in the community, to involve them in organizing and mobilizing people in order to take actions in saving the lives of people who are in an emergency situation. Thus, in the first training program, the village facilitator is equipped with knowledge and skills on facilitation of conducting a survey of self-assessment on the village health condition using participative methods and tools including this guideline, and of analyzing resources that they have.

The First Training program and Manual Training for the trainer can be found in separate documents of this toolkit.

Objectives of the training

General Objective: the participants are able to facilitate the process of community empowerment in MNH

Specific objectives: at the end of the training, the participants will be able to :

- Understand the concept of Community Empowerment in MNH
- Understand and be able to facilitate the application of participatory approach and techniques in conducting the Self Assessment Survey and in the process of empowering the community in MNH.
- To facilitate the villagers to conduct the self assessment survey in MNH and analyze the resources that the village has.
- To follow the guideline for conducting the Self Assessment Survey.
- To develop a plan of conducting Self Assessment Survey in each village.
- To be able to conduct a village meeting in doing Self Assessment.
- Participants of the training
- One person from each village, male or female who has potential for facilitation and organizing people.
- One staff member of the health center who is responsible for community participation or coordinator of Posyandu.
- One staff member of the District Health Office who is responsible for MNH or the community participation program.

D. CONDUCTING THE SELF ASSESSMENT SURVEY IN MNH: ANALYSIS ON MATERNAL AND NEONATAL HEALTH CONDITIONS AND RESOURCES OWNED BY THE VILLAGERS

After joining the first training, the village facilitator commences to facilitate the process of community empowerment by disseminating the idea of mutually helping each other in overcoming emergency situations to influential people in the village as well as to facilitate the villagers in understanding their health problems and resources they own through conducting the survey of self assessment focusing on MNH.

The Self Assessment Survey is a process of increasing the capacity of people to be aware about their health condition and it is a process of empowering them to take action on improving their health condition especially maternal and neonatal health.

This activity is conducted in two stages. The first stage is gathering people to talk about their MNH condition by conducting group discussions with topics on MNH such as a case of maternal and or neonatal death, availability of health services and facilities, people's access to health services, health seeking behaviors during pregnancy, delivery, infant/newborn illness and emergency situations, infant feeding behaviors, taboos during pregnancy and the post partum, the work burden of men and women in the village, knowledge on reproductive health and sexual and reproductive rights. The group discussions are conducted in every sub-village based on selected topics that are suited to the certain sub-village. After all topics have been discussed informally a formal village meeting is held to discuss all topics in larger groups. The aim of the village meeting is to facilitate the villagers to analyze their own health condition using the results of the small group discussions and to get the villager's commitment on how to improve their health condition using their own resources especially when facing emergency health situations. In addition, this village meeting is aimed at disseminating the concept of community empowerment in MNH so that people are aware that they are responsible to take action in overcoming health emergencies by establishing their own Alert System. Details on how to conduct the Self Assessment Survey are available in a separate document in this toolkit.

Output from this activity:

- A Village Portrait on the analysis of the Maternal Health Condition and the potential of the villagers to carry out actions is developed.
- The local health condition is understood.
- The concept of community empowerment in MNH is understood.
- Commitment of the villagers to establish their own Alert System is raised.

The results of small discussions together with the large village meeting on the MNH condition and analysis is written into a narrative report then distributed to those involved in the development and analysis of the village portrait such as the village office, village midwives, the health centre, the district health office for follow up in their health program in a broader context.

E. TRAINING PROGRAM II OF COMMUNITY EMPOWERMENT IN MNH: ORGANIZING THE COMMUNITY IN ESTABLISHING A COMMUNITY BASED ALERT SYSTEM IN MNH

This training is part of a process of increasing the capability of the village facilitator in organizing the villagers to establish their own Community Based Alert System. This second training covers knowledge on strategies and approaches of community organizing and skills on organizing the community for establishment of the Alert System in MNH including development of a local guideline and a plan of action to be done after the training. The training programs are available in a separate document in this toolkit.

Objective of the training:

General Objective: the participants are able to organize the villagers to form an Alert System

in MNH

Specific Objective: at the end of the training, the participants will be able to:

- Understand the concept of community organizing.
- Understand the steps in organizing the community in establishment of the Alert System.
- Facilitate the villagers in establishing the Alert System.
- Develop a local guideline on establishment of the Alert System.
- Develop a plan of action.

Participants:

- One person from each village, male or female who has potential in facilitation and organizing people.
- One staff member of the health centre who is responsible for community participation or coordination of Posyandu.
- One staff member of the District Health Office who is responsible for MNH or the community participation program.

Criteria:

The participants are those who have attended the first training of Community Empowerment in MNH.

F. MEETINGS ON ESTABLISHMENT OF COMMUNITY-BASED ALERT SYSTEM

A meeting for the establishment of each Alert System is facilitated by one of the villagers who has attended the first and second training of Community Empowerment in MNH, with support from the village/sub-village head, the head of the neighborhood, community/religious leaders and other influential people. The following attend as resource people; village midwives, staff of the health centre and the district health office.

The meeting for the establishment of the notification, transportation and communication systems and financial support system is held at the sub-village level in order to ease people into accessing these systems. The meeting for the establishment of a blood donor system is held at the village level in order to better cover all blood types from all the sub-villages. The establishment of each system should be done in each specific meeting in order to give a chance for more people to be involved and allow adequate discussion time on consensus items of each system so behavior change can be triggered. The guideline on the establishment of the Alert System is available in a separate document in this toolkit.

The aim of the meetings are to:

- To raise consensus to establish the system (the agreed system covers rules and functioning, a mechanism, rights and responsibilities, procedures and who is responsible for managing each system).

Once the consensus on helping each other is agreed, a recording on the use of the system should be done. For example, the notification system requires forms/book to record and monitor the agreed information, such as pregnant women, maternal death, infant/newborn death, etc.

Regarding the issues of provision support for the function of system, it needs to be discussed with the villagers about ongoing provision of books and pens, how and who will provide. For the beginning the provision of books and pens maybe supported by third parties. It is important to consider that the consensus raised by the people should be written/documentated on board/book and should be put in a public space so everybody can see it and are aware that they have developed their own consensus on helping each other for their own Community Based Alert System in MNH.

G. TRAINING PROGRAM ON FP INFORMATION POST FOR CADRES

In order to steer people closer to FP Information access, one of the community members from each sub-village who is willing and able to disseminate information and able to be a bridge between people with the FP service, is invited to attend training on FP. The training program covers the following topics: reproductive health, family planning (e.g. what is FP, what to consider in joining FP, FP methods), FP consumer rights and communication skills. The training program and manual training on FP is available in a separate document in this toolkit.

Objectives

General Objective: the participants are able to disseminate and share FP information in their neighbourhood.

Specific Objective: at the end of this training, the participants are able to:

- Understand the definition of FP, why FP is important; usefulness of FP, methods of FP, reproductive health; the role of FP Information Post; FP consumer rights and communication skills.
- Share or disseminate FP Information to others.
- Participants: One of the community members of each sub-village from the village site of Community Empowerment in MNH Program

H. MONITORING AND EVALUATION IN THE IMPLEMENTATION OF COMMUNITY EMPOWERMENT IN MNH

Monitoring and evaluation is conducted from the beginning of the process of community empowerment, such as the capability of the village facilitator, on the progress of the establishment of the Alert System, on the functioning of the established Alert System in order to see to what extent each system functions and to know the impact of community empowerment in improving the MNH condition.

Monitoring-evaluation can be conducted in various levels, as follows :

Monitoring and evaluation on the facilitation skills of the trained village facilitator

Objective: to observe and assist the facilitation skills of the village facilitator when conducting the Self Assessment Survey and holding meetings for the establishment of the Alert System.

Method: the trainer of the training conducts observation when the village facilitator is

conducting the survey and meetings using predetermined forms (see attached).

Monitoring and evaluation on the progress of the establishment of the Alert System

Objectives: to monitor the progress of and identify obstacles in the process of establishment of the Alert System, and to provide an assistance to the process facilitated by the village facilitator.

Method: this is done by the existing advisory team at each level (for instance : Posyandu working group, GSI working group, Desa Siaga team facilitator at health center level, women's organization, relevant sector), using predetermined forms (see attached).

Bi-Monthly Monitoring and evaluation Meeting at village level

Objectives of this meeting is to see the progress of the establishment of Alert System and to monitor and evaluate the functioning of the established system. This meeting is aimed to increase the capability of the villagers, the village/sub-village head, cadres, and village midwives on analyzing and using the information gathered from the notification system in order to increase the health status of the villagers. The notification information can be used to attract resources to the village from relevant institutions. In addition, the meeting is also a forum to maintain and to provide technical assistance toward the functioning of the systems as well as for advocacy for the ownership of people. The monitoring forms for the sub-village and village levels can be seen in Appendices 2 in this guideline book.

Quarterly monitoring and evaluation meeting at district level

Objectives of this meeting is to assess the progress of the establishment of the Alert System (during the process of establishment) and, to monitor and evaluate the functioning of the established system (after the Alert System established). In addition, this meeting is intended as a forum for maintaining the functioning of the Alert System and to raise to the attention of relevant districts institutions to respond to the information from notifications at the village level.

V. INDICATOR of SUCCESS

The successful of Community empowerment in MNH program can be assessed by three groups of indicators, as follows:

Indicator for Input

The input Indicator is a tool to see how many inputs have been put into the process of community empowerment in MNH. The indicator for inputs cover the following items:

- a. The number of villagers who take up roles to facilitate the process of community empowerment in MNH.
- b. Guidelines for conducting Self- Assessment Survey in MNH and for the establishment of a Community Based Alert System are available.
- c. The number of Alert Systems established.
- d. A coordinator volunteer for each system exists.
- e. A list of potential blood donors with their blood type is available.

Indicator for Process

An Indicator for process is a measurement of the intensity of the process happening at the village level in community empowerment in MNH. The measurement involved the following items:

- a. Self Assessment Survey in MNH is conducted.
- b. A document of the village portrait in maternal health in each village is developed.
- c. The village/sub-village meeting for the establishment of the Alert System is conducted.
- d. The established Alert System is functioning: notifications, transportation, communication, financial support, blood donation and FP Information Post.
- e. The Monitoring and Evaluation activity is conducted at each level.

Indicator for Output

The indicator outputs are a measurement to assess the impact of community empowerment in MNH activities. Indicators for the outputs are:

- a. Increased ANC coverage (K1, K4).
- b. Increased delivery assisted by SBA.
- c. Reduced maternal and neonatal deaths that are caused by three delays.
- d. Increased FP current users and new FP acceptors.

VI. REMARKS

This guideline is a guidance in implementing the process of community empowerment in MNH to support the National Development of Desa SIAGA, especially for the establishment of the Community Based Alert System that is very crucial for the functioning of the Poskesdes.

It is hoped that this guideline together with other products in the toolkit could be implemented in other areas and it hope it will bring fruitful results.

TRAINING I

MANUAL GUIDELINE & HANDOUT

TRAINING MANUAL FOR FACILITATORS IN COMMUNITY EMPOWERMENT IN MNH
THE FIRST TRAINING PROGRAM



MATARAM, 2009



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DEVELOPMENT OF TOOLKIT ON COMMUNITY EMPOWERMENT IN MATERNAL AND NEONATAL HEALTH TEAM

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Lay-out and Design of the toolkit

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I. INTRODUCTION

In order to increase the participation of people in solving their health problems, the Ministry of Health (MoH) of Indonesian Government issued a Ministry Decree nr 564/Menkes/SK/VIII/2006 about guidelines on the implementation of "Desa Siaga" development¹.

Desa Siaga is a term used to describe communities who live in villages who are aware of, have intention and capabilities for preventing and overcoming their own health problems, disasters and health emergencies based on a spirit of mutual support and togetherness. The goal of Desa Siaga is to achieve healthy villagers who are concerned and responsive towards health problems in their area.

Specific Objectives:

- Increased knowledge and awareness of villagers about the importance of health.
- Increased preparedness and readiness of villagers to overcome risks and dangers that cause health problems (such as a disaster, an epidemic, an emergency).
- Increased number of families that practice healthy life styles, have good nutrition and health status.
- Increased healthy environment in the village.
- Increased intentions and capabilities of villagers on mutual support amongst themselves in the health sector.

One of the emergencies often faced by people are the emergencies related to pregnancy and delivery that cause maternal death.

In West Nusa Tenggara Province (NTB) province, the maternal death rate is still high and one of the identified causes are the problems related to non medical aspects that are well known with the term of the "three delays and four toos". In order to overcome these problems the Provincial Health Office (PHO) of NTB supported by the SISKES, a GTZ managed Health Strengthening Support Program has developed a toolkit for "Community Empowerment in Maternal and Neonatal Health (MNH)".

The goal of community empowerment in MNH is to facilitate the community to help each other (from, by and for themselves) if there is an emergency, especially related to pregnancy and delivery, so that their capabilities and intentions to help each other with health problems are increased. Therefore, the community empowerment in MNH is a part of the National Desa Siaga Development Program of the MOH.

The efforts of helping each other, "from, by and for" the community members in the concept of community empowerment in MNH covers:

- helping each other in recording what health problems happen in the community (such as pregnant women, maternal death, infant death)

¹ **TIP:** The SISKES Program supported the costs of engaging experienced facilitators from the NGO sector in both the training and then "on the job" mentoring and support of village facilitators. If health staff with particular skills volunteered to mentor facilitators in the village, they were reimbursed for transport.

- helping each other in the provision of transportation and communication means
- supporting each other financially
- supporting each other with blood donation
- helping each other in disseminating family planning information

In order to trigger the community to organize themselves for supporting each other, one member of the local community (cadre) is required who are able to take a role to facilitate his/her community members to be able to and have intention to analyze their maternal and neonatal health conditions. By analyzing their conditions, the participants will be triggered to act to improve their conditions using their own resources and potential by establishing their community based Alert System. In order to increase capabilities of members of the local community in taking the role to facilitate the establishment of the community based Alert System the person/cadre is trained and mentored².

Those community members who take the role as facilitator (cadres) will attend two training programs. The first training is aimed at introducing the concept of community empowerment in MNH and the approach used in the process of implementing the concept is Participatory Learning and Action (PLA). The second training program covers community organization in establishing the community based Alert System in MNH.

After attending the first training program the participants will be able to facilitate their community to conduct a Self-Assessment in MNH Survey, which is analysing their maternal and neonatal health conditions and conducting village meetings on how to improve their MNH conditions.

The curricula and modules of the First Training cover topics on understanding the concept of community empowerment in MNH including the approach used, facilitation skills, application of various participatory techniques in facilitating people in discussions and analysing maternal and neonatal health conditions.

The curricula and modules of the First Training is a part of the toolkit of Community Empowerment in MNH.

II. PHILOSOPHICAL BASE OF THE TRAINING

The training is conducted based on the following principles:

- Adults Learning (Andragogy), meaning during the training process the participants are listened to and respected about their experiences and ideas.
- Participatory learning process, meaning that during the training process the participants are active in conducting discussions, giving presentations, studying case studies, active in conducting role-plays and practising the training topics in order to sharpen their skills to achieve the training objectives.

² **TIP:** The SISKES Program supported the costs of engaging experienced facilitators from the NGO sector in both the training and then “on the job” mentoring and support of village facilitators. If health staff with particular skills volunteered to mentor facilitators in the village, they were reimbursed for transport.

III. TRAINING OBJECTIVES

a. General Objective

Participants will be able to facilitate the process of community empowerment in MNH.

b. Specific Objectives

- Increased understanding of the importance of MNH.
- Increased understanding of the importance of community participation in improving MNH conditions.
- Increased understanding of gender issues related to MNH.
- Increased understanding of the concepts of community empowerment in MNH.
- Increased understanding of the approach used and PLA in the process of community empowerment in MNH.
- Increased knowledge and skills in facilitation.
- Development of a guideline for conducting the Self-Assessment survey in MNH and village meetings.
- Increased facilitation skills in conducting small group discussions in analyzing MNH conditions and village meetings.
- Development of a plan of action in conducting MNH analysis.

IV. PARTICIPANTS OF THE TRAINING

a. Number of participants:

Number of participants in one batch of training is 15-30; they could be from one district or different districts³.

b. Criteria of participants:

- One member from the village who is able and has intentions to use his/her spare time voluntarily to do facilitation work for his/her community.
- At least having a high school education, either female or male.
- Could be involved, staff members of institutions that are responsible for the program, for example, staff members of the health center or staff members of the sub-district office or staff members from relevant institutions from district level⁴.

c. Resources Persons:

Minimum is one resource person required for giving inputs on technical maternal and neonatal health, especially in the first and second days of the training program.

³ **TIP:** Spreading over a number of districts may assist in future “up scaling” in terms of providing local demonstration villages and village facilitator capability to assist others.

⁴ **TIP:** Beware of the absorptive capacity of government staff, often demands of various projects are in competition with actual service delivery. Sending an interested young officer maybe more worthwhile as continuing education and a more senior officer could attend the opening of the training.

⁵ **TIP:** Involving local clinical health staff will contribute to their understanding of community empowerment concepts and build social relationships, which may assist increasing utilisation of services.

d. Implementation of the Training Program:

- The training requires two supporting staff that are responsible for the administration and logistics of the training.
- Handouts of the training topics do not need to be provided before the session begins but will be handed over at the end of each session.
- Besides provision of a pen and book, the training organiser should also provide a folder for the participants for keeping the guidelines that will be developed during the training. The guidelines will be used when facilitating the village/sub-village meetings on establishing the Alert System in MNH.

V. TRAINING METHODS

The learning process during the training is not only a process of increasing knowledge and skills of participants but also the participants work on developing a guideline for conducting a self-assessment survey on analysing maternal and neonatal health conditions and village meetings after attending the training. Therefore, high participation of the participants is required.

In order to achieve the objective of this training the method of learning combines various methods that trigger participants to think actively, to analyse and to discuss the training topics during the training process:

- Presentations with question sessions.
- Brainstorming to gather perceptions, ideas and feelings of participants on the training topics.
- Demonstrations.
- Film.
- Doing tasks: group discussions, case study, developing guidelines, and role-playing.

a. The structure of the training program

The training will be conducted for 48 hours, equivalent to 6 days. One session is equal to 45 minutes. Over the 6 days, there will be 64 sessions.

No	Training Topic s	Sessions			
		Theory	Practice	Field work	Total
A	Basic Topics				
	Concept of Community empowerment in MNH	2	1	0	3

1. Gender in MNH	1	1	0	2
2. Community participation in improving MNH	2	0	0	2
3. Why is MNH important?	2	0	0	2
Main topics				
1. Process and requirements in community empowerment in MNH	1	1	0	2
2. PLA Approach in community empowerment in MNH	2	0	0	2
3. Stakeholder Analysis technique in community empowerment in MNH	1	2	0	3
4. PLA Techniques and methods in analysing MNH conditions and village meetings	4	24	0	28
5. Development guidelines for conducting self-assessment survey	2	9	0	11
6. Facilitation techniques and role of facilitators	2	2	0	4
Supporting topics				
1. Training program and group dynamics	0	2	0	2
2. Plan of Action	1	2	0	3
Total sessions	22	42	0	64

b. The schedule of the training

	Training Topics
Day 1	Opening Ceremony
	Introduction of the participants and orientation to the training program
	Development of learning contract
	Why MNH is important?
	Community participation in improving MNH
	Gender in MNH
	Evaluation of the first day
Day 2	Review on previous day
	Concept of community empowerment in MNH
	Process in community empowerment in MNH
	PLA approach in community empowerment in MNH
	Conducting stakeholder analysis in empowering community in MNH
	Role play in disseminating the concept of community empowerment in MNH
	Techniques and tools of PLA
	Evaluation of the day
Day 3	Review on the second day
	Techniques and tools of PLA-continued
	Development of a guideline for conducting Self-Assessment Survey on Analysing MNH condition and potencies owned by people

Day 4	Review on the third day
	Development of a guideline for conducting Self-Assessment Survey on Analysing MNH condition and potencies owned by people-continued
	Techniques and role of facilitation
	Practices on using PLA techniques in conducting Analysis on MNH condition
	Evaluation of the day
Day 5	Review on the fourth day
	Practices on using PLA techniques in conducting Analysis on MNH condition-continued
	Evaluation of the day
Day 6	Review on the fifth day
	Practices on using PLA techniques in conducting Analysis on MNH condition-continued
	Role play on village meeting
	Development of Plan of Action
	Evaluation of the days and whole training programs
	Closing ceremony

Monitoring and Evaluation of Training

a. Monitoring

The aim of the monitoring is to keep the process of training on track according to its design.

b. Evaluation

The aim of the evaluation is to know to what extent knowledge and skills are achieved by the participants, to gain an assessment of the learning process and to assess the organization of the training. These results can be used for assessing the effectiveness of training and improving the next training. Evaluation can be conducted for the following:

Participants

- Evaluation of the participants of the training to know the learning achievement of the participants. This can be done by: observing and assessment of training outputs, such as the plan of action developed by participants.

Training Facilitator

- Evaluation of the training facilitator is to know the capability of the training facilitator is in delivering the contents of the training according to the stated objectives that are understood by the participants.

Evaluation covers:

- Knowledge of topics/contents.
- Time management.
- Method and use of learning tools.

c. Management on conducting the training

The participants perform the evaluation of the management of conducting the training.

Aspects of evaluation include administration and theoretical relevance, that is:

- Objectives of the training.
- Correlation of training contents with the role to be taken by the participants.
- Contribution of each session in supporting the role to be taken by the participants.
- Social relationships between the training participants with the training facilitators and the organizer.
- Services provided by the training organizer.
- Accommodation.
- Consumption.
- References.

d. Certification

- The training certificate will be given to the participants who have attended the training program and have fulfilled certain conditions, these are:
- Attended a minimum of 90% of the whole training program.
- Having successfully learned based on the learning evaluation.

TRAINING MANUAL FOR FACILITATOR COMMUNITY EMPOWERMENT IN MNH

THE FIRST TRAINING PROGRAM

Session 1: Overview of the Training Program

Specific Learning Objective

By the end of this session, participants will be able to:

- Become familiar with the trainers and other participants as well as the training committee
- Understand the training program
- Generate their own expectation for the training
- Comprehend the training ground rules or learning contract and housekeeping information

Time: 1.5 hours

Training Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Colored cards

Activities 1: Knowing each other amongst the participants and the training facilitator



Welcome the participants to the training and do a game (see below for the example of the game), that has been prepared beforehand.

Aim to create a training climate so that all participants are familiar with each other including the training committee.

Put an emphasis on the importance of being familiar with each other during the training so the learning process goes smoothly. Before doing a game explain to the participants about the game itself. At the end of the game, facilitate the participants to discuss what has been learnt from doing the game.

One example of the game is evolution of the human being⁶. Each participant will act like a duck, dog, monkey and woman / man. At the beginning, all participants act as a duck and

⁶**TIP:** You can adapt this game according to local culture.

look for a friend to do the “rock, paper, scissors game”. The winner of the “rock, paper scissors game” improves her/his status by becoming a dog and looks for a friend who has become a dog to do the “rock, paper scissors game”. The winner will increase his/her status to become a monkey and look for a friend who has become monkey. The winner improves his/her status to become a human being and can have a seat. In this game, every one competes to evolve to higher status and finally become a woman / man as the highest evaluation.

Activities 2: Participants' training expectation, training goal, objective and schedule

Tell the participants that when they received the training invitation they knew the training topics but do not know the details of training program. Tell them that you would like them to share their expectation when coming to the training by posing the question:

- “What do you expect to learn through this training in order to support your role to facilitate the process of community empowerment in MNH in your village”?
- Ask them to also write a concern, which they think may happen during the training that could hinder their training expectation. Each participant is given two cards to write their expectation and concern. The cards are put on the soft board.
- The card is then categorized using the following categories by prioritizing, deciding a specific sign for each category: 1. could be achieved through the training; 2. impossible to achieve, 3. could be achieved by putting some effort on it.
- Post the training goal, objectives and outputs and compare them with the expectations and the concerns written by the participants.

Output of the training:

- Increased understanding about the importance of MNH
- Increased understanding about the need for community participation in improving MNH conditions
- Increased understanding of gender perspectives in MNH
- Increased understanding of community empowerment in MNH
- Increased understanding of PLA in the process of community empowerment in MNH
- Increased knowledge and skills of facilitation
- Developed guideline in conducting a self assessment survey in MNH (facilitating the analysis of MNH, the potential and resources owned by the villagers)
- Increased skills of facilitating the analysis of MNH and potential owned by the villagers
- Developed plan of action in conducting self-assessment survey in MNH (facilitating the analysis of MNH and potentials owned by the villagers) in each village.

Explain the methods that will be applied in the learning process during the training:

- Brainstorming
- Case studies
- Group discussions
- Making presentations
- Working groups
- Individual practice, especially in developing guidelines for conducting the self assessment survey after attending the training

Put emphasis on the importance of active participation in the learning process in order to achieve the outputs.

Explain that in addition to the training program, during the training there will be activities to review what has been learned and to evaluate the training process. The participants in small groups will conduct this activity so every day there will be a duty group. The duty group will have the following duties:

- **Review:** to remind what had been learnt during the previous day and to re-check whether there are topics that need to be discussed again in order to make sure the topic is understood before moving to other topics. The review can be combined with the morning energizer.
- **Daily Evaluation:** to assess the progress of the training so the training is on track. At the presentation of the daily evaluation results, the facilitator should pay attention to the results and always allocate time to discuss in order to improve the training process to achieve the outputs of the training.
- **Energizer:** is an activity to motivate / encourage participants in the learning process. In the entire process of the training, energizers from the facilitator can be used to form the group discussion so the participants will not get bored.
- **End Evaluation:** to assess to what extent topics are understood, capability of the facilitator, training organization, and feedback for improving the next training.

Post the expectations and concerns as well the goal of the training where everyone can see them. Periodically review them to ensure coverage.

Activity 3: Setting Ground Rules

Explain to participants that in order to have an enjoyable and productive training environment certain ground rules have to be developed by the participants. Solicit ideas from them, which may include the following aspects and write the agreement on a chart:

- Participants will keep to the training schedule e.g. coming on time to the sessions
- Participant will respect each other's opinions and contributions
- Participants will listen attentively to each other and to the facilitators
- Answering and receiving mobile phone call

Post the rules on the wall for the entire training period for reference. Before ending this session, ask the training committee to explain the policies and regulations regarding accommodation, per diem, and other relevant issues.

SESSION 2: MNH CONDITIONS AND THE IMPORTANCE OF COMMUNITY PARTICIPATION IN IMPROVING MNH CONDITIONS

Specific Learning Objectives



At the end of the session, participants will be able to:

- Describe the urgent need for improving MNH conditions
- Have a commitment to be involved in the efforts to improve MNH problems
- Understand the social role of community members regarding pregnancy and giving a birth
- Understand the importance of establishing a Community Based Alert System for MNH

Time: 3.25 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Colored cards
- Cases of maternal death or complications regarding pregnancy and delivery
- PowerPoint presentation on MNH conditions

Activities 1: Case study

Divide the participants into small groups consisting of 5-7 people and give each group one case on maternal death or a complication regarding pregnancy and giving birth. An example of a case study can be found in Annexe 2 and similar case studies can be found in your the local area⁷.

Each group has a different case study to be analyzed. Ask them to read it, analyze it and discuss it amongst their small group members. Post the questions that need to be answered by each group and ask them to write the answers on two flipcharts - first two questions on one flipchart paper and other two on the second flipchart paper:

- What happened?
- Why the case happened?
- How to prevent other women having the same problem?
- What can villagers do to prevent others from having the same problem using their own resources?

⁷ **TIP:** A key strategy (recommended by WHO) to be taken by health authorities in reducing maternal deaths is the “verbal autopsy”. These records could be used for the case studies as long as identifying details are removed e.g. names, village location.

Facilitate the participants to analyze the first two questions using logical thinking, causes – problem – consequence - what happened as a consequence - why this happened, causes and what the problem is.

Logical Thinking: Causes – Problems - Consequences

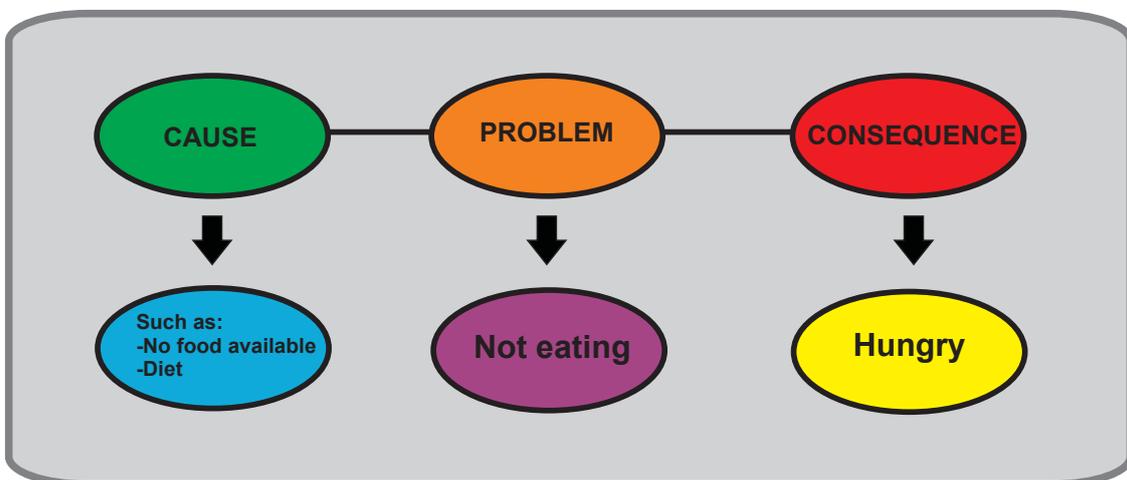
Through analysis of the cases, from answering questions of what happened and why it happened, the participant is led to logical thinking of cause - problem - consequence- in seeing any maternal death. Logical thinking will assist in understanding MNH problems so that the solutions will be focused on the causes of the problems and not blaming the victim.

Having an understanding on “causes”, will help to understand how people see a problem. This point of view will help to determine commitment on an action that could be taken to reduce consequences occurring from the problem.

This way of thinking, could produce labeling that determines an approach of action taken in solving the problem.

The most common way of thinking is blaming the victim. For example, in the case of rape. Most people see it as the fault of the woman who wears improper clothing so that the rape happens. In fact, most rapes that happen have been planned and occur to people of lower social status. Often, the police also blame the victim if the woman reports the crime.

The answer of the question of “what happens in a maternal death / pregnancy / delivery complication?” The answer of why it happens leads to an explanation of the problems and causes of the problems. Leading the analysis of each case to logical thinking: cause – problem - consequence, such as follows:



Try to give logical thinking to the participants that do not see that maternal death often occurs because the mother is uneducated or has low education. Should be thinking more:

- Why the mother has low education?
- Why the mother did not go to midwife?
- Why she went to the TBA?

Activities 2: Presentation on the current MNH conditions in the province or district

Ask the resources person to present a PowerPoint presentation on the current MNH conditions, women's health issues related to the human resources, and health as a right of everybody. See handout. Allow time for a question and answer session. At the end of the session put emphasis on that, the IMR is one of indicators of the Human Development Index (HDI) and it is the responsibility of everyone to prevent maternal and neonatal deaths⁸.

Activities 3: Community participation in preventing maternal death

Ask participants to mention local traditions or celebrations regarding pregnancy, giving birth and newborn care (seven month of pregnancy, hair cutting, others). Write the information given by the participants on the flipchart paper.

Facilitate the participants to analyze what is the value of conducting these celebrations and what are the aims of the celebrations. In fact, the aim is often to ask for God's blessing and help in order to expect a safe delivery and healthy baby (see below).

Link these messages with the answers of the two other questions of the previous activity (how to prevent others from suffering and what community members can do to save the lives of women).

Facilitate the discussion in order to raise awareness that community members can take a role to prevent maternal death. Everybody could take a role to save the lives of women. Therefore, maternal death is not only the responsibility of health officers and medical people, but everybody can help with the non-medical aspects. Link the answers of the two questions with the indirect causes of maternal death, those causes that could be prevented if everybody takes a role.

Close this session by raising the commitment of participants that as an individual each one can take a role to prevent maternal death in their community and by gathering the community together, maternal death can be prevented.

Values of traditional celebrations regarding pregnancy, give a birth and newborn

The traditional celebrations regarding pregnancy and giving birth show a form of social consensus about the importance of pregnancy and giving birth. This consensus that has existed since the old days demonstrates that pregnancy and giving birth are public affairs but because of the many changes that have happened, the value of those traditions have been reduced to family affairs. It has become the responsibility of the pregnant woman or the responsibility of women only. Consequently, pregnancy, giving birth and newborn care are assumed as women's affairs and responsibilities. The role and responsibility of men, fathers, family and the public / community have been eroded.

Being pregnant or giving birth is one of the basic human rights, so it needs more attention paid to it. Nowadays, human rights have become a traded commodity so the ignorance on the

⁸ **TIP:** You will need to gather data from your own province or district health office as well as the government statistics office. This can take some time and you may require a technical person to assist.

SESSION 3: GENDER IN MNH

Specific Learning Objectives:

At the end of the session, the participants will be able to:

- Explain what gender is
- Differentiate between gender and sex
- Understand gender bias, equity and equality of gender
- Understand gender issues in MNH

Time: 1.5 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- Sets of the Gender Game
- PowerPoint presentation and handout

Activities1: Gender Game

The aim of playing the game is to facilitate the participants in understanding what gender is and what is sex, and the roles performed by men and women according to biological differences and social-cultural constructs.

Divide the participants into 2-3 small groups that consist of 5-7 people for each group and give each group one set of the gender game. Explain to them that each group has the same set of cards.

Give an instruction that each group has to draw three columns on the flipchart paper with the name of each column as follows:

- What is commonly done by women only?
- What is commonly done by women and men?
- What is commonly done by men only?

Ask each group to sort out the cards into these three categories by discussing each card before posting each card in each category column. Ask them to then post the flipchart after all groups have done their tasks.

Pose questions:

- Was any card posted differently?
- Why is it different?
- Was the categorization done based on what is happening in the society or is it related to biological differences of men and women?

Ask the participants to give a clarification on these questions if any. Trigger the participants to discuss those categories in order to understand the different roles performed by men and

women based on biological difference and social-cultural constructs.

Activities 2: Presentation on Gender

Give a presentation on gender concepts, differentiation of gender and sex, gender bias and its impact on maternal and neonatal health. See handout of this session.

Allocate adequate time for discussion and a question-answer session.

Conclude this session by emphasizing that social-cultural constructs on the role of men and women in the society have an influence on maternal and neonatal health. People can change those social-cultural constructs that bring negative impacts on maternal and neonatal health and it can be started from the participants.

SESSION 4: THE CONCEPT OF COMMUNITY EMPOWERMENT IN MNH & THE PROCESS OF ESTABLISHING THE ALERT SYSTEM IN MNH

Specific learning objectives

At the end of this session, the participants will be able to

- Understand the concept of Desa Siaga
- Understand the concept of Community Empowerment in MNH
- Understand the process of establishing the Community Alert System in MNH

Time: 4 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- PowerPoint presentation and handout
-

Note for facilitator:

After having an understanding of the importance of improving the MNH conditions and the awareness of the responsibility to improve the MNH conditions using their own resources, bring the participants to the understanding that they can facilitate their community members to improve their health conditions through empowering them to take an action.

In this session, participants will be given an understanding of the concept of community empowerment in MNH, a process to establish the Community Based Alert System. All these topics are inseparable with the National Concept of Desa Siaga from Health Department of Indonesia (SK Menkes: 564/Menkes/SK/VIII/2006).

Activities 1: The value of tradition of helping each other and its link with the Concept of Community Empowerment in MNH

Ask the participants to discuss the existing tradition of helping each other in their own society where they came from (tradition of helping each other when someone dies, when someone gets married etc). List the participant's responses on the flipchart paper.

Take one of the traditions mentioned, such as “banjar kematian” (the community tradition of helping each when someone dies) as an example to be analysed further in this session.

Pose the following questions:

- Why it occurs, how it occurs?
- Who is involved in establishing it?
- What is the mechanism to get or give help?
- Who coordinates it?
- Who rules it? And so on.

Write these answers and explain that the existing tradition is a way of community organizing

“from, by and for themselves” and it was established because people need to share their burdens and explain what is meant by a system.

A system is defined as a set of interrelated principles, a consensus, an agreement raised by certain people to be applied by them, and the system covers:

- What it is
- Where it is
- For whom
- By whom
- How many / how much
- Who is responsible

Bring this analysis into the concept of community empowerment in MNH which is developing the Community Alert System, this is a method for helping each other that is formed by people, from people for themselves.

Activities 2: The Concept of Community Empowerment in MNH in the context of National Desa Siaga Program

Give a presentation on the concept of community empowerment in MNH and the Community Based Alert System in MNH, a network of the Alert System by priority presenting the concept of the National Desa Siaga - for Indonesian context only⁹. See handout 4. Allow time for discussion of this concept.

Link the content of this presentation to the conclusion of previous activities that the community can take actions to prevent maternal death by establishing their own System of Alertness.

Activities 3: A process on establishing the Community Based Alert System in MNH

Divide the participants into small groups, consisting of 5-7 people. Ask them to discuss what is needed in order to establish the Community Based Alert System; how to do it and what the process to do it is. Each group presents the results of their group discussion then gives a presentation on what is needed and the process to be taken in establishing the Alert System.

Before facilitating people to establish the Alert System, people need to realize that they have a MNH problem and they have problems in assisting members of the community in facing emergencies. Therefore, people need to be facilitated to realize that their problem, namely, many people need help when facing emergency situations, people did not have any information who has emergency situations, people need support on the means of transportation / communication, they need financial support for seeking health services, they need blood donation and access to FP information. A picture of these problems will be analysed through developing a portrait on the villagers in MNH as well as the resources they own to help each other to overcome the emergency by conducting a self-assessment survey. Furthermore, to facilitate this process, a facilitator is required, who is a member of the community where the Alert System will be established. Thus, what is needed before establishing the Alert System is a facilitator, who is an individual or group who takes the role

⁹ **TIP:** Find out what the policies are in your country. It maybe that there is a similar policy linked to other programs that can be adapted to use MNH as a tangible learning tool. Disaster Preparedness is one example, MNH is a subject people can practise with to gain confidence as it is happening on a day-to-day basis.

to facilitate a process of raising people's awareness on a problem they have and coming together to solve their problem by establishing their own Alert System.

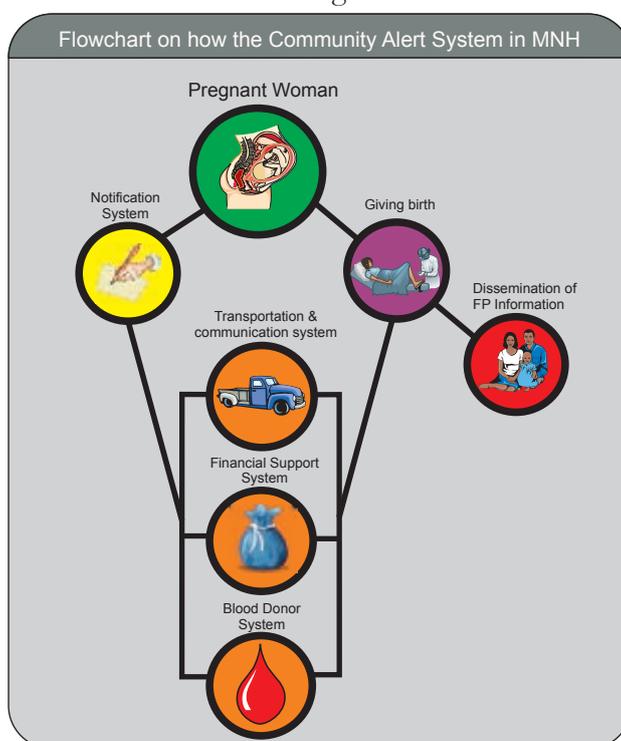
A process is the steps that are needed to be taken, in this context including improving the facilitator's capabilities, the development of the village portrait on MNH, and the establishment of the Alert System.

A process to be taken in conducting community empowerment in MNH

- Conducting the orientation meeting at district level, aimed to disseminate the community empowerment concept to relevant institutions as well as to nominate the site of the program and discussion on village facilitators
- Conducting the First Training: this training program is for the selected village facilitator and focuses on the concepts, process, approach and conducting the self- assessment survey on MNH for developing the village MNH portrait
- Conducting the Self Assessment Survey
- The village meeting on the development of the village MNH portrait
- Conducting the Second Training: this training is for the village facilitator who has attended the first training and focuses on improving the skills of the village facilitator in organizing people in establishing the Alert System.
- Facilitation on conducting the village/sub-village meetings in establishing the Alert System in MNH.

Activities 4: Showing a Film on *Siap Antar Jaga* “Community Alert System”.

Show the film¹⁰ in order to strengthen participants' understanding of the concept and ask their feelings after showing the film and get an idea on what they are going to do after the training. Allow time for discussion before closing this session.



¹⁰ **TIP:** The film is sub titled in English. Outside of Indonesia, the English sub titles will need translation and someone to tell the story as the film is shown. The data that is given in the film will need to be substituted with country specific data.

SESSION 5: STAKEHOLDER ANALYSIS IN THE PROCESS OF ESTABLISHING COMMUNITY BASED ALERT SYSTEM IN MNH

Specific learning objective of this session

By the end of the session, the participants will be able to:

- Understand the stakeholders that need to be involved in the process of establishing an Alert System in MNH
- Understand the importance of establishing relationships with the stakeholders and involving them in the process of establishing an Alert System.

Time: 3.5 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- PowerPoint presentation and handout

Activities 1: What is a stakeholder and how to do a stakeholder analysis in terms of organizing the community in establishing the Alert System.

Tell the participants that each facilitator cannot work alone in his / her own village to facilitate the rest of the community in establishing the Alert System. You need to involve influential leaders both formal and informal in order to gather people to understand their MNH health conditions and in order to make them see a need for establishing their own Alert System. In order to know who has influence in the community, who can be involved in organizing the community, who is the most difficult to when making new changes in the community, and who should be approached, the participants will be equipped with knowledge and techniques on conducting an analysis on stakeholders. Explain what the stakeholder is.

The stakeholder is defined as a person or group that has an investment, share, or interest in something or that could be involved in conducting any activity, in this context, namely, establishment of a community Alert System in MNH.

Stakeholder analysis is a tool that can be used to assist in decision-making situations. In the context of establishment of an Alert System, this analysis is about identification of people or groups that have to be involved in establishing an Alert System. This is important to be done in order to know who can be involved and who are in positions not supporting the concept and relations amongst the stakeholders and what the power of each stakeholder is. This analysis is important in order to develop a strategy on how to involve the main and important stakeholders in organizing people in establishing an Alert System.

How to do stakeholder analysis?

Ask the participants to form pairs, one take a role as facilitator and the other as the village informant. The facilitator will help the village informant to do stakeholder analysis for his / her village.

Start with listing who has influence and can be approached as a “friend” in the effort of organizing people for establishing an Alert System by considering these questions:

- Why these people can be a supporting team for the village facilitator?
- How to approach these people?
- Why these people have influence in the community?

Ask also to list who is assumed difficult to accept the concept or could be an “enemy” of your effort in organizing people to establish an Alert System.

- Why these people will become barriers?
- Is there a need to consider approaching them specifically?

Ask some of the participants to present the results of their paired work to emphasize the importance of involving stakeholders and how to identify the potential stakeholders in supporting their roles as the village facilitator. Discuss why the particular stakeholders have been identified.

Conclude this session by telling them that the stakeholder analysis is aimed at identifying potential stakeholders to be involved in the effort of developing an Alert System. In addition, the identified stakeholders need to be given an understanding of the concept so they understand what they will be supporting.

Activities 2: Role-plays in approaching the identified stakeholders

Ask some participants to do role-plays on how the village facilitator will approach the identified stakeholder in order to give them an understanding of the concept and convince them that the concept is worthwhile. In one role-play, one participant acts as the village facilitator and some others will act as the identified stakeholders - refer to the results of the analysis. After conducting some role-plays, facilitate the whole group to analyse the following aspects:

- The message that has been delivered to the stakeholders
- How the message was delivered
- Responses given to answering questions posed by the stakeholders, and so on

Ask the participants to make a list of focus messages that will be delivered to the identified stakeholders in order to attract people to be involved in organizing people for establishing an Alert System. These focal messages can be used in the field later after attending the training.

Activities 3: Group Tasks.

Tell them that the role-plays on disseminating the concepts of community empowerment can be done informally outside the training room like what has been done in the training room. Furthering and encouraging group talks aim to increase understanding and knowledge in sharing the concept to others.

Specific learning objective of this session

At the end of this session, the participant will be able to:

- Understand the PLA Approach and techniques in facilitating the process of establishing an Alert System
- Understand various PLA techniques, their usages, the kinds of information gathered by applying each technique and how to apply each technique.

Time: 3 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- PowerPoint presentation and handout

**Activities 1: PLA Approach**

Community empowerment is a process to facilitate people to think and to analyse their health conditions in order to raise their awareness that they have problems that need to be solved together by them.

In order to ease the village facilitator into facilitating his/her people in analysing their health conditions a participative approach and methods are required.

The PLA is introduced and this approach consists of participatory techniques and methods.

Present the data of maternal and neonatal death using an attractive technique such as a power point presentation. Ask the participants the following questions:

- What is your feeling after seeing this data?
- Why these feelings occur?
- Will your feelings be different if these facts were presented orally not visual?

Explain the importance of the approach, method and techniques as a tool to assist people in the learning process, in this context it is learning about their health conditions.

Present the PowerPoint on “What is PLA and PLA Techniques” and its application (see handout) in the process of raising awareness of people of their health conditions. Allow time for a question and answer session.

Activities 2: PLA techniques and its application in conducting the Self-Assessment Survey

Explain and demonstrate various PLA techniques, what information will be gathered by

using the techniques, and how to use them. When doing a demonstration of each technique try to involve individuals or groups participants as the respondents of demonstrating these techniques.

After demonstrating all the techniques, allow time for a question and answer session in order to know the understanding of the participants on techniques, how to apply them and the kinds of information that will be gathered from the application of the techniques.

SESSIONS 7: DEVELOPMENT OF GUIDELINES FOR CONDUCTING A SELF-ASSESSMENT SURVEY ON MATERNAL AND NEONATAL HEALTH AS WELL RESOURCES OWNED BY THE PEOPLE



Specific learning objective of this session

At the end of the sessions, the participants will be able to:

- Develop guidelines for conducting a Self Assessment Survey on Maternal and Neonatal Health as well as assessing the resources owned by the people

Time: 8.25 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Work sheet for guiding the development of the guidelines
- PowerPoint presentation and handout

Activities 1: The first step in the process of developing the guidelines

Explain to the participants that prior to facilitating people in establishing their Alert System; people need to realize that they have a problem to be solved by them. In order to raise people's awareness there is a need to facilitate them to understand their MNH conditions and the resources they own by conducting a Self Assessment Survey on MNH. In addition, to conducting the Self Assessment Survey, the participants need to have guidelines and they will develop the guidelines together in this training session.

Divide the participants into small groups.

Explain topics to be covered in the Self Assessment Survey on MNH.

Ask participants to work in the small groups, distribute work sheet 1 (column with empty technique) that consists of topics to be covered in analysing MNH condition with the community members. See handout session 7.

Ask them to discuss the topic in order to determine which technique is used to gather information for each topic.

Ask each small group to present the results of their group discussion in order to get an agreement on the technique used in each topic.

Note: output of this session is the agreement of the topics of the survey and techniques used for gathering information for each topic.

Activities 2: The second step in the process of developing the guidelines

Distribute the Worksheet No 2 (see handout of this session) that consists of the column with the filled topics and techniques to be used, but the empty column is for information to be gathered from the community members when they discuss the topics and the column of who will be the participants when discussing each topic.

Ask the participants to fill the empty columns after discussing them, and then ask each small group to make a presentation and all participants could put in additional information to complete the column. After filling this sheet, the summary of the guidelines is done and the training facilitator will put in narration, print them and distribute the guideline to all participants. The guidelines should be kept in their folders and brought to the field when conducting the survey.

SESSIONS 8: PRINCIPLES ON FACILITATION AND THE ROLE OF FACILITATION IN THE PROCESS OF COMMUNITY EMPOWERMENT IN MNH

Specific learning objective of this session

At the end of the project, the participants will be able to:

- Understand the role of facilitation in the process of conducting a Self Assessment survey in MNH and in the entire process of community empowerment for establishing an Alert System
- Understand the principles of facilitation

Time: 3 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- Power point presentation

Activities 1: Role of facilitation and its principles

Explain to the participants that the participants will perform a facilitation role after attending this training program and this is to facilitate the community in establishing an Alert System in MNH. In order to understand these roles and the principles of facilitation and facilitative works, this session will cover these topics.

Ask each participant to draw a picture that describes his/her facilitation roles that they will perform. Then ask each participant to explain the meaning of his/her picture in relation to the roles of facilitation.

The emphasis is that the role of facilitation is not a position. This role comes from the personal commitment to help each other for improving the current situation.

Present a PowerPoint presentation on the roles of facilitation and principles of facilitation (see handout of this session). Allow time discussion and for a question and answer session.

At the end of the activity, give emphasis that all theories on facilitation will be practiced in facilitating discussions when conducting role-plays of performing analysis on MNH during the following sessions.

SESSION 9: ROLE PLAYS ON CONDUCTING FOCUS GROUP DISCUSSION AND VILLAGE MEETINGS

Specific learning objective of this session

At the end of the session, the participants will be able to:

- Apply PLA techniques in the process of facilitating people in conducting analysis on MNH
- Facilitate people in analysing their MNH conditions and make a presentation of the MNH portrait during the village meeting

Time: 18 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- The results of practising each topic

Activities 1: Practices on applying PLA techniques in conducting MNH Analysis and assessing the resources owned by the villagers.

Explain to the participants that the facilitation role that will be performed by them after attending this training is to facilitate his/her people in analysing MNH conditions using participative techniques (PLA techniques) that had been learned in the previous session.

In order to develop their skills in applying the PLA techniques, each participant is given a chance to practice the application of each technique. The practices will be done in the classroom, because after conducting each role-play, they will discuss the following aspects:

- Facilitating techniques
- Application of the technique itself
- Kind of information explored during the discussion of the role-play
- Techniques and process of facilitating the discussion

The analysis of the role-play is aimed at gathering input from all participants and the process of internalizing what had been learned. This is not only for those who have done the role-play but also as a guidance when doing the real work in the field. Moreover, skills of giving a presentation are also practiced. The presentation will use the results of applying various PLA techniques that have been done in the role-plays. The emphasis is on skills of linking information from one discussion to others using different techniques. Therefore, this practice is important to be done properly.

Explain to the participants that each participant will practice on facilitation skills using PLA technique based on topics that will be discussed in the MNH Analysis. All the results that are gathered during the practices will be used for doing practice of giving presentations.

Each participant will take a "lucky dip" to select the topic that will be practiced and the technique used to discuss the topic. Write on the flipchart paper the name of each participant

together with the topic and its technique taken from the “lucky dip”. When one participant takes a role as facilitator of the selected topic, other participants will act as community members.

Activities 2: The village meeting and presentation on MNH Analysis

Explain to the participants about the village meeting for analysing the MNH conditions. See the handout of this session.

Using the results from each role-play, give an example on how to present and link the information gathered from the application of other tools to the topics. It will describe a MNH portrait of the village.

The aim of practicing skill presentation is to increase skills of participants in presenting the results of discussions that had been conducted in the small groups for each topic in different sub-villages with the various villagers. Skills are increased on making linkages of information gathered from other tools so that all the information will describe a portrait of MNH condition and resources owned by the villagers.

Next, ask some of the participants to do presentation practice. After conducting role-plays on giving presentations, facilitate a reflective discussion to provide feedback on skills of presenting information, linkages of the information, and skills on presentation.

SESSION 10: DEVELOPMENT OF PLAN OF ACTION

Specific learning objective of this session

At the end of the session, the participants will be able to:

- Develop a plan in conducting a Self Assessment Survey for MNH
- Develop a plan for the village meeting
- Understand technical assistance, logistics and administration support provision by the institution that supports this program (if any).

Time: 2.25 hours

Materials:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Form for Plan of action

Activities 1: Work out plan of action

Explain to the participants that a role to be performed after attending this training is to facilitate his/her community members in conducting a self assessment survey of MNH then analysing MNH conditions and resources owned by the community. In order to plan the survey, the participants are to facilitate to develop his/her own plan on conducting the survey and village meeting.

Ask each participant to make a list of the sub villages of the village where they come from. This list becomes their reference to decide where the survey will be conducted.

Ask the participants to group themselves based on sub-district areas or based on the health centre area where they come from, then distribute a sheet for the action plan. See handout of this session.

Compile the planning sheet that had been filled out so each participant may see others' plans. Then print and distribute the compiled planning.

Activities 2: Provision of support to implement the action plan

This activity gives the chance for resource persons who provide support to this program to provide information on provision of support in implementing this plan. Allow time for clarification, question and answer and writing an agreement on support provision. Type the agreement, print and distribute to the participants.

Activities 3: End of evaluation

Explain to participants about the evaluation of the entire training process, training program and training facilitator. Distribute the evaluation sheets and explain how to fill it out. Browse quickly the evaluation results and discuss them to get improvement for the next training. Perform the closing ceremony for this training.

GUIDELINE

For Conducting
Self-assessment Survey: (analyzing MNH Condition and Analyzing People's
Potential / Resources)

Using

Participatory Learning and Action (PLA) Approach

FOREWORD

Community empowerment in Maternal and Neonatal Health (MNH) is a process that ideally is initiated “from, by and for” the community members. However, most people are not aware that they have a problem in MNH, so they need to be facilitated in order to raise their awareness by analysing their own MNH conditions, specifically related to pregnancy and infant health from a non medical aspect. Therefore, a self-assessment survey is required. The aim of the survey is to analyse the MNH conditions and the potential and resources owned by the people to improve their MNH conditions.

This self-assessment survey will be conducted using a participatory learning and action approach (PLA) in which people who are involved in the process will learn from their current conditions and take action to improve them.

This guideline was developed as guidance in conducting a self-assessment survey, analysing MNH conditions and the potential and resources owned by the people in order to improve MNH conditions from a non-medical aspect using participative tools and approach.

Toolkit development Team

I. INTRODUCTION

“Desa Siaga” is an Indonesian term used to describe villagers coming together with the government to implement a just health system for the villagers. To achieve this ideal condition, a community empowerment effort is required in order to enable people to take active roles in increasing their health status. Regarding the MNH program towards achieving the National Desa Siaga Program, community empowerment in MNH is implemented, aiming to prevent maternal and neonatal death by putting emphasis on peoples' needs, interests and actions, based on their choices and their own capabilities.

The effort of community empowerment in MNH becomes a focus because the health status of pregnant women, post partum women, and neonates can determine the health status of the overall community. Through community empowerment in MNH, an awareness of husbands, midwives and community members are raised in order to go hand in hand in improving the health status of particularly women.

Through a community empowerment effort in MNH, people will be facilitated to:

- Have a recording and notification system on existing pregnant women in their area so that women will have access for pregnancy care and gain help when giving birth
- Prepare financial support when facing a health emergency and giving birth
- Prepare blood donors
- Prepare transportation means to reach health facilities and for emergency referrals
- Accompany the pregnant women when giving birth
- Encourage the mother to exclusively breastfeed as soon as the baby is born
- Assist the post partum mother and her infant to have postpartum care (for one week after delivery)

The Community Empowerment effort in MNH and its Relations to the Self Assessment Survey: Analysing the MNH conditions and the potential and resources owned by the people in improving MNH conditions

A big picture of the community will describe the living conditions, life styles, thoughts, feelings, pattern of relationships, the power of those who live in certain areas including aspects that influence their lives, problems, consequences and impacts that occur. Thus, it is important before facilitating people to establish the alert system to facilitate people to draw their own communal system picture through social analysis in order to understand their own big picture based on their experiences and using their own terms.

A process of facilitating people to form their Alert System in MNH is very dependent on their participation and their collaboration with the government. To increase people's participation and their collaboration, facilitation is required. Facilitation is the process of accompanying and assisting people to solve their problems in order to develop better lives. Facilitation is putting people as the subject of their changing process. Facilitation in the context of community empowerment in MNH is a process to organize people in order to assist them to analyse their own conditions and to solve their problems by analysing the potential and or resources they have.

PLA Approach in Conducting a Self Assessment Survey: Analysing MNH conditions and the potential of the people

To facilitate people to analyse their MNH condition, their potential and resources, a Participatory Learning and Action approach will be applied. By applying this approach, people will be involved to think, to analyse their conditions and problems critically. By involving in this process, people will be able to have a new perspective, having sense of their problems, having a new awareness that is possible to drive them to have intention to act and to change their current conditions. Their action is then assessed, re thought and re-observed to have further new perspectives gained from their experiences in order to determine their further actions. The facilitation process goes continuously in a cycle that never ends. In order to promote a participatory process, the facilitation will be conducted using simple tools and participatory techniques.

A Process of Self-Assessment Survey: Analysing MNH Conditions and the potentials and resources owned by the people will be conducted in 3 stages:

- The first stage: collecting secondary data in order to obtain information on potential and MNH health conditions in the village.
- The second stage: learning process in the form of an informal meeting or group discussion aimed at gathering information on MNH conditions and empowering people on analysing their MNH condition.
- The third stage: conducting a formal village meeting which is a process of empowering people to analyse their MNH condition using the previously gathered information (the second step) in order to understand and realize their MNH condition and find solutions to improve their current MNH condition using their own potentials and resources.

The aim of analysing MNH Condition is:

- To comprehend the MNH condition, including health facilities available in the village (kind of services, quality, peoples' access to the facilities) and health seeking behaviours in MNH.

Thus, this survey is as a tool of empowering community to comprehend their MNH conditions.

The aims of analysing potential and resources owned by the people are:

- To comprehend the potential and resources owned by the people in developing their Alert System in MNH.
- To gather peoples' participation in solving their health problems.

II. ANALYSING MNH CONDITIONS

This analysis covers the following topics:

- 1. Analysing the social structure of the society**
 - The village geographical map including information on the social structure

Participants of the group discussion: groups of adult women and men (could be included the village office staff and influential community leaders).

Steps:

- Invite the participants of the discussion.
 - Explain the aim of discussion, which is a process of learning together to comprehend the social structure of the community where they live, and explain also materials and tools that will be used to assist the discussion.
 - Ask the participants to draw the main road, borders of the village areas, sub-village streets, border of the sub-village, and footpaths within the sub-village areas.
 - Draw the main public facilities that exist in the village, such as the village office, cooperative, maternity post, health post, health centre, and the house of the Traditional Birth Attendant (TBA), mosques / other religious facilities and housing, use symbols that are agreed by the participants.
 - After the map had been drawn, facilitate the participants to discuss following topics: houses grouped based on ethnic/religion, people grouped based on original/new comers, if any, where they come from, when they came; why they came; is there any economic / social / health / education status differences between the original inhabitants and the new comers. If there is no grouping, discuss the important events that had happened in the village that can be categorised as important milestones to the villagers, when the village was formed and where the population came from.
 - Before closing the discussion, ask the feelings of the participants in doing this exercise (did they realize that information came from the discussion beforehand) and draw a conclusion what has been discussed.
 - Do not forget to write the summary of the discussion.
 - Do not forget to write name, sex, and age of each participant.
 - Do not forget to write the date and venue of the discussion.
2. Analysing Health Facilities both formal and informal (traditional) include available services and their quality, peoples' access to the facilities, the cost to get the services, access to transportation to the facilities, availability of public transportation and transportation cost to reach the facilities.
- Map on the availability of the health facilities formal and informal (traditional)

Participants: a group of community members (adult women and men), adolescents (male and female), pregnant women with their husbands, breastfeeding women and their husbands; cadres; TBAs, community / religious leaders and or influential leaders.

Steps:

- Invite the participants to the discussion.
- Explain the aim of this discussion, the materials and tools that will be used for processing the discussion.
- Ask the participants to draw a big circle as the symbol of the community in where the discussion is taking place.
- Ask the participants to mention health facilities available within and outside the village both formal and informal that are accessed by the community members of the village. Ask them to draw the distance of health facilities in relation to the big circle referring to the geographical distance.

- Ask them to discuss services provided by each facility then discuss quality of the services and the cost to get to the services.
- Ask them to discuss the availability of public transportation to reach these facilities and cost to reach the facilities.
- Ask them whether they have problems to reach those facilities especially at night (if there is any) and how to solve the problems.
- Ask them to analyse the access of people, men and women, to each of these health facilities. Discuss their satisfaction with these services.
- Ask their feelings after discussing this topic, are there any problems or any need for improvement from these facilities in terms of the usage, access and the services.
 - Draw conclusions from the discussion.
 - Do not forget to write the summary of the discussion.
 - Do not forget to write the name, sex, and age of each participant.
 - Do not forget to write the date and venue of the discussion.

3. Analysing health seeking behaviours of the pregnant / post partum women.

- Map on mobility of pregnant/post-partum women

Participants: groups of pregnant / breast-feeding women together with their husbands.

Steps:

- Invite the participants to the discussion.
- Explain the aim of the discussion, the materials and tools used in the discussion.
- Ask the participants, where they seek help when during pregnancy, giving birth, post partum period, and what they feel when seeking help.
- Ask them to draw their efforts on a sort of a map, firstly drawing a big circle that describes the group's discussion, then draw facilities or individuals where they seek out help in relation to pregnancy care, delivery, post partum care and cures both from within and outside the village.
- Ask them to discuss the services that are received from each facility and what they felt. Discuss costs to get those services and what they felt after getting the services.
- Ask their feelings after discussing this topic and draw points that have been discussed.
 - Do not forget to write the summary of the discussion.
 - Do not forget to write name, sex, and age of each participant.
 - Do not forget to write the date and venue of the discussion.

4. Analysing health seeking behaviour for the infant

- A map of mobility for infant

Participants: groups of women who have infants together with their husbands; cadres and influential leaders that exist in the village / sub-village.

Steps:

- Invite the participants to the discussion.
- Explain aim, the materials and tools to be used in the discussion.
- Ask the participants where they seek help for curing their infants when they get sick and what symptoms occur when seeking help.
- Ask them to draw their health seeking behaviour by firstly drawing a big circle that

describes the group's discussion then where they go to seek help for their infants both within and outside the village.

- Ask them to discuss services they received from those facilities and what they felt when seeking help at these facilities. Discuss also cost and what they felt after going to the facilities.
- Ask them what they felt after discussing this topic and draw conclusions after closing this discussion.
 - Do not forget to write the summary of the discussion.
 - Do not forget to write name, sex, and age of each participant.
 - Do not forget to write the date and venue of the discussion.

5. Social perceptions of people on health / sick conditions

- Conducting an interview or group discussion

Participants: group of adult men and women, adolescent men and women, groups of poor / rich, influential leaders, cadres and TBAs.

Steps:

- Invite the participants of this discussion.
- Explain the aim, materials and tools used in the discussion.
- Ask participants to mention in what condition someone is identified as being sick or healthy. Ask them to describe what they mentioned in materials that was used in the discussion.
- Ask them to discuss these conditions in relation to their health seeking behaviour; in what condition they seek help.
- Ask their feelings after discussing this topic and draw conclusions before closing the discussion.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

6. People's perceptions about poor / rich conditions and their relationship to the government health subsidy for the poor

- Interview / Group discussion

Participants: group of adults (men and women); adolescents (men and women); group of poor and rich, influential leaders, cadre, TBA, people who use the health care subsidy card

Steps:

- Invite the participants to the discussion.
- Explain the aim of the discussion, the materials and tools used for assisting this discussion.
- Ask the participants to mention a condition to which people categorise as being poor and rich. Ask them to draw / describe these conditions in the materials used.
- Ask them whether they know about the government health subsidy for the poor in health, ask them, who gets it (poor or rich); when and how to get it.
- Ask them to discuss the link of the concept of poor / rich with the health subsidy.
- Ask their feelings after discussing this topic and whether there is any need to improve

regarding the health subsidy.

- Draw conclusions from this discussion
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

7. Peoples' perceptions on emergency situations during pregnancy and giving birth or complication cases regarding pregnancy and delivery or maternal and infant death cases.

Before this discussion, firstly ask information from midwives, TBA or cadre about maternal / infant death cases or complication cases that have happened in the village.

- Maternal death cases

Participants: members of family who has the cases (husband / mother / sisters / brothers)

Steps:

- Meet with the family where the mother died because of pregnancy and ask them about the case. Explain the aim of gathering the information, which is to get lessons learnt from the case in order to improve the condition of pregnant women and during delivery.
- Start with posing simple questions to the informants, what happened before the woman died, what she felt, what had been done by the woman or her family members to help her. Key questions cover, what, why, when, how and who. If there was an effort to refer her to health facilities, ask what services she received, quality of the services, cost of getting the services, how to reach the facilities.
- Record the information gathered; try to visualize the information informed so that the information can be seen clearly.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.
- Infant death cases

Participants: The parents have an infant that died

Steps:

- Meet with the mother / father or family members who had an infant who died in order to gather information about the case.
- Explain the aim of gathering the information is to get lessons learnt from what happened in order to prevent similar cases happening in the future.
- Ask simple questions to the informant: what happened before the infant died, what was felt, what had been done to help the infant .The key questions cover: what, why, how, when and by whom. If there was effort to seek health help; ask the services received, quality of services, cost to get the services and how to reach the facilities.
- Record the information gathered; try to visualize the information informed so that the information can be seen clearly.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.

- Do not forget to write the date and venue of the discussion.
- **In this context: you may also analyse bleeding in delivery complication cases. Apply the above steps in gathering information of these cases.**
- Use the cases gathered to discuss with a group of people (adult men and women). Ask them: what was their response on what happened; in which condition they determine an emergency condition from the cases that have been analysed. Ask them to discuss what should be done to prevent others from similar cases.
- Record what had been discussed, try to visualize the information informed so that the information can be seen clearly.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

8. Social perceptions about seasonal work / incomes, critical periods regarding health conditions, livelihoods and availability of food

- Seasonal Calender

Participants: group of community members (adult men and women).

Steps:

- Invite the community members to discuss this topic. Explain aim of the discussion, that is, to know their social perception on seasonal work / no work, periods of sickness / health and availability of food. Explain materials and tool used in discussing this topic.
- Ask them to discuss about the months known and used as their calendar and activities (social and productive activities) done relating to these months.
- Ask them to draw a calendar by naming the months and activities happening in the month using horizontal and vertical columns.
- Ask them to discuss the following aspects: when they work / have income, when most of them get sick, when they have enough food, when there is no food, when they have critical periods of time in terms of their lives during the year. Ask them to visualize the information into the columns using symbols agreed.
- After drawing the calendar is finished, ask them to discuss the results of their visualization and the benefit of drawing the calendar. Ask them to discuss a strategy to overcome critical periods or sick periods and how to prevent sick periods.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

9. Feeding behaviours and taboos during pregnancy / post partum period

- Interview / group discussion

Participants: groups of pregnant women and breast feeding women together with their husbands as well groups of women of reproductive age.

Steps:

- Invite the participants to discuss this topic.
- Explain aim of the discussion, which is to discuss people's feeding behaviours during pregnancy and the post partum period.
- Ask them to discuss what kind foods are categorized as good food and taboos during pregnancy and the post partum period. Visualize the information using columns of weeks of pregnancy, post partum period then list food preferences and taboos in the horizontal rows.
- Ask them to discuss why foods are preferences and why taboo foods are prohibited.
- Record information being discussed. Ask them to discuss any privileges relating to pregnancy and the post partum period and how long the post partum period is considered locally.
- Ask them to discuss the kinds of diseases most often happening during pregnancy and the post partum period; link these to their feeding behaviours and taboos. Then ask them is there anything that needs to be improved from the current condition and how to do this.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

10. Analysis on feeding behaviours and diseases most happening to infants

- Calender on feeding behaviours and diseases happening to infants

Participants: groups of pregnant women and breast feeding women together with their husbands.

Steps:

- Invite the participants to discuss this topic and explain the aim of discussion, which is to analyse feeding behaviours towards infants and diseases most happening to infants. Explain also materials and tools used in discussing this topic.
- Ask them to discuss their feeding behaviours towards their infants since birth to 12 months and diseases happening to the infants.
- Ask them to draw columns that are divided into 0-12 months, and columns with food and diseases.
- Ask them to analyse whether there is any correlation between foods given to the infant with diseases occurring to the infant. Discuss any issues coming out from the answers of the participants.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

11. Social perceptions of people about family planning (FP) including issues and barriers related to FP.

- Interview / group discussion

Participants: groups of husband / wife couples; male and female adolescents

Steps:

- Invite the participants to discuss this topic and explain to them the aim of the discussion which is to know their perceptions on family planning, as well explain materials and tools to be used in the discussion.
- Ask them to discuss: what they understand about FP, why FP is important, what FP methods are known and most often used by people, what is the benefit of FP and what issues around FP they have. Ask them to visualize the information using the materials used.
- Ask them to discuss the availability of FP methods / devices, 'access to the methods, FP services; where they get FP information and their opinion on the FP services.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion

12. Social perceptions about the institution of marriage including age of getting married

- Focus Group Discussion (FGD)

Participants: groups of couples and groups of male and female adolescents

Steps:

- Invite the participants to discuss this topic and explain the aim of the discussion, which is to know peoples' perceptions on marriage and the age of getting married for males and females.
- Ask them what they think about marriage; visualize information given with materials used then discussing age for males and females.
- Ask them to discuss early marriage age; benefits and non benefits; do adolescent have knowledge about their reproductive health before entering marriage?
- Record all information and discussion: is there anything they can do to improve their current conditions of the topic under discussion.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

13. People's perceptions on men and women

- Group discussion

Participants: group of married couples and group of male and female adolescents.

Steps:

- ○ Invite the participants to discuss this topic and explain the aim of the discussion, which is, to know their thoughts about men and women. Explain also about materials

and tools used in the discussion.

- Start with posing a simple question such as: what do you think when someone mentions the words, men and women regarding their social roles? Draw their information on the materials used.
- Ask them to discuss which one is given and which one is socially constructed regarding the roles of men and women. Discuss whether the roles can be exchanged between men and women.
- Ask their feelings after discussing this topic and is there anything that can be done to improve the social roles of men and women.
- Record all information and draw a conclusion of the discussion.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

14. Analysing women's and men's work burden

- Diagram on daily activities of women and men

Participants: groups of couples (adult men and women).

Steps:

- Invite the participants to discuss this topic and explain the aim of the discussion and the materials and tools used in this discussion.
- Work in groups of women and men separately first, in order to draw separate a diagram on men's activities and one on women's activities. Ask each group to list activities that is done on a daily basis for 24 hours.
- Ask them to visualize their activities in a big circle that consists of an inner circle for describing men's activities and an outer circle for describing women's activities by dividing the time spent for each activity.
- After drawing the diagram, ask them to look at the diagram and pose the following questions: who has more activities? Who has the most time for having a rest? Are there any implications to women's health? Is this condition a problem to you? How to solve the problem?
- Ask their feelings after discussing this topic and what can be changed to improve the current condition / division of work between men and women.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

15. Peoples' perceptions on menstruation

- Group discussion

Participants: group of women that have been married and groups of female adolescents (unmarried).

Steps:

- Invite the participants to discuss this topic and explain the aim of the discussion, which is to get their thoughts about menstruation, and explain materials and tools used in the discussion.
- Start the discussion by posing simple questions such as when was the first time they got

their period? What was their feeling? To whom did they discuss this with (their mother, aunty, friend or whom)? What did they do the first time when having menstruation? Are there any traditions to celebrate the first menstruation? Then ask them; what they know about menstruation? From where did they get their information?

- How do female adolescents get information about menstruation, pregnancy and giving birth?
- Ask them to visualize their information so it can be seen clearly when discussing it.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

13. Peoples' perceptions on disease outbreaks that had been experienced and how they handled the cases

- Group discussion

Participants: groups of community members (adult men and women, influential leaders).

Steps:

- Invite the participants to discuss this topic, explain the aim of the discussion, which is to know about disease outbreaks that have happened. Explain materials and tools used in the discussion.
- Ask them to tell any experiences they have had regarding outbreaks in their village areas: what; when and how they overcame the cases. Ask them whether their efforts had helped them in overcoming the cases. Ask them what caused the outbreak in their areas. Ask them to visualize the information on the materials used.
- Record all information gathered in the discussion.
- Do not forget to write the summary of the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

III. ANALYSIS ON THE POTENTIAL AND RESOURCES OWNED BY PEOPLE

This analysis covers the following aspects:

1. Information on ownership of means of transportation and communication at the village/sub-village

- Interview / observation / mapping

Participants: population of the sub-village / village

Steps:

- Meet with the head of the sub-village / neighbourhood. Explain the aim of gathering this information, which is to know who owns the means of transportation / communication in the areas of sub-village/village. If the data does not exist; ask them to gather information from the people in their areas. After obtaining the data, integrate the information into the map that had been drawn in an earlier process in order to have a map of the ownership of means of transportation / communication.
- Do not forget to write name, sex, and age of each participant.

- Do not forget to write the date and venue of the discussion.

2. Information on the village development budget, especially the budget allocated to the health program

- Interview

Steps:

- Meet with staff members of the village office who have the responsibility for the development budget of the village.
- Explain the aim of gathering this information, which is to know potential and resources of the village, especially for health program.
- Copy the data.
- Ask the head of the village about the percentage of budget allocation for the health program compared to other budget allocations. What is their opinion about the health program, is it priority or not for the village development?
- Record the information gathered in the discussion.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

3. Information on the village institutions

- Diagram Venn

Participants: groups of the population, men and women, staff of the village office and community leaders

Steps:

- Invite the participants to discuss this topic and explain the aim, which is to know the village institutions, both formal and informal that exist in the village, known by the people and of benefit to the villagers. Explain materials used in the discussion: large-medium-small circles to describe benefits of each institution and far or close distance to describe to what extent people are close to each institution emotionally.
- Start with asking about the existing institutions; make a list of these institutions and specifically institutions related to the health program.
- Ask them to draw a large circle to describe the community where the discussion takes place; then discuss the benefits of each institution by describing them in one of circle sizes (large-medium-small) then put the distance related to the large circle. For each institution: ask why they decided to describe them in that size and distance, why it has large - small benefit and why far - close distance?
- Ask their feelings after discussing this topic
- Record all information had been discussed.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

4. Information on Migrant Workers

- Interview

Participants: groups of people who had been working outside the village either overseas or other islands, both men and women

Steps:

- Invite the participants to discuss this topic and explain the aim of gathering this information, which is to know the number of men / women who seek work outside the village, destinations, and problems occurring from the migration especially relating to health such as STI / HIV-.AIDS in the village.
- Ask them the destinations of people and what information they brought home? Is there any social problems occurring from the migration? Do they know about STI / HIV-AIDS? If know, ask them to explain.
- Record all information had been discussed.
- Do not forget to write name, sex; and age of each participant.
- Do not forget to write the date and venue of the discussion.

5. Information on the number of deliveries assisted by TBAs in the last 3 months.

- Interview

Informants: the village midwife or TBA

Steps:

- Meet with the village midwife or TBAs; explain the aim of gathering this information, which is for a baseline data before conducting the community empowerment process.
- Find out the data on number of deliveries assisted by TBAs, assisted by health personnel at the patient's houses and in the health facilities (village maternity post / health centre) within the last 3 months.
- Ask information on maternal/infant death cases in the last 3 months.
- Ask the number of TBAs who are actively assisting deliveries in the village.
- Record all information had been discussed.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

6. Information on the potential for blood donors together with their blood types

- Interview/ mapping

Participants: groups of adult men who are eligible as blood donors

Steps:

- Meet with the head of the sub-village / the head of neighbourhood, explain the aim of gathering this information and ask him / her to gather a meeting with the community members in his / her areas in order to identify who wants to be blood donors. Make a list of the potential blood donors with their blood type if known. If not yet known, make collaboration with the health centre to check the blood type of the potential blood donors. Integrate the data of blood donors into the geographical map so that there is a map of blood donors.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

7. Information on the existing traditions of helping each other in the society

- Group discussion

Participants: Groups of adult men and women

Steps:

- Invite the participants to discuss this topic and explain the aim of this discussion, which is to gather information about the existing traditions on helping each other in the community.
- Ask them: are there any traditions of helping each other existing in the community? When does it happen? How does it happen? Who coordinates? What is the mechanism? Who initiate it? What is the consensus?
- Ask them to discuss whether these traditions can be applied to other issues such as health emergencies.
- Record all information that has been discussed.
- Do not forget to write name, sex, and age of each participant.
- Do not forget to write the date and venue of the discussion.

The village meeting for analysing the MNH condition and potential and resources owned by the people

The village meeting is follow up of the process of gathering information previously done with various groups of people in the above topics.

The aims of the village meetings are:

- To analyse the MNH conditions all together and identify MNH problems and to understand the potential and resources owned by the villagers
- To disseminate the concept of Community Empowerment in MNH
- To raise people commitments to establish the Alert System in MNH
- Participants of the meeting
 - The head of the village
 - The head of sub-village
 - The village midwife
 - The village parliament
 - Health centre staff
- Representatives of the people who joined the small group discussions / interviews
- The village women's' organization
- Cadre
- Staff members of the sub-district office
- District Health Office

Steps:

- Meet with the village head in order to organise the village meeting.
- After the date, agenda; and venue is agreed, make preparations for the meeting. Post all the results of MNH analysis and potentials and resources. Involve the participants of the group discussions, if possible, to make a presentation.
- Present the information systematically so that people will get it as a picture of their own village that reflects their own lives.
- Allow time for clarification, answer / questions after the presentation.
- Ask the participants of the meeting to identify their health problems and which problems can be solved by, from and for themselves.

- Present the potential and resources they have that can be used to solve their problems from the non medical aspect.
- Facilitate them to develop a plan of action by considering their potential and resources.
- Present the concept of the Community Based Alert System and make a link to the plan of action.
- Ask their commitment to organise themselves to establish their own Alert System.
- Draw conclusions of the meeting.
- Do not forget to write a summary of the meeting and a list of participants of the meeting.

HANDOUT

Manual Training I for Facilitator

SESSION 2

AN EXAMPLE OF A CASE STUDY;

Marlia A Karim, 27 years old, second pregnancy. During her pregnancy she kept going to her farm that is located 5 km from her house until her pregnancy was almost ending. Marlia also did her household work such as washing, cooking and cleaning the house. She did not go to the ANC, she went to the mobile village clinic once and went to the village midwife only once but she did get immunization. One day, just back from her farm, around 21.30 pm, she complained about having a stomach ache, ache in her chest, not able to wake up properly. Under such conditions, her husband went out to call the traditional healer and according the healer, Marlia had got a disturbance from the devil called “iso“from the mountain so the healer gave her prayers. Then her husband called the TBA. Her husband admitted he did not call midwife because he was afraid of the cost. The TBA did a massage for the position of the baby and around 1 am the baby was born. Around 6 am, Marlia found she was not able to see anything, her sight was blurred. On the suggestion of her neighbour, her husband called the midwife and the midwife came to the house of Marlia. When the midwife measured her blood pressure it was 170, so the midwife suggested bringing Marlia to the health centre at Dompur Barat. Before her husband was able to take a decision, the midwife went to health centre to consult about the cost and after having information about the cost, her husband made the decision to bring Marlia to health centre accompanied by the midwife. At the health centre, Marlia got treatment and at about 10 am the health centre referred her to hospital because it was they were unable to treat Marlia and she should get treatment from a specialist. At the hospital, there was no treatment, Marlia passed away in emergency department.

MNH Picture

Maternal death is big problem. Indonesia has a much higher rate compared to Thailand, Vietnam and Malaysia for example, it is reducing but at a much slower rate than these countries managed.

The Tenth Revision of the International Classification of Diseases (ICD-10) defines a maternal death as: *the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.*

Trends of MMR in NTB Province compared to National

Year	National	NTB
SDKI (Health demographic survey) 1994	390	425
SKRT (Household health survey) 1995	373	-
SDKI 1997	334	394

Causes of Maternal Deaths

- Haemorrhage: 42 %
- Exclampsia: 13 %
- Infection: 10 %
- Long labor: 9 %
- Other causes: 11 %
- Related deases: 13 %

Indirect Causes

- Nutritional Status of the pregnant woman: anaemia 51%
- The Four Toos - too young, too old, too many, too close: 61%
- Level of education
- Socio-economic & culture
- Geographical factors, the Three Delays – delay in seeking care, delay in reaching care and delay in implementing appropriate care

In Indonesia there are 334 maternal deaths per 100.000 live births per year. This means 18,000 women died because of pregnancy and giving birth each year. Thus, there is one women dying every a half an hour.

And every year there are 34,000 born without a mother.

Impact of maternal death

- Many widowers remarry
- Children without mothers odten have inadequate education; inadequate nutrition / not healthy and lack parenting

Infant mortality is still high

There are an estimated 275 infants dying every day or 12 infants every hour. Do we want to see this happening???

Trend of infant mortality in NTB compare to the National

Year	National	NTB
SP – Census 90	71	94
SDKI 97 Health demograpfic survey	35	85
SP –Census 2000	47	91

Causes of Infant Death

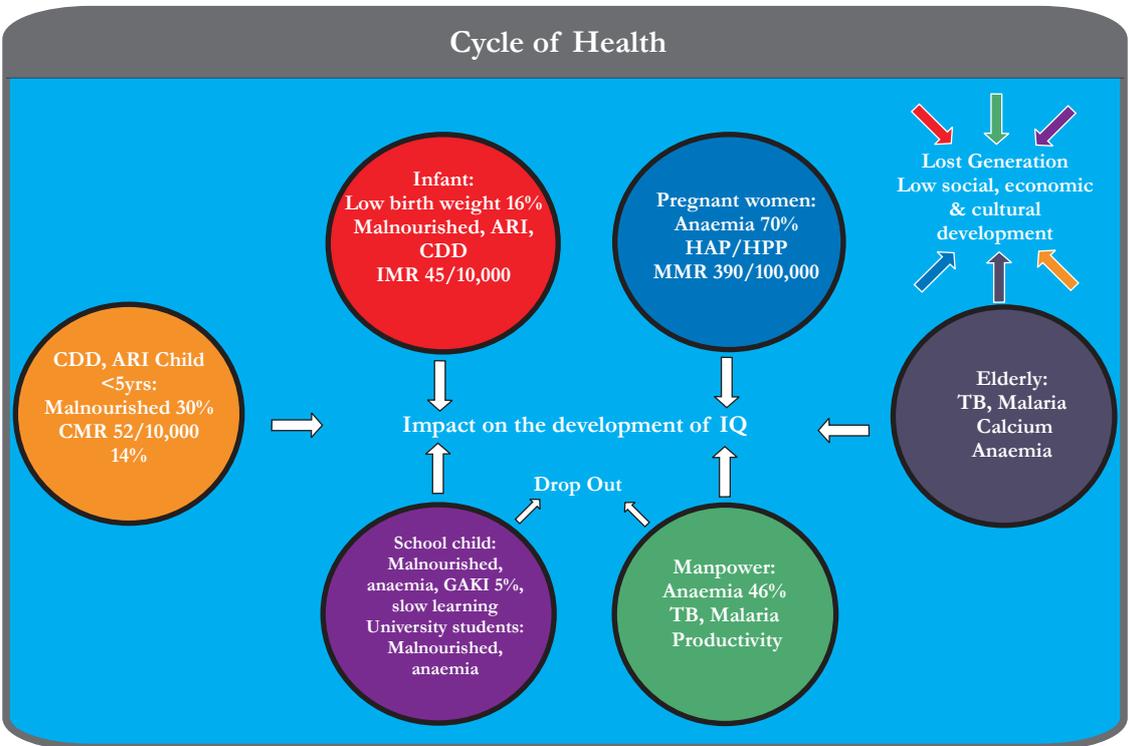
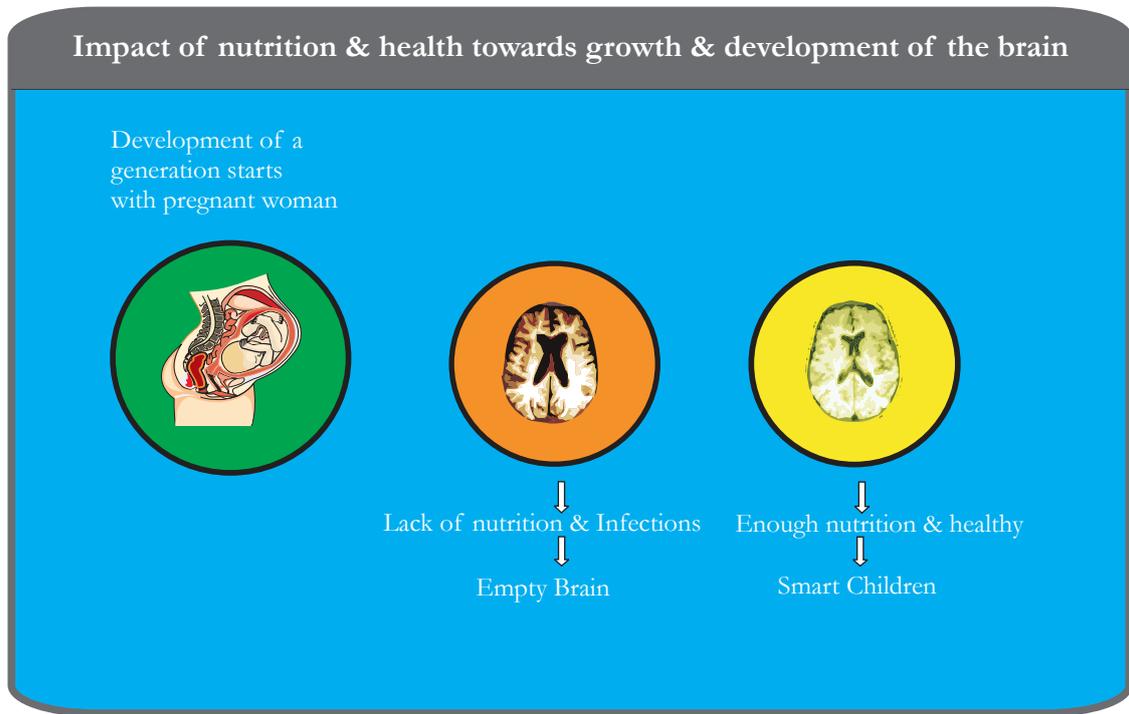
Causes of infant death	Java-Bali	Outside Java-Bali
Neonatal conditions	35.2	29.6
Respiratory	32.1	28
Diarrhoea	9,6	16.4
Neurological conditions	6	5.3
Infection	4.1	3.2
Tetanus	2.3	4.5

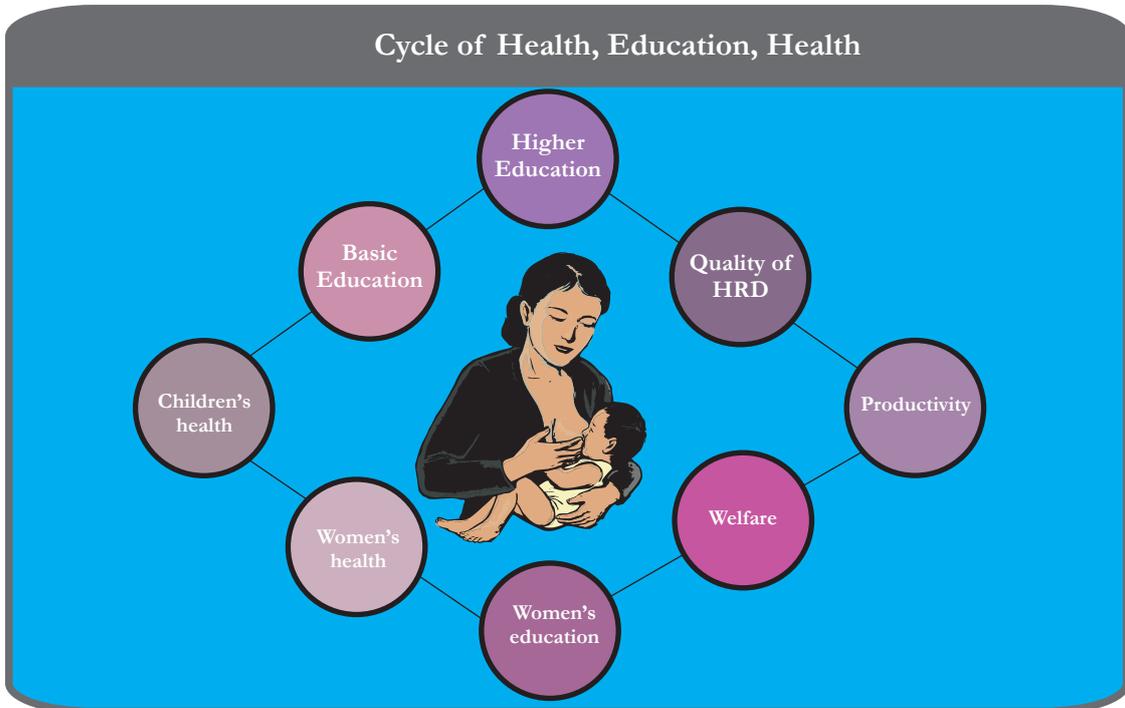
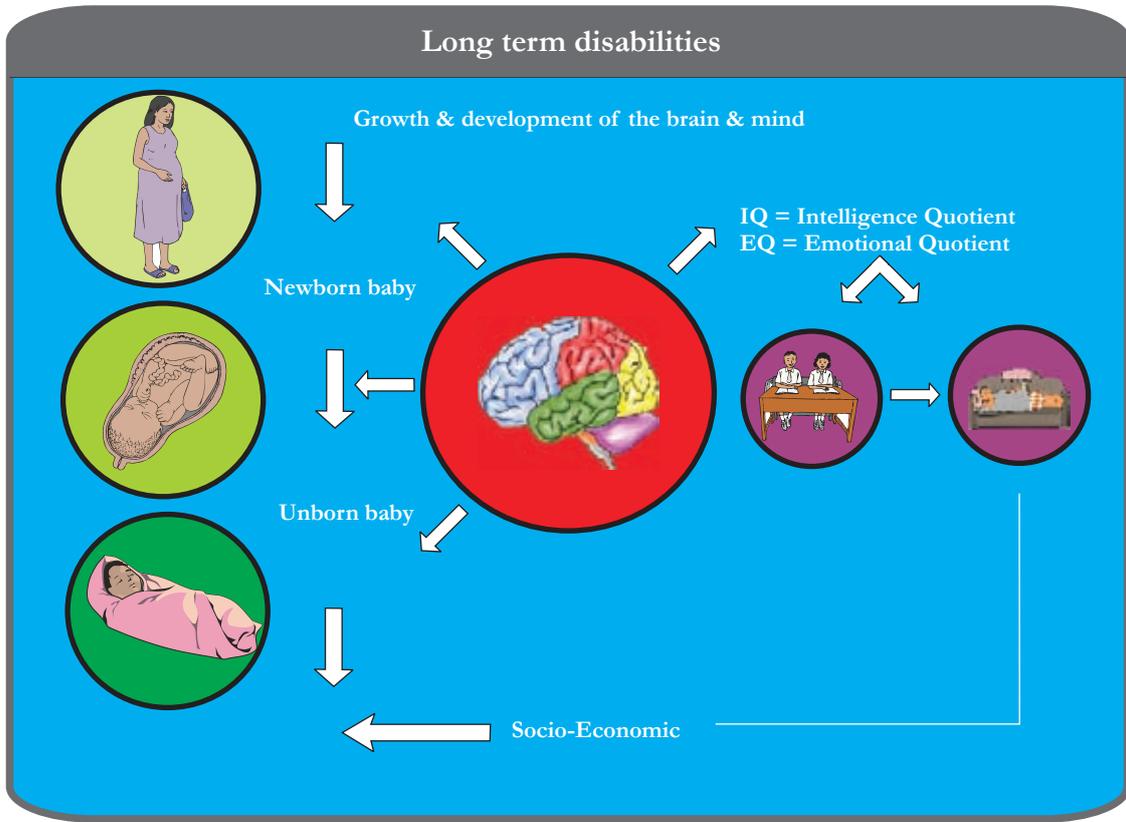
- Does not want to use FP methods
- Gets pregnant too soon
- Reproductive health low

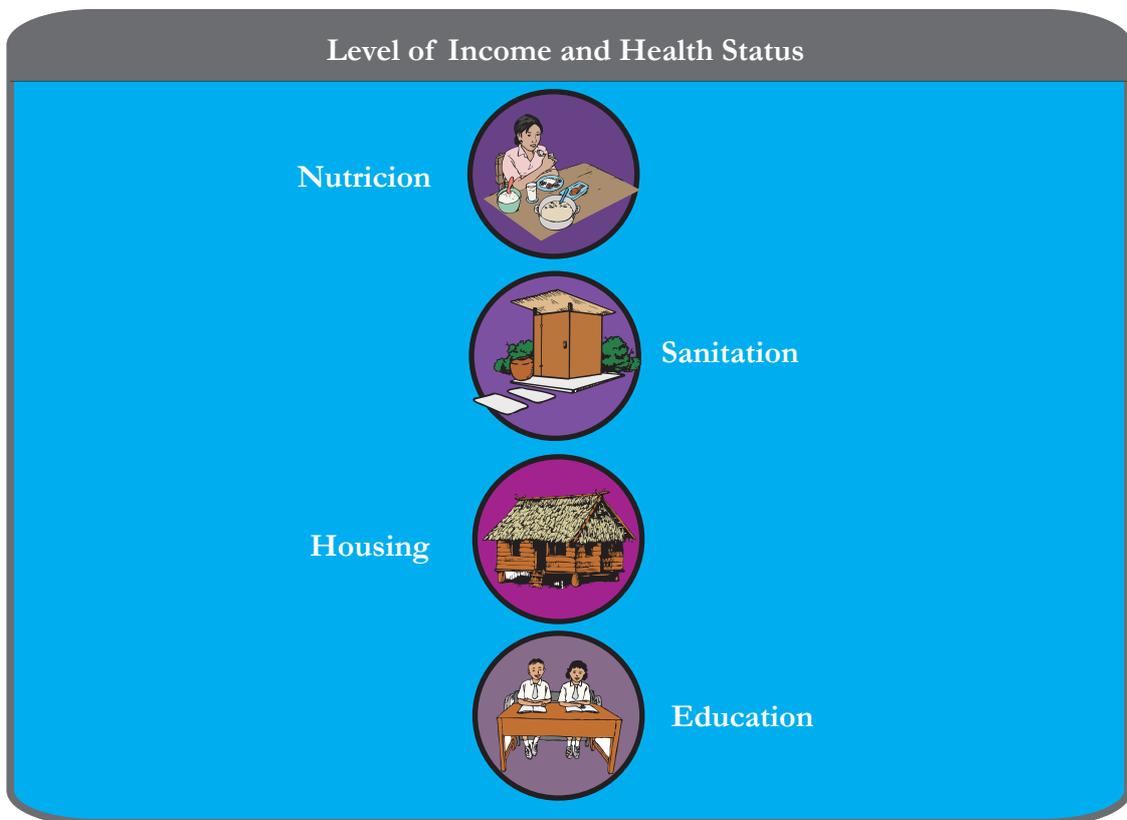
Impact of maternal and infant death

- Difficult to achieve healthy and quality families
- Threat on lost generation: weak capacities and lassitude

Note: the graphics can be updated according to the situation where the training is taking place







SESSION 3

GENDER AND MNH

What is the difference between gender and sex?

Gender:

The socially constructed roles, responsibilities, constraints and privileges that are assigned to women and men in a given culture or location.

You are not born with your gender identification. It can be changed. Gender is learnt and changes over time.

Sex

Is biological.

You are born with your sex. It cannot be changed.

Gender Bias:

Stereotyping on men and women, discrimination on opportunity, access towards men and women in domestic, social and public spheres.

Equality and equity of gender:

Certain conditions in which men's and women's relations are just and in equal collaboration.

Is gender a problem?

- In theory, gender is not a problem.
- Gender is the division of roles and responsibilities of men and women in order to create men and women who can live harmoniously and complementary to each other.

Gender is not a problem if:

- Men and women together determine their roles and responsibilities.
- There is a balanced division of roles between men and women.
- There are balanced opportunities owned by men and women.
- There is no disvalue of work, but appreciation and respectfulness.
- There are no disadvantages to each other.

When do the gender roles become a problem?

- Sub-ordination
- Discrimination
- Violence
- Poor economies
- Triple / double burdens
- Negative stereotyping.

Gender Issues in Reproductive Health

- Maternal and newborn health
 - Inability of women to make decisions about her own health conditions; when to get pregnant, where to give birth because of the weak position of women in the family and society.
 - Give priority for men to eat first.
 - Obligatory for women to keep working when pregnant or after child birth.
- **Family Planning**
 - Cannot decide which FP method will be used.
 - Men's participation in FP is low but men's control towards women is dominant.
 - Women as an objective of the FP program.
- **Adolescent Reproductive Health**
 - Unjust responsibilities to girls. An example: when having unwanted pregnancy, only girl is blamed while the boy is free although he was involved in creating the problem.
- **Unjust condition from legal aspect**
 - Illegal abortion: only women who are blamed.
- **Sexually Transmission Infection**
 - Women as the objective of the STI prevention program.
 - An effort of reducing prostitution, women are blamed as the main problem while men as the transmission agent are not targeted.

THE DESA SIAGA CONCEPT

Definition of Desa siaga

Desa Siaga is a term used to describe community members who live in villages who own resources and capacities for preventing and overcoming their own health problems, disasters and health emergencies based on mutual support and in a spirit of togetherness.

Objectives

General Objectives:

Villagers will have healthy lifestyles and are aware of and alert to their own health problems in their area.

Specific Objectives:

- Increased knowledge and awareness of the villagers about the importance of health.
- Increased preparedness and readiness of the villagers to overcome risk and dangers that cause health problems (such as disasters, an epidemic, and emergencies).
- Increased number of families that practice healthy lifestyles, having good nutrition and health status.
- Increased healthy environment in the village.
- Increased intentions and capabilities of the villagers on mutual support amongst themselves towards the health sector.

The Targets of Desa Siaga Development

The targets of Desa SIAGA development are categorised as follows:

- Individuals and families who live in the village will be able to practice healthy lifestyles and are aware of and alert to their own health problems in their area.
- Groups or individuals that have an influence on the behaviour change of individuals and families or those who are able to create support for behaviour change, such as community/religious leaders, female leaders, youth, cadres, and health personnel. In other words, those people or groups who have influence in the community.
- People or groups that are able to provide support on policy, law, regulation, budget, labour, resources, and infrastructure, such as the village head, sub-district head, relevant policy makers, donors, and other stakeholders.

Criteria of Desa Siaga

A village will be called Desa Siaga, if the village has at least a Village Health Post (POSKESDES), which is a community based health service established in the village in order to bring primary health care services closer to the villagers.

The personnel of POSKESDES are: a minimum one midwife assisted by two cadres.

Concept of Community Empowerment in Maternal and Neonatal Health (MNH)

As described previously, one of the objectives of the National Desa Siaga Development Program is to increase people's intentions and capabilities for helping each other in overcoming their health problems. Included in the program are emergencies related to pregnancy and delivery. The community empowerment linked to MNH is a crucial part in achieving the objectives of Desa Siaga.

Background

Conceptually, the community empowerment linked to MNH is developed based on the cultural practices of mutual assistance across the societies in NTB.

In all of the cultures in NTB, there is a practice through tradition of mutually helping each other in many aspects of life using community resources. The people help each other when someone dies, when a couple gets married, or when celebrating religious ceremonies.

This tradition of mutual help does not exist by itself, but it is developed through the centuries by people organizing themselves to overcome their own problems by raising consensus to help each other. The unwritten consensus becomes a local custom that the majority of the community abides by. The consensus is practiced by the people and it is passed on from one generation to the next producing tangible benefits of practice, leading to development of traditions in the society.

The tradition of helping each other, when a couple gets married or when a person passes away, exists in all cultural groups in NTB province but with different terms. These terms include “Banjar Kawin” and “Banjar Kematian” for Sasak Society, “Mboloweki” for Bima, Dompu and Sumbawa ethnic groups in Sumbawa Society.

The tradition of mutually helping each other are applied not only when marriages take place or when death occurs but are applied in other activities. For example, when someone builds a new house it is called “Banjar Rumah”, when working farmland it is called “Banjar Kerja” and when building a mosque. Thus, it can be said that the tradition of helping each other occurs because people find it is important for them to share the burdens and joys of life using their own resources.

However, this tradition of helping each other, unfortunately, is rarely applied for saving people's lives, when someone is facing health problems or an emergency health situation. One such emergency is related to pregnancy and delivery, and we know in reality, the high mortality and neonatal death rate is a big problem faced by the province of NTB.

The concept of community empowerment in MNH is developed as a strategy to reduce maternal and neonatal health through increasing people's participation in helping each other on the non clinical aspects related to pregnancy and delivery emergencies. The concept has been developed through learning from the existing traditions of mutual assistance and combined with lessons learnt from the previous Maternal and Neonatal Health (MNH) Project in West Java and the AusAID Project support of Women's Health and Family Welfare (WHFWP) in NTB.

Specifically, the community empowerment in MNH is developed in order to respond to following facts:

- High percentages of maternal deaths happen within 2 hours during and following the process of delivery.
- Most of the maternal deaths have a correlation to the “three delays “– delay in making the decision to refer the woman, delay to provide a means of transportation and delay to obtain adequate medical treatment.
- A high percentage of maternal death is caused by haemorrhage.
- Pregnancy and delivery is assumed as a natural occurrence that happens to every woman.
- Pregnancy is associated as women's affairs.

In fact, 85 % of maternal deaths could be avoided because:

- The "three delay" problem is a problem that is largely related to social and cultural behaviours within the community.
- There are still many myths/taboo that are related to pregnancy and delivery that need to be well explained.
- Pregnancy and delivery is not only women's affairs but it is also affair of the family and it should become a public affair.

Considering those facts, everyone: husband of the pregnant woman, her neighbor, her neighborhood (community leader), midwives, and health facilities (health center and hospitals), could help the pregnant woman by realizing their roles. However, we did not know what we can do to reduce maternal death and what role we can take to save a life of a pregnant woman. Therefore, in principle, we can take a role to save the life of a pregnant woman by promoting Birth Preparedness and Readiness to face complications through the following actions (Kusyunarti, 2004):

- Increasing the awareness of people that each pregnancy is our responsibility, it is not only women's responsibility.
- Each pregnancy and delivery has a risk and each pregnancy is unique to each woman.
- Revitalizing the values of helping each other in saving a life of pregnant woman from the non clinical aspects.
- Involving all stakeholders in dealing with this issue.

By implementing these actions it is hoped that access of people towards the birth planning mechanism and readiness to face any complication at the community level is improved. This improvement is through establishing a Community Based Alert System that is developed "from, by and for" people in terms of notifying the condition of the pregnant woman, provision of the means of transportation, communication, provision of blood donation, and financial support.

Definition

The community empowerment within MNH is an effort to facilitate people to establish a Community Based-Alert System in order to manage the non clinical aspects of emergency situations related to pregnancy and delivery.

The Community Based Alert System is defined as a system of people helping each other developed "from, by, for themselves" in the provision of the means of transportation, communication (phone, mobile phone), financial support, voluntary blood donation, notification, and Family Planning (FP) Information Post.

The Community based Alert System at the community level consists of:

1. Notification system.
2. Means of transportation/communication systems.
3. Financial support system.
4. Blood donation system.
5. Dissemination of FP Information.

A process of community empowerment in MNH is not only facilitating people in establishing their own Community Based Alert System but it is also a process of facilitation

for behaviour change, that is: (Kusyunarti, 2004)

- Social mobilization to prepare people to be ready to respond to an emergency situation, especially related to pregnancy and delivery.
- Increasing people's participation in reducing maternal death.
- Using resources owned by people in helping women during pregnancy and delivery.
- Achieving all deliveries assisted by Skilled Birth Attendants (SBA).
- Empowering the community so that they are able to solve their own problems.
- Involving men in solving maternal health problems.
- Involving all stakeholders in overcoming health problems.

Thus, community empowerment in MNH is from the following philosophical thoughts:

- Revitalizing values of social togetherness and mutual assistance for the woman during her pregnancy and delivery.
- Shifting the paradigm: delivery is a public affair; it is not only women's affairs.
- Shifting the mindset: health problems are not only the responsibility of government but they are a shared problem of people and the responsibility of people to overcome.
- Involving all stakeholders in the community.
- Applying participative approaches.
- Doing in action and advocacy.

OBJECTIVES

General Objectives:

To increase people alertness in facing maternal and neonatal problems and emergencies in order to accelerate reductions in maternal and neonatal deaths.

Specific Objectives:

- Established of Community Based Alert System: notification, provision of means of transportation, communication, financial support, blood donation, and dissemination of FP Information.
- Increased visits of pregnant women to the health centre.
- Increased deliveries attended by SBA.
- Increased number of active FP users.

SCOPE

The community empowerment in MNH is facilitating people to establish a Community Based Alert System in MNH, that is, an Alert System developed from, for and by people that covers the following content:

Community Based Notification System

- In order to be able to help someone who is in an emergency situation, people need to have information on what is happening in their community. They need to have a recording, monitoring and reporting system aimed at notifying themselves.
- This recording-monitoring-reporting system is participatory system that is done from, by and for themselves and focused on health issues.
- Information will be recorded and monitored but it is up for consensus to decide what is going to be monitored. For instance, information on the number of pregnant women, maternal deaths, neonatal deaths, number of population and kept up date. In other words, the health problem that will be recorded depends on what is agreed by the community members.
- Under this system, those who are having a health problem or condition go to the volunteer recorder who is agreed by the community.
- The volunteer recorder is a community member who has the spare time and wants to use her/his spare time to record what is happening in their area on health that is reported to her/him by those who are facing the problem. The voluntary recorder should exist in each neighbourhood in order to encourage people to record.
- Agreement on establishing this system is done through holding a meeting with community members that represent the population of the sub-village. However, the consensus raised in the meeting will rule all people who live in the sub-village.
- The consensus belongs to the people who developed them so they are implemented and become the responsibility of the people who live in the sub-village.
- The functioning of this system will be very worthwhile for neighbourhood, sub-village, and village office, therefore, the consensus is not only to be agreed but it is important that it should be applied by all people and the gathered information will be used to monitor the health problems in the area.
- This system is developed using forms that are agreed upon by the people.

Community Based: Means of transportation/communication systems

- Mutually assisting each other for the provision of the means of transportation and communication when health emergency situations and disasters occur.
- In order to run this system, people need to raise a consensus on helping each other with the provision of the means of transportation and communication with rulings on: who the owners are of transportation and communication means that are listed in the system, how to ask for help, how to give help (provide the means of transportation and communication), what costs (pay or free of charge) and who will coordinate this effort, etc.
- The consensus is developed from, for and by the people through holding a meeting at the sub-village level that is attended by the representative of the neighbourhoods.
- The consensus could be raised and agreed by people who attend the meeting but it will concern all people who stay in the sub-village, so the consensus itself has to be informed to others who do not join the meeting.

The consensus owned by the people needs to be applied by them continuously so that they take responsibility.

Community Based Financial Support System

- An emergency situation often happens when someone does not have any cash money and this often causes delay in efforts to save a life. People need to support each other in these emergency situations by establishing financial support, similar to the support when someone dies or gets married.
- The financial support system is an effort to help each other, developed from, by and for the people for finance matters when emergency situations or disasters happen.
- In order to manage this financial support, people need to raise a consensus amongst them by holding a meeting at the sub-village level that is attended by representatives of the neighbourhood or all families who live there.
- Using consensus the representatives will be guided on where the source of the fund will be raised, how much of the fund will be raised, what the fund will be used for, who will be eligible to receive, who will manage the fund, how much support will be given, in what conditions someone is eligible to receive funds and how the usage of the fund will be reported back to the people who formed the financial support.
- The consensus reached will belong to the people and it has to be applied by these people. So it is not only raising consensus but it should be an applicable consensus that supports each other financially.

Community Based Blood Donation System

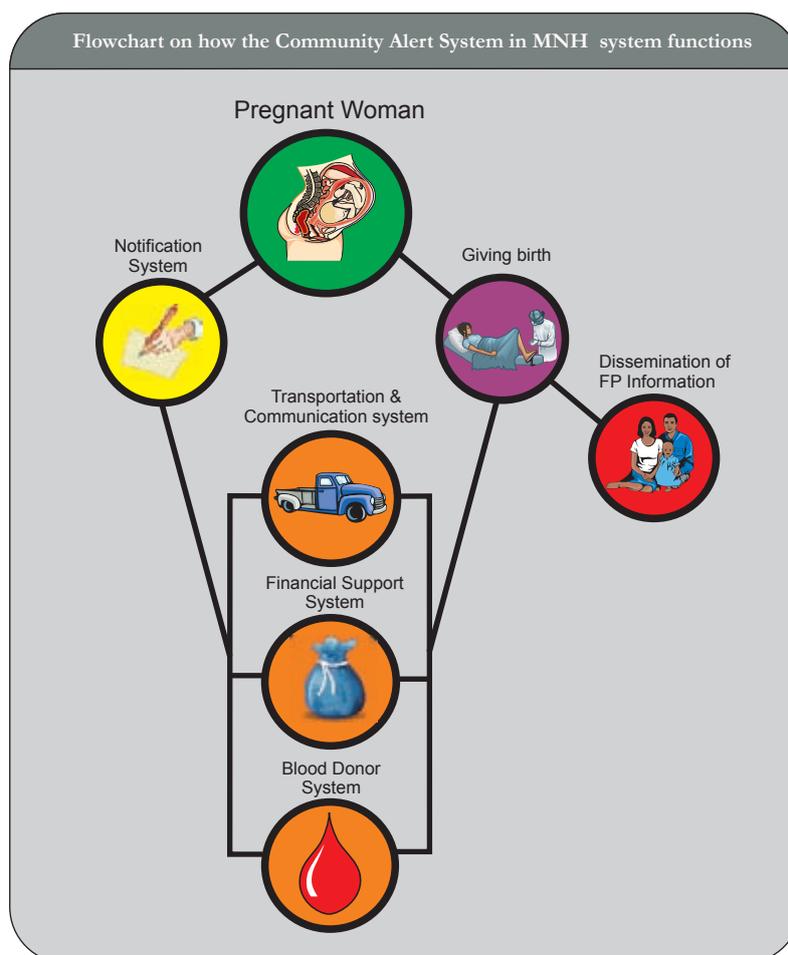
- It is an effort to help each other, “from, by and for themselves”, regarding the provision of a blood donor system when emergencies require blood transfusion.
- In order to establish this system, people need to have a list of potential blood donors with blood types, and how to provide the blood donors. People who are eligible to be the blood donor will be checked for their blood type in order to make them ready to donate their blood when needed.
- The meeting to establish this system is held at the village level.
- The meeting is attended by the potential blood donors and representatives of the villagers from all sub-villages, people from the health centre, the village midwives and Red Cross blood transfusion unit.

- The decisions raised through consensus in the meeting belong to the villagers and are implemented by them.

Family Planning (FP) Information Post

- An effort to help each other on the dissemination of FP information amongst the villagers, especially to males and females of reproductive age, in order to bring closer access of FP Information.
- To increase the capacity of the villagers to disseminate FP information, one of the community members from each sub-village is trained in Reproductive Health, FP, communication skills and equipped with IEC material on the topics so they will be able to disseminate the information to the rest of the people in their village.
- This sharing of information on FP will be sustainable because each sub-village has its own resource person who will act as a bridge between the villagers and the health services.

How the Community Based Alert System works can be illustrated as follows:



The process of community empowerment in MNH through facilitation of people in establishing their own Alert System involves the following activities:

- Developing the partnership between midwives and the traditional birth attendant
- Supporting the National Program of Birth Planning and Prevention of Complication (P4K) using the "sticker"
- Revitalizing an Integrated Services Post at the sub-village level (Posyandu).

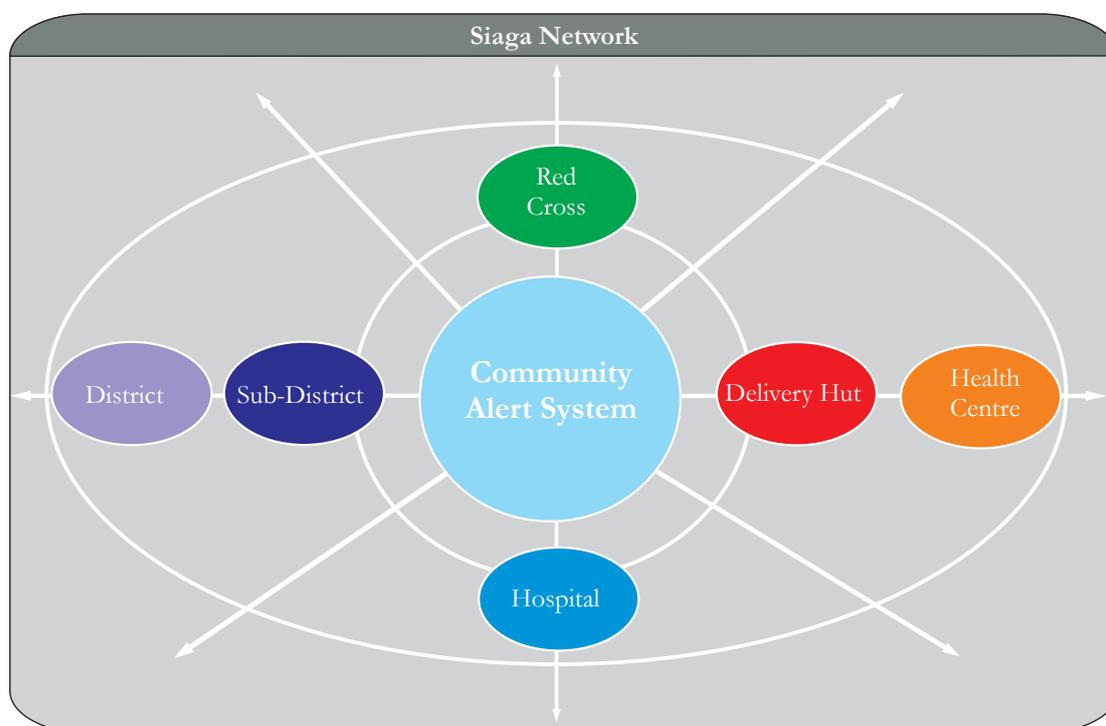
The establishment of the Alert System: notification, provision of transportation and communication means, financial support, and blood donation as well as FP Information Post combined will support the birth planning program that is planned by the pregnant woman together with her family. In addition, the functioning of the Alert System will be discussed in the community based primary health care services (Poskesdes) once a month, so all these activities will complement each other in order to achieve better health for the villagers.

A network on the Community Based Alert system

The alert system is formed at the community level at the scope of sub-village and village. In order to make the system functional, the system needs to establish a network. For example the notification system will have a network with the village office, sub-village office, Posyandu, Puskesmas hospital.

The transportation system will have a network with Poskesdes, Puskesmas, hospital, etc.

The network can be illustrated as follows:



INDICATORS of SUCCESS

The success of community empowerment in MNH program can be assessed by three groups of indicators, as follows:

Indicator for Input

The input Indicator is a tool to see how many inputs have been put into the process of community empowerment in MNH. The indicator for inputs covers the following items:

- a. The number of villagers who take up roles to facilitate the process of community empowerment in MNH.
- b. Guidelines for conducting the Self- Assessment Survey in MNH and for the establishment of a Community Based Alert System are available.
- c. The number of Alert Systems established.
- d. A coordinator volunteer for each system exists.
- e. A list of potential blood donors with their blood type is available.

Indicator for Process

An Indicator for process is a measurement of the intensity of the process happening at the village level in community empowerment in MNH. The measurement involves the following items:

- a. The Self Assessment Survey in MNH is conducted.
- b. A document of the village portrait in maternal health in each village is developed.
- c. The village / sub-village meeting for the establishment of the Alert System is conducted.
- d. The established Alert System is functioning: notifications, transportation, communication, financial support, blood donation and FP Information Post.
- e. The Monitoring and Evaluation activity is conducted at each level.

Indicator for Output

The indicators for outputs are measurements to assess the impact of community empowerment in MNH activities. Indicators for the outputs are:

- a. Increased ANC coverage (K1, K4).
- b. Increased delivery assisted by SBA.
- c. Reduced maternal and neonatal deaths that are caused by the “three delays”.
- d. Increased FP current users and new FP acceptors.

IMPLEMENTATION STAGE IN THE PROCESS OF COMMUNITY EMPOWERMENT IN MNH

The main process in the implementation of community empowerment in MNH is the provision of facilitation on the establishment of the Community Alert System because the system itself does not exist as yet in the community. Once it is established, the functioning of the system will depend on the people themselves. In this context, the process of community empowerment in MNH could be described as like putting an electricity installation into a house. Relevant institutions will help the villagers to install the installation which is establishment of the Alert System but when it was installed the villagers should take care, maintain the work and provide the operational resources of the system. Like electricity, after the installation of the hard ware, it is up to the owner or those who stay in the house, to

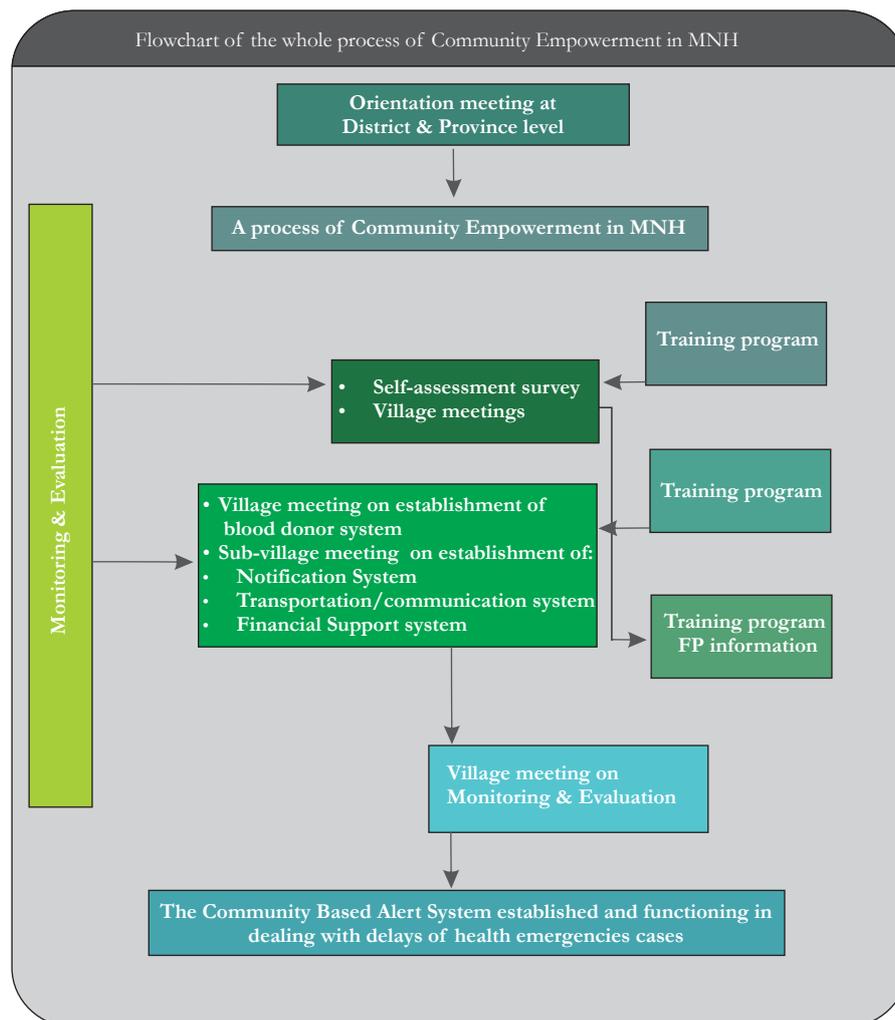
keep the light on. It is up to the villagers to maintain the activities of each system to better their health.

Within the facilitation process, the main actor in the development of the Alert Systems in the village is one of the community members having a role to do facilitation. In order to be able to perform his/her roles, the selected villager requires knowledge and skills on facilitation, how to organize people and how to mobilize people using a participative approach. In other words, they need training and guidelines to perform facilitation works with people as well as coordinating skills with relevant institutions in developing a network for each system.

Briefly the process of community empowerment in MNH can be divided into two main groups of activities, that is:

- The first main group of activities covers: the process of empowering and organizing people, facilitated by one of the villagers who has received two kinds of training.
- The second main group of activities cover: the process of provision of support for the first group activities, such as orientation meetings, monitoring and evaluation at provincial and district level.

The whole process of community empowerment in MNH can be drawn as follows:



A. Orientation Meetings at Province Level

1. Aims of the meeting include dissemination of the concept of Community Empowerment in MNH, including its approach, process, and discussions on the criteria of selecting the site of the support to districts and to relevant institutions where the program will be delivered.
2. Participants: Provincial Planning Board (Bapeda), Provincial Health Office (PHO), Provincial Community Empowerment Institutions, Family Planning Institution, Provincial Parliaments, Hospitals, private MNH clinics, Midwives Association, Red Cross and representatives from districts where the program will be delivered.
3. Organizer of the meeting: this is a one day activity and could be organized by the institution leading the program.
4. Output of the meeting:
 - The concept of community empowerment in MNH is understood.
 - A criterion on selection of the support program is agreed.
 - Commitment of relevant institutions, such as budgeting support from local government/other institutions for the whole process and support for the functioning of the established systems is agreed.

B. Orientation Meeting at district Level

1. Aims of the meeting include dissemination of the concept of community empowerment in MNH, including its approach, process and discussion on criteria of selecting members of the community who will take roles as village facilitators in the process of the empowerment of the community in MNH.
2. Participants:
 - From the district level: Planning Board, District Health Office, District Family Planning Institution, District Parliament, District Hospital, District Midwives' Association, District Red Cross, Blood Transfusion Unit, MNH Clinic, District Women's organization.
 - From the sub-district level: the head of the sub-district, head of the health centre, midwifery coordinator, sub-village women's organization, sub-village FP coordinator.
 - From the village level (the nomination of the site of the program): the village head, the village parliament, the village midwives and the village women's organization.
3. Implementation: this is a one day meeting and it could be organized by the relevant institutions that will lead the delivery of this program.
4. Output of the meeting:
 - The concept of the Community Empowerment in MNH is understood.
 - The selection site where the program will be run is agreed.
 - Commitment of the district/sub-district/village government and relevant institutions on the provision of budget and support of the process and the functioning of the established Alert System is agreed.
 - A criterion on selection for the village facilitator is agreed.
 - Commitment from the selected village government to implement this program and maintain the sustainability of the established Alert System gathered.

C. Training Program I of Community Empowerment in MNH: Concept and Approach

Regarding the principle of community empowerment in MNH, which is, “from, by and for the villagers themselves”, the facilitation process requires a facilitator from the selected village. To be able to facilitate the process, one of the community members is invited to a joint two training programs. Training activities within the process of community empowerment in MNH is a process of enabling one member of the village to be able to facilitate her/his community members for organizing themselves in overcoming their health emergencies or disasters by developing a consensus to help each other in saving the lives of people.

The first training covers the program of increasing the participants in understanding MNH problems. The emphasis is on the MNH problems from the villager's point of view including the village facilitator and how everyone could take a role to overcome the problems by looking at their own capacities, resources available in the village. These include the existing village organization or institutions, knowledge and technology owned by the villagers including their traditions of helping each other that can be used in saving lives of the people, especially the lives of pregnant women during pregnancy and giving birth. The village facilitators are equipped with knowledge on how to approach and involve those who have influence in the community, to involve them in organizing and mobilizing people in order to take actions in saving the lives of people who are in an emergency situation. Thus, in the first training program, the village facilitator is equipped with knowledge and skills on facilitation of conducting a survey of self-assessment on the village health condition using participative methods and tools including this guideline, and of analysing resources that they have.

The First Training program and Manual Training for the trainer can be found in separate documents of this toolkit.

Objectives of the training

General Objective:

The participants are able to facilitate the process of community empowerment in MNH

Specific objectives:

At the end of the training, the participants will be able to:

- Understand the concept of Community Empowerment in MNH
- Understand and be able to facilitate the application of participatory approach and techniques in conducting the Self Assessment Survey and in the process of empowering the community in MNH.
- To facilitate the villagers to conduct the self assessment survey in MNH and analyse the resources that the village has.
- To follow the guideline for conducting the Self Assessment Survey.
- To develop a plan of conducting a Self Assessment Survey in each village.
- To be able to conduct a village meeting in doing Self Assessment.

Participants:

- One person from each village, male or female who has potential for facilitation and organizing people.
- One staff member of the health centre who is responsible for community participation or coordinator of Posyandu.

- One staff member of the District Health Office who is responsible for MNH or the community participation program.

D. Conducting the Self Assessment Survey in MNH: Analysis on Maternal and Neonatal Health Conditions and Resources Owned by the Villagers

After joining the first training, the village facilitator commences to facilitate the process of community empowerment by disseminating the idea of mutually helping each other in overcoming emergency situations to influential people in the village as well as to facilitate the villagers in understanding their health problems and resources they own through conducting the survey of self assessment focusing on MNH.

The Self Assessment Survey is a process of increasing the capacity of people to be aware about their health condition and it is a process of empowering them to take action on improving their health condition especially maternal and neonatal health.

This activity is conducted in two stages. The first stage is gathering people to talk about their MNH condition by conducting group discussions with topics on MNH such as a case of maternal and or neonatal death, availability of health services and facilities, people's access to health services, health seeking behaviours during pregnancy, delivery, infant/newborn illness and emergency situations, infant feeding behaviours, taboos during pregnancy and the post partum, the work burden of men and women in the village, knowledge on reproductive health and sexual and reproductive rights. The group discussions are conducted in every sub-village based on selected topics that are suited to the certain sub-village. After all topics have been discussed informally a formal village meeting is held to discuss all topics in larger groups. The aim of the village meeting is to facilitate the villagers to analyse their own health condition using the results of the small group discussions and to get the villager's commitment on how to improve their health condition using their own resources especially when facing emergency health situations. In addition, this village meeting is aimed at disseminating the concept of community empowerment in MNH so that people are aware that they are responsible to take action in overcoming health emergencies by establishing their own Alert System. Details on how to conduct the Self Assessment Survey are available in a separate document in this toolkit.

Output from this activity:

- A Village Portrait on the analysis of the Maternal Health Condition and the potential of the villagers to carry out actions is developed.
- The local health condition is understood.
- The concept of community empowerment in MNH is understood.
- Commitment of the villagers to establish their own Alert System is raised.

The results of small discussions together with the large village meeting on the MNH condition and analysis is written into a narrative report then distributed to those involved in the development and analysis of the village portrait such as the village office, village midwives, the health centre, the district health office for follow up in their health program in a broader context.

E. Training Program II of Community Empowerment in MNH: Organizing the Community in Establishing a Community Based Alert System in MNH

This training is part of a process of increasing the capability of the village facilitator in organizing the villagers to establish their own Community Based Alert System. This second training covers knowledge on strategies and approaches of community organizing and skills on organizing the community for establishment of the Alert System in MNH including development of a local guideline and a plan of action to be done after the training. The training programs are available in a separate document in this toolkit.

Objective of the training

General Objective:

The participants are able to organize the villagers to form an Alert System in MNH

Specific Objective:

At the end of the training, the participants will be able to:

- Understand the concept of community organizing.
- Understand the steps in organizing the community in establishment of the Alert System.
- Facilitate the villagers in establishing the Alert System.
- Develop a local guideline on establishment of the Alert System.
- Develop a plan of action.

Participants:

- One person from each village, male or female who has potential in facilitation and organizing people.
- One staff member of the health centre who is responsible for community participation or coordination of Posyandu.
- One staff member of the District Health Office who is responsible for MNH or the community participation program.

Criteria:

The participants are those who have attended the first training of Community Empowerment in MNH.

F. Meetings on establishment of Community-Based Alert System

A meeting for the establishment of each Alert System is facilitated by one of the villagers who has attended the first and second training of Community Empowerment in MNH, with support from the village/sub-village head, the head of the neighbourhood, community/religious leaders and other influential people. The following attend as resource people; village midwives, staff of the health centre and the district health office.

The meeting for the establishment of the notification, transportation and communication systems and financial support system is held at the sub-village level in order to ease people into accessing these systems. The meeting for the establishment of a blood donor system is held at the village level in order to better cover all blood types from all the sub-villages. The establishment of each system should be done in each specific meeting in order to give a chance for more people to be involved and allow adequate discussion time on consensus

items of each system so behaviour change can be triggered. The guideline on the establishment of the Alert System is available in a separate document in this toolkit.

The aim of the meetings is to:

- To raise consensus to establish the system (the agreed system covers rules and functioning, a mechanism, rights and responsibilities, procedures and who is responsible for managing each system).

Once the consensus on helping each other is agreed, a recording on the use of the system should be done. For example, the notification system requires forms/book to record and monitor the agreed information, such as pregnant women, maternal death, infant/newborn death, etc.

Regarding the issues of provision support for the function of system, it needs to be discussed with the villagers about ongoing provision of books and pens, how and who will provide. For the beginning the provision of books and pens maybe supported by third parties. It is important to consider that the consensus raised by the people should be written/documented on board/book and should be put in a public space so everybody can see it and are aware that they have developed their own consensus on helping each other for their own Community Based Alert System in MNH.

G. Training Program on FP Information Post for cadres

In order to steer people closer to FP Information access, one of the community members from each sub-village who is willing and able to disseminate information and able to be a bridge between people with the FP service, is invited to attend training on FP. The training program covers the following topics: reproductive health, family planning (e.g. what is FP, what to consider in joining FP, FP methods), FP consumer rights and communication skills. The training program and manual training on FP is available in a separate document in this toolkit.

Objective of the training

General Objective:

The participants are able to disseminate and share FP information in their neighbourhood.

Specific Objective:

At the end of this training, the participants are able to:

- Understand the definition of FP, why FP is important; usefulness of FP, methods of FP, reproductive health; the role of FP Information Post; FP consumer rights and communication skills.
- Share or disseminate FP Information to others.

Participants:

One of the community members of each sub-village from the village site of Community Empowerment in MNH Program.

H. Monitoring and Evaluation in the implementation of Community Empowerment in MNH

Monitoring and evaluation is conducted from the beginning of the process of community empowerment, such as the capability of the village facilitator, on the progress of the establishment of the Alert System, on the functioning of the established Alert System in order to see to what extent each system functions and to know the impact of community empowerment in improving the MNH condition.

Monitoring-evaluation can be conducted in various levels, as follows:

Monitoring and evaluation on the facilitation skills of the trained village facilitator

Objective: to observe and assist the facilitation skills of the village facilitator when conducting the Self Assessment Survey and holding meetings for the establishment of the Alert System.

Method: the trainer of the training conducts observation when the village facilitator is conducting the survey and meetings using predetermined forms (see attached).

Monitoring and evaluation on the progress of the establishment of the Alert System

Objectives: to monitor the progress of and identify obstacles in the process of establishment of the Alert System, and to provide an assistance to the process facilitated by the village facilitator.

Method: this is done by the existing advisory team at each level (for instance : Posyandu working group, GSI working group, Desa Siaga team facilitator at health centre level, women's organization, relevant sector), using predetermined forms (see attached).

Bi-Monthly Monitoring and evaluation Meeting at village level

Objectives of this meeting are to see the progress of the establishment of Alert System and to monitor and evaluate the functioning of the established system. This meeting is aimed to increase the capability of the villagers, the village/sub-village head, cadres, and village midwives on analysing and using the information gathered from the notification system in order to increase the health status of the villagers. The notification information can be used to attract resources to the village from relevant institutions. In addition, the meeting is also a forum to maintain and to provide technical assistance toward the functioning of the systems as well as for advocacy for the ownership of people. The monitoring forms for the sub-village and village levels can be seen in Appendices 2 in this guideline book.

Quarterly monitoring and evaluation meeting at district level

Objectives of this meeting are to assess the progress of the establishment of the Alert System (during the process of establishment) and, to monitor and evaluate the functioning of the established system (after the Alert System established). In addition, this meeting is intended as a forum for maintaining the functioning of the Alert System and to raise to the attention of relevant districts institutions to respond to the information from notifications at the village level.

SESSION 6

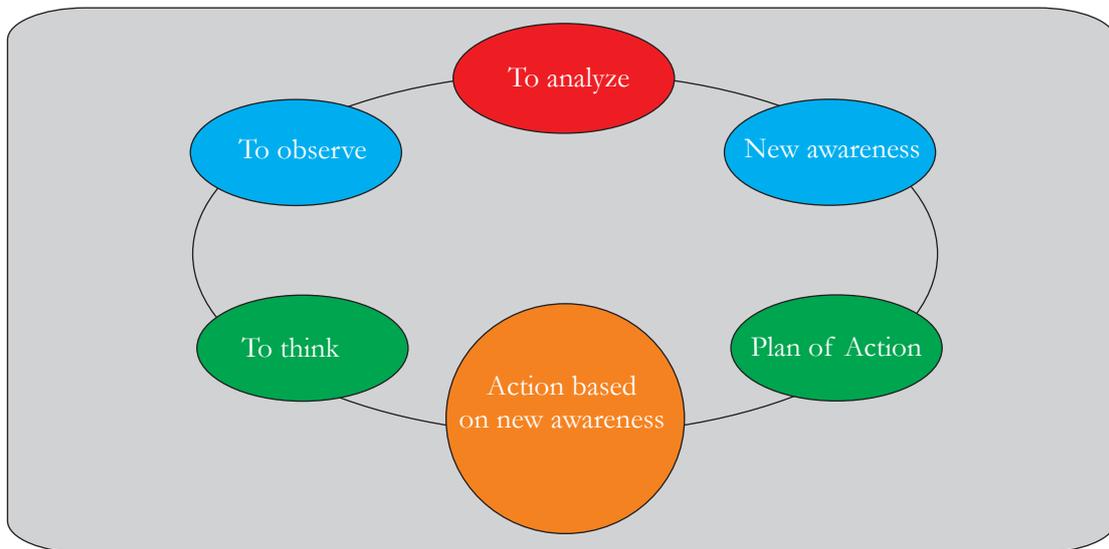
AN APPROACH APPLIED TO COMMUNITY EMPOWERMENT IN MNH: PARTICIPATORY LEARNING AND ACTION

A process of community empowerment in MNH is very much dependant on gender balanced community participation. To do so, it is necessary to put the community as the subject of their own development (Chamber, 1997)¹. Thus, how is the community made the subject?

To be able to be the subject, the community will need to be aware that they have problems that affect their lives; they have to be aware that they have their own resources to overcome these problems, so that they carry out the actions to solve the problems. This principle is supported by Paulo Freire's theory on conscientisation (1973)², development roots come by educating both disadvantaged and advantaged people. By raising awareness through self-reflection, people are able to assert their voices and stimulate their own self-driven collective actions to transform their reality.

In order to raise people's awareness it is important to facilitate them to think and to analyse their own condition and problems critically. By facilitating them to think, re-think and analyse their own health condition and problems, people will be able to have sensitivity and a new awareness that triggers them to have intention to act in order to change their current condition. Their new emerging action then will be observed, re-thought and re-analysed in order to have further awareness based on lessons leant from previous actions and used for forging new actions.

The cycle of this process can be illustrated as follows:



¹ Chambers, R. 1997, "Paradigm shifts and the practice of participatory research and development' in Power and Participatory Development, Theory and Practice, ed.N.Nelson and S Wrigth, Intermediate Technology Publication, London.
² Freire, P.1973, Pedagogy of the Oppressed, Penguin Books, London.

This cyclical process that allows people to comprehend their condition and take action in solving their problems is called Participatory Learning and Action (PLA). This approach facilitates people to explore and manage various components, strengths and differences, so that everyone has the same view on solving problems. It is also a process of organizing people so that they are able to think, to analyse and to take action to solve their future problems. This is the process of empowering people so that they are able to carry out actions to improve their condition. Thus, this is a process in which people transform themselves personally and collectively and they drive their power from their energy and strengths (Hartstock, 1981)³.

Regarding the establishment of the Community Based Alert System, people at the beginning need to understand and analyse their current health condition, such as maternal health, neonatal health, services available, power relationships that affect these conditions so that they are able to take action to improve the conditions based on their analysis of resources they have. In order to facilitate them to think, to analyse and to take action, the process of facilitation and who facilitates this process is important. In addition, the facilitator requires understanding both on community empowerment concepts in MNH and knowledge and skills on the application of participatory approaches, techniques and tools. Thus, the approach applied into this community empowerment process will determine the next and further processes and activities in the entire process community empowerment in MNH.

Participatory Learning and Action (PLA)

- An approach to facilitate people to understand their condition so they will take action to solve them.
- It is a process of facilitating people to explore and manage their strengths, varied factors and component in the community, so that they have similar views and understanding in overcoming their problems.
- A process of organizing people in order to enable them analyse their conditions and to find out solutions to their problems. One strategy is to facilitate them to think and to analyse their conditions critically.
- By doing this analysis, people will be able to have a new view, have sensitivity, and awareness that allows them to have intentions to take action to improve their conditions. Their action is then analysed, re thought and re-studied in order to have new views learnt from their experiences for plan further action.

The objectives of conducting Analysis on MNH conditions and the village potentials and resources using PLA are:

- To understand MNH conditions of the villagers including the health facilities available (services, quality, access of people toward the facilities) and people's behaviours especially in terms of MNH.
- To analyse health problems, especially MNH problems from a non medical aspect (maternal and infant death cases).
- To plan action to solve their problems.
- To comprehend the potential and resources owned by the villagers in the context of

³ Hartock, N.1981, "Political change: two perspective on power" in Building Feminist Theory: Essays from Quest, ed. Chalotte Bunch et.all., Longman Press, New York.

- establishing a Community Alert System in MNH.
- To gather people's participation in improving their health conditions.

PLA principles in conducting Analysis on MNH conditions

- Puts a priority to disadvantaged groups (women, the poor)
- Strengthen/empower the people
- Put people as the subject
- Mutual respectful, learning process
- Relaxed and informal
- Learning from experience
- Openness
- Varied techniques and sources of information

The village portrait about the MNH conditions is very important to be comprehended by the villagers so that they have awareness of their health conditions and intent to make improvements, one solution is to form an Alert System in MNH. Furthermore, the portrait describes the community big picture of their lives, their communal system, and their pattern of relationships, problems and consequences that occur from their relationships. Therefore, prior to facilitating the people to establish the Alert System, it is important to facilitate people to understand their big picture, their existing social and communal systems using their own experiences and their own terms used (language).

The process of establishing an Alert System depends on people's participation and collaboration between the village government and the community members. Therefore, facilitation work is required.

PLA Techniques and Analysis on MNH Conditions and Potential and Resources Owned by People

PLA techniques

- A tool to be used in doing an analysis
- The techniques could be in the visual (picture) format that is very important as materials for assisting discussion with people about their conditions
- These visual tools can be as learning forum for all the people whether literate or not.

PLA Medium

Materials that can be used to visualize the PLA techniques are:

- The earth
- Pencils
- Branches of the tree
- Beans
- Leaves
- Flowers
- Floor space
- Chalk
- Paper
- Markers

PLA Techniques

- A one day schedule for men and women
- Calender: seasonal calendar, calendar on feeding behaviours and diseases of infants 0 - 12 months, calendar of taboos and food preferences during pregnancy and post delivery
- Mapping : geographical map, mobility of people in seeking health care (pregnancy, postpartum mother, infant), map on ownership of means of transportation and communication, map on the availability of formal-informal health facilities, outside-inside the village for pregnancy care, delivery and infant care
- Venn diagram: community / mass organization that exists in the community
- Interview / focus group discussions: social perception of marriage, maternal and infant death cases, FP, STI/HIV-AIDS, menstruation, social concepts of poor / rich, health / illness.

Tips on commencing process facilitation of discussion

- Introduce yourself; who, where you come from, aims for gathering people in conducting discussions and interviews
- Explain about the aim, materials and process of the discussion
- Thank the participants at the end of the discussion session

SESSION 7

DEVELOPMENT OF THE GUIDELINE ON CONDUCTING A SELF ASSESSMENT SURVEY ON MNH AND POTENTIALS AND RESOURCES OWNED BY THE VILLAGERS

Work Sheet 1:

The work sheet (No 1) is distributed to a small group in order to fill the column of techniques used to discuss the topic that has been set out in the left column. The form distributed to the participants is similar with the form below but the column techniques is empty. This is the form with the correct answers in italics.

	Topics Analysis	Techniques
1.	Analysis on the social structure of the society	<i>Mapping</i>
2.	Analysis on the geographical location of the health facilities both formal and informal including access of transportation to reach the facilities and cost of transportation.	<i>Mapping</i>
3.	Analysis on services available in both formal and non formal facilities; include services available, access to the services and cost to get the services.	<i>Mapping</i>
4.	Analysis on health seeking behaviours of pregnant women, post partum women, for infants and children under five years old.	<i>Mapping Mobility</i>
5.	Social perceptions of people on the concept of healthy /illness	<i>FGD</i>
6.	Social perceptions of people on the concept of poor /rich	<i>FGD</i>
7.	Social perceptions of people on emergency situations during pregnancy, giving birth; or maternal/infant or complication cases	<i>FGD</i>
8.	Social perceptions on period of earning money/working; period of crisis and availability of food.	<i>Calender</i>
9.	Behaviours on feeding/eating during pregnancy, post partum, taboos.	<i>FGD</i>
10.	Analysis on feeding behaviours for infants	<i>FGD + calender</i>
11.	People's perception on FP including issues/barriers regarding FP.	<i>FGD</i>
12.	People's concepts on marriage including age and preparation for getting married	<i>FGD</i>
13.	People's concept on men and women's social roles	<i>FGD</i>
14.	Analysis on work burdens of men and women and their roles in society	<i>One day activities</i>
15.	People perceptions on menstruation	<i>FGD</i>
16.	People perceptions on disease outbreaks that have happened and how to overcome the outbreaks.	<i>FGD</i>
17.	Information on the ownership of the means of transportation and communication.	<i>Interview/ observation+ mapping</i>
18.	Information on the village development budget and its allocation to the health program at the village level.	<i>Interview</i>
19.	Information on village/community organisation/institutions	<i>Diagram venn</i>
20.	Information on migration and its impact on women's health	<i>FGD</i>
21.	Information on the number of deliveries assisted by TBAs and midwives within the late 3 months.	<i>Interview</i>
22.	Information on potential blood donors and their blood types.	<i>Interview + observation + mapping</i>
23.	Information on the existing traditions of helping each other when emergencies happen or when someone dies or gets married or other forms of helping each other.	<i>FGD</i>

Work Sheet 2

A form that consists of topics with techniques included but the columns of kind of information and participants/respondent to gather the information are empty as below:

	Topics Analysis	Techniques	Kind of information gathered	Respondent participants
1.	Analysis on the social structure of the society	Mapping		
2.	Analysis on the geographical location of the health facilities both formal and informal including access of transportation to reach the facilities and cost of transportation.	Mapping		
3.	Analysis on services available in both formal and non formal facilities; include services available, access to the services and cost to get the services.	Mapping		
4.	Analysis on health seeking behaviours of pregnant women, post partum women, for infants and children under five years old.	Mapping Mobility		
5.	Social perceptions of people on the concept of healthy /illness	FGD		
6.	Social perceptions of people on the concept of poor /rich	FGD		
7.	Social perceptions of people on emergency situations during pregnancy, giving birth; or maternal/infant or complication cases	FGD		
8.	Social perceptions on period of earning money/working; period of crisis and availability of food.	Calender		
9.	Behaviours on feeding/eating during pregnancy, post partum, taboos.	FGD		
10.	Analysis on feeding behaviours for infants	FGD + calendar		
11.	People's perception on FP including issues/barriers regarding FP.	FGD		
12.	People's concepts on marriage including age and preparation for getting married	FGD		
13.	People's concept on men and women's social roles	FGD		
14.	Analysis on work burdens of men and women and their roles in society	One day activities		
15.	People perceptions on menstruation	FGD		
16.	People perceptions on disease outbreaks that have happened and how to overcome the outbreaks.	FGD		
17.	Information on the ownership of the means of transportation and communication.	Interview/ observation+ mapping		
18.	Information on the village development budget and its allocation to the health program at the village level.	Interview		
19.	Information on village/community organisation/institutions	Diagram Venn		
20.	Information on migration and its impact on women's health	FGD		

	2 Information on the number of deliveries 2 assisted by TBAs and midwives within the 1 late 3 months.	Interview		
	2 Information on potential blood donors and 2 their blood types.	Interview + observation + mapping		
	Information on the existing traditions of helping each other when emergencies happen or when someone dies or gets married or other forms of helping each other.	FGD		

The guidelines can be seen in separate document.

SESSION 8:

FACILITATION

Role of facilitation:

- Facilitation is a process to accompany, to ease and assist people to understand and to take action in order to solve their own problems together.
- The facilitation process aimed at exploring and managing the varied strengths and differences so that people will have similar visions and understanding on solving their own problems. To do this, there is a need to encourage people to think, to analyse critically their own conditions and identify their own problems so that they will be able to have a new vision and awareness that triggers them to take action to improve their conditions. Their action then will be re analysed, re thought, in order to have lessons learnt for leading towards further action. The facilitation process will go as a cycle and never stop, like the cycle of the PLA Approach in the previous session.

Gender sensitivity and poverty in facilitation

- Gender

In the facilitation process, most often the process is dominated by men and the attendance of women is ignored without taking any role

- Poverty

The poor have fewer opportunities to take roles because it is dominated by the elite

In order to increase capability of facilitation there is a need to maintain self motivation.

Self motivation driven by

- Achievement motive: need for achievement, to get success, to improve and become mature in facing challenges
- Affiliation Motive: need for affiliation
- Power Motive: need for power

Technique for self motivation

- Develop self confidence
- Self - discipline

Skills for an effective facilitator

- Good listener
- Good in comprehending
- Good communicator
- Good time management
- Analysis and deductive reasoning skills

SESSION 9

THE VILLAGE MEETING

Aims:

- To analyse MNH conditions altogether
- To identify MNH problems
- To understand the potentials and resources owned by the villagers
- To disseminate the concept of community empowerment in MNH
- To raise people's commitments to establish an Alert System in MNH

Participants of the meeting

- The head of the village
- The head of sub-village
- The village midwife
- The village parliament
- The Health centre staffs
- Representative of people who joined the small group discussion/interview
- The village women's organization
- Cadre
- Staffs member of the sub-district office
- District Health Officers

Total participants: about 40 persons

Venue: the village office or other venue

Time: 8 am- 4 pm

Agenda:

- Opening speech and introduction
- Presentation of the results of the MNH Analysis and potential and resources owned by the people
- Presentation on the concept of community empowerment in MNH
- Group discussion
- Commitment to establish the Alert System

Monitoring and evaluation of the training

Monitoring of the training process is done by conducting daily evaluation using following form:

Quality of delivering the content of the session		Very Good	Good	Not Good	Bad
1.	Relevance of the training content to the training output	Very Good	Good	Not Good	Bad
2.	Improving skills and knowledge	Very Good	Good	Not Good	Bad
3.	Learn from each other	Very Good	Good	Not Good	Bad
4.	Relevance to the roles as facilitator	Very Good	Good	Not Good	Bad
5.	Training logistics	Good	Good	Not Good	Bad

Note:.....

End Evaluation

This is done at the end of the training session before the closing ceremony. Try to browse the results of the training so clarifications can be made before the training is closed.

Evaluation form

Instruction

Circle the number based on your opinion. There are 5 choices to be chosen and each number has the following meaning:

- 1 = Agree alot
- 2 = Agree
- 3 = No opinion
- 4 = Do not agree
- 5 = Do not agree alot

Content of the training

1	The objective of the training achieved very well.	1	2	3	4	5
2	This training fulfilled my expectation	1	2	3	4	5
3	The training content can be applied in my roles as facilitator because it was very practical	1	2	3	4	5
4	The training material is benefit to my own development	1	2	3	4	5
5	I was able to understand the training material given in this training	1	2	3	4	5
6	I was actively involved in this training	1	2	3	4	5
7	This training considering the local condition and culture that for me is important in facilitating the community	1	2	3	4	5
8	The following topics is useful for my understanding: <ul style="list-style-type: none"> • PLA Approach • Participation and community empowerment MNH and gender • Reading, understanding and analysing the PLA techniques • Making a map • diagram Venn • Interview • As facilitator of community empowerment in MNH at the field 	1	2	3	4	5
9	Positive aspects of the training topics : <ul style="list-style-type: none"> • PLA techniques with visualization help me to understand the MNH condition • Hand out as references for following the explanation clearly • Work groups and practices at the class room for understanding the PLA techniques and media • Explanation of the facilitator can be comprehended well • Has learn about PLA and the process of community empowerment in MNH • Participants understood about community participation 	1	2	3	4	5
10	The weakness of the training topics					

B. Capability of the training facilitators

1	The trainer had delivered all training materials clearly and effectively	1	2	3	4	5
2	Your opinion on the collaboration of the trainers	1	2	3	4	5
3	Comment on the effectiveness of the trainers:					

C. Training logistics and organization

1	Accommodation	1	2	3	4	5
2	Food	1	2	3	4	5
3	Class room	1	2	3	4	5
4	The training committee always provided the needs of the participants	1	2	3	4	5
5	Proposal for the training committee if any:					

D. Other comments:

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TRAINING II

MANUAL GUIDELINES & HANDOUT

TRAINING MANUAL FOR FACILITATORS IN COMMUNITY EMPOWERMENT
IN MNH FOR ESTABLISHMENT OF THE ALERT SYSTEM



MATARAM, 2009



gtz

TRAINING TWO

MANUAL COMMUNITY EMPOWERMENT IN MNH FOR ESTABLISHMENT OF THE ALERT SYSTEM

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GUIDELINE: CONDUCTING MEETINGS ON THE ESTABLISHMENT OF THE ALERT SYSTEM IN THE PROCESS OF COMMUNITY EMPOWERMENT IN MNH 124

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DEVELOPMENT OF TOOLKIT ON COMMUNITY EMPOWERMENT IN MATERNAL AND NEONATAL HEALTH TEAM

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Lay-out and Design of the toolkit

Karsten van de Oord

SESSION 1:



Review activities done by the participants after attending the first training and the linkages of the first to the second training

Specific learning objectives

At the end of the session, the participants will be able to:

- Review the main topics of the first training program, the activities that have been conducted after attending the first training and introduction to the second training
- Review the Community Empowerment Concept in MNH and the Community Based Alert System in MNH

Time: 2.25 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- Portrait of the village in MNH

Activities 1: Reviewing the main topics of the first training and link them with the second training

This training follows the first training, so there is a need to review:

- The main topics of the first training
- The activities that have been conducted after attending the first training
- The facilitation roles that have been performed by the participants after attending the first training
- The results of the self assessment MNH survey
- The linkages between the first and the second training

Group the participants based on their areas or health centre areas where they come from and ask them to discuss the following topics:

- What roles have been conducted with their community members in the context of community empowerment in MNH?
- What is the aim of their facilitation work in the context of community empowerment in MNH?
- What activities have been conducted after attending the first training before coming to this second training?

Ask each group to present the results of the group's work. Focus the information towards explaining that the self assessment survey was aimed to draw a portrait of MNH conditions and the potential and resources owned by the villagers.

The portrait describes:

- Health services and facilities available at the village¹
- Health seeking behaviours²
- Social perceptions about various topics
- Maternal and infant death cases
- Women's and men's work burden

Potential or resources owned by the villagers:

- Health facilities available at the village
- The village development budget
- Community organizations or institutions including the systems of ownership of:
 - Means of transportation
 - Communication
- A list of potential blood donors

Thus, the results of analysis on the MNH condition are depicted in the MNH portrait³. From the portrait it can be seen that the villagers have a MNH problem and to overcome the problems the people plan to establish an Alert System as one of the solutions.

Ask the participants to go back to their groups and discuss the following topics:

- What health problems have been identified from the portrait? List them for each village.
- Why do people feel the need to establish an Alert System?
- Who have the participants talked with about the Community Empowerment in MNH Concept who can support them to organize people in establishing the Alert System?
- What roles can the stakeholders take regarding the establishment of the Alert System?

After presentation of the results of the group discussions, give emphasis that each village has MNH problems and people's intentions to overcome the problem become the basis of why the Alert System needs to be established.

Before closing this session, again give emphasis that the MNH portrait of each village including the village potentials and resources had been drawn, each village has MNH problems and the establishment of the Alert System becomes the effort to overcome the MNH problems. Therefore, as the village facilitator the participants have the role to facilitate the rest of the villagers in establishing an Alert System. The participants of the second training will be equipped with skills and knowledge on facilitation of how to organize people in establishing an Alert System.

¹ **TIP:** In Indonesia buildings such as the Village Midwifery Post are owned by the village who are responsible for upkeep. On other countries it maybe the PHC Post or ownership is by the religious body. It is important for the community to know who is responsible for the upkeep and plan for this and ensuring the building is included in plans for basic services such as water / sanitation.

² **TIP:** In Indonesia village administration is usually allocated a development budget. This may not be so in other countries and on the other hand it maybe available but not distributed. In many countries villages have very small populations so the budget maybe allocated to a sub district level. Pro active villages are more likely to be able to source such budgets.

³ **TIP:** With assistance from SISKES resources each village have copies of a detailed document (the portrait) containing in addition to facts from the self assessment, photos and drawings so that it is interesting to read. The document was compiled by those involved in the assessment. SISKES resources included access to: advisory, computer use, photocopy including colour for photos and stationary. A copy of a portrait is included in this toolkit.

Activities 2: Organizing people in establishing their own system of helping each other

Tell the participants that people should have their own initiatives to organize themselves to solve their own problems, such as the system of helping each other when someone gets married, when someone dies, and when they do fund raising for celebrating religious ceremonies.

Take one or two of these systems as an example to explain:

- How the system occurred?
- Why it occurred?
- Who facilitated it?
- How it works?
- What is the mechanism or procedure?
- Who coordinates?
- How is the feedback report given to the community?

Take these examples from the portrait of the village that has been developed from the analysis of MNH condition and the potentials in order to make it clear to the participants. The example can be seen in Handout of Session 1.

Before closing this session make emphasis that self organizing by the community happens because one of them took the role as facilitator to organize the others in establishing the system. Thus, facilitation for organizing people is required and the participants of this training will do similar things in their own communities after attending this training, "to organize your community for establishing an Alert System". Through this training the participants will be equipped with knowledge and skills on how to organize their community to establish an Alert system, how to conduct meetings and how to develop guidelines on facilitating their community.

SESSION 2:

Participants' expectation and ground rules of the training

Specific learning objectives

At the end of the session, the participants will be able to:

- Develop their learning expectations
- Developed ground rules for the training program

Time: 1.5 hour

Material:

- Soft board with pins
- White Board and board makers
- Flipchart paper
- Coloured cards

Activities 1: Developing training expectations by the participants

Although the training has been warmed up with the review and linkage of the first and the second training, the participants need to set up their expectations for this training, and set ground rules for achieving their expectations.

Lead the participants to write their expectations for this training program by explaining:

- What has been done (the results of session 1)?
- What is going to be done (to facilitate the establishment of the alert system)?
- Where they are now (meaning what needs to be learnt in this training to facilitate the establishment of the alert system)?

Distribute Coloured cards to each participant and ask them to write their expectations and concerns in achieving the expectations.

The cards are then categorized using the following categories by priority, using a specific sign for each category: 1. it could be achieved through the training program, 2. it is impossible to achieve within this training program and 3. it could be achieved by putting some effort into it.

Post the training goal, objectives and output of the training and compare them with the expectations and the concerns written by the participants.

Output of the training:

- Increased understanding of community organizing for establishment of an Alert System in MNH
- Development of a Guideline for facilitating the establishment of an Alert System in MNH
- Improved capability on facilitating meetings for the establishment of an Alert System in MNH
- Development of a plan of action on conducting meetings for the establishment of an Alert System in MNH in each village.

Explain methods that will be applied in the learning process of the training:

- Brainstorming
- Case studies
- Group discussions
- Presentations
- Work group
- Individual practice

Give emphasis on the importance of active participation in the learning process in order to achieve the training outputs.

Explain that in addition to the training program, during the training there will be an activity to review what have been learnt in the previous day and evaluation of the daily training process. This activity will be conducted by the participants in small groups so there will be a duty group for each day. The duty group will have the following duties:

- Review: to remind what had been learnt during the previous day and to re-check whether there are topics that need to be discussed again in order to make sure the topic is understood before moving to other topics. The review can be combined with the morning energizer.
- Daily Evaluation: to assess the progress of the training so the training is on track. At the presentation of the daily evaluation results, the facilitator should pay attention to the results and always allocate time to discuss in order to improve the training process to achieve the outputs of the training.
- Energizer: is an activity to motivate / encourage participants in the learning process. In the entire process of the training, energizers from the facilitator can be used to form the group discussion so the participants will not get bored.
- End Evaluation: to assess to what extent topics are understood, capability of the facilitator, training organization, and feedback for improving the next training.
- Post the expectations and concerns as well the goal of the training where everyone can see them. Periodically review them to ensure coverage.

Activity 2: Setting Ground Rules

Explain to the participants that in order to have an enjoyable and productive training environment, certain ground rules have to be developed by the participants. Solicit ideas from them, which may include the following aspects and write the agreement on flipchart paper:

- Participants will keep to the training schedule, coming on time to the sessions
- Participants will respect each other's opinions and contributions
- Participants will listen attentively to each other and to the facilitators
- Answering and receiving mobile phone calls

Post the rules on the wall for the entire training period for reference.

Before ending this session, ask the training committee to explain the policies, regulations regarding accommodation, per diem, and other relevant issues.

SESSION 3:

The Concept of the Alert System in MNH and Behaviour Change

Specific learning objectives

At the end of the session, participants will be able to:

- Strengthen their understanding on the concepts of the Alert System in MNH and the Alert Network
- Understand behaviour change in relation to the establishment of an Alert System

Time: 1.5 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards

Note for the facilitator:

This session will review the concept of community empowerment especially about the Alert System and the network of the system, who should be involved in the process of establishment and what behaviours are expected to happen by facilitating people in establishing the Alert System. In addition, the establishment of the Alert System is one of strategies to create behaviour change in the community. People's behaviour can change because of their environment and if there are rules or a consensus that enforces the change.

Activities 1: The Alert System Concept and Behaviour Change

Explain to the participants that community organizing for establishment of the Alert System is an effort to change people's behaviour regarding MNH especially in making pregnancy and delivery safer.

Group the participants into 4 small groups and ask them to discuss the following topics:

- How many Alert Systems will be established by the community?
- Ask them to mention the systems and draw the network of each system.

Discuss the results of the group discussion and give a presentation on the Alert System and its network, put emphasis on the meaning of the system and who should be involved. Allow time for clarification through questions and answers. See Handout of Session 3.

Ask the participants to go back to their previous small groups and ask them to discuss behaviour changes that are expected to happen by establishing the Alert System.

Discuss the results of the work groups in a large group and give emphasis that behaviour can change by enforcing rules. In this case the community will establish their own system through raising consensus that will rule them in helping each other. By applying their own consensus they will create an environment that enforces them to change.

SESSION 4:



Organizing the Community for establishment of the Alert System in MNH

Specific learning objectives

At the end of the session, participants will be able to:

- Understand community organizing
- Understand the process and components of community organizing
- Understand attitudes, ways of thinking and the skills owned by those facilitating the process of community organizing

Time: 2.25 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards
- Case studies

Activities: Case Study

Note for the facilitator:

In this session, the participants will be facilitated to understand that the establishment of an Alert System is an effort to solve problems that are large in scope and for the long term.

Why the establishment of the system is large in scope and a long term solution? It is because having a system in helping each other, any member of the community whenever they need help will get the help because they have their own consensus to help each other. In other words, the solution is not only for certain people but for everybody who stays and lives in the areas where the system is established.

Group the participants into 4 small groups and give each group a different case each to be studied (the example of a case can be seen in the handout of this session). Each group will discuss the following questions:

- What happened in the case study that you received?
- How could this case be handled, taking into account large scope and long term sustainability?
- Who should be involved in solving the problem?

Present the results of the work groups and discuss together in a large group. The discussion

emphasizes how to solve the problem by considering large scope and a long term solution. Not only will this help similar cases but as a strategy in order to prevent these cases happening in the future. In this session each group will develop a solution to establish each system for their case study:

- Notification system
- Transportation and communication system
- Financial support system
- Blood donation system

Activities 2: Presentation

Present PowerPoint on the principles of community organizing. Allow time for a question and answer session. Put emphasis that in order to solve a problem with large scope for a long term solution, there is a need to organize people to establish an Alert System in MNH. Link this presentation to the community organizing done by the community itself such as helping each other when someone dies or when someone gets married. Allow time for a question and answer session.

What is organizing the community?

- Mobilizing the community for their own interests
- Mobilizing the community for certain goals
- Encouraging people to change for the better or improve

Characteristics of organizing work

- Character
 - Spontaneous
 - Planned/organized
- Scope geographical
 - Large
 - Limited
- Scope of change
 - Temporary
 - Permanent/ Structured

Levels of participation

- For natural mobilization, it does not require many activities at the beginning. One example is a funeral
- For planned mobilization with low levels of change and small scope areas, requires other partner involvement
- The larger scope will be achieved
- By more partner and or resources being involved
- By more varied components being involved horizontally and vertically (Village Health Post, Health Centre, District Health Office and other relevant institutions)

SESSION 5:

Development of guidelines for conducting a meeting on establishing an Alert System in MNH



Specific learning objectives

At the end of session, the participants will be able to:

- Develop guidelines in facilitating people on establishing an Alert System.
- Develop forms for monitoring and evaluation on the functioning of the established Alert System.

Time: 9 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards

Activities 1: Step 1 in the development of the guidelines

The main point of the community organizing in MNH is to organise the villagers to establish an Alert System in MNH. To do so, the villagers are facilitated to conduct meetings for the establishment of community based “helping each other” which is the Alert System in MNH that consists of 5 systems. In order to enable the participants to facilitate the meetings, a guideline is required.

To ease the participants into understanding and to apply the guidelines, the participants are involved in the development of the guidelines through steps of discussion. The guideline will be used for facilitating the villagers in conducting meetings on the establishment of the Alert System after attending this training.

Ask participants to go back to their previous small groups of the case study. Each group is to develop a guideline for the establishment of one alert system as the solution of their case study, so, with the four small groups assign a system:

- The establishment of a notification system
- Provision of transportation and communication means
- Financial support
- Blood donation systems

Ask each group to discuss the following topics based on the Alert System that will be established:

- What preparation should be done before conducting a meeting on establishing each alert system?
- What messages will be conveyed during the meeting?
- What points should be discussed in the meeting?
- What points should be agreed as the output of the meeting?
- Who should attend the meeting?
- In which level of the meeting should there be an assessment of the people in accessing the functions of the Alert System?

Each group presents the results of the group work. Discuss in detail in the large group to get an agreement from all participants for the guidelines of each system. By conducting this discussion participants will have guidelines on:

- Preparation before conducting the meeting
- The messages to be conveyed during the meeting
- Points of consensus raised from the meeting
- Where the meeting should be conducted (sub-village or village level)
- Who should be involved in the meeting for each Alert System

Activities 2: Step 2 in the development of the guidelines

Ask the participants to go back to their previous small groups to discuss:

- What sort of information needs to be recorded to show others that the established system is functioning?
- Develop a form to accommodate the recorded information

Present the results of the work group and facilitate discussion in order to get an agreement by all participants on the topics discussed for each system. Type and print the form with the information developed by the participants. Discuss a form for monitoring the functioning of each system at the levels of sub-village, village, district and province.

The kinds of information that can be documented to assess the functioning of the system are listed below. This can be added depending on what information has been covered by the participants:

Notification System

- Name of the household head and the members
- Name of the pregnant women and their husbands
- Age of pregnancy⁴
- Number of pregnancy
- Date of delivery, where and who assisted

⁴ **TIP:** This refers to the gestation of the pregnancy or weeks pregnant. Another category such as the age of the pregnant woman could be added to monitor the “too” young or old women.

Provision Transportation and or Communication System

- Who gave help
- Name of the owner of transportation and or communication
- Address
- Date
- Destination
- Who received help
- Cost if any

Blood Donation System

- List of the names of the potential blood donors
- Address based on the blood type⁵
- Date of event
- Name of who received blood donation
- Name of who gave blood donation
- Type of the blood

Financial Support System⁶

- The savings of pregnant women (Tabulin):
 - Name of the pregnant women
 - Book keeping
- Social health fund (Dasolin):
 - Income
 - Outcome
 - Who got support and amount
 - Balance of the fund
- **Family Planning Information Post**
 - Date
 - Name who enquired about information
 - Kind of information given
 - Needs to be followed up

Through this step the participants will have guidelines on:

- The forms for recording each system
- The forms for monitoring the functioning of each system

Before closing this session, print and distribute the guidelines to all participants, ask them to keep them in their folder. These guidelines are tools when organizing the community in establishing the Alert System of MNH. The developed guideline can be seen as a separate document.

⁵ **TIP:** The development of the blood donor register for the village in NTB Province is assisted by Indonesian Red Cross who will visit the village, explain blood donation principles and test people's blood group. Usually in Indonesia similar to other countries if people need a transfusion they are normally asked to provide someone who can donate a replacement unit back into the Blood Bank. The patient may need to provide a processing fee or are covered by social health insurance, donated blood lessens the cost and is also a safer source of blood for transfusion vis a vis blood obtained through payment.

⁶ **TIP:** The financial system is grounded in traditional systems of raising funds. In the Tabulin system each pregnant woman contributes a small amount each week to be used for emergencies. If it is not required the amount is given back following the birth. It is similar to a revolving fund. In the traditional system women often put money into a fund each week and then take it in turns to receive the collected amount.

SESSION 6:

Role playing in facilitating the meetings in establishing the Alert System

Specific learning objectives

At the end of the session, participants will be able to:

- Facilitate the meetings in establishing an Alert System

Time: 11.25 hours

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper

Note for the facilitator

After attending this training the participants will take the role to facilitate the villagers to organize a meeting for establishing an Alert System. In order to increase their skills in facilitating the meetings, the participants will do a role play on facilitating the meeting of establishing an Alert System. This practice is conducted in the class room because after conducting each role play, there will be a reflection on each. The reflection covers the following points:

- Opening the meeting or introduction
- Messages conveyed during the meeting
- Points of consensus
- Closing the meeting
- The technique on facilitating discussion during the meeting

Before conducting this role play, participants should read the guidelines that have been developed together in the previous session.

Activities

Tell the participants to prepare themselves for doing the role play. Explain to them that each participant has to do a role play on facilitating a meeting of establishing each system. In the role play, one participant will facilitate the meeting and the other will be a participant of the meeting.

Each will take a “lucky dip” to determine which system will be facilitated in the role play. Make a list of participants with his/her system to be facilitated. Give a chance to those who are ready to facilitate the meeting for doing the role play.

After each role play, facilitate the participants to provide feedback that covers the following points:

- Message delivered in the meeting:
 - Why they called people for the meeting?
 - What for?
- Points discussed during the meeting
- Points of agreement
- Skills in facilitating the meeting

SESSION 7:

Monitoring meetings at the village and district levels

Specific learning objectives

At the end of the session, participants will be able to:

- Understand village meetings as a tool for monitoring and evaluation on the functioning of the established Alert System
- Understand the village meeting as a coordination forum and network Alert System amongst the sub-village and with other institutions
- Understand how to facilitate the village and or district meeting

Time: 1 hour

Material:

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper
- Coloured cards

Briefing on this session

The established system is not only for establishing the systems but is important as the consensus to be applied by people to help themselves when facing emergency situations. In order to know the functioning of the established system, there is a need to monitor and evaluate at village level or at district level. The aims are to learn the successes and failures of community empowerment in MNH.

Activities:

Present what is monitoring and evaluation and the aims of monitoring and evaluation in the context of community empowerment in MNH.

Explain the forms for monitoring and evaluation of the established Alert System and who should join the monitoring and evaluation meetings at village level, district level and the agenda for the meetings.

The monitoring and evaluation meetings can be done as a "piggy-back" onto other meetings organised at village and or district level and it can be done quarterly both at village and district levels.

SESSION 8:

Development of the Plan of Action in facilitating the establishment of the Alert System and evaluation for entire training program

Specific learning objectives

At the end of the session, participants will be able to:

- Develop a Plan of Action in conducting meetings for establishing an Alert System in each village
- Develop a Plan of Action in conducting monitoring meetings in the village
- Understand technical, financial, logistic and administration issues in implementing the Plan of Action, if any
- To know the achievements of the training
- To get feedback for improving the next training

Time: 3 hour

Material

- Soft board with pins
- Whiteboard and board makers
- Flipchart paper

Brief on the session

The role of facilitation will be done by the participants after attending this training to facilitate their community members in organizing meetings for establishing an Alert System. In order to plan and to coordinate the meetings, participants are asked to develop a Plan of Action. After developing the Plan of Action, give explanations on the kind of support provided by institutions that support this program, if any, for implementing the Plan of Action.

Activities 1: Development of Plan of Action

Ask the participants to work in groups based on areas, either health centre areas or district areas where they come from, to develop a Plan of Action in organizing a meeting for the establishment of an Alert System in each village (the establishment of the four (4) parts / systems plus conducting training on family planning and monitoring meetings). Ask them to consider preparation, administration and logistic support when developing the time line of doing the planned activities⁸.

Compile each Plan of Action, and distribute to each participant as their road map in conducting his/her activities after attending the training.

Activities 2: Provision of support for implementing the developed Plan of Action

Invite resource people who provide support to this program to explain the kinds of support that are maybe available for implementing the developed Plan of Action. Allow time for questions and answers and write what has been agreed for provision of support.

⁸ TIP: The participants should try and keep inputs simple and what is available locally. If they require assistance they ought to think of “help with stationary and photocopying” rather than requests for a photocopier! Donors are more likely to fund small inputs when a well thought out Plan of Action is available.

Activities 3: Training Evaluation

Explain to the participants about the evaluation of the entire training process, topics and facilitations.

Distribute the evaluation sheets and explain how to fill in.

Browse quickly the evaluation results and discuss them to get improvements for the next training.

GUIDELINES

Conducting Meetings on the Establishment of the Alert System
In The Process of Community Empowerment in MNH

FOREWORD

This guideline is a reference for the facilitator in community empowerment for conducting meetings in establishing the Alert System in MNH, namely; notification system, system on provision of means of transportation/ communication, financial support and blood donation.

This guideline has been developed by the participants of the second training of community empowerment in the MNH program. This guideline used a participative approach and was developed based on the needs of participants in facilitating the process of establishment of the Alert System. The language in this guideline is often in the “first person”, recognizing the participative approach of development i.e. “we the people”.

Any improvement of this guideline based on its application in the field is welcome.

GENERAL PREPARATION

Facilitation work for the establishment of Alert System is a follow up from the previous facilitation work that has been done in the process of community empowerment in MNH.

For the facilitation of the Alert System establishment the village facilitator needs to continuously keep communication and collaboration with all components of the community at the village in order to raise their awareness on establishment of the Alert System, such as the head of the village, influential leaders and the village midwives or other health personnel within the village. In addition the village facilitator needs to keep communication and collaboration with the network of each system that exists outside of the village such as the health centre, sub-district office and other relevant institutions and personnel such as FP field workers.

Thus, keeping communication and coordination with various parties is important in order to disseminate the concept of the Alert System as well as to get support in organizing people in the facilitation process of establishing the Alert System so that all parties are aware of the importance of the system.

ESTABLISHMENT OF THE COMMUNITY BASED NOTIFICATION SYSTEM

Facilitation work for the establishment of notification system will proceed through conducting a meeting that involves all components in the community at the sub-village level including the network of this system. Therefore, prior conducting the meeting, it is important to do preparation such as:

Before conducting the meeting

The following are activities that should be done before conducting the meeting:

- Hold discussions with the head of the sub-village and have a "friendly" talk about the plan for conducting the meeting for the establishment of the notification system
- Discuss the people who will be invited as the participants of the meeting
- Discuss venue, date and time for conducting the meeting
- Discuss topics and materials for the meeting.
- Discuss cost of the meeting, arrangement for snacks, drinks etc
- Prepare a list of attendance of the meeting
- Prepare an invitation letter and its distribution

Notes:

- Using a written invitation or not for the participation is a choice that refers to the local situation.
- Participants: try to have representatives from all components at the sub-village.

Key messages as the background of calling this meeting

In the meeting it is very important to deliver key messages that become background of why this system needs to be formed.

Following are the main points of information or messages that should be delivered for establishment of the notification system:

- Generally each sub-village as a part of the village government administration system and does not have notification system to monitor the change of its population. As a consequence, it is hard to know how many people exactly live our sub-village
- Further consequences; if any disaster happens, such as flood, volcanic eruption, fire or other types of disaster it is difficult to find out how many people become victims or the number of people that will need our support or need to be supported.
- Therefore, it possible for us living in the sub-village to start to have a sort of system that records the people who stay here with changes so that we know who exactly lives in our sub-village.
- Regarding MNH, the problem that is still faced in the overall province are areas with a high number of mothers who die because of pregnancy and giving birth. This problem requires our attention and commitment. Emphasize that "the women who die could be one of our relatives, could be our own mother, could be our daughter; could be our wife and could be our sister. Similar to infant death, the infant who dies could be our baby,

could be our younger sister or brother, could be a baby of our sister or brother and could be a baby of our neighbor. Therefore, it is our problem, so together we need to make an effort to make maternal and infant death our responsibility. In this context, could we agree to establish a recording system of pregnant women in order to record the existing pregnant women because if the pregnant women do not go to ANC at the mobile clinic or health personnel she will not be recorded in the mobile clinic system or in the health system. As a consequence if something happens when she gives birth it is hard for people around her to give help. Therefore, the existence of pregnant women needs to be recorded in the notification system of the sub-village so that the target of mobile clinics is clearly known.”

- We have found that women who get pregnant at an older age are too ashamed to go to ANC at mobile clinics or health facilities. In fact, pregnancy at an older age needs to have special care for safer delivery. Similar cases happen to younger women who get pregnant without being married; they are too ashamed to go to ANC. In this regard, it is hard to accept what happens but in fact those young women need our support in order to have safer deliveries and a healthy baby. Therefore, if we establish a notification system in the sub-village, the women who get pregnant at an older age or who are pregnant without being married will be recorded, will get support to go to ANC and when giving birth.
- In recent years, outbreaks often happen such as dengue, malaria and so on. Because we do not have data on the number of people who get the diseases it is hard to ask support for assistance from the relevant institution for curative or preventative help. Therefore, establishment of a notification system on disease outbreaks is required in order to have data and use the data for developing strategies to eliminate the cases.
- Regarding the health finance program for the poor, it often happens that the number of the identified poor is more than the number of distributed cards. In order to facilitate discussion of this topic, it is worthwhile to include a record of people who have and use the card in the notification system in order to discuss this topic with the relevant decision makers because there is no data right now on the number of people who hold the card and who use the card in health facilities.
- If we have a consensus to form this system, it is not too hard to do the recording because it is recorded when someone has the case that needs to be recorded so that it does not have any cost. For example; everyone should record her/him self or his/her family members to the volunteer recorder who are agreed by the community members when there are cases that need to be recorded and the information needs to be updated when there is a change taking place in the family (such as: death, moving in or out, birth). For pregnant women, it is compulsory for her to record herself to the volunteer recorder when getting pregnant and after giving birth in order to record: when, where and who assisted her delivery.
- This notification system will monitor the usage of health budget for the poor by who are holding and using the card by recording her/himself to the volunteer recorder so the usage of the budget can be monitored and the planning and the usage of health care could be improved.

Points needed to be discussed during the meeting

Following are the points that need to be discussed in order to raise a consensus to form the system:

General information on the population of the sub-village

- Information on the population of the sub-village, kind of information that needs to be recorded in the system:
 - Name of the household head
 - Include all members of the household
 - Education
 - Occupation
 - Age
 - Sex
 - Record marriages, deaths, births
 - Record moving in or out
- Mechanism or procedure of the recording (when changes happen in the family, it should be reported to the volunteer recorder).
- Who wants to be a volunteer recorder and how many of them, refers to geographical areas of the sub-village?
- Who should be responsible to record/update the information?
- Where the recording should take place
- When the recording should take place
- Selection of the volunteer recorder

Information on the usage of the poor card

- Kind of information to be recorded:
 - Name the card holder
 - Sex
 - Age
 - Address
 - When using the card, in which health facilities and what services obtained
- Mechanism or procedure, those who using the card should report to the volunteer recorder
- Who will be the volunteer recorder?
- When the recording should be done?

Information on the MNH

- Kind of information to be recorded:
 - Name
 - Address
 - Age
 - Number of pregnancies
 - Age of the pregnancy when recorded
 - Date of giving birth
 - Place of delivery and who assisted the delivery
 - Name of the baby
 - Sex
 - Weight when born.

- Mechanism or procedure of recording (any case should be recorded to the volunteer recorder).
- Who wants to be a volunteer recorder and how many of them, refers to geographical areas of the sub-village?
- Who should be responsible to record/update the information?
- Where the recording should take place
- When the recording should take place
- Selection of the volunteer recorder

Information on disease outbreaks

- Kind of information to be recorded:
 - Malaria
 - Dengue
 - Diarrhoea
 - Avian influenza
 - Diseases of concern in your area
 - Name of person, sex, age and address of who got sick
- Who should be responsible to record/update the information?
- Where the recording should take place
- When the recording should take place
- Selection of the volunteer recorder

Who should be involved at the meeting?

Participants should be involved from the following components of the community:

- Community leaders
- Religious leaders
- The head of neighbourhood
- The head of sub-village
- Adolescents (male and female)
- Pregnant women and their husbands
- Cadres
- TBA
- The head of the village
- The village midwife
- Personnel at health centre
- The health centre staff members
- Household heads

Note:

The number of the participants should consider:

- Large areas
- Representative of the population
- Capacity of meeting venue in accommodating the meeting participants

ESTABLISHMENT OF THE COMMUNITY BASED PROVISION OF MEANS OF TRANSPORTATION AND COMMUNICATION

Facilitation work for the establishment of the provision of means of transportation and communication will be done by conducting a meeting at the sub-village level. Prior to the meeting, the village facilitator should do following preparation:

Preparation before conducting the meeting:

The following are the activities that should be done before conducting the meeting for the establishment of the system in provision of transportation and communication means:

- Have a coordination with the head of the village/ sub village to discuss the plan to hold a meeting for the establishment of this system in order to get support
- Discuss about the date, time and venue of the meeting
- Discuss about the participants of the meeting
- Discuss about the cost of the meeting and arrangement of the snacks and drinks
- Prepare the list of people who own means of transportation and communication in the sub village areas
- Writing and distribution of the invitation
- Prepare the list of attendance

Messages/information should be delivered in the meeting

In the meeting it is important to deliver key messages on the background of why this system needs to be formed. Following are the main points of the information/messages to be delivered in the meeting of establishing this system.

- Any emergency case such as giving birth, sick infants and children under five and other conditions can happen at night when public transport is not available. As a consequence, the family members often delay in seeking help or delay in bringing those who get sick to the health facilities because they have no means of transportation.
- It is often happens that emergencies cases are late to be brought to the health centre because of the long distance and cost of transportation is expensive, especially at night.
- Not everyone owns a means of transportation and communication.
- There is no public transportation that is on call for 24 hours any time.
- If there is a neighbour who possesses the means of transportation or communication, often people are shy to wake them because people never discuss about helping each other in the usage of means of transportation and communication.
- It is often happens that the owner of the transportation and or communication means do not know of any emergency that has happened around them, especially emergencies regarding pregnancy and giving birth.
- The ownership of communication means is diverse but there is no awareness on helping each other on the usage of the device in emergency situations, in fact assistance could be reached quickly when using a communication system.
- Considering the emergency cases that happen around us, we need to discuss this

issue to raise a consensus to help each other in the usage of the means of transportation and or communication because in this sub-village many people possess a means of transportation and or communication.

Points needed to be discussed in the meetings

Following is the points that need to be discussed in the meeting for establishing the transportation and or communication system:

- Who are the owners of the means of transportation and or communication that will take part to provide means of transportation and or communication in the system? Show the list of the owners of means of transportation and or communication that has been developed
- Who will be the coordinator of the system: whether per sub-village areas or neighbourhood?
- Mechanism or procedure in obtaining help on the usage of means transportation and or communication and provision of these means (whether they will apply a schedule system or other system)?
- Charging a cost and or free of charge, how much if charging, night and or day basis, based on the distance or could use other indicators?
- The means of transportation, can it be driven only by the owner or could be driven by others?
- An agreement on the phone number that can be contacted from the health personnel or health facilities or the owner of means of transportation and communication.
- How to access the means of transportation from the health centre in the emergency situation?

Who should be involved as participants of the meeting?

The meeting participants in the establishment of system of the provision of transportation/communication means are:

- The owner of transportation and or communication means
- Pregnant women, their husbands and family members
- Drivers
- Community/religious leaders
- TBAs
- The village midwives
- The health centre staffs
- Cadre

ESTABLISHMENT OF COMMUNITY BLOOD DONOR SYSTEM

Facilitating work on the establishment of the blood donor system will be done through conducting a meeting at the village level and will involve all components of the communities especially the potential blood donors and the network of the system. Thus, prior to the meeting the village facilitator should do preparation.

Preparation prior to the meeting:

Following are the activities that should be done before conducting the meeting for establishment of the blood donor system.

1. Identify who want to be blood donors according to the criteria of blood donation.
2. Checking blood type of the potential donor who do not know their blood type.
3. Preparation before checking the blood type:
 - Contact the health centre, the Red Cross blood transfusion unit
 - Contact the head of the village/sub-village and the potential blood donor
 - Determine date and time of checking blood type
 - Discuss the cost of blood type check
4. Steps on the checking of blood type:
 - The staff of the Red Cross or the health centre staff could come to each sub-village to do the blood type check. In this case the village facilitator together with the head of the sub-village gather people in one place
 - Each sub-village keep its own list of potential blood donors with their blood type
 - Compile the results of checking blood types for all sub-villages in the village (name, age, sex, address and blood types)
 - After the blood type check a meeting is held
 - The meeting is conducted at the village level

Preparation on the meeting

Following are the activities that should be done prior to conduct the meeting by the village facilitator:

- Coordination with the head of the village and discuss about the plan of the meeting.
- Discuss about date, time and venue
- Discuss the participants of the meeting
- Discuss on the meeting cost if needed as well as arrangement of snacks and drinks for the meeting.
- Write and distribute an invitation for the meeting
- Prepare the list of attendance meeting
- Contact a resource person on blood transfusion from the Red Cross blood transfusion unit to give a presentation at the meeting.

Information/messages that should be delivered in the meeting

In the meeting it is important to deliver messages that become the background of why this system needs to be formed. The following are points of information and or messages that can be delivered in the meeting:

- We, in the district and province still face problems on the high number of maternal deaths. This problem should become our responsibility in order to take action to prevent other women from dying. The fact that the maternal death is mostly happening because

- of haemorrhage during or after the delivery process.
- If the women get a haemorrhage when giving birth her life could be saved within 2 hours, if not getting any treatment she will die. This is different with other bleeding cases such as an accident, although a lot of blood is lost from the body, the victim can still live for 2-3 days in many cases.
 - It is very important to provide blood to women who get haemorrhage during delivery as soon as possible. However, the women often do not know their blood type and if the blood stock is not available at the Red Cross or blood transfusion unit, there is a need to look for a blood donor from her family members, friends or neighbours. In this case, the candidate for blood donation do not know their blood type when brought to the hospital and after checking their blood type it is often not compatible with the blood type of the women who has the haemorrhage. The effort of finding the blood donors take time, energy and cost. If the blood type is compatible with the recipient, the blood itself has to be screened for some communicable diseases that can be transferred through blood transfusion.
 - Promotion of blood donors is important because a factory cannot make blood, while the fact is everyone has blood in their body that could be donated to whoever needs it. So, it becomes our responsibility to help each other in terms of blood donation.
 - Our blood will not run out if we donate some of our blood because our body system keeps producing new blood.
 - The emergency conditions that require blood transfusion is increasing, such as accidents, dengue, malaria, and so on.
 - Because the blood transfusion process takes time, each pregnant woman should prepare her own blood donor before giving birth in order to anticipate blood transfusion is needed in the delivery process.

The points should be discussed in the meeting

Following is the points that should be discussed in the meeting of establishing blood donor system:

- After opening the meeting ask the resource person to give a presentation on blood transfusion. Allow time for questions and answers.
- Show the list of potential blood donors with their blood type.
- Discuss who will be the coordinator of the blood donors at the village level and the coordinator for each blood type.
- A mechanism and or procedure to ask blood donors (whether to contact the coordinator or direct to the blood donor).
- To whom the blood donation will be given (is it limited to people within the village or could be given to people outside the village)?
- Transportation for the blood donors.
- Any reward to the blood donors after the blood is taken (such as providing some eggs and milk).
- Provision of blood, will it be given to only the pregnant women or any cases that require blood transfusion?
- Whether a sort of statement is required from the blood donor that explains that the blood is given voluntarily?
- Whether the potential blood donor will give their blood routinely or only when a case happens or linked to a special day of celebration such as celebrating the Independence Day.

Note:

- The list of the potential blood donors can be put on a large board in each sub-village
- Each sub-village keeps the list of the potential blood donors including the contact person of the system

Who be involved in the meeting

The meeting participants in the establishment of system of blood donation are:

- The head of the village/sub-village
- Pregnant women with their husbands and family members
- The community/religious leaders
- Cadre
- TBAs
- The health centre
- The Red Cross
- The village nurse
- The village midwife
- The potential blood donors

ESTABLISHMENT OF COMMUNITY BASED FINANCIAL SUPPORT SYSTEM

Facilitation work for the establishment of financial support system will be done by conducting a meeting at the sub-village level. Prior to the meeting, the village facilitator needs to do preparation.

Preparation before conducting the meeting:

Following are the activities that should be done prior to conducting the meeting for the establishment of the financial support system:

- Discuss with the head of sub-village regarding the plan for conducting the meeting
- Discuss on date, time and the venue.
- Discuss about the meeting participants.
- Discuss on the snacks and drinks arrangement if needed.
- Write and distribute the meeting invitation.
- Prepare the list of attendance at the meeting

Information/messages that should be delivered in the meeting

In the meeting it is very important to deliver the key information and or messages that become the background of why there is a need to form this system.

The following are the main points of information and or messages for establishing this system.

- The causes of maternal death are linked to what is called the “3 Delays” in which one of them is a delay in referring the women to the health centre because there is no money.
- People, mostly the pregnant women did not prepare any money for their delivery; indeed, it is rare to save money for a delivery fund.
- However, people get used to raising funds to help each other for social events and gatherings but people did not think to raise funds for supporting each other for health purposes, especially for supporting each other when giving birth.
- It is often happens that delays on seeking help is because of inadequate budget and this causes death.
- Many women did not go to health centre for delivery because they think it too expensive.
- Considering all those facts it is better if we help each other in providing financial support amongst ourselves in emergency situations for increasing self-confidence in making decisions to bring someone to the health centre for receiving treatment in saving lives. It is often happens that a decision to refer or bring someone to the health centre is too late to be taken because there is no cash at hand, although the person maybe holding a poor health card. The available cash will support the confidence to make quick decisions.

The Points need to be discussed in the meeting

Following are the points that have to be discussed in the meeting of establishing the financial support system:

Social health fund support:

- Where the fund will come from and or the source of the fund?
- How much of the fund will be raised?
- When the fund will be collected?
- How to raise the fund?

- How the fund will be used?
- Who is eligible to receive the fund?
- In which condition the fund will be provided and how much?
- How a justification in the usage of the fund will be given to the community members; when, how often and by who and to whom?

Who should be involved in the meeting?

The meeting participants in the establishment of the financial system are:

- The head of the village/sub-village
- The community/religious leaders
- Staff from the health centre
- The village midwife
- TBAs
- Cadres
- Pregnant women with their husbands
- Donor representative
- People of reproductive age

HANDOUTS

TRAINING 2

SESSION 1

These examples are on self organizing conducted by the community in helping each other in Babakan Village in Mataram City.

In order to share the burden of facing problems when someone dies or when someone gets married, the Babakan community help each other by establishing their own system dealing with getting married or when there is a death in the community.

The system is as follows:

1. The system dealing with marriage:
 - Form a group
 - Members of the group, when getting married have to report to the group The group chairperson goes to the members to collect some money of an amount that was agreed when establishing the group
 - The collected money is then given to the member who will get married
 - The group has a book keeping system and the financial status is reported to the members each year

2. The system on dealing with a death:
 - Form a group called "Pauman Group"
 - Members of the community inform the head of the sub-village that a member of the community has died
 - The group then divided tasks to organize the funeral, informing other relatives, any ceremonies and collect some money from the members

When conducting social ceremonies such as celebrating Prophet Muhammad's Birthday, people in Babakan help each other by raising funds and organising the ceremony. They form a committee that will be responsible to organise the rest of community members.

The alert system and its network

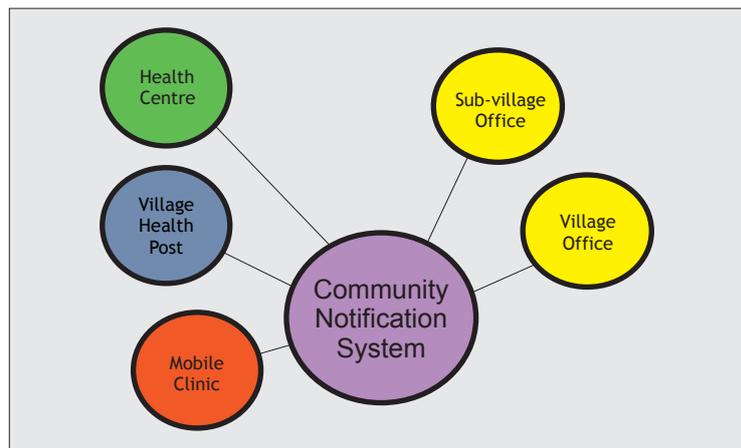
- Notification system
- Blood donation system
- Provision of transportation and communication system
- Financial support system
- FP Information Post

The network of the alert system

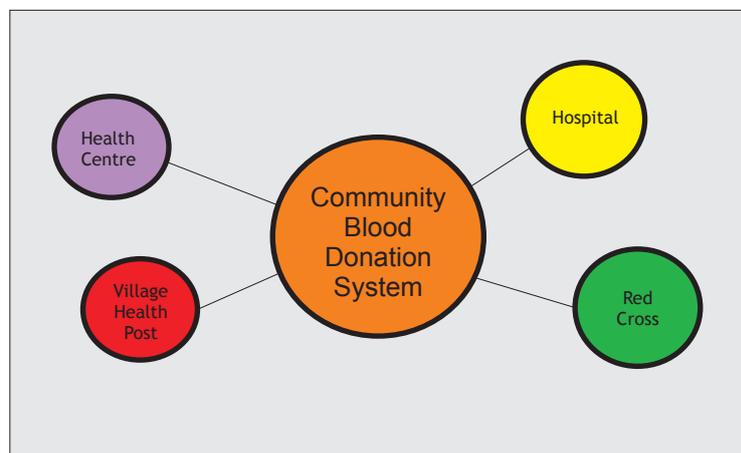
The network is the relationships that occur for the functioning of the established Alert System, formed by people in the sub-village/villages, with the relevant institutions and between the systems.

Developing a network is very important to ease the functioning of the Alert System. Therefore, during the process of the establishment of the system; a representative of the network of each system should be involved.

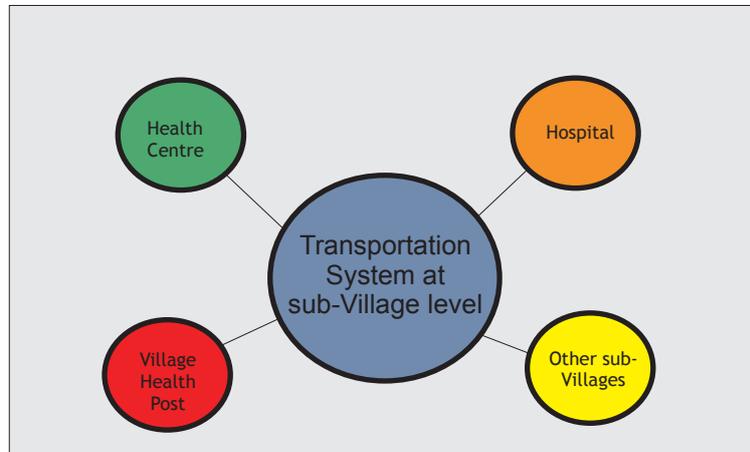
An illustration for the notification network:



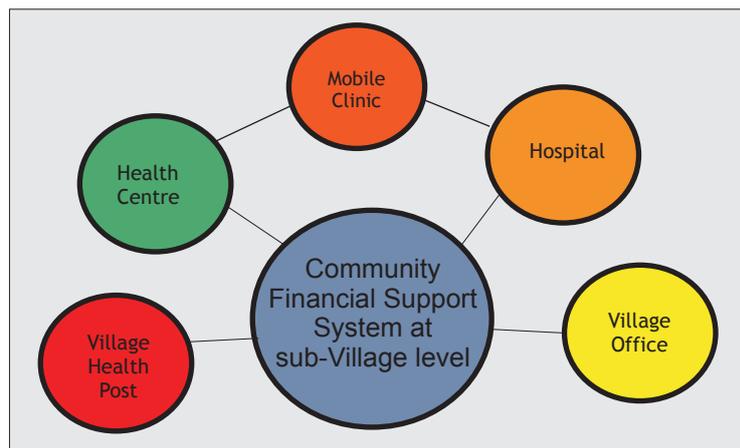
An illustration for the Blood donation network:



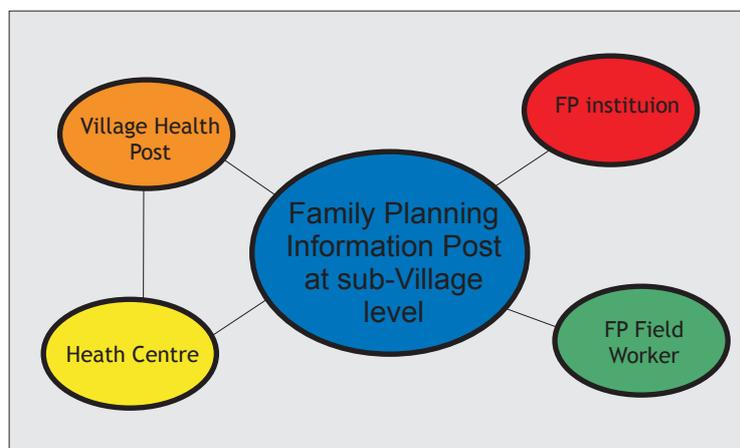
An illustration for provision of transportation and communication network:



An illustration for the Financial Support network:



An illustration for Family Planning (FP) Information Post:



Behaviours that are expected to occur and become a new tradition from the establishment of the Alert System are:

- When the woman knows she is pregnant, the woman with her husband and or family members notifies her pregnancy to the notification system where she lives in order to be recorded so that when she needs help from people around her they will be aware about her condition.
- The pregnant women attend antenatal care at health facilities during their pregnancy
- The pregnant women and her family prepare the cost of delivery, select where to give birth (delivery should be done at health facilities and assisted by skilled health personnel)
- The pregnant women get support from others on the means of transportation and or communication from the transportation system, they can get blood donation if needed from the blood donation system and receive financial support from the financial system
- The women or the couple will plan her future pregnancies by getting FP information from the FP information Post
- The parents report the birth of their baby
- The parents in the village encourage their adolescents to join the Adolescent Class for RH before getting married.

How to make those behaviours occur?

- Establishment of the Alert system by organizing villagers to form it and enforce the consensus raised
- Behaviour change of people

Basic Aspects that influence people behaviour

- Beliefs about health
- Easy to be influenced
- Growing values
- Harmonious environment
- Follow the follower
- Environmental Influence

Regarding organizing people in the establishment of the Alert System

- We are dealing with varied people that have different backgrounds
- The more people that are approached, and involved, the faster the changed behaviours happen

An example of a case to be studied

Nurjanah, 16 years old is in her first pregnancy. During her pregnancy she did not attend any antenatal care to health facility and or personnel. She was shy to go for antenatal care because she is very young. She went instead to TBA for pregnancy care three times, to look at the baby's position and she got "holly water" from the TBA.

During her pregnancy she often complained about getting headaches and her feet got swollen. Such a condition did not encourage her to go to the health services such as the mobile clinic because according to the community belief, such a condition is common in pregnant women.

Prior to giving birth, Nurjanah went to her parent's house in a different sub village than her own house and her husband stayed home. After 5 days staying at her parent's house, Nurjanah got stomach aches, categorized as the sign to give birth. Her family member called the TBA who she visited for antenatal care. The TBA could not help the delivery, so at 5 pm she was brought to the Village Maternity Post. The midwife got a shock because never knew about Nurjanah getting pregnant as well the cadres. Around 7 pm, Nurjanah gave birth assisted by the midwife. She had twins, both of them boys, with weights of 1.700 gram and 1.500 gram. After the babies were born, her husband and his family came visited her.

After one day back from the midwife to her parent's house, around 8 am, Nurjanah complained about her headaches, blurred vision and became unconscious. Her parents put her on the bed as they believed that she had got "something from the supernatural power". Around midday, Nurjanah regained consciousness. Nurjanah took a bath and went back to sleep till 6 pm. Nurjanah woke up again and had dinner but then became unconscious again. Around 7 pm she died.

Note:

Similar cases can be gathered from the local area where this program is being implemented. Health Offices could contribute cases from maternal and or neonatal death audits but details of the actual person and location should not be included – the Right to Confidentiality.

SESSION 8

Monitoring and evaluation of the training

Monitoring of the training process is done by conducting daily evaluations using the following form:

Quality of delivering the content of the session		Very Good	Good	Not Good	Bad
1.	Relevance of the training content to the training output				
2.	Improving skills and knowledge				
3.	Learn from each other				
4.	Relevance to the role of the facilitator				
5.	Training logistics				

Note:.....
.....
.....

End Evaluation

This is done at the end of the training session before the closing ceremony. Try to browse the results of the training so clarifications can be made before the training is closed.

FAMILY PLANNING INFORMATION POST

MANUAL & HANDOUT

TRAINING MANUAL FOR FACILITATORS IN
FAMILY PLANNING FOR CADRES



MATARAM, 2009



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TRAINING MANUAL FOR FACILITATORS IN FAMILY PLANNING FOR CADRES

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DEVELOPMENT OF TOOLKIT ON
COMMUNITY EMPOWERMENT IN MATERNAL AND NEONATAL
HEALTH TEAM

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LAY-OUT AND DESIGN OF THE TOOLKIT

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SESSION 1:



Overview on the training program, expectation and ground rules of the training

Specific Learning Objective

By the end of this session, participants will be able to:

- Becoming familiar with the trainers and other participants as well as with the training committee
- Understand the training program
- Generate their own expectations for the training
- Comprehend the training ground rules and housekeeping information

Time: 1.5 hours

Training Materials:

- Flipchart paper and markers
- Whiteboard/soft board
- Coloured cards - different colours

Activities 1: Knowing each other amongst the participants and the training facilitator

Welcome the participants to the training and ask each participant to find one word that describes him/her together with a body movement that expresses the word. Each participant should find a different word and different body movement. Ask each participant to write his/her word on the colored cards and post them to his/her chest.

Ask each participant in turn to mention the selected word together with demonstrating the body movement. The next participant has to mention his/her own word with the body movement first then copy what had been done by the previous participant. After all participants have their turn, ask their feelings and meaning of doing the game.

Before closing this activity emphasize that this game is to create a good climate so that all participants will be familiar to each other including the training committee. Tell them the importance of being familiar to each other during the training process, which is, to have a smooth and enjoyable training.

Note for the training facilitator: the game for these activities can be modified or can use a different game but must be fixed into the time management of the entire training process.

Activities 2: Participants' training expectations, training goal, objective and schedule

Explain to the participants that each of them as cadre have a role to share information about

Family Planning to others who live surrounding them.

Ask each participant to write on coloured cards the answer to the following question:

- What sort of knowledge and skills have to be possessed by cadre in order to perform their roles regarding the FP Information Post?

Post all the coloured cards that have been written on the soft board.

Ask them then to write the answer to the following question:

- What sort of knowledge and skills is expected to be learnt during this training in order to support the role of the cadre as the FP Information Post?

Post all the coloured cards on the soft board.

Facilitate the participants to analyse “knowledge and skills required as FP Information Post” and “knowledge and skill expected to learn from the training program”. Compare those two and find out the differences if any and discuss why the differences. If the answer of those two is the same, it means that the participants are aware of their roles as cadre to share information on FP.

Present the training goal, objectives and output of the training and compare them with the expectations written by the participants. Check whether all expectations are covered by the training program and if not discuss them.

Training program

- Definition of cadre and characteristics of cadre, role of cadre in FP Program, role of cadre regarding FP Post information at sub-village.
- Human Reproductive Health (human reproductive organs and system, both men and women)
- What is Family Planning?
- Why FP is important?
- Methods of FP
- Effectiveness of each method
- Aspects to be considered in choosing a FP method
- Male participation in FP
- Consumer FP Rights
- Communication Skills
- FP counseling skills

Explain methods that will be applied in the learning process, which is, brainstorming, case study, group discussion and putting emphasis on the importance of active participation in the learning process in order to achieve the output.

Post the expectations and the goal of the training where everyone can see them.

Periodically review them to ensure achievement.

Activity 3: Setting Ground Rules

Explain to participants that in order to have a productive but enjoyable training environment,

certain ground rules have to be developed by the participants. Solicit ideas from them, which may include the following aspects and write the agreement on the flipchart paper:

- Participants will keep to the training schedule, coming on time to the sessions
- Participants will respect each other's opinions and contributions
- Participants will listen attentively to each other and to the facilitators
- Answering and receiving mobile phone call.

Post the rules on the wall for the entire training period for reference.

Explain to the participants about following:

- Pre- and post training evaluation will be conducted before the training session starts and after the training session finishes. The aim is to know the knowledge of participants on FP before and after attending the training program.
- Morning review (review of the previous day of the training topics)
- Daily evaluation, to see the progress of the training, whether on track or not. Daily evaluation will cover the following aspects:
 - content of the training
 - facilitation process
 - participants' understanding of the training topics
- It can be done by drawing 3 rows of these aspects, 3 columns with 3 following categories:
 - satisfied
 - average
 - not satisfied
- Participants may put stickers for each row in the columns regarding his/her evaluation
- Energizer (sort of ice breaker, game that is aimed to energize people's motivation, spirit)

In the morning review, the daily evaluation and energizer will be done by a small group of the participants, so divide the participants into five small groups for the six days of the training program. Participants can be grouped using a game so the groupings will act as an energizer as well. Each group has a task to review, presenting the results of the daily activity and to lead an energizer. The review can be combined with morning energizer.

Before ending this session, asks the training committee to explain the policies, regulation regarding accommodations, per diem, and other relevant issues.

Note for the Facilitator:

An energizer from the facilitator can be used to form the group discussions so the participants will not get a bored, the facilitator therefore needs to prepare some games or energizers for the entire process of the training, in order to keep the participants awake and involve the participants in the energizer activities.

At the presentation of the daily evaluation results, the facilitator should pay attention to the results and always allocate time to discuss them in order to improve the satisfaction of the participants, especially regarding the training contents.



Roles of cadre regarding FP Post information and Pre-test

At the end of the session, the participants will be able to:

- Comprehend their role as cadre in FP Program
- Understood role of cadres regarding FP Post information Post
- Knowing the knowledge of participants about FP before receiving training sessions.

Time: 1.5 hours

Materials:

- Flipchart paper and markers
- Whiteboard/soft board
- Coloured cards - different colours
- Case studies
- Pre-test

A brief on the session

Assuming that the participants are the current cadre who are actively involved in FP development program in their sub-village, there is a need to review what they have done so far regarding the FP program. The review is aimed to assist them to comprehend and internalize their roles. Through this review their awareness within their current role as cadre so raised so they can also a play role to disseminate FP information to others so that access to FP information is more accessible.

Activities 1: Reviewing roles of cadre in the FP program and the role of cadre regarding FP Post Information

Group the participants into small groups in order to discuss their roles so far as cadre regarding the FP program. Ask each group to present their group's discussion and make an emphasis on their roles.

- In general, roles of cadres in the FP program are perceived as follows: looking for new FP acceptors, taking the candidates to the health services, and distributing certain FP methods such as condoms and pills. There is limited understanding about their role as resource persons that can share information about FP to others and there is inadequate knowledge and skills to perform this role. Thus, it is important to give understanding that it is the cadre who can be accessed by the others at the sub-village level for providing FP information.

Distribute the case study (Handout session 2) to each small group. The aim of studying the cases is to raise awareness of participants that these cases are happening around them. By having understanding about the cases as cadre they can take a role to prevent others from similar cases, so the participants will take on the role as FP information Post. Regarding the cases, the facilitator may get the real cases from the field where the training takes place. The cases used need to be prepared before conducting the training.

Ask them to read and analyse the case then discuss the following questions:

- What is the main problem of the case?
- What can each individual do in order to prevent others having the same problems as the case?

Ask each small group to present their discussion by firstly reading the case for all participants because each group studied a different case. After all the presentations of the small groups, pose these questions:

- Is the case study by each small group different?
- Is the main problem the same for all cases?

Emphasize that inadequate FP information can cause unwanted pregnancy which could cause problem pregnancy and delivery, and affect reproductive health of women. To overcome this problem, each can take role to share FP information, and this role could be done by everyone, because does not have any cost and it is simple as long as there is someone who wants to spend their spare time and energy to share FP information to others in FP Information Post.

Ask the participants to go back to their previous small groups and discuss the roles of cadre as the FP information Post. Ask each small group to present the results of their group discussions and put emphasis on the role of cadre regarding the FP Information Post.

Present a PowerPoint presentation about the definition of the FP Information Post, role of cadre, characteristics of cadre, and the role of cadre regarding the FP Information Post. Allow time for a question and answer session before closing this activity.

Definition of FP Information Post

- Post: sort of place or venue or some body
- Information: message
- FP: Family Planning

Thus, the FP information Post can be defined as a place or somebody who could be accessed for obtaining information about FP.

Role of cadres in FP Information Post:

- A place or somebody where FP information can be inquired
- A place or somebody that can share information about FP
- As contact person for FP information and services with relevant institutions for FP such as the district FP institutions, district health office, women's organization, and health facilities/personnel. Therefore, the role of cadre regarding FP Information Post is to share FP information to others, as resource person where people can access FP information and as contact person with the relevant FP institutions.

Characteristics of cadre

- Volunteerism
- Willing to spend their spare time and energy
- Willing to share information
- Willing to be part of network of relevant FP institution

Who is eligible called as cadre?

A cadre is someone who is able and willing to share their thoughts, energy and time for development programs especially FP in his/her areas.

Cadre should be

- Willing to spend time, energy and thoughts voluntarily.
- Having high social responsibility
- Willing to learn
- Able to convey messages or information
- Working without getting any payment for development of their areas.

Roles and function of Cadre regarding FP Program

- Cadre as facilitators (to share information in their surroundings).
- As the mobilize of his/her community to attract people to join the FP program
- As mediators, to link different stakeholders: community members, the village head, FP field workers, women's organization in implementing the following activities:
 - Strengthening community base institutions
 - Communication, information, education
 - FP method services
 - Integrated services
 - Supporting recording and reporting systems

Activities 2: Pre-test

Before commencing this training program, it is important to know to what extent knowledge is possessed by the participants so pre-test is needed.

Post the questions for the pre-test one by one, ask the participants to write the answer of each question on colored card. Post the answer of each question separately on flipchart paper. Check whether the answer of each question true or false after giving each answer. Take out the false answers and count the true answers. The results of the pre-test will be compared latter when doing the post-test.

Pre & Post -test

Knowledge about FP

Explain what you know about following topics:

1. What is the definition of Family Planning (FP)?
2. What is an acceptor?
3. Why joining FP is important?
4. What should be considered when choosing a FP method
5. Please mention the rights of the FP consumer
6. What is contraception?
7. Explain methods of FP: devices of each method including side effects, how it works and where to get services.

Use the form on the next page:

Nr	FP Method	FP Device	How its work	Side effects	Where to get the service

SESSION 3:

Community empowerment in MNH and Alert System in MNH and its links to the FP Information Post

At the end of the session, the participants will be able to:

- Comprehend the concept of Community empowerment in MNH and the Community Based Alert System
- Understand that the FP Information Post is a part of the community Alert System

Time: 1.5 hours

Material:

- Flipchart paper and markers
- Whiteboard/soft board and marker
- Film of Desa Siaga
- PowerPoint presentation

A brief on the session

The goal of the community empowerment in MNH is to facilitate people to build togetherness for helping each other in saving lives of women related to pregnancy and delivery. In order to facilitate them to organize themselves in establishing the Alert System that consists of five systems: notification, provision of communication and transportation system, financial support system, blood donation and sharing information on FP through the FP Post information. Thus, this training as a strategy to equip one villager from the sub-village level on FP knowledge and skills on communication to share FP information to others and this is a part of the Community Based Alert System. In addition, the training is done after four other Siaga Systems are established in the village where the participants came from and they possibly have been involved in the process of establishing these four systems in their villages.

Activities 1: The Alert System concept

Explain that FP Information Post is a part of Alert System that has been developed at each village where the participants come from. To understand that, show the short film on “Desa Siaga”.

To get their understanding, pose some questions:

- What is the impact of maternal death in your areas?
- How many maternal deaths happen every hour in Indonesia?
- Why people need to establish the Alert System for themselves?
- How many systems are in the Alert System?
- Which system is related to what we are doing now?
- What and how are you going to perform your roles after attending this training?

If the participants can answer those questions well considering not to present the PowerPoint about the concept of Alert System but if need it, present the concept separately in power point as additional to the film shown.

The links of the community empowerment in MNH with the FP Information Post

The community empowerment in MNH aims for increasing community participation in helping each other when facing emergencies, especially related to pregnancy and delivery, by notifying each other when emergencies happen, provide of means of transportation and communication, blood donation, financial support and helping each other in sharing FP information. Thus, the FP information Post is a part the Alert System that is established by the community for helping each other in accessing FP information.

The role of FP Information Post is very important because joining in FP is an effort to avoid being pregnant for those who do not want to be pregnant so that the women can be prevented from maternal death. In order to enable one cadre from each sub-village to perform the role as resources person for sharing FP information this training is required.

More on this topic can be seen at the hand out of this session.



Human Reproductive Health System

At the end of the session, the participants will be able to:

- Understand terms and definitions regarding human reproductive health
- Understand human organs/system of reproductive health, both men and women
- Understand menstruation, conception, pregnancy and delivery.

Time: 1.5 hours

Material:

- Flipchart paper and markers
- Whiteboard/soft board and makers
- Film of Human Reproductive Health
- PowerPoint presentation

A Brief on the session

Issues on FP are inseparable from reproductive health. To provide participants with knowledge about why family planning is important and its link with reproductive health, how the FP methods work, it is important to equip them with knowledge about human reproductive health. This session focuses on human reproductive health and its link to FP.

Activities 1: Brainstorming on reproductive health definition

Ask the participants to brainstorm on the meanings and definition of the word “reproduction”. Write on the flipchart paper their responses. Then brainstorm on the meaning of the word of Human reproductive Health.

Present the meaning of reproduction and reproductive health. After presentation compare with the answers of the participants. Emphasize that humans reproduce because they have reproductive organs.

Reproduction came from

- Re = again
- Production = to produce

Re-production:

A process in the life cycle of the human being in producing their offspring for their sustainability.

Activities 2: Reproductive organ of men and women

Pose the question to the participants: “what are the reproductive organs possessed by men and women?” Write their answers on the flipchart.

Ask the resource person to give a presentation on male and female reproductive health organs and systems and after that show the film on human reproductive health. Remind them to watch the film carefully and when they have questions it can be discussed later after seeing the film.

After showing the film, allow time for questions and answers before closing the session, posing some questions for making emphasis:

- What is menstruation?
- How many sperm are produced at once?
- How many sperm could go to the ovum?
- How many ovum are produced by women each month?
- What is conception?
- What is pregnancy?
- What is giving birth?

Reproductive Organ:

A part of the human body that has a function to reproduce the next human being.

Reproductive health is “the state of complete physical, mental and social health being not merely the absence of disease or infirmity in all matters relating to the reproductive system and its function and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if and when and how often to do so” (ICPD, 1994).

RH concerns how the function and development of reproductive organs affects life styles and daily activities of each individual. It is important to remember that many factors influence an individual's RH e.g. their socio-economic status, level of education, family and social obligations and related stresses.

Why Reproductive Health is important?

- Provision of true information (it is not the same as pornography and it is broader than sex)
- Having responsible attitudes and actions
- Preventive action and curative at early diagnosis

More on this topic can be seen in the handout of this session

SESSION 5:

What is FP? Why FP is Important and is it safe to join the FP?

At the end of the session, the participants will be able to:

- Understand and be able to explain what FP is, the importance of FP and benefits of FP and the safety aspects for joining FP

Time: 1.5 hours

Material:

- Flipchart paper and markers
- Whiteboard/soft board and makers
- PowerPoint presentation

Activities 1:

Group the participants into small groups and ask them to discuss: “what is definition of FP?” Write the answer on the flipchart paper, and then discuss why FP is important. Write the answer on the flipchart paper and post it on the soft board.

Ask the resource person to give a presentation on the definition of FP and why it is important. After the presentation, ask the participants to look at the results of their group discussions, ask each small group to read and compare them with the presentation of the resource person. Allow time for questions and answers before closing this session make repetition by posing question on the point has been just learnt.

Family planning

Is having the number of children you want, when you want them.

Is FP safe?

Every year, half a million women die of problems from pregnancy, childbirth, and unsafe abortion. Most of these deaths could be prevented by family planning

- Millions of women in the world use the FP methods.
- The FP methods are safer than getting pregnancy and giving birth

Why FP is important?

The importance of FP can be seen from following points of view:

- Economic
- Educational
- Family welfare
- Self and family development

The greater the number of family members there is more need in economics, education and health. Therefore, planning the number of children in the family is required as well as planning their economic, education and health for the future.

Small family size will create an opportunity for the head of the family or the mother to develop her/his career.

Small family size will give more chances to provide better education so that the children are successful in life.

FP is allowing the parent to develop potential economic conditions for the family. By having small family, it allows the mother to develop economically productive activities. With adequate income the needs of family can be fulfilled.

Benefits of FP

Every year, half a million women die of problems from pregnancy, childbirth and unsafe abortion, Most of these deaths could be prevented by Family Planning, For example FP can prevent dangers of pregnancies that are:

- Too soon: women under age of 17 are more likely to die in childbirth because their bodies are not fully grown. Their babies also have a greater chance of dying in the first year.
- Too late: older women face more dangers in childbearing especially if they have other health problems or have had many children.
- Too close: women's bodies need time to recover between pregnancies.
- Too many: women with more than 4 children have a greater risk of death after childbirth from bleeding and other causes.

Other benefits:

- Mothers and babies are healthier because risky pregnancies are avoided.
- Fewer children mean more food for the infant / young child.
- Waiting for children can allow young men and women time to complete their education.
- Fewer children can mean more time for the couple and their children.
- FP could make partners have more enjoyable sex because they are free from unwanted pregnancy.

SESSION 6:

Family Planning Methods

At the end of this session, the participants will be able to:

- Understand who is the decision maker of FP in the family
- Understand methods of FP
- Understand aspects to be considered in choosing FP methods
- Explain the FP devices of each method, how they work, side effects, where to get the services

Time: 3 hours

Material:

- Flipchart paper and markers
- Whiteboard/soft board and makers
- FP devices
- PowerPoint presentation

Activities 1: Decision on FP and Aspects need to be considered

Group the participants into small groups to discuss:

- Who should make the decision about FP?
- If deciding to join FP, what aspects should be considered?

Before looking at the results of group discussions, ask the resource person to present the topics then ask the participants to look at the results of their group discussion and compare with what has been presented. Is it the same or different? Look together at the results of the pre-test and account how many had the correct answer.

Decision on joining FP or not

The woman or the couple are the ones who should decide how many children they want to have and when they want to get pregnant. If they want to join FP or not, it is their decision.

It is best if the cadre can talk together with the woman and her husband or partner about using family planning and what methods they will use.

Some men do not want their wives to use family planning often because they do not know very much about how different methods work. A man may worry about his wife's health because he has heard stories about dangers of family planning. He may also think that if a woman uses family planning, she will have sex with other men. Or he may also think it is "happiness" to have lots of children.

- FP will allow husbands to take better care of the woman and her/their children
- Child spacing is safe for the couple and the children
- FP can make sex with husbands more pleasant because neither will have to worry about unplanned pregnancy. Being protected against unplanned pregnancy will not make women want to have sex with other men

If the husband still does not want you to use FP after learning about its benefits, the woman must decide whether she will use FP anyway. If she does, she may need to choose a method that can be used without her partner knowing about it.

Activities 2: FP Methods, side effects, how they work, and how effective each device is.

Ask the participants to go back to their previous groupings and discuss the following topics:

- Types of FP methods, devices of each method, how they work, side effects and where to get the services.

Ask them to put the information on a table and post the results of the group discussions.

Ask the resource person to present these topics and show each device and let the participants touch and feel them. After presenting each method ask the participants to look at the results of their group discussions and compare with what had been presented. Allow time for questions and answers after discussing each method and before closing the session, ask the participants to look at the results of the pre-test and account how many have the correct answer.

There are 5 main types of family planning methods:

1. Barriers Methods: prevent pregnancy by keeping the sperm from reaching the ovum (or ova).
2. Hormonal Methods: prevent the women's ovary from releasing an ovum (or ova), and or make it harder for the sperm to reach the ovum (or ova) and or keeps the lining of the uterus from supporting a pregnancy.
3. Method that inserts a device into the uterus (IUD), which interferes with the progress of the sperm meeting the ovum (or ova) and or implantation of the fertilized egg in the uterine lining.
4. Natural Methods: include exclusive breast feeding for up to six months which effect hormones that trigger return of fertility or charting the woman's temperature and state of vaginal mucus to indicate possible fertile and infertile times during the month.
5. Permanent Methods: these are operations which make it impossible for a man or a woman to have any more children.

Some questions you may want to consider in choosing methods of FP:

- How well does it prevent pregnancy (its effectiveness)?
- How well does it protect against STIs/HIV, if at all?
- How safe it? If the woman has any health problems?
- How easy is it to use?
- Is the woman's partner willing to use family planning?
- What are the woman's personal needs and concerns? For example, do they have all the children they want or are they breastfeeding their baby?
- How much does the method cost?
- Is it easy to get? Will they need to visit a health centre often?
- Will the side effects (the problems of the method) cause difficulties for the woman?

More on this topic can be seen in the handout of this session.

SESSION 7:

Male participation in FP

At the end of the session, the participants will be able to

- Understand the importance of male participation in FP
- Understand the kind of male participation in FP

Time: 45 minutes

Material:

- Flipchart paper and markers
- Whiteboard/soft board and markers
- PowerPoint presentation

Activities 1: Brainstorming and presentation on male participation on FP

Looking at the methods and types of FP devices for each method, most of the devices are for women while the FP devices for men are limited. This fact makes a difficult life for women if because of their health problems they cannot use the available devices. The facts show that men's participation in FP is very low, so it needs to be discussed.

This opening brainstorming is aimed at raising awareness that FP is not only women's affairs but it is the affairs of men and women so male participation is highly required.

Pose the following questions to participants.

- How many FP methods are available for women and how many methods for men?
- What is the function of contraception?
- Who determines conception?
- To what extent is the participation of male in FP?

After discussing the answers of these questions, ask the resource person to give a presentation on the topic of male participation in FP. Allow time for discussion of this topic and before closing this session make emphasis by posing the following questions: How many methods of FP are there? What kind of male participation is there in FP? What factors make low male participation in FP?

The current problem is that male participation is very low.

Increasing male participation in FP can be seen as a concrete action and attention of men /husbands in FP as well as reproductive health.

Low use of male contraception

- It is caused by limited methods and devices of male contraception available and inadequate knowledge on reproductive health.
- Low support from the influential leaders for male participation on FP.
- Misunderstanding that FP is only women's affairs.
- Support for efforts on increasing male participation in FP is still limited.
- Support from religious/community leaders on male participation is still low.

- Low knowledge on male participation of FP amongst families.
- Nationally, discussion on male participation in FP is adequate.
- Mass campaign on the increasing of male participation is still low.

Others factors

- Social environment.
- Assumption of people and families that male participation is not important.
- Knowledge and awareness of men joining FP is low.
- Limited access of men to FP services,
- Availability of counselling on male contraception is low.

What can be done to increase male participation in FP?

- In the provision of inter personnel communications there is a need to introduce male contraception methods such as condoms and vasectomy.
- Providing condoms, free of charge.

Kind of male participation in FP

- Direct

Using FP methods such as:

- Condoms
- Vasectomy
- Discontinue intercourse

- Indirect

A husband supports his wife for choosing a FP method:

- Suitable method.
- Support his wife to use the method in a proper way.
- Assist his wife to seek help if having side effects.
- Accompany his wife to go to health services.
- Looking for an alternative solution.
- As a motivator for his wife.
- Assisting to care for his wife and his infant after childbirth.
- Support his wife for FP.
- Planning the number of children and spacing of pregnancy together with his wife.
- Planning the safe delivery assisted by a skilled person.
- Avoid domestic violence toward women.
- Prevent his wife from getting a STI and or HIV/AIDS.

Why male participation has become important?

- It is because men are a “partner” in reproduction and sexuality.
- Men have responsibility socially and economically including to their children.
- Men are involved in fertility, as well as the importance of the role in deciding use of FP methods by his wife (low male participation causes low women and children health status).

What can be done to increase men's participation in FP involves?

- Positioning an image on men joining FP: disseminate values that male joining FP is part of their responsibility.

- Promotion.
- Independence: inform clients that the cost of FP is competitive, so there is a need to encourage the independence of joining FP.
- Distribution channels make sure the availability of FP services are also for men.

SESSION 8:

Rights of FP consumers

At the end of this session, participants will be able to:

- Comprehend and explain what is a Right, what are the rights of FP consumers, what is human right and the fulfilment of FP consumer rights.

Time: 1.5 hours

Material:

- Flipchart paper and markers
- White board/soft board and makers
- PowerPoint presentation
- Coloured cards

Activities 1: Brainstorming and presentations

FP consumers have rights that need to be protected however few people know their rights. Distribute coloured cards and ask the participants whether they have heard the word of “rights”, in which context and write the meaning of the word on the coloured card. Post the coloured cards on the board. Present the correct meaning of the word “right”.

Present the topic of Human Rights, and the Right to Health is contained in a number of conventions¹.

Human rights

- The basic right possessed by every human being, since her/him is birth or since she/he was in the womb of her/his mother.
- The Universal Declaration of Human Rights (Article 1)
- All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Principles of Human rights

Rights are universal

Rights apply to everyone

Rights apply in international laws and governments are expected to embed them in a country's laws once they have committed themselves in the United Nations

Participation is a basic and fundamental right

Rights are intertwined with each other and cannot stand alone

Present the topic of the Rights of FP consumers. Allow time for questions and answers. Ask the participants to look at their pre-test, account for the number that gave the correct answer.

¹ Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services".

FP consumer:

Is an individual who is using family planning either modern or natural methods.

Rights of FP consumer:

- Right to get FP information

Right to know the benefits and limitations of choices of FP methods

- **Right to make choice**

Right to decide freely in choosing and application of FP methods

- **Right to access**

Right to get services without discrimination on sex, religion, beliefs, race, marital status and location

- **Right to safety**

Right to get safe and effective services

- **Right to privacy**

Right to privacy in FP counselling and services

- **Right to confidentiality**

Right to get assurance that private information provided will be kept confidential

- **Right to equality and equity**

Right to get services with respect, full attention and equally with others and fairness

- **Right to convenience**

Right to get convenience in services

- **Right to give opinions**

Right to provide opinions freely

- **Right to sustainability**

Right to get assurance on the sustainability of availability of comprehensive FP methods and sustainability of services as long as needed

- **Right to compensation**

Right to get compensation if there is an abuse of FP consumer rights.

What should be done if the rights are abused?

- The person can ask for an explanation to the provider on why it happened
- The person can discuss and negotiate in order to prevent the case not happening again
- Ask an opinion from the other providers to make sure there is abuse
- The person could ask for legal protection

What others can do if knowing there is a rights abuse to someone?

- People could give assistance to the person, such as legal assistance and protection,

providing temporary shelter if there are women who are victims of violence or take the role as an advocator/negotiator for the victim.

What the government could do if knowing there is a rights abuse to someone?

- Due to reproductive rights being an integral part of human rights, the government has the responsibility to protect the individual who his/her rights abused, for example by providing shelter, provision of reproductive health services centres that are accessible to people.



Communication Skills

At the end of the session, the participants will be able to:

- Comprehend the communication process
- Comprehend communication aspects and FP counseling
- Increased skills on communication

Time: 2.25 hours

Material:

- Flipchart paper and markers
- Whiteboard/soft board and makers
- PowerPoint presentation
- Coloured cards
- Communication Game

Activities 1: Communication Game

Explain to the participant about the game. Group the participants into 2 large groups ask them to make two lines. Ask one person from each group to come closer to the facilitator who will show her/him the message that will be read then will be passed to other members of the group by whispering it from one to others. The winner will be the group that passes the message completely and faster.

After doing the game, analyse, whether the message passed through to the final members completely and if not complete why it failed.

Ask them to go back to the group to discuss the communication process in the game, what aspects were involved in the game and how to present information so that others can understand the information. Write the discussion on the flipchart paper and post on the board.

Present the topic of communication and ask them to look at the results of the group discussion, compare them to the presentation. Allow time for questions and answers before closing this session.

Communication

Is a process of giving or delivering a message orally or printed.

It is changing ideas and thoughts between two people or more.

It's relation to the FP Information Post, the FP information Post has the role to share, to exchange ideas, thoughts and information about FP either orally or printed.

Components of communication:

- Communicator (sender)
- Messages, ideas, feelings
- Recipient

Forms of communication:

- Interpersonal Communication
- Group communication
- Mass Communication

Communication consists of 6 steps

- The sender has information (message, thoughts) to be delivered
- The sender has to expose the information through voice, words or body language that is understandable by the recipient
- The sender has to deliver the information or message so that can be received by the recipient
- The recipient receives the message/information.
- The recipient should understand the message/information.
- The recipient should send back to the sender that the message has been received and understood

The good Communicator

To be good communicator, some following aspects need to be look at:

- The communicator should be a person who is trusted
- The communicator should have a high level of confidence
- The communicator should prepare the material that will be delivered.
- The communicator should be able to convey the message using simple words
- The communicator should know beforehand the target and their characteristics

A Message

The aim of communication is to convey a message from the sender to the recipient.

There are 4 aspects of messages:

- The content is factual, understandable and clear
- The sender
- Relation to the recipients
- There is willingness to influence

Barriers in communication

1. The recipients
 - Feelings, thoughts and curiosities
 - Not concentrating on the senders
 - Not a good listener
 - Personally not in good condition (problem of hearing, sight etc)
2. The message
 - Not clear
 - Having double meanings
 - Not systematic
 - Not common language

- Very noisy
3. **The sender**
- Not clear in talking or in delivering the message
 - Not able to convey the message
 - There is a "problem" in receiving the message

Communication in disseminating FP Information

- The message is understood and clear
- It can be delivered orally or by showing printed material, or can be readable by the recipients
- To bridge the resource person or FP services centre

More to this topic can be seen in the handout of this session.



Practice in counseling skills and disseminating FP Information

At the end of this session, the participants will be able to:

- Convey FP Information
- Communicate with others about FP

Time: 7.5 hours

Material:

- Flipchart paper and markers
- Whiteboard/soft board and makers
- Cases
- Lottery

Brief on the session

In order to increase the capability of the participants in performing their roles on disseminating FP information after attending this training program, the participants will be given a chance to practice disseminating FP information and practicing communication skills through conducting a role play. In other words, this role play is aimed to increase the skills of the participant to be able to share FP information to others and this skill is very important. The role play will be done in the class room because after conducting each role play, it will be analysed and discussed on the following aspects: communication skills and the delivered content or information. This discussion is aimed at feedback or improvement for the next role player as well for all participants.

Activities: Role Play and discussion

Explain about the role play. The participants will do the role play in pairs, one as the cadre of FP Information Post, and another one is as a member of the community who seeking out FP information. The seeker for information will take one case of a scripted role play. In this context they may improvise in order to create a relaxed climate and dialogue so that the role play will not be awkward. They may also use IEC materials available to support their role in giving FP information. When each pair are doing their role play, the rest of participants need to observe how the role play is going. To determine who will be the informant and who is the seeker of information, each participant will take part in a lottery and the seeker will take a case (see handout of this session) to be performed.

After each role play, facilitate the participants to evaluate the role play by looking at the following aspects: What is the case about? Has the information looked for been given? How has the information been given? Has the given information answered the questions raised by the seeker of the information? Has the IEC material been used in supporting the information given? What should be improved in the role play?

Make a summary on what should be noted when giving information to others so that the information is understood, such as: understanding on what information is looked for, providing information that is looked for, giving information clearly using available IEC material.

SESSION 11:

Post-test

At the end of the session, the participants will be able to:

- Know to what extent their knowledge is after the training program
- Comparing the results of the pre-and post tests

Time: 1 hour

Material:

- Flipchart paper and markers
- Whiteboard/soft board and makers
- PowerPoint presentation
- Coloured cards

Activities

Distribute coloured cards to answer questions one by one for questions 1-6. Question 7 is written on the form. The questions and the form of the post test use similar questions and forms as in the pre-test.

Post each answer on the flipchart paper for each question, take out the wrong answers and account for the correct answers.

Discuss together with the participants the results of the pre and post tests for each question. Discuss if there is no improvement from the pre to the post, in order to get feedback for improvement of the methods of training, organizing training contents and facilitation.

HAND OUT

MANUAL TRAINING for FACILITATOR of FP Training for Cadres

Below there are examples of case studies. In this regard the training facilitator can find a number of similar cases locally where the training is taking place.

Case 1

Darwisah, aged of 37 years old, she was not aware that she was pregnant because she took the pill (COC) as her FP method. The side effect she got from taking the pill was absence of menstruation. She realized herself she had become pregnant when she got morning sickness and she hated smelly things. She felt a stomach-ache as well. When her pregnancy reached 2 months old, she felt some pain and blood come out as like getting menstruation. She went to the midwives and the midwives referred her to hospital. At the hospital she was told that she had had an incomplete abortion so a curette was required.

Case 2:

Ramlah, 30 years old, became FP acceptor in September 2004. She did not joint FP before so she has 5yr old child, her fifth child. She joined the FP because there were free of charge services and because her friend asked her to join. On December 2004 she felt her eyesight was blurred and she had a blood discharge when she fainted. After having these symptoms several times within one month, she went to see midwife and the midwife gave her an injection and medicines. Besides going to see the midwives she went to see a traditional healer that gave her a herbal drink and prayed to her. She thought it happened because she had too much work at a farm.

WHAT IS COMMUNITY EMPOWERMENT IN MNH?

- Community empowerment in MNH is a community effort for helping each other when a member of the community faces an emergency situation or disaster, especially related to pregnancy and delivery of the baby.
- In order to be able to help each other, the community needs to establish their own Alert System.
- The Alert System covers: notification, provision of a transportation and communication system, financial support, blood donation and a FP Information Post.
- Thus, the Alert System is the system of helping each other, established from, by and for the community that covers the provision of means of the above topics.

Community Based Notification System

- In order to be able to help someone who is in an emergency situation, people need to have information on what is happening in their community. They need to have a recording, monitoring and reporting system aimed at notifying themselves.
- This recording-monitoring-reporting system is a participatory system that is done from, by and for themselves and focused on health issues.
- Information will be recorded and monitored but it is up for consensus to decide what is going to be monitored. For instance, information on the number of pregnant women, maternal deaths, neonatal deaths, number of population and kept up to date. In other words, the health issues that will be recorded depends on what is agreed by the community members.
- Under this system, those who are having a health problem or condition go to the volunteer recorder who is agreed by the community.
- The volunteer recorder is a community member who has the spare time and wants to use her / his spare time to record what is happening in their area on health that is reported to her / him by those who are facing the problem. The voluntary recorder should exist in each neighbourhood in order to encourage people to record.
- Agreement on establishing this system is done through holding a meeting with community members that represent the population of the sub-village. However, the consensus raised in the meeting will rule all people who live in the sub-village.
- The consensus belongs to the people who developed them so they are implemented and become the responsibility of the people who live in the sub-village.
- The functioning of this system will be very worthwhile for neighbourhood, sub-village, and village office, therefore, the consensus is not only to be agreed but it is important that it should be applied by all people and the gathered information will be used to monitor the health problems in the area.
- This system is developed using forms that are agreed upon by the people.

Community Based: Means of transportation and communication systems

- Mutually assisting each other for the provision of the means of transportation and communication when health emergency situations and disasters occur.
- In order to run this system, people need to raise a consensus on helping each other with the provision of the means of transportation and communication with rulings on: who the owners are of transportation and communication means that are listed in the system,

how to ask for help, how to give help (provide the means of transportation and communication), what costs (pay or free of charge) and who will coordinate this effort, etc.

- The consensus is developed from, for and by the people through holding a meeting at the sub-village level that is attended by the representatives of the neighbourhoods.
- The consensus could be raised and agreed by people who attend the meeting but it will concern all people who stay in the sub-village, so the consensus itself has to be informed to others who do not join the meeting.
- The consensus owned by the people needs to be applied by them continuously so that they take responsibility.

Community Based Financial Support System

- An emergency situation often happens when someone does not have any cash money and this often causes delay in efforts to save a life. People need to support each other in these emergency situations by establishing financial support, similar to the support when someone dies or gets married.
- The financial support system is an effort to help each other, developed from, by and for the people for finance matters when emergency situations or disasters happen.
- In order to manage this financial support, people need to raise a consensus amongst them by holding a meeting at the sub-village level that is attended by representatives of the neighbourhood or all families who live there.
- Using consensus the representatives will be guided on where the source of the fund will be raised, how much of the fund will be raised, what the fund will be used for, who will be eligible to receive, who will manage the fund, how much support will be given, in what conditions someone is eligible to receive funds and how the usage of the fund will be reported back to the people who formed the financial support.
- The consensus reached will belong to the people and it has to be applied by these people. So it is not only raising consensus but it should be an applicable consensus that supports each other financially.

Community Based Blood Donation System

- It is an effort to help each other, “from, by and for themselves”, regarding the provision of a blood donor system when emergencies that require blood transfusion.
- In order to establish this system, people need to have a list of potential blood donors with blood types, and how to provide the blood donors. People who are eligible to be the blood donor will be checked for their blood type in order to make them ready to donate their blood when needed.
- The meeting to establish this system is held at the village level.
- The meeting is attended by the potential blood donors and representatives of the villagers from all sub-villages, people from the health centre, the village midwives and Red Cross blood transfusion unit.
- The decisions raised through consensus in the meeting belong to the villagers and are implemented by them.

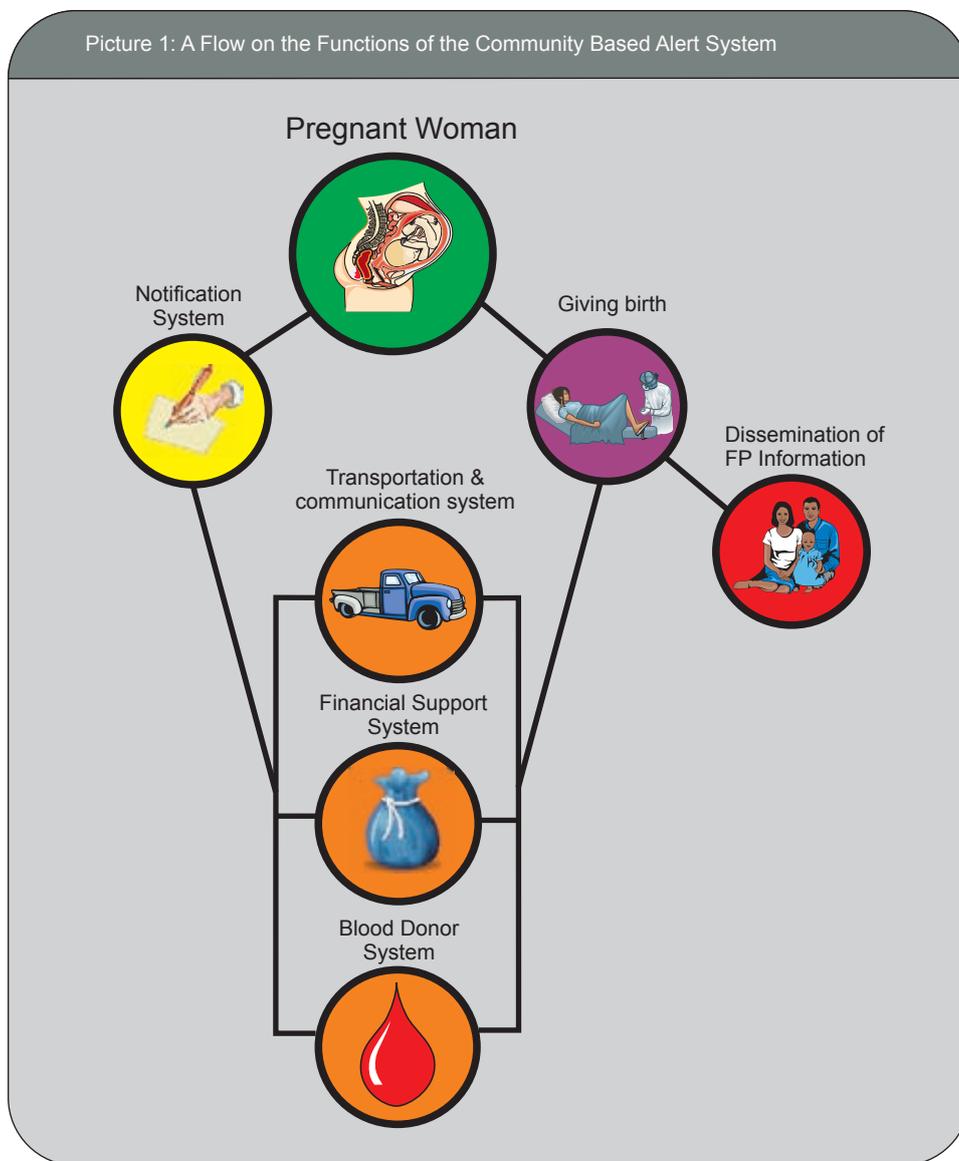
Family Planning (FP) Information Post

- An effort to help each other on the dissemination of FP information amongst the villagers, especially to males and females of reproductive age, in order to bring closer access of FP Information.

- To increase the capacity of the villagers to disseminate FP information, one of the community members from each sub-village is trained in Reproductive Health, FP, communication skills and equipped with IEC material on the topics so they will be able to disseminate the information to the rest of the people in their village.
- This sharing of information on FP will be sustainable because each sub-village has its own resource person who will act as a bridge between the villagers and the health services.

A network of the Alert System MNH

- The established Alert System at the community level will link to other existing systems at relevant institutions regarding the function of each system. How the Community Based Alert System works can be illustrated as follows:



WOMEN'S REPRODUCTIVE ORGANS

External View:

The vulva is outside a woman's body, between her legs. The moistness or dryness of the vulva is partly affected by hormones throughout the menstrual cycle. With sexual arousal, the vulva becomes moist and fuller as the area becomes engorged with blood. The vulva consists of:

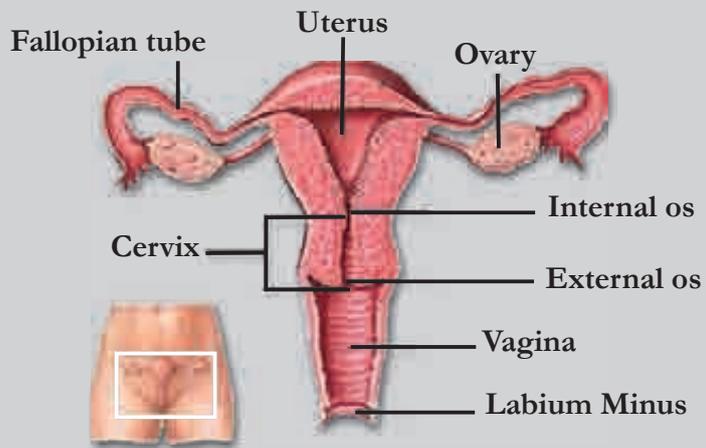
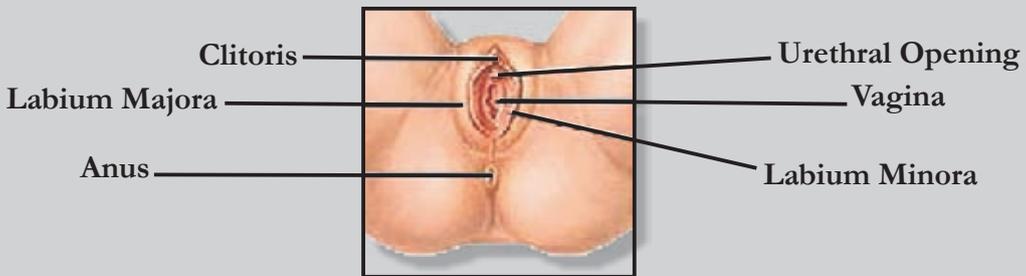
- The Labia Majora: are like lips which protect the vulva and vary in size and shape.
- The Clitoris is a sensitive organ full of nerve endings. It is like a small lump on the vulva, but is larger inside. The clitoris is made of erectile tissue and becomes erect when woman is sexually aroused.
- The urethral opening is a tiny hole where the urine comes out.
- The labia minora are the thinner lips surrounding the vaginal opening and vary in size and shape. They are moist and change colour when a woman is sexually excited.
- The vaginal opening is the entrance to the vagina.

Internal View:

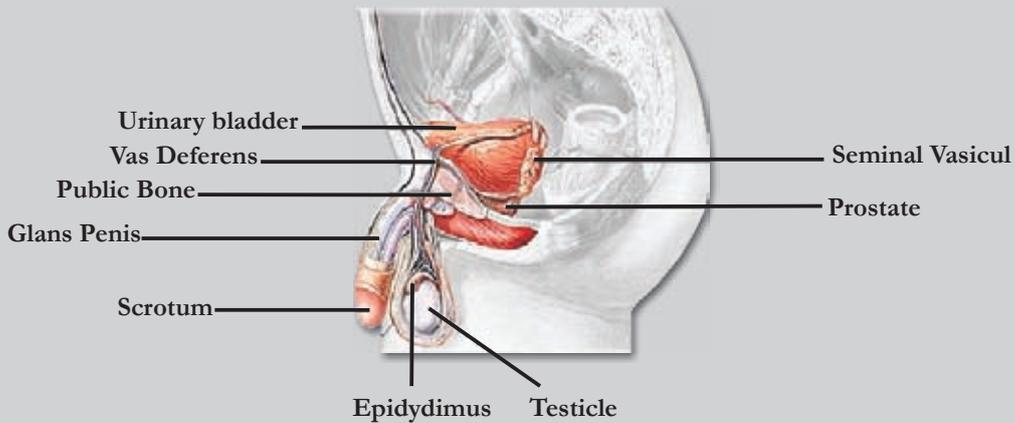
- The Fallopian tubes are narrow tubes which carry ova (eggs). The tubes are lined with fine hairs called "cilia" which help to move ova along.
- The ovaries are on either side of the uterus. They are attached to it by ligaments and are about the size of large olives. The ovaries contain something like 200-400,000 ova when a girl is born. The ova (or eggs) are released at ovulation. An ovum can survive for 24-28 hours. Ovulation is part of the menstrual cycle. This cycle ceases at menopause (unless there has been surgery to remove either the uterus or ovaries earlier).
- The uterus or womb is a strong muscular organ about the size of a fist. It protrudes in to the end of vagina. The lining of the uterus is called the endometrium and is dispelled from the vagina during menstruation. If a woman is pregnant, this lining develops into the placenta and the foetus grows inside the uterus.
- The cervix is sometime called "the neck of the womb" as it protrudes into the end of the vagina and feels like the tip of a nose. There is a small opening in the cervix called the "os". The cervix makes mucus which changes during the menstrual cycle due to the effect of oestrogen and progesterone. There are two types of cervical mucus. One which is called hostile, or infertile, mucus that helps to block the cervix and acts as a barrier. The other is called fertile mucus and is like egg white. If there are sperm in a woman's vagina when there is fertile mucus present, it allows for easier entry into the uterus and fallopian tubes.

The vagina is elastic muscle tissue lined with folds of skin but can be easily be stretched open. The opening of the vagina is surrounded by strong muscle and nerve endings. The vagina is moist. Its moistness varies throughout a woman's or girl's menstrual cycle and when she is sexually excited. The vagina ends the cervix and is able to keep itself clean and healthy.

Woman's reproductive organs



Men's reproductive organs



Internal View

- The Testicles are where sperm and testosterone, a male hormone, are produced. Once the production of sperm begins, it continues throughout a man's life unless something interferes with his fertility. Production of sperm happens continuously.
- The Epididymis is where the sperm are developed.
- The Vas Deferens are the tubes which store and carry sperm.
- The bladder is where urine is stored. There is a valve at the base of the bladder which closes when the penis is erect. This prevents urination.
- The Seminal Vesicles produce and store semen. Semen is the pale-coloured liquid which maintains and supports sperm. It is alkaline and contains fructose.
- The Prostate Gland produces semen and also stores both semen and sperm. The prostate is a sensitive organ which acts like a pump as it pushes the ejaculate (semen and sperm) out of the penis when a man has an orgasm.
- The Cooper's Glands are on either side of the urethra and contain a clear alkaline fluid that cleans the urethra before a man or boy ejaculates. This fluid is often called pre-cum or pre-ejaculate. It may contain sperm.
- The Urethra is the tube that runs from the bladder and seminal vesicles to the opening at the head of the penis. Semen, urine and pre-cum pass down the urethra.
- The Penis is made of spongy erectile tissues. When a man is sexually excited his penis becomes erect. Blood rushes into the spongy tissues making the penis bigger and stiffer. Men and boys can have erections when they are not sexually excited. Unwanted erections occur when the stimulation that is not necessarily sexual.

SOME DEFINITIONS

Menstruation and Fertilization

- The uterus lining breaks down and blood and fluid will come out of the vagina for the next few days because fertilization has not taken place.
- It will usually happen around 14 days after ovulation.
- An ovary releases an ovum every 3-5 weeks, so girls will get periods every 3-5 weeks, unless they are pregnant, until menopause.

How many sperm does it take to fertilize an egg?

- Although a man releases an average of 20-400 million sperm each time he ejaculates, it only takes one sperm to fertilize one egg.

How many eggs are generally released?

- Generally, only one egg is released at a time in each menstrual cycle.

When are the eggs released?

- An egg or ovum is released from the ovary midway through the menstrual cycle, about 12-16 days before the next period is due. This is called ovulation. The egg is drawn into the fallopian tube by the fimbria at the end of the tube.

Where does the sperm fertilize the egg?

- The sperm travel to the top of the uterus (or womb) and into the fallopian tubes. Fertilisation has to take place in the fallopian tube itself, generally in the part closest to the uterus.

Conception

- Conception occurs when the fertilized egg implants itself in the lining of the uterus. Once the egg implants in the uterus, it develops into an embryo. If the fertilised egg does not implant itself into the lining of the uterus, there will be no pregnancy.

Pregnancy

- A process of growing foetus in the uterus (womb) of the mother

Signs of getting a pregnant

- Do not have menstruation
- Stomach and breasts become bigger
- Get headache and vomiting in the morning
- Areas around the nipples become darker
- The woman feels there is baby movement
- Heart of the baby can be heard

Sign of dangerous pregnancy

- If these signs occurs, refer to hospital immediately:
 - Having a haemorrhage
 - Liquid coming out during pregnancy
 - Pale and weight less than 45 Kg
 - Convulsions
 - Swollen in the body especially in the feet
 - Blurred vision and often getting headaches
 - Increasing blood pressure

Giving birth

The process of the baby coming out from the mother

EFFECTIVENESS AND METHODS OF CONTRACEPTION

The results of effectiveness test of each method in Indonesia are estimated in the table below. If 100 women use the method for a whole year less than 1 of these women will get pregnant up to 20 of the women depending on the method. This is compared to the fact that if 100 women do not use any contraception then 85 of them will be pregnant within the year.

Method		Number who will still get pregnant:	How effective each method is in preventing STI:
	Injection	Less than 1	Not prevent
	Implant	Less than 1	Not prevent
	Sterilization both men and woman	Less than 1	Not prevent
	IUD	1	Not prevent
	Exclusive breastfeeding till 6 months.	2	Not prevent
	Integrated Pil	3	Not prevent
	Condom for men	12	Good
	Diaphragm	18	Only effective to prevent certain diseases
	Natural FP	20	Not prevent
	Condom for woman	20	Good
	Spermicidal	20	Only effective to prevent certain diseases
	Not used FP	85	Not prevent

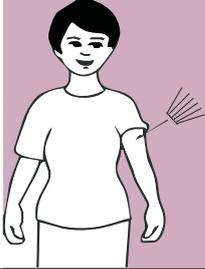
METHODS OF CONTRACEPTION

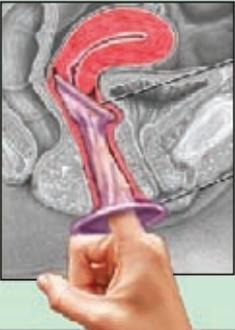
The following tables give additional information about each method common in Indonesia. The information given here is similar to the flip chart used by health staff. The colours in that chart for each method have been replicated here to lessen confusion in the field. That is, keeping the information flow standard through the system.

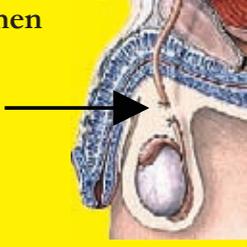
MAL (Metode Amenorea Lactation) 	This method depends on breast feeding. It will effective if the breast feeds are given full time during the day and night without giving any food supplements; the mother has not got her menstruation, and the infant has not reach 6 months old
How it works:	Postpones the restart of the fertility period, effective till 6 months if giving exclusive breastfeeding.
Benefit:	For infants: get maternal antibodies. The best source of nutrition for growth of the infant. For mothers: very effective, no side effects, no cost.
Prohibition:	Menstruation returns after child birth, not exclusively breastfeeding, the infant is over 6 months, working and separated from the infant for more than 6 hours. It is suggested that besides used the MAL, it is better to combine with other methods that will not interrupted breastfeeding, for example: IUD, pill, injection or implant.
Combined oral contraceptive pill (COC) 	This is a sort of medicine, in the form of pills that contain hormones like oestrogen and progesterone that are taken by the mother.
How it works:	Prevents the release of ovum from the ovary, thickens mucus in the cervix, so sperm have trouble penetrating into the uterus. Taken one each day, but if it is forgotten women can get pregnant. If women stop taking the pill, she can get pregnant immediately.
Benefit:	High effectiveness, easy to use, low risk in terms of health. It can be used for long term, menstruation cycle becomes regular; easy to stop any time. Could reduce bleeding during menstruation and cramps.
Side-effect:	Headache, nausea during the first 3 months, may gain weight, blood spotting at the first 3 months, could increase or reduce weight.

<p>If forgot to take pill:</p>	<p>Always:</p> <ul style="list-style-type: none"> • Take the pill immediately when remember, • Take the next pill based on the schedule, • Continues to take the pill as normal, one every day • If forgot to take 2 pills or more, or late to start the package for 2 days or more, need to use back up (avoid to have intercourse or use condoms for 7days) and pass the inactive pills and go direct to the new package. <p>Special rules for missed inactive pills: throw these pills away that are forgotten to be taken then continue to take the pill based on schedule.</p>
<p>Women who are out suggested to take pills:</p>	<ul style="list-style-type: none"> • Are exclusively breast feeding • Bleeding with unknown causes • Have hepatitis • Cancer: heart disease, high blood pressure , diabetes • Have migraines • Smoker with age > 35 years old • Have experience of breast cancer • Tuberculosis
<p>Where to get the services</p>	<ul style="list-style-type: none"> • Village midwife • Mobile clinic (Posyandu) • Family Planning Commission branches or cadre • Health centres and hospitals.
<p>FP Injection – Depo Provera</p> 	<p>This is an Injectable medicine that contains the hormone progesterone, and used for every 2 or 3 months. There is also FP injection that contains a combination of hormones (progesterone and oestrogen) that is given every month – the following information concerns the 2-3 month injection only.</p>
<p>How it works:</p>	<ul style="list-style-type: none"> • Prevents release of ovum from the ovary. • Thickens mucus in the cervix, so that sperm cannot penetrate to the uterus.
<p>Benefit:</p>	<p>It is very effective for long-term use, few side effects, reduces bleeding, prevents anaemia, suitable for women who breastfeed after child birth – can be given 6 weeks post partum.</p>
<p>Side-effect:</p>	<p>Late having or not getting menstruation, having blood spots during menstruation period, changes in body weight (gaining weight).</p>

<p>Intra Uterine Device (IUD) </p>	<p>IUDs are contraceptive devices made from smooth plastic, and there is type with copper wire around the plastic that is inserted into the uterus. The Copper T is an IUD type that is commonly used in Indonesia</p>
<p>How it works</p>	<ul style="list-style-type: none"> • To prevent the sperm and ova implanting in the uterus lining. • Very effective and does not depend on memory
<p>Benefit:</p>	<ul style="list-style-type: none"> • High effectiveness in preventing pregnancy, does not affect sexual activities, does not affect quality and quantity of production of breast milk, can be used for long periods (up to 10 years). • Can be taken out at any time and pregnancy can happen soon after. • Copper T 380 can work up to 10 years so good for women who have finished their family. • IUD has to be taken out 1 year after the last menstruation finished, when sure menopause has occurred.
<p>Prohibition:</p>	<ul style="list-style-type: none"> • Pregnancy, breast cancer, heart diseases, having genital infection.
<p>Side-effects:</p>	<ul style="list-style-type: none"> • May have stomach pains after insertion for a short time, may change menstruation cycles, blood spots between menstruation cycles, having more blood and longer menstruation period, back to normal after 3 months insertion. • Does not protect from HIV/STI, for having prevention from HIV/STI, use condoms as well.
<p>Cannot Used IUD if:</p>	<ul style="list-style-type: none"> • Can have insertion up to 2 days post delivery but if not then must wait for 4 weeks. • Having risk of STI including HIV). • Having abnormal menstruation –it should be assessed before inserting IUD. • Having an infection or problem related with women's organ: any infection should be cured properly; STI or other pain within last 3 months.
<p>Where to get the services:</p>	<ul style="list-style-type: none"> • Health centres. • Hospitals.

<p>Implant</p> 	<ul style="list-style-type: none"> • Is one, two or 6 plastic tubes that are put underneath skin in the upper arm. • Smooth tubes which will not disturb the women. • It can be seen under the skin, there is no scars if inserting and taking out properly. • Insertion and taking out done by trained staffs through simple operation. • Contain hormones progesterone without oestrogen.
<p>Very effective:</p>	<ul style="list-style-type: none"> • Effective for 3 years with 1-2 tubes and for 5 years with 6 tubes. • Easy to be stopped and can be taken out any time by someone trained in the procedure, fertility returns quickly after removal. • Mostly safe for all women, similar to 2-3 month injection • Usually effects menstruation cycle • Not preventative for STI/HIV
<p>Those who are not suitable use implant:</p>	<ul style="list-style-type: none"> • Giving breast feeding less than 6 weeks • Pregnant • Having serious health problems
<p>Possible side effect:</p>	<p>Very common:</p> <ul style="list-style-type: none"> • Spotting with menstruation <p>Common:</p> <ul style="list-style-type: none"> • Not regular menstruation • Not having menstruation <p>Rare;</p> <ul style="list-style-type: none"> • Headaches • Increasing size of ovaries • Dizziness • Breast pain • Restless • Nausea
<p>When can it be inserted?</p>	<ul style="list-style-type: none"> • It can be inserted any time as long as the woman is not pregnant. • After giving a birth even if breast feeding • It can start 6 weeks after child birth • If period of delivery within 6 weeks till 6 months, exclusive breast feeding and not yet got menstruation can be inserted any time. • If not breastfeeding, it is better to start 6 weeks after delivery. • After give a birth if not breast feed: • Can be done right after give a birth – no need special protection, • 6 weeks after give a birth if sure not yet get pregnant. If not yet get menstruation, avoid having sexual or use condom 7 days after inserting implant. • The implant insertion takes 5-10 minutes. • Taking out take about 15 minutes.

<p>Condom for men</p> 	<p>The condom is FP device that is thin rubber and elastic used by man when having sexual intercourse.</p>
<p>How it works:</p>	<p>To prevent the meeting between sperm and ova so that pregnancy will not happen.</p>
<p>How to use it:</p>	<p>Use it when about to have intercourse. Put it on when penis gets erect. Pull off the rubber by push it slowly to the end of penis, take it off soon before the penis goes back to normal and avoid the semen spilling around vagina. Use it once; throw away the used condom carefully into the rubbish bin after tying the opening. Do not keep in hot temperatures it makes it damage, do not use if damaged cover, do not used oil, except FP jelly.</p>
<p>Prohibition:</p>	<p>Partner who are skin allergic</p>
<p>Where to get it:</p>	<p>Family Planning Commission / cadre, village midwife, mobile clinic (Posyandu), pharmacy, health centres or hospitals.</p>
	
<p>Condom for women</p> 	<ul style="list-style-type: none"> • Use for preventing the meeting between sperm and ova. • Can be used inserted any time before having sexual intercourse. • Should not be reused. • This is the very effective device to prevent pregnancy and STI / HIV that is controlled by women. • Not to be used together with condom for men

<p>Permanents methods for women</p> 	<ul style="list-style-type: none"> • If it is used it will be for the entire life. • This method cannot be put back to the original condition –only for women who do not want to have any children any more. By using this method cannot get pregnant anymore. • It needs an operation in which fallopian tubes are cut or tied (the uterus is not touched, women still has menstruation). Have pain for few days after operation.
<p>How it works:</p>	<p>Fallopian tubes are cut or tied.</p>
<p>Benefits:</p>	<p>Very effective, safe for almost all women.</p>
<p>Prohibitions:</p>	<p>Almost none but it is not suggested for women who has not yet any child or just has one child but wants to have more children.</p>
<p>Side effects:</p>	<p>No side effect for the long term.</p>
<p>Where to get the services</p>	<p>Hospitals</p>
<p>Permanent contraception for men</p> 	<ul style="list-style-type: none"> • Method cannot be put back to original, especially for men who do not want to have more children. • Very effective and safe for almost all men. • Does not affect the ability to have sex. Men still get erections. • Work for prevent releasing sperm, can have ejaculation of semen, does not affect masculinity. • By doing small operation to cut or tie on the left and right sides of the scrotum so that the sperm cannot be released when having sex.
<p>Operation:</p>	<ul style="list-style-type: none"> • Still in conscious condition, has local anaesthetic injection to numb skin of scrotum. • Normally can go home few hours after operation • Gets some pain for few days after operation but less than circumcision! <p>Steps of operation:</p> <ul style="list-style-type: none"> • The man will be conscious for the procedure; the doctor will inject the skin of the scrotum with a local anaesthetic to make the area numb. • The doctor will make a small incision about 1 cm and will lift up the Vas Deferens (the tube that carries the sperm from the testes) and will either cut and tie it or put a clip on to block the tube. • The doctor will then place a small stitch to close the skin. • The doctor will then repeat on the other side. • The procedure takes about 15-20 minutes.

	<p>After the procedure:</p> <ul style="list-style-type: none"> • The man will rest at the clinic and can usually go home after he has passed urine. • The man should bring a pair of underpants that are cotton and firm to support him - he should wear this type of underpants for about 4 weeks but change daily or if dirty. • The man should be given pain tablets to take and rest at home for a few days. • The man can put ice packs on the area for 30 minutes at a time. • If he has stitches on the skin they usually will fall out in a week. <p>After having operation, check if the following and return to the clinic :</p> <ul style="list-style-type: none"> • Swollen within few hours after operation. • Having tremor within the first 3 days • There is abscess or bleeding from the wound • Painful, high temperature, redness. <p>The most important: The couple should continue to use other contraception for 6 weeks and have had at least 20 ejaculations during that time to flush out sperm already in the system before the procedure.</p>
Side-effects:	No side effect for long term.
Benefit:	<p>Very effective, safe for almost all men, does not affect the sexual ability, does not cause impotency.</p> <p>Almost all men can have operation any time he want but need to wait if:</p> <ul style="list-style-type: none"> • Have problems with the genitals, such as infection, swollen, wounded in the genital organ. • There is a serious problem or infection.
FP method for couple who partner is working abroad for long time.	<ul style="list-style-type: none"> • For couples who stay separately because one of them has to work overseas, they need to develop good communication and trust between them. • Before leaving each other they need to discuss the usage of FP methods. • If the current FP method used needs to be stopped or removed there is a need to plan the usage of FP methods prior to the arrival / return of the partner. • Communication needs to be kept in order to know when the partner will be back.

FP after childbirth

- Consideration of contraception after childbirth should be part of birth planning discussions with the midwife so that the woman has a set plan as to what she will do.
- If not giving exclusive or almost exclusive breast feeding, the mother can get pregnant within 4 weeks after childbirth.
- Giving exclusive breast feeding or almost exclusive within the first 6 months can prevent pregnancy but if the woman's menstruation returns then she is fertile again. It is common to ovulate before getting the first menstruation so women should plan their contraception before this time. The introduction of weaning foods is also a good time and reminder to start the injection or the pill.
- If wanting to have a permanent method after child birth, the mother should plan her delivery at a hospital or health centre. The permanent method should be done within 7 days after child birth. If not the need to wait another 6 weeks.
- If wanting to IUD after child birth, the woman needs to plan delivery at a hospital or health centre. The IUD should be inserted within 48 hours after child birth. If not, the woman needs to wait at least 4 weeks for inserting the IUD.

COMMUNICATION

Tips to be the effective communicator:

1. Explain the message clearly
2. Consider the receiver's feelings regarding the message to be delivered
3. Be sensitive to the receiver's attitude towards the communicator
4. Adjust the way of delivering the message to the characteristics of the receivers:
 - Try to put yourself in the position of the receiver
 - Deliver the message with simple and concise language
 - Deliver the message gradually and systematically
 - Repeat points that are important and need emphasis
 - Give concrete examples
 - Link an idea with what is known by the receivers
 - Explain the important ideas first, do not get into detail
 - Avoid noisy places

The active listener

- Active processes require active participation of the listener
- Listen with full attention
- Listen with an effort to comprehend the point of view of the person who is talking
- Listen with an effort to understand the feelings, felt and unfelt.

Tips for active listener:

- Accept the client and respect the client as a unique individual that is different to others
- Listen to what the client says and how the client says it
- Pay attention to the voice, words used, facial expression and body language
- Put yourself as the client during listening
- Allow time for the client to think, to ask questions and to talk depending on the speed of the client
- Listen to the client carefully, do not think of what you are going to say next
- Do repeat what you have heard, so both of you know that you understood
- Sit facing the client as convenient, avoid a move that may disturb, face the client when the client is talking
- Show verbal attention (hmm, yaa, go on,) and non verbal (nodding).

Tips on effective questioning

- Use the voice tone that shows attention, curiosity and familiarity
- Use words that are understood by the client
- Pose questions one by one. Wait for the answer with full attention, do not interrupt the answer
- Use the words that encourage the client to keep talking: “and?”, “how?”, “then?”, “meaning?”
- If needing to ask private things, explain why they are important to be asked

- Try to avoid using “why?”. Because the client could feel “blamed”
- Pose similar questions with various ways if the client has not yet understood
- Try to avoid leading questions
- Use “open questions” because they are more effective than “closed questions”

Interpersonal communication steps

- Greetings to client, welcome the client and pay attention to the client
- Ask questions

Ask the client in order to know their knowledge, feelings and the client's need about contraception

- Explain

Provide information on methods and devise FP that is wanted to be known by the client

- Help

Help client to see the appropriateness of the FP method with condition and needs of the client

- Explain in detail the method and FP device that is chosen by the client
- Further visit to FP service if needed

CASES FOR ROLE PLAYS

Ani, 20 years old

I have just one child that born 2 weeks ago, I want to join FP but I do not know about FP methods that I am going to use and where I can get information about FP because I want to delay to have another child in order to allow my child grow up.

Yuyun, 23 years old

I wanted to join FP but I am afraid because someone told me that if I am breast feeding, my breast milk will be disturbed, but I do not want to have another child because I have 2 children and the space between the first and second child was only 1 year. Do you think you could help me?

Johar, 35 years old

My husband is working overseas and I am using the IUD, I have 3 children, I want to stop using the IUD, but I do not want to have any more children. What if my husband comes home, I am afraid to get pregnant again.

Endang, 40 years old

I want to join FP, but my husband does not allow me but I do not want to get pregnant again because I already have 3 children and I am afraid to get pregnant because my age has reached 40 years. How I can explain to my husband so he will allow me to join FP.

Rehan, 37 years old

I had many problems with my last pregnancy. My doctor warned me that if I get pregnant again, I could die. I used the FP injection but it was not suitable. I used the IUD also but I got bleeding often, I want that my husband could join the FP but my husband does not yet know anything about FP.

Ami, 21 years old :

I have 1 child who is 2 months old, I want to join FP but I do not know which FP method I should use that will allow me to have another child after my child is 3 years old.

Ria, 39 years old

I and my husband have thought that we will not have any more children. We want to provide good lives to both of our children. We want to use a FP method but I heard the side effect that I may experience using FP pill.

Rian, 30 years old

I have 2 children and I want to joint FP but I have a problem because my parents in law did not allow me because they believe that FP is prohibited by religion.

Rani, 30 years old

I have 2 children and now I am pregnant with my third child because of failure of using the FP injection. After giving birth later, what FP method can I use?

Eka, 30 years old

I am afraid to use any FP method. I heard that if using the IUD I will not get pregnant any more. I have just 1 child and I want to have another child.

Yuli, 35 years old

I used the IUD last month, after that, I felt my condition was not well enough especially if I wanted to have sex, I felt I did not want to. Did I choose the wrong method? In fact actually I do not have any complaints about it.

Fitri, 22 years old

I am afraid to use any FP method. I heard that if using the IUD I will not get pregnant any more. I just have one child and I want to have another child.

SUPPLEMENTARY DOCUMENT

Desa Siaga Cost Analysis

in

the West and East Nusa Tenggara Provinces - Indonesia



DESA SIAGA COST ANALYSIS

IN NTB AND NTT

BASED ON THE SUPPORT
OF GTZ SISKES DURING
2006-2009



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DESA SIAGA COST ANALYSIS in NTB & NTT

BASED ON THE SUPPORT
OF GTZ SISKES DURING
2006-2009

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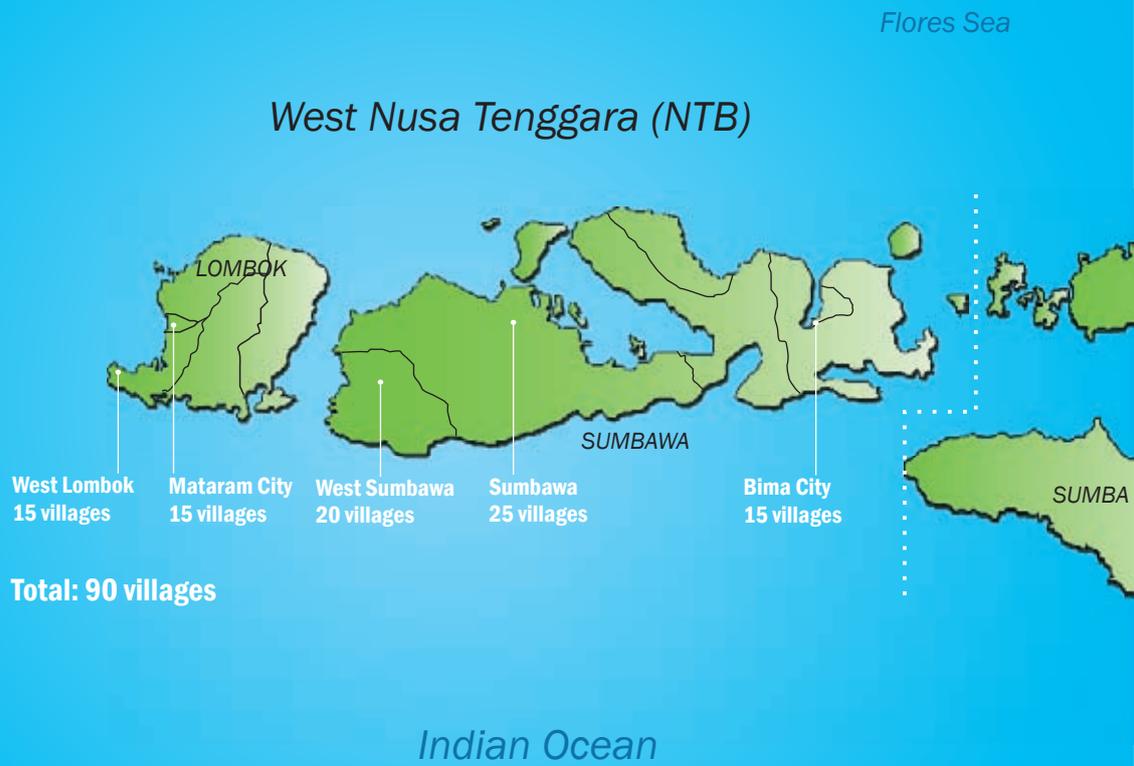
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List of Desa Siaga villages supported by SISKES in West Nusa Tenggara Province



List of Desa Siaga villages supported by SISKES in East Nusa Tenggara Province



1. EXECUTIVE SUMMARY

1.1 INTRODUCTION

Desa Siaga (DS) is part of the national program of the Ministry of Health (MoH) for the development of the Health Sector in Indonesia. The term “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. It covers many aspects: Improvement of maternal and neonatal health, improvement of people's nutrition, promotion of healthy life styles, improvement of sanitation and promotion of healthy environments, simple epidemiology and support of the community health centre. In order to achieve the objectives of Desa Siaga regarding reducing maternal and neonatal death, the strategy of “Siap Antar Jaga” (Ready to bring and to take care) has been developed and supported by GTZ SISKES during 2006-2009 in Nusa Tenggara Barat (NTB) and Nusa Tenggara Timur (NTT) provinces. GTZ SISKES facilitates the villages to form 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.

Each province uses its own strategy and approach adapted to the local context. 90 villages are established and are functioning in NTB and 50 villages in NTT. As the support of GTZ SISKES III ends at the end of December 2009, there is a need for takeover of the DS implementation strategy and a further roll out by other stakeholders. Furthermore, the national Minimum Service Standards (SPM) state as target a 80% coverage of all villages with active DS, to be achieved by 2015.

1.2 OBJECTIVE

This cost analysis provides additional information for all stakeholders (local government, MoH and its institutions, PHO, DHO, community, external agencies and NGOs) contributing to informed decision making regarding DS implementation and this from an economic perspective. It provides information for appropriate budget allocation for implementation, support, roll out and take over of DS, especially as resources are scarce and funding for DS is available through different sources and stakeholders. This cost analysis offers a tool to assist in planning, budgeting and analysis of the expenditure for DS. It completes the DS toolkit, which is a complete information box containing technical guidelines, case studies, training modules etc to support advocacy and implementation of DS.

1.3 METHODOLOGY

To enable the cost analysis, a tool in excel has been developed, which describes all DS activities in six steps and in terms of cost categories. For each cost category, physical unit costs are determined with intervals to cover all variations encountered in the data and to deal with the uncertainty this creates for the results. Breakdowns of the total unit costs for one village for one year are done enabling policy relevant information. First by considering the establishing versus the operational costs, then by step and activity and further by the location where the activity is organized and by cost category. A societal perspective is chosen and the boundaries of the cost analysis are set so that a clear decision could be made on which costs to include or to

exclude for the final unit cost calculation. Only direct cost for the implementation of DS are included, indirect and other costs linked to the development and dissemination of IEC material, the training modules, TOT etc are excluded. All results are expressed in unit cost per village for one year of activity. Some of the results are also expressed per batch of five villages and/or for each activity implemented only once. These estimations, which reflect the situation of sufficiently available resources, can be compared with the situation when resources are scarce. Qualitative advice is given on how to reduce the total unit costs and in the case of NTB a quantitative simulation and calculation of the absolute minimum costs to take into account is done. The costs, which can be excluded or decreased when resources are scarce, can be considered as “influencing factors”.

1.4 RESULTS

NTB and NTT implement DS in respectively 90 and 50 villages. The cost for the implementation of DS for one village for one year in NTB is Rp. 53,414,400 (or 4,109 €¹) and in NTT Rp. 74,615,500 (or 5,740 €). 80% of these costs are for establishing the DS concept in the village and 20% are for operational activities to maintain the functioning of DS. NTB spends more money on activities for establishing the networks in the villages and this at village level, while NTT spends more on the two trainings, organized at district level. It takes 17 separate activities in NTB and 19 in NTT to go through the whole process. NTB has more activities for M&E after establishment of DS while NTT has more separate activities for conducting the self assessment health survey and the establishment of the networks. Around 35% of the total unit cost goes to transport and daily allowances of the people involved, 30%

to the meetings and 20% to the honoraria of resource persons, trainers and moderators. 40% of the costs are for activities at village level, 60% for activities at district and province level, of which NTT focuses almost adaptations can be done entirely on district level.

When resources are scarce, several to decrease the total unit cost. The first adaptation is a decrease of the physical unit costs. Some activities can be done cheaper by using free meeting rooms, by negotiating lower unit costs for food with a catering service or by decreasing the stationary costs. Before the implementation started, an agreement was reached between GTZ and the local partner on the payment of fees, transport costs, daily allowances etc. These rates are lower than what is stipulated in the national and local regulations and differ between both provinces and all districts.

The second adaptation is a decrease on the number of people involved and on the number of separate activities. It is worthwhile to look where and how activities can be combined or included in other events (“piggy back” strategy) and if more villages can be involved at the same time (economy of scale) to go through the whole process together. It will depend on the availability of resources, the creativity of the decision makers and implementers and on their ability and willingness to pay for what is needed. The simulation done for NTB is based on the costs which are absolute necessary for the implementation of DS. The total unit cost for one village would then be Rp.36,579,350 (or 2,814 €).

The maximum and minimum values of the intervals, which are created to deal with the uncertainties regarding variations in the physical unit costs, are used to present two alternative scenarios. One scenario is based on all the maximum values and one is based on all the minimum values to recalculate the total unit costs. Somewhere in between lays the real cost for one village. In NTB, the minimum

¹ Rate: 1 euro=13,000 IDR

total unit cost for one village for one year of operation would be Rp. 35,265,800 (or 2,713 €) and the maximum total unit cost would be Rp. 71,145,600 (or 5,473 €). While in NTT, the minimum total unit cost would be Rp. 70,356,000 (or 5,412 €) and the maximum total unit cost would be Rp. 78,875,000 (or 6,067 €). The intervals are broader for NTB, the values of the minima and maxima vary max. 34% around the calculated unit cost. For NTT the intervals are much smaller, the values vary max. 9% around the unit cost.

1.5 INTERPRETATION

Implementation of DS costs time and money. Not only to establish but also to maintain the function. But once DS is established, only 20% of the total unit cost needs to be provided to maintain DS in the village. If this budget is not available, creativity can be used to reduce costs. The results show differences in the total unit costs and in the breakdown of the costs in steps, number, types and place of activities between both provinces. The costs of NTB are lower than the costs of NTT. These differences reflect the particular approach and strategy chosen in each province to implement DS.

NTB believes in a clear distribution of responsibilities and tasks between all stakeholders, linked to their place in the health system, with a coordination role for DHO. This approach of “the right stakeholder for the right activity at the right time” facilitates the implementation and it reduces the costs, confusion and delay of waiting for approval to go ahead with the next activity. While for NTT the involvement and role of DHO is much more prominent and comprehensive as the DHO is involved in all aspects of organization, coordination and implementation of DS. The disadvantages of the “DHO focus” are the higher total unit costs, a longer and more cumbersome process as the DHO have many other tasks and responsibilities and are therefore not always available. The high

turn-over of staff without proper handing over and transfer of knowledge and experiences regarding DS slows down the process. But NTT believes it is worthwhile investing the extra money, energy and time involving the DHO during the whole process as DS is part of the national program of the MoH. This approach is believed to strengthen their role in the coordination and implementation of DS and should have a positive impact on the sustainability of DS.

The longer the process, the more separately organized activities, the more participants per activity and the more activities at district and province level, the higher the costs are. Village activities are the cheapest activities as there are less transport costs, lower rates, cheaper food and meeting packages to be paid. NTT implements the DS concept by two more activities than NTB, spending more money for trainings and organizing most village activities separately for each village. While NTB spends more on activities of the actual establishment of the DS networks in the village, combines more activities and includes more villages into one activity, which all reduce the costs. Not all activities need funding in NTB, eg the selection and recruitment of the Village and District Facilitators. While in some districts in NTT these are organized as separately activities with extra costs. NTT involves more people for its activities which also leads to the higher total unit costs, while in NTB participation in activities is limited to the people really needed according to their responsibility in the DS process.

There are also differences between both provinces in the selection of the villages in which to implement DS with implications on the costs. In NTB the choice is made by DHO and GTZ based on a number of conditions and on the guiding principle of having interventions as well on the provider side as on the demand side at the same time to ensure impact on health indicators. All selected villages are in the catchment area of a

PONED PKM, which received also the PKM management training. The villages have an APN trained midwife and a POSKESDES. Some villages are in the same PKM catchment area which enables combining activities, limits DF and VF travel distances and facilitates regular support and follow-up. For NTT, the choice of villages is done by the DHO and this by equal geographic distribution within the district, which means the chosen villages are not around one and the same PKM, very far away from each other and spread out over the district. The PKM are not necessarily involved in other GTZ supported activities. This way of choosing the villages limits the possibility of combining activities for several villages at the same time, except for activities done at district level, eg training, which results in higher total unit costs.

The more villages in one batch, the less frequent activities need to be repeated, the quicker the process and the lower the total unit cost per village will be. NTB organizes its villages into two big groups, the Lombok group (3 batches of 10 villages each) and the Sumbawa group (3 batches of 20 villages each), and organizes the trainings at province level so that more villages can participate at once. Due to the individual district approach in NTT the batches are smaller, only 4 till 6 villages per district and per batch. The results show differences in width of the intervals of the total unit costs between both provinces. NTB has broader intervals than NTT. This means that the degree of uncertainty in terms of “what is now the exact total unit cost for one village?” is higher for the results of NTB and that the estimations of NTT are more certain or “precise”. This is because NTB uses data of all 90 villages to calculate the physical unit cost and encountered therefore much more variation in physical unit costs. There are more different geographical distances to be considered and thus differences in local transport rates, food prices and accommodation rates; while NTT uses data of only ten villages out of two

districts which means less variation in physical unit costs. Even though that all unit cost calculations are lower for NTB, the differences in unit costs between NTB and NTT may not be that big in reality as the intervals overlap each other slightly.

1.6 CONCLUSION & RECOMMENDATION

Implementing DS is a challenging process which needs a lot of resources in terms of time, money and people involved. Community empowerment is a means and not an end in itself. It is a long process in which people need to change their behavior and mindset, knowledge has to be disseminated, trainings have to be done, and an intense follow up has to be organized. It involves a whole range of different stakeholders, who need to meet and discuss regularly. Decision makers and implementers can choose a specific approach which fits their context the best, with implications on the costs.

Many factors influence the total unit cost for one village and should be taken into account when planning and budgeting for DS implementation. The approach, the physical unit costs and the number of villages in one batch have the highest influence on the total unit cost followed by the numbers of persons involved, the combining of activities and piggy back strategy. Besides the direct costs, there are a number of indirect and other costs which are not included in the total unit cost as presented here. They should be considered too. All resources come almost entirely from GTZ, except for NTT. In NTT, the local government of district Belu contributes up to 10% to the DS activities and there is cofinancing of all DS activities by VSO. The partnership with VSO is based on a grant agreement between GTZ Eschborn and VSO London, made possible through the Dfid cofinancing part of GTZ SISKES project. But it is possible to fund the entire process and all activities with

government funds. It is of tremendous importance to have a strong coordination of all stakeholders to obtain all funding for all activities from all the different funding sources timely to enable an appropriate chronological order in the implementation of the activities. A good collaboration with appropriate planning and budgeting is needed to be able to maintain what is build up and to replicate or roll it out to other villages. The DHO is the most appropriate structure within the health system and Bapeda outside the health system to take up this coordinating role. Not only a strong coordinator but also a strong implementer is needed because of the long and complex process of community empowerment. This can be achieved by working closing together and by distributing clear tasks and responsibilities with an intense follow-up. Not only the establishment of DS and the coverage of more villages are important but also attention is needed for the quality of the functioning of the alert system and networks in order to achieve impact. Decent M&E with impact measurement should be part of the process.

For each specific setting, the total unit cost will be different, depending on the available funds, creativity and the willingness and ability of the stakeholders to pay for what is needed. The roll out to other villages to scale up the coverage of DS in the same district or province will be easier and at a lower unit cost for the new villages as there is no need for orientation meetings at province and district level anymore, DF and VF are already selected, the guidelines and training modules are developed, and the PKM facilitators have the knowledge and experience. Organizing these new villages in large groups or batches will also keep the cost for one village down.

Adding more aspects out of the DS concept, for example the disaster preparedness into the existing framework of DS in the village will go much easier, faster and at a lower cost. Roll out to a new province or district will follow

the same base-case scenario as presented here in the cost analysis as all steps and activities will have to be implemented.

The next step is to link these results with the findings of the DS Impact evaluation. Both analyses will enable an economic analysis.

2. INTRODUCTION

Desa Siaga (DS) is part of the national program for the development of the Health Sector of the Ministry of Health (MoH) in Indonesia. The term “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 spirit of togetherness.²

It covers the following aspects:

- Improvement of maternal and neonatal health
- Improvement of people's nutrition
- Promotion of healthy life styles
- Improvement of sanitation and promotion of healthy environments
- Simple epidemiology
- Support of the community health centre³

In order to achieve the objectives of Desa Siaga regarding reducing maternal and neonatal death, the strategy of “Siap Antar Jaga” (Ready to bring and to take care) was developed. This strategy focuses on increasing the involvement and alertness of the community and on strengthening them to overcome the problems and to take action in terms of the non clinical aspects of maternal and neonatal emergencies.⁴

During 2006-2009 the GTZ SISKES project supported Nusa Tenggara Barat (NTB) and Nusa Tenggara Timor (NTT) provinces with the implementation of Siap Antar Jaga, as part of DS. SISKES facilitates the villages to form their own alert system and networks, which

cover notification of pregnant women (by using the P4K sticker⁵, flags or other symbols), provision of transport for medical emergencies, financial support, blood donors and a Reproductive Health, including Family planning Information post. Each province uses its own strategy and approach adapted to the local context enabling the communities to manage their emergencies. 90 villages are established and functioning in NTB and 50 villages in NTT.

As the support of GTZ SISKES III ends at the end of December 2009, there is a need for takeover of the DS implementation strategy and a further roll out by the other stakeholders, eg MoH, the local government, NGO, external agencies etc. Furthermore, the national Minimum Service Standards (SPM) state as target to achieve 80% coverage of all villages with active DS by 2015.

This cost analysis provides additional information for decision makers, other external agencies and all stakeholders to enable making informed choices and correct budget allocation for the support of DS, especially as resources are scarce and funding for DS is available through different sources and stakeholders.

Furthermore, the cost analysis can lead to a more in depth economic analysis when it will be linked to an evaluation of the results and impact of DS.

² More background information regarding the history and terminology can be found in the technical guidelines of NTT and NTB.

³ The community health center in NTB is the Poskesdes, in NTT the pustu.

⁴ Siap Antar Jaga is not used in NTT but replaced by “DS for the revolusi KIA” which is the MCH program of NTT.

⁵ P4K: program of MoH. Each pregnant women should put a sticker on her house with info related to her pregnancy (date of delivery, who will bring her to the health facility, etc).

3. OBJECTIVE

This cost analysis provides additional information for all stakeholders contributing to informed decision making regarding sustaining existing DS sites and implementing DS in new sites, and this from a financial perspective. More in particular, the analysis enables correct budget allocation for implementation, support, roll out and take over the DS, especially as resources are scarce and funding for DS is available through different sources and stakeholders.

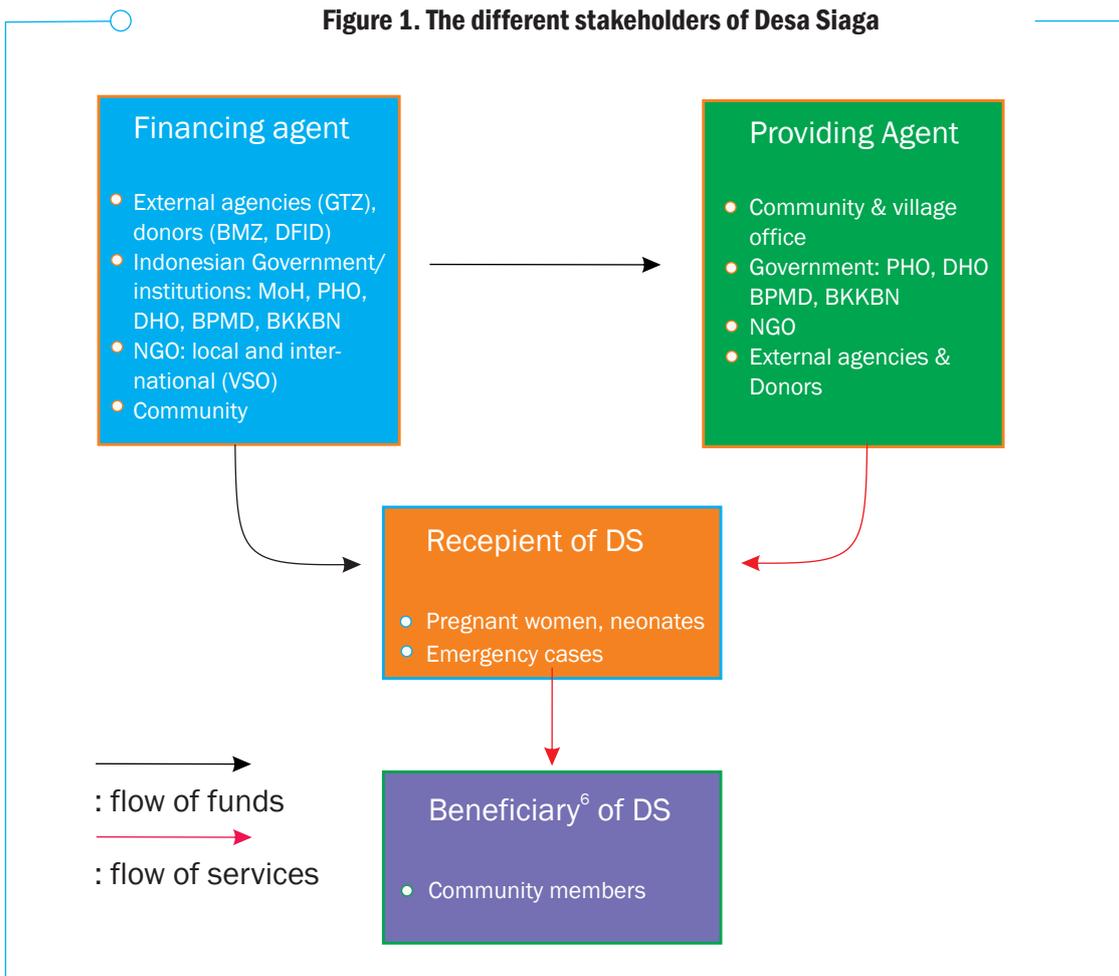
The analysis offers a tool to assist in planning and budgeting for DS implementation. The tool can be used to analyze the expenditure for DS and to compare different settings, here NTB and NTT provinces.

The analysis is part of the “DS Toolkit”, which is a complete information box containing technical guidelines, case studies, training modules etc to support advocacy and implementation of DS.

Linked to the results of an impact evaluation, the analysis provides the cost information necessary for an economic analysis.

4. THE DIFFERENT STAKEHOLDERS OF DS

In regard to this analysis, the different stakeholders can be categorized in financing, providing, receiving and benefiting agents.



This schematic overview demonstrates very clearly the principle that DS is a community empowerment project, in which the community takes up its responsibility. It is done by the community for the community in the community!

⁶ The beneficiaries of DS are the targeted persons whose circumstances, practices or habits changed.

5. METHODOLOGY

To enable the cost analysis, a tool⁷ in excel has been developed, which describes all interventions and activities in terms of cost categories. For each cost item, physical unit cost estimations are made with intervals to cover all variations encountered in the data and to deal with the uncertainties. By determining the perspective and the boundaries of the cost analysis, a clear decision could be made on which costs to include or to exclude for the final unit cost calculation, expressed in **unit cost per village** for one year of activity. Some additional costs and alternative scenarios are considered too.

5.1 DESCRIPTION OF THE INTERVENTIONS

The whole process of implementation of DS takes six steps. The first five steps are for the establishment of DS in the village and need to be done only once. The last step is to maintain the functioning of DS in the village and consists mainly out of M&E activities. These activities need to be repeated on a regular base.

5.1.1 Establishment of DS

For the establishment of DS, 5 necessary steps are considered:

- **Step 1:** Orientation meeting at Provincial (P), District (D) and Village (V) level
- **Step 2:** Training I “The concept of Desa Siaga” and the "Participatory learning and Action" approach of DS
- **Step 3:** Conduct of self assessment survey (Health Situation Analysis)
- **Step 4:** Training II “Community organization on establishment of Siaga

- **Step 5:** Establishment of DS Alert System and networks

All possible cost bearing activities to establish DS in the village are classified in one of these five steps. Each activity is analyzed in terms of “what on which level, for how many persons and how often” and contains all possible cost categories. This enables the comparison between NTB and NTT and the use of the same methodology for other provinces, districts or villages.

5.1.2 Maintaining the functioning of DS

Once DS is established, the functioning needs to be maintained by several kind of activities eg regular M&E meetings at village and district level, contributions of the community to the community fund, the fee for the District Facilitator (DF) in NTT, the transport costs of the network responsables etc. All these kind of activities are classified in step 6, except for the contributions of the community members to the community fund network. These costs are not included in the total unit cost calculation as there is too much variation between the villages.

- **Step 6:** Monitor and Evaluation (M&E) at village and D level

A more detailed and technical description of all steps and activities needed for the establishment and maintenance of the functioning of DS is given in the technical guidelines of DS.⁸ As NTB and NTT used their own approach in terms of number, types, place, costs and combination of activities and stakeholders to be involved, two separate guidelines were developed.

⁷ The tool is an excel framework with filter function, used for both provinces and applicable for planning and analysis of expenditure in any other context. See Annex 1

⁸ See DS toolkit

5.2 COST ESTIMATIONS

5.2.1 Identification of intervention & activity costs

A classic distinction between direct, indirect and other costs is used to classify the different steps and all intervention activities of each step. For some interventions the distinction between different players in terms of responsibility and financing agent is made (government, community or external agency). For each activity we use the same input cost categories.

- Direct-indirect-other costs
- Steps
- Activities
- Cost categories
- Physical unit cost

5.2.1.1 Direct Costs

These are the costs for establishing DS and the costs to keep DS operational after establishment (maintaining functioning of DS). All six steps are direct costs. The establishing costs can be seen as a kind of “investment costs” as these are only needed to be made once. The operational costs can be seen as the “recurrent costs” of the program as they need to be repeated on a regular base.

5.2.1.2 Indirect Costs

Indirect costs are related to loss of productivity for the volunteers and community

members who dedicate a lot of time into the DS activities without being paid. They lose this time to be productive and make money elsewhere, eg working on the field, in a company etc. This could be calculated but goes beyond the scope of this analysis. Neither the costs, made by the community members when applying for the services of the DS networks are included in the analysis. Not only providing a service costs money, accessing a service may have a cost as well, eg transport or phone costs to reach the DS network.

5.2.1.3 Other Costs

There are some additional costs to be taken into consideration. Most of these only have to be made once. These are costs related to:

- Making of advocacy material⁹
- Development and dissemination of the toolkit
- TOT District and Village facilitators

But also the costs made by donors and external agencies to support and evaluate¹⁰ the impact of DS need to be considered.

These costs, sometimes called “Overhead costs” include salaries of international and national staff (consultants, advisors, and drivers), finance agreements with NGOs, vehicles, fuel, office costs, communication, stationary, participation in international conferences for advocacy etc. In this analysis, the costs made by GTZ aren't considered as it is of no interest for the societal perspective chosen in this analysis (see section 5.3). Of

⁹ Posters, film “Siap Antar Jaga”, included in toolkit

¹⁰ A specific DS evaluation has been done in NTT and NTB, 2009, to evaluate the impact of DS. The evaluation is included in the toolkit as a form of salary.

course, if another external agency wants to support the implementation of DS, these costs will have to be considered in their budget.

5.2.1.4 Input cost categories of each activity

Each activity is further broken down into the same input cost categories. These are:

1. Meeting costs
 - Meals (lunch, snacks)
 - Rent of meeting room
 - Meeting package (meeting room and food)
 - Accommodation
2. Travel costs
 - Transport costs, travel allowance¹¹
 - Daily allowance, Per diem
3. Fees
 - Honorarium for facilitator/moderator/resource person (including report writing)
 - Honorarium for trainers, the opening ceremony of WS and trainings
 - Monthly fee for district facilitator
4. Support/material for DS
 - White boards, register/recording books for each network
 - Printing & binding of the results of Health Situation analysis and the community consensus
 - Sign for FP Information post
 - Blood check material, stretchers
 - Reference books, IEC material¹²
 - T-shirt and bag for VF
5. Material to support the activities
 - Stationary
 - Communication
 - Report writing (printing, dissemination etc).

A breakdown per cost category will be done to demonstrate the proportion of each of these input cost categories in the total unit cost per village.

5.2.2 Quantification of cost items in a physical unit cost

For each input cost category a physical unit cost is given, which is then multiplied with the number of persons (or subvillages) and number of times (days, month). The physical cost unit estimations are based on the existing market prices, internal GTZ regulations, national and local regulations and the agreements made between GTZ and the local counterpart (CP). They are a reflection of the real costs and customs of organizing activities in the health sector.

The physical unit cost, eg a transport fee, can be different for the same activity but taking place in a different district and/or province. This depends on geographical distances, government regulations¹³ and agreements between external agencies and local partners¹⁴. Each province deals with these variations differently when estimating the physical unit cost. The more villages and/or districts are considered in the analysis, the more variation is encountered which influences the degree of certainty on the final physical unit cost (see section 5.2.5).

NTB considers 90 villages out of five districts. The physical unit cost is the average or the most frequent appearing cost of all known physical unit costs.

For the analysis of NTT, as within one district the physical unit costs are fixed, the estimation

¹¹ Payment of transport costs (or travel allowance) is actually a form of daily allowance (or Per diem), while honoraria are considered as a form of salary.

¹² IEC book: "Where women have no doctor". A. Burns, R. Lovich, J. Maxwell, K. Sapiro, 1997.

¹³ Each local government has its own regulations determining the rates of local transport, daily allowances and honoraria etc. They differ from district to district and in between provinces.

¹⁴ Before the start of the implementation of DS, an agreement between GTZ and the local partner was made regarding the rates of daily and travel allowances, honoraria etc. These are generally lower than the local government regulations. If the local partner wants to establish and maintain DS, they will have to use their own physical cost units based on the rates stipulated in the national and local regulations.

of the physical unit cost is based on the average of two districts, Kabupaten Kupang and Belu. Including all six districts would have made the physical unit costs more accurate but at the time of the analysis, the other districts are still in the process of establishing DS and thus the real costs are not known yet.

5.2.3 Currency

All costs are expressed in local currency (Indonesian Rupiahs) and Euros¹⁵. The cost estimations date from the period 2006-2009 and vary over time.

5.2.4 Source of the data

The data used in the analysis come from the financial reports of GTZ which cover all activities for all villages, 90 in NTB and 50 in NTT.

5.2.5 Dealing with “Uncertainty”

Each cost analysis contains uncertainties with implications for the results. The uncertainties need to be considered, identified and quantified through a sensitivity analysis. After identification of these uncertainties, plausible ranges of variation (intervals with upper and/or lower values) will be determined over which the uncertain items may vary. By conducting the sensitivity analysis the impact and variation for the results will become clear and the different results can be presented under “alternative scenarios” using these ranges of distributions. In this way the implications of uncertainty are considered within the results of the analysis and provide the stakeholders a correct idea of the actual degree of uncertainty.

5.2.5.1 Types of uncertainty

There are three types of uncertainty possible, related to the level of analytical methodology, the data and the transfer of the results to another setting.

The first type of uncertainty, related to the analytical methodology, can be ignored in this exercise as it is of more importance when evaluating the impact of DS, not when only the costs are analyzed.

Of importance to this cost analysis is the uncertainty that results from the available data regarding the costs due to lack of information or knowledge. The reasons are:

- Insufficient observations on a cost item that is known to vary. In this exercise only the cost data of a limited amount of districts or villages are considered, 10 villages out of two districts in NTT and 90 villages in NTB, which are all supported for more than 95% by GTZ. Including a bigger amount of villages would have given a more correct cost estimations but broader intervals.
- Inaccuracies in recording systems and missing data: The implementation of DS is quite a complex process, in which the activities are not always done separately and in sequence, some may overlap and vary in different settings, leading to uncertainties in the results. Some costs like the indirect costs are difficult to measure precisely and are therefore excluded from the analysis.
- Instability in values, eg changes in prices over time for example for fuel, transport and honorarium fees. All data in this analysis are from the period 2006-2009 but even within this 4 year period prices changed.
- Uncertainty regarding to the method of measurement or valuation: the physical unit costs are based upon the agreement between GTZ and the local CP and reflect what

¹⁵ Rate: 1 euro=13,000 IDR

GTZ is willing and able to pay to support these activities. The costs reflect more or less the real market prices eg transport fees etc. but are in general lower than the national and local regulation rates. As this analysis has taken a societal perspective (see section 5.3) the uncertainty lies in the willingness and ability of the counterpart (local government, its institutions and community) to foresee/pay as much as what is needed.

The second type of uncertainty important for this analysis is associated with the transfer of results to another setting due to variations in environmental conditions, the socioeconomic context, the local regulations and policies, and the demographic characteristics of the population. As Indonesia is a vast country with many very heterogeneous provinces and districts and a decentralized policy, the results of NTT and NTB may not be valid in another province. The physical unit costs may vary based on the characteristics of the context.

5.2.5.2 Quantifying the “Uncertainties” in the cost estimations

As mentioned before, the physical unit costs vary depending on the circumstances and create uncertainty for the final results. To deal with this, intervals are created, which contain all possible variations encountered in the available data. The intervals include the physical unit cost, as the average or as the most frequent observed cost, and are based on the minimum and maximum cost estimations encountered.

The narrower the intervals are, the smaller the degree of uncertainty regarding the result. The broader the intervals are, the higher the degree of uncertainty.

5.2.5.3 Sensitivity analysis to create alternative scenarios

When uncertainty occurs in a cost analysis, a sensitivity analysis¹⁶ should be done to quantify the uncertainties and to improve the understanding of the possible variations in and impact on the results. It will reduce the risk of drawing false conclusions.

The type of sensitivity analysis chosen in this exercise is the “changing model assumptions”, in which assumptions change the results. The changes are related to changing inclusion/exclusion of costs, based on different perspectives, and/or calculating the unit cost by using the lowest or highest values of the intervals. This leads to different scenarios. For this analysis, two other scenarios are calculated based on the intervals for the physical unit costs. More scenarios are possible but this goes beyond the scope of this analysis¹⁷.

- Scenario 1: Base-case scenario based on the estimated physical unit costs
- Scenario 2: Considering the lowest values of the intervals
- Scenario 3: Considering the highest values of the intervals

¹⁶ There are three kind of sensitivity analysis possible: Varying data inputs over plausible ranges eg. one or multi-way analysis of extreme values; a threshold analysis and the changing model assumptions.

¹⁷ Scenario using the ranges and distributions of the biggest uncertainties with the biggest impact on the final result; scenario with variation in the inclusion or exclusion of costs; scenario based on the government regulation rates.

5.3 PERSPECTIVE OF THE ANALYSIS

The perspective taken in this exercise is a societal viewpoint. This is in essential a combination of different viewpoints, reflecting the most important stakeholders involved, eg the government, its institutions and the community.

The perspective has implications on the costs that will be included in the calculation of the total unit cost of implementing DS in one village¹⁸ and creates the need for policy relevant disaggregation of the data and the results.

5.3.1 Funding sources

In compliance with the societal viewpoint, an overview will be given of the available funding resources that exist to fund each of the activity, in case the local government finances the whole process of implementation.

5.4 DEFINING THE BOUNDARIES

After determining all possible costs, a decision needs to be taken which costs will be included and which costs will be excluded in the analysis. “Boundaries” need to be determined.

The boundaries are set by the choice of the perspective or viewpoint and the objective of this exercise. As we chose a societal perspective, the additional costs (or “Overheads”) made by an external agency, here GTZ, to support the implementation DS are not taken into account. The presence of an external agency is not a condition sine qua non for establishing and maintaining the

functioning of DS. And these costs will be different for each external agency. Off course the local government and other stakeholders have to consider their own “Overhead costs”, but including these here goes beyond the scope of the analysis.

A policy relevant disaggregation of the data and results is necessary, reflecting the costs made at each level and for what, ensuring a full overview or picture of the costs needed for implementing DS done by the different stakeholders. This is necessary as there are several funding possibilities. All stakeholders will have to collaborate, plan and coordinate together if they want to follow the same approach as the one analyzed here.

Taken into account the objective of this cost analysis of informing the MoH, its institutions, local government, the community and policy makers of the costs linked to implementation of DS and of enabling them to make informed decision and appropriate budget allocation for DS, only the direct costs will be considered and some additional costs (toolkit development etc) but not the indirect costs. Besides inaccuracies in estimating these indirect costs there are now 2 good reasons not to include these indirect costs.

5.5 EXPRESSION OF THE RESULTS: Unit cost per village

The cost analysis makes it possible to calculate the total unit cost of establishing and maintaining the functioning of DS and this for several “units”: for one village, for one batch of villages, for all activities just once implemented or for a period of one year.

¹⁸ see below section 5.4 “boundaries”

5.5.1 Influence of “Scale economy”

In reality, some of the steps and activities are taking place for several villages at the same time eg training, M&E meetings and the orientation WS¹⁹. This fixed group of several villages can be called a “batch” and for the purpose of the analysis five villages are considered per batch for each province. The costs are redistributed amongst these villages, which reflect more accurate the real cost for one village to go through the whole process. Each village consists out of different number of subvillages or hamlets, in average 4 to 6 per village. In NTB and NTT all hamlets of a village participate automatically in the DS process of a village²⁰.

will or will not take place or at a lower cost and will influence the presence, quantity or absence of the different cost items. Qualitative advice is given and in the case of NTB a quantitative simulation and calculation of the absolute minimum²¹ costs to take into account is done. This estimation can be compared with the results of this analysis, which reflects the situation of sufficiently available resources. The costs excluded or changed when resources are scarce can be considered as “influencing factors”.

5.5.2 Breakdown of the unit cost in policy relevant parts

Different breakdowns of the total unit cost are possible using the filter function in the excel framework: establishing versus operational costs, per step and/or activity, by level of organizing the activities (province, district and community). Each breakdown provides policy relevant information for each of the stakeholders and these data can be used to plan and budget for DS implementation. Decisions to reduce the costs when resources are scarce can be supported by this kind of information.

5.5.3 Minimum budget needed when resources are scarce

The institutional context, the availability of resources will influence whether some activities

¹⁹. Example: the fee for the training facilitator is fixed no matter how many villages participate. The fee can be redistributed over the participating villages instead of 1 village paying the entire fee.

²⁰. Exception: the district Kota Kupang has in some case up to 10 hamlets per villages. Not all hamlets participate then in the process, an average of 4 hamlets will.

²¹. Examples: who will participate in the trainings, how many persons of each institution present at meeting, the cost of the meeting room versus using a free room. The willingness and ability to pay for certain items like meeting room, are considered as influencing factors and will influence the results.

6. RESULTS

6.1 UNIT COSTS

As stated earlier, the reflection of the real costs is more accurate when a batch of five villages is considered first and when these costs are redistributed to one village. All further presented unit costs for one village will be based on this redistribution. The results of the unit costs, when activities are only implemented once, are purely informative. The unit costs expressed on a one year base, reflect more the reality as the activities related to maintaining the function of DS (operational costs) occur on a regular basis, each with their own specific frequency, and the costs should conform with the normal planning and budgeting cycles of the government, namely on a one year base.

- NTB:

The total unit cost for one batch of five villages, all activities implemented only once, would be Rp. 217,409,500 (or 16,724 €) and Rp. 267,072,000 (or 20,544 €) for one year of operation.

If this total unit cost is redistributed to each of the five villages, the cost for one village would be Rp. 43,481,900 (or 3,345 €) for all activities once and Rp. 53,414,400 (or 4,109 €) for one year of implementation.

- NTT:

The total unit cost for one batch of five villages, all activities only once, would be Rp. 308,907,500 (or 23,762 €) and Rp. 373,077,500 (or 28,698 €) for one year of operation.

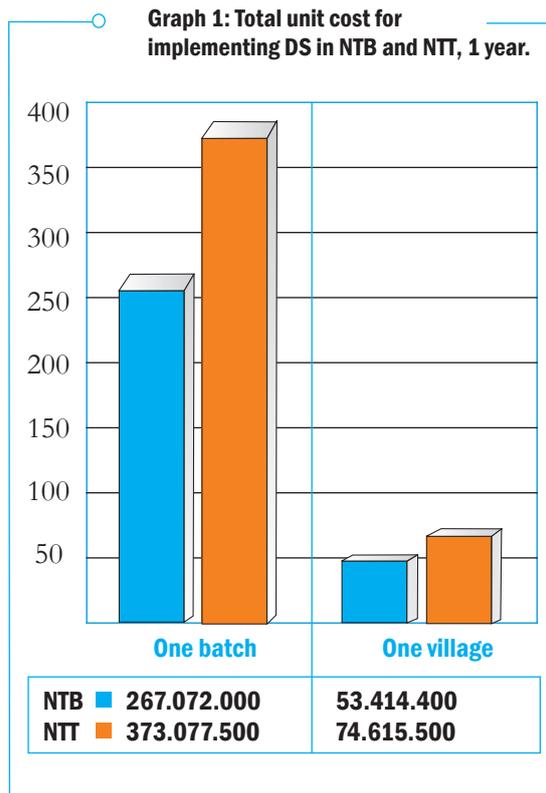
Table 1 shows the overview of all unit costs for both provinces.

OVERVIEW TOTAL UNIT COST		
	NTB	NTT
	UNIT COST (IDR - EURO ²²)	UNIT COST (IDR - EURO)
1 Batch. All steps once	217.409.500 (16.724 €)	308.907.500 (23.762 €)
1 Batch. All steps for one year	267.072.000 (20.554 €)	373.077.500 (28.698 €)
Redistribution for 1 village All steps once	43.481.900 (3.345 €)	61.781.500 € 4.752 €
Redistribution for 1 village For 1 year	53.414.400 (4.109 €)	74.615.500 (5.740 €)

²² Rate: 1 euro=13,000 IDR

If this total unit cost is redistributed to each of the five villages, the cost for one village would be Rp. 61,781,500 (or 4,752 €) for all activities once and Rp. 74,615,500 (or 5,740 €) for one year of implementation.

The same data are presented in graph 1 facilitating the comparison between both provinces.



- NTB versus NTT:

All unit cost calculations are lower for NTB. The difference for one village to go through the whole process is Rp. 21,201,100 (or 1,631 €) less for NTB.

6.2 BREAK DOWN OF THE COSTS: For 1 village, all activities for 1 year

A breakdown of the unit cost for one village for one year provides policy relevant information.

First by considering the establishing versus the operational costs, then by step and activity and further by the location where the activity is organized and by cost category.

6.2.1 Establishing versus operational costs

The first breakdown of the unit costs can be done according to establishing DS (establishing costs) and to maintaining the function (operational costs), see Table 2.

Table 2. The breakdown of costs for 1 village

Breakdown of costs for 1 village				
	NTB		NTT	
	Cost (IDR - Euro)	%	Cost (IDR - Euro)	%
1 village for 1 year	53.414.400 (4.109 €)	100	74.615.500 (5.740 €)	100
Establishing costs	43.184.400 (3.322 €)	81	59.067.500 (4.544 €)	79
Operational cost only	2.975.000 (229 €)	-	2.714.000 (209 €)	-
Operation costs for 1 year	10.230.00 (787 €)	19	15.548.000 (1.196	21

- **NTB:**
The cost of establishing DS in one village is Rp. 43,184,400 (or 3,322 €). The cost of all operational activities, only once, is only Rp. 2,975,000 (or 229 €) but for one year, these costs increase till Rp. 10,236,000 (or 788 €). This amount will have to be considered for each year of the follow up of the village. The proportion of the operational costs for one year is 19% of the total unit cost for one village versus 81 % for the establishing costs.

- **NTT:**
Establishing DS in one village cost Rp. 59,067,500 (or 4,544 €). All operational costs only once cost Rp. 2,714,000 (or 209 €) but taken all operational costs on a one year timeframe, these costs increase till Rp. 15,548,000 (or 1,196 €). This amount will have to be considered each year. The proportion of the operational costs for one year is 21% of the total unit cost for one village versus 79%

for the establishing costs.

- **NTB versus NTT:**
Both provinces have a similar distribution. The establishing costs are around 80 % of the total unit costs and around 20% is for the operational costs. In absolute numbers the costs of NTT are higher than the costs of NTB.

6.2.2 Per step

Table 3 presents a further breakdown of the costs according to all steps of the process for one village and for both provinces. As mentioned earlier, the first five steps need to be taken into account only once (establishing costs).

Step 6 reflects the maintaining of the functioning of DS and these costs are recurrent costs, considered here on a one year base.

Table 3. Breakdown of costs according to all steps of the process for 1 village and for both provinces.

All steps for one village, 1 year					
		NTB		NTT	
	Steps	Cost (IDR-Euro)	%	Cost (IDR-	%
Establishing costs	Step 1: Orientation meeting	4.046.000	8	9.172.500	12
	Step 2: Training 1	7.843.600	15	10.504.000	14
	Step 3: Conduct self-assessment survey	3.300.000	6	9.434.000	13
	Step 5: Establishment of DS system	22.572.000	42	19.262.500	26
Operational costs	Step 6: M&E at village/D level	10.230.000	19	15.548.000	21
	Total unit cost	53.414.400 (4.109 €)		74.615.500 (5.740 €)	100

²³ Networks of DS: notification of pregnant women, transport of pregnant women and sick children to health facility, the blood donation network, the community fund, and FP information Post and RH team.

- NTB:

The cost of step 5 is the highest of all steps, with 42 % of the overall total cost. This step contains all activities linked to the actual establishment of all networks of the DS system in the village, as well as all material needed for these networks (eg board, register books, IEC material, FP Post Info sign) and fee for DF. These costs are the double of the operational costs for one year, which represent 19%. Both trainings together are good for 25% of the total unit cost.

- NTT:

The costs for implementation of the activities of step 5 are the highest of all 6 steps, with 26% of the overall total cost. But both trainings (step 2 and step 4) together represent 28% of the total unit cost and this is more than step 5. The operational costs take 21% of the overall total.

- NTB versus NTT:

Both provinces use most of the budget for actually establishing the networks of the DS system, 42% for NTB and 26% for NTT of the total unit cost. The focus of NTT is on training (step 2 and 4), and the costs therefore are almost the double compared with NTB (Rp. 21,198,000 versus Rp. 13,266,400), while the focus of NTB is on the actual establishment of all networks of the DS system. In absolute numbers, the costs of step 5 are not that different for both provinces (Rp. 22,572,000 for NTB and 19,262,500 for NTT).

6.2.3 Per activity

It takes 17 activities in NTB and 19 in NTT for one village to go through the whole process of establishing and maintaining the function of DS.

Table 4 shows an overview of all activities in NTB and NTT, with the cost of each activity, the number of participants, the time and the level on which the activity takes place.

Table 4: Overview of activities in NTB & NTT, with the cost of each activity, the number of participants, the time and the level on which the activity takes place.

All steps and activities for 1 village, 1 year			
NTB		NTT	
Activity	Cost (IDR)	Activity	Cost (IDR)
Step 1: Orientation meeting at Provincial, District and village level			
Activity 1: Provincial Orientation WS for all districts, independent of number of villages. 17-29 persons, 1d WS	2,497,000	Activity 1: Orientation WS at Province level. Socialization concept DS. 2d WS. 30 participants.	5,400,000
Activity 2: Orientation WS at district level, once for each batch of 5 villages. 37-42 participants, 1d WS	1,549,000	Activity 2: Orientation WS at district level. 40-60 participants, 1d WS.	1,137,500
Activity 3: Selection of VF based on the consensus of District orientation meeting. Without any special activity and cost. At village level.		Activity 3: Socialization and orientation of DS in the village. Selection of Village Facilitator (VF). Participants: 50 persons per village.	2,505,000
Activity 4: Recruitment of DF, without extra costs. At district level.		Activity 4: Recruitment of the District Facilitator (DF) done by DHO at village level. Participatory selection process.	130,000

All steps and activities for 1 village, 1 year			
NTB		NTT	
Activity	Cost (IDR)	Activity	Cost (IDR)
Step 2: Training II			
Activity 5: Training of the concept of DS and PLA approach, 12-13 persons per batch of 5 villages, 6 days. At Province level.	7,843,600	Activity 5: Training "Participatory learning and Action". Total 35 persons. 6 days. At district level.	10,504,000
Step 3: Conduct self assessment survey			
Activity 6: Secondary data collection, self survey and FGD. 2 persons, 23 topics, involving 20-30 participants, covering all subvillages, 2-3 weeks.	1,120,000	Activity 6: Collection of secondary data. 2 persons per village, max 3 days.	955,000
		Activity 7: Self assessment survey. FGD with pregnant women, BF women, community, religious leader, done at hamlet level. 2 days per village.	2,780,000
Activity 7: Village meeting to discuss the results of self assessment, 39-42 persons.	2,180,000	Activity 8: Village meeting to discuss results and developing roadmap, 40-50 persons per village.	2,652,500
		Activity 9: WS at D level to discuss results with presentation to all stakeholders. Total 74 persons.	3,047,000

All steps and activities for 1 village, 1 year			
NTB		NTT	
Activity	Cost (IDR)	Activity	Cost (IDR)
Step 4: Training II			
Activity 8: Training II: organizing the community for establishment of DS System, 12-13 persons per batch of 5 villages, 4 days. At province level.	5,422,800	Activity 10: Training II for the establishment and organization of DS. Same participants as for training I. 6 days. At district level.	10,694,000
Step 5: Establishment of Desa Siaga system			
	1,120,000	Activity 11: Establishment of the 5 DS networks at sub-village level with consensus. 3 meetings of ½-1 day.	4,437,500
		Activity 12: Establishment of the 5 DS networks at village level with consensus. Review of the processes in the hamlets. 2 d WS. Max. 60 persons.	2,250,000
Activity 9: Establishment of blood donor system, at village level, 40-50 persons with identification potential blood donors. 1 meeting per village.	2,380,000	Act. 13: Blood donor network. 400 persons per village are tested. Followed by Health info meeting with villagers. Done by PKM.	2,700,000
Activity 10: Training cadres on FP to establish the FP Information Post, 20-30 persons, 3 days.	4,182,000	Act. 14: Establishment of a FP network in subvillage by exchanging info over 4 meetings.	2,300,000

All steps and activities for 1 village, 1 year			
NTB		NTT	
Activity	Cost (IDR)	Activity	Cost (IDR)
Step 5: Establishment of Desa Siaga system (continued from previous page)			
Activity 11: Establishment of Notification + Transportation System at subvillage level. 40-50 persons, 1 meeting per subvillage.	3,330,000	Act. 15: Establishment of the Notification network in subvillage by 5 meetings. Provision of reporting material.	6,575,000
Activity 12: Establishment of the community Fund, 40-50 persons, 1 meeting per subvillage.	3,330,000	Act. 16: Establishment of the community fund by 5 meetings.	1,000,000
Provision of support for the functioning of DS (Blood check material, recording books, white board, etc)	3,590,000		
Provision of technical assistance by DF (fee), only during establishment of DS, 1 year.	5,760,000		
Step 6: M&E at village/D level, for 1 year			
Activity 13: M&E visit by DHO, 1-2 persons, 2x/year, at village level.	300,000	Activity 17: M&E meeting of the District Core team (10 persons). 3-4x/year, 1 day.	640,000
Activity 14: District M&E/advocacy meeting, 40-45 participants. 2 x/year. At district level.	1,890,000	Activity 18: M&E WS at district level with all stakeholders. Advocacy. 2x/year, 1 day. 30 participants	3,008,000

All steps and activities for 1 village, 1 year			
NTB		NTT	
Activity	Cost (IDR)	Activity	Cost (IDR)
Step 6: M&E at village/D level, for 1 year (continued from previous page)			
Activity 15: Village M& E meeting, 40-50 persons, 3x/year.	3,615,000	Activity 19: Meeting at village level. Max 60 persons. 1x/month, 6-10x/year	3,500,000
		Operational Cost: Monthly salary for technical assistance by DF (3 years in total).	8,200,000
Activity 16: Puskesmas M&E visit to villages, 1-2 person, 4x /year.	825,000		
Activity 17: Monthly recording & reporting on the function of networks at village level.	3,600,000		

- **NTB**

Training is the most costly activity (Rp. 7,843,600 and Rp. 5,422,800), followed by the monthly fee to be paid to the DF for the provision of technical assistance (Rp. 5,760,000 for one year) and the village monthly recording and reporting and M&E meetings (Rp. 3,600,000).

All other activities are between Rp. 300,000 and Rp. 3,300,000.

- **NTT**

Training (Rp. 10,504,000 and Rp. 10,694,000), the DF monthly fee (Rp. 8,200,000 for one year), the establishment of the notification network including the material (Rp. 6,575,000) are the most costly activities, followed by the provincial orientation WS (Rp. 5,400,000).

All other activities vary between Rp. 130,000 and Rp. 4,437,500.

- NTB versus NTT:
NTT has only 2 activities more than NTB. NTB has more activities under step 6 (M&E), while NTT has more activities under step 3 (Conduct self assessment survey) and step 5 (Establishment of the DS system).

Not all activities in NTB need to be organized as separate activity costing money, eg the selection of the VF and the DF. For both provinces the trainings and the DF fee are the most costly activities. In general, the costs of the activities of NTT are higher than in NTB. The trainings in NTT include more people and more days and are therefore more expensive.

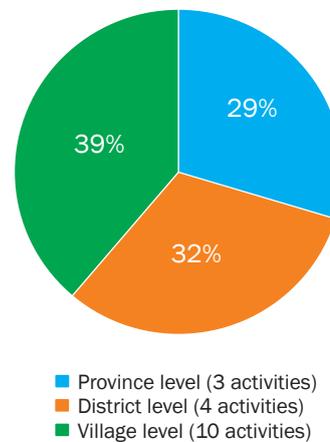
A difference in classification of the activities is the cost related to the salary or monthly fee paid to the DF. In NTB these costs are considered as establishing costs, because a DF is only needed in the beginning to build up the DS system and to be the link between the DHO, the community and GTZ. Once DS is established, the community is responsible themselves for maintaining the functioning of DS. While in NTT, these costs are considered as needed for the first three years of implementation of DS in the village to ensure the sustainability.

6.2.4 Location of activities

The activities take place at province, district or village level. The table 5 above indicates for each activity where it takes place and at which level it is organized. The following graphs 2 and 3 show the overview of NTB and NTT.

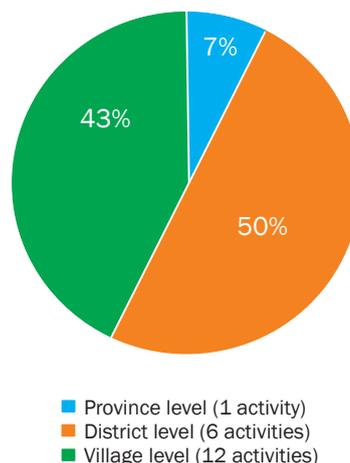
- NTB:
Most activities (10) take place at village level representing 39% of the total unit cost. The remaining 61% of the costs are for activities at district level (4) and province level (3), respectively 32% and 29%.

Graph 2: Breakdown of costs per level in NTB
Total Rp. 53.414.000



- NTT:
Even though most activities (12) take place at village level, the costs only represent 43% of the total unit cost. The costs of the activities at District and Province, together 7 activities, are higher than costs of the village level activities.

Graph 3: Breakdown of costs per level in NTT
Total Rp. 74.415.500



- **NTB versus NTT:**
For both provinces, most activities take place at village level, with a distribution of around 40% of the total unit cost for these activities. While 60% goes to activities at district and province level. NTT only has only the orientation meeting at province level, while NTB organizes its trainings at province level too.

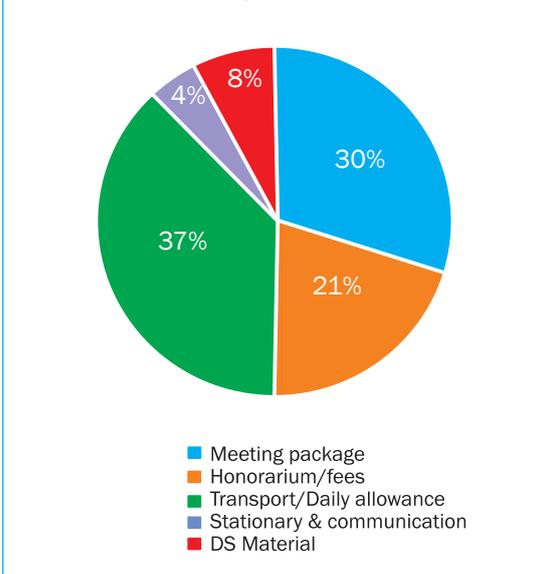
6.2.5 Per cost category

Section 5.2.1.4 describes all five cost categories. For most of these items fixed unit costs are used when implementing DS, based on the agreement between GTZ and the local government before starting the implementation of DS.

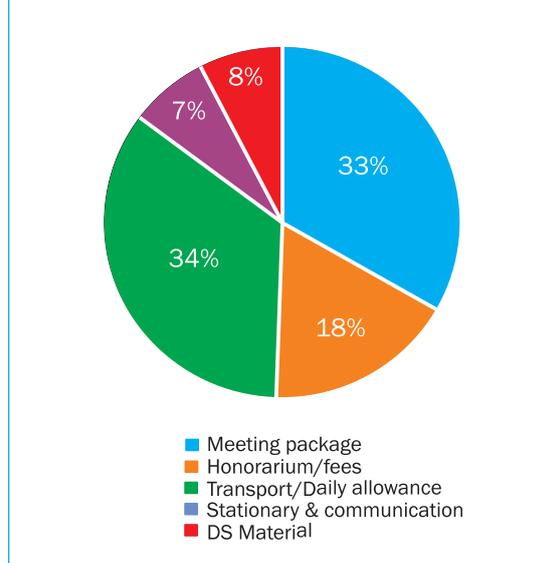
Graphs 4 and 5 present the breakdown of the total unit cost according to these cost categories for both provinces.

- **NTB:**
The cost of transportation, including daily allowances, is the biggest part of the total unit cost with 37%, followed by the costs of the meeting packages (food, rent of the room and accommodation) with 30% and the costs of honorarium/fee for facilitators, trainers and resource persons with 21% of the total unit cost.

Graph 4: Breakdown per cost category NTB, 1 village, all activities, 1 year
Total Rp. 53.414.400



Graph 5: Breakdown per cost category NTT, 1 village, all activities 1 year
Total 74.615.500



- **NTT:**
The cost of the transport of the participants, including the daily allowances, is the biggest part of the total unit cost with 34%, followed by the cost of the meeting packages with 33% and the honoraria and fees with 18%.
- **NTB versus NTT:**
Both provinces have more or less the same distribution regarding the cost categories, around 35% for transport and daily allowances, 30% for meetings and 20% for honoraria.

6.3 ALTERNATIVE SCENARIOS

Many variations are encountered in the physical unit costs. Depending on the specific geographic context within or between districts different transport costs occur but also difference in prices of accommodation, food etc. This creates uncertainty towards the final unit cost for one village. To deal with these uncertainties, intervals are created, which include all possible physical unit costs. The results can be presented as two alternative scenarios, one scenario using all the maxima and one using all the minima to recalculate the total unit cost. Somewhere in between lays the real cost for one village. This is presented in the table 5 on the following page.

Table 5 : Overview of the unit costs (IDR)

Overview of unit cost (IDR)						
	NTB			NTT		
	Min	Unit cost	Max	Min	Unit cost	Max
1 batch, All steps for 1 year	176,329,000 (13,564€)	267,072,000 (20,544 €)	355,728,000 (27,364 €)	351,780,000 (27,060 €)	373,077,500 (28,698 €)	394,375,000 (30,337 €)
Redistribution for 1 village, for 1 year	35,265,800 (2,713€)	53,414,400 (4,109 €)	71,145,600 (5,473 €)	70,356,000 (5,412 €)	74,615,500 (5,740 €)	78,875,000 (6,067 €)

- NTB:

The total unit cost for one batch, taken all minimum physical unit costs, is Rp. 176,329,000 (or 13,564 €) whereas all maximum physical costs are considered; the total unit cost for one batch of five villages is Rp. 355,728,000 (or 27,364 €).

When the costs are redistributed for one village, the minimum total unit cost is Rp. 35,265,800 (or 2,713 €) and the maximum total unit cost would be Rp. 71,145,600 (or 5,473 €).

- NTT:

The total unit cost for one batch, taken all minimum physical unit costs, is Rp. 351,780,000 (or 27,060 €) whereas all maximum physical costs are considered; the total unit cost for one batch of five villages is Rp. 394,375,000 (or 30,337 €).

When the costs are redistributed for one village, the minimum total unit cost is Rp. 70,356,000 (or 5,412 €) and the maximum total unit cost would be Rp. 78,875,000 (or 6,067 €).

- NTB versus NTT:

The intervals are broader for NTB, the values of the minima and maxima vary max. 34% around the calculated unit cost. For NTT the intervals are much smaller, the values vary max. 9% around the unit cost.

This means that the degree of uncertainty in terms of “what is now the exact total unit cost for one village?” is higher for the results of NTB and that the estimations of NTT are more certain or “precise”.

All unit cost calculations are lower for NTB and the difference for one village to go through the whole process is Rp. 21,201,100 is (or 1,631 €).

The following table 6 (next page) shows an overview of the breakdown of the costs according to establishing and operational costs with the uncertainty intervals. For NTT these minima and maxima values vary max. 8% around the unit cost. While for NTB they may vary to 30-50% around the unit cost.

Table 6: Breakdown of costs

Breakdown of costs for one village (IDR)						
	NTB			NTT		
	Min	Unit cost	Max	Min	Unit cost	Max
Cost for 1 village, 1 year	35,265,800 (2,713 €)	53,414,400 (4,109 €)	71,145,600 (5,473 €)	70,356,000 (5,412 €)	74,615,500 (5,740 €)	78,875,000 (6,067 €)
Establishing costs	30,198,400 (2,323 €)	43,184,400 (3,322 €)	57,000,700 (4,385 €)	54,236,000 (4,172 €)	59,067,500 (4,544 €)	63,899,000 (4,915 €)
Operational costs, only once	1,696,200 (130 €)	2,975,000 (229 €)	3,833,700 (295 €)	2,630,000 (202 €)	2,714,000 (209 €)	2,798,000 (215 €)
Operational costs, one year	5,067,400 (390 €)	10,230,000 (787 €)	14,144,900 (1,088 €)	14,976,000 (1,152 €)	15,548,000 (1,196 €)	16,120,000 (1,240 €)

The same distribution, namely around 80% for establishing costs and 20 % for operational costs occurs in these two scenarios.

6.4 OTHER COSTS

There are some other costs to be taken into account to support the implementation of DS. Most of these costs need to be made only

once. Examples are advocacy material such as posters and films, training modules and technical guidelines. All these products and tools can be combined in one toolkit. Once most of these items are available, only the replication costs like printing need to be reconsidered in the costs. The table 7 presents examples of other costs for both provinces.

Table 7: Examples of other costs

Province	Activities	Total amount (IDR)
NTB	Toolkit development (10 meetings + transport + ½d WS + printing of 150 toolkits)	91.185.000 (7.014 €)
NTB	Film (travel costs, material, fee)	41.000.000 (3154 €)
NTT	TOT for DF and VF to ensure the sustainability and roll out (6 days training, 3 districts, accomodation, food, fee trainer and transport.	59.800.000 (4600 €)

6.5 SOURCES OF FUNDING FOR DS

6.5.1 Current situation

The way DS is implemented in NTB and NTT, as described here and in the technical guidelines, is not done yet with national and local resources. All activities are for 90-95% support by GTZ, Exception is the district Belu in NTT which has own funds to contribute to the implementation, and also for the roll out and replication of the concept of DS to other villages. In NTT, GTZ has also a grant agreement with VSO, made possible through the Dfid cofinancing part of GTZ SISKES project. VSO volunteers support DS in their placement and most DS activities are cofinanced by VSO in NTT.

6.5.2 From a societal viewpoint

Imagine there is no additional financial support of external agencies or donors and that the province, districts and villages are keen to

establish and maintain the function of DS in their villages following the same process. The first remark that has to be made is that never the village itself will have to cover all costs of implementing DS.

There are many different funding sources available to cover all the costs. Ensuring a comprehensive financing of all activities is difficult and complex and will need a strong coordination to get all budgets planned, approved and available in time. This should be done by the DHO and/or PHO, who can bring all stakeholders together and who can ensure a follow up of the implementation of all activities.

An overview of the several sources of funding available for each of the provinces is given in table 8.

For each source is very clearly stipulated for what it can be used, eg a fixed amount of days for training, transport fees for who and how much per person, only for village activities or only for socialization and so on. There is no flexibility to shift funds around or to change the destiny

Table 8: Overview of funding sources

Source	Level of activities	NTB	NTT
APBN ²⁴ (MoH-MoHA / decon budget)	P-D-V	X	X
APBD I ²⁵ (DAU-DAK)	P-D-V	X	
APBD II ²⁶ (DAU)	D-V	X	X
APBDES ²⁷	V	X	X
P2DTK	V	-	X
DHS2	P-D-V	X	X

²⁴ APBN: National budget, of which part goes to health to fund activities at Province and district level (=decon budget). Can be used for specific activities of DS regarding socialization and training.

²⁵ APBD I: Province budget, of which a part is allocated to PHO and further to Health promotion, which can use it to fund DS activities: DAU or DAK

²⁶ APBD II: District budget, allocated for DS through DHO, BPMD and ADD. ADD is the village fund allocation of which a part can be used for activities of DS at village level

²⁷ APBDES: village budget of which part can be used to fund DS activities.

Annex 11.4 lists in a more detailed way all activities with the source of funding that can be applied for to finance the activity. 2 additional national programs exist, DHS2 and P2DTK, which can be used to fund DS activities, not mentioned in this table. DHS2 funding from the ADB can be requested by the village and is channeled through the DHO. P2DTK is national budget to fund specific programs for isolated areas (deconcentration budget from State Ministry for acceleration of development of isolated areas, coordinated by the Ministry of Social welfare). It can be used for DS activities (training and implementation) through Bapeda & DHO.

6.5.3 When resources are scarce

The first adaptation that could be done is a decrease of the physical unit costs. Some activities can be done cheaper by using free meeting rooms in the province and district health offices. A lower unit cost for meals and snacks with a catering service can be negotiated, and all stationary costs can be decreased. Before the implementation started, an agreement was reached between GTZ and the local partner on the payment of fees, transport costs, daily allowances etc. to keep the total unit costs as low as possible. These rates are lower than what is stipulated in the national and local regulations & differ between both provinces, see table 11.

Table 9: Physical Unit Cost

NTB				
Physical costs units (IDR) ²⁸				
Cost category	Agreement with local partner in NTB	GTZ regulations	Local regulations	
			APBN	APBD II
Local Transport	10.000 - 350.000	10.000-350.000*	100.000 - 200.000	60.000-350.000
Daily allowance with accommodation	191.000 - 366.000	600.000	263.000 - 597.500	250.000 - 650.000
Honorarium	30.000 - 400.000	604.000 - 3.228.000	100.000 - 500.000	240.000 - 600.000
NTT				
Physical costs units (IDR)				
Cost category	Agreement with local partner in NTT	GTZ regulations	Local regulations	
			APBN	APBD II
Local Transport	50.000 - 400.000	Real cost	100.000 - 200.000	120.000-300.000
Daily allowance with accommodation	150.000 - 600.000	600.000	263.000 - 597.500	400.000 - 550.000
Honorarium	250.000 - 500.000 / day	604.000 - 3.228.000	100.000 - 500.000	125.000 / hr

²⁸ Many variations occur depending on distances and local district regulations.

The second adaptation that can be done is on the number of people included in the activities and to look where and how activities can be combined and can include more villages at the same time (economy of scale). It is worthwhile to see whether the DS activities can be done during other events, eg including the M&E visit of the PKM staff into another M&E visit to the village, or include the M&E meeting of the village into another village meeting, or organizing the district advocacy WS as part of another WS with the same participants (“piggy back” strategy).

It will depend on the availability of resources, the creativity of the decision makers and implementers and on the ability and the willingness of the CP to pay what and how much for certain items.

6.5.3.1 NTB simulation

NTB has made a simulation for one batch and one village to go through the whole process when resources are scarce. The costs in this simulation are reduced to an absolute minimum: The physical unit costs for the meeting packages are lower, free meetings rooms are used and no provision of the IEC book, T-shirts and bag for VF. The rates for transport, daily allowances and honoraria are the lowest rates out of the APBD I regulations. Less people are invited for the orientation WS and meetings at village level.

All trainings are organized at Bapelkes²⁹ which provides the cheapest option in terms of accommodation, catering and training facilities. There is no difference in training duration, number of meetings and the rates for communication.

The total unit cost for one batch of five villages would be Rp. 182,896,750 (or 14,069 €) and for 1 village Rp. 36,579,350 (or 2,814 €).

²⁹. Bapelkes: health training centre

7. INTERPRETATION

7.1 WHAT DO THE RESULTS MEAN?

Implementation of DS costs time and money. Not only to establish but also to maintain the function. But once DS is established, only 20% of the total unit cost needs to be provided to maintain DS in the village. If this budget is not available, creativity can be used to reduce costs eg reducing the physical unit costs, combining activities or including activities on other activities (“piggy back” strategy).

7.2 DIFFERENCES BETWEEN NTB & NTT REFLECTED IN THE COSTS

The results show differences in the total unit costs and in the breakdown of the costs in steps, number, types and place of activities between both provinces. The costs of NTB are lower than the costs of NTT. The differences in costs reflect the chosen strategy of the way DS is implemented in each of the province.

- Way of involvement of the stakeholders

NTB established a clear distribution of the roles, tasks and responsibilities for each of the stakeholders before starting the implementation of DS. An agreement was made on which activities will take place at which level and organized by whom. This approach of “the right stakeholder for the right activity at the right time” facilitated the implementation and reduced the costs, confusion and delay of waiting for approval to go ahead with the next activity.

The PHO and DHO are the main coordinators and are responsible for activities taking place at province and district level. NGOs play a

prominent role in linking all stakeholders with each other and providing technical support in 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, as after establishing DS is owned by the community and the health system. For village activities the PKM facilitator and VF are the most important as the PKM is the responsible structure within the health system for village activities. The PKM staff, responsible for community empowerment, is strengthened in his role as DS facilitator. This will ensure sustainability and ownership of the concept but also the roll out as they are “close” to the community and DS activities can be combined with other outpatient services and activities of the PKM.

NTT choose to work directly through and with DHO for the whole process. The DHO coordinates and organizes all activities, even the ones at village level, and this in close collaboration with the DF from a NGO and other institutions eg district BKKBN and BPMD. This approach is chosen to improve the ownership and the sustainability of DS. Another reason to focus so strongly on the DHO is that the DHO should take up the role of main coordinator in assembling all stakeholders to plan, budget and implement all DS related activities. By working “DHO focused” each process enables a district specific process, which best fits the district conditions and preferences. Some DS activities will be rather combined or even unnecessary to do. For example, Kabupaten Kupang was the last district in NTT to start with the implementation of DS, so the orientation WS at D level was not necessary as they already knew the concept through other provincial activities. There was no need to select DF as they were already identified for other village activities. Socialization of DS, election of VF and collection secondary data can be done in 3 separate activities or can be combined depending on the choice of the district.

The disadvantages of the “DHO focus” are the higher total unit costs; a longer and more cumbersome process as the DHO staff have many other tasks and responsibilities and are therefore not always available. Another disadvantage is the high turn-over of staff without proper handing over and transfer of knowledge of existing programs. But strong coordination for DS is needed, so NTT believes it is worthwhile investing the extra money, energy and time involving the DHO during the whole process and strengthening their role in the implementation of DS. NTB believes in a clear distribution of responsibilities and tasks between all stakeholders, linked to their place in the health system, with a coordination role for DHO, while in NTT the involvement and role of DHO is much more prominent and comprehensive as they are involved in all aspects of organization (preparation, financial coordination etc) and implementation of DS.

- Implementation of the activities

The longer the process, the more separately organized activities, the more participants per activity and the more activities at district and province level, the higher the costs are. Village activities are the cheapest activities as there are less transport costs, lower rates to be paid, cheaper food and meeting packages. NTT implements the DS concept by two more activities than NTB, focusing more on the trainings and organizing most village activities separately for each village. While NTB focuses more on activities of the actual establishment of the DS networks in the village, combines more activities and includes more villages into one activity, which all reduce the costs. Not all activities need funding in NTB, eg the selection and recruitment of the VF and DF.

While in some district in NTT these are organized as separately activities with extra costs. NTT involves more people for its activities which lead also to the higher unit costs, while in NTB participation in activities is limited to the people really needed according to their responsibility in the DS process.

There are also differences between both provinces in the selection of the villages in which to implement DS. In NTB the choice is made by DHO and GTZ based on a number of conditions and on the guiding principle of having interventions as well on the provider side as on the demand side to ensure impact on health indicators. All selected villages are in the catchment area of a PONEP PKM³⁰, which received also the PKM management training.

The villages have an APN³¹ trained midwife and a POSKESDES³². Some villages are in the same PKM catchment area which enables combining activities, limits DF and VF travel distances and facilitates regular support. For NTT, the choice of villages is done by the DHO and this by equal geographic distribution in the district, which means the chosen villages are very far away from each other, spread out over the district and not around one and the same PKM. The PKM are not necessarily involved in other GTZ supported activities. This way of selecting the villages limits the possibility of combining activities and regular support. Only activities done at district level, eg training can be organized for all villages together. Most other activities have to be organized separately for each village, which make the costs higher.

- Economy of scale

The more villages in one batch, the less frequent activities need to be repeated, the quicker the process and the lower the total unit cost per village will be. NTB organized its villages into

³⁰ PONEP PKM: a health center that is capable to handle basic obstetric and neonatal emergencies

³¹ APN training: enables the midwife to do normal delivery care

³² POSKESDES: health post in the village, providing basic health care. Women can go to deliver there.

³³ NTB province exists out of 2 big islands, Lombok and Sumbawa. Each island grouped all the selected villages in 2 batches.

two big groups, the Lombok group (3 batches of 10 villages each) and the Sumbawa group³³ (3 batches of 20 villages each), and organized the trainings at province level so that more villages could participate at once.

In this way NTB realized to implement DS in 90 villages in the period 2006-2008. Due to the individual district approach in NTT the batches are smaller, only 4 to 6 villages per district and per batch. During the period 2006-2009 NTT realized the DS concept in 50 villages.

- Differences in physical unit costs

NTB uses lower physical unit costs for almost all cost categories in comparison with NTT because the costs for food, meeting rooms, transport and stationary are lower in NTB than in NTT. This results in the lower total unit cost for NTB.

7.3 QUALITY OF THE RESULTS

The total unit costs are estimations of what is needed for one village, because the physical unit costs vary within and between districts and provinces depending on the geographical context, the prices of food, accommodation and transport. Intervals are created to include all these variations and to provide an idea of the degree of uncertainty in terms of “what is now the exact total unit cost for one village?” Somewhere in between the maximum and minimum value of the interval lays the real cost for one village to go through the whole process. The intervals of NTT are narrower; the minimum and maximum values vary max. 10% around the physical unit cost. If more districts were included, the intervals might have been broader. The intervals of NTB are broader, the minimum and maximum values vary up to 50% in some cases around the unit cost, this is because all 90 villages are

considered in the analysis and thus more variation in physical unit costs is encountered.

There are more different geographical distances to be considered and thus more differences in local transport rates, food prices and accommodation rates; while NTT uses data of only ten villages out of two districts which means less variation in physical unit costs. Earlier was stated that all unit cost calculations are lower for NTB and that the difference for one village to go through the whole process is Rp. 21,201,100 is (or 1,631 €). But, when taking the intervals into account, the maximum values of NTB are higher than the minimum values of NTT, which means that all intervals overlap with each other. Therefore, the differences in unit costs between NTB and NTT may not be that big in reality.

All data itself are from the financial reports of GTZ and are evaluated as reliable.

The results are based on the specific condition of having sufficient resources to implement DS as an external agency, here GTZ³⁴, supports all implementation activities for 90-95%, with exception of district Belu in NTT. Therefore, the physical unit costs are based on rates agreed upon between GTZ and the local government and its institutions. These are lower than the local regulations and using the local government regulation rates will increase the costs. This means that in another setting, be it in another province or with or without support from another external agency or donor, the physical unit costs will be different and the total unit cost will vary accordingly.

Adaptations in number of persons involved, cheaper catering services, free meeting rooms and combining several activities and including more villages will then again decrease the costs. It all depends on what the decision makers and implementers are able and willing to pay.

³⁴ In NTT GTZ has a grant agreement with VSO, made possible by the Dfid cofinancing part of GTZ SISKES project.

8. CONCLUSIONS AND RECOMMENDATIONS

Implementing DS is a challenging process which needs a lot of resources in terms of time, money and people involved. Community empowerment is a means and not an end in itself. It is a long process in which people need to change their behavior and mindset, knowledge has to be disseminated, trainings have to be done, and an intense follow up has to be organized. It involves a whole range of different stakeholders, who need to meet and discuss regularly. Decision makers and implementers can choose a specific approach which fits their context the best, with implications on the costs.

Many factors influence the total unit cost for one village and should be taken into account when planning and budgeting for DS implementation. The approach, the physical unit costs and the number of villages in one batch have the highest influence on the total unit cost followed by the numbers of persons involved, the combining of activities and piggy back strategy. Besides the direct costs, there are a number of indirect and other costs which are not included in the total unit cost as presented here. They should be considered too.

All resources come almost entirely from GTZ, except for NTT. In NTT, the local government of district Belu contributes up to 10% to the DS activities and there is cofinancing of all DS activities by VSO. But it is possible to fund the entire process and all activities with government funds. It is of tremendous importance to have a strong coordination of all stakeholders to be able to maintain what is build up and to replicate or roll it out to other villages.

A good collaboration with appropriate planning and budgeting is needed to obtain all funding for all activities from all the different funding sources timely to enable an appropriate chronological order in the implementation of the activities. The DHO is the most appropriate structure within the health system and Bapeda³⁵ outside the health system to take up this coordinating role. Not only a strong coordinator but also a strong implementer is needed because of the long and complex process of community empowerment, which needs change in behavior and mindset. This can be achieved by working closing together and by distributing clear tasks and responsibilities with an intense follow-up. Not only the establishment of DS and the coverage of more villages is important but also attention is needed for the quality of operation in order to achieve impact. Decent M&E with impact measurement should be part of the process.

The roll out to other villages to scale up the coverage of DS in the same district or province will be easier and at a lower unit cost for the new villages as there is no need for orientation meetings at province and district level anymore, DF and VF are already selected, the guidelines and training modules are developed, the PKM facilitators have the knowledge and experience. Organizing these new villages in large groups or batches will also keep the cost for one village down. Adding more aspects out of the DS concept, for example the disaster preparedness into the existing framework of DS in the village will go much easier, faster and at a lower cost. Roll out to a new province or district will follow the same base-case scenario as presented here in the cost analysis as all steps and activities will have to be implemented.

³⁵ Bapeda: board of planning and budgeting. They can influence budget allocations for DS.

This analysis is part of the DS toolkit³⁶ and offers a tool to assist in planning, budgeting and analysis of the expenditure for DS. The analysis hopes to contribute in the decision making process of the local government and villages to implement DS by providing financial information. It provides information to all stakeholders, including external agencies, NGOs, enabling them to make appropriate budget allocation for implementation, support, roll out and take over the DS. For each specific setting, the total unit cost will be different, depending on the available funds, creativity and the willingness and ability of the stakeholders to pay for what is needed.

The next step is to link these results with the findings of the DS Impact evaluation. Both analyses will enable an economic analysis.

³⁶ Toolkit DS: is a complete information box containing technical guidelines, case studies, training modules etc to support advocacy and implementation of DS

9. ACRONYMS

ADD	Village fund allocation (Alokasi Dana Desa)
APBD I	Provincial Development Budget (Anggaran Pembangunan dan Belanja Daerah I)
APBD II	District Development Budget (Anggaran Pembangunan dan Belanja Daerah II)
APBDES	Village Development Budget (Anggaran Pembangunan dan Belanja Desa)
APN	Normal Delivery Care (Asuhan Persalinan Normal)
Bapeda	Development Planning board (Badan Perencanaan Pembangunan Daerah)
BKKBN/ BPPKB	Women empowerment and Family Planning institutions (Badan Koordinasi Keluarga Berencana/ replaced by BPPKB: Badan Pemberdayaan Perempuan dan keluarga Berencana)
BPMD	Community Empowerment Institution (Badan Pemberdayaan Masyarakat Desa)
D	District (Kabupaten)
DAK	Special Budget Allocation (Dana Alokasi Khusus)
DAU	General Allocation Budget (Dana Alokasi Umum)
Decon	Deconcentration Budget (Dana Dekonstrasi)
DF	District facilitator (Fasilitator Kabupaten)
DHO	District Health Office (Dinas Kesehatan Kabupaten/Kota)
DHS2	Decentralization Health System Support (Proyek Dukungan Desentralisasi Sistem Kesehatan)
DS	(Alert Village Model/Approach) Desa Siaga
IEC	Information Education and Communication (Komunikasi, Informasi dan Edukasi)
M&E	Monitor and Evaluation (monitoring dan evaluasi)
MoH	Ministry of Health (Departemen Kesehatan)
MoHA	Ministry of Home Affairs (Departemen Dalam Negeri)
MSP	Minimal Service Standards (Standar Pelayanan Minimum)
NTB	West Nusa Tenggara Province (Provinsi Nusa Tenggara Barat)

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11. ANNEXES

11.1 COST ANALYSIS TOOL

11.2 ILLUSTRATION NTB

11.3 ILLUSTRATION NTT: BELU AND KABUPATEN KUPANG

11.4 SOURCES OF FUNDING

The table below lists in a more detailed way all activities with the source of funding that can be applied for to finance the activity.

All steps and activities for 1 village, 1 year			
NTB		NTT	
Activity	Fund resources	Activity	Fund resources
Step 1: Orientation meeting at P, D and village level			
Activity 1: Provincial Orientation meeting	APBD I (PHO-BPMD)	Activity 1: Orientation WS at Province level.	APBN (MoH)
Activity 2: Orientation meeting at district level.	APBD II (DHO)	Activity 2: Orientation WS at district level.	APBN (MoH) APBD I (DAU) APBD II (DHO-BPMD)
Activity 3: Selection of VF based on the consensus of District orientation meeting.	/	Activity 3: Socialization and orientation of DS in the village. Selection of Village Facilitator (VF).	APBD I (DAU) APBD II (DHO-BPMD)
Activity 4: Recruitment of DF.	/	Activity 4: Recruitment of the District Facilitator (DF) done by DHO at village level.	APBD I (DAU) APBD II (DHO-BPMD)
Step 2: Training I			
Activity 5: Training of the concept of DS and PLA approach.	APBN (MoH-MoHA) ABPD I (PHO-BPMD)	Activity 5: Training on DS concept and the "Participatory learning and Action" approach.	APBN (MoH-MoHA) APBD I (DAU) APBD II (DHO-BPMD)

Step 3: Conduct self assessment survey			
Activity 6: Secondary data collection, self survey and FGD.	APBD I and II (PPMD)	Activity 6: Collection of secondary data.	APBD I (DAU-DAK) APBD II (DHO-BPMD)
		Activity 7: Self assessment survey.	APBN (MoH-MoHA) APBD I (DAU-DAK) APBD II (DHO-BPMD)
Activity 7: Village meeting to discuss results of self assessment	APBD I and II (PPMD)	Activity 8: Village meeting to discuss results and developing roadmap	APBD I (DAU-DAK) APBD II (DHO-BPMD) ADD
		Activity 9: WS at D level to discuss results with presentation to all stakeholders.	APBD I (DAU-DAK) APBD II (DHO-BPMD)
Step 4: Training II			
Activity 8: Training II: community organizing for establishment of Siaga System.	APBN (MoH-MoHA) ABPD I (PHO)	Activity 10: Training II for the establishment and organization of DS.	APBN (MoH-MoHA) APBD I (DAU-DAK) APBD II (DHO-BPMD)
Step 5: Establishment of Desa Siaga system.			
		Activity 11: Establishment of the 5 DS networks at subvillage level with consensus.	APBD I (DAU-DAK) APBD II (DHO-BPMD) ADD
		Activity 12: Establishment of the 5 DS networks at village level with consensus.	APBD I (DAU)-DAK APBD II (DHO-BPMD) ADD
Activity 9: Establishment of blood donor system.	APBD II (DHO)	Act. 13: establishing of the Blood donor network.	APBD I (DAU-DAK) APBD II (DHO-BPMD-PMI-UTD)
Activity 10: Training cadets on FP to establish the FP Information Post.	APBD I and II (P and D FP institution)	Act. 14: Establishment of a FP network in subvillage.	APBD I (DAU-DAK) APBD II (DHO-BPMD-FP office)
Activity 11: Establishment of Notification + Transportation System.	APBD I (BPMD) APBD II (BPMD- DHO)	Act. 15: Establishment of the Notification network.	APBD I (DAU-DAK) APBD II (DHO-BPMD-FP office)

Step 6: M&E at village/D level			
Activity 13: DHO M&E visit at village level.	APBD II (BPMD- DHO)	Activity 17: M&E meeting of the District Core team.	APBD I (DAU-DAK) APBD II (DHO-BPMD-FP office)
Activity 14: District M&E/ advocacy meeting	APBD II (BPMD- DHO-FP)	Activity 18: M&E WS at district level with all stakeholders. Advocacy.	APBD I (DAU-DAK) APBD II (DHO-BPMD)
Activity 15: Village M&E meeting.	APBDES	Activity 19: M&E meeting at village level.	APBD I (DAU-DAK) APBD II (DHO-BPMD) APBDES
		<i>Operational Cost: Monthly salary for technical assistance by DF, 3 years</i>	APBD I (DAU-DAK) APBD II (DHO-BPMD)
Activity 16: Puskesmas M&E visit to villages.	APBD II (PKM)		
Activity 17: Monthly recording & reporting on the function of networks at village level.	APBDES APBD II (DHO-BPMD)		