CHAPTER III

TRAINING PROCESS AND POLICY OF MCH PROGRAM IN SOUTHEAST SULAWESI PROVINCE

3.1 Health Policy

Southeast Sulawesi Province has developed an appropriate policy for maternal child health program according to the national health policy. In developing this policy government has set a target of 50 % reduction in maternal mortality during the implementation of health planning to achieve the mission of healthy Indonesia by 2010. The targets and the programs that included in the project are as follows;

1. Increase of antenatal care attendance (at least four visits/examination) during pregnancy to 90% and TT2 immunization coverage 85%;
2. Provision of iron foliate to 85% of antenatal woman;
3. Increase post natal care to lactating mother to 80%, including provision of high potency Vitamin A capsules and iron foliate;
4. Coverage of births assisted by health personnel to increase to 55% and by trained attendants to 75%; and percentage of high risk pregnancy cases to be referred to district hospitals to reach 50%;
5. Reduction of iron nutritional anemia to 40% in pregnant woman;
6. Percentage of low birth rate to be reduced to 10%;
7. Reduction of neonatal tetanus by at least 90%;
8. Reduction of diarrhoea morbidity rate and case fatality rate in under fives;
9. Reduction of IMR to 50% per 1,000 live births and tetanus neonatorum fatality cases to be eliminated;
10. Reduction of MMR to 225 per 100,000 live births.

A Provincial Safe Motherhood program has provided quality of care for pregnant mothers, management of antenatal care, management of high risk cases and obstetric/prenatal emergency in primary health care as well as the availability of obstetric and family planning services and facilities (Depkes,2001). The Provincial Safe Motherhood Program aims to enhance the overall health, quality of life and status of woman. The main objectives of this program are to significantly reduce maternal mortality and to ensure that every woman has an opportunity to have a baby in a safe

and healthy environment. The policy includes an emphasis on training to improve knowledge, skill and attitude of midwives and placement of village level midwives (Depkes,2001). Thus the government had taken steps to develop a method of training to improve knowledge and skills of health service providers in Southeast Sulawesi Province under the decentralization scheme and process.

3.2 The Concept of Competency Based Training and Conventional Training

The Competency Based Training (CBT) aims to link trainees to workplace performance. CBT is concerned with the individual achieving competencies to specific standards while at the same time emphasising what the trainee does in his or her workplace as a result of training. Competency is defined as a combination of knowledge, skills, and attitudes that can be consistently implemented in the workplace as the required exact, standard.

In addition, competency standard is officially used in Southeast Sulawesi Province. One such competency standard for communication and community entry is how village midwives can work with community members. The standard deals with the collection of information on the characteristic & resources within the catchments area of the work place, working with community members to analyze that information using participatory technique, to monitor community activities and the action required based on the problem faced and social communication to promote community health maintenance (Appendix A).

During the decentralization process, the Maternal and Child Health (MCH) program of Southeast Sulawesi conducted a pilot project for competency based training in Buton District while conventional training was being used in Muna District.

This study was undertaken in order to compare the cost effectiveness of the CBT and CT to determine which one is more effective. To determine the cost effectiveness of each program it is important to identify all related cost and expenses included in each of the programs. The following factors are important in this regard;

Competency Based Training (CBT)	Conventional Training (CT)
• Trainees must arrive on time for training, if they arrive a day after the training begins they are sent home	• If the trainee arrives late after training has commenced they are still included
• The timetable and norms of the training are discussed and agreed to by trainees, trainers and the organizing committee	• The timetable and norms are determined by the organizing committee
• The trainers do not proceed with new material until the trainees understand what has already been taught.	• The trainers continue with new material without reviewing whether the trainees have understood what has been taught.
• There is evaluation at end of each session and daily evaluation by the trainers and organizing committee to evaluate the teaching – learning process of the day and plan for the next day.	• There is no evaluation at the end of each session or at the end of the day. There may be no co-ordination between the trainers as to the material covered.
• Lesson plan considering knowledge, attitude and practice (KAP).	• There is no meeting between trainers and organizing committee. • Lesson plan focuses on knowledge and sometimes skill also
• Module sequence designed locally to achieve competency according to competency standard of role in workplace.	• Module developed nationally introduces concept and sometimes-new policy.
• Trainers is team work approach divide session responsibilities and during process all of them have to attend	• Training is conducted on a session by session basis. Each session is separate and may not link to the previous session
• At the end of each day the team reviews each session to identify strengths and weakness as well as	• Trainers come and go, work as individuals taking different session • Sometimes trainers don't have enough time to discuss with trainees
• Sandwich system is needs more time (The describe in session below)	• The Methods used are: presentation or lecture and some discussion.
• Methods used: role play, lecture, group discussion	• No consideration of ratio between trainers and trainees, sometimes class size of 30 trainees to one trainer.
• Ratio: 1 trainer for 3 or 4 trainees, and maximal of trainees 15 for each class and duration of training in the class is 8 days.	• Duration of training is 3 days some times shorter.

3.3 Sandwich System and Training Teams

The Communication and Community Entry (CCE) is a CBT package. The way the training was delivered for this package was using the "sandwich system" to ensure participants were active in the learning process. The "sandwich system" is structured so that initial classroom-based activities are followed by workplace practice, then a return to the classroom for review of the practice and further classroom-based activities. The sandwich system enabled participants to practice new tasks in the workplace as part of the training process. On return to the classroom participant's presented their work and discussed difficulties they faced. The trainers gave direct input on ways to deal with the difficulties and how to improve performance. As presentations were done in front of peers it also provided both motivation and challenges to the learners. The sandwich technique involved three phases:

(1) Phase one of the training was done in classroom and required four to five days (four days were estimated enough, following a review of the package), participants learned techniques and skills. The trainer-trainee ratio was 1:3.
(2) In phase two of the training, participants returned to their workplace to implement the new techniques and skills learnt from. The second phase lasted for approximately four to six weeks.
(3) In phase three, participants returned to the classroom to present the results of their field experiences. There were comments from other participants and trainers as well as recommendations for improvement. Following the presentations of the results by participants, additional material was taught by the trainers. This phase lasted for four days.

Thus, classroom training was approximately eight days. The sandwich technique combined both theoretical orientation and practical experiences to build the competency and capacity of the midwife (health worker). It had the advantage of using the trainee's own practical experience in the workplace as a training tool.

CCE Package has its own team of trainers. Members of the training team were program managers or their staff members, active professionals (such as hospital midwives) and members of professional organisations (such as the National Midwives Association - IBI). CBT Trainers are drawn from the health services at the provincial, district, and health centres levels, as well as hospitals.

The lesson plan should indicate how to best convey the necessary skills, knowledge and attitudes to participants. The lesson plan follows a sequence to achieve each competency. A timetable should be developed. During training, the trainers divide the sessions and the responsibilities amongst themselves for the duration of each training round. Generally there is a facilitator and co-facilitator for each training session. The other trainers act as observers and monitor the training process including group discussion and group work. At the end of each day the team reviews each session in respect of its strengths and weaknesses as well as responding to the participants' problems. Plans are made for the next day based on what was covered the day before. Good teamwork between trainers, who are totally familiar with the training material means complete attention is given to every session using a variety of teaching methods. A ratio of one trainer to 4-5 trainees means that a close relationship can be developed between trainees and trainer.

3.4 Assessment of Trainees at their Workplaces

Post training assessment in the workplace is a key activity in the CBT cycle. The definition of Assessment adapted from Australian ANTA Category 2 Trainers guidelines is as follows:

"Assessment is the process of collecting evidence and making judgments on the nature and extent of progress towards performance requirements set out in a standard...and, at the appropriate point, making the judgment as to whether competency has been achieved".

With competency-based assessment, trainers compare the workplace performance of trainees with the standard competency of the role or standard operating procedures for clinical practice. Assessment not only measures competency *per se*, workplace assessment also contributes towards a person achieving competency as part of the CBT cycle as assessment helps determine a workers future training and support needs.

Prior to the HMHB Project there was no concept within the Ministry of Health linking assessment of competency in the workplace with training activities. The Department expected the majority of trainees to automatically be competent in the workplace immediately following training. Because of this, and because of the already entrenched concept of "supervision" (which basically assessed a workers performance

against coverage indicators only), the Project experienced some initial difficulty in getting the Department to fully comprehend and accept the need for assessment of competency in the workplace. However, over time, the concept has taken hold.

The process of workplace assessment used by the HMHB Project utilized instruments based on the competency standards of roles in the workplace. Elements of the competency standard were arranged to determine the level of understanding and skills of the trainees. Each element had a set of performance criterion which are a guide (or map) to the level of comprehension and skills assessed. A minimum period of three months elapsed before the trainers assessed midwives (BDD) performance directly in the workplace. Trainers developed workplace assessment tools after a number of training rounds had been conducted. Several methods of collecting data are applied to ensure that the results of assessment were fair and effective. The following steps were used to conduct workplace assessments: 1) Auditing service data; 2) Observing trainees while providing services to clients and 3) Interviews with clients treated by the trainees.

The mapping model applied the categories of "competent", "needs further guidance", and "not yet competent". The assessment tools were tested before being used on the trainees. Trainees assessed as "not yet competent" received refresher training. Trainees assessed, as "needing guidance" did not need to join the class program but were given assistance at the time of the assessment. This approach reduced training costs. Refresher training was organised by the trainer and carried out in class or in the work place. Trainees were assessed again after they had undertaken refresher training. However, they continued to receive follow-up support through program management. The midwives co-ordinators (Bikor) were expected to supervise and coach the BDD in the catchments area of her health centres (Puskesmas), and district-level or provincial level program managers, in turn supervised her. Supervisory functions addressed by the Competency Standard for Supervision include: data collection, problem identification, problem solving, motivation, monitoring, re-supply of commodities, feedback, on the job training and evaluation.

In addition, programmers of the provincial health office in Southeast Sulawesi Province were able to lobby for a provincial policy on training – this was law No.417/XI/2002, whether conducting competency based training (CBT) or conventional training (CT), there must be a follow up assessment of the trainees, three to six months after training, in their workplaces using the competency standard competency standard. Muna District with general funds (DAU) and funds from the Asian Development Bank Decentralization Project tried to implement the principle of assessment using the same standard competency developed by Buton District to know the competency level of the village midwives.

To determine the output of the two training programs (CBT and CT) performance assessment of midwives prior to training by training needs analysis (TNA) and after training by assessment at their work place was conducted. To know this before training a training needs analysis (TNA) using checklist based on competency standard was conducted. Three to six months after training assessment is done using checklist based on performance criterion set by the competency test. The principles of assessment in competency based training is defined as;-

The process of collecting evidence and making judgements on the nature and extent of progress towards the performance criteria set out in a standard. The process entails the following steps; Plan the assessment, carry out the assessment, Record results and review the procedure, Recommend further training of follow-up for the trainee. Assessment in competency based training can be characterised as: *Criterion based*: trainees are not assessed in competition with each other, so the trainee is ranked or listed. *Evidenced based*: the decision on competency is based upon evidence provided by the trainee and gathered by the assessor. *Participatory*: The trainees and assessors have the scope to negotiate the evidence and the decision as to competency involves agreement by the trainee.

3.4.1 Assessment Techniques

A number of assessment techniques can be used for gathering the evidence required to make a judgement:

Table 3.1 Assessment techniques

Assessment techniques	Description
Direct observation	Appropriate for procedural situations, assessed how the job is done.
Third party reports	Performance is checked with another person (peer, supervisor or client)
Practical tasks	Emphasis is on the finished product
Written questioning	Knowledge assessed by written questions and answers – true/false, multiple choice or short answers
Oral questioning	To assess knowledge and understanding, or to determine communication skills
Simulation or role-plays	Imitate the conditions of a situation. Used when the situation is not readily available

3.4.2 Principles of Assessment

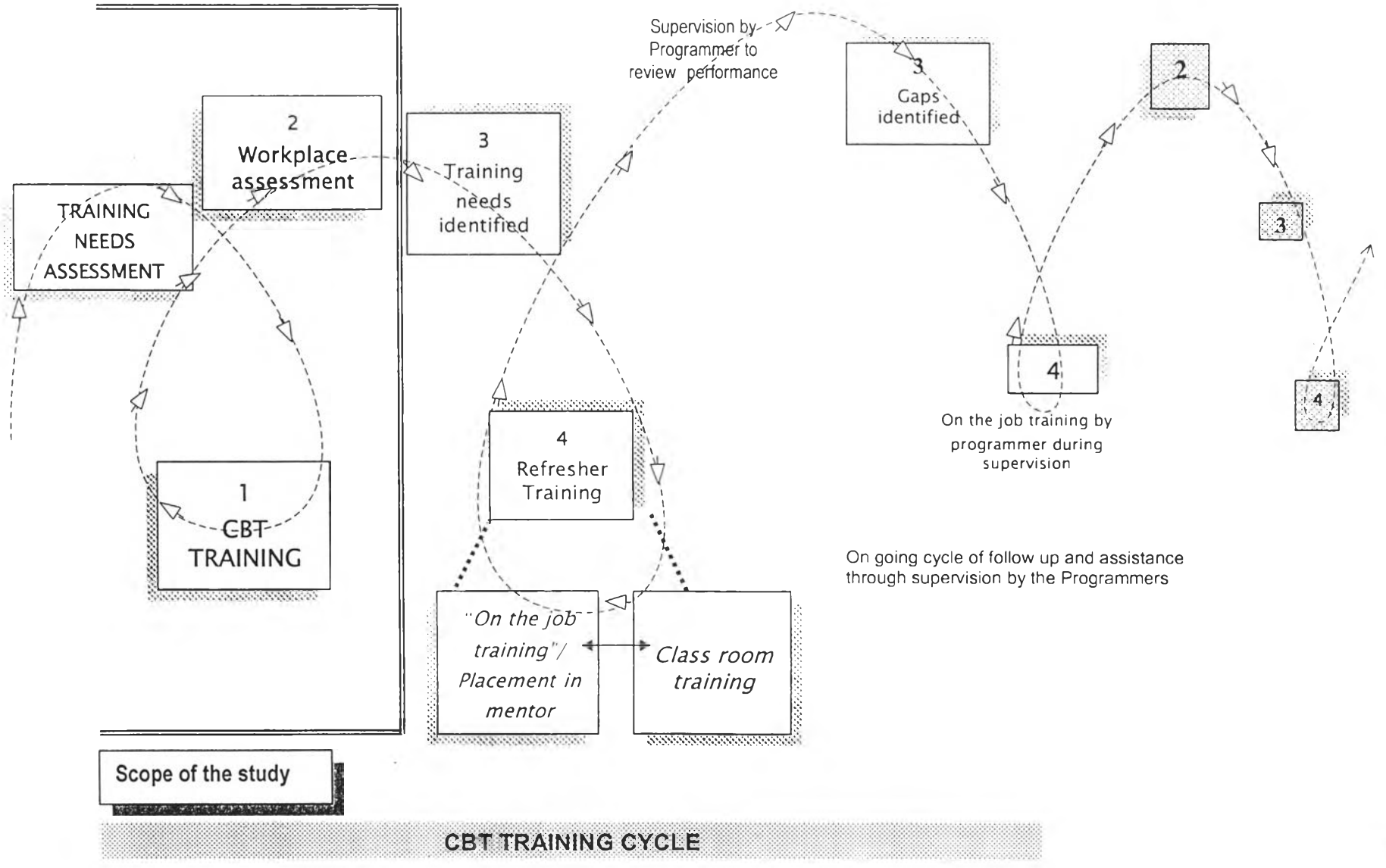
When planning the assessment the trainers have to take into consideration the following principles.

Table 3.2 Principles of assessment

1. Validity	2. Reliability	3. Flexibility	4. Fairness
Assessment should cover a range of skills and knowledge necessary to demonstrate competency. The evidence collected must reflect that the performance criteria have been met	Consistency amongst the assessors in the interpretation of evidence	Assessment methods should be appropriate for a range of delivery modes, sites of delivery and needs of the learners	Assessment practices and methods must be equitable to all learners and not disadvantage any trainee. The trainee must understand exactly what is expected of them. The result is negotiated with trainee, if dissatisfied an avenue for reconsideration is available

As noted earlier, to maintain the competency of midwives and the quality of primary health care services based on the use of competency standard a pilot project for CBT has been conducted in Buton district. To begin the process the CBT the trainers and programmers has been conducted TNA to identified gaps in the midwives performance that required a training response which became the CBT program. The CBT program also included the assessment of the trainees, post training, to know output of training program. The fact that there is a system in place to assess the competency of the health worker in the workplace after training and to provide follow up training if necessary is likely to make the CBT approach more effective even if there is not quantitative data to support this at this stage. The following cycle is important in this regard;

Figure 3.1. Spiral approach of CBT program (*CBT TRAINING CYCLE)*



3.5 Effectiveness of MCH Service Delivery

The ultimate goal of the training program in MCH is to improve knowledge and skill for health service providers to provide better quality primary health care services to the community. A critical step in the improvement of health services is to ensure that the trainee can carry out the skills and tasks needed for the role, i.e. is competent. The capacity of service delivery system but dependent on management and infrastructure support which has a major influence on the extent to which technically competent staff can provide good services. Thus, the emphasis is on capacity building of the individual and the system to deliver services.

Mobilising Community Participation by improved communication skills by the BDD have strengthened her partnership with the TBAs and Posyandu cadre. The BDD is aware that these people play important roles in the community that cannot be replaced by government health workers. Working closer with TBAs and Posyandu cadre has helped them each to define their roles in supporting health service delivery. This definition of roles has been supported by community leaders and has helped to ensure the community participates more in health awareness activities. Greater collaboration has assisted health workers to achieve their objectives and work targets.

Family and community practices often prevent women and children from receiving the full benefit of newly acquired skills of the health worker, and work still needs to be done in addressing these issues. Furthermore it will be expected to help improve the maternal and child health (MCH) condition and reduce maternal mortality rate (MMR), infant mortality rate (IMR) and morbidity at the end.