HOUSEHOLD SURVEY ON MATERNAL AND CHILD HEALTH PRACTICES & CARE-SEEKING BEHAVIOR AT COMMUNITY LEVEL

In East and West nusa tenggara




SURVEY DISSEMINATED
BY DISTRICTS IN 2007

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ACKNOWLEDGMENT

First of all, we would like to thank God His Almighty, for blessing and allowing us to accomplish the study at the community level in regard to Maternal and Child Health Care in all districts of West and East Nusa Tenggara, as a baseline for the project named Health Sector Support in both provinces.

This report is presenting the data on the variables mainly of seeking behavior in maternal and child health care, in addition to the description of its knowledge and practices. The expectation on the data to be the reference in evaluating the project comes along with the hope of usefulness in enriching the maternal and child health program at the district as well as at the provincial level.

Our thanks primarily are addressed to GTZ, Dr. Gertrud Schmidt-Ehry as the Principal Advisor of Siskes and HRD, Ute Jugert, Ibu Adriane Sopacua, Dr. Laxmi Zahara, Dr. Ating Solihin, Dr. Asmus Hammerich, Dr. Yustina Yudanita, for the support given in conducting the study. Our gratitude is extended to GTZ staff in Mataram and Kupang, for all supports during the field data collection. To the Head of West Nusa Tenggara Provincial Health Office and the Head of East Nusa Tenggara Provincial Health Office, we thank very much for your support.

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We hope the study will bring benefits for the improvement of maternal and child health in Indonesia, particularly in West and East Nusa Tenggara.

Sabarinah Prasetyo
Director of the Center for Health Research
University of Indonesia

PREFACE

All praise and thanks to God Almighty for enabling us to publish this report of the findings of the "2007 Survey of Maternal and Child Health Behavior and Treatment Seeking Patterns in Communities in the Provinces of East Nusa Tenggara and West Nusa Tenggara".

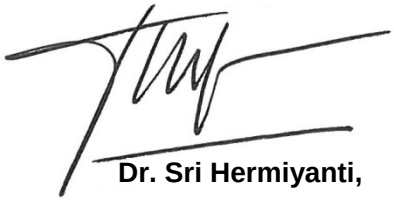
Health improvement measures in the provinces of East Nusa Tenggara and West Nusa Tenggara face major challenges. Every effort has, and will be, made by these two provincial governments, in particular by their Health Services together with other government agencies, and sections of international community that have been working in partnership with governments of these two provinces. The public, too, have an important role to play in all these measures, as targets for health improvement, and as actors in health development.

The aim of this baseline study, which was carried out at the community level, was to obtain a picture of care or treatment seeking behavior, customer satisfaction and perceptions of the quality of reproductive health services, safe pregnancy and contraception measures, and to assess the nutritional status of children under five years of age. Applying standard methods and performed in collaboration with local research institutes, this study is expected to be of use in the future and to supplement available data on health services obtained from other surveys and from routine reports.

It is hoped that this study report, which was produced by the Health Research Centre at the University of Indonesia with support from GTZ, will be of use as a reference in monitoring health development in general and reproductive health development in particular.

This publication is a valuable additional to the literature on maternal and child health behaviors in Indonesia.

Director of Mother's Health
Ministry of Health



Dr. Sri Hermiyanti,

FOREWORD

Praises to God Almighty for enabling us to complete a major household health survey on maternal and child health in provinces of West Nusa Tenggara and East Nusa Tenggara.

The survey covered 8,372 households with mothers of infants as the main respondents, and an addition 791 households with women who have been pregnant but have no infant children. The households were selected using a complex sampling method.

The results of this survey are of great value, not only to policy makers in these two provinces, but also at the national level, for the feedback that this survey from users of public service facilities.

National maternal and neonatal mortality rates have been falling since 2002/2003. According to 2007 National Health Survey (SKDI) figures, the maternal mortality rate was 228/100,000 live births, and neonatal mortality rate was 34/1,000 live births. But the maternal and neonatal mortality rates in the provinces of West Nusa Tenggara and East Nusa Tenggara are higher than average, prompting the need for evidenced-based measures, such as this household survey, to accelerate their reduction.

The challenges and threats related to measures to reduce the maternal and neonatal mortality rates require focused acceleration strategies in an action plan, covering supply, demand, financing, and changing public behaviors.

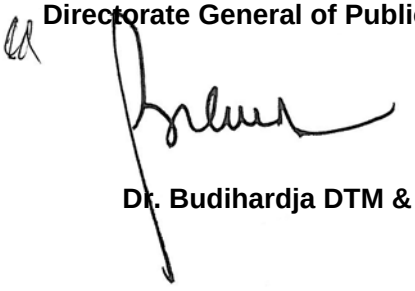
Much of the information collected from the public during this survey cab be used as input for implementing agencies in the field (village health posts, village birthing clinic, auxiliary primary health centres, and primary health centres), to optimize delivery of services to all health facility users, particularly mothers and children. More attention need to be given to the quality of antenatal, delivery, postnatal and neonatal care services, and to reducing the cost of managing delivery and neonatal complications in hospitals.

I would like take this opportunity to express my appreciate and gratitude to the GTZ management, the researchers from the Health Research Centre at the University of Indonesia, and to the Provincial and District/Municipal Health Service Heads in West Nusa Tenggara and East Nusa Tenggara for their contribution to this household survey.

Thank you.

Jakarta, February 2009

Directorate General of Public Health



Dr. Budihardja DTM & H, MPH

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ABBREVIATIONS AND GLOSSARY

AIDS	:	*Acquired Immunodeficiency Syndrome*
ANC	:	*Antenatal Care*
Arak	:	Traditional beverage with high concentrated alcohol, especially in NTT
ARI	:	*Acute Respiratory Infection*
ASEAN	:	*Association of South East Asia Nation*
Askeskin	:	Asuransi Kesehatan Keluarga Miskin or Health Insurance for Impoverished Family
AusAID	:	*Australia International for Development*
BCG	:	*Bacillus Calmette-Guerin*
BDD	:	Bidan di Desa or Village Midwife
BKBKS	:	Badan Keluarga Berencana Keluarga Sejahtera
BMZ	:	*German Ministry of Economic Co-operation and Development*
BPS	:	Badan Pusat Statistik or Central Bureau of Statistics (CBS)
Bupati	:	District Authority
CBS	:	Central Bureau of Statistics or Badan Pusat Statistik (BPS)
CEDES	:	*Center of Development Studies*
CHC	:	Community Health Center or Puskesmas
CHRUI	:	*Center for Health Research of the University of Indonesia*
Cidomo	:	Cikar Dokar Motor; A unique traditional Horse Cart for mass transportation in Lombok as its consist of Cikar (the Cart) Dokar (as pulled by a horse) an Motor (as the tire is using a car tire)
Colostrums	:	The first breast-milk produce soon after giving birth, yellowish in color and contains rich with antibodies
CU5	:	Children under-five years old
DEP	:	Data Entry Personnel
DFC	:	District Field Coordinator
DfID	:	the British Department for International Development
DHO	:	District Health Office
DPRD	:	Dewan Perwakilan Rakyat Daerah or District of Member of Parliament
DPT	:	Anti-Diphtheria, Pertuses, and Tetanus
Dukun	:	Traditional healer, and sometimes could be a traditional birth attendance (TBA)
FGD	:	Focus Group Discussion
FP	:	Family Planning
Gakin	:	Keluarga Miskin or Impoverished Family
GP	:	General Practitioner
GTZ	:	Deutsche Gesellschaft fur Technische Zusammenarbeit
HH	:	Household
HIV	:	Human Immunodeficiency Virus

HP	:	Health Personnel
HRD	:	Human Resource Development
HSS	:	Health Sector Support
IDHS	:	Indonesian Demographic and Health Survey
IEC	:	Information, Education, and Communication
IFC	:	Island Field Coordinator
ILC	:	Island Local Counterpart
IUD	:	Intra Uterine Device
JPS	:	Jaring Pengaman Sosial or Social Security Network
K1	:	The first visit for antenatal care during pregnancy
K4	:	Minimum visit for antenatal care during pregnancy (1-1-2)
K4-q	:	Minimum visit plus 5T of services
KBKS	:	Keluarga Berencana Keluarga Sejahtera
Kelurahan	:	Office for Village Authority
KN1	:	Neonatal contact at 1-7 days after birth
KN2	:	Neonatal contact at 8-28 days after birth
MCH	:	Maternal and Child Health
MDG	:	Millennium Development Goal
MoH	:	Ministry of Health
NGO	:	Non-Government Organization
NTB	:	Nusa Tenggara Barat
NTT	:	Nusa Tenggara Timur
Polindes	:	Pondok Bersalin Desa or Village Maternity Hut
Posyandu	:	Pos Pelayanan Terpadu or Integrated Service Post
PPS	:	Probability Proportionate to Size
Pre-lacteal food	:	Food that given to newborn or baby prior to breast-milk production
Puskesmas	:	Pusat Kesehatan Masyarakat or Community Health Center (CHC)
RH/MPS	:	Reproductive Health/Making Pregnancy Saver
RT	:	Rukun Tetangga or Neighborhood
Seameo	:	South East Asia Ministry of Education Organization
Sifon	:	Harmed traditional practice on male circumcision that mostly and still done in NTT
Siskes Plus	:	Sistem Kesehatan Plus
SSS	:	Sugar Salt Solution
SKIA	:	Survei Kesehatan Ibu dan Anak
SKTM	:	Surat Keterangan Tidak Mampu or Letter of Acknowledgement for Impoverished Household
SPH	:	Sector Program Health
STD	:	Sexually Transmitted Disease
Susenas	:	Survei Sosial Ekonomi Nasional

Tamang	:	Local term for Dukun in NTT
TBA	:	Traditional Birth Attendance or sometimes could be Dukun
Tropmed	:	Tropical Medicine
TT	:	Tetanus Toxoid
TTS	:	Timor Tengah Selatan
TTU	:	Timor Tengah Utara
UI	:	University of Indonesia
UNFPA	:	United Nation for Population Fund
VCT	:	Voluntary Counseling and Testing
WFP	:	World Food Program
WHO	:	World Health Organization

CHAPTER 1

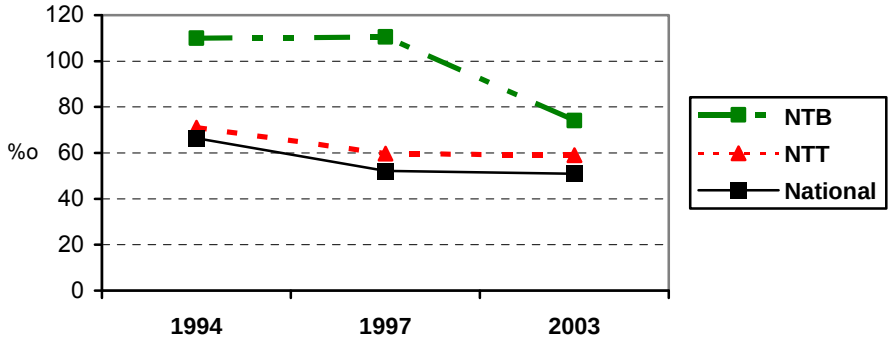
INTRODUCTION

1.1. BACKGROUND

Over the past fifteen years, Indonesia's under-five mortality rate has declined by 42%, infant mortality by 31%, and post-neonatal mortality by 50% (MOH, WHO and CBS, 2005). Despite these recent improvements, however, Indonesia's are still the highest maternal and infant mortality rates in the ASEAN region and it is recognized that major public health problems persist.

Nationally, life expectancy at birth was reported by MoH-WHO (2005) to average 68.1 years for women and 64.2 years for men. Among all provinces, West Nusa Tenggara (Nusa Tenggara Barat or NTB) ranks lowest at 59.3 years. East Nusa Tenggara (Nusa Tenggara Timur or NTT) averages 63.8 years. Review of the last three Indonesia Demographic and Health Survey figures shows that health status in these two provinces, in terms of Infant Mortality Rate (infants' deaths per 1,000 live births) for example, has not been improved much in a decade. Certainly this is a great challenge.

Figure 1. Trend of Infant Mortality Rate in the period of 1994-2003 in NTB and NTT, compared to the Indonesia national average



Source: IDHS, 1994, 1997, 2003.

In terms of health services indicators, the MoH and WHO (2005) ranked NTB and NTT lowest in percentage of births attended by health personnel, with figures of 45.3% and 34.4% respectively. The proportions of completely immunized children aged 1 to 4 years were also low, 22.0% in West and 39.7% in East Nusa Tenggara. Finally, convincing evidence demonstrates that in those two provinces catastrophic health expenditures push households below the poverty line as measured by out-of-pocket payments to the health system. The percentage of household impoverished in NTB was 2.5 and in NTT was 3.0, placing the two provinces in the "severe condition" group compared with other provinces in Indonesia (MoH-WHO, 2005).

According to Blum (1974) health status of the community is influenced by four major factors that are interlinked, namely environment, behavior, health services, and genetics. Enhancing the health system thus requires that other factors be tackled as well such as behavior related to prevention and treatment, and services delivered by health providers.

Health services are one critical factor which, among others, is expected to result in better outputs and outcomes if access to and quality of health services can be increased.

A program known as the Health Sector Support Program (**HSS**) has been introduced in NTB and NTT to strengthen health system development. It will be designed and carried out as a multi-level, multi-intervention approach that combines three health projects -- Strengthening District Health Systems (***Siskes Plus***), Human Resources Development (***HRD***), and Sector Program Health (***SPH***). These three projects have a strong focus on the poor, women, and children, with the aim of increasing the use of quality health care services.

HSS is implemented under the Ministry of Health by the Provincial and District Health Offices in NTT and NTB Provinces with financial support from the German Ministry of Economic Co-operation and Development (BMZ) and the British Department for International Development (DfID). The HSS program addresses services organization and quality as well as behavior and lifestyle related to health. The hypothesis tested by these interventions is that the likelihood of survival of mother and child is increased when they are supported by her family and community to adopt healthy behaviors and lifestyles, live in a healthy environment, and receive adequate quality health services. In terms of project management of MCH services, the districts in NTB and NTT can be divided into five clusters, with clusters 1 and 4 under GTZ support coordination, clusters 2 and 3 be under AusAID, and cluster 5 under Unicef,

To measure the efficiency and the effectiveness of HSS interventions, a household survey prior to major intervention is needed to establish baseline values. In addition, local health program managers also need information to recognize local obstacles and to monitor over time the effectiveness of their efforts to improve community health practices and care seeking behavior.

1.2. OBJECTIVES

1.2.1. The general objective

The general objective of the baseline survey is to identify and obtain community-based information to serve as baseline information for the Siskes Plus, HRD, and SPH Projects in NTT and NTB Provinces.

1.2.2 Specific objectives

Specifically, the objectives of the baseline survey are:

1. To describe health-seeking behavior (problem recognition, care-seeking, and access to care), satisfaction, and perceived quality (by clients) of reproductive health and Making Pregnancy Safer (RH/MPS) health services, including family planning, in general and in specific sectors of the community (urban poor and non poor and rural poor households).
2. To assess the nutritional status of children by measuring weight and height of children under five years of age.
3. To assess satisfaction and perceived quality of RH/MPS health services (including family planning) among relevant stakeholders including Bupati (District Authority), members of local parliament, heads of District Health Offices (Dinas Kesehatan) and local key informants.

Two additional objectives should be mentioned:

4. To apply appropriate methodology in partnership with local research institutions to facilitate replication in future surveys to monitor and evaluate the programs targeted.
5. To complement the findings of the health services survey of routinely recorded data to produce comprehensive pictures of health for both provinces.

The later two objectives are strongly linked to expectation that a baseline description can be assembled which reflects the comprehensive health conditions and systems in NTB and NTT Provinces and also contribute to sustainable monitoring and evaluation of their programs.

1.3. METHODOLOGY

1.3.1 Design

The design of the study consisted of a quantitative survey and a qualitative approach using in-depth interviews and focus group discussions. The implementation of the study is carried out in two times period. The first period is in January 2007, which covers all districts of NTB and 13 districts of NTT, and the second period is in June 2007 inlcludes other 3 districts of NTT, at Sumba Island and Alor. Therefore, all districts at these two provinces have covered by this study. Cluster areas based on the project implementation of GTZ, AusAIDS, and Unicef are shown in table 1.1.

1.3.2. Population and sample

Quantitative study

The baseline survey was cross sectional, conducted by drawing samples to represent each district as well as project cluster. The survey was designed to facilitate both project evaluation (at start-up and completion) and periodic monitoring during implementation. The HSS aims to include all 9 districts of NTB in two clusters and 16 districts in NTT in three additional clusters.

Two study populations were defined for the survey:

1. Households with women of reproductive age (15-49 years) who had children under five years old (children U5) at the time of the survey
2. Households with women of reproductive age (15-49 years) who have been pregnant but do not have children under five years old (non-children U5) at the time of the survey.

The sample size was computed based on the purposes of the survey estimations as well as to test hypotheses of two proportions (before and after intervention). The statistical assumptions used were 95% confidence level, 50% of estimated proportion of evidence or unknown figure, 10% acceptable precision, design effect of 2, and at least 10% detectable difference with 80% power of the study. For allowing us to recognize proportion change due to health program, the needed minimal sample size was 1565 in each cluster, or 194 per district.
At the second period of the study, it is informed that the district of Sumba Barat has just expanded into three districts, Sumba Barat, Sumba Barat Daya, and Sumba Tengah. With the limitation of research resources, and in order to occupy the representation of

new districts, the minimal sample for each new district is stated as high as 136, which has counted with lower assumption of confidence level at 90%, but other statistical assumption still same.

In actuality, acquired sample size at cluster or district level exceeded the target; thus are sufficiently large for inference purposes. In all, 3547 households were visited in NTB and 3736 in NTT at first period, and 870 household at the second period. Total household visited at two provinces are 8153 (table 1.1).

Sample selection followed a multistage complex sample design, with staging of the sampling procedures as follows:

1. In each district, stratification of sub-districts by poverty level was based on the Poverty Map of Indonesia (SMERU-Ford Foundation, 2000). Two groups by poverty level were constructed.
2. In each group of sub-districts based on poverty level, 2 sub-districts were chosen randomly using the probability proportionate to size method (PPS) and the sub-district's population as its size.
3. By considering that referral system is affected by the distance to reach health facility, 4 strata of villages in each selected sub-district were created according to their distance from the main community health center (Puskesmas) of the sub-district. In each stratum, one village was selected randomly.
4. A list of neighborhoods (Rukun Tetangga, RT) in each selected village, complete with data on population, was constructed using information from the village's administrative office. Then 2 neighborhoods (2 RTs) were selected randomly.
5. A census was conducted in each selected neighborhood to register every household in the neighborhood, noting the number of children under 5 years of age (children U5) in each household. A list of eligible households in each neighborhood was then constructed, and based on this list, a number of eligible households (different in each district) was selected using simple random selection. In addition, a list of households having women with no children under 5 years was also built, and then one was selected randomly.
6. For the selected households, the main respondent was a woman who met the criteria of study population. In sampling from the first study population (women with children under 5), the main respondent's youngest child was measured for weight and height.

Special treatment was employed for the district of Sumba Barat, regarding to the research resources limitation, in which the sampling procedures was slightly different, i.e. only two sub-districts were taken in each new district (Sumba Barat, Sumba Barat Daya, and Sumba Tengah) representing the poor and non-poor.

Qualitative approach

The qualitative approach employed in-depth interviews and focus group discussions to collect information. Informants chosen from the community were mothers with CU5 as female informants and fathers with CU5 as male informants. Each focus group was made up of 8 discussants. At the first period, in overall, 32 FGDs were conducted in four districts to reflect both poor and non-poor villages, and 102 in-depth interviews towards their stakeholders. And in the second period, 12 FGDs are carried out, as well as 15 in-depth interviews. Stakeholders selected for in-depth interview included important key informants such as Bupati, District members of Parliament, Head of DHO, Head of FP Office, and NGO/PPK. These interviews at provincial and district level were designed to gain insight into existing and potential health-related conditions of infrastructure, human

resources, and financial allocations across the districts. In the first period of the study, a total of 102 informants were interviewed. Females made up only 30% of the in-depth interviews, reflecting the reality that structural positions in institutions and offices are mostly occupied by males. Similar picture is also happened at the second period, from 15 informants interviewed only one-fifth is females.

1.3.3. Data collection, processing, and analysis

The household survey was conducted by UI researchers in collaboration with local research institutes in an effort to increase local capacity as well as to encourage partnership with local research institutes. Researchers were organized hierarchically at the level of each island by designating Island Field Coordinators (IFC) and Island Local Counterparts (ILC) and to supervise the district level (District Field Coordinator). Enumerators for each district were recruited and selected carefully by interview and/or written test. Most were under-graduates with a background in health or sociology. In the first period of the study, there were 246 enumerators and data entry personnel. The number of male enumerators compared to females (including Data Entry Personnel) was approximately in the ratio of 45%. In the second period, there were 27 enumerators with almost half of it are females.

Three-day training courses were implemented simultaneously on four islands (Mataram in Lombok, Bima in Sumbawa, Maumere in Flores, and Kupang in West Timor). For the second period, the training was carried out in Waingapu and Waikabubak in Sumba island, and Kalabahi in Alor. Directly after training, the procedures of data collection are performed. Procedures carried out to ensure the quality of data collected included cross-checking by enumerators, editing by district-field-coordinators and data-entry personnel, as well as spot-checks of 5% of completed questionnaires by the district field coordinators (DFC). Supervision by IFC and ILC for every district was employed to make certain the quality of the process as well.

The data collection method used was to interview housewives of selected households using a structured questionnaire and anthropometric measurement of her youngest child under five years of age (using Seca weighing scale and *microtois* or baby length board) as well as observation of the household. The length of time for one household visit averaged one hour and 15 minutes.

The qualitative study used in-depth interviews in each district of stakeholders selected purposively and available for interview at the time of the study. Topics for stakeholder interviews related mainly to decision-making in the area of maternal and child health by persons such as Bupati, parliament members, head of DHO, head of Family Planning Office, religious leader, or Non-Government Organization leader. The interviews were coordinated with the focus group discussions carried out in the planned sites. All data collectors for the qualitative study were experienced UI researchers. The qualitative data were subsequently analyzed by content using a matrix approach after transcription of each in-depth interview and focus group discussion. Procedures are applied in both period of the study.

At the first period, in each district, data entry personnel entered the survey data immediately in the field. Most data cleaning and processing was done at UI afterwards. The quantitative data were analyzed descriptively by producing frequency distributions, disaggregated on the basis of province and district as well as project cluster (for project baseline purposes). As mentioned above, the clusters had been determined by GTZ, with cluster 1 and cluster 2 in NTB reflecting urban and rural areas respectively and cluster 3 and cluster 4 in NTT representing Flores and western Timor. The complex

sampling design requested weighted analysis, with weights computed by multiplying the inverse of the sampling fraction (population size over sample size) at every stage of the sampling procedure.

Table 1.1 . Planned and actual sample size by district

District	Planned sample size		Actual sample size		% non-response of children U5 anthropometrical measured
	HH-children U5	HH-non children U5	HH-children U5	HH-non children U5	
NTB					
1. Kota Mataram	320	32	315	32	0.0
2. Lombok Barat	320	32	319	33	0.0
3. Sumbawa Barat	320	32	319	33	0.0
4. Sumbawa	320	32	320	32	0.3
5. Kota Bima	320	32	320	32	0.6
Cluster 1 total			1593	162	0.2
6. Lombok Timur	416	32	417	31	0.0
7. Lombok Tengah	416	32	427	21	1.2
8. Dompu	416	32	417	31	1.0
9. Kabupaten Bima	416	32	414	34	0.0
Cluster 2 total			1675	117	0.5
NTT					
1. Manggarai Barat	256	32	257	31	0.0
2. Manggarai	256	32	257	32	0.0
3. Ngada	256	32	256	32	0.4
4. Ende	256	32	265	31	0.4
5. Sikka	256	32	265	31	0.4
6. Flores Timur	256	32	256	32	0.0
7. Lembata	256	32	257	31	1.2
Cluster 3 total			1813	220	0.3
8. Kota Kupang	256	32	257	31	0.4
9. Kabupaten Kupang	256	32	244	32	0.0
10. Timor Tengah Selatan	256	32	246	30	0.8
11. Timor Tengah Utara	256	32	256	31	0.4
12. Belu	256	32	255	33	0.4
13. Rote Ndao	256	32	259	29	1.2
Cluster 4 total			1517	186	0.5
14. Sumba Barat	128	16	128	16	0.0
15. Sumba Barat Daya	128	16	128	16	0.0
16. Sumba Tengah	128	16	128	16	0.0
17. Sumba Timur	192	16	192	16	0.0
18. Alor	192	32	198	32	0.0
Cluster 5 total			774	96	0.0

Collecting good quality survey data requires proper and careful management. One way to check for data collection quality is to look at the non-response rate that results from unvisited households, respondents not at home, refusal to participate in the survey, or refusal to answer certain questions. Review of non-response notes revealed the classical reasons of not at home or not a convenient time for interview. The percentage of non-response, ranging from 0.3% to 4.7% in each district, is below the critical 10% limit. The drop out rate of 5% should be taken as a lesson learned when sample size is calculated. Overall, selection bias appears to be low. Refusal of anthropometric measurement of children was minimal as well, ranging from 0 to 1.4%, and probably due primarily to non-cooperative children who could not be measured.

The proportion of missing values for each variable was found to be less than 2% (quite small) except for 13% for the variable asking how quickly the baby was put to the mother's breast after delivery (probably due to the difficulty of recall). As a whole, evaluation shows that the data quality is adequate for analysis.

The finding from the survey must be associated with the background variables describing the interviewed women, children, and their households as a basis for further inference of the study. Following that, the findings relating to maternal and child health are detailed, followed by conclusions and recommendations. In each chapter and each section, quantitative results are depicted in graphs and tables, supplemented with relevant quotes from FGD or in-depth interview informants to expand on the quantitative information.

1.4. STUDY LIMITATIONS

Attempts have been made to reduce the possibility of sampling and non-sampling errors in the survey. Result pooled by province level should be interpreted cautiously, however, because the survey is conducted in two periods of field working. All nine districts of NTB and 13 districts in NTT were covered in January which has rainy season. While three districts of Sumba and Alor were covered at the second period in June during the dry season. Therefore, interpretation towards some diseases related to the season, for instance diarrhea, should be considered.

In regard to the second phase study which covers districts of Sumba island, the sample representing each new district has to be carefully considered, since the confidence level used is a bit lower, as well as a slightly different in employing the sampling procedure. Based on the result presented in tables, the reliable findings are shown when the data are pooled to describe the old districts. If the new district is expecting to use the survey result, then the confidence interval is preferrable to look at.

The primary limitations of the survey methodology relate to the validity of measuring the variables. Most of the variables relating to behavior were assessed by interview, meaning by self-report although some was taken from records such as the MCH book in possessed by the mother. A small proportion of respondents did not possess the MCH book, however. For those cases, self-report was the main approach.

Nevertheless, many variables used in the questionnaire were adopted from other national surveys such as 2003 Indonesia Demographic and Health Survey and 2005 Basic Human Services. Eventually, the methodology of this study follows the later one, and found to be more efficient in the field work. To some extents, the findings mostly were quite close with other studies result, and this support the study validity.

The survey had planned to use only females as enumerators, but in fact males took part as well. It was observed that male interviewers can do the job satisfactorily as well, and the District Field Coordinators (DFCs) reported that this resulted in no refusals to participate.

1.5. PARTNERSHIP WITH LOCAL RESEARCH INSTITUTES

To strengthen the capacity of local research institutes, researchers from the University of Mataram and CEDES in NTB, and from the University of Nusa Cendana and the University of Nusa Nipa in NTT were involved from the beginning as ILC and DFC. Their involvement in developing the conceptual design and instrument for the study as well as physical participation in the survey process is important. It is hoped that the relationship

built in this process between local research institutes and CHRUI strengthens research capacity locally as expected. Statements of collaboration with the local institutions clearly reflect their willingness to be involved in the future as well, and the enumerators and data entry personnel are valuable resources that complement and support local research competence.

Our local counterparts mentioned the following as useful experience, particularly relating to survey methodology:

1. The hierarchical organization of researchers for a big survey covering more than one district
2. The recruitment and selection of enumerators using written tests and interviews that were associated with field work performance
3. Very detailed procedures emphasized in the training and also written in detail in the manuals
4. Data quality control of data management system, applying the Epi-info public domain computer software program
5. Involvement of local counterparts in instrument development as well as in data analysis especially in the area of maternal and child health care and services.

In the course of the survey, UI researchers also noted observations that may be significant for future surveys:

1. There was no significant difference in capability and motivation as enumerators for males and females, either as interviewers or data-entry personnel. However, youth and good health is important for enumerators because the field work was full of adventure and challenging activities.
2. The time required for a household visit was around one hour and 15 minutes, or about 4 households per day per enumerator. This just as had been estimated in the proposal prior to the study.
3. The number of days expected to be needed to complete the overall survey must consider weather conditions as well as transport related to geographic difficulties, and a contingency plan should be in place, particularly with respect to the budget. The dry season would be the best time for such data collection.
4. Ability to speak the local language is an advantage for enumerators, especially to learn about the local culture. However, it was found that essentially all informants at community level understand questions posed in Bahasa Indonesia.
5. Anthropometric measurements require proper equipment such as Unicef's standard Seca weighing scale. Unfortunately, not all institutions can provide it. Most Posyandu (integrated health post) use a "bar weighing scale" (*dacin*) that is slightly less valid, and this could be considered for use in the future as long as all instruments used are of the same type and standardized before field use.

The UI researchers implementing the qualitative approach also noted observations that could be helpful for future studies:

1. Focus Group Discussion at community level should be preceded by small scale exploration of local culture or practice for meetings, providing "*sirih*" (chewing leaves) during the meeting, for example, or choosing the evening after respondents return from their field as a better time to meet.
2. In-depth interviews of local stakeholders can turn into group discussions when key informants suddenly invite other people (usually their sub-ordinates) to become informants as well and contribute supporting information.

CHAPTER 2

BACKGROUND CHARACTERISTICS OF WOMEN, CHILDREN AND HOUSEHOLDS

The extent to which the study results can be generalized depend upon the background characteristics of the population surveyed. This section describes the respondents, who were women living as housewives in the households selected and having children under five years of age, and a smaller number of women of child-bearing age with no children under five. Household composition and educations levels of the members of households surveyed are also presented here.

2.1. CHARACTERISTICS OF WOMEN AS RESPONDENTS

In this study, the main respondents were women with children under five years of age. This main group of respondents averaged between 29 and 30 years of age. The smaller group of women without children under five was older, averaging 34 to 35 years of age (tables 2.8 and 2.10).

Of the women with children under five years, 6% in NTT were not married and only 1% in NTB. The proportion of these women who work outside the home was 38% in NTB and 28% in NTT. Probably because of less need for time to take care of children under five, the proportion of women without children under five who work outside the home was slightly higher, 42% in NTB and 26% in NTT. Looking at district level, there is more variation, but no systematic pattern is apparent. There is slightly greater variation between districts in NTB than in NTT (table 2.8.a and 2.8.b; table 2.10.a and 2.10.b).

Figure 2.1. Percentage of working women with and with no children under 5 years old in NTB

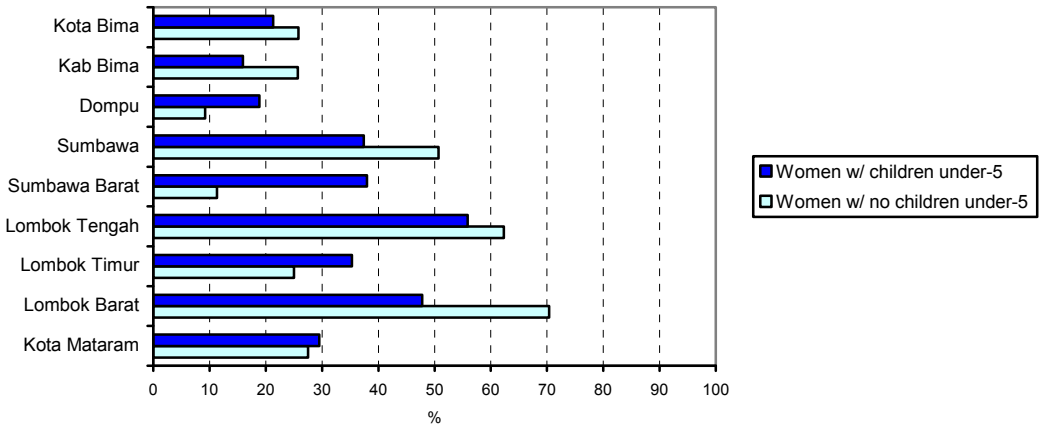
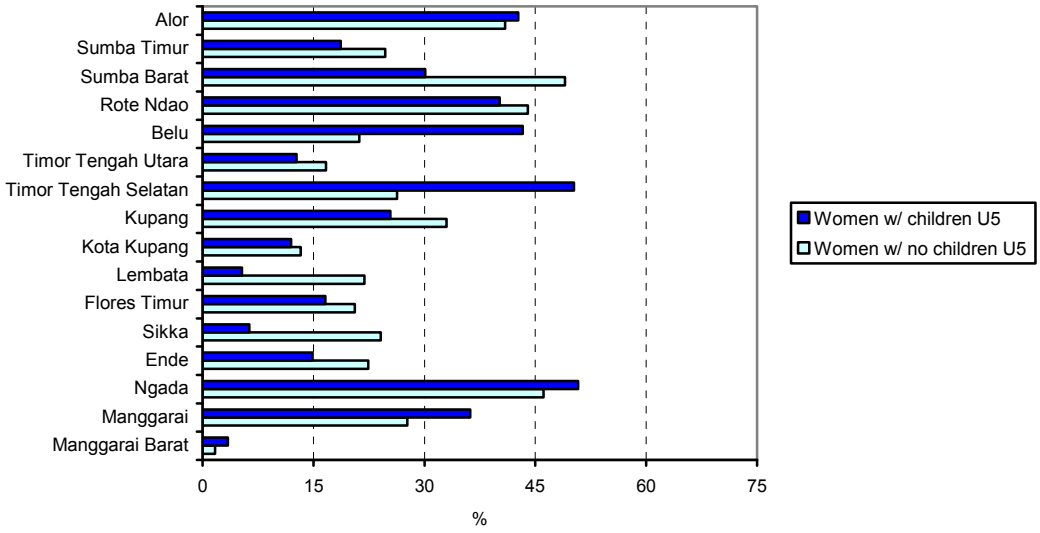


Figure 2.2. Percentage of working women with and with no children under 5 years old in NTT



Similarly, no significant difference is seen by province level in educational level between women with and without children under five. For both groups of women, the lowest category of education (elementary school or less) was most frequent, 68% and 78% respectively in NTB and half women respectively in NTT. District variation again was more apparent in NTB than NTT. In particular, Lombok Tengah and Lombok Timur in NTB and Sikka in NTT require greater effort to enhance literacy, especially for older women. Overall, it would appear that education levels are becoming better because no-school-illiteracy in the women with children under five, who are younger, is lower than for women without children under five (tables 2.8 and 2.10).

Figure 2.3. Percentage of no-school-illiterate women with and with no children under five years old in NTB

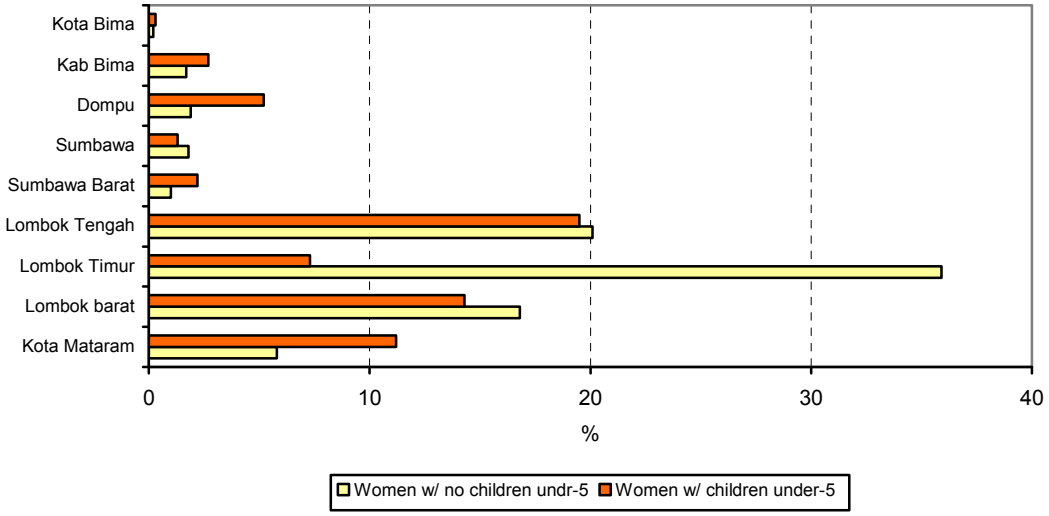
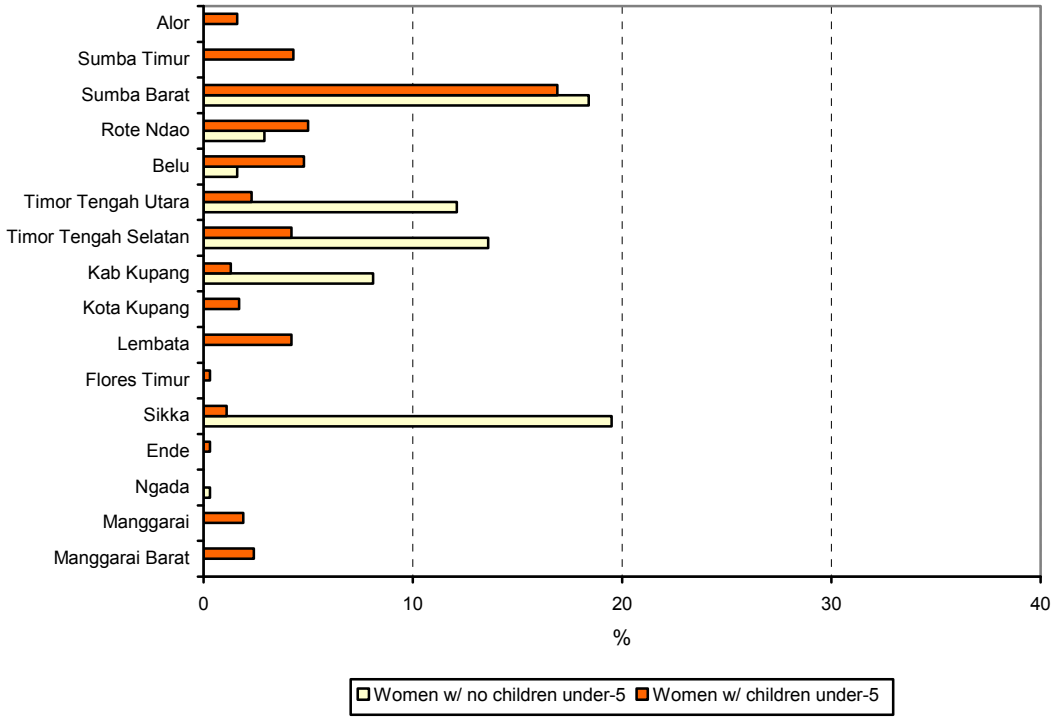


Figure 2.4. Percentage of no-school-illiterate women with and with no children under five years old in NTT



2.3. CHARACTERISTICS OF CHILDREN UNDER FIVE YEARS OLD

The children under five of the sampled women were included as part of the sample. Testing for adequacy of data, only 1.3% mission values were found (table 2.9) much less than the critical point of 10%. Thus the data on children are quite sufficient.

The characteristics of the children did not differ significantly across provinces, clusters, or districts. The average age of children included in this study was 24 months in NTB and 21 months in NTT. In both provinces about half the children were under three years of age. Overall, there was no difference by gender. Numbers of girls and boys were almost the same.

Figure 2.5. Distribution of children under five years by age group in NTB and NTT

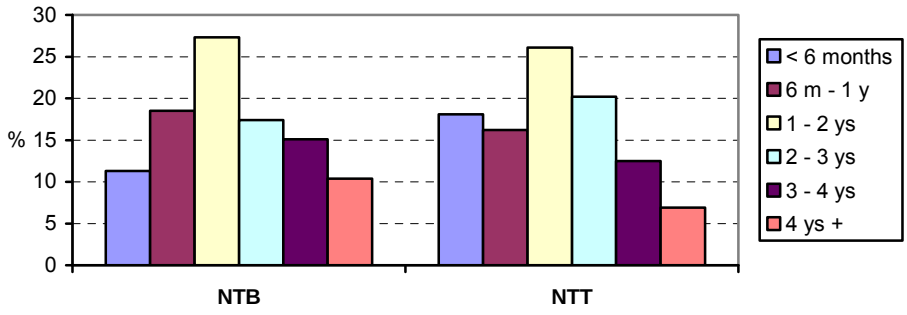


Figure 2.6. Distribution of children under five years by sex in NTB and NTT

2.4. CHARACTERISTICS OF THE HOUSEHOLDS

The pattern of the population pyramid of members of the selected households is similar between the two provinces. The young population of under-fives was the largest in number compared to other groups. This is understandable given our definition of the main population as households with women having at least one child under five years of age. The sex ratio in each age group was around one, slightly higher in the number of females than males (table 2.1).

Figure 2.7 . Distribution of household members by age and sex in NTB

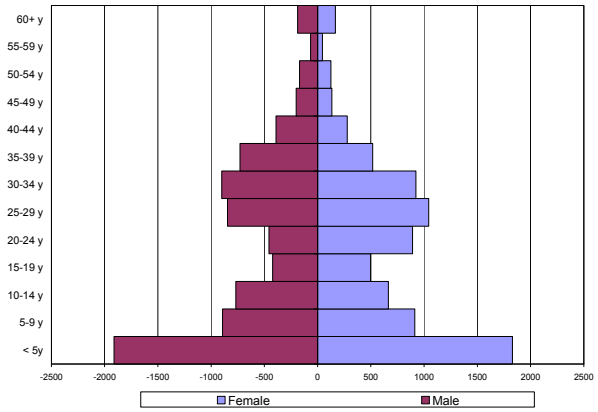
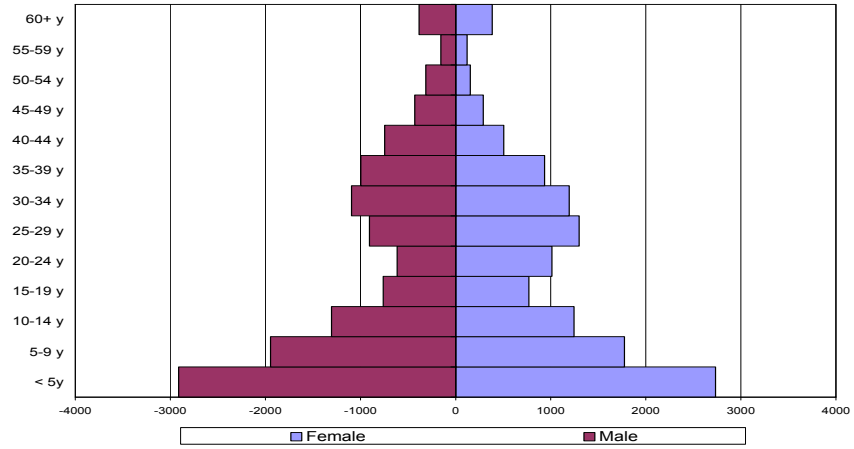


Figure 2.8. Distribution of household members by age and sex in NTT



The table 2.3 shows more worrisome levels of education in NTB, with 20% of household members over 10 years of age without schooling, and a large proportion of them unable to read. Gender inequality is clearly reflected in these data, with females twice as likely to be under-educated than males in NTB.

The above findings are consistent with those of other survey data. The 2004 Welfare Statistics reported similar rates, with illiteracy among males lower than among females in both NTB and NTT. This statistics showed that NTB had more illiterate people, 10% and 14% compared to 4% and 5% in NTT, with respect to males and females. Therefore, programs for enhancing education level are a must, especially NTB, and gender balance should be taken into account.

Figure 2.9. Drop out rate in primary school in NTB

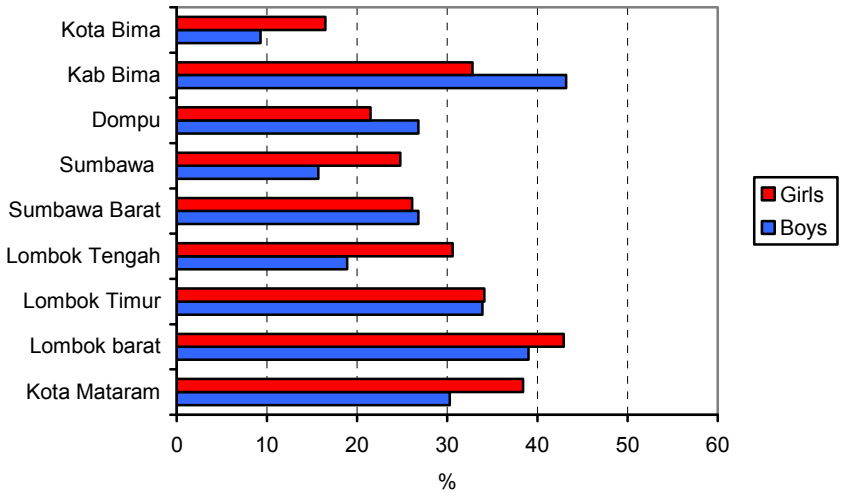
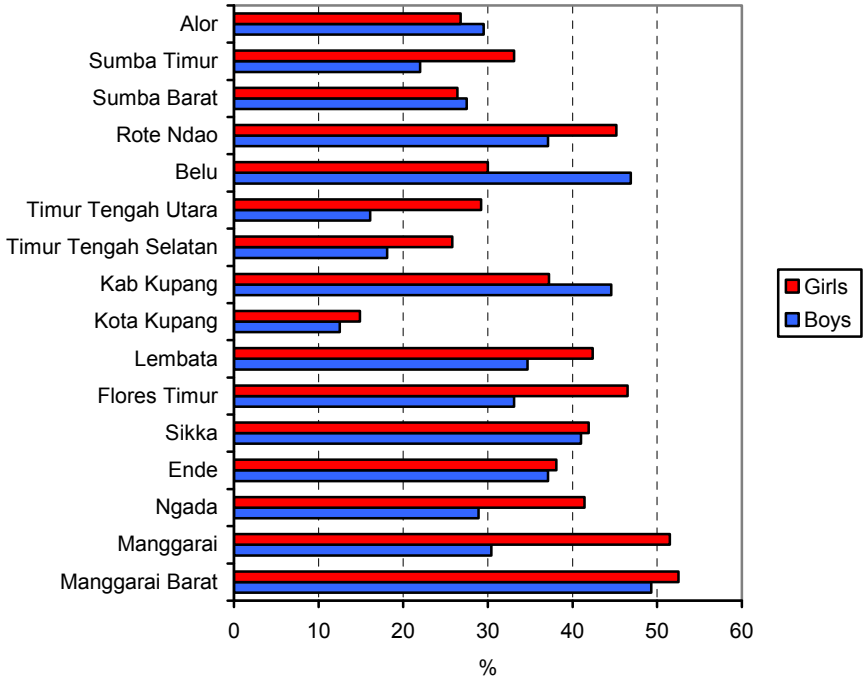


Figure 2.10. Drop out rate in primary school in NTT



With respect to economic conditions, this survey shows that devastating economic levels in both provinces. Although the majority of households own their own house, and over

three quarters have electricity, only about half have television or radio. Average monthly household expenditure is around 550 thousand rupiah in NTB and 602 thousand in NTT, below the minimum regional monthly wage of about 800 thousand rupiah. Moreover, expenditure reported lower than income brings a question whether there was occurred subsistence of the household, fulfilling their requirements with their own production without taking it into account as income, besides, among others, the possibility to have savings. Based on expenditure, it was shown that almost all households in NTB and NTT are below the poverty line, using either the $1 or $2 per capita per day cut-off point (table 2.6).

Figure 2. 11. Percentage of impoverished households based on three models in NTB

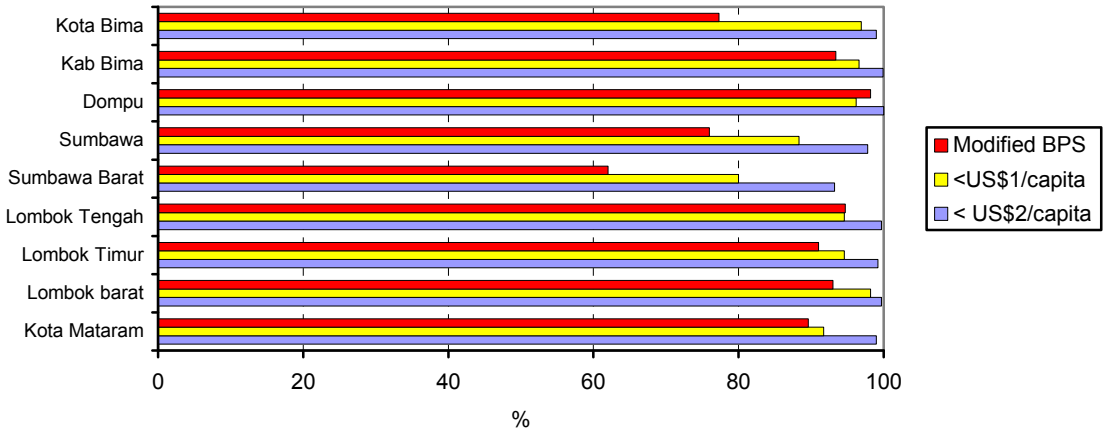
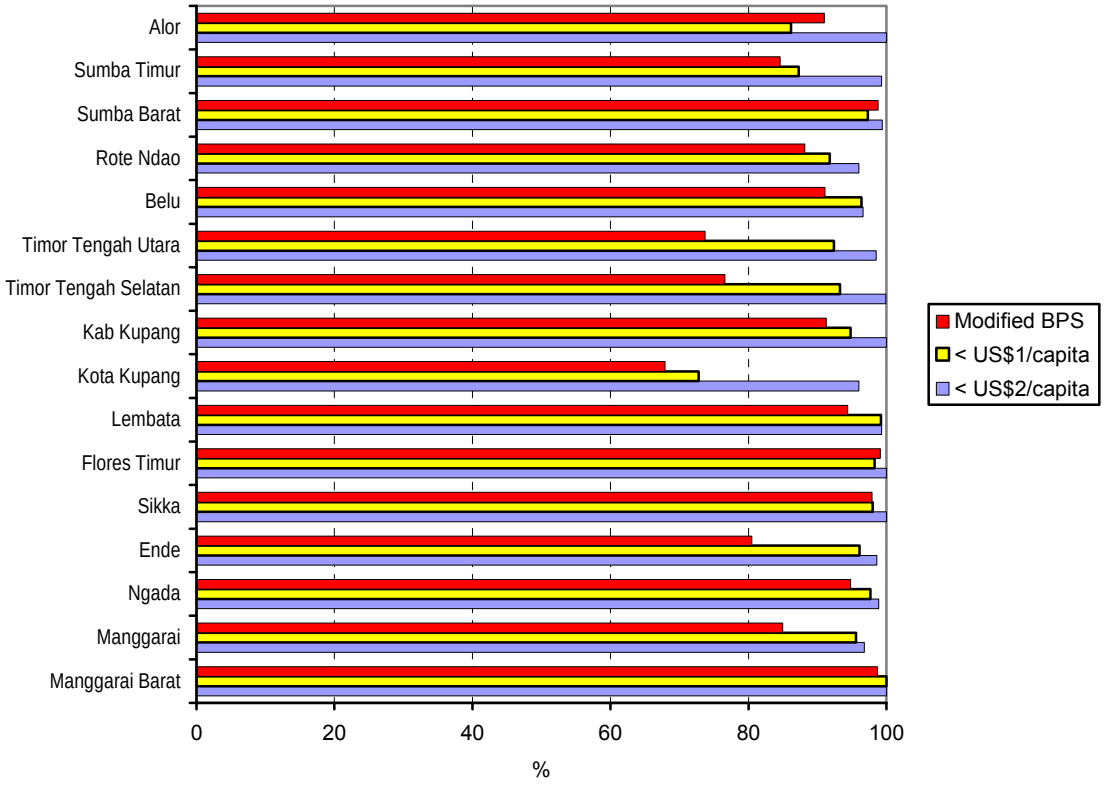


Figure 2.12. Percentage of impoverished households based on three models in NTT



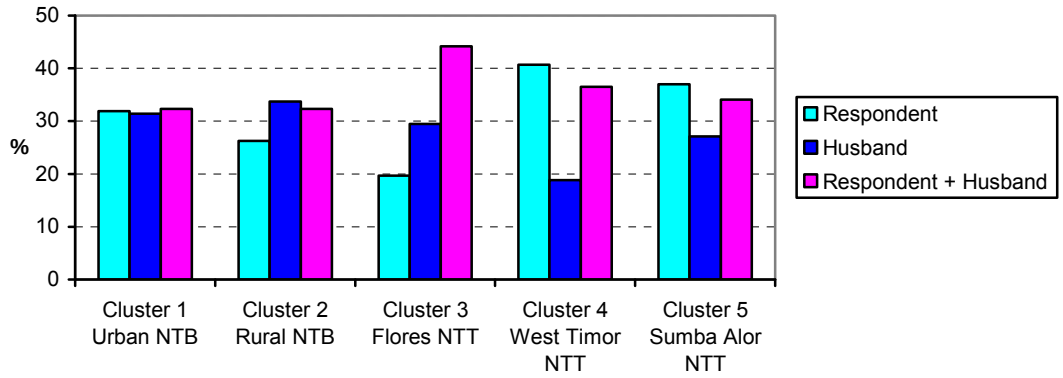
A more complex economic parameter can be based on a modification of the equation used by the Indonesian Central Board of Statistics (modified BPS). A score, ranging from 0 to 8, can be generated by considering six variables: density (at least 8 meter squares per capita), tiled floor, toilet (flush toilet) and source of drinking water (piped or protected well drinking water), household assets, and monthly expenditure of more than Rp.350.000. Specifically, household assets comprise electricity, television, bicycle (or small farm), motorcycle (or big farm), car, row boat and motor boat, each scored from 3 to 7 (by considering the price of each item), making a maximum possible total score of 34 which is then split into 4 groups valued 0, 1, 2, or 3. In sum, socioeconomic level variable can distinguish the poor group that has total score below 6.

Using that modified BPS model, it is found that 91% of households in NTB and 84% in NTT can be categorized into poor. This finding of poor households is much higher than what reported by BPS, for example in NTB was 45% (2005) and in NTT was 28% (2004). Looking at the district levels in the above graphs, the modified BPS model appears closest to the model employing the $1 per capita per day expenditure cut-off, namely the severely poor. That analysis shows that cluster 2 (rural NTB) and 3 (Flores) have relatively more poor households than the other clusters.

The above description indicates that a few districts have attained higher economic levels than the rest. Sumbawa Barat in NTB shows better conditions, perhaps due to substantial external support of a big private company, and Kota Kupang, the capital of NTT province, is now becoming an important transit point (table 2.6.a and 2.6.b).

In regard to decision-making in the household, equality appears to exist in both provinces, particularly when dealing with health or illness of a household member. This finding should be interpreted with caution, however, when considering issues other than health. In the area of family planning, focus group discussions (FGD) at community level found that the husband may be the main decision maker for contraceptive use, but the woman then decides which type of family planning is used. No significant variation in decision making patterns across the districts or project cluster sites was found (table 2.7, 2.7.a and 2.7.b).

Figure 2.13. Distribution (%) of households by decision maker at household level



CHAPTER 3

FERTILITY AND FAMILY PLANNING

This survey collected variables to indicate fertility level, at present or in the past, such as number of pregnancy, children ever born and children still alive. In addition, some factors related to this fertility would be described as well through the age of first pregnancy and birth spacing.

3.1. PREGNANCY, CHILDREN EVER BORN AND CHILDREN STILL ALIVE

Figure 3.1. Average number of pregnancy, children ever born, and children still alive in NTB

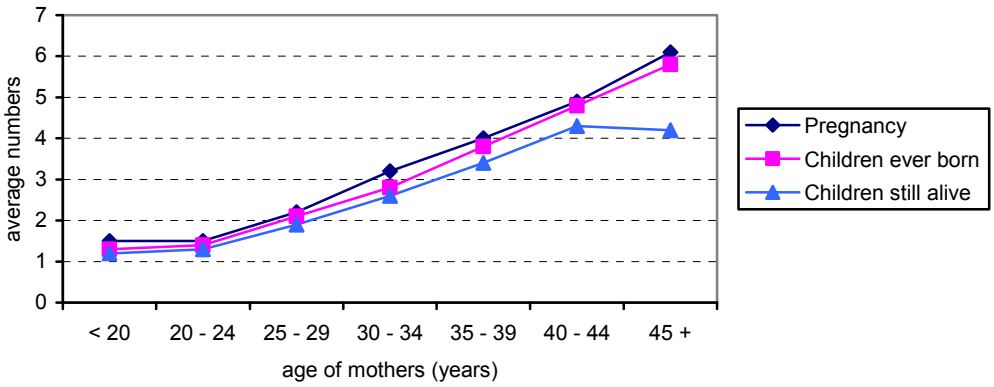


Figure 3.2. Average number of pregnancy, children ever born, and children still alive in NTT

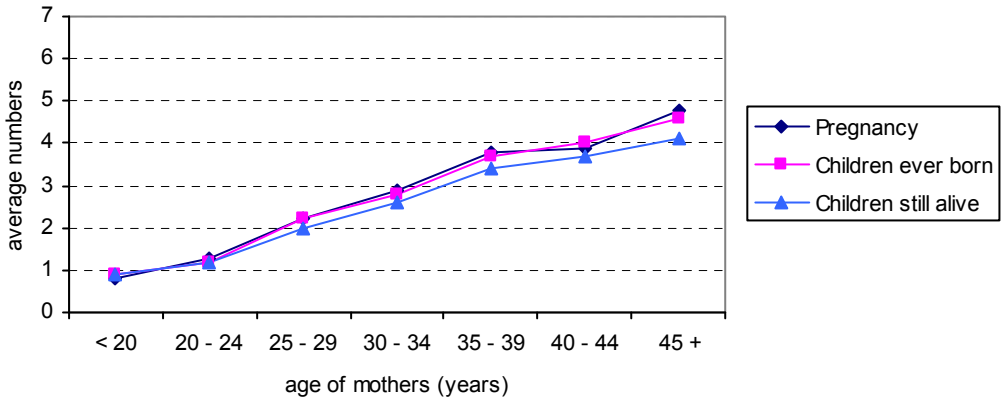
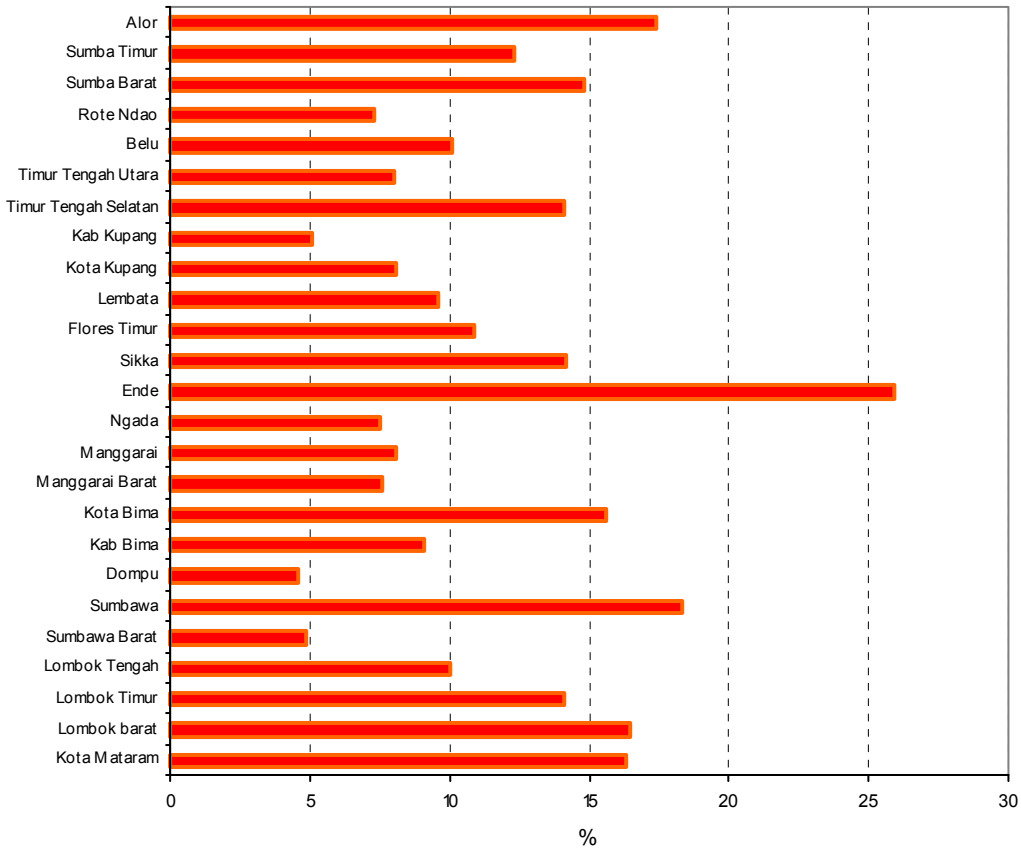


Table 3.1 and above graphs demonstrate a similar pattern of reproductive history in both provinces. Among mothers aged 40 to 44 years, the average number of children ever born was around 5 in NTB and 4 in NTT, but both ended with the same number (4) of children still alive. Interestingly, in NTB there is a large discrepancy between number of children ever born and still alive in mothers aged 45 years and older. That could mean that the likelihood of the child dying was somewhat higher over twenty years ago. Recently the gap between the number of pregnancies, children ever born, and children still alive is becoming smaller, a sign of improving child health.

Figure 3.3. Percentage of abortion history among respondents



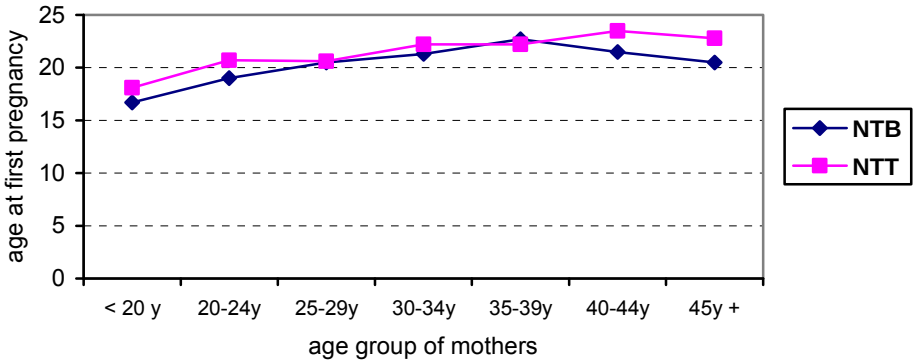
By asking respondents on their obstetric history, figure 3.3 depicted that proportion of women had abortion history ranged from approximately 5% (in Dompu) to 26% (in Ende). To compare, Utomo et al. (2001) reported that abortion cases recorded throughout selected service delivery points in Indonesia was 43 per 100 live births, in addition to estimates resumed from some facility based studies in Indonesia ranged from 5 to 35 abortions per 100 live births (cited in WHO, 1998:70).

3.2. FIRST PREGNANCY AND DELIVERY

A high risk pregnancy can be indicated, among other factors, by pregnancy occurring below 20 or older than 35 years of age. Age of first pregnancy is related to age at first marriage and also influences fertility since the child-bearing period will be wider in women married younger. In regard to this condition, NTB is of particular concern because half of all respondents reported their first pregnancy was below 20 years of age. In NTT a quarter of respondents were in this category, less than in NTB, but NTT still has reason for concern. The data also show a small portion of females who were underage at the time of marriage. A first pregnancy in an “old” female is also at increased risk. In general, the first delivery occurs in the first year of marriage (table 3.5 and table 3.6).

Interventions to reduce risk in both age groups must emphasize the dangers of being too young for marriage or too old for first motherhood. Stricter implementation of marriage laws requiring the woman to be at least 16 to get married should be followed by delaying the first age of pregnancy by using proper family planning method.

Figure 3.4. Average age (years) of mother at first pregnancy in NTB and NTT by age group of mothers



3.3. BIRTH SPACING

Birth spacing reflects the impact or success of family planning programs. Table 3.7 shows that both provinces average 4 to 5 years of birth spacing between the last birth and the last previous birth, and over 3 years spacing between the first and second previous births. The majority of births then are at intervals of more than two years as recommended by the family planning program. NTT looks to have a little higher fertility than NTB, however, consistent with that reported by the 2003 IDHS which found the median for birth spacing to be 38 months in NTT and 55 months in NTB.

The graphs below show that Sumbawa District in NTB, and Kota Kupang and Manggarai in NTT have more short birth intervals (less than 2 years) than other districts. However, it is nice to observe that this phenomena is improving since the proportion with short birth spacing between the last to previous birth is smaller than the percent with short spacing between the first and second previous births (table 3.7.a and 3.7.b).

Figure 3.5. Percentage of short birth interval from last to first previous child, and from first to second previous child in NTB

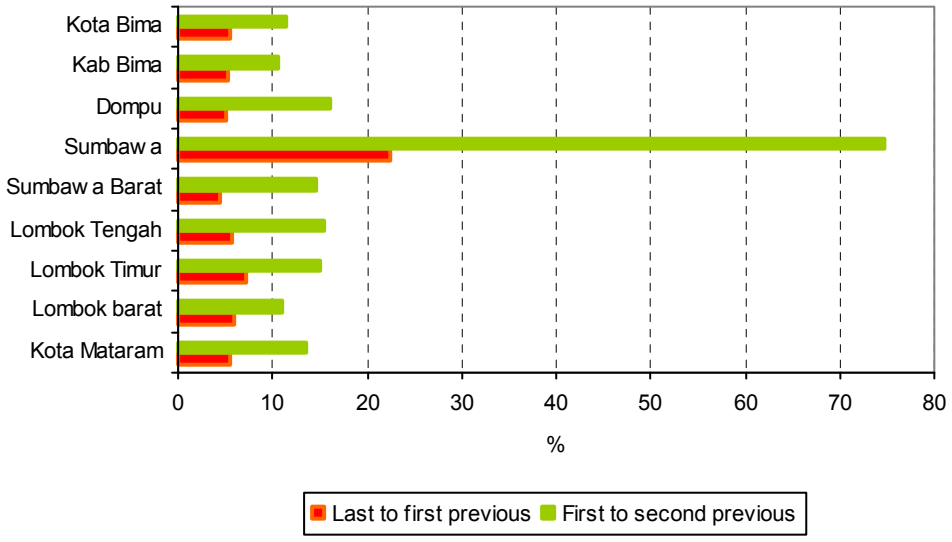
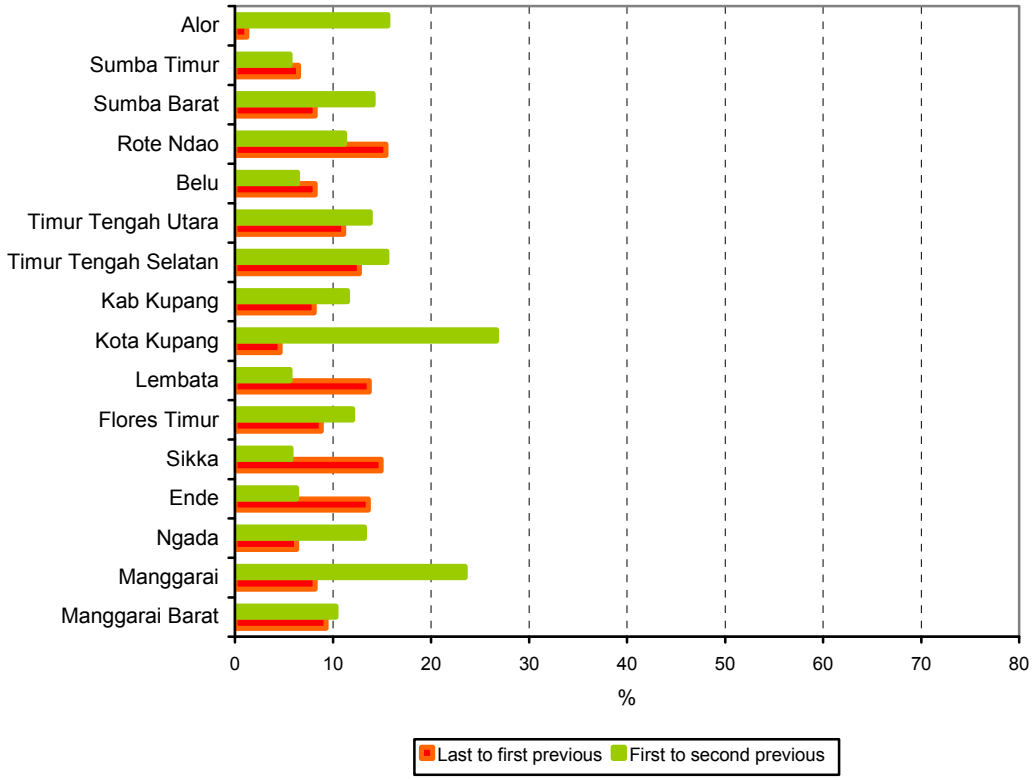


Figure 3.6. Percentage of short birth interval from last (L) to first previous child (1), and from first to second previous (2) child in NTT



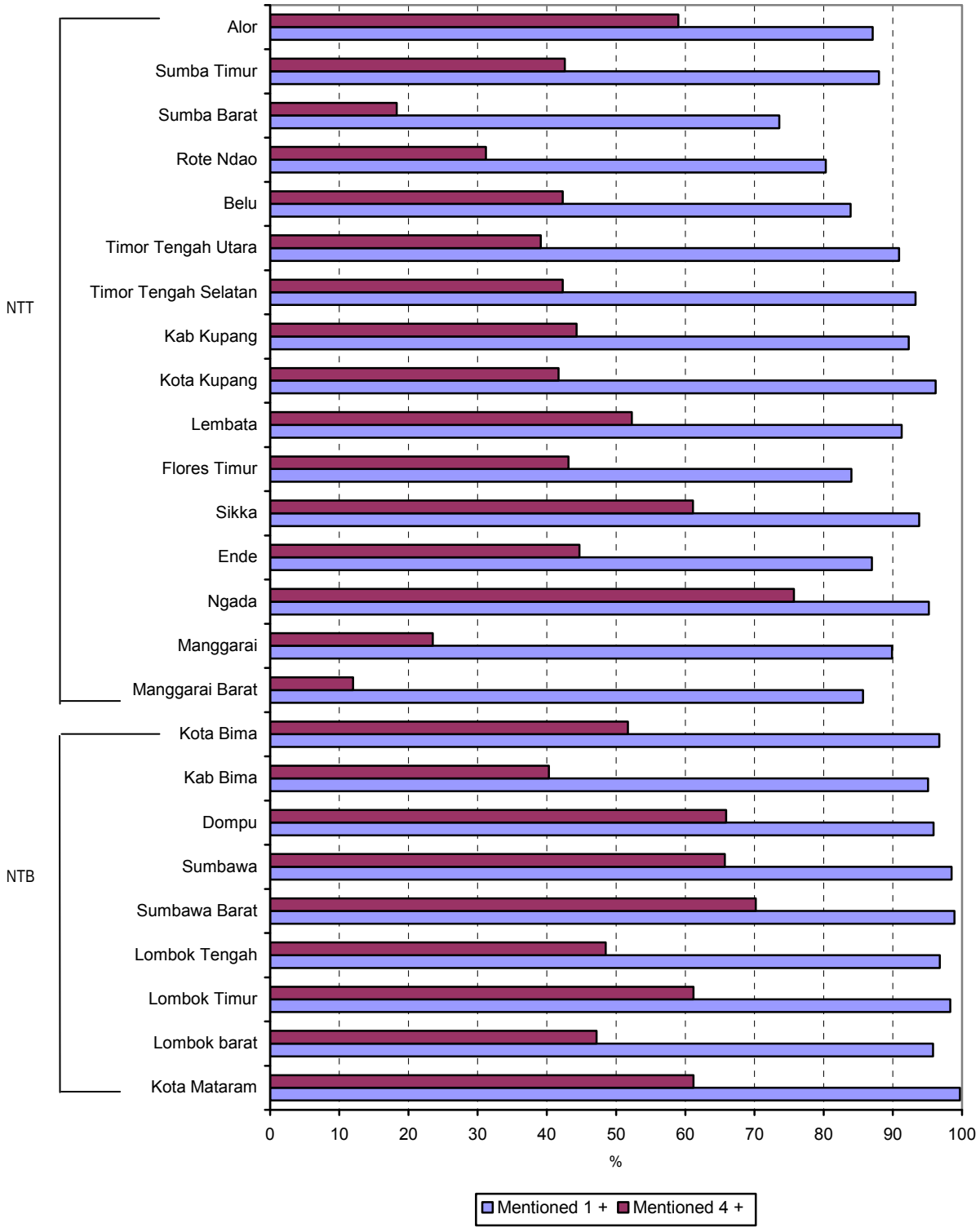
3.4. KNOWLEDGE ON CONTRACEPTION

The survey found that almost all respondents have heard of contraception. However, the percentage who could name more than 3 methods tells us that adequate awareness of mothers to deal with the "cafeteria method" has not been reached. Only 56% of respondents in NTB and almost 40% in NTT could recall more than three contraceptive methods. Injection, pills, IUD, and implant were the most well-known methods. It should be noted that the condom, the only method that also protects from sexually transmitted disease, was mentioned by only one third of respondents (table 3.8).

In NTB districts, mothers who were able to mention at least four contraceptive methods were quite moderate in number, ranging from 40 % to 70% of women (table 3.8.a). This was higher than in NTT where districts such as Manggarai Barat and Manggarai showed especially low levels while other districts were better (table 3.8.b).

The puskesmas is clearly mentioned as the most common source for obtaining family planning services. Hospitals, followed by village midwife (BDD) and maternity hut (polindes), were also mentioned by mothers as facilities with family planning services. No variation across the districts or clusters is shown (table 3.9, 3.9.a and 3.9.b).

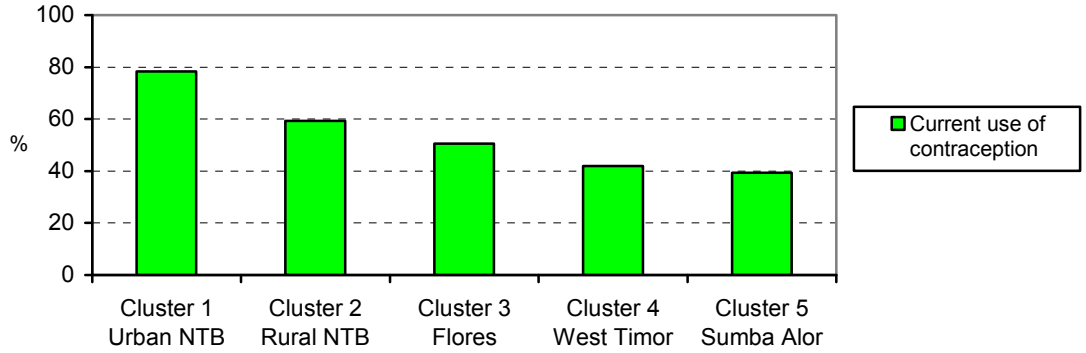
Figure 3.7. Percentage of women mentioned at least one and at least 4 contraceptions in NTB and NTT



3.5. CURRENT CONTRACEPTION USE

Table 3.10 shows impressively high prevalence of contraceptive use (74%) in NTB. At the same time, it is obvious that current use of family planning in NTT calls for serious notice. The percentage of around 44% in NTT is much lower than the 57% national prevalence (IDHS, 2003). These figures are somewhat higher, however, than those reported by IDHS then, 53.5% for NTB and 34.8% for NTT. The figure below shows clear variation across the clusters where clusters 1 (urban NTB) and 2 (rural NTB) have a higher figures than clusters 3 (Flores), 4 (West Timor) and 5 (Sumba and Alor) . However, the socioeconomic level is seem has no influence to the contraceptive use.

Figure 3.8. Percentage of current user of contraception by cluster in NTB and NTT



The graphs presented (figures 3.8 and 3.9) demonstrate highs contraceptive prevalence rates in districts Kota Mataram, Sumbawa Barat, and Sumbawa, in NTB, and Manggarai and Belu in NTT. The differences in prevalence in the two provinces are clarified by findings from some of the in-depth interviews with stakeholders. After struggling for some time with no data, the NTB Family Planning system now starts to provide records useful for program monitoring. In NTT, however, the data are handled by the Health Offices.

> "*... in general, BKBKS is not requested to do recording... but because I do not know the target, since two years ago I started to record it... therefore I can have the data of reproductive couples ....*"
>
> (BKBKS, NTB)

> "*.... in evaluating the program performance, we just use indicators such as delay of age at marriage ... delay the first pregnancy ..... and we do not have statistical figures... because the Health Office does the testing of program efficacy...*"
>
> (KBKS, NTT)

Figure 3.9. Percentages of current user of contraception in NTB and NTT by districts

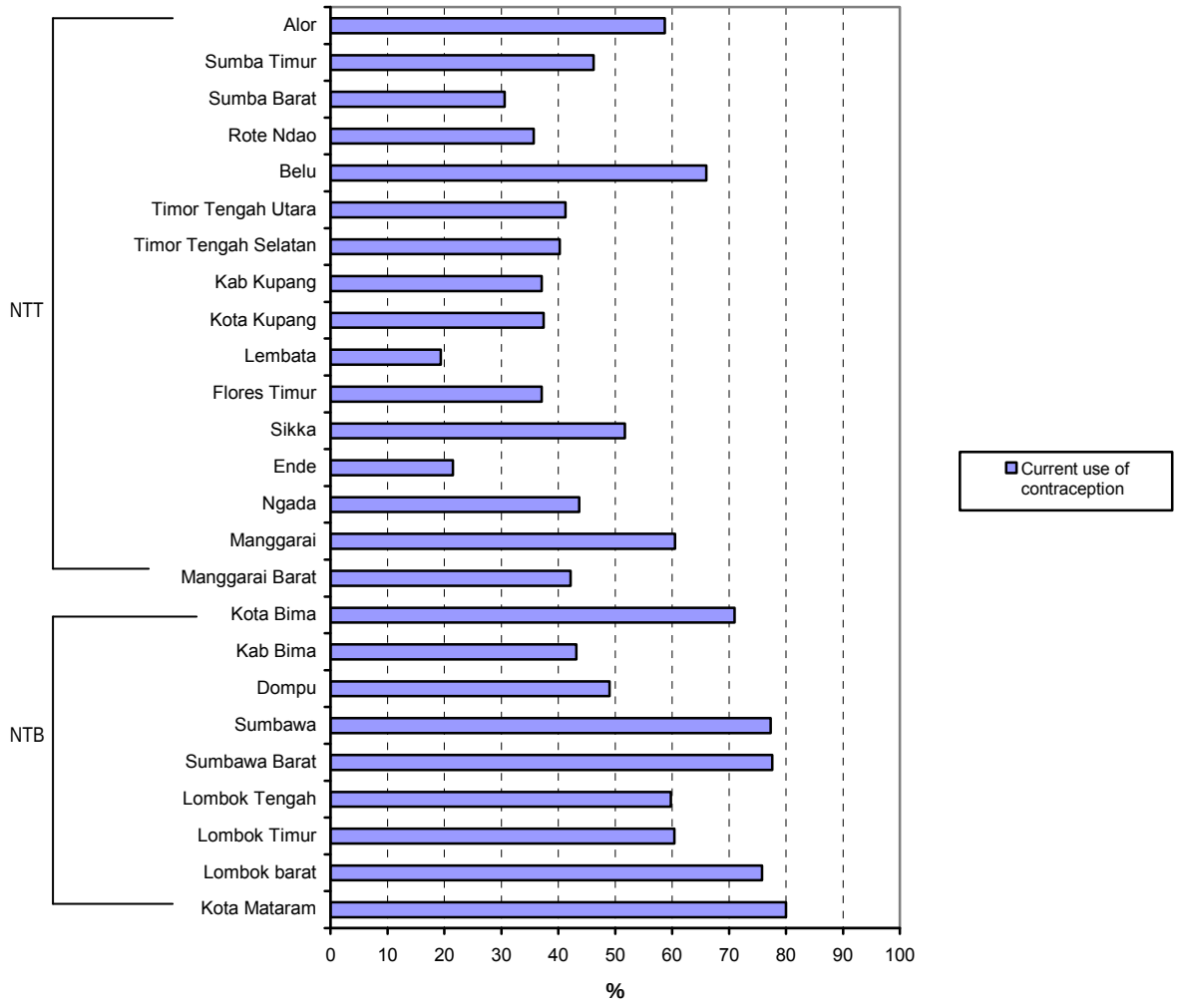
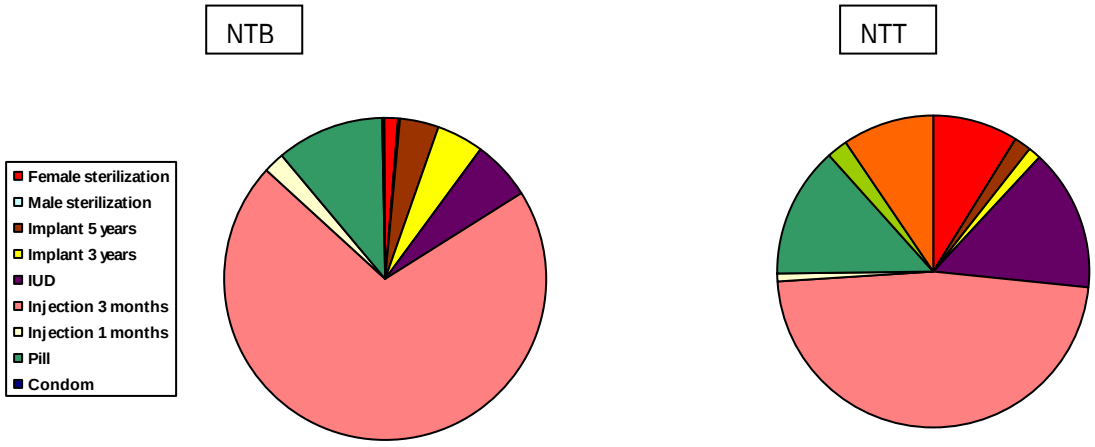


Figure 3.10. Distribution of contraceptive method currently used in NTB and NTT



The preferred contraception in NTB do not differ from NTT, being 3-month-injection, pill, and IUD. This pattern is similar to that found by the 2003 IDHS. The implant method is more popular in NTB than in NTT, this family planning method may correspond best with the ability to pay.

".... injection is more favorable, it is three monthly, inexpensive, so every three month I spend only 10 thousand rupiah" (FGD of mothers in NTB)

Reasons advanced for not using contraception are also interesting. Around 16% of respondents in NTT cited side effects, higher than 9% in NTB (table 3.11). This surprising difference may relate to service quality. Therefore, review of family planning services quality is recommended to maintain continuity of use.

".....if someone uses injection, sometimes it is okay, but sometimes not, allergy..... If she uses IUD, she needs to go for rechecking, meanwhile mothers are usually busy, while we know that regular check-ups should be done because we worry about a misplaced IUD .." (FGD of mothers in NTT)

"My wife does not use any contraception method because she used to be not comfortable with it. Once she had one-month injection after our first child, but then she developed headache... so she stopped it...." (FGD of fathers in NTB)

In addition to side-effects, the need to improve services was also reflected by reports from respondents in NTB and NTT of expensive services (both are 3.% respectively) and of no contraception available (0.6% and 1.7% respectively) (table 3.11). Although small percentages, these problems of service facilities should still be explored deeply and enhancing service quality should be a major priority in both provinces.

Non-use because of refusal by the husband was only found to amount of about 5% in NTB and 6% in NTT. This demonstrates that interventions must target husbands as well as women, since the mothers expressed their willingness to use contraception.

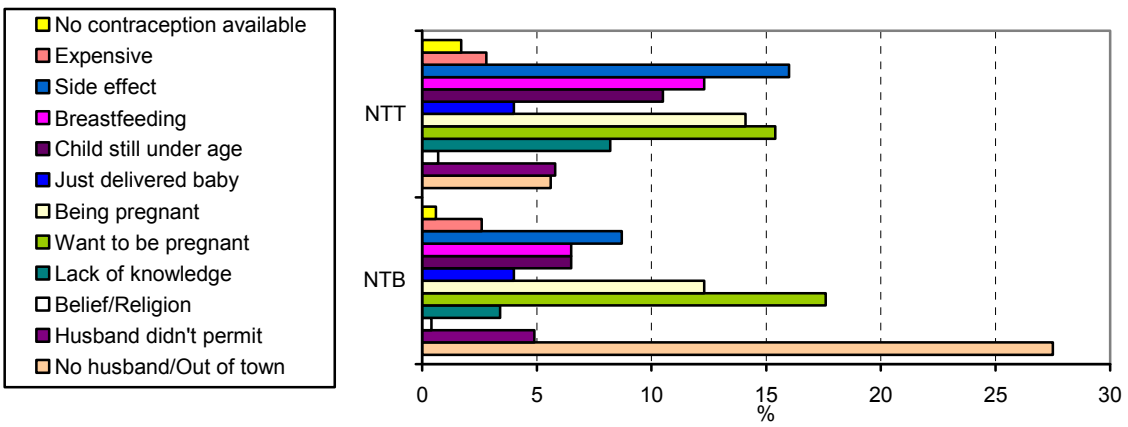
"Yes, I do not use any FP method. I have no permission from my husband, while actually I want to..." (FGD of mothers in NTT)

Interestingly, natural methods such as abstinence and the calendar are more popular in NTT than in NTB. Although only small portion of respondents refuse contraception for religious reasons, it was expressed by some male informants in FGDs in NTT.

"We use calendar, and also condom ..... the reason is religion....." (FGD of fathers in NTT)

No husband as the reason for not using contraception was higher in NTB (28%) than in NTT, and most probably it relates to the males work out of country (*Tenaga Kerja Indonesia*, TKI). Notably in Lombok Barat, nearly 45% of women confessed that their husbands were not at home (table 3.11.a).

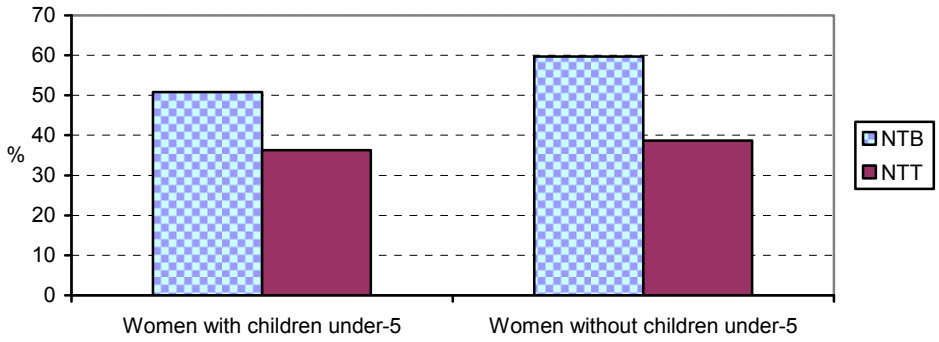
Figure 3.11. Percentage of women did not use contraception by their reason



3.6. CONTRACEPTION EVER USE

To complement the information on current contraceptive use, the survey found that about half of respondents who were not currently using contraception had ever used family planning (table 3.12). The rest had never used it. Among women with children under five, the percentage who had never used contraception was higher in NTT than in NTB. This was also found for women without children under five.

Figure 3.12. Percentage of women with and with no children under five years old (U5) who had ever used contraception



3.7. DESIRED, RECOMMENDED AND AVAILABLE METHOD

By asking respondents the family planning method they prefer, methods recommended by providers, and those available at facilities, the women's point of view and the capacity of the services to serve the family planning needs was examined. The tables (table 3.13 and 3.14) and figures below portray the findings. Discrepancies between percent desired and recommended methods compared with availability demonstrate the ability of services facilities to respond to the demand. For pills, NTB facilities have no problem providing the service, but NTT does. On the other hand, the popular method of injection was under-supplied in NTB but not in NTT.

Figure 3.13. Percentage of respondents who desired, received recommendation, and perceived available method in NTB

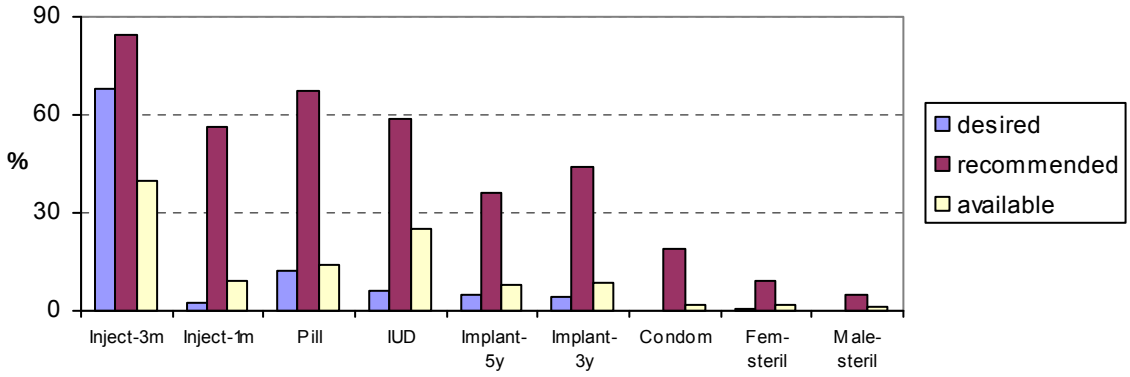
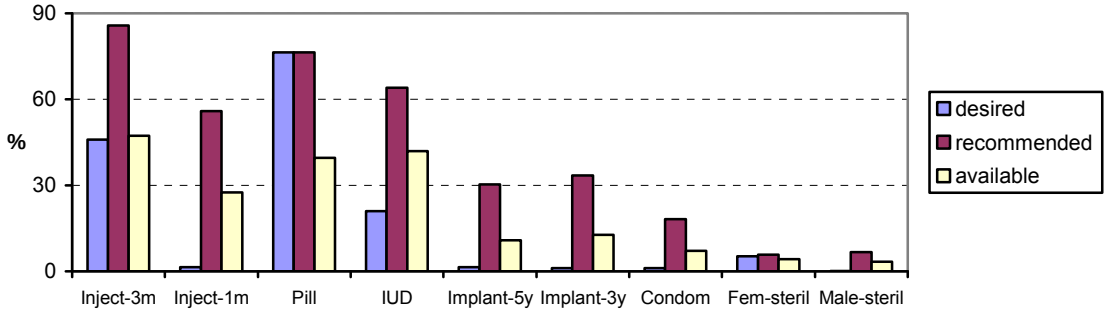


Figure 3.14. Percentage of respondents who desired, received recommendation, and perceived available method in NTT



In in-depth interviews with stakeholders, some informants explained that injections were more expensive to procure than, for example, IUDs, especially for decentralized management.

> "*... I push mothers to use the IUD instead of injection for example, because in its procurement, injection is more expensive than the IUD... we have to provide injections every three months ..."* *(BKBKS, NTB)*
>
> "*... contraceptive methods are always in our distribution system, directly distributed from center to province, and they are distributed equally and in sufficient numbers... because every contraceptive has its expiration date such as for injection .there are two kinds... one month and three month period... Contraceptives are dropped directly to health facilities ..."* (*KBKS, NTT*)

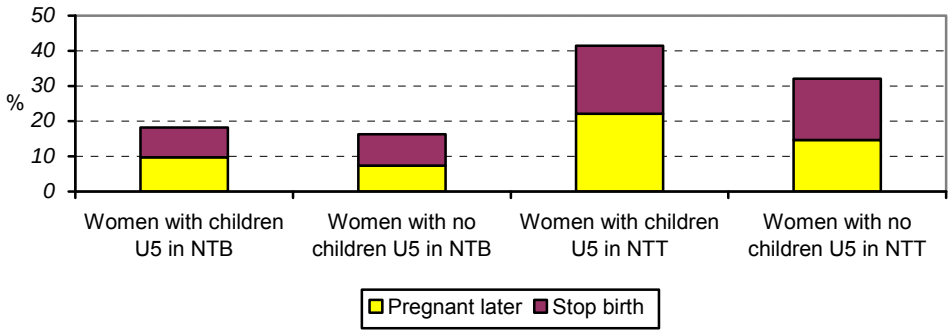
The tables show that the percentages of methods available in NTB and NTT facilities are lower than the recommendations of health personnel, showing that the reliability of facilities should be increased, since the recommendations of providers should correspond with what can be supplied to the facility (tables 3.13 and 3.14).

3.8. UNMET NEED OF FAMILY PLANNING

Unmet need is defined as the needs for contraception of married women who do not want any more children or who wish to space the next birth but do not currently use any method of family planning. In this study, unmet need refers to women who want no more children or want to space the next birth and do not currently use any method of family planning. According to these criteria, unmet need in this survey was one third in NTT and about one fifth in NTB (table 3.15). These figures are much higher than figures reported from previous surveys such as 2003 IDHS (around 4%) and show the need for extraordinary efforts to encourage contraception in NTT. Since contraceptive distribution in NTT looks likely to improve, it is expected that efforts to improve demand will focus firstly more on the community level.

Women who did not want to be pregnant again are similar in number to those who wish to delay their next pregnancy. This suggests that there are strong reasons to provide more counseling and promotion of sterilization methods, especially to women with older children.

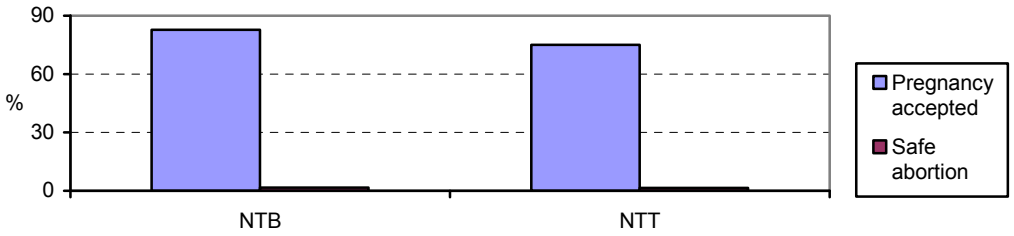
Figure 3.15. Reasons for non-use of family planning among women wanting no more or delayed pregnancy but not using contraception, in NTB and NTT



3.9. RESPONSES TO UNWANTED PREGNANCY

Unwanted pregnancy is a failure of family planning, and improper responses result in maternal morbidity and even fatality. At the level of awareness, around three quarters of women surveyed responded that an unwanted pregnancy would be accepted. However, in about 10% of cases in NTB and 20% in NTT, people resort to unsafe abortion by persons who are not health personnel (table 3.16). While the legal questions are debated, this reflects a failure of health facilities to accommodate this problem appropriately.

Figure 3.16. Percentage of women mentioning responses in case of unwanted pregnancy in NTB and NTT



CHAPTER 4
ANTENATAL CARE

Maternal care should begin when pregnancy is recognized in the first trimester, and antenatal care services are an important opportunity for reducing the risks that lead to maternal complications. Personnel visited by mothers, the frequency of those visits, danger signed detected, and care seeking to deal with dangers recognized, are some of the variables assessed in this study.

4.1. ANTENATAL CARE FREQUENCY AND SERVICES

Almost all mothers in NTB and NTT seek antenatal care. Overall, the average number of visits to personnel during pregnancy is 9, many more than the four visits recommended (table 4.1). The first visit, K1, should occur in the first trimester. The study found that K1 in the first trimester was higher in NTB (97%) than in NTT (80%). This does not differ significantly from the 2004 Indonesia Health Profile that reported 90% in NTB and 75% in NTT.

A minimum of four visits are needed to provide complete antenatal care as recommended (1 in the first trimester, 1 in the second, and 2 in the third). This is measured by the indicator K4 which shows the proportion of women visiting the health personnel for antenatal care at least four time was showing the numbers slightly lower than K1. Figures 4.1 shows the findings.

Some of the mothers in the FGDs admitted to missing the visit in the first trimester or completing the four visits required:

> *"I go to dukun (TBA), then in the six month I go to the bidan (midwife)."*
> *".. I never... but oh..yes once, yes, only once during my last pregnancy"*
> *"... I never go to be examined..... "* *(FGD of mothers in NTB)*

The quality of antenatal care can be assessed by determining whether five key antenatal services were performed as part of antenatal care during her last pregnancy. The five are weighing, Tetanus toxoid immunization, blood pressure measurement, abdominal examination, and distribution of 90 days of iron tablets. The proportion of pregnant women who receive all five essential services is called the "K4-q" indicator. Table 4.2 shows that across all clusters and both provinces only about half of mothers receive the five essential antenatal services.

In each province, no district shows good quality of antenatal services, as indicated in figures 4.2 and 4.3. Nonetheless, this perception of services could also be meant that women did not know what services they received because no adequate IEC accompanied this activity.

Figure 4.1. Percentage of first visit (K1), at least 4 visits (K4) and received 5 essential services (K4-q) in antenatal care by cluster

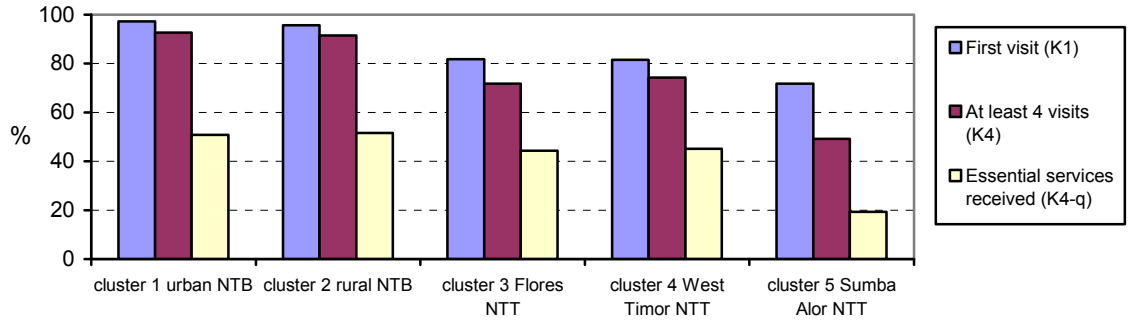


Figure 4.2. Percentage of first visit (K1), at least 4 visits (K4) and received 5 essential services (K4-q) in antenatal care by district in NTB

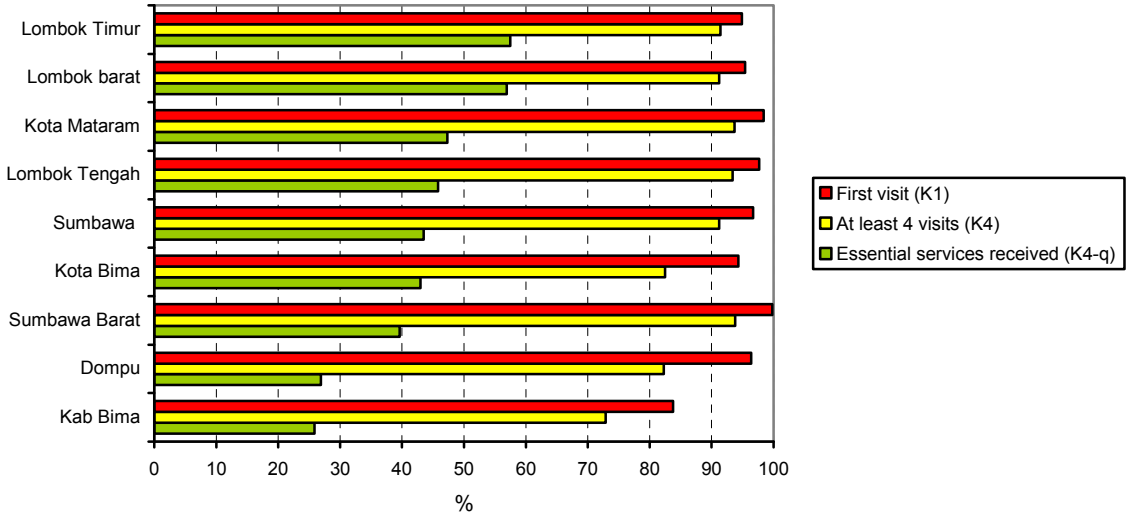


Figure 4.3. Percentage of first visit (K1), at least 4 visits (K4) and received 5 essential services (K4-q) in antenatal care by district in NTT

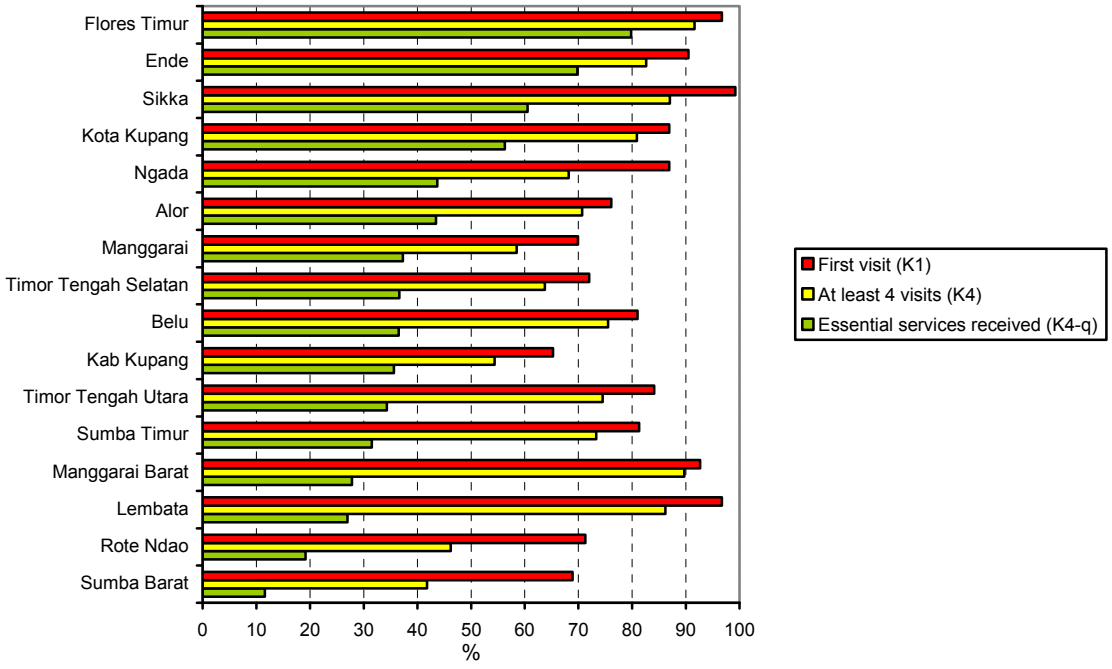


Figure 4.4. Percentage of blood test, Fe tablet distribution and anti-malarial drugs distribution, administered during antenatal care services by district in NTB

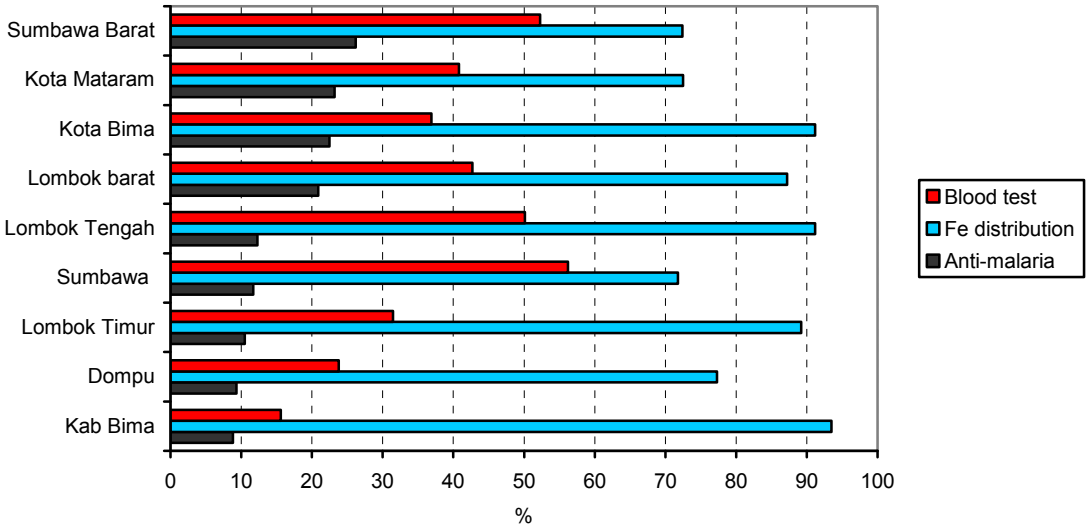
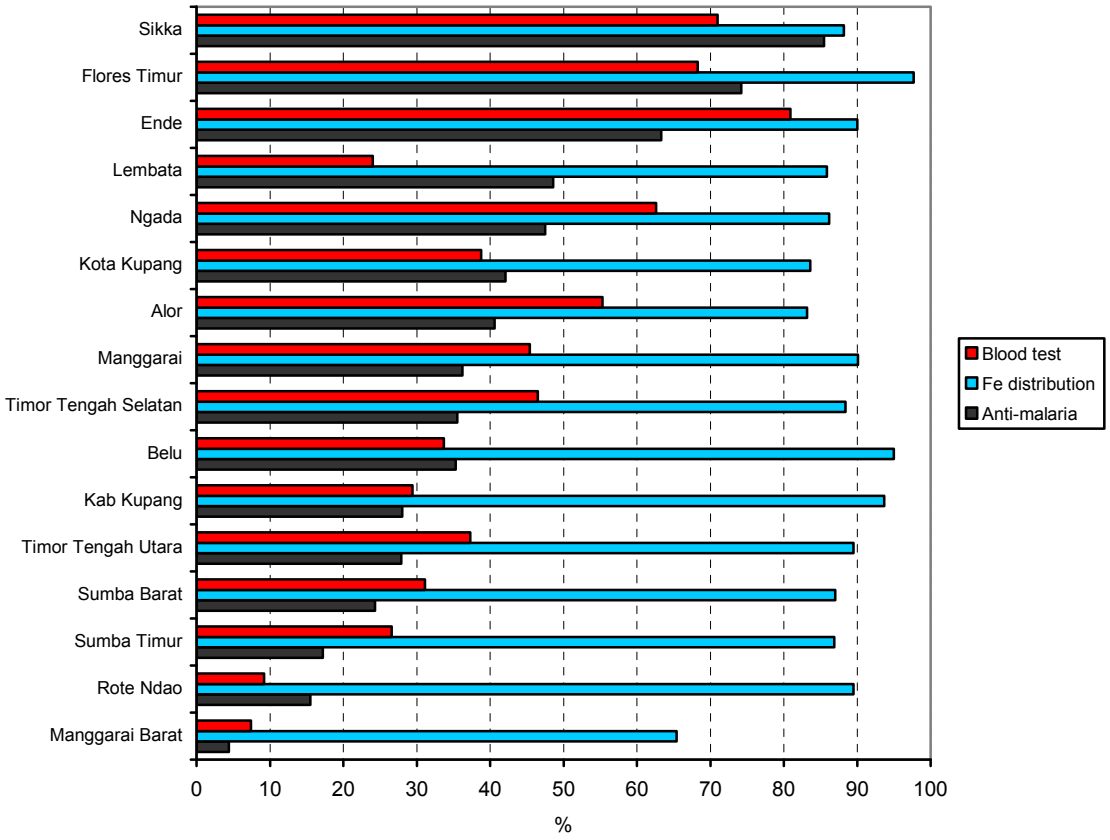


Figure 4.5. Percentage of blood test, Fe tablet distribution and anti-malarial drugs distribution, administered during antenatal care services by district in NTT



Maternal mortality is high in NTB and NTT. An important contributing cause, among other factors, is anemia during pregnancy, and testing for blood hemoglobin is important to screen for anemia. Around 40% to 50% of respondents in the household survey recalled that their blood had been tested (for any reason). Variation in blood testing across the districts was quite high as seen in the above graphs. Iron tablet distribution

was quite well preformed. Blood test requires both laboratory capacity and trained personnel and appears to be in particular need of strengthening.

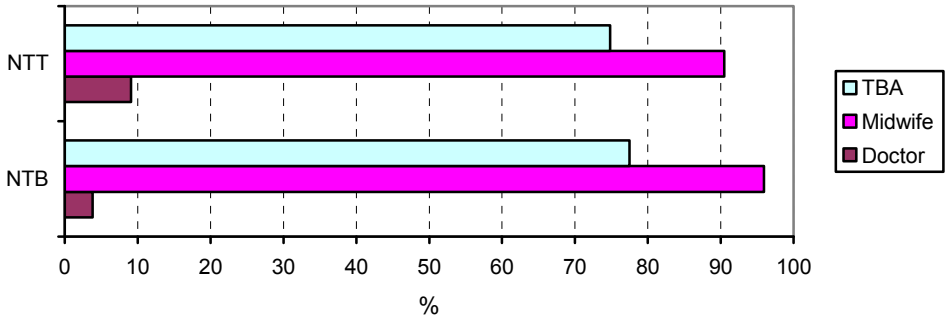
Because malaria contributes to anemia and NTB and NTT are endemic areas for malaria, the distribution of anti-malaria drugs to pregnant women should have some effect in reducing anemia. The survey found that anti-malaria drug distribution during pregnancy was only reported by a small number of mothers, 20% in NTB and 40% in NTT (table 4.2), and variation across the district was quite high as depicted in the above figures.

Messages communicated via IEC activities by health personnel during pregnancy include knowledge of danger signs, action to be taken for dangerous conditions, birth preparedness, and breastfeeding. Each was reported by less than 50% of mothers as having been mentioned by health personnel. Greater attention paid to the quality of services during antenatal care should include the communication of information as well as medical services.

4.2. ANTENATAL CARE PROVIDER AND FACILITY

For antenatal care, most mothers prefer to use midwives, 95% in NTB and 88% in NTT (table 4.3). These figures do not differ greatly from those reported by Sagric (2006) who found 93% in NTB and 95% in NTT.

Figure 4.6. Percentages of antenatal care providers in NTB and NTT



This finding is supported by the remarks of mothers in FGDs:

> *"Most of the time we go to bidan desa (village midwife (BDD)) because she lives here. But if she is out, we go to the puskesmas.... " (FGD of mothers in NTT)*
>
> *"..... puskesmas is far from here, so we go to polindes, close to our house."*
>
> *"Hence the midwife in the puskesmas is the same one who is in posyandu here ...."*
>
> *(FGD of mothers in NTB)*

Nevertheless, visits to traditional birth attendants (TBA), or *dukun*, were mentioned as well by three quarters of mothers. Half of them visited a *dukun* three or more times during their pregnancy (table 4.4). This is more than reported by the Sagric study (2006): 23% in NTB and 17% in NTT. The FGDs explored reasons for using the *dukun*, and respondents emphasized the importance of the availability of the village midwife (BDD).

> *".... sometimes the midwife is not in her place, so we go to dukun .."*

(FGD of mothers in NTT)

"at first we confirm it, then we care for (the pregnancy) by utilizing a dukun or traditional masseuse specializing in massage for pregnant woman... they are trained and can handle everything up to birth delivery."

(FGD of fathers in NTT)

Mothers also believe that *dukun* play an important role in ensuring a safe pregnancy, for example, by maintaining the baby in a good position. Some mothers believe that the *dukun* have been trained and therefore have attained some level of capability as well:

".....the (village) dukun is also trained .. and she knows how is the fetus in the womb....so besides going to bidan, I go to dukun... mixed.... so if there is a pain occurred caused by the baby('s head) stuck ... only village dukun can handle it ....."

(FGD of mothers in NTB)

" massage, so that the baby's position is correct for birth" *(FGD of mothers in NTT)*

The other reason for going to a *dukun* during pregnancy is financial, as explained by some informants:

".... actually we want to go to puskesmas, but we cannot afford it, our (financial) ability is limited, therefore finally we go to dukun.... but actually it is better go to puskesmas"

(FGD of fathers in NTB)

Geographical barriers can represent a great challenge in access to health personnel as explained by one District Health Office:

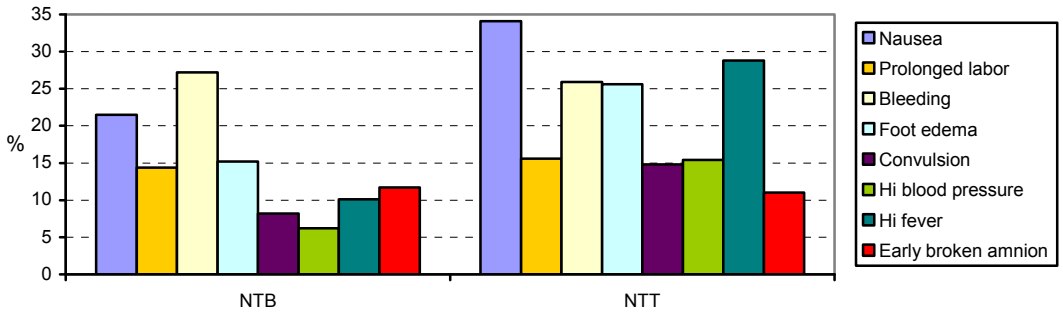
"if dukun in this kabupaten M…. (still exist), it is particularly for geographical reasons... so we need partners… at a minimum for helping with the birth. If we should eliminate them, I think that now is not a proper time to start… we still need them…"

(DHO, in NTT)

4.3. KNOWLEDGE ON MATERNAL COMPLICATION

Detecting maternal complications as early as possible depends partly on the level of knowledge of women. This survey revealed that only about half of mothers in NTB, but three quarters of those in NTT, could mention any danger sign during the maternity period. Only 5% and 11% of mothers in NTB and NTT respectively were able to recall at least 4 danger signs, however (table 4.5). This level of knowledge demands serious attention, especially in terms of IEC activities, administered either at the health facilities by health personnel or by mass media more generally.

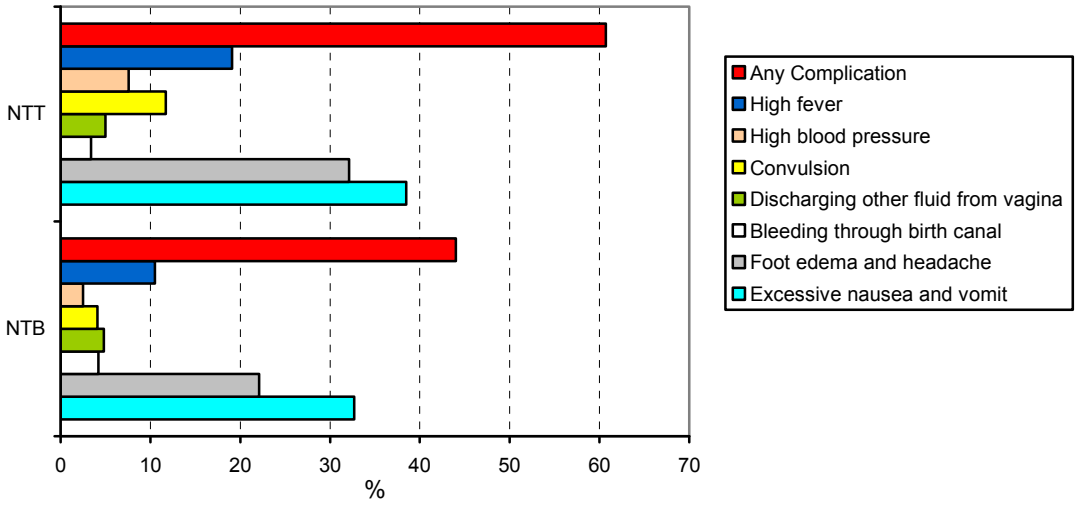
Figure 4.7. Percentage of known dangerous sign of maternal health by women in NTB and NTT



4.4. PREGNANCY COMPLICATION AND TREATMENT SEEKING

Table 4.6 and the figures below show that around half of mothers surveyed had experienced pregnancy complications, 63% in NTT and 44% in NTB. Pre-eclampsy appears to occur more often in NTT than in NTB, suggested by pedal edema and headaches (33% and 22%), convulsions (12% and 4%), elevated blood pressure (7.7% and 2.5%), and high fever (17% and 10.5%). These complications are reasons for concern because other studies have disclosed similar figures. The 2001 SKIA, for instance, reported anemia in pregnancy in 43% of women in NTT, somewhat higher than NTB (30%), and under-nutrition among women of reproductive age was found to be 19% in NTT compared with11% in NTB (WFP,SeameoTropmed, 2005).

Figure 4.8. Percentage of women who reported experiencing complications of pregnancy, in NTB and NTT



Cigarette smoking by the pregnant woman or someone else in the house can increase the risk of pregnancy complications. The survey revealed that 4% to 5% of women were still smoking cigarettes during their last pregnancy (table 4.7). This is not substantially different from the general prevalence of smokers among females. Worse is the finding that there are persons smoking inside the house of 60% to 70% of households. This agrees with the general prevalence of cigarette smoking in males which is about 62% (MoH, 2004).

Pregnancy complications can elicit responses both inside and outside the home. Inside the home, one fifth deal with the complication by taking a rest, and remedies are tried by 8% and 10% of mothers with complications in NTT and NTB respectively (table 4.8). Table 4.9 identifies the puskesmas as the most common place to seek treatment, used by one third of mothers with complications. The village midwife (BDD) was only selected by 8% in NTB and 11% in NTT. This demonstrates that the puskesmas is still regarded as a source of care for complications of pregnancy, regardless of the types of health personnel available there.

Figure 4.9. Percentage of type of home treatment for handling pregnancy complication

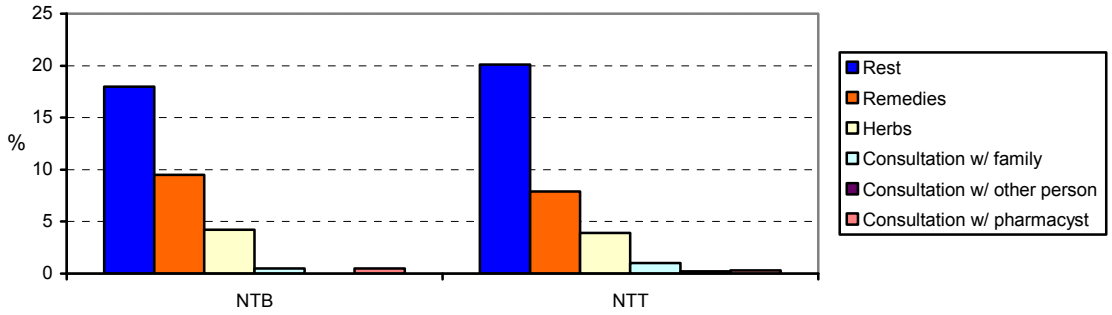
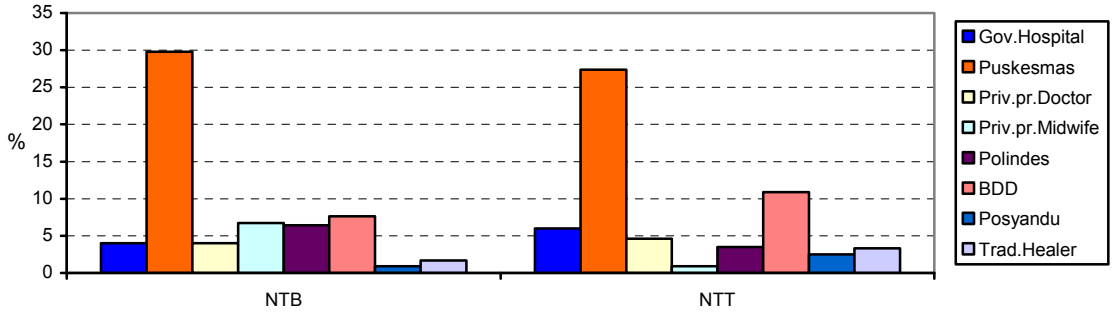


Figure 4.10. Percentage of source of care for handling pregnancy complication



The fact is that puskesmas as a favored source for pregnancy complication assistance reflects the effectiveness of previous effort to enhance its performance through the support of many agencies and parties. Stakeholders interviews credited this along with the importance of the policy of placing adequate health personnel in every puskesmas, even if the turnover rate remains quite high.

> *"... NTT gets help from various agencies, for example Unicef supplies complementary feeding to posyandu, WHO gives aids for facility, Care International attempts to reduce severe undernutrition by establishing a center for rehabilitation of under-nutrition, Plan International is also extending their hand, and WVI specializes in reducing TB and filariasis, also GTZ is known giving aids... so many parties for NTT ..."*
>
> *(DPRD NTT)*
>
> *"... because of very remote areas, for example Ampuang, so by the bus it reaches here (Kupang).. but practically transport is cut off now.... so basically we place two doctors in every in-patient puskesmas ...."* *(DHO, NTT)*
>
> *"... in our opinion, 6 months is too short to work there, no work at all...if possible they can spend one or two years there implementing their knowledge;.... yet they have not adapted to the place, friends in the office, but afterwards soon they are gone...."*
>
> *(DHO, NTT)*

As an important part of the chain of referral where basic emergency obstetric and neonatal care can be provided, the puskesmas should refer severe cases to hospital. In some cases this seems to occur, as explained by one mother in a FGD:

> *"At first in puskesmas.... but then they cannot (handle it). So directly they send me to the general hospital for an operation ... accompanied by a bidan...."*
>
> *(FGD of mothers in NTB)*

4.5. BIRTH PREPAREDNESS

Maternal complication must be handled immediately, and requests for action come not only from the pregnant woman and her family, but also from the community. The *Desa Siaga* concept, launched by MoH in 2006, envisions villages in which the community is prepared to respond to emergency situations, including complications of pregnancy and delivery. In regard to this model, table 4.10 suggests that husbands in NTB and NTT have already started to play their role as "alert" husbands (*suami siaga*). Approximately 80% of respondents reported that they had discussed with their husband the place for delivery and the person who would assist their last delivery. These results compare with the 2003 IDHS findings of 66% and 85% in NTB and NTT respectively.

Discussions of issues such as transport and contingency funding that can contribute to the "three delays" were reported by less than a quarter of mothers, however, and both provinces call for strong efforts in this area. NTT needs to improve the social aspect in particular since the figures reveal that planning for transport (24%) and contingency funding (16%) were lower than the NTB figures of 43% and 28% respectively.

Interestingly, 4% of respondents in NTB and 2% in NTT reported that they were not accompanied by their husbands during their pregnancy period. This may reflect the high numbers of male workers from both provinces who seek work outside of Indonesia. For the future, if this phenomenon is commonly occurring, community readiness is especially important to face the challenge.

Figure 4.11. Percentage of women discussed issues of pregnancy and delivery with husband during pregnancy

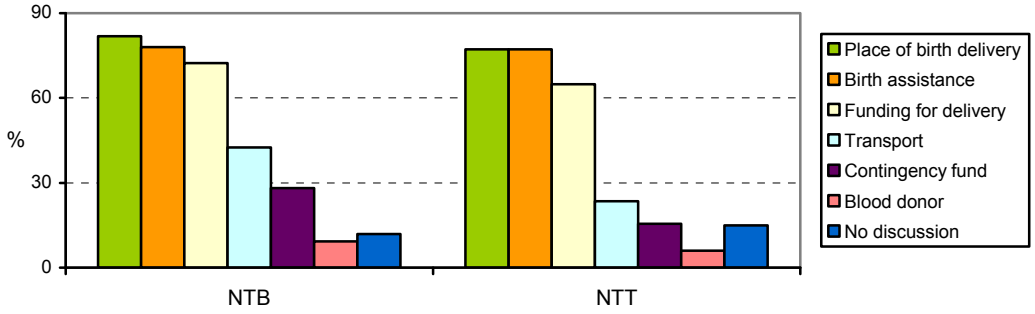
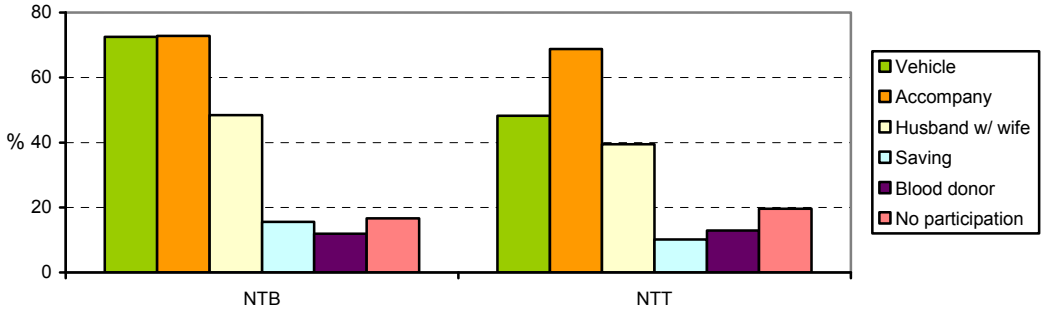


Figure 4.12. Percentage of women perceived village birth preparedness



Community readiness was assessed as well in this survey, and concern of communities for pregnant women appears quite high, with the respondents reporting that around 70% of people are willing to accompany women going for birth delivery (table 4.11).

One important issue mentioned by stakeholders are community traditions in decision making, for example communal prayers prior to leaving for the referral facility. It is very likely that this contributes to delay in handling emergency cases.

> *"Yes, we usually have family bonding so we should discuss things first in a family meeting, while the sick person may already be dying…. In Java or here, the same (situation).. questions about funding… meanwhile actually the services are free because of askeskin"* *(DHO, in NTT)*

With respect to transport, the survey reveals that only half of communities in NTT and three quarters in NTB have thought of providing vehicles for transport in emergencies. This contrasts with community perceptions, expressed by stakeholders in both provinces, that NTB and NTT have serious transport problems because of geographic conditions and poor land and sea transport.

> "*… delay in reaching the health facility often happens because of field conditions here, the transport mode for carrying mother who has problem is still difficult, some times we use motorcycle, while actually we should use car instead, and also duration to go takes time too because of far distances… so mother is late in arriving in hospital… in a severe condition.. or sometimes dead…. "* *(DHO, NTT)*

This difference in perception reflects lack of community awareness of the importance of transport as a contributing to one of the three delays – delay in transporting the woman from home to the referral facility. Only around one eighth of respondents reported that blood donation has been discussed during their pregnancy.

Financial preparation is not a big concern, and only a small percentage of women reported that their community was concerned about it. Most probably insurance for the poor (*askeskin*) is available for the majority of families.

> *" there is insurance for the poor, using white card, from the mayor"* *(FGD of mothers NTB)*
>
> *"here they use JPS (social safety net).."* *(FGD of mothers NTT)*
>
> *"Many have no JPS here..."* *(FGD of fathers NTT)*
>
> *"yes, about askeskin, alhamdulillah it helps us, for pregnant mother, or sick child. If we bring them to puskesmas but cannot be handled, then they can be referred to hospital without any additional cost, just a small amount of money for purchasing medicine.."*
>
> *(FGD of fathers in NTB)*

CHAPTER 5
BIRTH DELIVERY CARE

As one of the Millennium Development Goals, reduced maternal mortality depends largely on increasing the proportion of deliveries assisted by skilled health care personnel. Birth assistance, dealing with complications of delivery, and treatment seeking are presented in this section.

5.1. BIRTH ASSISTANCE

Around three quarters of mothers in NTB and two thirds of mothers in NTT report that they had planned to be assisted by health personnel at delivery. Others had planned to go to *dukun* for traditional birth attendance (16% in NTB and 30% in NTT), and about 10% of mothers say that had been uncertain what they would do. In the end, however, 26% of mothers in NTB and 38% in NTT used a *dukun,* and utilization of skilled health personnel to assist delivery was 72% in NTB and 56% in NTT (table 5.1). The findings are very similar to those of the Sagric study which found *dukun* utilization to be 24% in NTB and 30% in NTT. Both this and the Sagric study found much better rates than the 2003 IDHS study that reported birth assistance by health personnel to be 50.1% in NTB and 36.4% in NTT, similar to the 2005 MoH-WHO report of 45.3% in NTB and 35.4% in NTT.

Most women who chose to have trained health personnel as birth attendance chose the services of a midwife: 61% in NTB and 47% in NTT. The village midwife program is thus a successful program. Nevertheless, some mothers prefer to use *dukun* as explained by mothers in FGD at the community level as well as by some stakeholders.

> *"many of us, in average, go for birth delivery to 'tamang'..."*
>
> *(FGD of mothers in NTB)*

> *"I observed that village communities tend to prefer dukun (TBA) as the first choice for helping them in birth delivery and other matters as well.."*
>
> *(DPRD NTB)*

Dukun are clearly recognized as still important in these provinces, and some stakeholders suggested letting them continue to assist at births, ideally in partnership with the midwife.

> *"MoH has determined that dukun is not allowed to assist birth, but for us in the remote areas, this will be difficult, so we try to build partnerships, and hopefully step by step, indirectly, this can reduce dukun utilization although it will take long time not … only one or two years…"* *(DHO, NTT)*

> *"I don't like it if dukun are underestimated… but yes in its development I hope it will shift to bidan… if the bidan are ready … the dukun is only for assisting the process but does not need to be paid.."* *(Bupati, NTT)*

The table 5.1shows that socioeconomic level might affect choice of this birth attendance, in which non-poor group tended to use health personnel. Financial reasons for using the *dukun* were also explained by community members and stakeholders.

> *"go to tamang, and we don't have to pay, but they help us..."*
>
> *(FGD of mothers, in NTB)*

"*dukun still exist, but they have been trained, and they are useful and helpful, especially for those who do not have money, if we just buy one 'kain sarong' .. it is sufficient."* *(Vise Mayor of Kupang, NTT)*

Thus, in terms of *dukun* utilization, stakeholders view them as a part of the resources at present to overcome the financial and geographical barriers. For the time being, training for *dukun* is considered an opportunity to improve their knowledge even if, in the long run, they are not expected to remain the primary birth attendants. Issues on succession for *dukun* profession towards her daughter, for example, could be considered as providing education for her to become health provider (such as midwife) which then return to where she belong, to work in her homeland.

Figure 5.1. Percentage of planned and actual birth assistance using health personnel in NTB

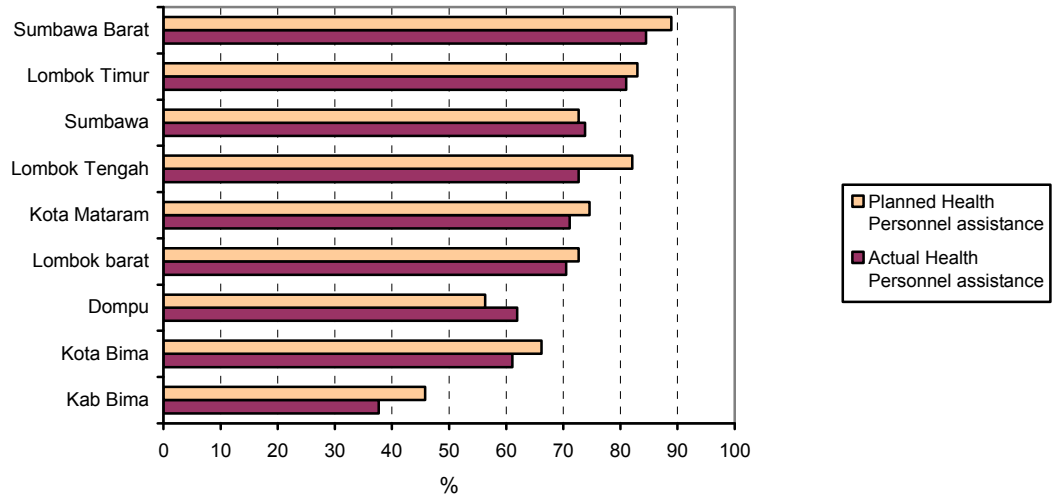
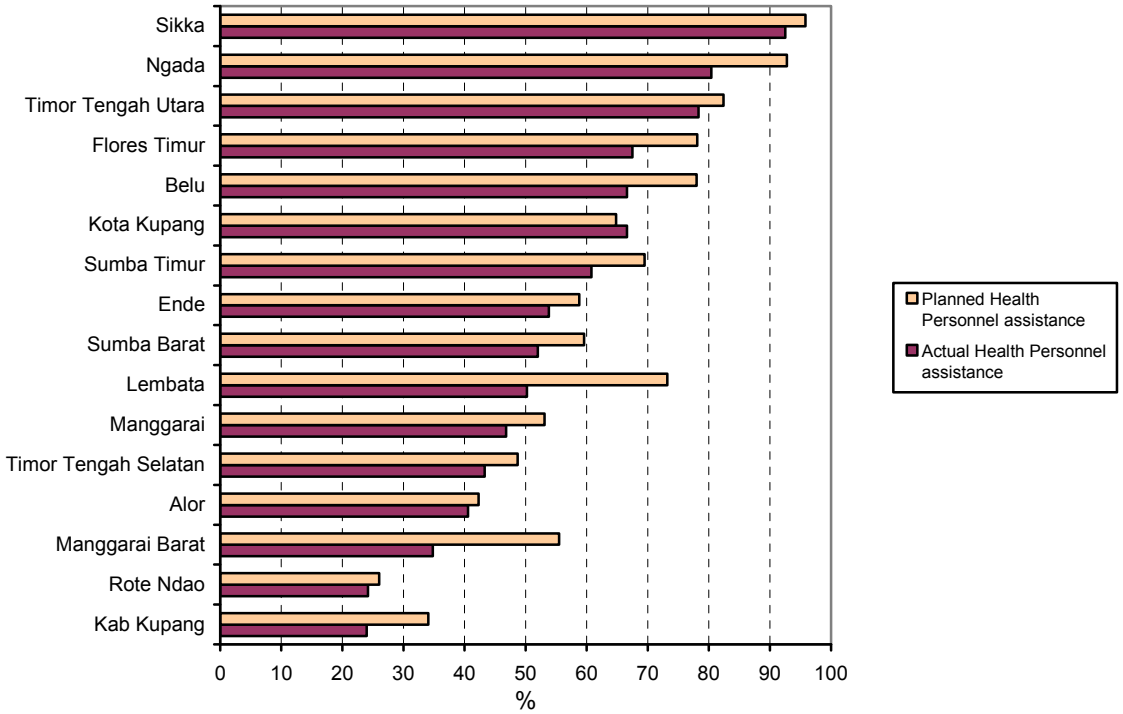


Figure 5.2. Percentage of planned and actual birth assistance using health personnel in NTT



5.2. PLACE AND MODE OF DELIVERY

For delivery, it seems that mothers choose a place to suit her comfort and convenience, regardless the type of birth assistance. Half of the mothers in NTT and nearly a quarter in NTB reported that they had planned to deliver at home (table 5.3). The others planned to deliver at a health facility. In reality, the percentages of home delivery increased to around 60% in NTT and 30% in NTB (table 5.4).

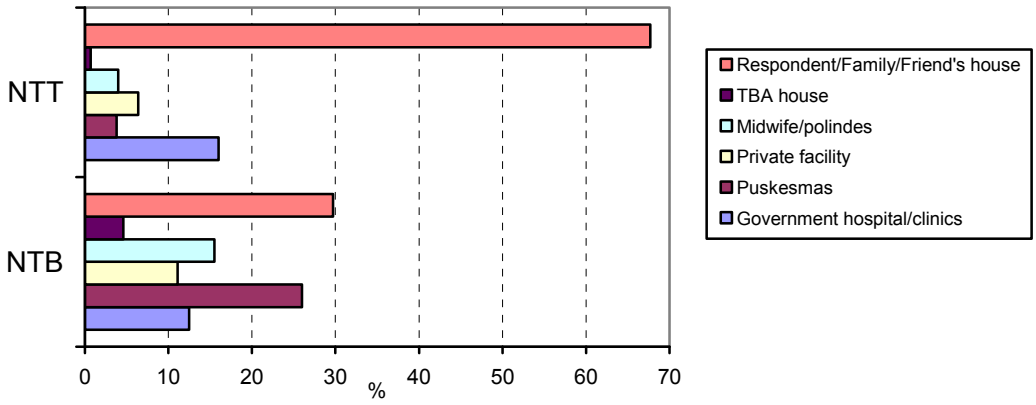
Health facilities mentioned as being utilized for delivery included puskesmas and polindes in NTB and hospitals in NTT. This pattern of place for delivery is similar to the findings of Sagric study (2006), but the proportions were slightly different. Sagric reported delivery at home in 50% of deliveries in NTB and 55% in NTT. The results were quite similar to the 2003 IDHS study, however, that reported that the health facility was not the preferred place of delivery, being used by only 13% in NTT and 27% in NTB.

Mothers who switched their choice to home delivery most probably did so because it was a normal delivery or because of previous bad experience in terms of quality at health service facilities.

> *"yes, (I) delivered at home, it was normal, no constraints"*
>
> *(FGD of mothers in NTB)*

> *"if hospital... I have trauma (since) the treatments are so various.."*
> *"If the place is at home, assistance is by the midwife.."* *(FGD of fathers in NTT)*

Figure 5.3. Distribution of women by actual birth place in NTB and NTT



If we consider the concept of *desa siaga*, the planned and actual place of birth it not so worrying for normal births. However, Caesarean section is generally expected to be needed in up to 15% of all deliveries, but this survey found that Caesarean section was performed in only 3% of deliveries (table 5.5), slightly higher than the 0.5% in NTB and 1.3% in NTT of the 2003 IDHS survey report. This suggests that referral for delivery complications that may need Caesarean section or other special handling is much less frequent than expected, and high risk pregnancies may not be handled properly. Referral of high risk cases should be examined more carefully in both provinces.

Figure 5.4. Distribution of women by non-normal mode of delivery in NTB

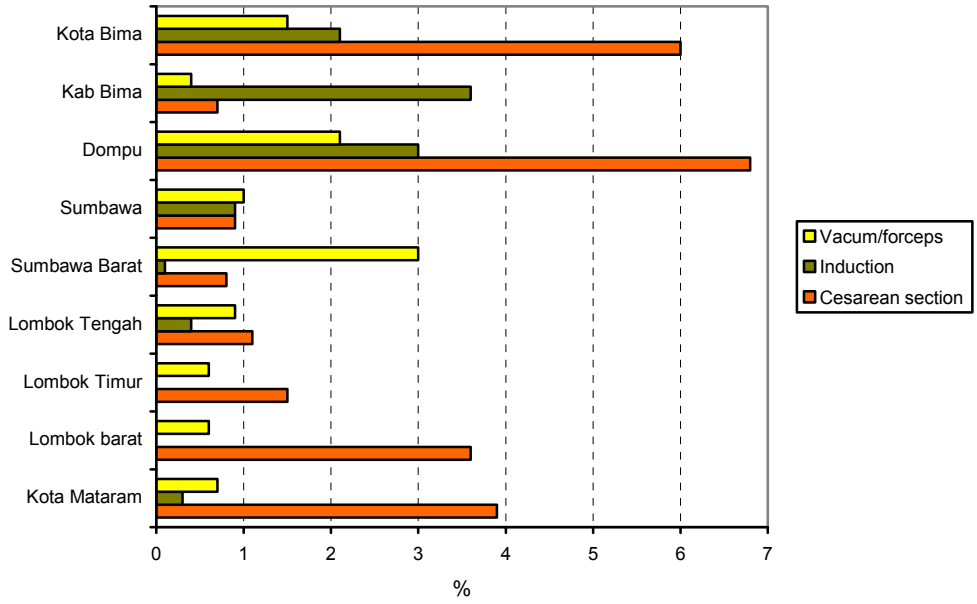
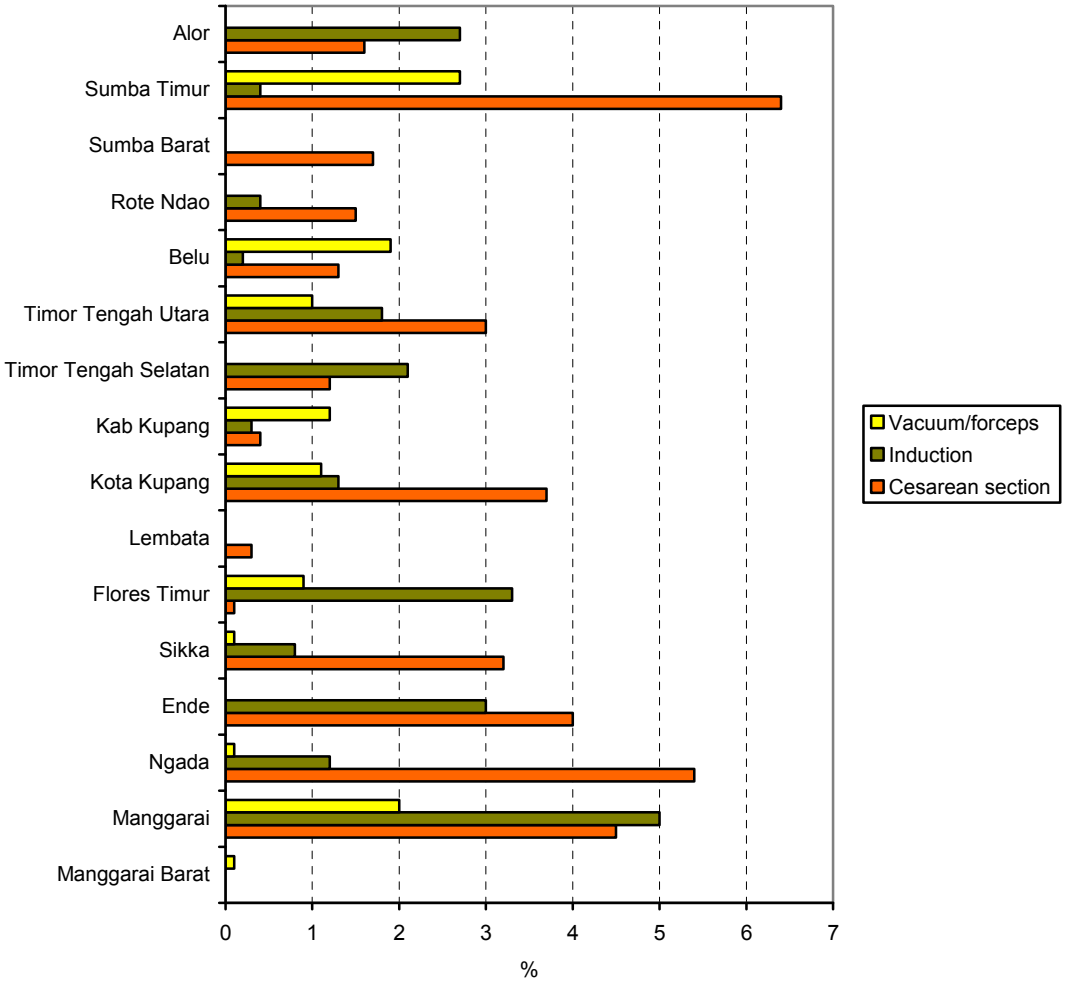


Figure 5.5. Distribution of women by non-normal mode of delivery in NTT



5.3. DELIVERY COMPLICATION AND TREATMENT SEEKING

Although the success of efforts to promote assisted delivery is apparent, the same does hold true for delivery complication, and the proportions are worrisome. The ability of mothers to report signs of delivery complications reflect an understanding of danger signs that should be detected. Around one third of mothers reported delivery complications. Early rupture of membranes occurred commonly, as did prolonged labor and excessive bleeding (table 5.6). Eclampsia, signaled by convulsions, was reported by 3% of women in NTB and 7% in NTT, much higher than the national figure of 1.4% reported by the 2003 IDHS.

In case of delivery complications, the most common being early rupture of membranes (broken amnion), excessive bleeding, and prolonged labor, the survey showed that 16% of mothers in both provinces chose to take rest. The village midwife (BDD), puskesmas, and hospital were mentioned as places they look for help.

FGD of mothers found that most delivery complications were handled by their birth assistant, either by *dukun* referring cases to the polindes or by the village midwife recommending that women with complications go to the hospital early in labor to deliver there.

> *"Once I would be helped by dukun ibu Suryati. But then I was brought to Polindes."*
>
> *(FGD of mothers in NTT)*
>
> *"It was recommended to deliver in hospital because the baby was twin and thus needed caesarean section"*
>
> *(FGD of fathers in NTB, poor group)*

It should be noted that the proportion of women who did nothing when faced with their delivery complication ranged from 10% in NTB to 12% in NTT. Another 8% in NTB and 14% in NTT sought treatment from a traditional healer. Thus a full fifth of all mothers in the two provinces failed to seek treatment from sources capable of dealing with delivery complications.

Figure 5.6. Percentage of type of delivery complication in NTB and NTT

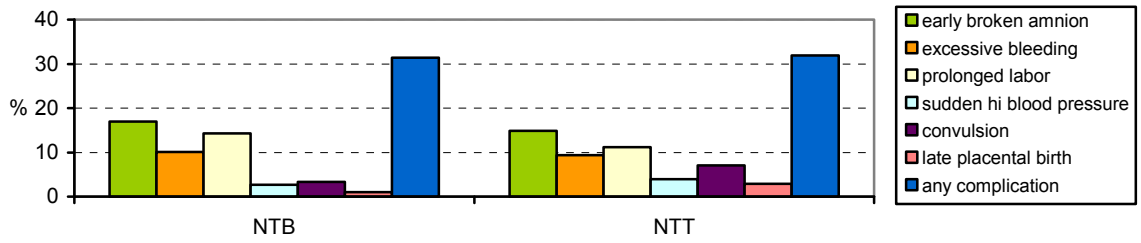


Figure 5.7. Percentage of type of home treatment for handling delivery complication in NTB and NTT

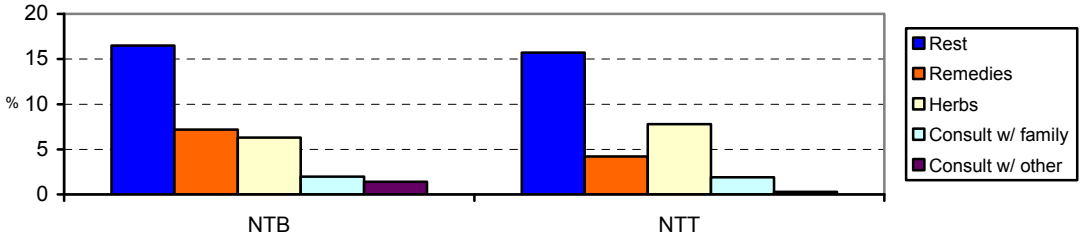
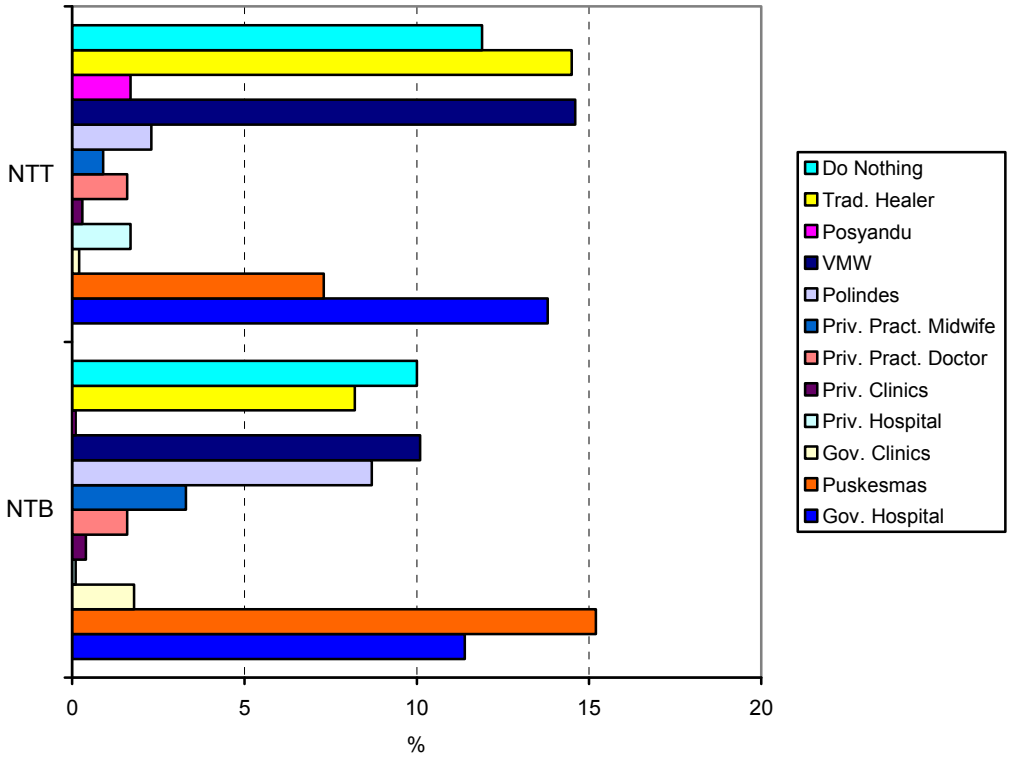


Figure 5.8. Percentage of source of care for handling delivery complication in NTB and NTT



CHAPTER 6

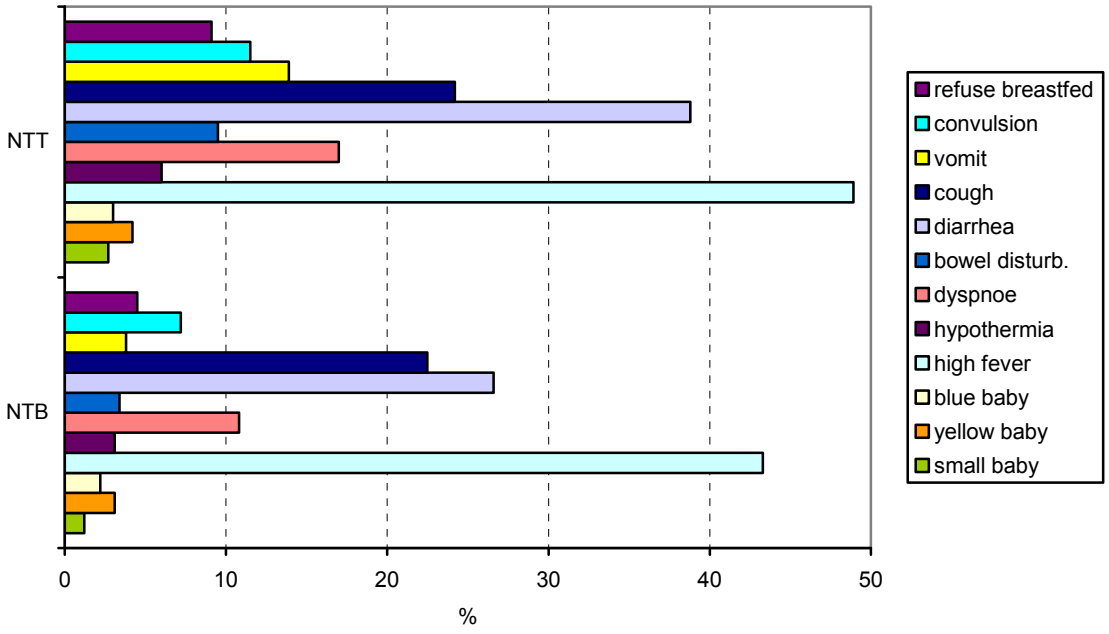
NEONATAL AND POSTPARTUM CARE

Maternal and neonatal complications that occur in the postpartum period, the first 42 days after delivery, have consequences to two persons, the mother and her new baby. This period may not always receive adequate attention, but it may become a critical period for interventions as well.

6.1. KNOWLEDGE ON NEONATAL COMPLICATION

The survey found out that the level of mothers' knowledge of neonatal complications in general is quite fair, 60% of mothers in NTB and 73% in NTT could name at least one complication. If we look at the ability to name 4 or more kinds of neonatal complications, however, all study sites were found to have low levels of knowledge, with NTB weaker (7%) than NTT (14%) (table 6.1). No clear difference across the districts was shown in the findings (table 6.1.a).

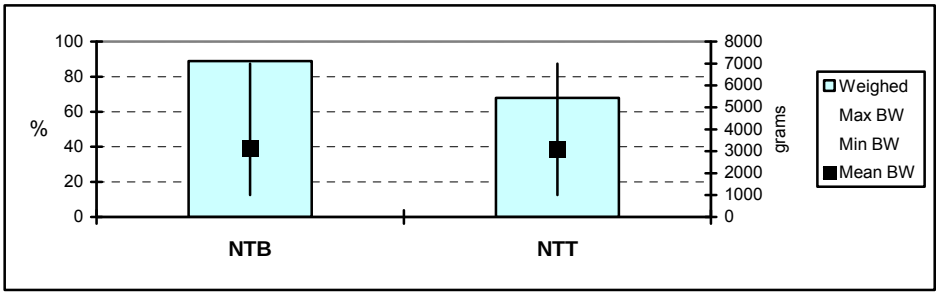
Figure 6.1. Percentage of women who could name various neonatal complications



6.2. BIRTH WEIGHING AND BABY BIRTH WEIGHT

The study found that the most deliveries are followed by weighing the baby immediately, with slightly higher numbers in NTB (89%) than in NTT (70%) (table 6.2). The mean weight of babies at birth was about 3100 grams. Only 8% of babies in both provinces were categorized as at risk of neonatal complications cue to low birth weight.

Figure 6.2. Percentage of baby weighed at birth and mean of birth weight (grams)



6.3. NEONATAL CARE CONTACT

Over half of all mothers in both NTB and NTT reported that they contacted health personnel (either visiting or being visited) for neonatal health matters in the period of 28 days after birth.

Figure 6.3. Percentage of neonatal contact in 0-7 days (KN1) and neonatal contact in 8-28 days (KN2) in NTB

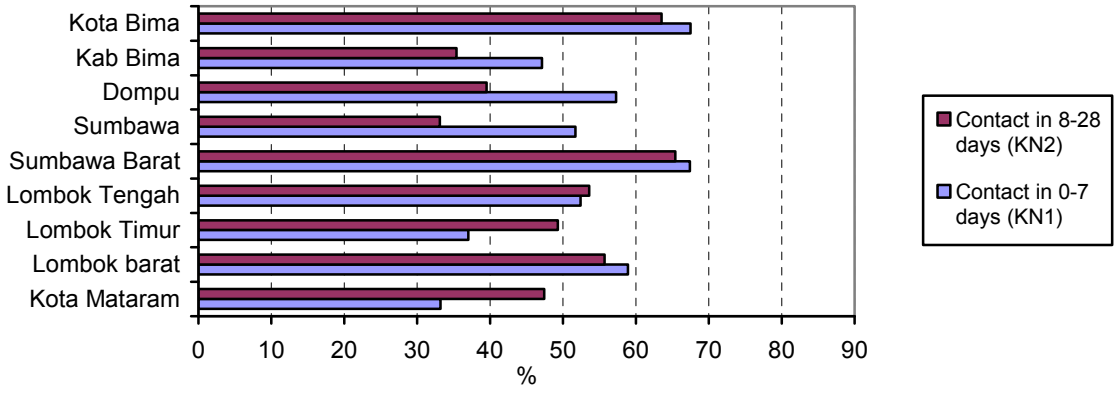
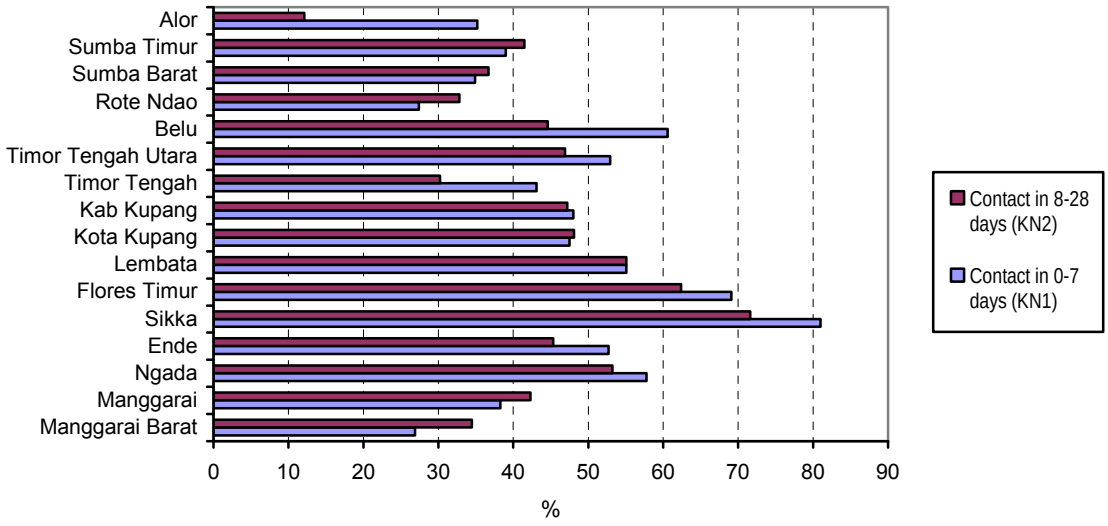


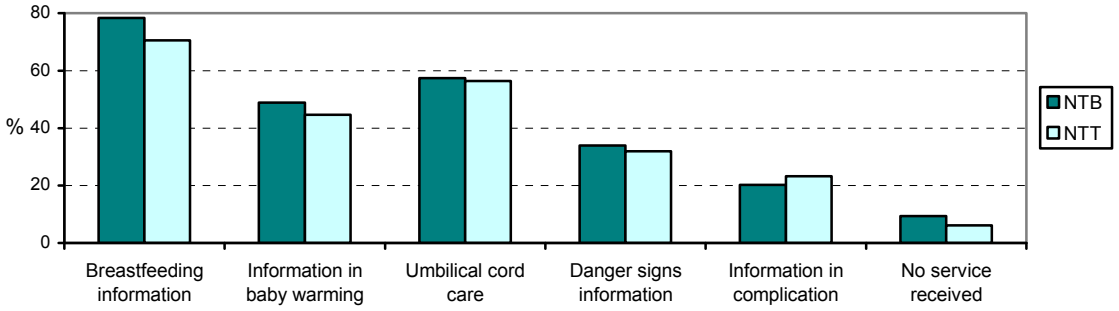
Figure 6.4. Percentage of neonatal contact in 0-7 days (KN1) and neonatal contact in 8-28 days (KN2) in NTT



The figures were 63% and 58% in NTB and NTT respectively (table 6.3). The 2003 IDHS had found this meeting between mothers and health personnel to be slightly higher, 74% in NTB and 65% in NTT, and the numbers presented in the desk review by the Faculty of Medicine, UI (2006) were even higher for neonatal contacts in the first week, 84.6% in NTB and 73.6% in NTT. The percentage of mother contacting health personnel within the first week appears to be higher than later in the period.

A midwife is the preferred person to do the neonatal contact according to most of the respondents. The most common service provided during this neonatal period was information about breastfeeding, reported by around 80% and 70% in NTB and NTT respectively. In addition, umbilical cord care was explained to about 60% of mothers in both provinces, and baby warming to approximately 50%. It appears, however, that more than two thirds of mothers were not informed of danger signs and neonatal complications (table 6.4).

Figure 6.5. Percentage of types of neonatal services received by mothers in NTB and NTT



6.4. NEONATAL COMPLICATION AND SEEKING TREATMENT

As reported by mothers, one third of newborn babies in NTB, and a little higher number in NTT, suffered from complications. Mostly the complications consisted of high fever, diarrhea, and cough, a pattern of disease that did not differ across the provinces or project cluster sites (table 6.5).

High fever was reported by an average of 20% of mothers in NTB or in NTT. Diarrhea and cough were in the range of 10% to 13%. These complications probably indicate infection. Neonatal resuscitation, a response to asphyxia, was reported following only about one tenth of deliveries. This almost took place in puskesmas or hospital, since these facilities were visited for neonatal complications by approximately 18% mothers in NTB and 17% mothers in NTT (table 6.6).

Figure 6.6. Percentage of any neonatal complication and resuscitation in NTB

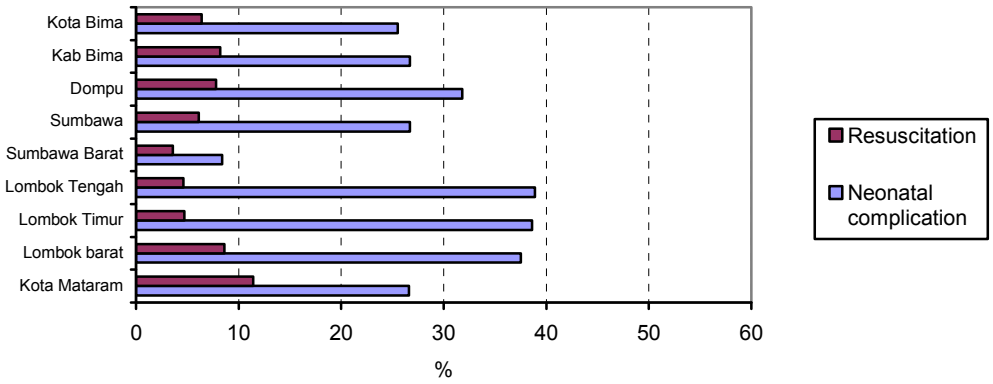


Figure 6.7. Percentage of any neonatal complication and resuscitation in NTT

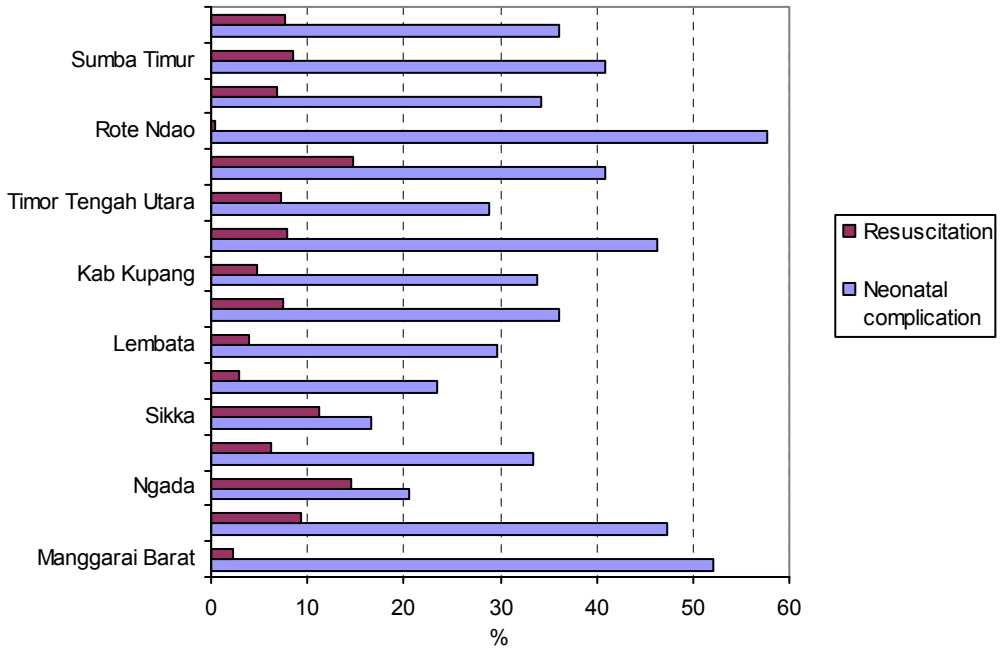
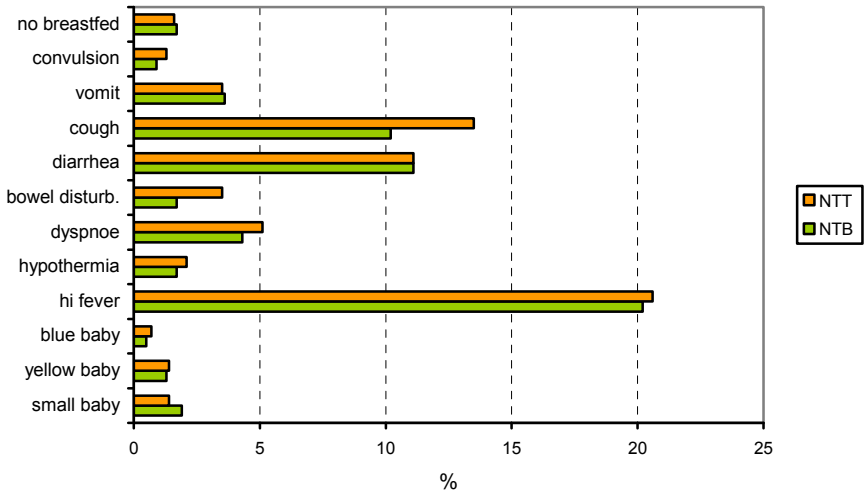


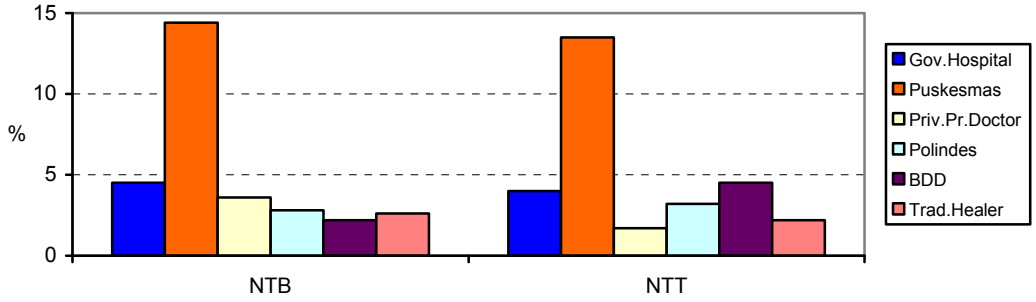
Figure 6.8. Percentage of types of neonatal complication in NTB and NTT



The survey found that only a small proportion of mothers (2% in NTB and 5% in NTT) went to a village midwife (BDD) to handle this problem, while actually the village midwife can be trained to manage asphyxia as shown by other studies. It is estimated that asphyxia accounts for up to half of perinatal deaths in developing countries. Therefore, this complication should be anticipated by the health facilities, both in terms of human resource skills as well as the availability of devices such as the techno-tube and mask (MotherNewBornNews, July, 2006). An Essential Reproductive Health Survey (CHRUI, 2002) found that training for resuscitation of health personnel in NTT, including midwives, was 8%, the lowest in coverage compared with other study sites (South Sumatra, West Java, West Kalimantan). In NTB one stakeholder observed:

> *" … in terms of quantity and quality, in this particular area, we think that health personnel is still low ……."* (DHO, NTB)

Figure 6.9. Percentage of source of care for handling neonatal complication in NTB and NTT



6.5. POSTPARTUM CARE CONTACT

The postpartum period is a critical time when bleeding often occurs and, along with other causes, result in maternal mortality. In both provinces two thirds of mothers contact health personnel usually a midwife, following delivery. On the average, women in NTT seek postnatal check-ups earlier (3 days) than those in NTB (7 days). The variation across the districts was not substantial (table 6.8.a).

Figure 6.10. Percentage of women with postpartum contact and median days of postpartum contact in NTB

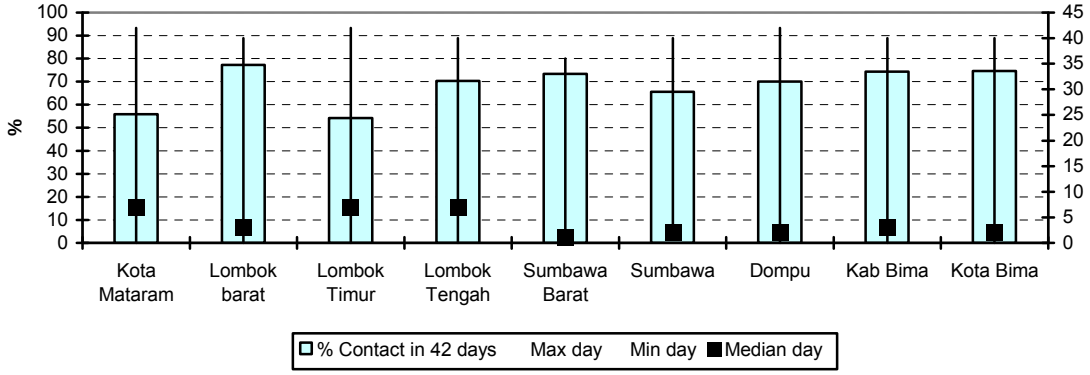
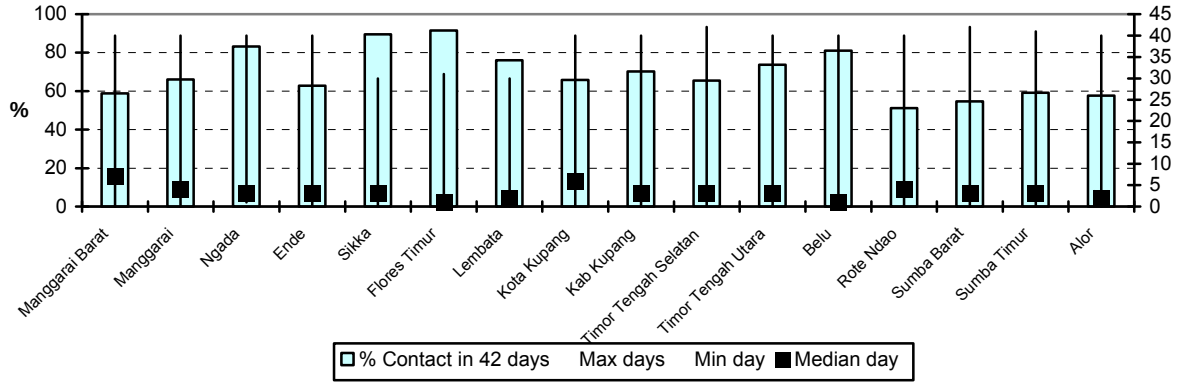
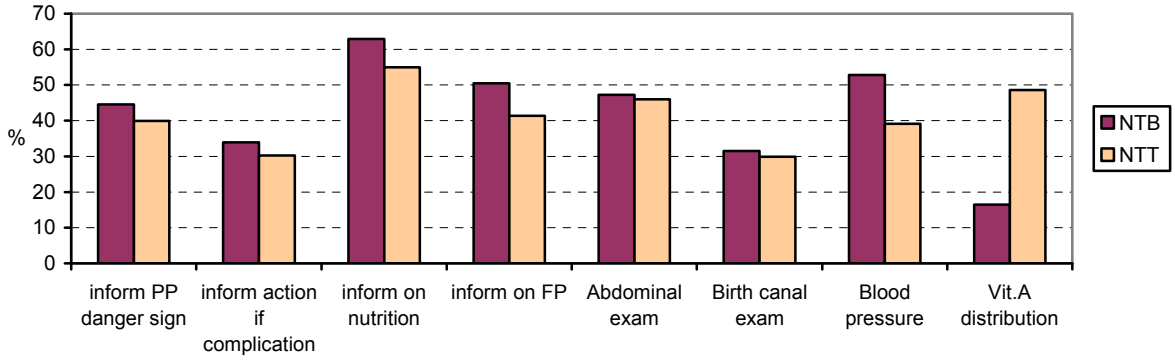


Figure 6.11. Percentage of women with postpartum contact and median days of postpartum contact in NTT



The service received by the majority of mothers was information on nutrition and family planning. As for potential postpartum complications, recognizing danger signs, and action to respond to it, around 35% to 40% of mothers reported receiving information (table 6.9). In terms of medical actions, half of mothers reported that their blood pressure was checked and an abdominal examination done. There were no clear differences between provinces or clusters except that vitamin A was more likely to have been distributed in NTT (48%) than in NTB (17%).

Figure 6.12. Percentage of types of postpartum services received in NTB and NTT



6.6. POSTPARTUM COMPLICATION AND TREATMENT SEEKING

Postpartum complications are a major cause of maternal mortality, especially bleeding and infection, so detection and care seeking is very important. According to the reports of the mothers interviewed, the rate of postpartum complications in NTT (27%) is double that of NTB (13%) (table 6.10). The districts whose respondents reported higher rates are Lombok Barat, Lombok Tengah, Lombok Timur, and Dompu in NTB, and Manggarai, Manggarai Barat, Kota Kupang, and Timor Tengah Selatan in NTT. Sumbawa Barat and Sumbawa were relatively low in postpartum complications (table 6.10.a and 6.10.b).

Figure 6.13. Percentage of postpartum complication in NTB

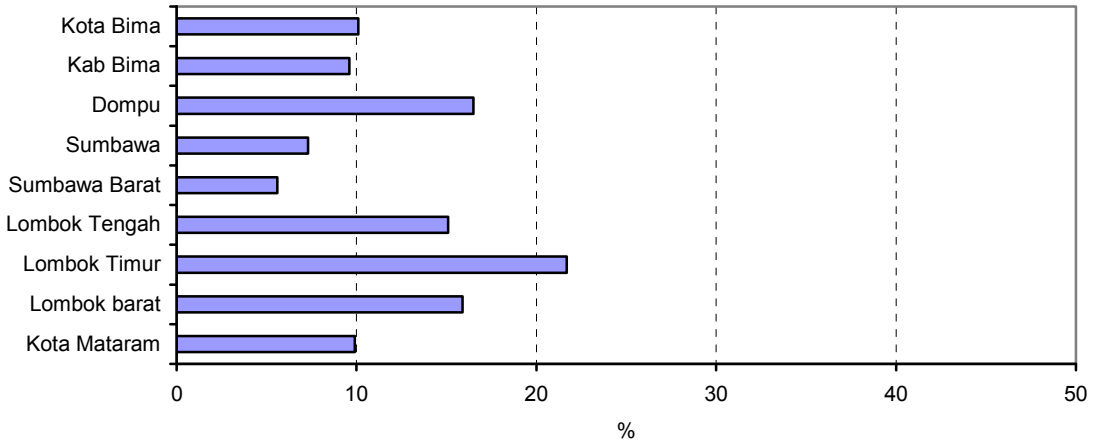


Figure 6.14. Percentage of postpartum complication in NTT

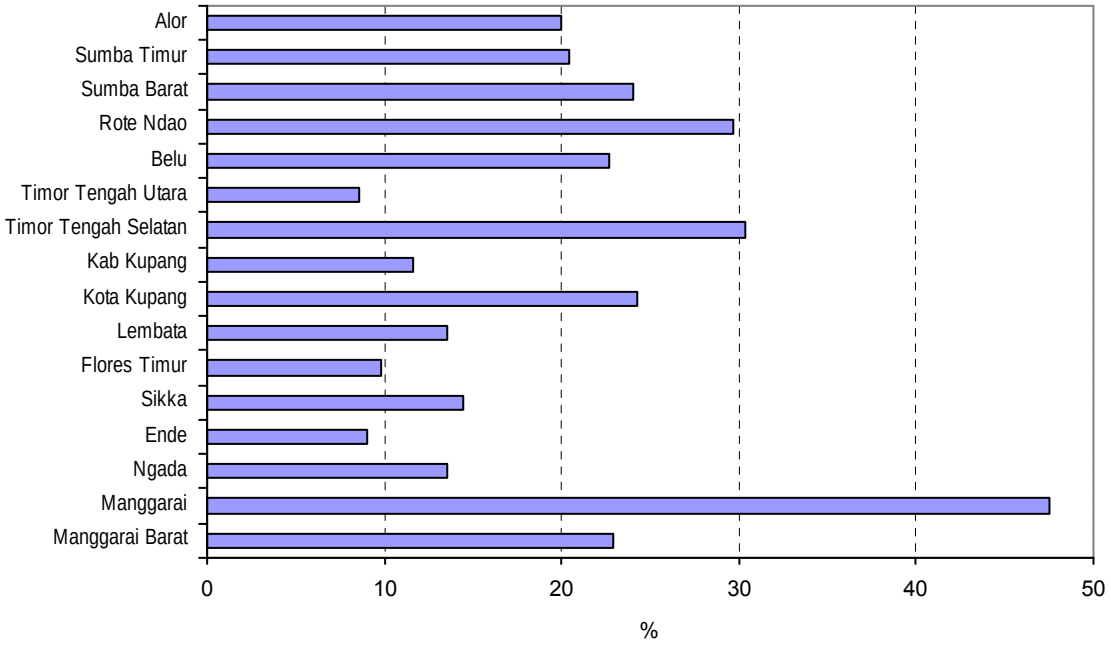
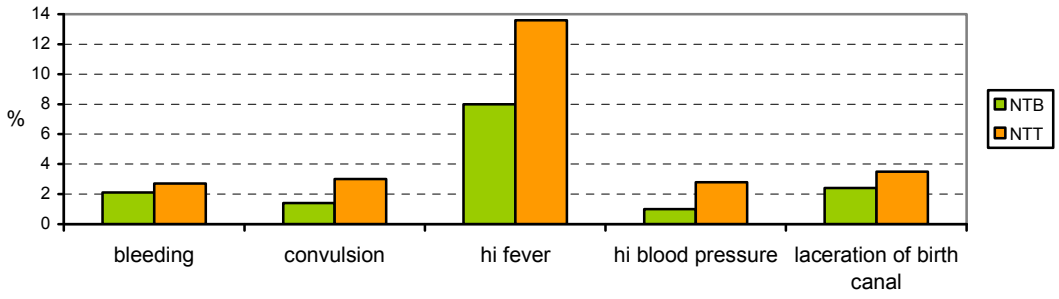


Figure 6.15. Percentage of types of postpartum complication in NTB and NTT



The most frequent complication reported was high fever (13% in NTT and 8% in NTB), probably associated with postpartum infection that is often mentioned as a major cause of maternal mortality. The main other complication was pre-eclampsia/eclampsia syndrome consisting of high blood pressure, edema, and convulsions that was reported

by 2% and 6% of mothers in NTB and NTT respectively. No variation across the project clusters was found.

Figure 6.16. Percentage of type of home treatment for handling postpartum complication among mothers reporting complications in NTB and NTT

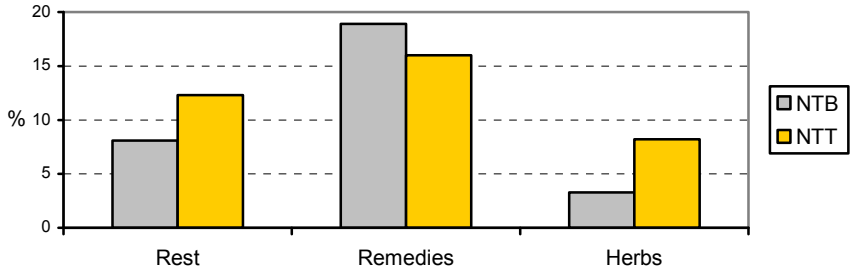
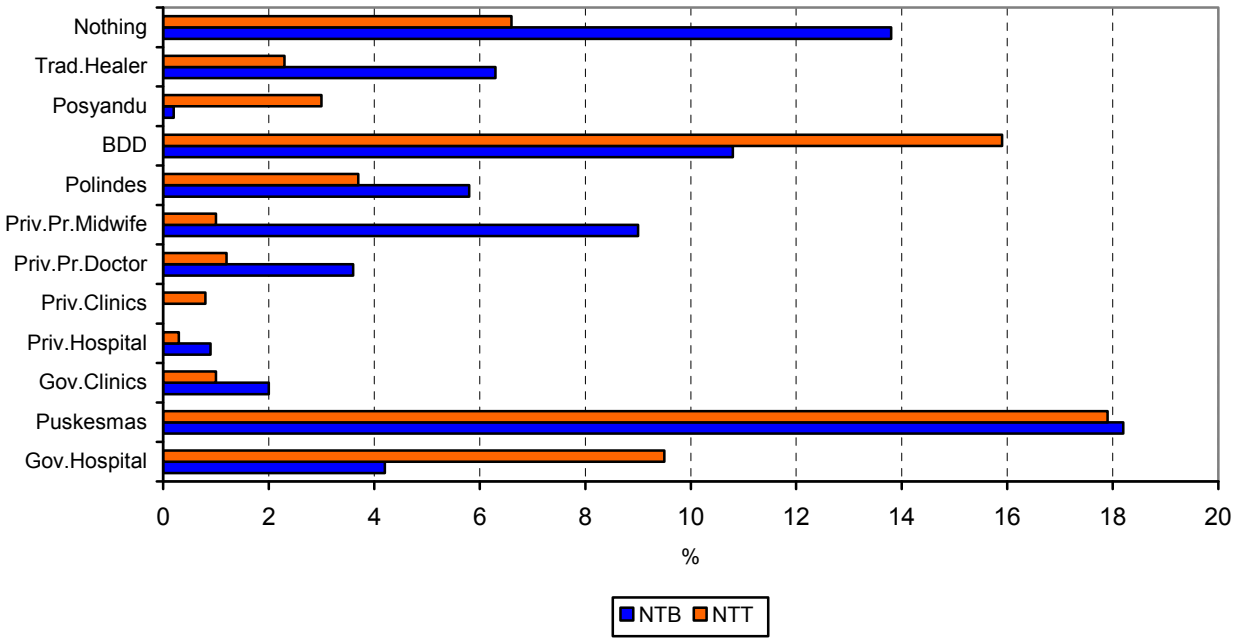


Figure 6.17. Percentage of source of care for handling postpartum complication in NTB and NTT



To handle postpartum complications, there was almost the same pattern of treatment seeking in both provinces as shown above. Less than one fifth of mothers suffering postpartum complications attempted to use self treatment by taking remedies, rest, and herbs. The Puskesmas is the preferred place for help, selected by approximately 20% of mothers with complications, followed by village midwives. Government hospitals were also used, more often in NTT (9%) than in NTB (4%) (tables 6.11 and 6.12).

CHAPTER 7

CHILD FEEDING PRACTICE

Child nutrition affects childhood morbidity by strengthening the body's immunity against communicable diseases and capacity to recover from illnesses. Enhancing child nutrition through good feeding practices is therefore encouraged. Beginning with breastfeeding initiated immediately after birth, good feeding practices should be adjusted gradually according to the child's age, resulting in good nutritional status.

7.1. IMMEDIATE BREASTFEEDING, COLOSTRUM AND PRELACTEAL FOOD

After delivery, it is recommended that the baby be put immediately to the mother's breast to stimulate breast milk production. In NTB this was done within one hour for two thirds of mothers in NTB and for about half of mothers in NTT (table 7.1). These figures agree with the 2003 IDHS findings of 66% in NTB and 52% in NTT.

Although approximately 90% of mothers in both provinces gave the baby colostrums, about a third also gave pre-lacteal feeding in the initial three days (38% in NTT, 28% in NTB). No big difference was recognized in the pattern of pre-lacteal feeding practices across the provinces or project cluster areas. Overall, NTT has somewhat poorer initial child feeding practices than NTB (table 7.1).

Figure 7.1. Percentage of initial child feeding practice in NTB and NTT

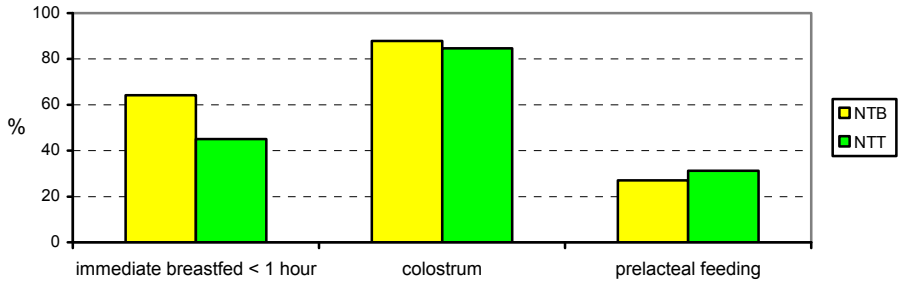
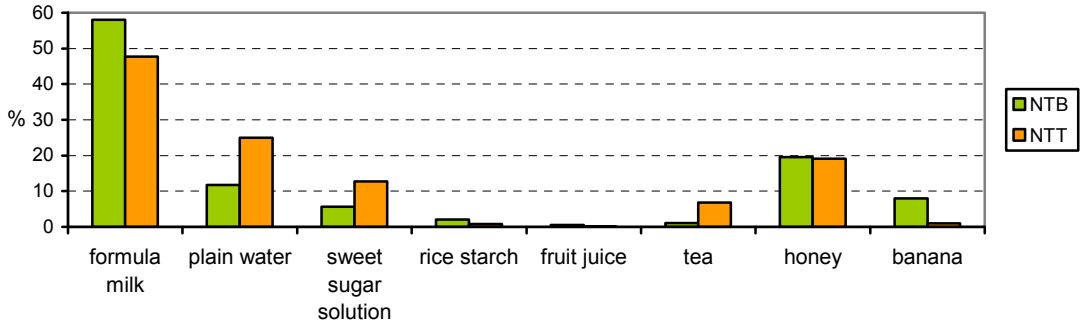


Figure 7.2. Percentage of types of prelacteal food in NTB and NTT



Giving pre-lacteal foods in the first three days of life is traditional in NTB and NTT. As explained by parents in FGDs, the practice may also be encouraged by supplementary foods distributed by health personnel.

> *"….bottled milk (was) given if (child) cannot be fed, the breast milk has not been produced "Puskesmas gives bottled milk, and polindes gives formula milk.."*
> *(FGD of mothers, NTB)*

> *"Yes, after my wife delivered the baby, her breast milk was not directly produced, so the baby was given formula milk provided by the hospital.."*
> *(FGD of fathers, NTB)*

Also mentioned in the FGD of mothers was the belief that colostrums should be thrown away until the breast-milk is clean. In place of colostrums, the baby can be given honey or coconut water.

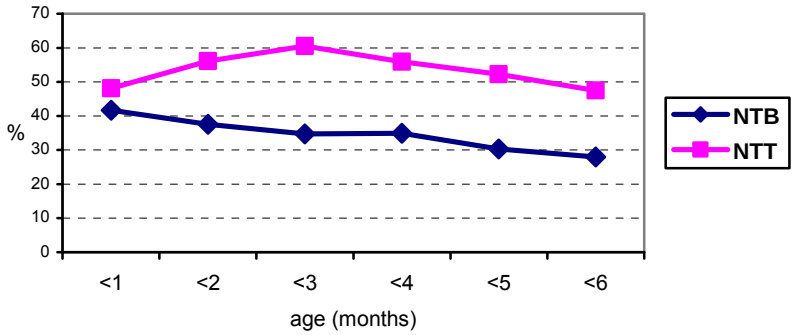
> *"...up to the third day, breast-milk was not excreted. So I give honey and coconut water to my baby. The first milk is dirty, so it should be thrown away until the milk is white and clean and ready to be given to the baby... that is my mother's advise... yes my mother is dukun... and she really means that dirty milk should be thrown away.."*
> *(FGD of mothers, NTB)*

One stakeholder interviewed in NTB explained that recommendations have been sent to midwives specifically about breastfeeding, and supplementary feeding other than breast milk only to be given for special cases such as if the mother suffers from disease.

7.2. EXCLUSIVE AND CONTINUED BREASTFEEDING

Exclusive breastfeeding refers to feeding a child with only breast-milk up to six months of age without any kind of supplementary foods, including pre-lacteal feeds, except for medications if indicated. The study found the rate of exclusive breastfeeding for the first six month to be higher in NTT (47%) than in NTB (28%) (table 7.2), which is lower than the national rate of 39.5% reported by the 2003 IDHS. About one-fifth of babies are exclusively breastfed up to four months, which is half of figure of the national average. No substantial difference in the pattern of exclusive breastfeeding is seen across provinces, districts, or project cluster areas (table 7.2.a and 7.2.b).

Figure 7.3. Percentage of exclusive breastfeeding by age of children in NTB and NTT



FGDs found that the recommended duration of exclusive breastfeeding needs to be correctly disseminated since some mothers understand it to be for 6 months while others stick to 4 months.

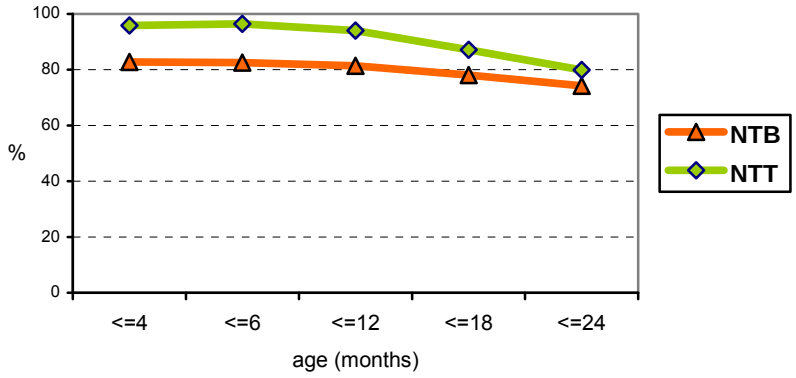
"Certainly more than 6 months of age.. is able to be supplemented .... this is advised by ibu bidan (midwife)...."

".. I give food to my child at the age of 4 months ..."

(FGD of mothers in NTB)

In general, most children in the survey areas were not breastfed exclusively up to six months of age, but the majority was breastfed for up to one year of age. At two years of age, around a quarter of children in both NTB and NTT were still being breastfed (table 7.3).

Figure 7.4. Percentage of continued breastfeeding by age of children in NTB and NTT



7.3. CHILD FEEDING PRACTICES

Child feeding practices were measured by noting the frequency and diversity of feedings given to children depending on their age. In the 6 to 9 month age group, the minimum should be twice a day of solid or semi-solid foods, from 9 months to 2 years of age, a minimum of 3 times a day. The study showed clearly that the majority of children aged 6 to 11 months were fed sufficiently often.

Figure 7.5. Percentage of sufficient frequency, high diversity, good child feeding practices in NTB

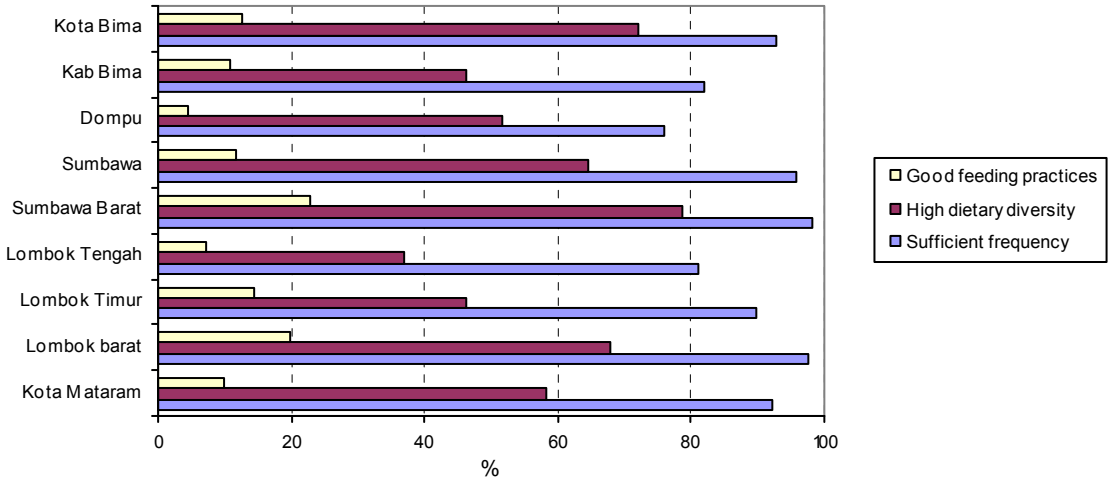
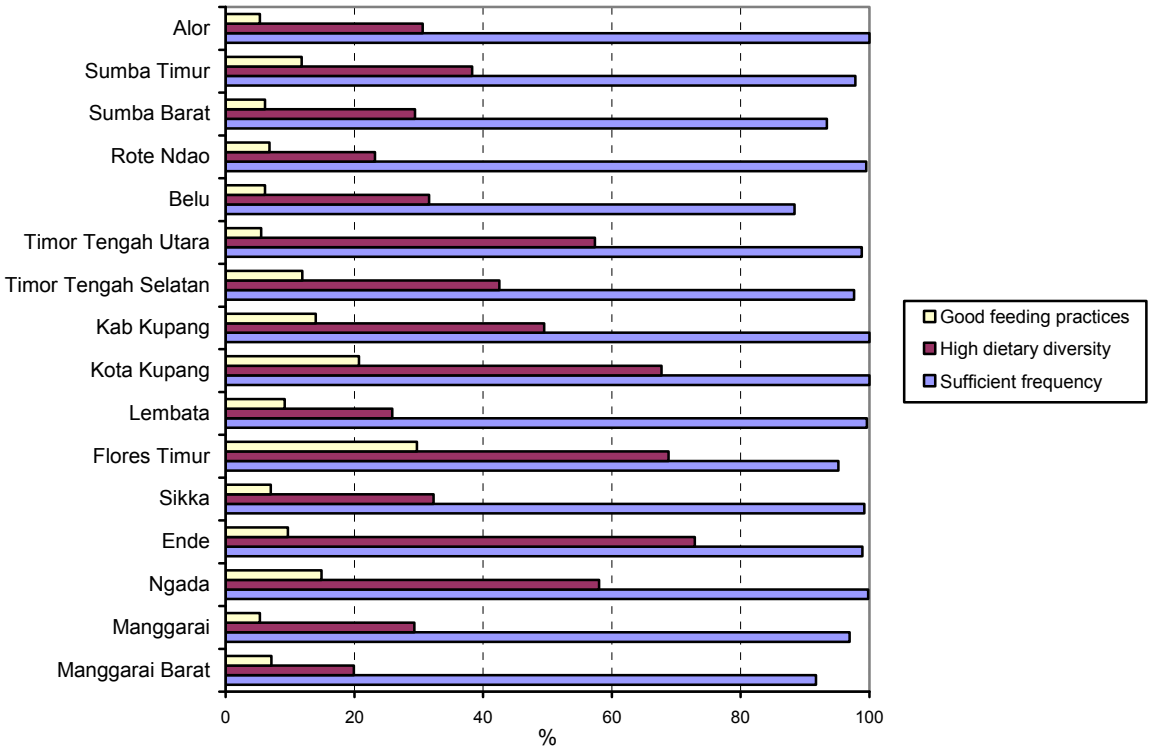


Figure 7.6. Percentage of sufficient frequency, high diversity, good child feeding practices in NTT



The study created an indicator of dietary diversity as part of good child feeding practice. Based on 24-hour recall of food groups consumed (carbohydrates (grains, root, tubers); food rich in vitamin A; other fruits and vegetables; organs, beef, poultry, fish; eggs; beans, legumes, nuts; diary, milk; food cooked with oil/fat), it was determined that, overall, around a quarter of children in NTB and 40% of children in NTT receive low dietary diversity, with three or less food groups consumed. This was also found for children aged 6 to 23 months (table 7.4). Greater attention should definitely be paid to this because this golden period for brain development must be met with adequate intake. For children less than two years old, a composite indicator of good feeding practices comprising breastfeeding, adequate frequency, and dietary diversity demonstrates poor intake for most children. In average only 20% to 40% of children in every group of age are receive a good feeding practice. The study also found that poor feeding practices most common in households of low socioeconomic level (table 7.5). Gender inequality in good feeding practice was also found, with females more likely to be underfed than male children.

Figure 7.7. Percentage of good feeding practice by children 's age group

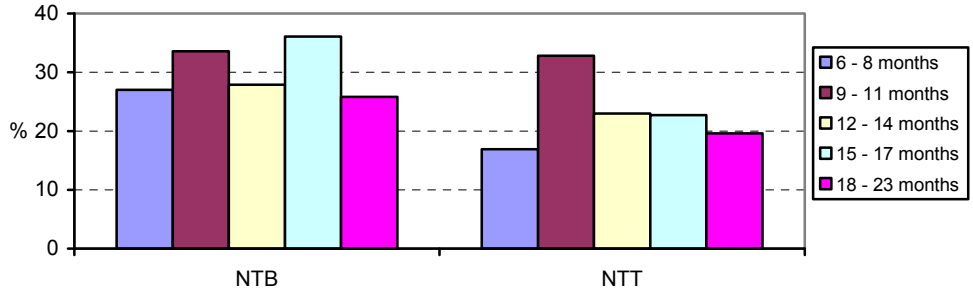
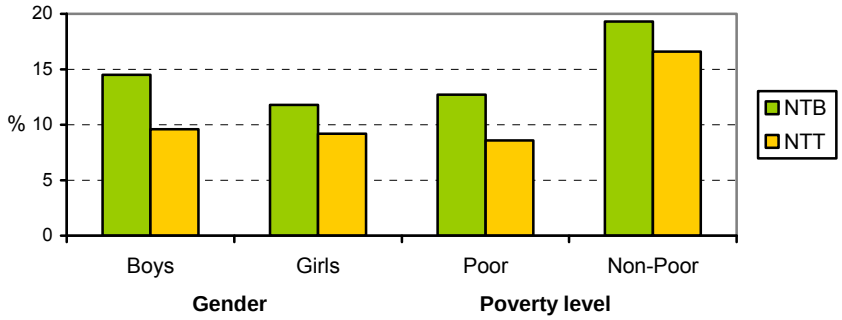


Figure 7.8. Percentage of good feeding practice in children by gender and poverty level



CHAPTER 8

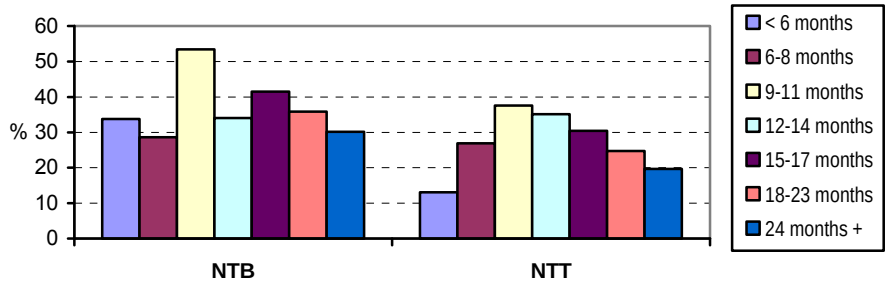
CHILD HEALTH

The fourth goal of Millennium Development Goal is reduced child mortality, and the sixth is to combat HIV/AIDS, malaria, and other common fatal infections. In pursuit of these goals, immunization and the early diagnosis and treatment of diarrhea, acute respiratory infection, and malaria are important components.

8.1. DIARRHEA

Of the children under five studied in the survey, a quarter of them in NTT and one third in NTB had suffered from diarrhea within the past two weeks (figure 8.1). This prevalence was somewhat higher than the 20% reported by the WFP and Seameo study (2005). Overall, this is more than twice of the national figure reported as 11% by the 2003 IDHS.

Figure 8.1. Percentages of children diarrhea in the last 2 weeks by age group in NTB and NTT



The frequency of diarrhea is seen to increase dramatically after 8 months of age and may be related to inadequate child feeding practices as well as to increased unhealthy exposures as the child ages. As seen in other studies, diarrhea was more likely to occur in male than in female children. Children in poor households were also more likely to have had diarrhea.

Figure 8.2. Percentage of children diarrhea in the last 2 weeks by gender and poverty level in NTB and NTT

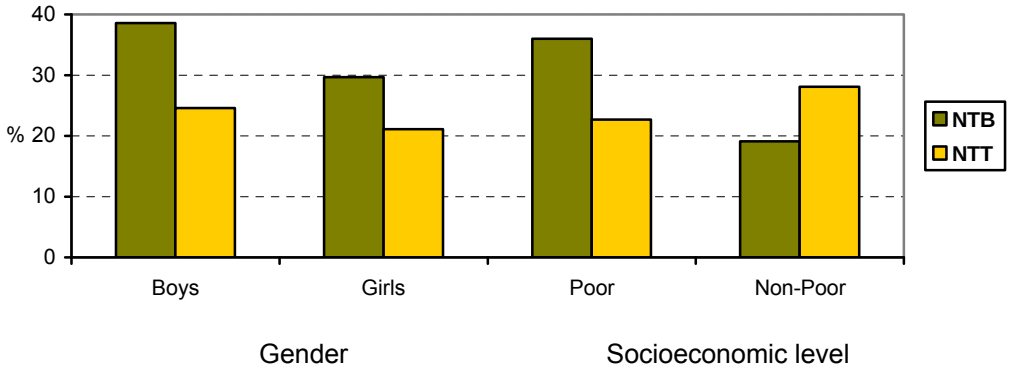


Figure 8.3. Percentage of child diarrhea, ARI, and malaria in NTB

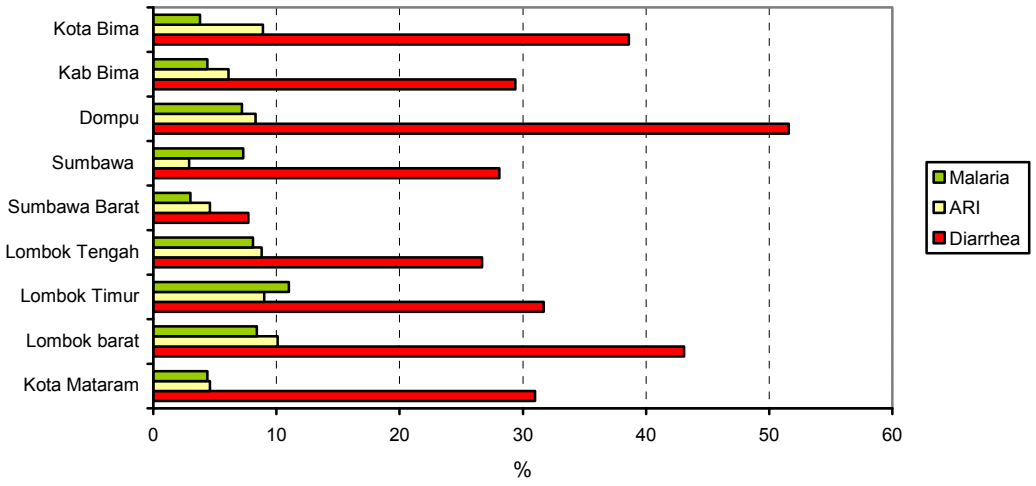
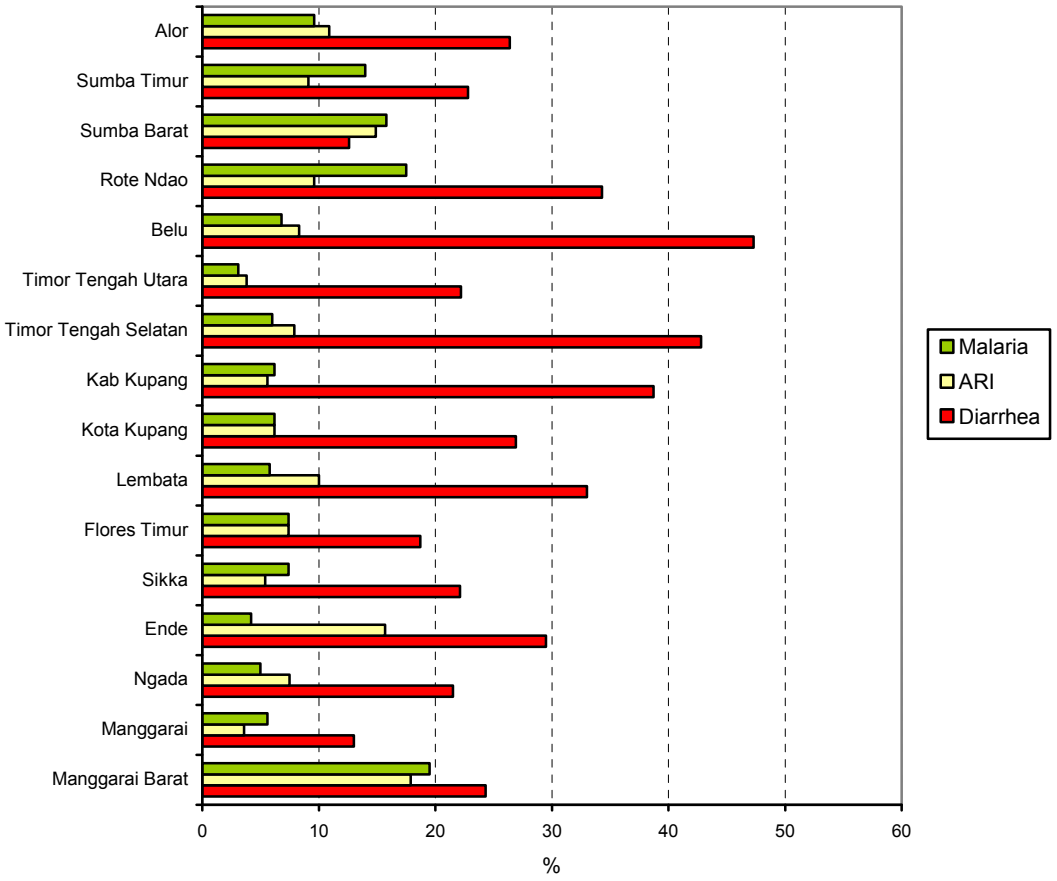
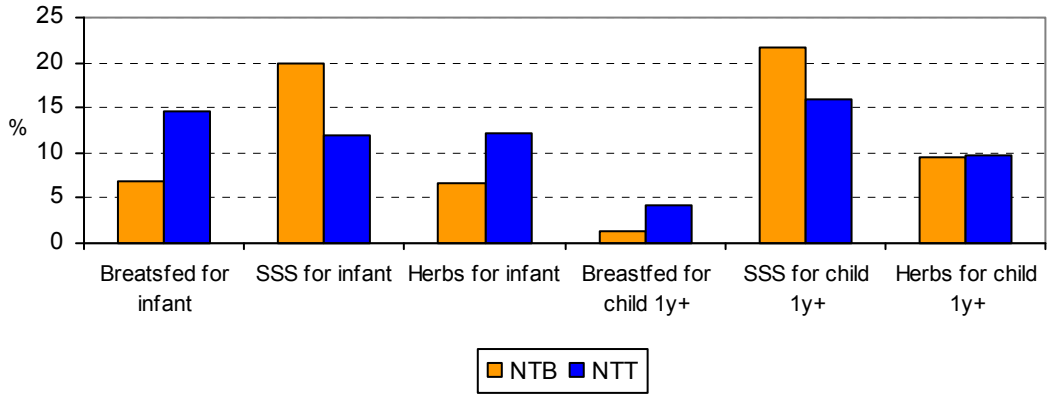


Figure 8.4. Percentage of child diarrhea, ARI, and malaria in NTT



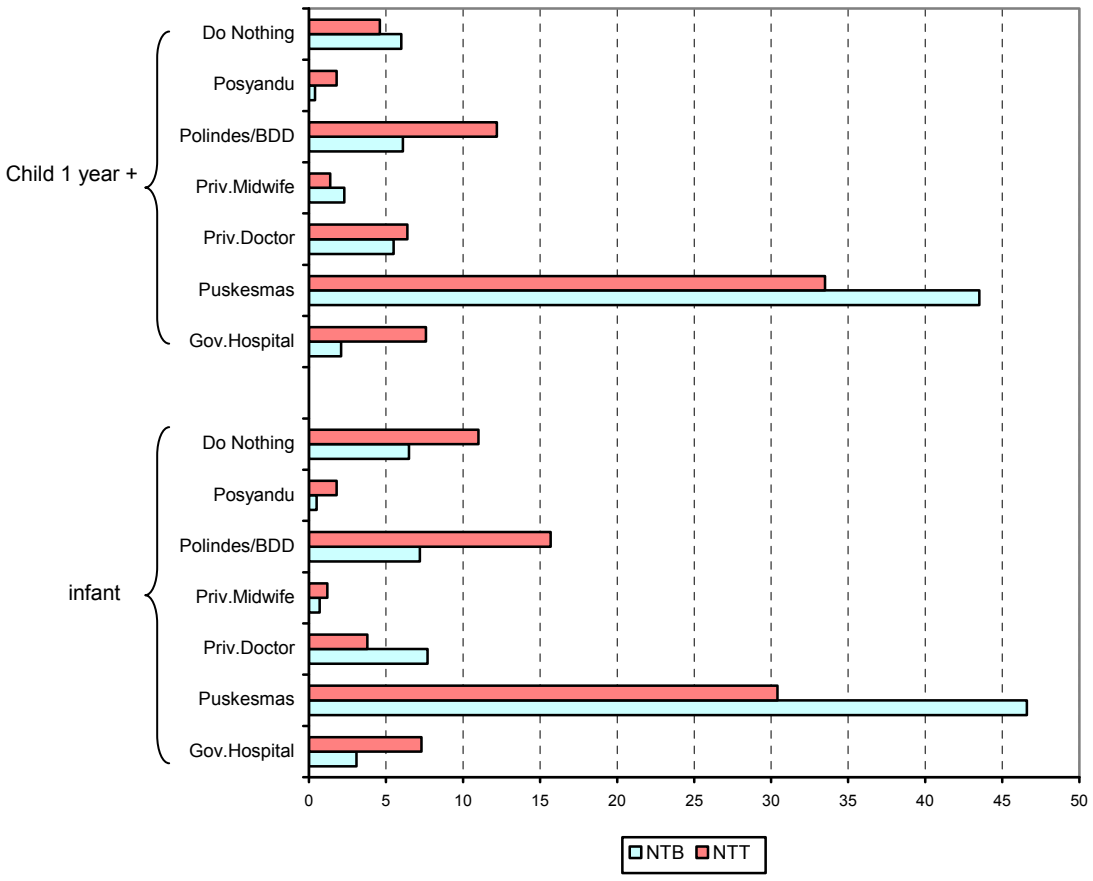
One third of mothers employed various home treatments to handle diarrhea. Oral re-hydration therapy in the form of sugar-salt solutions (SSS), continuing breastfeeding, or giving more fluids was the primary home method used. One fifth infants and a quarter of children over one year of age were given this home treatment for diarrhea in both provinces. Mothers in NTT, particularly on Flores, are more likely to use herbs or potions than in other sites, especially for children of younger ages (tables 8.2 and 8.3).

Figure 8.5. Percentage of types of home treatment for handling child-diarrhea in mothers with children had diarrhea in past 2 weeks



Around two third of mothers seek treatment outside of the home for diarrhea. The majority use the puskesmas (half of mothers in NTB and one third in NTT). The village midwife (BDD), maternity hut (polindes), or private midwifery practice are also used (table 8.4), slightly more often in NTT. The tables and figures below show small variations across the project cluster sites within provinces, and the pattern of treatment seeking for child diarrhea is essentially the same in both provinces, with puskesmas taking an important place, and also midwives, in addition to oral re-hydration therapy home treatment. Child age does not strongly affect this care seeking.

Figure 8.6. Percentage of source of care for handling child-diarrhea in infants and children aged 1 year and older



8.2. ACUTE RESPIRATORY INFECTION

Mothers reported cough in the past two weeks in 44% of children under five in NTB and in 39% of children under five in NTT. Around one fifth these children also suffered from shortness of breath so that, overall, acute respiratory infection (ARI) defined as cough and shortness of breath, occurred in about 7% of children less than five years old. This is close to the 8% prevalence in NTB and NTT reported by the 2003 IDHS. Cough and shortness of breath combined with fever, defined as suspected pneumonia, was reported in around 6% of under fives. There was no clear variation by age group or gender.

Figure 8.7. Prevalence of cough, ARI, fever, and suspected pneumonia, in children under five years of age, in past two weeks, NTB and NTT

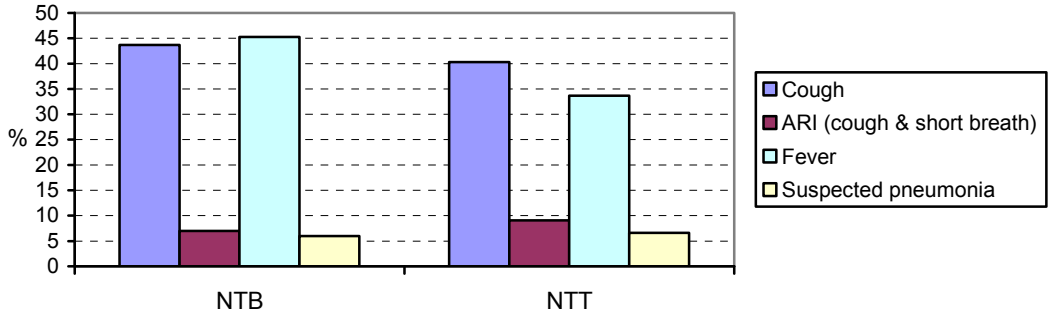
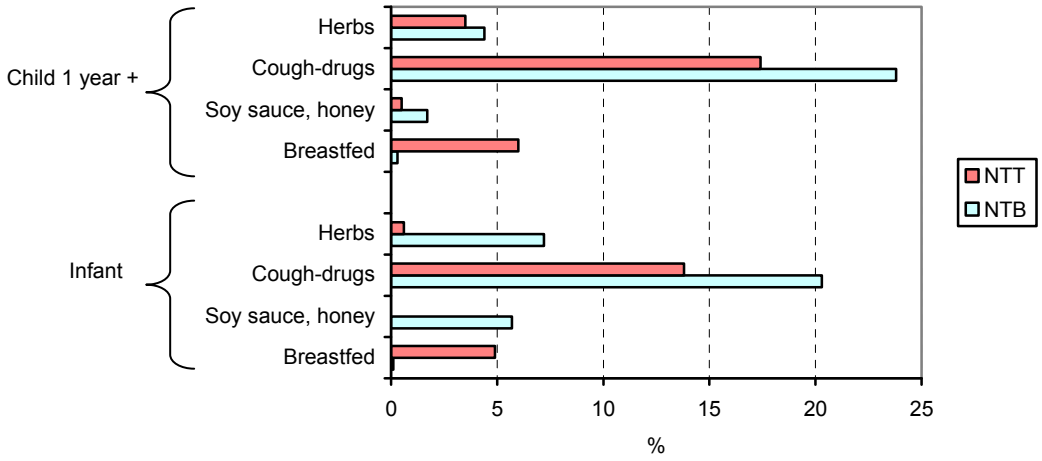


Figure 8.7 shows that cough and fever were somewhat more frequent in NTB than in NTT. The table 8.4.a exhibits high variation across districts. Of mothers with children suffered from ARI or suspected pneumonia, the pattern of care for the two diseases appear to be similar; both in the home and outside the home. Home treatment for infants differs slightly from that of older children. Soy sauce or honey and herbs were the second choice for infants in NTB. The similarity of the primary care seeking was in giving the child with the cough drug, in both age groups, and in both provinces.

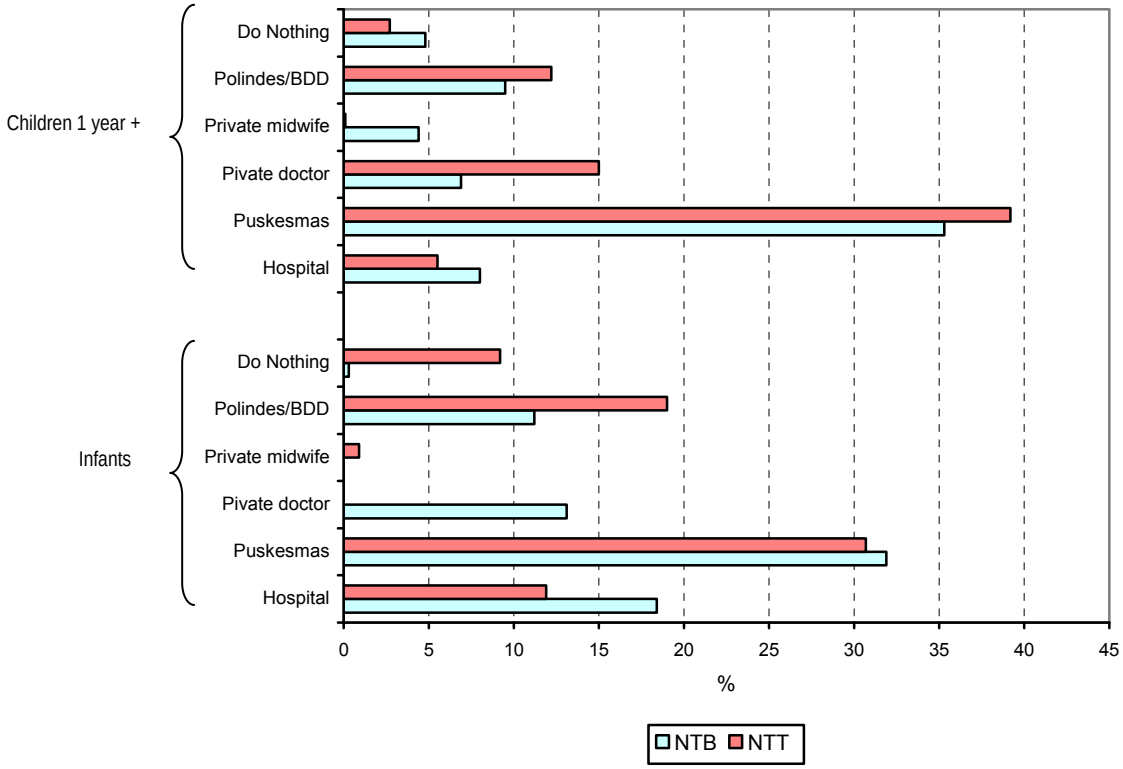
Figure 8.8. Percentage of types of home treatment for handling pneumonia



For ARI or suspected pneumonia in infants, mothers in both provinces seek care mainly from puskesmas or hospital, followed by village midwives (BDD). Private practice of doctors is popular in NTB. For older children, puskesmas, hospital, village midwives, and private practice are used. Private midwifery practices are chosen more frequently in NTB than in NTT. In generally, the puskesmas is the favored place for ARI care children n(tables 8.5 and 8.6, and, tables 8.8 and 8.9).

Giving antibiotics to treat ARI is irrational. Nonetheless, half of mothers mentioned that their children received antibiotics for treating child ARI. No large difference in use of antibiotics was observed across the districts (table 8.10.a).

Figure 8.9. Percentage of women did seeking care for child pneumonia



8.3. MALARIA

The 2003 Indonesia Health Profile compiled from data recorded and reported by health facilities showed the Annual Malaria Incidence (AMI) in NTT to be higher than in NTB. In this study, however, fever during the past two weeks was suffered by 45% and 33% of children in NTB and NTT respectively. If the symptoms of fever and shivering are combined, it was found that in each province about 7% of children under five years of age had suspected malaria (table 8.11).

Home treatment by mothers in NTB and NTT includes antipyretic drugs and body surface cooling for infants and older children as well. In NTT, herbs were more likely to be used for suspected malaria in infants. For both age groups, continued breastfeeding was mentioned more frequently in NTT (tables 8.12 and 8.13). Puskesmas, village midwifes (BDD) and private practices of doctor were used by mothers seeking further care for malaria, both for infants and older children. Surprisingly, around 7% of mothers reported taking no action at all for their infants.

Around 40% of mothers reported that they give drugs or anti-malaria remedies to their children in case of malaria. This calls for attention inasmuch as inadequate treatment may permit relapse and can be followed by side effects (table 8.14).

With respect to protection from malaria transmission, the possession and use of bed-nets is relatively very low in NTB but not in NTT. The study found that around 16% of households in NTB and 60% in NTT had and used bed-nets. Of them had and utilized, the net for children was in frequent in both provinces (90% and 94%), but relatively rare for adult in NTB (37%) compared to NTT (84%).

Figure 8.10. Percentage of type of home treatment for handling child malaria

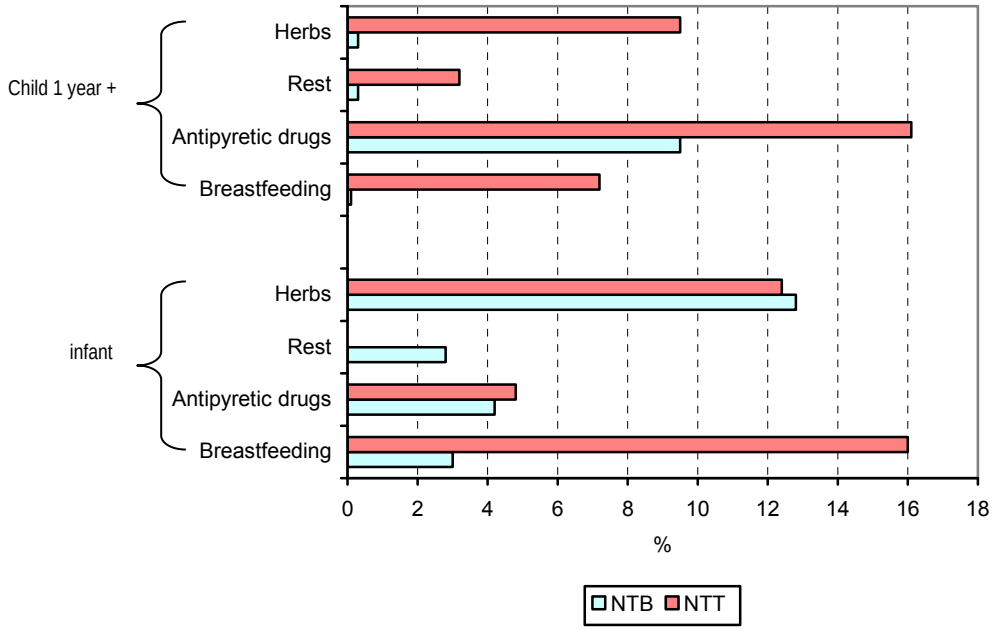


Figure 8.11. Percentage of types of home care for handling child malaria in infants and children aged 1 year and older

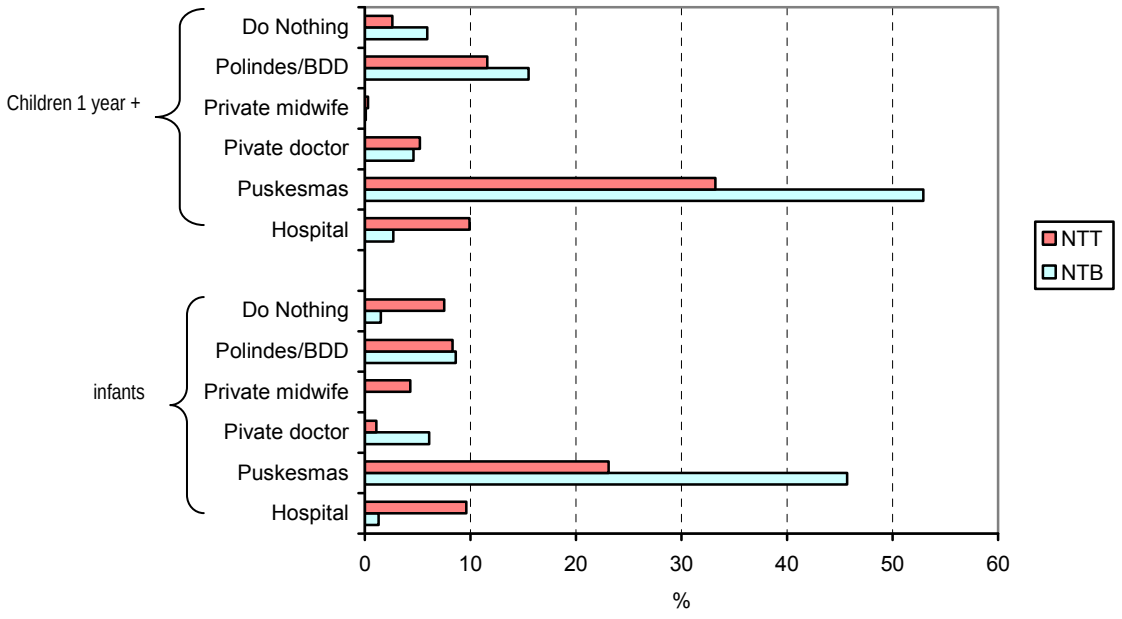


Figure 8.12. Percentage of women protection and treatment malaria in NTB

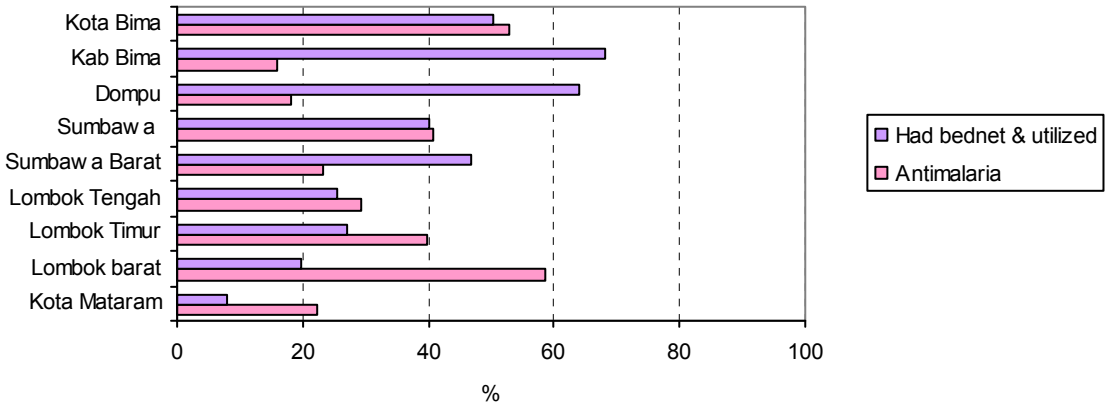
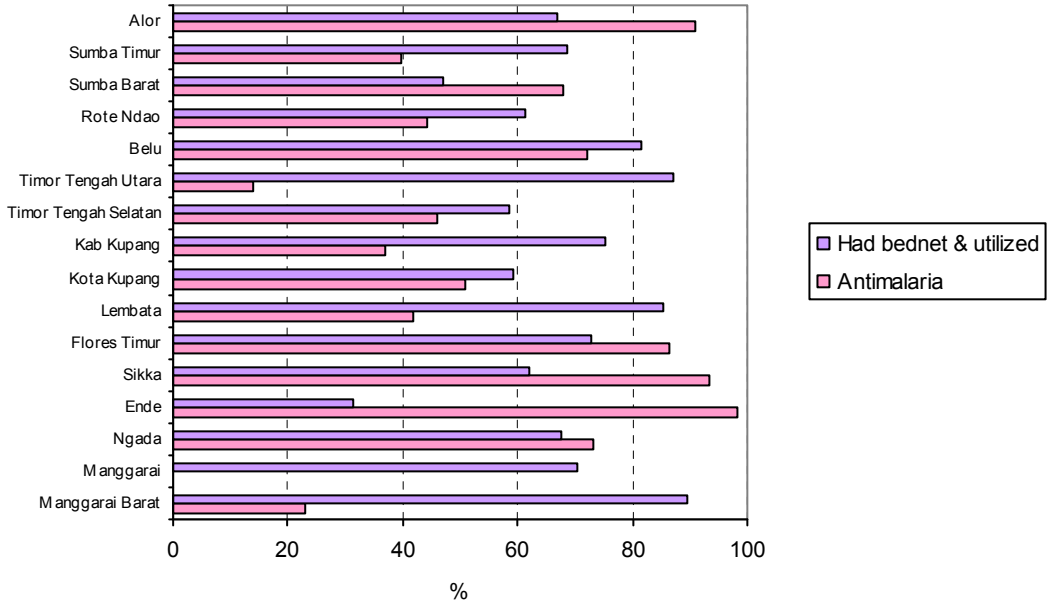


Figure 8.13. Percentage of women did protection and treatment for child malaria in NTT



8.4. CHILD IMMUNIZATION

Immunization of children prevents several communicable diseases that cause significant morbidity and some mortality in children. Overall, 6% of children aged 12 to 23 months in NTB and 2% in NTT were found to have had no immunization (tables 8.16 and 8.17). As commonly found in Indonesia, coverage declines with increasing age. In all, it was found that measles vaccination to the children aged 12 to 23 months had been given to 80% in NTB and 90% in NTT, and there were no substantial differences across project cluster sites.

Hepatitis vaccination invites attention because its coverage was found to be less than 80% in all project cluster sites even though NTB has a Center for Research specializing in hepatitis. Tables 8.16 and 8.17 demonstrate that immunization coverage is weaker in NTB than in NTT. This calls for further question since in NTB, particularly in Mataram,

there is a laboratory which produces reagents for diagnostics of Hepatitis B, namely Hepatika Laboratories.

The socioeconomic level is not clearly affecting this immunization coverage such shown in tables 8.16 and 8.17. Figure 8.15 below shows Dompu, followed by Lombok Barat, to be lowest in NTB in complete immunization coverage (including hepatitis). In NTT (figure 8.16) Rote Ndao and Kabupaten Kupang are most in need of immunization program attention.

Figure 8.14. Percentage of immunized children aged 12 to 23 months by type of immunization

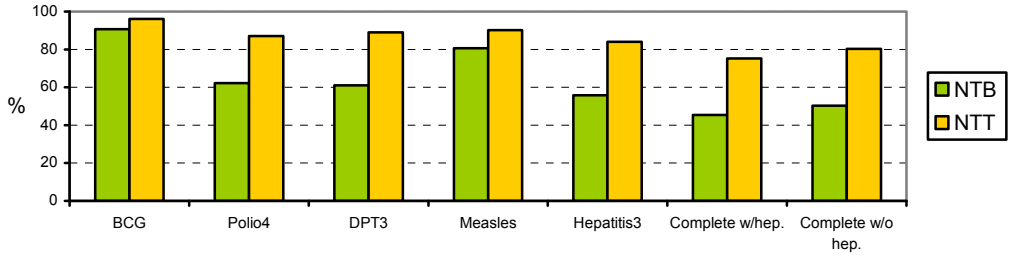


Figure 8.15. Percentage of coverage of measles and complete immunization in children aged 12 to 23 months in NTB

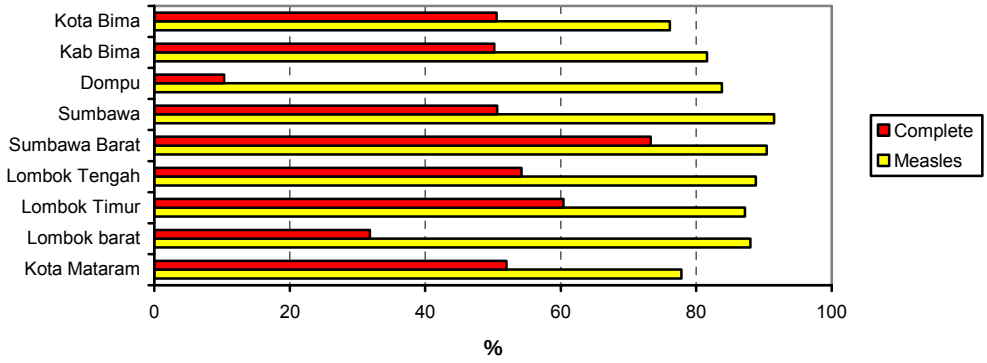
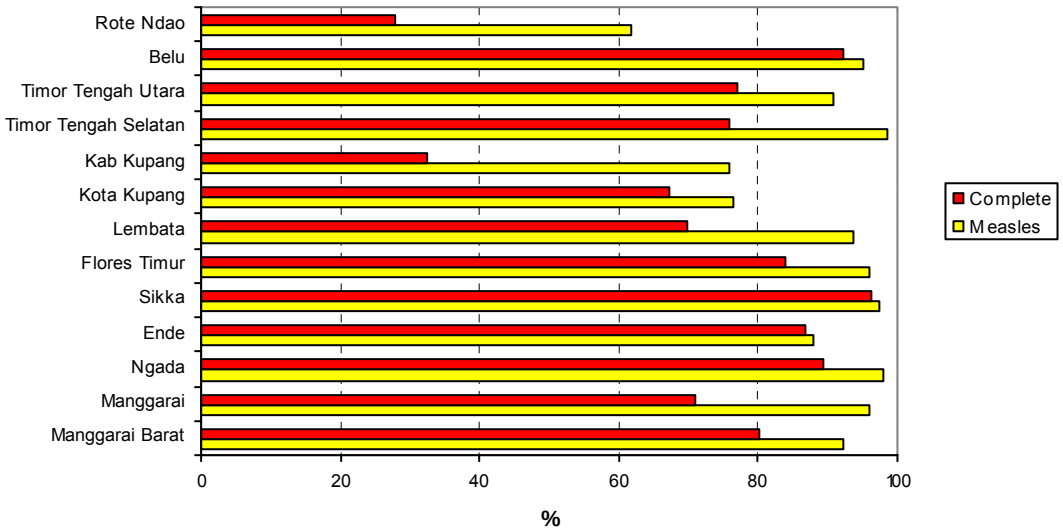


Figure 8.16. Percentage of coverage of measles and complete immunization in children aged 12 to 23 months in NTT



8.5. GROWTH MONITORING

Access to child growth monitoring appears to be satisfactory in both provinces because more than 90% of mothers have *Buku KIA* MCH books (table 8.15). Important information relating to child health in the book is less well known by mothers, however. Examples include knowledge of when infants cannot be breastfed and the significance of high fever as a sign to monitoring child health. The next question must be how mothers can be helped to use and understand more about MCH book. Illiteracy is probably an important factor limiting the impact of the MCH books.

Figure 8.17. Percentage of women having MCH book and knew at least 1 and 4 items of maternal and child health in NTB

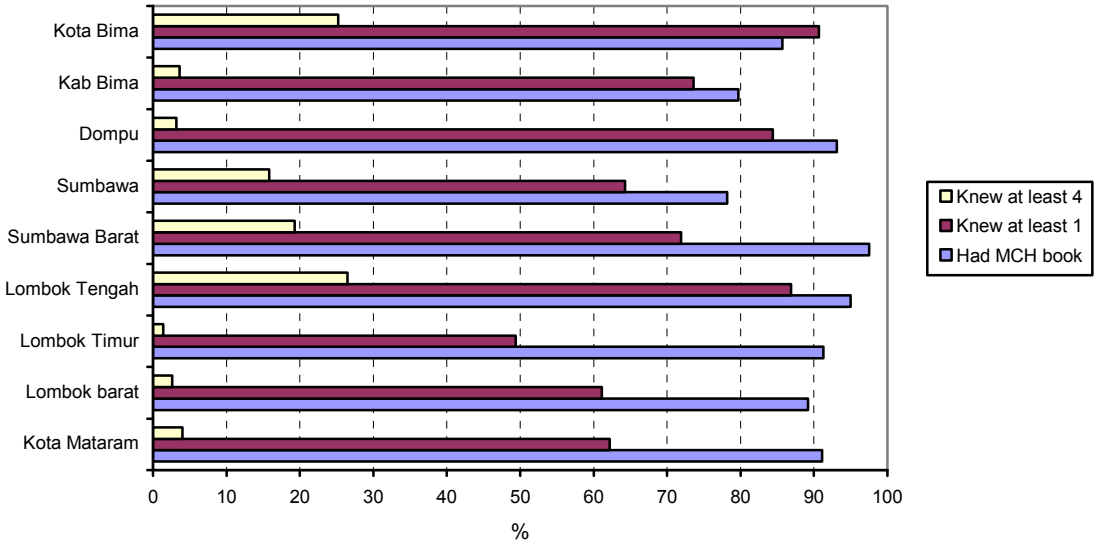
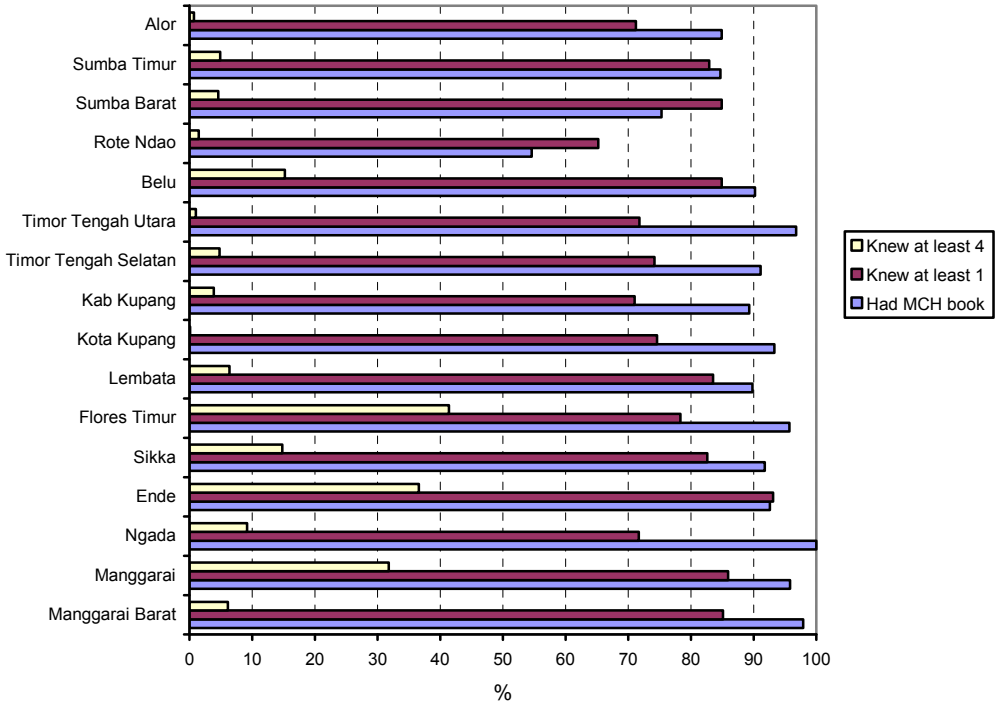


Figure 8.18. Percentage of women having MCH book and knew at least 1 and 4 items of maternal and child health in NTT



8.6. CHILD NUTRITIONAL STATUS

The anthropometrical measurement of each household's youngest child under five years of age was employed in the study. Weight and height were measured and, when combined with age, three nutritional status indicators were determined -- stunting (height for age), underweight (weight for age), and wasting (weight for height). The indicators were computed using Epi-Nut software using NCHS as the standard with a normal cut-off point of minus 2 standard deviations.

A worrisome picture of child nutritional status is shown in the following graphs. Half of all children aged two years and older, in both provinces, are stunted and underweight, reflecting acute and semi-chronic under-nutrition. Wasting is quite high, occurring in a quarter of the under fives. In certain age groups, there some differences, but in general the pattern is similar in males and females. These figures are much worse than the national figures, underlining the conclusion that childhood nutrition calls for serious notice in both provinces (tables 8.18, 8.19, 8.20).

Some districts show particularly high rates of under-nutrition. Figure 8.23 shows that, among children aged 12 to 35 months, wasting is higher than 20% in Dompu, Kota Mataram, and Lombok Barat in NTB and in Ende, Ngada, Sikka, Flores Timur, Kota Kupang, TTS, Belu, and Rote in NTT. It could be borne in mind that those children have survived infancy but still suffer from under-nutrition, and this increases the burden of the next generation.

Figure 8.19. Prevalence of Under-nutrition children in NTB

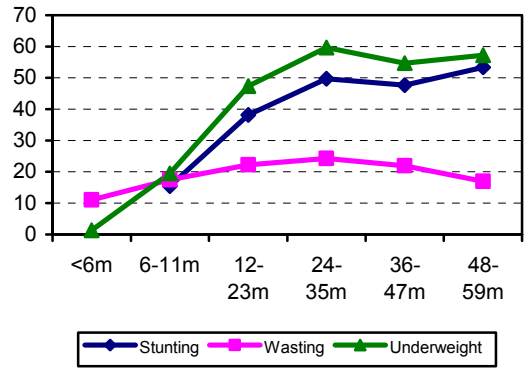


Figure 8.20. Prevalence of Under-nutrition children in NTT

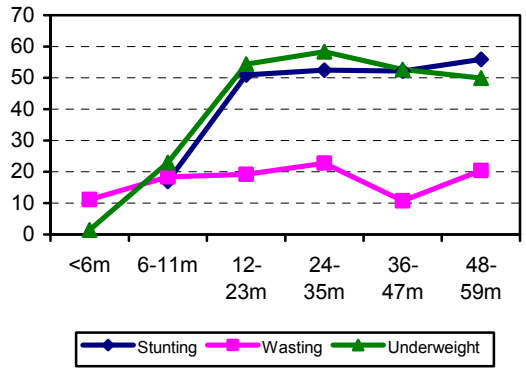


Figure 8.21. Prevalence of Under-nutrition in boys and girls in NTB

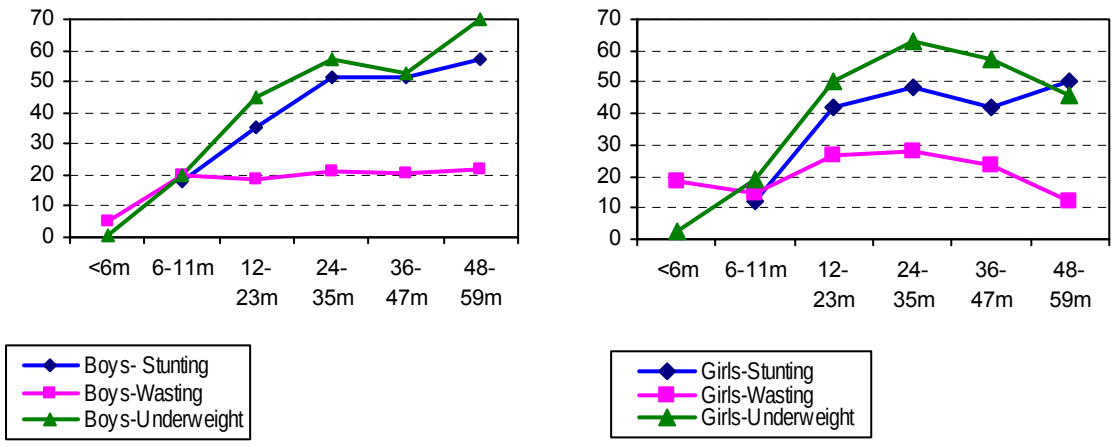


Figure 8.22. Prevalence of Under-nutrition in boys and girls in NTT

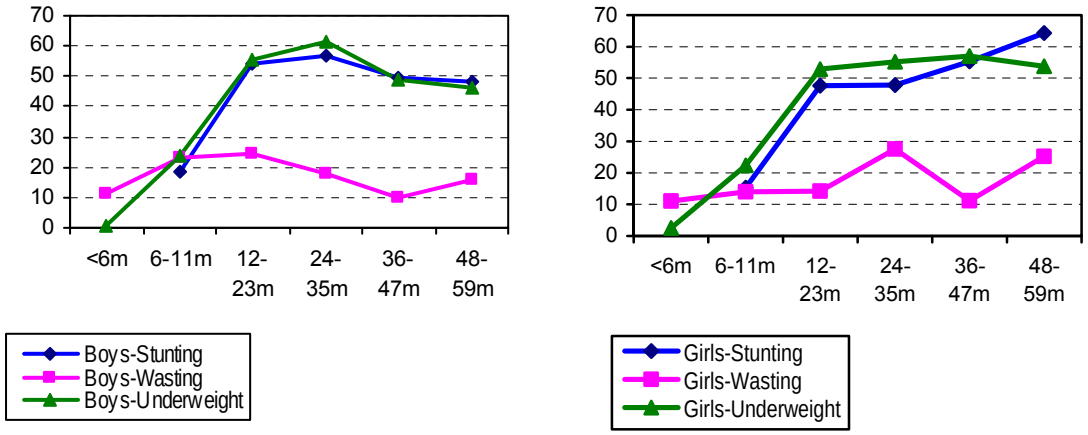
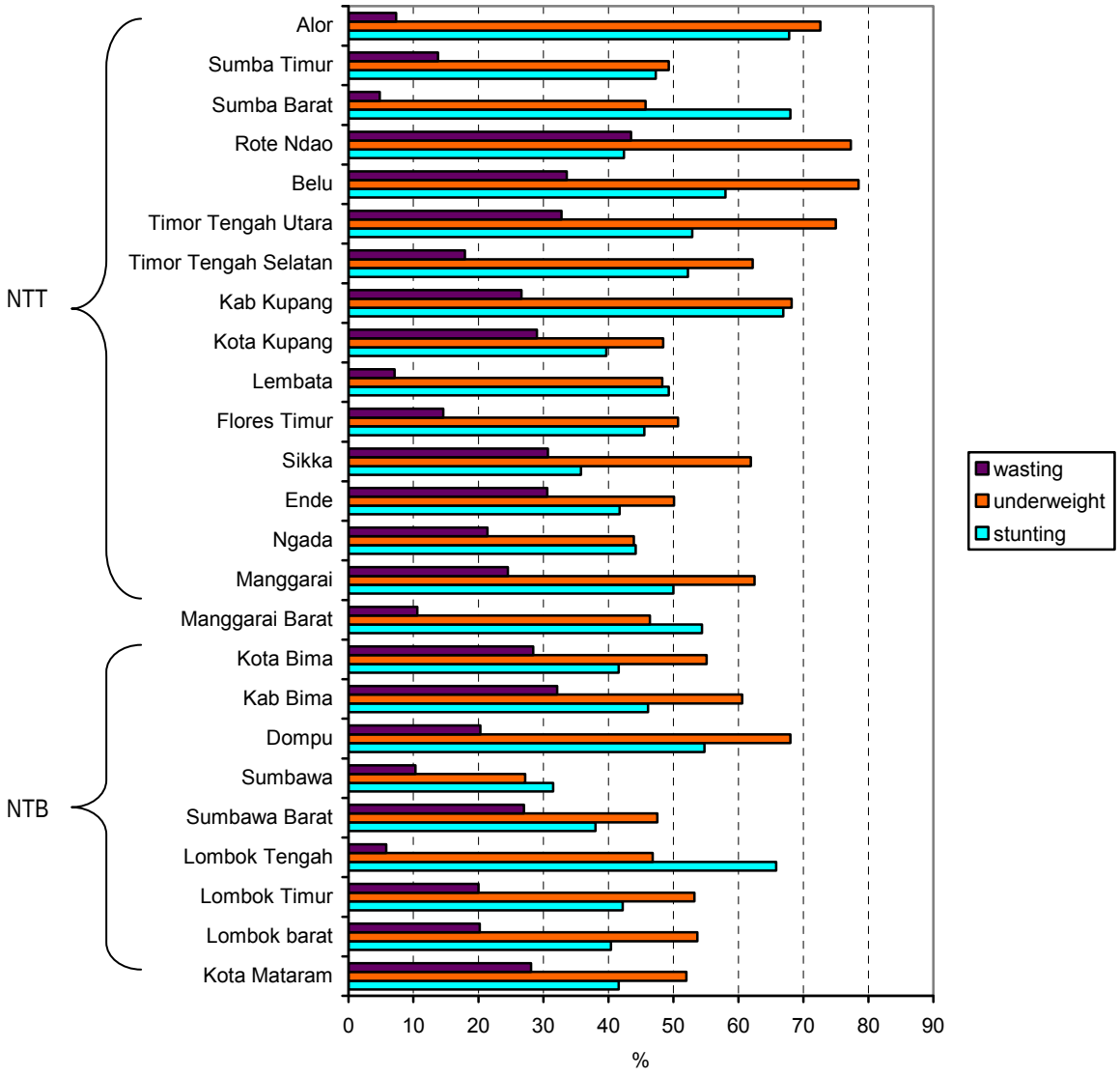


Figure 8.23 Prevalence of wasting, underweight and stunting among children aged 12 to 35 months in NTB and NTT by districts



CHAPTER 9

HIV AND AIDS

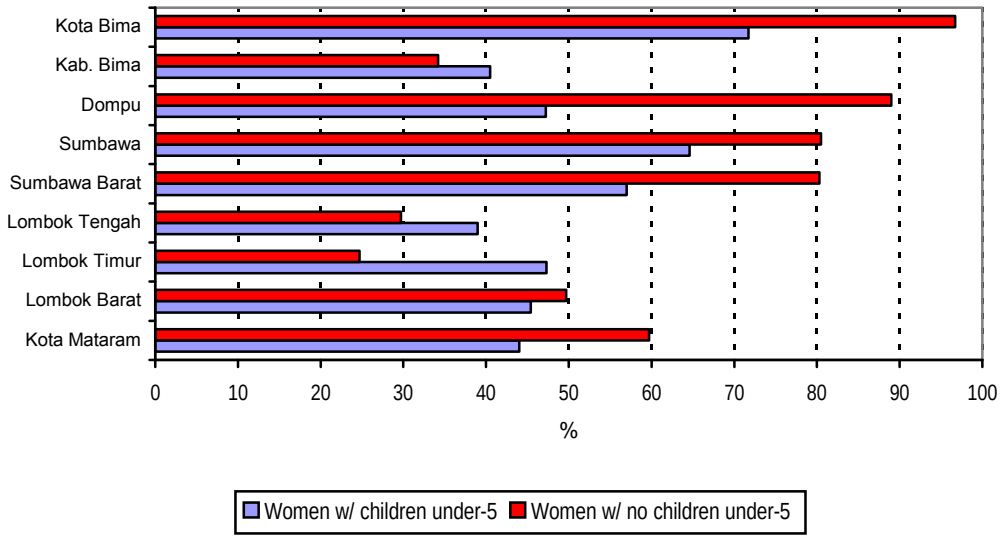
Combating HIV/AIDS and halting its advance by 2015 is one of the Millennium Development Goals. Behavior with risk of HIV/AIDS can be avoided if the person him/herself, the family, or the community understands the methods of transmission and prevention in particular. Therefore, community understanding of HIV/AIDS is a must these days. Level of knowledge was assessed in this study by asking respondents whether and from what source they have ever heard of HIV/AIDS, know how it can be transmitted and prevented, know where to obtain condoms easily, and know where to obtain treatment of sexually transmitted diseases (STD) as well as places for voluntary counseling and testing (VCT).

9.1. EVER HEARD OF HIV AND AIDS

Overall, almost half of NTT respondents and forty-five percent of those in NTB had heard of HIV and AIDS. The West Timor cluster shows the highest level of awareness at up to three quarters of respondents, while the lowest percent occurred in the cluster of Sumba-Alor, i.e. thirty percent. The other three clusters were about 40% (table 9.1). Women, with children under five, exhibit higher level of knowledge than those with no children under fives in NTB; but the other way around in NTT. Rates reported by the 2003 IDHS were a little lower, 35% in NTB and 31% in NTT. Overall, the women with no children under five have better understanding of HIV/AIDS than women with children under five.

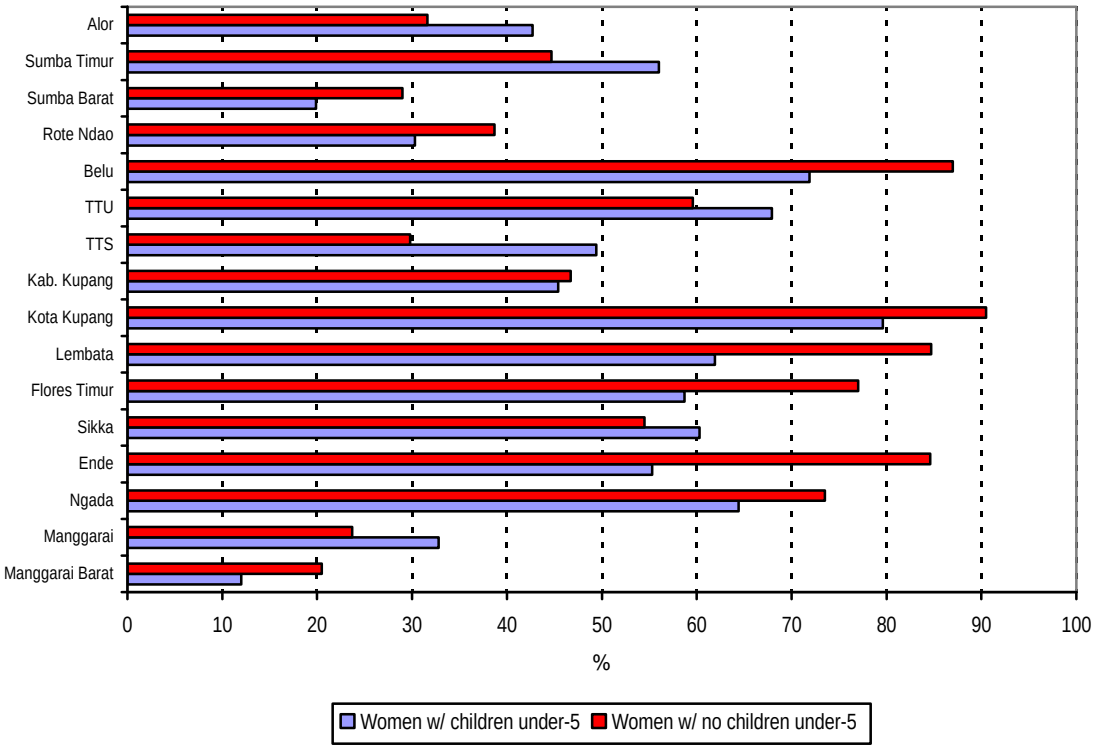
Among districts in NTB, the percentage who had heard of HIV/AIDS ranged from 37 to 78 percent. Aside from Kabupaten Bima, the districts of Sumbawa demonstrate better levels than those in Lombok (table 9.1.a).

Figure 9.1 Percentage of respondents who have ever heard of HIV/AIDS, NTB



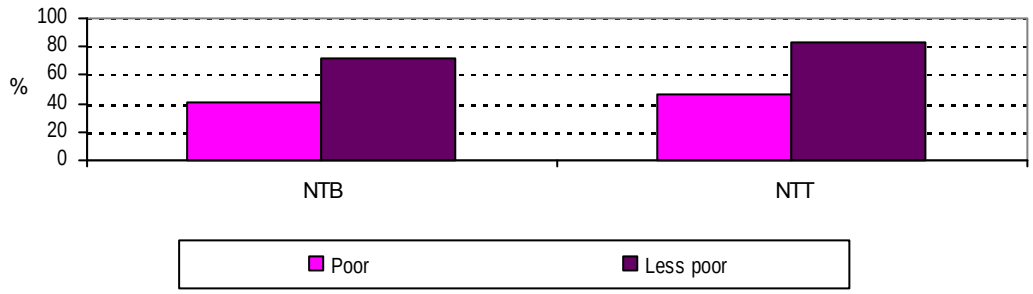
In NTT there was even greater variation across districts, ranging from a low of 13% in Manggarai Barat to a high of 87% in Kota Kupang. Overall, Kota Kupang, Belu, Lembata, Ende, Ngada, West Flores and Sikka show high levels of awareness, while districts of Manggarai Barat, Manggarai, Rote Ndao, Sumba Barat and Alor in need of better dissemination of information (figure 9.2).

Figure 9.2 Percentage of respondents who have ever heard of HIV/AIDS, NTT



By socio-economic level, the pattern of respondents had heard of HIV/AIDS was similar in both provinces with those of higher socioeconomic status more likely to have heard information abut HIV and AIDS (figure 9.3).

Figure 9.3 Percentage respondents who had ever heard of HIV and AIDS by socioeconomic level, NTB and NTT Provinces



Instead of the positive linear association seen in other districts, Dompu demonstrate an interesting pattern in that the poor had higher HIV/AIDS awareness than mothers in the better socioeconomic level. Positive-deviance analysis could be used to discern how

people of low socioeconomic status had been reached there. In contrast to the cities in NTB, awareness among the women of the highest socioeconomic status in Ende, Lembata, Sikka, Belu, and Manggarai Barat was among the lowest. Such findings also invite further research.

9.2 SOURCE OF HIV/AIDS INFORMATION

Although level of HIV/AIDS awareness variation considerably across districts, the major source of HIV and AIDS information was television in both provinces, 85% in NTB and 60% in NTT. Other sources include radio (32% both in NTB and NTT), newspaper (17.3% in NTB and 23.9% in NTT), and health personnel (13% in NTB and 23% in NTT) (table 9.2). The district of Belu is an exception in that person to person communication was the primary means of disseminating information there. However, this may largely reflect low socioeconomic status and low rates of television ownership (table 9.2.a).

It is noteworthy that health personnel were not mentioned as important sources of information about HIV/AIDS. FGDs reinforced the impression of poor performance by health personnel in disseminating health information in their communities. Among the comments:

> *"There are no health personnel who go down to the community, it's only a kader that came to the posyandu, and she only does the baby weighing"*
>
> *"No, never…… the doctor is never goes to the community, only kader who provide information on health in every monthly service at posyandu"*
>
> *(FGD of mothers in NTB)*
>
> *"I don't think that there are ever health personnel give health information dissemination here"* *(FGD of fathers in NTT)*

Figure 9.4. Percentage of reported sources of information on HIV/AIDS by type, in NTB

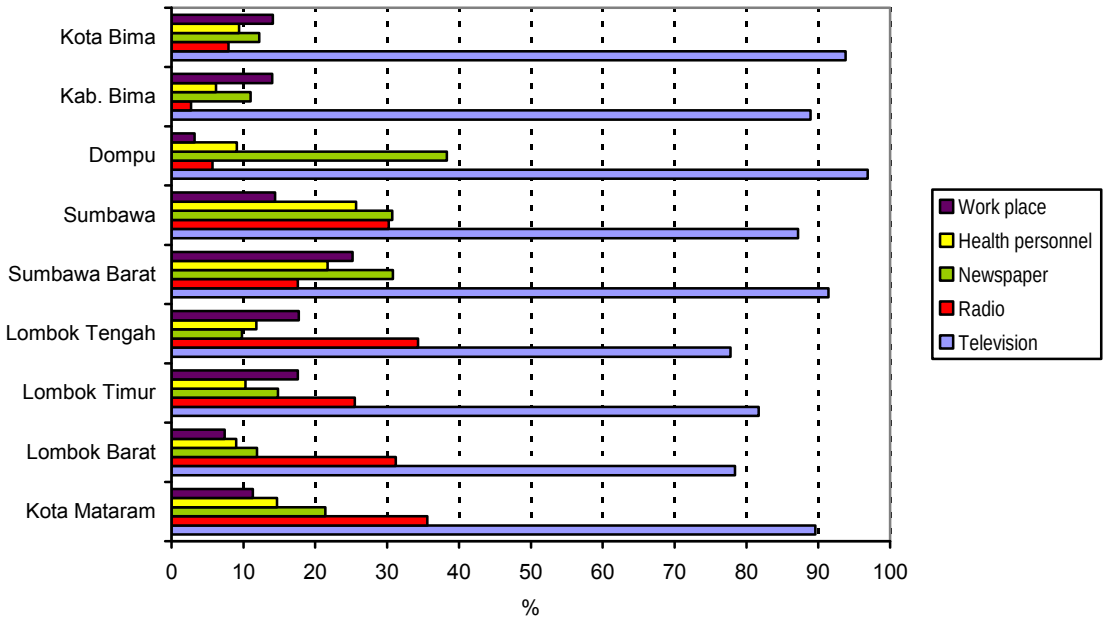
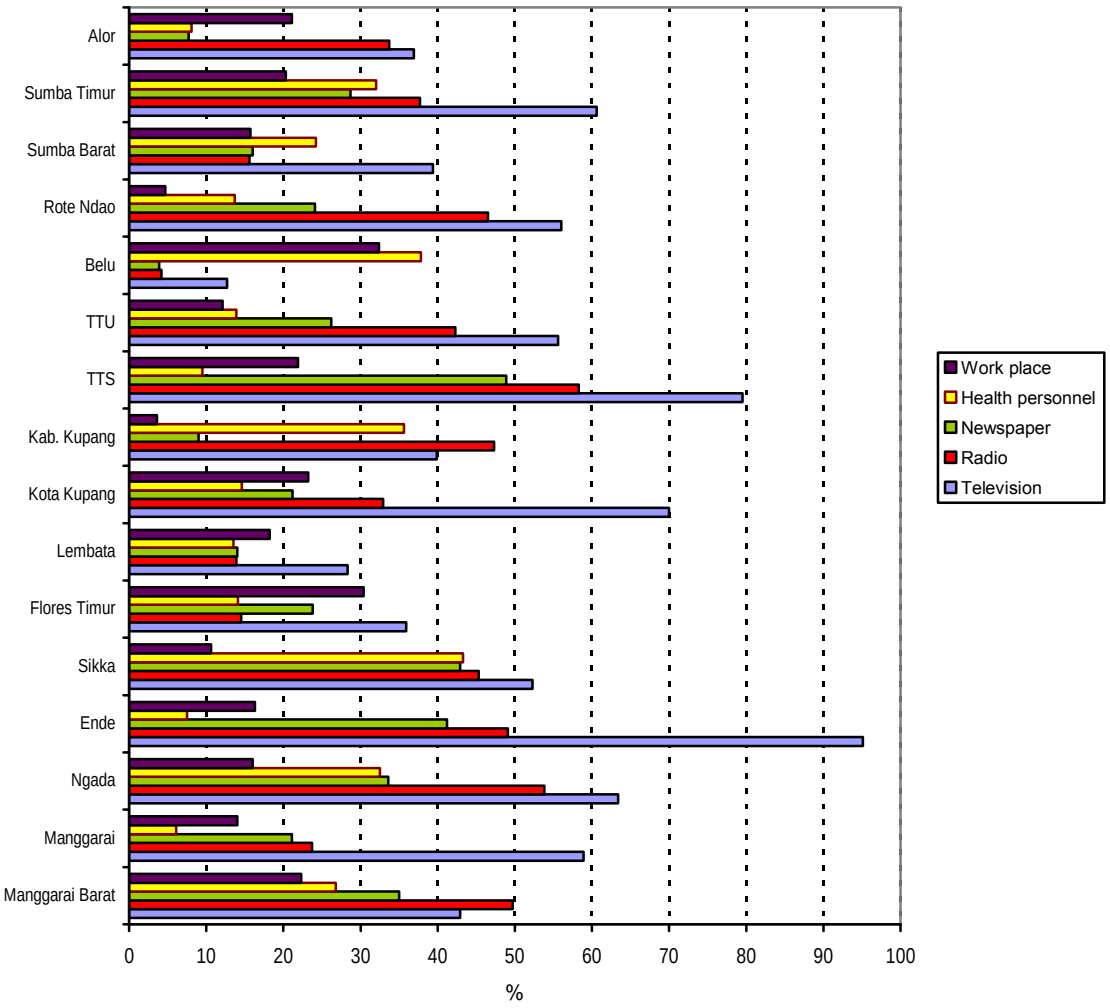


Figure 9.5. Percentage of reported sources of information on HIV/AIDS by type, in NTT



The same pattern of information sources was reported by the Indonesia Adolescent Health Survey (2002-2003) in which only 3% of respondents mentioned health personnel in regard to sources of information on HIV/AIDS (CBS, 2004). It can be concluded that the role of health personnel in disseminating this information is low and there is need for a program increasing the effectiveness of health personnel as a means of disseminating knowledge of HIV/AIDS.

9.3 KNOWLEDGE OF HIV/AIDS TRANSMISSION AND PREVENTION

Knowledge in NTT of both transmission and prevention of HIV/AIDS was almost double that in NTB. Abstinence was the method of prevention most often mentioned by respondents in both provinces. In NTT, being faithful to one's partner was next, followed by not sharing needles. In NTB the avoidance of shared needles and use of condoms were mentioned by similar percentages (table 9.3).

Overall, Sumbawa Barat scored best in NTB on the number of methods of transmission and prevention recalled. In NTT Kota Kupang scored best. Improvements are needed in other districts (table 9.3.a).

Findings from FGDs described some experience with condom use.

"Yes, I have used a condom, and its fine.....";

"It's not comfortable for me when I use it, especially when it comes to disposing of the used condom" *(FGD of father in NTB)*

"I don't want to wear it, for me, it is kind of wasting sperm" *(FGD of father in NTT)*

"My husband doesn't want to wear it (condom)" *(FGD of mother in NTT)*

The 2003 IDHS study reported that the levels of knowledge of HIV/AIDS transmission and prevention were similar in both provinces, averaging 11% and 9% in NTB and NTT respectively. After four more years NTT has advanced considerably in this knowledge, probably associated with improved educational levels.

Improved knowledge of HIV/AIDS transmission and prevention is urgently needed, particularly in the face of extramarital sexual activity permitted by local culture which carries obvious risks of sexually transmitted diseases. Interviews with NGOs, Members of Parliament, and the Head of the Family Planning Office of NTT described the traditional practice called "*sifon*" that is practices in some areas along the border with Timor Leste.

"Actually, these days, the government is only focused on a primary health care. However, there is still need for attention on the problems of maternal and child health, reproductive health, and STDs. Regarding STDs in NTT, the highest causes are gonorrhea, syphilis, and leucorrhea (vaginal discharge). This might be caused by the traditional practice of sifon . . . ." *(NGO in NTT)*

"I think that the Health Authority Office in NTT should pay attention towards problems on HIV/AIDS. We might study from the African countries as lesson learned"

(NTT Member of Parliament)

"I have been doing a several small researches among high risk CSW here at Belu, and I found that HIV positive cases have increased from only a few and to up to fifty cases already……. I also find that foreign troops are sometimes hanging out on the area of localization on the border with Timor Leste." *(BKKBN of Belu, NTT)*

Box 1

Sifon is a long-time tradition in Timor, particularly in rural areas of Kupang, TTS, TTU and Belu. *Sifon* means having sex with female. Traditionally, a man must be circumcised when his age is 17 years or over or he has married. Prior to the circumcision, the man is taken away from home by a *dukun* (traditional healer), usually to a place near the river. There the man immerses his body in the water until his penis becomes smaller, and the dukun does the circumcision. Three days after this minor operation, he must have sex with three women selected by the dukun who are not from the same village and not sex workers. Before each intercourse, the dukun hypnotizes the couple. The first woman must be a widow over 40 years of age, for the purpose of decreasing the mild fever resulting from the circumcision. The second woman, a widow under 40 years of age, should heal the inflammation. The third woman is a virgin, in order to prove his manhood.
Any attempt to avoid *sifon* is believed to make the man impotent, dirty, and excluded from the community. If he already has a wife, refusing to do it will make the woman looks likely older than her age. There is also a commercial side to the tradition, and some women demand a price of for being a sex partner, perhaps 50 thousand rupiah or more for a man with a large wound, less for a smaller wound. The overall result *sifon* is to contribute to the high prevalence of sexually transmitted diseases in Timor. (*In-depth interview to key persons in West Timor, NTT*)

Tables 9.2.a and 9.3.a show knowledge of HIV/AIDS transmission and prevention by district and demonstrate that Sumbawa Barat (NTB) and Sikka (NTT) are consistently high while Bima (NTB) and TTU (NTT) are low. It is disappointing to find understanding

of the ability of condoms to prevent HIV/AIDS in the range of only 3% to 7%, particularly in Flores Timur, TTU, Alor Bima, and Kota Bima. In regard to circumcision, NTB has it traditionally since mostly the population is Moslem. But this is rare in NTT, however, a customary *sifon* was recognized in some parts of West Timor island as a high risk behavior.

The method of transmission least recognized by the women is mother to child transmission, only 5% in NTB, much lower than 20% in NTT. The variation across districts was not very great, but the findings differ slightly from those reported by 2003 IDHS as approximately 20% in both NTB and NTT.

Figure 9.6. Percentage of respondents knowing HIV/AIDS prevention methods, NTB

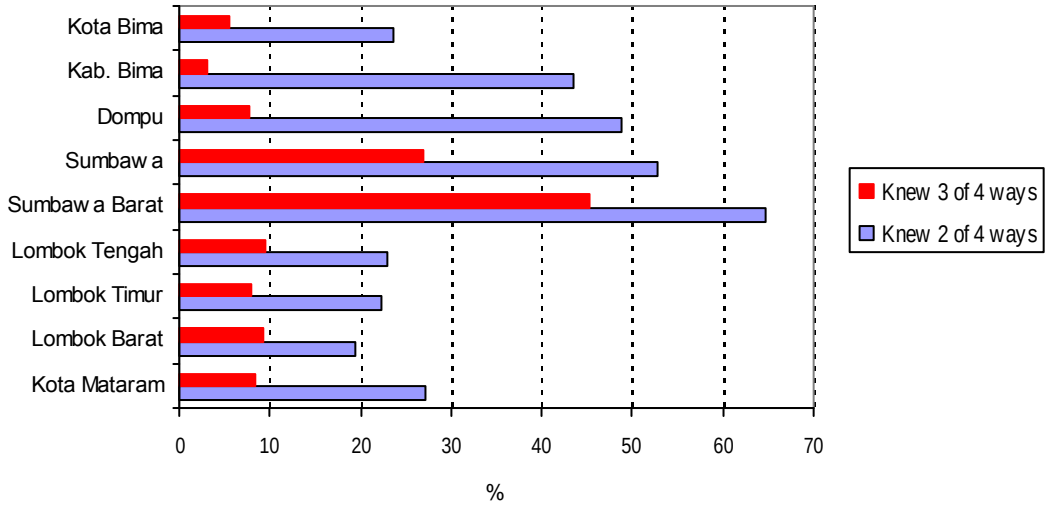


Figure 9.7. Percentage of respondents knowing HIV/AIDS prevention methods, NTT

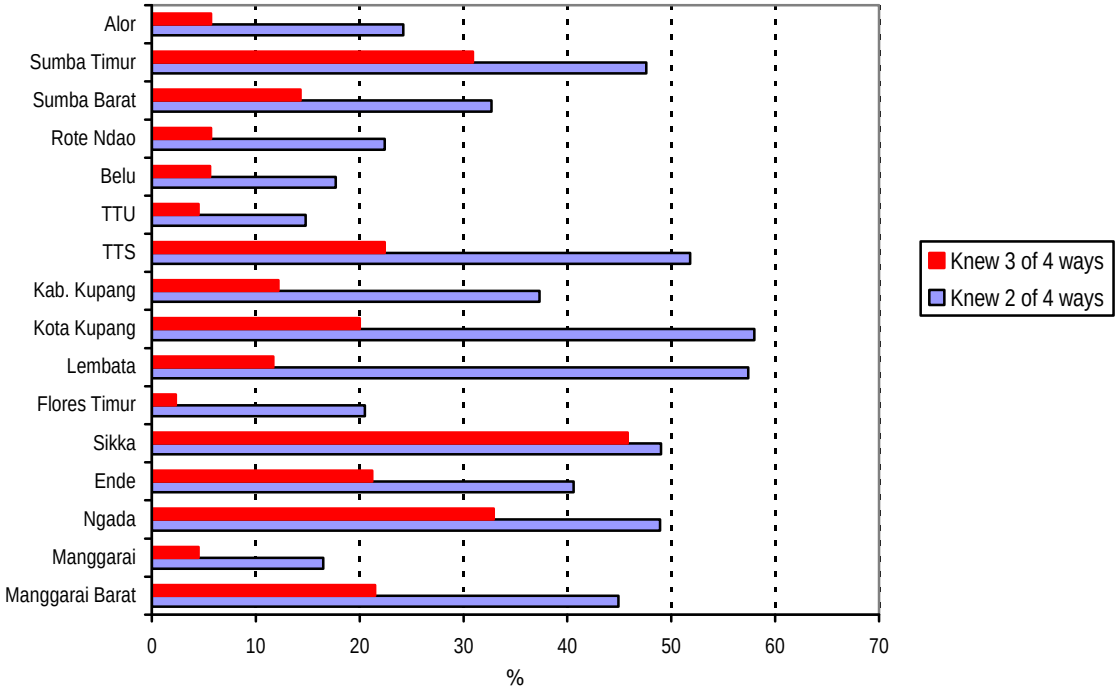


Figure 9.8. Percentage of respondent knowing HIV/AIDS transmission methods, NTB

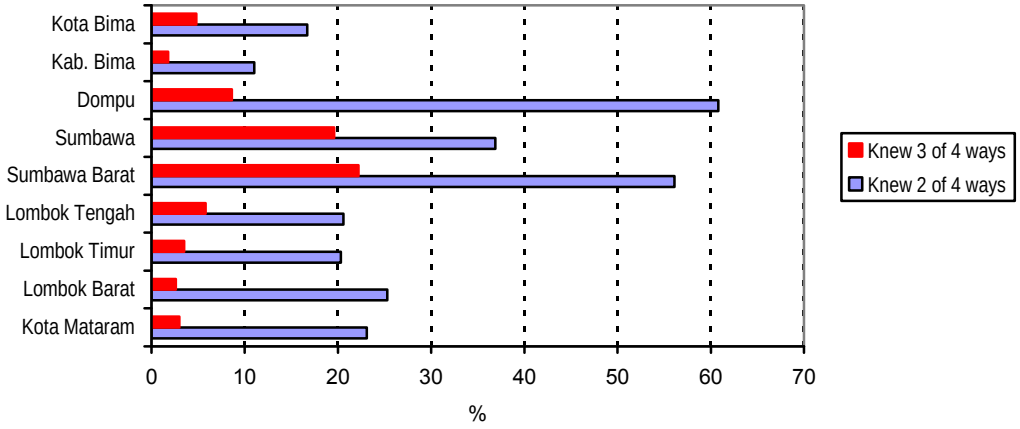
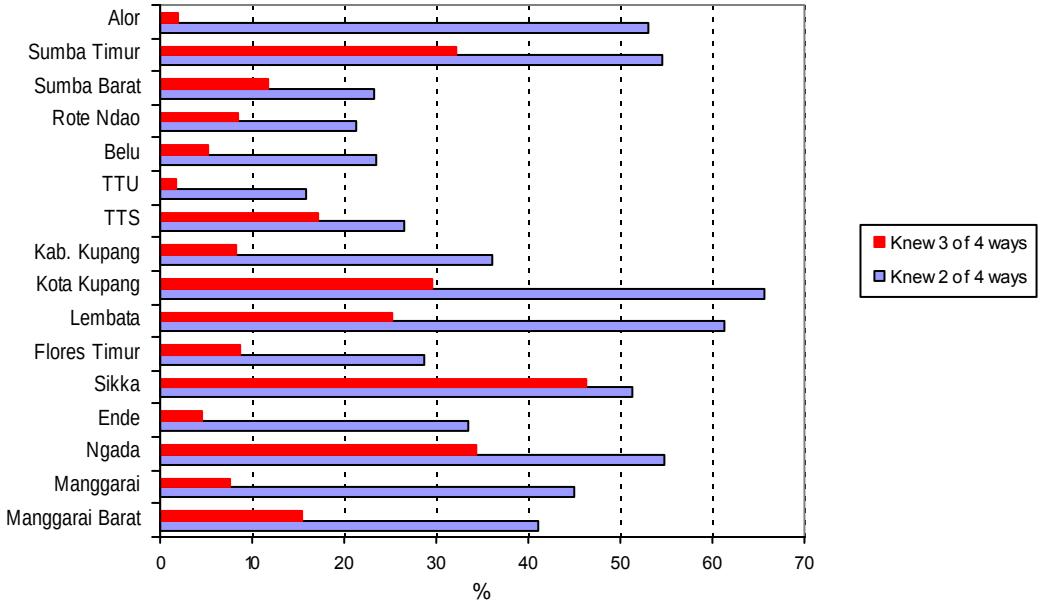


Figure 9.9. Percentage of respondents knowing HIV/AIDS transmission methods, NTT



9.4 KNOWLEDGE OF SOURCES FOR STD TREATMENT AND VCT

The study assessed respondent knowledge of STD treatment and, inasmuch as STDs are a predisposing and co-morbidity factor for HIV/AIDS, knowledge of where to find voluntary counseling and testing (VCT) for HIV/AIDS was assessed as well. The respondents of NTB and NTT identified hospitals (47% and 26% respectively) and puskesmas (22% and 6%) as places for STD treatment, followed by private practices of doctor (9% and 2%).

The responses concerning VCT were similar, identified by more than half of respondent as hospitals (52% and 28%), followed by puskesmas (32% and 5%), and private practice of doctor (10% and 2%) (tables 9.4 and 9.5). About 30-31% of women in NTB and 61-64% in NTT did not know where to find STD treatment and VCT. Knowledge of STD treatment and VCT appears to be higher in NTT than in NTB. The district with poorest knowledge of these facilities was Dompu (tables 9.4.a and 9.5.a).

Figure 9.10 Percentage of respondents knowing where to find STD treatment, NTB

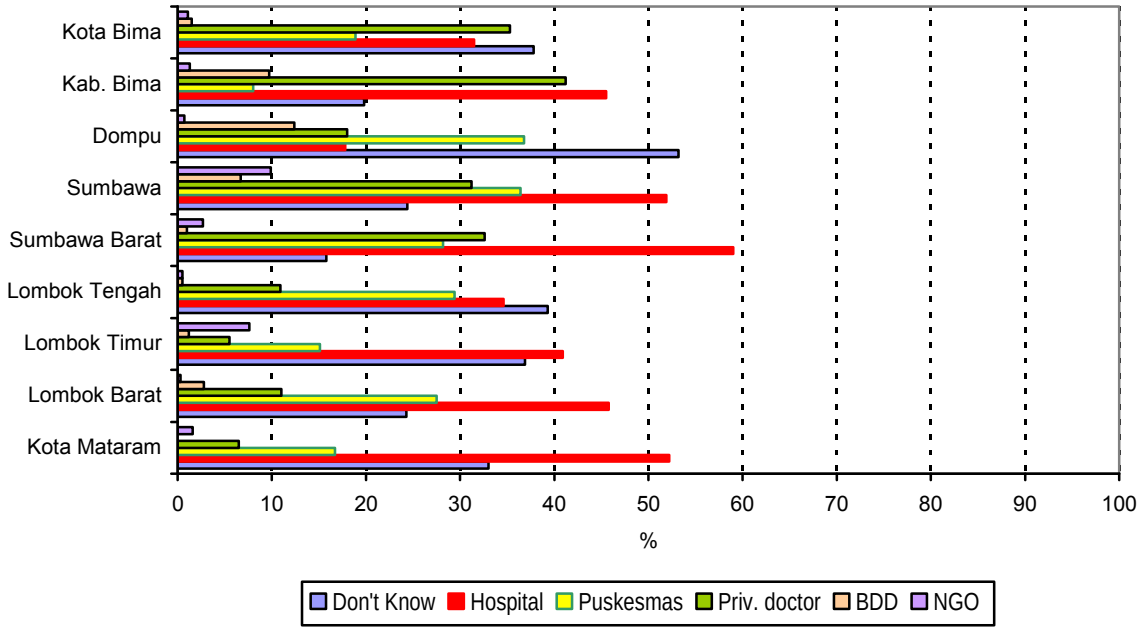


Figure 9.11 Percentage of respondents knowing where to find STD treatment, NTT

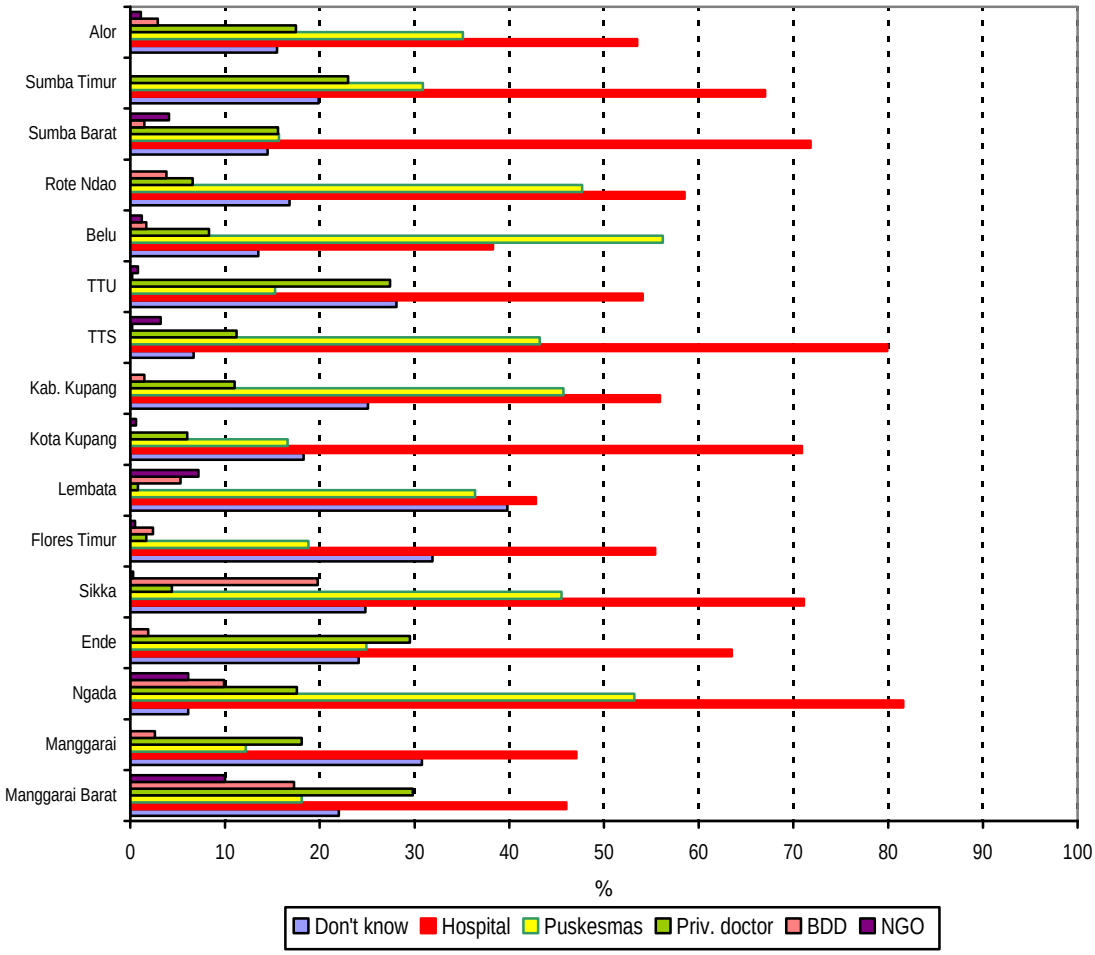


Figure 9.12 Percentage of respondents knowing where to find VCT, NTB

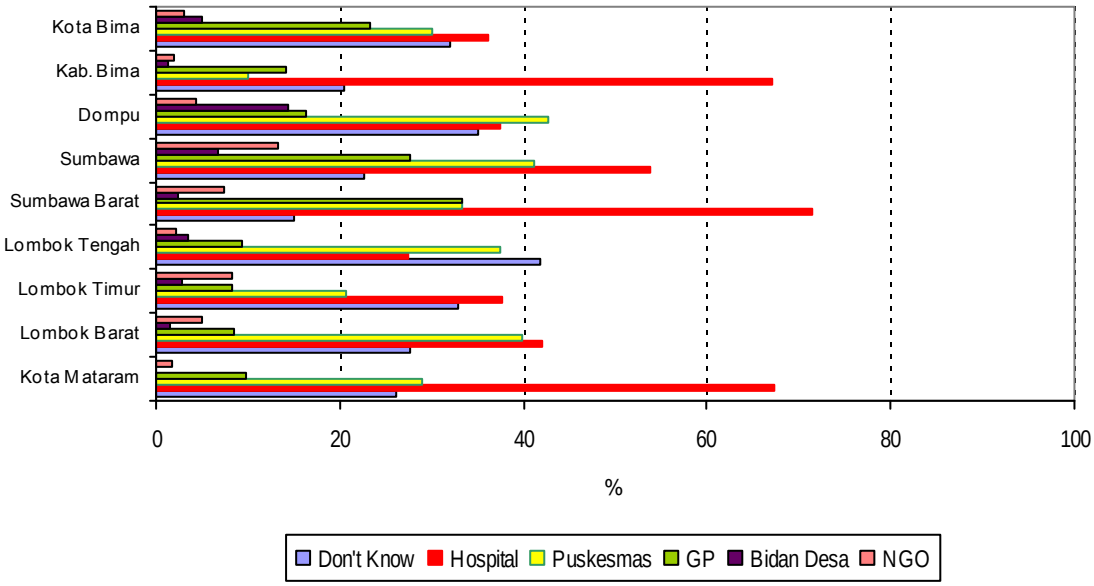
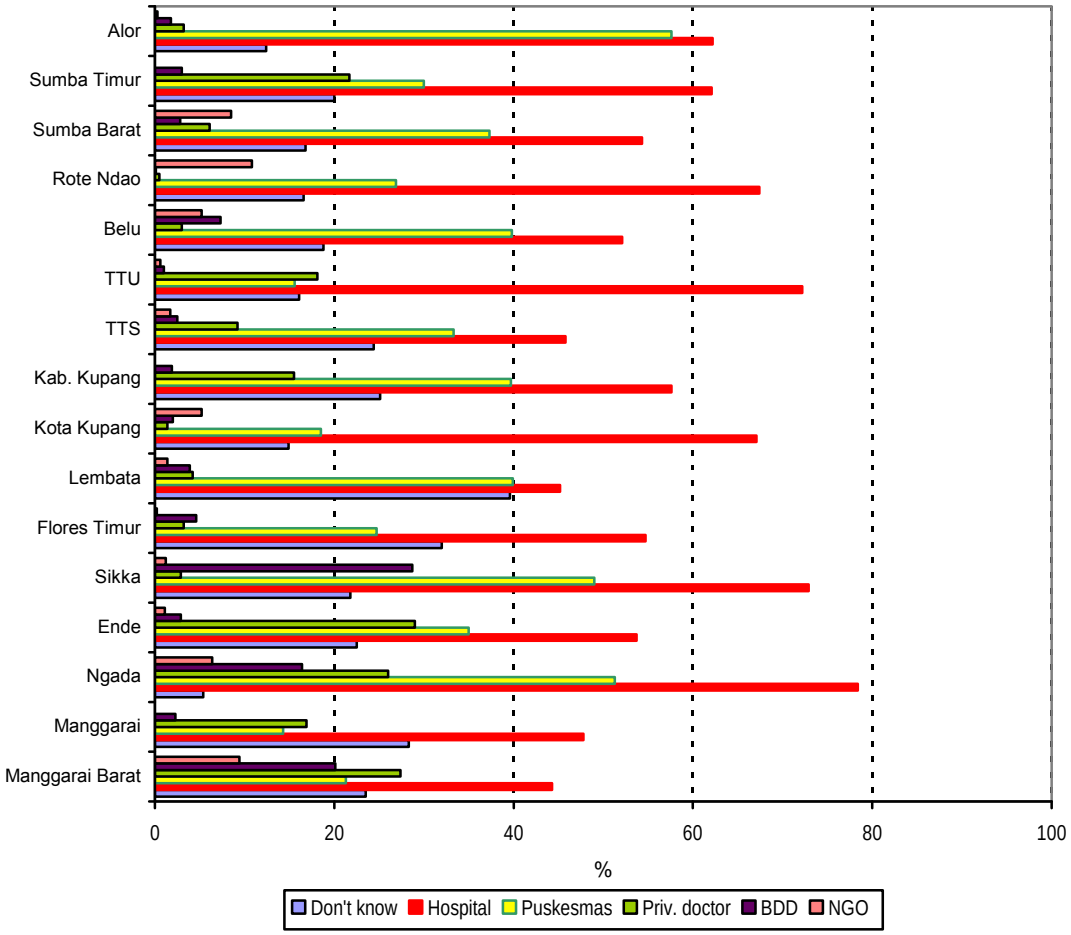


Figure 9.13 Percentage of respondents knowing where to find VCT, NTT



9.5 KNOWLEDGE OF PLACES TO FIND CONDOM

In both provinces, around 40% of respondents said they did know where to find condoms. Others mentioned pharmacies or drug stores (17% in NTB and 11% in NTT) and puskesmas (12% and 16%) as places to acquire condoms (table 9.6). FGD informants in both provinces explained:

"They sell it in the pharmacist, but I don't even try to buy it"

"Its easy, you can get everywhere, at the pharmacist, or even supermarket."

(FGD of mothers in NTB)

"It is available in any drug stores" *(FGD of mothers in NTT)*

The highest proportions mentioning were puskesmas, in Sumbawa (30%) and Lembata (47%), and pharmacies in Kota Mataram (30%) and Kota Kupang (28%). The highest proportions who did not know where to get condoms were from Lombok Barat (71%), TTS (72%), Kupang (75%), Sumba Barat (77%), Manggarai (78%), and Manggarai Barat (87%) (table 9.6.a and 9.6.b).

Figure 9.14. Percentage of respondents knowing where to find condoms easily in NTB

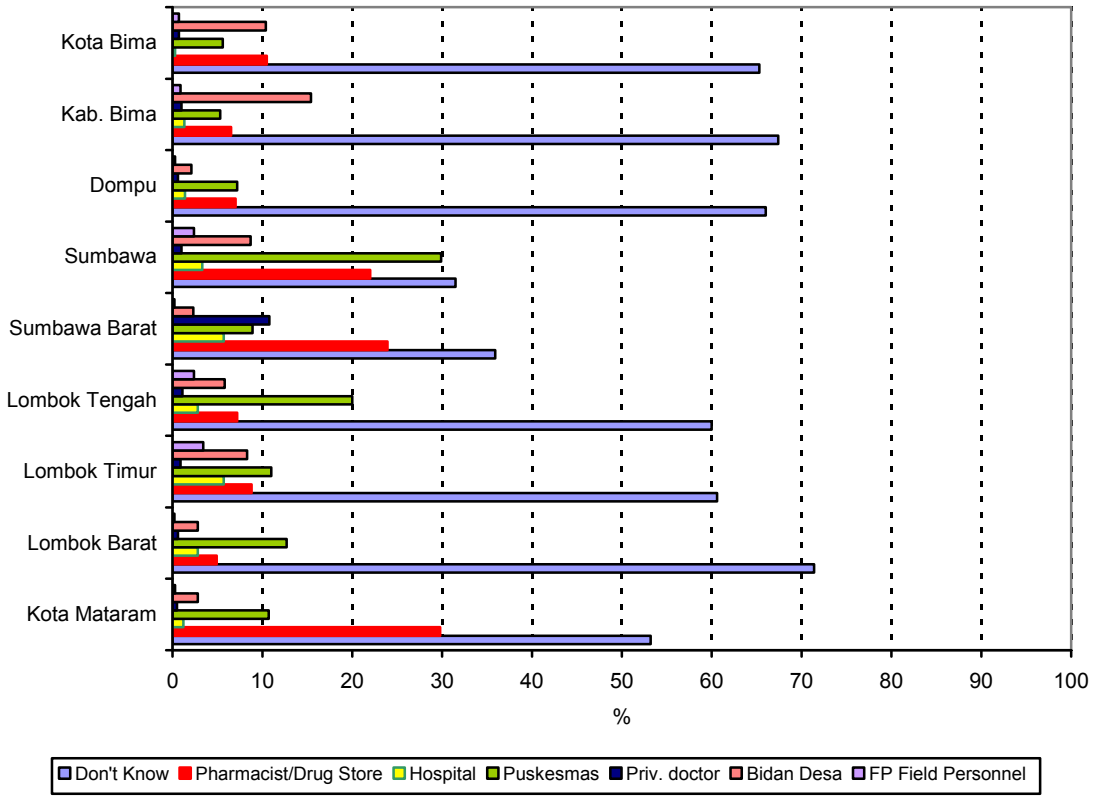
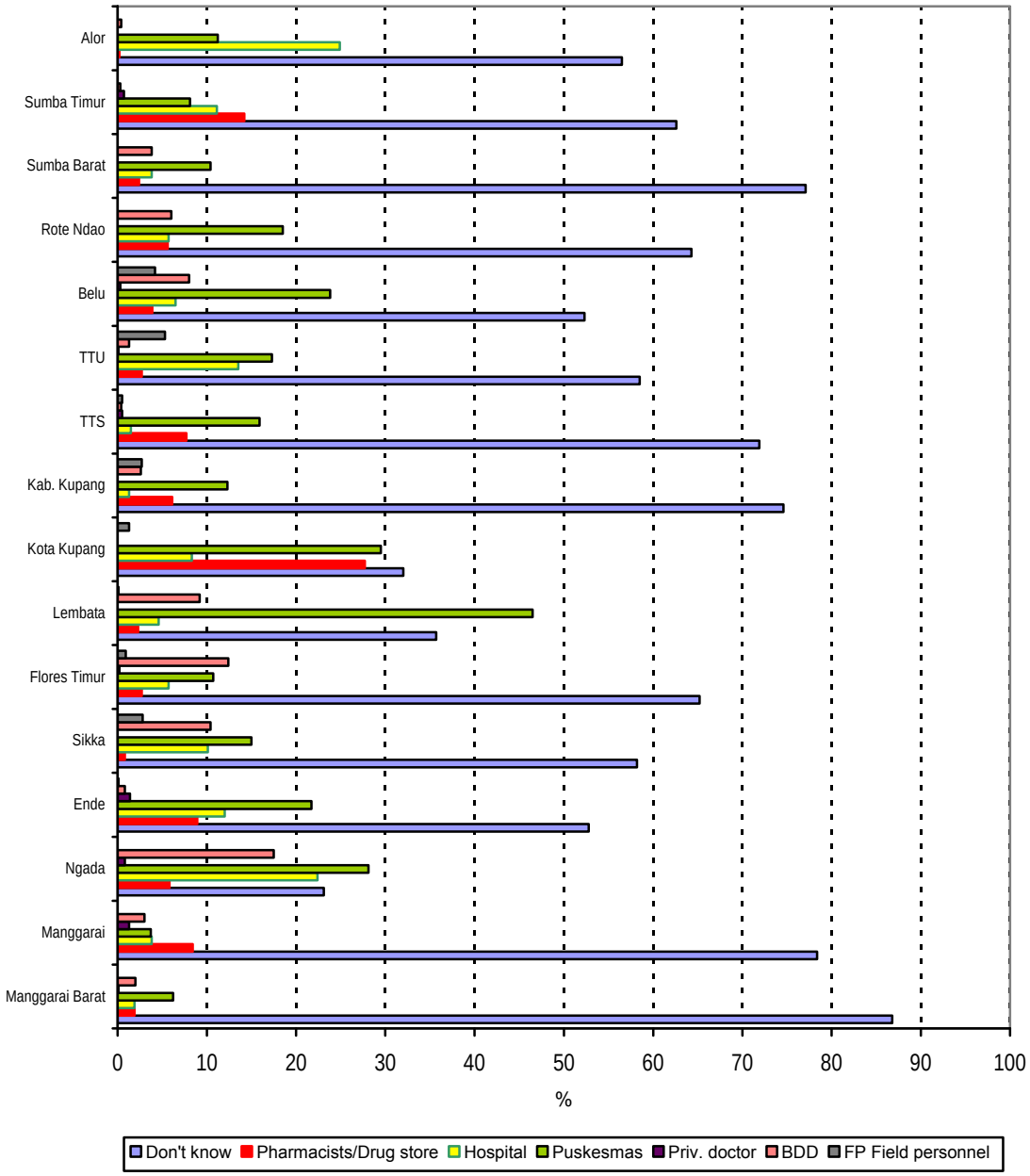


Figure 9.15. Percentage of respondents knowing where to find condoms easily in NTT



CHAPTER 10

COMMUNITY SOURCES OF MCH INFORMATION

Because providing information concerning maternal and child health (MCH) is expected to increase levels of knowledge, change attitudes positively, and thereby promote improved behavior, the study attempted to identify existing and potential channels for communicating information appropriate to the local context and resources.

10.1. SOURCES OF MCH INFORMATION

Respondents were asked whether they had received information in the past year concerning maternal and child health and family planning. 65% of respondents in NTT and 54% in NTB recalled receiving information. In both provinces, health personnel were identified as significant sources of information in addition to puskesmas, hospital, and health kader (table 10.1). Television was mentioned as a source of information by only nine percent of mothers in NTB and fifteen percent in NTT even though half of all households in both provinces own televisions (table 2.5). This suggests that more can be done by television programmers to create attractive and digestible programs on health issues, adjusted to local culture and context. Variation across the project clusters and districts was not obvious (table 10.1.a).

Figure 10.1 Percentage of sources of MCH and FP information in past year, in NTB

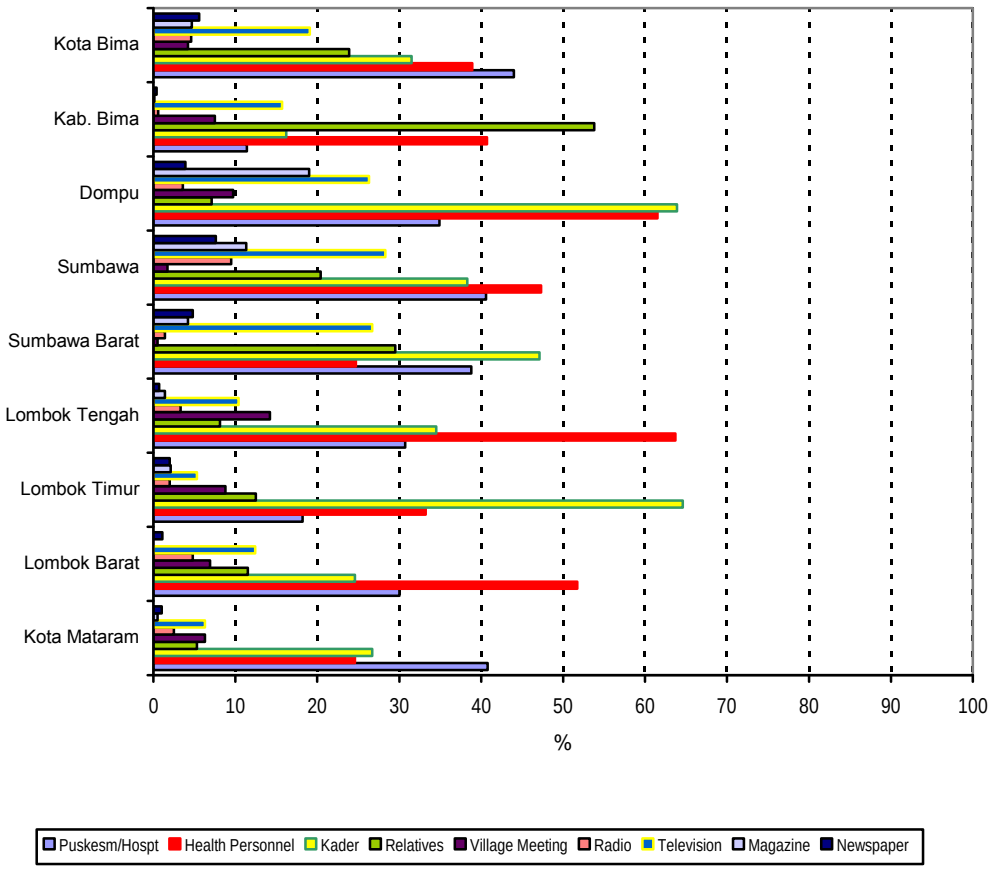
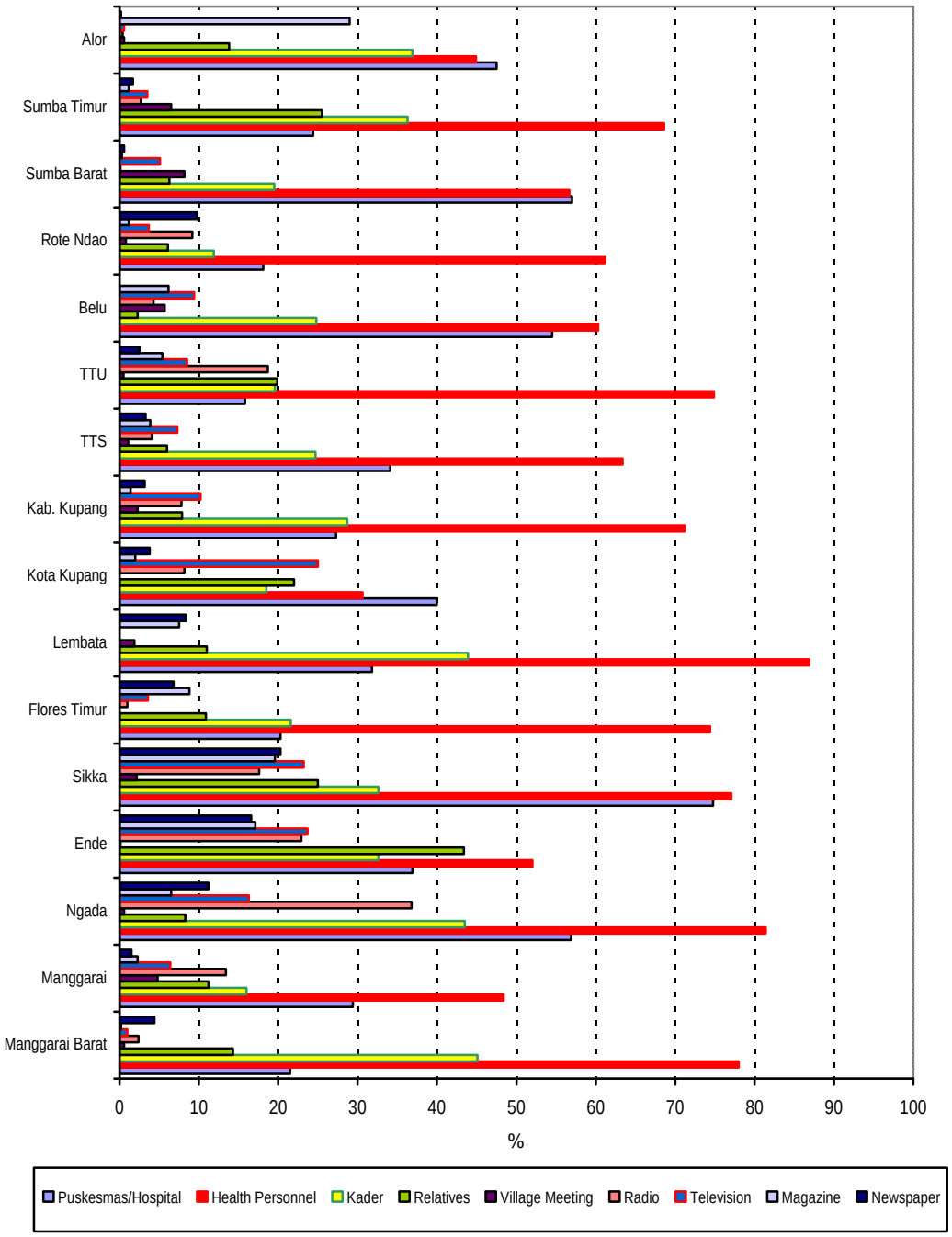


Figure 10.2 Sources of MCH and FP information in past year, by percentage named, NTT



10.2. INFORMATION IN HEALTH SERVICE FACILITIES

Because puskesmas and hospital were names as frequent sources of health information, the study was interested in the ways information is delivered within health facilities. The waiting room was first assumed to be a strategic place for delivering information through posters, but it was found that only 5% (NTB) to 7% (NTT) of women recalled reading those posters in waiting rooms (table 10.2). This underlines the importance that designing and pre-testing posters to be appropriate to local culture and context as well as eye-catching.

The survey suggests that person to person communication may be a key method of information dissemination. Most women primarily recalled chatting with other visitors while waiting (21% in NTB and 65% in NTT). Surprisingly, only 2% to 3% of women received information from health personnel during the time they were waiting.

Figure 10.3 Percentage of respondents receiving health information from various sources while waiting at health facilities

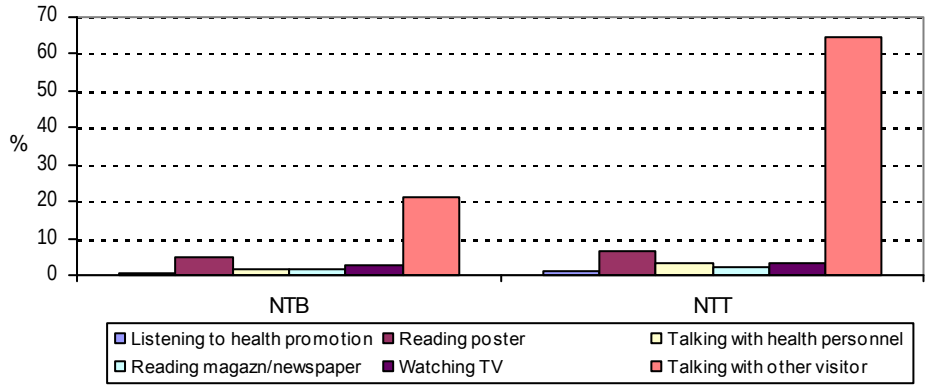


Figure 10.4 Percentage of respondents receiving health information from various sources while waiting at health facilities, NTB

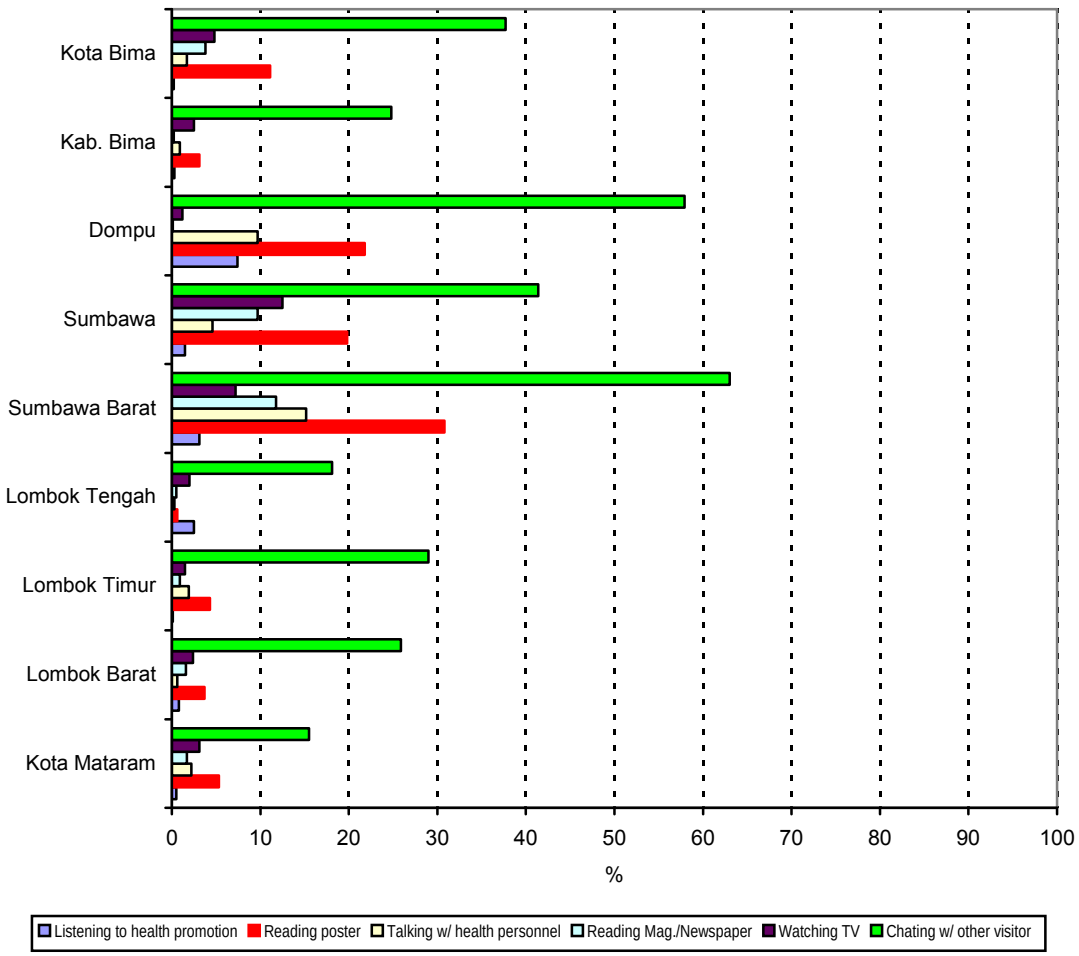
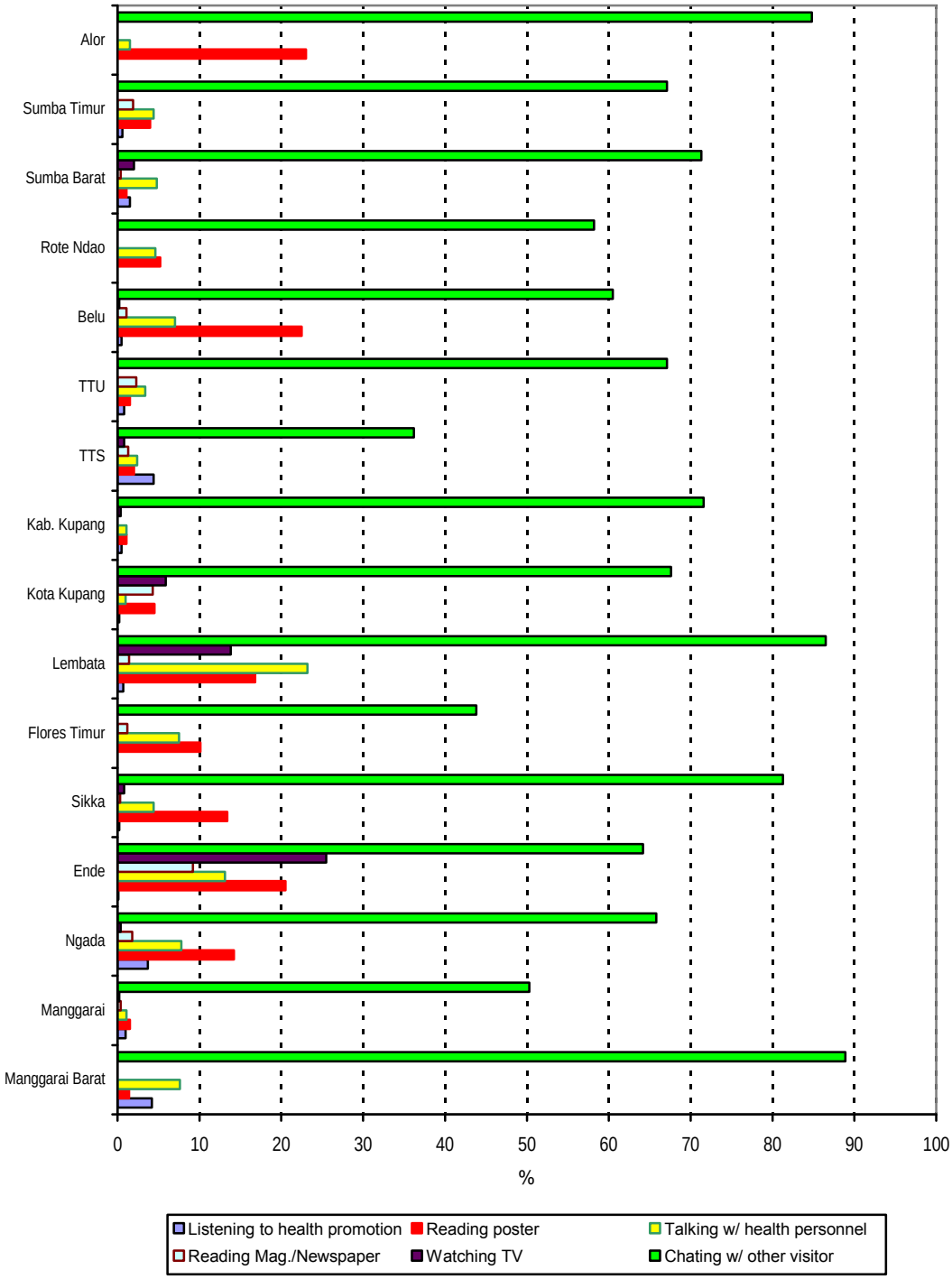


Figure 10.5 Percentage of respondents receiving health information from various sources while waiting at health facilities, NTT



CHAPTER 11

SANITATION AND PERSONAL HYGIENE

Clean and healthy behavior is one of the goals for achieving “Healthy Indonesia 2010”. Achieving this healthy behavior is not as simple as turning over the palm of the hand, however. Variations in geography, culture, customs, and values of the people, as well as socioeconomic and demographic conditions, can both promote and discourage change, especially in sanitation and personal hygiene. The main source of drinking water, use of toilet, quality of the house, and hand-washing with soap are some of features that can be measured to assess improved practices that relates also to maternal and child health.

11.1. MAIN SOURCE OF DRINKING WATER

The survey found that less than half of all households in NTB and NTT (36% and 40% respectively) utilize piped water as their main source of drinking water. Other sources include protected wells (36% in NTB and 20% in NTT) and protected springs (5% in NTB and 14% in NTT) (table 11.1). Unprotected wells are the source of drinking water for around 10% in both provinces. These findings are slightly better than reported by Susenas (2004) which found piped water used only by 12% and 18% of households in NTB and NTT respectively. This improvement probably reflects programs in water piping in the last three years.

There is high variation across districts. Households in Lombok Tengah, Sumbawa, Bima, Ende, Kabupaten Kupang, Belu, TTS and Alor have reported relatively high percentages of unprotected wells (table 11.1.a and 11.1.b).

Figure 11.1. Distribution of respondents by main source of drinking water, NTB

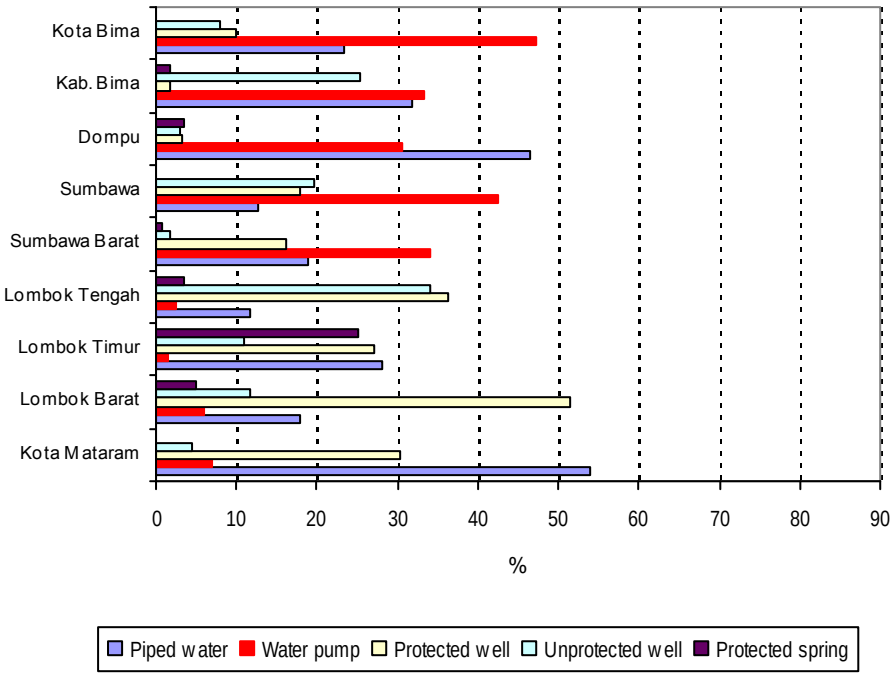
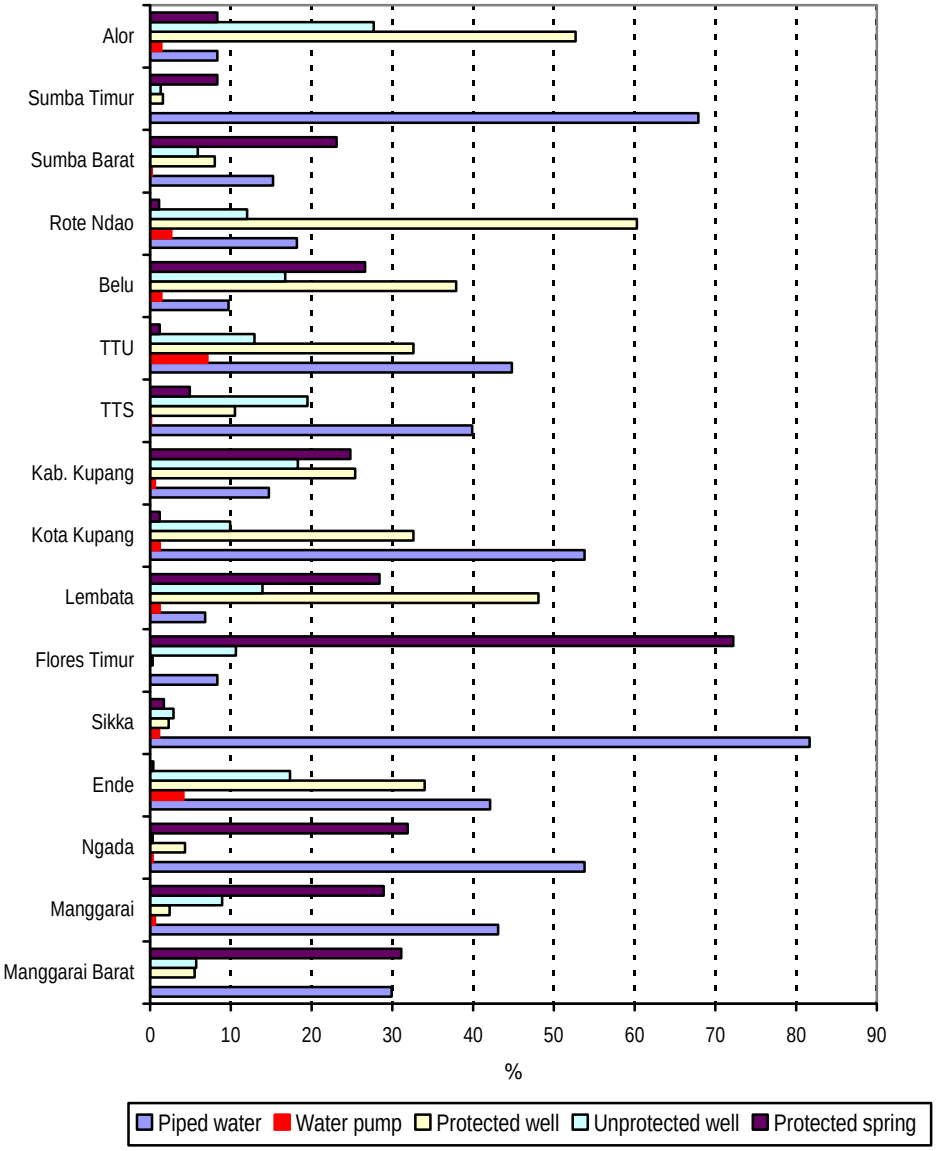


Figure 11.2. Distribution of respondents by main source of drinking water, NTT

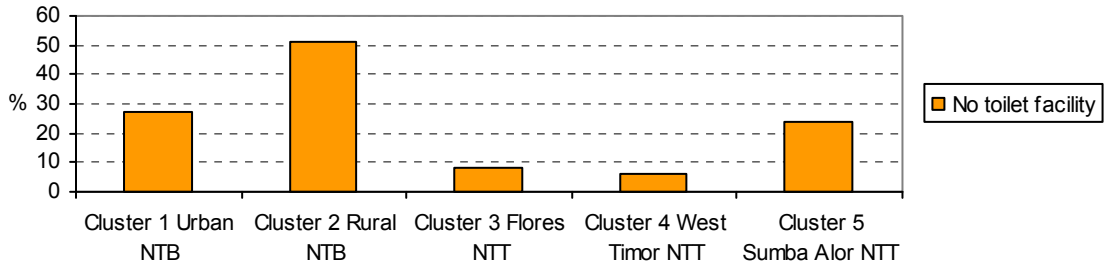


11.2. USE OF TOILET

By asking respondents what kind of toilet is usually used by household members, the survey found that one third (33%) of households in NTB and 38% of households in NTT go to the river, the bush, or use plastic bags to dispose of stools (table 11.2). Household members in NTT tend to use toilets without septic tank rather than going to the river or bush. These findings differ from the report by Susenas (2004) that around 5% to 10% households in NTB and NTT had no toilet facility.

There is very high disparity across districts. Most households in rural districts of NTB (Lombok Barat, Lombok Timur, Lombok Tengah, Dompu) and some districts of NTT (Belu, Rote Ndao, Alor and Sumba Timur) confessed to having no toilet facility (table 11.2.a). Manggarai Barat, TTS, Sumba Timur and Belu were identified as the poorest in toilets with septic tank, around 8 to 15% of households only.

Figure 11.3. Percentage of no toilet facility used by household members in NTB and NTT



11.3. QUALITY OF THE HOUSE

To assess the quality of the house, the study categorized houses based on density of persons living in the house (more or less than 8m^2 per person), type of roof (was or was not made of asbestos or palm leaves or fibers), wall (brick or other) and floor (dirt or not dirt). Around 57% and 44% of houses in NTB and NTT were grouped as low density. Most houses in NTB used tile roofs (70%), while in NTT zinc sheets were most common (82%) (table 11.3). Bamboo provides wall for one sixth of houses in NTB and one third in NTT. Floors were of dirt in 10% of housed in NTB and 32% in NTT. These findings are similar to the result of Susenas (2004).

As a composite indicator, it was concluded that only around 24% of houses in NTB and 11% NTT can be categorized as good quality. Of all the districts studied, Kota Mataram and Kota Bima in NTT (table 11.3.a), and also Alor in NTT (table 11.3.b) shows the best conditions of house quality.

Figure 11.4. Percentage of poor quality houses, NTB

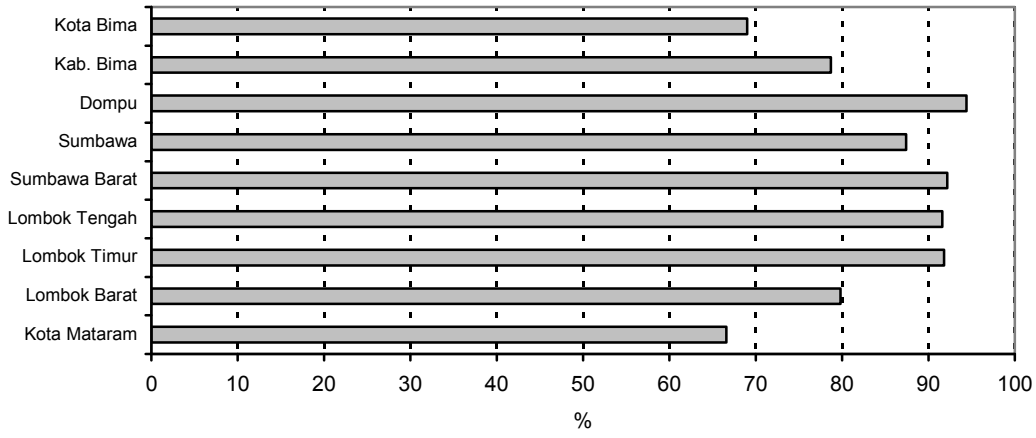
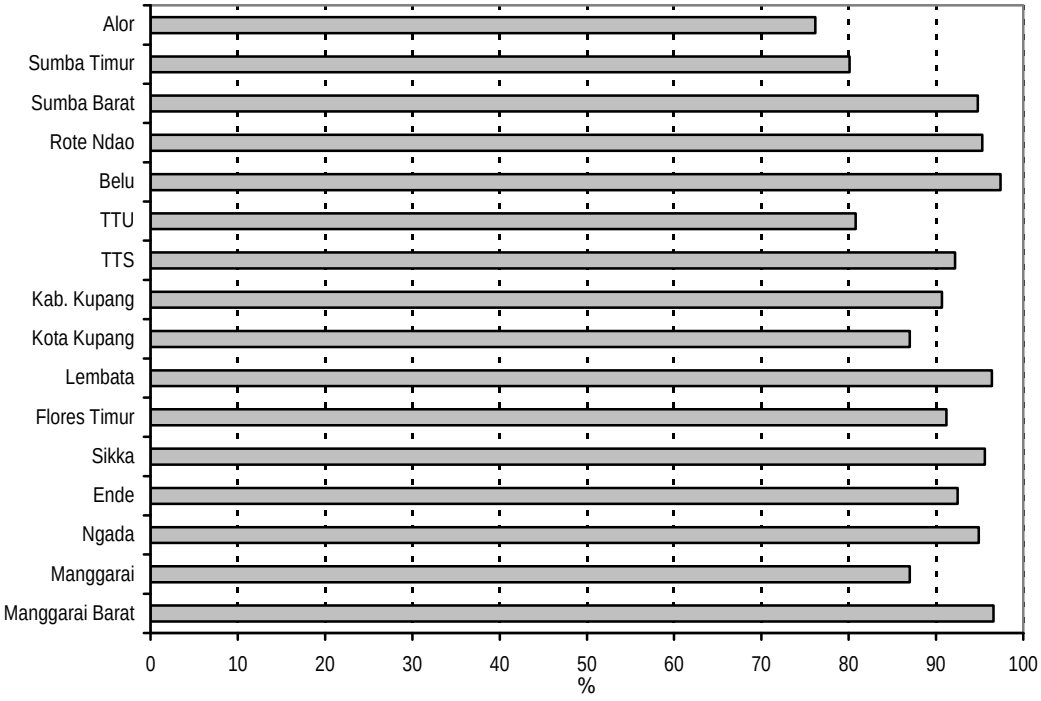


Figure 11.5 Percentage of poor quality houses, NTT



11.4. HAND WASHING

Good hygiene required washing hands with soap at critical times that include before preparing food, eating, feeding a child, and after defecation and helping a child toileting. In both provinces, washing hands with soap before eating was the most commonly reported by respondents, 60% and 73% in NTB and NTT respectively. Less than half of the respondents reported washing hands with soap after defecation or after helping or cleaning a child toileting or defecation. In general, practices are better in NTT than NTB in terms of always washing hands with soap, 10% and 6% respectively (table 11.4).

At the district level, almost all respondents in Sumbawa Barat (99.5%) wash their hands with soap at least in one critical time and approximately half (46%) at all critical times. In NTT, Sikka preformed best, with 32% of respondents always using soap at critical times (table 11.4.a).

Figure 11.6 Percentage of respondents washing hands with soap at critical times, NTB

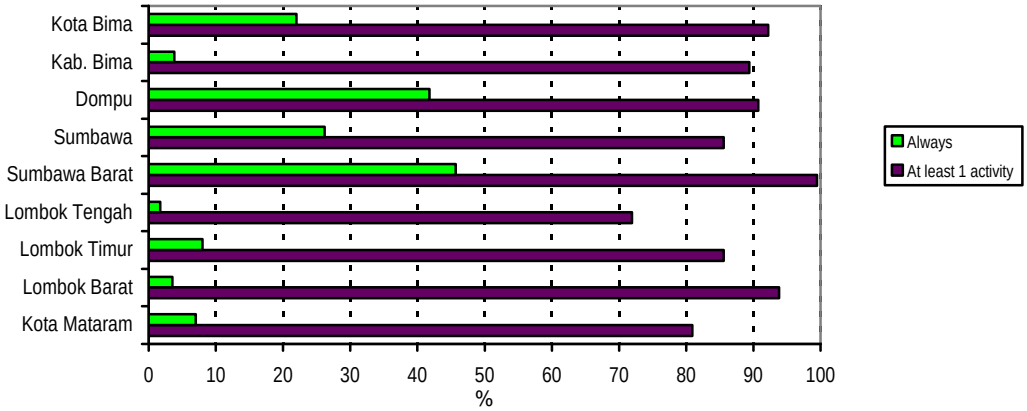
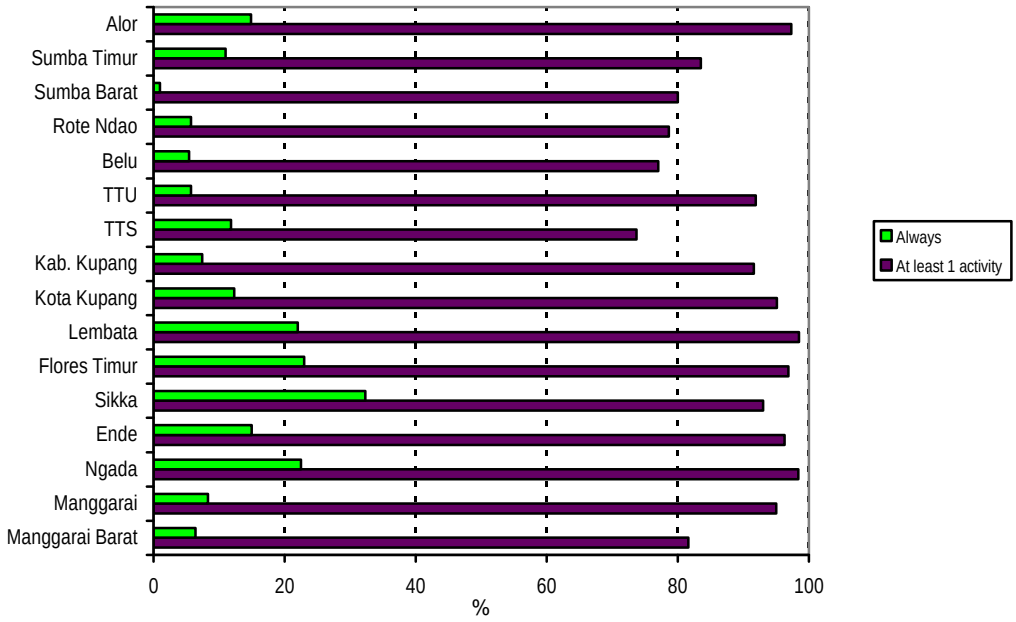


Figure 11.7 Percentage of respondents washing hands with soap at critical times, NTT

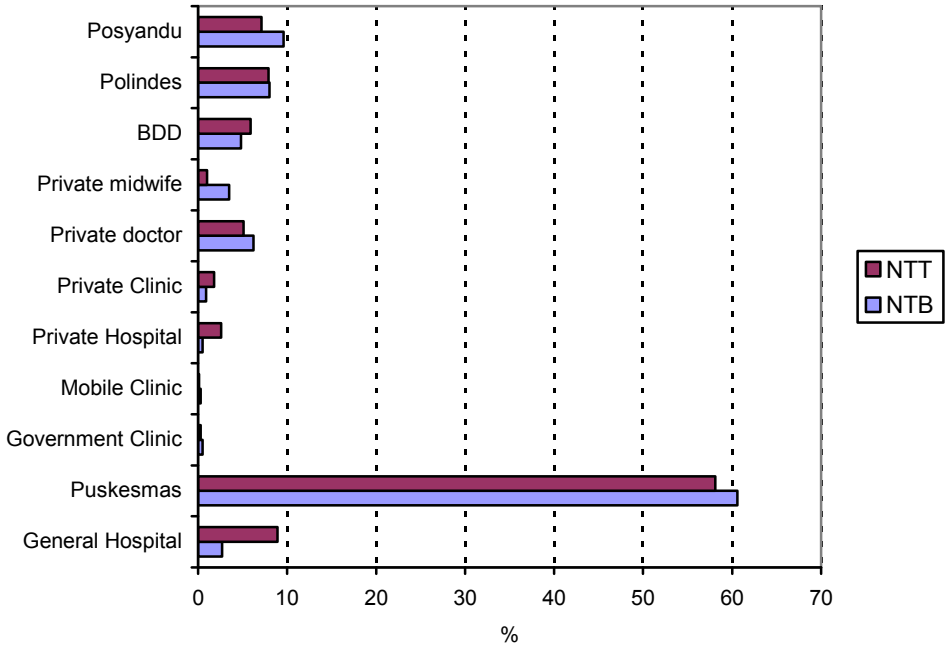


CHAPTER 12
ACCESS TO HEALTH FACILITIES

Principally, every person has a basic and fundamental right to privacy, including the right to seek and obtain all health care services. Access to these services is a matter of critical importance not only to the individual, but also to the health and welfare of all people. Intentional efforts to harass an individual in order to deter or prevent the individual from exercising his or her right to seek and obtain health care services are therefore contrary to the interests of the community.

In this study, access to health care comprised the distance and duration to reach the facility, the mode of and the cost for transportation to reach the facility, the cost for the health services itself, as well as health insurance. Since the result in this chapter and the following findings mainly refer to the last visited health facility, regardless the time frame, therefore, the description of frequently health facility visited is exhibited below.

Figure 12.1. Distribution (%) of mothers by last visited health facility in NTB and NTT



12.1. DISTANCE AND DURATION TO REACH HEALTH SERVICE FACILITY

Distance to health facility from home was measured by asking the respondent, and if necessary confirmed to other person who knew the address. This survey revealed that, in NTB and NTT, the mothers stated the farthest health facility from home was private hospital ranged from 5 to 20 km, or almost 84 km in Ende; followed by private clinics (1 to 7 km) and government hospital (2 to 4 km) or more than 20 km in Flores Timur and Kupang. Meanwhile, posyandu (0 to 1 km), village midwife (BDD) (1 to 3 km), polindes (1 to 20 km) and puskesmas (1 to 5 km), were estimated as being the closest (table 12.2, 12.2.a and 12.2.b). These findings were also verified by the statements recorded in FGD, where mostly informants chose posyandu as the place for antenatal care, besides

puskesmas and polindes, in terms of seeking health treatment, antenatal care or even for giving birth, because of the nearest ones.

> *"To posyandu, the nearest services, and after several months, 7th month, I take her routinely to puskesmas"*;
>
> *"My wife is having prenatal care with the midwife, because it's near, and the hospital is too far"*; (FGD of fathers of NTB)
>
> *"Say that puskesmas is far from home, and crowded, so all of us are prefer to go to polindes. Moreover, the polindes is near from our house."* (FGD of mothers of NTB)

Regarding to the time of duration to reach health facility, as the nearest health facility, posyandu, polindes and puskesmas were attained by respondents within six to fifteen minutes. To other health facilities, yet mothers took less than 20 minutes, except to the government private hospital in NTT whereby averagely worked within half an hour (table 12.3). Thus, posyandu, polindes, village midwife (BDD) and puskesmas were frequently told as being the closest facilities from home (table 12.4). In NTB, the farthest facility admitted was the government hospital in Bima, which required forty minutes to reach (table 12.3.a). While in NTT, the private hospital was recalled as the farthest facility in Sikka (2 hours) and Ende (4 hours) (table 12.3.b).

Figure 12.2 Median distance (km) from home to the last visited health facility in NTB

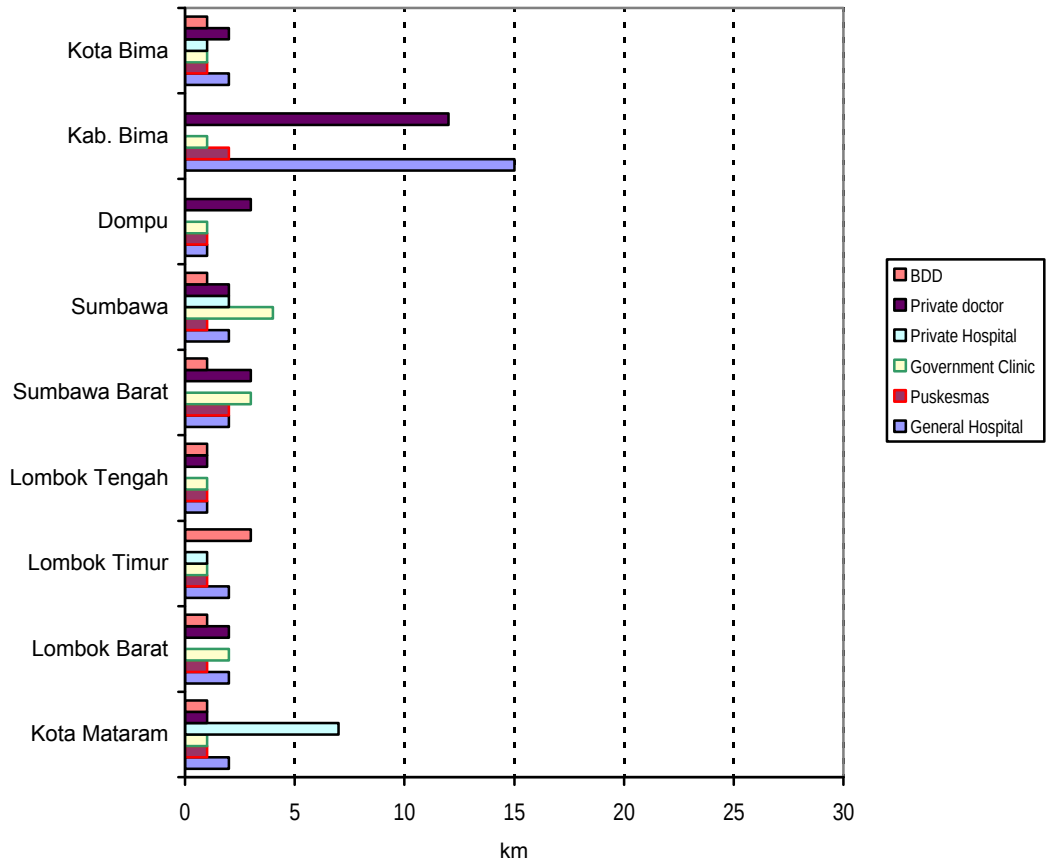
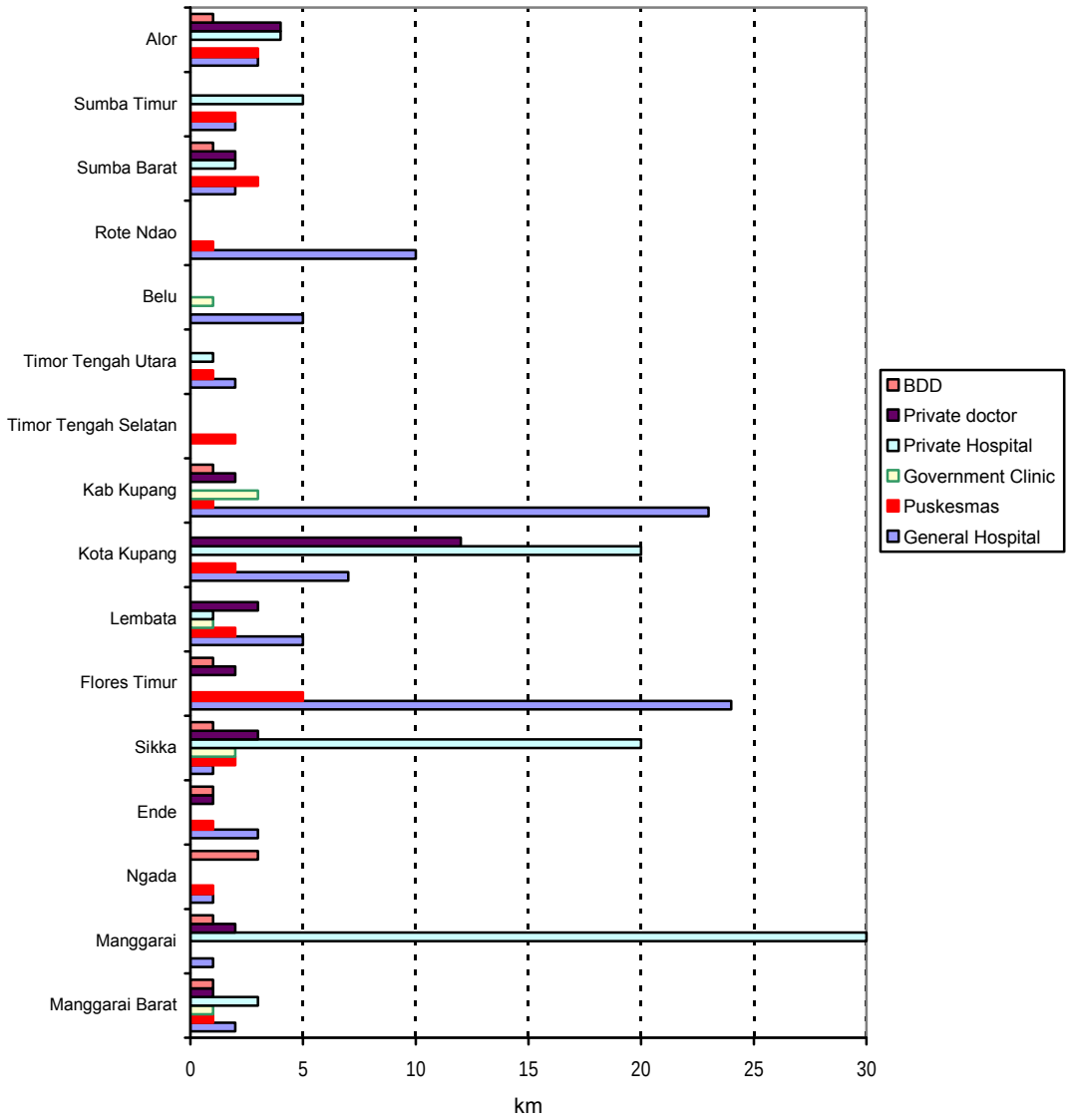


Figure 12.3 Median distance (km) from home to the last visited health facility in NTT



Generally, the transport mode chosen to reach the last visited health facility in both provinces was three favorite ways, namely walking, riding the car or motor cycle. Interestingly, horse cart (local term is 'cidomo') was common in NTB, but not so in NTT (table 12.5). Looking at differentiation by district, it was recognized that motor cycle was mainly used in most districts in Sumbawa island in NTB (table 12.5.a) and Kota Kupang in NTT. While in other districts in NTT, the transport was dominated by walking (table 12.5.b).

12.2. COST OF MATERNAL AND CHILD HEALTH SERVICES

Another component on the access on health services is the cost for services. Therefore, the study looked specifically at the perceived cost of MCH services at various sites based on experience in their last child. Services received by mothers were pregnancy complication treatment, delivery, delivery complication treatment, postpartum complication, and neonatal complication. In addition, to describe the findings statistically, median cost of those services was used as an average at the level of district or province.

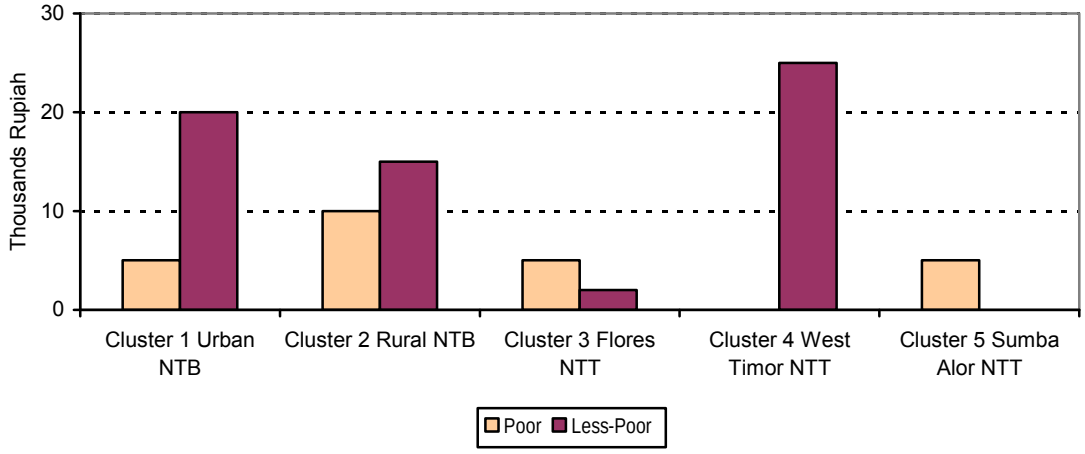
12.2.1. Cost of treating pregnancy complication

Under the private management, in both provinces, private hospital charged the service of treating pregnancy complication in the most expensive cost, which ranged from 30 to 220 thousands rupiah. Hence, generally, the cheapest cost recalled by mothers was for care provided by traditional healer, in only up to 10 thousands rupiah, followed by puskesmas, which normally asked up to 6 thousands rupiah (table 12.6). In between, averagely, government hospitals requested mothers to pay maximally 30 thousands rupiah in NTB and 6 thousands rupiah in NTT. Meanwhile, services provided by village midwife or BDD cost about 10 thousands rupiah in NTB, slightly was more expensive than in NTT 5 thousands rupiah.

Table 12.6.a and 12.6.b distinguishes the average (median) cost of this particular complication based on districts, and it exhibits that in NTB, the cheapest was offered by puskesmas and government clinic in about 3 thousands rupiah, except Lombok Tenngah. While in NTT the cheapest cost is BDD for the amount of 1 to 5 thousands rupiah. Meanwhile, the highest cost was recorded in mothers who visited government clinic for the amount of 500 thousands rupiah in NTB and 900 thousands rupiah for the cost to private hospital in NTT.

Furthermore, socioeconomic level influenced this payment for pregnancy complication. A closer look shows that majority mothers of non-poor households paid lower than from poor households, as occurred in Sumbawa Barat, Lombok Timur, Dompu and Bima in NTB, and most probably the insurance applied in that district could explain this phenomenon. However, evidence in Ngada, Ende and Lembata in NTT invites the questions, and nonetheless, the need for improvement in identifying the poor.

Figure 12.4. Median cost for handling pregnancy complication in NTB and NTT



12.2.2. Cost of birth delivery services

In term of cost, respondents in NTB mostly stated that having birth delivery at puskesmas and at home were being the cheapest (25 to 30 thousands rupiah), and the most expensive was at private hospital (700 thousands rupiah). In NTT, the cheapest was giving birth at home or at house of TBA or neighbor (25 thousands rupiah). Meanwhile, the most expensive cost was charged by private clinic or practice doctor (500 thousand rupiah) (table 12.7).

Looking at the district level, in NTB, yet mothers delivered their baby at her own house spent the lowest cost, except in Sumbawa (100 thousand rupiah) and Sumbawa Barat (300 thousand rupiah). Also, among others, respondents in Dompu reported that giving birth at village midwife (BDD) required cost as the lowest (5 thousands rupiah). In the opposite polar, the highest cost of delivery service was occurred in Sumbawa Barat for the services of private hospital for 2,250 thousands rupiah (table 12.7.a). For NTT, the figure was more varied, where most of districts show that cost spent for help done in house of TBA or neighbor and respondent's house have similar figure, except in Sikka, whereby its cost reached 200 thousands rupiah. In the meantime, village midwife (BDD) found to charge cost as the lowest in Manggarai (2 thousands rupiah) and also in Kabupaten Kupang and TTS (10 thousands rupiah). As well as NTB, the highest cost for birth delivery in NTT was for private hospital, in Kupang and TTU (5,000 to 6,000 thousand rupiah) (table 12.7.b). Pleasantly, cross tabulation of the cost for delivery by socioeconomic level demonstrates that the poor paid lower than non poor in all districts in NTB and NTT.

Figure 12.5 Median cost (thousand rupiah) for having delivery service by socioeconomic level in NTB

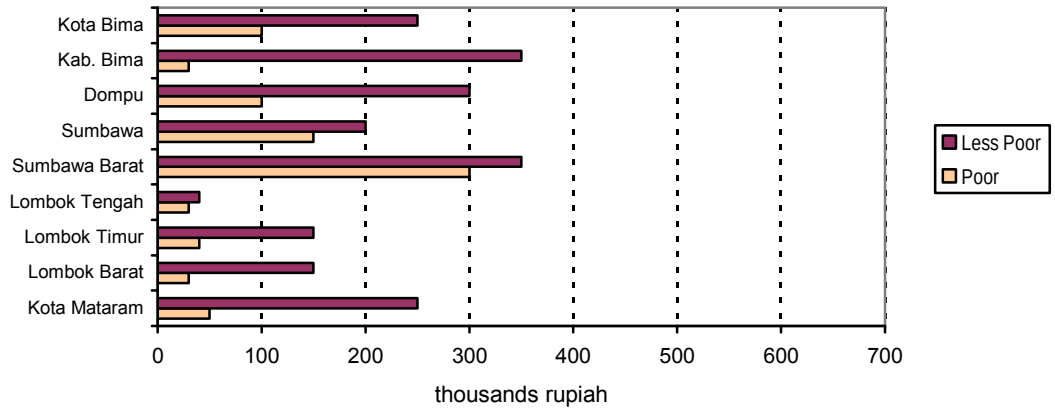
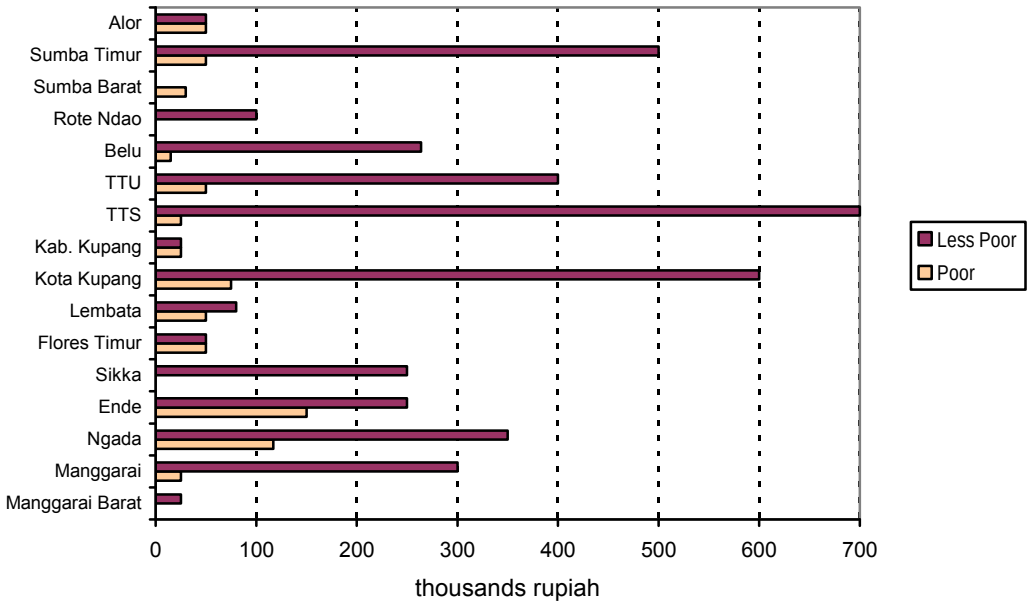


Figure 12.6 Median cost (thousand rupiah) for having delivery service by socioeconomic level in NTT



12.2.3. Cost of treating delivery complication

Complication occurred in birth delivery treated by private institution generally required higher cost, either at hospitals or clinics. However, some private hospitals in NTB decreased the charge, even lower than the government, to only 6 thousands rupiah, in contrast to 500 thousands rupiah in NTT (table 12.7.a). In spite of this high cost, commonly the government institution provided the services with low charge, ranged from zero to 25 thousands rupiah, and likely this was in accordance with insurance system.

At the district level, the lowest cost was recorded in Lombok Timur for having service at the traditional healer (2 thousands rupiah) and Lombok Barat for puskesmas (3 thousands rupiah). Meanwhile, the highest cost was identified in Kota Mataram charged by government hospital (1,000 thousands rupiah) (table 12.8.a). The situation in NTT was almost similar, where the maximum figure was obtained in Ende for government hospital service (2,000 thousands rupiah) and the minimum was at puskesmas in TTS (one thousand rupiah) and Lembata (3 thousands rupiah) (table 12.8.b).

Figure 12.7 Median cost (thousand rupiah) for treating delivery complication by socioeconomic level in NTB and NTT

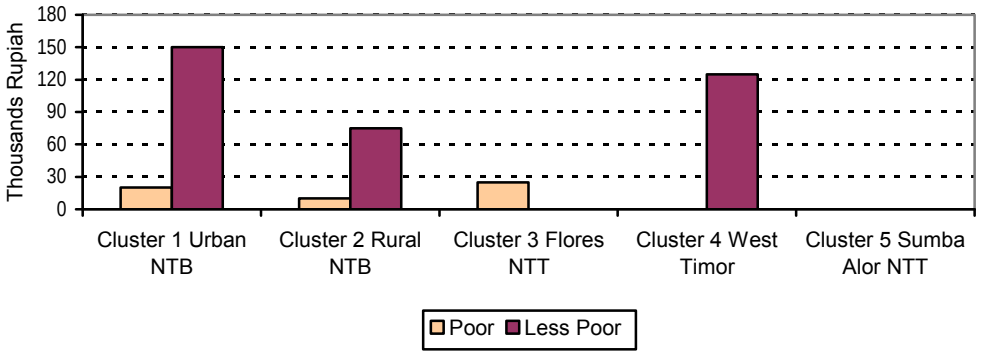


Figure in above describes that, in NTB, non-poor women who had birth delivery complication spent money higher than poor women. However, in NTT the evidence was in the other way around, and this calls for serious attention, especially in relation to insurance coverage. The detail figure by district could not disclose the clear phenomenon, since insufficiency in cases size per district.

12.2.4 Cost of treating postpartum complication

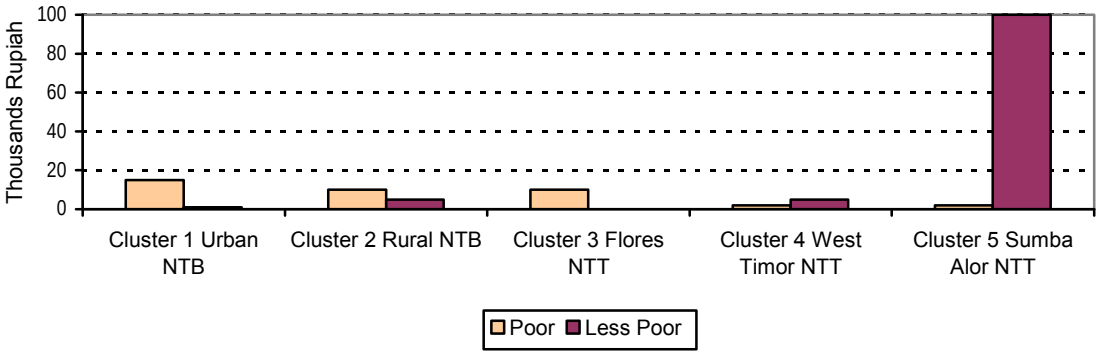
Postpartum complication is often ignored as a serious problem, though it actually also affects maternal survival. The effort to handle it depends on, among others, the access owned by mothers, including cost. Based on the table 12.9, notably in average, cost offered by private institution for this kind of services would be higher than the government services. This study revealed that women who got postpartum complication were asked around 2,000 thousands rupiah by private hospital in NTT, much higher than in other facilities. Cost of services at the government health facilities, covers hospital, puskesmas, and village midwife (BDD), was relatively low, ranged from 5 to 10 thousands rupiah, besides some cases were free of charge due to the insurance.

Details at the district level exhibit that mostly respondents looked for services at the puskesmas and village midwife (BDD) with the range of cost from zero to 25 thousands rupiah at puskesmas, and zero to 100 thousands rupiah at village midwife (BDD). The most expensive service was at the government hospital in Sumbawa Barat, NTB (2,000

thousands rupiah) and in Sumba Barat, NTT (500 thousands rupiah) (table 12.9.a and 12.9.b).

Graphs below is describing that payment scheme in NTB and NTT which not followed the universal pattern, poor women with postpartum complication had to pay more than less poor, except for cluster 4 and 5. However, if we look at the district figures, the pattern is not applied to all districts, only at Kota Mataram and Lombok Timur in NTB (table 12.9.a) and Kota Kupang in NTT (table 12.9.b). Again, this perhaps due to insurance system for the poor has still not organized and run well for the local people.

Figure 12.8. Median cost (thousand rupiah) for treating postpartum complication by socio-economic level in NTB and NTT

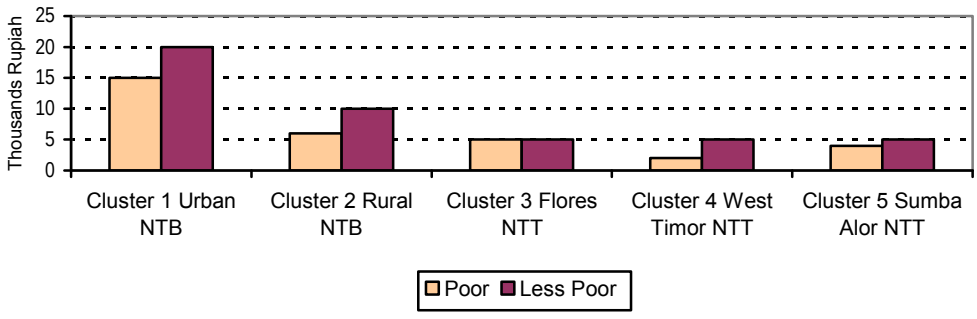


12.2.5. Cost of treating neonatal complication

In the case of neonatal complication, the cost for treating it factually ranged from 2 to 78 thousands rupiah in NTB and 1,200 thousands rupiah in NTT (table 12.10). The most expensive service was offered by government clinic in NTB and private hospital in NTT. At this time being, women had neonatal with complication who went to puskesmas should pay below 10 thousands rupiah, except in Sumbawa Barat NTB about 20 thousands, and in NTT around 25 rupiah in Manggarai (table 12.10.a and 12.10.b).

The question on whether poverty level has effect on the cost of neonatal treatment was explored, and this study found it follows general pattern in which less-poor women paid more than the poor. However, based on the districts, the scheme did not necessarily always meet that universal pattern, as happened in some districts. But this possibly was due to insufficient sample size for calculating the difference in those particular districts.

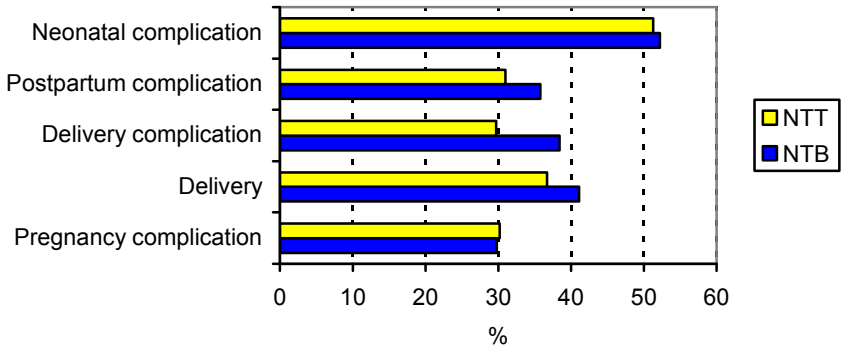
Figure 12.9. Median cost (thousands rupiah) for treating neonatal complication by socio-economic level in NTB and NTT



12.2.6. Perceived cost of MCH services

The findings on the cost of maternal and child health services written in above indicate that the highest amount of money spent by mothers was for birth delivery services, either in NTB or in NTT. Nevertheless, in overall, as the highest proportion, half of mothers perceived that cost of services for handling neonatal complication as the most expensive in both provinces; those were 52% in NTB and 51% in NTT, followed by birth delivery service, and service for handling pregnancy complication (in NTB) and postpartum complication (in NTT) (table 12.11). The discrepancy between the factual amount of money spent and perceived expensiveness was occurred in neonatal complication treatment, which could be meant as an unexpected event so mothers should prepare extra money for it, in contrast to delivery service cost which usually has been prepared prior to the birth date. Since in birth preparedness, discussion of wife and husband did not put contingency funding as a primary topic, so it is understandable that perception of mothers on the expensiveness of services would be mainly on the unanticipated complications.

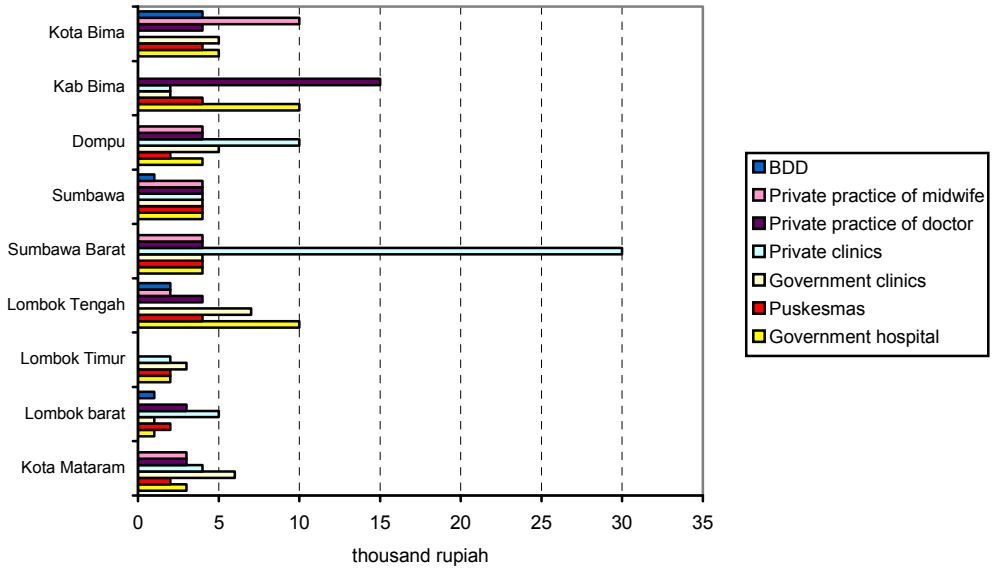
Figure 12.10. Percentages of expensive MCH services perceived by mothers in NTB and NTT



12.3. COST OF GENERAL HEALTH SERVICES

With referred to the last visit to health facility, this study covers two aspects explored in order to know the complement of cost of health services towards any condition, namely cost of transport to the facility, and perceived cost of drugs or remedies provided by the facility. Looking at the figure 12.11, puskesmas is recognized as a favorite place to go.

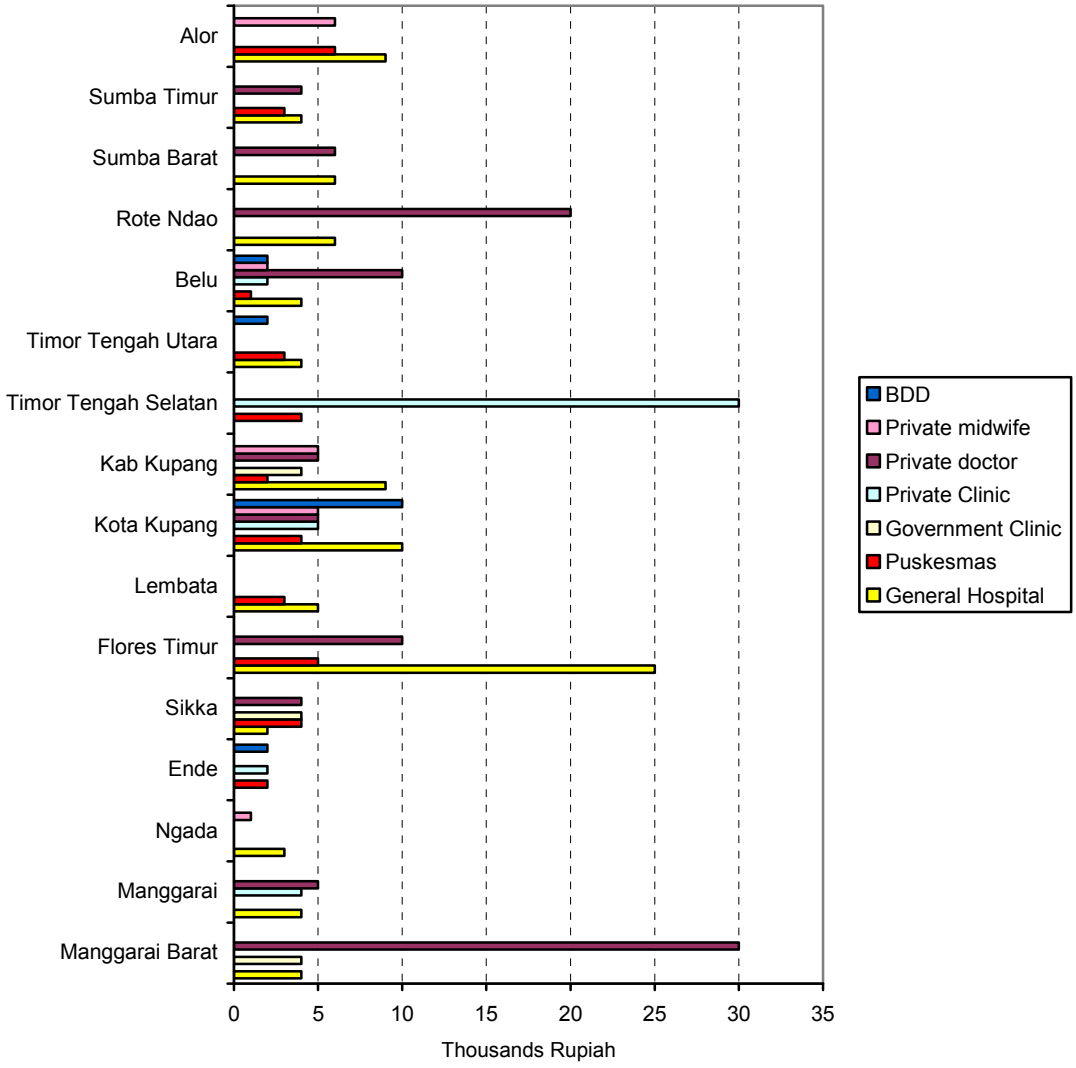
Figure 12.11. Median cost (thousand rupiah) for transport to last visited health facility in NTB



Based on tables 12.13.a and figure 12.14, in NTB, transport cost to reach government facilities, comprised hospital, puskesmas, and clinics, was 10 thousands rupiah or less. This was relatively lower in the amount of money, compared to cost for reaching private facilities, such as private clinics, private practice of doctor or midwife, ranged 2 to 30 thousands rupiah, the highest was in Sumbawa Barat. Yet for visiting village midwife or BDD, mothers still spent money for transport although it ranged from one to four thousands rupiah.

Figure below depicts the transport cost to health facility in NTT that has slightly different pattern with in NTB. Mothers went to government hospital in Flores Timur NTT, in fact, relatively paid a lot for more than in other districts up to 25 thousands rupiah. Likewise, this was related to geographical barrier as well that was existed in almost area in NTT. Hence, for reaching other government facilities, either puskesmas or village midwife, the transport cost was lesser than 10 thousands rupiah averagely, probably this was related to the distance as a consequence of quite well distributed facilities throughout the island. Meanwhile, transport cost for going to private facilities was higher, up to 30 thousands rupiah, as shown in Manggarai Barat and Timor Tengah Selatan (table 12.12.b).

Figure 12.12. Median cost (thousand rupiah) for transport to last visited health facility in NTT

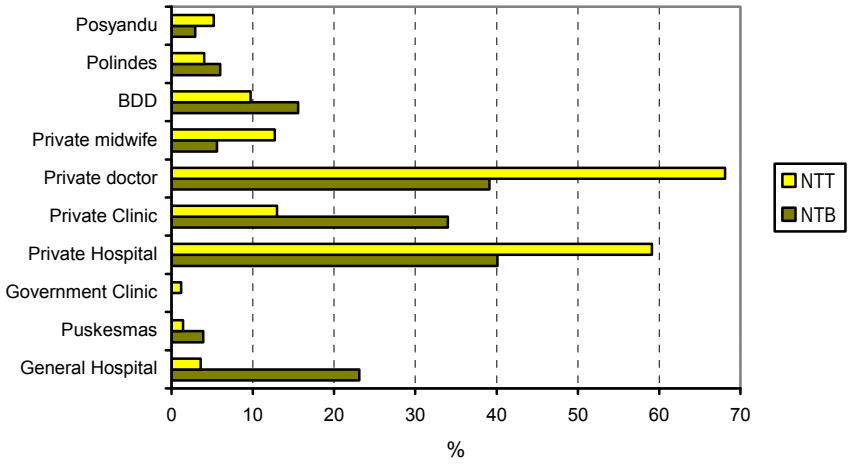


Considerably, puskesmas was found to be the most favorable health facility used by mothers in NTB and NTT for almost any kind of services, and besides disclosing on the

near distance, also the low transport cost added the reason for choosing it. Among others, drugs or remedy given by to the patient was also affordable. Moreover, only up to 4% of mothers perceived the cost of drugs or remedies given by puskesmas was expensive. This was likely because most of puskesmas provided subsidized treatment and medication. As estimated yet, mothers mentioned that cost of drugs or remedy was quite high in private clinics in NTB (40%), private hospital and private practice of doctor in NTT (60-70%) (table 12.13).

At the district level, NTB and NTT show a quite wide variation in the percentage of mothers telling the expensiveness of drugs or remedy. Data demonstrate that the expensiveness of drugs or remedy was occurred in services given by private clinics, besides private hospital. However, in Lombok Timur it was disclosed that issue in the services delivered by government clinic and private hospital (100%) (table 12.13.a). Inconceivably, in the district of Manggarai and Kupang, NTT, mothers told that private hospital or clinic provided the most expensive cost for drugs or remedy given to their client (100%) (table 12.13.b).

Figure 12.13 Percentage of perceived expensive drugs or remedy provided by health facility in NTB and NTT



12.4. HEALTH INSURANCE

In the year 2004, nationally, the regulation of applying insurance for the poor was issued through the decree of MoH, popularly called *askeskin (asuransi kesehatan bagi masyarakat miskin)*. Prior to that year, various type of insurance were tried to be provided such as JPS (*jaring pengaman sosial* or social security network), or SKTM (*surat keterangan tidak mampu* or letter of impoverished household).

By interviewing the respondents, there were 41% of respondents in NTB and 42% of respondents in NTT stated that they had no insurance at all, and moreover, 38% of respondents in NTB and 27% of respondents in NTT had *askeskin* card (table 12.15). The other few had other scheme of insurance, such as from private one.

Susenas (2004) data reported possession of health card was 34% and 38% of respondents in NTB and NTT respectively. Compared it to the study findings, yet NTB result was similar, but respondents in NTT reported lower than what Susenas disclosed, probably *askeskin* term was not so popular, and they understood more of JPS or SKTM

instead. Finding from an in-depth interview explains that NTT likely had a high coverage for health insurance for poor and its implementation was running well in the region.

> *"Most of people in District of K has already covered by askeskin and social health insurance, it is almost 78% and the rest of 22% still in being assessed by K District Health Insurance, namely JK3 (Jaminan Kesehatan Kabupaten K)"*
> *(DHO, NTT)*

> *"At the District of S, the District Authority of S has given health insurance for the poor family. It means that every poor family who need services can receive a 3rd class service at the Hospital, and they do not have to pay because the District Authority of S will pay for the services"* *(DHO, NTT)*

Basically, insurance for the poor or *askeskin* is supposed to be benefited by the poor only. However, a small portion of non-poor families (13%) had *askeskin*, either in NTB or in NTT. Factually, around 39% of poor in NTB and 28% of poor in NTT stated their joining in *askeskin*. Nevertheless, among poor women, around half of respondents did not have any kind of health insurance, which were 45% in NTB and 57% in NTT. Thereby it indicates there was still a problem in identifying the poor.

Figure 12.14 Percentage of having health insurance for poor (*askeskin*) by socioeconomic level in NTB

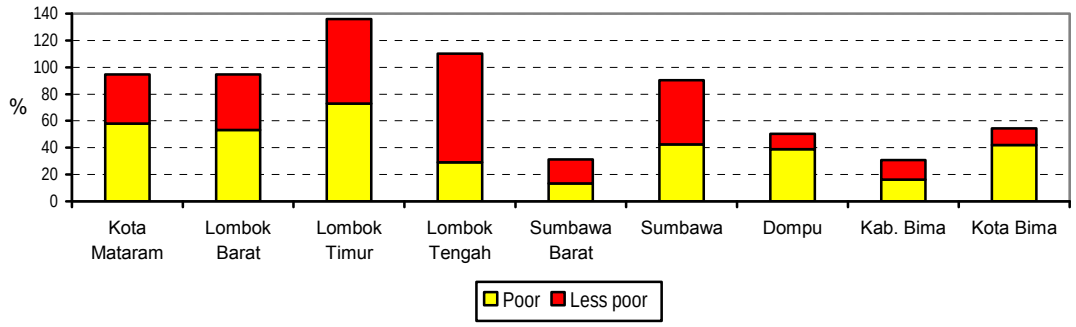
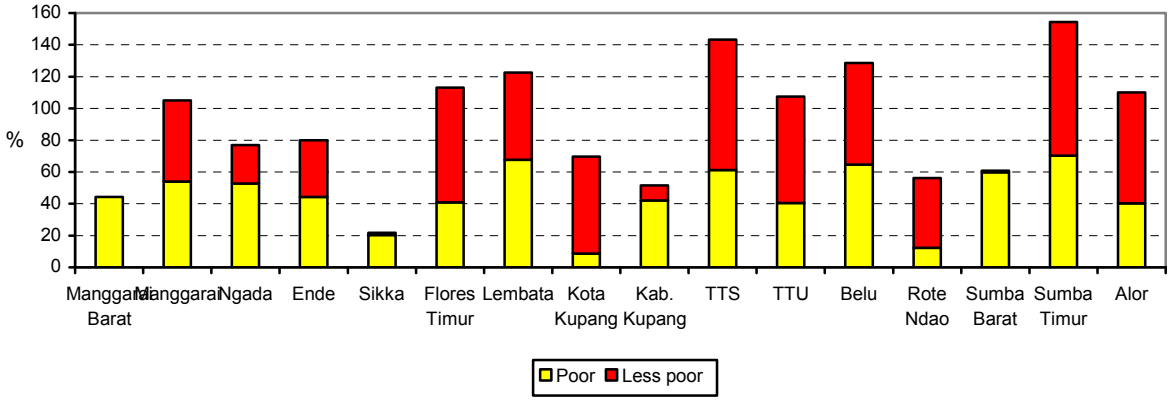


Figure 12.15. Percentage of having health insurance for poor (*askeskin*) by socioeconomic level in NTT



According to the figures 12.15 and 12.16, in overall, not a single district had covered completely all poor families with *askeskin*, instead it was only less than half. Details in the district level shows that, in NTB, the lowest percentage of *askeskin* engagement among the poor was in Sumbawa Barat (13%), and the highest was occurred in Lombok Timur (73%). Meanwhile among less poor, questionably Lombok Tengah recorded the highest figure for the *askeskin* ownership (81%) (table 12.14.a). In NTT, the lowest

percentage of *askeskin* ownership among poor families was in Rote Ndao (12%) and Kota Kupang (9%), while the highest, 70%, at the District of Sumba Timur. Among less poor women, the highest percentage of *askeskin* coverage was at the District of TTS (82%) (table 12.14.b).
Meanwhile, of the respondents who had insurance card, its utilization was almost 52% of NTB respondents and three-quarter in NTT. However, averagely, across the clusters, utilization of *askeskin* was quite good (60% to 81% in NTB and NTT respectively) (table 12.16). Report of Susenas (2004) shows that utilization of health-card was mostly for treatment (63% of NTB and 92% of NTT), prenatal care and giving birth (11% in NTB and 21% NTT) and family planning services (12% in NTB and 17% in NTT).

Description of any health insurance use at the district level shows that Lombok Timur (59%) and Sikka (71%) had the highest percentage for utilizing health insurance each in NTB and NTT respectively. In particular, for utilizing *askeskin*, the highest percentage were in Dompu and Kota Mataram (both 75%) and Manggarai (90%). The lowest percentage for *askeskin* utilization, as the consequence for the lowest ownership on *Askeskin*, was occurred in Sumbawa Barat (5%) (table 12.15.a and 12.15.b).

Additionally, finding from FGD explains that not all informants knew about health insurance card, and the distribution of the *askeskin* was somewhat not too well.

> *"I've never heard about askeskin, but there is gakin-card here, in this region"*
>
> *"Yes, we have askeskin, but have not yet socialized"*
>
> *"May be the distribution is not so evenly, there were some people who receive and some were not receive the card. Suppose that the officer in charge is not so familiar for the condition of this region" (FGD of father, in NTB)*

Besides the usefulness of *askeskin,* informants also stated about mild discrimination in obtaining the services at the health facility.

> *"Yes, the advantage of askeskin can reduce the cost that has to be paid for the hospital services" (FGD of fathers, in NTT)*
>
> *"Yes, there is health insurance for the poor, the white ones, from the Mayor"*;
>
> *"I think there are no difficulties on using gakin-card. I am very glad that it can help us"*
>
> *(FGD of mothers, in NTB)*
>
> *"It's useless to use gakin-card at Puskesmas; you will only have prescription and not even touch for physical examination" (FGD of fathers, in NTB)*
>
> *"It is said that using askeskin for hospital services will be acceptable, but in fact, it is not"*
>
> *"I have an experience in seen one family that having interrogation by administration officer as they use the JPS, and they receive a very slow services, and they have to prepare the letter of notification from the kelurahan and SKTM"*
>
> *(FGD of fathers, in NTT)*
>
> *"I've ever use the askeskin, but I'm not satisfied with the services, it's too slow"*
>
> *(FGD of mothers, in NTB)*
>
> *"I have tried to use askeskin someday to have services in the hospital, but they have refused, even I also brought the referral notification from Puskesmas".*
>
> *(FGD of mothers, in NTT)*

Although respondents had and utilized health insurance card for obtaining health services, but still a few (11% to 19%) was requested to pay additional money by the provider, and half or more for buying drugs or remedies (table 12.16).

At the district level, the highest percentage of respondents who had to pay supplementary cost was in Sumbawa (39%) in NTB, and Ende (42%) in NTT. Mostly the extra payment was for buying drugs or remedy, such was expressed by over 80% of respondents in Dompu and 88-96% of Belu and Alor (table 12.16.a and 12.16.b).
Furthermore, among the respondents who had insurance card, the source of extra money to complement the needed cost of services was shown in table 12.17. Mostly they preferred to borrow money from the neighbor (63% and 36% in NTB and in NTT respectively), or from their family or relations (45% and 56% in NTB and NTT).

Nevertheless, based on the district descriptions (table 12.17.a and 12.17.b), although most women looked for the additional money by borrowing it to neighbor, but not in the districts of Sumbawa and Sumbawa Barat, whereby they asked for help in their family first. This later action was also taken by mothers in almost all districts in NTT, except Manggarai and TTU which more likely asking help from the neighbor.

CHAPTER 13

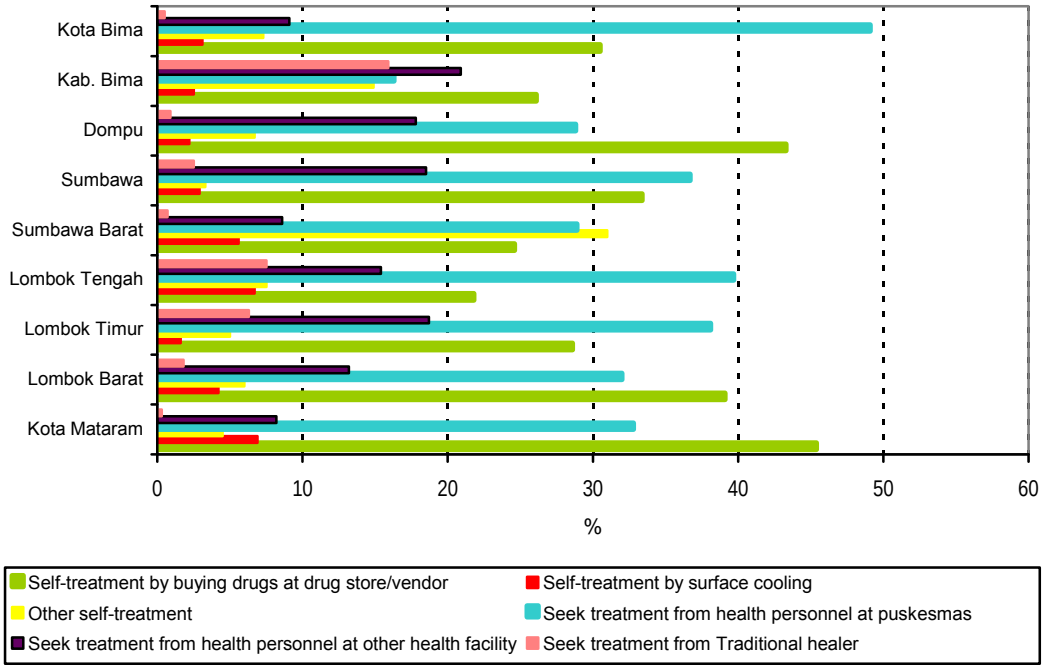
TREATMENT SEEKING BEHAVIOR

To our knowledge, behavior is influenced strongly, among others, by the culture thus people behavior on seeking treatment in Indonesia is almost typical ones. This study explored the self or home treatment as well as seeking treatment outside of home in the case of complication during maternity period, or in common uncomfortable condition, namely fever.

13.1. GENERAL TREATMENT SEEKING

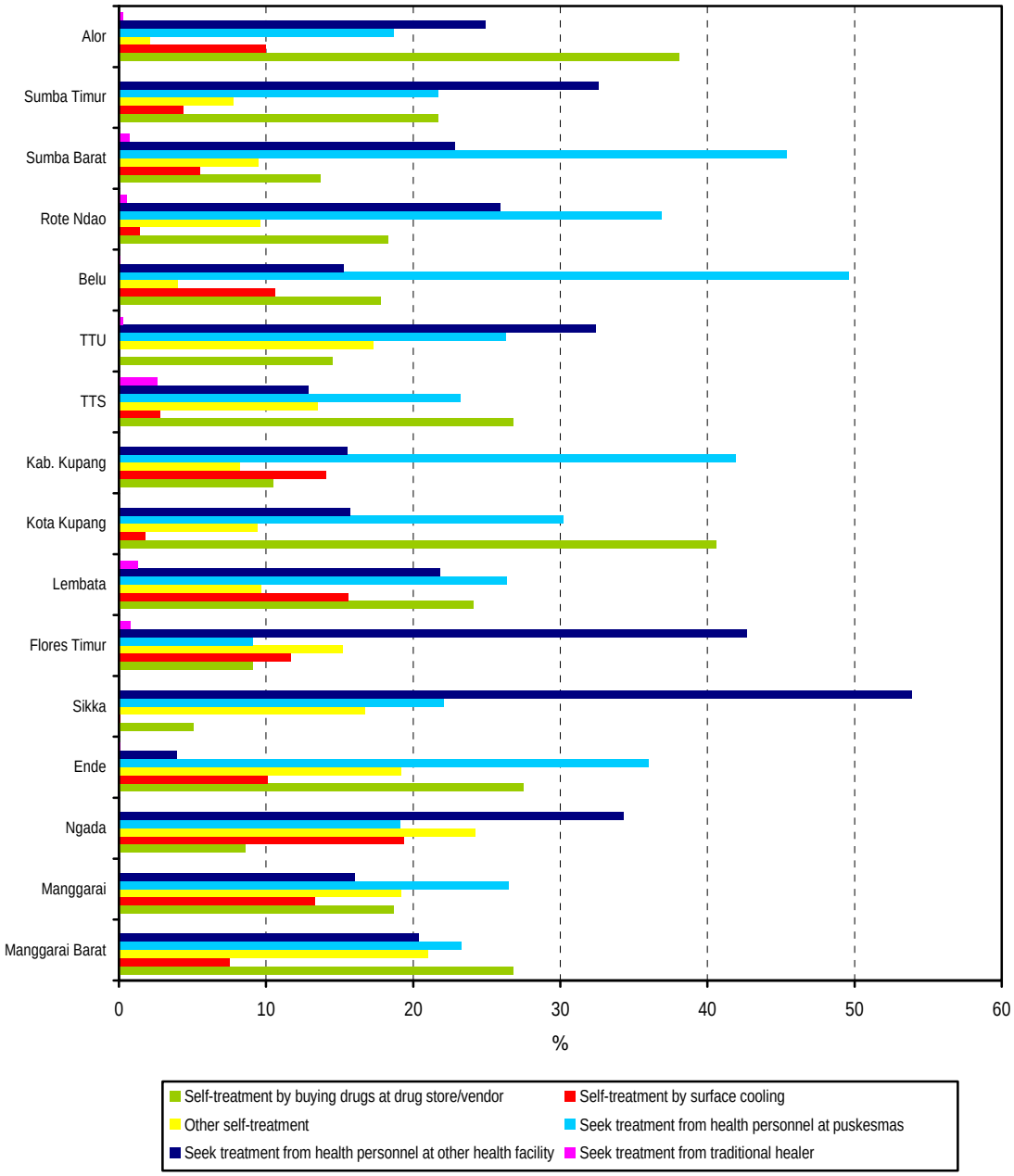
By questioning respondent on conditionally fever suffered by household member, this study revealed that in NTB, more people were likely to do self treatment first by buying drugs at small store (39%), besides going to puskesmas (34%) (table 13.1). Respondents in Kota Mataram, Lombok Barat, Dompu and Bima were those in this category. Interestingly, in Lombok Timur, Lombok Tengah, Sumbawa Barat, Sumbawa and Kota Bima, both action were also frequently mentioned but with the rank slightly in the other way around. Additionally, traditional healer was favorable in Bima (16%) (table 13.1.a).

Figure 13.1 Percentage of respondents taking the first action when fever in NTB



In NTT, similar pattern was occurred that people tended to seek help firstly from puskesmas (31%) and self treatment (25%). Hence, some mothers in Sikka and Flores Timur preferred to go to polindes and village midwife (BDD), and yet respondents in Ngada mostly did surface cooling for their first action towards fever (table 13.1.b). The finding was similar with report of Susenas (2004), which NTB had higher figure than NTT, in terms of having self treatment at the previous month, that was 72% and 58% respectively.

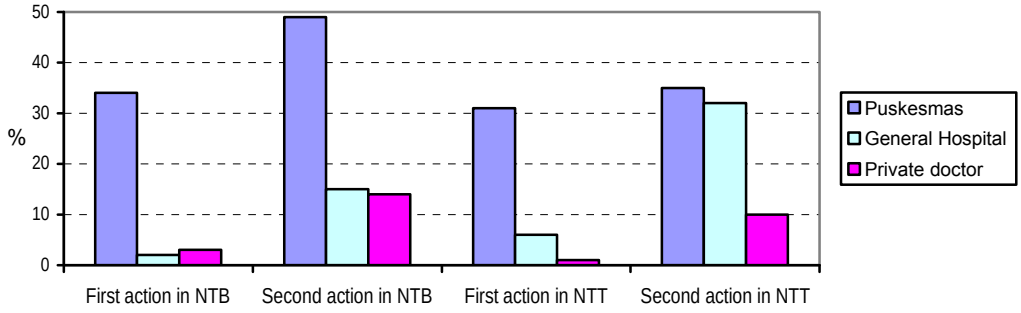
Figure 13.2 Percentage of respondents taking the first action when fever in NTT



Both in NTB and NTT, puskesmas was the most favorable place to go if the illness was not getting better after they tried the first action, such was 50% in NTB and almost 35% in NTT. Moreover, the other option was government hospital and private practice of doctor, and only a few went to non-modern health facility (table 13.2).

Some variation in this second step depicted in table by districts. For instance, only in Kota Bima in NTB, most respondents then went to private practice of doctor. In Kota Kupang, TTU, Sumba Barat and Timur, and Alor in NTT, majority thought of the government hospital. Notably, the traditional healer was chosen by one-ninth (11%) of respondents in Lombok Barat and Lombok Timur, and 8% in Ende (table 13.2.a and 13.2.b).

Figure 13.3. Percentage of first and following action taken when fever



The fact explored in FGD apparently follows the theory of treatment seeking behavior explained by Suchman, that the first action is employed by them selves, followed by going help outside of home. This study also disclosed that firstly self-treatment was carried out through the common actions taken namely taking symptomatic drugs, traditional herbs or potion, and going to traditional healers (*dukun or tamang*). When the illness was not getting better or even getting worse, afterwards they decided to seek treatment to health facility. Here are some recorded statements.

"If there is any family member got ill, it depends on the illness, if only mild I will do self treatment, but if it is severe then we will go to puskesmas, and if the illness is getting worse, we will seek treatment to the hospital";

"The main things are traditional treatment, if only mild, but when the situation is not going well, then we brought to puskesmas";

"To the dukun, then to the puskesmas" *(FGD of fathers in NTB)*

"Yes, we used to prepare paracetamol at home for curing the fever, if diarrhea we used to make a traditional potion from boiled water mixed with guava leaves or delima fruit"

"For me, if I got fever, I used to drink arak (high concentrated alcohol traditional drink)"

(FGD of fathers in NTT)

"If my child has a fever, firstly I will cure her with a mixture of red onion and eucalyptus oil, herbs, or else. And I try not to give her any chemical medication. If in three days there is no healing, then I bring her to puskesmas" *(FGD of mothers in NTB)*

"It depends on the illness, if diarrhea I will give anti diarrhea, and if fever, I will give paracetamol"

"I bought the drugs from the vendor, as puskesmas is far from here"

(FGD of mothers in NTT)

13.2. REASON FOR TREATMENT SEEKING

With the reference to the last visit to health facility, a variety of reasons were explored in this study. Majority of respondents proposed the reason in accompanying family members in relation to their not-well condition (52% in NTB and 42% in NTT), besides for tackling the same problem of respondents themselves (14% in NTB and 27% in NTT). More explanations on their action were disclosed such as looking for the care in outpatient services for family member (18% in NTB and NTT). In other words, the reason for visiting health facility frequently was seeking the outpatient services, perhaps due to mild illness. Nonetheless, only four to ten percents of respondents visited facility for the purpose of asking family planning services (table 13.3).

Differentiation by district shows that, in Dompu, half of women (52%) searched the antenatal care. The respondents of other districts told the similar reason as, in majority, looking for outpatient care, for example in Bima (31%) and Sikka (63%). Meanwhile, birth delivery was only mentioned by less than 10% of respondents (table 13.3.a and 13.3.b).

Interestingly, mostly women visited village midwife (BDD) for the reason of asking for physical (medical) examination or obtaining some drugs or remedy for their complaint. The pattern in NTB and NTT, and between women with and with no children under-five years were similar (table 13.4 and 13.5). Additionally, to get family planning services was the reason told by more mothers in NTB than in NTT, and higher number in women with children under five, who were younger, than women with no children under five. Although village midwife did not undertake the services much for the later group, but empowering village midwife to improve prevalence of contraceptive use in NTT could be done. Meanwhile, only less than 20% of respondents confessed that their motivation was concerning with their birth delivery in both provinces.

Figure 13.4. Percentage of reason for visiting the health facility in NTB and NTT

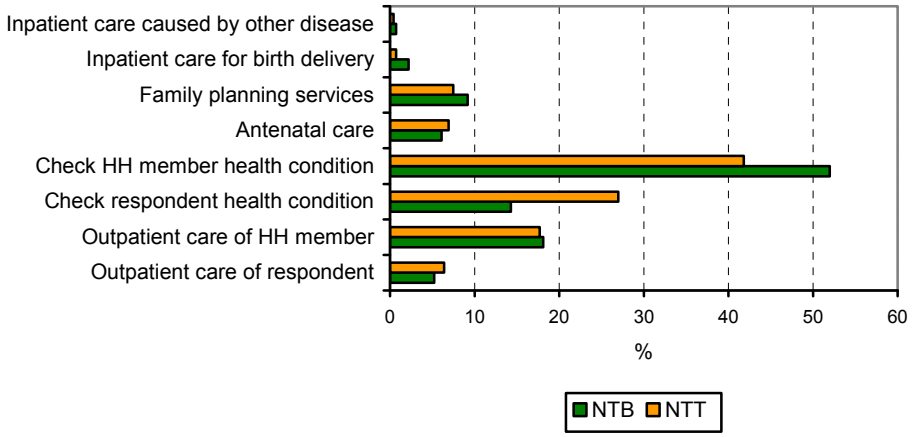
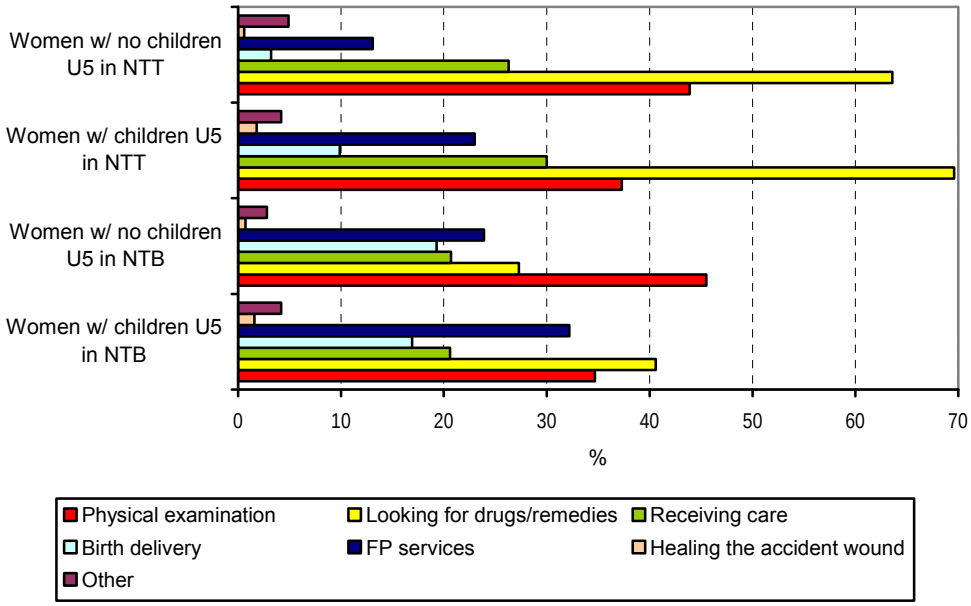


Figure 13.5. Percentage of reason for visiting village midwife (BDD) expressed by women with and with no children under five in NTB and NTT

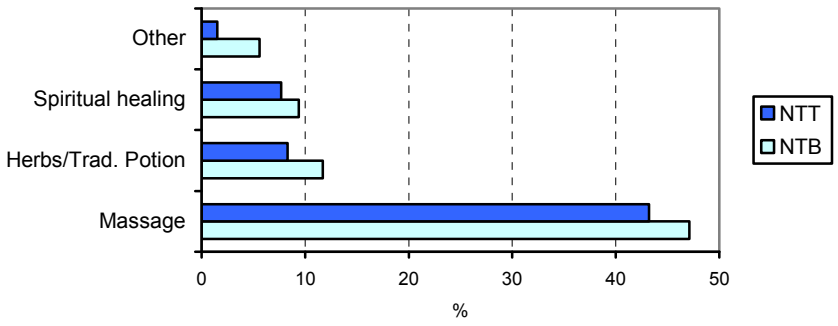


In details, as written in table 13.4.a and 13.4.b, and table 13.5.a and 13.5.b, it can be seen in NTB and NTT that both groups of women with and with no children under five had a same pattern of reason in searching for village midwife (BDD) services mainly that was for medication. It can also be seen that in almost all districts, both services for birth delivery and family planning were likely lower in percentage among women without children under five. Noticeably, that in NTB, in some districts, women with no children under five had higher percentage in visiting village midwife for the purpose of family planning services. This was quite interesting for taking the lessons from this description and need for further analysis to look for the chance to increase the contraceptive use in NTT.

Hence, traditional birth attendance (TBA) has important roles in the community (table 13.6). Surprisingly, figure 13.6 shows that most of respondents used TBA services for obtaining body massage as the physical therapy. Findings from FGD and in-depth interview also discover that some informants acknowledged that TBA was needed for having pregnancy examination, delivery assistance, and after delivery services. They also recognized that TBA had collaboration with village midwife (BDD) in giving birth delivery services.

> *"There are a lot of things that dukun can treat, any kind of disease, including when pregnant, as well as cancer"*;
>
> *"I never brought my wife to puskesmas. I used to bring her to TBA to get womb examined, to make sure that the baby inside is in a good condition"*
>
> *(FGD of fathers, in NTB)*
>
> *"Almost all of us are used to have dukun's services"*
>
> *"My wife gave birth at home, and has been assisted by skilled TBA, who has trained by the Health Authority Office in this region"* *(FGD of fathers, in NTT)*
>
> *"If assisted by the midwife, we have to wait for a long time for the opening, and always have the incision. While TBA always uses natural way in assisting the delivery, without any incision or any sutures"*
>
> *"When pregnant… we used to have tamang for assistance. Its impossible for us to gave birth at the Hospital as we cannot afford it"*
>
> *"The midwife will also look for TBA at polindes, they work together to assist the delivery. The TBA has also had to complete tools and instruments" (FGD of mothers in NTB)*
>
> *"..... except for delivery assistant, we use TBA services especially when there is breech position of the fetus, then the TBA will do reposition or giving massage to the womb"*
>
> *"As vehicles (for transport) are very rare here, we are afraid the women will soon give birth.. and before we call for midwife, we get TBA first"* *(FGD of mothers in NTT)*

Figure 13.6. Percentage of reason for visiting traditional healer in NTB and NTT



CHAPTER 14

PERCEIVED QUALITY OF HEALTH SERVICES

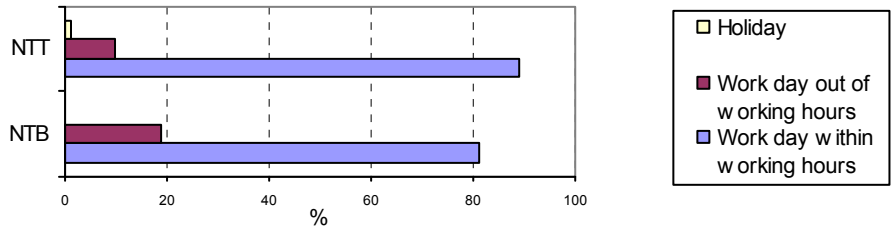
Quality of health service can be assessed by two approaches, through provider and client perspectives. Since this study done at the community level, so the quality of services can only be measured by asking the mothers, as the clients, in regard to their experience during they received the services provided by health personnel, namely perceived quality of services. However, this subjective appraisal has a limitation; especially clients did not know medical and technical aspect of the services. Additionally, a previous study, the Essential Reproductive Health Study (UNFPA and CHRUI, 2002), done among others in NTT, showed that a subjective opinion tended to give a 'satisfy' statement, this might be occurred as respondents had no other experiences in using other health facility services.

14.1. HEALTH SERVICES ON THE LAST VISITED FACILITY

Based on the figure 12.1 generally puskesmas was the most frequent facility visited by the mothers in both provinces. Government hospital was used more in NTT rather than in NTB, and posyandu was slightly higher in number of visitors in NTB than in NTT.

To see details at the district level, in NTB, puskesmas was the least visited in Bima (30%) and the highest at Kota Bima (69%). At this time being, in NTT, in some districts, the visitors of puskesmas was relatively rare, such in Ngada, Sikka, Flores Timur, Lembata, TTU, and Sumba Timur have figure less than 40%. Eventually, table 12.1.a and 12.1.b indicates the insufficient sample size was occurred in several districts. Obviously it made analysis for the health facilities other than puskesmas should be taken cautiously, especially in the advanced analysis or complex or multiple cross tabulation.

Figure 14.1. Distribution of visit time to health facility in NTB and NTT



Using the respondent's perception on the working hours, it was revealed that most of respondents of NTB and NTT (81% to 89% respectively) likely preferred to go to the health facility on the work day within working hours. (table 14.1 and 14.1.a). Furthermore, in regard to the chosen time the mothers visited health facility in NTB and NTT, their main reason was their time availability (48% and 60%), besides they expected to get better care or services (25% and 21%), and at that current time they were really suffered by illness (16% and 27%) (table 14.1). While most of the districts in NTB and NTT had a same trend, the District of Sumbawa Barat had some what different pattern, which was dominated by unbearable illness at that time, looking for the better care or services, and affordability or cheaper (table 14.1.a). This result had to be interpreted carefully since perhaps the existing service was offered by health facility only in the time the respondents visited.

"... Majority hospital is likely to be visited, but in the evening puskesmas gives the services as well... but not hospital....."

(*FGD of father, NTT)*

Figure 14.2. Percentage of respondents of having reason for choosing time of visit to health facility in NTB

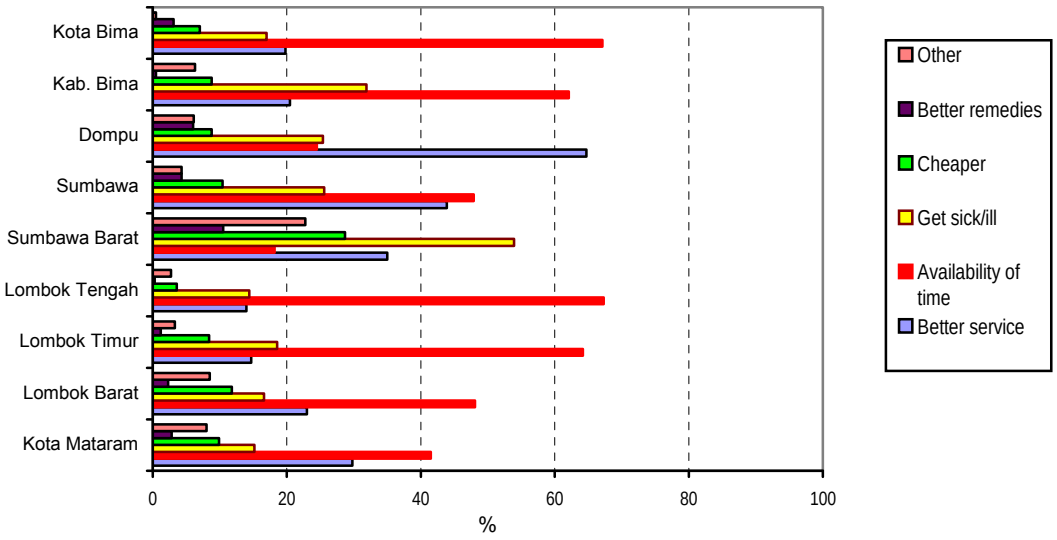
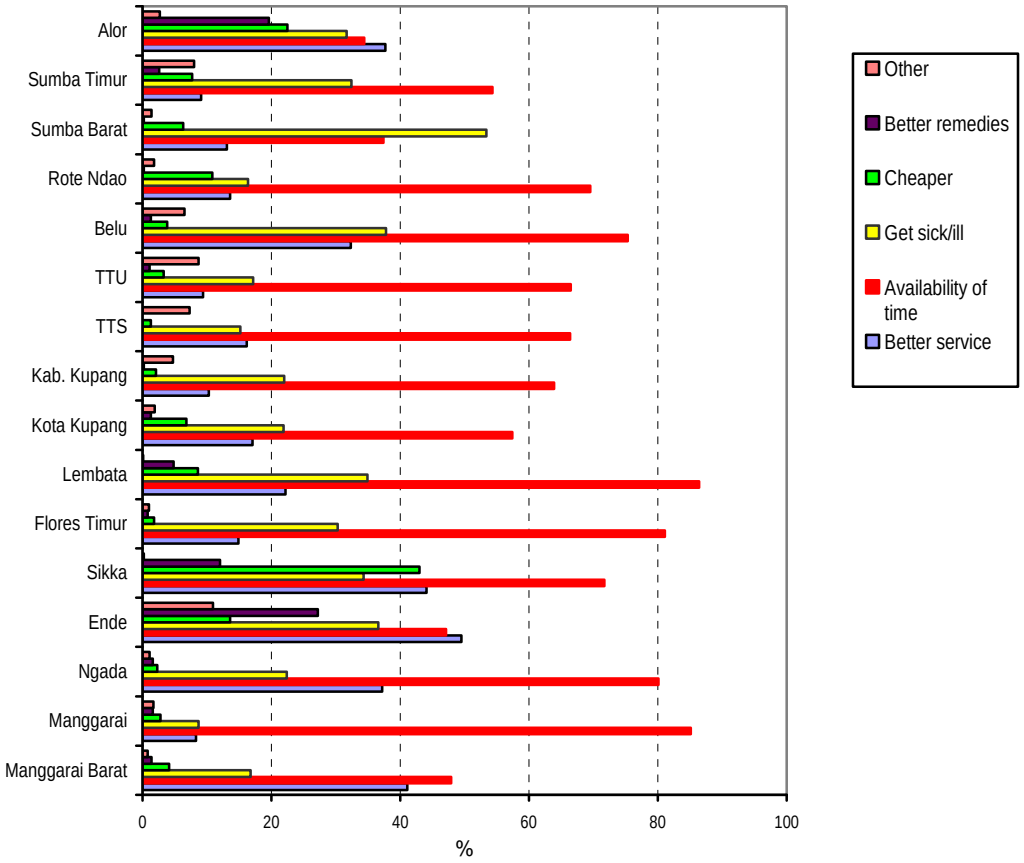
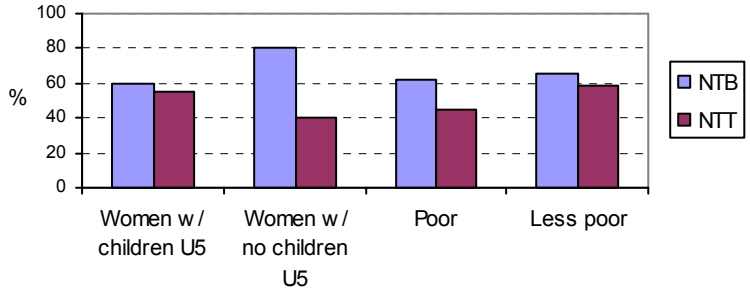


Figure 14.3. Percentage of respondents of having reason for choosing time of visit to health facility in NTT



Interaction between health provider and the respondents was valued by themselves, and the opinion was reflected in the response of sixty and eighty percents of women with and without children under-five in NTB, who perceived that health personnel was available at any time in giving services. This was quite high appreciation, and the pattern of that availability in the two groups was nearly similar in each of socioeconomic levels, poor (62%) and less poor (65%). Hence, NTT had slightly different pattern, both groups of women in fact was almost equal in numbers. Moreover, mothers of poor household (45%) rated health provider a bit unavailable than mothers of less-poor (60%) (table 14.2).

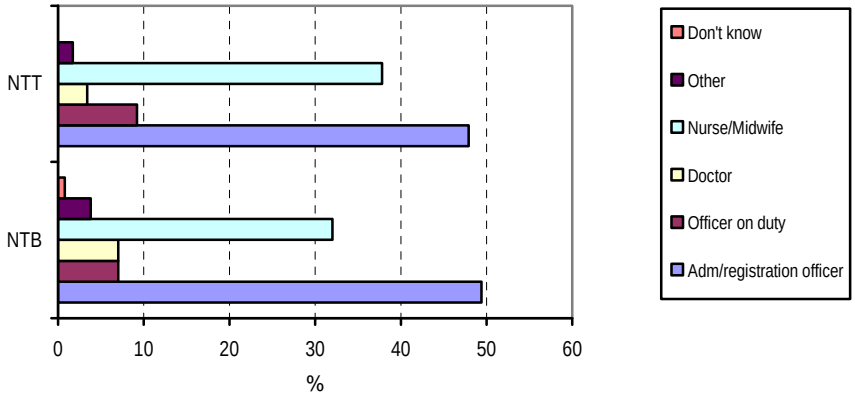
Figure 14.4. Percentage of available health personnel as perceived by respondents among women with and with no children under five, and poverty level in NTB and NTT



Description at the district level portrays that a quite wide range of percentage in figuring the health personnel availability was existed. In NTB, the lowest percentage was 40% of women with children under-five and the highest (98%) was almost all of women without children under-five in Kota Bima (table 14.2.a). Meanwhile, in NTT, the lowest percentage was recorded in Kota Kupang as 28% of women with children under-five, and the highest was achieved in Rote Ndao as 96% of women without children under-five (table 14.2.b).

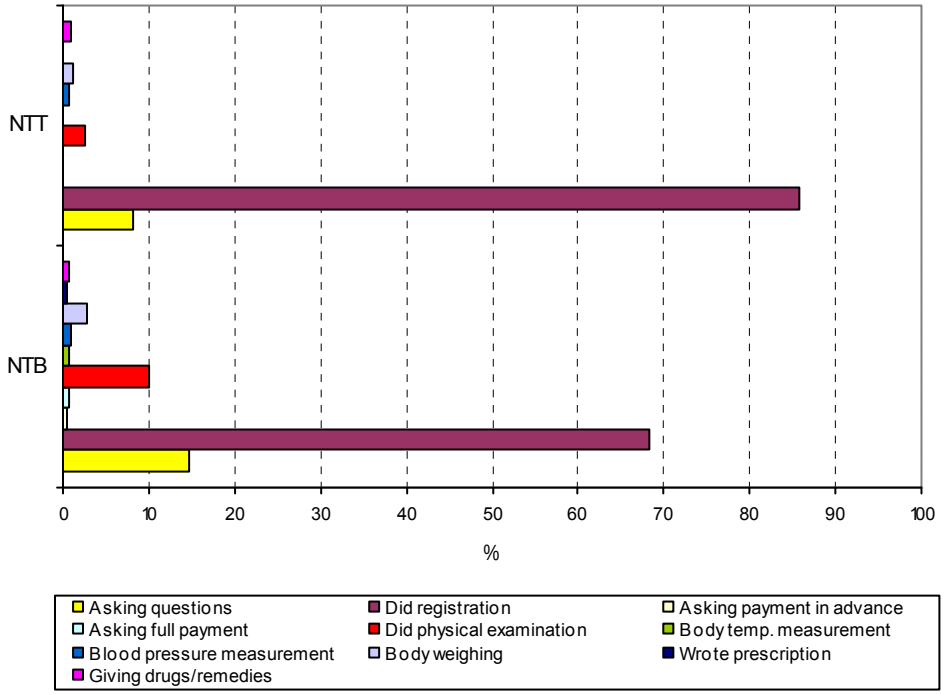
In both provinces, the common person who receives clients for the first time in health facility was mostly the administration/registration personnel besides the nurse or midwife (table 14.3). The trend was quite same across the districts, except in Sumbawa Barat and Sumbawa in NTB as well as in Lembata and Sumba Barat in NTT, where officer on duty was the second person frequently mentioned (table 14.3.a and 14.3.b). The client's first impression and obtaining complete information were on the hand of those administration or registration personnel and also midwife or nurse, so ignoring their role should be avoided, since the gate to the services was going through them.

Figure 14.5. Percentage of first person met in the last visited health facility



Generally, the health care provided in the facility is supposed to meet the standard operating procedure. However, in this study, figure 14.6 demonstrates that the universal first action carried out by health personnel was registration and asking question to the clients were in common. Variation across the district was also small. Certain proportion of mothers reported that health provider did physical examination directly at the first time they interact, specifically in Lombok Timur in NTB (table 14.4.a) and Manggarai Barat in NTT, but in Sumba Timur some mothers also reported on payment in advance. It can be sid that improving the IEC component in the services then is highly needed.

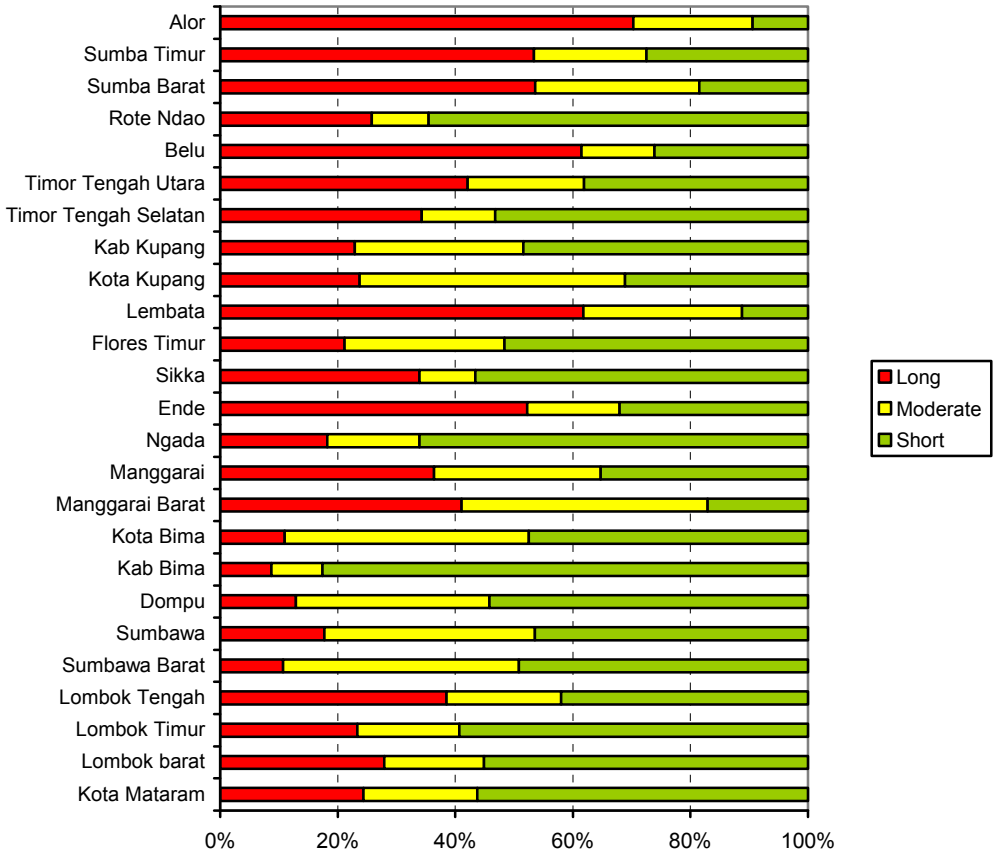
Figure 14.6. Percentage of first action carried out in the last visited health facility



The other key quality indicator is waiting time, which refers to as duration since the client arrived in the facility until they received the medical services. Averagely (median) time spent for waiting in NTT (20 minutes) was longer than in NTB (10 minutes), but both reflected as long enough (table 14.5); and variation across the districts in NTT was found to be higher (ranged from 10 to 60 minutes) than in NTB (ranged from 10 to 15 minutes).

Moreover, surprisingly, half of respondents in NTB and more than one third in NTT, perceived it as short time. A closer look by districts shows that Sumbawa island, for example, has districts that had a few of percentage of long waiting time. Hence, picking up this indicator might be viewed with care since it was probably influenced by the local culture which gives the room for interact with other people during they wait for the medical services. Nevertheless, inevitably, of mothers, 26% in NTB and 40% in NTT, recognized the time as too long, and it requires more concern.

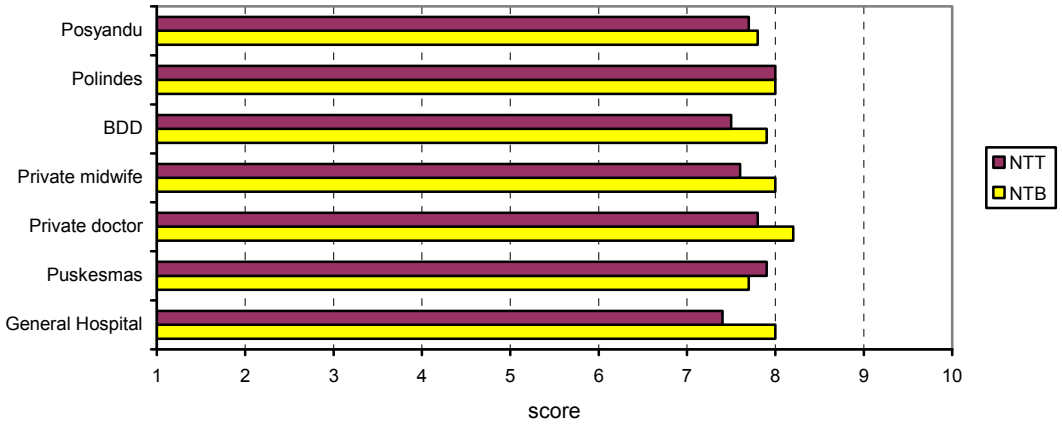
Figure 14.7. Percentage of perceived waiting time in the last visited health facility



14.2. PERCEIVED QUALITY OF HEALTH FACILITY

To measure the quality of health services provided by health facility, mothers were questioned on ten items of services, covering the aspects of tangible and non-tangible, and each item then was valued ranged from 1 to 10. To the end, the total score could be calculated, which was ranged from 10 to 100, and finally divided it by 10 to get means in the scale of 1 to 10. For statistical description, median score then was calculated. In overall, the finding of this study portrays that the range of median score for various services in NTB and NTT was around 4.7 to 9.6 across the districts (table 14.6). In other words, generally respondents categorized the quality of service as fairly to nearly satisfy. Consistently, finding from ERH Study using exit interview to the clients in NTT similarly showed that 84% stated that they were fairly satisfied with the service received from the health facility visited (UNFPA and CHRUI, 2002).

Figure 14.8. Median score of perceived quality of any services by type of health facility



Particularly, maternal and child health services made mothers satisfied enough, with the range score between 6.7 and 9.6 for antenatal care services (table 14.7), and between 6.9 and 9.6 for birth delivery services (table 14.8). Additionally, it can be noted that an extremely high appreciation was addressed to private clinic in Rote Ndao for antenatal care services and private midwife and polindes in NTT for delivery service. Meanwhile, private clinics for birth delivery service were scored higher in both provinces. Eventually, respondent's satisfaction in Manggarai towards delivery services is mostly low, excep services in the government and private clinic, and BDD (table 14.8.b).

Regards to the family planning services, the score is quite good, ranging from 5.8 in polindes at Dompu to 9.6 in government clinic in Sumbawa and Dompu, NTB (table 14.9.a). While in NTT, the score is ranging from 4.7 for general hospital in Manggarai to 10.0 for private clinic in Rote Ndao and private doctor in TTS (table 14.9.b).

Figure 14.9. Median score of perceived quality of maternal health services in NTB

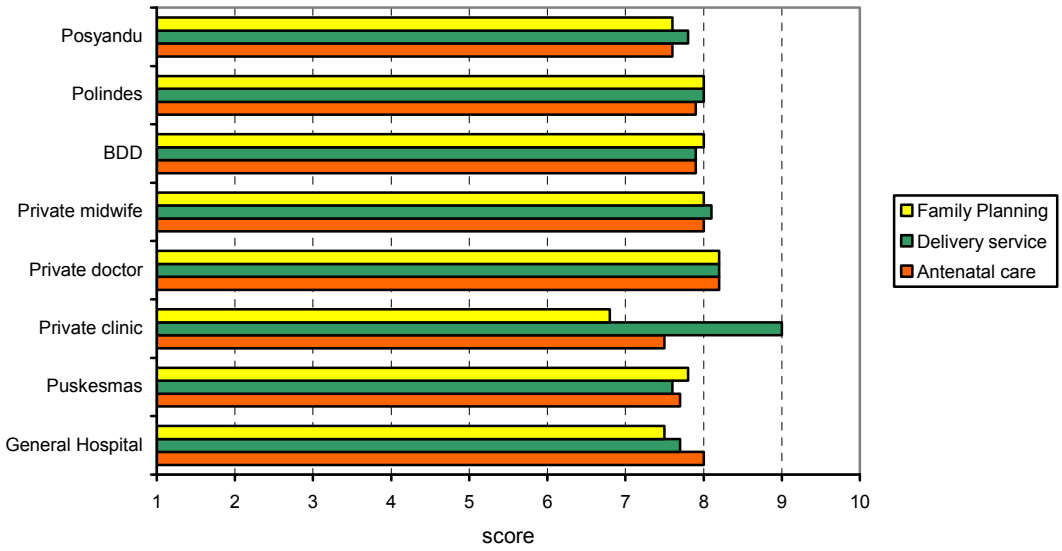
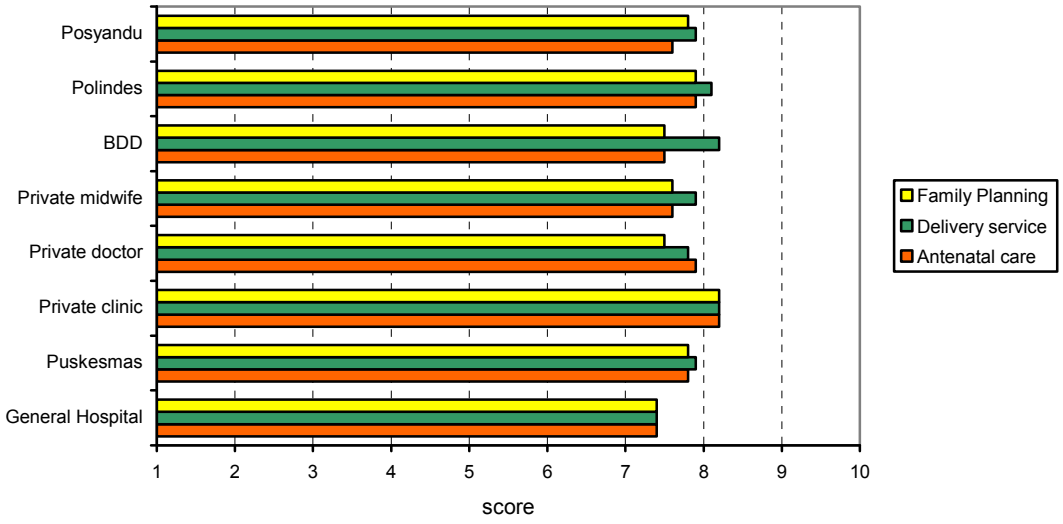


Figure 14.10. Median score of perceived quality of maternal health services in NTT



In regard to the services for the purpose of healing the illness, the respondents then were asked about their satisfaction. Generally, it was mentioned explicitly in the score of 7.2 to 8.5 NTB gave a good score for these facilities, namely private practice of midwife (8.5), private hospital (8.4), and private practice of doctor (8.2). In NTT, a good score ranged between 7.5 and 8.3, and it was given to government clinic (8.3), private clinic (8.2), and polindes (8.1) (table 14.10).

Respondents' satisfaction towards child health examination for health facility in NTB is consisting of good score for private clinic (9.0), and private practice of doctor (8.4). In NTT, the high score is given to government clinic (8.3), private clinic (8.2), and private practice of doctor (8.0) (table 14.12). Refer to immunization services, in NTB, a high score was pointed to private practice of midwife (8.3), village midwife (BDD) (8.0), and polindes (8.0). As in NTT, the high score was addressed to government clinic (8.3), private clinic (8.2), and health mobile service as well as polindes (7.9) (table 14.11).

Figure 14.11. Median score of perceived quality of child health services in NTB

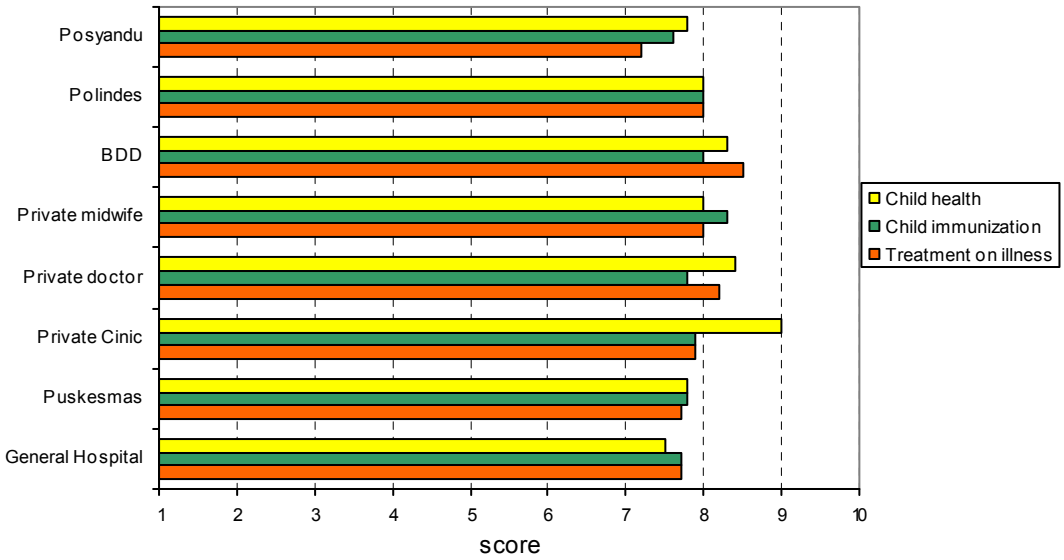
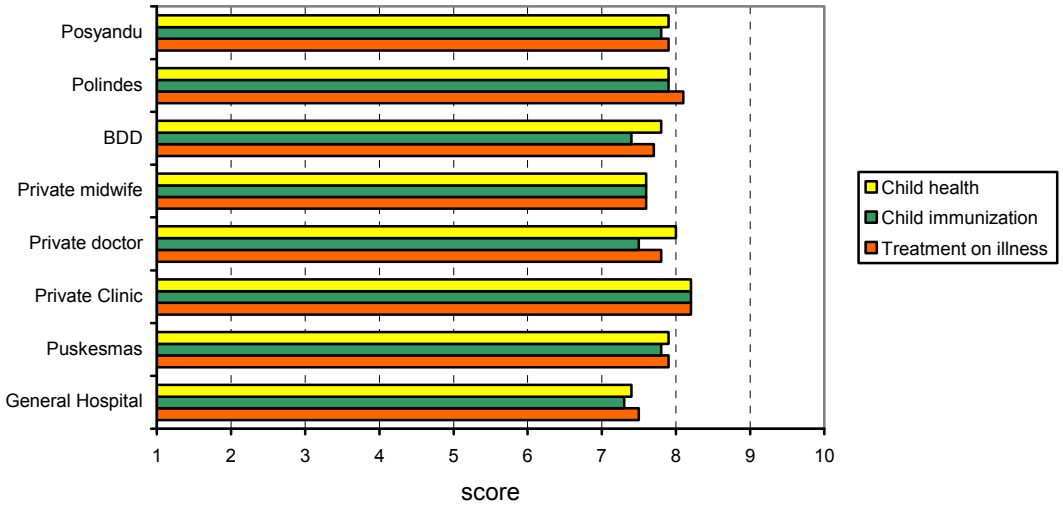
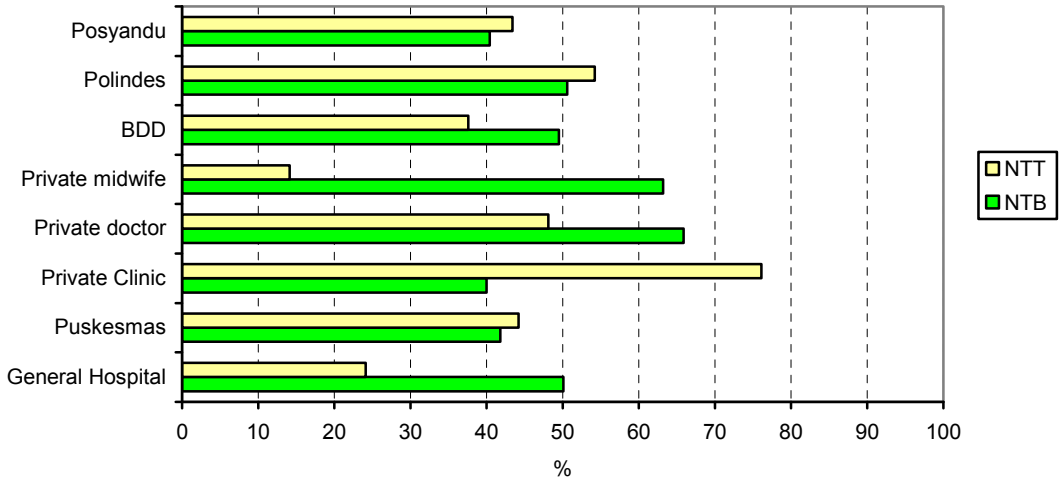


Figure 14.12. Median score of perceived quality of child health services in NTT



Eventually, since the subjective valuation on the health services experienced by mothers was averaged in the "good" category, so further analysis tried to disclose the group of having score 8 and higher, and further was viewed as high score of satisfaction. Factually, smaller percent of mothers were satisfied by government hospital services in NTT (18%), in contrast to what measured in NTB (50%). Almost similar evidence was noticed in the services of private practice of midwife, in which respondents in NTT (14%) were more unsatisfied than in NTB (63%) (table 14.13).

Figure 14.13. Percentage of high score (≥ 8) of satisfaction in health services



According to table 14.14, NTB and NTT have the same pattern on the socioeconomics level influenced the degree of satisfaction on hospital services in which the higher the socioeconomics level, the lesser the satisfaction of mothers. Likewise, in general, government hospital must improve their quality standard. Interestingly, this socioeconomic level did not affect the satisfaction with puskesmas services, either in NTB or in NTT. Meanwhile, for village midwife services, the higher socioeconomic level, the more satisfaction is stated.

Despite valuing at the detail level, finally a question on the general satisfaction was asked, and it looks likely that mothers who were very satisfied was relatively smaller in

percentage than other categories. However, description in both groups portray that almost all of respondents were very satisfied or satisfied by the services provided. Specifically, mothers were very satisfied with private clinics services in both provinces. Besides that, women were also satisfied with the services provided by village midwife or BDD (table 14.15). Notably, in NTT, posyandu and government clinic need attention since proportion of satisfaction was less than 80% (figure 14.14).

Figure 14.14. Percentage of very satisfied and satisfied in health services in NTB

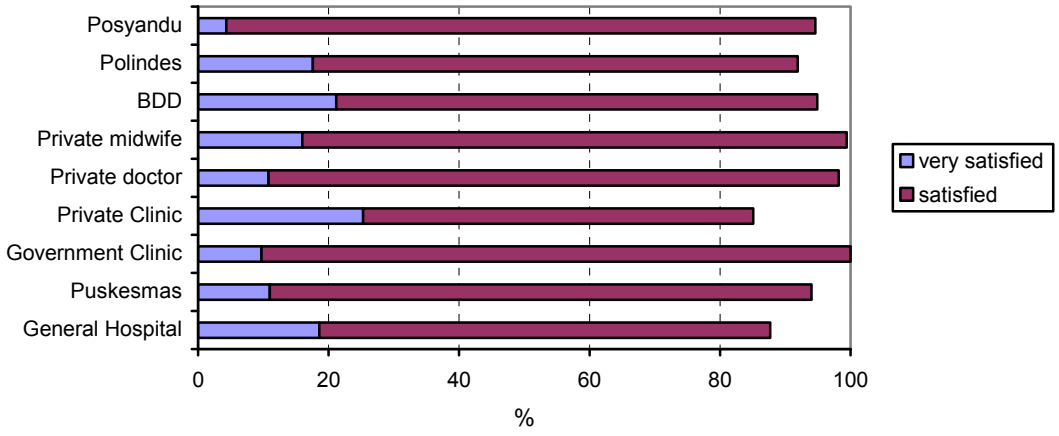
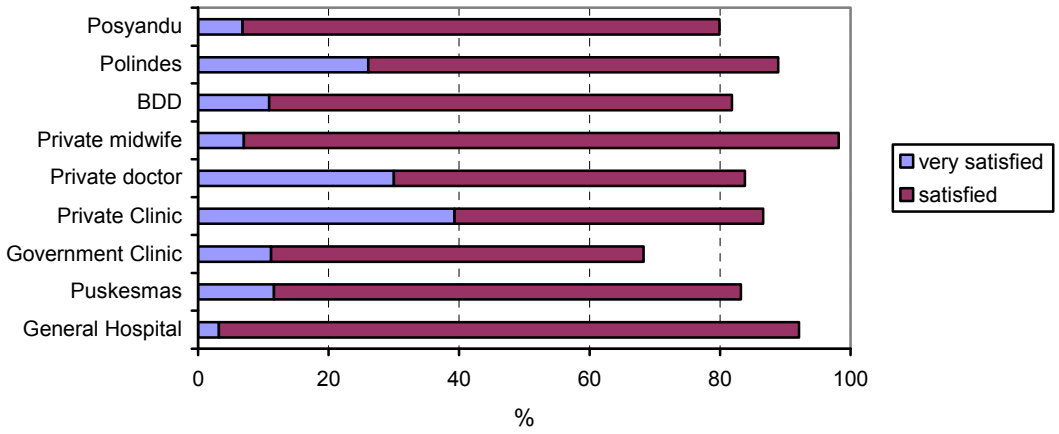


Figure 14.15. Percentage of very satisfied and satisfied in health services in NTT



In addition, recommending other people to come to certain health services reflects the satisfaction as well. This study revealed that almost all respondents still recommended other people to come to the chosen facility (table 14.16). Indeed it was not so related with mothers' satisfaction, and so it invites further analysis.

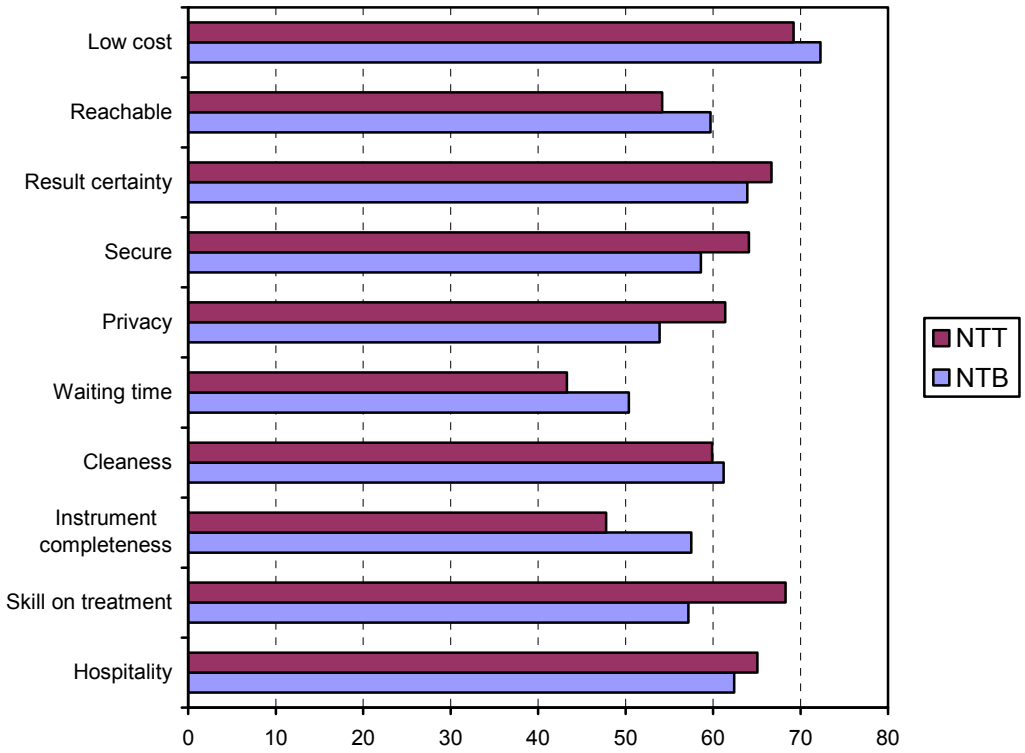
Interestingly, in case those respondents were not satisfied by health services, some action would be taken. Apparently, mothers in NTB would not upset in front of health provider but behind them and it was in contrast to in NTT whereby women would say it explicitly (table 14.17). This was depicted in the table 14.17.a, such as mothers in 96% in Sikka and 46% in Ende would be upset, and 45% in Ende would complain to the chief of health facility. However, there are 46% in Ngada and 69% in Flores who will be angry behind the person. In NTB, as table 14.17.a, there are 12% in Sumbawa Barat and 7% in Kota Bima who choose to write down for suggestion box, and 18% in Bima for angry behind the health providers.

In-depth interview to some stakeholders underlined the study findings that the quality of health services needs to be improves.

> *"(posyandu) is running well, uses 5 tables. Mothers come to posyandu because of afraid of punishment ….*
> *" It is good, the hospital is managed by sister, and their role is very good… the cost is moderate…"* *(Stakeholders in NTT)*
>
> *".... posyandu services is not so good…"*
> *"private hospital is an alternative.... people can choose the service... although the cost is quite high..".* *(Stakeholders in NTB)*
> *" .. many critics... firstly, people are not fully healthy... the socializing of health information is rare to be carried out... either from DHO or puskesmas .... posyandu is existed already, but only weighing the baby ... immunization .... so actually, the health personnel should do it....".*
> *(FGD of fathers, NTT)*

Furthermore, respondent's satisfaction towards puskesmas services are reviewed based on 10 components of services which has quite high score of 8+. In both provinces, it seem that waiting time for receiveing services as an critical problem, beside the medical instrument completeness in NTT need to be noticed. In overall, respondents in NTB gave higher score for puskesmas than NTT (table 14.18).

Figure 14.16 Percentage of high score (≥8) of satisfaction with puskesmas in NTB dan NTT



CHAPTER 15
CONCLUSIONS

This baseline study at the community level was conducted in all districts in NTB and NTT, which implemented in two times period, in the beginning and in the middle of the year of 2007, and employed the quantitative and qualitative methods. Survey selected totally 8372 households with women had children under five as the main respondents, in addition to 791 households with women had been pregnant but with no child under five, whereby households chosen using complex sampling design. Focus group discussions were administered in Lombok, Sumbawa, West Timor, Sumba and Alor islands, in 44 discussions, besides 110 in-depth interviews to five stakeholders in every studied district.

The result of survey shows the respondents of women with children under five were in the age younger (20 to 30 years) and less working outside of home (38% in NTB and 28% in NTT) than women with no children under five (34 to 35 years old and working of 42% in NTB and 20% in NTT). Children averagely aged 24 months in NTB and 21 months in NTT. Education level of mothers and household members in NTT was better than in NTB. However, females were under educated twice than males. The quality of the house in both provinces mostly was poor. The study shows devastating socioeconomic levels in both provinces, in which almost all households were below poverty line, using either the $1 or $2 per capita per day cut off point, or score calculated using the BPS model. Head of households mostly were males, and the average size of household was 5. The decision maker in health aspect mainly was taken by respondents as housewives, but the similar number was also happened together with husbands.

Fertility and family planning
The pregnancy rate, children ever born, and children still alive were occurred not too different across the provinces. The age at first pregnancy was below 20 years old. NTT has fertility rate higher than NTB, as shown in birth spacing shorter than in NTB. The contraceptive currently used was 44% in NTT lower than 74% in NTB. The popular methods were three-month injection, pill and IUD. Issue on contraception availability and monitoring of contraceptive side effect in health facility was revealed.

Antenatal care
Lack of quality of antenatal care services was disclosed. Indicator of K1 pointed out the first visit in first trimester of pregnancy in NTB was higher than in NTT, so were K4 reflecting minimally 4 visits. However, only half of mothers received minimally five kinds of services (weighing, tetanus toxoid injection, blood pressure measurement, abdominal examination, and iron tablet distribution) as indicated in K4-q indicator. The figure of K4-q in NTB is around 25% to 55%, while NTT has around 11% to 70%. Notably, blood test and anti-malarial drugs in antenatal care should be completely carried out.

Dukun was still popular for antenatal care. Yet, mothers chose midwife (90%) for antenatal care, and also *dukun* (78%) in both provinces. The level of knowledge of mothers in maternal complication was still low, in which half knew the maternal dangerous sign. In fact, half of mothers reported having any pregnancy complication, in NTT it was higher than in NTB. Mostly they took rest immediately, and one third of mothers went to puskesmas.

Birth delivery
As birth assistance, *dukun* was chosen by one third of mothers in NTT (38%) and one fourth (26%) in NTB. Majority of the remaining selected midwife as the birth attendance. Home as their birth place was also favorable in NTT (60%) than in NTB (30%). About one third of mothers reported delivery complication, comprised early broken amnion (16%), prolonged labor (13%), and bleeding (10%). In NTB, getting rest was chosen as their first action taken, and puskesmas, hospital, village midwives and polindes, were their reference to go when they seek treatment outside of home. In NTT, dukun competed with village midwives.

Neonatal and postnatal care
Generally, contact made in neonatal period by 60% of mothers. Majority they went to midwives to check their newborn babies health. Informing breastfeeding, warm the baby and umbilical cord care were some of often mentioned the services received by mothers.

Occurrence of neonatal complication was confessed by 32% in NTB and 40% in NTT. Mostly the types of complications were diarrhea, coughing, and high fever. Resuscitation was reported by 10% of mothers. The ways to handle the complication mainly were going to puskesmas. The pattern in both provinces was the same. Postpartum contact in NTT was done earlier (3 days) than in NTB (7 days). Overall, this postpartum complication occurred more often in NTT (28%) than in NTB (13%), in which often mentioned were postpartum fever (12% in NTT and 8% in NTB), while low birth weight was reported in around 8%. Considerably, there is a possible association of postpartum and neonatal complications with *dukun* as birth assistance.

Child feeding practice
Around 85% of mothers reported that they give colostrums to their babies. Prelacteal feeding was quite high (27% in NTB and 38% in NTT) mostly formula milk. Exclusively, breastfeeding up to the age of 6 months was very low in percentage given in only 16% of babies in both provinces. Diversity of their food in children older than two years old was not maximum, since there was still one third did not get it. Overall, percentage of good child feeding practices was very low (13% in NTB and 10% in NTT) and higher in boys than girls.

Child health
Child diarrhea in the last two weeks was frequent (35% in NTB and 25% in NTT). Likely it relates to small proportion of mothers with habit of hand-washing using soap. For self treatment, one fifth of mothers in both provinces did giving more fluid. Moreover, puskesmas was the main reference for care seeking, besides private practice of doctor.

Acute respiratory infection was happened in 6% of children in both provinces. The mothers look after the children by doing self treatment through giving cough potion. Furthermore, puskesmas was looked for, besides doctor and midwives. Meanwhile, suspected malaria was reported in 7% of the children, and mothers gave antipyretic drugs for them, besides herbs or traditional potion.

Complete immunized children aged 1 to 2 years were less than 80%, while measles achieved 83% in NTB and 91% in NTT. MCH book owned by almost all mothers does not show its effect on the level of knowledge on maternal and child health, which is still low.

The under-nutritional children in both provinces were quite high, strike jumping at the age of 6 months to 12 months, and by the age of 24 to 35 months, half were stunting and underweight, and one forth was wasting. This condition might be related to bad child

feeding practices as well as high prevalence of communicable diseases such as diarrhea. Poverty shows its effect, in which the poor has higher under-nutrition cases.

HIV and AIDS
The level of knowledge of mothers on HIV/AIDS was low, since percentage of ever heard of HIV/AIDS was 44% in NTB and 59% in NTT. It should be noticed that mostly mothers are not so comprehend on knowing that condom can prevent the spreading of the disease, as only 3% to 7% who know the function of the condom. Frequent sources of information stated were television, radio, and newspaper.

MCH source of information
In NTT, mothers heard about MCH in the last one year (69%) were more frequent than in NTB (54%). Health personnel were their sources (37% in NTB and 51% in NTT).

Access to health service facility
The closest health facilities in both provinces were posyandu, polindes, and puskesmas in terms of distance and duration of time spent. The expensive service reported by mothers generally was the private facilities.

Cost for delivery services was highest among others. However, cost for handling neonatal complication was perceived as being expensive. Likewise, it relates to birth preparedness of family or community on anticipating complication such as not thinking of contingency fund. Strengthening the community preparedness is underlined. Cost for transport from home to health facility averagely five up to ten thousand rupiah. Cost for drugs provided by private health facilities was perceived as being expensive. In case of lack of funding, majority would borrow money from their neighbor or their family.

Coverage of health insurance was around 60% in both provinces. Factually, of all mothers, 38% in NTB and 22% in NTT, mentioned of having *askeskin*, although it was recognized that a few was less-poor.

Care seeking behavior
When mothers faced the problem of household members suffered from fever, mothers would buy drugs from store or vendor, besides going to puskesmas. Furthermore, puskesmas was their reference if this fever was not recovered (50% in NTB and 40% in NTT).

Perceived quality of health services
Generally respondents evaluated the health services in the category of satisfied fairly to good, in the range of score 7.1 to 8.8 using 10 scales. However, high satisfaction score (8+) portrays that all modern health facilities need quality improvement. A special attention is addressed to puskesmas that should concern the waiting time to include as one indicator of quality on health services, and in NTT the completeness on the medical instruments should be underlined.

Recommendation

1. Puskesmas needs to be improved, in terms of privacy (room management) and completeness of equipment.
2. Human resources:
    a. Puskesmas personnel should be enhanced in their skill, either medical or managerial, resulting the waiting time as one of indicators showing quality of care, might be shortened.
    b. Bidan Di Desa (village midwife) might be considered to have higher right to deliver the simple curative services.
    c. To consider the strategy of reducing dukun successor, such as giving the chance to them to enroll in school of midwifery for being able to be midwife.
3. For improving health education, poster and MCH book shall be designed by considering local culture. An effort to encourage mother to read and aware the printed materials can be done, such as through village meeting, or religious meeting. This community participation in reducing "three lateness" is important, which emphasizes particularly the anticipation of complication, its care seeking, as well as financial support.
4. The future study can be done to answer the quality of care more comprehensively, such as using "quick investigation of quality". The local research institution can contribute to the study.
5. The attention to contraception distribution system in both provinces might improve the quality of care of family planning.
6. The antenatal quality of care should be completed by essential services, not only five components, but others important such as blood test, and anti-malarial drugs particularly in NTT.
7. In addition to prevention activities that should be improved, the insurance system known as *askeskin* is encouraged to be well distributed. The issue of transport cost might also be thought, among others through strengthening the community preparedness on birth delivery.

*** *** ***

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APPENDIX 1

LOCATION OF THE STUDY

LOCATION OF THE STUDY

Prop.	Kode Kab	Kabupaten/Kota	Kategori	Kode sd.	Sub district	village			
						1	2	3	4
NTB	1	KOTA MATARAM	NP1	1	MATARAM	Mataram Timur	Pagesangan	Monjok	Rembiga
(1)			NP2	2	AMPENAN	Ampenan Selatan	Ampenan Utara	Tanjung Karang	Pagutan
			P1	3	CAKRANEGARA	Bertais	Cakra Selatan	Cakra Barat	Sayang-Sayang
			P2	4					
	2	LOMBOK BARAT	NP1	1	GUNUNG SARI	Sesela	Jatisela	Taman Sari	Kekait
			NP2	2	BAYAN	Sukadana	Anyar	Akar-Akar	Bayan
			P1	3	GERUNG	Gerung Utara	Dasan Geres	Gapuk	Suka Makmur
			P2	4	SEKOTONG	Sekotong Tengah	Buwunmas	Sekotong Barat	Kedaro
	3	LOMBOK TIMUR	NP1	1	SELOK	Denngen	Kelayu Utara	Pancor	Selong
			NP2	2	KERUAK	Sepit	Selebung Ketangga	Pijot	Tanjung Luar
			P1	3	AIKMEL	Lenek Daya	Lenek	Kembang Kerang	Aikmel
			P2	4	SAMBELIA	Sambelia	Sugian	Obel-Obel	Belanting
	4	LOMBOK TENGAH	NP1	1	PRINGGARATA	Pringgarata	Sepakek	Sintung	Bagu
			NP2	2	JONGGAT	Ubung	Jelantik	Perina	Barejulat
			P1	3	PUJUT	Sengkol	Pengembur	Teruwai	Prabu
			P2	4	PRAYA TIMUR	Mujur	Ganti	Semoyang	Bilelando
	5	SUMBAWA BARAT	NP1	1	TALIWANG	KUANG	SAMPIR	BUGIS	DALAM
			NP2	2	JEREWEH	BERU	BELO	GOA	SELENGA
			P1	3	SEKONGKANG	SEKONGKANG ATAS	SEKONGKANG BAWAH	TONGO	ESPE I
			P2	4	BRANG REA	BERU	SAPUGARA BREE	TEPAS	BANGKAT MUNTEH
	6	SUMBAWA	NP1	1	EMPANG	EMPANG ATAS	JOTANG	ONGKO	GAPIT
			NP2	2	SUMBAWA	SEKETENG	UMASIMA	SAMAPUIN	BRANG BIJI
			P1	3	LUNYUK	LUNYUK REA	LUNYUK ODE	PADASUKA	SUKAMAJU
			P2	4	ALAS BARAT	MAPIN REA	LABUAN MAPIN	LEKONG	GONTAR
	7	DOMPU	NP1	1	DOMPU	BALI 1	KARIJAWA	KRAMABURA	MANGGE NA'E
			NP2	2	KEMPO	KEMPO	SORO	TA'A	KESI
			P1	3	HUU	RASA BOU	DAHA	HU'U	ADU
			P2	4	KILO	MALAJU	LASI	KERAMAT	KIWU
	8	KABUPATEN BIMA	NP1	1	WOHA	RABAKODO	TALABIU	DADIBOU	KELI
			NP2	2	SAPE	NARU BARAT	BUNCU	BOKE	POJA
			P1	3	SANGGAR	KORE	TALOKO	PIONG	OI SARO
			P2	4	WAWO	NTORI	KAMBILO	RABA	SAMBORI
	9	KOTA BIMA	NP1	1	RASANAE TIMUR	LAMPE	NUNGGA	RONTU	PENANAE
			NP2	2	RASANAE BARAT	TANJUNG	SARAE	SAMBINAE	SANTI
			P1	3	ASAKOTA	JATIWANGI	JATI BARU	MELAYU	KOLO
			P2	4					

Prop.	Kode Kab	Kabupaten/Kota	Kategori	Kode sd.	Sub district	village			
						1	2	3	4
NTT	10	MANGGARAI BARAT	NP1	1	KUWUS	Coal	Pangga	Colang	Tueng
(2)			NP2	2	LEMBOR	Wae Bangka	Pong Majok	Nanga Lili	Poco Rutang
			P1	3	MACANG PACAR	Golo Lajang	Compang	Pacar	Kombo
			P2	4	SANO NGGAONG	Nampar Macing	Watu Wangka	Tondong Belang	Liang Ndara
	11	MANGGARAI	NP1	1	KOTA KOMBA	Watu Nggene	Rongga Koe	Komba	Tanah Rata
			NP2	2	LANGKE REMBONG	Golodukal	Wali	Pau	Mbaumuku
			P1	3	WAE RII	Lalong	Ranaka	Longko	Wae Ri'i
			P2	4	ELAR	Golo Munde	Sisir	Tiwu Kondo	Lengko Namut
	12	NGADA	NP1	1	WOLOWAE	Tenda Toto	Tenda Kinde*	Anakoli	Totomala
			NP2	2	NGADA BAWA	Bajawa	Faobata	Ubedolumolo	Kisanata*
			P1	3	BOAWAE	Nageoga	Wolopogo	Wolowea	Natanage*
			P2	4	AIMERE	Aimere Timur	Foa*	Warupelle I	Paupaga
	13	ENDE	NP1	1	WOLOJITA	Tenda*	Nggela	Wiwipemo	Nuamulu*
			NP2	2	ENDE SELATAN	Mbongawani	Rukun Lima	Paupanda	Tetandara
			P1	3	MAUROLE	Mausambi	Aewora*	Maurole/Kedoboro	Detuwulu
			P2	4	KOTA BARU	Hangalande	Tou*	Taniwoda*	Detuara
	14	SIKKA	NP1	1	LELA	Sikka	Watutedang	Koli Detung	Iligai
			NP2	2	ALOK	Nangalimang	Madawat	Hewuli	Kota Uneng
			P1	3	TALIBURA	Natar Mage	Darat Pante	Nebe	Kringa
			P2	4	BOLA	Wolokoli	Kloang Popot	Umauta	Hebing
	15	FLORES TIMUR	NP1	1	KLUBAGOLIT	Muda	Mangaaleng	Suku Tokan	Redon Tena
			NP2	2	TANJUNG BUNGA	Sinamalaka	Bandona	Bahinga*	Nusa Nipa
			P1	3	SOLOR BARAT	Ongalereng	Balaweling I	Sulengwaseng	Kenere
			P2	4	WOTAN ULU MADO	Nayu Baya	Oyang Barang	Tana Tukan	Wai Lebe
	16	LEMBATA	NP1	1	NUBATUKAN	Baolangu*	Watokobu	Waijarang	Lewoleba Utara
			NP2	2	ATADEI	Lerek	Atakore	Katakeja	Nuba Atalojo
			P1	3	NAGAWUTUNG	Pasir putih	Wuakerong	Atawai	Lusiduawutung
			P2	4	WULANDONI	Lelata	Puor	Wulandoni	Posiwatu
	17	KOTA KUPANG	NP1	1	KELAPA LIMA	Fatubesi	Merdeka	LLBK	Lasiana
			NP2	2	ALAK	Alak	Nunhila	Manutapen	Manulai 2
			P1	3	OEBOBO	Naikoten II	Bakunase	Fontein	Liliba
			P2	4	MAULAFA	Maulafa	Naimata	Fatukoa	Belo
	18	KABUPATEN KUPANG	NP1	1	AMARASI SELATAN	Sonraen	Retraen	Nekmese	Sahraen
			NP2	2	TAEBENU	Baumata Timur	Baumata Utara	Oeltua	Oeletsala
			P1	3	AMARASI BARAT	Niukbaun	Soba	Nekbaun	Tunbaun
			P2	4	FATULEU BARAT	Naitae	Kalali	Poto	Nuataus
	19	TIMUR TENGAH SELATAN	NP1	1	KOTA SOE	Kabekamusa	SoE	Cendana	Nonohonis
			NP2	2	BATU PUTIH	Oebobo	Baentuka	Tuppan	Oehela
			P1	3	AMANUBAN TIMUR	Mauleun	Telukh	Kaeneno	Oeleon
			P2	4	AMANUBAN BARAT	Mnelalete	Pusu	Eonnenotes	Tubmonas
	20	TIMUR TENGAH UTARA	NP1	1	KOTA KEFAMENANU	Maubeli	Tubuhue	Benpasi	Aplasi
			NP2	2	BIBOKI UTARA	Biloe	Nakun	Makun	Birunatua
			P1	3	BIBOKI ANLEU	Oemanu	Nifutasi	Kota fon	Motadik
			P2	4	INSANA UTARA	Humusu C *	Fatumtasa	Hamusu A*	Fafinisu C
	21	BELU	NP1	1	MALAKA TIMUR	Dirma	Sanleo	Weweda	Numponi
			NP2	2	LAEN MANEN	Uabau	Teas	Nueke Kusa	Meotroi
			P1	3	KAKULUK MESAK	Daulaus	Fatuketi	Jenilu	Leosama
			P2	4	TASIFETO BARAT	Lookeu	bakastulama	Tukuneno	Naitimu
	22	ROTE NDAO	NP1	1	ROTE BARU	Olafuliha'a	Edalone	Oebau	Lenupetu
			NP2	2	ROTE BARAT LAUT	Busalangga	Temas	Daudolu	Tolama
			P1	3	LABALAIN	Ba'adale	Namodale	Tuanatuk	Oematmboli
			P2	4	ROTE BARAT DAYA	Batutua	Oehandi	Oeseli	Oelasin

APPENDIX 2

QUESTIONNAIRE

HSS BASELINE DATA SURVEY IN NTB AND NTT 2007

Confidential

I. STUDY SITE	**CODE**
1. PROVINCE: _____	
2. DISTRICT/KABUPATEN/KOTA: _____	
3. SUBDISTRICT/KECAMATAN: _____	
4. VILLAGE/DESA/KELURAHAN: _____	
5. NEIGHBOURHOOD/RT/DUSUN/DUKUH:	
6. NAME OF HEAD OF HOUSEHOLD : ..... (M / F)	
7. NAME OF RESPONDENT:	
8. NUMBER OF HOUSEHOLD:	
9. CONFIRMATION OF MOTHER :	
HAD BEEN PREGNANT.....A	
IS PREGNANT ....B	
HAVING CHILD < 5 YEARS OLD, HOW MANY CHILDREN?.....	

II. INTERVIEW AND CHECKING

	I	II	III		
DATE OF INTERVIEW	.....	.....	.....	DATE OF CROSS CHECK	.....
TIME (CLOCK) START	.....	.....	.....		
FINISH	.....	.....	.....	NAME OF CHEKER (SECOND INTERVIEWER)	.....
NAME OF INTERVIEWER	.....	.....	.....		
SIGN	.....	.....	.....	SIGN	.....

	DISTRICT FIELD COORDINATOR (DFC)	DATA ENTRY PERSONNEL
NAME & SIGN	_____	_____
DATE	_____	_____

INFORMED CONSENT

Good morning/afternoon, my name is ... and I am working for the Center for Health Research University of Indonesia. Currently we are conducting a household survey. We will ask about mother and child health in your household. The information will be useful for the government in planning the health services. The interview will take around one hour, and your child under 5 years old will be weighed and height measured. Your information will be confidential and not to be shown to other people. You may contribute in this survey voluntarily, and you can refuse to answer or not continue the interview. However, we hope you can participate since your opinion and information are very important. At this moment, are you available to participate in this survey? May I start the interview?

IF RESPONDENT AGGREES TO BE INTERVIEWED, INTERVIEW CAN BE STARTED.
IF RESPONDENT DOES NOT AGGREE TO BE INTERVIEWED → STOP AND REPLACE WITH OTHER BASED ON PLANNED SAMPLING PROCEDURE.
SIGN, IF RESPONDENT AGGREES (IF POSSIBLE): .....

B1. HOUSEHOLD MEMBER

Now I want to ask some information of the member of this household who are living in this house and having one kitchen

NO	NAME	RELATION	AGE	SEX		MARITAL STATUS	OCCUP-ATION	EDUCATION LEVEL			
	Please mention the name of the member of household who live in this house INFORMATION OF RESPONDENT IS ASKED IN THE LATEST.	What is the relationship of NAME with respondent? *	How old is NAME? UNDER 1 YEAR OLD CODE '0'	Is NAME male or female?		Is NAME currently married, not-married, or divorce? **	What is the main occupation of NAME? ***	Has NAME ever been in school?	What is the highest level of the school accomplished ? (TST) What is the highest class attained? (KLS) ****		Is NAME still in school?	Can NAME read ? ASKED IF 108=2, OR 109 = TST = 1 OR 2
(101)	(102)	(103)	(104)	(105)		(106)	(107)	(108)	(109)		(110)	(111)
			YEAR	M	F			YES NO	TST	KLS	YES NO	YES NO
01				1	2			1 2			1 2	1 2
02				1	2			1 2			1 2	1 2
03				1	2			1 2			1 2	1 2
04				1	2			1 2			1 2	1 2
05				1	2			1 2			1 2	1 2
06				1	2			1 2			1 2	1 2
07				1	2			1 2			1 2	1 2
08				1	2			1 2			1 2	1 2
09				1	2			1 2			1 2	1 2
10				1	2			1 2			1 2	1 2
11				1	2			1 2			1 2	1 2
12				1	2			1 2			1 2	1 2
13				1	2			1 2			1 2	1 2

* CODE 103

01 = Respondent
02 = Husband of respondent
03 = Son/Daughter
04 = Child in Law
05 = Grand child
06 = Parents
07 = Parents in Law
08 = Sibling
09 = Relatives
10 = Adopted child
11 = Foster child
12 = No relationship
99 = Do not know

** CODE 106

1 = Not married
2 = Married
3 = Divorce
4 = Widow/widowed

*** CODE 107

01 = Housewife
02 = Civil employee
03 = Professional
04 = Private employee
05 = Farming
06 = Owner of car/motorcycle/boat
07 = Owner of beautysalon/car-service/etc
08 = Merchant/owner of small shop
09 = Labour/Driver/Motorcyle-taxi
10 = Fisherman
11 = Daily-paid
12 = Student
13 = Not working
99 = Other

**** CODE 109

Level of education (TST)
1 = Pre-school
2 = Elementary
3 = Junior secondary
4 = Senior high school
5 = College
6 = University
8 = Do not know

Class (KLS)
Elementary = 1 – 6
Junior secondary = 1 – 3
Senior high school = 1 – 3
University/college = Complete = 1
Not complete = 2

B2. CHARACTERISTIC OF SOSIOECONOMY

INTERVIEWER DOES NOT READ THE OPTION OF ANSWER UNLESS THERE IS A SPECIFIC INSTRUCTION.

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
B201	In what month and year were you born?	MONTH ..... [ ][ ] DO NOT KNOW ..... 98 YEAR ..... [ ][ ][ ][ ] DO NOT KNOW 9998	
B202	Who is the owner of the house you live now? [ONLY ONE OPTION OF ANSWER]	RESPONDENT..... 1 PARENTS/FAMILY ..... 2 CREDITS..... 3 RENT..... 4 OFFICIALLY..... 5 OTHER (WRITE)_____..... 6	
B203	Does your household have the following housing appliances or property .....? USE THE DEMO-CARD	ELECTRICITY ..... A MATTRESS ..... B BED ..... C CHAIR ..... D TABLE ..... E CLOCK/WATCH ..... F FAN ..... G RADIO..... H TELEVISION ..... I PARABOLA..... J TELEPHONE/HANDPHONE ..... K REFRIGIRATOR ..... L WATER PUMP (MANUAL OR MACHINE)..... M BICYCLE/ FARM WITH GOAT/SHIP/HEN (>5) ..... N MOTOR CYCLE/ FARM WITH COW/HORSE ..... O CAR..... P TRUCK..... Q TRACKTOR..... R ROW BOAT ..... S MOTOR BOAT ..... T	
B204	Who is the person in this household taking the decision if one of the member suffered from sick/disease?	RESPONDENT..... 11 HUSBAND ..... 12 RESPONDENT & HUSBAND TOGETHER ..... 13 HUSBAND & OTHER TRUSTED PERSON ..... 14 RESPONDENT & OTHER TRUSTED PERSON ..... 15 TRIBAL/VILLAGE LEADER/HEAD ..... 16 PARENTS ..... 17 OTHER (WRITE) 96	
B205	How many rooms are in this house?	NUMBER OF ROOMS ..... [ ][ ] NO ROOM DIVISION 99	
B206	What is the main water source in this household?	PIPE WATER ..... 11 WATER PUMP (MANUAL OR MACHINE)..... 21 PROTECTED WELL ..... 22 UNPROTECTED WELL ..... 23 PROTECTED SPRING ..... 31 UNPROTECTED SPRING ..... 32 RAIN WATER ..... 41 REFILL WATER ..... 51 BOTTLED WATER ..... 61 SUPERFICIAL WATER (RIVER/PONDS/LAKE/ DAM/CANAL/SEA/ ..... 71 OTHER (WRITE)_____ 96	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
B207	What is the type of latrine or toilet in this household?	TOILET WITH SEPTIC TANK ..... 11 TOILET WITHOUT SEPTIC TANK ..... 12 COMPOSTED/DRIED LATRINE ..... 22 LATRINE ON THE FISH POND ..... 31 NO FACILITY (RIVER, BUSH, PLASTIC BAG) ..... 41 OTHER (WRITE)_____ 96	
B208	In total, how much money does this household member earn every month? PROBE IF RESPONDENT HAS DIFFICULTIES IN ANSWER.	IN THOUSAND RUPIAH	
B209	How much money is the expenditure of this household every month..... and also for some items such as follows …	TOTAL EXPENDITURE (IN THOUSAND RUPIAH)	
		a. Tuition fee (SPP):	
		b. Cigarette:	
		c. Alcohol:	

W1. CHARACTERISTICS OF REPRODUCTIVE HEALTH

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
W101	How many sons and daughters do you have, who were live birth delivered and are still alive at this moment?	SONS ..... DAUGHTER	
W102	How many sons and daughters do you have, who were live birth delivered and have died at this moment?	SON ..... DAUGHTER	
	W102A SUMMING THE LIVE BIRTHS = W101 + W102		
W103	How many pregnancies were terminated through abortion or miscarriage?	ABORTION OR MISCARRIAGE	
W104	How many pregnancies were terminated with still birth?	STILL BIRTHS	
	W104A SUMMING ALL PREGNANCIES = W101 + W102 + W103 + W104		
W105	How many times do you have twins/multiple births	FREQUENCIES	
W106	At what age did you have the first pregnancy?	AGE IN YEARS	
W107	At what age did you have your first live birth ?	AGE IN YEARS	

Now I will record your last three children, either still alive or have been died, started from the last child.

W108 Who is the name of your last child? Before the last child?	W109 Is the birth twins ?		W110 What is the sex of the child ?		W111 In what month and year this child was born ? IF RESPONDENT DOES NOT USE THE COMMON CALENDER, DO CONVERTION	W112 Is this child still alive?		W113 IF THE CHILD HAS BEEN DIED: In what age this child was died ? Write in month if less than 2 years old. Write in days if less than 1 month old. If less than 1 day, write '00' in DAY box
	Ye	No	M	F		Yes	No	
01	1	2	1	2	MONTH ☐☐ YEAR ☐☐	1 → Previous child	2 → W113	1 ☐☐ .....YEAR 2 ☐☐ .....MONTH 3 ☐☐ .....DAY 4 Still birth
02	1	2	1	2	MONTH ☐☐ YEAR ☐☐	1 → Previous child	2 → W113	1 ☐☐ .....YEAR 2 ☐☐ .....MONTH 3 ☐☐ .....DAY 4 Still birth
03	1	2	1	2	MONTH ☐☐ YEAR ☐☐	1 → W2	2 → W113	1 ☐☐ ..... YEAR 2 ☐☐ ..... MONTH 3 ☐☐ ..... DAY 4 Still birth

W2. FAMILY PLANNING

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
W201	In your knowledge, could you mention the method of family planning aims for preventing or delaying the pregnancy? Any other else? (PROBE)	TUBECTOMY/FEMALE STERILIZATION ..... A VASECTOMIY/MALE STERILIZATION ..... B IMPLANT ..... C IUD ..... D INJECTION ..... E PILL ..... F CONDOM ..... G DIAPHRAGMA/INTRAVAGINAL JELLY ..... H EMERGENCY CONTRACEPTION ..... I COITUS INTERRUPTUS ..... J NATURAL METHOD (BREASTFEEDING, ABSTINENT, CALENDER) ..... K OTHER, (WRITE)_____ X DO NOT KNOW ..... Z	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
W202	Where can you get the family planning method ? Where else? (PROBE)	HOSPITAL ..... A COMMUNITY HEALTH CENTER/PUSKESMAS ..... B PRIVATE CLINIC ..... C PRIVATE PRACTICE OF DOCTOR ..... D PRIVATE PRACTICE OF MIDWIFE ..... E FP FIELD PERSONNEL ..... F MOBILE CLINIC SERVICE ..... G MATERNITY HUT/POLINDES ..... H VILLAGE MIDWIFE/BIDAN DI DESA ..... I INTEGRATED HEALTH POST/POSYANDU ..... J FP POST/POS KB ..... K PHARMACIST/DRUG STORE ..... L SUPERMARKET/OTHER KIND OF STORE ..... M OTHER (WRITE) _____ X DO NOT KNOW ..... Z	
W203	In your opinion, where can you get condom easily and quickly?	HOSPITAL ..... 11 COMMUNITY HEALTH CENTER/PUSKESMAS ..... 12 PRIVATE CLINIC ..... 13 PRIVATE PRACTICE OF DOCTOR ..... 14 PRIVATE PRACTICE OF MIDWIFE ..... 15 FP FIELD PERSONNEL ..... 16 MOBILE CLINIC SERVICE ..... 17 MATERNITY HUT/POLINDES ..... 18 VILLAGE MIDWIFE/BIDAN DI DESA ..... 19 INTEGRATED HEALTH POST/POSYANDU ..... 20 FP POST/POS KB ..... 21 PHARMACIST/DRUG STORE ..... 22 HOTEL/BAR ..... 23 COMMERCIAL SEX WORKER ..... 24 SUPERMARKET/OTHER KIND OF STORE ..... 25 OTHER (WRITE) _____ 96 DO NOT KNOW 98	
W204	In this month or at this moment, do you or your husband use the certain family planning method?	YES ..... 1 NO 2	→ **W208**
W205	If not, what are the reasons?	WANT TO BE PREGNANT ..... A IS PREGNANT ..... B IS BREASTFEEDING ..... C JUST DELIVERED BABY ..... D THE CHILD IS STILL UNDER AGE ..... E NO PERMIT OF HUSBAND ..... F IS EXPENSIVE ..... G HAVING SIDE EFFECT ..... H TRIBAL/RELIGIOUS BELIEF ..... I LACK OF KNOWLEDGE ..... J NOT AVAILABLE OF CONTRACEPTION ..... K OTHER (WRITE)_____ X	→ **W207** → **W207**
W206	Do you want to be pregnant at this moment or do not want to be pregnant any more ?	WANT TO BE PREGNANT, BUT LATER ON ..... 1 DO NOT WANT TO BE PREGNANT ANY MORE 2	
W207	Have you or your husband ever used family planning method ?	YES ..... 1 NO 2	→ **W209** → **W210**

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
W208	What method do you or your husband use ? IF RESPONDENT MENTIONED IMPLANT OR INJECTION, PROBE THE TYPE: 'YEAR OF IMPLANT' OR 'MONTHS OF INJECTION?' IF RESPONDENT USED MORE THAN ONE METHOD, DETERMINE ONE METHOD COMMENCED BEFORE THE OTHER	TUBECTOMY/FEMALE STERILIZATION ..... 11 VASECTOMY/MALE STERILIZATION ..... 12 IMPLANT - 5 YEAR ..... 13 IMPLANT - 3 YEAR ..... 14 IUD ..... 15 INJECTION - 3 MONTHS ..... 16 INJECTION – 1 MONTH ..... 17 PILL ..... 18 CONDOM ..... 19 DIAPHRAGMA/INTRAVAGINAL JELLY ..... 20 EMERGENCY CONTRACEPTION ..... 21 COITUS INTERRUPTUS ..... 22 NATURAL METHOD (BREASTFEEDING,ABSTINENT, CALENDER) ..... 23 OTHER (WRITE) _____ 96	

			a	b	C
W209	a. What FP method do you like/prefer? b. What FP methods have been provided by health facility in this area ? c. What FP methods are recommended for you by health personnel in this area?	TUBECTOMY/FEMALE STERILIZATION 11	... A	..... A	
		VASECTOMY/MALE STERILIZATION 12	... B	..... B	
		IMPLANT - 5 YEAR 13	... C	 C	
		IMPLANT - 3 YEAR 14	... D	..... D	
		IUD 15	... E	..... E	
		INJECTION - 3 MONTHS 16	... F	..... F	
		INJECTION – 1 MONTH 17	... G	..... G	
		PILL 18	... H	..... H	
		CONDOM 19	... I	 I	
		DIAPHRAGMA/INTRAVAGINAL JELLY 20	... J	..... J	
		EMERGENCY CONTRACEPTION 21	... K	..... K	
		COITUS INTERRUPTUS 22	... L	 L	
		NATURAL METHOD (BREASTFEEDING,ABSTINENT, CALENDER) 23	... M	..... M	
		A. OTHER (WRITE) _____ 96	...		
		B. OTHER (WRITE) _____		X	
		C. OTHER (WRITE) _____			X
		NO PREFERRED, AVAILABLE OR RECOMMENDED METHOD 97	... Z	..... Z	

W210	In your knowledge, what do people usually do if there is unwanted pregnancy ?	ABORTION BY SELF EFFORT (HERBS, INGREDIENTS, DRUGS, ETC) .... A ABORTION HELPED BY TRADITIONAL HEALER/DUKUN ..... B ABORTION HELPED BY HEALTH PERSONNEL ..... C ABORTION HELPED BY OTHER PERSON ..... D TRIED TO DO ABORTION ..... E PREGNANCY IS ACCEPTED/CONTINUED ..... F CONSULTATION WITH HUSBAND/OTHER PERSON ..... G OTHER (WRITE) _____ X DO NOT KNOW ..... Y	

M1. PREGNANCY OF LAST CHILD (FOR MOTHER OF CHILD <5 YEARS OLD)

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M101	During being pregnant of (NAME), did you do antenatal care to health personnel?	YES ..... 1 NO 2	 → **M105**
M102	Who was the health personnel taking care of pregnancy of NAME?	HEALTH PERSONNEL: GENERAL PRACTITIONER ..... 1 OBSGYN SPECIALIST ..... 2 MIDWIFE ..... 3 NURSE ..... 4 OTHER (WRITE) _____ 6	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M103	Please mention in detail, how many times did you take care of the pregnancy of NAME to health personnel : READ A TO C. WRITE '98' IF DO NOT KNOW .	A. Month of 1 to -3 of pregnancy ..... B. Month of 4 to -6 of pregnancy ..... C. Month of 7 to delivery time	
M104	During you did antenatal care of NAME, did you receive the services such as follows: READ **A** TO **Q**. IF C IS NOT SERVED, NO NEED TO READ D .	Body weighing? ..... A Height measuring? ..... B Injection in the upper arm for preventing neonatal tetanus? ..... C Twice injection during pregnancy? ..... D Blood pressure measurement? ..... E Abdominal measurement? ..... F Blood hemoglobin test? ..... G Blood test for screening of diseases/other risks? ..... H Blood test, but not knowing the aims of the test? ..... I Urine test? ..... J Ferrous tablet distribution? ..... K Vitamin A distribution ..... L Anti malaria drug distribution? ..... M Information on : - danger signs of pregnancy ..... N - action to be taken when there is a danger sign ..... O - Birth preparation (birth attendance, blood donor) ..... P - Breastfeeding ..... Q No service ..... Y	
M105	During pregnancy of NAME, did you do ante natal care to traditional birth attendance/healer?	YES ..... 1 NO 2	→ **M107**
M106	How many times did you go to traditional healer/ birth attendance during you were pregnant of NAME? CODE '98' IF DO NOT KNOW .	FREQUENCY	
M107	During the pregnancy of NAME, did you have discussion with your husband on some issues such as follows : READ A TO F.	Place of birth delivery ..... A Person who will assist birth delivery ..... B Funding allocation for birth delivery ..... C Transport will be used (if needed) ..... D Contingency fund if problems occured during delivery ..... E Place of blood donor provision if needed ..... F No discussion on the above issues ..... Y No husband ..... Z	
M108	In your opinion, what are the danger signs might become problems those can be occured during pregnancy or delivery and postpartum? Any other else? (PROBE)	EXCESSIVE NAUSEA AND VOMIT ..... A PROLONGED HIS ..... B BLEEDING THROUGH BIRTH CANAL/PATHWAYS ..... C FOOT EDEMA AND HEADACHE ..... D CONVULSION/SEIZED ..... E HIGH BLOOD PRESSURE ..... F HIGH FEVER ..... G EARLY BROKEN AMNION ..... H OTHER (WRITE) _____ X DO NOT KNOW ..... Z	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M109	During pregnancy of NAME, did you have any problems such as : READ A TO G	Excessive nausea and vomit ..... A Foot edema and headache ..... B Bleeding through birth canal/pathways ..... C Discharging of other fluid from vagina ..... D Convulsion/seized ..... E High blood preasure ..... F High fever ..... G No complication ..... Y	→ **M113**
M110	What did you do to solve the problems? Any other else? (PROBING) IF HOSPITAL OR CLINICS: DO PROBING, 'OWNED BY GOVERNMENT OR PRIVATE '?	SELF TREATMENT: REST ..... A TAKE REMEDIES ..... B HERBS/PARSLEY ..... C CONSULTATION WITH FAMILY ..... D CONSULTATION WITH OTHER PERSON ..... E CONSULTATION WITH PHARMACYST ..... F SEEK HEALTH PERSONNEL : GOVERNMENT: HOSPITAL ..... G COMMUNITY HEALTH CENTER/PUSKESMAS ..... H CLINIC ..... I MATERNITY CLINIC/RUMAH BERSALIN ..... J MOBILE HEALTH SERVICE ..... K PRIVATE: HOSPITAL ..... L PRIVATE CLINIC ..... M MATERNITY CLINIC/RUMAH BERSALIN ..... N PRIVATE PRACTICE DOCTOR ..... O PRIVATE PRACTICE MIDWIFE ..... P COMMUNITY: MATERNITY HUT/POLINDES ..... Q VILLAGE MIDWIFE ..... R INTEGRATED HEALTH POST/POSYANDU ..... S NON-HEALTH PERSONNEL: TRADITIONAL HEALER/DUKUN ..... T OTHER (WRITE) _____ X NOTHING TO DO ..... Y	**M113** → **M113**
M111	How much money did you spend for solving that problem ?	IN THOUSAND RUPIAH	
M112	In your opinion, was that amount of money spent being so expensive, moderate, or cheap?	EXPENSIVE ..... 1 MODERATE ..... 2 CHEAP 3	
M113	In your opinion, do people in this village do such follow things ..... READ A TO F.	Be ready to provide vehicle for transporting pregnant woman to the delivery place ..... A Be willing to accompany pregnant woman in the time of delivery ..... B Recommend the husband to be with his wife during pregnancy and delivery ..... C Prepare the saving for cost spent during pregnancy and delivery ..... D Be ready to donate blood if pregnant woman needs during pregnancy and birth ..... E Others (write) _____ X No participation given by village people ..... Y	
M114	During the pregnancy of NAME, did you have Mother and Child Book (*Buku KIA*)? IF YES, ASK ABOUT UTILIZATION OF MCH-BOOK .	YES, UTILIZED ..... 1 YES, BUT NOT UTILIZED ..... 2 NO ..... 3 DO NOT KNOW 8	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M115	During pregnancy of NAME, did you smoke cigarrette?	YES ..... 1 NO 2	
M116	During pregnancy of NAME, did any other people in this house smoke cigarrete?	YES ..... 1 NO ..... 2 DO NOT KNOW 8	

M2. LAST CHILD DELIVERY (FOR MOTHER OF CHILD < 5 YEARS OLD)

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M201	Before delivery, to whom did you plan to ask for helping the birth of NAME?	HEALTH PERSONNEL ..... 1 TBA/DUKUN ..... 2 NO PLAN 7	
M202	Before delivery, where did you plan to deliver the birth of NAMA?	HEALTH FACILITY ..... 1 TBA HOUSE ..... 2 RESPONDENT/FAMILY HOUSE ..... 3 NO PLAN 7	
M203	Who assisted the birth of NAME finally? BIRTH ASSISTANCE IS THE PERSON WHO ACTED AND ROLED PRIMARILY IN HOLDING THE BABY DURING BIRTH PROCESS, OR WAS PAID MORE.	HEALTH PERSONNEL: GENERAL PRACTITIONER ..... 11 OBSGYN SPECIALIST ..... 12 MIDWIFE ..... 13 NURSE ..... 14 NON-HEALTH PERSONNEL : TBA/DUKUN ..... 15 FRIEND/FAMILY ..... 16 OTHER (WRITE) _____ 96 NO ASSISTANCE 97	
M204	Where did you deliver the baby (NAME)? IF HOSPITAL OR CLINICS, DO PROBING, 'OWNED BY GOVERNMENT OR PRIVATE '?	GOVERNMENT: HOSPITAL ..... 11 COMMUNITY HEALTH CENTER/PUSKESMAS ..... 12 CLINICS ..... 13 PRIVATE: HOSPITAL ..... 21 CLINIC ..... 22 MATERNITY CLINIC ..... 23 PRIVATE PRACTICE OF DOCTOR ..... 24 PRIVATE PRACTICE OF MIDWIFE ..... 25 COMMUNITY VILLAGE MIDWIFE ..... 31 MATERNITY HUT/POLINDES ..... 32 TBA HOUSE ..... 41 HOUSE OF OTHER PERSON ..... 42 RESPONDENT/FAMILY HOUSE ..... 43 OTHER (WRITE) _____ 96	
M205	Was NAME delivered normally, or assisted by using additional equipment, or cesarean section?	NORMAL/SPONTAN ..... 1 I.V. LABOR INDUCTION ..... 2 VACUM/FORCEPS/OTHER EQUIPMENT ..... 3 CESAREAN SECTION 4	
M206	How much money did you spend for the delivery of NAME at that time? *(total amount of delivery cost)?*	IN THOUSAND RUPIAH	
M207	In your opinion, was that delivery cost being so expensive, moderate, or cheap?	EXPENSIVE ..... 1 MODERATE ..... 2 CHEAP 3	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M208	During the birth of NAME, did you have problems such as follows? READ A TO F	Early broken amnion ..... A Excessive bleeding during the birth ..... B Prolonged labor/no progress within 12 hours ..... C Sudden high blood pressure ..... D Convulsion/seized ..... E Late placental birth ..... F Other (WRITE)_____ X No complication ..... Y	→ **M301**
M209	What did you do to solve the problem? Any other else? (PROBE) IF HOSPITAL OR CLINICS: DO PROBING, 'OWNED BY THE GOVERNMENT OR PRIVATE'?	SELF TREATMENT: REST ..... A TAKE REMEDIES ..... B HERBS/PARSLEY ..... C CONSULTATION WITH FAMILY ..... D CONSULTATION WITH OTHER PERSON ..... E CONSULTATION WITH PHARMACYST ..... F SEEK HEALTH PERSONNEL: GOVERNMENT: HOSPITAL ..... G COMMUNITY HEALTH CENTER/PUSKESMAS ..... H CLINICS ..... I MATERNITY CLINIC ..... J MOBILE HEALTH SERVICES ..... K PRIVATE: HOSPITAL ..... L CLINIC ..... M MATERNITY CLINIC ..... N PRIVATE PRACTIVE OF DOCTOR ..... O PRIVATE PRACTICE OF MIDWIFE ..... P COMMUNITY: MATERNITY HUT/POLINDES ..... Q VILLAGE MIDWIFE/BIDAN DI DESA ..... R INTEGRATED HEALTH POST/POSYANDU ..... S NON-HEALTH PERSONNEL TBA/DUKUN ..... T OTHER (WRITE) _____ X NOTHING TO DO ..... Y	**M301** → **M301**
M210	How much money did you spend for solving the above mentioned problem ?	IN THOUSAND RUPIAH ☐☐☐☐ INCLUDED IN THE DELIVERY COST 9997	→ **M301**
M211	In your opinion, was that cost being so expensive, moderate, or cheap?	EXPENSIVE ..... 1 MODERATE ..... 2 CHEAP 3	

M3. POSTPARTUM OF LAST CHILD (FOR MOTHER OF CHILD < 5 YEARS OLD)

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M301	In the period of 42 days after birth of NAME, did health personnel do post partum care or examine your health? POSTPARTUM CARE: VISIT OR BE VISITED BY HEALTH PERSONNEL .	YES ..... 1 NO 2	→ **M304**
M302	How many days after delivery of NAME were you visited or examined firstly by health personnel?	DAYS ..... ☐☐	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
M303	What health personnel type did visit or examine your health at that time?	HEALTH PERSONNEL: GENERAL PRACTITIONER ..... 1 SPECIALIST OF OBSGYN ..... 2 MIDWIFE ..... 3 NURSE ..... 4 OTHER (WRITE) _____ 6	
M304	In the period of 42 days after the delivery of NAME, did you have any problems such as : READ A TO E.	Excessive bleeding (more than 3 sheets of sarongs) .....A Convulsion/seized .....B High fever .....C Sudden high blood pressure .....D Laceration of birth canal/pathway .....E Other (WRITE)_____ X No complication .....Y	→ **M308**
M305	What did you do to handle that problem ? Any other else? (PROBING) IF HOSPITAL OR CLINIC: DO PROBING: 'OWNED BY GOVERNMENT OR PRIVATE '?	<u>SELF TREATMENT:</u> REST ..... A TAKE REMEDIES ..... B HERBS /PARSLEY ..... C CONSULTATION WITH FAMILY ..... D CONSULTATION WITH OTHER PERSON ..... E CONSULTATION WITH PHARMACYST ..... F <u>SEEK HEALTH PERSONNEL</u> : GOVERNMENT : HOSPITAL .....G COMMUNITY HEALTH CENTER /PUSKESMAS.....H CLINIC .....I MATERNITY CLINIC .....J MOBILE HEALTH SERVICES.....K PRIVATE: HOSPITAL .....L CLINIC .....M MATERNITY CLINIC .....N PRIVATE PRACTICE OF DOCTOR .....O PRIVATE PRACTIVE OF MIDWIFE .....P COMMUNITY: MATERNITY HUT/POLINDES .....Q VILLAGE MIDWIFE .....R INTEGRATED HEALTH POST/POSYANDU.....S NON-HEALTH PERSONNEL TRADITIONAL BA/HEALER/DUKUN .....T OTHER (WRITE) _____ X NOTHING TO DO .....Y	**M308** → **M308**
M306	How much money did you spend for the above mentioned treatment?	IN THOUSAND RUPIAH	
M307	In your opinion, was the cost being so expensive, moderate, or cheap?	EXPENSIVE..... 1 MODERATE..... 2 CHEAP..... 3	
M308	After the delivery of NAME, did you seek traditional birth attendance (TBA) or healer (*dukun*)?	YES, FOR EXAMINING MOTHER ONLY..... 1 YES, FOR EXAMINING CHILD ONLY ..... 2 YES, FOR EXAMINING MOTHER & CHILD ..... 3 NO..... 4	→ **C101**
M309	How many times did you go to TBA after the delivery of NAME? CODE '98' IF DO NOT KNOW.	FREQUENCY.....	

C1. NEONATAL CARE OF LAST CHILD (FOR MOTHER OF CHILD < 5 YEARS)

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C101	Was NAME weighed immediately after birth?	YES ..... 1 NO 2	 → C103
C102	How was the birth weight of NAME? CODE '9998' IF DO NOT KNOW	GRAMM …….. ☐☐☐☐	
C103	After birth, was the baby given assisted-respiration through pipe/special equipment by health personnel?	YES ..... 1 NO ..... 2 DO NOT KNOW 8	
C104	In the period of 28 days after birth of NAME, did any health personnel examine the health condition of NAME? EXAMINATION: VISIT OR BE VISITED BY HEALTH PERSONNEL .	YES ..... 1 NO 2	 → C108
C105	Please mention in detail, how many times NAME was examined by health personnel in: a. 1-7 days after birth? b. 8-28 days after birth?	A. 1-7 DAYS AFTER BIRTH ☐☐ B. 8-28 DAYS AFTER BIRTH ..... ☐☐	
C106	At that period of time, who examined the health condition of NAME? Any other else? (PROBING)	HEALTH PERSONNEL : GENERAL PRACTITIONER ..... A PEDIATRICIAN ..... B MIDWIFE ..... C NURSE ..... D OTHER (WRITE) _____ X	
C107	At the time of examination, did you receive the services such as follows : READ A TO L.	FOR MOTHER: Explanation of postpartum danger sign ? ..... A Explanation of action to be taken if there is any danger sign or complication occured in postpartum period? ..... B Explanation of nutrition for mother ? ..... C Abdominal examination ..... D Birth canal/pathways examination ? ..... E Blood preasure measurement ? ..... F Explanation of family planning methods? ..... G Distribution of vitamin A ..... X FOR CHILD : Recommendation to breastfeeding ? ..... H Recommendation to baby warming ? ..... I Explanation of umbilical cord care ? ..... J Explanation of neonatal danger sign ..... K Explanation of action to be taken if there is complication or danger sign? L No kind of service received ..... Z	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C108	In your opinion, what are the danger sign or health problems able to be occured in the period of 28 days after birth ? Any other else? (PROBING)	SMALL BABY/LOW BIRTH WEIGHT ..... A YELLOW BABY ..... B BLUE BABY ..... C HIGH FEVER ..... D HYPOTHERMIA ..... E DYSPNOE/BREATHING DIFFICULTIES/ CANNOT CRY ..... F BOWL DISTURBANCES ..... G DIARRHEA..... H COUGH ..... I PNEUMONIA..... J EXCESSIVE VOMIT ..... K CONVULSION ..... L DOES NOT WANT TO BE FED WITH MILK ..... M OTHER (WRITE) _____ X DO NOT KNOW ..... Z	
C109	In the period of 28 days after birth, did NAME have problem such as follows: READ A TO M.	Small baby/low birth weight ..... A Yellow baby ..... B Blue baby ..... C High fever ..... D Hypothermia ..... E Dyspnoe/breathing difficulties/ cannot cry ..... F Bowl disturbances ..... G Diarrhea ..... H Cough ..... I Pneumonia ..... J Excessive vomit ..... K Convulsion..... L Did not want to be fed with milk ..... M Other (WRITE) ..... X NO PROBLEM ..... Y DO NOT KNOW ..... Z	→ C201 → C201
C110	What did you do to handle the above mentioned problem of NAME ? Any other else? (PROBING) IF HOSPITAL OR CLINIK: DO PROBING, 'OWNED BY GOVERNMENT OR PRIVATE '?	SELF TREATMENT: REST ..... A TAKE REMEDIES ..... B HERBS /PARSLEY..... C CONSULTATION WITH FAMILY ..... D CONSULTATION WITH OTHER PERSON ..... E CONSULTATION WITH PHARMACYST ..... F SEEK HEALTH PERSONNEL: GOVERNMENT: HOSPITAL..... G COMMUNITY HEALTH CENTER/PUSKESMAS..... H CLINIC ..... I MATERNITY CLINIC ..... J MOBILE HEALTH SERVICES ..... K PRIVATE: HOSPITAL..... L CLINIC ..... M MATERNITY CLINIC ..... N PRIVATE PRACTICE OF DOCTOR ..... O PRIVATE PRACTICE OF MIDWIFE ..... P COMMUNITY: MATERNITY HUT/POLINDES..... Q VILLAGE MIDWIFE ..... R INTEGRATED HEALTH POST/POSYANDU..... S NON-HEALTH PERSONNEL TRADITIONAL BA/HEALER/DUKUN ..... T OTHER (WRITE) _____ X NOTHING TO DO ..... Y	→C201 → C201

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C111	How much money did you spend for the above mentioned treatment ? CODE '9999' IF DOES NOT REMEMBER	IN THOUSAND RUPIAH	
C112	In your opinion, was the cost spent being so expensive, moderate, or cheap?	EXPENSIVE ..... 1 MODERATE ..... 2 CHEAP 3	

C2. CHILD FEEDING PRACTICE (FOR MOTHER OF CHILD < 5 YEARS OLD)

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C201	Did you breastfeed your child NAME?	YES ..... 1 NO 2	→ **C208**
C202	After birth, at the first time, when (how many hours or days) did you put your baby NAME immediately on your breast or being breastfed? IF LESS THAN 1 HOUR, CODE '00' IN THE BOX OF 'HOUR'.	HOURS ..... 1 DAYS 2	
C203	Did you give colostrum or first breastmilk after birth to the child NAME? PROBING; COLOSTRUM IS YELLOW FIRST PRODUCED BREASTMILK	YES ..... 1 NO 2	
C204	In the first 3 days after birth, did you give water, food, or other fluid other than breastmilk to the child NAME?	YES ..... 1 NO 2	→ **C206**
C205	What kind of fluid or food did you give to the child NAME? Any other else? (PROBING)	FORMULA MILK/BABY MILK ..... A PLAIN WATER ..... B SWEET SUGAR SOLUTION ..... C RICE STARCH SOLUTION ..... D FRUIT JUICE ..... E TEA ..... F HONEY ..... G BANANA ..... H OTHER (WRITE) _____ X	
C206	At this moment, is the child NAME still being breastfed?	YES ..... 1 NO 2	→ **C208**
C207	At what age the child NAME was weaned or being stopped to have breastmilk?	MONTHS	
C208	Has the child NAME ever been given formula milk regularly?	YES ..... 1 NO 2	→ **C210**
C209	At what age the child NAME was given formula milk regularly?	MONTH	
C210	Has the child NAME ever been given food other than breastmilk regularly?	YES ..... 1 NO 2	→ **C212**
C211	At what age did the child NAME start to receive that regular food?	IN MONTHS	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C212	How many times did the child NAME drink the following fluid from morning till night yesterday?		FREQUENCY
	a. Plain water		
	b. Formula baby milk		
	c. Packaged milk, sweetend milk, full cream powder milk, fresh milk		
	d. Fruit juices or extract, honey		
	e. Rice starch solution, soup		
	f. Syrup, softdrink, tea, coffe		
C213	How many times did the child NAME eat the following food from morning till night yesterday?		FREQUENCY
	a. Food made of carbohydrate: rice, rice porridge, milk porridge, bread, noodle, cookies, corn, meat ball, etc		
	b. Potatoes, cassava		
	c. Vegetables: spinach, leafy vegetable, string bean, etc		
	d. Fruits: banana, orange, papaya, advocado, tomato, etc		
	e. Meat, chicken, eggs, liver, salted fish, fresh fish, etc		
	f. Food made of beans, tempe, toffu, etc.		
	g. Cheese, yoghurt		
	h. Snack with ingredient of fat, butter, fried snack, etc		
C214	So, since yesterday morning till night, how many times the child NAME was given main course of food? NOT INCLUDING SNACK OR LIGHT MEALS.	FREQUENCY OF MAIN FOOD..... ☐☐ DO NOT KNOW.....98	
C215	In what occasions do you usually wash your hand with soap ?	BEFORE PREPARING THE FOOD/MEALS ..... A BEFORE EATING ..... B BEFORE CHILD FEEDING ..... C AFTER DEFECATION ..... D AFTER HELPING CHILD DEFECATED ..... E OTHER (WRITE) _____ X NOT IN THE ABOVE OCCASION ..... Z	

C3. IMMUNIZATION, DIARRHEA, ARI (FOR MOTHER OF CHILD < 5 YEARS OLD)

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C301	Do you have record of immunization of your last child NAME (in the form of Child growth monitoring card/KMS, MCH Book)?	YES ..... 1 NO 2	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
C302	IF THE CHILD (NAME) HAS MCH BOOK/KMS CARD, LOOK AT THE RECORD, AND ANSWER THE FOLLOWING QUESTIONS. IF DOES NOT HAVE MCH BOOK/KMS CARD, ASK THE FOLLOWING QUESTIONS: Was the child NAME given the following type of immunization ....: READ A TO L. IF MOTHER DOES NOT REMEMBER, DO PROBING BY EXPLAINING THE SENTENCES WRITTEN IN THE BRACKET.	BCG (Injection at the upper arm and usually has scarred) ..... A POLIO1 (Vaccine coloured white or red, dropped in the child's mouth)..... B POLIO2..... C POLIO3..... D POLIO4..... E DPT1 (Injection at the leg, usually causes slight fever) ..... F DPT2 ..... G DPT3 ..... H CAMPAK (Injection at the upper arm to prevent measles) ..... I HEPATITIS1 (Injection at the outer side of leg)..... J HEPATITIS2 ..... K HEPATITIS3 ..... L HAS NOT BEEN IMMUNIZED ..... Y DO NOT REMEMBER ..... Z	
C303	In your opinion, what are the danger signs related to the life or survival of the child?	CANNOT BE BREASTFED/GIVEN MILK ..... A BEING LAZY OR DOES NOT WANT TO DRINK ..... B VOMIT WHATEVER THE INTAKE ..... C CONVULSION ..... D UNCONSIOUS ..... E HIGH FEVER ..... F DYSPNOE/BREATH DIFFICULTIES ..... G OTHER (WRITE) _____ X DO NOT KNOW..... Z	
	HISTORY OF DIARRHEA (OF THE LAST CHILD) WITHIN THE LAST 2 WEEKS		
C304	Has the child (NAME) suffered from diarrhea, that was watery stools/ defecation 3 or more times per day, in the last 2 weeks?	YES..... 1 NO 2	→ C306
C305	Where did you seek treatment for that diarrhea? Any other else? (PROBING) IF HOSPITAL OR CLINIC, DO PROBING, 'OWNED BY GOVERNMENT OR PRIVATE '?	SELF TREATMENT: CONTINUE TO GIVE BREASTMILK ..... A GIVE FLUID MORE THAN USUAL ..... B CONTINUE TO GIVE FOOD..... C ORALIT/SALT-SUGAR-FLUID ..... D CHILD GETS A REST ..... E HERBS/PARSLEY/POTION..... F SEEK HEALTH PERSONNEL: GOVERNMENT: HOSPITAL ..... G COMMUNITY HEALTH CENTER/PUSKESMAS ..... H CLINIC ..... I MOBILE HEALTH SERVICES..... J PRIVATE: HOSPITAL ..... K CLINIC ..... L PRIVATE PRACTICE OF DOCTOR ..... M PRIVATE PRACTICE OF MIDWIFE ..... N COMMUNITY: MATERNITY HUT/POLINDES ..... O VILLAGE MIDWIFE..... P INTEGRATED HEALTH POST/POSYANDU..... Q OTHER (WRITE) _____ X NOTHING TO DO ..... Y	

NO	QUESTION	ANSWER AND CODE OF CATEGORY		SKIP
	HISTORY OF COUGH WITHIN THE LAST 2 WEEKS			
C306	Has the child (NAME) have cough in the last 2 weeks?	YES NO	1 2	 → C3**10**
C307	Was the cough occured along with difficulties in breathing ?	YES NO	1 2	
C308	What did you do for handing the above mentioned cough? Anything else? (PROBING) IF HOSPITAL OR CLINIC, DO PROBING, 'OWNED BY GOVERNMENT OR PRIVATE '?	SELF TREATMENT: CONTINUE TO GIVE BREASTMILK GIVE FLUID MORE THAN USUAL STAY AWAY FROM SMOKE OF CIGARRETE CONTINUE TO GIVE THE FOOD GIVE SWEET SOYA SAUCE, HONEY, LIME/CITROEN CHILD GETS A REST GIVING COUGH REMEDIES GIVING HERBS SEEK HEALTH PERSONNEL: GOVERNMENT: HOSPITAL COMMUNITY HEALTH CENTER/PUSKESMAS CLINIC MOBILE HEALTH SERVICES PRIVATE: HOSPITAL CLINIC PRIVATE PRACTICE OF DOCTOR PRIVATE PRACTICE OF MIDWIFE COMMUNITY: MATERNITY HUT/POLINDES VILLAGE MIDWIFE INTEGRATED HEALTH POST/POSYANDU OTHER (WRITE) _____ NOTHING TO DO	 A B C D E F G H I J K L M N O P Q R S X Y	 → **C310** → **C310**
C309	Has the child (NAME) been given antibiotics (remedies should be taken within 4-5 days of cure)?	YES NO DO NOT KNOW	1 2 3	
	HISTORY OF FEVER WITHIN THE LAST 2 WEEKS			
C310	Has the child (NAME) suffered from fever (increasing body temperature) in the last 2 weeks?	YES NO	1 2	 → **C314**
C311	Has the fever been along with shiver and happened repeatedly?	YES NO	1 2	

NO	QUESTION	ANSWER AND CODE OF CATEGORY		SKIP
C312	Did you seek treatment for handling that high fever? Anything else? (PROBING) IF HOSPITAL OR CLINIC, DO PROBING, 'OWNED BY GOVERNMENT OR PRIVATE '?	SELF TREATMENT: CONTINUE TO GIVE BREASTMILK GIVING FLUID/SOLUTION MORE THAN USUAL CONTINUE TO GIVE FOOD REDUCE GIVEN DRINK/FLUID OR FOOD GIVING ANTIPIRETIC SLEEP USING BEDNET WEAR THIN CLOTH BODY SURFACE COOLING CHILD GETS A REST GIVING REMEDIES FOR REDUCING FEVER HERBS/PARSLEY/POTION SEEK HEALTH PERSONNEL: GOVERNMENT: HOSPITAL COMMUNITY HEALTH CENTER/PUSKESMAS CLINIC MOBILE HEALTH SERVICE PRIVATE: HOSPITAL CLINIC PRIVATE PRACTICE OF DOCTOR PRIVATE PRACTICE OF MIDWIFE COMMUNITY: VILLAGE MIDWIFE MATERNITY HUT/POLINDES INTEGRATED HEALTH POST/POSYANDU OTHER (WRITE) _____ NOTHING TO DO	 A B C D E F G H I J K L M N P Q R S T U V W X Y	
C313	Has the child (NAME) been given antimalaria remedies such as quinine?	YES NO DO NOT KNOW	1 2 8	
C314	Does this household have bednet ?	YES NO DO NOT KNOW	1 2 8	 → H101 → H101
C315	Is the bednet utilized?	YES, CHILDREN UTILIZED IT YES, ADULT UTILIZED IT DO NOT UTILIZE	A B C	

H1. ACCESS TO HEALTH SERVICES

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
H101	Usually, what is the first action taken when one household member suffers from fever?	SELF TREATMENT: REST ..... 11 TAKE REMEDIES BOUGHT FROM SMALL STORE ..... 12 DRINK PRAYED/SUPERSTITIOUS WATER ..... 13 HERBS/PARSLEY/POTION ..... 14 SURFACE COOLING ..... 15 PUT WARM WATER ..... 16 SEEK HEALTH PERSONNEL: GOVERNMENT: HOSPITAL ..... 21 COMMUNITY HEALTH CENTER/PUSKESMAS ..... 22 CLINIC ..... 23 MOBILE HEALTH SERVICES ..... 24 PRIVATE: HOSPITAL ..... 31 CLINIC ..... 32 PRIVATE PRACTICE OF DOCTOR ..... 33 PRIVATE PRACTICE OF MIDWIFE ..... 34 COMMUNITY: VILLAGE MIDWIFE ..... 41 MATERNITY HUT/POLINDES ..... 42 INTEGRATED HEALTH POST/POSYANDU ..... 43 PRACTICE OF NURSE ..... 44 TRADITIONAL HEALER/DUKUN ..... 45 OTHER (WRITE) _____ 96 NOTHING TO DO 97	
H102	If the disease has not been recovered, where do you usually seek the further treatment?	GOVERNMENT : HOSPITAL ..... 11 COMMUNITY HEALTH CENTER/PUSKESMAS ..... 12 CLINIC ..... 13 MOBILE HEALTH SERVICES ..... 14 PRIVATE: HOSPITAL ..... 21 CLINIC ..... 22 PRIVATE PRACTICE OF DOCTOR ..... 23 PRIVATE PRACTICE OF MIDWIFE ..... 24 COMMUNITY: VILLAGE MIDWIFE ..... 31 MATERNITY HUT/POLINDES ..... 32 INTEGRATED HEALTH POST/POSYANDU ..... 33 PRACTICE OF NURSE ..... 34 TRADITIONAL HEALER/DUKUN ..... 35 OTHER (WRITE) _____ 96 NOTHING TO DO 97	
H103	Usually, what is the reason of you or other household member for visiting village midwife?	PHYSICAL EXAMINATION ..... A LOOKING FOR DRUGS/REMEDIES ..... B RECEIVING CARE ..... C BIRTH DELIVERY ..... D FAMILY PLANNING SERVICES ..... E HEALING THE ACCIDENT WOUND ..... F OTHER (WRITE) _____ X NEVER VISIT VILLAGE MIDWIFE ..... Y	
H104	Usually, what is the reason of you or other household member for going to traditional healer/ dukun?	MASSAGE ..... A HERBS ..... B SPIRITUAL HEALING ..... C OTHER (WRITE) _____ X NEVER VISIT TRADITIONAL HEALER/DUKUN . ..... Y	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
	EXPERIENCES IN UTILIZING HEALTH SERVICES THE LAST TIME		
H105	When did you go to health personnel or health facility at the last time? CODE '99' IF DOES NOT REMEMBER	…… ☐☐ MONTHS A-GO	
H106	What was the reason of you for visiting above mentioned health personnel or health facility?	OUTPATIENT CARE OF RESPONDENT HERSELF WHO WAS SICK ... A OUTPATIENT CARE OF OTHER HH MEMBER WHO WAS SICK ..... B CHECK THE HEALTH CONDITION OF RESPONDENT ..... C CHECK THE HEALTH CONDITION OF OTHER HH MEMBER ..... D ANTENATAL CARE ..... E FAMILY PLANNING SERVICES ..... F INPATIENT CARE FOR BIRTH DELIVERY ..... G INPATIENT CARE CAUSED BY OTHER DISEASE ..... H OTHER (WRITE) _____ X	
H107	What was the type of health facility or health personnel you visited at that time ?	GOVERNMENT: HOSPITAL ..... 11 COMMUNITY HEALTH CENTER/PUSKESMAS ..... 12 CLINIC ..... 13 MOBILE HEALTH SERVICES ..... 14 PRIVATE: HOSPITAL ..... 21 CLINIC ..... 22 PRIVATE PRACTICE OF DOCTOR ..... 23 PRIVATE PRACTICE OF MIDWIFE ..... 24 COMMUNITY: VILLAGE MIDWIFE ..... 31 MATERNITY HUT/POLINDES ..... 32 INTEGRATED HEALTH POST/POSYANDU ..... 33 OTHER (WRITE) _____ 96 DO NOT KNOW 98	
H108	When did you visit the health facility or health personnel at that time?	WORK DAY WITHIN WORK HOURS (AT 08.00 -14.00) ..... 1 OUTOF WORK HOURS ..... 2 HOLIDAY 4	
H109	What is the reason of choosing the time for visiting health facility or health personnel?	BETTER CARE/SERVICES ..... A AVAILABLE TIME OF RESPONDENT. ..... B SUFFERED FROM SICK/ILL AT THAT TIME ..... C CHEAPER ..... D BETTER DRUGS/REMEDIES ..... E OTHER (WRITE) _____ X	
H110	What is the estimated distance from your house to that health facility (ANSWER OF H107)? DO PROBING, OR LOOK FOR OTHER WAY OF ESTIMATION IF RESPONDENT HAS DIFFICULTIES IN REMEMBERING	DISTANCE IN KM ..... ☐☐☐☐	
H111	How did you go to that health facility (ANSWER OF H107)?	FOUR WHEELS VEHICLE / CAR ..... A TWO WHEELS VEHICLE / MOTORCYCLE ..... B WALKING ..... C BOAT ..... D HORSE CART ..... E MOTOR CART ..... F CIDOMO (SPECIFIC MOTOR CART) ..... G OTHER (WRITE) _____ X DO NOT KNOW ..... Z	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
H112	How was the length of time needed for going from your house to that health facility (ANSWER OF H107) ? DO PROBING IF RESPONDENT HAS DIFFICULTIES IN REMEMBERING THE LENGTH OF TIME	LENGTH OF TIME: ☐☐ HOURS ☐☐ MINUTE	
H113	How much money was needed for transport to reach that health facility?	TRANSPORT COST IN THOUSAND RUPIAH ☐☐☐☐	
H114	Is that health facility (ANSWER OF H107) one that closest to your house?	YES ..... 1 NO ..... 2 DO NOT KNOW 8	
H115	Can health personnel in that health facility (ANSWER OF H107) be met or visited any time needed?	YES ..... 1 NO ..... 2 DO NOT KNOW 8	
H116	Who was the first person received you when you arrived in that health facility (ANSWER OF H107) ?	ADMIN/REGISTRATION PERSONNEL ..... 11 DUTY OFFICER ..... 12 DOCTOR ..... 13 NURSE/MIDWIFE ..... 14 OTHER (WRITE) _____ 96 DO NOT KNOW..... 98	
H117	What did that person do to you from the beginning till the time you received the medical care? WRITE THE **RANK** BASED ON WHAT RESPONDENT MENTIONED.		**RANK**
		ASKED QUESTIONS A	
		DID REGISTRATION B	
		ASKED THE DOWNPAYMENT C	
		ASKED THE FULL PAYMENT D	
		DID PHYSICAL EXAMINATION E	
		TOOK BODY TEMPERATURE MEASUREMENT F	
		TOOK BLOOD PRESSURE MEASUREMENT G	
		DID BODY WEIGHING H	
		WROTE PRESCRIPTION I	
		GAVE DRUGS/REMEDIES J	
		OTHER (WRITE) X	
		DID NOTHING Y	
		DO NOT REMEMBER Z	
H118	How long did you have to wait from the time you arrived at that health facility (ANSWER OF H107) until you were requested to be cared/examined?	WAITING TIME ☐☐ HOURS ☐☐ MINUTE	
H119	In your opinion, was that length of time being too long, short, or just moderate?	TOO LONG ..... 1 MODERATE ..... 2 SHORT ..... 3 DO NOT KNOW 9	
H120	During you waited for the service, what did you do?	LISTENING TO PROMOTION GIVEN BY HEALTH PERSONNEL ..... A READING THE BOOK/MAGAZINE/NEWSPAPER ..... B READING THE POSTER POSTED ON THE WALL ..... C WATCHING TELEVISION ..... D TALKING WITH HEALTH PERSONNEL ..... E TALKING WITH OTHER VISITORS ..... F OTHER (WRITE) ..... X DO NOTHING ..... Y	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
H121	Who did examine you in the examination room at the health facility (ANSWER OF H107) ?	DOCTOR ..... 1 MIDWIFE ..... 2 NURSE ..... 3 OTHER (WRITE) _____ 6 DO NOT REMEMBER 8	
H122	Did you get explanation from the health personnel (ANSWER OF H107) about the disease you suffered at that moment?	YES ..... 1 NO 2	→ **H125**
H123	Can you tell us, what were the explanations you received at that time?	RESULT OF EXAMINATION ..... A DISEASE SUFFERED AT THAT TIME ..... B ACTION TO BE TAKEN TO SOLVE THE PROBLEM ..... C ACTION TO BE TAKEN TO PREVENT FURTHER PROBLEM ..... D MATTERS/ITEMS SHOULD BE AVOIDED ..... E OTHER (WRITE) _____ X DO NOT REMEMBER ..... Z	
H124	In your opinion, how long did you get that explanation ?	LENGTH OF TIME RECEIVING EXPLANATION ☐☐ HOURS ☐☐ MINUTE	
		a	B
H125	a. Do you have card for discounted payment or free of charge of health services or insurance card.... please mention it ... b. Please show it to us .. [CARD OWNERSHIP: INDIVIDUAL OR HOUSEHOLD]	ASKES (GENERAL INSURANCE) ..... A ASKESKIN (INSURANCE FOR POOR) ..... B PRIVATE INSURANCE ..... C JAMSOSTEK (INSURANCE FOR LABOR FORCE) ..... D SURAT KETERANGAN TIDAK MAMPU (LETTER OF POVERTY) ..... E OTHER (WRITE) ..... X DOES NOT HAVE ANY ..... Z	A B C D E X Z
H126	Did you use that card (Kartu Sehat, Askes, Askeskin, JPKM, Asuransi Swasta) at the time you go to that above mentioned health facility ?	YES ..... 1 NO 2	→ **H130**
H127	If yes, what card did you use?	ASKES(GENERAL INSURANCE) ..... 1 ASKESKIN (INSURANCE FOR POOR) ..... 2 PRIVATE INSURANCE ..... 3 JAMSOSTEK (INSURANCE FOR LABOR FORCE) ..... 4 SURAT KETERANGAN TIDAK MAMPU (LETTER OF POVERTY) ..... 5 OTHER (WRITE) 6	
H128	Did you have to pay any additional cost for the services ? If yes, what for ?	NO ..... A YES, - FOR COMPLEMENTING THE PAYMENT THAT WAS NOT INSURED ..... B - FOR ADDITIONAL SERVICES ..... C - FOR BUYING DRUGS/REMEDIES/HEALTH EQUIPMENT ..... D	
H129	If you have lack of funding for health services payment, usually what do you do?	BORROWING MONEY TO FAMILY/RELATIVES ..... A BORROWING MONEY TO NEIGHBOUR ..... B BORROWING MONEY TO VILLAGE-COOPERATION ..... C WITHDRAWING THE SAVING ..... D SELLING LAND OR VALUABLE THINGS ..... E PAWNING THE VALUABLE THINGS ..... F OTHER (WRITE) _____ X	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
H130	Did the health facility (ANSWER OF H107) provide the needed drugs/remedies?	YES ..... 1 NO 2	→ H132
H131	In your opinion, compared to other places, how was the price of the drugs/remedies provided in the above mentioned health facility? Was it being more expensive, same price, or cheaper?	CHEAPER ..... 1 SAME ..... 2 MORE EXPENSIVE ..... 3 INCLUDED IN THE FEE FOR SERVICE OF DELIVERY ..... 4 DO NOT KNOW 8	

SATISFACTION ON THE SERVICES

H132	At the time you received health services *(*ANSWER OF H107*)*, were you satisfied in some items such as follows ...: READ A TO J, ASK RESPONDENT TO EVALUATE, GREATER VALUE MEANS MORE SATISFIED. USE DEMO-CARD	Very unsatisfied ..... Very satisfied									
		1	2	3	4	5	6	7	8	9	10
	a. Hospitality of personnel who provided services	1	2	3	4	5	6	7	8	9	10
	b. Skill of personnel provided care and treatment	1	2	3	4	5	6	7	8	9	10
	c. Completeness of equipment	1	2	3	4	5	6	7	8	9	10
	d. Cleanliness of health service facility	1	2	3	4	5	6	7	8	9	10
	e. Waiting time for services	1	2	3	4	5	6	7	8	9	10
	f. Providing services privately	1	2	3	4	5	6	7	8	9	10
	g. Providing secure services	1	2	3	4	5	6	7	8	9	10
	h. Providing the certainty of result of treatment	1	2	3	4	5	6	7	8	9	10
	i. Easy to reach the place of facility	1	2	3	4	5	6	7	8	9	10
	j. The cost is inexpensive relatively	1	2	3	4	5	6	7	8	9	10

H133	What kind of services have been provided in the health facility you visited ?	ANTENATAL CARE ..... A FAMILY PLANNING ..... B HANDLING/TREATING THE DISEASES ..... C IMMUNIZATION ..... D BIRTH DELIVERY SERVICES ..... E CHILD HEALTH EXAMINATION ..... F OTHER (WRITE) _____ X	
H134	Generally, how is your satisfaction towards the services given by health personnel in that facility (ANSWER OF H107)	VERY SATISFIED ..... 1 SATISFIED ..... 2 LESS SATISFIED ..... 3 NOT SATISFIED 4	H136
H135	If you were not satisfied, what did you do ?	COMPLAINING TO THE CHIEF OF HEALTH FACILITY ..... A WRITING SUGGESTION TO BE PUT IN THE SUGGESTION BOX ..... B BEING UPSET TO HEALTH PERSONNEL ..... C BEING UPSET BEHIND THE PERSONNEL ..... D NOT RECOMMENDING OTHER PEOPLE TO COME. ..... X OTHER (WRITE): ..... Y DOING NOTHING ..... Z	
H136	Do you recommend other people to get health services provided by this health facility (ANSWER OF H107)	YES ..... 1 NO ..... 2 DO NOT KNOW 3	

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
H137	In the last one year, have you received information related to family planning, pregnancy, birth delivery, and neonatal care ?	YES ..... 1 NO 2	→ H201
H138	How did you get the above mentioned information?	MAGAZINE ..... A NEWPAPER ..... B POSTER/ LEAFLET ..... C BOOKLET ..... D RADIO ..... E TELEVISION ..... F RELIGIOUS PLACES ..... G VILLAGE MEETING ..... H AT SCHOOL ..... I AT THE WORK PLACE ..... J CHC/PUSKESMAS/ HOSPITAL/CLINIC ..... K HEALTH PERSONNEL ..... L HEALTH CADRE ..... M FRIEND/FAMILY/RELATIVES ..... N OTHER (WRITE) _____ X DO NOT KNOW ..... Z	

H2. KNOWLEDGE ON HIV/AIDS

NO	QUESTION	ANSWER AND CODE OF CATEGORY	SKIP
H201	Have you heard about HIV/AIDS?	YES ..... 1 NO 2	→ STOP
H202	Where did you get information on HIV/AIDS? Any other else? (PROBING)	RADIO ..... A TELEVISION ..... B NEWPAPER ..... C MAGAZINE ..... D POSTER/PAMPHLETE/BANNER ..... E HEALTH PERSONNEL ..... F CHC/PUSKESMAS/HOSPITAL/CLINIC ..... G HEALTH CADRE ..... H RELIGIOUS INSTITUTION ..... I SCHOOL ..... J VILLAGE MEETING ..... K FRIEND/FAMILY/HUSBAND ..... L WORK PLACE ..... M OTHER (WRITE) _____ X DO NOT KNOW ..... Z	
H203	In your opinion, what causes can transmit the HIV/AIDS?	BODY FLUID EXCHANGED ..... A MOTHER TO CHILD ..... B HUSBAND TO WIFE ..... C SHARING INJECTION ..... D OTHER (WRITE) _____ X DO NOT KNOW ..... Z	
H204	In your opinion, how is the prevention way of HIV/AIDS?	ABSTINENCE ..... A BE FAITHFUL ..... B USE CONDOM IN SEX RELATIONSHIP ..... C NOT SHARING NEEDLES/INJECTION ..... D OTHER (WRITE) _____ X DO NOT KNOW ..... Z	

NO	QUESTION	ANSWER AND CODE OF CATEGORY		SKIP	
			a	b	
H205	a. In your opinion, where can people find the services providing explanation of HIV/AIDS (conseling) as well as doing testing for HIV/AIDS?	HOSPITAL	A	A	
		COMMUNITY HEALTH CENTER/PUSKESMAS	B	B	
		CLINIC	C	C	
		MATERNITY CLINICS	D	D	
		MOBILE HEALTH SERVICES	E	E	
	b. In your opinion, where can people get the treatment of sexual transmitted diseases ?	PRIVATE PRACTIVE OF DOCTOR	F	F	
		PRIVATE PRACTICE OF MIDWIFE	G	G	
		MATERNITY HUT/POLINDES	H	H	
		VILLAGE MIDWIFE	I	I	
		SCHOOL	J	J	
		CHURCH/MOSQUE	K	K	
		HOTLINE OF HIV/AIDS	L	L	
		N.G,O DEALS WITH HIV/AIDS CARE & SUPPORT	M	M	
		INSTITUTION DEALS WITH HIV/AIDS CARE & SUPPORT	N	N	
		TRADITIONAL HEALER/DUKUN	O	O	
		A. OTHER (WRITE) _____	X		
		B. OTHER (WRITE) _____		X	
		DO NOT KNOW	Z	Z	

ANTHROPOMETRICAL MEASUREMENT OF LAST CHILD

WRITE DOWN THE RESULT IN THE FOLLOWING TABLE.

IDENTIFICATION				RESULT AND METHOD OF MEASUREMENT		
NO. OF HH MEMBER *	NAME	DATE, MONTH AND YEAR OF BIRTH **	SEX OF CHILD	HEIGHT	METHOD OF HEIGHT MEASURE-MENT	WEIGHT
(1)	(2)	(3)	(4)	(5)	(6)	(7)
				CM	1: SUPINE 2: STANDING	KG
			M F	,	1 2	,

* No. of row is the same with what written in B101 page 2.
** This part should be obtained and explored acurately, do conversion if using local calender.

OBSERVATION:

O1	Wide of the house (estimate the length and width of the house)	IN METER SQUARE
O2	Type of the roof (widest) .	CONCRETE 11 CERAMIC ROOF TILE 12 SHINGLE ROOF 13 CORRUGATED METAL/IRON SHEET 14 ASBESTOS TILED 15 PALM FIBER 16 OTHER (WRITE) 96
O3	Type of the wall (widest)	CONCRETE/BRICKS 1 WOODEN (“BEBAK”) 2 BAMBOO 3 OTHER (WRITE) 6
O4	Type of the floor (widest)	DIRT/GROUND-SOIL 1 OTHER (CONCRETE/WOODEN/CERAMIC) 2

THANKS TO RESPONDENT FOR TIME AVAILABILITY FOR INTERVIEW

APPENDIX 3

GUIDELINE OF IN-DEPTH INTERVIEW AND FOCUS GROUP DISCUSSION

To the INTERVIEWER:

- The interview has a purpose on gathering information on the perception and point of view from stakeholders, which related to health, towards the quality of health services, especially the reproductive and making pregnancy saver services (including family planning), as well as health system in the region;
- The guideline consist of some outline of direction for interviewing the informant in order to deeply explore the interview;
- Suppose to be the interview is following the flow of the guideline in order to acquire a comprehensive information;
- Do encourage the informants to feel free in giving any information, perception or opinion they know; **(It is better if in the introduction session you stressed that "there is no judgment on RIGHT or WRONG answers, and every answer or perception or opinion is important and you are free to say so")**;
- **Probing** should make for some conditions, such as explaining questions that quite difficult to understand; reminding the context of the question; or when the answer is out of the context. **Probing is the researchers' effort to elaborate question in order to explore or to clarify the answer given by the informants or when her/his answers are not consistent**;
- **Do not** lead or give clues for the answer;
- Recording device should prepared before the interview begin, such as to prepare the battery and to check whether the tape recorder is worked;
- Ask permission to record the interview, and explaining that there will be no name is stated in the study report;
- The conclusion of the interview should be summarized at the end of the interview, and before closing you can ask whether there is still any information that has not yet being summarized;
- Any question ask by informant is should be kept and explained later after the interview, or explain that the question should be answered by the authorized health personnel as you have no capacity to answer it;
- Don't forget to say THANKS to the informant;
- Another important thing is don't forget to write down into the LABEL of the cassette for the date, time and place, as well as the type of informant that being recorded;
- Thank you very much of being a moderator and good luck.

IN-DEPTH INTERVIEW GUIDELINE
HOUSEHOLD BASELINE SURVEY FOR
HEALTH SECTOR SUPPORT PROGRAM AT WNT AND ENT

Januari 2007

Informants:
Bupati (Head of the District), Parliament Member, Head of District Health Office, BKKBN, NGO, CBO, and Community/Religious Leader

[Greet the informant] Good (morning/afternoon) Sir/Mam, my name is ..... from the Center of Health Research, University of Indonesia. I am very pleased that you have a time for being interview in the middle of your duty as (Bupati/Parliament Member or else). Our center have a duty on doing a research on health, especially towards maternal and child health. Therefore, we would like to know about the situation in this region about the issues from the first source.

As the information you gave will be very important, I ask for permission to record the session of interview as we don't want to loose any information you gave to us. There will be no RIGHT or WRONG answers, and your answers will be welcome, as well as your critiques or suggestion for the issues we discuss.

Now, we want to know more about you, and we started from asking you your complete name, what is your education background?, how long have you been in this position of work [*organization*]?, and what is your area of interest?

So, lets we start with our topics interview:

1. [**Commitment**] Would you please explain to us in what area is your responsibility in this region [*at your organization*]? How is relationship between your responsibility with the health system in this region? [explore the answer]
2. [**Recent condition**] In your point of view, as long as you have been working, what the main health problem in this region? How community deal with those problems? How far the government [*your organization*] get involve in solving the problems? (Probing: what kind of policy, or program, or intervention) How is the result? [if it has not stated, ask specifically what is the problem in regard to maternal and child health] What commitment has done by government [*your organization*] for the achievement on health sector in this region? [How big the fund allocation/policy influence the effort on managing problems in health sector in this region]
3. [**The expected condition**] What opportunity that you can see in order to support the health sector in this region? What is your expectation for the health sector/area in this region? What is your future plan in order to support the improvement on increasing the health status in this region?
4. [**Decentralization**] What do you think about the influence of decentralization policy regarding to the health sector? (probing: a positive or negative effects; pros and cons; advantages or disadvantages) Is there any opportunity that you can take from the decentralization on the health sector to improve the community health status in this region?

5. [**Perceived human resources**] In your experience and observation, how are health providers quality in this region? How you appraise their performance? Can you tell us about doctors PTT (internship), how the system on allocation for doctors in the district? Do you have any critiques, suggestion, or hope?
6. [**Traditional Birth Attendance (TBA)**] Regarding to maernal health, what is your opinion on TBAs? Is it advantageous or disadvantageous? Is there any policy or regulation on the existence of TBAs? How community use the service that given by TBAs? How do you “see” a “TBA” personally?
7. [**Community partisipation**] How is your opinion on posyandu as you observe lately? How is community utilization on posyandu?
8. [**Perseption on government vs public services**] Is there any health services provided by public (such as by professional association, or religion base foundation, etc) in this region? In your observation, how is the effect of public services towards community? Are they utilize the services? What kind of policy given to public services?

Well, the interview will come to an end, is there any critique, suggestion, or expectation that you feel important to say before we close the session? Please, feel free to say so.....

At the end of the interview, the Interviewer will summarized the essence of the interview, and close it afterward.

Thank you very much for your time, and we almost ..... hour(s) ..... minutes of interview. Thanks for your open mind and all answers, opinion, critiques, and suggestions to our questions. We do hope that the rsult of the interview will give inputs on the improvement of our health services. Thank you and good luck.

To the MODERATOR:

- The FGD has a purpose on gathering information about health seeking behavior, and the satisfaction on health services as well as informants' perception on the quality of reproductive health/making pregnancy saver services, including family planning services;
- The FGD Guideline consist of some outline of direction of the discussion;
- **The discussion** is suppose to follow the flow of the guideline in order to have a thorough information;
- Do encourage the informants to feel free in giving any information, perception or opinion they know; **(It is better if in the introduction session you stressed that "there is no judgment on RIGHT or WRONG answers, and every answer or perception or opinion is important and you are free to say so")**;
- Please notice that some of informants might be talking too much and some might be too silence. Therefore, to deal with her/him, who is **dominant**, you can say "thank you very much for your useful/incredible/marvelous information. However, I would like to ask the other to give their opinion in this issue". As you say so, you turn your body or head to face other informant that you want her/him to answer such question. This kind of body language is very important to show that your preference is directed to the other, and this strategy will also work when you deal with silence informant;
- List of informants attendance at the discussion will provide characteristics information on each informants (consist of: name, age, level of education, occupation, number of child(ren) and CU-5), and it should be filled before the discussion;
- **Probing** should make for some conditions, such as explaining questions that quite difficult to understand; reminding the context of the question; or when the answer is out of the context. **Probing is the researchers' effort to elaborate question in order to explore or to clarify the answer given by the informants**;
- **Do not** lead or give clues for the answer;
- Recording device should prepared before the discussion begin, such as to prepare the battery and to check whether the tape recorder is worked;
- Ask permission to record the discussion, as there will be no names are stated in the study report;
- The conclusion of the discussion should be summarized at the end of the discussion, and before closing the session you can ask whether there is still any information that has not yet being summarized;
- Any question ask by informant is should be kept and explained later after the discussion, or explain that the question should be answered by the authorized health personnel as you have no capacity to answer it;
- Don't forget to say THANKS to the member of the discussion;
- Another important thing is don't forget to write down into the LABEL of the cassette for the date, time and place, as well as the type of informant that being recorded;
- Thank you very much of being a moderator and good luck.

INTRODUCTORY SESSION

Good (morning, afternoon, night) ladies [*gentlemen*], my name is ……. from the Center of Health Research, University of Indonesia, and mr/ms …….. my local counterpart is …… from …… Thank you for giving your time to be a member of this discussion. We are gathering here, in this place, to have a discussion on health issues, especially on mother and child health. We would like to know from the very root sources that are the mother [*father*] who had children under-five.

As the discussion is very important, we would like to record the discussion, as we do not want to loose any information you gave to us. Therefore, we ask for your **permission** to record it. There will be no name stated in the report of the study, therefore, please feel free to answer the question, or to express your opinion for the issues. Your inputs, whether it is critique or suggestion will be worthy for us.

Well, before we begin the discussion, we would like to have the information of your demographic background. Can we start from my right hand side please, [start to ask and write down the information in the list of attendance for FGD, name, age, level of education, occupation, etc]

Start the discussion

FOCUS GROUP DICUSSION (FGD) GUIDELINES
HOUSEHOLD BASELINE SURVEY FOR
HEALTH SECTOR SUPPORT PROGRAM AT WNT AND ENT

Januari 2007

FGD for Mother/Father with CU-5

TOPIC I:

PREGNANCY, DELIVERY, AND FAMILY/COMMUNITY PREPAREDNESS/SUPPORT ON THE PROCESS, INCLUDING HEALTH SERVICE UTILITY

1. [**Delivery preparedness**] Would you tell me, what do you do when you know that you [your wife] are [is] pregnant? How their antenatals care? (when, where, with who you [your wife] go for antenatal care) Is there any prohibition/taboo or suggestion for pregnant woman? What kind of custom/tradition on pregnancy/delivery/after delivery woman? How is the attitude and treat from husband/other family member on delivery preparedness
2. [**Complication and referral**] What is family/community usually done, if there is a problem/complication on its pregnancy/delivery? How early detection on problem/complication during pregnancy/delivery is made? How to decide for health referral? (Who decide? Where to go? Whom to handle?) [explore on **3 delays** → too late to detect; too late to refer; too late to handle] What kind of community organization on dealing with problem/complication on pregnant/delivery woman in its community?
3. [**Desa Siaga and Village Midwife**] Ever heard about desa SIAGA? Would you tell us about it? [Who involve in the organization? what kind of activities?, how is community involvement?, what is benefits acquired?] How about village midwife (VM)? [how is community interaction with VM?]
4. [**ASKESKIN**] Opinion on ASKESKIN? [Probing: How to obtain? How its distribute? How its benefits?]

TOPIC II:
HEALTH SEEKING BEHAVIOR AND ACCESS TO HEALTH SERVICES

5. [**Self-care**] If member of your family is getting ill, what the first thing to do to deal with the illness? [Probing: If the answer is '*self-care*', do explore on why, what did you do, and what did you do if its not getting better]
6. [**Type of facility**] If the answer is refer to one of the type of health facility → explore on why you use the facility, is there any special reason to choose, who decide to choose, why you/him/her to decide. The facility chosen for certain illness or different health problem will also have different facility to go? Why?
7. [**Unfavorable facility**] Is there any health facility that never been chosen? Why? If the reason is the cost of the facility, how the possibility on using the ASKESKIN?

8. [**To decide on choosing the facility**] How long it takes to decide on choosing the health facility? [Probing: if the answer is lead to a long delay (more than 6 hours), ask why and what the reason for the delay]
9. [**Free service delivery**] Is there any free health service delivery given in this region? If so, how it is utility?
10. [**Satisfaction on services**] How can you describe on 'satisfaction on services' for health facility you have chosen? [how its health providers? Their attitude? Their skill and competence?; how about the facility circumstances? Comfortness on the facility? the cost?, etc]
11. [**Health provider participation on the community**] Is there any routine community activities that involving any health providers (except posyandu), in order to increase the public health status? Is a community or religion leader also been involved?
12. [**Information on health**] How information on health is delivered to you? Who use to be delivering the information? Are you satisfied with the method of delivering? What is your opinion?

TOPIC III:
PREVENTION ON UNINTENDED PREGNANCY (UP)

13. [**Unintended Pregnancy**] What do you think on unintended pregnancy? How the community deal with UP?
14. [**Abortion**] If the answer is abortion, what do you think about abortion? Who suppose to be dealing with abortion? Why people choose abortion? How communities see on abortion?
15. [**Prevention on UP**] What kind of action giving to prevent UP? [How it will be for married/unmarried women, or even to adolescents] What kind of services should have in order to prevent UP?
16. [**Family Planning (FP)**] What is your opinion on FP? Do you use any FP method? Why you choose? And why you don't choose the other?
17. [**FP services**] Opinion on FP services received? Quality and satisfaction?
18. [**FP services for adolescents**] Opinion on FP services for adolescent (unmarried) if that services do **exist**?

Well, our discussion will come to the end, is there any critique, suggestion, or expectation that you feel important to say before we close the discussion? Please, feel free to say so.....

At the end of discussion, the Moderator will summarized the essence of the discussion, and close it afterward.

Thank you very much for all of you, and we almost ..... hour(s) ..... minutes discussion. Thanks for your open mind and all answers, opinion, critiques, and suggestions to our questions. We do hope that the result of the discussion will give inputs on the improvement of our health services. Thank you and good luck.

APPENDIX 4

ORGANIZATION OF RESEARCHERS

ORGANOGRAM OF RESEARCHERS
Community Baseline Household Survey in NTB and NTT 2007

Principal Investigator:
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DR. Mardiati Najib, DDS

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Repelliawati, SE

Yudarini, SH, MKes

Site Researchers

No	Nama	Area	Posisi
1.	Ruth Stella Thei	Pulau Lombok	Island Field Coordinator
2.	Arif Rachman	Pulau Sumbawa	Island Field Coordinator
3.	Salmiyati Kaunang	Pulau Timor	Island Field Coordinator
4.	Yohanes Wilhelmus Pega	Pulau Flores	Island Field Coordinator
5.	Sri Supartiningsih	Kota Mataram	District Field Coordinator
6.	Herlina	Lombok Tengah	District Field Coordinator
7.	Cahyowati	Lombok Barat	District Field Coordinator
8.	Rosmilawati	Lombok Timur	District Field Coordinator
9.	Deni Wan Putra	Sumbawa Barat	District Field Coordinator
10.	Husnulyati	Sumbawa	District Field Coordinator
11.	Rukyatul Hilaliyah	Dompu	District Field Coordinator
12.	Zuriati	Kabupaten Bima	District Field Coordinator
13.	Nurfarhati	Kota Bima	District Field Coordinator
14.	Yopie	Lembata	District Field Coordinator
15.	Maria Meak	Sikka	District Field Coordinator
16.	Yakobus Dewa Raya Lamablawa	Flores Timur	District Field Coordinator
17.	Emiliana	Ende	District Field Coordinator
18.	Donatus Meak	Manggarai	District Field Coordinator
19.	Daniel F Wogo	Ngada	District Field Coordinator
20.	Jacobus Wara	Manggarai Barat	District Field Coordinator
21.	Maria Bano	Kota Kupang	District Field Coordinator
22.	Simon Seran	Kabupaten Kupang	District Field Coordinator
23.	Kiswa Ariyani	Timor Tengah Utara	District Field Coordinator
24.	Lewi Jutomo	Timor Tengah Selatan	District Field Coordinator
25.	Silverius Leki	Belu	District Field Coordinator
26.	Wem J Saduk	Rote Ndao	District Field Coordinator
27.	Yublina Padarangga	Sumba Barat	District Field Coordinator
28.	Sulaiman Landi	Sumba Timur	District Field Coordinator
29.	Rahmat Zainudin	Alor	District Field Coordinator

± 280 enumerators