JAYAWIJAYA WATCH PROJECT
KANGGIME EXTENSION

AN AusAID PROJECT

PROJECT DESIGN DOCUMENT

World Vision of Australia
in partnership with
World Vision International Indonesia

IDN004

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TABLE OF CONTENTS

Annexes

GLOSSARY

ADF	Australian Defence Force
ADP	Area Development Program
AIPCC	Australia Indonesia Project Coordinating Committee
ARIF	A Depkes based criteria for measuring progress of groups
Bidan	Midwife
Bidan di desa	Community/village midwives
BCG	Bacillus Calmette-Guerin, a vaccine for tuberculosis
Bupati	Chief of the district; mayor
Cadre	Voluntary worker - in the health system and project groups
CMP	Case Management Protocols
Dana sehat	Village based health insurance groups
Depkes	Department/Ministry of Health
Desa	Village
DHO	District Health Office
Dinas Kesehatan	Provincial/district level health department/office
Dukun	Traditional birth attendant
Dusun	Sub-village, hamlet
GOI	Government of Indonesia
HIS	Health Information System
IEC	Information, Education and Communication
IMR	Infant mortality rate
Kabupaten	District
Kanwil Depkes	Provincial health office
Kecamatan	Sub-district
LEISA	Low external input for sloping agriculture
LKMD	Lembaga Ketahanan Masyarakat Desa (Village council)
mandiri	self reliance
mantri	Nurse auxiliary
MEO	Monitoring and Evaluation Officer
MMR	Maternal mortality rate
MUAC	Middle upper arm circumference
NGO	Non government organisation
PCC	(See AIPCC above)
PKK	Pembinaan Kesejahteraan Keluarga (Family welfare movement)
PLA	Participatory Learning and Action
Polindes	Village birthing centre
Pos obat desa	Privatised cadre run village drug post; village dispensary
Posyandu	Integrated village services post
Puskesmas	Sub-district health centre
Pustu	Village health post
SPK	Nurses Training College
TBA	Traditional birth attendants

WVA	World Vision Australia
WVII	World Vision International Indonesia
Yayasan	Foundation which operates similarly to NGOs

SECTION 1 - PURPOSE AND CONTEXT

1.1 AUDIENCE

This Project Design Document (PDD) will be used primarily by AusAID, the Department of Health in Indonesia, the contractor and future reviewers of the project.

1.2 PURPOSE

The purpose of this document is to explain how this project extension came about and what is planned during the life of the project and explain how these will achieve the project objectives. This will include the setting out of objectives as well as schedules detailing the costs and activities.

1.3 BACKGROUND MATERIAL

The key background document for this project is the report of the review conducted for AusAID by a consultant, Ms Gaynor Dawson, in December 1997. It is due to a recommendation of that report that this design is being written. A further useful document is the draft Project Completion Report (PCR)of the Jayawijaya WATCH Project Extension, dated September 1997. The draft PCR contains a list of other documents from the project or about the project that may be of interest to readers.

1.4 NEXT STEPS

The Jayawijaya WATCH Project Extension is currently in an interim stage, having finished officially in September 1997 but given an interim extension pending the recommendations of the review and an acceptable design. When AusAID approves this PDD the next stage will be to enter contract formalities and then the project would commence activity per this design as close to 1 August 1998 as possible.

1.5 EXECUTIVE SUMMARY

1.5.1 Title and classification

Country	INDONESIA
Activity name	Health: Indo-Jayawijaya Health (WVA)
Activity ID	907J32
Program	Bilateral
Activity type	Implementation
AusAID sectors	Health, gender, poverty, environment, indigenous peoples

Gov't counterpart	Department of Health (Depkes)
Organisation	World Vision Australia (WVA)

1.5.2 Project description

The $1.1m Jayawijaya Women And Their Children's Health (WATCH) project commenced in April 1990 and was completed in September 1994. Following a positive review in April 1994, the project was extended for a further 3 years at a cost of $1.5m, until September 1997. A second review in December 1997 has recommended that the project be extended in order to consolidate interventions to date and maximise sustainability and impact. The goal of the project is to improve the health of women and children in Jayawijaya district in the highlands of Irian Jaya where the problems faced by the population include high death rates, malnutrition, high incidences of communicable diseases and low life expectancy.

Major development objectives

The objectives of the project will be to show that a community based model of primary health care can be a successful and important medium for the provision of health care services in rural and remote locations. The extension will be a period of intense activity to finalise and consolidate previous interventions and to further evaluate and comprehensively document the model.

Major activity components

Maternal and infant health services : Deliver appropriate ante-natal services, immunisation program and training program
Health system capacity: Enhance the capacity of existing health services to diagnose and treat basic diseases and to extend coverage. Establish a functional and appropriate computerised health information system
Preventative health : Implement a preventative health and nutrition program and support the health system in training health personnel as well as community based health cadres and groups
Community development: Strengthen existing community development initiatives and train groups in a range of new understandings in gender, health, agriculture and income generation
Management: Implement a data collection system and management coordination

1.5.3 Lessons learned

The WATCH project has attempted to formulate a model of primary health care that allows for greater community participation and ownership. This has been attempted in the Jayawijaya district of Irian Jaya. The project has worked at two levels: improving the capacity of the formal health system; developing the community in a variety of skills. The project has found the following:

- the plan to cover the whole district has placed severe constraints on the project staff and district administration. It would be better to service a smaller area. To some

extent this was done through the life of the project by strategically selecting areas within the district but this has still been difficult due to logistical and other constraints

- there has been significant pressure on committed staff to accommodate all the work demands, including the technical input. A higher level of technical input on a more consistent basis would have been more beneficial to the project
- the development of case management protocols (CMP), the training integrated through the Nurses Training College and the training of doctors and health personnel has been successful in providing systems that are adapted to local conditions and can be used quickly by 'outsiders' when coming into the district eg the CMPs were used in the recent famine.
- it has been important to develop more locally appropriate data gathering systems for the formal health system. These still require more work but there has been recognition of its worth at national level.
- the main strategy for working with groups and villages has been visitation. A higher level of supervision by being in the villages for longer periods of time would have been better than limiting activity to visits. This will also enable closer monitoring to occur
- the use of groups strategy, workshops and exposure visits has worked successfully. These will be continued
- there is a need for a higher level of documentation of activities. This will provide information to a wider group of interests and provide a more comprehensive base from which to analyse the model of primary health care and project progress.

1.5.4 Key issues and risks

There are long standing institutional, structural, organisational and financial constraints facing the health services in Indonesia. The series of events leading to the change of government in May 1998 will exacerbate these constraints, apart from the obvious uncertainty that exists throughout Indonesia as to the country's future. Throughout the project's history the issue of sustainability has been raised, especially given the government's difficulties in servicing such a remote area with little to attract competent civil servants and professionals. It is highly likely that this situation will continue. The risks are that government systems will not be able to supply adequate supplies of drugs, equipment and staffing in the near future. Addressing those issues is well beyond the capacity of this project except that conceptually, this project is designed to provide a community based approach to health care so that communities themselves can overcome the shortfalls in the government system. The risks attached to this approach are part of the issues raised below.

A second issue is that of the isolation and geography of the project area. This issue has been raised consistently throughout the project life and is no different now to the start 7 years ago. The Kanggime and Mamit areas are unlikely to receive road links within the next 5, and perhaps even 10, years and will be dependant on air services and walking tracks for transport. The cost of air transport has risen considerably within the last 6 months due to the economic crisis but even at the best of times, air transport was beyond the means of most villagers. These conditions make it difficult to raise income levels within these communities

as the access to markets is linked to transport. A further risk during the period of the project extension will be the adequacy of air transport. The requirements during this period of project activity will be fairly heavy and there are often delays or unavailability of aircraft due to lack of fuel, lack of pilots and maintenance.

A third issue is capacity to change behaviour within the allotted time frame. Any kind of behavioural change is difficult but the context of the project area is of a people that have experienced 'first contact' within the last 45 years. Tremendous changes have already occurred and are currently occurring.

The redressing of gender imbalance is of primary importance to better health. Significant steps have already been made in terms of materials and training but such a social shift will require a considerable time to become evident. There are PLA surveys which indicate that a degree of change has already occurred in some groups and villages.

A key to providing behavioural change is to ensure that adequate monitoring of the project occurs and that the monitoring will lead to evaluation of project activities so that they move to a conclusion. The major risks will be to not only gather valid data but also to know how to use it and to train and supervise those who collect and use the data.

Mention has been made of the use of local NGOs to carry on activities after the project completion. Most lack the necessary human resources and funding to adequately continue supervision or conduct activities after the project closes. However, steps are being taken to take group leaders to specialist training in Java that will enable them to learn about the mechanics of running an NGO.

1.5.5 Justification and indicators

The review has recommended that the project be extended in the area of Kanggime, to the north west of the district of Jayawijaya. The reason for this is that it is a smaller area therefore better able to be supervised. Secondly, this area offers more opportunities to fulfil the project's aims of demonstrating how the community based approach can improve health care. This is because the area has better access than another smaller area nominated ie Kurima, the anthropometric measurements are better and the area is less susceptible to drought.

The reasons for an extension include the following:

- community development and social change require a long time frame
- the gender interventions need further adjustment and greater inclusion of women in activities
- more focus need to be made to improve supervision of groups
- further training is needed for the CMPs and the HIS
- there will be more opportunity to strengthen capacity of local NGOs
- there will be greater opportunity for testing the model and documenting it.

The key indicator for the project will be how many groups in the target area achieve self

reliant status. Ultimately, the impact indicators will be reduction in maternal and infant mortality rates and higher nutrition levels.

1.5.6 Estimated costs and financing

Components	GOA	GOI	Total
1. Maternal and infant health	31,992	27,569	59,561
2. Capacity building	22,559	1,300	23,859
3. Preventative health	14,922	-	14,922
4. Community development	153,295	-	153,295
5. Management	234,886	25,800	260,686
Total	**457,654**	**54,669**	**512,323**

1.5.7 Expected project duration

The project is expected to take 24 months.

SECTION 2 - SITUATION ANALYSIS

2.1 SETTING THE PROJECT IN CONTEXT

2.1.a Project Origin

The Jayawijaya WATCH Project began in July 1991 and was a response to AIDAB's call for submissions focussed on women and their children's health. The project set out to:

. Extend and improve existing health services
. Develop community and formal capacity to extend coverage of village health care
. Enhance the role of women in Jayawijaya district
. Facilitate village based initiatives to address causes of poor health

Following a review of the project in 1994 the project was extended to develop a model of primary health care suitable and sustainable for the highlands of Irian Jaya. This model is not clearly articulate as yet but the project has been responsible for several programming innovations and an impact on government activity and policy at district, provincial and national levels.

The project was due to conclude in September 1997 and it was not anticipated that a further extension would be requested. However, following recommendations and appeals from senior health personnel in Irian Jaya and from the bupati of Jayawijaya, World Vision wrote a concept paper for a further extension concentrating on the subdistrict of Kurima. This was submitted to AusAID in March 1997.

It was required that formal notification from the Indonesian government (GOI) be received in order to proceed. The GOI (Bappenas) gave in principle approval for the second extension on 24 November 1997. AusAID agreed to consider the situation conditional upon a review of progress, need for extension and conditional upon a satisfactory design to be submitted by World Vision. The project has been operating on an interim extension from October 1997 to 30 June 1998.

The review was conducted for AusAID by Ms Gaynor Dawson in December 1997 and a report circulate in January 1998. The main findings of this report were:

- it was well managed with high quality, committed staff, who were well regarded by all levels of government
- successfully coordinated activities with various government departments and other institutions
- enjoyed a good working relationship with its counterpart, the DHO
- staff were over extended and had difficulty implementing and supervising activities
- there were delays in activities and development of key components as well as slippage in personnel replacement
- some interventions to strengthen the formal health sector were close to sustainable
- there were weaknesses in the collection and evaluation of data as well as the supervision of monitoring
- there was some concern about the sustainability of community activities.

It was recommended that the project continue for a further two years in the Kanggime/Mamit area in the northwest of the district of Jayawijaya. The advantages of this area compared to the proposed Kurima area were that there was better access to the area, there was a higher nutritional need, the groups' ratings for self reliance were higher and there was stronger acceptance of change. These factors would increase the chance for sustainability in the area.

2.1.b Identification of development problem/need

Maternal and infant mortality in Irian Jaya is high and life expectancy is low. Prevalent diseases include respiratory tract infections, diarrhoea and an increasing incidence of malaria. The Jayawijaya district is poorly serviced with health centres and clinics and travel is difficult; the population is scattered and human resource levels are low. Added to this list are the problems of poverty, social transformation and dislocation, women's low status, increasing incidence of sexually transmitted diseases, low education levels, general nutritional deficiency, lack of clean water, poor sanitation, periodic famine and political unrest.

The formal health system is burdened with cumbersome demands when placed in the context of this remote and mountainous region. Few professionals from outside Irian Jaya are available to support the system although the missionary presence has basically established and maintained the health system in the district for many years. Even when services are available the income levels of local people place an enormous constraint on access. In addition, the scattered nature of the system places severe constraints on adequate supervision.

The inequity in work roles and social relationships between men and women in the highlands has a direct negative effect on the health of the women and their children. The women are in a subordinate position socially and are over burdened with work as the result of both traditional culture and more recent interventions.

Despite the project having been implemented for over 6 years and achieving some important results, the project has had limited success in changing gender behaviour, less than adequate supervision of both health and community development activities, insufficient technical inputs and poor documentation of its processes. This project aims to address these more specific needs.

2.1.c Identification of beneficiaries and stakeholders

The key beneficiaries of the project will be the communities of Kanggime and Mamit areas. They will be provided with substantial inputs of training, supervision and supplies. The particular beneficiaries of these areas will be women and children as the project is designed to specifically target the maternal and infant mortality rates.

The major stakeholder in this project is the Indonesian government Department of Health.

The project will assist it to implement protocols, information systems, training and supervisory systems that will enable it to implement its charter more efficiently and effectively. Hopefully there will be a higher level of motivation and confidence amongst the Health staff as a result of higher level inputs. These include all levels of health staff from cadres and TBAs who are not part of the formal health system through to midwives, mantris, nurses and doctors. They will all also be beneficiaries of the project in that their skills, equipment and materials will have been enhanced.

This project is an important project for both governments. For the Australian government, the project provides evidence of its commitment to humanitarian concerns in the delivery of its aid program especially to its Asian neighbours, and particularly to sectoral concerns such as women, gender, health and indigenous peoples.

For the Indonesian government it provides an opportunity to trial innovative assistance to one of its remote areas and seek ways to replicate the ideas in other areas. Government staff, in particular, have an opportunity to be involved in a more focussed, high level activity that is clearly producing change.

World Vision International Indonesia (WVII), as the implementing agency, has had a long term commitment to the highlands of Irian Jaya and will continue to do so. This project has enabled the agency to establish higher standards of activities as this special project's initiatives are integrated into its mainstream activities.

2.2 TARGETED BENEFITS FOR RECIPIENTS

2.2.a Project objective

The objective of the project is to improve the health and nutritional status of women and children in rural communities in Jayawijaya district. This will be achieved by a functioning and sustainable primary health care system with high levels of community participation and ownership. This extension will provide 2 years of consolidation, evaluation, documentation and improved sustainability for the approaches developed over the last 7 years.

2.2.b Performance indicators to measure achievement of objective

The key performance indicator to measure this objective will be how many groups in the target area achieve self reliant status on a scale of 4 stages that leads finally to inclusion of an operational posyandu (integrated post where first level registration of births and deaths occurs, immunisation and first level treatment for disease) and pos obat desa (village level dispensary of basic drugs and supplies). The rider to this indicator is that the posyandu has to be visited at least once every 3 months by a representative from the puskesmas (health centre) to show that the formal system is engaging with the community.

Ultimately, the impact indicators for this objective will be lower maternal and infant mortality rates, lower malnutrition and lower morbidity. The current maternal mortality rate (MMR) is over 450 deaths per 100,000 live births. The national government has just set a

target of 225 deaths per 100,000 live births for the year 2000. Although this would be a dramatic result statistically, other community based projects (eg Alor) have shown that with appropriate and intensive activity, communities can achieve these dramatic results. The current infant mortality rate (IMR) is about 98 deaths per 1,000 live births. The project will aim to reduce this figure by 35% to a target rate of 65 deaths per 1,000 live births. Malnutrition is known to be a serious problem and this is measured by a weight for height scale. Currently the average z score is less than the -2 standard deviation on the WHO scale. The project will aim to increase the average z score for the target area. Finally, another measurement that indicates well being of pregnant women is the middle upper arm circumference (MUAC) measurement. Current averages in Jayawijaya are about 18cm but should be around 25 cm. The project will aim to show that the average MUAC level has increased over the two years.

The project will conduct 3 baseline surveys during the course of the project: firstly in July/August 1998, the second in May/June 1999 and the final one in March 2000. These surveys will have a variety of questions that will provide the information base to show whether the project objectives have been achieved.

2.3 PROJECT RATIONALE

2.3.a Project rationale

Women and their children's health is a significant concern in the Indonesian government's health program. However, the provision of health services, especially to remote regions, is a daunting task. Studies in the late 1980s pointed to the urgent need to improve the effectiveness of the primary health care program in Irian Jaya where historically missions, mainly through their health oriented NGOs, have played an important role in filling the gaps in government health services.

Maternal and infant mortality in Irian Jaya is high and life expectancy low. Prevalent diseases include pneumonia and related respiratory tract infections, diarrhoea and malaria. The highland district of Jayawijaya presents particular challenges for tackling health issues and the delivery of health services. These include mountainous terrain, lack of transportation, imbalance of gender roles, low education levels, lack of clean water, poor sanitation and periodic famine.

Jayawijaya is poorly serviced with health centres and clinics. Travel to distant health centres is difficult, especially for women who cannot be away from home for long periods because of domestic and agricultural responsibilities. The level of human resource development is a problem. There is a lack of well trained health service personnel and a high turnover of medical staff.

Health knowledge amongst the community is lacking with few people understanding the basic principles of health and nutrition. Poor nutrition is widespread. Animal protein is not eaten regularly and the range of food consumed is limited. Furthermore, while the population density in Jayawijaya appears low relative to land area, the capacity of the land

to provide the nutritional requirements for the population on a sustained basis is low. In the latter half of 1997, drought conditions and fires reduced food production, in particular that of the staple food, sweet potato.
The complex and challenging nature of the situation in Jayawijaya has demanded an innovative and flexible approach to improved health care. This has to a certain extent been able to be achieved by the WATCH team who, within the financial and logistical constraints imposed on them, have responded to challenges with new approaches when necessary. One example of this is the development of the use of sweet potato as a treatment for diarrhoea and as a weaning food.

2.3.b Response to Review Recommendations

7.1 Extension for 2 years
The project design is for 2 years according to the recommendation

7.2 Scope
7.2.1 Location - Kanggime or Kurima
The project has taken up the recommendation to work in the Kanggime area, including Mamit. The review made further recommendations regarding Kurima:
. Integrated agricultural/water management/health project with a gender component
There is still a substantive operation in this area servicing the drought but addressing some of the issues raised. An ADF contingent with $7.5m backing is conducting activities in the area. Furthermore it will be a decision that AusAID will have to make whether they wish to invest further funds in this area
. SAS project administered through a local NGO
Again this will be a matter for AusAID to address
. WVII or GOI funded interventions
WVII have been involved with drought relief in the area and have an ADP on the edges of the sub district. They will continue to utilise techniques and materials developed through WATCH. It is unlikely that WVII will have the funding capacity to establish a further project in the area.

7.2.2 Activities
No new activities are planned for commencement during the extension. The proposed involvement with CASE/LIPI is rather an intensification of existing training in alternative technology.

7.2.3 Staff
. Male GAD Assistant - this person is budgeted for and a job description is attached at Annexe 6.
. Monitoring and Evaluation Officer - this person is budgeted for and a job description is attached at Annexe 6
. A new staff chart is attached at Annexe 4

7.2.4 Consultant inputs
. GAD/PLA/Community Development -

. Small business enterprise/Cooperative Development
. Community health education
. Project documentation - The design has taken up this recommendation but has taken up another suggestion to split this task into two phases. The design proposes that an initial survey be undertaken to develop a framework for how the project should be written up. This will be undertaken in the first 6 months and the report/recommendations from this consultancy will be presented to the first PCC in December for discussion. The second phase will be undertaken within the last 6 months of the project and will undertake the writing according to the framework agreed upon at the December 1998 PCC.

7.3 Development of the Concept Plan

The project milestones in Annexe 5 set out the project plan. Activities have been designed to be linked to the PCCs so that issues such as the documentation framework and annual survey results can be discussed at these meetings.

7.4 Recommendations for Improved Project Impact and Sustainability

7.4.1 Internal coordination

This recommendation is already operating in the project. Monthly meetings are regularly held and indeed are more regular when there are particular problems or pressures.

7.4.2 Improved supervision

A male Gender and Development Assistant (GADA) and Cadre Assistant have been nominated, with job descriptions attached at Annexe 6. These people will spend up to 8 and 4 months, respectively, in the field moving around the groups. The arrangements to be shared between these staff have changed since the writing of the draft design document to better reflect their responsibilities and capabilities; overall the supervision months have increased. The Cadre Assistant will sometimes travel with the GADA but will also be able to back up the inputs of all staff who have provided inputs in the field. Other staff will be spending more intense and longer time with groups when they are in the field than was the case in the earlier phases of the project. Higher levels of supervision will be given for groups lower on the ARIF scale.

7.4.3 Training

Training of health workers will be maintained with activities already identified in Output 2. Nearly all of this training will be conducted in the local area as recommended. It is important to note that there are no doctors in the target area and the most senior health staff are midwives, of which there are only two. Most posyandu training will be attended by women with few men; however an attempt will be made to involve more women in the other activities eg a target of 25% has been set for the exposure trips. The DHO will be supporting the continuing training of doctors.

7.4.4 Gender imbalance

The project staff are aware of the difficulties in providing equal opportunities for men and women to participate in income generating activities. This will be emphasised in staff meetings and training.

7.4.5 Gender awareness

The design provides for gender awareness workshops that will provide an opportunity to explore the issues raised: child rearing practices and gender awareness for school children. Some efforts have already been made towards the development of material for school children.

In addition to these topics, there are other topics that have been identified as serious issues for discussion:

. Referral for obstructive labour - it is common for the men to decide whether this should occur or not

. Teenage pregnancies - there is significant tension within communities, especially for girls who are given the opportunity to live in Wamena to attend high school

. Disbursement/access of/to family income - this has been an issue for some time but will be even more apparent as increase income is generated

. Marriage between Irianese - there is a higher incidence o mixed marriages and there is an opportunity to explore this issue

. Female leadership - how can this be accepted in traditional society.

7.4.6 Cisarua

This recommendation is accepted with qualification. It should be noted that the idea of insisting women travel to Java is a very controversial step to take - it is not that the project is reluctant to take women, it is more that it is very difficult to obtain 'permission' for the women to go away. It is better to take extra men than not take a full group. The design contains plans to continue this activity. It is expected that one trip per year will be made with about 20 cadres in each trip. The project target is for 25% women on each trip.

7.4.7 Crop diversification and nutrition

The LEISA strategy will be continuing and there will be ongoing contact with expert groups such as LIPI.

7.4.8 Marketing

It is agreed that marketing is a real problem. The project will continue to support the development of local cooperatives and will also promote the development of a business sense with a workshop in Wamena and consultancy in the villages. Activities in Output 4 cover this recommendation.

7.4.9 Community Health Education

There has been continuing effort in this sector and considerable success in changing behaviour patterns, particularly in latrine building. There will be no diminution of effort in this sector as the project recognises the importance of these activities. Activities in Output 3 cover this recommendation.

7.4.10 Community contribution

Misunderstandings always occur in projects such as this. It is hoped that with greater presence on the ground during this extension there will be more opportunity to sort out any future misunderstandings. The project will ensure community understanding and agreement

on project goals. Apart from the issue of understanding, the policy of the project has been consistent - to ensure that there is as much community contribution to activities as possible to ensure sustainability and ownership.

7.4.11 Monitoring, evaluation and reporting

. The project will be reappointing a Monitoring and Evaluation Officer as recommended in 7.2.3

The MEO will incorporate the suggestions on womens participation etc into the monitoring schedule

. The project will be providing monthly reports of activity as recommended

. The HIS will be reviewed and completed and an assessment is planned after a year of full operation.

7.4.12 Puskesmas doctors

It should be noted that there are no doctors in the new target area. However, a simple supervisory system has been suggested in Output 2 for the puskesmas midwives to follow and to be inspected on a regular basis by the DHO. The DHO will be encouraged to pursue at least this strategy in other puskesmas.

7.4.13 Quality of Service Delivery

. The thrust of this recommendation is accepted. The difficulty of translating into local languages is that many of the people we are trying to reach are already illiterate; thus translation is not necessarily the answer. Providing colour and lamination can be done and is budgeted for in Output 4.

. Preliminary discussions have been held with Depkes officials re shortages in supplies.

. Plastic sleeves come under the same conditions as lamination above.

7.4.14 Networking and coordination

. Inter community visits are more likely to be conducted through Wamena. The exposure visits and visits to training NGOs in Java will also assist cross fertilisation. The high level of consultant input will also feed further diversity into the villages

. Regular inter governmental meetings are scheduled in Output 5

7.4.15 Improved Inter-institutional Program Linkages

. Following discussions with Depkes, expenditure by DHO has been identified. An agenda item for the first PCC is to discuss the issue of counterpart funding.

. Linkages to other institutions are ongoing - a list of institutions with which the project has links is included at Annexe 11 . The WVII schools program is a slight misnomer as there are no WVII schools but the occasional 'scholarship' - the WVII system of involvement is slower than WATCH however they have plans to assist in this area over the next few years.

7.4.16 Equipment

. Budget has been proposed for the upgrading of computer equipment in Output 5

7.4.17 Nutrition

. As expressed above, nutrition plots and the LEISA program will work together with agricultural experts to increase diversity of food resources. It is recognised that there may be difficulty in this behaviour change.

7.4.18 Latrines

. Provision for this activity has been made in Output 3. It is not accepted that the latrines need further quality but further encouragement for usage.

7.4.19 Bridge construction

. Provision has been made for this activity in Output 1. Provision has been made for the MEO to evaluate bridge use.

7.5 Strategies for Handing Over on Project Completion

7.5.1 PLA/PRA techniques

. See Recommendation 7.2.4

. Output 4 provides for the construction of group plans after the annual PLA survey in June 1999. These will be a step to ownership of activities and can be monitored for a year before project closure.

7.5.2 Strengthening NGO capacity

. Provision has been made in Output 4 for NGO training to occur in Java

7.5.3 Institutionalising of Gender Awareness Module

. Discussions have been held with the DHO to incorporate the gender module into the SPK curriculum

. Provision has been made for the GADC to visit the UNDP office in Jakarta in Output 4

7.5.4 Documentation

This recommendation is supported with the 2 phase process described in Recommendation 7.2.4 above.

7.6 Costs

Costs appear to be lower than expected given the lesser number of trips and the considerable change in the exchange rate. The coverage is much less than the previous project or its extension.

SECTION 3 - DETAILED DESIGN

3.1 DETAILED DESIGN OF THE PROJECT

3.1.a Component Objectives

The goal of the project is to improve the health of women and children in Jayawijaya district in the highlands of Irian Jaya where the problems faced by the population include high death rates, malnutrition, high incidences of communicable diseases and low life expectancy. The objective of the project will be to show that a community based model of primary health care can be a successful and important medium for the provision of health care services in rural and remote locations. The extension will be a period of intense activity to finalise and consolidate previous interventions and to further evaluate and comprehensively document the model. The major components of the project are:

1. Primary Health Care - to continue to promote improved levels of morbidity and mortality, especially in women and children, through a series of sustainable activities with particular reference to community participation and formal health sector competency.

2. Community development - to build on to an existing series of activities that will assist community groups to attain self reliance status, including the establishment of self managed community health institutions. Self reliance has criteria that includes ability to concurrently manage several activities to set standards including the attainment of agreed standards of gender rebalancing.

3. Program support and management - to improve the levels of contact and reporting, in depth, quality and intensity, so that there is sufficient evidence to support a conclusion that sustainable activities have been implemented.

3.1.b Component Outputs

Output 1 - A maternal and infant health program consolidated

Obstructive labour continues to be one of the major reasons for high maternal mortality in Jayawijaya. The basic reason for this is that the mother is usually malnourished leading to reduced strength to deliver the baby. The reasons for this are varied but include too much carbohydrate in the diet, not enough fat, not enough iron, worm infestations and chronic malaria. The dietary issues are covered in later outputs but this output focuses on anaemia brought on by low iron counts and chronic malaria. Anaemia can lead to low viscosity of the blood and low strength can lead to slow contraction of the womb, extended delays in the issuing of the placenta and can also lead to increased potential for infection. The anaemia and low strength are then reasons for post partum haemorrhage. In order to affect the mortality rates of both mothers and infants it is important that as part of the care program there is a strong immunisation program.

In order to ensure that there is sufficient expertise to provide appropriate care, the project

will provide refresher training for maternal care. This will follow protocols already agreed upon within the district during the last 4 years. In addition, it is expected that several bidan di desa will be posted to the district in the next two years and they will need to be trained in the protocols and specific practices of the local area.

Output 2 - Capacity of health system, staff and community strengthened

Systemic issues were regarded as issues needing attention in the recent review of the project. This included supervision systems as well as the health information system (HIS). On the one hand, there are technical issues which have to be addressed such as the programming of the HIS but on the other there are administrative issues such as planning for adequate supervision. However, underpinning all this is the fact that the lack of education of many staff makes it difficult for them to adequately grasp the importance and content of training and that many positions in the health system remain vacant. Thus, this output is intended to focus on strengthening the existing capacity of the system.

Output 3 - Implement a preventative health and nutrition program

This output focuses on communities taking control over their own behaviour. This output will campaign to assist groups to establish enhanced behaviours in addressing basic nutrition, disease and sanitation. Some initiatives have already been established by the project such as the use of sweet potato for diarrhoeal control and weaning food. However, efforts to change basic nutritional patterns have not been as successful.

Output 4 - Existing community development initiatives strengthened

It is generally recognised that a considerable amount of behaviour change is required within the target communities in order for them to manage new interventions in their lives, including better health measures. This is critical as the world around these communities has changed rapidly over the past 45 years and is continuing to change out of their control. Basic behaviours concerning the role of women, organisation of groups of people and business are challenges that this output is assisting communities to address. This is being done primarily by introducing them to a range of new thinking and new skills.

Output 5 - Management system implemented

The management of the project has faced difficulties in the past from the distances between the project activity and contractual management as well as logistical difficulties on the ground. This has also placed pressure on staff to discern exactly how to juggle what is required from AusAID, contractors and local government. This has at times been complicated by the policy to only employ national staff but on the other hand this has delivered a higher level of integrity and sustainability to the program.

This output will seek to deliver a more focused, documented management framework for the project in the ensuing two years, using a higher number of consultant inputs. This

management output will also focus on drawing this project to a conclusion.

The project will conduct annual quantitative baseline and qualitative PLA surveys. Other information collected in between times will feed into these surveys in terms of content and training. These will be the major monitoring and evaluative tools. Increased visitation, supervisory systems and checklists are proposed for DOH personnel to follow.

3.1.c Output Performance Indicators, Means of Verification, Key Assumptions

Output 1 - Maternal and infant program consolidated

Output 1 will deliver a selected ante-natal services with at least 2 ante-natal visits pre pregnancy, and each pregnant woman given full courses of tetanus toxoid and checked for blood pressure and MUAC. In addition, all pregnant women will be registered in posyandu or polindes and take prescribed medication for anaemia. All bidans and TBAs will have been trained in case management protocols for delivery and in high risk pregnancies. An immunisation program for all infants will have been conducted with every infant immunised.

The means of verification will be registers in posyandu and polindes that will record the names of women and children, their treatment and the dates of treatment. Project records will show the names of attendees at refresher training including all pre test and post test results.

The key assumptions for this output are that medicines will be available and affordable. This is particularly uncertain at this point of time when some medications have been in short supply or increased dramatically in price from the economic crisis. The second assumption is that local people will understand the importance of the health service and will trust it sufficiently to register pregnancies and use trained personnel for deliveries.

Output 2 - Capacity of existing system strengthened

The output performance indicators for capacity building will be the establishment of a supervision system for the formal health system in the target area. The target area covers 2 puskesmas and 8 pustu. In addition, the computerised health information system (HIS) formulated in the project over the last 2 years will be revised and made functional, meaning that computer generated reports need to be sent back to puskesmas providers of information. The HIS is actually working but not at full capacity. The HIS is a special system allowed by the national government because of the difficult circumstances of the district.

The final deliverable will be a refresher training program for health system staff: bidans (midwives), TBAs (birth attendants), mantris (paramedics) and cadres in posyandu. There will be 4 training sessions over the 2 years supervised by the Health Coordinator.

The means of verification for this output will be inspection of project records and interviews

of community members about visits. A second means of verification will be inspection of computer generated reports and finally, pre and post test records of training participants.

The key assumption of this output is that the government can at least maintain and replace existing staff levels. Irian Jaya is not a popular place to work so it is difficult to get a full complement of doctors; it is also difficult to get fully qualified local staff.

Output 3 - Preventative health and nutrition program implemented

The output performance indicators for preventative health and nutrition will be a campaign for improved nutrition conducted that established nutrition plots in all 65 groups. Secondly, a campaign for basic health, concentrating on the 3 basic diseases of pneumonia, diarrhoea and malaria, basic components of diet and sanitation training in construction and use of latrines, will be conducted. Thirdly, a program will be conducted in how to use sweet potato as a diarrhoeal control and weaning food.

The purpose of the nutrition plots will be as an adjunct to the larger gardens. The plots will be located next to the dwellings and will not be large. They will largely service vegetable needs and be an attempt to diversify food consumption. In most cases water will need to be carried to the dwelling for the specific purpose of watering the plot; most dwellings do not have water nearby nor do they have household waste water.

The means of verification will be the recording of training sessions in project reports. Some of the training will be backed up in the community outreach training program in Output 4. The nutrition component can be assessed by inspecting group nutrition plots and use of sweet potato can be surveyed by asking how many children with diarrhoea were treated with super oralyte in the past 2 weeks.

The key assumptions will be sufficient and timely rainfall to assist crop growth and secondly the acceptance by the community of alternative and new ideas.

Output 4 - Existing community development initiatives strengthened

Performance indicators for this output will be an outreach training program conducted quarterly for all cadre leaders that covers gender, income generation, LEISA agricultural method and home industries. Secondly, two gender workshops will be conducted and a small business workshop will be conducted. Thirdly, the project will increase the number of groups from the present 40 to 65 groups.

A key to increased access to health services is income. Agricultural output is obviously central to that possibility but so is marketing. Marketing strategies are linked to the generation of a business mentality. The ability of the villagers in Kanggime and Mamit areas to market their products would appear to be relatively modest given that transport links to their area, other than by air are unlikely to occur within the next 5 years and perhaps even the next 10 years. The strategy however is to develop a business mentality and to utilise local markets and nearby markets that are accessible by foot. Some products may even be

able to be transported to a village that has road access; identification of such products will be critical to promotion of this business mentality.

A further means by which income can be generated is the development of technical expertise 'for sale' or for production. There is an opportunity to link up with the joint LIPI/CASE appropriate technology project on two occasions to provide an introduction to higher levels of appropriate technology.

Cooperatives are a means by which product can be better organised and utilise the business mentality. The strategy of the project is to assist the groups to form cooperatives and to establish a connection with a cooperative or other outlet in Wamena. Part of this strategy is to assist the groups to establish these links themselves so as not to rely on project staff to make linkages. The cooperative in Wamena has been established but its capacity to integrate and market all potential produce is limited. It will take time to see evidence of a strong cooperative market network and will be something that local NGOs will be encouraged to take on. Provision of seed money to the Wamena market is not likely to make a difference to the market as it is more the logistics and business sense to compete against other trading places that will determine viability.

Recommendations following the recent drought have been to develop concepts such as sweet potato 'seed banks'. This possibility can be investigated and initiatives being taken in southern areas of the district can be integrated into the LEISA program.

Means of verification will be project records on the training sessions for cadre leaders. Secondly, there will be project records and reports on the specific workshops.

The key assumptions for the output will be acceptance by the community of gender role adjustments and secondly, that communities can develop sufficient skills to make their own arrangement for activities outside their own community.

Output 5 - Management system implemented

The performance indicators for this output will be that baseline and PLA surveys will be conducted, PCCs conducted and reports submitted. These reports will be the regular monthly, 6 monthly and financial reports as well as the Project Completion Report.

The surveys will be in addition to regular monthly reporting that will monitor what groups are doing, which groups are doing what, trend information and issues arising from the activities. This information will be fed into the content of the annual surveys and the training for data collectors for those surveys. In addition to this data, the project will collect case studies on particular groups. Supervision systems for DHO personnel will feed back into the DHO and the counterpart manager will make supervisory visits to ensure the system is being carried out.

An issue here is the sustainability of these systems. The health system will be the responsibility of the DHO. For the duration of the project, the Cadre Assistant will be able to

provide ongoing on site supervision. It has been recommended that NGOs be encourage and supported to continue supervision in the are after the project. The current linkages with NGOs will be supported and support will be provided for strengthening of local groups with training NGOs in Java. However, there is some doubt that they will have necessary skills to manage an NGO by two years. The review of December points out that human resources and funding will compromise the ability of local NGOs to continue supervision. There is the possibility that WVII could schedule its activities into the project area in order to provide ongoing support and this will be negotiated during the course of the project.

The means of verification for this output will be the submission of reports on all the surveys as well as the regular submission and acceptance of reports. Attendance at PCCs and acceptable conclusion of proceedings will be the indicators for the PCCs.

There are several assumptions for this output: the employment of sufficient staff of sufficient quality, adequate transport and communication systems available and the ability to gain approval to change activities to consolidate and enhance the primary objectives.

A further assumption of interest is that the contractor/implementor can focus staff on deliverables and conclusion of the project rather than the processes of development. One of the strengths of the project to date has been the commitment of staff to the project aims. However, one of the observations is that most people who have been involved with the project have recognised that development in Irian Jaya is a long term process and emphasis has been to address the long term rather than the project specific. The challenge will be to bring this project to a conclusion.

3.1.d Activities and Recommended or Non-negotiable Inputs

Output 1 Activities - Maternal and infant health

1.1 In order to achieve the output, the project will promote the registration of all pregnancies. Many women lack understanding and trust of the services of the formal health system. In the PLA surveys in Output 5, questions will be asked to discern more precisely what are women's attitudes to disease and perceptions of the pregnancy process. Hopefully this knowledge will assist the campaign to register all pregnancies. The registration of pregnancies is essential in order to ensure appropriate medication is taken and ante natal care is provided.

1.2 It is clear that obstructive labour and anaemia are a key difficulties in deliveries. The project will distribute medication to improve the iron content in the blood, to fight against worms which reduce the body's strength and to guard against malaria through chloroquine prophylaxis during the first 3 months of the pregnancy. The government usually has supplies of these medications.

1.3 An immunisation program will also be implemented throughout the project area. The project aims to promote the registration of all births and to immunise every child with

the full immunisation program before they are 12 months old. The health system already has immunisation programs but they require more supervision to ensure full coverage. The Health Coordinator and the project Bidan will work with the relevant sections of the DHO to promote immunisation coverage. A registration system already exists but is not utilised and monitored properly. Children that are born and registered with the health system receive growth monitoring cards. Again, however, it is a case of ensuring that local women fully understand the importance of issues such as immunisation and that they are adquately followed up. The role of the project will be to encourage and support better monitoring and supervision.

1.4 Due to the high level of high risk pregnancies and also because of the low capacity of the staff, special efforts will be made to train all bidans and TBAs in the case management protocols (CMP) for deliveries and also in how to manage high risk pregnancies, including referral procedures. This training will be conducted on regular visits to the target areas by the Health Coordinator. There are 27 midwives altogether in the target area with another 56 TBAs.

1.5 There is also a great need to ensure that there is adequate supervision and monitoring of staff in these procedures. The Health Coordinator and bidan will be the key people involved in this supervision but this will be done in conjunction with senior puskesmas personnel in order to ensure that the health supervisory systems are sustainable. Visits will be made into the target area at least once every two months.

1.6 Bridge construction has been an important part of the attempt to provide better services for community health. Many women, assuming they are allowed to accept referrals to proceed to a puskesmas, are often faced with steep mountain tracks and fast flowing rivers to get to the puskesmas. The construction of simple swing bridges usually with metal cable and bolts into boulders provide an easier journey for women who are already under stress. The project will build four bridges during 1999. Each bridge will necessitate a community contribution that will be negotiated with the community beforehand. The MEO will coordinate an evaluation of the use fo the bridges to determine to what extent they are being used and the extent to which they are supporting the access to higher levels of health care.

Output 2 Activities - Capacity of the health system

2.1 & 2.2 In order to develop the capacity of the health system the project will assist the health office to design a supervisory system that will encompass the target area. This proposal has been endorsed by the DHO but will require enforcement through formal procedural instructions and personal visitation. The supervision system will entail regular visits being made by the most senior puskesmas personnel, whether a doctor or bidan or nurse, to the 8 pustu in the target area. These visits will then need to be carried out at least once every 3 months. It is possible that a supervisory system may have more visits, especially in the Baliem valley area but in the areas not accessible by road, a regular 3 month visit would be satisfactory.

2.3 The project will also improve the capacity of mantris through training. There are currently 38 mantris in the target area. This training will focus especially on capacity to give injections, especially BCGs for TB and so they can complete full immunisation for children. This training will be given on regular visits by the Health Coordinator. Included in this training will be how to test for haemoglobin levels which will enable staff to check the progress in checking anaemic levels of the pregnant women. The project will purchase two Hb testers in order to facilitate the testing at the two target centres.

2.4 Health cadres in the posyandus are the key element to a community based health system. In the target area, there are 130 cadres, 65 in each area of Kanggime and Mamit. The cadres require constant refreshing in understanding of the basic diseases, their diagnosis and treatment. There are protocols developed which they can follow which have been developed in the district through the project. This training will be given on regular visits taken by the Health Coordinator.

2.5 & 2.6 The HIS is in need of review. The district health office (DHO) allowed some work to be carried out on the system in January 1998 but that work is still unfinished. A consultancy is planned to ensure that all bugs are taken out of the system, that it can be implemented by local staff, that DHO staff are suitably trained to operate it and maintenance schedules are in place.

2.7 Although it will be important to have the HIS fully installed and operational it is also important to ensure that there is some evaluation of its usage. An assessment is planned for August 1999, one year after the review and final installation. A consultant who is familiar with HIS procedures will be invited to conduct this assessment and make recommendations to the project and to Depkes; the report will also be circulated at the PCC meeting in November 1999.

2.8 NGO workshop. A recommendation has been made that a workshop be conducted to assist local NGOs to consider how to support the project initiatives after the project. This workshop will take place in Wamena as the key groups have bases there and there will be opportunity to engage NGOs involved in other areas of the highlands to consider whether a broader strategy than just Kanggime/Mamit can be implemented. The workshop will be coordinated by the Project Manager with assistance from the project staff and will bring together government departments with which the project has had links and with whom the NGOs will need to work. The workshop will be planned for the end of 1999 so that there will be time to consider the findings before the scheduled PCC and also to link with the plans being constructed by the groups in the project target area.

Output 3 Activities - Preventative health and nutrition

3.1 In order to achieve this output the project will distribute nutrition starter packs. These will be packs of seeds that they can grow in small nutrition plots near their houses. These seeds will be for a range of small vegetables, some of which are not ordinarily consumed. Training in how to use these seeds and how to use the produce will be given in the outreach training program in Output 4.

3.3 The objective to change dietary behaviour will not only be attempted through nutrition packs. It will require a change of mind set and this will be achieved by an education campaign that will include posters and booklets produced following input from the PLA surveys in Output 5. This campaign will be made mainly through the posyandus and also through the project groups. Training for these cadres will be given in health system capacity training and in the outreach training program.

3.4 & 3.2 Other activities to achieve the output will be to train groups in different kinds of food preparation. This will accompany the nutrition plot packs and will also support the LEISA activities in Output 4. This training and demonstrations will be given through the outreach training program. The other food related activity will be to continue to promote the use of sweet potato products such as super oralyte for diarrhoea and 'power powder' as a weaning food. These products have been successfully applied in some groups but they need to be more widespread.

3.5 A further activity will be to support the campaign for better understanding of basic health, including sanitation. This will include training in the 3 basic diseases of pneumonia, diarrhoea and malaria as well as in the construction of and use of latrines. These activities will also be conducted through the outreach training program.

3.6 The final activity in this output is the contracting of a health education specialist who can assist the project staff to use their skills and resources to more profit and to introduce alternative ideas to promote health in the villages. The PLA methodology is of considerable use to find more qualitative information but the skills to use this methodology need to be upgraded and refined. This activity will be held in February 1999 as the first 6 months of the project are very full and the training can feed into the next annual baseline and PLA survey in June.

Output 4 Activities - Community development initiatives

4.1 The key activity to achieve this output will be to support the project groups to realise 'mandiri' or self reliant stage. Over the past 3 years, the project has been using a criteria system to rate the stage of each group's achievement with the intention of bringing each group to self reliant stage. The system has 4 stages so it is possible to observe the progress of groups. This measurement is taken on an annual basis through the baseline survey. The inputs required to achieve this growth are an outreach training program conducted over 6 five-day training sessions for groups cadres who will in turn pass on the training to their group members. Accompanying this input will be 160 packs of materials that will match each group's stage eg agricultural tools, seedlings, animals, small technological implements and stationery. These packs will be distributed in 3 phases throughout the project life. There will be 130 cadres attending, of whom 50% will be women.

4.2 In order to emphasise the importance of utilising this training, the project has been conducting group competitions and it is planned to hold 3 competitions over the next 2 years. Two of these will be held in Wamena to coincide with special workshops and PCCs.

These competitions will also include groups from the Wamena area which will be operating without specific project support from the beginning of this extension. The main input for the group competitions will be transport and costs. The competition will essentially be an opportunity to inspect what level of skills the groups have achieved. The benefits of the competition will be firstly to ascertain that certain groups have reached sustainable levels and secondly, to identify those groups that need further supervision or additional training.

This will be the main input for supervising the groups, another activity which will be essential in monitoring the development of the groups. It is important that the skills of the training officer be upgraded and provision will be made for her to travel to Jayapura to link up with training NGOs on 2 occasions.

4.4 Gender awareness has been a very important element of the group strategy. Gender awareness training will continue through the outreach training including through the promotion of the LEISA (Low External Input for Sloping Agriculture) program where it is hoped that men will start to work on the LEISA plots. Each group will be given a supplementary LEISA pack to support the agricultural activity and advice will be provided in the outreach training program.

4.5 There are two more significant gender activities. Firstly, two gender workshops will be held for the district. To date, the project has had some impact on district policy with special modules being written by the Gender and Development Coordinator (GADC). The project wants to build on this by conducting innovative workshops which will be result focussed, addressing real problems such as men deliberating on referrals for obstructive labour, teenage pregnancies and disbursement of family income. These workshops will also address the issues of female leadership, intermarriage between Irianese or other races and the development of modules for children. These workshops will be conducted by the GADC with assistance from other project staff but venues and supplies will incur costs. The other gender activity will be to appoint women as leaders of some of the groups. This has potential to be a dramatic step and is difficult to predict whether this can last long term. The GAD Coordinator will also link up with networks such as UNDP and their gender development plan when in Jakarta.

4.6 Income is a critical means of ensuring sustainability for the groups. The outreach training program will provide advice and support for the sale of vegetable and animal produce but more depth is required such as using cooperatives. Cooperatives have been started in both Kanggime and Mamit but are only at early stages. The project will sponsor two small business workshops in Wamena that will coincide with an outreach training in Wamena and in the target sites. These workshops will invite a consultant from Jayapura to conduct the workshops and will also invite local NGO participation.

4.7 Supervision is a key issue for the project and there will be a new focus on having qualified staff spend more time in the field. The male GAD Assistant will spend part of every month, totalling up to 8 months, in the villages working alongside the groups. This will include the follow up of training and provision of additional input and direction to groups. In addition, the Cadre Assistant will assist the GADA in working with groups in the

field. He will be able to follow up training and provide culturally specific advice. All staff will spend more time with the same groups than they have ever had the opportunity to in the past. Most project staff who have a field responsibility will travel to the sites 6 times a year and often for more than 2 weeks at a time.

4.8 The project has already conducted 2 very successful trips to the agricultural training institute at Bogor, near Jakarta. These trips have brought villagers through a variety of experiences that have helped them to understand the nature of the world around them from travel by plane and sea to big cities, foreign animals and places of national importance. This then places their villages in a context of what is Indonesian and what is development and progress. The project will send 30 cadres in 2 trips to Java during the project period. They will attend training at the Bogor Institute for appropriate agricultural training and be given the opportunity to visit sites between Bandung and Jakarta that will assist them to understand the lareger world in which they live.

4.9 The Project Review recommended that some cadres be given the opportunity to learn from specialist NGO training institutes in Java. The project has planned for 2 trips to enable cadres to do this training. These trips will be conducted at the same time as the exposure trips to Java. There will be 5 cadres participating in each trip. The purpose will be to learn the mechanics of running an NGO and to assess issues that will impact on the viability of NGOs in the Irian highlands.

4.10 The Project Review recommended that the materials be upgraded in terms of presentation and this will be done by more colour, lamination, plastic sleeves etc. The issue of language has been canvassed in the response to the recommendations. Most of the materials will be in pictures with a minimum of words.

4.11 The Centre for the Application of Solar Energy (CASE) have funding to conduct project activity in the Jayawijaya area. This funding is from UNIDO, the West Australia government and from AusAID. The project activity is managed in conjunction with LIPI, the sciences institute of Indonesia. A program has been started to introduce alternative energy sources but also to train villagers in different methods of how to use this energy. In addition to this, there is training on appropriate technology to do with the production, preservation and preparation of food. Some of the equipment can be used with electricity but much of it is mechanical. There is a good opportunity to link up with this program and introduce ways that reinforce the messages the project has been giving over the past few years. 30 villages will be involved in two training courses held in September and December respectively.

4.12 There is always the need to improve and update and be encouraged in the core sectors of work. Community development is part of the core of this project and gender awareness is an important part of that as PLA is an important methodology to understand the people better. A consultant with all these skills will be invited to the project to provided more high level input and encouragement to the staff and go to the field with the staff to observe, demonstrate and recommend approaches and activities. This consultancy will be held early in the project and will coincide with group training in the target area.

Output 5 Activities - Management system

5.1 & 5.2 & 5.3 The activities in order to achieve this output will be to design surveys for all project related activities. In addition, the students from the nurses training college (SPK) will be assisting in collection and will need to be given refresher training on each occasion in collection methods. These surveys will be analysed and written up with trend charts where applicable. A summary of the methodology is at Annexe 10.

5.4 A requirement of the Project Completion Report is to complete documentation of project activities. To date, this has not been a successful exercise, especially in English. The project will hire a consultant to assist in designing a framework for documenting the project and then later to do the actual documenting. The usual activities of conducting PCCs, writing reports on a regular basis will be conducted. In addition, there will be several new staff to employ for the extension and some new computer equipment. This will enable a more professional operation to conduct the activities.

5.5 The PLA methodology provides for communities to be involved in their own planning. Due to the use of this methodology there is an opportunity for groups to develop their own plans for the future of their groups. It is hoped that after the mid term survey of the groups they will all provide a plan that will see them to at least the end of the project with a plan to develop a further plan for the time after the project.

3.2 COSTS AND FINANCING

3.2.a Costs by component, year, Australian and local currency

The following table shows a summary breakdown of costs for the project over the 2 years. The rate being $US1=Rp8,000 and $US1=$AUD 0.63. This equates to approximately $AUD1=Rp5,040. The $US rate is based on advice received from banks in Jakarta and the $US/$AUD rate is based on advice received from banks in Australia. Both currencies are volatile at the moment and the currency situation will be watched closely.

	Year 1		Year 2		TOTAL	
	GOA	GOI	GOA	GOI	GOA	GOI
Output 1	16,738	12,400	15,254	15,169	31,992	27,569
Output 2	11,261	700	11,298	600	22,559	1,300
Output 3	10,122	-	4,800	-	14,922	-
Output 4	81,731	-	71,565	-	153,295	-
Output 5	130,197	14,300	104,689	11,500	234,886	25,800
TOTAL	**250,048**	**27,400**	**207,606**	**27,269**	**457,654**	**54,669**

A more detailed cost schedule is attached at Annexe 2.

3.2.b Financing arrangements - Australia; partner government

Within the first year of the project, the Australian government will fund most of the activities. However, there will be substantial contributions from the health service by way of office space, vehicle use and medicines. The timing of the project has made it difficult to participate in the budget rounds for the Indonesian financial year. It is planned that the project will participate in the next budget round and will have to submit estimates by the beginning of December 1998. This will coincide with the planned PCC in Wamena which will be fortuitous timing. The results of this round will form the counterpart budget for the second year. The recipient government agencies do not have access to AusAID funds nor are any recipient government funds managed by the project.

Within Australia, the usual financial arrangements engaged for this project over the past 6 years have been that funding is in the form of six monthly tranches paid in advance and acquitted every 6 months.

3.2.c Recurrent cost implications

Most recurrent cost items will already be handled by the government during the project period. This is planned so that no recurrent cost items will be provided by the project by the second year, thus aiding sustainability.

3.3 IMPLEMENTATION TIMETABLE

3.3.a Location, duration and phasing

The Jayawijaya WATCH Project to date has attempted to cover all subdistricts of Jayawijaya. The review of December 1997 has recommended that the project now concentrate only on areas that have had relative success in becoming self reliant ie Kanggime and Mamit areas. These areas are located in the north western corner of the Jayawijaya district. The northern part of this area begins the descent to the swamplands of the Mamberamo River and is therefore subject to warmer weather and malaria incidence. The area is still quite mountainous although not as difficult as the southern and eastern parts of the district. Transport is still reliant on MAF light aircraft to the small airstrips in Kanggime and Mamit. Transport from these two centres to other locations in the NW corner is by foot. It is anticipated that a road from Karubaga may reach Kanggime in a minimum of 5 years but this will be subject to funds being available.

The review of December 1997 recommended that the project proceed for a further 2 years. This period will start in July 1998 and end in June 2000. The first phase of activity will be to conduct the initial baseline and PLA surveys and conduct the first batches of training and workshops before the PCC in December 1998. The surveys will be completed within two months with a possible further month for documentation. That point will be an opportunity to reflect on whether the new focus is working and consider any additional activities. From then on through 1999, emphasis will be on consolidation

of activities. A further annual survey is scheduled for April May 1999 prior to the PCC in Jakarta. The final 6 months will see an emphasis on documentation of the project being completed and bringing the project to a conclusion. A final survey is scheduled at the beginning of the last quarter with a report scheduled for presentation at the closing PCC. An activity schedule is attached at Annexe 1.

3.4 OTHER PROJECT CONSIDERATIONS

3.4.a Proposed role and support from the Recipient Government

There has been strong support from the recipient government for this project. An unusual situation has occurred where the GOI has requested this extension and that it be managed by an NGO, the current contractor, World Vision. The project has also received very strong support from the local mayor (bupati) and local officials as the project has often been the catalyst to integrate the activities of various departments

3.4.b Risk Assessment and Risk Management Plan

The most significant broad risk is the current political and economic uncertainty. It is almost impossible to predict what will happen in 6 months time but there is a possibility that there will be limited food and medical supplies as well as increasing costs of these items for some time to come, even for several years.

The most immediate local risk is the lack of planes and fuel. There has been a shortage of fuel over the past 6 months and this has hampered the relief operation. At the same time, the planes have been dedicated to relief operations and it is less easy to obtain a flight to the project target areas. This is exacerbated in the 3 months from June when many of the pilots are on leave overseas. A contingency plan has been suggested that will see flights from Wamena to Sentani by either MAF or AMA diverted to Kanggime or Mamit. This situation will require consistent liaison with the airlines.

Further constraints on the project may be the number of requests made to the project by local government and the number of visitors that the project has attracted. In one sense these are the consequences of the success of the project. It is very difficult to control either of these issues but a more thorough reporting and communication of these issues may result in higher level negotiation to assist the project control these requests.

The final risk may be the appointment of the new bupati. The recent bupati had occupied the position for 10 years and knew the project and area well. It is unclear who the new incumbent will be but arrangements are in place to ensure an introduction and welcome.

A further analysis of the risks involved in the project can be found in the Risk Matrix at Annexe 7.

3.4.c Sectoral Policy considerations

This project has had a very proactive role in promoting gender awareness in the district. Modules have been written not only for the project but also for the government. The gender program has attracted interest from beyond the district.

The project has been environmentally friendly in that the LEISA program, although ostensibly to promote the inclusion of men in gardening, is also essentially a method to regreen the hills in the community areas. This program has received strong support from government officials.

Poverty is one of the reasons for poor health in Jayawijaya. The project has attempted to develop ways in which communities can understand concepts of money so they can participate in the monetised economy. In addition, attempts have been made to establish cooperatives with links in Wamena so that groups can market their produce. These activities will be continued and a special workshop on small business will be conducted in the extension to assist this process further.

3.4.d Project Management Issues

Managing agent - World Vision Australia

WVA is the contractor to the Australian government. WVA provides management support and is responsible for reporting and liaising with AusAID. The management includes regular visits to the project area for monitoring purposes and regular visits to Indonesia for Project Coordinating Committee (PCC) meetings. This usually results in liaison with the Indonesian Department of Health (Depkes) at national and provincial levels as well as at district level. WVA is responsible for the writing of all annual plans, contracting of expatriate consultants and liaison with other interested projects in Australia.

Implementing agent - World Vision International Indonesia

WVII is responsible for the conduct of the implementation in the field. Responsibility includes staffing, activity coordination, relationships to government and NGO organisations in Jakarta, Jayapura and Wamena, logistics between Jakarta and Wamena and daily management of the project. WVII staff have provided support to project staff where necessary and provide regular monitoring of narrative and financial reports.

WVII is managed through an office in Jakarta. There are several branches throughout the islands which provide administrative support for WVII work and the mangers in these offices have responsibility for projects in their areas. WVII has worked in Jayawijaya since 1975, initially in the health sector.

Counterpart agency - District Health office (DHO)

The DHO (Dinas Kesehatan) in Wamena is the counterpart agency for the project as stipulated in the MOU. The district health officer, Dokter Kabupaten (Dokabu) is the counterpart Project Manager. He is responsible for GOI inputs to the project, maintenance and continuing support of project initiatives and activities, including ongoing relationships with the local bupati and other government departments..

Project staff

All project staff will be Indonesian nationals and will be based in Wamena, except for the local Field Officers. The head of the team will be the Project Manager, Drg G Yuristianti Andayani. A management structure with list of staff is at Annexe 4 and staff job descriptions for new staff are at Annexe 6.

3.4.e Procurement Arrangements

The only assets that will need to be purchased for the extension are computers and they can be acquired in Jakarta and organised through the implementing partner office in Jakarta

3.4.f Recommended Reporting Requirements

It is recommended that the project produce monthly reports that will be submitted to AusAID through the contactor. A six monthly report will be produced for the PCCs. Six monthly financial acquittals will also be produced by the contractor for submission to AusAID in Canberra. An Annual Plan for the financial year 1999-2000 will be prepared in March 1999 for submission to AusAID in Canberra.

3.4.g Recommended Monitoring Arrangements

Regular PCCs will be held throughout the project and will provide an opportunity to discuss the progress of the project and highlight any issues. These are being planned for the following times:
August 1998 (in Alor), December 1998 in Wamena, June 1999 in Jakarta, November/December 1999 in Alor and the final and closing PCC in June 2000 in Wamena.

Both WVA and WVII will undertake at least 2 visits a year to observe activities and hold discussions with staff and officials. It is expected that AusAID may make an additional visit to the PCCs.

Within the project, the annual baseline surveys will provide an indication of progress with group movement to self reliance. This is the key indicator that will determine whether the community can manage their own health. The baseline survey will also collect data that will indicate progress with maternal and infant mortality and nutrition, as shown in the indicator column in the logframe. These figures should already be in posyandu and other health system registers and recording systems. However, there will

be regular checks by the Health Coordinator, bidan and Monitoring and Evaluation Coordinator to monitor compliance with procedures and accuracy of data. The regular training sessions for both health cadres and group cadres will be a further opportunity to monitor progress of groups.

The writing of the Annual Plan will be an opportunity to follow up discussions at the December 1998 PCC and to plan revised activities based on the initial results of surveys and reports.

3.4.h Other projects that impact on this one

The AusAID project most similar to this project is the Alor Community Based Health Project in the district of Alor in NTT province. It has been recommended that the August 1998 PCC for that project be attended by staff from WATCH and that a joint PCC be held in Alor. This will enable the WATCH staff to observe a community, malaria and monitoring system that is operating well. Conversely, it is being recommended in this document that the ensuing PCC for both projects be held in Wamena in December 1998. This will allow the Alor project to gain better insight into the Health Information System and the operation of the case management protocols, amongst other activities.

The WATCH project has had links with other projects in the past, such as the Wantoat WATCH project in PNG but in general, other projects, whether bilateral or multilateral have tended to visit WATCH to learn about its approaches to community development.

There has been recent discussion with representatives of CASE who have funding from UNIDO, AusAID and the WA government to develop alternative energy sources in an area to the south of Kanggime. A link with this project has been proposed and budgeted at Output 4.

Anexes 3
JAYAWIJAYA WATCH PROJECT - KANGGIME EXTENSION
PROJECT LOGFRAME

Hierarchy of objectives	Objectively Verifiable Indicators	Means Of Verification	Assumptions
Goal: To improve the health and nutritional status of women and children in rural communities in Jayawijaya	. Decreased MMR from 450+/100,000 to 225/100,000, national standard for 2000 . Decreased IMR by 35% from 98/1,000 to 65/1,000 . Increased # under 5s above <-2 line in the WHO weight/height scale . Increased # &% of pregnant women with MUAC of >18cm	Annual baseline survey	
Purpose: A functioning and sustainable primary health care system with high levels of community participation and ownership	. # of village posyandu which received a visit from the formal health system in the past 3 months . At least 50% groups from Kanggime and 30% groups from Mamit reach 'mandiri' stage	Annual baseline survey	
Output 1: Appropriate maternal and infant health program consolidated	1.1 Appropriate ante-natal services maintained by # of women with full courses of TT, blood pressure checks and MUAC tested 1.2 Refresher training for all health system staff 1.3 Immunisation program conducted with every infant fully immunised (BCG, DPT3, OPV3 and measles) 1.4 All pregnant women registered in posyandus and polindes take prescribed medication for anaemia	. Posyandu registers list names of women and children, treatment and date of treatment . Project records of refresher training include pre test and post test results	. Medicines are available and affordable . Local people understand the importance of health and are willing to trust the formal health system services
Output 2: Capacity of health system, staff and community strengthened	2.1 Supervision system implemented by establishing checklists in 8 pustu and 3 monthly visits to each 2.2 Health information system functional by generating reports back to each puskesmas 2.3 Refresher training program for bidans, TBAs, mantris and posyandu cadres	. Inspection of records; interviews . Inspection of generated reports . Project training records; pre and post test results	. Government can at least replace and maintain existing staffing levels
Output 3: A preventative health and nutrition program implemented	3.1 Establishing of 65 nutrition plots - one in every group 3.2 Campaign on basic health understanding including 3 basic diseases, diet and sanitation 3.3 # and % of groups using sweet potato flour for diarrhoeal control & weaning	. Inspection of nutrition plots . Training recorded in outreach reports . Materials observed in posyandu and groups	. Sufficient and timely rainfall to assist crop growth . Acceptance of alternative and new ideas by community
Output 4: Existing community development initiatives strengthened	4.1 Outreach training program for 40 cadres conducted in both villages that covers gender, income generation, LEISA,	. Project records on training sessions	. Acceptance by community of gender role

Hierarchy of objectives	Objectively Verifiable Indicators	Means Of Verification	Assumptions
	cooperatives and home industries 4.2 2 Small business workshop conducted 4.3 Gender workshops conducted 4.4 # of groups increased from 40 to 65	. Project records of specific workshops	adjustments . Communities develop sufficient skills for their own arrangements with Wamena
Output 5: Management system implemented	5.1 Baseline surveys conducted 5.2 PLA surveys conducted 5.3 PCCs conducted 5.4 Monthly, 6 monthly and financial reports submitted 5.5 Project Completion Report	. Survey reports on every survey . Attendance at PCCs . Reports submitted	. Focus staff on deliverables & conclusion rather than dev't process . Transport and communication available . Ability to gain approval to change activities
HEALTH ACTIVITIES Output 1: 1.1 Promote registration of all pregnancies 1.2 Distribute iron tablets, pyrantel and chloroquine 1.3 Immunise all infants (0-11 months) 1.4 Conduct refresher training of all bidans and TBAs in delivery CMP and high risk pregnancies 1.5 Supervision of all maternal health 1.6 Construction of bridges 1.7 Evaluation of bridge usage	1.1 Visits to all villages through health and community activities 1.2 Government supplies to cover according to stages of pregnancy 1.3 Government to supply all vaccines 1.4 Four training sessions conducted over the 2 year period. There will be 27 midwives and 56 TBAs trained 1.5 Visits by Health Coordinator and/or Bidan to target areas at least once every 2 months 1.6 Four bridges built during 1999 to assist women referred to puskesmas 1.7 Site visits and interviews by MOE of 2 bridges in each centre	. Project and puskesmas activity records . Posyandu registers . Health system records . Attendance records and post test records . Project records . Site inspection . Evaluation report	. Accurate dosages dispensed . Health system staff understand local perceptions of health Women are allowed to accept referrals
Output 2: 2.1 Develop and explain supervisory system to health staff 2.2 Supervisory visits implemented 2.3 Mantris trained in haemoglobin testing and BCGs 2.4 Cadres trained to diagnose and treat 3 major	2.1 Supervisory checklist completed and letter sent to 2 puskesmas 2.2 8 pustu receive 3 monthly visits and quarterly supervisory visits 2.3 Thirty-eight mantris trained; Hb testers procured 2.4 All cadres can diagnose & treat pneumonia, diarrhoea and malaria. Sixty-	. Inspection of checklist . Health system records . Training registers . Inspection of equipment . Inspection of post test results	. Sufficient government resources . staff . equipment . supplies and motivation to make the system work

Hierarchy of objectives	Objectively Verifiable Indicators	Means Of Verification	Assumptions
preventable diseases 2.5 Programmer to revise and install completed health information system 2.6 Assistance and training given to district health officers in HIS 2.7 Assessment of the use of the HIS system 2.8 Prepare strategy for NGO sustainability	five cadres of whom 50% women will be trained 2.5 Consultant hired 2.6 Consultant to provide training and maintenance schedule 2.7 Consultant hired in August 1999, one year after review and training undertaken 2.8 Conduct NGO workshop in late 1999 with attendance by highland NGOs and relevant government departments	. Consultant contract . Inspection of maintenance schedule . Report . Workshop report	
<u>Output 3:</u> 3.1 Distribution of nutrition plot starter packs 3.2 Promote use of sweet potato flours and powders 3.3 Develop IEC materials based on PLA studies 3.4 Training given in food preparation 3.5 Promote use of and assist construction of latrines 3.6 Increase capacity of staff to use PLA and other knowledge to promote health education	3.1 # of starter packs distributed 3.2 Training given to all cadres and groups; information available through all posyandu 3.3 # of posters and booklets produced 3.4 All groups trained and supervised 3.5 # of trainings and demonstration units 3.6 Health education specialist employed for one month	. Project records . Training registers . Inspection of posters and booklets . Inspection of demonstration units . Consultant contract	. Groups utilise training
COMMUNITY ACTIVITIES <u>Output 4:</u> 4.1 Support and training provided for groups according to self reliant stage 4.2 Promote group skills 4.3 Supervision of groups by staff and cadres 4.4 Assist groups to develop functional LEISA systems 4.5 Increase gender awareness at district level 4.6 Increase small business awareness and capacity 4.7 Supervision of community activity 4.8 Exposure trips to skill training in Java conducted	 4.1 160 assistance packages provided in 3 phases over 2 years. 130 cadres will be trained and given responsibility of whom 50% will be women 4.2 Three group competitions held in Wamena (2) and Mamit 4.3 # of visits and transport costs 4.4 40 LEISA packs supplied in 2 distributions 4.5 Two gender workshops with district level participants; organisation costs. Development of gender module supplements 4.6 Two workshops conducted in Wamena including on site training in the field 4.7 Travel costs 4.8 30 cadres travel to Java - one trip per	 . Project distribution records . Project training records . Project records . Site inspection . Inspection of completed modules . Project reports . Project records . Trip reports	. Groups utilise training . Decision makers attend workshops . Women are given more responsibility

Hierarchy of objectives	Objectively Verifiable Indicators	Means Of Verification	Assumptions
4.9 Exposure trips to NGO training in Java conducted 4.10 Upgrading of module/ materials carried out 4.11 Training in appropriate technology conducted by CASE 4.12 Increase group skills in gender awareness	year; 25% are women 4.9 5 cadres travel to Java - one trip per year 4.10 Budget for design, drawings, colour and lamination 4.11 Thirty villagers trained in use of mechanical equipment for food preparation, production and preservation 4.12 GAD/PLA/CD consultant employed for one month	. Trip reports . Inspection of materials . Site inspection and project reports	
MANAGEMENT ACTIVITIES <u>Output 5:</u> 5.1 Design surveys for all project related activities 5.2 Refresh SPK students in collection methods 5.3 Collections conducted, analysed and written up 5.4 Documentation framework designed and implemented 5.5 Community plans are drawn up following the mid term annual survey 5.6 Equipment purchased 5.7 Project reporting completed on time	5.1 Staff coordination and linkage with DOH 5.2 Training costs 5.3 Travel costs; collection fees 5.4 Consultant ; documenter hired; document/s completed 5.5 Each group produces a plan for at least 12 months based on results of PLA survey 5.6 Computer equipment for upgrading of office as recommended by review 5.7 Monthly narrative reports, six monthly acquittals and final PCR completed on time	. Project records and reports . Consultant contracts . Inspection of plans . Inspection of equipment . Documents	. Survey collectors count and interview accurately . Staff are not distracted by visitations and national and local politico-economic pressures

Anexes 11
INSTITUTIONAL LINKAGES

In the community development component, partner agencies are mostly local yayasans working in grass roots development programs. The most strategic of these yayasans are the church based ones as the majority of people in Jayawijaya are Christian with strong allegiance to the church structure. These groups are located at both the village level and at higher levels such as kabupaten or provincial level. The project has had an ongoing relationship with these organisations and is committed to strengthening their capability base. These groups are:

. Yapelin - linked to GIDI, the Evangelical Church of Indonesia, covering a number of mission organisations such as the Asia Pacific Christian Mission

. Yahukimo - linked to GIDI, related to Regions Beyond Missionary Union
. Unevangelised Field Mission - linked to GIDI
. Yapelbaptis - linked to Gereja Baptis Indonesia Irian Jaya and related to the Australian Baptist Mission Society
. Yakpesmi - linked to Gereja Jemaat Protestan Irian Jaya, and related to the Netherlands Reformed Church
. Gereja Kemah Injili Indonesia - related to the Christian Missionary Alliance
. Kingmi - linked to the Catholic church
. Gereja Pentekosta di Indonesia
. Gereja Advent Indonesia
. Refsos, Gereja Katolik Indonesia

In addition to these yayasans, there are community based yayasans linked to the government:

. PKK - this is technically a national family welfare movement but based on the involvement of women. Most Indonesian women belong by default, as is assists in community mobilisation. The movement in Jayawijaya is strong in the Baliem valley and surrounds but is not strong throughout the district.
. LKMD - these are village based committees forming part of the government administration. They are led by the village head (and elders) and are responsible for all village based activities and local development planning.

Another area of government partners are the government departments and agencies. These groups have been associated with the project in providing training and advice:

. Departments of :
  Agriculture
  Animal husbandry
  Fisheries
  Cooperatives
  Village development
. LIPI - National Academy of Sciences
. BPPT - Agency for Application and Development of Technology

The community based organisations are particularly important as they contain a lot of expertise in the community and are very committed to new approaches within the communities. The key ones here are:

. YPMD (Yayasan Pengembangan Masyarakat Desa) - is the largest independent NGO in Irian Jaya based in Jayapura
. Bethesda Health Foundation (YKB - Yayasan Kesehatan Bethesda)
. Yasukhogo - a new NGO based in Wamena to provide assistance in agricultural and animal husbandry

Anexes 8
PROCUREMENT LIST

Output 1
. Worm tablets (pyrantel)
. Haemoglobin testers

Output 2
. IEC posters
. IEC books

Output 3
. Plot starter packs

Output 4
. Supplementary packets
. Self reliance packs
. Training session materials
. CASE training equipment

The training will be appropriately tailored to individual needs and will include packages of equipment such as:
. Slicers
. Blenders
. Pressing devices
. Cooking devices etc

Output 5
. Desktop computers
. Upgrade computers
. Laptop computer
. Training session materials
. External modem

Anexes 9
TRAINING SCHEDULE

1998

August 1998 - Output 4 - Training in community development in villages
September 1998 - Output 4 - Training in community development in villages
- Output 4 - CASE appropriate technology workshop (#1)
October 1998 - Output 2 - Case management training
- Health Cadre training
- Output 4 - Gender workshop and consultancy
November 1998 - Output 4 - Agricultural skills training in Java
- NGO capacity training in Java
December 1998 - Output 4 - CASE appropriate technology workshop (#2)
- Coop consultancy and workshop (#1)
- Group cadres training - community development

1998

January 1999 - Output 2 - Mantris training in haemoglobin testing
February 1999 - Output 4 - Training in community development in villages
April 1999 - Output 2 - Case management training
- Health Cadre training
- Output 5 - Refresher training for SPK students in survey work
August 1999 - Output 2 - Case management training
- Health Cadre training
- Output 4 - Coop consultancy and workshop (#2)
September 1999 - Output 4 - Training in community development in villages
- Group competition in Mamit
November 1999 - Output 4 - Agricultural skills training in Java
- NGO capacity training in Java
December 1999 - Output 2 - Mantris training in haemoglobin testing

2000

February 2000 - Output 4 - Group cadres training - community development
- Output 5 - Refresher training for SPK students in survey work
April 2000 - Output 2 - Case management training
- Health Cadre training
July 2000 - Output 4 - Group competition

Anexes 7
RISK ASSESSMENT AND MANAGEMENT ACTION

Risk	Probability	Consequence	Overall Rating	Action plan indicating target dates and performance measures	Responsibility for implementation	Monitoring of treatment plan and monitoring frequency
1. National elections to be held end of 1999 has potential to disrupt activity as the format and process of the elections is unknown	Medium	High	Medium	Discuss this issue at the May 1999 PCC as to what precautions to take	Project Manager	Project Manager
2. Availability of planes due to fuel, pilot or plane shortage	Low	Medium	Medium	Forwarding of travel plans to MAF on a fortnightly basis	Project Manager/staff	Project Manager
3. Monetary crisis may cause the banks to place limits on the amount of local currency the project can withdraw	Low	High	Medium	Discussions with WV Jakarta office as to alternative action by end July	Project Director WV Jakarta office	Project Director Project Manager
4. Contracting consultants on schedule	Medium	Medium	Medium	Discussion between WV Jakarta office and Project Manager. Schedules to be established by Project Director	Project Director WV Jakarta office	Project Director Project Manager
5. Ability of groups to establish cooperative and market produce	Medium	Medium	Medium	Efforts are already being made through the project but action will be taken through the Area Committe to encourage planning in the target area	Project Manager Counterpart Project Manager	Project Manager
6. Low motivation of puskesmas staff to carry out	Medium	Low	Medium	Discussions to be held with project counterpart manager and reminders	Project Manager Health Coordinator	Checks made each visit will amount to quarterly reminders

Risk	Probability	Consequence	Overall Rating	Action plan indicating target dates and performance measures	Responsibility for implementation	Monitoring of treatment plan and monitoring frequency
supervision				made on each visit to two centres. Possible incentives to be offered of training in Jayapura or Java		
7. Visits of the project by government officials and aid agencies disrupt activity	High	Low	Low	Incidence and plans of visits to be recorded I monthly reports. Assessment to be made on a 6 monthly bases of whether to try an curtail visit acceptance and involvement	Project Manager	Project Manager
8. Low level of counterpart funds may do the following: a) delay or impede PCCs in the field b) lack of equipment and supplies especially essential drugs c) supervision of health staff	 Low Low Medium	 Medium Low Low	 Low Low Low	 Discussions with Depkes and AusAID post generally and at PCCs Discussions with counterpart project manager and provincial staff	 Project Director Project Manager	 Issue to be placed on agenda at each PCC for discussion 6 monthly review

MANAGEMENT STRUCTURE