JAYAWIJAYA WATCH PROJECT - KANGGIME EXTENSION

An AusAID funded project

ANNUAL PLAN 1999-2000

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World Vision of Australia
in partnership with
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ABBREVIATIONS AND GLOSSARY

Adat	Customary law
AusAID	Australian Agency for International Development
BCG	Bacillus Calmetted-Guerin – vaccine for tuberculosis
Bidan	Midwife
Bidan de desa	Community/Village midwife
Cadre	Voluntary health worker (community level)
CASE	Centre for Applied Solar Energy – Consultancy firm from Western Australia
Dana sehat	Village based health insurance system
Depkes	Department/Ministry of Health
Desa	Village/Remote administration
Dinas Kesehatan	Province/District level health department/office
Dukun	Traditional birth attendant
HB	Haemoglobin
HIS	Health Information System
IDT	Inpres Desa Tertinggal (Presidential instruction on backward villages)
Kabupaten	District
Kecamatan	Subdistrict
KMS	Growth monitoring cards used in posyandus
KSM	Kelompok Swadaya Masyarakat – community based self help group
KPC	Knowledge, practice and coverage
LEISA	Low External Input for Sloping Agriculture
LKMD	Lembaga Ketahanan Masyarakat Desa (village council)
MEO	Monitoring and Evaluation Officer
NGO	Non-government organisation
PHC	Primary health care
PKK	Pembinaan Kesejahteraan Keluarga (family welfare movement)
PLA	Participatory Learning and Action – qualitative survey methodology
Polindes	Pos bersalin desa (Village birthing centre)
POD	Pos obat desa (Privatised cadre run village drug post/dispensary)
Posyandu	Integrated village services post
Puskesmas	Subdistrict community health centre
TBA	Traditional birth attendant
WVA	World Vision Australia
WVII	World Vision International Indonesia
Yayasan	Foundation which operates similarly to NGOs

EXECUTIVE SUMMARY

The past year has seen substantial changes to the Wamena district. The famine of 1997-98 brought in many people and agencies to assist in relief efforts. Some of those agencies, viz.: Merlin and MSF, have stayed on and expanded their services, particularly in the health sector although Merlin is now leaving. The political and economic crises have brought about a reduction of air services and food supplies on the one hand but on the other they have allowed more programs to be started, particularly for infrastructure. Unfortunately, these programs appear to have reinforced a tendency amongst communities to expect handouts and payment for services rather than pursuing self reliance through their own efforts. This has had some deleterious effects on the project.

The innovations of the project were appreciated during the famine. Case management protocols were used by visiting doctors for analysis of malnutrition and malaria. Although many groups in the famine affected areas dropped in their group self reliance rating, there is evidence to suggest that they have also been able to recover more quickly because of their increased resources and better management practices. The crisis provided an opportune time to introduce new agricultural products such as long life crops, new types of crops as well as display the advantages of alternate food technology to preserve food.

Of particular interest has been the performance of the fledgling NGO, Yasumat based in Soba. This NGO, which the project has assisted, now has an office in Wamena, maintains a school of 140 students with 4 teachers and is supporting 2 students to study in Jayapura. The leadership is clear about ownership and rejects proposals or funds that might compromise its independence.

The project is now focussed on the areas of Kanggime and Mamit, both of which have recently been made subdistricts. This poses new challenges as the leadership does not appear to have a strong vision for the area. The baseline survey conducted at the beginning of the extension has identified several changes in mood amongst the communities, even over the past year.

1. INTRODUCTION

1.1 Project origin and preparation stages

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. A second review in December 1997 recommended that the project be extended in order to consolidate interventions to date and maximise sustainability and impact. The project operated on an interim extension from October 1997 to 31 October 1998.

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.

1.2 Main implementing agencies

The main implementing agency at central and provincial levels is the Ministry of Health. At district and subdistrict levels it is the Dinas Kesehatan. WVII and WVA collaborate in administration and coordination of project activities and direction. The project is also working through the quasi government institutions such as the PKK and LKMD. These institutions are weak in the project target areas.
The project works closely with the local churches and mission agencies which have been the major

institutions in the area to date. This situation is changing as both Mamit and Kanggime have recently been made kecamatans (sub districts) which invariably means another layer of bureaucracy to work with. At the central level of the district, Wamena, the project has excellent relationships with government agencies such as LIPI, local NGOs and some external agencies such as MSF, Merlin and CASE.

1.3 Preparation of Annual Plan

The staff of the project prepared drafts of the budget, activity schedule and work plan for the Annual Plan. These were discussed through electronic mail and finalised by the Project Director. Project staff liaise consistently with Dinas officials and project activity is prepared in accordance with district level plans.

2. PROJECT DESCRIPTION

2.1 Strategy for implementation

The project aims 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 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.

2.2 Project objectives

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. The extension will be a period of intense activity to finalise and consolidate previous interventions and to further evaluate and comprehensively document the model.

2.3 Component description

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.

2.4 Expected outputs

Output 1 - *A maternal and infant health program consolidated*

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 need attention. This includes 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. 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

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.

2.5 Major activities and their implementation schedule

In the health component the major activities will be to:
. promote the registration of all pregnancies
. immunise all infants under 11 months
. conduct refresher training of bidans and TBAs
. supervise maternal health programs
. construct strategically located bridges for access to health facilities
. complete and assess the use of the health information system
. monitor supervision protocols
. conduct training in major diseases
. develop educational materials
. promote use of nutritional programs

In the community development component, the major activities will be to:
. promote group skills to attain self reliant stage
. promote functional LEISA systems
. increase gender awareness and behaviour
. increase small business capacity
. support training in appropriate technology.

In the management component, the major activities will be to:
. conduct and analyse surveys
. ensure community plans are drawn up
. monitor and report on project progress
. complete project documentation.

2.6 Inputs

The major inputs in the health component will be:
. medical supplies

. training
. health education consultancy
. materials for bridges, water supply and latrines
. nutritional starter packs.

The major inputs for the community development component will be:
. group assistance packages
. training in variety of skills
. exposure trips to Java for skills and awareness training
. consultancies in small business, gender awareness and NGO development.

The major inputs in the management component will be:
. consultancies for documentation
. materials and training for surveys.

3. SUMMARY REVIEW OF PROGRESS

3.1 Achievement by objectives

This extension phase is only in early days and it is too early to see clear progress. However, several points are worth noting:

a) the rationale of placing staff in the village locations is proving to be successful. Initial indications are that the two men placed in the villages for substantive periods of time are able to supervise, coordinate and monitor activities much more effectively than in previous phases of the project. In addition, they are able to spend more time explaining the purposes and methods of the project.
b) Liaison with other groups is still a significant contribution of the project to life in the district. The project has built a reputation for innovative and committed activity that is recognised in other parts of Indonesia, including being cited in a WHO award in late 1999. This liaison includes other international NGOs as well as government instrumentalities.
c) Initiatives taken by the project in the past have been taken up by others. During the famine from 1998-9, a significant input from the project was the use of case management protocols, particularly for those coming in to assist with the outbreak of malaria. This led to further collaboration with new agencies such as Merlin and MSF, specialising in malaria research and control.
d) It is also worth noting the development of groups where the Watch project has had involvement. Several places have contemplated establishing yayasans in a more formal way than their churches are set up but few have moved very far. One such success has been the groups in Soba. The groups in Soba have had input from a missionary, Sr Sue Trenier, and from Watch for several years. The groups decided to form an NGO that not only covered Soba but also further into the south eastern valleys thus giving rise to the acronym Yasumat representing

various tribal entities. The initial plans were to base this NGO around health provision and conducted an opening ceremony attended by senior health officials and Watch personnel in 1995. It has progressed slowly but steadily to the point where it now has an office in Wamena, maintains a school of 140 students and 4 teachers and is supporting 2 students to study in Jayapura. The leadership of the NGO is clear about the ownership of the activities ie must be under the control of the NGO and not directed by external donors, and rejects proposal or funds that might compromise its independence.

3.2 Achievement by component

Component 1 - Health

Training in food preparation has been very successful right through the project areas. Surveys in mid 1998 showed that this was one of the more successful initiatives of the project. The new methods and foods have not been universally adopted but key persons within groups and villages have taken up these initiatives. Displays of new foods have indicated an understanding of new ingredients and new methods to prepare food. This program is ongoing and is closely linked to nutritional awareness promotion.

Training for TBAs is a priority and has commenced. Progress is slow both in the number of trainings conducted and the numbers of people attending training. The project has found that it is difficult to get TBAs to come together for training and also that many TBAs easily forget information and skills passed on to them. The project will thus use the bidans to train TBAs as well. The process will be that continuous refresher courses are held for bidans and TBAs when project staff visit. Bidans will be required to work with TBAs and keep monthly records on their activities and progress with TBAs. There are encouraging signs amongst health cadres that in some areas there is an increased level of competence.

	October 97 – October 98		**November 98 – June 99**		**Comments**
	# trainings	# trained	# trainings	# trained	
TBA	1	13	2	21	
Bidan	1	35	2	23	
Visits	8	20 desa	8	20 desa	
Cadres	2	122	3	131	
Posyandu	-	-	2	46	
Nutrition	-	-	51	51	# plots and # of packages

Component 2 – Community development

Gender awareness has had a solid beginning in the extension. A workshop and preparatory workshops have included many leaders both from within the district and without in trying to analyse

the key issues and determine the most effective ways of addressing the problems. Gender awareness in Wamena is designed to try and ensure that government and institutional level activity is galvanised for the future. The gender workshops do not include village women as they are generally overawed by the context of Wamena and it is an expensive proposition to transport people from villages to Wamena. However, the project has a program whereby gender training and awareness raising at the village level with appropriate visual material has been a consistent feature of the project activities.

There have been consistent calls from schools and other groups for the gender awareness materials and training, viz: the Catholic school system and the Nurses Training School have both adopted the gender module for instruction in their respective environments.

Groups have started to take up the LEISA (Low External Input for Sloping Agriculture) agricultural system. This is a technique of farming using organic fertilisers, mulch, terracing and companion planting to fertilise the soil and to lessen the length of fallow periods. The technique also provides for the planting of wood, shelter and productive trees for regreening as well as nutritional and commercial purposes. Training is continuing and staff are monitoring progress. Activity is continuing on several other fronts of group activity including animal husbandry and small business activity.

Surveys in mid 1998 indicated that the community development activities had brought significant benefits to groups and communities. They identified increased knowledge and skills in agriculture, more variety in activity and diet and an increased income. Two interesting outcomes from this progress were identified as more students being sent to Wamena for schooling and better domestic cooperation in the home.

	October 97-October 98		November 98-June 99		Comments
	Training	Groups	Training	Groups	
Gender workshop	-	-	1	32 *	* # of people
Leisa training	-	-	4	51	This includes the distribution of 4 packs of seeds
Animal husbandry	-	-	4	51	
Visits to villages - CD Coordinator - GAD Coordinator - Training Officer - Cadre Supervisor	 2 2 2 2	 2 10 3 10	 1 8 8 4	 3 63 26 33	This column refers to the number of 'gereja' ie the church administrative unit used in the highlands

Component 3 - Management

Baseline surveys have been conducted and results collated. Training has also been continued with the local nurses training college for the purposes of data collection and health information system training. In addition to this, many groups have started to put together plans based on the findings of the PLA surveys.

3.3 Significant problems and issues

a) Constraints of formal health system. Supervision is an issue in many health projects throughout Indonesia. Indications from initial monitoring is that staff from health facilities are often absent and even when they are in attendance their performance cannot always be guaranteed. Enforcement of standards is often inadequate and there is lack of a strong customer service culture. The objectives to ensure that supervision regimens are followed through will have to be monitored carefully.

In addition to the lack of supervision is the poor teaching methods that have trained health staff and officials. The training has not provided staff who have clear conceptual ideas about why and how to do achieve their objectives. This consequently brings about a lack of trust in the system and reinforces low quality. That is not to say there have not been improvements eg registers are now filled in on a more consistent basis than before; the level of knowledge of many health staff is more thorough.
There has been much debate and frustration as to how to improve the supervisory capacity of the formal health system. One suggestion has been to provide more government staff at the health centre (puskesmas) level in a kind of assistant head of health centre for supervision and coordination but the argument is that this will not work unless there is enforcement from the district level and the head of the health centre. One of the current problems is the non attendance of the heads of health centres. Moreover, it is likely that there would be intense resentment from other health centre staff. This resentment would probably lead to false reports being submitted.

A second suggestion has been made that a person be appointed to assist the DHO in matters of coordination and supervision amongst the heads of DHO sections. This person would need to have a medical background, preferably a doctor, would not have power to discipline or fund. The assistant position would not need to be full time, would not need field level supervision but would relieve the DHO of these duties and take responsibility for coordinating section budgets for supervision and ensuring that the section heads go the field on a scheduled basis. Reporting would be required and would be administered, followed up and reported in writing and in person to the DHO. In the case of Wamena, it is known that there is a retired government health official who holds positions of responsibility in the community and is highly respected.

In discussion with Dr Zulfian, we found that the district has had some recent meetings trying to set out a series of plans for each of the sections. These have still not been implemented and are being costed for budget purposes. Further meetings will be held with the section heads to clarify exactly what can be done and when it will be done. This is an important step and, if implemented, will go some way to addressing the supervision problem. It was acknowledged in this meeting that the idea of the assistant DHO would be a valuable one but a number of administrative hurdles would need to be crossed before this could be achieved.

The problem with all of these ideas is that the situation of the health environment in Wamena has changed over the weekend of 21/22 August. The health structure provides for a district officer to

administer the interests of the MOH and this person administers the Kandep. There is also provision for a person to administer the health system on behalf of the local government. This person administers the Dinas and is responsible for the administration of the sections, the puskesmas and other health officials below that. Up to now, and this is common in many parts of Indonesia, both roles have been fulfilled by Dr Zulfian Muslim. On 21 August, the bupati appointed a new person to head up the Dinas. Dr Zulfian will continue as Kandep and surgeon to the hospital but his link with the Watch project will not be operational. On the one hand, he is the link to the central government with whom bilateral programs are negotiated. On the other hand, he now has no responsibility or power to administer the conduct of the health system. This situation affects the counterpart relationship and will need to be followed up with introductions and briefings.

b) Community development concept. There appears to be a lessening of community cooperation and participation at some levels. Some of this is due to wrong perceptions of the term 'project' and implications that the project staff are corrupt. Social mobility has also increased over the last 2 years which is exacerbating the difficulty of contacting people in an area which is already extremely difficult to travel around. These developments are relatively new and culminated in a meeting between project donors, contractors and manager in February 1999. The approaches of the Watch project were explained and there has been an effort by project staff to ensure that all groups, hamlets and villages understand the development concepts behind the Watch project. This has been undertaken by the GAD Assistant living and moving around the target area as well as core staff from Wamena when they come into the target areas. In addition, the distribution of group support packages is a reminder that the Watch project is able to deliver tangible services.

The project strategy to overcome the problem of 'project' is to continue to explain the approach of Watch and to try and avoid using the term 'project'. Words such as 'activity' or 'program' are preferable in this context.

c) Community self reliance. The problems of the community development concept described above have also contributed to the lower than expected advancement of some aspects of local community groups. There is the potential for this to affect the targets of 50% of groups in Kanggime and 30% of groups in Mamit reaching 'mandiri' or self reliant status. At the same time however, it should be acknowledged that some aspects of the group development program have exceeded expectations. This would apply particularly to the area of food preparation. This is cause for optimism that groups can grasp the principles of instruction and implement skills.

The project staff have been constantly reflecting on this issue because the demands of the number of groups cannot be met easily and therefore impact on the capacity to bring groups to mandiri stage. At the beginning of the extension invitations were issued to existing groups to attend a meeting. More than the expected number came and there was an expectation that the project would supply assistance to all. The total number increased from an expected 65 to 105. The staff will visit each group at least once but then cut back to the 65 groups. Of these, there will be a greater focus on a small number of groups: 6 from Kanggime and 4 from Mamit. It is hoped that at least this group of

10 will reach mandiri stage and some other groups may also.

A paper outlining the criteria for assessing groups based on the report published by the project in April 1996 (in Indonesian) is attached.

d) Illegal drug disbursement. A development of some concern over the past year or so has been an increasing incidence of government health system drugs being illegally sold to other areas. This is a disturbing trend because it raises the possibility of people taking wrong medicines, taking wrong doses and being disenchanted with the use of drugs for curative purposes. The project is monitoring reports of this issue, trying to ascertain the veracity of reports and taking the opportunity to discuss these issues with the DHO when appropriate.
A responsibility of the Assistant to the DHO described in 3.3.a would be the development of checks and standards for each section of the DHO. This would include the pharmacy section. It would be hoped that a system that sets out who can order drugs, who can collect drugs and what process there is to validate those people or delegates will ensure that the gaps described above will be reduced substantially.

Given the new situation, at this stage it would be anticipated that the Project Manager would mention this issue along with others in the initial or subsequent meeting.

e) Perennial problems. There are some issues which will take a long time to change. One of these is the penning of animals, especially pigs. This is due to the argument that to pen animals means that one has to find feed for them whereas if they can free range they can find their own food. Secondly, geography is a constant constraint in that villages/hamlets are scattered and transport logistics between them is limited to walking. Thirdly, the geography inhibits the marketing of products which in turn inhibits income growth and potential. This lack of access and growth restricts the ability of communities to try new things and develop new mechanisms.

The main issue here that the project can try to address is that of pigs. The staff have considered a two step process. Firstly, that pigs should be corralled into an area away from the centre of the village and habitats. The pigs still are able to wander around but they will often receive some supplementary feeding. There are already some villages who have been able to move to this step. The second step is to have individual or much smaller pens for the pigs. If this is done it will require the pigs to be given feed as they will not be able to forage themselves. This is a burden the community want to avoid but some have successfully made this change. There is one person in Kurulu and one in Mamit who have done this.

One of the cultural constraints is that pigs are the medium for paying debts and for bride price. Accordingly, the logic runs that if energy and expense are spent on pigs, it counts as a loss to the owner because the pigs will go to someone else. The incentive for change is therefore low. There are a number of issues here in terms of cultural practices and how they can be changed or adapted to new situations. This is beyond the capacity of the project to address except to note these issues and

record them.

f) Contradictions. There are often apparent contradictions within the highland society that make it difficult to explain and plan activity. Four examples will suffice:
(i) the crumbling national economy over the past two years including the famine in Irian Jaya is inconsistent with the increased level of aid flows into the district
(ii) the distribution of project aid grants actually has the tendency to undermine community development initiatives as described in b) and c) above
(iii) the low status of women is inconsistent with the increased level of mobility of some women due to improved transport linkages
(iv) the perception of increased interest in Irian Jaya breaking away from Indonesia is inconsistent with the strong vote for the Golkar party.

4. WORK PLAN FOR NEXT FINANCIAL YEAR

4.1 Strategy

The thrust of the years activities will be to:
. see the short term consultancies activated
. ensure training is conducted in maternal health issues and monitored closely for progress
. documentation framework recommendations completed and used as a guide for activity
. focus on key groups to ensure they reach self reliant status.

4.2 Schedule of activities and resources

A Work Plan of activities is shown at Annexe 1 and a Schedule of these activities is shown at Annexe 2. The Work Plan presents a detailed plan of targets for all activities with a list of sub activities and commentary on the targets.

The major milestones in this year will be:

. the 2 PCCs due to be held in August 1999 and March 2000
  the first of these meetings will be held in Jakarta and will discuss the findings of the project documentation survey as well as progress
. baseline surveys and village plans in September
  these surveys will cover information to help rate groups on the self reliance scale eg organisational ability, care of introduced gardens and animals, savings, use of sweet potato flour, establishment of POD, posyandu, latrines, and understanding of the 3 basic illnesses etc. Statistical data from posyandu records on neo natal registrations, immunisation, child growth records, anthropometric data and recall of food consumption will also be taken
. the training with CASE in September
  this is training in the use of simple equipment to do with production, preservation and preparation of food. The liaison with CASE is the result of relationships with LIPI (the Indonesian Institute of Sciences) and local government who are trying to establish a higher order of productive/commercial activity in the district as well as a new hub of activity
. gender workshop in December
  these workshops include government, community and institutional leaders from the district and seek to establish frameworks for continuing the raising of awareness but also the implementation of recommendations from the workshops
. Cooperatives workshop in November
  this consultancy will assist groups to develop plans to understand basic principles of marketing and how to establish improved capacity and systems for a small business, albeit on a limited scale. An external consultant from Semarang is being approached.
. Revision of HIS programming in September
  the health information system has been placed on computer but needs to be revised. This revision will allow the system to be placed on a sound technical footing with training for

DHO officials.

. HIS review in February

the health information system has been simplified but there are issues regarding the implementation of the system at puskesmas levels and district level. This consultancy will analyse how successful the new system is and how it can be better implemented.

. The exposure trips to Java in August 1999 and February 2000

these trips provide opportunities for local people to see first hand what scale Indonesia encompasses and specifically to receive training in micro development activity at professional institutions. The project is trying to ensure there is a representation of women on these trips – this is often difficult given the length of time away, there being few precedents for women being away from home and the standards required to participate in courses.

The larger group will be of dvelopment cadres. Past groups have gone to the Bogor Institute for Agriculture but the first trip in August/September will visit institutions in Malang in central Java. Training has included mulching, basic animal husbandry techniques for small animals, growing vegetables and food preparation. Experiences have included air and sea travel, cities, Taman Mini.

As second group will be made up of yayasan leaders and will go to Java for exposure as well as management training. They will be trained by YIS, a well known Indonesian NGO, based in Solo.

. The Community Health and GAD consultancy in September.

The project has approached consultants experienced in combining gender, health and community development to establish a framework for improved health education.

. documentation framework recommendations completed and approved

this consultancy will provide the framework for documenting the activities of the project over the 8 year period, especially the model of integrated health pursued in the project. The consultant's report will be available for discussion at the PCC in August.

5. COSTS

The table below shows a summary of costs for the financial year:

Components	Total
1. Health	58,394
2. Community development	100,041
3. Management	112,633
TOTAL	**271,068**

JAYAWIJAYA WATCH PROJECT - KANGGIME EXTENSION
ANNUAL WORK PLAN AND TARGETS FOR 1999-2000

CODE	MAJOR ACTIVITIES	TARGET/INDICATOR	REMARKS
Comp 1	**Maternal and Infant Health** Objective : Appropriate ante-natal services maintained by 711 pregnant women with full course of TT, blood pressure checks, fundal height measured, iron tablets minimum 90 tablets and nutritional status (weight, height & MUAC),.		
Output 1	Appropriate maternal and infant health program consolidated		
ACTIVITIES			
1.1.1	Promote registration of all pregnancies	- 298 pregnant women have registered and hold KMS in Mamit - 413 pregnant women have registered and hold KMS in Kanggime	
1.1.2	Promote registration of all delivery helped by midviwes	- To register all deliveries helped by midwives in Mamit and Kanggime	- Availability of KMS for pregnant Women in Polindes and Posyandu
1.1.3	Promote registration of all infant births	- To register 272 newborn babies and to give them KMS in Mamit - To register 375 newborn babies and give them KMS in Kanggime	- Cross check on delivery monthly report which is sent to Puskesmas/Dinas Kesehatan
1.1.4	Promote registration of all maternal and infant mortality cases	- To register all maternal and infant mortality case	- Cross check mortality monthly report from Puskesmas
1.2	Distribute Iron tablets, Pyrantel Pamoat and Chloroquine	- 413 pregnant women in Kanggime and 298 pregnant women in Mamit receive minimum 90 iron tablets during pergnancies - 413 pregnant women in Kanggime and 298 pregnant women in Mamit receive Pyrantel Pamoat on 2nd terms (trimester) of pregnancies - 413 pregnant women in Kanggime and 298 pregnant women in Mamit receive chloroquine on the 2nd terms (2 tablets per week).	- Site inspection on the availability of iron tablets, pyrantel, chloroquin provide by Dinas - Monthly activity reports from midwives.
1.3	Immunise all infants (0 - 11 months)	- All newborn babies receive complete immunization (BCG, DPT 3 times, Polio 4 times dan Campak/Measle) - in Kanggime there are 375 babies - in Mamit there are 272 babies	- Inspection on the availability of Vaccine in Puskesmas and Pustu - To Check an availability KMS for children - Monthly report of immunization activity
1.4.	Conduct refresher training of all midwives and TBA's in : - antenatal care - high risk pregnancy - 3 major diseases	- 13 midwives in Kanggime and 14 midwives in Mamit get Case Management Protocol (CMP) and maternal & infant health training twice a year . - 56 TBA's in Kanggime and Mamit get refresher training twice a year	- 13 midwives in Kanggime and 14 midwives in Mamit have CMP pocket book - Inspection /observation the use of CMP by midwives
1.5	Supervision of all Maternal Health	Supervision in Kanggime, including these areas : - Kanggime-Wama-Kumbur-Kupara-Nabunage; Yaliwak-Bogunuk; Egoni-Dolonggun Supervision in Mamit, including these areas : - Mamit-Woraga-Gatini-Kalarin; Nambu-Nologpur-Yali; Kembu; Kage-Telengeme; Panaga-Tirib	- checklist - observation - activity report
1.6	Construction of bridges	Kec. Kanggime 1. Desa Kupara; 2. Desa Bogonuk Kec. Mamit 1. Desa Kage; 2. Desa Nambu	- survey or site inspection. This has already been conducted for the bridges in Mamit and community consultation made. Community will participate in the bridge building and contribute labour and some materials.
1.7	Evaluation of bridge usage	- Site visits and interview by MEO of 2 bridges in each centre	- Evaluation reports

Output 2	**Capacity of health system , staff and community strengthened**		
ACTIVITIES			
2.1	Develop and explain supervisory system to health staff .	- 24 mantris in Kanggime and 17 mantris in Mamit get HIS training. - Puskesmas Staff supervise POD, Posyandu and Polindes in each area - SP2TP Officer in Puskesmas are able to make records, to do simple analysis and monthly reports to be sent .	- Pretest and post-test training result - Site inspection and observation on monthly report activity of Puskesmas, Pustu and Polindes - Integrated supervision check-list available
2.2	Supervisory visit implemented	- Puskesmas staff supervise Posyandu and POD at least once every 3 months - Project Health Staff conduct a supervision visit 4 times a year	- check-list , Inspection - reports
2.3.1	Mantris trained in Case Management Protocol and BCGs	- 24 mantris in Kanggime and 17 mantris in Mamit are able to diagnose & to treat 3 major preventable diseases properly	- Pretest and postest training result - Observation and activity report
2.3.2	Mantris and Midwives trained in HB testing	- 41 mantris and 27 midwives are trained and able to examine Haemoglobin rate of pregnant women properly	- HB testers are prepared in every polindes.
2.4	Cadres (POD Cadres and Posyandu Cadres) trained to diagnose and treat 3 major preventable diseases	- 40 POD cadres in Kanggime and 30 POD cadres in Mamit are able to diagnose and treat pneumonia, malaria and diarrhoea properly - 70 POD cadres are able to make reports of diseases correctly and to send the reports to the health center every month - 26 Posyandu cadres in Kanggime and 28 Posyandu cadres in Mamit are trained and able to do the following jobs : ° Weighing, recording, reporting and conducting health education campaign ° Providing and distributing supplementary foods	- Pretest and post-test training result - Inspection/observation . - Inspection and observation - Pretest and post–test . - Observation/inspection - Activity report
2.5	Programmer to revise and install completed health information system (HIS)	- Consultant hired – September 1999 - HIS program completed	- Inspection of maintenance schedule
2.6	Assistance and training given to district health officers in HIS	- To conduct training in use and maintenance of HIS program by Consultant	- Report
2.7	Assessment of the use of HIS system	- Consultant scheduled to arrive on early 2000 and will conduct evaluation.	- Report
2.8	Prepare strategy for NGO sustainability.	- Conduct NGO workshop at the end of 1999.	- Workshop report

Output 3	**A preventative health and nutrition program implemented**		
ACTIVITES			
3.1	Distribution of nutrition plot starter packs	- 65 nutrition plot established in every groups in Kanggime and Mamit (in backyard and garden).	- Inspection and survey on the diet pattern (frequency and variety) - Conduct recall survey on the last 24 hours consumption and take anthropometric data.
3.2	Promote use of sweet potato flours and powders	- All Posyandu cadres, POD cadres, CD cadres and health workers (mantris & bidan) in Kanggime and Mamit have trained about the using of sweet potatoes flour as oral rehydration therapy and baby weaning food and how to make it - 50 % Posyandu and 50 % POD in Kanggime and Mamit have sweet potatoes flour supply to be used for oral rehydration therapy and baby weaning food. - 50 % groups in Kanggime and Mamit have sweet potatoes flour supply and already know how to make and to use the flour as oral rehydration therapy and baby weaning food.	- Pretest and post-test - report activity - Site inspection of the availability of sweet potato flour in Posyandu and POD - Site inspection and report diarrhoea incidence covered by oral rehydration therapy with sweet potato flour
3.3	Develop IEC materials based on PLA studies	- All Posyandu, POD, BP , Pustu dan Puskesmas already have the posters and booklets follow IEC materials on basic health - Posyandu cadres, POD cadres and health workers are able to conduct IEC using the materials based on PLA study . - 10 % of groups have changed their attitudes i.e. personal hygiene and sanitation, frequency and variety of diet	- Inspection - Observation - Survey and site inspection
3.4	Training given in food preparation	- 65 groups have trained how to cook and to provide the nutrition food - 13 groups in Kanggime and 8 groups in Mamit have changed their manner in processing (cooking) the food, their diet pattern (frequency and variety)	- Pretest and post-test - Observation and survey
3.5	Promote use of and assist construction of latrine	- 13 groups in Kanggime and 8 groups in Mamit already have and use latrine properly	- PLA survey - Initial survey
3.6	Increase capacity of staff to use PLA and other knowledge to promote health education	Community health/GAD consultant ocnducts assessment, training and recommendations for materials and training methodology	- Consultant report
3.7	Safe water construction	Surveys in May/June identified Kanggime and Parari in Kanggime area and Mamit and Gatini in Mamit area as sites for water supply construction. These sites will involve piping water from a spring into the village. Construction will be in September and October.	Dept of Public Works staff to assist in construction. Community required to support activity with labour and materials
Comp 2	**Community Development** Objective : At least 25 % groups from Kanggime (base data 52 groups) and 15 % groups from Mamit (base data 53 groups) reach 'mandiri' status		

Output 4	Existing community development initiative strengthened		
Activities			
4.1.1	Training provided for groups with training materials such as agriculture, animal husbandary, appropriate technology and LEISA.	1. 40 groups in Kanggime and 25 groups in Mamit get training in agriculture and animal husbandary with LEISA system, appropriate technology and small enterprises development . 2. Cadre's knowledge & skills on agriculture, animal husbandary as well as appropriate technology and gender awareness increase. 3. 50% of cadres in each area should be female	- Training activity report. - Pretest and post-test training result
4.1.2.	Support provided for groups according to selfreliant stage	Support packages for 105 groups are given according to the level of progress/development achieved by the groups: - 40 Pratama groups (12 Kanggime and 28 Mamit) are given basic supporting package - 24 Madya groups (15 Kanggime and 9 Mamit) are given basic supporting package and small enterprise package - 20 Purnama groups (12 Kanggime and 8 Mamit) are given small enterprise package - 21 Mandiri groups (13 Kanggime and 8 Mamit) are given small enterprise package	- Distribution package report - Site inspection
4.2.	Promote group skills	- Group competitions are held twice a year in each area	- Activity report
4.3.	Supervision of groups by staff and cadres	1. Supervision by GAD Assistant is conducted every month 2. Supervision by GAD Coordinator and Training Officer 4 times a year in each area 3. Supervision by Cader supervisor 6 times a year in each area	- Visit and activity report
4.4	Assist group to develop functional LEISA system (include organic agriculture and terracing system).	1. 50% of groups in Kanggime and Mamit have a plot for LEISA system 2. Minimum 1 member of 50 % of groups is able to implement LEISA system. 3. Each group has minimum 2 kinds of top commodity for sale	- Observation and visit groups; activity reports - Observation and activity report - Observation and activity report
4.5	Increase gender awareness at district level	1. Gender Workshop is held once this year at district level 2. To facilitate the foundation of a Women's empowerment institution (non formal organisation).	- inclusion of sub district level representatives - Workshop activity report - Inspection of completed module - Non formal institution established
4.6	Increase small business/cooperatives awareness and capacity	1. Small enterprise development workshop held in Wamena with external consultant 2. Home industry is carried out by 5 groups/individual in each area	- Consultant's report - Activity reported regularly through monthly reports
4.7.	Exposure trip for skill training in Java conducted	1. Exposure trip to Java is conducted twice during project period 2. 50 % of 40 cadres who are sent to Java should be female 3. 50% of those who are sent are able to teach what they learn in Java to group members 4. 30 % of those who are sent to Java are able to practice back home what they have learned in Java.	- Visit report - Exposure activity report - Observation and interview with cadre and groups . - Site inspection and observation
4.8	Exposure trip to NGO training in Java	10 local NGO board members can be sent to Java to undertake NGO	- Visit report

Output 5	Management system implemented		
		Activities	
5.1	Design surveys for all project related activities	1. Co-ordination linked with DHO in survey and supervision 2. Survey designs are ready for baseline, midterm and end of project surveys	- Project records and reports
5.2	Refresh SPK student in collection methods	1. Yr 3 SPK students about to undertake Practical Field Work get training in methods of compiling data. 2. Yr 3 SPK students are involved in undertaking initial and mid term surveys	- Reports - Initial/midterm survey result accurately
5.3	Collections conducted, analysed and written up	1. Baseline survey conducted in Kanggime and Mamit 2. PLA survey conducted in 3 villages in Mamit and 3 villages in Kanggime 3. Midterm/initial survey will done in Kanggime and Mamit 3 times during the project period	-Baseline data record and report document
5.4.	Documentation framework designed and implemented	1. Consultant and Documenter hired 2. Document/s completed	- Consultant contracts - TOR
5.5	Community plans are drawn up following the midterm annual survey	- 65 groups had annual plan based on result of baseline survey with PLA method	- Inspection of groups plan - To compare the initial/midterm survey with baseline survey data
5.6	PCC meetings	Meetings to be held in Jakarta in August and February	
5.7	Reports submitted regularly	. Regular (at least monthly) internal meetings . Monthly reports submitted within 3 weeks of months end . Acquittals submitted within 6 weeks of period end . Final PCR completed	Reports in English will be submitted to WVA by mid month to ensure time for editing
5.8	Area Committee meetings	These meetings to be held on a quarterly basis involving local government, government institutions, NGOs and local institutions	

CHANGE FRAME

PDD reference	PDD	Change	Justification	Impact on budget		Change
				Design	Proposed	
Comp 1	**HEALTH**					
Obj 1	**Maternal and infant health**					
O1.2	Bridge construction	Decreased costs	A survey for the bridges has now been done and a more accurate costing proposed.	14,881	7,463	- 7,418
Obj 2	**Capacity building**					
P2.3	HIS assessment consultant	Timing of activity and increased cost	The timing of this consultancy has been moved back to allow for the changes in the HIS consultancy	1,528	1,536	+8
Output 3	**Preventative health**					
E3.2	Safe water construction	Additional expenditure	The community has requested assistance with water supply in several places: Kanggime and Pariri in Kanggime area and Mamit and Gatini in Mamit area. A survey for the water supply has been conducted, the method will be to use piping and preliminary plans have been drawn up	1,984	3,731	+1, 747
Comp 2	**COMMUNITY DEVELOPMENT**					
Output 4	**Community Development**					
T4.6	Cooperative workshop	Increased cost	The workshop will require more substantive funding than estimated to cater for villagers to come into Wamena to attend this training. Previous estimates had allowed for travel to villages in other line items but current planning has the workshops in Wamena, not in the villages	123	1,200	+ 1,077
T4.7	CASE workshop	Decreased cost	This training will not be as costly as estimated.	8,333	1,866	- 6,468
O4.7	Cooperatives – fares & accom	Decreased cost	Some work has already been carried out with provincial based NGOs rather than only using Java or external based consultants. There will be one coop workshop which plans to bring a consultant from Java	6,151	1,500	- 4,651
Comp 3	**MANAGEMENT**					
Output 5	**Management system**					
P5.7	Documentor – Data collection	Decreased cost	The total cost of this consultant is the same but the cost in the financial year is less due to the later start date and the final month being in the next year	6,000	4,500	- 1,500
P5.8	WVA – salary and admin	Increased cost	The revised estimate is to provide for increased costs and time spent on projects	15,600	16,800	+ 1,200
P5.9	WVII – salary and admin	Increased cost	The revised estimate is to provide for increased costs and time	12,000	13,800	+ 1,800

ADJUSTMENTS						
Obj 1	**Maternal and infant health**					
E1.1	Worm tablets	The following adjustments are based on using different exchange rates to reflect the existing fluctuations in the rupiah and Australian dollar in relation to the $US and also using different rates to forecast expected movements in these currencies. All these adjustments show a small decrease in forecast expenditure.		595	560	- 35
E1.2	Haemoglobin testers			298	280	- 18
O1.1	Costs of haemoglobin testing			295	280	- 15
Obj 2	**Capacity building**					
P2.2	HIS consultant			1,548	1,500	- 48
P2.3	HIS assessment			1,536	1,444	- 92
O2.1	Supervision			676	634	- 42
O2.2	HIS consultant: fares & accom			1,238	1,200	- 38
O2.3	HIS assessment: fares & accom			1,577	1,483	- 94
O2.4	NGO workshop			298	280	- 17
Obj 4	**Community Development**					
E4.2	Supplementary packs			1,935	1,819	- 116
E4.3	Self reliance packs			21,329	20,477	- 852
E4.4	Freight for packs			794	770	- 24
E4.5	Supervision checklists			10	9	-1
E4.6	Materials for training sessions			1,584	1,493	- 91
T4.3	Training in Wamena			6,488	6,101	- 387
T4.4	Group competition – Wamena			436	410	- 26
O4.1	Supervision – senior staff			745	700	- 45
O4.2	GADA supervision			1,668	1,567	- 101
O4.4	Cadre Assistant – travel			1,428	1,007	- 421
O4.9	UNDP visit			298	0	- 298
Obj 5	**Management system**					
E5.5	Equipment maintenance			2,476	2,328	- 148
E5.7	Communications			4,333	4,075	- 258
E5.8	Computer maintenance			1,548	1,455	- 93
E5.9	Freight/miscellaneous			2,476	2,328	- 148
O5.2	Annual baseline surveys			2,462	2,315	- 147
O5.6	Documentor 2 – housing			1,091	1,026	- 65
O5.7	Documentor – fares & accom			1,984	1,925	- 59
TOTAL				485,973	378,644	-107,330