JAYAWIJAYA WATCH PROJECT

1991 - 2000

PROJECT
COMPLETION REPORT

Submitted by
World Vision Australia
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MAP

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ABBREVIATIONS AND GLOSSARY

AIDAB	Australian International Development Assistance Bureau
AusAID	Australian Agency for International Development
BAPPENAS	National Development Planning Authority
Bidan	Midwife
Bidan di desa	Community/Village midwives
BPPT	Agency for Application and Development of Technology
Bupati	Chief of a district/district mayor
Cadre	Voluntary health or community worker (community level)
Camat	Chief of a sub-district
CHN3	Community Health and Nutrition, Phase 3 (World Bank project)
Dana sehat	Village based health insurance system
Depkes	Department/Ministry of Health
Desa	Village/remote administration
Dinas Kesehatan	Provincial level health department/office
Dukun	Traditional birth attendant
GOI	Government of Indonesia
HIS	Health Information System
IDT	Inpres Desa Tertinggal
Kabupaten	District
Kanwil Depkes	Provincial health office
Kecamatan	Sub-district
LIPI	National Academy of Sciences
Mantri	Nurse auxiliary
MOH	Ministry of Health
NAMRU	American naval research unit based in Jakarta
NGO	Non-government organisation
PHC	Primary Health Care
PHO	Provincial Health Office
PKK	Pembinaan Kesejahteraan Keluarga (family welfare movement)
PLA	Participatory Learning and Action – a qualitative methodology
Polindes	Village birthing centre
Pos obat desa	Privatised cadre-run village drug post/village dispensary
Posyandu	Integrated village services post
PRA	Participatory rural appraisal
Puskesmas	Sub-district community health centre
SPK	Sekolah Perawatan Kesehatan (Nurses Training College)
TBA	Traditional Birth Attendant
WATCH	Women and Their Childrens Health
WVA	World Vision Australia
WVII	World Vision International Indonesia
Yayasan	Foundation which operates similarly to NGOs
YKB	Yayasan Kesehatan Bethesda
YPMD-IRJA	Irian NGO based in Jayapura

BASIC DATA SHEET

. *Contractor*:

. World Vision Australia in partnership with World Vision International Indonesia

. Indonesian government partner: Department of Health.

Phase 1

. *Dates :*

. Submission of concept paper by WVA - October 1989
. Submission of design by WVA - April 1990
. Submission of revised design by WVA - October 1990
. Appraisal by AusAID post - December 1990
. Letter of intent to start project - 4 June 1991
. Contract start - 15 April 1991
. Contract end - 30 September 1994
. Project review by AusAID consultant - February 1994

. *Contract* Agreement No 3287, dated 4 June 1992

. *Location* . District of Jayawijaya in Irian Jaya province, Indonesia
. Office location in Wamena, the main town of Jayawijaya district

. *Cost :* . Budget for first phase: $ 1,330,869
. Actual cost of first phase: $ 962,230

Phase 2

. *Dates:*

. Submission of design for Extension - May 1994
. Approval of Extension - July 1994
. Contract date for Extension - 1 October 1994
. Contract end for Extension - 30 September 1997
. Project review by AusAID consultant - December 1997

. *Contract :* Agreement No N301, dated 30 September 1994

. *Location:* Activity conducted throughout the whole district but concentrated in 8-10 locations

. *Cost:*

. Budget for Extension: $ 1,459,641
. Actual cost of Extension: $ 1,105,216

Interim phase

The project continued to implement activities from October 1997 to October 1998. An contract extension covered this period but the project was waiting for the outcome of the proposal to design a further extension.

Actual expenditure in the Interim period : $ 81,602

Phase 3

. *Dates :*
. Submission of design for Kanggime Extension – July 1998
. Approval of Extension - 7 August 1998
. Contract date for Extension - 1 November 1998
. Contract end for Extension - 30 October 2000

. *Contract :* Agreement No 07679, dated 27 October 1998

. *Location :* Activities were conducted in only 2 locations over the final 2 years: Kanggime and Mamit

. *Cost :* . Budget for Extension: $ 457,654
. Actual cost of Extension: $ 425,270

EXECUTIVE SUMMARY

The Jayawijaya Women and Their Children's Health (WATCH) Project was located in the Jayawijaya district of Irian Jaya, the most eastern province of Indonesia. The project was funded by the Australian Agency for International Development (AusAID), and administered under the umbrella of the bilateral program with Indonesia. The project was managed through World Vision Australia (WVA) and implemented by World Vision International Indonesia (WVII) in conjunction with the Indonesian Department of Health in the district of Jayawijaya.

The project started in mid 1991 and directly benefited approximately 27,000 people but has influenced systems that will affect the whole district of over 400,000 people. The essence of the project centred on concern for primary health care, especially for women and children. The project sought not only to assist in the clinical problems but also the root causes of primary health care such as poverty, gender imbalance and lack of community organisation.

The project was located in the Jayawijaya district of Irian Jaya. This province can only be accessed by plane and most of the district is isolated and accessible only by light plane or several days of walking. The linguistic diversity is quite marked with at least 8 groups of languages for under 500,000 people. The district was first accessed by outsiders in the mid 1950s and within the last 5 years there has still been first contact for several villages. Although the province is resource rich in minerals, the human resources and skills to participate in the modern world are lacking.

The project has sought to address primary health care needs at both an infrastructural and community level. At the institutional level, the project supplied infrastructure, equipment and training. It has also developed case management protocols for 30 diseases and a simpler, more appropriate, health information system.

At the community level, the strategy was to establish groups and facilitate their development, learning new skills and experiences to the point where they could become self reliant. Self reliance in this context included the criteria of management of a posyandu (integrated post), pos obat desa (dispensary) and dana sehat (health insurance). To date less than 10% of the original 150 groups have reached this status although all groups have moved forward and many are approaching self reliant status. The project adapted a rating system called ARIF, based on a health system rating system for posyandu, to measure the self reliance status of the groups.

The project was as much about establishing an approach to health as opposed to producing outputs. On the one hand the project acted as a bridge, increasing community awareness of health to bring them closer to an improved service delivery from the government. On the other hand, the project looked for innovative approaches to overcome lack of supplies, such as making oralyte solution from sweet potato, to stimulating conceptual changes regarding organisation, wealth and food and to providing a coordination facility for government and other interested agencies.

The project was implemented in 3 phases. The project was originally imagined to last three years and the first phase thus ran from 1991 to 1994. The emphasis of this phase was on infrastructure and establishing activities. Following a review of the project, it was recommended to continue the project to refine the approach of the project and more fully implement the range of interventions. The second phase thus ran from 1994-1997. The main emphasis of this phase was the development of systems such as case management protocols and a health information system. This phase also saw the development of gender programs and community development activities expanding. At the end of this phase, due to requests from the Indonesian government, a request was submitted to extend the project in particular areas of the Jayawijaya district. Another review was conducted which again

recommended an extension but subject to a satisfactory design. This third phase of the project ran from the end of 1998 to the end of 2000. This phase concentrated on two subdistricts in the north west corner of Jayawijaya district with a purpose of consolidating the perceived gains made in these areas over the previous phases. A feature of this phase was the documentation of activities and approaches.The project staff were evacuated from the area in early October 2000, a month before the contractual close, due to poltical instability in the area.

The major outputs of the first phase were the building of a new dormitory and classrooms for the Nurses Training School, the distribution of 3 solar fridges, 195 vaccine carriers and training of over 200 immunisation field workers. Over 150 groups were formed in the process of developing links between the community and the formal health system.

The major outputs of the second phase were the development of a draft computerised health information system based on a set of case management protocols. These protocols developed through the auspices of the project are now in use through the district and in other districts of Irian Jaya. The groups were now concentrated around 10 centres and saw several reach self reliance stage.

The third phase saw a much higher concentration on provision of grants to groups in order to assist the progress to self reliance. There were also much higher levels of supervision and training. However, the economic and political instability through the country affected the district and made progress very slow. Of note, however were the establishment of several small NGOs, one a womens organisation, that are testament to the sound, long term strategy to build self reliance.

The project was challenged throughout by the fact that establishing change in a place like Irian Jaya makes numerous assumptions about what kind of change is appropriate. Given that this project was a bilateral project, assumptions were made that the project would follow government guidelines that were inherently inappropriate to the cultural and linguistic landscape of the Irian highlands. In addition, the institutions that were part of the overall government strategy for communities in the nation were unimplementable in the highlands context. Thirdly, the level of government resources, both in quantity and quality, were severely limited to ensure adequate implementation of project initiatives or ensure sustainable systems.

To add a further complexity to this project was the fact that an NGO was the contractor and implementor of the project. This is not of necessity a problem but the level of influence available to NGOs under the Indonesian government system through the 1990s, especially in a place like Irian Jaya made it difficult to extend too far beyond the government limits. The NGO approach was to find out what the community wanted. The project thus was innovative in so far as it introduced methodologies that were concerned about establishing needs identified by the community and seeking ways in which these could be systematised.

Whether this approach has provided a sufficient foundation for future health care needs only history will tell. The underlying issues of sustainability, self reliance and supervision will remain as challenges to both the government and the community. These have been exacerbated over the last 3 years (1997-2000) due to the enormous changes facing Indonesia and Irian Jaya and the future remains unclear. The political climate is still very unstable and the evacuation in October meant an unsatisfactory ‘closure’ to communities and staff who feel a great sense of loss.