

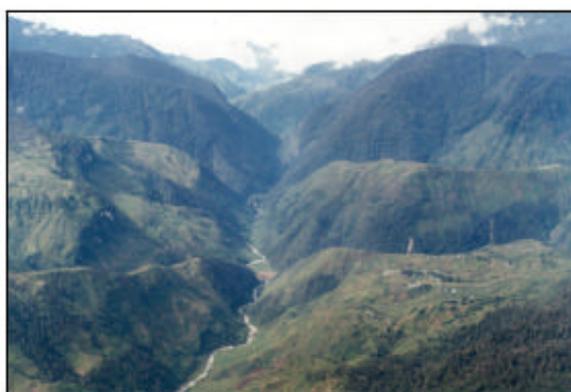
CHAPTER 1 - INTRODUCTION

1.1 Project rationale

Irian Jaya is one of a few provinces in Indonesia which remains comparatively undeveloped because it has an insufficient labour force and/or level of education and is geographically isolated, far away from the administrative centre of Indonesia.

In 1991 the central highlands of Irian Jaya were home to 24% of the population of Irian Jaya. The vast majority of the population of Irian Jaya were engaged in subsistence agriculture and fishing which contributed 23.8% of GDP. The highland districts of Paniai and Jayawijaya were designated as highest priority for development activities, including health. The major rationale for this designation was their isolation as there were no land transport links to the highlands; although the roadway has now been cleared from Jayapura to Wamena, there are major shortcomings such as service and maintenance facilities.

The Jayawijaya district is an area of 52,916sq kms, 11.7 % of the area of Irian Jaya. The population of the district is over 426,416 (1996 figures state 219,626 men and 206,788 women)¹. Outside Wamena, the district centre, most people are subsistence farmers, living in small villages or hamlets and following a traditional way of life. The difficulties of transportation in the highlands and the related problem of accessible markets make the development of new enterprises complicated.



Transport links are limited to air services and walking. Road links are being built through the highlands and these have made access to markets and communications easier and provide options to the more expensive air transport. At the time of writing however, air transport to the 2 target areas is non-existent for one centre and very limited to the other.

The level of education was not high in Jayawijaya. In 1980, only 52.8% of the total district

¹ Population figures are notoriously unreliable in Irian Jaya as are many health statistics. A census was conducted in Indonesia in May 2000, and claimed over 5 million people in Irian Jaya. However, we are aware that in the Jayawijaya district alone there were significant errors:

- a) many people were not counted because their location was too remote – in fact, it is possible that the counting was concentrated only on the Baliem valley.
- b) some areas inflated their estimates because this would result in more money under forthcoming autonomy regulations eg Kanggime area suddenly escalated from a population of 16,000 to 26,000
- c) project staff were never counted in the census.

population over 9 years of age had ever attended school and illiteracy rates were still 81.55% (versus 18.8% in the district of Fak Fak). Literacy rates for men were double those of women. The needs of women in Jayawijaya had not been specifically addressed, in part due to under-representation of women in leadership and decision making positions. Traditional economic roles and obstacles to womens education continued to be supported by the social system.

Health indices suggested that urgent attention was also required in the health sector. The infant mortality² rate in Irian Jaya ranged between 70-200 per thousand, with the average being 133, compared with an early 1990s national average of 73. Maternal mortality was at least 4.5 per thousand in Jayawijaya. This compared with a rate of 1.3 in other parts of the country. The immediate causes of this high rate of maternal mortality were haemorrhage and infection and, less directly, the fact that indigenous women were traditionally assisted in childbirth only by other untrained women and there was a critical shortage of female health personnel, including trained traditional birth attendants (TBAs) in the district.

Nutritional problems were widespread in Jayawijaya due to continued dependence on sweet potato, the unavailability of continuous animal protein and a lack of knowledge about cooking methods and skills. In 1986 the Household Survey recorded over 20% moderate malnutrition and another 2.5% severe malnutrition. Other problems included access to clean water; knowledge of, and resources for, good sanitation were very unevenly spread.

Communicable diseases, including malaria, were emerging in the highlands. Tape worm infection, venereal disease, acute respiratory tract infection (ARI) and diarrhoea were still significant health problems. Pneumonia accounted for 26% of infant death, diarrhoea 19% and malaria 11%, but the major underlying cause was clearly malnutrition.

Jayawijaya had critical gaps in the health delivery system. There was only one hospital with 70 beds, 13 health centres and 51 sub health centres; in 1996 only 3 puskesmas were headed by doctors. They tended to be concentrated around Wamena and other smaller urban centres. There were many pockets of poorly serviced areas in the district. Supply of cheap, good quality medicine and basic equipment was a constant problem as was the lack of cold chain equipment and supply of vaccines and sterile vaccination equipment

Lack of trained personnel was also a serious problem. There was rapid turnover of medical staff in rural areas, if they had them at all. Christian missions, which had begun operating in Jayawijaya in 1953 in very primitive conditions, filled many of the gaps. Many of the government health centres were ineffective. Apart from the absence of personnel, there were other problems such as lack of communication and transport infrastructure. Getting to a health centre was particularly difficult for women, who were less able to be away from home than men.

Low income levels in some communities made community medical financing very difficult, lack of clean water or other primary preventative measures made curative routines ineffective, supervision was very poor and most importantly, in many communities, only a few people understood the basic principles of basic health and nutrition, which led to poor compliance patterns.

The rationale of the original project in this context was to improve womens and childrens health by

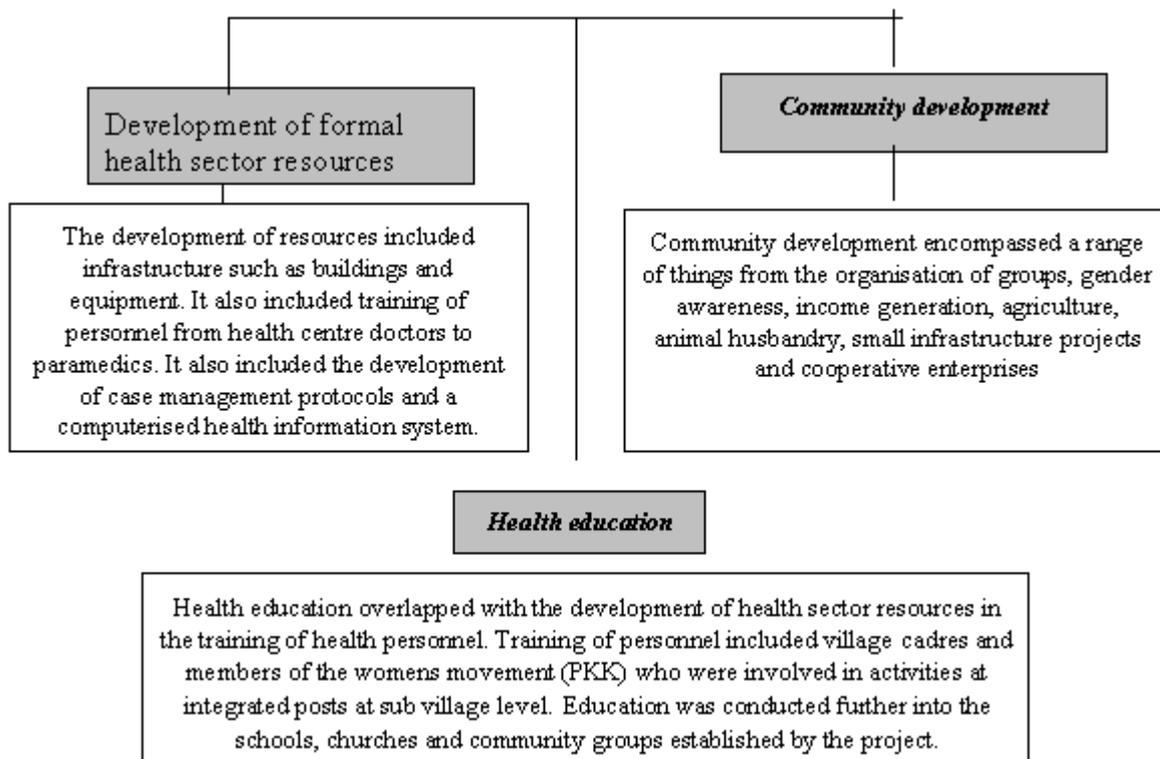
² Projected figures for 1996 stated an infant mortality rate of 98/1,000 compared with the provincial estimate of 80/1,000. No maternal mortality rate was given although the hospital's Annual Report for 1997 stated 2 deaths from 283. In 1998 no deaths from 301 and in 1999, 2 deaths from 279 cases.

increasing the effectiveness of primary health care programs in the district. The project was also to integrate community development and women in development (WID) principles and activities into the project. Rather than establishing new structures, the project would strengthen and extend existing government and mission services.

This rationale was further refined to address not only the symptoms of poor health with community development tacked on but rather that some of the community development issues were in fact root causes of poor health. This resulted in a program which addressed issues such as gender imbalance, poverty and lack of community organisation. This approach formed the basis of a primary health care model that saw health care in a more comprehensive light.

1.2 Project components and implementation plan

There were three general areas of activity in the project:



The components and outputs for the Kanggime Extension are listed in more detail in Section 2.1.2 but a summary is listed here as follows :

KANGGIME EXTENSION

GOAL

To improve the health and nutritional status of women and children in rural communities in Jayawijaya

PURPOSE

A functioning and sustainable primary health care system with high levels of community participation and ownership

HEALTH COMPONENT

- Output 1 Appropriate maternal and infant health program consolidated
- Output 2 Capacity of health system, staff and community strengthened
- Output 3 A preventative health and nutrition program implemented

COMMUNITY COMPONENT

- Output 4 Existing community development initiatives strengthened

MANAGEMENT COMPONENT

- Output 5 Management system implemented

These components were implemented throughout the project life and did not really change. The outputs and focus area of these components changed over time; some of this is covered in the history section below.

There were two important changes from the first phase to the second phase. The first was the major infrastructure inputs were completed ie the dormitory and classrooms for the Nurses Training College. The focus in the first extension then shifted from infrastructure to systems and work concentrated on establishing a comprehensive Case Management Protocol system and a Health Information System (HIS) to support it. The basis of these systems was completed in the first extension but work was continued in the second extension to review the HIS. This was done in order to ensure the type of information being collected was accurate but also to complete the programming of the computer based data entry and reporting system. This latter activity was not completed.

The second major change was from WID to GAD. During the first phase, the staff began to realise that concentrating on women would not satisfy development principles for the community. It was therefore recommended that a more comprehensive and inclusive approach of gender be implemented. This has been more successful and has been implemented throughout the last 2 phases.

The training activities have generally been successful in completing targets but this has not necessarily meant sustainability. The project has found that continued supervision was necessary to reach sustainable levels.

The major areas of difficulty with reaching implementation outputs has been with surveys and staffing. Conducting of surveys in the district posed many problems and few were implemented satisfactorily. Key staffing positions in the final phase were left unfilled for long periods of time which impeded the project's ability to complete monitoring, evaluation and documentation tasks. Part of this was due to the difficulty of attracting qualified personnel to Irian Jaya and/or the difficulty of gaining GOI approval for expatriates to work in the area.

A further key area of delay was with the self reliance packages and the building of bridges and water supply systems. Delays in all these activities came about due to the length of time it took to ensure appropriate community development principles of participation were sufficiently understood by the community and also by the logistical constraints of the district in delivering materials. In latter times, some of this was due to significant social and political changes that affected the whole province.

1.3 Historical overview

The original project proposal was generated in response to AusAID's (formerly AIDAB's) (call for submissions focused on women and their childrens health (WATCH). World Vision International

Indonesia (WVII) identified the target population and suggested a general approach. The project was located in Jayawijaya for two reasons:

The district had been identified as an area of special need by the Indonesian government, and it was an area where WVII had worked in the past and had established a network of contacts and working relationships.

Drawing on the development expertise and local knowledge of WVII staff based in Irian Jaya, a feasibility team, with members of World Vision Australia (WVA) met to develop the outline for a women's health project in June 1989. The outline was approved by the appraisal panel for AusAID's (formerly AIDAB's) WATCH Program in December 1989 and WVA was invited to submit a detailed project design.

A design was submitted under the WATCH Program in April 1990. As a result of AusAID's (formerly AIDAB's) appraisal of the Design Document, WVA was asked to undertake further design work and a revised design was submitted in October 1990. The Appraisal by the AusAID (formerly AIDAB) post in Jakarta in December 1990 resulted in two significant issues. Firstly, it made it apparent that the project was to be a pilot project under Australia's bilateral development program with the Government of Indonesia (GOI). Secondly, the appraisal recommended that the project include the eastern parts of the district which were not in the original design. This significantly enlarged the area to be covered, especially in terms of difficulty of access.

The background to the incorporation into the bilateral program was that in 1988, the Indonesian Department of Health proposed a joint Project Identification Mission to eastern Indonesia to consider options for the development of primary health care activities within the AusAID Indonesian Country Program. The Depkes/AusAID mission identified three projects for early implementation in the provinces of Maluku, Southeast Sulawesi and Irian Jaya. Funds were not available at the time to implement any of the three PHC projects identified and it was decided that Australia would instead support, under the SE Asia Regional Program, the World Vision WATCH Project in Wamena, Irian Jaya. Despite the project being under the bilateral umbrella, the project was initially administered by the SE Asia section of AusAID until the PIDs were completed.

A second issue related to the incorporation of the project under the bilateral program was counterpart funding. WVA had never had experience of a bilateral project and WVII had never had to deal directly with government departments. The project had not been designed with counterpart funding in mind, and the expectations upon both WV and Depkes were never fully negotiated by AusAID. The precedents set at this stage continued throughout the project whereby the obligations of the Indonesian government were never enforced.

A third issue was that the WATCH project was seen as an interim measure before a fully fledged bilateral project could be commenced. Thus WATCH was seen as a pilot activity. This pilot activity eventually continued for 9 years in 3 phases.

The first phase began in 1991 and continued until 1994. The project received its first tranche of funding in June 1991. However, the project did not really get under way until November 1991 when the full complement of staff had arrived. The opening ceremony for the project was held on 12 December 1991 and was attended by a representative of the Governor, a Director General of Health and senior officials from the Department of Health in Jakarta and other government representatives.

A review recommended an extension of the project and this was implemented from 1994 to 1997.

A review of the project was conducted by Dr Michael Dibley, an Australian epidemiologist/ nutritionist working at Gadjah Mada University in Yogyakarta, in February 1994 with his report being produced in March 1994. His report supported a recommendation for the extension of the project in order to refine the approach to developing a packet of community development, gender role change and health care interventions for highland communities in Irian Jaya and to document the impact of the program on the health and nutrition of women and children.

The proposal for an extension to the Jayawijaya WATCH project stemmed from the fact that for the project to accomplish its objectives more time was needed to realise the investment made by both governments.

The second phase concentrated less on infrastructure and more on systems. The second phase of the project selected 8-10 key areas for activities rather than trying to target the whole district. The development of groups continued along with the continuing program of training at all levels of the formal health system. This phase saw significant gains from consultancies resulting in the development of case management protocols and a locally appropriate health information system. It also saw the government adapt the gender awareness program from the project into its own training for district and sub district government officials. These consultancies and the more targeted approach of the second phase were a result of the recommendations from the review of the first phase.

The second phase of 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 be received in order to proceed. The GOI (Bappenas) gave in-principle approval for the second extension of 24 November 1997. AusAID agreed to consider the situation conditional upon a review of progress (see box below), need for extension and conditional upon a satisfactory design to be submitted by World Vision. The project then operated on an interim extension from October 1997 to November 1998.

A review of the second phase of the project was conducted by Ms Gaynor Dawson in December 1997 and a report circulated in January 1998. It was recommended that the project continue 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 group's ratings for self reliance were higher and there was stronger acceptance of change. These factors would increase the chance for sustainability in the area.

During the interim period between the second and third phases of the project, a series of events began that affected both the project area and the nation of Indonesia:

- Fires, sleet and famine were experienced in Jayawijaya district from September 1997

culminating in the arrival of Australian troops in November 1997 to assist in the logistics of food distribution.

- The financial crisis in Indonesia began at the same time, followed by the tumultuous events that led to the downfall of President Suharto. Economic collapse occurred throughout many parts of the archipelago and a range of social safety net programs were subsequently introduced to assist communities.
- An election was held in mid 1999 that was far more contested than any in the previous 35 years and the Presidency of Mr Habibie came to an end.
- The province of East Timor was offered a referendum to decide on autonomy or self rule and the overwhelming vote for self rule brought about the end of Indonesian sovereignty over East Timor.

These events caused disruption to the progress of the project, particularly in terms of changes in people's perceptions of community development projects. The grants distributed through the government following the fires/famine and through the social safety net following the economic collapse led communities to expect that all 'projects' should be handing over money to the villages. The WATCH philosophy, on the other hand, had been to require communities to contribute themselves in order to develop a sense of ownership of activities.

The process of all the changes listed above led to considerable political instability. Part of this was due to the enormous political freedoms and competition that ensued in the election but it was also due to the overwhelming reaction in Irian Jaya to see these events as an opportunity to press for independence. This movement has been strong in the project area.

Another issue from these changes that affected the project were increased restrictions on expatriate personnel working and visiting the area and this affected the project's ability to employ expatriate staff for documentation purposes. In addition, the instability was exacerbated in the final 6 months of the project by restrictions to availability of aircraft into the target areas.

The project extension formally began in November 1998 and was now known as the Jayawijaya WATCH Project – Kanggime Extension, and targeted the areas of Kanggime and Mamit. Some of the key changes to implementation as a result of the review (see box above) were locating staff in the field for longer periods, more frequent and intense supervision due to a smaller area, a much stronger emphasis on community development through delivery of materials to groups and the development of nutrition gardens. Some small infrastructure was also planned ie 4 bridges and 2 water supply dams but these were delayed substantially due to repeated negotiations over the respective roles and funding from the project and the community.

It was expected that the groups would perform strongly but, as explained above, the groups developed alternative views of development 'projects' during the interim and the project lost a lot of time in having to resolve these issues and reestablish the community development principles taught in earlier phases of the project.

Despite these difficulties, there have been some important developments. Local organisations are beginning to establish, the most encouraging being a women's organisation, Humi Inane. This organisation is being run by local women and is being noted by government agencies and international agencies. It is the culmination of many years work and its establishment has been significantly influenced by the WATCH project.

The project is now at an end after 9 years of activity which have witnessed significant changes in the district of Jayawijaya. The final documents will bring together the story of this extraordinary

experiment by the Australian and Indonesian governments working with the Indonesian health system through NGOs to bring better health and social conditions to some of the most remote people on earth.