

CHAPTER 2 - THE PROJECT

2.1 Project description

Section 2.1.1 provides a generic schema of the broad thrust of the life of the project. Section 2.1.2 gives a detailed description of the Kanggime Extension from 1998-2000 and Section 2.1.3 provides a summarised description of all the components, outputs and inputs over the life of the project.

2.1.1 Goals and purposes

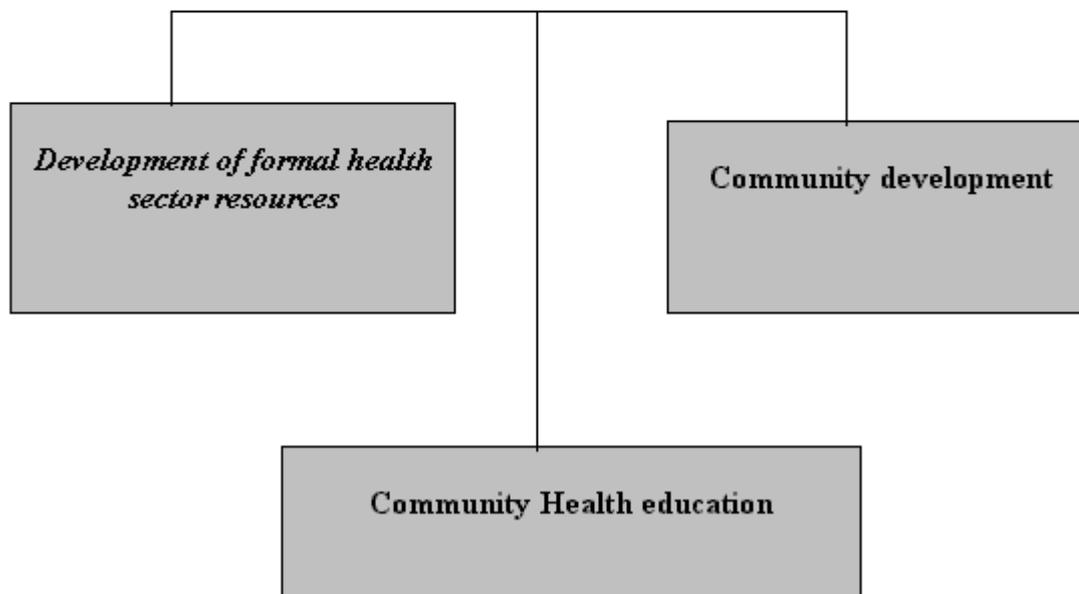
Goal

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

Purpose

To develop a functioning and sustainable primary health care system with high levels of community participation and ownership

Project components



2.1.2 Project Description for Kanggime Extension

HEALTH COMPONENT

Output 1 Appropriate maternal and infant health program consolidated

- 1.1 Promote registration of all pregnancies
- 1.2 Distribute iron tables, 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

Inputs

- . Health Coordinator
- . Worm tablets
- . Haemoglobin testers
- . Bridge materials

Output 2 Capacity of health system, staff and community strengthened

- 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 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

Inputs

- . Midwife
- . HIS consultants
- . IEC materials production
- . Training and supervision

Output 3 A preventative health and nutrition program implemented

- 3.1 Distribution of nutrition plot starter packs
- 3.2 Promote use of sweet potato lfours and powdes
- 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

Inputs

- . Nutritionist
- . Plot starter packs
- . Training and supervision
- . Community Health consultancy

- . Additional costs for safe water construction

COMMUNITY COMPONENT

Output 4 Existing community development initiatives strengthened

- 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
- 4.9 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

Inputs

- . GAD Coordinator and 4 staff
- . Self reliance packs
- . Training and supervision
- . CASE training materials/equipment
- . Gender workshops, modules production
- . Exposure trips to Java
- . PLA and GAD consultancy

MANAGEMENT COMPONENT

Output 5 Management system implemented

- 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 (computer) purchased
- 5.7 Project reporting completed on time.

Inputs

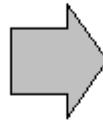
- . Project Manager and 4 staff
- . Documentation consultancies
- . Additional computing equipment
- . Survey costs
- . AIPCC costs
- . Contractor costs
- . Additional costs for translation and submission of sector papers
- . Additional costs for closing ceremony in Jakarta and production of CD Rom

2.1.3 Summarised Outputs, Activities and Inputs for life of project

1. Development of formal health sector resources

OUTPUTS

- Development of case management protocols for high level mortality/morbidity treatments
- Training of medical personnel
- Nutrition education and feeding program
- Increase # and effectiveness of trained nurses graduating from the SPK training college in Wamena
- Enhance and improve the government correspondence course for mantris seeking to upgrade their skills and qualifications
- Extend the coverage of immunisation of children



ACTIVITIES

- Train 340 TBAs in ante natal delivery and post natal care
- Construct new SPK female dormitory and 3 new classrooms
- Work with SPK on curricula development, improving teaching methods, providing additional equipment and materials for teachers and students
- Establish revolving loan fund for teaching materials for nurses correspondence courses
- Provide 10 cold chain units and vaccination kits for 22 puskesmas
- Train 5 vaccinators in each puskesmas in immunisation procedures, record keeping and vaccination coverage assessment
- Vaccinators to attend mobile points for surrounding villages
- Review TBA training and kits
- Monitor case management protocols for 3 common diseases
- Promote and evaluate sweet potato powder as a super oralyte
- Implement nutrition education program
- In service training for health personnel



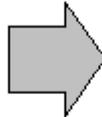
INPUTS

- Health Coordinator
- Dormitory and 3 classrooms
- Cold chain equipment
- Training
- Health officials conferences

2. Community Health education

OUTPUTS

- Help community members establish health groups
- Help community members establish identified basic level behaviours and health services
- Promote basic hygiene behaviours, malaria prevention, clean water supply and use of latrines
- Mantris to work with CD facilitators to implement water supply and latrine construction
- Implement a community health education program



ACTIVITIES

- Provide instruction in health education activities such as breast feeding, growth monitoring, child nutrition, prevention of diarrhoeal dehydration and Vitamin A
- Train health workers, community leaders and teachers in malaria prevention, including biological control
- Construct 10-20 demonstration mud brick houses
- Encourage construction of healthy houses and smokeless stoves
- Provide hygiene and sanitation education
- Provide nutrition education to mothers including promotion of new protein sources and training in food processing and cooking
- Promote, and assist in supplies, the use of safe water facilities
- Promote, and assist in supplies, the use of latrines



INPUTS

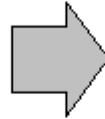
- Health education materials
- Water supplies
- Latrine materials
- Training courses

3. Community Development

OUTPUTS

Women in Development

- To enhance the capacity of women in Jayawijaya to participate in community processes and identify and address their own health and development needs
- To prepare an appropriate WID training module using baseline information from 20 surveyed villages
- To implement village womens programs through 200 WID facilitators to be recruited, trained and supported by 20 WID trainers
- To establish womens income generation activities in selected villages



ACTIVITIES

- WID facilitators to collect baseline information from 20 selected villages on womens issues
- WID training module designed by WID Coordinator and consultant in association with trainers
- WID consultant and WID Coordinator to conduct a series of 5 day workshops for selected women trainers
- WID trainers to select WID facilitators per village and provide training using previously designed module
- WID facilitators to implement village programs including skills training, focus groups discussions with women, identification of womens needs and potential resources
- Annual review workshop of effectiveness of WID module used by facilitators and trainers
- Identification and prioritisation of needs for income generating activities undertaken by WID facilitators and community
- WID facilitators organise groups and individual



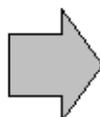
INPUTS

- WID Coordinator
- WID consultant
- Workshops
- Grants

OUTPUTS

Gender and Development

- development of a gender awareness module
- income generation and cooperatives development
- construction and maintenance of small infrastructure
- appropriate technology development
- To facilitate village based initiatives which address the major constraints which affect the health of women and their children
- To appoint, train and support CD workers to work with communities to identify and prioritise development needs and constraints
- To implement community development activities within 100 villages determined by CD workers and communities
- To undertake necessary infrastructure improvements of bridges, tracks and clean water supplies within 10 target villages



ACTIVITIES

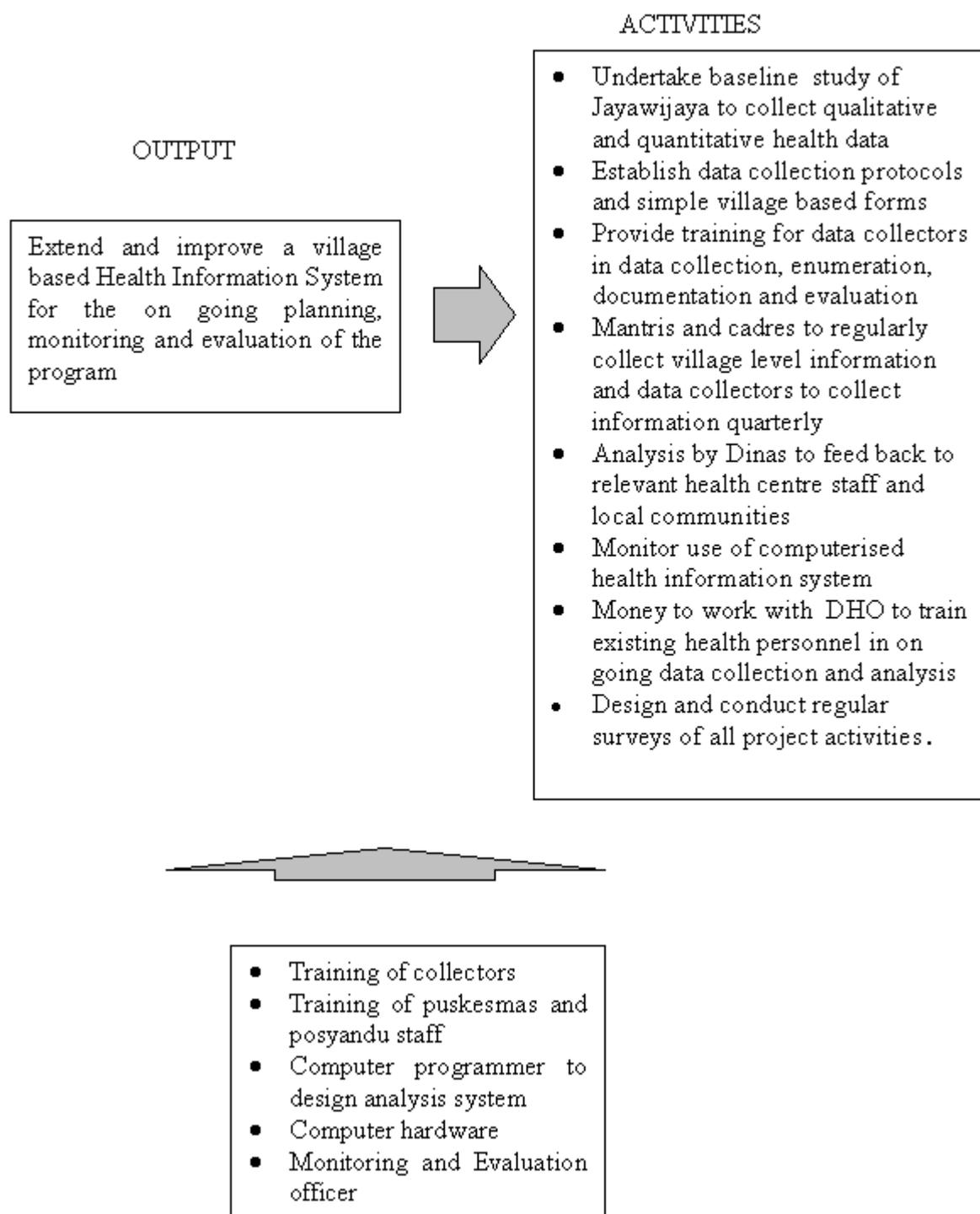
- Mantris and cadres to work with PKK to train village women in cooking and food processing for improved nutrition
- Initial feasibility studies undertaken by communities in association with PKK
- Identify partner agencies, CD workers and target areas through which CD activities will be implemented
- An on going training program for CD workers
- CD workers to work with target villages to assist communities in assessing community needs and potential resources
- CD workers to assist villagers to implement localised activities including: backyard gardens and fish ponds, utilisation of appropriate technologies, mud brick houses, rabbit raising, tree planting, goats and sheep
- Construct over 20 strategically placed bridges
- Select sites and implement improvement of 50 kms of tracks and airstrip maintenance
- Assist communities to improve water supply facilities
- Assist communities to construct 200 pit latrines
- Organise the establishment of viable and sustainable community groups
- Train cadres/coordinators in the gender awareness and application modules
- Research and introduce product lines for income generation
- Support the establishment of cooperatives



INPUTS

- . Coordinators
- . Workshops
- . Grants
- . Gender specialist
- . LEISA materials
- . Materials for bridges and tracks

Monitoring and evaluation program



2.2 Project implementation

2.2.1 Management arrangements

Managing agent - World Vision Australia (WVA)

World Vision Australia was the contractor to the Australian government. WVA provided management support and was responsible for reporting and liaising with AusAID. Management included regular visits to the project area for monitoring purposes and regular visits to Indonesia for Project Coordinating Committee (PCC) meetings. This usually resulted in liaison with the Indonesian Department of Health at national and provincial levels as well as at district level. WVA were involved in the review of the project and closely involved in the design of all stages of the project. WVA was also responsible for the editing of all annual plans and the project completion report. The management of the project has involved oversight of all consultant contracts.

WVA placed the project director in Jakarta for two years (1994 and 1995) which enabled closer understanding of the Indonesian social and government context. This also enabled more extensive contact networking with other AusAID projects such as the ANU-LIPI Eastern Indonesian Population and Development Research Project and the Lombok Community Health project. Networking also encompassed relations with World Bank researchers, health authorities, NGOs of both international and local networks, and more frequent contact with AusAID at the post.

Implementing agent - World Vision International Indonesia (WVII)

World Vision International Indonesia (WVII) had responsibility for the conduct of the implementation in the field. Responsibility included staffing, activity coordination, relationships to government and NGO organisations in Jakarta, Jayapura and Wamena, logistics between Jakarta and Wamena, daily management of the project and contingency planning. WVII staff provided support to staff where necessary, provided regular monitoring of narrative and financial reports and provided internal audit control.

WVII is managed through an office in Jakarta. There are several branches throughout the islands which provide administrative support for WVII work and the managers in these offices have responsibility for projects in their areas. WVII has worked in Jayawijaya since 1975, initially in the health sector. Amongst a number of initiatives, this evolved into a large integrated rural community development project which involved the establishment of 38 health posts, training of village workers, clean water, immunisation and health education.

The continuing presence of WVII activity in Jayawijaya has meant the integration of WATCH project initiatives into its own projects and has influenced the establishment of a series of larger projects in the district which will continue the kinds of activity begun by WATCH.

Counterpart agency - District health office (DHO)

The district health office (Dinas Kesehatan) in Wamena was the counterpart agency for the project as stipulated by the Memorandum of Understanding signed by both governments. The district health officer (Dokter Kabupaten [Dokabu]) was the counterpart project manager. He is responsible for Government of Indonesia (GOI) inputs to the project, maintenance and continuing support of project initiatives and activities. The relationship between the Project Manager and the counterpart was crucial to the smooth operation of the project.

In many parts of Indonesia, the Dokabu shares the policy and administrative roles of the position. The policy role emanates from the Department of Health (Depkes) in Jakarta and flows through the Kantor Department or Kandep. On the other hand, administrative and implementation responsibility

flows through the local regent or bupati, funded through Bappenas and Bappeda, and the dokabu is answerable to the district regent and council.

In August 1999, the dokabu position in Jayawijaya was separated for the first time and the incumbent dokabu was relieved of implementation responsibilities. This effectively created a situation where the new counterpart manager was not technically answerable to the counterpart central government department. This situation may still be difficult to resolve as districts attain more autonomy in 2001.

The counterpart managers for the 9 years have been:

Dr Sujito – July 1991 – September 1991

Dr Zulfian Muslim – October 1991 – July 1999

Dr Mauritz H. Rumsayor – August 1999 - 2000

Project staff

The core staff for the project have been relatively stable during the nine years of the project with 2 staff serving the whole 9 years. A list of staff and periods of service is at Appendix 1.

2.2.2 Monitoring, ongoing review and data collection for post evaluation

The project has endeavoured to continually learn from its activities to derive an appropriate approach to primary health care in the highlands. The project staff have kept records of all activities in all groups so that a comprehensive picture can be drawn of the project.

- . Reports on every training
- . Trip reports when visiting centres
- . A book on every centre in the project
- . Records of consultations with cadres
- . Books recording distribution of grants, equipment and supplies
- . Forms established to record health activity in villages

On an official level, annual summaries of progress are recorded in the Annual Plans. On a more frequent level, reports are presented to 6 monthly PCB meetings; monthly reports were presented during the first 3 years of the project followed by quarterly reports during the second 3 years and finally by bi monthly reports. Acquittals of expenditure were presented annually during the first 3 years and 6 monthly from then on.

The staff have also documented the progress of the project in various reports. These are mostly in Indonesian language. In addition, reports have been written for journals and newspapers. These have been listed and included in the documentation review report. Communities have also been trained to keep records and assess their progress. Changes have occurred to the way the project implemented activities as a result of the findings from these reports. Appendix 2 on Groups provides more detail on these changes.

The collection of data has been somewhat problematic for a variety of reasons. Adequate reports of baseline information are not readily available. On the other hand, on the community development side of the project, an effective measurement system of the progress of the groups was developed that has been written up in reports and provides the theory of the measurement system, the questions asked by data gatherers and results in both narrative and graph form. In addition to this data on communities, a series of Participatory Learning and Action (PLA) surveys have been conducted at

the end of the project which have provided an assessment by the communities of the change in their communities.

On the government health sector side of the project, the most important development has been that of a more appropriate health information system that has been acknowledged by the central government authorities. This system will provide for more accurate and relevant information to be collected within the district over the next 5 years. District level enthusiasm for this system has not been high and its functioning has been undermined by lack of collection at the field level, lack of quality, lack of accuracy in recording and lack of analysis at the Dinas level. The computer program designed to analyse this information was in place but needed final repairs to be servicable. It remains in that state.

However, there were difficulties in the collection of data. The project determined to collect baseline data in the first 6 months of the project. A plan was devised to collect data in 4 separate areas in areas reasonably accessible to Wamena. Training was conducted for two groups of collectors. The first group were WVII staff stationed in the Jayawijaya district; the second group were leaders like school teachers. A questionnaire was designed to collect this data.

The baseline data collection was not successful. Firstly, many of the collectors were relative newcomers to the area and did not understand the problems of the people or the nature of the area they were collecting from. Thus there was little innovation in interpreting questions so as to ensure accurate information was collected. Secondly, all areas in Jayawijaya are different and assumptions were made that areas would be the same. There was a problem in training, design as well as data collection. Thirdly, there were too many places to collect from and the distances between places was often vast. This meant that some data was not collected at all and sometimes when forms were filled in they were 'doctored'. Fourthly, a number of collectors were not aware of the importance of the data and were less than careful in collecting the data or were unwilling to pursue the target person or pursue an answer to a question. These are the main reasons why the baseline data collection failed.

An underlying issue that was part of the early stages of the project was the lack of understanding between the Department of Health and the project. The implementor's status of NGO was unusual and it therefore took time for an adequate relationship to be established. A further issue was that there were few local staff that could adequately collect reliable data. This continued as an issue throughout the life of the project.

The baseline data collection was lost as a document for future use but two things emerged from the exercise. Firstly, there was a significant amount of qualitative data that was collected and secondly, the project staff decided to collect information themselves to ensure the quality of data. This was a difficult decision because it meant that very limited amounts of information were to be collected and over a longer period of time because the data was collected from outer lying areas as well as around Wamena.

The data gathering by the project staff concentrated on anthropometric surveys, measuring upper arm circumference, height and weight of infants and children. This data was very important in establishing that the paradigms for height/weight correlation promoted by central authorities did not necessarily apply to the Irian highlands. Project staff wrote papers on this issue for medical journals and discussed this at PCB meetings. One of the issues highlighted by this data was that the nutritional status of the children was very low and this led to the recommendations by Dr Michael Dibley, the AusAID reviewer in 1994, to focus more on nutrition in the extension phase of the project. It should also be stated here that mortality rates were not collected because they were too difficult to collect.

To some extent, qualitative data can be collected, but the recording mechanisms required to collect verifiable quantifiable data were insufficient and the reliability of health staff to record accurately was limited.

In the extension phase of the project, it was initially decided to use a set of specially trained data collectors on a regular basis. It was determined that the most suitable candidates would be SPK students. However, it became apparent that a more satisfactory basis for collecting was to use many students. The reasons for this were that there would be a transfer of skills from project staff trainers to students. Secondly, the students would learn about the WATCH approach to primary health care. Thirdly, it was important that these students use their skills to complement the new computerised health information system. This was extremely important as a lot of work had gone into the production of case management protocols and the HIS and a reliable systemic collection system was required to ensure the district health office was given information from which to make strategic decisions.

The idea of using the students was a good one. The teachers were supportive and linked into the activity. However, there were still problems as some of the students did not have sufficient grasp of numeric skills, they had to walk large distances and they were still entrenched in cultural assumptions. Therefore the information was not always complete nor did not cover the relevant issues sufficiently, such as gender. It may also have been that the project was trying to collect too much in the surveys. It would be fair to say that the collection from 1996 was a significant improvement on 1995. The 1996 surveys were used to provide evidence of the change in groups self reliance.

The PLA survey was a useful instrument for collecting data. It produced qualitative information but confirmed the quantitative data that emerged from other collections. A series of PLA surveys carried out on 6 centres during the last 6 months of the project. In many ways, this was been the most successful means of collecting data because it enabled a good relationship with the community, it allowed the community to speak for themselves as to how they were progressing, reacting to the project initiatives and how they saw their way forward.