

PD-AAP-135

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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D.C. 20523

PROJECT PAPER AMENDMENT

Health Training, Research and Development

Project No. 497-0273

AUGUST 1983

USAID/Indonesia

UNCLASSIFIED

PDAAP 135

Health Training Research and Development  
Project Paper Supplement  
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August 5, 1983

ACTION MEMORANDUM FOR THE DIRECTOR

From : Jonathan L. Sperling, PRO 

Subject : Project Authorization

Your approval is requested for an increase of \$3.8 million in grant funds and \$2.6 million in loan funds from Section 104 - Health of the Foreign Assistance Act of 1961 as amended, appropriation to Indonesia for the Health Training, Research and Development Project, Project No. 497-0273. It is planned that a total of \$1.5 million grant and \$1.45 million loan will be obligated in FY 1983.

Discussion: Project No. 497-0273 was authorized in May 1978 involving obligation of not to exceed \$3.6 million in grant funds. The Authorization was amended in 1980 to add an additional \$0.9 million in grant funds. The increase of \$3.8 million in grant funds and \$2.6 million in loan funds is to further strengthen MOH institutional capability to plan, implement and evaluate the recruitment, training and management of public health personnel; applied research; and community health education. A severe health services delivery problem - diarrheal disease mortality/morbidity reduction - has been added.

Waivers: A waiver is being planned for a non-competitive procurement of services but is not part of this package.

Justification to the Congress: FY 83 Congressional Notification (See JAKARTA 7552 on CN and STATE 176954 on notification of expiration of CN).

Action Requested: That you sign the attached Project Authorization Amendment and the Project Data Sheet indicating your approval of the Project Paper Amendment.

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number

One

DOCUMENT CODE

3

2. COUNTRY/ENTITY

Indonesia

4. BUREAU/OFFICE

ASIA

04

3. PROJECT NUMBER

497-0273

5. PROJECT TITLE (maximum 40 characters)

Health Training, Research & Development

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM | DE | YY  
 09 | 30 | 87

7. ESTIMATED DATE OF OBLIGATION  
 (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 78

B. Quarter 3

C. Final FY 84

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	2,480	470	2,950	9,700	1,200	10,900
(Grant)	(1,180)	(320)	(1,500)	(7,300)	(1,000)	(8,300)
(Loan)	(1,300)	(150)	(1,450)	(2,400)	(200)	(2,600)
Other U.S.						
1.						
2.						
Host Country		500	500		4,200	4,200
Other Donor(s)						
<b>TOTALS</b>	<b>2,480</b>	<b>970</b>	<b>3,450</b>	<b>9,700</b>	<b>5,400</b>	<b>15,100</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	530 B	510		4,500		3,800	2,600	8,300	2,600
(2)									
(3)									
(4)									
<b>TOTALS</b>				<b>4,500</b>		<b>3,800</b>	<b>2,600</b>	<b>8,300</b>	<b>2,600</b>

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code BR R/H DEL NUTR  
 B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To strengthen Ministry of Health institutional capability to plan, implement, and evaluate the recruitment, training, and management of public health personnel; applied research; and community health education.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY  
 1 0 8 4 0 3 8 7

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  941  Local  Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a page PP Amendment.)

Based on experience of project implementation thusfar, the amendment prescribes more specific and sophisticated work in manpower planning, personnel administration, training administration, and decentralized health services management than was possible in the original project design. In addition, a specific and practical case study for coordinated planning, training and management of a severe health services delivery problem - diarrheal disease mortality/morbidity reduction - has been added.

17. APPROVED BY

Signature

William P. Fuller

Title: Director

USAID/Indonesia

Date Signed

MM DD YY  
 08 05 83

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

PROJECT AUTHORIZATION AMENDMENT

INDONESIA

Health, Training, Research and  
Development Project  
Project 497-0273

1. Pursuant to Part I, Chapter 1, Section 104(b) of the Foreign Assistance Act of 1961, as amended, the Health, Training, Research and Development Project for Indonesia, the ("Cooperating Country") was authorized on May 1, 1978, involving planned obligations of not to exceed \$3,600,000 in grant funds. That authorization was amended in 1980 to authorize an additional \$900,000 in grant funds. The authorization, as amended, is hereby amended further to authorize planned obligations of not to exceed \$2,600,000 in loan funds and \$3,800,000 in grant funds, with the additional funds provided herein available for obligation over a two year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project, thereby authorizing a total for the life of the project of not to exceed \$2,600,000 in loan funds and \$8,300,000 in grant funds.

2. The Project Authorization is further amended by deleting the terms and conditions (a) provided therein and substituting the following:

a. Interest Rate and Terms of Repayment

The Cooperating Country shall repay the Loan to A.I.D. in U.S. Dollars within forty (40) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country shall pay to A.I.D. in U.S. Dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Commodities, Nationality of Services.

Commodities financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in countries included in A.I.D. Geographic Code 941, if loan-funded, or in the United States, if grant-funded, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, suppliers of commodities or services shall have the Cooperating Country or countries included in Code 941, if loan-funded, the United States, if grant-funded, as

their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels or the United States, if grant-funded, or Indonesia and Code 941 countries if loan-funded.

Signature: William P. Fuller  
William P. Fuller  
Director

Date: 5/2/83

Clearances: HN: E Calder [Signature]  
PRO: JSperling [Signature]  
A FIN: RMcClure [Signature]  
L/A: LChiles cc  
DD: RClark [Signature]

<sup>cc</sup>  
Drafted: LA: LChiles: 07/01/83, mai

## Project Background, Rationale and Description

### A) Background

The Project Paper, prepared in 1977, proposed five sub-projects whose overall purpose was to strengthen public health planning, research and health education capabilities of the GOI. The goal toward which these activities contributed was to make the Government's health program more effective and responsive to the health needs of the poor. Two of the proposed sub-projects (primary health nursing and immunization) were eliminated by the APAC and the project was authorized in 1978 with three sub-projects (planning, research and development, and health education) and a LOP amount of \$3.6 million. Project activities got underway in 1979 following execution of a minority 8A-set aside contract with Koba Associates, with Management Sciences for Health as sub-contractor. Later, in 1980, with increased funding of \$800 thousand, the second phase of the nutrition surveillance research activity was included in the research subproject of HTR&D. A final addition of \$100 thousand, also in 1980, increased the current LOP cost to a total of \$4.5 million. All funding to date has been Grant.

The mid-project evaluation (Summary Findings and Recommendations included as Annex F) concluded in March 1983 found that progress of the health planning sub-project, the major focus of which has been on manpower development, has been good, with measurable progress in manpower planning, training and personnel management, which are high priorities of the GOI. The progress of the research and development sub-project was found to have been less than fully satisfactory; recent events suggest that with certain alterations in implementation techniques measurable and meaningful progress can occur in this very important area. The education sub-project has achieved considerable success.

The evaluation, conducted by three outside expert consultants, concentrated on two of the three sub-projects (planning and research) which the Mission was considering extending. It was decided that the health education sub-project would be phased out on the present work schedule, by September 1983, because it is not central to the Mission's health sector strategy, other resources were available for the Health Education Directorate, and because the Mission staff wished to concentrate its energies on the highest priority elements of its strategy.

The Evaluation Team confirmed the Mission's assessment of the project, and recommended continuation of the planning and the research and development activities, with modifications which are included in the proposed project extension.

B) Rationale and Relationship to CDSS; GOI Long-Range Plan; Fourth Five Year Plan.

The PP supplement proposes a continuation of successful or promising components of the HTR&D project, with modifications of original design to adapt to health sector circumstances and new opportunities. The goals and purpose remain essentially unchanged.

In 1982 the GOI completed a new foundation document for a National Health System and in 1983 is completing a Strategy to the Year 2000, both of which are the culmination of two years of intensive, collaborative work of many elements of the Health Ministry. The HTR&D consultants made significant contributions to that process, especially in manpower development. The National Health System and the 4th Five Year Plan assign priority to:

Strengthening of Health Service Delivery Systems (esp. in Primary Health Care, Immunization, MCH) and Utilization of Drugs (appropriate selection, use and financing).

Health Manpower Development  
(Stressing Primary Health Care Paramedical Personnel, Nursing Assistants and Village Health Volunteers).

Drug Policy and Management.

Nutrition Improvement and Strengthening Environmental Health Programs.

Strengthening of Management Capability and Legislation.

Decentralized planning and decision making and manpower development for Primary Health Care services are key elements of the NHS long-term strategy. These components are also central to the USAID Health Strategy as expressed in the recent CDSS and remain specific objectives of the Comprehensive Health Improvement Program - Province Specific (497-0325) (CHIPPS) and HTR&D Projects. The Ministry of Health determination to pursue these objectives vigorously has been strengthened considerably during the past two years (with the HTR&D project activities contributing to that strengthening). Existing workplan objectives pertinent to manpower planning and training systems development continue to guide implementation progress, under strong demand-pull from the GOI.

USAID's CDSS Priorities in Health (1983) are very compatible with GOI health plans and may be summarized as follows:

CDSS Priorities -- Health

Specific Disease Control;

Improving the coverage, effectiveness and efficiency of programs aimed at the reduction of morbidity/mortality from diarrheal diseases and select vaccine preventable diseases of childhood.

Improving Health Program Management; including:

Manpower planning, training management, personnel management.

Management information systems.

Management of Primary Health Care program delivery, including improved use of epidemiologic information for planning and management.

Management of drug utilization and financing.

Financial planning for primary health care.

Nutrition

Development of information systems on the epidemiology of nutritional problems and for operational monitoring of nutrition interventions, including the integrated family planning/nutrition project currently supported by USAID.

Research and Development;

Support to applied/operational research and development, especially "client oriented" research on high priority health services delivery issues.

USAID is therefore well positioned to play an important role in the realization of GOI Health plans. The HTR&D consultants are well accepted and are making important contributions to comprehensive manpower development in the MOH. Project funds for training, research and evaluation can be supportive during the next few years in accelerating desired changes. The HTR&D project resources are directed primarily at Ministry of Health central level units responsible for planning and supporting activities from central to field levels. The consultants' efforts and other resources increasingly will be directed to helping the central offices work with Provincial and Kabupaten (district) levels to determine manpower, training and research requirements and methods to achieve more efficient and more decentralized management of health services delivery.

This project is supportive of and compatible with the CHIPPS project (497-0325), which takes another approach by working directly with three distinctly different provinces to strengthen provincial capabilities for planning and implementing programs within the same policy guidelines but in markedly different conditions.

C) Project Description -- Components

The extension period will continue two of the three sub-projects of the original project but with a somewhat different orientation and a sharper focus. It will also add two components which were implied in the original design -- Management Information Systems and Diarrheal Disease Mortality/Morbidity Reduction. Needs and opportunities now are more clearly defined as the Ministry has made progress in setting its goals and determining priorities. Furthermore, USAID has acquired a better understanding of the dynamics of the present health system.

The two basic elements which will continue, as well as the two added, will constitute an integrated project. This will reflect the coordinated relationship which should exist between Manpower Development, Health Services Research, and Management Information Systems. To attain the desired cohesion, a substantial part of the necessary "coordinative" and "integrative" function will be assumed by:

a.) a Project Coordinating Committee to be organized by the Ministry of Health; and

b.) the specific responsibility of one of the long term technical advisors to coordinate the Project's components.

Summary of USAID and GOI Inputs  
Project Components  
(US\$ 000)

Project Component	USAID	GOI	Total
1. Planning/Manpower Development	3,300	950	4,250
2. Research	330	125	455
3. Management Information	420	125	545
4. Diarrheal Disease Mortality/ Morbidity Reduction	1,650	750	2,400
5. Contingency/Inflation	700	250	950
	6,400	2,200	8,600

The project components are described are as follows:

1) Planning

a) Manpower Planning - This is a continuation of work begun in the original project; the principal counterpart agency is the MOH Planning Bureau reporting to the Secretary General. The major continuing activities include:

1) Strengthening of the Manpower Planning Unit of the Planning Bureau;

2) Strengthening Manpower Planning Functions in the Planning Units of the Provinces and other MOH Directorates General;

3) Manpower Studies;

4) Manpower Information System Development;

5) Staff Development.

Counterparts will include central and provincial-level entities including the Planning Bureau, Center for Education and Training (PusDikLat), Community Health Services Directorate General, Communicable Disease Control Directorate General, and Provincial Planning and Provincial Training Units. Emphasis on interactions with lower levels of Government is to be more heavily stressed and is consistent with the strategy toward decentralized management supported by the Ministry of Health and USAID.

b) Personnel Management - This element has had a slower record of implementation and will be less ambitious than other components in its objectives during the extension. Activities scheduled include the progressive development of:

1) Career Systems;

2) Personnel Information Systems;

3) Task Analyses and Job Descriptions;

4) Personnel Administration Procedures.

The principal counterpart agency remains the Bureau of Personnel of MOH.

c) Training Management and Planning - This element expands upon the work already begun. MOH recognition of training system deficiencies and USAID's recognition of opportunities for constructive contributions lead to the expansion of efforts in:

- 1) Training System Development;
- 2) Training Methods and Materials Development;
- 3) Management Training at Provincial and Kabupaten Levels;
- 4) Training Information System Development;
- 5) Studies of Training Needs and Methods; and
- 6) Evaluation and Monitoring.

Work on these activities will take place at the Central, Provincial and Kabupaten levels. The principal counterpart agency will be the Center for Education and Training (PusDikLat).

The Technical Assistance at Central level and in two of three initial Provinces selected by M.O.H. - Central Java and South Sulawesi - which is already in place is to continue. At the Center it is to go on unbroken until about April 1986, at one-third time. Main continuing objectives will be to help Pusdiklat expand and upgrade staff, design and establish administrative and financial procedures appropriate to running a very large, dispersed national training system and to modify its organization and external linkages accordingly. Pusdiklat's upgrading to Echelon I status in M.O.H., now in process, will legitimize these developments.

In the selected Provinces two kinds of consultants will be engaged. Province-based consultants (6 man-months per Province) will help develop the training system there, including the establishment of the new Provincial Training Centers with full-time staff, and the development of training programs in line with annual manpower plans and production targets. These Province-based consultants will also integrate and give continuity to the intensive training inputs of a planned sequence of additional shorter term technical consultants to the provinces. These short-term technical consultants will be used for running workshop series in trainer and consulting skills (e.g., Case Development, Task Analysis) - a total of 2 1/2 man-months per selected Province.

Six additional Provinces in turn are to receive this assistance, i.e., 2-3 at any one time during 2 to 2 1/2 years beginning September 1983. The combination and pacing of the intensive inputs will be varied to suit circumstances, e.g., in Sulawesi and Sumatera where adjoining Provinces have been selected for this program, implementation will differ from the pattern in more remote Provinces, such as Aceh or N.T.T.

Training/Staff Development. The largest activity is to provide advanced training to 3 to 5 provincial trainer consultants and training center principals in up to 8 Provinces, and also to 10 professional staff members at Pusdiklat. This will be done through 42 fellowships.

Two lines of programming are being explored and a judicious mixture may serve best. One aims at two 8 to 12 week full-time residential programs in the middle of G.O.I. fiscal year 1984-1985 and 1985-1986, each for PusDikLat staff. The other places a small number of institutionally-based trainees into specialized programs abroad, preferably in nearby Asian countries with the expertise and setting needed, and lasting no more than 3 months. Developing competence in Case Teaching is one specialization in which advanced overseas programs of this kind will be essential.

Studies and Management Assessments provide for up to 20 operational type studies of issues for decision within PusDikLat. Topics so far identified include field studies to provide the basis for updating pre-service curricula and to identify the content, composition and pacing of supportive in-service programs, and of monitoring procedures for planned changes in the organization. Some will be carried out by PusDikLat's own staff working with a consultant, and so also be part of staff development. Other studies will be carried out by other parts of the M.O.H., or outside in universities or private organizations.

Importantly, the major aspects of manpower development with which the project has been working remain fundamental to the expansion of the Health Delivery System if it is to provide even minimal coverage to greater than the 20% of population estimated now to be covered. An efficient public health sector in Indonesia will of necessity be large and complex, and the Manpower Planning, Personnel Administration and Training Management will require much greater sophistication than now available. Also, manpower issues pervade all sub-sectors of the Health System, and often they are excellent tools for creating discussion on important related issues of efficiency, targetting, choice of services, decentralization and recurrent financing.

Within the past two years, "manpower development" has been one of the Ministry's top priorities. Presently there are about 130,000 Ministry and local government health employees on official rolls; it is estimated there are another 20-30% outside of central funding, i.e. paid from local funds. There are 92 categories of staff as described by their principal training qualification, each requiring specific pre-service and in-service training, functional guidelines, career development opportunities, and routine and special personnel administration handling. To facilitate the process of future planning, the number of categories of health personnel will be reduced, and their job descriptions rationalized and streamlined. Annual MOH recruitment is

about 8000. The ratio of public sector health personnel per population unit varies nearly 6-fold (2.3 to 12.7 per 10,000 population) in different provinces.

Personnel management is highly centralized and is striving to improve its efficiency. Career development and continuing education need more serious attention. There is as yet little personnel management and manpower planning capability in the provinces. The Ministry's training system has more than 220 Ministry schools and a plethora of upgrading and "crash courses". Functional job descriptions and task analyses are only beginning to be approached in an organized manner.

A recent disciplined planning exercise in the MOH projected a manpower requirement for the year 2000 to be 444,000 "full-time" employees; there also was an additional estimated requirement for about 396,000 volunteer health workers. Obviously the gap between these projections and present realities is striking.

It was only coincidental with the HTR&D Project that a central manpower planning unit became fully functional. The quality of information analysis and projections has increased dramatically (see summary of HTR&D Interim Evaluation Report). This unit is young and still fragile; it will benefit from several more years of close attention and input from skilled, experienced professionals in Manpower Planning. As it is the provinces (delivery end of the health system) that are the "consumers" of the manpower that is planned, it is obvious that their role(s) in manpower planning must be defined and grow in an orderly manner. So in addition to strengthening the central manpower planning unit, this Project will assist the Ministry better define provincial roles and responsibilities, the manpower information system(s) (bi-directional) to support them, and, in addition, the relationships of the provinces to the central bureau of health personnel administration and the Center for Education and Training, and the information systems to support these relationships.

Widespread experience and some formal studies (one supported by this Project) have indicated areas of extensive under-utilization of existing health system personnel. Underutilization issues are, of course, extremely complex as to causation and resolution. But in the face of the enormous and probably unbridgeable gap between existing levels of manpower and projections of needed manpower in the decades ahead, dealing with these issues is mandatory. This Project offers flexibility for the Ministry to assess and analyze personnel utilization determinants in a variety of manners and settings.

Situations in the 27 provinces around this vast archipelago vary enormously - demographically, epidemiologically, culturally, economically, socially, and in terms of abilities and resources local officials have to achieve their goals for improving the health status of their populations. Over-centralized, rigidly defined training "packages" obviously are unfit to meet the disparate training needs around the country. The Ministry recognizes this situation and has included in its major plans the strengthening of training staffs and formal training institutions at provincial level, with the process beginning in earnest during Pelita IV. In support, this Project will assist in up to 8 provinces with province-specific analyses of training resources available; coordinative and information system mechanisms; techniques for planning, conducting, evaluating and following up on training. And as another practical exercise in province-specific training, it will continue to plan, conduct and evaluate the kabupaten health services management training that proved so successful during Project life thus far.

The yearly budget projections are detailed in the table:

Planning/Manpower Development  
September 1983 - September 1987  
 (US\$'s in 000's)

	Year I	Year II	Year III	Year IV	T o t a l
<u>Technical Assistance</u>					
<u>L.T.C./S.T.C.</u>					
Central Planning	53	40	25	15	133
Provincial Planning	40	40	25	15	120
	-----	-----	-----	-----	-----
	(93)	(80)	(50)	(30)	(253)
Central Personnel	66	53	15	12	146
Provincial Personnel	13	40	30	13	106
	-----	-----	-----	-----	-----
	(79)	(93)	(45)	(25)	(252)
Community Health Services (Manpower Development and Utilization)	46	66	31	15	158
Central Training	146	158	56	40	400
Provincial Training	125	188	26	12	351
	-----	-----	-----	-----	-----
	(271)	(46)	(82)	(52)	(751)
Central Integration	116	116	78	38	348
Provincial Integration	61	86	13	12	183
	-----	-----	-----	-----	-----
	(177)	(202)	(91)	(50)	(531)
SubTotal T.A.	(666)	(787)	(299)	(177)	(1,945)
Studies, Assessments <sup>1)</sup>	130	135	130	130	525
Training/Staff Development	190	220	70	50	530
Commodities	60	70	20	-	150
Evaluation	-	-	-	150	150
<u>T o t a l</u>	<u>1,035</u>	<u>1,266</u>	<u>519</u>	<u>507</u>	<u>3,300</u>

1) Includes: Policy and procedure assessments, studies, baseline data gathering.

End of Project Status (EOPS)

MANPOWER PLANNING

- 1) Activities of planning personnel fully coordinated with training at Pusat and in 50% core provinces.
- 2) Health Service activity plan linked to manpower plan at Pusat and in 50% of core provinces.
- 3) Plan implementation monitored and used as input in future plan cycles at Pusat and 50% of core provinces.
- 4) Key staff in planning, training and personnel at center and province receive specialized training and practice, with special emphasis in core provinces.
- 5) Coordination committees at the center and core provinces formed, meeting regularly and providing policy and executive guidance.
- 6) Written protocols and procedures prepared and at least one annual manpower plan encompassing 27 provinces issued.
- 7) At least 50% of the core provinces have written protocols and procedures for annual manpower planning and submit at least one annual manpower assessment to be used in annual plan preparation.
- 8) Requirements for monitoring defined at center and core provinces. At least one report on plan implementation prepared by 75% of the provinces and by the Pusat.
- 9) High level manpower management committees formed at Pusat and core provinces and meeting at least once a year. At least 75% of staff planned for core provinces in a given year trained and recruited into the province.

- 10) At least one workshop held for all provincial manpower units. Two annual workshops held for core provinces and Pusat staff. Short and long term training for one member of each of the planning units in core provinces.
- 11) Continuing mechanisms and regular meetings between staffs in above units at policy and at operating levels, at Pusat and in selected provinces; and between Pusat and provinces.
- 12) Use of information from two or more studies carried out by 1984/1985.
- 13) Two staff development programs with participants from partner units in MOH. Three more Provinces have begun establishing their integrative mechanisms and processes.
- 14) Regular participation in collaborative mechanisms among planning personnel and PusDikLat at Pusat and in province.
- 15) Strengthened procedures for performance-oriented monitoring and evaluation established, funded, and used for policy development and decision-making.
- 16) 3 (three) longitudinal action-research studies under way in service-delivery areas (Kabupaten), PusKesMas, and referral hospitals in collaboration with the communities in focus.

End of Project Status (EOPS)

PERSONNEL MANAGEMENT

- 1) Career system linking job requirements to individual skill development designed and initial steps completed in 50% of the core provinces.
- 2) Reject rate by National Civil Service Administration of applications because of incomplete or incorrect supporting documents decreased from current values. Proportion of cases processed in the same year should indicate 90%. Staff productivity increases.
- 3) Fewer complaints, less dissatisfaction from management and staff with operation of career system.
- 4) Fewer mismatches between plans, provisions of posts, training and recruitment.
- 5) Reject rate by the MOH Bureau of Personnel of applications because of incomplete or incorrect supporting documents decreased from current values.
- 6) Fewer mismatches between announced plans, training, recruitment.

End of Project Status (EOPS)

TRAINING SYSTEM DEVELOPMENT

- 1) Training linked to job descriptions for key medical and paramedical staff.
- 2) Core training team established in 6 - 8 provinces. It produces an annual training plan for Province and staffs it; also professional and system development plans. The plan is actively linked with multi-dimensional formal mechanism for manpower development in province and with national networks and PusDikLat.
- 3) Policies developed centrally to guide provincial training plans, facility and program development, and budgets and to coordinate them nationally.
- 4) Frequent pre-planned and ad hoc contact between PusDikLat and provinces for developing and maintain standards, information and resource exchange, materials and professional development, as well as for administrative and coordination purposes.
- 5) Processes established for developing and revising standards and accreditations based on competent practice.
- 6) Consultancy unit established at PusDikLat with primary task of supporting trainer and training system development in provinces. National network of consultants established and anchored in core provinces -- i.e., those identified to help other provinces in turn (e.g. Sumatra Barat, Sulawesi Selatan).
- 7) Task analysis and job description process established for nursing and management tasks, used in preservice education and routinely updated.
- 8) Career profiles developed for nurses and Kabupaten-level administrators, used in in-service training and routinely updated.

## 2) Research and Development

Project implementation experience and a recent evaluation effort provide strong encouragement for the GOI and USAID to continue some promising approaches developed to date, as well as explore new approaches to health systems research. The Project extension, therefore, will pursue the following:

1) Continue supporting the MOH policy to strengthen individual research unit capabilities for generating and managing research projects. This will be done through the transfer of technology, participant training, and direct research funding support.

2) Continuing major stress on client oriented research principles, through intensified dialogue between researchers and clients/users of research, leading to the formulation of research needs, the generation of proposals, and the actual implementation and application of research information.

3) Extramural (outside MOH) as well as intramural (MOH) research, with the former targetted at increasing the involvement of universities, and establishing administrative mechanisms to make this possible. Research emphasis will be directed toward: a) studies relevant to manpower development, b) PusKesMas (Sub-District level Public Health Centers) management and services development (including relevant Kabupaten level management development; creating viable local financing systems; nutrition program management; and efficient use of pharmaceuticals).

\$ 150,000 in loan funds will be earmarked for research conducted by universities, coordinated by MOH LitBangKes, and in cooperation with regional health officials, on health services management and delivery problems in the regions where the universities are located. Grant funds for research already available from the original project will continue to be used for client-oriented research efforts, intra and extramural to MOH, in health services delivery issues of high mutual priority to MOH and USAID.

Following a long-term consultancy for improving research competencies in Litbangkes and its specialized Institutes and two additional short-term consultancies focussed on improving research management, the most promising work in the next phase of the Project will be to sustain and follow-through with one major aspect: Client-Oriented Research. The M.O.H. units participating in the integrated H.T.R.D. Project are natural clients in this sense. An accumulation of policy and operational questions await clarification by appropriate research and fresh issues emerge continuously in Indonesia's rapidly expanding health system. Since April 1983 twenty client-oriented projects have been identified and, through series of intensive workshops for clients and researcher consultants together, carried forward step by step for development in actual practice. The MOH plans to use AID/HTRD funds to support some of these (up to 18), those which satisfy the planned steps of an orderly procedure concerning project identification, client commitment towards using the research results, organizational support in both researcher and client systems, appropriateness within AID's known funding priorities in the health sector, and those which have emerged with some urgency and would be unduly delayed if they had to await the standard GOI budget cycle. Added to the funds still available in the Project, the proposed new funds suffice to support the projected rate at which projects with these criteria may require AID support from September 1984 until 1987 in Litbangkes and also in universities. Additional S.T.C. help can be provided ad hoc, for important projects around which to develop some specialized competencies or to assist the G.O.I. in developing its own mechanism for giving support to client-oriented research. Minor consulting help with organizational issues in the client systems is included in the scopes of work planned for consultation to be provided for these units through other, closely related parts of this Project.

End of Project Status (E.O.P.S.)

Research and Development

- At least 10 studies funded and completed according to the existing Client Oriented Research (COR) concept, with the result of strengthening the current NIHRD process of research identification, selection, implementation leading to a timely application of research results by the client institutions of the MOH.
  
- At least half (5) of the HTR&D funded research activities will have been implemented by extramural institutions (e.g. universities), thus establishing an ongoing viable client-oriented process of utilizing universities to carry out relevant applied R&D to meet information needs for use in priority MOH programs. The majority of research activities funded by this project will have addressed operational problems in the following fields:
  - Manpower Development (including aspects of manpower planning; personnel management and utilization, training management and related areas)
  
  - Public health center management and services delivery
  
  - Local Health Care Financing
  
  - Nutrition Program Management
  
  - Efficient use of pharmaceuticals

Research and Development  
September, 1983 - September, 1987  
(Additional Funding with Project Extension)  
(US\$ 000)

	Year I	Year II	Year III	Year IV	T o t a l
Technical Assistance	53	53	27	27	160
Extramural Research <sup>1</sup>	30	30	40	50	150
Evaluation	-	-	-	20	20
T o t a l	83	83	67	97	330

<sup>1</sup> Represents university performed research, coordinated by MOH LitBangKes.

### 3) Management Information Systems (MIS)

An emerging high priority of the MOH is the development of practical Management Information Systems, both for services management and planning. In a country as diverse and large as Indonesia, this is a difficult undertaking. Indonesia's highly dispersed public sector health system already has more than 5000 Puskesmas and 8000 Sub-Puskesmas, in every kecamatan in the country, no matter how remote. There are hundreds of public hospitals, in every province and kabupaten. These organs of the MOH are charged with providing a full range of individual and collective preventive services, curative services from the simple to the sophisticated, educative/promotional services targetted to individuals and communities, surveillance for trends as well as outbreaks or special events, and supportive functions for other sectors and other local government programs. The current 130,000 registered employees will grow to several hundred thousand, each of whom will require pre-training and in-service training, routine personnel administration, career development and assurance that his job and the support provided to do it will remain relevant within wide disparities among areas and rapidly changing circumstances.

Both simple and sophisticated information systems will be required. Indonesia's disbursement of population throughout an archipelago implies that sophisticated information systems will be necessary to tie the units together for policy guidance and graduated system development, but at the same time that simple information systems will be necessary locally for the inevitable decentralized management of the widely dispersed units.

Planning, management and surveillance information systems will be required; there may be some overlap but basically the needs are different. A great deal of analysis will be required to determine for each of the information systems what information can and should be collected; in what form and by which persons; what analysis and/or collation should be performed at which levels; frequency of collection, analysis and reporting; what skills are required at which levels; and what data in what form move in which directions.

The task ahead to the MOH is forbidding considering the responsibility of the public sector in Indonesia to respond to the ill-health of the population on 3000 islands. Obviously, this small project component can make only a small contribution, and at most only in the broader issues relevant to management information systems for manpower development and Puskesmas services.

Introducing an Integrated Management Information System will require the following:

- The identification and specification of management roles and functions and their associated information needs throughout the health system.
- The design and development of coordinated information collecting, handling and processing networks at district, province and central levels of the Ministry.

The scale of effort involved is such that a coordinated program of development is needed which will allow the development to take place through a series of well defined phases which are within the development capacity of the Ministry.

Given that detailed plans for MIS development are not yet formulated, a modest element of the extended project is planned to concern itself with the processes of defining specific cost effective MIS objectives, and assisting in establishing an implementation process. Again, recognizing the inability of this project to deal with all MIS issues, project efforts will concentrate on those most directly concerned with information systems for manpower development and PusKesMas services. Project assistance to PusKesMas management information systems will address M.I.S. needs at Kecamatan and Kabupaten levels, with efficient linkages to appropriate central entities.

The process of an in-depth needs assessment is scheduled to begin in the summer of 1983. Once this process is complete, it will form the basis for a more detailed plan for determining focus, priorities and timing of Project support for MIS. An approach to determining specifications, procurement, installation of hardware, software, and related training of professional and support staff will be next.

As an early input during the Project extension, an estimated 12 person-months of technical assistance will be provided to assist the Ministry more precisely define MIS objectives and intra-ministerial organizational responsibilities for developing, and then operating, the MIS. Before AID shall agree to disbursements of project resources for MIS commodities, the Ministry shall provide to AID, in form and substance satisfactory to AID:

- a) An agreed Ministry implementation plan for Management Information System development, with resource requirements identified and set aside to meet the plan; and
- b) Evidence that a position, or unit, has been created within the Ministry organization with official responsibility for the management of MIS development and this position filled by person(s) whose major function is the management of this MIS development process and with the necessary authority and staff to do so.

It is expected that the Ministry of Health will meet these requirements by the end of the Calendar Year 1984.

Since the requirements are vast and the importance of this activity very high, AID's assistance will be designed to maximize quality, practicality and rational choice.

MANAGEMENT INFORMATION SYSTEM

End of Project Status (E.O.P.S.)

A) Intermediate Status -- Target: December 1984.

- 1) Cost-effective MIS objectives defined precisely and the related intra-ministerial organizational responsibilities for developing and operating the MIS are well understood and accepted by the relevant MOH units.
- 2) Detailed short term and long-term MIS implementation plan prepared and authorized; an adequately staffed unit organized and officially charged with the responsibility of continuing the long-term development of the Ministry-wide MIS.

B) End-Of Project Status

To be finalized after the above intermediate status has been met. At this time, the anticipated E.O.P.S. is as follows:

- 1) Focusing on the central and peripheral MIS subsystems relating to Manpower development and public health center service delivery, the minimum necessary hardware, software, related training and technical support are in place and functioning purposefully.

- 2) Information requirements for planning, training, personnel and user management specified.
- 3) Regular manpower reports and analyses sent to all units in Pusat according to agreed schedules.
- 4) Ad hoc manpower reports and analyses issued to all units in central MOH on request.
- 5) Staff in all provinces trained to provide specified data to central MOH institutions.
- 6) Staff in all provinces trained to produce and use basic reports and analyses of provincial manpower situation.

Management Information System Development  
September, 1983 - September, 1987

	Year I	Year II	Year III	Year IV	T o t a l
Technical Assistance L.T.C./S.T.C.					
At Center	70	40	20	20	150
At Province	40	40	20	20	120
Subtotal	(110)	(80)	(40)	(40)	(270)
Studies, Assessments <sup>1</sup>	20	20	10	10	60
Commodities	20	30	10	-	60
Evaluation	-	-	-	30	30
T o t a l	150	130	60	80	420

<sup>1</sup>Includes studies and management analyses of information requirements and techniques

4) Diarrheal Diseases Morbidity/Mortality Control -  
A Case Study

As a result of CHIPPS field work in Aceh province and other groundwork, an opportunity has arisen recently to assist MOH in developing Indonesia's Diarrheal Disease Control (DDC) Program. This will be approached by including it as a "Case-study" in the HTR&D extension, stressing a coordinated approach in research, planning, training and manpower development. This component includes:

A) Studies to document mortality/morbidity, economic impact, social impact of the non-cholera diarrheal diseases in Indonesia;

B) Improving surveillance systems, and performing epidemiologic studies documenting incidence, etiologies, seasonality, etc.;

C) assessing relative strengths and weaknesses of existing programs for the care and reduction of mortality/morbidity of diarrheal disease patients in Indonesia, especially oral rehydration therapy (ORT) programs.

D) Conducting feasibility studies on alternative production strategies of oral rehydration salts, each analyzed in comparison to village based production;

E) Testing training methods for DDC program managers, patient contact personnel and for parents and siblings who generally will administer oral rehydration solutions;

F) Development of training materials.

Given that it will be many years yet before environmental sanitation and clean water are provided and people's behaviors are changed enough around Indonesia to break the chains of transmission of diarrheal disease infectious agents, the case load is not likely to reduce in the near term. More, then, needs to be done to reduce the deaths and reduce the not insignificant morbidity attendant to repeated attacks of diarrhea among Indonesian's millions of surviving children.

The MOH has a relatively new but well-led Sub-Directorate for the Control of Diarrheal Diseases. They are well aware of the seriousness of the problem; they accept that proper treatment - with maintenance of hydration as the cornerstone - is vital to reducing mortality and severe morbidity, but they require more assistance to develop MOH capacity to meet the need. And they need more information in order to convince the many people who are unalarmed about diarrheal diseases - health and non-health people - that the problem is huge and that there are practical measures that can be taken in the short-term before every household has access to and routinely utilizes clean water and proper sanitation.

Currently Indonesia uses oral rehydration salts produced through public manufacturing and private manufacturing, and prepackaged salts imported (generally through UNICEF). There have been many local trials with oral therapy using these pre-packaged salts and using home-made solutions prepared with various techniques. General population awareness of dehydration/rehydration aspects of diarrheal diseases is growing, but it is still very unusual to find villagers or urban dwellers using ORT correctly, and it is still not the treatment of choice of the great majority of health practitioners. So much work is yet to be done before this low cost, relatively simple technology has much impact on mortality/case severity in Indonesia.

At this time the Project extension offers the combination of predictable multiyear funding (i.e. reliability of funding for better planning of efforts) and critical technical and management analysis for organizing disparate data and field experiences for more comprehensive policy, planning and management decisions.

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The GOI is hoping to receive a large IBRD loan aimed at "integrated health/nutrition/family planning", probably beginning in GOI Fiscal Year 1984-5. There will be a substantial component related to diarrheal disease control, but these funds are expected to be used to purchase/produce prepackaged ORS, intravenous solutions, medications and equipment. The relatively modest AID input proposed in the HTR and D extension could be effective in seeing that these larger expenditures are used with maximal effectiveness.

The assistance will include two long term consultants for at least a year each and up to 25 person months of short term consultants. The first long term consultant, in epidemiology, should arrive in late 1983 and the second, in operations management, in late 1984. The short term consultants should include specialists in designing field assessments of economic impact of illness on population groups; in the cost implications of alternative treatment strategies; in designing field assessments of social impact of illness burden on population groups; in laboratory methods for determining specific etiologies of diarrheal diseases; in reviewing impact and costs of various ORT programs; in running clinical training centers for management of diarrhea diseases (largely based on principles of ORT); in assessing economics of options for ORS production on industrial scale, as cottage industry, or village based; in designing demographic data base and monitoring systems for possible kabupaten ODD field study area; on training for diarrheal disease mortality/morbidity reduction programs; in data processing; and in assessing the population's knowledge, attitudes and practices towards diarrheal diseases as well as social and behavioral determinants of why children at present are not being given proper treatment for diarrhea-induced dehydration. To the extent that well qualified Indonesian consultants are available they will be utilized if administrative arrangements can be completed in a timely manner.

Training activities will include reviewing ongoing training, expansion of the effective elements and revision of the less effective elements, new types of training as appropriate, and upgraded clinical and laboratory training for key institutional staff. A major activity will be the development of training materials.

Field assessments will be conducted which will include examination of the economics and social impact of diarrheal diseases, the epidemiologic data base, and etiologies of diarrheal diseases at different locations around Indonesia. In addition, assessments will be made of the effectiveness of existing treatment programs and options for ORS production. The feasibility of developing a kabupaten-wide special ODC study area and several centers of excellence for training in the treatment of diarrheal diseases will be examined.

Project supplied commodities will include data processing equipment (microcomputers and software) if assessments determine this to be necessary and feasible, small equipment and consumables for reference laboratories, small equipment for ORS production, and books and reference materials.

The MOH, recognizes that optimal control of diarrheal disease consequences will require cooperative efforts from elements in the Ministry concerned with policy, surveillance, education and training, manpower management, health services delivery, etc. In addition, it is recognized that organizational resources outside the MOH, such as PKK (women's clubs), BKKBN (family planning organization), Public Works, Ministry of Information, etc. all will have potentially vital roles to play. This Project component strongly supports these cooperative attitudes. Also, there already exists a well-qualified technical advisory board for diarrheal diseases whose important role is recognized and whose functioning will receive direct Project support.

Diarrheal Disease Control- USAID FUNDING

September 1983 - September 1987

(US\$ 000)

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	Year I	Year II	Year III	Year IV	Total
Technical Assistance	150	200	200	100	650
Studies, Assessments	100	150	150	100	500
Training	100	100	100	100	400
Commodities	10	20	10	10	50
Evaluation	-	30	-	20	50
<b>T o t a l</b>	<b>360</b>	<b>500</b>	<b>460</b>	<b>330</b>	<b>1,650</b>

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EOPS - DIARRHEAL DISEASE COMPONENT

- Studies will have been completed and discussed with health and non-health decision makers documenting economic and social consequences of diarrheal diseases, and further studies will be completed documenting mortality and morbidity on age and sex basis in various parts of Indonesia.
  
- Routine surveillance system will have on time reporting from 80% of CDD field posts; data will be analyzed routinely at most CDD Puskesmas, Kabupaten, Provincial levels as well as Central level. Special studies in several areas will have documented seasonality, patterns of etiology.
  
- Studies will be completed documenting strengths and weaknesses of ORT program experiences thus far in the country; lessons learned will have been applied to alter policies and training methods. Some new training materials and programs will be in use, for CDD program managers, for villagers, for non-health sector officials. Curricula in medical and nursing schools will be improved. Feasibility studies will be completed for establishing diarrheal disease treatment centers of excellence which would serve as regional training centers. Teaching physicians from all of Indonesia's government medical schools will have received special ORT "hands-on" training.

- Alternative production strategies for oral rehydration salts at Central or provincial manufacturing sites, or as cottage industries, will be completed. Government will have issued clear policy guidelines (and necessary regulations) regarding production through government and private manufacturing sectors. Government policy on promotion of village or home-based ORS production will be clear and will be adhered to by DEPKES, BKKBN and other agencies.
- Study of Central CDD unit data processing requirements will be completed; needed training and equipment will be provided and being used routinely. There will be routine feedback of information and comment to lower levels.
- Feasibility analysis will be completed on using one or more kabupatens as "special areas of concentration" for CDD programs.
- Studies will be completed in several areas assessing the populations' knowledge, attitudes and practices towards diarrheal diseases as well as social and behavioral determinants of why children are not receiving proper treatment for diarrheal-induced dehydration.

### Financial Plan and Analysis

The project financial plan is presented in a series of tables. USAID's proposed additional contribution is \$6,400,000 for a life of project total of \$10,900,000. It comprises an additional \$3,800,000 of grant funds and \$2,600,000 of loan funds; \$4,990,000 are allocated for foreign exchange costs and \$1,410,000 for local costs. The GOI additional contribution is estimated at the rupiah equivalent of approximately \$2.2 million or 25% of added project costs.

Cost estimates are based on experience gained with previous USAID projects and current USAID and GOI cost guidelines.

Line item calculations are based upon GOI, USAID and other institutional experience with past and present programs. Costs are based upon AID/W cost guidelines for equipment and supplies, and local experience of the Indonesian government. Training costs are based on guidelines in AID Handbook 10, with some USAID revisions resulting from experience, and GOI guidelines and experience with local training costs.

An average cost of \$12,500 per person month has been assumed for short term technical assistance and \$14,500 per person month for long term technical assistance. This is based upon recent experience in the ongoing project. When it is likely that a combination of short term and long term technical assistance will be required, an average of \$13,250 has been assumed - based on an estimated mixture of three eighths long term and five eighths short term. This also reflects experience to date. Management Information Systems costs are based upon catalog figures for small computers and USAID-GOI estimates of local training costs and technical assistance costs.

Research and assessment costs are derived from past USAID-GOI experience, GOI cost guidelines, and current AID guidelines.

Approximately 11% of the total cost is included for possible inflation or contingencies. This is considered a conservative estimate based upon recent experience but provides sufficient flexibility to maintain each component at originally planned real cost levels in the face of potential inflation and uncertainties.

Loan funding of commodities is provided only for mini/micro computer equipment, software and related equipment which because of its compactness will be airfreighted to Indonesia to minimize delay in providing this resource on-line and initiating training activities. All other commodities will be grant funded.

For all the activities this project assists, the GOI will budget approximately \$2.2 million under the "development" heading. Since over three quarters of the AID inputs will be for non-recurring foreign exchange costs (primarily for technical assistance), this should not result in overburdening the GOI in the future. USAID funded consultants will be working with ongoing ministry functions and processes to improve their efficiency, effectiveness and impact. Since this is largely an institution building project to support key health ministry units at the national and provincial levels in their top priority programs, USAID expects the GOI to furnish the support required. The Ministry of Health is fully committed to supporting each project component and has agreed to provide the necessary inputs. The estimated GOI contributions are based on Repelita IV budget planning.

Table A  
Additional Funding by Component and by Input  
 (US\$ 000)

	Manpower Development	Research	Management Info System	Diarrheal Disease Mortality/ Morbidity Reduction	Miscellaneous	Total
Technical Assistance	1,945	160	270	650	-	3,025
T r a i n i n g	530	-	-	400	-	930
Commodities	150	-	60	50	-	260
Evaluation	150	20	30	50	-	250
Other Costs <sup>1</sup>	525	150	60	500	-	1,235
Contingency/Inflation	-	-	-	-	700	700
<b>T o t a l</b>	<b>3,300</b>	<b>330</b>	<b>420</b>	<b>1,650</b>	<b>700</b>	<b>6,400</b>

<sup>1</sup> Includes: Policy and procedure assessments, studies, baseline data gathering.

Table B  
Proposed USAID Obligation by Fiscal Year  
By Component and By Grant and Loan for Project Extension  
(US\$ 000)

	FY 1983			FY 1984			T O T A L		
	Grant	Loan	Total	Grant	Loan	Total	Grant	Loan	Total
Planning/Manpower Development	965	875	1,840	770	690	1,460	1,735	1,665	3,300
Research	50	205	255	20	55	75	70	260	330
Management Information	100	155	255	70	95	165	170	250	420
Diarrheal Disease Mortality/Morbidity Reduction	385	215	600	1,050	-	1,050	1,435	215	1,650
Contingency/Inflation	-	-	-	390	310	700	390	310	700
T o t a l	1,500	1,450	2,950	2,300	1,150	2,450	3,800	2,600	6,400

Table C  
Proposed USAID Obligation by Fiscal Year  
By Input and By Grant and Loan for Project Extension  
(US\$ 000)

	FY 1983			FY 1984			T O T A L		
	Grant	Loan	Total	Grant	Loan	Total	Grant	Loan	Total
Technical Assistance	920	840	1,760	425	840	1,265	1,345	1,680	3,025
Training	215	275	490	440	-	440	655	275	930
Commodities	75	185	260	-	-	-	75	185	260
Evaluation	-	-	-	250	-	250	250	-	250
Other Costs	290	150	440	795	-	795	1,085	150	1,235
Contingency/Inflation	-	-	-	390	310	700	390	310	700
<b>T o t a l</b>	<b>1,500</b>	<b>1,450</b>	<b>2,950</b>	<b>2,300</b>	<b>1,150</b>	<b>3,450</b>	<b>3,800</b>	<b>2,600</b>	<b>6,400</b>

Table D  
Foreign Exchange and Local Currency Project Extension  
By Components  
(US\$ 000)

	FY 1983				FY 1984				T o t a l				Grant Total
	Grant		Loan		Grant		Loan		Grant		Loan		
	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	
Planning/Manpower Development	765	200	875	-	360	410	690	-	1,125	610	1,565	-	3,500
Research	50	-	55	150	20	-	55	-	70	-	110	150	330
Management Information	80	20	155	-	30	40	95	-	110	60	250	-	420
Diarrheal Disease Mortality/Morbidity Reduction	285	100	215	-	800	250	-	-	1,085	350	215	-	1,650
Contingency/ Inflation	-	-	-	-	200	190	260	50	200	190	260	50	700
<b>T o t a l</b>	<b>1,180</b>	<b>320</b>	<b>1,300</b>	<b>150</b>	<b>1,410</b>	<b>1,890</b>	<b>1,100</b>	<b>50</b>	<b>2,590</b>	<b>1,210</b>	<b>2,400</b>	<b>200</b>	<b>6,400</b>

Table E

Summary of USAID and GOI Inputs to Project Extension  
Project Components  
(US\$ 000)

Project Component	USAID	GOI	Total
1. Planning/Manpower Development	3,300	950	4,250
2. Research	330	125	455
3. Management Information	420	125	545
4. Diarrheal Disease Mortality/ Morbidity Reduction	1,650	750	2,400
5. Contingency Inflation	700	250	950
	6,400	2,200	8,600

Table F

Health Training Research and Development Project

Inputs	USAID Portion of the Project Budget (US\$ 000)		
	To Date <sup>1)</sup>	Added in this Amendment	T o t a l L.O.P.
Technical Assistance	3,000	3,025	6,025
Training	300	930	1,230
Commodities	50	260	310
Research and Development (including surveys, studies audits, assessments)	1,100	1,485 <sup>2)</sup>	2,585
Contingency	50	700	750
<b>Total Project Cost</b>	<b>4,500</b>	<b>6,400</b>	<b>10,900</b>

1) Per PIL No. 14 of June 8, 1983

2) Includes policy and procedure assessments, studies, baseline data gathering and evaluations.

Table G

Health Training, Research and Development Extension  
Projected Project Inputs by Fiscal Year Obligation  
 (US\$ 000)

	FY 1983			FY 1984*			Life of Project		
	Grant	Loan	GOI	Grant	Loan	GOI**	Grant	Loan	GOI
Planning/Manpower Development	965	875	200	770	690	200	1,735	1,565	950
Research	50	205	70	20	55	50	70	260	125
Management Information	100	155	50	70	95	100	170	250	125
Diarrheal Disease Mortality/Morbidity Reduction	385	215	150	1,050	-	200	1,435	215	750
Contingency/Inflation	-	-	30	390	310	50	390	310	250
<b>T o t a l</b>	<b>1,500</b>	<b>1,450</b>	<b>500</b>	<b>2,300</b>	<b>1,150</b>	<b>600</b>	<b>3,800</b>	<b>2,600</b>	<b>2,200</b>

\* Future obligations are subject to the availability of funds and mutual agreement of the parties concerned.

\*\*GOI input are to be provided over four years in the budget for the appropriate GOI fiscal year.

Table H

Health Training Research and Development Extension  
Summary of GOI/AID Committed Input  
by Project Components  
(US\$ 000)

	Grant		Loan		Total	GOI	
	FX	LC	FX	LC		LC	Total
Planning/Manpower							
Development	1,125	610	1,565	-	3,300	950	4,250
Research	70	-	110	150	330	125	455
Management Information	110	60	250	-	420	125	545
Diarrheal Disease							
Mortality/Morbidity							
Reduction	1,085	350	215	-	1,650	750	2,400
Contingency/Inflation	200	190	260	50	700	250	950
<b>T o t a l</b>	<b>2,590</b>	<b>1,210</b>	<b>2,400</b>	<b>200</b>	<b>6,400</b>	<b>2,200</b>	<b>8,600</b>

V. IMPLEMENTATION PLAN

IMPLEMENTATION SCHEDULE

	Component	
8/83	P, R, M, D	- Project Agreement signed.
10/83 - 4/84	P	- High level manpower coordinating committees established in center and core provinces.
11/83	D	- First year annual workplan for diarrheal disease component agreed to by Ministry and USAID
11-12/83	D	- LTC epidemiologist hired
	D	- field test VHW surveillance forms (1-2 STC months)
11/83-1/84	D	- Conference in Jakarta to clarify goals and methods for CDD ORS program (representatives from CDD, AID, UNICEF, WHO, Family Planning, Maternal & Child Health, other appropriate donor agencies) (1 STC month)
	D	- Selection of provincial CDC persons to oversee the activities of the 2 to 4 sentinel PusKesMases in each of 10 sentinel provinces

Components: P = Planning/Manpower Development  
R = Research  
M = Management Information Systems  
D = Diarrheal Disease Mortality/Morbidity Reduction

- D - Selection of hospitals in 5 to 6 of the 10 sentinel provinces to serve as sentinel microbiology laboratories.
- D - Laboratory equipment and supplies ordered
- D - University - CDD conference in Jakarta to design training materials on treatment of diarrhea (ORT, IV, antibiotic use) for government hospital and PusKesMas staff (and, it is hoped, medical & nursing students) (1 STC month)
- D - ORT "hands on" treatment experience for 10 provincial supervisors of sentinel PusKesMas + 1 MD from the 10 sentinel provincial hospitals; at Infectious Disease Hospital, Jakarta (1 STC month)
- 11/83-1/84 D - Establish CDD library with reprints, textbooks, and journal subscriptions
- 12/83 M - Manpower Information System concept designs completed covering Pusat and Provinces.
- 1/84 P - Handbook of office procedures for Biro Kepegawaian completed.
- P - Manual method of manpower projections operating in Biro Kepegawaian.
- P Provincial training assessment.

- |              |   |  |
|--------------|---|--|
| 12/83        | P | - Planning activities for three year program detailed and approved.  |
| 12/83 - 3/84 | P | - Annual Manpower Planning process designed at center and core provinces and put in place for fiscal 1985 planning cycle.  |
| 12/83        | R | - Administrative mechanisms established with LitBangKes for Project Loan funds to be used for University - conducted health research.  |
| 1/84         | R | - First batch of research proposals generated by research mapping and client-oriented workshops proposed to USAID for Project funding.   |
| 1-5/84       | P | - Procedures completed for annual and semi-annual manpower review.   |
| 1-3/84       | D | - Sentinel PusKesMas (30) conference:<br>2 conferees per PusKesMas (MD + VHW supervisors)<br>+ the 10 sentinel PusKesMas supervisors<br>+ 5 to 6 laboratory technicians<br>(1 to 1 1/2 STC months) |
|              | D | - Laboratory technicians trained ; 2 week course at on esentinel lab. site<br>(3 STC weeks)  |

- |                     |   |  |
|---------------------|---|--|
|                     | D | - Purchase scales and packaging equipment for 10 sentinel Kabupaten hospitals to make ORS (trial basis)  |
| 1-12/84,<br>1-12/85 | D | - STC available for specific projects dealing with epidemiologic investigations, clinical teaching, laboratory assessment, ORS production and distribution, and program evaluation |
| 2/84                | P | - Provincial training assessment   |
| 3/84                | M | - Basic (first-stage) Manpower Information System working at Pusat   |
| 3/84                | P | - Job specifications for Biro Kepegawaian staff completed. Research study completed of working procedures in a sample of provincial personnel offices                              |
| 3-11/84             | M | - Test information system operation in core provinces and at center  |
| 4-6/84              | D | - ORT "hands on" treatment experience for 30 sentinel PusKesMas MD's, nurses + VHW trainers + Kabupaten hospital MD's + nurses from 3 provincial hospitals (2 STC months)          |
|                     | D | - Training session for VHW supervisor from 30 sentinel PusKesMas   |
|                     | D | - Training session for VHWs (1 STC month)  |

- |         |   |   |
|---------|---|---|
| 5/84    | M | - Workshop for Pusat staff on the use of the basic Manpower Information System and its outputs, and next steps of development |
| 5/84    | P | - National workshop to produce handbook of office procedures for provincial personnel offices                                 |
| 6/84    | P | - Training material for Biro Kepegawaian staff completed  |
| 6/84    | R | - Agreement reached on first University conducted research studies using Project funds.                                       |
| 7/84    | P | - Career analysis methods installed and operating in Biro Kepegawaian   |
| 7/84    | M | - Workshop for Pusat and Province staff on the set-up and operation of province Manpower Information Systems                  |
| 8/84    | P | - First review meeting of annual manpower plan  |
|         | P | - First provincial manpower planning workshop   |
| 7-9/84  | D | - Sentinel "supervisors" biannual meeting.  |
| 7-12/84 | D | - Field study of KAP, ORT use, VHW visits, morbidity and mortality rates in 3 to 5 sentinel areas (3 STC months)              |

- |          |   |  |
|----------|---|--|
|          | D | - Design training materials and conduct conferences in each of 30 sentinel areas to stimulate PKK and primary school instructors in CDD program                                    |
| 8-9/84   | P | - First 8-10 week intensive training staff development program for PusDikLat and initial 4 Provinces   |
| 9/84     | P | - Provincial training assessment   |
| 10/84    | D | - Evaluation.  |
| 10-12/84 | D | - 3 months anthropological studies in 1 urban and 1 rural setting to determine KAP on diarrhea treatment and ORT use (6 STC months - Indonesian anthropologist and/or sociologist) |
|          | D | LTC Operations Officer hired   |
|          | D | - Field evaluation of VHW performance (2 STC months)   |
|          | D | - Expanded number of sentinel provinces and PusKesMas (select additional supervisors)  |
| 11/84    | P | - Provincial training assessment.  |
| 11/84    | P | - Job specifications for Provincial personnel office staff completed   |

12/84	P	- Staff selected in Center and in core Provinces for long/short term training in manpower planning
12/84	P	- Annual workshop to review results
1/85	P	- Second manpower development review meeting
1-3/85, 1-3/86	D	- Sentinel PusKesMas conference yearly review of project
2/85	M	- Workshop for all provinces to train staff on implementation of information system
	P	- Review meetings organized
	P	Annual provincial manpower workshop held
3/85	P	- National training course(s) for Provincial personnel office staff
4/85	P	- Provincial training assessment
7/85	M	- Manpower Information Systems set up and operating in 50% of Provinces
7-9/1985, 7-9/86	D	- Sentinel PusKesMas supervisors meeting
8-9/85	P	- Second 8-10 week intensive training staff development program for PusDikLat and four more Provinces

- |        |         |  |
|--------|---------|--|
| 8/85   | P       | - Second annual provincial manpower planning workshop  |
|        | P       | - Third manpower development review meeting  |
| 9/85   | M       | - Workshop for Province staff on the set-up and operation of Province-level Manpower Information System, and the production and use of outputs |
| 10/85  | P       | - Provincial training assessment   |
| 12/85  | P, M    | - Manpower Information System outputs used to develop and/or modify 1986 Annual Plan   |
| 12/85  | P       | - Staff selected from center and core provinces for long and short term in training manpower planning  |
| 1/86   | P       | - Fourth Manpower Development Review meeting   |
| 5/86   | P       | - Province-based consultation ends   |
| 12/86  | P       | - Staff selected from center and core provinces for long and short term training in manpower planning.   |
| 3/87   | P,R,M,D | - Evaluation.  |
| 1-9/87 | P       | - Special studies in manpower development  |
| 7/87   | R       | - All Project supported health research studies completed and final reports available.   |

Planning/Manpower Development, Research and MIS  
Implementation Targets for Technical Assistance

	Year 1 person months	Year 2 person months	Year 3 person months	Year 4 person months	Total person months
A. For inter-unit and Center-Province integration: L.T.C. Province-based C (2)	8 4	8 6	8 2	- -	24 12
B. <u>For core H.T.R.D. units:</u>					
<u>At Center:</u>					
1. Manpower Planning	4	3	3	-	10
2. Training/Production	4	4	4	-	12
3. Personnel	5	4	2	-	11
4. Community Health Services/Planning	3	5	4	-	12
<u>In Selected Provinces:</u>					
1. Manpower Planning	3	3	3	-	9
2. Training/Production	17	22	4	4	47
3. Personnel	1	3	2	2	8
4. Community Health Services/Planning	-	-	-	-	-
C. <u>For service units:</u>					
<u>At Center:</u>					
1. Manpower Information System	5	3	3	-	11
2. Research (Province-based)	4	4	4	-	12
<u>In Selected Provinces</u>					
1. Manpower Information System	3	3	3	-	9
Subtotal at Center	(29)	(27)	(24)	(0)	(80)
Subtotal In Selected Provinces	(32)	(41)	(18)	(6)	(97)
Total:	61	67	41	6	177

Planning/Manpower Development  
Funds for Special Studies and Commodities  
 (By Sub-component)

	Year I	Year II	Year III	Year IV	Total
<u>Special Studies</u>					
Integration	50	65	80	80	275
Manpower Planning	40	35	25	25	125
& Personnel Admin.	40	35	25	25	125
Training					
Total:	(130)	(135)	(130)	(130)	(525)
<u>Commodities:</u>					
Integration	-	-	-	-	-
Manpower Planning	40	30	5	-	75
& Personnel Admin.	20	20	15	-	75
Training					
Total:	(60)	(70)	(20)	-	(150)

TRAINING COMPONENT STAFF DEVELOPMENT

USAID INPUTS

	Year I		Year II		Year III & IV		Total
	\$		\$		\$		\$
	Number/Costs		Number/Costs		Number/Costs		Number/Costs
1.a. <u>12-week residential</u>							
<u>Summer Program for</u>							
<u>Management trainers</u>	30		30		--		60
(in ASEAN country)							
Fares	30	15,000	30	15,000	--		30
Fees	30	45,000	30	45,000	--		90
Living Expenses	30	45,000	30	45,000	--		90
b. Ditto (in Indonesia)					--	--	-- --
2.a. <u>12 week residential program</u>							
<u>for Case Teachers</u>							
(in Philippines or India)	6		6				12
Fares	6	6,000	6	6,000	--		12
Fees	6	12,000	6	12,000	--		24
Living Expenses	6	18,000	6	18,000	--		36
b. Ditto (in Indonesia)					--	--	-- --
Miscellaneous/contingency		9,000					
	150,000		150,000		--	--	300

1. Following the concentrated efforts in using technical assistance, etc. to strengthen each of three components of Health Manpower Development in 1980-1983, the emphasis in the next three years is to integrate the components, especially with the Community Health Services Directorate where H.T.R.D. coordination will show up in higher service performance. Effective integrative activities are peculiarly dependent on the changing readiness of many levels of officials. No difficulties are expected to delay the formation and legitimization of a top-level coordinating mechanism for the Project and of its executive arm which will act more continuously as an organizational counterpart to the consulting team. The question is how to ensure that the desired integration has sufficient weight and continuity to more than offset the tendencies towards separation and independent action, especially where these are backed by prevalent administrative and budget arrangements and, often, personal habit and inclinations.

The need for active husbanding of inter-unit relationships and for a series of detailed interventions on the part of the team leader are, therefore, foreseen. From the beginning of the extension of project, therefore, two-thirds of his/her time is allocated to this integrative work in three essential areas: 1) inter-unit integration in the Central Ministry; 2) Center-Province integration; and 3) the essential integration of the consulting team to match this essential task through day-to-day activities dispersed in several locations and frequent short-term technical consultancies.

For each selected Province the project also provides up to two man-months for similar integrative work among the H.T.R.D. related units at Provincial level (out of the 8 man-months provided for Province-based consultation in each Province).

2. The planning, funding and administration of manpower development programs have been accorded formal positions in organized hierarchies in the ministry. The establishment of functional positions and career ladders for full-time training staffs at the Center and in Provinces is expected in 1983-5 and should create conditions for the necessary upgrading.

The intensive 8-10 week programs for 40 to 60 participants from the Center and selected Provinces are designed especially for upgrading training staffs and to contribute to the necessary upgrading under these conditions.

3. The diarrheal disease mortality/morbidity reduction program will be administered by the Directorate for Control of Diseases of Direct Transmission of the Directorate General for Communicable Disease Control (CDC). Signatory authority will reside with the Director General for Communicable Disease Control or his designate. Annual workplans will be developed for this project component by CDC in collaboration with USAID.

As responsibility for epidemiologic surveillance activities relating to diarrheal diseases resides partly in the Subdirectorate for Surveillance of CDC, this unit will be involved as well. Training will involve not only the CDD unit, but responsibilities for design, performance and evaluation of training will be cooperative efforts with the Ministry's Center for Education and Training (PUSDIKLAT) and Directorate for Health Education (PKM).

Aside from the activities (budget) directly operated by the CDD unit, it has major advisory activities for diarrheal disease management in the country's 5000 public health centers (PUSKESMAS) directed by the Ministry's Directorate General for Community Health Services (BINKESMAS) and by local governments. Also, it has a similar advisory and guidance role, of lesser degree, for diarrhea related work in the country's hospitals, directed by the Directorate General for Hospital Services (YANKESMAS). This Project recognizes these important inter-relationships and will work to strengthen them.

The Ministry of Health has declared that the CDD program will strive to be as integrated as possible with other basic services, with special emphasis on integration at the Kabupaten level and below. This project will work to strengthen activities toward that goal.

## VI. Monitoring Plan

The recent combination of the Family Planning Division with the Health and Nutrition Division provides some flexibility for USAID backstopping, but since current projects are continuing - and, if fact, expanding - and there is actually a decrease in the total newly combined staff, monitoring will be a challenge. It will continue to be essential for advisors to indicate to O/PH staff recommended areas requiring action as part of the monitoring process, as appropriate, along with their technical assistance functions.

USAID's Legal, Program, Finance Management and Contract Offices will work directly with the Health staff, as required in project execution.

Monitoring functions are carried out in regular meetings with appropriate Health Ministry staff, with other agencies, during field visits, through analysis of periodic reports and statistics as well as special reports and analyses as required.

## VII. Project Analyses

The most directly relevant analysis to this project extension is the evaluation team's report recently completed. This provided an independent judgement that the project should be extended, that, with modifications, the planning and manpower development component should be continued, and that the research and development component had promising aspects after a slow start. The team also recommended that efforts be continued to develop more effective Management Information Systems. Finally the team suggested that an action program, such as the diarrhea component, be undertaken. This correlated closely with the Mission's views and those of the consultants working on the project - although the choice of the diarrhea component was USAID's based upon the priority assigned to it in this January's CDSS document (and in AID/W's Health Strategy statements). This in turn was based upon a Health Sector Background paper prepared just prior to the CDSS itself. In addition 3 field studies were undertaken in 1982 and early 1983 by USAID and GOI on Diarrheal Disease Control (including cholera). These are available in USAID's project files.

An exercise "Mapping of Health Services Research" covering a health research identification and design process was carried out from January to March 1983 to make research "client oriented" and more directly relevant to Ministry of Health decision making. This experience is directly related to the refined approach to research and development to be continued in the Project extension.

The social and economic analyses in the PP when this project was originally approved have been reviewed and are considered still relevant in the main. The major modification to update them with the addition of a major focus a diarrhea control is that the social benefits can be substantially increased since diarrheal diseases are a major cause of death in children under 5 and exacerbate morbidity and malnutrition. The economic benefits from reduced mortality/morbidity strengthen the

previous economic conclusions. Flattening out of oil revenues do clearly make the ability of the GOI to continue expanding health care at past rates of increase more difficult, but make even more important the focus on planning and improved efficiency which are at the heart of this continuation.

The administrative arrangements discussed in the original project paper reflect the current situations as well. While improvements are being made, the basic structure has not changed. The newly expanded component - the diarrheal disease mortality/morbidity reduction program - will be administered by the sub-directorate of Control of Diarrheal Diseases (CDD) under the Director General for Communicable Disease Control. The relationships for administering this program are discussed in detail in the implementation plan.

### VIII. Conditions and Covenants

First Disbursement. Prior to the first disbursement under the Loan, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Borrower will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) An opinion of the Minister of Justice of the Borrower that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Borrower, and that it constitute a valid and legally binding obligation of the Borrower in accordance with all of its terms; and

(b) A statement of the name of the person holding or acting in the office of the Borrower specified in Section 9.2, and of any additional representative, together with a spicemen signature of each person specified in such statement.

#### Special Condition Precedent for Management Information System Component

Before AID shall agree to disbursements from AID Project resources for MIS commodities, the Ministry shall provide to AID, in form and substance satisfactory to AID:

- a) An agreed Ministry implementation plan for Management Information System development, with resource requirements identified and set aside to meet the plan; and
- b) Evidence that a position, or unit, has been created within the Ministry organization with official responsibility for the management of MIS development and this position filled by person(s) whose major function is the management of this MIS development process and with the necessary authority to do so.

Special Covenants.

Project Evaluation. The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter: (a) evaluation of progress toward attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems; and (d) evaluation, to the degree feasible, of the overall development impact of the Project. The composition of the evaluation team shall be mutually agreed upon prior to the initiation of such an evaluation program, and may include external technical assistance from various sources.

Training. the Borrower agrees that it will budget sufficient funds from sources other than A.I.D. for international transportation cost of participants who will receive long-term training (one year or more) under the Project.

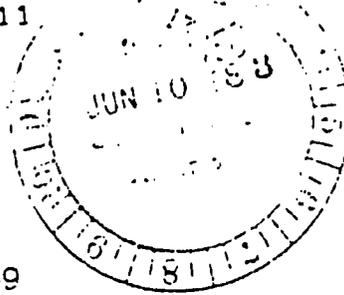
IX. Evaluation Arrangements

With the evaluation just completed as a major basis for the shape of this project extension, the value of the evaluation process is reenforced. The general approach originally adopted remains generally valid except for the need for an additional evaluation toward the end of this project. In addition, special efforts to establish baseline data for the diarrhea control component should be undertaken as an early emphasis in this project component. A special evaluation of the diarrhea component will be undertaken for in late 1984 to provide a basis for deciding what further action USAID might take in this field to support the GOI programs.

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TAGS

SUBJECT: HEALTH TRAINING, RESEARCH AND DEVELOPMENT  
PROJECT (497-0273) REQUEST FOR PACE EXTENSION

REF: JAKARTA 7156

1. AA/ASIA HAS APPROVED REQUEST TO EXTEND PACD OF  
SUEJECT PROJECT FROM SEPTEMBER 30, 1984 TO SEPTEMBER  
30, 1987 AND AN INCREASE IN LOP FUNDING BY DOLS 6,420,000  
TO A NEW TOTAL OF DOLS 10,900,000.

2. COPIES OF APPROVED MEMO TO BE POUCHED ASAP. EAGLEBURGER

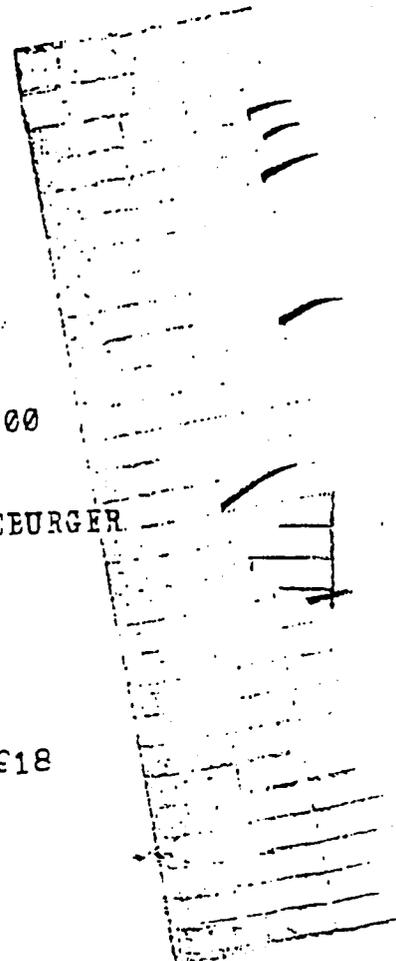
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Best Available Document

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

Project Title: Health Training Research and Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>PROGRAM OF SECTOR GOAL:</u> (The broader objective to which this project contributes).</p> <p>To make health program more effective and responsive to the health needs of the poor in terms of both coverage and quality.</p>	<ol style="list-style-type: none"> <li>1. Activities of planning, personnel and training at center and in 50% core provinces fully coordinated.</li> <li>2. Health Service activity plan linked to manpower plan at center and in 50% of core provinces.</li> <li>3. Plan implementation monitored and used as input in future plan cycles at center and 50% of core provinces.</li> <li>4. Training linked to job descriptions for key medical and para-medical staff.</li> <li>5. Career system linking job requirement to individual skill development designed and initial steps completed in 50% of the core provinces.</li> </ol>	<ol style="list-style-type: none"> <li>1. Plan documents, annual reports from Provinces, Pusdiklat, Personnel.</li> <li>2. Binkesthas, YarkesMas annual reports.</li> <li>3. Annual plan document - planning bureau.</li> <li>4. Curricula Development Reports.</li> <li>5. Operational manuals, personnel procedure manuals.</li> </ol>	<p>The existence of commitment at the Center and Provinces to the integration of manpower management.</p> <p>Adequate information system development.</p> <p>Commitment of resources to support initiatives at Center and Provinces.</p>
<p><u>PROJECT PURPOSE:</u> To strengthen the public health planning, research and education capabilities of the DDI in such a way as to contribute to goal achievement.</p>	<ol style="list-style-type: none"> <li>1. Key staff in planning, training and personnel at center and province receive specialized training and practice, with special emphasis in core provinces.</li> <li>2. Coordination committees at the center and core provinces formed, meeting regularly and providing policy and executive guidance.</li> <li>3. A coordinated manpower information system in place and operating.</li> <li>4. Relevant research executed and the results being used by</li> </ol>	<ol style="list-style-type: none"> <li>1. Project reports on staff training.</li> <li>2. Committee reports and action plans.</li> <li>3. Data/Information outputs Center and Province,</li> <li>4. Research and Implementation reports,</li> </ol>	<p>Coordination committee is substantive and has delegated authority.</p> <p>Information coordination unit formally established in Ministry organizational structure.</p> <p>Client Orientation of Research staff is developed and sustained.</p>

Sp

**OUTPUTS:**

**A) PLANNING**

**Manpower Planning**

**(Integration)**

1. Annual manpower planning established and running as a routine process at the center.
2. Core provinces integrated with the center in a bottom up planning process.
3. Monitoring of manpower plan integration established and running in province and center.
4. Planning, training, personnel processes coordinated at the center and in core provinces.
5. Provincial and center unit provided with training in manpower planning methods and application.
6. Well-functioning relationship, including integrated decision-making re HRD between Manpower Planning, Production, Personnel and Community Health Services (BirkesMas and YarkesMas) at national level and in at least six Provinces.
7. Integrative processes monitored for effectiveness and cost and improved.
8. Beginnings of joint staff development programs processes under way for using experiences in selected Provinces for

1. Written protocols and procedures prepared and at least one annual manpower plan encompassing 27 provinces issued.
2. At least 50% of the core provinces have written protocols and procedures for annual manpower planning and submit at least one annual manpower assessment to be used in annual plan preparation.
3. Requirements for monitoring defined at center and core provinces. At least one report on plan implementation prepared by 75% of the provinces and by the center.
4. High level manpower management committees formed at center and core provinces and meeting at least once a year. At least 75% of staff planned for core provinces in a given year trained and recruited into the province.
5. At least one workshop held for all provincial manpower units. Two annual workshops held for core provinces and central staff. Short and long term training for central manpower planning staff and for one member of each of the planning units in core provinces.
6. Continuing mechanisms and regular meetings between staffs in above units at policy and at operating levels, at the center and in selected provinces and between Center and Provinces.
7. Use of information from two or more studies carried out by 1984/1985.
8. Two staff development programs with participants from partner units in MOH. Processes exist. Three more provinces have begun

1. Manual, Annual Manpower Plan.
2. Manual.
3. Biro Perencanaan Report.
4. Committee reports, Biro Kepegawaian records reports.
5. Workshop reports and project training records.
2. Studies and follow-up data.
3. Plans and reports; participants lists.
4. Written progress reports; interview.

- MOH continues to support integrated approaches and decision-making by HRD units and inselected Provinces.
- MOH continues support for dissemination and building on experience in selected Provinces in other Provinces.
- Manpower unit is institutionally established at the center and a head of unit appointed.
- Central commitment to strengthening provincial role is confirmed.
- Management committee is given necessary authority to discharge responsibilities.
- Information system center established with necessary skills and authority to guide informations system development.
- Commitment exists to expanding annual plan process from fiscal base to include manpower.

developing HIS in integrated fashion in other Provinces.

(SERVICES DIRECTORATES-GENERAL, BINKESMAS AND YANKESMAS)

9. Regular active participation in of manpower information system manpower planning and development in collaboration with the Bureaus of Planning and Personnel and Puskesmas, both at Pusat and Provinces.

10. Strengthened procedures for conducting and using performance oriented monitoring and evaluation of service units, with special attention to paramedical and managerial manpower utilization.

11. Kabupaten - and Puskesmas (Primary Health Center) - level experimentation with staff, facilities and organization designs and mechanisms for widespread learning from this action research.

establishing their integrative mechanisms and processes.

9. Level and regularity of participation in collaborative mechanisms with planning, personnel and Pusdiklat at Pusat and in Province.

10. Strengthened procedures for performance-oriented monitoring and evaluation established, funded and used for policy development and decision-making

11. 3 (three) longitudinal action-research studies under way in service-delivery areas (Kabupaten), Puskesmas and referral hospitals) in collaboration with the communities in focus.

PERSONNEL MANAGEMENT

1. Improved operations within Biro Biro Kepegawaian:

- a. improved staff capability and performance in the office procedures in Biro Kepegawaian.
- b. Improved management planning and control in the activities of Biro Kepegawaian.

2. Improved capability of health manpower management by introducing:

- a. career analyses and their interpretation.
- b. manpower projections and their use and encouraging more integration within Pusat.

3. Improved operations within provincial personnel units arising from improved staff capability and performance.

PERSONNEL ADMINISTRATION

Reject rate by BAKN of applications because of incomplete or incorrect supporting documents decreased from current values. Proportion of cases processed in the same year should be 90% staff productivity increases.

Fewer complaints, less dissatisfaction from management and staff with operation of career system.

Fewer mismatches between plans, provisions of posts, training and recruitment.

Reject rate by Biro kepegawaian of applications because of incomplete or incorrect supporting documents decreased from current values.

PERSONNEL ADMINISTRATION

Biro Kepegawaian records reports.

Biro Kepegawaian records/reports.

Biro Kepegawaian records.  
Provincial personnel unit records.

PERSONNEL ADMINISTRATION

Biro Kepegawaian managers at each level must be able to train subordinates adequately.

Ministry of Internal Affairs and governors agree to staff training job specifications.

4. Improved capability for Health Manpower Management in Provinces.

Fewer mismatches between announced plans, training, recruitment.

C. TRAINING

1. Training teams developed in core Provinces each supported by network of additional trainers and by formal structure in Provincial Government that integrate training with planning, personnel, health services delivery units and manpower information and operational research services.

2. Pusdiklat's services and organization at Central MOH reoriented to support these new capacities in Provinces and coordinate manpower production with national plan.

3. Central consultancy units established to maintain unified standards and maximize system learnings nation-wide.

4. Pre-service education of paramedical manpower and of administrators more closely related to organizational as well as technical requirements.

5. In-service training more directly related to work and career structures.

TRAINING

1. Core training team established in 6 - 8 provinces. It produces annual training plan for Province and staffs it; also professional and system development plans. It is actively linked with multi-dimensional formal mechanism for manpower development in province and with national networks and with Pusdiklat.

2. Policies developed centrally to guide Provincial training plans, facility and program development, and budgets and to coordinate them nationally.

3. Frequent pre-planned and ad hoc contact between Pusdiklat and Provinces for developing and maintain standards, information and resource exchange, materials and professional development, as well as for administrative and coordination purposes.

4. Processes established for developing and revising standards and accreditations based on competent practice.

5. Consultancy unit established at Pusdiklat with primary task of supporting trainer and training system development in Provinces. National network of consultants established and anchored in core Provinces - i.e., those identified to help other Provinces in turn (e.g., Sumatera Barat, Sulawesi Selatan).

6. Task analysis and job description process established for nursing and management tasks, used in pre-service education and routinely updated.

1. Quarterly and annual reports.
2. Guidelines; Provincial plans etc. as part of routine planning cycles.
3. Reports (various and standard)
4. Draft standards and processes (in writing); procedure for testing and revision.
5. Organization chart and budget membership list; task assignments; reports.
6. Curricula; plans and reports revision.
7. Written career profiles for nurses and Kabupaten Administrators; training reports.

Re Outputs

- Activities and travel funds for Indonesian trainers, consultants and participants included sufficient amounts in yearly budgets at center and provinces.
- Staff time for preparation follow-up of training programs and for training and consulting system development is provided and funded.
- MOH/GOI maintains high interest in services performance and evaluates and supports Pusdiklat's contribution to this.
- MOH/GOI maintains high interest in having successful initiatives contribute to nation-wide learning and service improvements.

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7. Career profiles developed for nurses and Kabupaten-level administrators, used in in-service training and routinely updated.

**MANAGEMENT INFORMATION SYSTEMS (MIS)**

Integrated manpower information networks in place and working to provide managerial information on planning, training, personnel and selected operational elements of the Ministry at centre, at provinces and at BKKBN.

1. Information requirements for planning, training, personnel and user management specified.
2. Regular manpower reports and analyses sent to all units in Pusat according to agreed schedules.
3. Ad hoc manpower reports and analyses issued to all units in central MOH on request.
4. Staff in all provinces trained to provide specified data to central MOH institutions.
- c. Staff in all provinces trained to produce and use basic reports and analyses of provincial manpower situation.

1. Inspection of annual schedule of regular reports and analyses produced by computer department.
2. Inspection of list of ad hoc manpower reports and analyses produced by computer department.
3. At least one complete year of specified data inputs submitted.
4. Training of provincial staff completed.

MOH makes resources available in computer department to cope with extra work.

Ministry of Internal Affairs and Governors agree to staff training.

**RESEARCH AND DEVELOPMENT**

) A more decentralized and client-oriented process of research identification, selection, implementation leading to timely application of research results.

At least 10 Studies completed according to the existing Client-Oriented approach. At least 5 of these studies should be implemented by extramural institutions. In either case, the study results delivered on time to client organization(s), and results incorporated in changes in practice in manpower planning/management/training personnel utilization, health care financing or pharmaceutical delivery/utilization.

- Project Implementation Letters-providing research support.
- Research Progress reports.
- Consultant Contracts; scopes of work; and written reports.
- Unit Implementation reports; Conference documents.
- Periodic assessments by Project Officer.
- Special reviews/evaluations.

- Commitment to client-oriented research training and process development.

- Commitment to encouraging participation of Universities in generation and implementation of needed applied R&D on the issues/topics outlined in the first column (Narrative Summary).

Annex B

Draft Logframe for Diarrhea Component

<u>Purpose</u>	<u>Method to Accomplish</u>	<u>Means of Verification</u>	<u>Assumptions</u>
Improve effectiveness of surveillance system	1) Evaluate quality, analysis and timeliness of data presently available.	Evaluations of quality, level of analysis and timeliness of data flowing in system.	
	2) Recommend methods for improving and supplementing baseline data now available.	Evaluate effectiveness of routine surveillance and sentinel areas in documenting trends and unusual events in diarrheal diseases.	
	3) Recommend alterations in routine and sentinel surveillance systems.	Evaluate management of surveillance data at central level.	
	4) Assess data processing equipment and training needs. Provide equipment and training.	Compare relative standards and effectiveness of reference laboratories.	
	5) Establish official reference laboratories for diarrheal disease microbiology.		
	6) Assign epidemiologist consultant for at least one year, and other STCs as necessary, to assist.		

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Purpose

Method to Accomplish

Means of Verification

Assumptions

Document the impacts of diarrheal diseases, and the knowledge, attitudes and practices of the population to toward diarrheal diseases.

Special field studies and data reviews to demonstrate impacts of diarrheal disease in economic and social terms as well as mortality and morbidity terms.  
Special field studies of population's knowledges attitudes and practices regarding diarrheal diseases.  
Short-term consultants.

Evaluation of special studies and how results are used.

That field studies in several locations expected to show variations will describe reasonably well the variability around the country as a whole.

Strengthen quality and modestly expand coverage of proper ORT, especially for children, by health personnel and the general population.

Field studies to assess strengths and weaknesses of past and existent ORT programs in Indonesia through various sponsoring organizations.  
Small field trials of new approaches in techniques, support and monitoring ORT programs, through government and non-government organizations.  
Long-term consultant operations officer for at least one year; additional short-term consultants as necessary.

Surveys on KAP toward oral rehydration.  
Hospital and clinic records. Coverage surveys.

Handwritten initials or mark.

<u>Purpose</u>	<u>Method to Accomplish</u>	<u>Means of Verification</u>	<u>Assumptions</u>
Strengthen CDD training program for public and private practitioners, non-technical decision makers at several levels, and for the general population, especially parents of young children.	<p>Assess effectiveness of existent training materials and methods.</p> <p>Design and test new approaches as necessary.</p> <p>Expand coverage of successful approaches as resources permit.</p> <p>Design different training programs for health care providers, managers, and other decision makers.</p> <p>Design special training approaches for parents and elder siblings.</p> <p>Short-term consultants as necessary.</p> <p>Visits to special training programs in other countries.</p>	Survey quantity and quality of information retained and practiced after training.	
Provide information to government upon which to base decisions for alternate means of production of ORS.	<p>Assess capabilities and costs for different levels of ORS production through public sector at national, regional and local levels.</p> <p>Assess capability, costs to consumers and potential regulatory issues of ORS production and marketing through the private sector.</p> <p>Assess experience thusfar in Indonesia with different methods of making home-based solutions.</p> <p>Further test, as necessary, alternative systems for cottage industry and village/household level ORS constitution.</p>	Periodic assessment of production problems, costs, marketing issues, public acceptance, quality control, effectiveness of regulatory controls, reliability of supply, percentage of "market share" for each at village level, in urban areas, and in hospitals.	That GOI policy will remain one of encouraging private sector, public sector and household production of oral rehydration salt mixtures.

Annex C

STATUTORY CHECK LIST

A. GENERAL CRITERIA FOR PROJECT

for FY 1983 (P.L. 97-377)

The committees on appropriations of Senate and House were notified of this project amendment through a Technical Notification to the June 9, 1983 advising AID's intention to increase the the grant level and to use loan funds also.

2. FAA Sec. 611(a)(1).

Yes, cost estimates are based on past project experiences and current known prices for commodities and services

1. Second Continuing Resolution

FY 1982 Appropriation Act;  
Sec. 523; FAA Sec. 634;  
Sec. 653(b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project; Congress on

(b) Is assistance within (Operational Year Budget) country or international

organization allocation reported to Congress (or not more than \$1 million over that amount?

Prior to obligation in excess of \$100,000, will there be

(a) engineering, financial other plans necessary to

carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

3. FAA Sec. 611(a)(2)

If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No further legislative action is required.

4. FAA Sec. 611(b); FY 1982

Appropriation Act Sec. 501.

N.A.

If for water or water-related land resource construction, has project met the standards and criteria as set forth in international trade; (b) foster private initiative and competition; and the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973?

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5. FAA Sec. 611(e).

If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N.A.

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs

No

7. FAA Sec. 601(a).

Information and conclusions whether project will encourage efforts of the country to:  
(a) increase the flow of  
(c) encourage development and use of cooperatives, and credit unions, and savings and loan associations;

N.A.

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(d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

8. FAA Sec. 601(b).

Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N.A.

9. FAA Sec. 612(b), 636(h);

FY 1982 Appropriation Act Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

GOI will gradually assume ongoing local costs obligations.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
12. FY 1982 Appropriation Act Sec 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N.A.

13. FAA 118(c) and (d). Does the project take into account the impact on the environment and natural resources? If the project or program will significantly affect the global commons or the U.S. environment, has an environmental impact statement been prepared? If the project or program will significantly affect the environment of a foreign country, has an environment assessment been prepared? Does the project or program take into consideration the problem of the destruction of tropical forests?
- This project will have no adverse environmental impact. This project for health manpower development and reduction of disease through simple non-toxic therapies
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?
- N.A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance  
Project Criteria

a. FAA Sec. 102(b), 111,  
113, 281 (a).

Extent to which activity will  
(a) effectively involve the  
poor in development, by  
extending access to economy at  
local level, increasing labor-  
intensive production and the  
use of appropriate technology,  
spreading investment out from  
cities to small towns and  
rural areas, and insuring wide  
participation of the poor in  
the benefits of development on  
a sustained basis, using the  
appropriate U.S. institutions;  
(b) help develop cooperatives,  
especially by technical  
assistance, to assist rural and  
urban poor to help themselves  
toward better life, and other-  
wise encourage democratic  
private and local governmental  
institutions; (c) support the  
self-help efforts of developing

Yes

countries; (d) promote the participation of women in the national economies of developing countries of women's status; (e) utilize and encourage regional cooperation by developing countries?

- b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used? Yes
- c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N.A.
- d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Yes

e. FAA Sec. 110(b).

Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

No

f. FAA Sec. 122(b)

Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes

g. FAA Sec. 281(b).

Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental process essential to self-government.

This project will strengthen Ministry of Health institutional capability to plan, implement, training, and management of public health personnel; applied research and community health education.

h. FAA Sec. 133.

Notwithstanding any other provision of this joint resolution, none of the funds appropriated under section 101(b) of this joint resolution may be available for any country during any 3-month period beginning on or after October 1, 1982, immediately following the certification of the President to the Congress that such country

N.A.

is not taking adequate steps to cooperate with the United States to prevent narcotic drugs and other controlled substances (as listed in the schedules in section 202 of the Comprehensive Drug Abuse and Prevention Control Act of 1971 (21 U.S.C. 812) which are produced, processed, or transported in such country from entering the United States unlawfully.

2. Development Assistance  
Project Criteria (Loans  
Only)

a. FAA Sec. 122(b)  
Information and  
conclusion on capacity of  
the country to repay the  
loan, at a reasonable  
rate of interest.

The GOI is able to repay the  
loan.

b. FAA Sec. 620(d).

If assistance is for any productive enterprise which will compete with U.S. enterprise, is there an agreement by the recipient country to

N.A.

prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

c. ISDCA of 1981, Sec. 724(c) and (d). If for Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)?

N.A.

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a).

While this assistance promote economic or political stability? To

N.A.

the extent possible, does it reflect the policy directions of FAA Section 102?

b. FAA Sec. 531(c).

Will assistance under this chapter be used for military, or paramilitary activities?

N.A.

c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance of, or the supplying of fuel for a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives?

N.A.

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N.A.



REPUBLIC OF INDONESIA  
NATIONAL DEVELOPMENT PLANNING AGENCY  
JAKARTA, INDONESIA

No. : 1828 /D.I/8/1983

Jakarta, August / , 1983

Dr. William P. Fuller  
Director  
USAID  
American Embassy  
Jakarta

Re : Health Training Research  
and Development

Dear Dr. Fuller,

On behalf of the Government of Indonesia, we hereby request a loan of \$ 2,6 million and a grant of \$ 3,8 million over a four year period to continue two of the sub-projects of the original project, Planning of Manpower Development and Research, and add two components implied in the original design : Management Information Systems, and Diarrheal Disease Mortality/Morbidity Reduction. This new assistance would increase the project to the total of \$ 10,9 million with an \$ 8,3 million grant component and a loan of \$ 2,6 million.

This project will be implemented by the Ministry of Health.

Looking forward to your favorable consideration.

Sincerely yours,

Mochtarudin Siregar  
Deputy Chairman

FAA, Section 611(e) Certification (not applicable)

In view of the importance of the role of the evaluation team to extending this project, the team's findings and recommendations in the executive summary are quoted in full as follows:

Health Training, Research and Development Project

Mid-Project Evaluation

Executive Summary

Finding and Recommendations of the Evaluation Team

Through a series of interviews with key MOH officials, USAID/Jakarta staff, Project long term and short term consultants and the review of a considerable body of documentation, the Evaluation Team found the project to be well-conceived and necessary. It has undergone modification since its inception in 1977-78, as documented in specific sub-project workplans, focusing upon the manpower aspect of health planning, training systems development and upon 'client-oriented' research capabilities. Activities at the provincial and local levels were found to be "appropriately" emphasized.

Annex F-2

The Health Planning Sub-project has progressed towards its objectives, but subject to a series of delays and deficiencies. These are attributable to higher priority MOH activities, staff shortages, changes and reorganization, and to restricted information flow particularly between central and provincial data sources. Despite these difficulties, the consultants have established excellent working relationships with their counterparts and have encountered interest, enthusiasm and a willingness to learn. Many problems originate from a traditional, highly centralized decision-making hierarchy, the resolution of which will depend upon engendering confidence and ability to make rational decisions locally.

The need for well constructed, useful job descriptions has been identified as key to the success of this subproject. Collaboration with the Bureau of Personnel has been delayed and is now scheduled to begin in May 1983. The Evaluation Team views the delay as a major impediment to the subproject but believes that the way is now clear for progress to be resumed.

Activities with the Bureau of Planning and with the Center for Education Training are now progressing satisfactorily. The development of the Comprehensive Manpower Information System has experienced several changes of direction and is now to be incorporated into a comprehensive Management System that will contain several other information elements including the Health Center (PusKesMas) sub-system.

The Health Research and Development project has attained little success. The project consultants have conducted educational activities at both central (LitBangKes) and provincial levels designed to stimulate identification and problem-solving research projects. One project, a study of staff activities in a group of Health Centers, has been completed. The information gathered has been utilized extensively in the construction of the Fourth Five-Year Plan. A number of other projects are under consideration.

Responsibility for the slow rate of progress must be placed upon the USAID contractor who has been unable to find a long term consultant with the necessary prestige, expertise and institutional backing that would ensure his credibility.

The Evaluation team recommends that the project continue with expansion and redirection. In particular, changes in the procurement of long term and short term consultants are proposed.

The Health Planning Sub-Project should continue as presently constituted, with additions of long term and short term consultants to work at the provincial level and provision of training in management and administration for up to 40 institute principals, trainers and central staff, either abroad or in-country. Expansion of the Center for Education and Training's staff is recommended to the MOH, also reinforcement of facilities locally.

Sequential expansion of activities to 8 new provinces over three years is also proposed. Review of the plans for a Comprehensive Manpower Information System in May-June 1983 by a CT consultant is recommended.

Recommendations for the redesign of the Research and Development Sub-Project are made. In particular, linkages with other national and international research institutions are proposed using the 'paired investigator' concept, among others. The recruitment of a long term consultant with extensive experience in the field, with knowledge of research management, with a record of substantial accomplishment and with a strong and appropriate institutional backing is recommended. Short term technical expertise is also required on an 'as needed' basis.

Recommendations for alternatives have been proposed for USAID-assisted interventions in the health sector in Indonesia. These include extension of integrated health activities to the kabupaten level including strengthening of planning, management, manpower and research, together with a series of categorical programs designed to reduce mortality of infancy and early childhood. Exploration of needs to assist other administrative and executive units basic to health care delivery at central, provincial and kabupaten levels is recommended.

Finally, programs directed toward the elimination of selected nutritional deficiencies including goiter, hypovitaminosis A and iron-deficiency anemia should be considered.

Annex G

In order to provide information on the program history and plans of the MOH on diarrheal disease control, a translation of the latest summary report on this subject, "Program for Diarrhea Control in Indonesia" is quoted in full (in translation) as follows:

PROGRAM OF DIARRHEAL DISEASE CONTROL IN INDONESIA

1. Introduction

Diarrhea is one of the major public health problems because of its high morbidity and mortality. Each year, the morbidity rate in Indonesia is about 200-400 per 1,000 inhabitants (about 60 million episodes). Most of the children aged under 5 years (70-80%) suffer from this disease. About 3-5% of them fall into dehydration when they are not treated; 50-60% of these will die. It is this situation that makes the number of deaths of children aged under 5 years at 350,000 - 500,000 each year. These diseases frequently emerge as epidemics; each year about 200 such events are reported, with about 30,000 - 50,000 patients.

Based on experience with modern technology and methodology, namely rehydration programs (particularly oral rehydration, the Case Fatality Rate (CFR) of 36.8% in 1969 was reduced to 2.5% by 1982. Due to various factors, no changes in the incidence are predicted in the near future.

2. Background of Program

The WHA (World Health Assembly) Resolution in 1978 reaffirmed that diarrhea is the cause of high mortality in children aged under 5 years. Moreover, it is recommended that each member country should develop the program of diarrhea control, including training and research.

Annex G-2

In line with the National Health System (SKN) by Year 2000, all diarrhea patients should be able to be covered by the health service system, both by formal health service and efforts made by private sector/community (Primary Health Care).

Since 1981 the target of cholera and gastroenteritis control has been developed into diarrhea control. The plan for achieving the target of the Diarrhea Control Program by year 2000 is found in planning documents. The targets are: - detecting and treating diarrhea patients; coverage; and Puskesmas P4D (CDD). The impacts of activities are: declining morbidity rate and mortality rate.

Targets for Work	Pelita III	Pelita IV	Pelita V	Pelita VI	Year - 2000
<b>1. <u>Activities Target:</u></b>					
- Contact and Treatment of diarrhea cases	14.3 million	27.7 million	29.3 million	44.2 million	43.1 million
- coverage	23%	45%	70%	95%	100%
- Health Centers participating in CDD "special program"	1,200	2,650	4,525	6,700	7,200
<b>2. <u>Impact of Activities:</u></b>					
- number (%) sick	40%	35%	29%	22%	20%
- number (%) dying	2.8%	2 %	1.2%	0.3%	0.15%

### 3. Results Achieved in PELITA III

#### a. Upgrading:

2,000 officers and 1166 doctors, in clinical, epidemiological, laboratory and management aspects.

b. Epidemic intermention - each year about 200 outbreaks are handled.

c. Developing regency laboratories to isolate diarrhea agents: East Java 13 regencies; Central Java, 13 regencies; West Java, 7 regencies; D.I. Aceh, 2 regencies.

d. Adding 477 PusKesMas into the P4D (CDD Program) (from 1981 to 1983) and establishing 30 sentinel areas.

e. Epidemiological impact: Reducing the CFR.

### 4. Constraints

#### a. Manpower:

- Volume of work keeps increasing, whereas personnel in PusKesMas are inadequate, both in quantity and quality.

- Many of the upgraded personnel do not spend much time on diarrhea control.

#### b. Organization and administration:

- Health organization in PusKesMas, Regency and even in Province is not well established.

- The reporting system is not perfect yet; it is still in development.

c. Technical policy:

- There are still many health personnel in PusKesMas and hospitals who do not realize the benefits of oralit/salt and sugar solution for patients with diarrhea.
- Many of the hospitals still use different methods of treating diarrhea.
- It is still difficult detecting mode of transmission for an epidemic.

d. Management:

- Heads of health services in different levels are insufficiently sensitive towards KLB (extraordinary events), so that KLB becomes a prolonged epidemic.
- There are still some people who think that epidemics are projects for central office management and that the central office will bear all control burdens.

e. Budget and facilities:

- Budgets from Development Budget (DIP) for P3M (CDC) are not sufficient any longer because of change in the target of activity, namely from cholera to diarrheal diseases.
- Lack of laboratories and analysts in provinces and regencies.
- InPres Program, NFPCB, Nutrition Programs, P3M (CDC) all provide oralit for diarrhea. Lack of coordination for its operational use.

- Standards of salary, wage/field money for sub-district officers are very low, particularly in the areas in which transportation is difficult (NTT, Irian Jaya, Maluku, etc.).

- Lack of follow up support and supervision for rural volunteers who have been established.

5. Expectations at the end of Pelita III and Pelita IV:

The operational targets of Diarrhea Control are as follows (Pelita IV):

- a. Incidence of diarrhea.
- b. Coverage: - served by health facilities, and  
- served by Primary Health Care.
- c. Intervention of KLB (extraordinary events)
- d. Puskesmas P4D (inclusion in CDD program).
- e. Upgrading of rural personnel.

In order to achieve the above-mentioned targets, the following policies are needed:

- a. Improving the integration in Puskesmas and village, supported by the echelons above them.
- b. Promoting cross-sectoral and cross-program cooperation.
- c. Increasing public/private sector participation.

d. It is necessary to disseminate the concept of P4D program in all meetings/consultations at all levels.

e. Integrated upgrading for PusKesMas/Hospital officers and rural volunteers.

f. It is necessary to established harmonious cooperation for planning, implementation and supervision with immunization, Mother and Child Health, NFPCB, Nutrition, etc because of common targets.

Targets for Work	Pelita III	Pelita IV	Pelita V	Pelita VI	Year 2000
<b>1. <u>Activities Target:</u></b>					
Contact and treatment of diarrhea cases	14.3 million	27.7 million	29.3 million	44.2 million	43.1 million
- coverage	23%	45%	70%	95%	100%
Health Centers participating in CDD "special program"	1200	2650	4525	6700	7200
<b>2. <u>Impact of activities:</u></b>					
- Number (%) sick	40%	35%	29%	22%	20%
- Number (%) dying	2.8%	2%	1.2%	0.3%	0.15%

Annex G-7

Year	Suspected cholera	Mortality	Case fatality rate	I.R. (per 100.000)
1978	23,945	1,231	5.1%	16.9
1979	31,516	1,491	4.7	21.7
1980	29,288	1,026	3.8	19.9
1981	31,928	831	2.5	21.7
1982	31,010	903	2.9	20.9

Targets For Pelita IV

Target	1984	1985	1986	1987	1988
a. Incidence diarrhea	62.5 million	62.4 million	62.1 million	61.8 million	59.6 million
b. Coverage	15.6 million	18.7 million	21.7 million	24.7 million	26.8 million
- served by medical services	65%	60%	55%	53%	50%
- served by Primary Health Care	35%	40%	45%	47%	50%
c. Epidemics resolved	200	160	120	100	80
d. Health Centers participating	1200	1500	2000	2500	2650
e. Number of villagers trained	275,000	357,000	445,000	504,000	558,000