

MID PROJECT REVIEW  
OF THE  
COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM -  
PROVINCE SPECIFIC

Prepared for  
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Sumatera Barat, Nusa Tenggara Timur,  
Planning Bureau of the Ministry of Health (GOI)  
and  
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Executive Summary

- . A mid-project review of CHIPPS was conducted to determine progress being made in achieving the project's objective of establishing an epidemiologic health planning approach in the three provinces of D.I. Aceh, Sumatra Barat and Nusa Tenggara Timur.
- . The review team established that virtually all activities agreed to between the GOI and USAID four years ago have been or are being carried out.
- . Although each province is at a different stage and undertaking different activities, highlights of achievements include: neonatal tetanus mortality surveys, tuberculosis prevalence surveys, intervention designs, work on a vital statistics/cause of death reporting system, development of system to support community-level nutrition-health program, and training in critical analysis skills and techniques, such as, epidemiology task analysis, and drug management.
- . Surveys carried out indicate that neonatal tetanus is accountable for 25% to 35% of deaths of children under one in two provinces.
- . Issues identified in the review focused on how the problem - identification/problem-solving approach was understood, practiced and was becoming part of the system.

- . Kabupatens are not being included in the planning process by provincial officials..
- . At province level too much of the project planning was being done by the pimpro.
- . Some local control over Pusat funds (Kakanwil's discretionary, supervision funds) plus Daerah and kabupaten funds constitute a significant source of currently available funds for local programming.
- . The organizational development training activities were not being followed-up sufficiently.
- . More information on the economic implications of CHIPPS approach or on the planning/budgeting process at the kabupaten and province levels would be beneficial for future orientation of health activities.
- . Inadequate information was available on future funding possibilities for Come and SPK activities after CHIPPS.
- . Delays in posting SPK graduates is a concern.
- . Provincial system to monitor project Loan/GOI fund distribution or loan reimbursement status needs to be strengthened with LTC and pimpro monitoring the process more closely.
- . Pusat-level officials generally were aware of CHIPPS but not familiar with details on policy implications of results of some of the activities. Bureau of Planning still has a need for assistance to orient, monitor process and advocate institutionalization at Pusat level.

. Based on findings, the following recommendations were made:

1. A facilitator be appointed at Pusat to focus attention on institutionalization and process issues;
2. More efforts be made to publicize CHIPPS activities, results, and policy implications at Pusat;
3. Greater emphasis be placed on institutionalization of CHIPPS approach (i.e., systemic/budgetary support that will ensure that epidemiologic planning will continue);
4. Broader-based involvement take place in CHIPPS planning at the province level to include the kabupaten and to coordinate among the subactivity project managers;
5. Long-term Indonesian consultants, who have undergone advanced training action-oriented/task analyses training approach, be appointed in all three provinces to follow-up and promote training/organizational development activities;
6. Quarterly Loan/GOI Disbursement and Reimbursement forms be adopted to facilitate financial management of the activities;
7. Studies be conducted on the economic implications of CHIPPS and planning/budgeting process at the kabupaten/province levels;
8. SPK curriculums and field activities be evaluated and problems with posting new graduates investigated; and
9. A process review be conducted in November 1986 to coincide with the 87/88 DIP planning cycle.

### Acknowledgement

The Review Team greatly appreciates the time and energy devoted to our field visits by the Officials and staffs of the three provinces. Their cooperation in answering sometimes difficult questions was generous. Their candor and honest appraisal of constraints within the CHIPPS Project as well as the Ministry's systems provided the material upon which this report is based. Without their constructive support, this review would not have been a meaningful exercise.

Dr. David Pyle was made responsible for preparing the initial draft of this review report; he is indebted to the team's contributions to the effort. The team's insights and willingness to explore the multiple aspects we were called upon to cover permitted the completion of the assignment. While each member of the team has been asked to review and comment on the final version of the report, any inaccuracy and misinterpretation of facts remains the responsibility of the review's drafter. We sincerely hope that this report is useful to the three provinces involved in CHIPPS and to DepKes in strengthening the project and in improving the quality of health services provided to their populations. We thank Ms. Molly Mayo Gingerich of USAID and Dr. Brotowasisto of the Bureau of Planning for their logistic and moral support of the Review Team.

Glossary

ACR	Activity Completion Report
APBD 1	Provincial Budget
APBD 2	Kabupaten Budget
APBN	National Budget
ARI	Acute Respiratory Infection
BAPPEDA	Regional Planning Board
BAPPENAS	National Planning Board
BKKBN	Family Planning Coordination Board
BK3S	Coordination Board for Private Voluntary Organizations in NTT
BMC	Supplementary Food
Bupati	Head of Kabupaten
Camat	Head of Kecamatan
CDC	Communicable Disease Control
CHIPPS	Comprehensive Health Improvement Program-Province Specific
CHS	Consortium for Health Sciences
COME	Community Oriented Medical Education
DepKes	Department of Health
D.I. Aceh	Daerah Istimewa Aceh
Dinas Kesehatan	Office of Provincial Health Service Implementation
DoKaBu	Head of Kabupaten Government Health Service
DUP/DIP	Budget and Programming System (Requested/Approved)

EPI	Expanded Program of Immunization
FETP	Field Epidemiology Training Program
Gizi	Nutrition
GOI	Government of Indonesia
HIS	Health Information System
HTRD	Health Training Research and Development Project
IFY	Indonesian Fiscal Year
IHS	Integrated Health Services
IMR	Infant Mortality Rate
INPRES	"Presidential" Funds (sent directly to local implementation unit)
Kabupaten	Regency (Sub-Provincial Administrative Unit)
Kader	Village Level Volunteer
KanWil Kesehatan	Office of Provincial Representatives of Ministry of Health
KaKanWil	Head of Provincial Health Services
Kecamatan	Sub-Regency Administrative Unit
Kotamadya	Municipalities
Litbangkes	National Institute Health Research and Development
LTC	Long-Term Consultant
MCH	Mother-Child Health
MOE	Ministry of Education
MOF	Ministry of Finance
NTB	Nusa Tenggara Barat
NTT	Nusa Tenggara Timur

O/PH	Office of Population and Health (USAID)
ORS	Oral Rehydration Solution
PIL	Project Implementation Letter
Pimpro	Project Director
PIU	Project Implementation Unit
PKK	Pendidikan Kesejahteraan Keluarga (Family Welfare Movement through Village Women)
PLKB	Family Planning Extension Worker
Pos Yandu	Integrated Services Post
P3M	Centers for Communicable Disease Control
Pusat	Central Government Level
Pusdiklat	Center for Education and Training
Puskesmas	Community Health Center
PVO	Private Voluntary Organization
Repelita	Five Year Plan
Rakerkesda	Provincial Health Conference
Rakerkesnas	National Health Conference
SPK	Sekolah Perawat Kesehatan (Nursing School)
SumBar	Sumatera Barat
TOTCA	Training of Trainers cum Change Agents
UPGK	Family Nutrition Improvement Program
USAID/I	United States Agency for International Development/Indonesia
WHO	World Health Organization
YIS	Yayasan Indonesia Sejahtera (Foundation for Indonesian Welfare)

## I. Introduction

The Comprehensive Health Improvement Program - Province Specific (CHIPPS) or P2KTP-1\* agreement was signed in September 1981. This mid-project review provides an opportunity to determine the project's progress in relation to the original agreement and objectives.

The review team, consisting of officials from DepKes in Jakarta, two CHIPPS provinces and a foreign consultant, visited the three participating provinces for approximately five days each between 26 April and 13 May 1985. The team leader was Azis La Sida (Planning Bureau, DepKes). Dr. David Pyle (John Snow Public Health Group, Inc.) was the one other member to visit all three provinces. A P2M & PLP (Communicable Disease Control) representative, Rajim Singalingga, MPH, joined the team in D.I. Aceh and Nusa Tenggara Timur (NTT). BinKesMas (Community Health Programs) was represented by Priyono Azhari in Sumatera Barat (Sumbar) and Soepriadi, MPH, (Community Participation Bureau) in NTT. Dr. Gusti Abdulchaliid from the Inspector General's office participated in the evaluation in Sumbar. Dr. Idrian Chadir of Sumbar was with the team in Aceh and NTT and dr. Soewarto Kosen of NTT in Sumbar. Dr. Timothy Mahoney, who heads the Evaluation section of the Program Office at USAID/Jakarta, was with the team in Aceh and NTT.

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\* Proyek Peningkatan Pembangunan Kesehatan Terpadu Propinsi-I

The review consisted primarily of interviews with the officials at the provincial and Pusat levels who have been intimately connected with CHIPPS activities during its three and a half years of operation (Attachment I). In addition, project field activities were observed and documents as well as records reviewed.

The Scope of Work (Attachment II) instructed the team to "assess project progress, analyze problems, suggest corrections and identify policy and program issues for future consideration." The team reviewed: (1) program activities that have taken place in systems development (surveys, trials and organizational development efforts), (2) manpower development (training and capacity building), (3) program administration and (4) process (constraints and institutionalization). These four aspects are described for each province. The individual province reviews are followed by a section discussing implementation of the program in all three provinces. Finally, a set of recommendations for institutionalizing an epidemiologic health planning approach in the three project provinces are presented. First, however, it is helpful to give an overview of the country background, project objectives and project history. For a more complete description of the project's history, the reader can refer to the Process Review of June 1984.

### I.1 Country Background

The health situation in Indonesia is similar to most developing countries: a high infant mortality rate (IMR) of approximately 100 per 1000 live births, considerable malnutrition, vitamin A deficiency blindness, death from diarrheal diseases, inadequate immunization coverage and ante-natal care as well as high prevalence of malaria and tuberculosis.

The resources, both human and financial, to address these health problems are limited. Outer island provinces like those included in CHIPPS may have less than Rp.1,500 or US\$1.50 per capita/year to respond to health concerns.

The government health sector is highly centralized. Priorities, programs and targets are identified, developed, planned and assigned at the national level. Plans are made according to central government (Pusat) guidelines and implemented according to programs designed in Jakarta. Health activities consist of a set of vertical programs - each province must implement some 15 programs and each puskesmas carry out 16 different communicable disease control (CDC) programs.\*

While the quantity of health services has increased in terms of manpower and facilities in the recent past, the GOI has become increasingly concerned that the quality has not kept pace. To upgrade health services, a major focus of Repelita IV (1984-89), significant and fundamental changes in the way rural health care is structured are being discussed. One important concept is integration of vital, life-saving interventions (nutrition, family planning, diarrheal disease control, immunization, maternal-child health). These integrated activities are meant to reduce infant mortality, a priority in Repelita IV. Another issue is the decentralization of health planning and programming which, in principle, will place greater responsibility at the provincial level to determine the content and management of the local health system.

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\* The CDC programs are: malaria, arbovirus, filariasis, vector control, rabies, tuberculosis, diarrhea control, leprosy, sexually transmitted diseases, intestinal parasites, immunization, surveillance, haj pilgrims, transmigration, quarantine, port health.

## I.2 Project Objective

Currently provinces have data collection systems that identify the nature of their health problems but these are used predominantly for central government planning.

One objective of CHIPPS is to develop the capacity in the project provinces to collect basic data on IMRs and age-specific causes of death. In the last several years the GOI has demonstrated a willingness in some cases to increase resources to be programmed by individual provinces. There is an expressed interest in building self-reliance at the provincial level, manifested by strengthening the local development planning bodies (BAPPEDA) and channeling increasing amounts of "Presidential" (INPRES) funds to provinces and kabupatens. CHIPPS was designed with the objective of improving the capacity of the provincial health staff to identify and solve their special needs.

CHIPPS is a "process project", which means that it is concerned mostly with accelerating the improvement in the quality of health care through the upgrading of the skills of staff to bring about changes in the way they and the systems respond to local health problems. In this light, CHIPPS must be viewed as a learning experience, and project activities a "field laboratory". CHIPPS will have succeeded when all levels from puskesmas staff to Pusat officials see things in terms of problem identification and problem solving at the point of service delivery.

The CHIPPS project paper referred to a desire of the GOI to decrease IMR to 75/1000 live births by 1990 and to increase effective health and nutrition services to mothers and children. Although interested in the impact of health services in the project provinces, CHIPPS was primarily concerned with the process or how the impact was to be achieved. Project activities did not consist of such traditional inputs as the construction

of facilities or provision of equipment; rather the main activities were capacity building, (i.e., health systems and manpower development).

The health systems development activities focus on the identification and solution of health problems affecting the province, kabupaten and individual puskesmas (health centers). To achieve the objective, emphasis is placed on epidemiologic surveys, studies on how to improve health services delivery, development of information systems, and management of a problem-solving approach.

The manpower development component includes the training of nurses, nursing teachers, rural sanitarians, laboratory technicians, village kaders (voluntary workers), medical school faculty and students in community medicine, health center doctors and staff, and provincial/kabupaten health and nutrition officials.

The review of such a project is difficult. CHIPPS can be reviewed quantitatively, e.g., personnel trained as against targets, money disbursed against total projected in the agreement. However, the most important activities must largely be described qualitatively. The review team must determine ultimately how far the province has moved on the spectrum from a largely Pusat directed and controlled health program to one in which priorities are determined on the basis of locally identified needs. This depends on provincial orientation and participation, but also on Pusat's receptivity and willingness to modify systems and perspectives. Progress in a process project is more difficult to observe. This review will describe the progress this innovative program is making as it nears mid-life.

### I.3 Project History

D.I. Aceh, Sumatera Barat and Nusa Tenggara Timur were selected because they represent a wide variety in terms of environment, level of development, socio-culture background and interests.

A number of problems slowed the early phase of CHIPPS. The project was initially 100% loan funded. In August 1982, a third of the \$9 million loan was converted to grant funds \* and project activities were greatly facilitated. Grant funds are required for innovative programming so that the benefits of a flexible problem-solving approach can be demonstrated.

Delays were experienced in locating and contracting the long-term consultant (LTC) that was to serve in each of the three provinces. Host country contracts were drawn up and underwent a very time-consuming review by USAID/I. One LTC was delayed five months, another six months. The consultants then underwent language training and assumed their post as follows:

Aceh	(Steve Solter)	Mid August 1983
NTT	(Allen Lewis)	Late February 1984
Sumbar	(Roger Feldman)	Mid August 1984

Because the LTC is important for orientation of the local staff and stimulation and follow-up of project activities, the delays in their arrival slowed project progress.

The Annual Budget for 1982/83 (DIP) was not approved until early 1983, some 16 months after the original loan agreement was signed. With the delay in receipt of project funds by the provinces and the late arrival of the LTCs, CHIPPS effective project life is at most two years (availability of project resources) but more accurately one to two (arrival of the LTC). Project activities and progress must be evaluated with this timeframe in mind.

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\* The GOI has committed to expend another \$9 million from its own budget in support of project-related activities. Recently, USAID and the GOI have agreed in principle to extend the project two years (until September 1989) and to add \$2 million of grant funds.

II. D.I. Aceh (26 April - 1 May)

The level of CHIPPS activity in Aceh continues to be high with the LTC having been in place for almost two years and the provincial orientation to the CHIPPS approach developing well. After having identified the nature and extent of several serious health problems in the province, project directors are designing interventions that will be implemented in the coming months. While the overall impression of the province's work is positive, continued emphasis needs to be placed on the organizational development and institutionalization aspects of project implementation.

II.1. Systems Development

The CHIPPS systems development activities in Aceh are divided into two types: field studies and trials; and organizational development efforts.

a) Field Studies/Interventions: Six field studies have been conducted. High-lights of the major studies are:

. Tuberculosis Prevalence Survey - Found high prevalence rates for pulmonary TB (1.1 % of the over 15 population vs. the national average of 0.3% - 0.6% for the entire population). Two kabupatens had higher than 2% sputum positives among adults. Field trials are now underway to determine the effectiveness of various incentive schemes for kaders who are responsible for case finding and case holding. Attachment III gives a brief summary of the study design, findings and intervention.

. Neonatal Tetanus Survey - The neonatal mortality rate in Aceh province was found to be 20.9/1000 live births. Health officials became concerned and motivated to resolve the problem when the rate was translated into an absolute number (i.e., 6 deaths every day). This is nearly 20% of the IMR for the province which was calculated to be 91/1000 in the 1980 census or 110/1000 by the survey. Two kabupatens had rates of over

30/1000 live births and are the sites selected for the first two mass campaign sweeps in which all women of reproductive age will be given two injections of tetanus toxoid (one month apart). Attachment IV gives details on the study.

. Nutrition Survey - The data collection for the province-wide nutrition survey was completed in mid-May 1985. Preliminary data tabulations are underway using two approaches. First, the nutritional status data for all kabupatens will be analyzed in order to present a general profile of current provincial nutritional status. Second, individual kabupaten specific data will be processed in sequence of field data collection. The results from these kabupaten specific data analysis will then be used to plan kabupaten specific interventions. It was decided during the design phase that kabupaten specific interventions would potentially be more innovative and easily managed, thereby allowing the province to test out small scale pilot nutrition interventions.

. Population-Based Information System - Beginning in August 1984 all births and deaths were to be reported in over 100 villages in three kabupatens as part of a prospective study. The puskesmas doctor determined the causes of death by means of an oral autopsy while the bidan gathered information on births. Incentives were given to the dukun bayi and village head for births/deaths reported and to health personnel for reports investigated. Two kecamatans reported very low rates and were dropped. Poor communications and insufficient incentives were reported reasons for the significant under reporting.

. Drug Study - A study of drug usage in an urban area near Banda Aceh by doctors, health facilities and patients found that a high level of antibiotics were being prescribed; over 65% of the patients at the puskesmas were prescribed at least one antibiotic. This dropped to 48% in private practice. Almost Rp.6,000 was spent on each private practice prescription which contained an average of about three drugs. Interest stimulated by the study resulted in a drug management workshop in Aceh which is drawing a high level of attention at DepKes Pusat.

. Rabies Intervention - This is not a priority health problem. Rabies is, however, a visible, emotionally-charged disease and is therefore a politically important program. It also happens to be a special interest of the CDC section in Aceh. As such, it was included as one of the field studies in the original project agreement. Activities to date consist of assistance to a regional crash program to vaccinate dogs and kill strays to reduce rabies transmission. Sixteen vaccination teams were trained, a large number of immunizations given, and strays eliminated, but real impact is difficult to measure since the total dog population for the province is unknown.

These studies have provided provincial health officials with considerable data that they can use effectively to plan their health program. The province now has a much improved idea of some priority health problems and is beginning to develop interventions to reduce prevalence or incidence rates of important causes of mortality. Little activity has been carried out to date on diarrhea and acute respiratory infections (ARI). The training workshop on the former was just completed and a trial is planned to test the efficacy of developing diarrhea kader to be responsible for educating the community on diarrhea treatment and being oral rehydration solution (ORS) depot holders. This trial will test a social marketing approach by allowing kader to sell oralit for a small fee (Rp.25 per 200cc packet) that would become their incentive. No activities are being considered at this time concerning the ARI problem although it was listed as the leading cause of death of the under one group in the population-based information system report. While the subject presents significant technical difficulties, possibly some innovative approach could be developed and tested to see if ARI can be treated at the community level.

Finally, alternative ways to institutionalize a population-based information system should be explored. Early indications are that the process being used in the prospective study is difficult to operate and

data processing is time-consuming. Moreover, the incentive payments utilized for a study may be difficult to institutionalize in a routine system. The surveillance system that is being discussed for SumBar should be considered as another way of approaching the problem. Consultations between Aceh and Sumbar on vital registration and surveillance systems are encouraged.

b) Organizational Development - It is obvious that the two Epidemiology and Management Workshops have had a great impact on the orientation and capability of the health personnel in Aceh, at provincial as well as at kabupaten levels. The basic concept of what data-based planning is and its implications appears to have been an extremely important focus for the CHIPPS activities in the province. The original idea and support for the province-wide neonatal tetanus survey arose from the community survey conducted by participants of the first Epidemiology and Management workshop after they identified the little known or "quiet killer" (neonatal tetanus) as the leading cause of infant death in the survey population.

The large field studies have caused maximum attention to be directed at large scale collection and intervention design activities. Consequently, it is difficult to follow-up or supervise the smaller training/organizational development activities. For example, the mini-proposals from the first Epidemiology Workshop appear not to have been adequately followed-up. There is an identifiable need to strengthen supervision of the training/organizational development aspect of the Aceh program to ensure that capacity building is occurring.

Discussions are in process for one of the Health Training Research & Development (HTRD) project training consultants to work in Aceh beginning late August 1985. The skills included in the "training of trainers cum change agents" experience would be valuable to strengthening and broadening the critical analysis skills that were introduced at the

Epidemiology and Management workshops. Skills such as task analysis and the ability to design training curriculum and materials are essential if the epidemiologic approach is to be made an effective part of Aceh's health system. The HTRD Project, as will be described in greater detail in the Sumbar section, complements and reinforces the CHIPPS approach. Consequently, the Review Team supports the idea of intergrating HTRD training program with CHIPPS activities in Aceh.

Some concern was expressed in Aceh about the use of CHIPPS funds to support some HTRD field activities. The projects need to be thought of as mutually supporting and reinforcing the same objective. HTRD can be viewed as providing technical assistance support for CHIPPS, assisting it to achieve its objectives. Hence, no objections should be raised if a relatively small amount of funds are devoted to supporting HTRD (but also CHIPPS-serving) training exercises. The investment, as demonstrated in Sumbar, was mutually beneficial.

## II.2 Manpower Development

No problem is expected to be experienced in terms of fulfilling the quantitative targets established for the manpower development component of the CHIPPS project in Aceh. The two major activities in the manpower development aspect are the nurses training (SPK) and the Community-Oriented Medical Education (COME) program at the Unsyiah Medical College.

a) SPK Training - The primary concern voiced during discussions with the SPK officials was lack of teachers. The schools, particularly the one in Banda Aceh, was having trouble recruiting candidates to send for SPK teachers training. Nonetheless, we were told that the ratio of teachers to students has improved to approximately 1 to 20, in all the schools including Banda Aceh which last year had a 1 to 30 ratio. The cost of housing for teachers coming from outside Banda Aceh contributes to the difficulty.

An important CHIPPS-supported activity is the field training exercise for the SPK students. Some problems mentioned by the SPK officials and outside consultant's reports, concern students getting bored during the extended eight-week stays in the village. Dividing the field training into four, two-week segments that are dispersed throughout the year is being considered. From a learning perspective this suggestion has several advantages;

- . enables the students to relate classroom experience to the village problems throughout the year;
- . exposes the students to a village over a longer period of time;
- . gives the students a greater opportunity to stimulate and observe improvements in the community's health status.

This is a suggestion that may be worthwhile to consider for the SPK field training in the other CHIPPS provinces. The present schedule makes the field training the last activity before graduation, which also limits its effectiveness.

As we found in all the SPK field training exercises and has been identified in consultant's reports, the trainers/supervisors need to be trained in data tabulation and analytic techniques. Two teachers from Aceh will attend the "field epidemiology" course for SPK teachers being held in Sumbar in July. This, however, only begins the process.

One of the major problems facing the SPK is the placement of its graduates. While positions and budget support exist for them in the province, new nurses often wait for a year or so before they receive an assignment. This appears to be due primarily to the tedious bureaucratic process in Jakarta that is required to register the graduates in the civil service system.

b) COME - The activities at the Medical School are still in their formative stages. CHIPPS support has consisted of technical assistance in COME curriculum design and observational tours to other COME programs. Two faculty members attended the Supervision Course for field training held in Sumbar in January 1985 and two more will attend the second course planned for July 1985.

### II.3 Administration

a) Use of Funds - Attachment V gives the amount of Loan & GOI money programmed for CHIPPS activities in the four Indonesian fiscal years (IFY), 1982/83 through 1985/86. The total comes to just over Rp. 2 billion, but because of continual devaluations of the Rupiah since the CHIPPS project began, it would be misleading to convert the amount into dollars\*. Some 64% of the total amount is loan; the remainder is counterpart funds. The percentage of loan money fluctuated from year to year with a slight decrease in GOI counterpart contribution in the current fiscal year (IFY 1985/86).

Attachment V also illustrates that Aceh has utilized a satisfactory portion of its programmed allocation through the end of calendar year 1984. To date 92% of the 1982/83 budget has been spent; 77% of the 1983/84 budget; and approximately half of the 1984/85 budget. To facilitate the monitoring of loan/GOI utilization of Project funds, it is recommended Aceh adopt the Disbursement Monitoring Form (Attachment VI) that is used in Sumbar and is described in the SumBar section.

b) Planned vs Actual Activities - The activities originally listed in the project paper and in the agreement between the GOI and USAID (Attachment VII) have been addressed to a large degree. As mentioned, diarrheal

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\* The current rate of exchange is approximately Rp. 1,100 = \$1.

disease control programs are only now beginning. The only aspect of real deficiency is vehicles - only two out of the programmed 15 have been delivered. The vehicle procurement issue has been a constant problem and has hampered activities (i.g., SPK field training) and resulted in unnecessary costs (e.g., rental of vehicles to carry out the nutrition survey). Provincial officials know efforts are being made to procure 7 vehicles with loan funds, pending SekNeg clearance.

c) Project Administration - The provincial project director (pimpro) identified lack of manpower to maintain project records and accounts as a problem. However, with the assistance of Bureau of Planning project staff from Jakarta and Mr. Cornelis Boeky from the USAID Office of Population & Health, progress has been made in managing the financial aspects of the project. Record keeping could be improved, however, by opening a separate file for each activity - each item listed in the GOI DIP or each subactivity identified in a USAID PIL (Loan or Grant). This would facilitate quick reference and ease the bookkeeping and record keeping burden.

d) Loan Reimbursements Monitoring - The issue of requesting more frequent reimbursements for prefinanced loan funds utilized was discussed. Of the Rp. 668 million programmed as loan through the 1984/85 budget, Rp. 208 million (31%) has been requested for reimbursement. The tendency is to allow loan expenditures to accumulate and then submit a large request for reimbursement. In Aceh, only one reimbursement has been submitted and that occurred in October of 1984. The review team encouraged the administrative unit to accelerate the reimbursement procedure and initiate the practice of submitting for partial payments even if the project activity has not been completed. The pimpro and LTC were encouraged to monitor the reimbursement process more closely. A Loan Reimbursement Monitoring Form (Attachment VIII) has been designed as a suggested form to facilitate this process.

e) Activity Completion Report (ACR) - The need for an ACR was identified in last year's Process Review. Project staff from USAID/I recently circulated a sample format (Attachment IX) and asked the provinces to discuss what should be included in the report. The ACR would be the final piece of paper in an activity file, the one that closes it operationally. The province has begun the exercise and plans to continue until all completed project activities have been covered. Copies will go to the Planning Bureau of DepKes and USAID/I (O/PH) for informational purposes as the final document from the province on each project activity.

#### II.4 Process

The review team observed that the CHIPPS approach of problem identification and problem solving has not only been understood by the health officials in Aceh but also has been adopted as part of their normal operations. CHIPPS is no longer seen as a special project with a pot of money that could be utilized to expand national programs or extend the infrastructure. Rather the epidemiological perspective is now becoming part of the entire health program, influencing the way some officials see their work and deliver health services. Of special interest when discussing process are the issues of leadership, planning activities, financial resources and structure.

a) Leadership - The Kakanwil has become a strong believer in and advocate of the CHIPPS concept. He speaks articulately in support of strengthening local capabilities to plan effectively to improve the impact of health services. He along with a team of Aceh health officials presented a seminar at P3M in Jakarta in January that reviewed the results of the surveys. The demonstration of a province's capacity to quantify some of its most serious health problems created a great deal of interest at the Pusat level. CHIPPS was no longer just a concept;

officials now had an example of how it could be applied so that they could more easily appreciate its contribution to improving the health status of the local population.

In March 1985 the Kakanwil devoted his presentation at the Rakerkesnas (the Annual National Health Conference) to CHIPPS activities. Rather than reviewing the health program of the province as most Kakanwils do, he focused on what CHIPPS had accomplished and what it was contributing to the quality of the provincial health program. Although this was a short presentation, it gave the health leaders in Indonesia some idea of what CHIPPS was all about. The Kakanwil's understanding of the CHIPPS approach and advocacy for epidemiologically based planning has helped provide the considerable momentum that is clearly present in Aceh.

b) Planning Activities - The planning process should reflect the results of the field work. The problems identified in the surveys need to be made part of the province's program so that they can be solved. A four stage process is involved:

Stage I	Stage II	Stage III	Stage IV
Data Collection	Intervention Design/ Implementation	Expansion (CHIPPS DIP)	Institutionalization (Development DIP)

Aceh has carried out successfully the first step. A lot of revealing and highly persuasive data have been made available. The problems of neonatal tetanus (20% of the IMR) and T.B. (several times the national prevalence) warrant attention.

The province is now in the process of designing and implementing trial interventions to address the problems identified. They are concentrating

their trials in kabupaten (Pidie) that had high rates (number 2) in both surveys. A sweep, in which all women of child-bearing age will be given two injections of tetanus toxoid, is planned for September/October 1985. Work is simultaneously being done to pass a law requiring women to be immunized against tetanus before they can receive a marriage license. If the sweep proves successful (at least 80% coverage), it will be tried in the kabupaten with the highest rate of neonatal tetanus (Aceh Selatan with 35.8 deaths per 1000 live births). It may be possible for Aceh to reduce its IMR by as much as 20-25% and achieve a large proportion of the Repelita IV objective with this one relatively simple intervention.

The tuberculosis intervention utilizes volunteers from the community who actively locate cases and assure they continue treatment. As described in Attachment III, the motivation for the workers is a monetary incentive. The question raised in this case is replication. Even if this approach proves successful, there is a chance that the national government might not be able or willing to fund such a program. The point here is that very little has worked so far; the number of T.B. cases is increasing and a way must be found to reverse this trend. As will be discussed in Section V, serious consideration must be given to what programs work in what areas. The concept of a single "National Program" is restrictive.

The test of CHIPPS success in process terms will come when the intervention results are known and time comes to fund expansion to a larger portion of the province. Currently this can be done in the CHIPPS DIP, which is still viewed at the Pusat level as "extra money" that can be utilized in "special" or "innovative programs". What will happen when the intervention must be included as part of the regular program, funded out of a regular Development DIP? The answer to this question will be the indicator that the CHIPPS process has been completed and its ultimate objective achieved.

One example of the institutionalization process is the Epidemiology and Management Workshop. The first two workshops were grant funded activities. The third scheduled for later this year will be funded from GOI funds. The final step is to make it part of a Development DIP; this will constitute total institutionalization. If the analysis of the T.B. field trials is known by September, there might be an opportunity to include intervention expansion plans in the provincial DUP for 1986/7. This could be funded initially with CHIPPS loan funds and then used as a test case in 1987/8 to be funded under the development DIP.

- Reservation of Loan Funds - The DUP/DIP planning and budgeting process continues to warrant considerable attention. Aceh has made great progress in learning to work with the system and achieve what it requires to improve program effectiveness. While the pimpro was at first reluctant to utilize the "starring" (bintang) system to block loan funds, he was encouraged to do so and won his case at the Pusat level. Bappenas in general discourages the practice of starring (saying it is a reflection of an inability to plan), but made an exception in this case since USAID loan funds were involved. The justification was that Aceh did not yet have the data that would permit them to plan interventions in detail. They reserved (or blocked) a total of Rp.120,000,000 for:

- . A tetanus toxoid mass immunization campaign in the kabupaten having the highest neonatal tetanus mortality rate to be planned based on the experience of the mass campaign in Pidie in September/October 1985 (Rp.50,000,000);
- . Nutrition Interventions - planning has to await the completion of the nutrition survey to identify and prioritize the kabupaten with worst nutritional status (Rp.20,000,000);
- . Rabies Intervention - has to await the results of the crash program before a long-term rabies control strategy can be developed (Rp.50,000,000).

If the province had been unable to convince BAPPENAS that they were unprepared to make a detailed budget until the data were available and analyzed, Aceh would have had to wait until the 1986/87 DUP/DIP cycle and lose six to nine months of valuable project time. The official at BAPPENAS who is responsible for the health sector mentioned that he was prepared to accommodate the CHIPPS requests because project officials could justify their budget requests and presented strong arguments for their proposals. He said there was a noticeable difference in how CHIPPS provincial officials presented DUPs now in comparison to other provinces.

- Revision - The restrictiveness of the DUP/DIP process is illustrated in the case of the neonatal tetanus intervention in Aceh. The system is inflexible and requires a great deal of lead time to change. It was originally thought that a blitz campaign would be the most appropriate way to cover the target group. The province prepared the DIP accordingly. However, after provincial and kabupaten officials visited Lombok (NTB), which had successfully conducted a sweep operation, they modified their plans. Because the sweep will have different financial requirements (number of people and days), the budget must be revised. This requires considerable investment of time and effort at the Pusat level. Generally, provinces are reluctant to change DIPs because it is viewed as a manifestation of bad planning. This psychological barrier adds to the rigidity of the system.

- Discussion - CHIPPS DUP preparation still is considered to be a responsibility of the Provincial Planning Chief, therefore there is not as much group participation in the DUP preparation process as one would like or expect to see in a CHIPPS province. The various program heads were asked individually to propose what actions they would like to have included, rather than doing this through a group planning process. This also reduced the coordination and integration of CHIPPS activities. For example, several important activities (the existing population based information system study, the neonatal tetanus mass campaign, and funds

for nutrition interventions) were left out of the original DUP draft, in part because it was submitted without the LTC and CHIPPS team having an opportunity to review it.

- Delegation - The kabupaten level has not been included in the CHIPPS planning process. There are plans to introduce the concept and delegate some planning responsibilities to the kabupaten level in June 1985 when a CHIPPS planning meeting is held for the 1986/87 DUP. The CDC section is asking the Dokabus to develop a plan of action (a national requirement but rarely done) based on the resources allocated in the 1985/86 DIP. This is primarily an implementation planning exercise. The provincial CDC plans to have the kabupaten officials plan their program and draft the DUP for their program in the coming year. There is confidence that with the Epidemiology Workshop behind them and the CHIPPS orientation, the kabupaten are ready to begin to do their own planning. This delegation of planning responsibilities should be supported and encouraged to the fullest extent possible.

Another opportunity for Dokabus to demonstrate their capacity to identify and address health problems in their own areas is at the RaKerKesDa. Instead of giving a lot of service statistics which say little about the health status of the local population, this would be an excellent forum to outline specific health concerns in each area and discuss plans to resolve them. The kabupatens could be given guidance and support to enable them to do this in the preparation of 1986/87 provincial DUP.

- Development DIP - To date there is no reflection of changes in the routine Development DIPs because of CHIPPS activities. In the CDC budget covering 17 different programs, for example, tuberculosis received over 25% less funding this year than last year despite the survey findings that documented a very high prevalence rate. The province receives enough drugs (rifampicin, pyrazinamide) to treat only about 450 patients a year. These drugs are distributed to each puskesmas. Consequently no

one has enough drugs to make a significant reduction in the prevalence rate. The absolute number of cases in the population over the age of 15 is estimated to be approximately 20,000. Unless half the cases are treated, the prevalence will increase due to rapid spread of infection. The question arises regarding how the T.B. problem will be approached after CHIPPS has finished. What flexibility can be introduced to reallocate funds from one CDC program to another (e.g. from worms and yaws to T.B.)? These are policy questions that need to be addressed in the remaining years of the project.

c) Financial Resources - One way of reacting to locally identified health problems is to utilize and restructure national budgets. This is a tremendous task, requiring considerable time. Another way that has a possibility of succeeding, especially in the short term, is making the best possible use of local funds and budgets. Several possibilities came to the team's attention in Aceh.

- National Resources - There is some flexibility in the national budgets. For example, in Aceh the provincial CDC is dividing the discretionary funds for supervision of CDC programs among the kabupatens. Instead of designating a specific amount for a particular program, the kabupaten are given the money and told to use it on whatever program requires it. This, in fact, legitimizes what is often done (supervision is done as required and charged to the budget having supervision funds available). The Dokabus receive between Rp. 15 and 20 million which they will have the responsibility of programming. The head of CDC in Aceh, said he would never have been able to consider such a delegation of authority had it not been for the training in the CHIPPS orientation and planning approach that has given the Dokabus the confidence and ability to assume this responsibility.

- Provincial Funds - The Governor's office is another source of funds. The local budget or Dhaire (APBD 1) in Aceh spends approximately Rp.200

million to support two hospitals. The provincial government requested Pusat to take them over several years ago but was turned down. The review team suggests that the support of public hospitals may be an area for centralized monetary support. The Rp.200 million could be effectively programmed on priority programs identified in the province by local authorities and more fiscal responsibility for public hospitals could be shifted to national support.

- Kabupaten Funds - Another source of funds is from the kabupaten itself (APBD 2). The registration fees collected at the puskesmas represent a significant source (usually second highest) of revenue for the kabupaten. With data on local health problems it could be possible to convince the Bupati that these funds should be programmed so as to improve the health status of the kabupaten population. In Pidie, for example, the Bupati has agreed to allocate the Rp.16 million collected from the puskesmas and add another Rp.3 million from his own funds to fund health programs in the kabupaten.

- Puskesmas Funds - In addition, there is the Rp.275 per capita for drugs which is sent directly to the puskesmas as INPRES money. For a kabupaten of 300,000 population, this amounts to over Rp.80 million. If this is programmed according to the finding of epidemiologic field exercises, it can be targetted effectively. This was one of the areas being discussed at the drug management workshop held in Aceh in May 1985.

If the four potential sources of funds are totalled, a figure of roughly Rp.500 million is arrived at. This is not an insignificant amount. It is close to the entire CDC annual budget for Aceh. It is not far from the CHIPPS budget that includes considerable start up, capacity building and administrative costs. It is conceivable in other words, to consider the possibility of funding local priority health programs with the partial support of locally available, hence more flexible, funds.

d) Structure - Last year's Process Review Team spent considerable time discussing and formulating a Project Implementation Unit (PIU) for the administration of CHIPPS in Aceh. While there have been few formal meetings of the unit, it is clear that the structure has improved project operations. The Core Group has provided the pimpro with the support he needs to carry out a high volume of CHIPPS activities. The Core Group consists of one person for manpower development, one for field surveys/trials and one for community programs. The pimpro has effectively delegated responsibility to Core Group members and program implementation has gone relatively smoothly as evidenced by the satisfactory utilization of CHIPPS resources.

### III. West Sumatera (1-6 May)

The epidemiologic field exercises have been started and results are impressive. Officials are not only talking about numbers, but they are interested in them, understand their significance and, most importantly, are utilizing them.

#### III.1 System Development:

##### a) Field Studies - Various surveys have been conducted in West Sumatera:

- Neonatal tetanus - A survey of over 4600 live births gave an estimate of a neonatal tetanus mortality rate of 8.8/1000 live births (or 4 per day). Four kabupatens had rates between 12 and 22/1000 live births. 92% of mothers had had two or more visits to a professional health worker but less than 20% of these received two injections of TFT; 88% of the neonatal tetanus deaths were born to mother who had two or more prenatal contacts. Attachment X gives details of the survey.

The nature of the neonatal tetanus problem in Sumbar calls for variable responses. The P3M officials plan to develop several alternative strategies. These include an upgrading of the puskesmas Ante-natal Care (ANC) and immunization program. In an associated activity, the Maternal Child Health (KIA) section is developing and will test a pregnancy monitoring card. This could help in measuring TFT coverage, and tracking at-risk pregnancies.

- Tuberculosis - Results from 4 kabupatens indicate prevalence rates among the over 15 population from 0.79% in Pesisir Selatan to 0.36% to 0.29% in the other three kabupatens. All but the first is below the national average. Data continue to be collected.

- Infant Mortality - A significant effort to determine the causes of death in the under five age group will soon begin. There is a project to make use of the already existing data in structuring a surveillance system that utilizes the camat (for village recorder), PLKB (family planning extension worker) and health staff from the puskesmas. After identifying and recording deaths under five, the health professional would conduct an oral autopsy to determine cause. These and other data will be utilized by the puskesmas and kabupaten officials to develop and direct programs according to community need. The first step is to do a modified task analysis of a puskesmas, then at the kabupaten level (second step), culminating in a Data Management and Community Epidemiology Workshop. This is a modification of the population-based information system being tested in Aceh.

- Other Surveys and Studies - Smaller studies were also conducted. A survey of the school health program (UKS) in one kabupaten was completed. Curriculum was adapted based on the study's finding. Frustration was expressed over the fact that they do not know how to evaluate whether or not the new UKS program has had any impact. A respiratory disease survey was carried out on balita and infants in two city hospitals and two outpatient clinics. After the first six months of the study, preliminary results show between one third and one half of the respiratory disease outpatients were under 5; the figure was between 17% and 26% for inpatients. ARI was the cause of almost 12% of the deaths in this age group. Some of the other activities include nutrition, goiter control (lipidol injections) and the extension of the village primary health care program. A review of the nutrition activities should be done and more innovative, problem-solving types of activities identified for CHIPPS funding in the next planning cycle. The same review should be done of the goitre program.

Two students from the Field Epidemiology Training Program (FETP), supported by USAID assistance to the national EPI Project at P3M in

Jakarta, will be sent to Sumbar for a three-month field experience in connection with CHIPPS. One will work with the CDC office, the other with the planning office.

b) Organizational Development - The focal point for organizational development activities in Sumbar has been the Health Training, Research and Development (HTRD) activities. Dr. Uday Pareek spent 10 months in Padang during 1984. He came with an outline of the process although with no predetermined agenda. Rather he identified needs and developed training courses accordingly. This can be described as the epidemiologic approach to training. It is obvious that the courses provided under HTRD have had a beneficial effect on the health program and CHIPPS activities in Sumbar.

The activities and areas covered in the training were multiple. A short description is provided in Attachment XI. Very briefly, the first and the most important activity was the two "training of trainers cum change agents" (TOT/CA) courses. A total of 28 people were trained in these courses using 1983/84 CHIPPS DIP funds. This indicates the CHIPPS planning team already had considered this project in general terms before the HTRD consultant arrived. The principle component consisted of a Task Analysis of the Integrated Health Services at a puskesmas. The students analyzed the way the staff utilized their time. Findings of the task analysis revealed considerable unused time and little time spent in the field. The course members recommended data be collected on manpower, facilities, budget, IMR, morbidity patterns in mothers and children, and birth rates so that an IHS plan and strategy can be developed and program impact evaluated. The course illustrated the basic philosophy of the approach that "training is meaningful only when it becomes an instrument of improving action".\* The trainees can now diagnose management problems and design suitable interventions.

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\* Pareek, U., memo to Kakanwil, 12 December 1984

In the course of the HTRD effort a total training strategy for the province was developed - who needed to be trained, the number, sequence, in what areas and what should happen before and after training. The training was action rather than concept oriented, and precautions were taken to prevent the training from "reverting to rituals."

The HTRD training, using the existing CHIPPS budget, led to a number of other activities (Attachment XII). A course was given on case development, another on consulting skills. Eight people were selected to undergo the advanced training course. Sumbar now has a corps of trainers capable of being co-trainers and consultants\*\*. The enthusiasm generated for and by the training is remarkable.

Among the spin-off activities was a course for the supervisors of field training of medical students. The course started with a task analysis of the supervisory role. From this, the type of training and an appropriate curriculum were developed. Five of the trainers from the TOT/CA course participated in the instruction. In addition, an evaluation of SPK field training will be carried out with a task analysis and include curriculum revision as required.

The Epidemiology and Management Workshop recommended in the 1984 Process Review has not yet been conducted in Sumbar. The HTRD experience, however, has achieved much the same objective by giving the health staff the critical analysis capability which is essential to the CHIPPS approach. As mentioned, the Data Management and Community Epidemiology workshop, a variation of the Aceh effort, will be conducted as the third step in the development of Sumbar's Surveillance System when epidemiologic skills will be required.

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\*\* Dr. Idrian Chadir who participated in this CHIPPS mid-project review was an HTR&D trainee and participated in the advance program.

The review team observed and was told of difficulty in follow-up on the activities generated by HTRD. One reason is the large number of activities that remained when Udai Pareek left in December (Attachment XIII). An example of the need for follow-up is the limited number of case studies that have been completed. A Bidang Diklat (head of training) has been appointed, but he has no staff and is unable to cope with the range and quantity of work. The idea of an Indonesian LTC specifically for support of the training/ organizational development activities was received with interest by the CHIPPS officials in Padang. Such a person is available from the group of advanced trainees who completed the HTRD course in East Java earlier this year. The LTC position would be one way to utilize a trainee while simultaneously exposing more people and health programs to the training methodology.

### III.2 Manpower Development

The CHIPPS manpower development activities in Sumbar center around very active COME and SPK programs.

a) COME - Under the strong leadership of a highly committed and supportive new dean, the COME Program at Andalas Medical School continues to develop. The course, especially the field training aspect, is still undergoing changes. A problem with phasing was identified by one consultant (students were to training kader without ever having served as a kader themselves). Some juggling rectified this problem. A problem with faculty field exercise supervision was addressed by a training program (a spin-off from the HTRD). Among other things, their data analysis capabilities were strengthened.

According to the dean, CHIPPS funding has allowed them to modify and develop the COME curriculum to their own needs. The financial and intellectual support has given them the means and confidence to proceed. The question arose concerning future funding. Currently over Rp.50

million is budgeted each year in CHIPPS to support COME field activities at Andalas. This is 20% more than the medical college's entire operating budget (not including salaries).

COME at Andalas was introduced to the Consortium for Health Sciences (CHS) of the Ministry of Education (MOE) in 1982 as a concept and a broad outline of what it was to consist of was circulated. It remains to be seen what budget will be available from the MOE, which is responsible for medical education. No mention or request for budgetary information has been issued to date although the DUP process is still in its early stage. After devoting considerable resources to the COME field activity, CHIPPS officials should make an effort to ensure that it will be institutionalized once CHIPPS funding stops. CHIPPS is assisting the Medical College develop a capacity to prepare research proposals for submission to donor agencies. A small course was provided on how to put together such proposals for grant funding. If successful, such grants could be a source of revenue for the medical college as well as good field training experience for its students.

b) SPK - CHIPPS support includes funding parallel classes of nurses to augment the numbers available to fill vacant posts in the Puskesmas, with special attention and support placed on the field training activity. The review team observed a group of third years students in the final phase of their field exercise. Their enthusiasm was high, and they appeared to have had a positive educational and motivational experience.

The nurses while on field training serve three purposes - trainee, trainer (of the Puskesmas staff), and service deliverer. The energy provided to the Puskesmas by the infusion of active, bright students makes it tempting to use them as extra staff. For example, after finding that only 30% of the population was immunized during the data collection exercises, one Puskesmas utilized the SPK students to carry out immunizations in the villages to which they were assigned. Having 60

students for 60 days equals 3600 person days or 12 person years of work which is considerable, especially when a puskesmas is understaffed. But the temptation to use these students as workers must not be allowed to detract from the primary function which is to learn about the health problems and perceptions of the community.

The SPK students perform a variety of tasks during their field training: community needs assessments/data collection; data analysis and tabulation; priority setting with the community, health staff and instructors; training of kaders; immunization of children and pregnant women; conducting health education; motivation for family planning; training of TBAs; evaluation of the program.

Problems were observed with the data collection. Rarely is the data used for comparative purposes. Data presentation goes no further than 1x1 tables. Tabulation errors are made (e.g. going from 40 to 70 percent is said to be a 30% increase rather than a 75% increase). This is because the supervisors have little more experience with data analysis than the students. This problem has prompted the training of the supervisors in mid-1985 on field data collection, tabulation, analysis and use. This training will be done in conjunction with nurse epidemiologists at P3M/Jakarta.

A great deal of the data collected (estimated at 80%) is not used. The questionnaire is being revised so that important aspects can be added and irrelevant material dropped. A consultant considered the orientation as more family than community focused and the curriculum will be revised accordingly. Another suggestion was for improved non-formal education materials to be located and introduced into the health education component and for nursing school teachers to receive some training in how to train kader.

An interesting project to evaluate the community-oriented SPK curriculum has been drafted by the principle of the Padang SPK and funds allocated by CHIPPS. Nurses will be interviewed and observed to determine their effectiveness in puskesmas operations. The curriculum will be modified according to study findings, strengthening skills which may be weak and reducing emphasis on others that are not required or used. The study was originally scheduled to begin in early 1985 but has been delayed several times. It is a valuable study which will give much needed insights into the SPK program. For this reason efforts must be made to begin it as soon as possible. The addition of the LTC for training and organizational development would be most helpful in assisting the study to get underway and in assuring that it is completed on time.

Placement of the SPK students is a problem but not to the extent of Aceh. Most students are placed after 6 months. In the meantime, they work in hospitals and receive honoraria.

Funding for SPK field training after CHIPPS may be a problem. This issue must be addressed at the Pusat level, and some guidance provided to the SPKs on what can be expected in 1989 when CHIPPS funding terminates. Attempts should be made to include the SPK field training in the GOI aspect of the budget and eventually in the Development DIP to ensure it is institutionalized by the time CHIPPS comes to a close.

### III.3 Administration

The utilization and administration of CHIPPS resources in Sumatra Barat has been good. Mr. Cornelis Boesky, O/PH USAID/I has made several visits to Padang and helped the province develop an effective administrative system.

- a) Use of funds - As Attachment VI shows, Sumbar has been allocated over Rp.1.5 billion in loan and GOI funds. Of this amount, 63% has been loan. Amounts have increased steadily each year. The utilization of these resources as of December 1984 was only slightly behind Aceh's rate and is considered satisfactory.
- b) Files - The Planning Office has developed a file for every PII subactivity so that any question on a particular activity can be traced quickly.
- c) Loan Disbursement Monitoring Form - Sumbar has developed a simple, effective system to monitor the utilization of CHIPPS funds (Attachment VI). Separate forms are maintained for DIP funds that include GOI (APBN) and loan. Moreover, each year's DIP is listed separately. No more than three years are listed under any DIP since the money lapses at the end of the third year. As of April 1985, this is reduced to two years making expedient utilization all the more important. The form serves as a management tool which allows the project staff in Padang as well as Planning Bureau of DepKes and USAID to know the exact status of each project loan or GOI activity each quarter. Whenever a particular activity has utilized only a small portion of its funds, follow-up action is taken and constraints identified.
- d) Reimbursement - To date Sumbar has requested reimbursement of prefinanced Loan funds of Rp.195 million. This represents 36% of the total of Rp.542 million that was obligated through IFY 84/85. Efforts should be made to expedite requests for reimbursements. There is no need to wait until all funds are spent on a particular activity. Any funds accounted for should be submitted for reimbursement at the end of each quarter. Utilization of the Activities Completion Report - ACR - (Appedix IX) will help the province, Jakarta, and USAID monitor the reimbursement problem more closely.

e) Activities Completion Report (ACR) - Padang is in the process of completing ACR for those activities that have been completed. An ACR should be completed for Loan, Grant and GOI funded activities.

#### III.4 Process

By virtue of the HTRD training program and the orientation provided by the LTC, a great deal has been achieved in the past year. The epidemiologic approach to health planning and management has taken root. Health personnel are able to design and carry out field studies with steadily decreasing input from the LTC.

- a) Leadership - CHIPPS leadership is more diffused in Sumbar than in Aceh. Individuals at the operational level have taken an active role in carrying out CHIPPS priorities.
- b) PIU - The PIU met infrequently over the past year. There was some confusion over the broader steering committee (including peripherally associated groups such as the BKKBN and BAPPEDA) and the PIU (made up of DepKes staff with responsibility for CHIPPS activities). Since CHIPPS activities are being carried out with little trouble, one is hesitant to suggest any change. However, to reduce the pressure on the Project Director and his immediate staff, it may be helpful to consider forming a core group similar to the one existing in Aceh. With one person looking after manpower development, another system development activities and a third organizational development issues, the Project Director would delegate responsibility for activity implementation and follow-up. This would allow him to devote more time to strengthening the planning process at the sub-province level.
- c) Planning Activities - As in the other CHIPPS provinces the planning process is not yet significantly participatory. The review team

recommends that two meetings be held to plan the 1986-87 CHIPPS DUP before its submission to the Bureau of Planning in August: a) one in July to outline initial plans, and b) one in August to review more detailed plans.

- Reservation of Loan Funds - Sumbar was not able to utilize the starring or loan fund "blocking" procedure in the 1985-86 DIP. They were the only one of the three CHIPPS provinces not to use it. The local BAPPEDA was not in favor of it, saying that it was not permitted by BAPPENAS, an impression that is not correct. This reservation mechanism would have been most helpful to Sumbar. They could have reserved Loan funds for neonatal tetanus or tuberculosis intervention activities since that had not been able to be planned in detail as survey results were not to be available until after the 1985/86 DUP was submitted. It is a mechanism they should keep in mind in the future to facilitate activity funding with the Loan. It provides the measure of flexibility that is welcomed and often necessary in an otherwise rigid, sometimes inflexible system. It will be necessary for a clarification of the Bappenas role on the reservation of AID loan funds to be made to the SumBar Bappeda.

d) Rakerkesda -- The governor opened the meeting with a review of the neonatal tetanus survey data. He reportedly was proud to have data from and specifically on the province, rather than part of a national study of which Sumbar was only a small piece. CHIPPS data are not yet used at the Kabupaten level for planning. Efforts should be made to use CHIPPS data in the Kabupaten presentations in the coming year.

e) Kabupaten Level - One Bupati was aware of CHIPPS but was not fully oriented to the use of data or to what the data and CHIPPS could do for his kabupaten. Little effort has been made to involve the two project kabupaten and one kotamadya in the planning process. The three project areas should be fully oriented and trained in data-based planning and be asked to do a work plan that will serve as a basis for kabupaten

submission for the 1986/87 DUP. This effort should be facilitated by the surveillance system, but that is at least a year away from realization.

f) DIP Status - Sumbar was basically satisfied with the project DIP for 1985/86. The CHIPPS experience with vehicles continues to be unsatisfactory as field implementation is still hampered by lack of project vehicles.

g) Publicity - Sumbar has started only recently to get data from its field studies. The members of the Kanwil who delivered the slide presentations on the two Sumbar field studies to the review team did well. They are ready to make presentation to technical offices in Jakarta. The neonatal tetanus report should also be widely circulated to policy makers. The executive summary of the neonatal tetanus survey could be circulated itself if it included information on how to get the complete report if the reader were interested. Some short statement about policy implications would alert the decisions makers to the relevance of the study's findings.

#### IV. Nusa Tenggara Timur (8 - 13 May)

CHIPPS activities in NTT have been concentrated in nurses training, development of a community based PKK nutrition-health program and preparation for field studies. Although manpower limitations, a less developed health infrastructure and a lower level of socioeconomic development combine to make CHIPPS programming more difficult in NTT, progress has been made over the past year in getting CHIPPS activities on track. The NTT health officials now have a clear appreciation for the CHIPPS approach and its implications.

##### IV.1 Systems Development

While several large-scale field studies are ready to begin, small surveys have been carried out in a number of villages.

a) Field Studies - The first major field study is the neonatal tetanus survey that will be conducted with support of the EPI project personnel at P3M, Jakarta. A team of 28 field epidemiologists will go to NTT to assist in data collection and supervision.

Soon after the neonatal tetanus survey is completed, the birth, death, cause of death study will start. Ten villages in five kecamatan of two kabupaten of Timur island (a total of 100 villages) will be sampled. The early problems faced in Aceh with their study make it sensible for NTT to consider a Puskesmas surveillance system utilizing more of the proposed Sumbar approach. Our field visit to villages under the Kapan Puskesmas indicated considerable data on births and deaths already existed at the village level. If the system could be strengthened and Puskesmas staff, rather than only the doctor, trained in the oral autopsy methodology, the Puskesmas staff will have a good source of data from which to plan and manage their operation. If both doctors and nurses were trained, skill continuity in performing oral autopsies would be maintained. Where

manpower is limited, and apparently will continue to be so within the foreseeable future, innovative ideas must be tried. A study comparing the accuracy of oral autopsies done by doctors and nurses would demonstrate the efficacy of this idea.

A number of village surveys have been carried out in conjunction with village-level CHIPPS activities. 19 CHIPPS villages have been surveyed in four kabupatens (East Flores, TTS, Sumba Barat, Alor). The data for the four villages of the Timur kecamatan were analyzed last year. The preliminary results of the surveys of the two kecamatan in East Flores have just been released. The data for the final two kecamatan are now being processed.

Based upon initial experience in TTS, the survey design has been revised and is divided into two parts. First is the Family Health Record (Attachment XIV). This record consists of two pages as opposed to the original 12-page questionnaire. The entire community is still being surveyed but the individual health data are being used as the basis for a family health record. The value of this exercise depends on how the data will be utilized. The second part collects data about the general village situation and social system. The information is gathered by interviewing a focus group in each village. This technique was designed by the local university (Undana).

The effectiveness of this dual survey format is yet to be determined and questions may be raised about the adequacy of supervision. In the case of Alor and West Sumba, the questionnaires and a description of the methodology were mailed to the local puskesmas doctor for collection. The surveyors received no standardized training or orientation. The lack of control raises concern for survey results. Limited manpower and time of the responsible person were cited as reasons for this situation.

Despite these shortcomings, some of the preliminary results from TTS are of interest. The infant mortality rate was reported as nearly 140/1000

live births. Although small sample sizes limit the validity of the data, the causes of death are revealing. Neonatal tetanus was number one, accounting for 31.3% of the mortality; respiratory infections and encephalites/ meningitis were next, each with 18.8%; diarrhea was fourth with 12.8% and measles fifth with 6.3%. In the balita age group (1-4), measles was first with 37.5%, diarrhea and respiratory infections next with 18.8%, T.B. and pertussis fourth and fifth with 6.3%. The immunization record was practically nil despite the area being under the EPI program; zero out of 73 pregnant mothers received two TFT slots. Less than 1% of the balita had received DPT II or Polio I.

The review team had an opportunity to visit the CHIPPS field site in Kabupaten Mollo Utara. Since the village survey was completed last year supervision visits from Kupang have been rare. The CHIPPS activities this past year consisted of some kader training and the supplying of some equipment for the puskesmas and for the processing of supplementary food (BMC). A bright, energetic and motivated new doctor arrived in late 1984. The staff of the puskesmas recently has been increased, going from a total of 6 (3 of them medical) to a total of 15 (13 medical). The nurses have increased from 2 to 11. The Kakanwil has given this CHIPPS puskesmas special staffing, however it was not clear how the experience of this pilot area was going to be used to provide replicable lessons for other areas in NTT. Further discussion of this pilot effort is required.

On our visit to several of the project villages we learned of what appeared to be good work. In the two villages where the kader had undergone special training, the percentage of gizi buruk (severely malnourished) children reportedly went from 5.2% and 6.5%, respectively, to zero in both. Moderate malnutrition (gizi kurang) went from 28.7% in 1983 to 20.6% in March 1985, when 102 children out of 104 in the village were weighed. However, an incident occurred in March at the Pos Yandu (integrated post) that may affect the nutrition activities. The Camat, PLKB (family planning worker) and puskesmas doctor strongly motivated

villagers about family planning. Eleven IUDs were inserted and 25 males sterilized. In April only two people attended the weighing program, presumably for fear KB motivation may happen again. A very good nutrition/health program had been interrupted. Such an experience illustrates potential problem when targets are met without regard for what effects the results may have on the existing programs and motivation of villagers to participate in Pos Yandu activities. This incident needs to be analyzed by provincial officials so that corrective actions can be taken for implementation of the integrated program in this kecamatan and lessons learned applied to other areas.

The surveys on leprosy, drugs and intestinal parasites have received little or no attention since last year. These activities need to be reviewed and decisions made on whether funds will be spent on follow-up actions.

Some interesting work has been done in the health education field. Media experts from Jakarta have adapted several visual aids (flip charts and posters) to the local culture. Some of the balloons for captions were left blank so that local languages could be filled in. This is essential when one island alone (Alor) is reported to have 28 distinct languages.

Finally, formative work has been done on two other potentially far reaching activities. One is a sub-stratification system or Puskesmas Study. It consists of six stages, starting with the assessment of the range of Puskesmas in NTT. Variables include staff, population, geographic factors. The facilities will be ranked according to potential. How the puskesmas operated within its limitations would be monitored, constraints identified, solutions discussed, modifications made. An outline of the proposed study is provided in Attachment XV.

The other innovative activity is the Health Information System (HIS). The objective is to design a very simple, easy to maintain form (all the information taken from available information) that will be useful to the Puskesmas doctor as well as those above him at the kabupaten and provincial level. The doctor would be able to identify the most common causes of morbidity and even mortality in the area served by the Puskesmas. This information provides the data necessary to manage and plan the Puskesmas operation. The Kapan Puskesmas we visited started its own simple morbidity data collection exercise in 1984. Every month the doctor listed the top 10 diseases based on patient visits to the Puskesmas and sub-centers. Anemia and diarrhea were always in the top 10. Anemia was in the top 5 each month. Diarrhea ranged from number three in November and January, number 4 in February and December, to 8 in March, 9 in May, and 10 in April. A seasonal pattern can be identified and should alert the Puskesmas staff to periods when diarrhea outbreaks may be expected. It is hoped that the HIS idea is developed and tested by the Kanwil in NTT.

b) PKK - The nutrition and MCH focus for PKK activities has led to the development of a package of capacity-building inputs to strengthen the local PKK that will deliver the services to the target group.

Moving the PKK experimental project from Kabupaten Belu to Kabupaten Kupang has permitted those responsible for developing the PKK program to oversee and support the activities more actively, thereby enabling them to discover what works and what does not work. Conversations with the kabupaten level PKK program developers are sprinkled with numerous "we have learned ...." or "based on our experience ...." statements. They have tried things, found out what worked and what did not and made program decisions based on experience.

The CHIPPS-supported PKK activities have been taking place in nine villages in three kecamatans in Kabupaten Kupang. The package of inputs developed over the last year include:

- . Practical, narrowly focused training
- . Increased supervision
- . Village survey methodology
- . Limited, well defined tasks
- . Management training for the supervisors

The project has devoted time to building a PKK structure at kabupaten level that will be capable of running the programs. At the top is the "Group of 10" from the kabupaten level, who will serve as trainers as well as managers. At the kecamatan level, PKK project supervisors (7 per kecamatan) were given training nutrition and project planning. The village kader are being trained and retrained as required. Attention has been given to improving the selection of kader and to assuring their morale remains high so that high drop out rates can be reduced. The PKK leadership remains strongly opposed to monetary incentives for kader. They have identified the three most important factors in maintaining morale as: sense of accomplishment, sense of personal growth, and a reasonable support system (moral and technical). The PKK in NTT does support compensation for expenses (e.g. transportation) incurred in supervising the program and feels strongly that this is required since volunteers cannot be expected to and will not pay for program operational costs from their own pockets. This point is still being discussed with Pusat officials. Finally, a locally produced weaning food or BMC (Bahan Makanan Campuran) - mixture of a cereal and a pulse - has been developed and introduced in the PKK villages. CHIPPS has provided some small milling machines (hand and machine operated) for use at the kecamatan level.

The PKK leadership feels the need to develop an information system as fragmentary and anecdotal reports of increased attendance at weighing sessions and improvements in nutritional status being to be reported. Information that might be considered for inclusion in a PKK village information system includes:

- . Kader drop-out (% active)
- . Participation in weighing (% attending)
- . Gizi buruk (% of those weighed under 60% of standard)
- . Immunization coverage (% balita with completed immunization)
- . TFI coverage (% of pregnant mothers with 2 doses);
- . Births and deaths under 5
- . Low birth weights (report when occurs)

These few numbers will provide the data required by the community, kader and PKK supervisors to know if the program is functioning effectively and where extra attention (village and activity) must be placed. To permit the determination of low birth weights, the testing of an inexpensive hand-held tubular (fish) scale might be considered. As the number of births are not frequent in a village, one scale per village should be sufficient; it can be given to a kader who has a woman in her area that is due to deliver.

The reports by the part-time CHIPPS consultant for community participation are being submitted regularly. As the work progresses, the content of the reports is increasingly interesting. It is hoped that once a PKK village information system is introduced, some performance data on the field activities can be included. Coordination and cooperation with Puskesmas staff in operationalizing a village based PKK system could provide a critical link to the HIS or Puskesmas surveillance system being developed. The mutual inter dependency of PKK and the local health officials on each other is beginning to be appreciated in NTT and should increase as the PKK efforts are introduced to the CHIPPS pilot kabupaten.

The question of how a PKK - Puskesmas system can be institutionalized and the necessary support/motivational system put in place should be addressed seriously in the remaining years of the project. This issue needs to be discussed thoroughly by PKK and health officials in the coming years, and alternative sources of funding for PKK, such as the PVO coordinating body, the Badan Koordinasi Kegiatan Kesejahteraan Sosial (BK3S), considered.

c. Organizational Development - One of the most dramatic changes over the past year is the greatly increased use of technical assistance. Last year's process review commented on the apparent reluctance of NTT to utilize outside consultants. In the past twelve months nine different Indonesian consultants and three foreign consultants have been involved in NTT CHIPPS programming. Attachment XVI gives the names and assignments of each. In addition, teams have made visits to other programs in Indonesia - SPK to Padang to observe field training, CDC officials to Yogyakarta to see the immunization program, and participants were sent to Aceh to attend the Second Epidemiology Course and the Drug Management Course.

The need for more short-term consultants occupied a considerable portion of the wrap-up meeting. A concern for how to locate well-qualified consultants and how to write good scopes of work for them was voiced. With the assistance of the LTC, DepKes and USAID, this can be resolved satisfactory.

The Epidemiology and Management Workshop, with some modifications, was held in NTT in early December 1984. To date only two of the participants have submitted mini-proposals. The project staff at the Kanwil has not had time to follow-up on the mini-proposals and assure submission. The absence of the mini-proposal exercise would diminish the total learning experience and it is hoped this aspect of the training can be completed. NTT is a good candidate for HTRD project activities. As in Aceh, if a graduate of the Advanced Training Course could be assigned to Kupang as a LTC for Training/Organization Development, he could be involved in the training of trainers. He would be supported by an HTRD senior consultant based in Surabaya, serving the eastern region of Indonesia. The capacity-building aspect has not received the attention it deserves and requires in NTT, and the need for it increases as CHIPPS activities develop.

#### IV.2 Manpower Development

With no Medical School in NTT, nurses training dominates the manpower development activities. In fact, SPK support accounts for almost half of the entire CHIPPS loan/GOI budget in NTT in 1985/86. A projection of the number of nurses who will be trained by the end of Repelita IV is given in Attachment XVII. In the past year five "extended schools" were opened with almost 150 students attending. Problems arose with lack of full-time teachers and books. The doksbu and the head of the local hospitals were given responsibility for teaching but were only part-time. Recently, they have been given three days a week to devote to the SPK teaching. Books were in short supply in all the schools. General complaints were heard about the lack of Pusat support on locating and acquiring the books recommended for nurses training. This problem deserves special attention.

Supervision has also been a problem since funds were allocated for only one trip to each of the extended schools. To date more attention has been placed on quantity rather than quality. More supervision is required for quality control purposes. The review team recommends a study similar to the one proposed for Sumbar be developed to determine the effectiveness and appropriateness of the training and curriculum in the NTT SPKs. The extended schools will not graduate their first class until 1987, but in the meantime the training at the three main schools (Kupang, Ende and Lela) could be evaluated. The evaluation methodology would be as important as the evaluation exercise itself. This would be an extremely useful activity for an HTRD consultant in NTT.

Postings for the SPK graduates take about six months. In the meantime, many of the new graduates work in the hospitals and are paid with honoraria.

In addition to SPK support, CHIPPS funds have trained dental technicians, sanitarians, midwives and nutritionists. Qualified candidates (i.e., minimum educational background) for laboratory technicians and drug management trainees could not be found. This is a reflection of the scarce manpower in NTT. Several candidates have studied abroad, one just completing and two just starting an MPH course in the United States.

#### IV.3 Administration

- a. Funding - A total of Rp. 1.7 Billion of Loan and GOI money has allocated to NTT since the CHIPPS project began (Attachment V). This is slightly more than Sumbar and somewhat less than Aceh. The percentage of loan funds is very similar to the other two provinces.
  
- b. Disbursement - The major problem of NTT is absorptive capacity. With its limited manpower at the provincial as well as puskesmas level, they often find it difficult to carry out proposed activities. There has been a concerted effort on the part of the province to reduce the number of activities proposed each year. They have gone from 25 separate systems development activities in the 1983/84 DIP to 13 major activities and 10

subactivities (total of 23) in 1984/85 to 6 activities in 1985/86. Over the first three years of the project, however, NTT has experienced disbursement problems. They lag considerably behind the other two provinces. Almost 60% of the funds in the first three project DIPS have yet to be utilized. As of December 1984, none of the 1984/85 DIP had been expended. This, as will be described below in Section IV.4.c had serious repercussions on the 1985/86 DIP. The DIP Disbursement Monitoring Form (Attachment VI) will help NTT as well as DepKes and USAID keep a closer watch on when funds are being utilized and which activities need special attention.

c) Decommitment of Funds - The LTC has encouraged the province to decommit funds for activities that will not be carried out, however no decommitments have been made to date. Possible activities to be decommitted include laboratory technician training and drug management training (if it is ascertained that no qualified candidates can be found), some community participation activities and leprosy intervention (no qualified person). Each pokja (subunit of the PIU) should review in detail each outstanding activity for which it is responsible and identify those to be decommitted. This should be priority activity before the next DUP/DIP cycle begins to improve the fund utilization picture and reduce the possibility of DIP reductions due to unexpended resources. The new regulation that limits the use of Project funds to 2 fiscal years will force this process as funds become unavailable for use.

d) Reimbursement Requests - Only Rp. 30.2 million of loan funds have been requested for reimbursement. This amounts to only 5.3% of the total amount of funds allocated to NTT through IFY 84/5. Even when reimbursements are considered as a percentage of the amount of funds utilized, it comes to only approximately 12%. NTT is urged to adopt the suggested Loan Reimbursement Monitoring Form (Attachment VIII) and improve its performance in this regard.

#### IV.4 Process

There are several process-related problems that were identified in the NTT CHIPPS project which deserve attention so that the good work started this year can be continued and improved upon in the future.

a) Leadership - The Kakanwil , upon whom the project depends for policy decisions, is extremely busy with multiple assignments. The possibility of having the assistant Kakanwil, Dr. Lada, and the Planning Chief, Dr. Gatot Suroso who has just completed a M.P.H. in the U.S., assume greater responsibilities in CHIPPS policy matters should be discussed.

b) PIU - The PIU, redesigned after last years Process Review (Attachment XVIII), has met occasionally during the year, and the experience with the eight Pokja has ranged from poor to good. One of the main problems is several key people have too many responsibilities, thus making supervision and follow-up of CHIPPS activities extremely difficult.

A new pimpro will assume office in June when the present project director leaves for a MPH course in the U.S. The new pimpro currently holds eight positions (Attachment XIX). Someone is to assume responsibility, but not title, for his former job (Head of the Community Health Division in the Dinas) and he will resign from four other positions. It is imperative that the pimpro be relieved of these other assignments and not given others in their place so that he can devote the time required to the CHIPPS job. He will be the third pimpro for the project. The lack of continuity has added to the project's problems in leadership.

Two doctors will be returning from graduate training shortly and will be assigned to assist the pimpro manage CHIPPS activities. One is Dr. G. Fernandez, with a Master of Occupational Health, who will assist in the planning and administrative support of CHIPPS activities; the second is Dr. Emiliana, with a Master in Tropical Medicine, who will be assigned to

support the systems development/ field studies and interventions activities. Again if CHIPPS is to progress as is expected, these two individuals must be assigned as described and allowed to devote their time exclusively to CHIPPS. However, so as not to create a unique project management unit, these two individuals should be absorbed after one year in the line units having the closest association with their work, probably Planning and CDC, respectively. They would still devote attention to CHIPPS but would have broader responsibilities as well.

Finally, it is recommended the pokjas be reduced from eight to six. This will make it more manageable as the heads of the pokjas will become, in effect, a core team to oversee and manage CHIPPS activities. The pokjas would include separate units for manpower development, PKK, surveys/CDC, health information/drugs, KIA/gizi/health education.

c) DUP/DIP - NTT's 1985/86 DIP reflected a reductions in what they proposed in their DUP. Reductions were particularly severe in the systems development activities. A major reason for the reductions was that no money from the 1984/85 DIP had been utilized by December 1984. One activity was reduced because funds for similar work had not yet been utilized. It is hoped that the decommitment of funds for activities that will not be carried out and the Disbursement Monitoring Form will assist the resource utilization situation.

Two activities that were reduced were the malaria community participation project and the birth, death cause of death study. In the former, the proposed budget for an innovative community based approach in Flores was reduced by 50%. The explanation was that all malaria activities had to be restricted to Timor Island where a special AID-supported project was being carried out. This is confusing as the approach proposed for Flores was entirely different and the need extremely high. In addition, two special letters of justification for each project had been sent to-Pusat by the Kanwil in support of the project. Unfortunately, no communication

of concern was given to the province. Some funds finally were allocated but not enough: The province will need to request grant funds to be able to carry out activities in a technically sound way.

The other concern came when the proposed budget for the birth, death, causes of death prospective for the study were reduced by half. The explanation was the funds requested for supervision did not follow central guidelines for operational programs. While this is true, the province felt a monthly field visit was required to ensure proper implementation of a study that would provide important data for provincial health planning. The reduction of an important part of the budget for this field study indicates a lack of understanding of what is trying to be achieved in this specific CHIPPS activity. Again, grant funds may have to be requested to enable the study to be technically sound.

d) DUP Preparation - An attempt was made to involve pokjas in the preparation of the provincial health DUP. Their response was minimal. As a result, the piapro put together most of the DUP. It was also observed that the kabupaten level was not involved in the planning process.

Serious efforts should be made during the current DUP/DIP cycle to develop broader participation in the planning process. A meeting of the major parties (i.e. pokja heads) should be held prior to the initiation of the DUP preparation to discuss program activities and direction. This will help in the development of a coherent package of activities and make for a more participatory CHIPPS effort. Another meeting could be held prior to DUP submission to Jakarta so that the list of proposed activities and respective roles can be reviewed. Finally, meetings need to be held with the Dokabu, Bupati, Camat of the CHIPPS field sites so that they are involved in the planning process as well. These officials need to be exposed to the principles of data-based planning, and involvement in the planning process is one of the best way to orient them.

d) Financial Support - Support from the APBD (provincial budget) for the PKK and community level development efforts has been extremely generous. From only several million Rps. in the early 1980s, support from the provincial budget was increased to Rp. 70 million in 1984/85 and Rp. 99 million in 1985/86. BAPPEDA said the increase was due to a favorable impression of PKK and the community work it is doing. In addition, another approximately Rp. 80 million from Dalam Negeri will be programmed directly to the kabupaten and kecamatan PKK organizations (Rp. 5,000,000 per kabupaten and Rp. 200,000 to the kecamatan level). Another Rp. 60 million is budgetted for community health programming (kader training and basic activity support in 50 villages in all 12 kabupatens) and Rp. 30 millions for nutrition activities. This financial support from the province is encouraging in terms of institutionalizing CHIPPS-type activities in NTT and reinforces the need for BAPPEDA to play an active role on the CHIPPS steering committee.

## V. Issues

After having reviewed CHIPPS activities in each of the provinces in detail, we turn our attention to issues that require attention from project managers and policy makers.

### V.1 Performance

In terms of overall project performance, almost all the elements described in the project paper have been addressed. Many of the quantitative targets have been reached (and in some cases surpassed) or will be reached in the near future. The only activities which have lagged are utilization of vital statistics (just beginning in Sumbar and NTT), diarrheal disease control program in Aceh (being designed) and nutrition intervention program (in Sumbar). In the last case, some nutrition activities have been carried out in Sumbar, but the problem has

not been found to be severe enough to warrant a major province-wide nutrition intervention program. A major deficiency to date has been in vehicle procurement. Each province has received only two of the 15 vehicles programmed to support field activities. Seven vehicles per province are planned to be procured through the Loan pending SekNeg concurrence that USAID can do the procurement. Resolution of this outstanding issue should facilitate provincial capability to support the multiple field activities being carried out.

## V.2 Systems Development

a) Field Studies and Trials - CHIPPS has achieved its most impressive results in the field study and trials area. The neonatal tetanus and tuberculosis surveys in Aceh and Sumbar have attracted considerable attention both within the provinces and in Jakarta. It is assumed the same will be true for the neonatal tetanus survey in NTT which began May 20. The involvement, support and technical assistance provided to the provincial neonatal tetanus surveys by staff of the national EPI program has been extremely valuable. Moreover, the assignment of several Field Epidemiology Training Program (part of the EPI project) students to Sumbar for three months of field experience will provide the province with much needed epidemiologic support and capacity to analyze data.

Important work has begun on information systems. The Population-based Information System in Aceh and the surveillance system concept (still in the formative stage) in Sumbar are two different approaches being tested. NTT has begun giving attention to a Puskesmas information system which could be a basis for data-based planning at the health center level in that province.

While the volume of activities in the field studies area has been impressive, many policy makers in Jakarta are only vaguely aware of CHIPPS activities, results or their implications. Reports of survey

findings have been circulated but have not been read in detail. There is a need for short (one page) summaries of studies, results and some comment about policy implication which can be circulated to policy makers. The development of a periodic CHIPPS (maybe quarterly) newsletter might also be considered. Seminars, as presented at P3M by Aceh, are also effective means of publicizing activities. Sumbar is ready to make a presentation and NTT should be able to do so in six months. By that time, Aceh will be ready to present data on the impact of its neonatal tetanus sweep and/or its tuberculosis intervention.

b) Organizational Development - It is vitally important the organizational development not be neglected. All three provinces have experienced difficulties in supervising and following up on training and organizational development efforts. The mini proposals which are an integral part of the Epidemiology and Management Workshop have not been pursued actively in Aceh and NTT. In Sumbar there is a long list of activities resulting from the HTRD training program that await attention. It was suggested during the review meetings that qualified Indonesians be hired as a LTC for training and organizational development. This possibility was received warmly in the three provinces.

One possible source of candidates for these Organizational Development positions is the people who have completed the HTRD Advanced Training Program. These health professionals are now qualified as expert trainers and health system management consultants. The HTRD program complements the CHIPPS project by providing its trainees with a critical analysis capability. It is, in fact, a type of epidemiology training; however, instead of determining the cause of death, its objective is to determine the cause of organizational ineffectiveness (through task analysis) and then to determine ways to improve performance. Thus, while health epidemiology will improve health status, organizational epidemiology will improve service delivery effectiveness.

During the review, numerous requests were made for organizational development consultants. Thus, the supply exists as well as the demand; what is missing is the mechanism. The LTC for Training/Organizational Development could be hired by the province and paid from CHIPPS project funds. Another approach would be to program these LTCs through an established health consulting group in Indonesia.

The HTRD project is more likely to succeed in a CHIPPS province, as was demonstrated in Sumbar. Arrangements are now being made to initiate HTRD activities in Aceh. The LTC for Training/Organizational Development could serve as one of the trainers as well as provide follow-up support. HTRD project officials also plan to visit NTT in the near future to discuss the possibility of starting training activities there. Once again the T/OD LTC could be involved in training and following-up unfinished and newly initiated training/organizational development activities. An activity requiring someone with an HTRD background is currently being carried out in NTT, namely the sub-stratification exercise. The province will require four months of consulting to do task analyses at the Puskesmas level in stage II of the study. A LTC who has undergone HTRD training would be well qualified to undertake such an assignment.

The HTRD approach is trying to do for health training primarily what the CHIPPS approach is trying to do for health service delivery. If HTRD succeeds, Pusdiklat (the central organization responsible for all health training) must modify its approach and normal training routine. Rather than giving a detailed training design from Jakarta, more freedom to design training according to local needs and problems is required. This is equivalent to CHIPPS successfully orienting DepKes to let the provinces measure their health problems and design appropriate programs. The two approaches are synergistic; neither can be completely successful unless supported by the other.

### V.3 Manpower Development

While the training discussed in the Systems Development section strengthens the capacity of those already in the organization and focuses mostly on management-related issues, the training falling under the Manpower Development aspect is infrastructure building, providing mostly technical training. When CHIPPS was being designed, there was a serious shortage of trained paramedical personnel in the three project provinces. This was especially acute in the nursing field. CHIPPS, therefore, is training additional nurses while simultaneously increasing the community, public health orientation of the training, both for nurses as well as doctors.

In evaluating training, quantity and quality questions must be asked. In terms of quantity, the following has been achieved through CHIPPS.

Category of Health Worker	Target to be Trained (by 3/86)	No. Completed Training (1982-85)	No. in Training (1985-86)	Total
Nurses (3 yr. course)	290			
Nurse Retraining (3 mo. course)	840			
Asst. Nurse to Nurse (1 yr. course)	450			
Nursing Teachers (1 yr.)	125	71		
Sanitarians (NTT/Aceb)	85	34		
Laboratory Tech. (Aceh)	80	4		

In addition, 33 provincial health staff have been trained at schools of Public Health in Indonesia, eleven in the U.S. (one long term, ten short term) and one in Asia.

The quantity of training is important, but only if quality is maintained. CHIPPS has supported the strengthening of the field training

activities, both in the nursing schools (SPK) as well as COME, to teach the students how to identify problems at the community level by introducing them to data collection and analytic methods. This ensures that when they enter the health system they will at least be familiar with and trained in the epidemiologic, problem solving approach.

How effective is the SPK training? How relevant is what is being taught when the nurses get to the puskesmas? These questions will be addressed in the SPK curriculum study that is scheduled to be conducted in Sumbar. This initiative will utilize the task analysis methodology taught by the HTR&D consultant. This is one example of where the presence of an LTC for Training/Organization Development would be helpful in facilitating the study of important questions.

The review team was concerned about the quality of the nurses training in NTT where five "extended schools" were added last year. It is recommended that a curriculum study similar to the one to be undertaken in Sumbar be carried out in NTT to determine the correlation between what is taught at the SPK and what skills are required in the health centers. The HTRD task analysis exercise should be a prerequisite so that the provincial health/SPK personnel are familiar with and understand the value of this approach.

Serious concern arose over the future fundings support for SPK and COME field training after the CHIPPS project ends. At present no one is able to say where the financial support will come from. The best way to ensure continuation is to prove the value of such training. The evaluation of the SPK curriculum in Sumbar may provide some support, but a study of the impact of the community field training for nursing and medical students is recommended. The results could provide the supporting evidence that the community experience pays dividends and is a good investment for the Government.

V.4 Administration

a) Distribution of Project Funds - The administration of an innovative project like CHIPPS is difficult, especially when it involves mostly loan funds. The loan component has forced the project to deal with the structure and procedures that it is attempting to influence. Thus, although it raises problems, the present mix of funding is appropriate. It is important, however, for all those attempting to carry out primarily "process projects" to understand the importance of having the flexibility that grant funds permit.

Concern has been raised that CHIPPS has not programmed money at a sufficiently fast rate. A process project should not be expected to start with a flurry of activities. The first phase consists of the orientation of the provincial officials, then training and finally preparation of field surveys. None of the preparatory steps consume a lot of funds.

In the last six months, the activity level has accelerated and with it the distribution of project funds. As can be seen in Attachment XX, some 63% of the loan money obligated has been committed through the end of IFY 1985/86. The maximum utilization comes in the administrative aspect which has run slightly over the obligated amount. Manpower Development has committed 76% while Field Studies and Trials and COME were slightly under 50%. Considering the fact that little money was spent during the first two years of CHIPPS, this is excellent progress.

In terms of Grant Funds (Attachment XXI), almost 65% of the obligated amount has been committed as of May 1985. The highest amount is in Training (77%), followed by Field Studies and Trials (72%) and, finally, Technical Assistance (62%).

GOI counterpart funds committed through IFY 85/86 amount to a total of Rp.2.2 billion (Attachment V), about 20% of the amount pledged. The

percentage of loan funds has shown slow increase from 47% in IFY 1982/83 to a high point of 75% in IFY 1985/86. The in-kind contribution (salaries, office space, etc.) is estimated by the Ministry of Health to be 25% of the GOI contribution.

b) Improved Procedures - As discussed in reference to each province, the review team identified a need to streamline project administration. Several forms will be introduced for this purpose:

- Loan Disbursement Monitoring Form (Attachment VI) - To track disbursements of loan funds, each province will report each quarter the percentage of work completed and amount of money spent on each DIP activity for every DIP still being implemented. Copies of the form will be sent to the Planning Bureau (DepKes) and O/PH, USAID. Expedient expenditure of funds is made all the more critical because new GOI regulations have reduced the time permitted for use of DIP funds from three to two years. That means that not only will the 1982/83 DIP close as of the end of March 1986, but so will the 1983/84 DIP.

- Loan Reimbursement Monitoring Form (Attachment VIII) - A form has been designed to ensure that the project provinces request loan reimbursements on a timely basis. Each quarter the amount of loan funds spent and eligible for reimbursement will be listed. It is expected that this amount will be requested for reimbursement at that time. The provinces are encouraged to submit requests even if the particular activity is not yet fully completed. More timely reimbursements of prefinanced loan funds will reduce the losses suffered by the GOI through the gradual devaluation of the Rupiah, and will also improve the CHIPPS loan fund disbursement record at USAID. The Planning Bureau of DepKes has recently been able to develop means to expedite clearance of the reimbursement requests at the MOF so that it requires only about two weeks.

In addition to these new forms, two other actions are recommended. One is for a concerted effort by each province to review every DIP activity

and Grant request since the beginning of CHIPPS to identify those activities that will not be carried out. The funds reserved for these activities should be decommitted. Although a similar action was recommended in last year's Process Review (item number 9), only Sumbar has done this review. NTT is urged to review their plans and decommit funds as soon as possible to improve their utilization rate before the next DUP is submitted to Pusat for review.

Secondly, Activity Completion Reports (ACR) must be submitted for all activities that have been carried out. This was included in recommendation number 8 in the previous Process Review. The forms have been sent to the provinces and work has been started on them but none has been sent to Jakarta as yet.

The provinces have found the several visits made by Mr. Cornelis Bosky (O/PH, USAID) very helpful. He should continue to visit each province possibly twice a year, to follow-up on financial procedural matters. NTT has requested he make monitoring visits every 3 months. His technical assistance is particularly necessary when new forms are being introduced. Being able to explain the purpose and review how the form is to be used greatly facilitates the provincial project administrator's job and results in better financial reporting. Continued and frequent involvement of Mr. Bosky is strongly encouraged to increase the compliance of the provinces with the reporting requirements for the projects.

## V.5 Process

a) Accomplishment - In reviewing the Project Outputs (Appendix VIII) included in the USAID's Project Paper and in observing what CHIPPS has accomplished to date, one has the impression that most of what CHIPPS set out to accomplish has in fact been done. People have been trained or are in the process; field studies have been undertaken and trials are being implemented or designed. If some of these interventions are successful,

significant impact on such a priority indicators as IMR, will be achieved. This is especially true in the case of neonatal tetanus which, by itself, apparently accounts for at least 20% of the infant deaths in the project provinces. Such an impact was beyond the expectations of the CHIPPS designers and must be seen as a credit to those who have been involved in carrying out the project.

While the progress and potential impact of CHIPPS gives a great deal of hope, it must be remembered that CHIPPS is a "process project". Thus, its success is not measured in terms of either funds expended or number of activities carried out or even impact achieved. It is always possible for a crash program with generous external funding to reduce the prevalence of a selected disease in the short-run. One of the dangers of a process project like CHIPPS is that people focus on short-term results (i.e., survey results and impact) rather than the process issues. The latter are more complex, difficult to modify, take considerable time, and are easily over-shadowed by the more tangible results.

b). Phases - In terms of progress on the process aspect, CHIPPS is still in the early, formative stage. Using the continuum laid out in Section II, CHIPPS is moving from stage I to stage II; field studies have been carried out and field trials are being designed or implemented. Grant funds have played an important role to date providing the flexibility required to carry out innovative activities on a timely basis. But the CHIPPS process development work and progress toward the institutionalization of an epidemiologic planning methodology at the provincial level with the concurrence and support of Pusat has only begun.

The current process position in the provinces has changed on one level but not on another. Provincial health staff are beginning to be able to convince Pusat-level officials in DepKes and BAPPENAS of their special needs. However, to date this has only been related to the CHIPPS DIP. The ultimate indicator of CHIPPS success is greater flexibility in the way health programs are planned and implemented at the provincial level.

- National Disease Pattern - During the current review several examples of difficulties raised by Pusat-dominated programming were identified. As pointed out, there is still no reflection in the CDC DIP for Aceh of the high prevalence rates for tuberculosis found in the province's field study. All provinces still receive funds for such things as intestinal parasites and yaws, while problems relating to immunization and diarrhea disease control remain underfunded. A province cannot shift funds from one CDC line item to another (except for supervision); if they indicate their desire not to have a particular program, their overall CDC budget will be reduced proportionately rather than having the amount shifted to a higher priority disease. National programs still take priority over provincial problems and needs.

- National Program Pattern - Pusat officials specify not only on which diseases the funds are to be spent but how. National programs give directions plus unit costs for standardized, disease-specific interventions. The inappropriateness of such rigid programs is illustrated by the neonatal tetanus interventions being discussed in two different CHIPPS provinces. Aceh, with its weak health infrastructure, will carry out a sweep of child-bearing age women; only half the women were found to have had two or more pre-natal visits. In contrast, Sumbar has a better developed health system where a very high percentage of pregnant women already have pre-natal visits; thus only a strengthening of the existing system is envisaged. A single program that all provinces would be required to implement is not appropriate.

- National Effort to Decentralize - At the same time CHIPPS is establishing a problem-identification, problem-solving approach at the provincial level, Pusat is advocating decentralization and instituting a micro-planning exercise. For these concepts to be fully realized, Pusat should pay close attention to the experience of CHIPPS which is demonstrating the necessary ingredients for an effectively decentralized health system.

The implications of a decentralized system affect several different parts of Ministry of Health operation. CDC, as mentioned, could allow programs to be more responsive to locally identified problems. Pusdiklat could be more willing to see training in terms of action orientation, depending less on predesigned, routinized training programs. Local problems must be identified and serve as the basis for the training, a model developed by the HTRD project that supports the CHIPPS approach so well. In addition, Litbangkes could encourage and develop provincial capabilities to conduct their own field studies. The positive effect of such studies on the province's pride, feeling of ownership and understanding of their problems has been demonstrated clearly in CHIPPS.

c) Facilitator - As described in this report, considerable activity is being carried out and experience gained in the CHIPPS provinces. There is less consciousness at the Pusat level for what CHIPPS is and what implication it has for the national health system. The first recommendation of the 1984 Process Review concerned the appointment of a Facilitator whose responsibility it would be to keep Pusat officials in DepKes, BAPPENAS and MOF appraised of what CHIPPS is accomplishing and what it means in terms of national policy. The job combines orientational skills as well as gentle persuasion regarding those type of changes required if CHIPPS is to be institutionalized. There is still no facilitator in place. The review team stresses the need to have this post filled as soon as possible.

Several possibilities exist as to who could carry out the facilitator function. One is to hire a special person whose only responsibility would be to observe the CHIPPS process in the provinces (in affect carrying out continued process reviews) and to make sure decision-makers in Jakarta are aware of the policy implications. A more practical suggestion, however, may be to have the Head of Planning at DepKes assume the responsibility. He would have CHIPPS support to organize workshops and seminars, publish material, hire consultants to assist in carrying

out this job. Since CHIPPS' objective is to upgrade provincial planning capacity, it is appropriate to have the Head of DepKes planning operations be in charge of promoting the institutionalization of the process as it demonstrates its effectiveness.

d) Publicity - One of the principle jobs of the Facilitator would be to publicize CHIPPS activities. There is currently a general understanding at the Pusal level of the CHIPPS project, but details and an appreciations for the policy implications of the project are more difficult to identify. Having provincial presentations, as Aceh did at P3M's regular monthly seminar (last Saturday of the month) in January, is a good means of letting people know about CHIPPS activities. Sumbar is ready and NTT should have data in several months to share. Reports on field studies and trials should be circulated to decision makers in Jakarta. But the provinces must remember these officials have very little time to read thick reports. Provinces should issue one page summaries of study results and policy implications in Bahasa Indonesia to all relevant decision makers in DepKes being sure that all those in Echelon II receive a copy. A series of CHIPPS Bulletins could be started. The possibility of having the Facilitator put together . . . . . quarterly newsletter reviewing significant findings and progress should be considered.

e) Institutionalization - As CHIPPS enters the second half of the project increased attention must be given to institutionalizing what CHIPPS has started. The concept of phasing, ending with the activity being supported in a regular Development DIP, has been discussed. The movement toward this objective must be an important indicator by which CHIPPS is evaluated in the future. Special concern has been raised about the future of the SPK and COME training activities in which CHIPPS has invested considerable effort and funds. Discussions with the involved officials must begin in the near future to explore the long-term future of such programs. The answer of putting the activities in the "Blue

Book" for donor agency funding is not a viable option since it avoids the question of institutionalization.

The possibility of expanding the CHIPPS approach to other provinces was raised by a Pusat official. USAID and GOI should consider over the next several years the support of the introduction of the epidemiologic health planning approach in one additional province (possibly Central Kalimantan which has expressed an interest and has an innovative Kakanwil). The effort would include an Indonesian LTC and a package of organizational development training and field studies/trials support. The LTCs and other experienced personnel from the three original CHIPPS provinces would be available to provide technical assistance and guidance. The exercise would not require huge financial inputs (possibly \$200,000 over a couple of years) while providing an excellent opportunity to test the replicability and ability to internalize the approach. It would be a transition from a large, donor-funded effort to a much more heavily Indonesian effort, a vital part of the institutionalization process.

f) Provincial Planning - Institutionalization at the provincial level must also become a greater concern. All three provinces must initiate planning meetings to discuss what will go into the provincial DUP. Less of this responsibility should be assumed by or fall on the pimpro. Two meetings, one prior to DUP preparation in June and one in August prior to submission, are recommended.

At the same time more emphasis must be placed on work with local officials at the province and kabupaten level to inform them of local health problems and the results of field trials to encourage greater local financial support. The flexibility provided by local resources offer a greater possibility for support of innovative programs than Pusat, especially in the short run.

As kabupaten-level personnel are oriented and trained in the epidemiologic planning techniques, they must be encouraged to participate

more actively in the planning process. The first attempts at such an effort are to take place this year in Aceh and should be monitored to determine what additional support is required. It is recommended that the other two provinces take steps in this direction in the near future.

g) Studies - Several process-oriented studies are recommended. In addition to the important SPK curriculum evaluation study being done in Padang and suggested for adoption in Kupang, two other studies can be identified as being helpful in clarifying several process-related issues.

- Cost Studies - Little attention has been given to the economic implications of the CHIPPS approach. While highly sophisticated economic analyses are not called for at this stage, the cost advantages of a better planned health program emphasizing locally identified priorities should be defined and understood clearly. Economic arguments can be persuasive when trying to convince policy makers of the value of a particular approach. Simple cost-effectiveness studies could be effective in establishing the validity of the CHIPPS approach.

- Process Documentation - There is still a great deal to learn about the planning/budgeting process at the kabupaten and province level. For one thing a clearer understanding is required of the different local funding sources (several possibilities mentioned in Section II). If changes are to be realized, there must be an accurate picture of what the existing system is as well as what resources are available to provide a flexible sources of funding to carry out CHIPPS-like health activities. A two-person study is envisaged - one based at the kabupaten level, the other at the province. The researchers should be trained and experienced in the process documentation methodology.

h) Central Procurement - The central procurement of vehicles and other equipment remains a problem, although it is not clear how the Sekneg problem is to be described. A clearer understanding of the basis for this problem is needed.

## VI. Recommendations

While a number of province-specific suggestions have been made in the discussion of each province's program, there are a number of recommendations that apply to the CHIPPS Project as a whole. The recommendations listed below are discussed in detail in the body of the review. The Review Team considers the recommendations to be feasible, within the funding capabilities of the sponsoring agencies and fully consistent with the original project agreement. The Review Team recommends that:

1. Facilitator - a senior Indonesian health professional serve in Jakarta to focus on process issues. The facilitator can support process progress in the provinces, orient officials at the Pusat level on the epidemiologic, health planning methodology and its policy implications, and coordinate publicity relating to CHIPPS activities.
2. Publicity - greater efforts be made to publicize CHIPPS activities. Seminars on the results of province-specific field surveys and/or trials can be arranged for decision makers. Brief summaries of project findings in Bahasa Indonesia should be prepared and circulated. The possibility of initiating a CHIPPS newsletter to inform policy makers about program progress can be investigated.
3. Institutionalization - increasing attention be placed on the institutionalization of CHIPPS-initiated activities, and incorporation of innovative province-specific interventions. Discuss the future funding resources for the SPK and COME activities.
4. Provincial-Level Planning - greater participation by CHIPPS-involved Kanwil and Dinas health staffs in planning and preparation of the province DUP. Discussions of those involved in project activities should be held at the beginning and end of the DUP preparation stage for the purpose of broadening input into the process.

5. Kabupaten-Level Planning - steps be taken to initiate the practice of planning CHIPPS activities at the Kabupaten level.
6. LTC for Training/Organization Development - an Indonesian consultant who has undergone the advanced training program under the HTRD project be appointed as the long-term consultant (LTC) in each of the three CHIPPS provinces to follow-up on organizational development activities that have been started but often not completed. In Aceh and NTT the LTC could participate as a trainer in planned HTRD project activities that the review team strongly supports and those that are expected to begin in the near future.
7. Administrative Procedures - Loan/GOI Fund Disbursement Monitoring and Loan Reimbursement Monitoring Forms be introduced as regular part of the CHIPPS reporting procedures. The forms are a management tool that should be prepared at the end of each quarter to track the status of disbursements and reimbursements. In addition, an Activities Completion Report should be completed for all activities on which all work has been finished and/or all funds expended. Regular technical assistance should be provided by USAID/I to facilitate province compliance with reporting procedures.
8. Studies - several studies be conducted to improve the understanding of process issues. Suggested studies are:
  - o Economic implications of the CHIPPS approach (cost-effectiveness improvements that are possible);
  - o Documentation of province and kabupaten level planning/budgeting procedures and process (possibly in Aceh);
  - o Evaluation of SPK training to ascertain the relevance of current curriculum and value of field training exercise (in Sumbar and NTT).

9. Follow-up - a review focusing on process issues be conducted midway between the mid-project review and the final project review (scheduled for January 1989). November 1986 is suggested as an appropriate time and coincides with a critical phase of the DUP/DIP cycle which will be important to observe.

ATTACHMENT I

Persons/Officials Interviewed

In United States:

Henry Mosley	Johns Hopkins (informal advisor on process issues)
Robert Northrup	Univ. of Alabama (Consultant, COME)
Patricia Taylor	CEDPA (Consultant, Nutrition Training for PKK)
Ann Voigt	CDC (Consultant, SPK Field Training)

USAID:

William Fuller	Director
Molly Mayo Gingerich	CHIPPS Project Manager, O/PH
David Korten	Consultant
Emanuel Voulgaropoulos	Chief, O/PH

Jakarta:

dr. Bimo	Acting Director, Yayasan Indonesia Sejahtera
dr. Brotowasisto	Chief, Bureau of Planning
dr. S. Gunawan	Chief, Directorate of Epidemiology and Immunization
Ig. Tarwotjo	Chief, Directorate of Nutrition
dr. Suyono Yahya	Director General Community Health Services
Dr. Rolf Lynton	HTRD Project Director
Michael Merrill	Consultant, HTRD

D.I. Aceh:

dr. Achmad Azof	Kakanwil
dr. Ali Azir	Chief, Planning Division, CHIPPS Pimpro
dr. Burhannudin Yusuf	Chief, Kanwil CDC
dr. Cut Idawani	Principal, Banda Aceh SPK
dr. Marwan	Planning Division
dr. S. Anwar	Dokabu, Kabupaten Pidie
Dr. Steven Solter	LTC

Sumatera Barat:

dr. Rafki Ismail	Kakanwil
dr. Bachtiar Karatu	CHIPPS Pimpro and Chief Planning Division
M. Remfil	CHIPPS Treasurer
dr. Reinal Fendi	Immunization Program
dr. Zainal	Tuberculosis Control Division
Daltias Churchil	Principal, Padang SPK
Dr. Roger Feldman	LTC

Nusa Tenggara Timur:

dr. H. Fernandez	Kakanwil
dr. Servas Pereira	CHIPPS Pimpro
dr. Gatot Suroso	Chief, Planning Division
dr. Lada	Chief, Kanwil CDC
dr. Nafsiah Mboi	Chief, PKK
Karen Smith	Part-time Consultant, PKK
Dr. Allan Lewis	LTC

Scope of Work for  
CHIPPS Mid-Project Review

A. Objective:

A team of 4-5 persons will conduct a mid-project review of the Comprehensive Health Improvement Project - Province Specific to assess project progress, analyze problems, suggest corrections and identify policy and program issues for future consideration.

B. Scope of Work:

1. Review, DepKes Pusat & Provincial and AID project documents.
2. Interview DepKes Pusat & Provincial, Bappenas and USAID officials to discuss the process of the Project's implementation and progress made in responding to recommendations of Process Review of May 1984. Identify impediments to Project implementation and suggest actions to overcome obstacles.
3. Examine with DepKes Pusat & Provincial and USAID official the management of the Project with special consideration of: a) the organization of the Pusat and Provincial Project Implementation Units (PIU); b) understanding of and support for the CHIPPS approach; c) provincial health staff awareness of and involvement in CHIPPS activities; and d) existence of problems/constraints in the Project's management system. Suggest actions needed to correct problems.
4. Review with DepKes Pusat & Provincial and USAID official the Technical aspects of the sub-activities being carried out or proposed as part of the Health Sector Improvement component of the Project. Describe the "process" used by the Provincial Health Office in determining the priorities of the subactivities selected. Describe existence of problems/constraints for implementation of technical subactivities, and suggest actions to overcome problems.
5. Review all components of the Project and ascertain the level of activity undertaken in each component as identified by the Project Agreement. Describe existence of problems/constraints for each component and suggest actions to overcome problems.

6. Identify changes that are occurring or have occurred in planning for improved delivery of health services in the 3 CHIPPS provinces and in DepKes Pusat because of CHIPPS project activities. Indicate how institutionalization of these changes are occurring or what actions need to be taken to assist the process of institutionalization, both in the provinces and in Pusat (DepKes and Bappenas).
7. Make recommendations based on the review on how CHIPPS implementation can be improved for the remainder of the project period.
8. Draft and discuss with the appropriate officials in DepKes Pusat, Bappenas, and USAID a report that will review the status of the Project findings of the review and outline recommendations for the remainder of the project period. Policy and program issues should be outlined for consideration for future Health program development following the CHIPPS approach.

ATTACHMENT III

Tuberculosis Prevalence Survey/Intervention (Aceh)

- Objectives :**
- . to determine the extent and where (which kabupatens) TB prevalence rates were highest
  - . to learn who was at highest risk of TB (age and sex) to set priorities for active case-finding
  - . to understand better the dynamics of TB transmission

**Date**

**Sample Size:** 100 villages, random examination of 12,967 adults over age of 15 in 8 kabupatens

**Results :** T.B. prevalence rate: 1.1%  
Male 1.25%; Female 0.89%  
Male to Female ratio was 1.4 to 1 (vs. assumed 5 to 1)

<b>Prevalence rate by kabupaten:</b>	<b>A. Tenggara</b>	<b>- 2.3%</b>
	<b>Pidie</b>	<b>- 2.1%</b>
	<b>A. Utara</b>	<b>- 0.8%</b>
	<b>A. Tengah</b>	<b>- 0.4%</b>
	<b>A. Barat</b>	<b>- 0.4%</b>
	<b>A. Besar</b>	<b>- 0.3%</b>
	<b>A. Timur</b>	<b>- 0.3%</b>

**Intervention:**

A one year test on three models of active case finding /case holding with varying kinds and amounts of incentive; all will use one village-level kader per 1000 population; activities will be carried out in 10 of 23 kecamatans in Pidie.

- . Rp. 5000 each month when bring at least on suspected TB case for sputum testing;
- . Rp. 5000 only for patients brought who are diagnosed sputum positive; if convert to sputum negative after 6 months, kader receives another Rp. 10,0000;
- . Given no money but be provided bicycle, shoes, shirt at beginning.

**Source:** "Neonatal tetanus mortality survey in Daerah Istimewa Aceh, May 1984"

ATTACHMENT IV

Neonatal Tetanus Prevalence Survey/Intervention (Aceh)

- Objectives:**
- . to determine if neonatal tetanus was a major cause of infant death in Aceh
  - . to find out where the high incidence areas were (i.e., which kabupatens)
  - . to help in deciding what control strategy would be most effective in reducing neonatal tetanus mortality.

**Date:** May 1984

**Sample Size:** 30 clusters (20,880 households visited) in 8 kabupatens to find 4,836 infants born in previous 13 months (WHO survey Methodology)

**Interviewers:** 60 midwives or nurses from Aceh Puskesmas.

**Supervisors:** From P3M/Jakarta, P2M Banda Aceh and kabupaten

**Results:**

- Infant deaths - 287
- IMR - 110/1000 live births
- Neonatal deaths - 101 (35.2% of infant deaths)
- Neonatal tetanus mortality rate - 20.4/1000 live births

**Estimated Number of deaths per year; perday - 6**

Mortality Rate by kabupaten (per 1000 live births):

A. Selatan	-	35.8
Pidie	-	32.1
A. Utara	-	29.6
A. Tengah	-	25.2
A. Tenggara	-	18.0
A. Barat	-	17.4
A. Timur	-	8.8
A. Besar	-	1.6

- Other Findings:
- . Women having two or more prenatal visits - 50.2%
  - . Women receiving two doses of tetanus toxoid - 10%
  - . Neonatal tetanus mortality rate of infants delivered by trained dukun - 2.7%, by untrained dukun - 2.9%;
  - . Rate inversely correlated with level of education

**Intervention strategy:** Sweep of kabupaten planned for September to November 1985; two doses of tetanus toxoid to 90% of child-bearing age women; support from community (PKK and ulamas) required; if results warrant, conduct sweep in A. Selatan; future actions - how to prove women fully immunized with tetanus toxoid before marriage license issued.

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**Sources:** Burhanuddin, S. Solter, R. Arnold, et al, Results of a Survey to Estimate the Neonatal Tetanus Mortality Rate in D.I. Aceh, (Banda Aceh: DepKes, 1984).

Loan/GUI Funds Allocated and Utilized (by IFY 84/85)  
(In Rp.--,(UUU))

Province	GUI	1982/83		% Loan	Utilization (SIAP as of 12/84)	1983/84		% Loan	Utilization (SIAP as of 12/84)	1984/85		Total	
		Loan	Total			Loan	Total			Loan	Total		
Aceh	118,123	90,495	208,618	43.4	92%	146,243	331,685	477,928	69.4	77%	272,500	245,724	518,
Sumatra Barat	68,690	81,776	150,466	54.3	86%	131,439	121,932	253,371	48.1	78%	175,000	338,750	513,
Musa Tenggara Timur	87,290	70,093	157,383	44.6	66%	112,948	103,948	216,896	48.1	63%	240,000	447,032	687,
Pusat	50,668	45,327	95,995	47.2	46%	83,364	6,476	89,840	11.6	88%	80,500	45,440	125,940
<b>Total</b>	<b>324,771</b>	<b>287,691</b>	<b>612,462</b>	<b>47.0</b>	<b>77%</b>	<b>473,994</b>	<b>564,041</b>	<b>1,038,035</b>	<b>54.5</b>	<b>75%</b>	<b>768,000</b>	<b>1,076,946</b>	<b>1,844,946</b>

Province	% Loan	Utilization (SIAP as of 12/84)	1985/86			% Loan	Total GUI	Total Loan	Total GUI & Loan	% Loan	Utilization (SIAP as of 12/84)
			GUI	Loan	Total						
Aceh	47.4	46%	191,842	618,301	810,223	76.3	728,708	1,286,286	2,014,994	63.8	71.7
Sumbaw	65.9	35%	195,000	439,085	634,085	69.2	570,129	981,543	1,551,672	63.3	66.3
N.I.T.	65.1	0	211,411	426,967	638,378	66.9	651,649	1,048,039	1,699,688	61.7	43.0
Pusat	36.1	34%	64,303	538,244	602,547	89.5	278,835	635,487	914,352	69.5	56.0
<b>Total</b>	<b>58.4</b>	<b>26%</b>	<b>662,566</b>	<b>2,022,677</b>	<b>2,685,233</b>	<b>75.3</b>	<b>2,229,321</b>	<b>3,951,555</b>	<b>6,180,676</b>	<b>63.9</b>	<b>59.3</b>

## Loan/GOI Fu Distributed Monitoring Form

Daftar : Perkembangan Realisasi Fisik dan Keuangan  
 Proyek P2KTF-I Sumatera Barat Tahun Ang-  
 garan 1982/1983 per 31 Maret 1985 .-

## 1. ( L O A N )

No.	Jenis Kegiatan/Tolok Ukur	Akhir 31 Ma- ret 1983.		31 Maret 1984		31 Maret 1985	
		Fisik	Keu.	Fisik	Keu.	Fisik	Keu.
I.	<u>PENGEMBANGAN TENAGA KESEHATAN.</u>						
1.	Peningkatan Pendidikan Guru Sekolah Perawat Kesehatan (5org.12 bln)	75	"	100	"	100	"
2.	Peningkatan Pendidikan Guru Sekolah Perawat Kesehatan (3 org. 45 hari)	0	"	0	"	100	"
3.	Pendidikan Perawat Kesehatan (40 org/ 12 bulan).	75	"	100	"	100	"
4.	Peningkatan Penyemang Kesehatan menjadi Perawat Kes. di SPK.Solok.	18	"	100	"	100	"
5.	Latihan Lapangan Kesehatan Masyarakat bagi siswa SPK,Padang dan Bukit-Tinggi.	0	"	0	"	100	"
II.	<u>PENGEMBANGAN SISTEM KESEHATAN PROP.</u>						
1.	Survey Kebutuhan Pendidikan Tenaga-Dokter Fakultas Kedokteran Unand.	100	"	100	"	100	"
2.	Lokakarya Perumusan Kebutuhan Pendidikan di Padang.	100	"	100	"	100	"
3.	Survey/Penelaahan Informasi Tentang Masalah Kes. di 5 Kecamatan.	0	"	142,8	"	100	"
4.	Pembinaan dan Pengembangan PKMD.	0	"	185,71	"	100	"
5.	Usaha Kesehatan Sekolah (U.K.S).	0	"	-	"	100	"
				136,8	-	162,8	100

Padang, 21 Maret 1985.-

Pemimpin Proyek :

Peningkatan Pembangunan Kesehatan  
 Terpadu Prop. I Sumatera Barat,

dto

= DR. BASILAR KARATU SIKI =  
 NIP. 140023213.-



Daftar : Perkembangan Realisasi Fisik dan Keuangan  
 Proyek P2KTF-I Sumatera Barat Tahun Ang -  
 garan 1984/1985 per 31 Maret 1985 .-

( L O A N . )

No.	Jenis Kegiatan/Tolok Ukur	Akhir 31 Maret 1985.-	
		P i s i k	Keuangan
I.	<u>PENGEMBANGAN TENAGA KESEHATAN.</u>		
1.	Peningkatan Pendidikan Guru Sekolah Perawat Ke- sehatan di SGP Bandung/ Jakarta.	60	45,44
2.	Pendidikan Perawat Kesehatan di SPK, Padang, Bu- kittinggi dan Solok.	70	51,53
3.	Peningkatan Penyemang Kesehatan menjadi Perawat Kesehatan di SPK Bukittinggi dan Solok.	70	62,34
4.	Praktek Lapangan Masyarakat bagi siswa Kls. III.	50	0
5.	Penataran Management Ka. Kandop dan Staf.	0	0
II.	<u>PENGEMBANGAN SISTIM KESEHATAN PROPINSI.</u>		
1.	Pelaksanaan Kurikulum Ceme.	75	7,93
2.	Lokakarya Ewaluasi Pelaksanaan Ceme.	0	0
3.	Program Usaha Kesehatan Sekolah (U.K.S).	100	16,38
4.	Survey Penyakit Jalan Pernapasan pada Bayi dan Anak.	55	61,25
5.	Survey Prevalensi Tuberkulosa di 14 Kabupaten.	85	48,21
6.	Peningkatan Pengelolaan Obat, Penataran Petugas- Pengelola Obat Puskesmas.	100	100
7.	Survey Tetanus Neonatorum utk daerah pedesaan.	100	86,66
8.	Peningkatan Kesehatan Ibu dan Anak.	70	25,36
III.	<u>PERENCANAAN PROYEK.</u>		
1.	Administrasi Proyek.	80	30,64
2.	Konsultasi Proyek Pusat - Daerah.	0	0
		610	431,8

Padang, 31 Maret 1985.

Pemimpin Proyek P2KTFI Sumbar,

ditto

- Dr. Rachid Karim SIM -  
 NIP:140023213.-

Daftar : Perbandingan Realisasi Fisik dan Keuangan  
 Proyek P2KTF-I Sumatera Barat Tahun Ang -  
 garan 1982/1983 per 31 Maret 1985 .-

2. ( A.P.D.N. )

No.	Jenis Kegiatan/Tolok Ukur	31 Maret 1983		31 Maret 1984		31 Maret 1985	
		Fisik	Kou	Fisik	Kou	Fisik	Kou
I.	<u>PENGEMBANGAN TENAGA KESEHATAN</u>						
1.	Pendidikan Perawat Kesehatan (40 org. 12 bulan).	75	150,84	100	94,75	100	94,75
2.	Peningkatan Penyandang Kes. - menjadi Perawat Kes. di SPK-Solok.	18	1,70	100	95,17	100	97,56
3.	Pengadaan Peralatan Pendidikan.	50	41,89	100	55,20	100	90,54
II.	<u>PENGEMBANGAN SISTEM KESEHATAN PROPINSI</u>						
1.	Survei Kebutuhan Pendidikan Tenaga Dokter FK. Unand.	100	0	100	80,25	100	80,25
2.	Lokakarya Perumusan Kebutuhan Pendidikan.	100	0	100	32,74	100	32,74
3.	Kunjungan Kerja dan rangka- Study Perbandingan ke Pusat Pendidikan Ceme Jawa Bali	100	25,17	100	98,33	100	98,33
4.	Penyusunan Kurikulum COME.	100	71,09	100	96,21	100	96,21
5.	Pertemuan Motivasi Lintas - Program (Sektoral di 2 Kab)	0	0	100	94,66	100	94,66
6.	Survei/Penyalahan Informasi tentang masalah kesehatan - di 5 Kecamatan.	0	0	42,96	-	100	100
7.	Pembinaan dan Pengembangan- PKD.	0	0	85,71	11,16	100	99,94
8.	Administrasi/Pembinaan Ke- atan di Kabupaten.	100	0	100	77,12	100	86,76
9.	Study Kelayakan Sarana Air Bersih dan Pembuangan Kotoran.	0	0	100	99,99	100	99,99
III.	<u>PELAKSANAAN BAGIAN PROYEK</u>						
1.	Administrasi Bagian Proyek.	40	143,33	100	71,32	100	90,01
		4123	16,00	97,69	95,41	100	40,06

Padang, 31 Maret 1985.-

Penjabat Proyek P2KTF-I Sum. Barat,

d/c

dr. Lucatlar Kartono, SKM

DIFTAR : Perkembangan Realisasi Fisik dan Keuangan Proyek  
P2KTI Sumatera Barat Tahun Anggaran 1983/1984  
per 31 Maret 1985.- ( APBN/GOI)

NO. :	JENIS KEGIATAN/ TOLOK UKUR :	31 Maret 1984		31 Maret 1985	
		Fisik	Keuangan	Fisik	Keuangan
I.	<u>Pembangunan Tenaga Kesehatan</u> :				
1.	Peningkatan Penyejang Kesehatan - jadi Perawat Kes.di SPK.Solok :	100	71,52	100	93,62
2.	Training Of Trainers. :	0	0	100	99,75
II.	<u>Pembangunan Mutu Kes.Pros.</u> :				
1.	Persiapan Pelaksanaan Kurikulum di COME. :	100	0	100	67,31
2.	Pelaksanaan Kurikulum COME. :	100	0	100	88,33
3.	Pembinaan Kegiatan COME :	100	59,65	100	100
4.	Pembinaan dan Pengembangan PICMD. :	0	0	100	100
5.	Survey Peranan Wanita dalam Pembangunan Kesehatan. :	0	0	5	0
6.	Vital Statistik Percontohan/Pen- cetakan kelahiran/Konartian di Kotya Jayakumbuh :	0	0	5	0
7.	Peningkatan Pengelola Obat,Pe- nataran Petugas Pengelola Obat: Puskesmas :	100	96,02	100	96,02
8.	Peningkatan Management Pimp- nan Staf Puskesmas. :	0	0	100	35,78
9.	Program U K S. :	0	0	100	51,64
10.	Program Gizi ( UPGK). :	0	0,31	90	64,31
11.	Pencegahan Gondok Endemik/Opera- sional Penyuntikan Ipiodol :	0	1,07	100	99,96
III.	<u>Pembiayaan Proyek</u> :				
1.	Administrasi Proyek :	90	72,53	100	95,67
		<u>3163</u>	<u>42,23</u>	<u>9706</u>	<u>92,67</u>

Padang, 31 Maret 1985.-

Revisi, in Proyek P2KTI-I Sumbar,

dtd

Dr. Isantiar Harutu, SKM

Daftar : . . . . . kembangan Realisasi Fisik dan Keuangan  
 Proyek P2KTF-I Sumatera Barat Tahun Anggaran  
 1984/1985 per 31 Maret 1985 .- (

( A.P.B.N. )

No.	Jenis Kegiatan/ Tolok Ukur	Maret 1985 .-	
		Fisik	Keuangan
I.	<u>PENGEMBANGAN TENAGA KESEHATAN.</u>		
1.	Pendidikan Perawat Kesehatan di S.K Padang, Ekt. Tinggi dan Solok.	70	9,04
2.	Peningkatan Penyeimbang Kesehatan menjadi Perawat Kesehatan di SPK B. Tinggi dan SPK. Solok.	70	29,76
3.	Penataran Management Ka. Mandap dan Staf.	5	0
II.	<u>PENGEMBANGAN SISTEM KESEHATAN PROPINSI.</u>		
1.	Pelaksanaan Kurikulum Gomo.	75	11,00
2.	Lokakarya Evaluasi Pelaksanaan Gomo.	0	0
3.	Peningkatan Manajemen Staf Pengajar PK. Urang.	60	50,00
4.	Pembinaan Kegiatan Gomo.	80	41,54
5.	Pembinaan dan Pengembangan PKMD.	35	0
6.	Administrasi/Pembinaan Kegiatan di Kabupaten.	80	56,42
7.	Program Gizi (UPGR).	35	0
8.	Pencegahan Gondok Enderik.	95	87,48
9.	Pembinaan dan Pengembangan Vital Statistik.	5	0
10.	Survey Penyakit Jalan Pernapasan pada Bayi/Anak	55	37,04
11.	Survey Prevalensi Tuberkulosa.	85	43,84
12.	Peningkatan Pengelola Obat Puskesmas.	100	0
13.	Survey Tetanus Neonatorum untuk pedesaan.	100	100
III.	<u>REKORD BAGIAN PROYEK.</u>		
1.	Administrasi Bagian Proyek.	80	63,43
2.	Zamsiltasi Proyek Pusat - Daerah.	0	0
Jumlah -		62,95	41,21

Padang, 31 Maret 1985.-

Pemimpin Proyek P2KTF-I Sum. Barat,

010

Dr. Soentir Marsu, SKM  
 NIP. 22062213.-

ATTACHMENT VII

Project Outputs  
(from Project Paper - USAID)

Project Outputs - Summarized for all Provinces

a. Manpower Development

1) Primary Health Nurse (Perawat Kesehatan or PK)

All three provinces will place high priority on expanding the numbers and improving the capabilities of the primary health nurse (PK) working in their Puskesmases. Since many nurses and midwives currently working in the provinces were trained under previous systems and have not had the full PK curriculum, two types of in-service training will be provided in addition to enrollment of new students in the full three year curriculum.

- 3 year course - 290 graduates by March 1986
- 3 month retraining - 840 graduates by March 1986
- 12 month supplemental training - 450 graduates by March 1986

In addition, it is expected that the quality of performance of all PK participating in the program will be enhanced through a) on-the-job training received as part of their participation in studies, surveys and intervention trials, b) expanded community participation training and c) in some cases short-courses for upgrading technical, analytical or managerial skills.

2) Nursing Teachers

Many additional teachers will be required to staff adequately the nursing schools (Sekolah Perawat Kesehatan or SPK) where the nurses will be trained. Therefore, in each province nurses who apply to become teachers will receive one year training and some current teachers will receive a six week upgrading course at special nursing teacher schools in Java or South Sulawesi. These teachers will serve as classroom and fieldwork instructors for the full three year curriculum, three month retraining and twelve month upgrading courses. A total of approximately 125 teachers are expected to be trained in all provinces by the end of the project.

In addition, some of the new or existing teachers will receive additional qualitative improvement through short-courses, observation tours to innovative programs or even formal degree training in Indonesia.

### 3) Rural Sanitarians

D.I. Aceh and NTT provinces feel a great need to expand more rapidly the number of sanitarians assigned to Puskesmas to promote environmental sanitation measures. They will send new candidates, and some persons currently assigned as sanitarians but who were trained only in a short crash program, to the newly expanded sanitarian schools in Bali (from NTT) and either Medan or Lampung (from D.I. Aceh) for the full two-year curriculum. Approximately 85 new sanitarians will be trained from the 2 provinces.

### 4) Laboratory Technicians

In D.I. Aceh a maximum of eighty sanitarians or other Puskesmas paramedical staff will be given a three month course at the provincial laboratory technicians training school (Sekolah Analis) in basic laboratory techniques and return to their posts. Although newly trained sanitarians should have received thorough training in laboratory techniques many of those trained earlier are now lacking in those skills. The regular laboratory technician students will receive an improved education as a result of the training to be provided to their instructors.

### 5) Laboratory Technician Teachers

Faculty of the Aceh Sekolah Analis will receive some training to upgrade their technical, teaching and administrative skills.

### 6) Community Volunteers

Through a number of health services intervention trials in all three provinces, especially the Community Participation Program, many villagers (especially women) will be recruited and trained to become volunteer health/nutrition workers. They will receive training in community diagnosis, case finding, simple treatments, case follow-up, illness prevention and health/nutrition/family planning education. Supervisors will receive training in supervisory, motivational and managerial skills.

### 7) Medical School Faculty

Faculty involved with the community medicine programs of the medical school being developed in D.I. Aceh and the one operating in Sumatera Barat will receive training in community medicine approaches directly from consultants and through short courses, observational tours and perhaps degree training courses.

## 8) Medical Students

All students, many of whom will become Puskesmas doctors upon graduation, will receive instruction, including extensive field work, in community medicine. The graduates will have a better understanding of community dynamics, community-level diagnosis and the relationships between conditions of the village and condition of the villager (health/nutrition status). They will also receive technical and managerial training intended to help them design and manage health sector programs as Health Center doctors/managers following graduation.

## 9) Health Center Physicians and other staff

Those persons participating in surveys, special studies and intervention trials will receive on-the-job training in the required skills as necessary. Various staff members will take part in observation tours and short-courses. Puskesmas physicians will have opportunities to exchange technical information and program experiences with their colleagues at provincial-level conferences/workshops.

## 10) Provincial and Kabupaten Health/Nutrition Officials

Many of these officials, responsible for managing the provincial health delivery systems, will receive training and otherwise improve or update their skills through a variety of means, including direct participation in surveys, studies, intervention trials and evaluations, observational tours and short courses and even some long-term academic degree programs in public health and management, mostly in Indonesia.

## b. Sectoral Systems Development

### 1) Epidemiological Survey

Various surveys will be carried out in each Province at different levels according to the problem and purpose, including village-level (by the villagers), regional and province-wide surveys. Among others, surveys will include protein-calorie malnutrition, nutritional anemia, goiter and cretinism, nightblindness, diarrheal diseases and tuberculosis. The surveys will have the objective of increasing the capacity of the provincial health staff to: a) identify and quantify the nature and extent of a particular problem, b) design and carry out the appropriate field trial and intervention, and c) decide on provincial policy and response to the problem. (All provinces)

## 2) Vital Statistics

A simple but reasonably accurate vital statistics gathering system will be initiated in pilot areas in one or two kabupatens per province. (All provinces)

## 3) Diarrheal Disease Control Program

In one kabupaten of D.I. Aceh the epidemiology and patterns of epidemic and endemic diarrheal diseases will be studied, alternative interventions analyzed and a kabupaten-wide control program undertaken. (D.I. Aceh)

## 4) Tuberculosis Control

Province-wide strategies for tuberculosis control will be developed (or revised) on the basis of surveys and intervention trials. (D.I. Aceh)

## 5) Nutrition Intervention Programs

Province-wide nutrition intervention programs will be developed (or revised) based on analyses of results of nutritional status surveys, food and consumption studies and intervention trials. These programs will include strategies and interventions to combat goiter and cretinism, iron deficiency anemia and Vitamin A deficiency, and protein-calorie malnutrition (PCM). (All provinces)

## 6) Role of Women

Opportunities to strengthen the role played by village women (and men) volunteers in health/nutrition/family planning improvement program will be studied. (All provinces)

## 7) Other Studies

Some other specialized studies to be carried out include the following:

- a). strengthening the school health system (NTT, Sumbar)
- b). upgrading the services of traditional birth attendants (All provinces)
- c). maximizing coverage of pregnant women with tetanus immunization (All provinces)
- d). improving cold chain maintenance for immunization program (Sumbar)
- e). rabies control (D.I. Aceh)
- f). drug management (NTT)

## 8) Information System

A viable two-way data and management information system will be developed to operate between province headquarters and the field in parts of at least one province (NTT).

## 9) Role of PKK in Health Sector Delivery System

The function of the PKK village welfare movement and its relationship to the Puskesmas will be analyzed in pilot project areas and findings incorporated in design of community-level programs supported by the Project in new PKK areas. Also the relationship between PKK supervisory networks and the Provincial Health services will be studied to adopt the most synergistic relationship possible. (NTT, possibly Sumbar and D.I. Aceh)

## 10) Community Medicine/Health Services Delivery

In Kabupaten Pasisir Selatan, Sumatera Barat the Medical School Community Medicine program (COME) and the Provincial and Kabupaten health services will collaborate to a) provide practical training to the medical students and b) provide intensified health services to the community as an example of what can be done through careful diagnosis and planning and dynamic organization and service delivery in collaboration with the community. (SUMBAR) The designers of the Community Medicine program for Universitas Syiah Kuala D.I. Aceh will receive some assistance in planning their program and training their instructors.

## 3. Project Inputs

### a. Technical Assistance

1) Long-term Consultants - One long-term consultant will be assigned to each Province for a period of four years. The consultants will be physicians with experience in public health and clinical practice. They will provide technical and management assistance to the Provincial Health Chiefs (Kakanwil) in their role as Project Officers in their respective provinces. The consultants will work closely with all elements of the Provincial Project Implementation Units providing inputs as appropriate in planning, training, design, implementation and evaluation of studies, surveys and field trials. They will also advise their counterparts on the need for and selection of short-term consultants who will provide specialized expertise not readily available in the province. Loan funds will be used to pay the basic costs of the consultants with some local support costs provided by the counterpart budget.

2) Short-term Consultants - Approximately 120 person months of short-term consultants will be utilized in all three provinces as needed. Their services are expected to be especially helpful with regard to training, survey methodology, design and analysis of field studies, intervention trials, management information and evaluation. The consultants will be recruited from Indonesia and abroad as appropriate. Funds for these consultants will be provided equally by the loan and counterpart funds. The counterpart share will include the in-country support for all the consultants including office space, secretarial services and intra-province travel by vehicle or plane.

3) Fellowships - Various provincial health officials and faculty of the medical and nursing schools will be sent for long-term academic training in Indonesia or abroad. The costs of this training will be shared equally by both the loan and counterpart funds.

4) Observational Travel and Short-term Courses - Costs of these training activities will be supported by both loan and counterpart funds.

#### 5) Community Medicine

Costs of consultants, fellowships and observation tours for both provinces (D.I. Aceh and Sumatera Barat) are included above. Operational costs for West Sumatera (D.I. Aceh will not be operational during the project period) will be included in both the loan and counterpart budgets. They will include such things as preparation of COME study modules, student and faculty transportation to and living costs in the field, field equipment, limited research funds, data analysis, vehicles, faculty salaries, etc.

#### 6) Other Manpower Development

Additional inputs required to produce the desired manpower development outputs may be considered in three basic categories - infrastructure, teaching costs and students costs.

School buildings required for training the nurses, and other para-medical personnel are either already available or will be provided by the Government. In most cases existing facilities are adequate. In others, decisions to expand existing schools or build new ones will be made soon by the Government. Either alternative is satisfactory for the Project. All costs of building construction and utilities will be assumed by the Government.

Teaching costs will include basic salaries of faculties (provided by the Government), honoraria or incentives for additional teaching load and more field site instruction

resulting from the Project, transport and per diems for teachers during field training, and appropriate equipment and materials. Costs of these inputs and others required will be provided by both the Loan and Counterpart funds and apportioned as most convenient..

Students costs will be handled in the same way. These costs will include tuition and fees, books and materials, food and lodging, transportation, and field training costs.

#### 7) Health Sector Studies and Intervention Trials

Inputs required for these activities will consist primarily of the time of professional and paramedical personnel and community volunteers in each province, funds for travel, per diems, and honoraria, vehicles and their operating costs, equipment and materials. These will be shared by the Loan and Counterpart funds as appropriate.

#### 8) Vehicles

Each province will require a minimum of 15 vehicles to be able to carry out Project activity, specifically field implementation, supervision and follow-up. Counterpart funds will support the acquisition of Project vehicles which will be essential to successful Project management.

#### 9) Equipment

Purchase of simple audiovisual equipment, physical exam equipment, laboratory equipment and health/nutrition/family planning materials for classroom use will be supported by Loan funds. Counterpart funds will provide some other capital equipment as appropriate.

#### 10) Evaluation

Costs of a mid-Project and final-Project evaluation will be supported by both Loan and Counterpart funds.

ATTACHMENT IX

Activity Completion Report

Tanggal Laporan Dibuat:  
(Date of Report):

Laporan Penyelesaian Kegiatan PIL NO.:  
(Activity Completion Report of PIL NO.):

1. Judul Kegiatan:  
(Title of Activity):
2. Tujuan Kegiatan:  
(Objective of the Activity):
3. Sasaran Kegiatan:  
(Targets of the Activity):
4. Hal-Hal Yang Telah Dicapai:  
(Achievements):
5. Tindak Lanjut:  
(Follow-up):
6. Biaya:      Loan \_\_\_\_\_      GOI APBN \_\_\_\_\_      Grant \_\_\_\_\_  
(Funding):  
  
Anggaran: \_\_\_\_\_  
(Budget):  
  
Realisasi: \_\_\_\_\_  
(Disbursements):

ATTACHMENT X

Neonatal Tetanus Prevalence Survey (SumBar)

- Objectives:
- . to determine the neonatal mortality rate and where (which kabupaten) it was highest;
  - . to determine the infant mortality rate in Sumbar;
  - . to determine the mortality rate due to measles complications.

Date: December 1984

Sample Size: 30 clusters (23,587 households visited) in 12 kabupatens to find 4,769 infants born in previous 13 months.

Interviewers: 70 midwives or nurses from SumBar Puskesmas.

Supervisors: 30 supervisors and 10 senior supervisors from P3M/Jakarta, P2M Padang and kabupaten.

Results:

- Infant deaths - 157;
- IMR - 103/1000 live births;
- Neonatal deaths - 42 (26.8% of infant deaths);
- Neonatal tetanus mortality rate - 8.8/1000 live births;
- Estimated number of deaths per year - 1542; per day - 4;
- Measles case fatality rate - 0.8%

Mortality Rate by kabupaten (per 1000 live births):

Pasaman	-	21.9
Pesisir Selatan	-	14.3
Padang	-	12.9
Agam	-	12.7
Sawah Lunto/ Sijunjung	-	6.5
Padang Pariaman	-	6.3
Solok	-	6.2
Remaining five	-	0

- Other Findings:
- . Women having two or more prenatal visits - 92.1%
  - . Women with two or more visit having received TT2 - 18.1%
  - . Neonatal tetanus deaths occurring after mother had two or more visits - 88.1%
  - . Neonatal tetanus mortality rate of infants delivered by trained dukun - 1.1%. by untrained dukun - 2.0%

Intervention strategy: Still being planned but considering upgrading of ante-natal care program to ensure pregnant women receive two doses of tetanus toxoid.

Sources: R. Fendy, A. Jacob, F. Burhanuddin, R. Arnold, R. Feldman, "Results of a Survey for Neonatal Tetanus Mortality, Infant Mortality, and Mortality caused by Measles Complications, in Rural Areas of West Sumatra," December 1984 (Padang: DepKes, 1985).

ATTACHMENT XI

HTRD Training Activities in Sumbar - Description

**Basic Assumptions:** Participants learn most from direct experience (therefore surveys/field work integral part of training);

Immediate experience is richest source of learning;

Skills better learned through action and practice.

- Activities (last Qtr. 1984):**
- . Nine modules completed for Puskesmas Management Training (government policy, puskesmas management, epidemiology, planning, interpersonal communication, leadership, community involvement, supervision, integrated program);
  - . Second batch of trainers trained (using selected trainers from first batch);
  - . Potential internal resource persons identified;
  - . Forty-hour seminar on consulting skills (12 received certificate);
  - . Matrix of training competencies (four groups - those who are qualified to train; train plus prepare training materials/modules; train, prepare materials plus work on various dimensions of before and after training; all rest plus design training systems, strategies and undertake advance consultancy work);
  - . Developed case teaching skills;
  - . Developed training system structure with appointment of new Bidang Diklat for training and organizational development;
  - . Utilized competencies developed in developing course to upgrade supervisory skills for SPK and COME field training exercises.

**Task Analysis (TA):** Purpose - to identify training needs, developing training program content for different functionaries and examining implications for national level policies;

Ten Steps - Introduction; steps in Task Analysis, Content Analysis, Content Analysis, Activity Analysis, Grouping Activities into tasks, Performance Analysis, Competency Analysis, Discrepancy Analysis, use of Task Analysis.

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**Source:** Materials written by Dr. Udai Parek including his final quarterly report.



ATTACHMENT XIII

NTRD - Outstanding Activities as of 12/1984 (SUMBAR)

<u>Items</u>	<u>Dr. Feldman's Role</u>	<u>Dr. Lynton's Role</u>
1. Papers from consulting seminar	Remind, assess, edit send for publication	
2. Training modules (8) (using puskesmas programmes experience) about 20 pages each module	Remind, get evaluated	Disseminate to other provinces
3. Tim Diklat structure	Pursue and feed to Rolf	Feedback, support
4. Training strategy	Pursue and feed to Rolf	Provide STC visit the province
5. Development of SPK, Padang	a. stimulate special project on evaluation b. training of SPK staff in case development	Facilitate FUSDIKLAT participation, national meeting provide STC
6. Utilisation of "trainers"	a. provision in next DIP b. search opportunities and feed to Rolf	Search opportunities and feed to Roger
7. Special projects a. Distance training b. Performance evaluation c. Indicators of puskesmas performance/effectiveness	Get proposals prepared, stimulate, send to Rolf for grants	a. respond to the proposals b. feedforward to Roger about new potential areas
8. Organization Development	Develop commitment, communicate with Rolf	Provide STC
9. Puskesmas Management Programmes	a. developing next strategy b. followup and evaluation	
10. Kabupaten Mgt. Programmes	a. develop a strategy, including areas of training etc b. stimulate starting programmes	Provide STC as needed
11. Medical school	a. Revive interest in development of cases in COMB etc (already evident) and arrange commitment b. communicate with Rolf	Arrange STC help in developing cases and case teaching competency



(1) NO. RUMAH ..... (2) GESA ..... (3) R K .....  
 BUNUN ..... R I .....

II. SITUASI KEHAMILAN - PERSALINAN - KEGUGURAN DALAM KELUARGA.

	(23) GRAVIDA	(24) PARA	(25) ABORTUS	(26) LAHIR MATI	(27) LAHIR HIDUP	(28) ANAK YANG MASIH HIDUP
JUMLAH						

III. PERISTIWA DALAM 12 BULAN TERAKHIR.

(29.1) KELAHIRAN HIDUP	(29.2) KELAHIRAN MATI	(29.3) KEGUGURAN SATU KALI	(29.4) KEGUGURAN DUA KALI

IV. SITUASI KESEHATAN :

APAKAH TERDAPAT ANGGOTA KELUARGA YANG MENDERITA SAKIT DALAM 4 MINGGU TERAKHIR ? ( 0 ) TIDAK  
 DILA ADA, ISILAH FORMULIR KESEHATAN TERLAMPIR UNTUK SETIAP ORANG YANG SAKIT

( 1 ) YA, JUMLAH ..... ORANG

V. SITUASI KEMATIAN :

APAKAH TERDAPAT ANGGOTA KELUARGA YANG MENINGGAL DUNIA DALAM 12 BULAN TERAKHIR ? ( 0 ) TIDAK  
 APAKAH TERDAPAT ANGGOTA KELUARGA YANG MENINGGAL DUNIA DALAM 1 BULAN TERAKHIR ? ( 0 ) TIDAK  
 DILA ADA, DOKTER YANG BERTUJUAN ANAK MELAKUKAN ANAMNESA DAN MENDIAGNOSIS SEBAB KEMATIAN UTAMA DENGAN MENGGISI FORMULIR KHUSUS KEMATIAN.

( 1 ) YA, JUMLAH ..... ORANG

( 1 ) YA, JUMLAH ..... ORANG

VI. RINGKASAN PERISTIWA KEMATIAN :

NO.	(30) USIA BERTIKA MENINGGAL	PENYAKIT UTAMA YANG MERUPAKAN BASIS RUMPLATNYA PENYAKIT (UNDERLYING ANTECEDENT CAUSE)	NO. KLASIFIKASI ICD IX	(31) NO. KODE PENYAKIT	TERJADI OLM SATU BULAN TERAKHIR	TERJADI DALAM 12 BULAN TERAKHIR
1						
2						
3						

ATTACHMENT XV

Puskesmas Study (NTT)

**Objective:** to enhance puskesmas support and effectiveness.

**Methodology:** a series of analyses and interventions which consists of six stages

- Stages:**
1. Create a sub-stratification procedure for ranking puskesmas according to capacity and potential and analyze present puskesmas performance according to task analysis (full-time consultant for three months who will develop and test newly developed instruments in 10-12 puskesmas);
  2. Improve puskesmas performance of assigned task using existing facilities and staff by developing prioritized objectives and means to identify constraints to achieving them (full-time consultant for four months to establish a procedure to establish achievable objective for puskesmas according to local problems and a method for teaching/training puskesmas managers on approach);
  3. Study external constraints to efficient puskesmas functioning (identify nature, extent, source, solutions);
  4. Form high level commission to consider solutions to the identified internal and external constraints;
  5. Improve puskesmas functioning through modifications in manpower, equipment and budgeting;
  6. Improve functioning of puskesmas supervisory/support level.

**Source:** Draft of "Outline for Puskesmas Study" by Allen Lewis (NTT, 1985).

ATTACHMENT XVI

Consultant List, 5/1984 - 5/1985 (NTT)

Indonesian

<u>Name</u>	<u>Institution</u>	<u>Purpose of visit</u>
Soeroto	NAMRU (Jakarta)	Malaria-Vector Control
Sandjaya	Nutrition Inst. (Bogor)	Malaria-Nutrition (Robek)
Djoko	DepKes (Jakarta)	Nutrition
Hermans	Nutrition Inst. (Bogor)	BMC
Bimo	YIS (Jakarta)	Epidemiology Workshop
Rossi	Gadjah Mada Univ.(Yogyakarta)	Epidemiology Workshop
Emma Wibowo	YIS (Solo)	PKK
Ratna Budiarto	DepKes (Jakarta)	Birth/Death Survey
Harry	Gadjah Mada Univ.(Yogyakarta)	Puskesmas Study

Foreign

Annie Voigt	CDC (Atlanta)	SPK
Patricia Taylor	CEDPA ( Washington)	Nutrition/PKK
Richard Arnold	CDC (Jakarta)	Neonatal Tetanus Survey
Doug Klauke	CIC (Jakarta)	Neonatal Tetanus Survey

Observational trips

Kupang Lele and Ende SPK visited Sumbar SPK (to observe field training); P2M visited Yogyakarta (to observe, immunization program); participants to Aceh for Second Epidemiology Workshop and Drug Management Workshop.

## PERKIRAAN LULUSAN TENAGA PERAWAT KESEHATAN DALAM REPUBLIKA IV

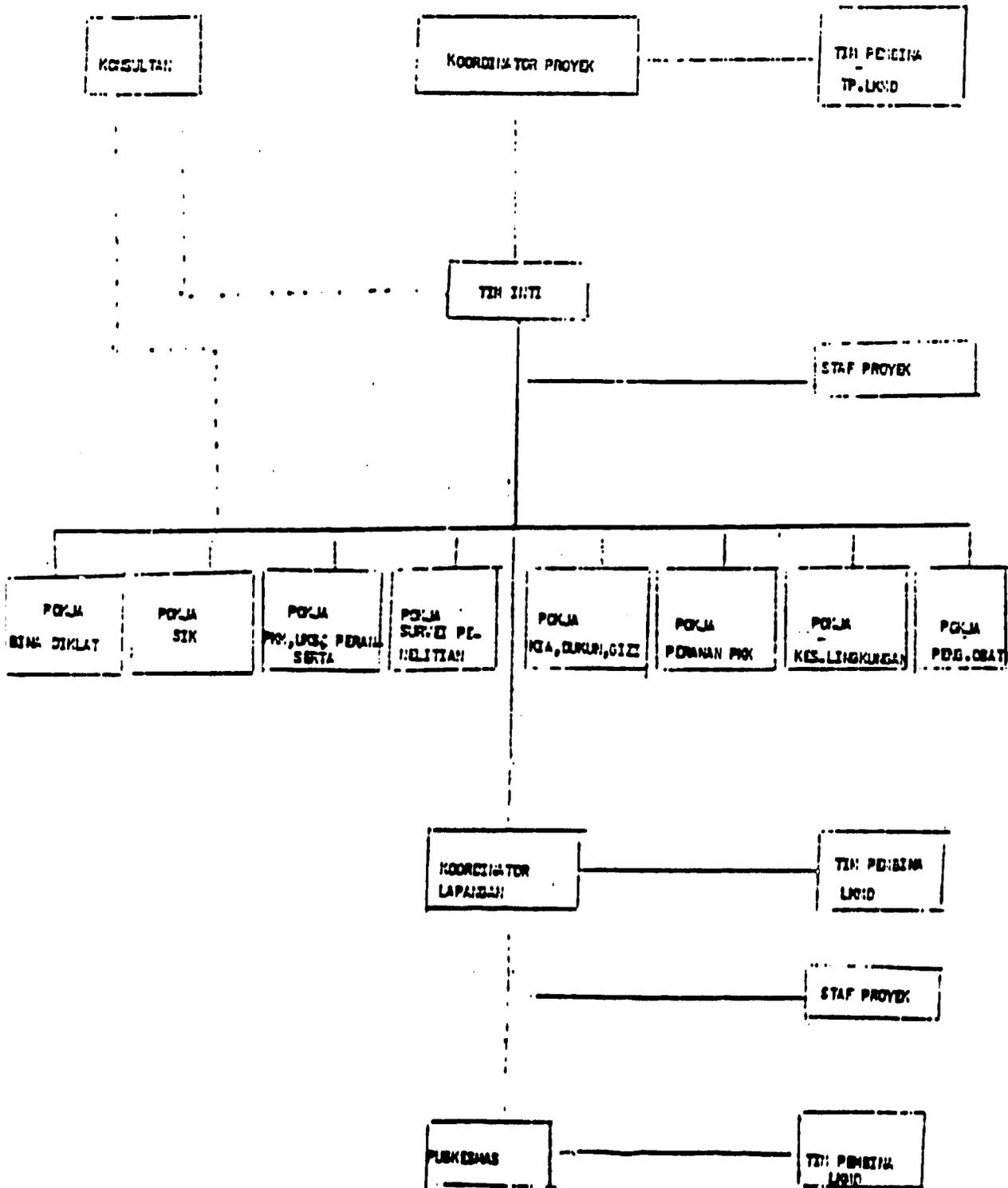
No.	Jenis Sekolah	84	85	86	87	88	Jumlah	Biaya	Keterangan
<b>A. Sekolah Pemerintah :</b>									
<b>I. Kupang :</b>									
-	Reguler	28	30	38	37	37	170	Pusdiklat ( Rutin )	* Rencana - Pencanbangan
-	Paralel	-	40	-	-	40 <sup>o</sup> )	80	Proyek P <sub>2</sub> IP	Klas Paralel
-	Atambua	-	-	-	30	20 <sup>o</sup> )	50	Proyek P <sub>2</sub> KIP I	Rangan biaya dari P <sub>2</sub> KIP I
-	Waingapu	-	-	-	20	-	20	s d a	thn. 1985/86
-	Waikabubek	-	-	-	30	-	30	s d a	
<b>II. Ende :</b>									
-	Reguler	37	-	40	45	40	162	Pusdiklat ( Rutin )	
-	Paralel	-	-	-	-	40 <sup>o</sup> )	40	Proyek P <sub>2</sub> KIP I	
-	Maumere	-	-	-	38	20 <sup>o</sup> )	58	s d a	
-	Larantuka	-	9	-	30	-	30	s d a	
<b>III. Lela :</b>									
-	Paralel	-	-	-	40	-	40	Proyek Pengan- bangan RSU.	
		65	70	78	270	197	680		
<b>B. Swasta :</b>									
<b>I. Lela</b>									
		12	22	27	26	20	107	S w a s t a	
<b>II. Waingapu Paralel</b>									
		-	-	-	10	-	10	s d a	
<b>III. Waikabubek Paralel</b>									
		-	-	-	10	-	10	s d a	
		12	22	27	46	20	127		
<b>IV. Luk - Luk Impres.</b>									
		154	-	-	-	-	154		
<b>V. Lulusan Perawat Kes. yang belum diangkat s/d. tahun 1984/1985</b>									
							110		

ATTACHMENT XVIII

PIU Structure (NTT)

STRUKTUR PENGELOLA

PROYEK PKTP I NTT



ATTACHMENT XIX

PIMPRO - Designate Responsibilities (NTT)

- . Head of Community Health Division\*
- (X) . Head of Primary Health Care Program
- (X) . Secretary of Puskesmas Development Project
- . CHIPPS Core Team
- (X) . Member CHIPPS Pokja
- (X) . Puskesmas Staff Trainer
- . Acting Head of Provincial Health Office (Dinas)
- . Intersectoral Trainer

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\* Dentist will be doing this job although Pimpro will be responsible person

(X) Will resign position with permission of KaKanwil

## ATTACHMENT XX

Summary of Obligation, Commitment and Disbursement  
 Project No. 497-0325, Loan 497-U-067  
 As of May 2, 1985

Project Element/ Province	Obligation	Commitment		Reimbursement		% Commitment
		Amount	% Obligation	Amount	% Obligation	
<b>Manpower Development:</b>						
D.I. Aceh		\$ 361,500.00		\$110,148.00		
Sumbar		\$ 350,620.00		\$142,850.00		
N.T.I.	\$2,585,000.00	\$ 352,123.00		\$ 65,861.00		
Pusat		\$ 40,896.00		\$ 28,155.00		
PIU/P (all provinces)		\$ 161,804.00		\$ 85,880.00		
Subtotal Manpower Dev.		<u>\$1,275,119.00</u>	49.32	<u>\$432,894.00</u>	16.74	33.94
<b>Field Studies &amp; Trials:</b>						
D.I. Aceh		\$ 294,667.00		\$152,186.00		
Sumbar		\$ 139,710.00		\$ 35,903.00		
N.T.I.	\$2,800,000.00	\$ 247,875.00		\$ 22,522.00		
Pusat		-		-		
Subtotal FS & T		<u>\$ 682,252.00</u>	24.36	<u>\$210,611.00</u>	7.52	30.86
<b>Community Medicine:</b>						
D.I. Aceh		-		-		
Sumbar	\$ 220,000.00	\$ 54,288.00		\$11,469.00		
		<u>\$ 54,288.00</u>	24.67	<u>\$11,469.00</u>	5.21	21.12
<b>Contingency:</b>						
D.I. Aceh		\$ 2,464.00		\$ 950.00		
Sumbar		\$ 10,077.00		\$2,727.00		
N.T.I.	\$ 395,000.00	\$ 7,910.00		-		
Pusat		-		-		
		<u>\$ 20,451.00</u>	5.17	<u>\$3,677.00</u>	0.93	17.97
<b>Total Project (Loan)</b>	<b>\$ 6,000,000.00</b>	<b>\$2,032,110.00</b>	<b>33.86</b>	<b>\$650,651.00</b>	<b>10.97</b>	<b>32.41</b>

ATTACHMENT XII

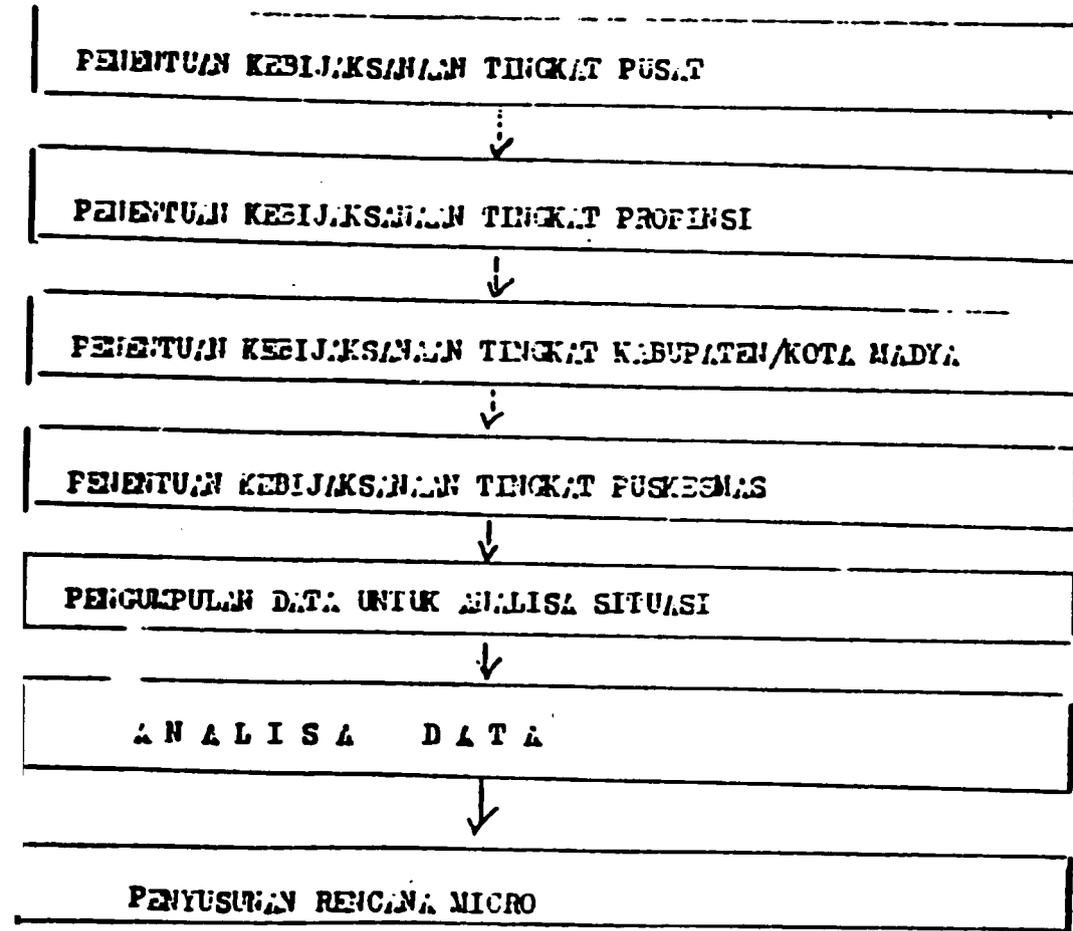
Summary of Obligations, Commitment and  
Disbursement, 497-0325 (Grant), in \$  
As of May 6, 1985

PROJECT ELEMENT/ PROVINCE	OBLIGATION		COMMITMENT		DISBURSEMENT	
	AMOUNT	% OBLIGATION	AMOUNT	% OBLIGATION	AMOUNT	% OBLIGATION
<u>Technical Assistance</u>						
D.I. Aceh	439,405		405,199			
Sumbor	423,880		190,562			
N.Y.T.	436,467		245,661			
Pusat	35,902		35,105			
Fully Liquidated	17,009		17,809			
	2,200,000	1,353,463	61.52	894,336	40.65	66.07
<u>Training</u>						
D.I. Aceh	79,541		50,625			
Sumbor	110,671		38,031			
N.Y.T.	28,609		17,789			
Pusat	2,822		2,822			
	300,000	229,650	76.55	109,267	36.42	47.57
<u>Field Studies &amp; Trials</u>						
D.I. Aceh	162,830		30,531			
Sumbor	101,890		9,913			
N.Y.T.	95,984		21,444			
Pusat	-0-		-0-			
	300,000	360,704	72.14	70,288	14.05	19.48
<b>TOTAL (GRANT)</b>	<b>3,000,000</b>	<b>1,943,817</b>	<b>64.79</b>	<b>1,073,891</b>	<b>35.79</b>	<b>55.24</b>

ATTACHMENT XXII

Diagram of Micro-Planning Process (BINKESMAS MODEL)

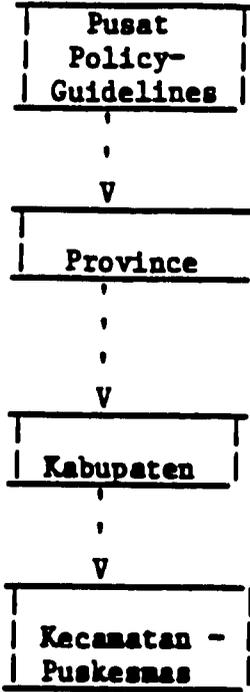
**E. LINGKAR-LINGKAR PENYUSUNAN RENCANA MICRO :**



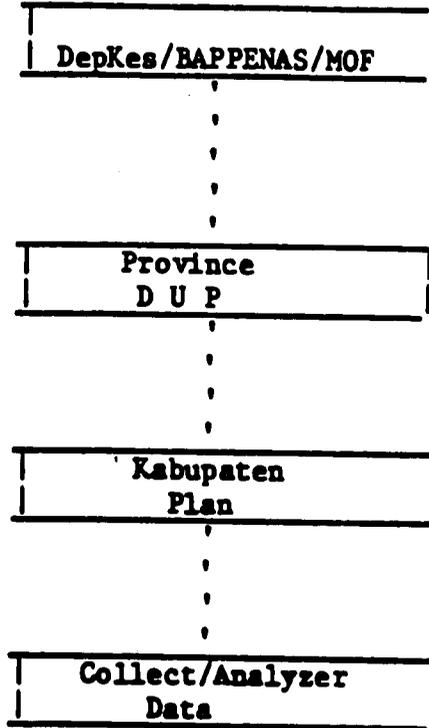
ATTACHMENT XXIII

Data-Based/Micro-Planning

POLICY



PLANNING



PROGRAM IMPLEMENTATION

