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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20522

PROJECT PAPER
AMENIMENT 1

VILLAGE FAMILY PLANNING/
MOTHER-CHILD WELFARE
497-0305

JULY 1986

USAID/INDONESIA

UNCLASSIFIED

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GLOSSARY

- Banjar - Sub-village administrative unit in Bali
- BKB - Social development program for children under 5 years old (Bina Keluarga Balita)
- BKKEN - National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional)
- CBR - Crude birth rate
- CMR - Child mortality rate, for children ages 1 to 4
- DIP - National budget for a list of project activities (Daftar Isian Proyek)
- FP - Family planning
- GOI - Government of Indonesia
- IEC - Information, education and communications
- IMR - Infant mortality rate
- Kabupaten - Regency - the administrative level below the Province
- Kader - Village-level health volunteer working at the weighing posts
- KAP - Knowledge, attitudes and practices
- KB-Gizi - Family planning - nutrition services, an integration of the National Family Planning Program and the Family Nutrition Improvement Program
- KB-Kes - Family planning - health services, an integration of five programs: Family Planning, Nutrition, Immunization, Diarrheal Disease Management and Mother/Child Health
- Kecamatan - Administrative level below the Kabupaten
- Kelian - Head of a banjar in Bali
- KMS - Weight recording card (Kartu Menuju Sehat)
- LKMD - Village Development Institution (Lembaga Ketahanan Masyarakat Desa)

- M&E - Monitoring and evaluation
- MOH - Ministry of Health
- NTB - Nusa Tenggara Barat, a province in Indonesia
- ORS - Oral rehydration salts
- ORT - Oral rehydration therapy
- PACD - Project assistance completion date
- PCM - Protein-calorie malnutrition
- PEM - Protein-energy malnutrition
- PGP - Program for Rural Nutrition Development
(Pengembangan Gizi Pedesaan)
- PKK - Women's groups for family welfare education
(Pendidikan Kesejahteraan Keluarga)
- Pokbang - Weighing post for children under-five (Kelompok Penimbangan)
- PosYandu - Post for delivery of integrated services for family planning, nutrition, immunization, oral rehydration and mother/child health (Pos Pelayanan Terpadu)
- P2K - Income generating schemes under the UPGK program
(Peningkatan Penghasilan Keluarga)
- R&R - Recording and reporting
- Repelita - National 5-year development plan (Rencana Pengembangan Lima Tahun)
- RKB-PKK - Sub-village family planning group organized by PKK
(Rukun Keluarga Berencana - PKK)
- SKN - Indonesia's National Health System
(Sistim Kesehatan Nasional)
- SKDN - Growth monitoring system (S = all children under 5; K = those issued growth/health cards; D = those weighed this month; N = those whose weight increased this month)
- TFR - Total fertility rate

- UPGK - Family Nutrition Improvement Program (Usaha Perbaikan Gizi Keluarga)
- UPPKA - Income generating for family planning acceptors, directed at women's groups (Usaha Peningkatan Penghasilan Keluarga Akseptor)
- VCDC - Village contraceptive distribution center
- VFP/MCW - Village family planning/mother child welfare

-1-

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET	1. TRANSACTION CODE <input type="checkbox"/> A = Add <input checked="" type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number 1	DOCUMENT CODE 3
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2. COUNTRY/ENTITY Indonesia	3. PROJECT NUMBER 497-0305
---------------------------------------	--------------------------------------

4. BUREAU/OFFICE ANE 04	5. PROJECT TITLE (maximum 40 characters) Village Family Planning/Mother-Child Welfare
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6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 10 5 30 9 01	7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4) A. Initial FY 8101 E. Quarter 3 C. Final FY 8161
---	--

8. COSTS (\$000 OR EQUIVALENT \$1 =)						
A. FUNDING SOURCE	FIRST FY 80			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
All Appropriated Total	300	700	1,000	1,350	12,650	14,000
(Grant)	(300)	(700)	(1,000)	(1,350)	(12,650)	(14,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country	2,681		2,681	18,150		18,150
Other Donor(s)						
TOTALS	300	3,381	3,681	1,350	30,800	32,150

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	530	530		10,000		4,000		14,000	
(2)									
(3)									
(4)									
TOTALS				10,000		4,000		14,000	

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each) 510 440 963	11. SECONDARY PURPOSE CODE 320
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12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)						
A. Code	BWW	R/H	DEL	INTR	NUTR	
E. Amount	14,000	2,250	9,325	9,325	3,000	

13. PROJECT PURPOSE (maximum 480 characters)

The project purpose is to reinforce the National Family Planning Program objective of a small, healthy family, with a corresponding increase in the level of family planning acceptance and continuance. This will be accomplished by a) a village-based health services system linked to the Village Family Planning Program that will decrease the prevalence of malnutrition and diarrheal disease among under fives; and b) community development and evaluation activities.

14. SCHEDULED EVALUATIONS Interim MM YY MM YY Final MM YY 9 8 7 1 2 8 8	15. SOURCE/ORIGIN OF GOODS AND SERVICES <input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify)
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16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page FP Amendment.)

The purpose of this amendment is to secure additional AID grant funding to allow for the continuation of innovative support for a community-based family planning-health services delivery program, research and evaluation, and program and policy determination, and to extend the project for approximately three years.

17. APPROVED BY	Signature: William P. Fuller Title: Director, USAID/Indonesia	Date Signed: MM DD YY 10 8 14 86	18. DATE DOCUMENT RECEIVED IN AID/M, OR FOR AID/M DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
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2. PROJECT AUTHORIZATION AMENDMENT NO. 1

INDONESIA

Village Family Planning/
Mother-Child Welfare
Project No. 497-0305

1. Pursuant to Section 104(b) of the Foreign Assistance Act of 1961, as amended, the Village Family Planning/Mother-Child Welfare Project for Indonesia was authorized on March 21, 1980. That authorization is hereby amended as follows:

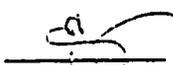
Paragraph 1 is amended to authorize planned obligations of not to exceed \$14,000,000 in Grant funds. The additional funding herein is authorized for obligation through September 30, 1986, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process. The Project Assistance Completion Date is extended to May 30, 1990.

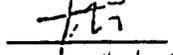
2. The amended authorization cited above remains in force except as hereby amended.

3. Prior to the execution of the Project Agreement Amendment the Congressional Notification waiting period shall have passed without objection and USAID/Jakarta shall have received a cable notification that funds have been allotted.

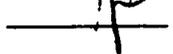
Signature: 

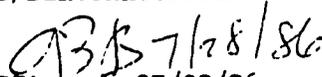
William P. Fuller

Clearances: OPH:EVoulgaropoulos 

PRO:TMahoney 

FIN:RMClure 

D/DIR:JAnderson 


Drafted:LA:GBisson: 07/28/86

3. PROJECT BACKGROUND

3.1 Magnitude of the Problem

A disproportionate percentage of the total deaths in Indonesia each year occur amongst children, infants, and newborns. In 1980 48% of all deaths occurred in children less than five years old, an age group which comprised only 14% of the population. Infants (children less than one year of age), which comprised approximately 2.5% of the population in 1980, accounted for 30% of total deaths. Neonates (children less than 30 days old) alone accounted for fully 12% of all deaths occurring in Indonesia in that year.

Not surprisingly, infant mortality rates (IMR) remain high, 98/1000 live births according to 1980 Census data and estimated at 90.3/1000 live births in 1984. The mortality rate for children 1-4 years of age was 21/1000 in 1980, and estimated at 17/1000 in 1984. Both of these sensitive indicators of health status surpass by several orders of magnitude the rates in the other ASEAN countries, and more closely approximate rates in South Asian and African countries.

The 1980 National Household Health Survey found that infectious and parasitic diseases such as typhoid fever, dysentery, diarrhea, diphtheria, tetanus, and measles caused 47% of all deaths in the first five years of life. Influenza and pneumonia caused another 24%, and meningitis, as the terminal condition of the above diseases, caused 10% of deaths in children under five. Neonatal tetanus and birth-related injuries comprise 66% of all mortality in the neonatal period, and respiratory ailments and diarrheal diseases cause 65% of post-neonatal (1-11 mos.) mortality. With existing health technologies, a substantial portion of this mortality can be prevented.

Malnutrition and low birth weight are considered frequent underlying causes of infant and child mortality. The synergistic effect of malnutrition upon susceptibility to infectious diseases was identified as

an associated cause for over 50% of childhood deaths in Java and Bali (GOI, 1982). Malnutrition in some form affects approximately 23 million Indonesians. Nearly one third of all children less than five years of age, or 10 million children, suffer from some form of protein-energy malnutrition.

Low birth weight babies (those weighing less than 2,500 grams at birth) were estimated to represent around 14% of all infant births in 1983. Low birth weight is associated with a higher risk of infection and death in infancy and early childhood. Puffer (1983) has found that mortality rates for those weighing less than 2,500 grams at birth are 5 to 9 times higher than for those in the 2,500 - 2,999 grams weight group, and 7 to 13 times higher than among those weighing 3,000 - 3,999 grams.

Although the causes of infant and childhood mortality are multifactorial with environmental, social, and economic determinants, the judicious use of selected health interventions can have a substantial impact upon reducing infant and childhood mortality. Improved nutrition, expanded immunization coverage, prevention of dehydration caused by diarrhea through oral rehydration therapy, family planning, and better maternal-child health care can all make a significant contribution to child survival. The health technologies for these interventions are all available in Indonesia's health services delivery systems. Bringing these technologies to the population at highest risk is the major remaining ingredient needed to effect substantial reductions in infant and childhood mortality and improve the quality of life.

3.2 Program Background

3.2.1 Program Goals and Purpose

The national adoption of a small, happy and prosperous family norm and the improvement of the health and nutritional status of the family are explicit goals of the Government of Indonesia (GOI), as stated in Repelita IV (the national 5-year development plan for 1984-1989).

Specifically, Repelita IV goals for 1989 include a reduction in the crude birth rate (CBR) from 33.5/1000 to 31.02/1000 and a reduction in the total fertility rate (TFR) from 4.1 to 3.4 children per mother of reproductive age. A reduction in the infant mortality rate (IMR) from 90.3/1000 to 70/1000, and a reduction in the mortality rate of children ages 1 to 4 (CMR) from 17.8/1000 to 14/1000 has also been targeted for 1989.

Longer range goals have also been set by the GOI for the National Health System (Sistim Kesehatan Nasional, SKN). By the year 2000, the IMR should be reduced to 45/1000 live births, a 50% reduction in the incidence of most communicable diseases should be achieved, and a 67% reduction in protein-calorie malnutrition (PCM) should be achieved.

USAID's Village Family Planning/Mother Child Welfare (VFP/MCW) Project, initiated in 1979, was designed to assist the GOI in achieving its goals for reducing infant mortality and crude birth rates. The purpose of the project is to reinforce the National Family Planning Program objective of a small, healthy and prosperous family along with a corresponding increase in the level of family planning acceptance and continuation. This is to be accomplished by establishing a community-based family planning-health services delivery system that links basic nutrition and health services with on-going village family planning operations in order to decrease the prevalence of malnutrition and diarrheal diseases among children under five years of age while reinforcing family planning behavior.

3.2.2 Program History

The Government of Indonesia established its National Family Planning Program in 1970, beginning with a clinic-based system to distribute reversible contraceptive methods in the provinces of Java and Bali using Ministry of Health (MOH) clinic facilities. BKKBN (the National Family Planning Coordinating Board) pioneered the development and replication of its community-based contraceptive delivery system

during Repelita II (1974-78). By 1979 this community-based system, which distributed oral pills and condoms through a Village Contraceptive Distribution Center (VCDC) staffed by volunteers drawn from influential community groups, had been established in all villages in the six provinces in Java and Bali, with further expansion to the Outer Islands I and II provinces during Repelita III and IV.

GOI efforts in nutrition were consolidated under the Family Nutrition Improvement Program (UPGK), established in 1975. The UPGK Program is an intersectoral effort combining, at that time, inputs from the Ministry of Health (MOH), Ministry of Agriculture, and Ministry of Religious Affairs in order to improve the health and nutrition status of mothers and children under five years of age through modifications in the nutrition-oriented behavior of mothers. During this period a strategy and package of nutrition-related services was developed for UPGK, but coverage was hampered by the lack of a delivery system which could bring these services to the target population, mothers and children under five years of age in rural areas.

A community-based approach for linking nutrition and family planning services using BKKBN's village family planning network as the delivery system was initiated in 1979, when the MOH and BKKBN signed a joint agreement to implement the KB-Gizi program. The KB-Gizi program combined the services provided by BKKBN through the village family planning network with those provided by the MOH through the UPGK program. The KB-Gizi program was supported by USAID Project 497-0305 VFP/MCW through the BKKBN, and was implemented in areas where acceptor rates for the family planning program were already high, while the MOH targeted areas

*Outer Islands I N. Sulawesi, S. Sulawesi, W. Kalimantan,
S. Kalimantan, Aceh, N. Sumatera, Lampung, W. Nusa
Tenggara, S. Sumatera, W. Sumatera.
Outer Islands II Bengkulu, Jambi, E. Kalimantan, C. Kalimantan, C.
Sulawesi, S.E. Sulawesi, Maluku, W. Irian, E. Timor,
E. Nusa Tenggara, Riau.

of the country where PCM was prevalent. The MOH-supported portion of the program was simply called UPGK. The Ministry of Religious Affairs was to motivate mothers to participate in the program, and the Ministry of Agriculture was to assist through the development of home gardens and education.

The nutrition activities at the village level consist of monthly weighings of children under five, the provision of nutrition and family planning information and education to mothers, food demonstrations to educate mothers on ways to prepare inexpensive but balanced meals, the provision of nutritional first aids (high dosage Vitamin A capsules to children once every six months, oral rehydration therapy, and iron supplementation for pregnant and lactating mothers), the referral of severely malnourished children to health center staff for treatment, education intensifying the use of home gardens, and the provision of simple family planning services to married women.

The focus of these activities is the village weighing post, or Pos Penimbangan (Pokbang), where the monthly weighings are done. Trained village nutrition volunteers, or kaders, manage activities at the weighing posts. In the KB-Gizi program, the family planning village distribution and acceptor groups served as the primary source of both program participants and kaders, and the program's management and implementation were integrated with BKKBN's routine village family planning activities.

The USAID-supported KB-Gizi program focused its efforts on developing replicable delivery systems for the integrated nutrition-family planning program in the provinces of East Java, Bali, and West Nusa Tenggara. Support for the KB-Gizi program was also provided by UNICEF through the MOH and the BKKBN. By the end of Repelita III (1984), this program's coverage had expanded to 20,000 villages. Together with the 14,000 UPGK villages under the MOH and also supported by UNICEF, the total program coverage was 34,000 villages in 1984.

A mid-term process evaluation of the VFP/MCW Project, conducted in 1982 (BKKBN, 1983), identified conceptual and operational constraints in the KB-Gizi strategic design (see Section 3.5.2). In particular, recommendations were made to improve the training, reporting and recording, IEC (information, education and communication), and income generating components of the project, and set the stage for a final evaluation scheduled for completion in 1986. The mid-term evaluation also identified constraints in service availability which limited the project's potential to have a positive impact on child survival.

In March 1984 cooperation between the MOH and BKKBN in providing integrated family planning and health services was formalized when the Directorate General of Community Health of MOH, the Directorate General of Communicable Diseases and Environmental Health of MOH, and the BKKBN Deputy for Program Planning and Analysis signed a Memorandum of Understanding. This document provides the legal basis for future joint projects and cooperation in family planning and health between the two agencies under the proposed VFP/MCW Project Amendment. Five major areas for integration and cooperation between the MOH and BKKBN were identified. These are nutrition, family planning, immunization, diarrheal disease management and mother-child health care. The delivery of these five program services is now conducted under the Integrated Family Planning-Health Services Program, or KB/Kes. During Repelita IV (1984-1989), KB/Kes has become the national program for decreasing fertility and maternal-child mortality through the expansion of weighing posts (Pokbang) to integrated family planning-health services posts (PosYandu).

Under the KB/Kes approach, the agencies involved have agreed to divide responsibilities functionally rather than territorially. For example, the MOH will be technically responsible for the program, and will develop information, provide training, and provide supplies such as weighing scales. The BKKBN will provide motivation, information and education. The roles and responsibilities of these two agencies regarding reporting and recording and monitoring and evaluation will continue to develop and

unfold. At present, however, the April 1984 National Working Meeting on Nutrition has identified the functions and responsibilities of these sectors. BKKBN will hold primary responsibility for developing the recording, reporting, monitoring and evaluation indices that will affect the entire KB/Kes program, based on its experience with the family planning and UPGK monitoring systems. The MOH line agencies that are responsible for the delivery of services (e.g., the Directorate General for Community Health, the Directorate General for Communicable Diseases and Environmental Health, the Sub-Directorate of Nutrition and the Sub-Directorate for Diarrheal Disease Control) will continue to record, report, monitor and evaluate specific information on nutrition, certain PosYandu activities, immunization, diarrheal diseases incidence, etc., that is relevant to their services delivery. The Ministry of Agriculture will also help motivate kaders and mothers, provide information, and work on the development of home gardens. The Ministry of Religious Affairs will provide motivation to program participants. This Memorandum also established an Integrated Task Force, representing the three signatories, which coordinates all inputs and plans to formulate all policy for the KB/Kes program.

The organizational linkages and redefined responsibilities embodied in the Memorandum of Understanding were first made operational for the KB/Kes program in Central Java, and will form the basis for the future implementation of this program in other provinces.

3.3 Project Accomplishments

USAID's Village Family Planning/Mother Child Welfare (VFP/MCW) Project has provided support to the BKKBN-implemented integrated family planning-nutrition program in East Java, Bali, West Nusa Tenggara (NTB), and most recently Central Java. Through this project, province-specific models of integrated, community-based nutrition, family planning, health, and income generating activities are being tested.

Since the project's inception in 1980, it has contributed to the formation of operational delivery models for integrated KB-Gizi and KB/Kes services, and has provided the research and development laboratory needed by the GOI to test, refine and modify various strategies and approaches, which in turn have provided the input for policy formulation and implementation. The following section summarizes some of the specific accomplishments attributable to this project.

3.3.1 Pilot Development of an Integrated Program

The VFP/MCW Project provided the forum in which the GOI has experimented with province-specific integrated program delivery models. The integrated nutrition-family planning model was deployed and tested in East Java and Bali first. Income generating schemes were then developed, tested, and integrated into the KB-Gizi program in both provinces. Health services such as immunization, oral rehydration therapy (ORT), and mother-child health care were then integrated into the KB-Gizi program in East Java to form the prototype for the integrated KB/Kes program.

Although the KB-Gizi and KB/Kes programs follow basic standard models developed through the VFP/MCW Project, Indonesia's ethnic, cultural, social, geographic and topographic diversity requires province-specific adaptations to enhance program effectiveness. In East Java, for example, intersectoral management teams have been established at each administrative level, comprising representatives from MOH, BKKEN, the Department of Local Government, the Ministry of Agriculture, Ministry of Religious Affairs, Ministry of Information, Department of Cooperatives and Bank Rakyat Indonesia, among others. These intersectoral teams are coordinated by the respective office of the local government, from the provincial to Kecamatan (the administrative unit below the regency) levels, with each sector having a well-defined role and responsibility in planning, implementing and monitoring the integrated program. This East Java model integrates not only family planning, nutrition and health services but also small credit schemes (P2K), a presidential assistance hybrid coconut incentive program for family planning acceptors, and civic

education components. This model, which was pioneered in ten East Java Kabupaten (regencies), has now been adopted province-wide.

In Bali, a banjar-based (sub-village units based on the traditional governing system) program has been developed under the leadership of kelian banjar (sub-village heads). This program was promoted through a special orientation and training of the kelian. At higher administrative levels, an intersectoral team similar to the one developed in East Java is being organized to oversee the integration of the family planning program, UPGK, the immunization program, diarrheal disease management services and the mother-child health program. In NTB, village nutrition services in VFP/MCW project areas are now implemented in smaller sub-village family planning acceptors groups under the leadership of PKK (women's groups for Family Welfare Education) members. Compared with the villages in East Java, NTB villages are much larger in geographic size and more diverse in ethnicity. Therefore, these sub-village implementing units are important in helping to overcome the problems of inaccessability experienced by isolated families.

In addition to the integration of services, the project has made contributions to the expansion of services. Under the project, BKKBN has established community programs and sub-village level weighing posts in 1,790 villages in East Java, 3,228 banjar in Bali, and 100 villages in NTB, in accordance with the guidelines established for the UPGK Program. Systematic monthly weighings for children under 5 years of age are now maintained in most of these villages or sub-villages by trained kaders.

3.3.2 Process Evaluation and Modification

A mid-term process evaluation conducted in 1982 (BKKBN, 1983) identified critical areas of project design that served as constraints to project implementation. The process of evaluation itself made a significant management contribution to the project. In addition, the findings of the process evaluation resulted in policy changes and substantial modifications and revisions in the program. Most important among these were:

Kader training: A modular system for kader training has been designed, tested and implemented in East Java, Bali, and NTB. Using the standard UPGK kader training curriculum, a series of teaching modules was developed to assist kader trainers. The modules are self-contained teaching packets which include clear statements of learning objectives, incorporate participatory teaching methodologies to stimulate the interest and participation of kaders in the training and simultaneously enhance learning, and contain the media and teaching materials needed to support the training.

The training modules are now being refined and expanded for use by MOH and UPGK training outside the VFP/MCW Project provinces (for example, East Java has adopted this approach for the province as a whole), and it is being applied for training in such other programs as UPPKA (Income Generating), BKB (Mental Development for Young Children), and in refresher training for kaders at the PosYandu. In Bali, a training module was developed and used for the orientation and management training of kelian for the KB-Gizi Program.

Weaning practices: This project is being developed as part of an IEC (information, education, communications) strategy. The breast feeding practices of mothers are now being examined to see what practices should be changed and how they should be changed (for example, should mothers supplement breast feeding with food, and if so, when, how often and in what form). Based on the results of this examination, a social marketing strategy will be devised to encourage correct breast feeding practices.

Income generation/credit schemes: The Program for Rural Nutrition Development (PGP) Project was designed to improve the ability of rural poor families to meet their nutritional needs through greater access to, and the efficient use of, income in producing/procuring food. Under this project, Rp. 100,000 (about US \$100) were offered to villages, which were then to use this money to improve the nutritional status of families. However, no clear guidelines were given on specific ways in which this money could be used. As a result, much of the money was unused or

unaccounted for, and many of the income-generating schemes that were devised failed.

Another community activity, the pilot Income Generation (P2K) Project, did experience success. In this project, small loans were given to the mothers of pre-school children for entrepreneurial activities. After careful design and planning for the phasing of project activities and their monitoring and evaluation, the project was tested and refined in East Java. An evaluation of the project found that P2K activities have served as a method for drawing attendance at weighing sessions. Further, kader dropout rates are lower in project villages than in non-project villages, largely as a result of giving kaders small incentives (e.g., providing uniforms) from the profits of the income-generating activities. Because of the improvements put into effect by this project, the original USAID- and UNICEF-donated funds for the PGP Project have now been funneled into the P2K Project, and other income-generating models in support of family planning are now being developed in Bali and NTB. Other BKKBN-implemented income generating activities that are funded by the GOI and other donor agencies are now adopting the guidelines, training methods and reporting system of P2K.

Research Capacity: The project has emphasized the use of on-going operations and health services research to constantly refine and improve the KB-Gizi and KB/Kes service delivery system. The mid-term process evaluation and the final project evaluation (see Section 3.3.5) are manifestations of this policy. Three research institutions, Udayana University, Airlangga University, and Brawijaya University, have conducted research through this project. All research has been overseen and coordinated by BKKBN's Center for Family Planning Program Studies. The experience gained through this project has developed the institutional capacities of these agencies to coordinate and conduct research, and has contributed to the continued growth and development of research institutions in Indonesia to support health and family planning programs.

3.3.3 Progress Toward Further Program Integration

Flexibility in project design allowed the VFP/MCW Project to respond to evolving GOI needs. The KB/Kes model was first tested in East Java through this project. USAID also served as a catalyst in the formulation of the Memorandum of Understanding signed in 1984 and the Task Force for Integration, which will effect the coordination and cooperation signified by that agreement. The Integrated Task Force, composed of the Directorate Chiefs for the five programs to be integrated at the PosYandu, is now being developed to provide an objective analysis of integration issues, identify problems and seek solutions to problems through collaboration, and provide recommendations for improvements in the integration of services across the nation. In addition, it should lead to coordinated efforts among the line agencies to identify policy options and support policy developments for the integrated program.

The Task Force provides an extremely promising opportunity to share experiences in the planning, implementation, monitoring and evaluation of program components for the KB/Kes Program. Linkages with other USAID-funded projects e.g., the Expanded Program for Immunization and the Diarrheal Disease Control Component of the Health Training, Research and Development Project) are also being coordinated through the Task Force. This forum will provide a source of valuable inputs for program and policy development in anticipation of planning for Repelita V.

3.3.4 Integrated Management of KB/Kes

Another aspect of integration concerns the refinement of management aspects of the program. In three Central Java Kabupaten, management trials are being conducted on the development of operational guidelines for the PosYandu, training, a recording/reporting system, and an intersectoral organizational scheme. A joint BKKBN-MOH integrated planning effort for all five program areas successfully allocated operational costs for equipment, medical supplies and local food for 1,666 PosYandu in Central Java from GOI and community resources. As a

result, the VFP/MCW Project funds are no longer required for operational support costs in the Kabupaten where these PosYandu are located.

Through the Task Force, a procedure for the replication of successful program management components is now being developed, based on the VFP/MCW activities in Central Java. This procedure includes the preparation of manuals, a series of provincial training exercises, and improved management and supervision techniques to ensure that attention is paid to improving the quality of services delivered through the program. In addition, seminars are being held at the central level to encourage the exchange of information on a number of integration issues, including training, reporting and recording, PosYandu services, management and system improvements, etc.

3.3.5 Further Project Evaluations and Modifications

Preliminary findings have emerged from the final 2-year program evaluation, which is anticipated to be completed in September 1986. This analysis, which is being conducted by Community Systems Foundation of Ann Arbor, the BKKBN Center for Family Planning Studies, the University of Udayana, University of Airlangga, and the University of Brawijaya, has three components. The first two are 1) a large household survey of women of reproductive age (particularly the mothers of children under 5, conducted in East Java and Bali, and supplementary community profiles, and 2) a resurvey of 79 banjar that were included in the 1980 Bali baseline survey (University of Udayana, 1980). The third component consists of 12 determinant studies, which will focus on various issues of program implementation and provide a qualitative interpretation of the household and community surveys.

The household and determinant studies have provided not only BKKBN but also the research centers of participating universities with valuable experience in conducting studies of this magnitude. An intensive data analysis, which is the focus of a special 1986 summer training program at the University of Michigan, is designed to upgrade the research skills of Indonesian counterparts in the BKKBN, MOH, and several universities.

An important contribution of the project in this regard is the inclusion of social scientists and nutritionists in the research process. Traditionally, health and other medical researchers were the major participants in these surveys and evaluations. However, project findings that sociological and economic factors often play an important role in a family's nutritional status have prompted the inclusion of nutritionists, anthropologists, sociologists, psychologists, economists and demographers in the project team and have helped these participants gain both academic and field experience in the KB/Kes Program. In addition, their research methodologies have broadened the scope of the project's research techniques and evaluations.

3.4 Challenges Facing GOI Efforts to Improve Program Effectiveness

While considerable progress has been made toward developing successful implementation models, the MOH and BKKBN still face several major challenges in their efforts to deploy the KB/Kes Program throughout Indonesia. These challenges concern assumptions that need to be tested, and strategies that need to be reexamined subsequent to the shift from KB-Gizi to KB/Kes.

The mid-term evaluation of 1982, the provincial report for East Java (BKKBN, East Java, 1986), and preliminary findings from the final program evaluation have identified a number of obstacles impeding successful program implementation. These are summarized below.

3.4.1 Program Participation by Mothers

On average, fewer than half of the mothers and their children attend the monthly weighing sessions (GOI, 1983; Kumbara, 1985). This raises important questions concerning the reasons for the underutilization of posts. The high percentages of villagers' household budgets expended on health care (often for expensive private health services and for medicines) suggests that demand in some form is high. Yet mothers are clearly not choosing to make use of the essentially free services which are being offered through the program.

The KB-Gizi evaluation determinant studies, particularly in Bali (Kumbara, 1985), examined incentives and disincentives regarding attendance at weighing posts, as seen from the mothers' point of view. Four incentives for attendance were noted. First, mothers are instructed by village leaders to attend and it is difficult for them to ignore these instructions. Second, weighing posts provide an avenue for social interaction with other mothers and children. Third, mothers can sometimes obtain medicines at the weighing posts. Last, supplementary meals at the posts serve to calm children, making weighing and other examinations easier.

Despite these incentives, a number of factors seem to inhibit mothers' attendance. First, most mothers attend posts primarily for reasons other than obtaining health services for themselves and for their children. They do not feel that the program does much to serve their specific health-related needs or demands. Second, many mothers cannot attend because they are busy earning a living or attending to household chores. Third, many mothers lack easy access to the posts which are too far from their homes. Fourth, weighing post schedules are often inappropriate (set in the morning, when most mothers are busy), or schedules are altered unexpectedly making it difficult for mothers to attend regularly. Fifth, mothers usually will not bring children who are ill because they fear this will expose them to greater illness. Last, mothers are becoming bored with the weighing routines at the post, especially since most do not understand either the weight-recording card (KMS) or many of the messages presented through posters and other means.

3.4.2 Program Impact on Mothers' Knowledge, Attitudes, and Practices (KAP)

Child health is often dependent upon mothers' willingness and ability to perform certain health-care actions in the home, and upon mothers' judgments concerning whether and when to seek medical care for their children. Consequently, mothers' KAP is a strong determinant of child health. For this reason, a central element of both the KB-Gizi and

KB/Kes programs has been the educational component, consisting of a series of key program messages delivered both publicly in the weighing posts and privately.

The program has had mixed success in its educational component. For example, there appears to be a general increase in mothers' knowledge concerning certain messages (such as the importance of breast feeding, use of ORT, and association of eye dysfunction with lack of Vitamin A-rich vegetables in the diet), yet the limited studies currently available suggest that these improvements may be resulting from factors other than the presence of program activities (e.g., mass media and nurse-midwives). Wirawan's (1986) review of data at the village level in Bali showed no significant differences between participant and non-participant villages across a wide range of KAP and other health variables, except for immunization. These findings await more precise analyses at the household level which are now being carried out with Community Systems Foundation.

While their findings remain tentative, a number of evaluations have identified certain problems that would at least partially explain low program impact on mothers' KAP levels. Most important, while the education component has received strong emphasis in the program's design, in terms of both training and material investments, it receives limited if any emphasis in actual post activities, and home visits are rarely undertaken. Posts are often too large and procedures too confused to allow adequate attention to educational activities. Visual aids are often not available. When they are available, they are confusing or inappropriate due to untested illustrations and use of the national, instead of a local, language. Another major problem is that mothers cannot understand the complicated growth monitoring cards (KMS), and there is therefore no way for kaders to introduce new messages by tying a particular mother's activities to a record of specific change in her child's health.

3.4.3 Kader Effectiveness

Both the KB-Gizi and KB/Kes programs depend heavily on village kaders for program implementation. Kaders are in many ways at the crossroads of both programs because all village-level activities are expected to be carried out by them. For this reason, much of the program's training and supervisory efforts are invested in kader.

Because of the major role which kaders are playing in the program, they have received much attention in various research efforts. These studies' findings have suggested that while much has been accomplished in terms of improved training of kaders (including development of new modular courses), there are also a number of problems concerning low motivation and effectiveness which have yet to be fully addressed.

Kader drop-out rates average roughly 35% within the first few years of the establishment of weighing posts. This represents a major drain on program resources and tends to preclude the build up over time of local expertise for carrying out program activities. While studies suggest that some kader drop-out is related to uncontrollable attrition (for example, marriage or schooling outside the village), much of the problem in fact has to do with low kader motivation. While there are many cases of strongly committed kaders, Mariyah (1985) found that upon close examination, a high percentage of kaders wished to withdraw from the program but felt they could not do so for social reasons.

The degree of kader motivation appears to be related to the methods of their selection, levels of supervision, and types of compensation. While kaders are generally described as "volunteers," they are in fact usually "drafted" by village heads. The limited pool of persons with the free time and educational prerequisites for kader training in any given village may preclude alternative selection methods. Supervision, both by GOI field personnel and local semi-governmental groups such as the PKK, has been shown to be effective in some cases in making kaders feel that their role is being supported.

A third problem related to kader motivation concerns compensation. Program policy dictates that direct wages cannot be paid from program funds. Various other forms of compensation have been tried (e.g., provision of uniforms), but with the exception of the provision of small wages from the P2K, none has been particularly effective. Further experimental efforts are therefore needed.

Concerning kader effectiveness in the tasks assigned to them, the tentative findings of various studies are mixed. It does appear, however, that when kaders are adequately trained, they may be a more effective instrument in certain types of tasks (collecting data, motivating small groups to participate in the posts) and less effective in others (such as general educational activities).

Given the central role that kaders are playing in the KB/Kes Program, it is essential that the above problems be investigated further and that innovative solutions be developed and tested.

3.4.4 Accuracy and Utility of Village-Level Service Statistics

Kaders collect information on four elements of child health on a monthly or more frequent basis: the number of children under the age of 5 in their village (S), the number of children with growth charts (K), the number weighed that month (D), and the number gaining weight that month (N). In addition, kaders record information on the distribution of Vitamin A capsules and DPT (diphtheria, pertussis, tetanus) and BCG (tuberculosis) immunizations. Using the SKDN system, the kaders can theoretically make individual decisions on who should be targeted for more intensive interventions. Although the responsibility for collating these data is properly the responsibility of BKKBN or MOH field workers, this administrative task normally falls to the kader.

Since the UPGK program's inception, questions have been raised regarding the accuracy, specificity and utility of the SKDN data, not only for triggering management decisions and educational messages by the kader,

but also their aggregate value for monitoring the program. While collecting SKDN is relatively simple, reporting and recording is time consuming and laborious, creating an excessive burden on the kader. Because of the information demands of the reporting and recording system, more kader training time must be devoted to that task than to their other critical responsibilities such as weighing children and health education.

The mid-term and final evaluation results have raised further questions about SKDN. The information is not always relevant for kaders and does not seem to enhance their ability to give immediate feedback to mothers. Furthermore, kaders do not always understand the importance of collecting and collating the SKDN data, nor how to utilize this information for targeting high risk children or tailoring educational messages. The temporal demands of recording and reporting leave them with less time for their primary function, to communicate with mothers. Important issues regarding responsibility for data collection, types of data being collected, and their utility for the program need more critical review.

3.4.5 Monitoring and Evaluation System

SKDN data collected at the village level are aggregated monthly at the sub-district, district, and province administrative levels, and quarterly at the national level. Data collection and compilation at the weighing post level functions reasonably well, despite tolerable inaccuracies in reporting. However, because of inadequate supervision of kaders by paramedical personnel and field workers, the utilization of this information is compromised. These personnel are not trained in integrated monitoring and supervision, and thus fail to provide kaders with the necessary educational and skills development opportunities, and hence the ability to solve problems in a more immediate fashion.

As information is passed on to higher levels where the need for assessing impact is more important, the system loses some of its effectiveness. For example, the system of assessing program effectiveness using N/D does not correct for children who have not received two consecutive monthly

weighings, and does not allow for estimates of continuity of individual children's participation. Also, program planners need more specific information than what is now collected in order to evaluate the program's progress and make more sophisticated judgments on program direction. These problems are complicated by the lack of clear delineation of responsibility, lack of funds, poor coordination and communication both between and among departments and sectors, and the lack of mechanisms for seeking advice.

As a result of incomplete information collection and the still inadequate research/analysis capabilities at various levels of the system, the potential for the use of program monitoring and evaluation data by government officials at the regency, provincial and sub-district levels has not yet been fully realized.

3.4.6 Program Integration

Although there appears to be strong commitment at all levels for the implementation and expansion of the program, the coordination of the program's extensive inputs among various sectors has proved to be a difficult undertaking. The number of activities to be integrated (nutrition, health, birth spacing, home food production), the number of government agencies (MOH, BKKBN, Ministries of Agriculture and Religious Affairs) and health workers (over 40,000 kaders alone), and the number of villages in which the program operates (over 30,000) have complicated the problems of scheduling resources and activities in efforts to integrate the program.

Significant progress has been made to integrate program activities at the highest levels through the formation of the Task Force for Integration, and mechanisms for coordinating the program will continue to be tested. However, lack of sufficient human and financial resources for coordinating activities continues to be a major obstacle, as will manpower shortages, particularly in the MOH. For example, the vertical nature of many program activities, where each agency trains its own

kaders, prepares its own IEC materials, has its own budget, defines its own target villages, has its own reporting and recording system, etc., constrain effective integration. The results of this lack of integration lead, for example, to IEC messages that are inconsistent among programs, duplicative reporting and recording, and lack of consistent incentives to kaders.

Coordination at the provincial and district levels for the various vertical line agencies remains weak. As is the case at the national level, differences in approaches and strategies to health and family planning, budget and manpower shortages, uneven budget allocations, and sectoral priorities all have negative effects on program coordination and integration at the provincial and district levels.

Last, although integration has been attempted at the lowest (PosYandu) level, it has occurred only to a very limited extent there. Integration at this level has contributed to some efficiencies in services delivery, but integration efforts have sometimes delayed the development and implementation of activities, resulted in an uneven quality of services at the village level, and placed strains on the delivery system. The number of children actually being weighed remains low at 40% and some villages have been late in beginning their program activities because of funding and other delays.

3.4.7 Program Coverage

The East Java 1986 Provincial Report, which examined the 1985 coverage for family planning acceptors, monthly weighings, immunizations, diarrhea cases treated, and mother child health services in 10 East Java project posts, indicates that the project's impact upon expanding coverage for these essential services was ambivalent and unremarkable.

In general, all 10 project posts slightly increased their coverage of new family planning acceptors, compared to control posts in the same Kabupaten. The project posts reached between 43 and 86% of their target

levels, while non-project posts reached between 38 and 85% of their targets. For existing family planning acceptors, the project posts were able to reach 68 to 78% of their target for maintaining program participation. The actual impact of the project is difficult to assess in this instance because of previously-high acceptor rates in some Kabupaten and because some project managers also managed activities at non-project Kabupaten, and may have adopted project concepts there.

The attendance of children under the age of 5 at monthly weighing sessions was not as high as originally anticipated. The project met 42.3% of its 1985 target for weighing (the national and East Java averages were 40.7 and 36.6% of target, respectively).

The project's impact on the immunization of children under the age of 5 was mixed. Target coverage for two types of vaccinations rose from their 1984 levels: Polio 1 immunization rose from 58% of its 1984 target level to 60% in 1985, while Tetanus Toxoid (TT1) rose from 31 to 45%. Coverage for three other immunizations fell: BCG (tuberculosis) fell from 78% of target in 1984 to 65% in 1985, DPT (diphtheria, pertussis, tetanus) fell from 73 to 66%, and measles from 39 to 33%. Data on subsequent immunizations indicate that follow-up may be more efficient through an integrated services approach. Repeat vaccinations on DPT3 rose from 28% of target in 1984 to 40% in 1985, while those for Polio 3 rose from 19 to 44%. However, TT2 vaccinations fell slightly, from 24% of the 1984 target to 22% in 1985. The immunization of pregnant women also fell overall, by about 7.6% in 1985.

The number of diarrhea cases treated among children under 5 was targeted at 50% but only 45% were treated.

Mother-child health services also showed mixed results. New referrals for pregnant mothers ranged from 35 to 55% of target, while coverage for lactating mothers ranged from 32 to 89% of target. Coverage for infants and children ranged from 58 to 114% and 18 to 48% of target, respectively.

3.4.8 Transfer of Program Responsibility to Villages (Alih Peran)

One of the core assumptions in the development of the KB-Gizi and now KB/Kes programs has always been that village recipients would come to take increasing responsibility for running and financing the program. For this reason, it was expected that GOI subsidies could be reduced over time. However, while post "self sufficiency," or alih peran, has remained an important objective, a clear determination of just how much responsibility the local post should or could take, and a clear-cut plan of action for achieving this, remain in the early stages of development.

A recent study in Bali (Tangking, 1985) has attempted to identify the characteristics of posts that have been able to take responsibility for a minimal number of post activities (weighing children, recording weights, writing reports, etc.), with minimal BKKBN supervision. Involvement of the banjar head, presence of a dynamic program organizer in the village, proper supervision and training, and effective kaders were all found to be essential ingredients in the more successful cases. However, the number of KB-Gizi posts in Bali and East Java that have been able to achieve even this minimal degree of self sufficiency still lags behind expectations.

Concerning the transfer of financial responsibilities, some consideration has been given to developing local financial resources. An unsuccessful transfer of limited funds to banjar without clearcut guidelines for their use was tried in Bali. A more successful effort was the development of the P2K in East Java. However, though strong potential contributors to the coverage of post costs, most P2K are facing problems of management which will probably require greater GOI supervision. This, in turn, will increase program costs in a different way.

The problems of achieving some level of alih peran, however defined, represent a major challenge facing the KB/Kes program because all costs cannot continue to be borne by the GOI and donors. Initial expectations may have been unrealistic. It will be necessary over the next year or

two to clearly define the level of responsibility that communities can and should assume and to work toward this end in concrete ways.

3.5 Future Actions

The development of an integrated services delivery system through the PosYandu, which builds on the family planning-nutrition weighing post model, is still in its early stages. However, the urgency of reducing fertility and mortality rates requires immediate intervention. In response to this need, the GOI plans to expand the community-based integrated family planning-health services model (KB/Kes) to all 27 provinces, so that by the end of Repelita IV all villages throughout Indonesia will have a PosYandu.

The PosYandu will deliver between two and five services: family planning, nutrition, diarrheal disease management, immunization and mother/child health. For this purpose, the GOI has appropriated a budget for equipment and logistics support for the weighing posts (the basic point of services delivery where other health services will be integrated). The expansion of KB/Kes is receiving substantial operational support during Repelita IV from UNICEF (full support for 11 provinces) and the World Bank (11 provinces). As part of this donor support, the MOH will cooperate with BKKBN to develop, refine, and test service delivery and supervision strategies, a monitoring and evaluation system, and a policy-making apparatus through the VFP/MCW Project. These refinements will be incorporated into the national program, and in the replication efforts in all 27 provinces.

4. PROJECT AMENDMENT DESCRIPTION

4.1 Project Purpose and Goal

The purpose of the Village Family Planning/Mother-Child Welfare Project is to "reinforce the National Family Planning Program objective of a small healthy family, with a corresponding increase in the level of family planning and continuance." This is to be accomplished by developing and maintaining:

- . a village-based system -- linked to the Village Family Planning program -- of food and nutrition surveillance, education, and services that will decrease the prevalence of malnutrition and diarrheal disease among children under 5, and
- . community development and evaluation activities designed to stimulate community initiative and self-reliance in identifying and meeting children's nutritional needs.

The project's goal is to "contribute directly to the Repelita III goal of improving the nutrition of mothers and children under 5 years, reducing infant, child and maternal mortality, and therefore, will support the long-term Ministry of Health goal of reducing the country crude death rate (CDR) from 17 deaths per 1,000 population to below 10 by the year 2000" (USAID, 1979).

The original project purpose and the means for achieving it, as well as the original project goal, will continue to be supported through this amendment.

4.2 Project Amendment Rationale

The Government of Indonesia has signalled its commitment to the integrated KB/Kes service delivery approach through its decision to expand the PosYandu nationwide during Repelita V. Operational support

for the replication phase will be provided with assistance from the World Bank in 11 provinces and from UNICEF in 11 provinces.

Through its support first for the KB-Gizi integrated strategy and then for KB/Kes, the VFP/MCW Project has been instrumental in the design of the core model for the PosYandu, and has contributed toward the development of a replicable prototype for the upcoming expansion phase. However, results from the health service and process evaluation studies conducted to date indicate that flaws remain in several components of the delivery system, as described in Section 3.4. Some of these are currently being addressed, for example, the development of training modules to enhance the effectiveness of kader training, but still need further refinement. Others have received little or no attention due to limited research defining the extent and parameters of the deficiencies.

The integrated service delivery approach embodied in the PosYandu is still in its early development stages; hence, such flaws are not uncommon. Since the form and content of the PosYandu are accordingly still somewhat flexible, a unique opportunity presents itself at the present time to identify the remaining weaknesses in the integrated service delivery approach and rectify them before the final service delivery model is approved for replication.

The design and conduct of research and development efforts to overcome these problems in the delivery system are premised on four assumptions held by the Government of Indonesia and USAID regarding rural health services in Indonesia. First, mothers are the primary catalyst in programs designed to improve the health and nutritional status of children. Second, a strong community support system exists in rural health care that can be used to motivate mothers. Third, kaders are the primary vehicle for transferring knowledge to mothers about the children's health. Fourth, a program of integrated services can be developed through a constantly-evolving process, with services added at each village post as the village is able to support them. These four assumptions, which will lead to a dynamic and effective integration of

health services, form the basis for the activities to be undertaken in this project amendment.

At present, neither the MOH nor other international donors are in a position to carry out and manage the research and development efforts needed. BKKEN, supported by USAID, has taken significant steps in recent years to improve its research and development capacities. It is therefore in a strategic position, with continued USAID assistance, to collaborate with MOH in conducting further operations research aimed at addressing present and anticipated problem areas in the KB/Kes Program. The MOH, which has primary responsibility for implementing the KB/Kes Program, will then be in a position to adapt and to test research and evaluation findings for implementation on a larger scale.

A three-year VFP/MCW project amendment is therefore necessary to provide the time and additional resources to support operations research aimed at testing and redesigning various program components. These components include: the PosYandu, the monitoring system, management and supervision, policy development, and the replication of program innovations.

4.3 Objectives of the Amendment

This amendment will assist BKKEN and the MOH to identify and address problems and constraints that hamper the efficiency and effectiveness of the integrated family planning and health services program (KB/Kes). USAID's primary role under this amendment will be to support the research and development needed to identify problems, design and test possible solutions, and establish the policy framework to incorporate refinements into the KB/Kes service model, which will be replicated nationwide during Repelita V.

The amendment has five major objectives:

1. to identify problems and develop modifications and refinements

in operations components of the PosYandu service delivery system aimed at achieving greater program effectiveness.

2. to revise and redesign the supervision system component of the integrated Kb/Kes system to enhance management effectiveness.
3. to develop a built-in monitoring system that routinely collects, analyzes, and feeds back relevant data on key program variables to improve management decision making.
4. to develop and establish a policy-formulating mechanism that can assess refinements recommended by the research and development activities and translate them into policy.
5. to incorporate policies and system refinements into the nationwide integrated Kb/Kes program being replicated during Repelita V.

In addition to these five objectives, USAID will continue to support the operations of integrated program activities in the villages that are in their first year of program implementation (see Section 4.4.6). This practice is in accordance with the original project agreement, which states that three years of support for such villages is a reasonable amount of time for these activities to be institutionalized in the communities, which then can become self-sufficient in providing program services. This provision of support, plus the activities under the five objectives of this amendment, will assist the GOI in achieving its goals of improving the quality of health care, expanding the efficiency and effectiveness of program coverage, and developing the mechanisms necessary to move from the integration of two programs to the five-program KB/Kes system.

4.4 Components of the Amendment

The thrust of this amendment is primarily on research and

development for policy formulation. The operations, supervisory, and monitoring elements of the integrated KB/Kes program will receive the research and development emphasis (systems refinements and design). Conscious effort and attention will be given to feeding research findings into a policy-formulating mechanism centered on the BKKBN-MOH Integrated Task Force, and accessing the policy-making process in both agencies. In addition, operational support will be continued for recently-established integrated posts in new project villages. Each of the amendment components is described below. Figure 1 depicts the history of the program to date plus the components envisioned under this project amendment.

4.4.1 Modifications and Refinements in Operations Components of the PosYandu Delivery System

This component of the project is aimed at improving the design of the PosYandu in an effort to achieve greater program impact on health conditions at the village level. The problem areas currently reducing impact (see Section 3.4) include low mothers' participation, minimal impact on mothers' KAP, problems with kader effectiveness, low program coverage, lack of an adequate M&E system, limited program integration, and lack of plans and mechanisms for transferring program responsibility to villages. Under this component, BKKBN and MOH will address these issues through a program of special studies, assessments, operations research, and pilot trials. A particular strength of this R&D program is that it includes a continued questioning of the assumptions underlying current approaches as well as further refining PosYandu elements.

While the precise research agenda will be determined during the Transition Phase by the ITF, in concert with USAID and appropriate offices of the MOH and BKKBN, enough is now known from past and current efforts to identify several key research topics which will be considered under this component. The research design will be kept flexible as project amendment activities proceed in order to ensure that the most appropriate areas are investigated.

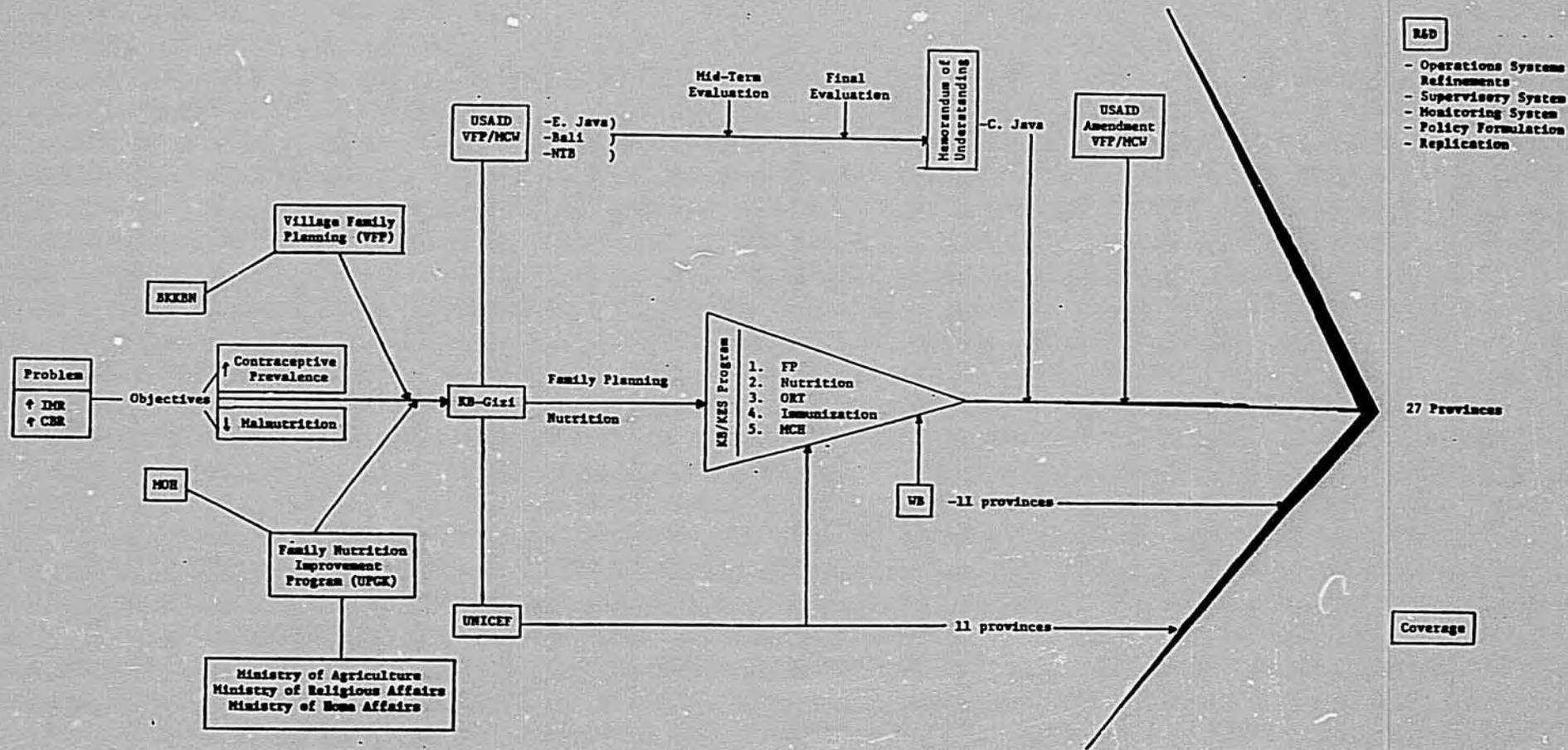


Figure 1. Evolution of KB-Gizi to KB/KES, USAID and Other Donor Participation

- Development of Sub-Desa Units. Currently available data indicate that both smaller weighing post size and a lower ratio of kaders to participants show high correlation with increased program participation. Such findings have lead BKKBN to experiment with decreased post sizes through an increase in the number of sub-desa posts. PosYandu units are currently expected to consist of 15 to 20 participating families each. These efforts may well overcome some of the problems of low mothers' participation and low kader motivation. However, given the additional costs of multiplying the number of PosYandu units, it will be important to experiment with optimal sizes and compositions of posts.
- Studies of the Roles of Village Administrators and Village-Based Organizations. BKKBN has recognized the importance of village and sub-village leaders in ensuring that kaders are appointed, weighing post activities are carried out, and that mothers participate. In Bali, the increased involvement of hamlet leaders (banjar) in the KB-Gizi post through a modular village leader training program has been cited as a major program improvement. Given the success of this effort, the amendment will support further investigation of and experimentation with the role of local leaders at both the village level (through the LKMD) and sub-village level in garnering village cooperation for program activities.

A similar, but different potential source of local support for KB/Kes activities is government-sponsored village organizations such as the PKK. Further study and experimentation are needed on the roles that PKKs and other local organizations have been and could be playing in the KB/Kes program.

- Improvements in Kader Effectiveness. Given the major role that kaders are expected to play in the KB/Kes program, it is

essential to address the problems of high drop-out and limited kader effectiveness. In response to earlier evaluations, more effective approaches to kader training have now been designed. Further research and experimentation are now needed to address several other key kader-related issues:

Task Categories: Assumptions are currently built into the program concerning the capabilities of unpaid and often minimally educated kaders. What is needed is a clearer sense of what kinds of tasks kaders have and have not been able to perform well, given the resources available for training. For example, a common experience across a wide range of programs is that kaders do not do as well as expected as educators. This could be a result of still inadequate training, but it could also result from the fact that mothers may not accept health-related information from minimally educated and trained "equals." On the other hand, kaders may be quite successful, under the right circumstances, at motivating mothers and informing them about post schedules.

Motivation/Incentives: Kaders officially receive no compensation for their work, and this appears to be a major factor in problems of low motivation and reduced effectiveness. What is needed is a clearer sense of what, if any, compensation kaders themselves feel they need or deserve. Findings from studies of this kind can be fed into experimentation with different incentive structures, to determine the most effective methods for increasing kader motivation at lowest program costs. These incentives might include scholarships, free medical services in health centers or hospitals, certificates of recognition, prizes such as sewing machines or motorcycles, and award certificates from the Camat, Bupati, governor, and chairman of BKKBN, Minister of MOH and the President.

Supervision. Current data identify the lack of kader supervision as a factor in both low kader motivation and reduced kader effectiveness. We need to identify reasons for the current lack of adequate supervision, to experiment with ways of overcoming current constraints, and develop more effective supervision.

- Participants' Demand for Program Services. Underlying earlier program design was the assumption that villagers (especially mothers) would be drawn to program health services by an inherent demand for health-related information. The high percentage of household budgets allocated to health services indeed indicates great concern with health. In recent years, however, it has become increasingly clear that while less-educated villagers do demonstrate a high demand for curative services, they do not place a high value on preventative efforts especially when they require the assimilation of new and (to them) unproven knowledge. This suggests that developing a successful PosYandu may require a judicious integration of curative and preventive elements. To this end, a clearer understanding of what the demands are for health services is essential, and research efforts will be directed toward such "recipient focused" studies. Drawing on these studies, experimentation with various "mixes," for example, of curative and preventative elements, can be undertaken.
- Development of an IEC Plan and Improved Materials. Conclusions concerning the precise extent of program impact on mother's KAP await completion of the final program evaluation. However, current evidence suggests the need for major efforts to strengthen IEC elements in the KB/Kes program. Although certain program weaknesses involving kader training materials and methods have been identified and addressed to some extent, other weaknesses in current IEC

efforts remain. For example, the curative vs. preventive distinction in villagers' health concerns will need to be more fully considered in future efforts to improve IEC methods and materials, so that the information provided to mothers is more concretely grounded in their immediate health problems. We may find, for example, that certain kinds of information might be best provided through kaders or mass media, while other information might be more successfully provided through nurse mid-wives and other health workers in the course of curative efforts. A carefully designed IEC-related research effort addressing these issues can help to identify the most promising and cost effective approaches to health education. A clear overall IEC plan will then be formulated.

- Improvement of the KMS. The fact that both mothers and kaders have difficulty in comprehending and using the KMS (weighing recording) card is widely recognized. Studies will therefore be aimed at identifying the source of these difficulties, and at identifying and testing modifications in the KMS that would increase the comprehensibility and, ultimately, the utility of this important tool.

- Improvements in Training at the Village Level. In an effort to improve both kader effectiveness and the support role of village leaders and the PKK, further refinements will be undertaken in the modular training courses that have already been developed to overcome the constraints inhibiting kader effectiveness. Special efforts will be undertaken to reach, motivate and educate mothers at the village level in order for them to assume greater responsibility for program implementation.

- Further Investigation of P2K and Other Potential Sources of Post "Self-Funding." At least some responsibility for funding the PosYandus is expected to be taken over by participant

communities, and this will require identification and experimentation with various forms of self-financing. One promising approach is the pilot P2K (village-level credit provision units) effort in East Java. A recent P2K evaluation found that, where successful, the P2K appeared to reduce kader drop-out and had a marginal influence on weighing post participation. However, only about 25% of the pilot P2Ks showed evidence of good capital turnover and growth, despite high program investments. This suggests that further investigation of P2K problems and potential is needed before this component is considered for integration into the PosYandu design on a wider scale.

Although no more capital funds will be provided for P2K expansion under this project amendment, monitoring, recording and reporting, data management, supervision and training systems need to be developed further to support ongoing and future P2K groups funded from revolving funds and other sources. BKKEN is committed to expanding the P2K component as a strategy to raise funds that will be used to support operational activities in the integrated posts (e.g., kader incentives, supplementary feeding, menu demonstration).

Possible operations research activities that can be supported under this systems refinement component are:

- simplified recording and reporting system, including data management and feedback mechanisms;
- the development of built-in monitoring and supervision mechanisms with the community, e.g., camat and lurah;
- identification of beneficiaries and practical skills training needed to maintain a productive activity; and

- feasibility studies on productive activities in specific regions (agricultural, fishing and cottage industries, etc.).

Meanwhile, alternative sources for funding for local contribution to PosYandu activities will also be explored. These might include, for example, funding from village accounts, charging participating mothers small sums for demonstration meals, PPK donated funds, etc. Referring back to the issue of participant demand for PosYandu services, the willingness of local communities (especially post participants) to contribute in some way to funding post activities is a good measure of the extent to which services provided are meeting recipients' perceived needs.

- o Development of a Plan for Transferring Responsibilities to Communities: A core expectation of the KB-Gizi program supported under the VFP/MCW Project has been that recipient communities would assume major responsibility for post management and post finances after an initial start-up period. For this reason, posts were to be funded for only three years. The challenge is essentially to adjust the program's management expectations of communities to what communities are in fact willing and able to give for the health services received. The importance of avoiding the implementation of a PosYandu which is too costly for villagers (both in funds and management time) is fully recognized. The first step in designing a strong plan of action for transferring at least some responsibilities for the PosYandu will be to develop a better understanding of the constraints that have delayed transfer in KB-Gizi PokBangs in the past. Clearly, a major factor in determining villagers' willingness to support such programs is the degree to which services meet their demands. One line of investigation will therefore focus on how the PosYandu can maximize its ability to meet recipient demands. A second line of research will be aimed at determining what level of management and financial burdens

communities are willing to assume for the PosYandu's health services.

Using the findings of these studies, a clear overall plan can be formulated that defines precisely what level of alih peran is to be expected from recipient communities, and how the transfer of these responsibilities is to be achieved.

- o Program Integration: Substantial strides have been made over the years towards integration at the national level, particularly through the establishment of the ITF in 1985. Related efforts aimed at integrating operational management have been made at the provincial and kabupaten levels, and trials are currently being conducted in three East Java kabupaten. Continued improvements, particularly in supervision, are supported under the following amendment component (4.4.2).

At the community level, integration involves the combined delivery of services through the PosYandu itself. A core program assumption has been that bringing together several key health services (first two and later five) at the community level would bring about a kind of "synergism" in which the achievement of each service's objectives would be enhanced by delivering all services through a single system. While this assumption still appears valid, the actual integration of services into a single delivery system will require more attention. For example, while the KB-Gizi program brought two basic services together at the conceptual and administrative level, the actual activities involved in delivering these services at the community level were not fully integrated (the PokBang involves growth monitoring and nutrition education with minimal FP services). Because the PosYandu will attempt to "add on" several more services to the PokBang, it is important at this stage to gain a better sense of the factors delaying integration. Investigation may show, for example, the delays are merely resulting from inevitable start-up difficulties confronting

the KB/Kes program as it takes on more definite shape. Alternatively, there may be more program-related challenges growing out of differences in the services themselves, or out of community preceptions of these differences.

Investigations aimed both at questioning underlying assumptions and refining the ways in which services are presented will therefore be an R&D activity under the amendment.

Envisioned here is a dynamic process to identify key problem areas for refinement and revision, involving results from the mid-term and final evaluations plus the continued review and assessment of ongoing activities. A mechanism will be developed through this project to identify operational deficiencies and target them for intervention.

4.4.2 Revision and Redesign of the Supervision System

This component will improve the integrated KB/Kes program's management efficiency through the development of an integrated supervision system. The elements of the system that will be addressed through this component are:

- Delineation of responsibilities: Under the new inter-organizational arrangement between MOH and BKKBN for the KB/Kes program, roles and responsibilities have been reallocated. This decision will have consequences for supervision. Categories of personnel from each organization who will be responsible for supervision at each administrative level must be clearly delineated, and their roles and responsibilities clearly defined. Supervision schedules must also be established at a frequency which is simultaneously sufficiently frequent from a management standpoint yet whose current costs are sustainable and within the budget.

- Development of a supervision protocol: Each supervisory visit must have clearly-defined objectives. The project will develop a supervision manual for each category of personnel which details activities that must be completed, information that must be collected, and objectives that must be accomplished. The manual will also contain the format for a brief supervisory report which must be completed and submitted to superiors following each supervisory visit.
- Utilization and feedback of supervision data: A system will be designed whereby results of the supervision reports are collected, analyzed, and utilized by managers at each administrative level, and key data fed into the project monitoring system.
- Supervision as a training activity: The supervision system will emphasize the importance of supervision as an opportunity for on-site training and education, especially for village level kaders. Efforts will be made to inculcate this concept in the supervisors, and provide them with the requisite knowledge and skills to provide on-the-job training to the kaders.

Once developed, the supervision system will be tested for affordability and replicability.

4.4.3 Development of a Monitoring System

This component will develop a monitoring system capable of measuring changes in variables that are central to the effectiveness of the KB/Kes program, and can be used to evaluate the usefulness of both management and program innovations. Key variables monitored might include, for example, growth monitoring, local participation rates, FP-related variables, immunization rates, quantities of supplies disbursed, and so forth.

The development of the project monitoring system will be carried out as follows:

- Review and assessment of the present reporting and recording system: Copious amounts of data are routinely collected through the present reporting and recording system. Village kaders must fill out 10 separate reporting forms on a monthly or regular basis. The quantity, utility, and accuracy of these data will be critically scrutinized, especially the SKDN data, which at present are subjected to no routine analysis. Crucial data will be retained, and non-essential data discarded.
- Incorporation of additional variables: Data on a large number of variables are being analyzed in the final program evaluation to determine program effectiveness. A number of these variables may prove suitable for routine data collection. Based upon this information and program needs, new data that need to be collected routinely will be identified.
- Systems design: Based upon inputs from the above efforts, a complete set of program monitoring variables will be identified and data needed to measure these variables will be determined. Data collection forms, and procedures for collection, tabulation and reporting will be designed. Mechanisms will also be developed to integrate information from the supervision system into this overall monitoring system.
- Data analysis and feedback: The final component of the monitoring system will be the development of procedures for data analysis, the design of feedback reports, and the development of methods to guarantee their utilization by managers at various administrative levels.

- Pilot testing: The monitoring system developed under this project will be pilot tested in all villages in selected Kabupaten. Refinements will be made based upon this testing prior to completion of the system design.

4.4.4 Development of a Policy-Formulating Mechanism

This component will support the formation of a policy-formulating body that can assess policy options arising from the research and development activities in the first three project components. Due to the composition of its membership and Steering Committee, the BKKBN-MOH Integrated Task Force is strategically positioned to provide a forum for focusing on policy-related issues in the KB/Kes Program, and to serve as a source of valuable inputs for program and policy development for Repelita V.

The Task Force will establish the research agenda for this project, obtaining a consensus between BKKBN and MOH regarding operational weaknesses requiring attention from the systems design components of this project. Once operations, supervision and monitoring systems have been designed, the Integrated Task Force, by virtue of its members and their structural positions within BKKBN and the MOH, will lobby important decision makers at the central and provincial levels in both agencies, educating them about the new systems and obtaining their support. Through the Integrated KB/Kes Task Force and its members, the systems innovations developed through this project will be able to access the policy-making process in the MOH and BKKBN.

General activities to be supported under this amendment component will include research seminars, dissemination of research results, program reviews, inter-ministerial policy meetings, and an investigation into the long-range cost implications of, and the most appropriate mechanism for, supporting the Integrated Task Force after the completion of project amendment activities. Specific activities and schedules will be developed as opportunities become clear.

4.4.5 Incorporation of System Refinements into the Replication Phase of the National KB/Kes Program

Under this component of the project, large-scale demonstration projects, which contain the integrated program systems refinements being developed in the operations, supervision, and monitoring components of this amendment, will be conducted. Also, refinements that have already been tested or are about to be completed under the original VFP/MCW Project may also be slated for replication during this phase. (It should be noted that this phase is not a time-dependent one; rather, once an activity is deemed to be developed sufficiently, it can be replicated any time during the project amendment period.) It is expected that these refinements will require considerable tailoring and adaptation to account for geographic, religious and social variations among provinces.

The demonstration projects will be carried out by the MOH on a Kabupaten-wide scale in any appropriate province. These innovations could also be demonstrated in areas assisted by other donor agencies. The Kabupaten has been chosen as the unit for demonstration because its size is deemed sufficiently large to identify problems that will be faced in wide-scale replication, yet sufficiently small to make demonstrations financially reasonable.

This component of the amendment is particularly important given the GOI's plans for nationwide replication of the PosYandu during Repelita V. The demonstration projects being anticipated will provide the GOI with models of the operations, supervision, and monitoring system refinements which are ready for replication. Testing these systems on a demonstration scale is also considered necessary to convince decision makers in the GOI and the donor agencies that the systems refinements being proposed are technically and administratively feasible for wide-scale replication. This component is also the final mechanism built into the amendment design to guarantee that successful modifications and refinements developed through this project become national policy and are incorporated into the KB/Kes model which will be replicated during Repelita V.

4.4.6 Continued Support for KB/Kes Services in Recently-Established Posts

The VFP/MCW Project has implemented, in a phased manner, the establishment of village FP-nutrition services in the three project provinces. During the last year of program implementation, East Java initiated activities in 1,000 villages, Bali began services in 948 new banjars, and NTB has just completed the first year of support for 100 villages. Some of these "year one" villages can become self-sufficient in maintaining activities at the established weighing posts within one year. However, many villages do not have the means to continue village FP-nutrition activities without external support. For this reason, and to help villages make the transition from the KB-Gizi to the KB/Kes Program, the newly-initiated villages/banjars will need continuing operational support for another year, or at most, two years.

The original VFP/MCW Project has provided for up to three years of continuing support for these villages. After this period, it is expected that the communities will be able to maintain most program activities. At the end of this three-year period (or earlier, if villages show evidence of self-sufficiency in program activities), AID operations support will be phased out.

This support will consist of sustained on-the-job training for kaders who have not yet developed enough confidence and skills to carry out Pokbang activities without close supervision. Interviews with kaders and field workers have revealed that the initial 5-day kader training is too short and too intensive to effect a change in knowledge, attitudes and behavior. Thus, trials on different intervals and durations of training using one teaching module at a time will be carried out in these villages. The success of these trials will ensure the continuity of activities in the Pokbang, which will be independently staffed by these re-trained kaders. This measure is corollary to the need for intensive supervision in the newly-established posts. Administrative support for travel is also needed to ensure on-going supervision for new project activities by previously-trained in-service personnel.

The integration of other health and community development programs in the established weighing posts in year-one villages must be supported in order to keep post activities from becoming too routine and dull, resulting in mothers and kaders becoming bored with the program and dropping out. Other factors that have also been attributed to participant and kader dropout must be examined, and such issues as "is there a critical time period where activities taper down and why" must be explored. The year-one villages would seem to be an appropriate location to conduct such special studies.

In newly-established posts it is not very likely that the community can afford to provide local food for demonstrations or supplementary feeding, or can support meetings, local transportation, supplies and other miscellaneous expenses incurred by kaders. Continuing project support to stimulate community support (such as cooperation and productive activities to maintain health and nutrition funds for the posts) is still deemed necessary.

4.4.7 Monitoring and Evaluation

The final component of this amendment is monitoring and evaluation. Activities contained in this component are more fully described in Section 8 ("Monitoring and Evaluation Plan"). A mid-term review will be conducted by a team of domestic and international consultants following the first 18 month planning cycle to review implementation during this period and to advise the project management on proposed revisions in phasing and strategy. The final review will also be conducted by a team of domestic and international consultants and will focus on the amendment's success in achieving its objectives.

4.5 Project Strategy

The activities proposed under this project amendment are a strategic continuation of final-year activities conducted under the VFP/MCW Project. A conceptual framework of the project strategy

(Figure 2) illustrates this strategic continuum. While Figure 2 depicts these phases as occurring in sequential order, many activities can be implemented concurrently, particularly those of Phase III (Replication).

Three critical events were either initiated or completed during the final year of the VFP/MCW Project: (1) final project evaluation, (2) integrated KB/Kes program in Central Java utilizing the new integrated management model, and (3) first year implementation of the KB-Gizi program in 1,000 East Java villages, 100 NTB villages and 948 banjar in Bali. These events provide the foundation for activities proposed in the project amendment.

During a transition phase extending from September until November 1986, experience from the VFP/MCW Project will be reviewed, and preparations will be made for the systems design phase of the project amendment. Results of the final evaluation will be available in September 1986. A seminar will be conducted by BKKBN in September to review findings and recommend follow-up actions. A three-province program review will be held in October 1986 to review implementation of the KB-Gizi and KB/Kes programs in East Java, Bali and NTB, and to plan the operations research agenda for the project amendment. Finally, a policy meeting sponsored by the Integrated Task Force will be held in October 1986 to review project implementation, and make final guidelines for the operations research agenda. The operations research agenda will identify the critical components of the operations, supervision, and monitoring systems which require further research as inputs to the systems design phase.

The systems design phase will inaugurate the first 18-month implementation cycle of the project amendment, and will be characterized by discrete operations research projects studying the previously agreed upon elements of the operations, supervision, and monitoring sub-systems. Findings from these studies will be utilized to modify and refine those three sub-systems.

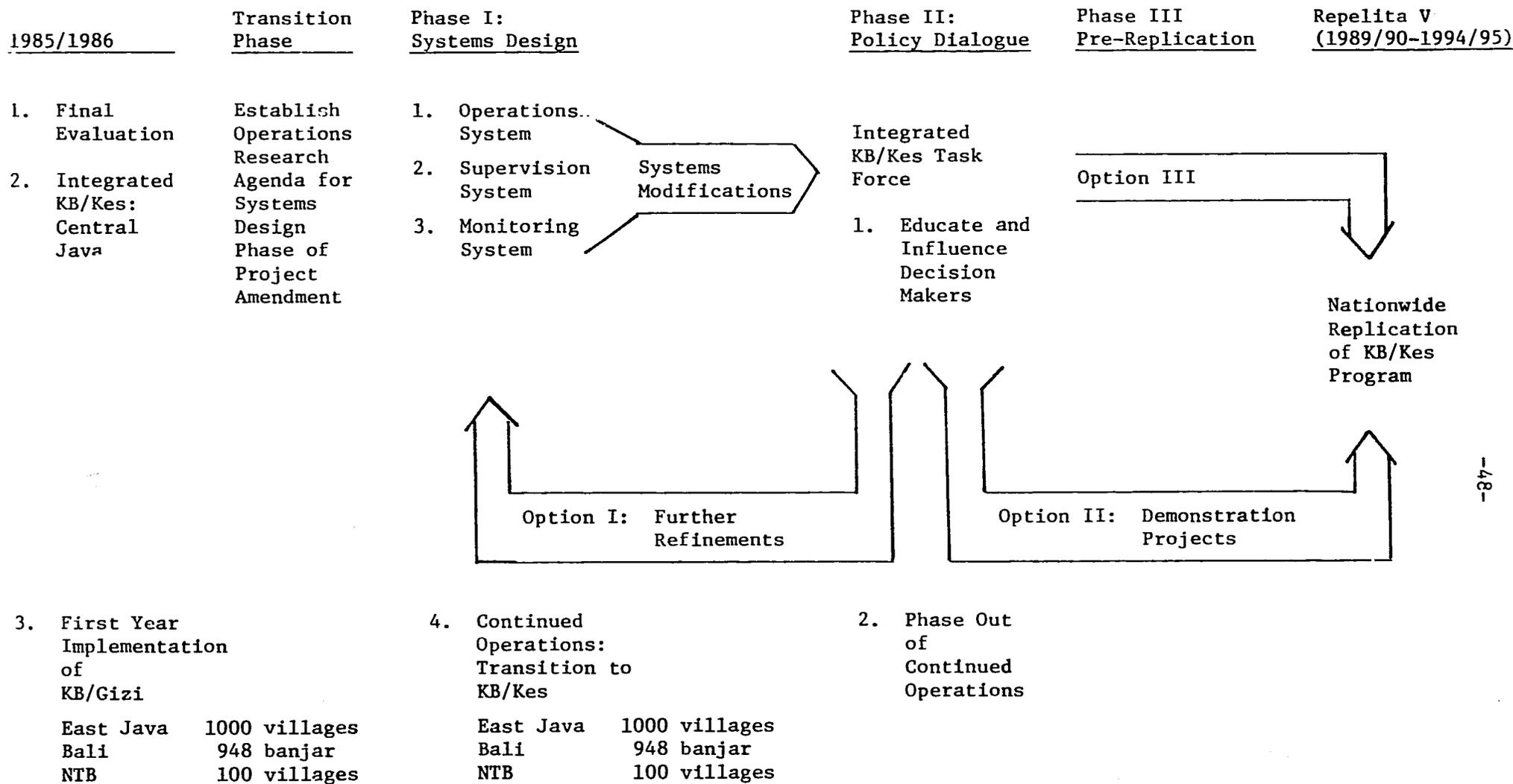


Figure 2. Strategy for Project 497-0305 Amendment (1985/85 - 1988/89)

Once all of the sub-systems or components thereof have been revised, the refinements will be submitted to the Integrated Task Force (ITF) for consideration of their policy implications. During Phase II of this project amendment, the ITF must consider the policy options regarding the particular sub-system or component, and how best to access the policy-making apparatus in MOH and BKKBN. From this point, during the policy dialogue phase, the Integrated Task Force has three options. A hypothetical example will be used to illustrate these options.

For the purposes of this example, suppose that an operations research study was performed during the system design phase which identified the reasons for kader attrition and recommended concrete proposals for increasing kaders' length of service. These proposals would be submitted to the ITF to consider their policy implications. Based upon its deliberations, the ITF could take one of three steps, as follows:

1. It could seek further refinement in the proposals by requesting further operations research studies on the issue. This is depicted as Option I in Figure 2.
2. It could request that the proposals be tested on a demonstration basis in one Kabupaten to test the technical feasibility of replication. Proposals or refinements which are recommended for large-scale demonstration move into Phase III (pre-replication) of the project amendment. This is depicted as Option II in Figure 2.
3. If satisfied with the technical and administrative feasibility of the proposals for increasing kaders' length of service, the ITF can exercise a third option, depicted as Option III in Figure 2. In this case the proposals are referred directly into the policy and planning process for the nationwide expansion of the KB/Kes program during Repelita V.

Demonstration projects will assess technical and administrative feasibility of the refinements and modifications designed during Phase I. The demonstration projects will also ascertain adaptations which may

be necessary due to geographic, social, cultural, or topographic peculiarities of a certain region. For example, a demonstration project might address the issue of increasing attendance of mothers and their children at KB/Kes posts in riverine provinces. Once a refinement has been tested on a demonstration basis, it will be referred directly into the planning and policy process for nationwide expansion of the KB/Kes program.

Coincident with Phases I and II of the project amendment, the KB/Kes program will be continued in the new villages in East Java, Bali, and NTB where the KB-Gizi program was introduced in 1985/86. During Phase I, the program in these villages will be transformed into the KB/Kes model, and then project support will be phased out during Phase II and assumed by the GOI. This bridging assistance will carry implementation through a critical transition phase, stimulate community support and involvement, and allow the GOI to allocate resources for continued operations in these villages.

4.6 Other Donor Activities

Beginning in the second half of Repelita IV and continuing until 1991, the World Bank's loan for the Second Nutrition and Community Health Project will provide the largest amount of support for Indonesia's five-program integrated KB/Kes services. World Bank project funds are targeted at strengthening the coordination and management of community health in 16,500 villages in eleven provinces. Specific activities supported under this project's integrated program include health center microplanning and stratification, training, development, and the reproduction of IEC materials. Funds are also available for the acquisition of supplies (vaccines, medicines, other consummable materials and equipment) for the five-program services in the PosYandu. Nutrition surveillance and nutrition manpower development are other components of this ongoing project.

UNICEF assistance and bilateral funds for the UPGK Program will cover all villages in Indonesia by 1989. This support consists of training, nutrition education materials, and supplies and equipment for the PosYandu. UNICEF is supporting eleven provinces, five of which are being provided with intensive assistance for other health, environmental, and development inputs, in addition to the UPGK package.

Research and development activities do not receive top priority support from these bilateral fundings. Assistance is focused more on operations and the rapid expansion of the program throughout Indonesia. The primary role for USAID assistance, which will be shifted almost entirely to research and development, will complement and support ongoing national programs in this respect. Through this project amendment, USAID can build on its ample experience with BKKBN and the MOH for conducting the necessary research development and evaluation. As part of its ongoing dialogue with other donor agencies, USAID will continue its efforts to ensure that donor activities are properly coordinated and that research findings are disseminated.

4.7 Project Inputs

The project will have four inputs, as described below.

4.7.1 Technical Assistance

Three long-term technical consultants will be assigned to this project, an Operations Research Specialist, a Management Specialist and a Project Technical Advisor. Each will be assigned to the project for two years during Phase I and Phase II. These consultants will be shared by the BKKBN and MOH, and will provide liaison to the Integrated Task Force and USAID. The Operations Research Specialist will focus 100% of his/her time on the systems design phase of the project amendment, assisting with the conduct of the operations research studies and the design of refinements and modifications in the operational sub-systems

design. The Management Specialist will spend half time on the redesign of the supervision sub-system and half time on the monitoring sub-system. The Project Technical Advisor will work on all phases of the project amendment activities. He/she will oversee the implementation of the entire project and will assist in coordinating its overall administration.

In addition, 60 person months of short-term international technical assistance and short-term domestic technical assistance will be made available through this project amendment. Expertise will be needed in the following areas:

- . Management information systems
- . Computer systems analysis
- . Research design
- . Operations research
- . Evaluation
- . Epidemiology
- . Communicable disease control
- . Nutrition
- . Policy formulation and analysis
- . Maternal-child health

The scopes of work for these consultants are depicted in Appendix D.

4.7.2 Research and Development

Criteria for research and development proposals and studies, and a system for developing and reviewing the proposals and studies will be coordinated by the Integrated Task Force. The approved research and development proposals and studies will then be submitted to the appropriate implementing unit within the BKKBN and or the MOH for funding and subsequent implementation. BKKBN and MOH will be provided technical assistance in developing a management system for the KB/Kes research program, in developing and reviewing research proposals, in monitoring research implementation, and in disseminating research results.

It is anticipated that operations research funds will be available to support all components of this amendment. The research input will be most intensive for the systems design components of the project amendment. Guidelines for the project amendment research agenda will be made final during the transition phase between the VFP/MCW project and the systems design phase in the project amendment (see Figure 2). Research funds will also be available to the Integrated Task Force for use in educating and influencing decision makers and for facilitating policy dialogues. Research funds will also be available to support the pilot demonstration project in the pre-replication phase, and for monitoring and evaluation of the project amendment.

4.7.3 Operations Development Support

Approximately \$1.5 million will be provided for operations development support. Operations support for the research and development component will include operational activities of pilot projects such as family planning acceptor group support, kader incentives, and reproduction of IEC materials. Local food for demonstrations and interventions, and equipment and supplies not routinely provided by the family planning and health program can be supported as needed. Operations also include in-country costs for research such as preparatory activities, working meetings, field trials, secondary data analysis and additional computer training. Field operations costs will also be provided by the project in the villages with recently-established posts in East Java, Bali and NTB, as well as in MOH replication areas.

Task Force activities will be supported in terms of administrative funds for the Secretariat and officers. Routine meetings and reproduction/printing of materials for these meetings, facility rental, local transportation costs and GOI approved honoraria and per diems will be provided for Task Force activities.

4.7.4 Training and Seminars

Funds from this input will be used to support all components of the amendment. These funds will be used for the following purposes:

- for operations costs not provided by the routine budget for training related to operations research and systems design activities,
- additional personnel training necessitated during the systems design phase and during the demonstration projects.
- short-term overseas and in-country fellowships for key managers and decision makers to facilitate policy making and replication, and
- for seminars conducted by the Integrated Task Force to facilitate policy dialogue.

4.8 Project Outputs

The project will have five distinct outputs. The first output will be refinements in operations components of the PosYandu delivery system. A dynamic process will be developed through this project amendment to identify weaknesses in the PosYandu model and design modifications through a series of operations and health services research. The result will be a PosYandu model that is technically and administratively feasible, financially replicable, and programmatically effective at increasing service coverage and ultimately the impact of the PosYandu on reducing infant and child mortality.

The second output will be a redesigned supervision system for the integrated KB/Kes program which can more effectively oversee program operations at more peripheral levels and make timely management interventions to correct programmatic or performance discrepancies. The

supervision system will have clearly delineated supervisory schedules and responsibilities. Supervision protocols for each category of personnel functioning as supervisors, and procedures for feedback and utilization of data collected during supervisory visits will be established.

The third output will be a monitoring system for the integrated KB/Kes program capable of measuring changes in variables central to the effectiveness of the program. These variables can be used to evaluate the usefulness of both management and program innovations. The data included in the new monitoring system will have been field tested for accuracy, reliability, utility and suitability before incorporation into the monitoring system. Simplified procedures for reporting, recording analyzing and feedback will be designed for inclusion in the monitoring system.

The fourth output will be to develop a functional system to identify weaknesses in an operational program; design research studies to investigate and analyze the reasons for those weaknesses and suggest methodologies to overcome them; refer these refinements into a policy formulating process; and based upon their feasibility, have the refinements incorporated as operational policy for the MOH or BKKBN. The Integrated Task Force will play a focal role in this process, and its institutionalization will guarantee continuation of this system.

The fifth and final output will be the design of a comprehensive KB/Kes service delivery model that can be replicated by the MOH and BKKBN during Repelita V.

4.9 End of Project Status

The following conditions will exist at the end of the project:

- For the research areas identified (e.g., sub-desa units, kader incentives, IEC materials, etc.), a research agenda will be developed, testing will be carried out, and modifications will

be made where appropriate.

- A comprehensive and effective service delivery model for the integrated KB/Kes program will have been designed and field tested. This delivery model will incorporate operational refinements into the PosYandu aimed at increasing the efficiency and coverage of services, and consequently maximizing the impact of the PosYandu upon improving prospects for child survival in Indonesia. The KB/Kes model will have a redesigned supervision system aimed at enhancing the management efficiency of the KB/Kes program in general and the PosYandu in particular; and a monitoring system will be in place which is capable of measuring changes in variables central to the effectiveness of the KB/Kes program.

- A consensus will have been reached at the highest echelons of the MOH and BKKBN to adopt this model as the unit for replication for the nationwide KB/Kes expansion planned for Repelita V. This consensus will have been translated into policy via its incorporation into Repelita V, and its adoption into the operational plans of BKKBN and MOH for KB/Kes replication during Repelita V.

- A functional mechanism embodied by the Integrated Task Force will exist to coordinate all multi-sectoral inputs into the KB/Kes program, to develop policy options for program improvements based upon on-going research and development, and to access the policy-making apparatus in both BKKBN and MOH by referring its policy recommendations to the highest policy and decision-making echelons of those agencies. It is expected that the existence of a multi-sectoral body such as the Integrated Task Force will have been accepted and institutionalized and that its membership and mandate will have been expanded to include private voluntary organizations and the private sector's role in expanding and improving the integrated KB/Kes program.

5. ADMINISTRATIVE ANALYSIS

5.1 General Responsibilities: MOH, BKKBN, Task Force

Under the KB/Kes approach ratified through the MOH-BKKBN Memorandum of Understanding in 1984, the MOH is technically responsible for the KB/Kes program in general, and has specific responsibilities for kader and health worker training, evaluation, and the provision of supplies. As discussed in Section 3.3.2, BKKBN will be in charge of monitoring the KB/Kes program, but will have specific responsibility for IEC and motivation. The MOH, in turn, will monitor specific relevant program indices. The Integrated Task Force, created by the 1984 Memorandum of Understanding, coordinates all inputs to the KB/Kes five-program delivery system.

The Integrated Task Force will play a focal role during this project amendment by coordinating all inputs into the six components, and will serve as a forum for the analysis and definition of policy options and their elevation to the policy apparatus of BKKBN and the MOH. However, funds will continue to be channeled through the MOH and BKKBN.

An 18-month planning cycle will be followed in order to provide ample time for preparatory activities and a full year for operations activities. At the end of the first planning cycle, a mid-term implementation review will be conducted for input into the second planning cycle. In the third year of the project amendment, a final project review will be conducted to determine the project's success at meeting its objectives and to review its policy impact upon the expansion of the KB/Kes program in Repelita V.

5.2 Role of the Integrated Task Force in Project Administration

Although the ITF is not an executing body, its pivotal role in

this project deserves further explanation and elaboration because of the influence it will have on the administration and management of this project. As depicted in Figures 3 and 4, the ITF will have a Steering Committee which consists of the MOH Directorate General for Community Health Development and Directorate General for Communicable Disease and Environmental Health, and the BKKBN Deputy for Planning and Analysis and Deputy for Program Operations. The purpose of the Steering Committee is to provide policy guidance for the Task Force on matters concerning development plans and activities of the KB/Kes program. More important, the Integrated Steering Committee is the immediate link for elevating policy options to the respective agencies for official adoption into the replication scheme for KB/Kes.

The Integrated Task Force itself has been given a mandate to coordinate the design, planning, monitoring and supervision of KB/Kes pilot projects implemented through BKKBN and MOH. As such, it will formulate the research agenda for the operations research inputs to the systems design phase and identify appropriate sources of funding in the implementing agencies. Refinements resulting from this research will be reviewed by the ITF for their policy implications. They will then either be approved for demonstration projects or through the Steering Committee elevated to the policy level for inclusion into the policy-making process for Repelita V replication of the KB/Kes program. The composition of the Steering Committee and Integrated Task Force, as shown in Figure 3, reflects the line agencies primarily responsible for the delivery of the individual components (nutrition, family planning, immunizations, diarrheal disease control, and MCH) of the KB/Kes program. USAID has completed (June 1986) a US \$3 million amendment to the Health Training, Research and Development Project supporting a Diarrheal Disease Control Program which will also be coordinated through the ITF.

At present, there is no definite administrative or secretarial support for the Integrated KB/Kes Task Force. It operates on an ad hoc basis which has slowed the flow of information among its members and the documentation of important meetings and activities. A Secretariat is

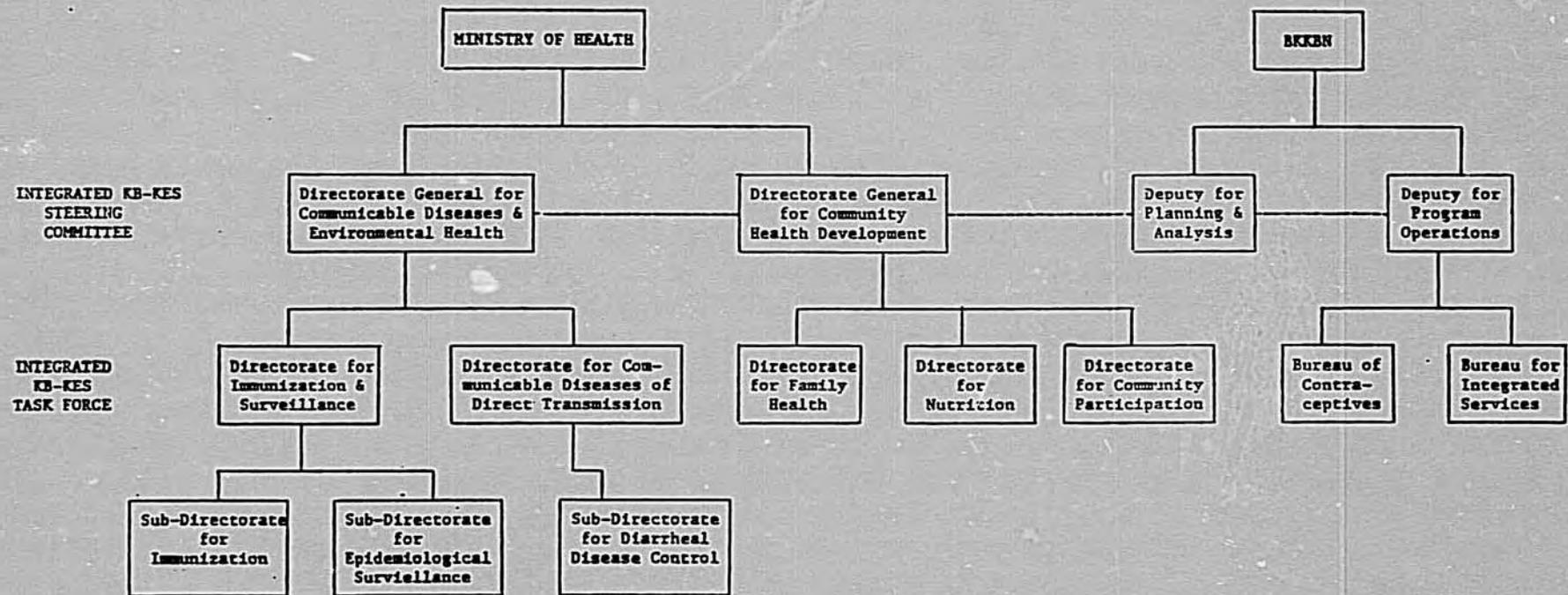


Figure 3. Organizational Composition of the Integrated KB/Kes Task Force

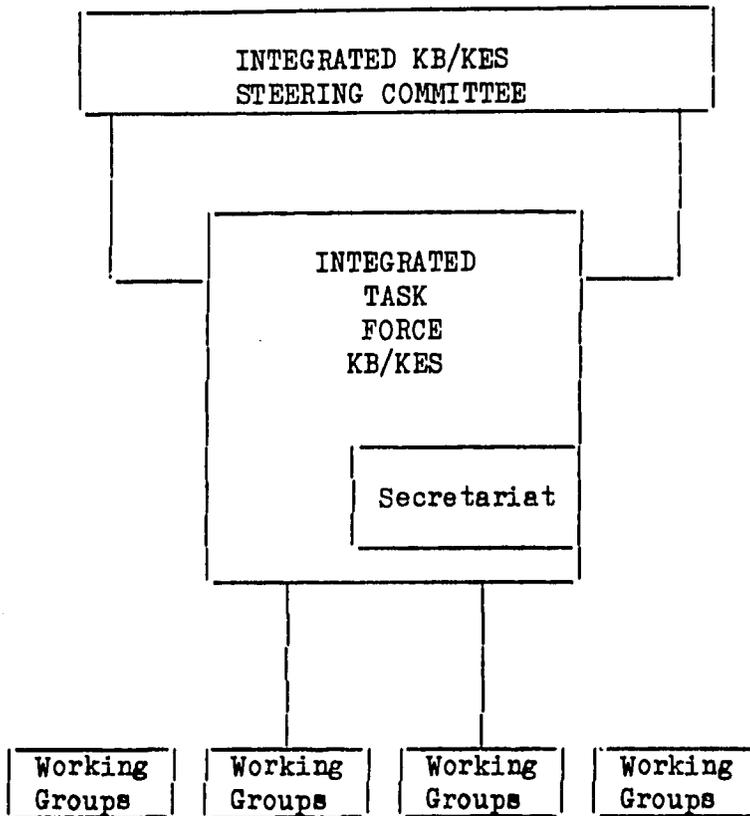


Figure 4. Organizational Structure of Integrated KB/Kes Task Force

being proposed to provide a staff function to the ITF. The Secretariat will perform day-to-day liaison between the sectors involved, prepare agendas and schedule meetings, and document and disseminate the results of meetings and other activities. Funds will be provided to support one-full time professional staff member in the Secretariat and two secretarial assistants. An office space and facilities will be provided in the MOH Directorate General for Community Health. It is anticipated at this time that at the end of the project amendment period, AID financial support for the Task Force will cease and the MOH and BKKBN will assume these support costs. As noted in Section 4.4.4, the most appropriate mechanism for continuing support for the Task Force will be explored as part of the project amendment's research agenda.

Ad hoc working groups (see Figure 4) will be formed to assist the ITF on specific technical issues and problems. For example, a working group could be formed to oversee the design of the supervision sub-system, and would provide BKKBN with technical guidance on operations research and systems development. The working groups will have a temporary mandate and will be dissolved upon completion of their tasks.

The working mechanism adapted for the Integrated KB/Kes Steering Committee, Task Force, and working groups is shown in Figure 5. The Steering Committee, in a joint working meeting with the Task Force, determines policy guidelines for the development and implementation plans of the KB/Kes program. The materials and inputs for these policy development meetings will be prepared by the working groups through a series of consultation meetings, monitoring, field and supervision visits, analysis of records and reports, and results of previous studies. The output of these activities is a development and implementation agenda or plan covering the systems development components of the project (components 1, 2, and 3). This plan will include specific activities, budget allocations, implementation guides, monitoring and supervision.

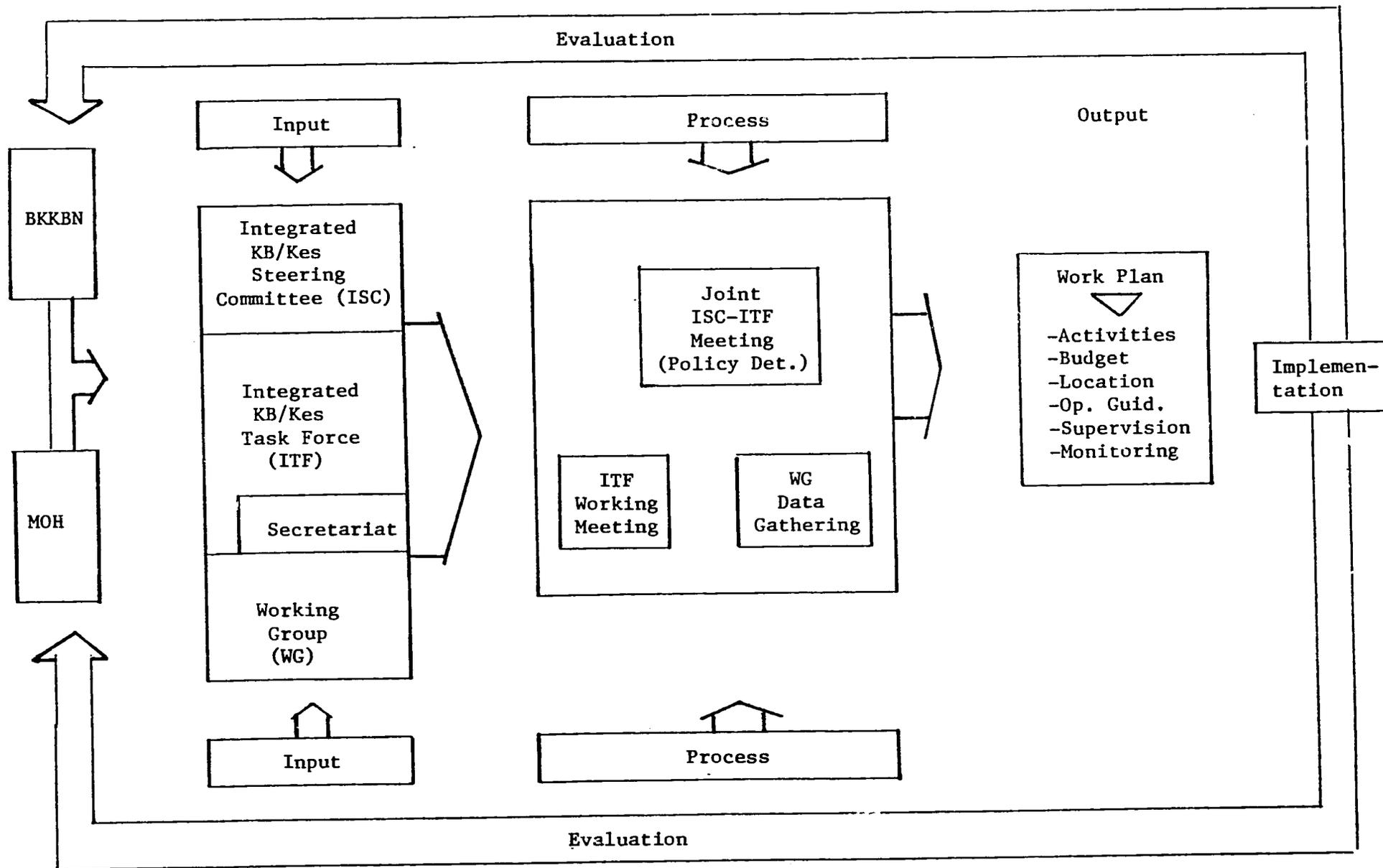


Figure 5. Working Mechanism of the Integrated KB/Kes Teams

6. COST ESTIMATE AND FINANCIAL PLAN

6.1 USAID Costs

The VFP/MCW amendment adds \$4 million in AID grant funds, of which \$3 million will be channeled through BKKBN and \$1 million through MOH, and extends the PACD for 3 years up to May 30, 1990. This brings the total cost of the project to \$14 million in AID grant funding. Project funds available as carryover for training and operations development during this extension is estimated at \$2.3 million (Table 1).

Grant funds will be used for research and development, technical assistance, training and operations development for the seven project components (Table 2). Funding for the amendment has shifted largely from village nutrition services to research and development aspects with the GOI and other donor agencies picking up routine operating costs for the integrated KB/Kes program as coverage is extended.

The project inputs are spread out over three years, with most research and development activities planned for the first two years and the replication studies for the last two years of the project amendment (Table 3).

Table 1. Estimated Budget: (US Dollars)

<u>Item</u>	<u>Existing Budget</u>	<u>Proposed Additional</u>	<u>Total</u>
Research and Development	2,300,000	{1,750,000}	5,600,000
Technical Assistance		{1,550,000}	
Training	925,000	700,000	1,625,000*
Operations Development	6,775,000	-	6,775,000**
Total:	10,000,000	4,000,000	14,000,000

<u>*Carry Over Budget</u>	
Training	1.2 M
Operations	1.1 M
	<u>\$2.3 M</u>

Table 2. Total Estimated Budget by Project Component
(US. Dollars '000)**

<u>Project Components</u>	<u>R.D.</u>	<u>L.A.</u>	<u>INPUTS</u>		<u>Total</u>
			<u>TR.</u>	<u>OP.</u>	
1. Operations/Delivery System Refinements	800	450	200*	100*	1550
2. Supervisory System	175	250	200*	150*	775
3. Monitoring System	300	350	300*	50*	1000
4. Policy Formulation/ Implementation System	75	100	100*	200*	475
5. Systems Components Replication	200	100	300	400*	1000
6. Continuing Operations Support	-	200	400	500*	1100
7. Project Evaluation	200	100	-	100*	400
Total	1750	1550	1500	1500	6300

*Proj. 305 carry-over: local cost = \$ 2.3 M
 additional grant funds = \$ 4.0 M
 Total: \$ 6.3 M

**To provide for the most appropriate use of funds, reallocation of funds may be made based on mutual GOI-USAID agreement for individual disbursements.

Table 3. Disbursement Schedule (\$ 000)

	<u>1986-1987</u>	<u>1987-1988</u>	<u>1988-1989</u>
1. Research and Development	600	700	450
2. Technical Assistance	500	550	500
3. Training	400	600	500
4. Operations Development	400	600	500
Total:	1,900	2,450	1,950

Both long and short term technical assistance will be funded via AID direct contracts with direct payments. These contracts are subject to audit by AID/IG/AUD. Overseas training will be funded through PIO/Ps. Costs associated with research and development, short-term in-country training, and operations development will be committed by PILs. For the funding of these local costs, advances of funds will be made to the GOI. These expenditures will be subject to the Voucher Verification site review program conducted by the Controller's Office. It is anticipated that some of these activities may be carried out through small Host Country contracts and if so, project funding will be made available for audits. Such audits will be performed through local representatives of US CPA firms.

6.2 GOI Costs

The GOI maintains approximately a \$10.7 million contribution to the amended project. GOI funds will largely pick up operations costs of the integrated family planning-health program in the four project provinces, East Java, Bali, NTB and Central Java. These funds are administered through provincial DIP and central DIP. The operations funds in the BKKBN budget include supervision and monitoring, information and motivation, and contraceptive services. Some funds are available for training and research and development, but the bulk of the GOI contribution goes to operations (Table 4).

Table 4. Project Amendment Financial Plan (\$ 000)

	<u>USAID Grant</u>	<u>GOI</u>	<u>Total</u>
1. Research and Development	1,750	618	2,368
2. Technical Assistance	1,550	-	1,550
3. Training	1,500	350	1,850
4. Operations Development	1,500	9,800	11,300
Total	6,300	10,768	17,068

7. IMPLEMENTATION PLAN

7.1 Contracting for Technical Assistance

Technical assistance funded under this amendment will consist of the following:

<u>Long-Term Advisors (3)</u>	<u>84 person months</u>
1. Research and Management Specialist:	<u>24 person months</u>
- develop research and evaluation program	
- develop appropriate research strategies and research management system	
- identify researchers/research groups	
- assist in research proposal development	
- review research results for dissemination and application	
- provide liason between BKKBN/MOH and research groups	
2. Integrated Health Services Operations Research Specialist:	<u>24 person months</u>
- design and implement alternative models of program integration	
- develop monitoring and supervision systems	
- monitor program implementation	
- provide liason with ITF and implementing units	
- develop strategies for replication	
3. Project Technical Advisor	<u>36 person months</u>
- monitor and supervise management of operational activities	
- formulate policy options with ITF	

- provide liason with central BKKBN-MOH and USAID on technical and administrative matters
- maintain contact with appropriate government bodies and donors for integrated health programs
- oversee general project activities

Short-Term Contractors

60 person months

Short-Term International and Indonesian Consultants and Contractors:

- develop research designs and research instruments
- data management and analysis
- set up monitoring system
- conduct short-term technical training
- develop program indicators
- conduct project evaluation
- prepare research proposals
- develop research instruments
- conduct data collection and analysis

With the exception of the Project Technical Advisor, who will be funded through a personal services contract, the technical assistance will be provided through a directly-funded institutional contract which will be competitively bid to ensure high quality and consistent TA for the 3-year project amendment. This technical assistance will be sought through a research-oriented institution with the proven capacity to mobilize resources and conduct research in Indonesia through the public and private sectors. The institutional contract will consist of services for 2 long-term contractors for approximately 4 person-years and a total of 60 person-months for short-term consultants, both foreign and domestic. The institution contracted will be responsible for the identification of research contractors and the overall design of a research and development

program in collaboration with BKKBN and MOH. This program will be reviewed by the Integrated KB/Kes Task Force and endorsed by its Steering Committee. Specific research proposals will then be prepared and implemented through the issuance of Project Implementation Letters in BKKBN or MOH.

In order to integrate both operations and research, the long-term consultants will be based, as appropriate, in the Integrated Task Force Secretariat, BKKBN Bureaus and MOH Directorates. The long-term consultants will provide the continuity of program development and liason with MOH, BKKBN and USAID. The Project Technical Advisor will be the AID liason with the ITF, MOH and BKKBN, and will be subject to AID supervision. For this reason, a PSC has been chosen for this position. Short-term technical consultants will be based in the implementing units at the central level, provinces or universities.

AID/Indonesia has reviewed the list of firms that might qualify for work on this Project Amendment as Gray Amendment entities. However, because of AID's and BKKBN's highly satisfactory past experience with certain contractors for activities under the VFP/MCW Project, AID does not wish to preclude these firms from competitive bidding for work under this amendment. Thus, an award under for competition to a Gray Amendment entity is not anticipated for the prime contract, although such entities will be eligible to compete for this work.

Evaluations of the work required, however, have led AID to conclude that opportunities do exist for subcontracting portions of the technical assistance work under this amendment. In particular, AID will make every reasonable effort to have its prime contractor identify and make practicable use of a small or disadvantaged firm as a subcontractor to provide 60 person months of short-term international technical assistance.

In executing the Project Paper Amendment, the Mission Director certifies that the use of Gray Amendment entities to implement the amendment has been considered to the maximum practicable extent.

7.2 Training

Short-term in-country training will be provided for BKKBN and MOH program staff as well as university researchers involved in the project. Short-term overseas training may be provided under a PIO/P.

The training inputs in this project will include seminars and workshops to discuss issues of program integration and policy developments. These meetings may be held in project sites or in Jakarta.

7.3 Core Support to the Integrated Task Force

Funds will be provided for honoraria, travel, and per diem for members of the Steering Committee, Integrated Task Force, and working groups. One full-time staff person and two secretaries will be assigned to the ITF's Secretariat with salaries and routine expenses coming from this amendment. The ITF will also have available funds for research, seminars, technical assistance and short-term overseas training. These costs will be provided via a central PIL with the BKKBN, and via PIO/P for short-term overseas training. The composition, scope of work, and responsibilities of the ITF were established via the 1984 Memorandum of Understanding. The ITF will establish a research agenda for the first 18-month planning cycle.

7.4 Implementation Schedule

The implementation schedule is presented chronologically and involves activities that are funded under the original project. This overlap is anticipated because of on-going evaluation activities which will provide inputs for the planning of the research agenda. Villages in East Java, Bali and NTB that are still in their year-one support are also on-going and will not be affected by the 18-month planning cycle.

Schedule of Major Actions

<u>Action</u>	<u>Estimated Completion Date</u>	<u>Responsible Party</u>
- Project Amendment Agreements	August 1986	BKKBN/MOH/AID
- PILs for E. Java, NTB for 2nd year Support of Village Operations	September 1986	AID
- PIL Amendments for Central Java and Weaning Project	September 1986	AID
- KB-Gizi Evaluation Final Seminar Output: Final Evaluation Results and Recommendations for Further R&D Activities	September 1986	BKKEN/CSF
- 3-Province Program Review Output: Operations Research Alternatives for E. Java, Bali, NTB	October 1986	BKKEN/MOH
- Policy Meeting Output: Project R&D Agenda	October 1986	BKKEN/ITF/AID
- PCS contract with Long-Term Project Technical Advisor	Sept./Dec. 1986	AID
- Institutional Contract for Foreign and Local Technical Assistance	Oct./Dec. 1986	AID
- Preparation and Review of Research Proposals	Oct./Dec. 1986	BKKEN/MOH/TA
- Central PILs for Operations Research, Monitoring and Supervision Systems Development, Phase I	December 1986	AID
- Central Java Mid-term Review	December 1986	ITF/BKKEN/MOH

- Implementation for Operations	January/PACD	BKKBN/MOH
Research and Systems Development		
- Monitoring and Supervision	January/PACD	ITF/BKKBN/MOH
- MOH Replication Studies	January/PACD	ITF/MOH
- Research Agenda Approved	June 1987	
- Central Java Final Review	December 1987	ITF/BKKBN/MOH
- Mid-Term Project Reviews	May 1988	ITF/TA
- Policy Meeting	June 1988	ISC [*] /ITF
- Final Project Review	January 1990	ITF/TA
- Policy Meeting	March 1989	ISC/ITF
- PACD - All activities end	May 30, 1990	AID

* Integrated KB/Kes Steering Committee

8. CONDITIONS AND COVENANTS

8.1 Conditions

Additional Disbursement: Research. Prior to the disbursement under the Amendment, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, for research, the Grantee will, except as the parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. individual research proposals endorsed by the Integrated Task Force until such time as a research agenda covering a period of no less than twelve months is submitted to and approved by A.I.D. and endorsed by the Integrated Task Force which list the criteria used to select project-funded research studies/pilot projects; explains the relationship of each proposed study to project objectives; and describes the purpose, methodology and estimated costs of each proposed research study, including the use of short-term technical assistance if required.

Additional Disbursement: Replication Activities. Prior to the disbursement under the Amendment, or to the issuance by A.I.D. of documentation pursuant to which annual disbursements will be made, to replicate successful program modifications on an expanded scale, the Grantee will, except as the parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. an annual workplan, describing the activities to be replicated for that period and a monitoring system to track the performance of the expanded program activities.

8.2 Covenants

The Grantee shall establish a Secretariat as part of the Integrated Task Force, consisting of a Secretary and two administrative assistants. Members of the Secretariat will work full time for the Task Force. The purpose of the Secretariat is to provide assistance to the Task Force in the (a) planning of a research and development framework

for integration activities; (b) monitoring of planned integration activities, identification of discrepancies in any technical or operational guidelines, and the provision of recommendations for resolution of these problems; and (c) monitoring of funds earmarked for use by the Ministry of Health for replication activities; and (d) assessing the performance of integrated field activities for policy inputs.

9. MONITORING AND EVALUATION PLAN

Monitoring and evaluation activities have played and will continue to play an integral role in the management of the Village Family Planning/Mother-Child Welfare Project. The major focus of these activities will continue to be providing rapid feedback on project performance to program managers and policy makers within BKKEN and the MOH. Figure 2 in Section 4.5 outlines the direct linkages between monitoring and evaluation efforts and project decision-making envisioned for the new activities.

Efforts associated with monitoring and evaluation are divided into four general categories; project implementation, performance monitoring, replication studies, and project evaluations.

Project Implementation: Existing reporting systems of the Mission and of BKKEN and the MOH provide a solid basis for tracking input/output indicators relate^d to operations development, training and technical assistance components funded through the project. However, for the research and development component, routine reporting and recording information will be supplemented by quarterly reports of the long-term consultants detailing the status of the various activities. The basis for these reports will be annual workplans developed by the ITF in collaboration with the consultants and which reflect priorities established in the development of the research agenda and implementation plan. These reports will be expected to highlight the progress of individual research and development activities including the implications and utilization of major findings with regard to program development and policy formulation. In effect, the information included in these quarterly reports is intended to serve as the basis for a monitoring system to be established within the ITF to facilitate communications among the various members and with key policy-makers.

Performance Monitoring: A specific objective of the amendment is the development of a monitoring system capable of measuring changes in variables related to the effectiveness of the KB/Kes program. The establishment of the system will be based upon a review of the present reporting/recording system as well as an assessment of the information requirements associated with tracking the performance of the KB/Kes program. Under the amendment, design and testing of a new reporting/recording system based on the above assessments will be carried out. The variables to be incorporated in this system include: growth monitoring indicators, participation rates, immunization rates and family planning variables.

Replication Studies: A significant portion of the new funds in this amendment will finance pilot efforts to test innovations in program delivery. Each of these innovations will include its own evaluation component to ensure that the results of the tests are immediately available and implications for program development and policy formulation empirically grounded. Examples of studies to be included in this category can be found in Section 4.4.1. These studies will be expected to measure changes, whenever it is deemed appropriate, in impact variables such as participation rates; knowledge, attitudes and practices indicators; and health status.

Project Evaluations: Two evaluations are planned as part of the project, a mid-term review and a final review. Both evaluations will be led by non-project related personnel and will generally focus on progress made in achieving project objectives.

The mid-term review will focus on process issues and specifically examine the implementation status of all project components and recommend mid-course corrections to optimize gains resulting from the project. Issues to be examined include:

- . the development of the research agenda and implementation procedures for conducting the studies;

- . the establishment of dissemination procedures associated with the research findings to ensure that appropriate audiences remain well informed of the progress of the research and development agenda;
- . the establishment of appropriate procedures for implementing replication activities based on successfully tested program innovations;
- . the role of the ITF in developing improved coordination among different ministries and directorates within the ministries.

The final project review will focus on the results achieved during the project and involve an examination of the following issues:

- . contribution of the project in developing modifications and refinements in the PosYandu service delivery system aimed at achieving greater program effectiveness, both in terms of improved service delivery and impact upon health status;
- . contribution of the project to the development of an improved supervision system for the KB/Kes program;
- . contribution of the project to improved KB/Kes program coordination;
- . contribution of the project to the establishment of a policy forum for management and decision-making in support of KB/Kes; and
- . contribution of the project to increased in-country capabilities to conduct operations research.

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APPENDIX A

PP AMENDMENT APPROVAL MESSAGE

MAR 26 1985

DECISION MEMORANDUM

SUBJECT : FY 1987 Indonesia Program Week
REFERENCE : Wrap-up Meeting of March 15, 1985

The following findings/decisions were reached with the Mission based on the review and discussions which were held March 13-15.

In general, the Indonesia FY 1987 Action Plan and its supplementary reports were well received. The Action Plan was responsive to the May 1984 Bureau Guidance on Action Plans, and the reports fulfilled the requirements that resulted from the FY 1986 CDSS and Program Week reviews of a year ago.

I. Action Plan

A. Strategy Recap

- The Mission Director reviewed recent events in the economy and confirmed the continuing validity of the program strategy which was approved following the FY 1985 CDSS review. He specifically cited the continuing program focus on three development goals: (1) expanding productive off-farm employment; (2) diversifying food production and strengthening related resource management; and (3) improving primary health care and developing further the family planning program (particularly the urban program) with more emphasis on integration. In view of the continuing validity of the CDSS, the Bureau will ask of PPC that it concur in a one year extension of the three year CDSS approval period, i.e., from FY 1985-88 to FY 1989 unless, of course, later significant changes in the strategy require an earlier submission.
- Programming trends were described as being: (1) a greater focus on secondary crop development; (2) strengthened rural credit institutions; (3) and the development of major outer islands, i.e., Sumatra, NTT and Sulawesi. These trends are evident in the new

2. Agricultural Extension Support (0354): The Bureau approves the project for the Mission's ABS but the Mission should prepare a revised concept paper. Director Fuller said that the purpose is not to work exclusively with the government extension system but to explore and test alternatives for delivering technology, with emphasis on the private sector. Based upon lessons learned, the Bureau (ASIA/TR) will provide the Mission with guidance with respect to the private sector role in agricultural extension.

3. Rural Enterprise Development (0355): The proposed project has the potential for developing opportunities for rural employment generation. In this respect, the Agency's experience particularly in Latin America, could prove useful. The Bureau approves the concept for PID development with approval of the PID to remain in AID/W.

4. Aquatic Resources Development (0352): The Mission and the Bureau are concerned with the number of planned activities, the number of proposed implementing agencies and the building of a research capacity within the implementing agencies under this project. However, given that the Mission staff has as much (if not more) experience and expertise in this field than the Bureau could provide, the project is approved for PID development with PID approval delegated to the Mission. The Mission will undertake to reduce the scope of the project to a manageable size.

C. Project Paper Amendments:

1. Applied Agricultural Research (0302): The Bureau concurs in the Project Committee's recommendation to amend the project as presented. Given the magnitude of the proposed funding and PACD, the Mission may proceed to develop the project paper amendment with approval of the amendment resting with A/AID. ASIA/PD will request an ad hoc redelegation of authority to the Mission to approve this project.

2. PVO CO-Financing II (0336): The Bureau concurs in the Project Committee's recommendation to amend the project as presented with approval of the project paper amendment delegated to the Mission. Consequently, approval of the PACD extension of 4 years is redelegated to the Mission.

3. East Timor Agricultural Development (0330): The Bureau concurs in the Project Committee's recommendation to amend the project as presented with approval of the project

paper amendment delegated to the Mission. Consequently, approval of the PACD extension of 2 years is redelegated to the Mission.

4. Financial Institutions Development (0341): The Bureau concurs in the Project Committee's recommendation to amend the project as presented. Given the Bureau's interest in the project and the proposed PACD extension period to 10 years, approval of the project paper amendment will remain with the Bureau.

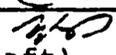
5. Village Family Planning/Mother-Child Welfare (0305): The Bureau concurs in the Project Committee's recommendation to amend the project as presented and delegates approval of the project paper amendment to the Mission. Consequently, approval of the PACD extension of 3 years is redelegated to the Mission.

6. Health Training Research and Development (0273): The Bureau concurs in the Project Committee's recommendation to approve the project amendment as presented. Given the proposed extension period of 3 years, which will produce a LOP of 12 years, ASIA/PD will seek an ad hoc delegation from A/AID to the Mission to extend the project PACD.

7. Comprehensive Health Improvement Program (0325): The Bureau concurs in the Project Committee's recommendation to approve the project paper amendment as presented and delegate approval of the project paper amendment to the Mission. Consequently, approval of the PACD extension to 3 years is redelegated to the Mission.

The guidance which has been provided by the Bureau's Project committee as a result of its review of the above projects will be provided by separate cables.

Clearances:

AA/ASIA, C. Greenleaf, Jr. 
DAA/ASIA, E. Staples (Draft) 
USAID/Jakarta, W. Fuller (Draft)
USAID/Jakarta, J. Sperling (Draft)
ASIA/EA, V. Mollrem (Draft)
ASIA/PD, P. Bloom (Draft)
ASIA/TR, B. Sidman (Draft)
ASIA/EMS, J. Jordan (Draft)
ASIA/DP, J. Westley (Draft)

Drafted: ASIA/DP/JMcCarthy/ASIA/PD/Gimhoff:jat/cjs 3/21/85
(Doc. #2455d)

APPENDIX B

GRANTEE REQUEST FOR ASSISTANCE



BADAN KOORDINASI KELUARGA BERENCANA NASIONAL

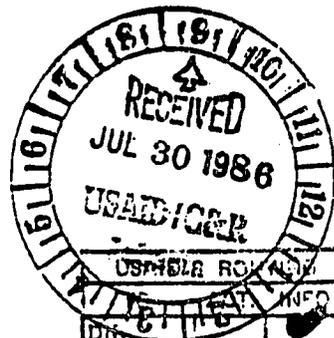
JALAN LET. JEN. M.T. HARYONO - JAKARTA 10002

No. 5705/RC-201/A/86

July 28, 1986

WORKING COPY

Mr. William P. Fuller
Director
USAID Mission
c/o American Embassy
Jakarta, Indonesia



Dear Mr. Fuller,

On behalf of the Government of Indonesia, we hereby request an additional grant of \$4.0 million, of which \$3.0 million will be channelled to the National Family Planning Coordination Board and \$1.0 million to the Ministry of Health, and an extension of the completion date of approximately three years to allow for the continuation of innovative health and family planning system development under the ongoing Village Family/Mother-Child Welfare Project 497-0305. This Amendment will support the research and development needed to identify problems, design and test possible solutions, and establish the policy framework to incorporate refinements into the KB/Kes service model.

This grant amendment would increase the project amount to a \$14.0 million grant over the 8-year life of project and bring the project amendment completion date up to May 1990. The Government of Indonesia will provide an additional rupiah equivalent of \$10.7 million in cash and in-kind support to this project.

This project will be implemented by the National Family Planning Coordinating Board and the Ministry of Health.

We look forward to your favorable consideration.

Sincerely yours,

DR. Haryono Suyono
Chairman
National Family Planning
Coordinating Board.

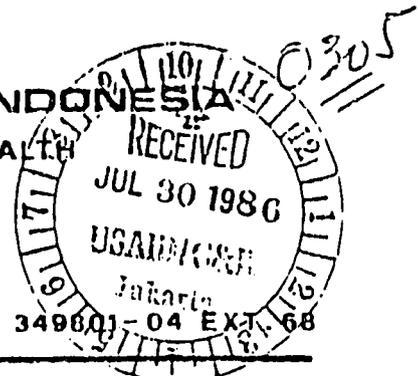
cc: Dr. Suwardjono Surjaningrat,
Minister of Health

Deputy for Planning, BKKBN.

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OFFICIAL FILE

**MINISTRY OF HEALTH REPUBLIC OF INDONESIA
DIRECTORATE GENERAL OF COMMUNITY HEALTH**



JALAN PRAPATAN No. 10

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PHONE : 343788 & 349801 - 04 EXT. 68

REFERENCE : 1039/Binkesmas/DJ/VII/86

JAKARTA July 28, 1986

Mr. William P. Fuller
Director
USAID Mission
c/o American Embassy
Jakarta, Indonesia.

Dear Mr. Fuller,

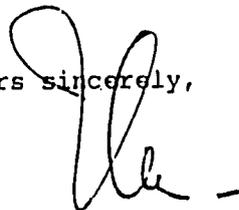
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On behalf of the Government of Indonesia, we hereby request an additional grant of \$ 4.0 million, of which \$ 3.0 million will be channelled to the National Family Planning Coordinating Board and \$ 1.0 million to the Ministry of Health, and an extension of the completion date of approximately three years to allow for the continuation of innovative health and family planning systems development under the ongoing Village Family Planning/Mother-Child Welfare Project 497-0305. This Amendment will support the research and development needed to identify problems, design and test possible solutions, and establish the policy framework to incorporate refinements into the KB/Kes service model.

This grant amendment would increase the project amount to a \$ 14.0 million grant over the 8-year life of project and bring the project amendment completion date up to May 1990. The Government of Indonesia will provide an additional rupiah equivalent of \$ 10.7 million in cash and in-kind support to this project,

This project will be implemented by the National Family Planning Coordinating Board and the Ministry of Health.

We look forward to your favorable consideration.

Yours sincerely,

Dr. Suyono Yahya, MPI
Director General of
Community Health, M.O.H.

- cc. : 1. Minister of Health.
2. Dr. Haryono Suyono, Chairman BKKBN.
3. Director General C.D.C. MOH.
4. Dr. Vulgaropoulos USAID

APPENDIX C

STATUTORY CHECKLIST

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only:
B.1. applies to all projects funded with Development Assistance loans, and
B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

YES. SEE ANNEX F, GPT II
PP AMENDMENT NO. 2

A. GENERAL CRITERIA FOR PROJECT

1. FY 1986 Continuing Resolution Sec. 524; FAA Sec. 634A.

Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project.

A CN has been prepared. Obligation will occur upon expiration of the notification period, without Congressional objection

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes.

(b) Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No further legislative action is required.

4. FAA Sec. 611(b); FY 1986 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.)

N/A.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A.

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

No, but Project compliments other donor (World Bank and UNICEF) activities. See p. 49 of PP.
N/A.

7. FAA Sec. 601(a). Information and conclusions whether projects will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

(c) Project will stimulate development of Village-based cooperatives for improving local food production and generating additional income.

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A.
9. FAA Sec. 612(b), 636(h); FY 1986 Continuing Resolution Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. The GOI is contributing approximately 53% of the total project cost, in cash or "in-kind", and gradually will assume ongoing local costs.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.
N/A.
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.
12. FY 1986 Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A.

13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16. Does the project or program take into consideration the problem of the destruction of tropical forests?
- Yes. See Annex L, Initial Environmental Examination.
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?
- N/A
15. FY 1986 Continuing Resolution Sec. 533. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution?
- No
16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?
- No set amount of Project funds will be available only for activities of such entities, but a major emphasis will be made for meaningful subcontracting with such entities.

B. FUNDING CRITERIA FOR PROJECT

**1. Development Assistance
Project Criteria**

a. FAA Sec. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status, (e) utilize and encourage regional cooperation by developing countries?

(a) The Project will develop mother's group income generating activities.

(b) The Project will develop village-based cooperatives for improving local food production and augmenting income.

- b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used? Yes. It meets fully Sec. 104 criteria. It will "Piggyback" maternal-child nutrition and primary health care activities into the GOI's existing cost-effective village family planning program.
- c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N/A.
- d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country)? Yes. Approximately 53% in cash or "in-kind".
- e. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth? Yes.

f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes. It is so designed and will be so monitored.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

In Indonesia, there is great interest in linking nutrition and primary health care activities to the existing cost-effective village family planning system. Many GOI agencies, universities and private institutions are prepared to contribute to this effort.

2. Development Assistance Project Criteria (Loans Only) Not a DA Loan.
- a. FAA Sec. 122(b). Information an conclusion on capacity of the country to repay the loan, at a reasonable rate of interest. N/A.
- b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? N/A.
3. Economic Support Fund Project Criteria Not ESF-Funded.
- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of part I of the FAA? N/A..
- b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? N/A.
- c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction of, or the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified N/A.

that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?

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

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?? Yes.

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? Indonesia does not so discriminate.

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A.

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries which receive direct economic assistance under the FAA and which are otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one of these areas? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries? N/A.
6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No.
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes.

No PASAs or RSSAs are planned under the amended Project.

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

9. FY 1986 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

All direct AID contracts under the amended Project will so provide.

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP)?

N/A.

C. Other Restrictions

- 1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? N/A.
- 2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A.
- 3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.
- 4. Will arrangements preclude use of financing:
 - a. FAA Sec. 104(f); FY 1986 Continuing Resolution Sec. 526. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo (1) Yes. (2) Yes.

- sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion? (3) Yes.
- b. FAA Sec. 488. To reimburse persons, in the form of cash payments, whose illicit drug crops are eradicated? Yes.
- c. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? Yes.
- d. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.
- e. FAA Sec. 662. For CIA activities? Yes.
- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes. DA/AID's light-weight vehicle blanket waiver applies.

- g. FY 1986 Continuing Resolution, Sec. 503.
To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? Yes.
- h. FY 1986 Continuing Resolution, Sec. 505.
To pay U.N. assessments, arrearages or dues? Yes.
- i. FY 1986 Continuing Resolution, Sec. 506.
To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)? Yes.
- j. FY 1986 Continuing Resolution, Sec. 510.
To finance the export of nuclear equipment, fuel, or technology? Yes.
- k. FY 1986 Continuing Resolution, Sec. 511.
For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.
- l. FY 1986 Continuing Resolution, Sec. 516.
To be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes.

APPENDIX D

TECHNICAL ASSISTANCE SCOPES OF WORK

LONG-TERM TECHNICAL ASSISTANCE

1. The Operations Research Specialist will assist the BKKEN and MOH offices in:
 1. exploring alternative models for the integration of FP-Health programs
 2. identifying promising program variations and developing designs for these programs
 3. identifying capable researchers and program staff to carry out operations research
 4. developing appropriate research proposals, designs, and field instruments with local research groups and program managers
 5. monitoring/assisting field training, data collection and management, analyzing and interpreting findings
 6. preparing workshops, seminars, and reports of operations research activities in the province
 7. providing liaison with central BKKEN-MOH and USAID in matters concerning technical and administrative aspects of research activities in the province
 8. developing strategies for replication of tested and successful program variations outside the project area
 9. developing operational mechanisms for integration of program elements and coordination of participating sectors through the central-level Task Force for Integration
 10. assisting the Task Force in the planning, conduct, evaluation and feedback of monitoring and supervision activities in project areas
 11. providing technical advice and assistance to the BKKEN Bureau of Integrated Services, Bureau of R&R, and Bureau of Planning and Analysis
 12. backstopping for USAID in the R&D activities of the Task Force.

2. The Research and Management Specialist will assist the BKKBN and MOH in:

1. designing a research and evaluation component of the VFP/MCW Project Amendment
2. developing appropriate research strategies
3. identifying groups and individuals capable of carrying out the required research and evaluation
4. soliciting and reviewing research proposals
5. reviewing and improving research contracting procedures/provisions
6. developing a research management system for the BKKBN-MOH Task Force for Integration
7. strengthening research management skills in the office of the Deputy for Program Development and the BKKBN Center for FP Studies
8. monitoring the conduct and administration of research projects given to contractors
9. preparing and/or reviewing reports of research activities, research papers, research component quarterly reports, workshops and seminars
10. making provisions to disseminate research evaluation results for optimum application.

3. The Project Technical Advisor will assist the BKKBN and MOH in:

1. planning, monitoring and supervising the operational activities of VFP/MCW continuation villages in East Java, Bali and NTB
2. providing liason with central BKKBN-MOH and USAID on matters concerning technical and administrative aspects of project implementation, including contracting
3. assisting the Integrated Task Force in the formulation of policy options and inputs to program improvement

4. providing recommendations to strengthen the technical capacity of central, provincial, Kabupaten and Kecamatan program management in monitoring the integrated FP-Health program
5. providing liason among agencies such as BKKBN, MOH, BAPPENAS, USAID, other donor agencies and research groups, technical consultants, and long-term consultants in the field on matters concerning operations, research and evaluation of integrated FP-Health programs
6. providing logistical and technical support for foreign technical consultants to the VFP/MCW Project
7. overseeing general project activities, from project implementation to closing (e.g., reviewing all project documentation, progress reports and contracts; disseminating information to appropriate GOI and USAID bodies)
8. maintaining information exchange among USAID, the IFT, donors, and other agencies for KB/Kes and other related programs, including liason with other USAID-sponsored projects (Diarrheal Diseases Control, Expanded Program for Immunization, CHIPPS, Child Survival, etc.).

SHORT-TERM TECHNICAL ASSISTANCE

The Data Management and Analysis Specialists and other Short-Term Technical Consultants will assist the BKKBN and MOH in:

1. assessing the extent to which the current monitoring systems for FP and health programs can be integrated and utilized in the monitoring component of VFP/MCW Project Amendment
2. incorporating KB-Gizi evaluation findings in the development of a monitoring and data collection system
3. suggesting possible analysis methods for utilizing existing operational data and simplification of R&R system
4. developing sensitive indicators of program impact
5. initiating the overall design and plans for the implementation and evaluation of an integrated FP-health monitoring system
6. developing operations manuals, orientation and training programs for program managers in the integrated FP-health monitoring system
7. providing recommendations for monitoring system trials, assessments and further trials
8. providing liason with BKKBN or MOH Computer and Data Center on computer hardware and software needs of the monitoring system
9. developing test programs for microcomputers whenever appropriate to increase local capacity to process and handle data promptly
10. developing and/or providing training using computer facilities as required
11. providing liason with BKKBN, MOH, BAPPENAS and USAID on matters concerning the MIS of FP and health programs.