

UNITED STATES GOVERNMENT
M E M O R A N D U M

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FROM: Joy Riggs-Perla, Deputy Chief, OPH 

SUBJECT: Project Assistance Completion Report (PACR), Village Family Planning/Mother Child Welfare Project, Project No. 497-0305;
Total LOP Authorized Funding: \$14,000,000 (G)

TO: Lee Twentyman, Acting Director

THROUGH: John Rogosch, Chief, OPH 

A. PROJECT PURPOSE

The Village Family Planning/Mother Child Welfare Project was initiated in 1980 with the purpose of reinforcing the Government of Indonesia National Family Planning Program objective of a small, happy and prosperous family through innovative support for an integrated, community-based family planning/health services delivery program. Specific objectives included decreasing the prevalence of malnutrition and diarrheal disease among children under 5, while increasing the level of family planning acceptance and continuance.

The project was amended in 1986, reflecting changes recommended by a 1982 evaluation, as well as subsequent policy change and project modifications.

The amended project plan included meeting the following additional objectives:

1. to identify problems and develop modifications and refinement 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 Family Planning and Health (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 Last Five Year Development Plan.

The main inputs of the project were:

- * 3 long term technical consultants in management systems (84 person months) and short term technical assistance (60 person months) in research, health services operations and data management (\$1,550,000);
- * training of trainers, kaders, village leaders and program managers, orientation to computer software to monitor income generating projects, and short-term study/observational travel (\$1,625,000);
- * research, including the completion of studies intended to test key innovations, such as inclusion of Traditional Birth Attendants (TBAs); cost effectiveness studies; development of software for computer assisted data collection (\$4,050,000);
- * operations related to intergovernmental coordination, as well as coordination with research communities, non-governmental organizations, and other USAID projects (this component included staff travel, as well as subcontracting with consultants for specific services) (\$6,775,000).

The expected outputs of the project:

The expected outputs of the project were village-based programs, delivering nutrition information and services on a regular basis to mothers and their children under 5; a series of research and development sub-projects focusing on development of community management of, and support for, nutrition activities; evaluation studies and workshops to assist National Family Planning Coordinating Board (BKKBN) and Ministry of Health (MOH) in designing and implementing village nutrition services in accordance with regional and local priorities and conditions.

B. ACCOMPLISHMENTS

The Village family Planning/Mother-Child Welfare Project provided the forum in which the Government of Indonesia has experimented with province-specific integrated program delivery models. Program effectiveness was further enhanced by adapting the Family Planning/Nutrition (KB/Gizi) and KB/Kes programs to province-specific environments, taking into account differences in social norms, ethnicity, culture, geography and topography.

This project worked closely with the GOI in identifying major problems affecting the well-being of mothers and children and attempted to respond flexibly in contributing to effective solutions. Through Project support and creative leadership (both from USAID and the GOI (BKKBN and MOH), a number of substantive accomplishments were realized as outputs:

1. family planning services were developed at the village level moving beyond the previous pattern of clinic-based only;
2. village-based, income-generating activities were designed and supported to impact positively on poverty; and village-based health promotion services were broadened;
3. A great deal was learned both in process and content by many participants that has had a major impact on policy, planning, management, guidance and delivery of posyandu services.

For example:

The GOI recognized the role it has in facilitating program development for services offered to mothers and children within village settings. The government's role is to do what is needed to make the services available; the recipient's role is to use the services in order to promote their health and that of their children. In this regard, the village leaders and village people share responsibility in assisting service development by taking an active role, wherever possible, in contributing space for the posyandu service, selecting and supporting kaders to staff the service, and encouraging village residents to use the services. The ultimate objective was to have posyandu that are "village owned" and backed up by technical support from the government health and family planning services. The underlying philosophy of the government with respect to the village-owned concept is that services should evolve from a pattern of being provided for the people, to being provided **with** the people, to being provided **by** the people.

4. A total of 58 studies were funded through the project (far beyond the originally planned 20). Research and field trials of interventions contributed to shaping the posyandu as a community based service delivery model; some research projects had an impact on policy decisions while others provided opportunities for improving research skills, without necessarily having any direct impact on policy.
5. The number of posyandu had increased from 90,000 to over 200,000 during the 1985 to 1990, although the coverage and quality of services were still variable. The project was successful in raising the issue of posyandu at the national level, and in taking some actions such as development of a national coordinating body and an Operational Working Group, to sustain the activities of the program.

C. PROBLEMS ENCOUNTERED:

1. Project activities were to support a community-based family planning-health services delivery program. Lack of strong and supportive supervision of KB-Kes program activities at the lower levels of the administration became a serious problem. Aside from the general guidelines, no clear definition exists of supervisory activities. This problem was exacerbated by the shortage of personnel and funds for travel for supervisors. Although indicators for each health service (village-based activity) have been developed by the respective sectors, in the field they have not been collapsed into an integrated supervisory checklist.
2. During this project, the underutilization of the posyandu by mother and children (especially pregnant women for antenatal care) was still a problem. The underutilization of the posyandu is caused by the distance from home, inconvenient schedules, boredom with the weighing routines, and incomprehensibility of the child growth card.
3. The problem of referring high-risk pregnancies has remained a major obstacle impeding effective antenatal care. A large number of pregnant women are attended by Traditional Birth Attendants (TBAs) for pregnancy, delivery, and postnatal care. The TBAs failure to make an appropriate referral may result from her inability to identify a high risk pregnancy, her lack of knowledge about the referral system, or her sense of failure in referring a patient. As a consequence, the TBA seeks the assistance of the health system as a last resort, often when the patient is in a critical condition.

4. Although the posyandu is regarded as a community activity, there exists confusion as to whether management and responsibility for posyandu system lies in the communities or in the Ministry of Home Affairs. In order to achieve self sufficiency among the posyandu, a clear plan for transferring responsibility to the village must be developed.
5. More imaginative approaches are needed, and these may be built into an USAID follow-on project, in terms of social marketing and other health strategies, which are being tested to provide better quality information and services.

D. LESSONS LEARNED:

Through the Integrated Task Force (ITF), the project created a unique mechanism for (1) directly linking the researchers and their research findings with the policy makers and program managers; and (2) establishing priorities to guide researchers. This structure seems to have been particularly successful in understanding the problems and defining some components of the posyandu through research.

Data flow and feedback to the village leaders with useful indications about posyandu service results needed to be strengthened. The village kaders and leaders needed to be included in data feedback in order for them to see that their efforts were contributing to the improvement in the quality of life for the mothers and children of their community.

Training and supervision for kaders should focus on guidance for how they should deal with identified problems. Supervision and monitoring of posyandu activities still need to be further developed and institutionalized. The chosen method of step-down training where staff from higher administrative levels have responsibility for training those at lower administrative levels was generally only partially successful. For instance, in training, it was not enough to say to kaders that they should refer children who have fallen below an acceptable growth curve or refer high antenatal risk women if it was unlikely that the child or the mother can reach a distant service. If the problems were based on limited food availability, other resources were needed to help solve the problem. Or it may happen that the mother can reach the service, but the staff or medical treatment, for any of a variety of reasons, were unavailable. Training in good management, monitoring and supervision was originally not sufficiently reality-based, but there has been improvement, and should focus on guidance for how they should deal with identified problems.

The area that needs greatest strengthening is a shortage of professionals in the sub-health centers, which link to the posyandu. The sub-health centers (puskesmas pembantu) are intended to provide personnel and technical advice to the posyandu. However, these sub-health centers are under staffed themselves and unable to provide such support to their associated posyandu. The research in West Java on possible role of the sub-health centers in management of technical support to posyandu that is being replicated in two other provinces has great potential for contributing to this strengthening.

While an impressive level of coordination of various program elements has been achieved, there continues to be room for:

1. further progress with respect to integration of services: The addition of input from Ministry of Agriculture and the Ministry of Religious Affairs should be considered in order to gather their views and experience. The forum for this input could be through the Operational Working Group at various levels.
2. application of improved management concepts, which promotes the policy of decentralization by strengthening local capability in management of posyandu. There is a need to continue to bridge the manpower gap between puskesmas and posyandu.
3. continuing research and development efforts focussed on priority issues to assist in understanding the operations and difficulties of delivering posyandu services and improving program.

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