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**FINAL EVALUATION REPORT OF
CARE INTERNATIONAL INDONESIA'S**

**VILLAGE PRIMARY HEALTH
CARE II PROJECT
1988-1992**

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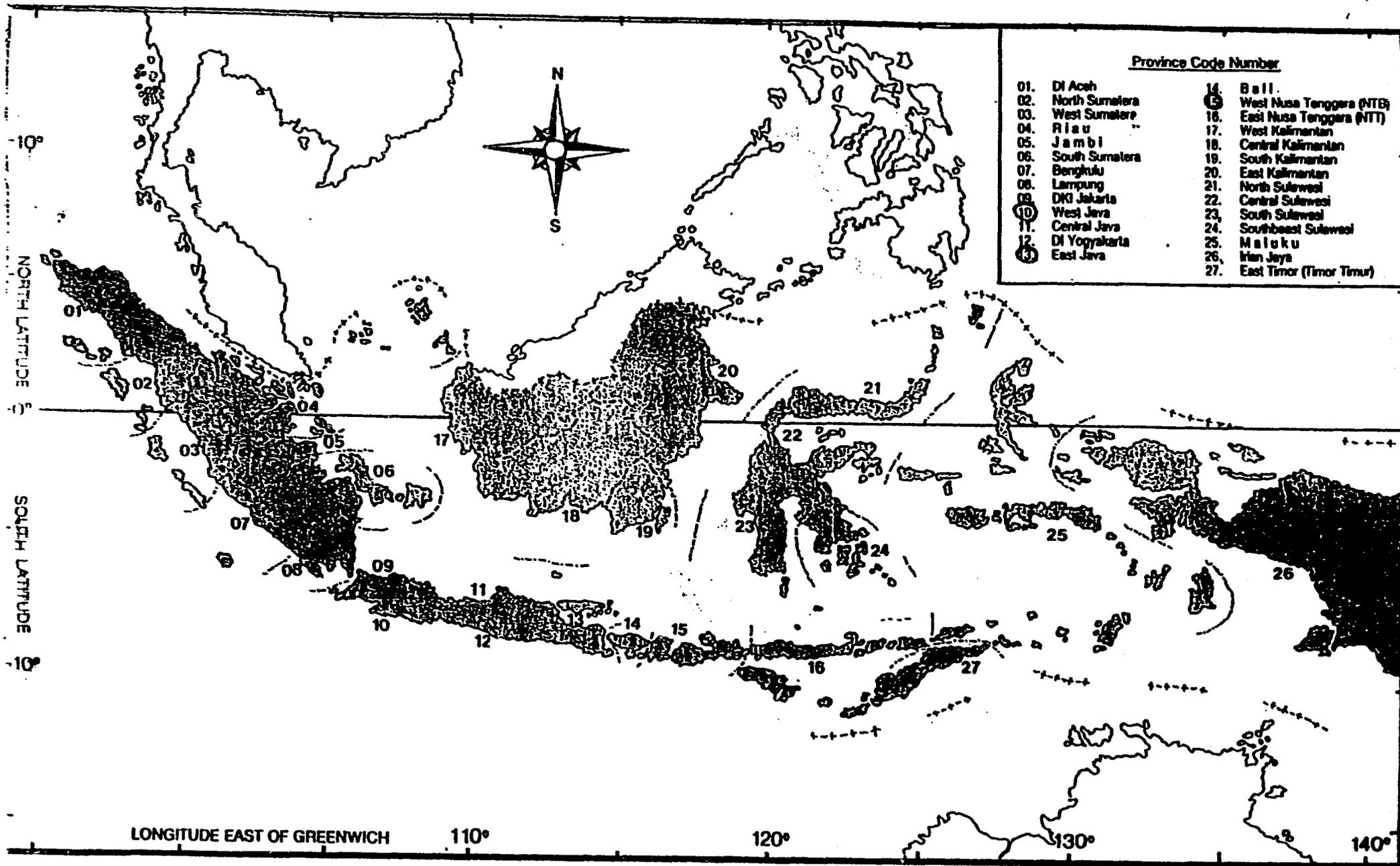
The evaluation team appreciates the cooperation extended by Provincial, District and Sub-District Government of Indonesia officials. Representatives of these offices demonstrated their keen interest in CARE project activities and provided much support. Despite their busy schedules, they answered many long questions.

The people of rural Indonesia whom we met during our site visits, many of whom were direct beneficiaries of CARE's VPHC II development efforts, were extremely generous and hospitable, providing our team with new insights and much warmth.

We hope this report will be of use to CARE, other NGOs, government agencies and donor groups working to provide primary health care in rural Indonesia.

GLOSSARY OF TERMS

AID	United States Agency for International Development
APBD	Local Government Annual Budget
ARI	Acute Respiratory Infection
BKKBN	National Family Planning Coordinating Board
CMR	Child Mortality Rate
CR	CARE Staff: Chief Representative
CS	Child Survival
DIP	Detailed Implementation Plan
EJ	CARE's East Java Field Office
FO	CARE Staff: Field Officer
GHS	Health Life Movement
GOI	Government of Indonesia
IMR	Infant Mortality Rate
KADER	Voluntary Health Worker
KAP	Knowledge, Attitudes and Practices
KB-KES	Integrated Family Planning-Health Services
KISS	Kader Incentive Support System
LKMD	Village Community Resilience Committee
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non-governmental organization
NTB	Nusa Tenggara Barat Field Office
ORT	Oral Rehydration Therapy
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PKK	Family Welfare Women's Organization
PM	CARE's staff: Project Manager
POKJANAL	Working Group for the Operation of Posyandu
PUSKEMAS	Health Center
POSYANDU	Integrated Health Post
SDT	Sub-District Supervisory Team
SKDN	Government Posyandu monitoring tool
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TPKKBS	Supervisory team at sub-district in East Java
UNICEF	United Nations Children's Fund
VPHC	Village Primary Health Care Project
VST	Village Supervisory Team
WJ	CARE's West Java Field Office



I N D O N E S I A

EXECUTIVE SUMMARY

Purpose of the Evaluation

This is the final evaluation of the Village Primary Health Care Project II, implemented by CARE International Indonesia, and jointly funded by the Agency for International Development (AID)/Washington and CARE USA.

Project Background and Summary

The evaluation was conducted in August/September 1992, four years after the project was initiated. The Village Primary Health Care Project (VPHC) II extended activities started during VPHC I, however, the goals and strategy were different. The overall goal of this project was to reduce the rate of child morbidity and mortality in subdistricts by working in collaboration with the local government and village leaders to increase the effectiveness and quality of service offered in the Posyandu (integrated health posts).

Rather than providing direct support to Posyandu as in VPHC I, CARE attempted to meet this goal through a community management approach. CARE's strategy was to organize communities to manage their own Posyandu, through the establishment of the village supervision team (VST). At the subdistrict level, multi-sectoral teams were established to supervise and support the village level teams, called the subdistrict supervision team (SDT). The total population served by the project was approximately 278,000.

Using the guidelines established by AID/Washington, the Final Evaluation Team attempted to measure program accomplishments against the intermediate goals set in the Detailed Implementation Plan. Representative project sites were visited and VSTs, SDTs, government officials, volunteer health workers (kaders), mothers, traditional birth attendants (TBAs) and religious leaders were interviewed. The team also attended Posyandu and conducted home visits.

A baseline survey was conducted in three VPHC project sites in February/March 1989 and in a fourth site in February 1991. The data collected represents the primary health care knowledge, attitude, and self-reported practices of women with children under-four years of age and of kader. In July 1992, a close-out survey was conducted to measure changes which occurred during the life of the project. There have been significant increases in knowledge, attitude and practice scores among both groups in all areas. A survey report will be available in November 1992.

Major Findings:

1. CARE's community management approach was successful in increasing Posyandu attendance and increasing knowledge, attitudes and practices of mothers and kaders in the project areas.
2. The project goals were accomplished successfully, following recommendations made during the Mid-Term Evaluation (MTE) and following the Detailed Implementation Plan.
3. Village Supervision Teams and Sub-district Supervision Teams have been functioning well, providing important moral support and rallying broad based community participation in Posyandu.
4. Health education materials introduced during the project were well appreciated, especially by religious leaders. The materials integrated strong health education messages into religious teachings. Religious leaders became active health educators in the community.
5. Kader Incentive Support Systems using traditional mechanisms were beneficial to kaders. The introduction of medicine posts (Pos Obat Desa) were added incentives for both community and kaders.

Major Recommendations:

1. Working with the **District level government, the lowest autonomous administration**, would be appropriate for CARE. District level government is capable for designing its own budget, setting its own priorities, and working out policies. At the district level, an organization can have larger impact and coverage, higher continuity, and more influence on funding mechanisms affecting the subdistrict.
2. **Memorandums of Agreement** with appropriate technical Ministries within government should be made by the project, as CARE's official counterpart is a non-health department.
3. **Quality of Posyandu** is the necessary next step after increasing participation and the actual number of Posyandu. Once the quantity is increased, the quality needs to be improved to sustain high levels of participation.
4. Emphasis on **follow-up to weighing** should be strengthened in any growth monitoring exercise. Growth promotional activities need to be strengthened and are outlined in more detail in this report.
5. Kaders, VSTs and SDTs require further **skills in data analysis and validity data checks**.

6. Follow-up assessment of phased-over villages after six months and after one year are recommended to evaluate the sustainability of the project and determine if the phase-over criteria and strategy were appropriate.

7. An anthropologist is needed to provide expertise to programming efforts in NTB given its difficult socio-cultural context. If possible, it is recommended that CARE continue to work within Gunung Sari.

Major Lessons Learned:

1. The notion of peer groups has proven to be an important factor in positively affecting group behavior. New expected behaviors are beginning to become norms in the project sites among the groups formed: VSTs, SDTs, kader groups and among mothers who attend Posyandu. The peer pressure helps to maintain active participation in health activities.

2. A community management project focus is more sustainable than a direct intervention focus as investments are made in human resource development and community organization.

3. Local community agents besides kaders can make tremendous contributions to primary health care. Religious leaders are powerful health educators, given materials which integrate health messages within religious teachings.

4. Working within the government context has highly increased the chances of regeneration, leading to sustained activities. As a change of personalities within the government can affect the support given to community management structures, it is important to involve the second and third layers within a system to assure the system will continue.

PART ONE: BACKGROUND

CARE has been operational in Indonesia for 25 years. Current projects in Indonesia include Sulawesi Rural Community Development (SRCDD), Community Self-Financing for Water (CSFW), Dryland Farming Systems (DFS), Environmental Education Teaching Materials (EETM) and the Village Primary Health Care project (VPHC). Starting in October 1992, another health project focusing on maternal and child health care through a Child Survival VIII grant will operate in Nusa Tenggara Barat (NTB).

CARE began its first VPHC project in 1985 under Child Survival I funding from AID/Washington. The project focussed on assisting communities to develop their capacity to understand, identify and solve day to day health problems. VPHC I's strategy was to work directly with mothers and voluntary health worker (kader). The project was implemented in West Java, East Java and Nusa Tenggara Barat through providing direct support to upgrade Posyandu, working at the village level.

VPHC II, October 1988-September 1992, was developed from the experience gained during VPHC I and included a shift in emphasis to **community management**. This project was designed to improve village leaders' and kader supervisors' ability to plan and implement quality primary health care services through the Posyandu (integrated health post). CARE staff worked primarily with health supervisory teams at the subdistrict and village level.

VPHC II was implemented simultaneously in three subdistricts from 1989. A fourth subdistrict, Bandar, was added in 1991.

	# of Villages	Subdistrict	Pop.
Nusa Tenggara Barat	10	Gunung Sari	77,066
West Java	17	Gunung Halu	93,853
East Java	16	Tulakan	71,124
East Java	8	Bandar	36,281
TOTAL	51	4	278,324

Selection of the sites was based on government reported high infant mortality rates, isolation, poverty and the absence of appropriate health support services.

At the subdistrict level, CARE staff helped form and then worked closely with a government coordination team consisting of health staff and members from other related departments, such as agriculture, religion and rural development. CARE's efforts at this level were directed towards improving the effectiveness and efficiency of this team in establishing and supervising Posyandu services. CARE's goals at the village level are achieved through the training and organization of village leaders and kader supervisors.

Project activities began in 1988 with the training of CARE staff and in 1989 a baseline survey was conducted. To measure the impact of CARE's Village Primary Health Care project, a Quasi-Experimental survey design was utilized. All project sites had two sets of data: mothers and kaders. Control sites were selected within each district with data sets for mothers and kaders as well.

The training of subdistrict teams began and subsequently the training of village teams including religious leaders, teachers and kader supervisors occurred. In between training, CARE field staff worked as facilitators both at the subdistrict and village level. In July 1992, project activities were phased out and the Knowledge, Attitude and Practices (KAP) close-out survey was conducted for two weeks. On October 1, 1992, all activities will be finished.

PART TWO: EVALUATION METHODOLOGY

The purpose of this final evaluation was to : 1) assess the project's success in achieving its goals, 2) assess the sustainability of activities, 3) assess any visible impacts on local health policy, 4) document lessons learned and 5) make recommendations for future health projects.

The evaluation team was composed of 5 members: (1) Team leader recruited from Save the Children, Donna Sillan; (2) Indonesian consultant (anthropologist), Raharjo Suwandi; (3) USAID Child Survival Coordinator, Nurmaulina Suprijanto; (4) Ministry of Health officers, Rosani Azwar and John Mokoginta; (5) CARE Indonesia Evaluation Point Person, Hanna Tobing.

Resource persons available for the team during the evaluation were the VPHC Management Support Officer, Margaret Newens and the Project Coordinator/Assistant Country Director, Anne Goddard.

For a brief description of team members and evaluation terms of reference, see Appendix 1.

In total the evaluation team worked for 25 days. Three days were devoted to preparation in Jakarta, fourteen days were spent in field visits to three provinces, two days were spent in Jakarta for feedback sessions to CARE staff, USAID, and Ministry of Health/Department of Community Health. The remaining time was spent preparing the draft report. For the detailed schedule see Appendix 2.

The evaluation methodology consisted of semi-structured group interviews, field observations and secondary data review. A list of the project documents reviewed are in Appendix 3. During the field visits, the following people were met:

1. Provincial government officials
2. District level government officials
3. Sub-district supervision teams/officials (SDT)
4. Village supervision teams/leaders (VST)
5. Kaders: health volunteers
6. Puskesmas staff (health center)
7. CARE field staff and management
8. Mothers attending Posyandu

Home visits to households with pregnant women and mothers of under-five children were also conducted.

Questions and checklists of major issues to be discussed with each group were developed by the team. Checklists were also developed to guide observation during Posyandu and for conducting home visits. (Appendix 4). Villages visited by team members (who were divided into 2 groups during village visits) were selected by the team based on the following:

- 1) Level of readiness for phase-over. The team selected a range of villages in each subdistrict which represented the most sustainable to the least sustainable based in the project's phase-out criteria. Phased out villages were also selected.
- 2) Regularly scheduled Posyandu. Villages which had a model Posyandu or regular Posyandu running during the dates of the visit.
- 3) Logistics and time constraints. Selected villages had to be within a reasonable distance from a subdistrict town because of time constraints, however, some remote villages were also visited.

In total, 27 villages were visited, representing 53% of all project villages. 21 Village Supervised Teams were interviewed. Six Posyandus were attended and 60 home visits were conducted. See Appendix 5 for details.

Briefings and discussions with related government and health authorities at provincial, district and sub-district levels were held. In general whenever available in each province, the team met with the provincial staff that deals with CARE's VPHC II project and with district government authorities, particularly officials from the district Development Planning Board and the health office. At the sub-district government office, the team interviewed sub-district officials, including the doctors and/or officials from the sub-district health clinic. In the village, the team interviewed VST members, community leaders, religious leaders, TBAs, kaders and mothers.

At CARE's field office, the team was first briefed on the project's status and specific local issues. An extensive discussion with the management as well as field staff was held after field visits, particularly regarding findings from the villages. At the end of the field trip, a feedback session was held with Provincial, District and Subdistrict level government officials in WJ, with District level officials in EJ, and with Provincial and District level officials in NTB. A detailed list of persons consulted is presented in Appendix 6.

PART THREE: FINDINGS

The principle findings of the evaluation team are grouped here according to the major areas of: Midterm Evaluation Follow-up, Project Accomplishments and Sustainability Issues.

I. Midterm Evaluation Follow-Up

The Mid-Term Evaluation (MTE) of October 1990 made many recommendations which were adequately addressed by CARE's project team. One recommendation focused on the need to include only one impact goal of increased Pcsyandu attendance. The other impact goals were to be discarded. The DIP was revised according to Midterm Evaluation recommendations and the original six intermediate goals, which were changed to 25 intermediate goals in early 1990, were consolidated to four intermediate goals. This final change was submitted to USAID as part of a revised Detailed Implementation Plan which was an appendix to the 1991 Annual Report. This change in goals was meant to concentrate efforts on the community management aspects of the project rather than health targets. The change in focus was from impact goals to more process oriented sustainability goals, emphasizing efforts to strengthen SDTs and VSTs.

The concept of Model Posyandu was introduced as recommended by the MTE, whereby there is at least one sustainable demonstration Posyandu established in each subdistrict with the assistance of the VST and CARE. In EJ, each village has one (24) Model Posyandu and in NTB and WJ there are two in each subdistrict. Development of a kader incentive support system (KISS) was also introduced at that time.

The MTE team also recommended that CARE try to follow through with the VST concept within the Ministry of Home Affairs at the central government. At the time of the MTE, East Java already had a decree from the Provincial government for the establishment of VSTs but the other provinces did not.

During the mid-term, in West Java the project was suffering from weak government relations, lack of government decree, high CARE staff turn-over and basic misconceptions about project implementation. This has changed dramatically with strong CARE management and staff in WJ. There has been a turn around in the degree of government support and enthusiasm for the project. It was also recommended there that the kader support team which had been formed by the CARE staff, be dismantled as it was running parallel to the VST. VSTs have thus been restructured and made swift progress since the MTE. It required special efforts and high dedication of the field staff. Villages in general are ready to be phased out but need a little more time, actually to solidify their achievements.

In East Java, favorable community conditions, strong government support and a clear understanding of the project design by the field staff lead to excellent progress by the time the mid-term evaluation was conducted. Consequently, some villages were ready to continue activities without CARE's assistance. Following through a MTE recommendation, in early 1991 six villages were phased out and the project expanded to 8 villages in another subdistrict, Bandar. The phased-out villages visited by the evaluation team were running well on their own. It should be noted that one of these villages already had a well-run Posyandu before CARE began activities.

The MTE pointed out that in NTB, existing structures and institutions were weak and the communities were not as receptive to external interventions as those on Java. In addition, there was not a government decree clearly defining a VST. Since the mid-term, the NTB local government has started to official support the establishment of VSTs. Despite the local government's strong support, divided community solidarity, ignorance and resistance hampered the project from making good progress in NTB. The main recommendation was to facilitate the community more closely at the hamlet level rather than the village level. It was hoped that this would help to overcome the external constraints of poor or non-existent village leadership structures and the varying social, culture, and economic situations found in each hamlet. Another Field Officer was hired as recommended. The recommendations for NTB, however, were not broad or strong enough to encourage staff to organize Posyandu with more flexibility around natural groupings (e.g. religious schools). Villages still need external assistance to further develop what they have achieved to date.

Training in resource mobilization skills in coordination with CARE's other projects, especially the Community Self-Financing water project, was recommended. An in-service staff training did address this topic.

II. Project Accomplishments

The following section compares the quantitative goals, as stated in the Detailed Implementation Plan, with the project accomplishments. The following **Summary of Project Achievement** displays quantitatively the progress attained towards each intermediate goal. Discussion of each intermediate goal follows the matrix.

A brief summary of selected KAP survey results is included in this section followed by a brief discussion on the effectiveness of project activities, the monitoring system and staff development efforts.

1. Intermediate Goals Achievements

Intermediate Goal # 1: Village Supervision Teams (Tim Pembina Desa) operates independently to improve and maintain village health system. (See Appendix 7 for definition of VST). **Eight of nine indicators achieved.**

PART VIII II
SUMMARY OF PROJECT ACHIEVEMENT
(SOURCE: AMF, HIC, CHECKLIST, KAP)

BY JUNE 1992

INDICATORS	WEST JAVA		EAST JAVA				N.T.B.		TOTAL	
	Gunung Halu		Tulakan		Bandar		Gununges?		Baseline	Current
	Baseline (July 89)	Current (June 92)	Baseline (June 89)	Current (June 92)	Baseline (June 91)	Current (June 92)	Baseline (Oct. 89)	Current (June 92)		
INTERMEDIATE GOAL # 1:										
VILLAGE SUPERVISION TEAM (TIM PEMBINA DESA) OPERATES INDEPENDENTLY TO IMPROVE AND MAINTAIN VILLAGE HEALTH SYSTEM										
Indicators:										
70% of villages have VST	0	100%	0	100%	0	100%	0	100%	0	100%
70% of VST meet regularly in accordance with agreed schedule	NA	88%	NA	80%	NA	100%	NA	60%	NA	82%
70% of VSTs implement workplans for priority health problems	NA	82%	NA	80%	NA	100%	NA	60%	NA	80%
70% of Posyandu sessions are supervised by VSTs.	NA	67%	NA	85%	NA	95%	NA	94%	NA	82%
70% of VSTs conduct training for kader.	NA	94%	NA	100%	NA	100%	NA	60%	NA	90%
70% of TBAs trained by the project are active in promoting the Posyandu relaying health messages and/or referring high-risk pregnancies	NA	80%	NA	75%	NA	60%	NA	60%	NA	67%

NA - Not appropriate

NK - Not known

INDICATORS	WEST JAVA		EAST JAVA				N. T. B.		TOTAL*	
	Gunung Halu		Tulakan		Bandar		Gunungsari		Baseline	Current
	Baseline (July 89)	Current (June 92)	Baseline (June 89)	Current (June 92)	Baseline (June 91)	Current (June 92)	Baseline (Oct. 89)	Current (June 92)		
70% of informal community leaders (religious leaders and/or teachers) trained by the project are actively involved in promoting the Posyandu and relaying health messages	NA	90%	NA	70%	NA	70%	NA	57%	NA	75%
70% of villages have at least 2 oralit posts/diarrhoea treatment centres distributing and restocking their supplies	76%	100%	100%	100%	100%	100%	0%	0%	73%	80%
# of post oralit active	76	100	63	587	40	48	1	41*	180	776
Support system for kader established in 50% of villages	0%	94%	0%	63%	0%	38%	0%	100%	0%	76%
INTERMEDIATE GOAL # 2:										
COMPREHENSIVE AND CONVENIENT POSYANDU SERVICES ARE REGULARLY FUNCTIONING IN ALL VILLAGES										
<u>Indicators:</u>										
Number of Posyandu	90	102	63	91	40	43	58	75	251	311
90% of Posyandus hold sessions monthly	89%	97%	100%	99%	95%	93%	93%	94%	94%	96%
70% of Posyandu operate with "four table system"***	20%	66%	45%	64%	25%	76%	3%	59%	23%	71%
50% of children under 5 weighed at Posyandu	29%	57%	43%	52%	41%	61%	11%	17%	27%	41%
Number of children weighed per month	1,926	3,764	1,799	3,212	1,253	1,576	893	1,686	5,871	10,238

* Oralit posts established, but no regular supply of Oralit from Puskesmas.

INDICATORS	WEST JAVA		EAST JAVA				N T. B.		TOTAL	
	Gunung Halu		Tulakan		Bandar		Gunungsari		Baseline	Current
	Baseline (July 89)	Current (June 92)	Baseline (June 89)	Current (June 92)	Baseline (June 91)	Current (June 92)	Baseline (Oct. 89)	Current (June 92)		
50% of pregnant women are examined during their pregnancy	19%	69%	24%	98%	10%	94%	21%	52%	19%	72%
70% of mothers report they would provide the appropriate treatment if their child had diarrhea	71%	99%	83%	98%	81%	95%	62%	85%	76%	93%
KAP score for mothers	1.6	4.0	2.3	3.7	2.4	3.8	1.8	3.4		
Kader at 70% of Posyandu are making home visits.	38%	76%	6%	85%	45%	62%	3%	60%	23%	73%
70% of Posyandu complete F1 form	NK	97%	50%	94%	93%	93%	NK	72%	NK	89%
70% of Posyandu have feedback session	32%	61%	11%	79%	0%	90%	0%	57%	14%	71%
Children 0 to 12 months receive immunization as follows:	April 89- March 90	Jan. 91- Dec. 91	April 89- March 90	April 88- March 89	Apr. 90- March 91	Jan. 91- Dec. 91	April 90 March 91	Jan. 91 - Dec. 91		
- BCG 90%	69%	100%	78%	100%	100%	100%	100%	100%	NA	100%
- DPT 1 90%	69%	100%	81%	100%	100%	100%	96%	100%	NA	100%
- Polio 3 80%	58%	86%	83%	100%	95%	100%	89%	100%	NA	100%
- Measles 80%	52%	100%	62%	100%	97%	100%	59%	100%	NA	100%
80% of pregnant women receive complete TT immunizations	13%	48%	31%	83%	78.6%	80%	41%	50%	NA	57%
40% of malnourished children are enrolled in a feeding/nutrition education group	0%	70%	0%	0%	0%	0%	0%	2%	0%	8%

INDICATORS	WEST JAVA		EAST JAVA				N. T. B.		TOTAL	
	Gunung Halu		Tulakan		Bandar		Gunung Sari		Baseline	Current
	Baseline (July 89)	Current (June 92)	Baseline (June 89)	Current (June 92)	Baseline (June 91)	Current (June 92)	Baseline (Oct. 89)	Current (June 92)		
INTERMEDIATE GOAL # 3										
SUBDISTRICT TEAM AND PUSKESMAS STAFF ADOPT A COMMUNITY PARTICIPATORY APPROACH TO VILLAGE PRIMARY HEALTH CARE SERVICES										
<u>Indicators:</u>										
100% SDTs develop written plan and monitor Posyandu activities	NA	100%	NA	100%	NA	100%	NA	100%	NA	100%
100% SDTs conduct quarterly supervision visits to VST	NA	100%	NA	100%	NA	100%	NA	100%	NA	100%
100% SDTs implement participatory training events which have as outputs action plans which are followed	NA	100%	NA	100%	NA	100%	NA	100%	NA	100%
SD/Puskesmas staff provide immunization services to 70% of Posyandu as required	NK	100%	100%	100%	67%	90%	100%	100%	NK	99%
INTERMEDIATE GOAL # 4										
INFORMATION, MATERIALS AND MEDIA TO SUPPORT THE PHC PROGRAM DEVELOPED AND UTILIZED										
<u>Indicators:</u>										
RIAI System to assist mothers monitor their children's growth utilized in at least 1 subdistrict **	NA	0	NA	0	NA	0	NA	NA	NA	0
At least 2 materials developed and promoted by project are utilized in a subdistrict	NA	4	NA	3	NA	3	NA	3	NA	6

Discussion:

Teams generally meet regularly in accordance with agreed schedules and have developed written workplans. VST members attend and "supervise" Posyandu sessions. Ninety percent of VSTs conducted or organized training for kader and 67% of TBAs trained by the project are now active in promoting Posyandu, relaying health messages and/or referring high-risk pregnancies. The few TBAs interviewed by the teams were active at Posyandu and had good knowledge of proper primary health care messages. They were using TBA kits, some of which were provided by CARE.

Seventy-five percent of informal community leaders trained by the project are now involved in promoting Posyandu. The religious leaders and neighborhood leaders met have been advocating Posyandu.

Eighty percent of villages have at least two ORT posts distributing and restocking supplies. There already were 179 posts across West and East Java and one in NTB, when the project commenced. Now there are 776 posts, a fourfold increase.

Support systems for kaders have been established in 76% of villages starting from zero. CARE introduced the concept of Kader Incentive Support System (KISS) in the project areas, which are activities developed by the VST in order to provide incentives for the voluntary health workers. The various schemes tried will be discussed in a later section.

The formation of VSTs in each village has been an impressive accomplishment which is now being institutionalized at the village level. Community organization efforts by the CARE staff have proven successful, as they have formed groups with clearly delineated titles and roles which meet regularly and attend Posyandu regularly. The recognition accorded to kader through the VST presence at the Posyandu is a good motivator for kader as well as for mothers. This plays an important role in raising Posyandu attendance rates.

VST workplans reflect quarterly activities to be carried out by the teams. Activities include supporting kaders in Posyandu administration, meeting immunization targets, filling in reporting forms, identifying community resources as incentives for kaders, giving feedback to kaders about VST meetings, organizing special occasions such as religious holiday for disseminating health messages, and training new kaders. Although these activities are written, the actual implementation is difficult to determine. From interviews with VST members, their knowledge of Posyandu administration, monitoring and operations appeared to be limited.

In terms of supervision know-how of Posyandu operations, skill levels are not yet high, but most likely will develop further over time. For health-related technical matters, kaders are better trained in the nuts and bolts of a Posyandu and seek advice from either health center staff or family planning workers (PLKB) rather than expect the team to assist in these matters.

Weaknesses still lie in adequate monitoring skills. This task takes not only a considerable amount of monitoring expertise but supervision skills as well. Although data is being collected and compiled and posted on the meeting hall walls, the interpretation and use of the data is weak.

Generally, there is a lack of understanding about SKDN, the government standard for measuring Posyandu performance. It is an indication of the percentage of children weighed, and the number of children who are gaining weight. It is a difficult standard with many different ways of interpretation since the denominator used is not always uniform. Some villages use "S" (all under-5 children) and some use "s" (only those attended Posyandu). The "N" in the system measures the number of children who gained weight. This is affected by the regularity of attendance, as children who were not weighed the previous month are not included in this figure.

There are also problems in terms of report submission and the recapitulation. Some of Posyandu in Bandar use a 35 day cycle for Posyandu and thus the Posyandu statistics do not get included in even monthly recapitulation. Those hamlets without Posyandu are not counted either. Therefore, the tool itself has inherent problems. Because of these problems, VPHC II did not put much emphasis on training in the use of SKDN. Since it is a required government standard data for measuring Posyandu performance, however, most VSTs seem to be keeping these records and displaying a graph. When asked what the graph means, few were able to explain. In one village where there is a Model Posyandu, the team was unable to detect 6 consecutive months of falling N (those children gaining weight at Posyandu).

VST responsiveness to local health problems is yet to be proven as oralit posts and Acute Respiratory Infection (ARI) messages were introduced by CARE. The communities' "problem-solving" ability to tackle new, unforeseen problems is not yet demonstrated and the capability of the teams to develop a response system which is tailored to the local conditions has not yet been initiated. However, with more time and experience VSTs will most likely be able to initiate new activities. VSTs have begun to consider funding for nutrition follow-up of severely malnourished children. In one village in EJ, tax income earned from the village market is being designated to support Posyandu activities.

In West Java the VSTs were re-structured after the MTE due to a lack of clarity in the original concept of VST. A separate kader team had also been formed and has subsequently been dismantled. New VSTs were developed since then and are currently functioning well. It is a noteworthy accomplishment in correcting an activity which had gotten side-tracked due to management difficulties.

In East Java, VSTs are well-defined and functioning. They are well represented and active. The phased-out villages' VSTs are continuing to run well after six months.

In NTB, in addition to the relatively weak village administration, VST membership is not fully representative. There are powerful religious groups which fall outside of the "expected" structures in a typical Indonesian village and whose involvement is hampered by the sectarian nature of the community. This has weakened the existing VSTs in NTB.

In general, the VSTs have created a broad-based support system which acts to motivate both kader and community to be actively involved in Posyandu. The evaluation team feels that the quality of the VSTs are varied. In EJ, the VSTs are likely the most sustainable after CARE withdraws and visiting already phased-out villages attests to that after six months of CARE's withdrawal.

Intermediate Goal # 2: Comprehensive and convenient Posyandu services are regularly functioning in all villages. Eleven of 14 indicators achieved.

Discussion

Within the timeframe of this project there has been a 25% increase in the number of Posyandu and a 73% increase in the number of children weighed. The revised DIP included the impact goal of increased Posyandu attendance (attendance/all children) as recommended by the MTE team. Although there were large increases in children weighed, this indicator was not reached (41% achievement versus 50% target). A summary of outputs follows:

	WJ	EJ	EJ	NTB	TOTAL
SDT formed	1	1	1	1	4
VST formed	17	16	8	10	51
VST members trained (minimum 17 hrs.)	254	193	99	213	759
Kader supervisors trained	233	117	40	150	540
Kader trained	501	288	157	300	1246
Religious leaders trained (minimum 12 hrs.)	307	413	80	50	850
TBAs trained (minimum 17 hrs.)	71	47	23	40	181

# of Posyandu	102	91	43	75	311
% increase in # of Posyandu	13%	0.44	7%	29%	25%
# of children weighed	3764	3212	1576	1686	10238
% change # of children weighed	95%	78%	26%	89%	73%

One reason that attendance levels did not reach 50% is that inevitably, children's attendance drops off considerably after their immunizations are completed. The attendance profile includes very few 3-5 year olds and a high drop-out as soon as a child turns one year. This is a natural phenomenon throughout Indonesia. The attendance criteria in NTB for phase-over was reduced to 35% from 50% due to strong community resistance and the ignorance as well as the weak role of women in community affairs.

As explained earlier, this indicator is difficult to measure accurately given the inherent problems in calculating the denominator of "all children". Some Posyandu report the "S", which is a total count of all under-fives and others count the "s" which is the total of only those under-fives attending Posyandu. Therefore, the figures are often not comparable.

The lack of a consistent denominator also effects the immunization coverage data. According to the government data, 100% of all antigens have been achieved. However, the KAP survey results reveal lower rates (see immunization coverage rate matrix on page 20). Appendix 8 shows a comparison of expected populations applying typical population percentages against census figures using UNICEF data.

TT coverage was not achieved although it reached 57% (instead of 80%). Health center staff involvement at Posyandu was high with prenatal examinations being conducted and TT provided.

Kaders at Posyandu demonstrated skills and knowledge in running a Posyandu. They were active, enthusiastic and highly motivated. During discussions with kaders in all three sites, they expressed their appreciation of the transfer of skills. They requested more training to further improve, displaying a thirst for more knowledge, although they felt they had adequate skills to do the job well at present. It was refreshing to hear kaders request the "intangibles" (skills) rather than ask for uniforms or payment for their efforts.

The weakness in the Posyandu rests in Table 4 and in the follow-up to the weighing. Table 4 is where health education is delivered to the mother, explaining her growth chart and providing nutritional and other messages, e.g. ORT. The main key to Posyandu success, as stated by MOH personnel throughout the health department, is Table 4. This table was not operating well at the six Posyandu sessions which the team observed. This is a recognized weakness throughout the country.

Although kader knowledge is high, the transfer of that knowledge to mothers appears to be low during Posyandu. However, the KAP survey results reveal significant increases in KAP scores among mothers. Comparing baseline and closeout KAP scores (based on five key health knowledge scores) for mothers the following impressive percentage increases were achieved:

Site	Scores		
	Base	Close	Increase
West Java	1.60	4.02	151%
East Java (Tulakan)	2.36	3.66	55%
East Java (Bandar)	2.44	3.76	54%
NTB	1.84	3.39	81%

Mothers are receiving health messages either during Posyandu or outside of Posyandu, through home visits by kaders or, most likely through the influence of religious leaders.

The ability of kader (or even MOH personnel) to recognize high-risk children through weighing was also not demonstrated at Posyandus sessions observed. The records indicated malnourished children, yet a special intervention was not taken, especially in the case of severely malnourished children. In NTB it was observed at a Posyandu session which was attended by three Puskesmas staff and four nursing students, that two severely malnourished (BGM) children whose weights were recorded on growth monitoring cards, were not detected as severely malnourished and provided with special messages or interventions.

The formation of feeding nutrition education groups reached 8% versus a target of 40%. There have been individual initiatives to care for at-risk families by kaders, however it is not yet systematized. The treatment of malnourished children varies from going undetected to referral to Puskesmas where there are funds provided for special supplementary food.

In all three sites, the nutrition groups were short-lived. The numbers of severely malnourished children were low and the children spread out geographically. The costs involved in setting up group activities became too high. Thus, the project felt a sustainable system could not be developed and the activity was reluctantly dropped as a priority.

In Tulakan there were 11 children in June 92 who were severely malnourished (<60% weight for age). A total of 11% of the under-fives weighed (which is 25% of the total under-five population) are malnourished (mild and moderate). The training of nutrition feeding program was held during a VST meeting. Although 16 villages were trained, an actual feeding program was developed in only 1 village. It was short-lived and stopped for over a year once the supply of food provided by the government was finished.

The health center doctor is aware of the problem, and has future plans to feed them, but in the meanwhile follow-up is not occurring as quickly as it should. In three villages visited (one each in West Java, East Java and NTB), kaders had not yet referred severely malnourished children who had 4-5 consecutive months of growth faltering to the health center to examine if there was any underlying illnesses.

The project increased the quality of Posyandu through the introduction of "Model" Posyandu. A model Posyandu serves as an example for other Posyandu as it is complete with five tables and offers extra services such as a Pos Obat (medicine post), play group, special activity for kaders (a quiz), or the use of educational materials. The designation of "model" was an inspiration for kaders to maintain a higher quality Posyandu. It also provided an incentive for others to aspire to, as any Posyandu could become a "model". This is implemented quite well in West Java, and being developed in NTB. In East Java the concept seems to be less understood as a model Posyandu appears as a Posyandu plus Pos Obat.

Puskesmas involvement at the Posyandu is fairly regular despite the difficulties in transport and time. Regular immunization services are available. With the provision of prenatal services at the Posyandu, a midwife also usually attends. In NTB where kader drop-out is high, the VST members and Puskesmas staff have to play a crucial role in running Posyandu sessions.

Overall, this intermediate goal was reached by CARE using a strategy of working through community managed Posyandu structures rather than directly intervening at the Posyandu level. In terms of knowledge among mothers in all three sites, there have been substantial improvements.

Intermediate Goal # 3: Subdistrict Team and Puskesmas staff adopt a community participatory approach to village primary health care services. All four indicators achieved.

Discussion:

The evaluation team was able to interview all four SDTs formed. SDT's meet quarterly and use their written workplans.

The representation on the SDT teams was wide and varied. In WJ and EJ, the SDT is well-represented and active. In EJ (Tulakari), the SDT has formed sub-teams responsible for supervising one particular village. However, the quality of supervisory visits is not known. Most visits are made in conjunction with field visits made by SDT members for their respective jobs. Certainly separate funding for transport is not available and a multi-purpose visit is efficient, as long as adequate attention is given to Posyandu.

In NTB, the SDT has not met for the last five months due to lack of funding for transportation, slow downs during the fasting month, campaigning and elections. With the advent of an operating budget for Pokjanal (see below) from the district, the team will hopefully get back on track. This fund for transportation will be made available for two villages per subdistrict. However, the district government has agreed to make a special arrangement for Gunung Sari, the VPHC II project site, that allows for all ten villages to be covered by the scheme.

The SDTs are fairly clear as to how they will be able to train new kaders. In one village, kaders have made a request to the SDT, requesting training of new kaders. The Puskesmas is expected to respond to these requests. This is a created demand which can motivate Puskesmas to train kader. In villages already phased-out, informal training has taken place. SDTs and VSTs are not sure, however, how religious leaders will be trained on health issues under normal government procedures. TBAs will be trained by the midwives from the health center.

With the advent of Pokjanal, the multi-disciplinary working group required by the government at the subdistrict level, the SDT has been decreed by the government and the teams officially institutionalized. The broad spectrum of membership is positive in that more people are involved in Posyandu activities.

Since GOI and MOH can not possibly manage Posyandu alone, the SDT is a community management tool for organizing communities and obtaining a broad base of both political and social support for Posyandu. Community involvement in Posyandu has been greatly enhanced with through SDTs.

Intermediate Goal #4: Information, materials and media to support the PHC program are developed and utilized. Two indicators, one dropped, one achieved.

Several health and education materials were developed by the project with funding support from the British Embassy, as follows:

(1) **Kader Reference Cards:** The pack contains eleven cards in a plastic pouch. Small-ringed color coded cards with bulleted health messages have been produced. They are to be used by kader and VST members as a reference. The health content combines both MOH messages and FACTS FOR LIFE, a UNICEF produced book. The cards were developed in conjunction with district health officials. Features include:

- * ability to add on cards for new health problems encountered (ie. a card on dengue fever)
- * a compact, handy size to encourage bringing along on a home visit and Posyandu. Avoids the tendency to hide behind large flip charts.
- * easy access by topic (one per color-coded card)
- * not inhibiting as it is small and colorful
- * low cost (600 rupiah each = \$.30)

(2) **Posyandu Invitation Cards:** This blue card is a tool to motivate mothers to attend Posyandu. The cards are delivered to mothers the day before the Posyandu and the mothers are asked to bring the card with them when they attend. The cards are re-distributed every month, used up to a year. They are meant as a handy vehicle to track and motivate Posyandu defaulters.

(3) Religious Sermons: A booklet of sermons which focus on health topics and related religious teachings was produced in a collaborative effort between international agencies with health projects in NTB, government departments of Health and Religion and local religious leaders.

(4) Religious Leaflets: These leaflets were produced to be distributed during the fasting month of Ramadan at mosques in all three sites. The leaflet is composed of illustrated health messages and quotes from the Qur'an.

(5) Cassettes and Pictures: This media was developed in NTB, in the local Sasak language and in Indonesian. It is a series of episodes on tape with accompanying illustrations to be used in women's groups. This media has been field tested in three CARE locations and in three other locations in Lombok. The evaluation study recommends some revision to the materials before they are used on a wider basis. This teaching pack will be useful in the new CS VIII project in NTB which focuses on women's groups.

Discussion

The first indicator of using the Nilai system of growth monitoring was dropped. Catholic Relief Services developed the system and was in the process of conducting an evaluation of its effectiveness, thus CARE made the decision to wait until the "product" was evaluated. The second indicator was achieved whereby at least two materials are being used in each subdistrict (WJ: 4, EJ: 5, NTB: 4).

Over 25,000 kader reference card packets were distributed in the Province of NTB and Districts of Pacitan (EJ) and Bandung (WJ). In all three sites, kaders found them beneficial and useful. Some VST members also used them. The cards are a welcome change from large, expensive flip charts which often form a wall between a health worker and the mother. These packets are small and inexpensive.

The cards have been distributed well beyond the project sites. There have been some delays in distributing the cards outside CARE sites in NTB because clarification was needed about the date of the first Hepatitis B immunization. The nutrition messages do not include any mention of adding high-fat foods to increase caloric intake beyond increasing the frequency of feeding. In Indonesia, coconut milk and oil are available and can greatly aid in fighting calorie deficiencies.

Over 27,000 invitation cards were printed for use in all three sites. According to an evaluation of these cards, short-term use led to a substantial increase in Posyandu attendance. However, it was not clear whether the village leaders and kader understood that the cards are intended for regular distribution, and it seems that in some locations they had only been distributed once. Long-term sustainability of their use is, therefore, uncertain.

In WJ, the district government showed interest in replicating CARE's kader reference cards and Posyandu invitation cards. In East Java, the booklets containing health messages and religious teachings are having an impact beyond the project. CARE worked closely with the Department of Religion in the district of Pacitan, EJ, developing the content and sharing the costs of the materials. GOI officials have reproduced the books throughout the district. In some remote villages, the book has been photocopied by the VSTs when there were not enough copies available.

In NTB, an evaluation of a book containing health messages and religious teachings has not yet been completed. There has been some resistance among some religious leaders who believe that religious events are strictly for religious purposes.

The religious leaflets were distributed in CARE sites during Ramadan. Twenty six thousand leaflets were printed and distributed to reach large numbers of the population with simple health messages supported by religious teachings. It was an important opportunity as during the fasting month more people attend mosques.

This project has proven how religious leaders are powerful messengers of health education. The religious leaders greatly appreciated written materials, including quotes from the Qur'an and actual sermons. Islamic religious sessions provide a new channel for reaching more poor families with health information, as community religious activities are followed faithfully.

The teaching pack cassette will be useful in the new CS VIII project in NTB which focuses on women's groups. It is an interesting media which can captivate an audience as it is based on episodes. There is potential for wider scale use as it is planned that health centers will soon be supplied with recorders.

2. KAP Survey Results

A brief summary of selected KAP survey results is included in this section. A separate KAP Survey Report is being prepared. The baseline survey was excessively long and detailed, and collected data on mothers and kaders in both CARE site areas and control sites. Producing the draft report of the baseline survey took one and one half years. Thus, the full benefits of the survey were not realized, since the information was not available for programming until near the midterm of the project.

For the closeout survey, CARE reduced the length of the questionnaire while adding a few questions based on USAID/CS's latest guidelines. Although USAID now requires only mother's of under-two years old to be surveyed, the project continued to survey mothers of under-fives in order to be able to compare close-out data to baseline data.

PERCENTAGES OF BASELINE COMPARED TO CLOSEOUT

	WEST JAVA		EJ: TULAKAN		EJ: BANDAR		NTB									
	Mothers:Kaders		Mothers:Kaders		Mothers:Kaders		Mothers:Kaders									
	B	C	B	C	B	C	B	C								
Know why immunization is important	15	87	68	100	21	73	68	98	51	84	68	98	11	63	64	93
Colostrum should be given	51	75	58	98	50	65	78	93	32	54	78	93	50	71	64	93
Knows to prevent night blindness	22	68	70	100	49	58	84	95	37	63	84	95	37	67	78	93
Knows 2 ways to prevent diarrhea	15	68	45	100	34	50	66	80	25	55	65	80	21	47	52	78
Knows amount of ORS	55	95	73	100	32	80	66	98	56	76	66	98	23	78	48	93
Knows 2 ways for healthy pregnant	25	81	73	100	57	89	79	98	56	87	78	98	20	62	68	93
Knows 1 more symptom ARI	53	91	63	100	73	89	97	90	78	97	97	90	82	97	82	98
Health Knowledge score BASE	1.60		3.05		2.36		3.87		2.44		3.87		1.84		3.30	
Health Knowledge score CLOSE	4.02		4.98		3.66		4.58		3.76		4.58		3.33		4.53	

CODE: B: Baseline C: Closeout

BASELINE & CLOSE-OUT DATA

KAP survey data: 12-23 months

IMMUNIZATION COVERAGE RATES

	WJ	EJ: T	EJ: B	NTB
> 12 mos. ever immunized: base*	33	61	75	11
<12 mos. ever immunized: base*	46	80	68	33
Complete (closeout data)	53	70	67	62
BCG	66	89	86	65
DPT 1	65	89	86	65
POL 3	54	75	76	63
Measles	54	70	70	63

*(verbal confirmation by mother).

Given the state of the art 30 cluster KAP survey technique, two weeks of analysis can produce descriptive survey results with high statistical validity and reliability. In the future CARE plans to utilize this sampling technique. Use of the 30-cluster is now required by USAID but this was not the case when the baseline survey was conducted. Again, in order to have comparable data to the baseline survey, the project's stratified random sampling technique was again utilized in the phase-out survey.

As displayed in these matrices, health knowledge among both kaders and mothers has increased significantly. Kaders knowledge remains higher than mothers, although the amount of increase is consistently less than the amount of increase in mother's knowledge. It can be concluded that kaders are doing a better job of increasing mother knowledge than they probably were in the past. The knowledge transfer may not be occurring at Table 4 of Posyandu, but it is occurring. There has been a large increase in home visiting (23%-73%) by kader, so it could be concluded that health education is being disseminated in the home.

Immunization coverage rates using data from the survey show complete rates for under-ones between 53% and 70%. The baseline survey collected data on those children less than 12 months who had ever been immunized and those above 12 months who were complete, thus, the baseline figures are not comparable to the close-out results.

3. Effectiveness of Activities

In terms of achieving the goals of the program, the activities were effective. Review of the achievement of project indicators reflect the ability to achieve what the project set out to do. Strengthening community management clearly had an impact on health knowledge as the KAP survey reveals.

The project appropriately addressed the communities felt health needs. The major health problems are diarrhea and ARI, as expressed by kader, mothers and village leaders during field visits. In response to these problems, over 600 Oralit posts have been set up during the project accompanied with kader training. ARI prevention and proper referral messages were provided in kader training as well as printed in health education materials used.

The effectiveness of focusing on community management contrasted with VPHC I which was a direct implementation project. The change in project design has developed institutional capability which is more sustainable.

4. Monitoring System

The project's monitoring system has been efficient. Qualitative forms (e.g. Activity Monitoring Forms) were designed for the field officers to monitor activities within the communities. The forms were considered burdensome and thus were reduced after the MTE.

Utilizing the government data system is good in that CARE did not create a parallel system which doubles the workload for kaders. The reliability and validity of the reported data is, however, affected by the under-reporting of under-fives. As aforementioned, a consistent denominator ("S" or "s") is not used for determining coverage rates. The "S" which covers all under-fives in the village is an appropriate denominator. The government system is not necessarily reaching the unreached as large numbers of the children are missing. See Appendix 8 for a comparison of populations expected in the sites. Although appropriately utilizing the government data for monitoring purposes, the project was able to verify the validity of these figures through data collected in the phase-out KAP survey (see KAP survey results, page 20).

Death reporting is not being analyzed although it should be available at the village or hamlet office. This would be an important indicator to track in order to find out what the major causes of childhood deaths are in the community. Accurate IMR, CMR and MMR may be difficult to obtain, but a general idea of the cause specific, age-specific deaths would be helpful.

5. Staff Development

Numerous management and technical training has been carried out to support staff development. Training of Trainers, Management Training, Survey Methodology, and Lessons Learned about Sustainability are some of the topics of training. During one of the five day staff training events, the following topics were covered: problem analysis, community resource management, training needs, analysis of facilitating skill, analysis of project data, phase-out strategy and close out survey. CARE training of staff was appropriate and effective.

Cross visits between field offices and a Project Officer's visit to CARE Bangladesh were invaluable exchanges of experience. Cross visits were also facilitated between SDTs and VSTs. In NTB, SDT members felt that these were major, positive learning experiences.

III. Sustainability Issues

This section follows the guidelines provided by AID Washington which specifically address sustainability of the project.

A. Sustainability Status

A1. USAID funding for child survival activities ends on 30 September 1992. Project activities have ceased in the end of June 1992 and since then the staff took on a monitoring role only.

A2. By the end of September, staff contacts end for this project. In WJ and EJ, CARE would like occasional follow-up visits to be made and arrangements for this need to be worked out with CARE staff from other projects who will remain in the office.

In NTB, where a Child Survival VIII project begins on 1 October 1992, it is recommended that follow-up will continue by CARE staff every 1-2 months for up to a year, as the villages are not yet ready for phase-over. CARE staff will play a limited facilitation role in strengthening the communication link between the SDT and VST.

A3. Responsibilities have been phased over to local institutions within the community structure (VST) and within the government system at the sub-district level (SDT).

B. Estimated Recurrent Costs and Projected Revenues

B 1.& 2. Key child survival activities which project management perceives as most effective and would like to see sustained are:

- I. Training (refresher and new) for kaders, religious leaders, TBAs, VST and SDT members (total \$13,400)
 - a) KADER Refresher/Review: The cost of a three days training for 1,300 kader would cost approximately US\$7,500.
 - b) VST Refresher/Review: The cost of a two day training for 800 VST members is estimated at \$2,000.
 - c) SDT Refresher/Review: The cost of a two day training for 80 members is approximately \$600.
 - d) TBA Refresher/Review: 250 TBAs for 2 days would cost approximately \$1,200.
 - e) RELIGIOUS LEADER Review: 650 leaders for 2 days would cost approximately \$ 2,100.

II. Supervisory visits of SDT to VSTs

51 villages x 4 visits x transport = US\$ 600.

B3. TOTAL: Training and Supervision yearly: \$ 14,000
Over three years: \$ 42,000

(WJ: \$5,500, EJ: \$5,500, NTB: \$3,000)

B4.5.6. These costs are reasonable given the environment in which the project operates. The training, supervision and monitoring that CARE promoted supported the monthly visits and training conducted by the health center staff and, therefore, are already included in the MOH budget. The district government has committed itself to continue to fund inservice training and supervision activities for Posyandu after VPHC II funding ends.

B7. Lessons to be learned in this project which may apply to other CS projects is that working within the government system allows a chance to influence government budgeting allocations. Working at the district level is important in Indonesia as decentralization to the district level is being developed. Projects which work at the district level will have more influence in channelling funds to particular areas. It is also important that the appropriate technical counterpart is chosen so that budget allocations can flow into the proper activity.

C. Sustainability Plan

C1. In all three sites, the team interviewed the CARE Chief Representative, the Project Manager or Officer, all Field Officers involved in the project, kaders, VST, SDT and health center staff, as well as formal and informal community leaders and mothers.

CARE maximized the involvement of both GOI subdistrict officials and villages leaders in the planning phase. In each province a DIP was prepared that was specifically created to fit the needs of that particular area. The provincial plans were drafted by CARE project management staff and formally reviewed by the appropriate provincial, district and subdistrict government counterparts. The provincial plans were approved by the local governments in January 1989.

C2. The plan for sustainability was clearly delineated in the DIP and there are specific indicators to measure the progress towards sustainability. CARE staff facilitated change by working with government counterparts, community leaders and kader leaders. CARE was not providing direct health services but instead focussed on facilitating the better utilization of existing resources.

C3. Several sustainability-promoting activities which were carried out over the lifetime of the project include:

- * Organized 51 VSTs and 4 SDTs: CARE facilitated community management teams
- * Trained team members in Posyandu management: skills transfer rather than material support of Posyandu
- * Played a facilitation role rather than implementation role
- * Measured sustainability through indicators for phase-over
- * Worked within government structure
- * Tapped government budgets as much as possible
- * Used existing government data rather than introduce another health information system.

Sustainability of SDT is likely as the government has provided a clear mandate to form Pokjanal teams in each subdistrict. In all locations, sub-district officials were convincing in their willingness to continue to support the team approach to Posyandu management. Political will is required to allow government budgeting to put "their money where the mouth is".

VSTs have been integrated into local semi-official institutions. In WJ, the Health Life Movement (GHS) structure, as decreed by the Governor is being used. In EJ, the choice is TPKKBS (supervisory team) as decreed by the Governor in 1986. In NTB, the project used the concept of KB-KES teams (family planning-health) as the vehicle for promoting the VST.

In terms of team formation, both SDTs and VSTs are clearly defined. In terms of teams function, to monitor, evaluate, supervise and train kaders, it is highly unlikely that the teams will be able to carry out all of these tasks fully. In terms of providing moral support and attention, however, they certainly have proved their worth.

It is possible that with time the teams become more adept at understanding Posyandu and providing the appropriate needed support. The government may also step up their part in providing the necessary skills to the SDTs and VSTs. A guideline booklet has been developed for the Pokjanal and CARE is supplementing this with a booklet entitled "The Secret to Posyandu Sustainability", including case studies on CARE's experience in working with GOI through SDT and VST development.

C4. In the DIP it was stated that resource generation approaches would be explored and CARE would seek assistance from their Regional Technical Advisor in Small Enterprise Development. It was also planned that CARE Indonesia staff would participate in SED training. Although the Regional Advisor could not come, staff training in resource generation did occur.

The project's objective is to have communities provide the financial support required by themselves together with the health center. CARE's role is only to provide skills and training. During the second half of the project, an effort was made to identify incentives that communities can provide themselves to kader in return for their services. Kader Incentive Support Systems (KISS) were developed by each VST. Each village determines for themselves appropriate schemes. Many indigenous, organic activities which are traditionally found in the villages are now being activated.

a) Community Resources for KISS and/or Posyandu support:

- 1) Simpan-Pinjam: Savings and Loan
- 2) Jimpitan (rice collection): each member contributes a can of rice to a pot which is then sold in the market.
- 3) Arisan: traditional rotating credit group
- 4) Donators within community
- 5) Household collection
- 6) Government/village funds
- 7) Profit from Pos Obat Desa (Medicine Posts)

b) KISS takes various forms:

- 1) Rewards in the form of certificates, uniforms, prize to one kader attending Posyandu (door prize basis), gift/payment at end of fasting month (Lebaran).
- 2) Free medical services (pre-payment) for Puskesmas doctor services
- 3) Special facilities in administrative matters, such as arranging identity card, signing of money orders, etc.
- 4) Providing new skills, opportunities to meet with other kader, status, training for Pos Obat Desa, cross-visits and kader seminars.

c) Posyandu Support:

A recurring cost of Posyandu is the cost for supplementary food at Posyandu (a snack) and small amounts of money for administration. The cost varies per Posyandu.

There are KISS activities in all 10 villages in NTB, in 3 of the 8 villages in Bandar (EJ), in 10 of 16 villages in Tulakan (EJ) and in 14 of 17 villages in WJ. CARE offered seed money of 50,000 rupiah (\$25) to each village that requested (WJ: all villages, EJ: none, NTB: 4 villages).

Sustaining kaders' motivation through simple, incentive systems is possible, although at times the community self-financing does not seem logical nor rational. Kaders are motivating themselves through savings and loan schemes, through rice collection, etc. Profits made through these activities are given to Posyandu for supplementary food and materials needed. The volunteer worker not only gives her/his time and effort to the community, but also gives her/his

incentives back to the community. Providing lunch to themselves after Posyandu is another motivator, even though it is their own contribution once again. These activities understood in a socio-cultural sense rather than a mere economic sense, contribute to the idea of "peer group", providing a sense of belonging.

The development of medicine posts has been an effective incentive for kader and increased the quality of Posyandu. Kaders receive extra training to learn how to manage a medicine post. Medicines are purchased on credit from the Puskesmas. Profits from the selling of medicine can go towards Posyandu activities after restocking supplies.

C5.6. Counterpart institutions made financial commitments during the design of the project. CARE staff worked closely with the district level staff in order to assure budget allocations for PHC activities.

West Java: Although CARE worked closely with the district government, there was a problem in allocating funds for health activities given that at the provincial level, CARE's counterpart is the Bureau of Social Development of the governor's office. For the coming year the province allocated funds for training and supervision. Since it is under a different department than health, projects for health cannot be funded. However, the department will try to put Posyandu supervision costs under "routine operational costs".

East Java: The District of Pacitan has been matching CARE's project funds out of APBD (district funding mechanism) for the life of the project. Memorandums of Agreement have been signed and commitments kept. In 1990, the government contributed 35 million rupiah (\$17,500) for this primary health project with an extra 13.5 million (\$ 6,700) for monitoring and supervision. This coming year's budget has not yet been allocated and is undergoing the process of approval.

NTB: The district received a budget for Pokjanal which will be available for all villages in Gunung Sari for Posyandu supervision starting this coming fiscal year. This will be used for the operating budget of the SDT and for VST supervision.

D. Monitoring and Evaluation of Sustainability

D1. In order to ascertain when villages have achieved a sustainable level of improved Posyandu supervision and implementation, phase-out criteria were developed. The phase out criteria select the most important indicators of the project's goals and apply them to individual villages. These criteria were applied to the six phased-out villages in East Java in mid December 1991.

CORE INDICATORS: (100% must be achieved)

1. 70% of Posyandu sessions are supervised by VST.
2. VST conducts training for kader
3. 50% of children under-five are weighed at Posyandu (35% for NTB as per MTE recommendation).
4. 70% of Posyandu have referral system to Puskesmas operating.

IMPORTANT INDICATORS (50% must be achieved)

1. VST meets regularly in accordance with agreed schedule.
2. VST implement workplans for priority health problems.
3. 70% of TBAs trained by the project are active in promoting the Posyandu, relaying health messages and referring high risk pregnancies.
4. 70% of informal community leaders (religious leaders and/or teachers) trained by the project are actively involved in promoting the Posyandu and relaying health messages.
5. Village has at least 2 Oralit posts distributing and restocking their supplies.
6. 80% of Posyandus hold monthly sessions.
7. 70% of Posyandus operate with "four table system".
8. 70% of mothers demonstrate improved health knowledge and attitudes.
9. Kader at 70% of Posyandu are making home visits.
10. 70% of Posyandus have feedback sessions.
11. Children 0-12 months receive immunizations as follows: BCG: 90%
DPT1 90%, POL3 90%, Measles 80%
12. 80% of pregnant women receive TT immunizations.

D2. These indicators show high sustainability standards. Overall, 28 villages out of 51 (55%) passed these phased-out criteria.

D3. Qualitative data indicating a change in sustainability potential of project benefits were collected monthly by the Field Officers through a reporting form which grades the quality of work of the VST or SDT.

D4. In-country agencies consulted by CARE on the design, implementation and analysis of the midterm and final evaluations were the MOH and CARE's provincial GOI counterparts.

During the evaluation process feedback-discussion sessions were provided to USAID, MOH central level and, in all three sites, provincial, district and sub-district government officials.

D5. When reviewing the original proposal, USAID technical reviewers recommended that CARE concentrate on identifying the most cost-effective ways to develop a village health post so that the government can maintain the process after CARE leaves. This recommendation was clearly followed.

Reviewers of the DIP were concerned that the project indicated very little coordination with MOH sub-district health center staff and recommended that at least some of the training, supervision, and data collecting skills be transferred to sub-district staff before the end of project. Upon interviewing health center staff, relationships have been well-maintained. Some of the skills mentioned above have been transferred as recommended although not as much as was hoped for in the design.

D6. Recommendations made by the MTE Team regarding sustainability were effectively addressed by CARE staff. All of the recommendations were followed up. See section 1 of FINDINGS for details.

E. Community Participation

E1. The evaluation team interviewed the following groups of people regarding community participation: community leaders, kaders, TBAs, health center staff and mothers.

E2.3. Community leaders perceived the following activities as being effective at meeting current health needs: training of kader, TBAs, religious leaders, VST and SDT teams. CARE worked at developing effective community management skills to supervise Posyandu. These are activities carried out to enable the communities to better meet their basic needs.

E4. The Child Survival grant process limits the opportunities for community participation in analyzing health conditions and planning the project. The beneficiary population participates only in the implementation of such projects.

E5. Each village in all three provincial sites has a functional health committee, so that there are a total of 51 VSTs and 4 SDTs. VSTs meet monthly and SDTs meet monthly or quarterly. Although the groups have appointed members, they are fairly representative of the community. The male/female ratio is about 70:30. The only group not represented are the poorest of the poor.

E6. The most significant issue being addressed by these health committees is the running of Posyandu. They discuss attendance levels and kader participation. Some teams discuss the SKDN (government Posyandu data graph), although it seems they do not look at trends. Although morbidity or mortality data are not being collected, discussions regarding major health problems are held. Besides reviewing the results of the Posyandu, they also plan for longer term developments such as creating new Posyandu or setting up a village medicine post.

E7. Each community has contributed in some way to continue the activities after donor funding ends. Besides contributing their time and effort, VSTs look for ways to fund activities through resources available to them as a village (funds from government). They also actively tap resources within their community, including in one case the taxes generated by the village market.

E8. KISS is an example of how the community is willing to provide incentives from their own resources. There are various schemes in villages, which are reviewed in the Sustainability Plan section C4. Some VSTs expressed their desire to pay for transport cost of the SDT to supervise quarterly. If the activity is valued, villagers usually are able to tap "swadaya masyarakat" (local resources).

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F1. Persons from the counterpart institutions involved with the project were interviewed prior to field visits and provided feedback after field visits in each respective district and subdistrict.

Sustainability of the SDT depends on the institutionalization of the teams. Approximately one and a half years after CARE began the SDT concept, GOI under a joint instruction from the Ministries of Home Affairs, Education, Religion and Health, created an institution (Pokjanal) to improve the quality of supervision and support to Posyandu activities. With this move, the GOI established integrated teams at the central, provincial, district and subdistrict levels to improve the village management of the Posyandu.

In effect the decree established as official government strategy CARE's approach: the establishment of subdistrict and village teams. There is a direct link between the subdistrict and village teams. The subdistrict teams are now legitimized by the government as they are the teams now required under the Pokjanal initiative.

F2.3.6. Counterpart willingness to sustain project activities was extremely high in WJ. A district level official instructed the sub-district to include Posyandu costs in the village budgets. Government officials expressed an interest in replicating some of CARE's health education materials, such as the reference cards and invitation cards.

In EJ, the district has been matching CARE's input and expressed a willingness to do so in the future, although this year's budget is not yet allocated. Provincial government officials are interested in adopting "CARE's methods" throughout the province and have requested CARE to organize a workshop to share their experiences in working through VST and SDTs with all district governments.

In NTB, the district will fund operational support activities for Posyandu, so supervision will be included. CARE was requested to document their experience by the District of West Lombok. CARE project staff are developing an official guidebook including case studies from CARE's VPHC II project.

F4. GOI personnel perceive the VST teams and CARE's training as the most effective activities. Enthusiasm runs high at this time and counterpart institutions are confident that they will be able to sustain activities.

F5. CARE's project directly trained and facilitated GOI personnel, supporting them in organizing teams to manage Posyandu, to train new kader and to plan and monitor health activities.

G. Project Expenditures

G1. CARE International Indonesia will separately submit the Pipeline Analysis of project expenditures.

G2. As compared to expenditures identified in the DIP, there have not been any changes between categories of expenditures as planned.

G3. CARE's financial reporting system is centralized and standard financial policies and guidelines are used by all Field Offices. The financial reports are prepared on a monthly basis and submitted to CARE Headquarters. Separate ledgers are maintained for VPHC expenses. Senior management monitors overall project budget whereas the program team is responsible for managing directly the project related budget which is approved at the beginning of the fiscal year. The finances have been running smoothly.

H. Attempts to Increase Efficiency

H1.2. CARE attempted to reduce costs by keeping inputs to a minimum from the start and investing in human resources and management skills rather than materials. The staff have pushed existing channels for materials, such as UNICEF for materials (growth charts). Government resources have been tapped, not only for phase-over support, but during program implementation.

H3. Reflecting on the strategy chosen for this project compared to the VPHC I project, it is clear that this "process" oriented approach is much more efficient than directly supporting Posyandu activities.

I. Cost Recovery Attempts

I1. Cost recovery mechanisms were not included in this project. The project has initiated several Posyandu support schemes which includes the Pos Obat Desa. The health centers agreed to give a line of credit for the initial purchase of simple medicines kept by a trained kader. There are now 8 posts in WJ, 24 in EJ, and 3 in NTB.

J. Household Income Generation

J1. Household income generating activity was not part of the project plan.

PART FOUR: SUMMARY AND CONCLUSIONS

CARE has demonstrated its competence in improving families' practice of protective health behaviors (KAP survey results) and in widening community management of Posyandu. CARE has undertaken innovative steps to ensure sustainability. In summary, CARE's sustainability strategies were as follows:

1) Building linkages. Collaboration with the government was evident, as CARE worked towards strengthening the government institutions.

2) Developing capacity. Formation of community management teams at the village and sub-district level. Training community members to supervise the Posyandu. Developing adaptive problem solving capacity.

3) Generating a demand for PHC activities. Increased demand on government services through community motivation.

4) Shifting responsibilities. Management, service delivery and financing responsibilities have been shifted to the VST and SDT. Developing Posyandu support and kader incentive mechanisms at the village level.

5) Maintaining community and government ties. Technical reinforcement, special purpose financing and sharing experiences with government. Educating community representatives at the subdistrict level about health issues within their communities.

The project was competent in carrying out its activities. It was refreshing to listen to villagers explain CARE's role in enabling them to carry on once CARE leaves. It is premature to tell if the program will be sustainable, however, well planned strategies were acted upon to greatly increase the chances. Ultimately, it is will be decided by the government and community.

Factors which may maximize chances of sustainability are:

1) More emphasis on transfer of training skills (adult, participatory methods) to community as well as government institutions. CARE's role in training events may be too dominant. Developing training plans with counterpart would enhance VST and SDT skills for the future.

2) Links with central GOI and district require more attention and strengthening. Finding the proper level of government to influence budget decisions is needed.

3) More TIME would be better than more STAFF for project sustainability.

4) Lack of knowledge about socio-cultural contexts leads to unsustainable projects. Anthropological perspectives aid in determining an appropriate strategy.

5) USAID grants expectation of reaching targets in a limited time (3-4 years) renders sustainability difficult to achieve.

6) Project did not explore possible replacements of FOs. Government openly expressed the FOs crucial role and the inability of government employees to take the community development approach. FOs provide that link between government and community, although the VST is supposed to continue this link. Two to three years may not be long enough to expect this to happen on its own. Training local motivators to replace Field Officers positions through either social organizations (LSMs) or local NGOs (LPSMs) is a possibility.

PART FIVE: RECOMMENDATIONS AND LESSONS LEARNED

This section summarizes recommendations and lessons learned based on the findings, discussion and conclusions. There are eight major topics addressed: VSTs and SDTs, Posyandu Sessions and Services, Counterpart Options, Training, CARE's Role, Sustainability, Significance of Community Management Approach, and Socio-Political Environment. Specific recommendations are marked with an asterisk (*).

1. VSTs and SDTs

VSTs and SDTs are able to provide effective moral support to rally high levels of community participation. The teams mobilized broad support for Posyandu resulting in community members acting as advocates, agents and sponsors of Posyandu. Puskesmas staff are members of each SDT, so that VSTs are able to tap the appropriate resource for assistance in technical matters regarding Posyandu.

The concept of "peer group" describes the group cohesion created in this project. Peer groups are being formed and are beginning to exert a silent pressure on people to conform to new community "values", such as attending Posyandu. Peer groups are developing within the SDT, within the VST, within the kader groups and among mothers who attend the Posyandu in a hamlet. A support system is being created which elicits group cohesion. A member of any of these groups will feel personally "malu" or ashamed if they do not follow the expected norm. The notion of peer group is an interesting finding in that it can be a powerful tool for positively directing group behavior. This could be an important potential for social marketing activities.

Peer group formation assists in sustaining health practices and behaviors. New norms can be internalized and become part of the culture once groups form. It was observed that Posyandu has become a social gathering, not to be missed. It is considered a "sin" not to attend Posyandu in some villages.

This pressure to oblige, however, has its drawbacks in that passive adherence may be bred. Caution must be taken as there is also a possibility of a negative transformation of values whereby "poor" behaviors become the norm rather than healthy ones. Dominance of one group may also cause disharmony between peer groups.

72. Posyandu Sessions and Services

While encouraging community self-help, programs must nevertheless take responsibility for the technical quality of PHC services and ensure that communities' trust in their kaders is not misplaced. Individual trainers and supervisors have to pay greater attention to the quality of worker technical performance.

The closeout survey results provide evidence of considerable improvements in health KAP. The survey, however, did not cover nutritional status issues so that changes in nutrition were not measured. From observations at the Posyandu sessions attended, follow-up to weighing at Posyandu is weak. Growth monitoring is inextricably linked to nutrition interventions and if it is not, the weighing process loses its meaning.

Recommendations for future nutrition programming include:

- * Increase kader skills in giving nutrition education during Posyandu at Table 4.
- * Improve nutritional messages regarding high-calorie foods in health education materials.
- * Positive deviant study of children who are well-nourished within the community, so that mothers can learn from families that are able to feed nutritious foods to their children and are similar socio-economically. These "model" mothers can set a good example for others in similar circumstances, demonstrating to others the means by which some mothers are able raise well-nourished children within the community.
- * A malnourished child flags a dysfunctional family with a social problem. Closer attention in seeking a solution for the family is recommended. This requires more "social work" skills among kader.
- * Develop a protocol for malnourished children so that kaders are clear as to the procedure once a child is detected as malnourished, which includes a referral system to the health center for examination to detect the possibility of underlying illnesses.

The community emphasis that contributes so significantly to demand creation may ultimately be less productive for this side of the equation. Community-based groups have sustained simple supply systems (ORS, medicines, contraceptives) but not the more complex knowledge and practice changes needed for growth monitoring, ORT and even prenatal care referral. The commitment of established bodies to strengthen and expand the service supply side is the natural extension to this project.

This strategy of increasing participation (quantity) and later addressing quality

issues is similar to the evolution of Indonesia's family planning program. The quality of GOI's family planning program has increased tremendously through the years after the population was rallied to first accept family planning. Similarly, Posyandu attendance has risen. Now the quality will need to be increased in order to sustain high levels of attendance. This requires among other things, kader skills in communication. Perhaps this could be emphasized during future kader training conducted by the VST and SDT.

- * Greater attention to data ANALYSIS and data quality may be an important input from CARE as data collection is a government requirement to be done for each Posyandu. If the reason for collecting data was made clearer and had more meaning, then the quality of data will naturally rise.
- * VSTs presently do not track under-five deaths and, therefore, are uncertain as to the major causes of death in their communities. Attention to cause and age of deaths is a useful task of the VST.

3. Counterpart options

- * Working at the District level in Indonesia will provide more continuity in programming, as the District level plans for five years. There is high level of mobility among sub-district heads, so that personalities change frequently, whereas District heads are more stable. It is also the level of government charged with the responsibility of allocating funds to the village as well as to the Puskesmas for training purposes.
- * Memorandums of agreement should be made with technical bureaus involved in a project, even though the PVO may have an official counterpart within a non-health department, to help facilitate operational health activities and funding mechanisms.

4. Training

In training SDT members, VST members and kaders, the use of adult, participatory methodology has been well-appreciated. Emphasis on transferring active learning techniques is more valuable than content in the beginning as the framework will be set and additional knowledge modules added. Kader especially need to develop training skills as they become community trainers and require communication skills.

- * Training of kaders as health educators was mentioned as a need among kaders interviewed. Training to date has not emphasized communication skills enough, but rather health knowledge. The VST should be aware of the need to organize training which focuses on knowledge transfer skills for kaders.
- * Additional training which is also important for CARE's field officers and staff might include:
 - a. Nutrition interventions
 - b. High-risk approach: how to transfer these skills to the community
 - c. Community diagnosis: social structures and health needs, rural rapid appraisal
 - d. Communication skills transfer for kaders
 - e. Internal checks for analyzing health data

5. CARE's Role

CARE as a change agent has been effective in producing new found confidence among government and community. CARE was an important catalyst in mobilizing the VST and SDT (Pokjanal) concept. It was aptly stated by a doctor in a district health office that CARE was able to fill the gap between government and community using their skillful, community development approach.

The government by nature is unable to get as close to the community given its bureaucratic culture and psychology. Besides the fact that they wear uniforms which automatically separate and distance them from the community, it is not feasible for government workers to reach to the grass roots level as NGO workers do. Government officials and community development workers necessarily have different approaches and, therefore, the role of NGOs is considered a necessary component of development.

CARE was able to impact health policies in NTB. They were invited to be part of a district team in formulating Pokjanal structures and operational policies. The District has now published booklets providing Guidelines for Supervision, Monitoring and Management of the Posyandu. CARE also developed the position of the family welfare movement (PKK) members on the SDT.

- * For the new project to be started in NTB it is recommended that an anthropologist be hired to avail further insights into the social structures. There are also at least five doctoral students researching various socio-cultural issues in NTB whose work will be important for CARE to tap. This knowledge greatly effects the success of the project. Since villages in NTB are not fully ready for phaseover, continuation of health activities in Gunung Sari is recommended.

6. Sustainability

In terms of creating institutional capability, the system has been activated, leading to a greater chance of sustainability. Given the high mobility of government officials, there is a potential to have programs fall as their leaders leave. If the leaders of groups change, will the groups still function? Thus, it is important to assure that not only the first layer of leadership is trained, but the second and third layers as well. A stable network and culture which "buys" into the concept is a requirement for sustainability.

Kader are not the sine qua non of PHC. Local community agents are essential, but many kinds of people can make a contribution to PHC: religious leaders, teachers, and TBAs. Religious leaders, using health education materials during Koran readings and sermons, are powerful health educators, as this project demonstrates.

Kader Incentive Support Systems, supported by VSTs, are decided by the villages. The schemes chosen are often traditional activities which have added value for the kader group. The addition of a medicine post is an incentive to kaders as it increases their status in the community and makes Posyandu more attractive.

In the villages which have been phased out already, the evaluation team was able to see activities sustained after six months with CARE staff monitoring progress only once monthly.

- * It is recommended that CARE re-evaluate the sustainability of the project in six months in all sites to learn whether the project strategy in fact produced sustainable results. An evaluation again after one year would be valuable.

7. Significance of Community Management Approach

A community management approach implemented by the project has proved to be successful even in remote, isolated areas. It was found that building systems is more sustainable than providing direct interventions. Investing in human resource and management skills will have more lasting effects, as the chances of sustainability are heightened.

The community development approach taken by CARE staff has bridged the gap between government and community. The government can not take the role of CARE's Field Officers given the differences inherent in approach. The formation of the VST and SDT will hopefully fill that gap.

8. Socio-Political Environment

A community management approach can be more successful when it becomes "biological" rather than merely mechanical. A variety of PHC approaches are needed to adjust to local interests and resources. For example, an approach specific to the social groupings and social reality in an area is needed. A NGO can develop program activities with enhanced effectiveness, if they tap into existing research to better understand the local cultural context and reflect on their own experience. NGOs can exercise greater flexibility than the government in testing new approaches and strategies.

The role of formal leaders is dominant in community leadership due to the strong bureaucratic pull factor. This is quite evident in WJ, and especially EJ, in that government interventions are dependent on formal leaders. However, in NTB, the role of informal leadership is still strong and government interventions require a different approach.

The team observed that working in a smaller scale district lends itself to higher visibility, attention and government support. In EJ, due to the district's isolation and poor geographic condition, the district government is very supportive of CARE's project. In WJ, the sub-district level is isolated and neglected, whereas the district is well-developed and active commercially and politically. Within the district, the project is but one of several other activities. In NTB, a sense of backwardness is apparent and the provincial government greatly appreciates outside assistance.

APPENDIX 1 a

TEAM MEMBERS:

TEAM LEADER: Donna Sillan, MPH

Donna is Save the Children's Asia/Pacific Regional Health Consultant based in Jakarta, Indonesia. She managed an urban Child Survival program in Jakarta for three years before she became regionalized. She has lived in Indonesia for 5 years. She has a Masters in Public Health concentrating in health education.

COMMUNITY MANAGEMENT SPECIALIST: Raharjo Suwandi, PHD

Raharjo is a social research specialist with a PHD in Anthropology. He has studied and worked in rural villages throughout Indonesia for over 20 years. As a free lancer he has a multitude of experience in PVO evaluations and was a member of the MidTerm Evaluation team for this project.

MOH REPRESENTATIVE:

Rosani Azwar, SKM

Rosani is a staff member of the "Seksi Upaya Pengobatan Swasta" or the Section for Non-Governmental Medical Services of the Ministry of Health.

Dr. John Mokoginta, MPH

Dr. John is the head of "Seksi Pembangunan Kesehatan Masyarakat Desa" or the Section for Village Community Health Development of the Ministry of Health.

USAID REPRESENTATIVE: Nurmaulina Suprijanto, S.E., M.Sc.

Nurmaulina is the Child Survival Coordinator in Jakarta's USAID mission overseeing all Child Survival grants in the country. She was a part of this project as Assistant Project Coordinator from 1989-1991.

CARE's EVALUATION POINT PERSON: Dra. Hanna Tobing, M.Sc.

Hanna joined CARE in 1991 in the Evaluation and Monitoring Unit. It has been renamed the MIS Unit. The unit is responsible for coordinating monitoring and evaluation of CARE International Indonesia's projects. She is the Assistant MIS Officer.

CARE's RESOURCE PERSONS:

Margaret Newens

Margaret has volunteered for 4 years with CARE as the Management Support Officer of this project, placed through the Voluntary Services Overseas. She was based in Lombok for the first three years. She has a Masters in Animal Physiology and a Masters in Social and Preventive Medicine.

Anne Lynam Goddard, MPH

Anne is the Assistant Country Director for CARE Indonesia as well as the Project Coordinator of this project. She has over 10 years of experience in managing health and child survival projects in developing countries. She has a Masters in Public Health focussing on Health Education in International Health.

47.

TERMS OF REFERENCE
FOR FINAL EVALUATION OF THE
VILLAGE PRIMARY HEALTH CARE PROJECT II
(VPHC II)

01. Country : Indonesia
 Project Title : Village Primary Health Care II (VPHC II)
 Project Number : 30
02. TOR prepared by : Hanna Tobing
03. Date TOR prepared : April 1992
04. Evaluation point person : Hanna Tobing
05. Project funding cycle : 1988 - 1992
06. Donor : CARE USA - USAID
07. Background of the project:

CARE Indonesia's first Child Survival Project, VPHC I, started in 1985. The project focused on the upgrading/promotion of community health activities by working directly with the mothers and the village voluntary health worker (or kader). VPHC I, which was operating in the provinces of West Java, East Java, and Nusa Tenggara Barat (NTB) ended in 1988.

Based on the lessons obtained during the first phase, a new Child Survival Project, VPHC II (1988-1992) emphasized improving village leaders' and kader supervisors' health management capabilities. The strategy was to work primarily through the integrated health services (POSYANDU) program. VPHC II is being implemented in four subdistricts, one each in West Java and NTB, and two in East Java. Project coverage is seen as follows:

<u>Province</u>	<u>Subdistrict</u>	<u># villages</u>
West Java	Gunung Halu	17
East Java	Tulakan	16
	Bandar	8
NTB	Gunung Sari	10

VPHC I and II were jointly funded by CARE USA and USAID through a Child Survival Grant.

08. Project Goals

Final Goal

To reduce the rate of child morbidity and mortality in subdistricts by working in collaboration with the local government and village kaders to increase the effectiveness and quality of services offered in the integrated health post (POSYANDU).

Intermediate Goals

1. Village Supervision Team operates independently to improve and maintain village health system.
2. Comprehensive and convenient POSYANDU services are regularly functioning in all villages.
3. Subdistrict Team (SDT) and PUSKESMAS health center staff adopt a community participatory approach to village primary health care services.
4. Information, materials and media to support the PHC program developed and utilized.

09. Overview of Evaluation

This is a final evaluation of VPHC II and is scheduled to be conducted from 18 August to 11 September 1992. The specific focus of the evaluation would be the assessment of project's success in achieving its goals, sustainability of the activities, and visible impacts on the local health policy. Project sites in three provinces (West Java, East Java, and NTB) will be visited during the evaluation.

10. Evaluation Questions

1. Have the changes made to VPHC project design been useful? Are the project's current goals appropriate? Have these goals been attained?
2. How appropriate and effective were the project's activities for achieving the goals? Has the project's monitoring system been effective and efficient?
3. What management and technical training has been carried out to support staff development? Was the training appropriate and effective?
4. Identify visible impacts of the project on local health activities/policies.
5. What are major lessons learned from the past three years of VPHC?

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11. Proposed Evaluation Team

The evaluation team will be composed of five members:

- (1) Team Leader/Health Specialist
Qualifications: experience as evaluation Team Leader, extensive knowledge and experience in areas of primary health care and child survival, familiarity with community-based development project evaluation, experience working in rural Indonesia, fluency in Indonesian language is preferred.

Responsibilities: production of the evaluation report, development of evaluation workplan, assignment of responsibilities to team members, represent evaluation team at meetings, project assessment focusing on health/child survival activities.
- (2) Health Specialist/Social Scientist
Qualifications: Social Scientist with experience as member of an evaluation team, knowledge and experience in community development projects, familiarity with health/child survival programs, knowledgeable of government institutions and policies, experience working in rural Indonesia.

Responsibilities: project assessment focusing on sustainability and policy improvements, writing of sections of evaluation report agreed during the workplan development.
- (3) Central Government Official from MOH
- (4) USAID Representative
- (5) CARE Indonesia's Evaluation Point Person

VPHC Project Coordinator, CARE staff members and one provincial government representative will accompany the team.

12. Evaluation Workplan

The evaluation workplan will be prepared during the team planning meeting (TPM) at the outset of the evaluation. The final workplan must be approved by CARE Indonesia. The workplan should include:

- o purpose of evaluation
- o review of evaluation questions and data collection methodology - develop new list of questions as appropriate
- o list of data sources and sites to be visited
- o scope of work for each team member
- o timetable of evaluation activities with deadline for each task
- o draft report outline

13. Evaluation Report

The evaluation team is expected to produce the following document/report:

- o a final workplan document;
- o summary of evaluation findings and recommendations; and
- o a final draft evaluation report

The final draft report should follow CARE's guidelines for evaluation reports, and is subject to CARE/USAID Indonesia review.

14. Schedule: Attachment 2

15. TPM Agenda: Attachment 3

17. Budget: Annex IV

HT/hh
July 1992

4/6

SCHEDULE OF EVALUATION ACTIVITIES:

Fri: 21 Aug DAY 1: Jakarta
Introductory Meeting
Project Review
Terms of Reference
Draft Workplan

Mon: 24 Aug DAY 2: Jakarta
Develop lists of questions
Delegate topic areas
Site selection

Tues: 25 Aug DAY 3: Jakarta-WJ
Complete the question sets
Travel to Bandung

Wed: 26 Aug DAY 4: West Java: Bandung
Meet with CARE WJ staff: project review
Meet with Provincial officials
Meet with District officials
Meet with CIWJ Field officers FO
Meet with CIWJ Management: CR & PM

Thr: 27 Aug DAY 5: West Java: Gunung Halu
Travel to Gunung Halu
Visit villages (2 villages/sub-team)
Evening meeting with Camat, SDT, Puskesmas,
and religious leaders in Gunung Halu

Fri: 28 Aug DAY 6: West Java: Gunung Halu
Visit villages (2 villages/sub-team)
Travel back to Bandung

Sat: 29 Aug DAY 7: West Java: Bandung
Team organizes findings
Feedback to CIWJ staff: dialoguing all day
Feedback to Government officials during
official dinner, officials feedback to team

Sun: 30 Aug DAY 8: West Java-East Java
Travel to CIEJ
Meet with Chief Representative

Mon: 31 Aug DAY 9: East Java: Pacitan
Meet with District government officials
Meet with CIEJ Field officers
Meet with CIEJ Management: CR & PO

Tue: 1 Sep DAY 10: EJ: Bandar Sub-district
Meet with subdistrict team and Camat
Visit villages (2 villages/sub-team)

Wed: 2 Sep DAY 11: EJ: Tulakan Sub-district
Meet with subdistrict team and Camat
Visit villages (2 villages/sub-team)
Feedback to CIEJ staff

Thr: 3 Sep DAY 12: EJ: Pacitan
Feedback to District government officials
Official lunch
Travel to Bali

Fri: 4 Sep DAY 13: NTB: Mataram
Meet BAPPEDA, Provincial government official
Meet Kanwilkes, Provincial health department
Meet CILOK: CARE Lombok staff
Dinner with District officials: West Lombok

Sat: 5 Sep DAY 14: NTB: Sites
Meet subdistrict team
Visit 4 villages
Interview CILOK Program Manager

Sun: 6 Sep DAY 15: NTB: Mataram
Home visits in 6 villages
Interview CARE field officers
Interview Chief Rep. & Assist. Chief Rep.: CARE

Mon: 7 Sep DAY 16: NTB: Mataram
Feedback to CILOK

Tue: 8 Sep DAY 17: NTB-Jakarta
Attend Posyandu (2)
Visit health center (Puskesmas)
Feedback to Provincial/District officials

Thr: 10 Sep DAY 18: Jakarta
Evaluation team meeting in CARE office: compile
findings and prepare presentations

Fri: 11 Sep DAY 19: Jakarta
Compile findings continued
Present to USAID mission

Sat: 12 Sep DAY 20: Jakarta
Draft evaluation report

Mon: 14 Sep DAY 21: Jakarta
Present to CARE staff
Present to Ministry of Health officials

Tue: 15 Sep DAY 22: Jakarta
Draft evaluation report

Wed: 16 Sep DAY 23: Jakarta
Submit final draft report

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VPHC II PROJECT DOCUMENTS

1. CARE Indonesia Village Primary Health Care II Project Proposal FY 1989 - 1992, November 1987
2. CARE Indonesia Village Primary Health Care Final Evaluation, Child Survival I Grant 1985 - 1988, October 1988 (with separate attachment).
3. Final Draft of Midterm Evaluation Report for VPHC II CARE Indonesia, 21 November 1990
4. CARE Indonesia Child Survival IV, VPHC 1991 Annual Report without attachments.
5. CARE VPHC II Detailed Implementation Plan 1989 - 1992, Revised, April 1991
6. Materials and Aids to improve the sustainability of Village Primary Health Care Programs. Final Report on Project funded under the British Embassy Grant. CARE International Indonesia, August 1991.
7. CARE Indonesia Village Primary Health Care II Baseline Survey Summary Report (Revised), October 1991.
8. Project Implementation Reports, July - December 1990, January - June 1991, July - December 1991.

Appendix 4 a

Kader Group Interviews

1. Is your role with CARE, SDT and VST clear?
2. Who supervises Posyandu and kaders?
Who motivates mothers to Posyandu?
3. Did you receive effective training?
What other training do you need?
4. Were the Health Education materials used?
5. What about Phase over? Is the area ready?
6. What motivates you most?
Why do kaders drop out?
How do you replace?
7. Who supervises you?
Is it sufficient?
8. What are the incentives the program has provided?
9. What happens for follow-up of weighing?
Successful? Feeding groups
10. Are Posyandu beneficial? What are the constraints?
11. Who are the poorest in the area? Do you reach them?
12. What are the changes you see?
13. How will you continue once CARE phases out?
14. What's the most effective activity to sustain?
15. What sustainability activities were carried out?
16. What are the most effective activities to meet current health needs?
17. What enabled the community to meet it's health needs more?
18. What has the community contributed to sustain activities?
19. Any cost recovery mechanisms? Any income generating?
20. Recommendations you have:
21. Lessons learned
22. Incentive program (KISS):
 - Credit Union
 - Pos Obat
 - DUKM
23. Do you make home visits?
24. Do you hold feedback sessions after Posyandu?
25. Have the VST + SDT, made a difference? How?

Appendix 4 b

VST Interviews:

1. Goals and Objectives met?
2. Program change in design useful?
3. Is MIS effective?
4. Activities appropriate?
5. Did you receive training? Do you train kaders? TBA?
Did you learn to train?
6. Is your role clear?
7. What are your responsibilities?
How do you supervise Posyandu and kaders? Were you trained?
How do you motivate mothers to Posyandu?
8. What is the project impact? How do you measure?
9. What lessons learned?
10. Were MTE recommendations helpful?
11. Were the Health Education materials used?
12. What about Phase over? Are you ready?
13. How to provide incentives to kader?
14. What motivates kaders most?
15. What happens for follow-up of weighing?
16. Are Posyandu beneficial?
17. What are the changes you see?
18. Will you continue?
19. What's the most effective activity to sustain?
20. What expenditures are needed to carry on?
21. What sustainability activities were carried out?
22. Did you make any financial commitment?
23. What are the most effective activities to meet current health needs?
24. What enabled the community to meet it's health needs more?
25. How often do you meet? How many teachers are active?
26. What issues do you address?
27. What has the community contributed to sustain activities?
28. Any cost recovery mechanism?
29. Any household income generating?
30. Recommendations you have:
31. Support system for kader?
32. Oralit posts in villages?
How is this different from standard government policy?

Appendix 4 c

Puskesmas Interviews

1. Goals and Objectives met?
2. Activities appropriate?
3. Did you receive training? TOT? Supervision + management?
4. Is your role with CARE, SDT and VST clear?
5. Who supervises Posyandu and kaders? Who train kader?
6. What is the project impact?
7. What lessons learned?
8. Were the Health Education materials used?
9. What about Phase over? Is the area ready?
11. How to provide incentives to kader?
12. What motivates kaders most?
13. What happens for follow-up of weighing? Successful?
14. Are Posyandu beneficial?
15. What are the changes you see?
16. How will you continue once CARE phases out?
17. What's the most effective activity to sustain?
18. What sustainability activities were carried out?
19. Did you make any financial committment?
20. What are the most effective activities to meet current health needs?
21. What enabled the community to meet it's health needs more?
22. How much would it take to continue ctivities for 3 years?
23. What is reasonable/possible to fund? Which activities?
24. Identify costs not likely to be sustainable.
25. What is the current ability to provide the necessary financial and human resources?
26. What has the community contributed to sustain activities?
27. Any cost recovery mechanisms?
28. Recommendations you have:

Appendix 4 d

SDT Interviews:

1. Goals and Objectives met?
2. Program change in design useful?
3. Is MIS effective?
4. Activities appropriate?
5. Did you receive training? Management? Training skills?
6. Is your role clear?
7. What are your responsibilities?
How do you supervise Posyandu and kaders?
How do you motivate mothers to Posyandu?
8. What is the project impact? How do you monitor it?
9. What lessons learned?
10. Were MTE recommendations helpful?
11. Were the Health Education materials used?
12. What about Phase over? Are you ready?
13. How to provide incentives to kader?
14. What motivates kaders most?
15. What happens for follow-up of weighing?
16. Are Posyandu beneficial? An immunization services offered every time?
17. What are the changes you see? How do you monitor Posyandu activities?
18. Will you continue?
19. What's the most effective activity to sustain?
20. What expenditures are needed to carry on?
21. What sustainability activities were carried out?
22. Did you make any financial commitment?
23. What are the most effective activities to meet current health needs?
24. What enabled the community to meet it's health needs more?
25. How much would it take to continue activities for 3 years?
26. What is reasonable/possible to fund? Which activities?
27. Identify costs not likely to be sustainable.
28. What is the current ability to provide the necessary financial and human resources?
29. How often do you meet?
30. What issues do you address?
31. What has the community contributes to sustain activities?
32. Any cost recovery mechanisms?
33. Any household income generating activities?
34. Any household income generating activities?
34. Recommendations you have:
35. Did you learn to train VSTs & kader?
36. What is your opinion of VST?
37. How do you supervise them?
38. How do you monitor them?
39. Do you develop action plans in the VST? How do you finance these training events?
40. How is this different from other areas?

Appendix 4 e

Interviews with CARE Field staff:

Topics:

1. Goals & Objectives met?
2. Program Change & new design useful?
3. Were the activities appropriate?
4. Is MIS effective?
5. What training did you receive?
6. Was it appropriate and effective?
7. Visible impact on local health activities?
8. Major lessons learned? Recommendations
9. What about the VST and SDTs?
10. Posyandu & Feeding groups?
11. Have major activities to be sustained.
12. Identify key CS activities to be sustained.
13. What expenditures are needed for 3 years to sustain abovementioned activities?
14. Are the costs reasonable?
15. What did you do for sustainability?
16. What worked well? Not so well?
17. Did the counterpart make a financial commitment?
18. If so, did they keep it, if not, why not?
19. What are your sustainability indicators?
20. What are the results?
21. Did you carry out recommendations from DIP and MTE?
22. What activities assisted communities to better met their health needs?
23. How did the communities participate in your project?
24. How many functioning health committees are there?
25. If there are, who is on them?
26. What issues do they address?
27. What resources have the communities contributed?
28. What are reasons for success or failure of committees to contribute resources?
29. What linkages exist between project and key agencies (MOH)
30. Did you build skills of MOH staff or kaders?
31. What strategies were done to reduce costs?
32. Successes, failures at reducing costs?
33. Any lessons learned regarding increased efficiency and cost reduction?
34. What about cost-recovery? How much?
35. Any household income-generating activities?
36. HE materials
37. Is the VST democratic & representative?
38. Supervision & Monitoring system

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Home Visits

	Alive	Dead	If death, cause & age
How many children?			
How many balita?			

	this month	last month	Regularly?
To Pos Yandu?			
Where is PY?			
Tanggal berapa?			
Why did you go?			
What did you get?			
What's your opinion of it?			

	Filled?	Not fill?	Understood by mother?
How many KMS?			

	complete?	not cmpt?
Children immunized?		
Why immunized?		
Why not immunized?		

Why do you weigh your child?	
What do you do if yr. child loses weight or is malnourished?	

	use?	buy where?	how to use
Oralite:			
Other solutions?			

If pregnant:	
Where for exams?	
Do you have TT?	
Plan for delivery: (place/attendant)	
Are you aware of PY for bumile?	
Do you take Ferrous?	
Do you have a KIH card?	

Perception of kaders:	
Perception of VST's	
Major community health probs:	
What are major killers?	

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Pos Yandu Checklist

Appendix 4 g

No. of kaders:

No. of children by age:	<1 yr	1-2 yrs	>2 yrs
No.			
Immunization given by age:			
BCG			
DPT/Polio			
Measles			

No. of pregnant women:	
No. of high-risk detected:	
No. of HR referred:	
No. of women needing TT:	
No. of women rec'ing TT:	

Puskesmas staff attended:	
TBA attending:	
No. of Sub-district team:	
No. of VST members:	

Services: ___ Registration ___ Weighing ___ Nutrition counselling
 ___ immunization ___ Prenatal care ___ HE ___ PMT ___ KB

Materials:	
KMS	
registration buku	
F-1	
SKND graphic	
education materials	

Supplies:		
sterilized syringes/needles	ORT	
cold chain		available
vaccine & TT	ARI	referrals
dacin		education
Vit A		
Ferrous		
PMT		
KB supplies		

Quality:		
KMS filled in properly?		No. children growth falter?
Weighing done properly?		No. 2nd or 3rd degree?
KMS explained to mother?		No. of above rec'd
High-risks referred?		counselling or referred?
Nutr. advice given?		
Contribution to dana sehat?		

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SITES VISITED

Province	District	Sub-District	Villages	PY + = Model PY	Home Visits	Phase- out	Interview
W. Java Team: DS, RS HT, RA LS, MN	Bandung (Met govt.)	Gunung Halu (Met SDT)	Cilangari	Posyandu	2 HV	Yes	VST
			Warga Saluyu		2 HV	Yes	VST
			Sirnajaya		2 HV	Yes	VST
			Celak	Posyandu	6 HV	Yes	VST
			Taman Jaya		1 HV	Yes	VST
			Bumijaya		3 HV	Yes	VST
			Sukamanah		4 HV	No	VST
E. Java Team: DS, RS MN, HT	Paotian (Met govt.)	Bandar (Met SDT)	Jeruk	Posyandu	40 mothers	Yes	VST
			Bandar		2 HV	No	VST
			Petungsinarang			Yes	VST
			Watupatok		2 HV	Yes	VST
		Tulakan (Met SDT)	Ngile			Already	VST
			Padi		2 HV	No	VST
			Tulakan			Already	VST
			Bungur		1 HV	Yes	VST
Nglaran			Yes	VST			
NTB Team: RS, JM MN, HT	Mataram (Met govt.)	Gunung Sari (Met SDT)	Mambalan			No	VST
			Kekeri			No	VST
			Sandik	Posyandu	HO	No	VST
			Midang		4 HV	No	VST
			Sesela		5 HV	No	
			Gunung Sari	Posyandu	4 HV	No	
			Penimbung		5 HV	No	
			Kekait		4 HV	No	
			Meninting		6 HV	No	
Batulayar		4 HV	No				
			27/71=53% villages	6 Posyandu	60 HV		21 VST

DS = Donna Sillan
 RS = Raharjo Suwandi
 JM = John Mokoginta
 RA = Rosani Azwar
 LS = Lina Suprianto
 HT = Hanna Tobing
 MN = Margaret Newens

LIST OF PERSONS CONTACTED

WEST JAVA

Provincial level Jawa Barat
Staff of Head of Community Health Section: M. Solihin

District level Bandung
Assistant II Drs. Dede Oeron
Ka. Sub. Community Health Irwan Setiawan
Dinas Kesehatan (Health services) Drs. Unjang Surjana
Dinas Kesehatan (Health services) Agus Nurjaman

Subdistrict level
Head of Health Center Gunung Halu Dr. Sudirman
Head of Health Center Rongga Dr. Zainal Asikin
Head of Religious Sub-district Drs. Yusuf Jumena
Head of Villages
Religious leaders
Secretary of Sub-district E. Michmud
Head of Social Welfare Section Mansyur Z.

Village level: Head of villages, Kaders, Mothers

CARE's STAFF

		date appoint:
Chief Representative:	Kusumo Adinugraha	
Project Manager:	Prabowo Soejoso	2/90
Jr. Project Officer:	Joko Siswanto	1/89
Field Officers:	Aris Mawardi	12/88 *
	Agus Priatna	2/91
	Cucu Astri Yulani	2/91
	Bimawan Wahyudi	2/91
	Haryani	7/91

* with VPHC I

EAST JAVA

District level:

Head of District Pacitan:	Soedjito
District Planning board:	Ir. Rini Sustiatl
Head of Health Office:	Dr. Sulistriwarso
Staff of Health Office:	Supriyanto BSC
Head of Village Development:	Widiatmojo
Head of Religious section:	Drs. Munir
Staff of Religious section:	Drs. Imam Sudigdo

Sub-District level:

Sub-District Head Bandar:	Bambang Marcono BA
Head of Health Center Bandar:	Dr. Dolf Tanumidjoyo
Family planning Field worker:	Ibu Ismiyati
Midwife health center Bandar:	Ibu Sri Sutarmi
Midwife health center Jeruk:	Ibu Prihartini
Development Section:	Widi Rahmanto BA
Staff subdistrict:	Ilyas
Mantis:	Rokhimin
Education and Culture officer:	Sumadi
Youth representative:	Bitarto

Sub-district head Tulakan:	Bambang Marcono BA
Head of Health Center Tulakan:	Dr. Eko Budiono
Linked sector:	Ngadi, Sukirno, Isah Anshori Sukadi, Tusiran, Pamuji, Budi Sanyoto, Darmo, Sujatmo
Religious affairs	Achwan Chudori
PKK	Wenni Supawit Mulyadi
Information officer	Arbangi
Education Section	Parnyoto
Midwife Puskesmas	Siti Djuwarin

Village level: Head of villages, Kaders, Mothers

CARE's Staff

		Appointment
Chief Representative:	Hadi Soetjipto	
Project Officer:	Subari	11/88 *
Field Officers:	Agus Samsulhadi	11/88 *
	Yohana Sumaryani	12/88 *
	Eddy Sugiharto	3/91
	Etik Nuzulianti	3/91
	Moh. Arif Suprpto	3/91
Management Trainee:	Subardi	

* with VPHC I

NTB

Provincial Level Lombok

Head of Planning Commission	Drs. Muhidin Aziz
Sosbud: Social Services	H. Ahmad Rifaj SH
KaKanwil: Head of Health Dept.	dr. Muharso SKM
Head of Communicable Diseases	dr. Agus Susanto

District Level West Lombok

Sosbud:	Drs. H. Abdurrahim
Dinkes:	dr. Sagaf Uman
	drg. Sri Sundari
Bangdes	Drs. SM Pirnadi
PKK	Lalu Hambali

Sub-District Level Gunung Sari

Head of Subdistrict	Soewardi BA
PKK	Solechah Soewardi
	Mrs. Yoenoos
PJO/BBK PJO	Dewa Ketut Ardana BA
Puskesmas	dr. H. Baharia
Sekwilcam: Sub-dist. secretary	Dewa Andana

CARE's Staff

Chief Representative	Muljanto
Project Manager	Jenny Zebedeus

Field Officers

	Appointment
Slamet Riyadi	1/89 *
Vidiya Nefowaty	12/88 *
Tasnim	12/88
Widodo Goetarto	1/89
Nur Akhmad Yani	12/90
Syami Tarikh	7/91

* with VPHC I

CARE International Headquarters Jakarta

Peter C.A. Middlemiss	Country Director
Anne Lynam Goddard	Assistant Country Director
Lala Tanudjaya	Finance Officer

USAID Mission Feedback Session

Nurmaulina Suprijanto:	Child Survival Coordinator
Joe Carney:	Human & Institutional Resource Development
Nancy Langworthy:	Program and Support
Abas Rozali:	VHP Voluntary and Humanitarian Program
Victor Panjaitan:	HIRD

Ministry of Health
Tanya

Staff of Dept. of Community Participation

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WHAT is a VST?

Membership:

A VST consists of: village head, Head of the LKMD, Head of the Health Section (LKMD), Head of the Women's Section (LKMD), the head of the hamlet, and kader supervisor, village officials and community leaders. The team members are appointed. Religious leaders, nonformal leaders and TBAs are also encouraged to be team members.

Job description: VST responsibilities include:

- 1-Promoting and maintaining a sufficient number of kaders
- 2-Developing a support system for kader
- 3-Monitoring and supervising operational management of PY
- 4-Monitoring & supervising PY recording and reporting system
- 5-Summarizing and reporting PY data to the Sub-district
- 6-Collaborating with other sectors
- 7-Developing system for PY financial support
- 8-Participating in PY feedback session
- 9-Meeting on a regular basis to plan work
- 10-Encouraging community participation at PY

CARE introduced the concept of VST in all four subdistricts. Project activities included training to newly formed VSTs in the following areas:

- * "How to Manage Posyandu and PHC Activities"
- * PY evaluation during monthly meeting
- * Informal leaders on promoting PY
- * TBAs on promoting PY and referring pregnant women
- * Post Manager on ORS packet distribution
- * Development of Kader Support system
- * Nutrition feeding/education program
- * Immunization target lists
- * How to train new kaders

Population Figures and Services

	NTB	WJ	EJ: Tulakan	EJ: Bandar	TOTAL
Tot Pop	77066	93853	71124	36281	278324
Women 15-49	14171	2	12328	7688	58343
<1	2793	3481	1116	569	7959
1-<5	7566	11346	5273	2688	26871
Under-5	10359	14827	6389	3255	34830
Kader	310	657	432	166	1565
US/Kader	33	23	15	20	
Posyandu	74	102	91	49	318
Kader/Posyandu	4	6	5	3	
US/Posyandu	140	145	70	66	
Dr./Pop*	38.533	46.928	46.562	18.140	*recent
KISS	10/10	14/17	10/16	3/8	
Pos Obat	3	8	16	8	35
ORT Pos	40	102	561	49	752
US/ORT Pos	259	145	11	66	

Expected Population Figures & Deviation

	NTB	Percent	Expect	Diff.	WJ	Percent	Expect
Tot Pop	77066				93853		
Women 15-49	14171	18.4%	20.0%	-8.1%	22156	23.6%	20.0%
<1	2793	3.6%	4.0%	-9.4%	3481	3.7%	4.0%
1-<5	7566	9.8%	11.0%	-10.7%	11346	12.1%	10.0%
Under-5	10359	13.4%	13.3%	1.1%	14827	15.8%	12.0%

	EJ: Tulakan	Percent	Expect	Diff.	EJ: Bandar	Percent	Expect
Tot Pop	71124				36281		
Women 15-49	12328	17.3%	20.0%	-13.3%	7688	21.2%	20.0%
<1	1116	1.6%	4.0%	-60.8%	569	1.6%	4.0%
1-<5	5273	7.4%	10.0%	-25.9%	2687	7.4%	10.0%
Under-5	6389	9.0%	12.0%	-25.1%	3256	9.0%	12.0%

Expected estimates are based on UNICEF 1988 figures.
For NTB, Census 1990 figures are used for expected %.