

PD-ABN-579

CARE INDONESIA  
MID-TERM EVALUATION REPORT  
VILLAGE MATERNAL AND CHILD HEALTH CARE PROJECT  
(V M C H)

September 12 - 27, 1994

Beginning Dates: October 1, 1992  
Ending Date: September 30, 1995

Submitted to:  
Child Survival and Health Divisions  
Office of Private and Voluntary Cooperation  
Bureau for Food and Humanitarian Assistance  
AID

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December 1994

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**MID-TERM EVALUATION OF VILLAGE MATERNAL AND CHILD  
HEALTH PROJECT (VMCH), CARE, NTB**

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## GLOSSARY

APC	-	CARE's Assistant Project Coordinator
Bappeda Tk I	-	Regional Development Planning Board, Province level
Bappeda TK II	-	District Development Planning Board, District level
Bidan di desa	-	Community Village Midwife
Bumil	-	Ibu hamil (pregnant mother)
Baduta	-	Ibu bawah dua tahun (mother of the under-two year children)
Cadre	-	Voluntary health worker
CMP	-	Community medicine post (Pos Obat Desa - POD)
CO/CD	-	Community Organization/Community Development
CR	-	CARE's Chief Representative
CIHQ	-	CARE International Indonesia Headquarters
Dikes Tk I	-	Provincial Health Office
Dikes Tk II	-	District Health Office
EETMP	-	Environmental Education Teaching Materials Project
FO	-	CARE's Field Officer
GOI	-	Government of Indonesia
IMT	-	International Management Trainee
IMR	-	Infant Mortality Rate
IPVO	-	International Private Voluntary Organization

KPKIA	-	Kelompok Peminat Kesehatan Ibu dan Anak (Mother Awareness Health Education Group)
Kanwilkes	-	Regional Health Office, a representative of the MOH at the province level
MCH	-	Mother and Child Health
MOH	-	Ministry of Health
Lobar	-	Lombok Barat (West Lombok district)
Loteng	-	Lombok Tengah (Central Lombok district)
Lotim	-	Lombok Timur (East Lombok district)
NTB	-	Nusa Tenggara Barat
ORT	-	Oral Rehydration Therapy
PO	-	CARE's Project Officer
Posyandu	-	Integrated health and family planning post
PLD	-	Petugas lapangan desa (field/village supervisor officer)
PM	-	CARE's Project Manager
Polindes	-	Village maternity post/birthing hut
PTT	-	Pegawai Tidak Tetap (new method of hiring "Bidan di desa" and doctor which is based on a 3 year contract basis)
Puskesmas	-	Government Public Health Center
SDT	-	Subdistrict Supervision Team for Posyandu (Tim Pokjanal Posyandu Kecamatan)
TBA	-	Traditional Birth Attendant (dukun bayi)
TOGA	-	Tokoh agama (religious leader)
TOMA	-	Tokoh masyarakat (community leader)

- TT - Tetanus Toxoid Immunization
- VMCH - Village Maternal and Child Health Project
- VPHC II - Village Primary Health Care Project II
- VST - Village Supervision Team for Posyandu (Tim Pembina Posyandu Desa)

## ACKNOWLEDGMENTS

We thank the many people and institutions whose talents and contributions made this report possible. The CARE Indonesia International Headquarters (CIIHQ) not only provided an opportunity but also trust to the Core Evaluation Team for conducting the midterm evaluation assignment of the VMCH Project in NTB. Special thanks is due to Mrs. Catharina Haryono, the Health Sector Coordinator of CIIHQ for her support and continuous cooperation during the midterm evaluation both in Jakarta and in the field.

We appreciate, as well, the contributions of CARE's counterpart representatives in giving ideas and input during the midterm evaluation especially to Mr. Syafruddin Aly (Bappeda I), Dr Margaretha Cephas and Mrs. Wachidah (Dikes Dati I NTB), Dr I Nengah Sudana and Mrs Ertiah (Dikes Dati II Lombok Tengah), Dr Arif Priatna (Puskesmas Gangga, Lombok Barat), Mr. Lalu Buchari (Sekwilcam Praya Barat) and Mr. Akmaluddin, SH (Kades Suntalangu, Lombok Timur).

CARE's staff of NTB worked and cooperated well to make this midterm evaluation take place:

- Mr. Adji Setioprojo (Chief representative)
- Mr. Slamet Riyadi (IMT) and Mr. Widodo Goentarto (PO),
- Mr. Ngadiran Zalib, Mr. Saharudin and Drs Syami Tarik (FOs), and
- Mrs. Elizabeth Bhoomkar (MCH Advisor)/ VSO.

We appreciate the exceptionally hard work from the following FOs: Ety Nuzuliyanti, Hidayatul Fatikiyah, Asdiah Triana, Nurikawati and Hartati in recording all data during the writing of this report. We also appreciated the contribution and share of ideas from Dr Maya Hosein, MPH from Directorate of Family Health, Ministry of Health (MOH) who served as an observer and at the same time as part of the evaluation team representing the Central MOH office.

Many thanks is also extended to all individuals whose names cannot be mentioned one by one for their genuine as well as candid responses which made this report possible.

We would like to express our gratitude to Dr Nardho Gunawan S, MPH, Chief Directorate of Family Health, MOH who gave special permission to Dr Maya Hosein, MPH to become an observer and part of the team during the midterm evaluation.

Finally we thank Dr Ascobat Gani, MPH, Dr PH, the Dean of the Faculty of Public Health, the University of Indonesia who supported our involvement in this midterm evaluation assignment.

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**MIDTERM EVALUATION OF THE MATERNAL AND CHILD HEALTH (VMCH)  
PROJECT, CARE NTB, SEPTEMBER 12- October 2, 1994**

**EXECUTIVE SUMMARY**

A participatory midterm evaluation of the VMCH project in NTB was conducted in which CARE project staff, representatives of the main counterparts (Bappeda I, Dikes I/II, Puskesmas, Kecamatan and Desa) and a team of external evaluators took an active part during the preparation. A two and a half day (pre) evaluation workshop was conducted prior to the evaluation to familiarize the participatory team with the project and its activities and build up the team work among the participants. The output of this workshop was a joined agreement and common perceptions on purpose of evaluation, meaning of participatory evaluation, and roles & responsibilities of each participating team.

The sample location was chosen using two categories namely "those located far" and "those located close" to the sub-district capital and six (6) villages representing 30% of the total location were selected for the evaluation. The instruments of the data collection were mainly qualitative methods, namely in-depth interview, focus group discussion and observation. In addition, a review of secondary data was conducted to complement the analysis. A qualitative data analysis technique was used to analyze the data.

The project design was appropriate to achieve its stated goals and objectives. The targetted activities at the midterm life of the project has been accomplished satisfactorily, as it has established Village Supervision Teams (VSTs), women groups (Mother Awareness Group-KP KIA), Community Medicine Posts (CMPs), and has trained cadres and community village midwives (bidan di desa) as planned.

Additionally, the project planning and management has been executed adequately, however the routinely collected data has not been utilized to the fullest extent for internal managerial problem solving and for productive collaborative work with the counterparts.

The following short-term recommendations were made to be implemented before Sept. 1995, namely improving communication & coordination with counterparts at different levels and internal communication in the project as well as in the CARE organization. It is also necessary to negotiate with the GOI for completing the original design of intervention by requesting the availability of new "Bidan di desa" at the selected villages. Optimizing use of data is strongly recommended for the purpose of monitoring & problem solving and sharing information with counterparts. Strengthening capacity of human resources especially improving technical aspects of health for the FOs, increasing sensitivity of PO towards the needs of FOs and urgent needs of availability of a project manager should be given full consideration. Facilitating the improvement of quality of intervention especially SDTs/VTSs, Polindes, Posyandu and POD are utmost important for future implementation. The project should also further market the use of appropriate, low cost technology for TBA training, write into documents and disseminate the practical experience gained in Community Organization/Community Development (CO/CD) in the Sasak ethnic community. Reviewing and adjusting the project indicator specifically for targeting POD attendants and income generating is worth of consideration.

In the long run, future innovations beyond the life of the project should be carefully looked into. Trying new focus of interventions at the district level; developing community-based emergency transport for maternal and child care using CO/CD skills; enhancing the role of prominent religious leaders in issues of maternal and child health; taking opportunity of the current GOI policy on Inpres Daerah Tertinggal (IDT) especially in providing technical assistance; tapping of local resources from NTB; expanding new area of activities such as STD (sexually transmitted diseases), AIDS and reproductive health and initiating working together with locally based NGOs as well as other IPVOs are among long term key recommendations. Finally, it is also recommended to advocate the replication of the CARE's PHC model into another area once the projects are completed and successful.

There are several lessons learned derived from this project. First, this project provided field-testing of a model and design of Primary Health Care (PHC) institution linkages for Child Survival in Indonesia. Secondly, the project also described the unique approach of CARE's VMCH which focus on a combination of facilitating role in strengthening capabilities of counterparts, encouraging intersectoral involvement at different levels and generating more indigenous resources at the community level.

The project's primary involvement is facilitating the role and function of existing or supposedly existing structure and services. Of course, it has a high probability of sustained activities once the project terminated. However, there are still many variables determining the success which are beyond the control of the project. This particular project has provided evidence that in such a low educated community and low income levels, there are indications of the existence of high spirits of altruism and substantial voluntary community contribution both in cash and in kinds. The practical experience which was gained by the project especially in CO/CD in a predominantly Sasak ethnic group becomes a very unusual resource. Finally, the participatory midterm evaluation became a unique experience which provided involvement of counterparts and self-critical review of the project.

## **I. INTRODUCTION**

### **1.1. Background to the evaluation assignment**

Village Maternal and Child Health (VMCH) is a USAID funded Child Survival project. It is a three-year project and is implemented in 17 villages in three sub-districts in Lombok Island, Nusa Tenggara Barat (NTB, West Nusa Tenggara) Province. (for project location see Appendix I).

A mid-term process evaluation was conducted for the VMCH- Child Survival VIII upon request of the CARE International Indonesia based in Jakarta. The evaluation took place in Nusa Tenggara Barat Province from September 12 - October 2, 1994. This document is part of a participatory evaluation process which was specifically designed to assess the progress of the VMCH project in NTB. The objectives of the mid-term evaluation of the VMCH project are as follows.

#### **General and Specific Objectives of the Midterm Evaluation**

The general objectives of the evaluation are:

1. To provide expert advice to the mid-term evaluation of CARE Indonesia Child Survival Project, and
2. To prepare an evaluation report using the USAID issued guidelines for CS VIII,

Meanwhile, the specific objectives of the mid-term evaluation are listed below.

1. To review strategies implemented towards sustaining project benefits and to identify other strategies to further enhance sustainability of Child Survival (CS) interventions,
2. To make key recommendations for improving project quality and future directions of the project in terms of possible extension/expansion,
3. To prepare a comprehensive and analytical midterm evaluation report incorporating the following:
  - Composition of the midterm evaluation team,
  - Methodology used,
  - Sustainability status and major accomplishments,
  - Achievements in institutional sustainability and strengthening management capacity of local counterparts,
  - Review of project budget, management, project recurrent costs, common efforts, cost recovery and income generation,
  - Main project accomplishments and measurable outputs
  - Assessment of applicability and quality of CS activities,
  - Key recommendations, and
  - Relevance of lessons learned to other CS projects,

## **1.2. Method of midterm evaluation**

A participatory evaluation process was employed during the mid-term evaluation. A representative of the Direktorat Bina Kesehatan Keluarga, Dep Kes Pusat (Directorate of the Family Health Division of the Ministry of Health in Jakarta), CARE International Indonesia headquarters as well as local staff and local counterparts were equally involved in the major steps of the evaluation process, particularly in preparing the evaluation plan, collecting and analyzing results and making decisions on how to make use of the evaluation results. (for List of Participating Team see Appendix 2).

A special meeting was conducted in which results of the evaluation were presented to the CARE IIHQ and representatives from all over Indonesia (Quarterly meeting at Santai Hotel Senggigi). This meeting was a unique opportunity in which results of the evaluation were shared with other CARE representatives in the country.

In Jakarta, two separate meetings with the USAID and the Family Health Division of the MOH were conducted. The purpose of these meetings was to share the results of the evaluation with key donors and decision-makers at the MOH.

## **1.3. Evaluation team members**

The core evaluation team members consisted of two external evaluators and one representative of the Ministry of Health in Jakarta. Dr Hadi Pratomo, an associate professor of Health Education of the Faculty of Public Health, the University of Indonesia who is also the Program Director of the Perinasia (the Indonesian Society for Perinatology) served as the team leader.

Dr Pratomo has extensive experience in conducting perinatal and safe motherhood intervention in different parts of the country including in NTB. The co-team leader is Dr Anhari Achadi who is also an associate professor of the Health Administration and Policy Analysis of the same educational institution. Dr Achadi is also co-Director of the PUSKA UI (Center for Child Survival, the University of Indonesia) which previously conducted different child survival interventions.

Dr Maya Hosein who is a staff of the Underfives sub-division of the Directorate of Family Health, Ministry of Health (MOH) served as an observer and represented the central MOH office. Previously she was the Section chief of the Nutrition and Family Health of the Special Territory of Yogyakarta (Sie Gizi Keskel, Kanwilkes DIY) and she is very familiar with MCH government programs.

## **II. EVALUATION WORKSHOP**

### **2.1. Process of the workshop**

The evaluation process began in Jakarta where a preparation meeting was conducted among Core team evaluation members, Health Sector Coordinator of CARE IIQ and a representative of the MOH. The purpose of this meeting was to provide brief information of

the Child Survival (CS) project to external evaluators and discuss a tentative schedule of the evaluation.

In the province capital, a two and a half day pre-evaluation workshop was conducted and involved CARE IIQ and local staff, a representative of the MOH and representatives of key local counterparts. The workshop was a true participatory process in which all parties involved shared their significant contributions. An evaluation plan was jointly developed which included field visits, review documents, meeting key persons and observation.

Upon returning from the field visit, a data analysis workshop was conducted to train all parties involved on how to conduct qualitative data analysis and write results of analysis. The core team evaluator conducted extensive discussion on the results of data collection, major findings and proposed recommendations with all evaluation team members.

In Mataram, a special meeting was convened in which local key decision makers (Bappeda, Dikes) and related sectors were invited and informed about the results of the evaluation. Key inputs were solicited and integrated into the draft of the final report. The complete schedule can be seen in Appendix 3.

## **2.2. Output of the workshop**

The major output of the workshop was achieving common perception on the purpose of evaluation, definition of participatory evaluation and identification of appropriate project counterparts at different administrative levels. In addition, all participating evaluation members also jointly agreed in identifying involving parties, roles and responsibilities of each party.

## **III. OVERVIEW OF THE PROJECT**

### **3.1. Goals and Objectives**

The VMCH's goal is to decrease infant and child mortality and morbidity by enhancing the participation of women as planners, implementors and users of government sponsored and community managed health services. The measurable objectives to be met by September 1995 include :

- 4,000 pregnant women fully utilize the services of government trained village midwives and the traditional birth attendants (TBA) they support/supervise;
- 34 women's health education/support groups for pregnant women and mothers of under-2s (KP KIA) are effectively functioning;
- 30 community medicine posts (CMP) are functioning viably - making available first line treatment to 120,000 villagers, identifying and referring high risk children, and generating financial support for 30 Integrated Health Posts (Posyandu); and
- 3 subdistrict Posyandu supervision teams (SDT) effectively train and support 17 village Posyandu supervision teams (VST).

Planned inputs include : 468 person months national technical staff (Project Coordinator, Assistant Project Coordinator, Project Manager, Project Officers, Field Officers), 3,6 person months from an international Technical Advisor, 1 person month from CARE's in-house

Management Information System unit, surveys (baseline, midterm, close-out), three technical assistance visits from CARE USA's Primary Health Unit Staff, a 15 day gender consultancy, materials, and equipment including midwifery kits, TBA kits, lockable medicine cupboards and four motorcycles.

Planned outputs include : 17 trained village midwives, 75 trained TBAs, 5190 pregnant women received TT, 34 women groups established, 85 women group leaders trained, 30 CMPs established, 150 CMP managers trained, 30 SDT members trained, 17 VSTs established, 270 VST members trained, 270 Posyandu cadres trained, 2 evaluations conducted (mid-term and final) and women group's formation strategy developed.

Expected outcomes include: improved and more fully utilized government services which are responsive to the needs and concerns of women; and a model for financial support to Posyandu which is replicable on a larger scale.

The baseline survey was used somewhat to modify objectives but primarily to serve as a baseline against which the final survey results will be compared. The survey results proved to be most useful in developing and targeting the health messages the project will utilize.

The overall project design for VMCH is based on improving government services for women and children through project training, facilitation and supervision. At the subdistrict level, CARE will : help train and facilitate the SDT which is responsible for training the VST to improve Posyandu effectiveness; and facilitate the health center to provide the needed support to the village midwives. At the village level, CARE will facilitate the work of the VST which will play a support/supervision role not only for Posyandu but for CMPs and women groups as well; train and facilitate the village midwives who will provide needed maternal care services. At the hamlet level, CARE will : train, supervise and facilitate the managers/leaders for functioning of Posyandu. The CMPs will provide direct, first line treatment for common ailments. The women groups will serve as a vehicle to identify and respond to women's concerns. The TBAs will be a major avenue to providing educational messages to women. Posyandu is the GOI strategy for delivering child survival interventions.

### **3.2. Project Strategies**

Specific child survival interventions include several activities such as maternal care, nutrition, oral rehydration therapy (ORT), and immunization. Groups targeted for education activities include : mothers of children under-2, pregnant women, mothers attending Posyandu, and TBAs.

The activities will be phased in as follows : SDT and VST formation and training will start the second quarter, year one; village midwife training the third quarter, year one; formation of women groups the fourth quarter year one and the establishment of CMPs will occur in the first quarter, year two.

This design was chosen for several reasons: to strengthen existing government programs/services rather than developing new ones; to focus more attention on women; to take a more direct service delivery approach and to test a model for financial support to Posyandu which has a strong chance for replication on a wide scale. This last rationale highlights the project activity which is the most unusual and perhaps the most difficult to achieve-financial support for Posyandu through the CMPs.

## IV. EVALUATION DESIGN AND METHODOLOGY

### 4.1 Design of the midterm evaluation

The design of the evaluation is guided by the objectives of the evaluation as stated in Section I (Introduction). Since the objective of the evaluation is to examine the progress of the project, the evaluation is focused on the examination of the process and output of the project. At this stage, evaluation on impact of the project is not yet emphasized.

### 4.2 Methodology

#### 4.2.1. Sample size and selection

The evaluation is carried out in three districts, three subdistricts, three health centers, six villages (30 % of the total number of villages where the project activities are located), and eleven (11) sub-villages or dusun. Based on the assumption that distance to the health center will influence the accessibility of the population to health-related information from the health providers, the villages were divided into two categories, namely "those located far" and "those located close" to the sub-district capital. Six (6) villages were chosen representing both categories. Based on the availability of the project component activities such as Polindes (Village Maternity Post), Posyandu, POD (Pos Obat Desa or Community Medicine Post), and KP-KIA (Kelompok Peminat Kesehatan Ibu dan Anak or Mothers Awareness Group or Women Group), one or two sub-villages ("dusun") were selected from each village. In order to more accurately depict the actual situation in the field, the stage of development of each component activity (which is based on the information provided by the Project staff) also became one of the considerations. Hopefully, the collected information will also reflect various stages of development. Through these processes, a number of sub-districts, public health centers, villages, and sub-villages were selected as presented in the following table.

Table 1. Sample of location of the midterm evaluation

District	Sub-District	Public Health Center	Village	Sub-village (Hamlet)
West Lombok (Lombok Barat)	Gangga	Gangga	Sesait Rempek	Jugil Sesait Santong Asli Rempek
Central Lombok (Lombok Tengah)	Praya Barat	Darek	Darek Kabol Bale Buwuh Orok Solong	Mentokan Kabol
East Lombok (Lombok Timur)	Pringgabaya	Suela	Selaparang Suntelangu	Selaparang Timur Selaparang Barat Suntelangu

#### 4.2.2. Source of data/information and method of collection

For this evaluation, data and/or information was gathered from various sources. A specific instrument was developed for each source of information (Detail of each instrument can be seen in Appendix 4). A total of 18 (eighteen) instruments were developed. Basically, there were four methods of data/information gathering, which include:

##### 4.2.2.1. In-depth interview

Interviews were carried out to gather information from Bappeda Tk I and II (Provincial and District Planning Board), Dinas Kesehatan Tk I and II (Provincial and District Health Office), Kecamatan and Desa (Local Government at sub-district and village level), Puskesmas (Public Health Center) personnel (doctor, midwife), other health service providers (TBAs, community village midwives), and community members (Sub district Supervisory Team, Village Supervisory Team, pregnant mothers, lactating mothers, mothers of two year old babies).

##### 4.2.2.2. Focus Group Discussion

Focus Group Discussion (FGD) was carried out to gather information from members of Women Groups ("Kelompok Peminat Kesehatan Ibu dan Anak or KP-KIA") and CARE Field Officers.

##### 4.2.2.3. Review of documents / secondary data

Documents and data on the project and the project components were gathered from the report prepared by the CARE Headquarters and Project Staff. Other data and information was collected from the government offices in Lombok.

##### 4.2.2.4. Observation

During the visit the evaluation team also conducted several observations to Polindes and POD. Table 2 presents Source of information, instruments, and methods of data collection employed in this mid-term evaluation.

Table 2. Source of data / information

CARE Int. Indonesia	Institution / persons
Headquarters CARE of West Nusa Tenggara	Health Sector Coordinator CARE Representative Internal Management Trainee Project staff VMCH Project Officer Project Health Advisor /VSO VMCH Field Officers EETM Project Officer

Counterparts

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Administrative level	Institution / person
Provincial level	Kepala Dikes Dati I & Kepala Subdin KIA & Provincial Health Office Chairman and MCH Section), Bappeda Tk I (Regional Development Planning Board)
District	District Health Office of Lobar, Loteng and Lotim Bappeda Tk II (Regional Development Planning Board of the above three districts)

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Counterparts

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Administrative level	Institution / person
Sub district	Camat and staff (Head and staff Sub district Office) Chairman and staff of Puskesmas (Health Centers) Village Kepala Desa and staff (Head and staff of Village Office) Community Village Midwives ("Bidan di desa")
Sub-Village/ Community	Kepala Dusun and staff (Head and staff of Sub-Village Office) TBAs Pregnant and lactating mothers

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Non Government and International Organization

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PATH (Project of Appropriate Technology in Health)  
Save the Children  
UNICEF Representative in West Nusa Tenggara

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Other Sources of Information

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Pediatrician from the Department of Child Health and an Obgyn  
from the Department of Obgyn of Mataram General Hospital  
Former IPPA (Indonesian Planned Parenthood Association) Officer, NTB branch

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### **4.3. Instruments of the midterm evaluation**

Instruments were developed to gather data / information related to the rational & design, planning & management, and the accomplishment of the project. Depending on the source of information, a specific instrument was designed, so that a particular issue can be answered by various respondents. This way, rich information is expected to be collected, and at the same time it enables to perform a cross-validation of data by different respondents. These instruments were developed using the 1994 BHR/PVO Child Survival Mid-term Evaluation Guidelines provided by the project. (see Appendix 5). There were 18 (eighteen) instruments utilized during this evaluation as can be seen in the appendices.

### **4.4. Field work (data collection)**

All the members of the evaluation team took part in the fieldwork to collect data and information. The team was divided into two groups and each group consisted of an external evaluator, project staff and counterparts. Some team members were assigned as transcribers who took notes of the interviews, discussions and observations and a data compiler who collected secondary data which were available at the offices/sites visited. Each team interviewed and made observation of the counterpart offices and the people at the project site at sub-district, village and sub-village levels.

The fieldwork started on the afternoon of Sept. 15, 1994 when the team visited the Bappeda I (Provincial Development Planning Board) and the Bappeda II (District Development Planning Board) and Dikes Tingkat II (District Health Office) of Lombok Barat, all were located in Mataram. On Sept. 16, 19 and 20 the evaluation team visited all offices and people relevant to the VMCH project at district, sub-district, village and sub-village levels in Lombok Tengah and Lombok Timur respectively.

On Sept. 18, 1994, a focus group discussion was held with all Field Officers (FOs). A separate discussion with the Project Officer (PO) and Internal Management Trainee (IMT) was also carried out on the same day. A separate discussion was also conducted with the Chief Representative (CR). On Sept. 22, 1994 a focus group discussion was held attended by all project staff included CIIHQ and the MCH Advisor. The complete list of contact persons can be seen in Appendix 6.

### **4.5. Data processing and analysis**

Following the completion of all the field notes and transcript results from interviews, discussions and observations, a two-day workshop was carried out to further process and analyze the data and information. The quantitative data collected were reviewed and cross-checked whenever deemed necessary to do so.

During the workshop, the process of data reduction and clarification were made. For the purpose of data reduction and clarification, a special matrix featuring information collected based on issues and source of information was developed and then a thorough discussion on the information contained in the matrix was conducted. Conclusion of findings were derived from this matrix.

## V. MAJOR FINDINGS

### 5.1. Accomplishments

5.1.1. The project was started in October 1992, and the baseline survey was completed in December 1992. Based on this baseline, a detailed implementation plan was developed, and completed in April 1993. Up to September 1994, the project has been effectively operating for 24 (twenty four) months. Table 3 provides information on the achievement of the project per July 1994 (20 months since it was started).

Table 3. Project Achievement, per July 19, 1994

No.	Component	Planned	Achievement	Deviant
1	VST	17 VSTs	17 VSTs established	00 %
		270 VST members	177 VSTs members trained	- 35 %
			243 religious leaders trained	
2	KP-KIA	34 KP-KIA	23 KP-KIA established	- 32 %
		85 cadres	57 Women Groups (trained)	- 33 %
3	Polindes	14 Bidan di desa	7 midwives trained	- 50 %
4	POD	30 PODs	33 POD established	+ 10 %
5	Posyandu	270 cadres	602 cadres trained	+123 %

Note: 
$$\text{Deviant} = \frac{(\text{Planned} - \text{Achievement})}{\text{Planned}} \times 100\%$$

Table 3 shows that the planned inputs have been achieved satisfactorily. All of the Village Supervisory Teams (VSTs) have been established, 70 percent of the women groups have been developed, while the establishment of PODs have exceeded the plan.

From the output perspectives, the project has trained the community leaders (Village Supervisory Team) 50 percent more than what had been planned. Almost 70 percent of KP-KIA

cadres, 50 percent of the midwives, and 300 percent of the Posyandu cadres of what have been planned, have been trained.

Even though the project was not targetted directly to mothers and children, it focused on the community development. It would be useful to examine the beneficiary population who have been reached by the related activities. However, at this point, the evaluation was not directed to examine these outcome indicators.

## 5.2. Relevance to Child Survival problems

Nusa Tenggara Barat province still has the highest Infant Mortality Rate among provinces in Indonesia. Due to intensive attention from the central government, international donors, and NGOs/PVOs, Infant Mortality Rates (IMR) in this province has declined from more than 200 per 1,000 live births in 1970s to around 180 in 1980s, and 145 in early 1990. The figures for the IMR according the 1990 census data was 142 in Lombok Barat, 146 in Lombok Tengah and 178 in Lombok Timur respectively.\* However, compared to the national figure, this indicator of community health status is still considered very high. The causes of infant deaths include acute respiratory infection, tetanus neonatorum, low birth weight, and diarrhoea.

Despite the lack of accurate data, Maternal Mortality Rate (MMR) is also suspected exceeding that of the national rate (which is also still high, about 450 per 100,000 live births). From the six districts in West Nusa Tenggara, the MMR in the three districts in Lombok island (West, Central and East Lombok) were considered worse than that of the other three districts (Sumbawa, Dompu and Bima). According to recent data the MMR in the province was approximately 700 per 100.000 live births which is the highest MMR in the country.

Many studies have been carried out trying to explain the high IMR in this area. The study in NTB commissioned by the Ministry of Health and carried out by University of Indonesia in 1990 has tried to examine the community factors associated with the problems. The study concluded that the underlying factors to low health status of the community include low utilization of government provided health services due to their "wrong" concept of health and illness perception of health problems and ways to overcome the problems. Some of the common health - illness concepts perceived by the community were as follows: "illness" was mainly caused by supernatural force; it was also believed that it was due to imbalance between the hot - cold concept. Finally, it is also commonly believed that the death of the infant will lead a clear way to heaven for the parents.\*\*

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\* Indikator komponent kesejahteraan Anak Prop. NTB, 1992 (Welfare Composite Indicator for NTB Province, 1992, Pemda Tk I & Bappeda (Provincial Government and Regional Planning Development Board)

\*\* Community Knowledge, Attitude and Utilization of Health Services in Kalimantan Timur and Nusa Tenggara Barat, Report of a Study, Ministry of Health (MOH) and Faculty of Public Health, the University of Indonesia (FKM-UI), 1990.

Low education level in general, and low exposures to health information have contributed to their low level of contact with modern medicine.

Viewed from the above perspectives, the VMCH Project has a very sound basis. Population in this area needs to be encouraged to utilize the existing health facilities, and one of the ways to do so is by strengthening the supposedly existing community supporting system.

The project carried out the following component activities:

- activate the sub district (SDT) and VSTs to play an active role in guiding and encouraging child survival related activities to take place in their area (implementation of integrated health service activities, utilization of village midwives and trained TBAs, and Polindes);
- encourage the establishment of women groups (KP-KIA) which will play a role as motivator of pregnant and lactating women for improved health care practice for themselves and their children;
- encourage a more effective implementation of Posyandu;
- Polindes; and
- stimulate the development of POD.

It seems that the above mentioned project design is an appropriate mix of the activities to encourage the use of government provided health services in the community. However, it should be noted that the success of such effort will greatly be contingent upon the readiness of the health service system personnel. The implementation of the activities in the field were spearheaded by the project field officers. Even though theoretically activating SDT (sub-district team) should be prioritized since this team could facilitate other component activities, in reality every component activity received equal attention by the field officers. None of the component activities received special focus. In fact, that is the appropriate way of activating the community.

### 5.3. Effectiveness

As has been stated in section 5.1 (Project Achievement), the project has completed targetted activities quite satisfactorily. However, it should be noted that this judgement was only based on quantitative measure without any attempt to consider the qualitative aspect of the output. From the observation in the field, it was obvious that the quality of the project outputs varied greatly from one place to another.

Identification of the high risk pregnant women was the task of the "Bidan di desa". Based on the examination of the available data in some village maternity posts (polindes) and interviews with "Bidan di desa", it was clearly indicated that identification of high risk groups has not been carried out effectively.

### 5.4. Relevance to development

Development in Indonesia requires high quality and skillful human resources. This requirement only exists in those individuals who are healthy. It is without question that healthy individuals are prerequisites to any development. Serious effort must be continuously made to achieve this condition.

Health is one of the basic needs of a community. Due to the low level of education, knowledge and socioeconomic status of the community in Lombok, health has not become the real needs of the community. This condition was hampered by the following conditions, such as high number of marriages among relatively young population, unproper antenatal and delivery care, fatalistic idea (philosophy) among the people towards death and susceptible nutrition problems which relate to the high incidence of low birth weight babies (LBWs).

Dikes Lotim (District Health Office of East Lombok) suspects the high incidence of low birth weight babies among its population. However, in so far there is no effective surveillance system to detect the LBW babies. The Dikes of Loteng (District Health Office of the Central Lombok) informed the pilot testing of early detection of the low birth weight babies in three Puskesmas and suggest the high incidence of the low birth weight babies resulted in the high number of IMR in the area.

Even though the government of NTB has extensively deployed "Bidan di desa", it was reported that their performance is still unsatisfactory due to the following reasons such as relatively young age, lack of experience, lack of knowledge regarding community development. These conditions will definitely affect the program achievement.

The VMCH CARE project developed Kelompok Peminat Kesehatan Ibu dan Anak (KP KIA/ The Mother Awareness Group). This is not a new institution, rather, it has become the government program to fill up the gaps and increase the knowledge of the community regarding health. The strategy developed by CARE is to strengthen the KP KIA group with the active involvement of "Bidan di desa" and the Puskesmas midwives. Therefore, the VMCH project developed a plan to train and improve the quality of the "Bidan di desa" in community development.

Apart of that effort, the VMCH project focuses the activities on the strengthening of institutions of KP KIA through training and intensive supervision to the cadres. With the support of the Bappeda Tk I, the government made available a cash loan up to Rp 125.000 (approximately US \$ 62.50) for CARE supervised project activities. This financial support is primarily directed to fund the development of a loan and saving cooperative in which the management guideline is still being prepared to insure proper handling.

To support the establishment of KP KIA in Lombok Barat district, the Bappeda Tk II has provided an additional incentive of Rp 50.000 (about US \$ 25) for each group so the total support for each KP KIA was Rp 175.000 (about US \$ 85).

This development of the institutions among others are the following:

- For binding the community member (sugar coated program),
- Improvement of socioeconomic status which eventually resulted in improving nutritional status of the members.

Obviously, by stimulating the local institutions to be more functional (SDT, VST), and by encouraging the community to organize themselves (implementing Posyandu, organizing CMP, building a Polindes, etc), the project has been directly emphasizing community potentials to solve their problems utilizing their own resources. This way, the project has been fostering environment of the community for self reliance.

## 5.5. Design and implementation

### 5.5.1 Design

The VMCH project's goal is to decrease infant and child mortality and morbidity by enhancing the participation of women as planners, implementors and users of government sponsored and community managed health services. At the same time the project is intended to indirectly improve government services for women and children through training, facilitation, and encourage supervision.

The design of the project was devised in such a way that the project activities were not directly targeted to mothers nor children. Rather, they were targeted to community organization, with the expectation that these organizations will in turn play an effective role as motivator.

In addition, the work of the project is also not targeted directly to the beneficiaries (i.e. pregnant and lactating women and mothers of under two years old children). Instead, the project is working with the counterparts, i.e. the local government and community leaders (SDT and VST team), and the government health service system (health center, sub health center, and government supported village midwives). In this sense, the project is almost totally dependent on the level of commitment of the counterparts. The variability of project success from one sub village to another is partly due to this factor, which is to some extent difficult to be controlled by the field officer of the VMCH project.

The objectives of the VMCH project are the following:

- Four thousand (4,000) pregnant women fully utilize the services of government trained midwives and the TBAs they supervise,
- Thirty-four (34) KP KIA groups for pregnant women and mothers of under-two years are effectively functioning,
- Thirty (30) CMP are functioning viably, by making available first line treatment for 120,000 villagers, identifying and referring high risk children, generating financial support for 30 Posyandu.
- Three (3) sub-district Posyandu supervision teams (SDT) effectively train and supervise 17 Posyandu supervision teams (VST).

The VMCH project is located in three sub-districts (kecamatan) of the three districts (kabupaten) with a total of 17 villages as the project sites for intervention. In sub-district of Pringgabaya, district of Lombok Timur six out of 13 villages namely Sapit, Suela, Suntelangu, Selaparang, Ketangga and Perigi were selected as project sites.

In sub-district of Praya Barat, district of Lombok Tengah six out of 12 villages were selected for intervention. Names of the selected villages are as follows: Darek, Plambik, Kabol, Ungga, Ranggagata and Montong Sampah. In sub-district Gangga, district of Lombok Barat the following villages were selected: Sesait, Gondang, Bentek, Rempek and Kayangan (all five villages were selected as project sites).

The project has limited its area to these 17 (seventeen) villages. It has been designed carefully, and so far there was no intention to expand the project activities to other areas. Measurable objectives of outputs have been set, and on the way some changes on the target have taken place.

In collaboration with the local government the selection was made using criteria discussed and agreed by the local government. The main criteria which was used were:

- Degree of health status,
  - No other IPVO operational in the subdistrict
  - The level of female education, and
  - The possibility for replication in other areas.
- The project is intended to carry out the following:
- At the sub district level, help train and facilitate the Sub District Team (SDT) to effectively execute their task, i.e. to train the Village Supervisory Team (VST) to improve Posyandu effectiveness, and to facilitate the health center to provide the needed support to village midwives.
  - At the village level, help the VST to play a support/ supervision role for Posyandu, CMP and KP-KIA groups, and train and facilitate the village midwives to provide needed maternal care services.
  - At the sub village (dusun) level, train, supervise and facilitate the managers of the CMPs and women groups, and facilitate the work of the TBAs and the functioning of Posyandu.

### **5.5.2 Management and use of data**

The project has used some special simple forms (Health Information System Forms - HISF) to document the baseline as well as output of the activities carried out in the field. Three forms (Form 1 to 3) were developed to record the baseline data which identify the location and situation at the beginning of the project. Form 1 is used for sub-district baseline records (Data dasar kecamatan) and Form 2 indicates the village baseline data (Data dasar desa). Form 3 refers to baseline information of the Mother Awareness Group (Data dasar KP KIA) which is supposed to be renewed every 6 months.

For monitoring purposes Form 4 (Lembar Pemantauan Kegiatan Proyek) was developed in which in each village the following records are made: Posyandu/pregnant mothers, POD, Polindes/Bidan Desa, KP KIA, VST and SDT. Finally, Form 5 was developed to record training conducted by CARE.

There are 5 (five) forms that have been developed by the project. Besides quantitative data, qualitative information was also collected. This qualitative information had enabled the project to categorize the output indicators. KP-KIA for example, had been categorized into those at the starting phase (KP KIA Awal), developing (KP KIA Berkembang), and developed (KP KIA Mantap). So were Polindes, POD, Posyandu, VST, and SDT. This categorization is really an innovative idea which is based on practical experience. No organization not even the GOI has formulated this different categorization. Based on this categorization the project has prepared a list indicating project components' status in each district. Detail of the 5 HISF can be seen in Appendix 7. Categorization of each component and status of the project components can be seen in Appendix 8.

The baseline data collected in December 1992 had been used for planning development, especially in developing a detailed implementation plan. Data on project output indicators which was collected using the HISF such as number of KP KIA, Polindes, POD etc developed and their progress were used for internal quarterly project review. Sharing information with the

counterparts was done through submitting a quarterly report and project presentation. However, not all counterpart representatives during the evaluation were aware of the information. This was due partly to the high load of information received by counterparts (from their own project activities) and there was no permanent representative sent by the counterpart during project presentation. As a result each meeting was attended by different officers from the same counterpart office.

### 5.5.3. Community education and social promotion

The community has not effectively utilized yet the existing government health services. This can be seen by the ratio between number of the underfives visiting Posyandu and total number of the underfive population in the area (D/S), antenatal care visit and place of delivery at government health services. There are two underlying reasons this phenomena took place. First, there is unavailability of intensive social marketing of government health services; and secondly, knowledge and awareness of the community concerning health benefits is still lacking.

The project has focused its activities on social mobilization or community development. The aspect of direct service provision and health promotion has not been emphasized. In this project the health center staff and village midwives were involved in delivering health education and providing medical services to beneficiary population. In NTB, formal and informal leaders, religious leaders, cadres, and TBAs also have a prominent role in community education. Therefore, the project staff took part in not only facilitating the learning process of cadres, TBAs, religious leaders other informal as well as formal leaders, but also provided education. The involvement of the project staff in the technical aspect of the TBAs training were made possible by the availability of an MCH advisor who is also a midwife.

The VMCH project provided training and skills in delivering health messages and also made available training and conducted community education. Project staff informally approached and motivated the target audience. This effort is essential in keeping motivation high among health communicators so that they are able to take every opportunity for delivering the messages.

The VMCH project strengthened the existing institutions through increased supervision to the managers of the institutions. One of the operational programs was the KP-KIA group in which the program focuses on social marketing of the existing health services. Village supervisory teams whose members came from the community mobilized the community (pregnant and lactating mothers) to visit Posyandu. The project staff provided intensive supervision to the location. The purpose of this strategy was to keep the turn over less.

Basically, the project did not develop any special Information, Education & Communication (IEC) materials for use in its activities. The materials used were those produced by the Ministry of Health, such as flip charts for cadres at Posyandu sessions, or materials for discussion at the women group gathering. The IEC materials used in the project are mostly already existing materials. However, due to unavailability of specific IEC materials for training the mostly old, forgetful and illiterate TBAs the project staff facilitated the locally made appropriate health education materials, such as virtually no-cost "birthing box" which is aimed to train TBAs on the process of delivery, and how to appropriately help mothers, simple nutrition education visual aids etc. These IEC materials for the TBAs have been used every now and then in the field.

From the observation it was reported that these materials stimulated the active learning of the TBAs who were mostly very enthusiastic and joyful during the training sessions. No formal evaluation has been conducted to assess the effectiveness of these IEC materials on the change behavior of the TBAs. This material development process which is made possible through the availability of an MCH advisor to the project who is a midwife (Ms Elizabeth Bhoomkar) is also primarily intended to encourage the local community to be able to produce locally made IEC materials without depending on the supplies produced by the government which were quite often delayed.

Apart from the above IEC materials the VMCH project has distributed the following such as Kartu Pegangan Kader for VSTs, religious leaders and cadres for Posyandu and leaflets and sermon book for Friday prayer meetings for the religious leaders. The IEC materials for KP-KIA Groups and posters for the Posyandu cadres were also provided. These materials were apparently developed and produced by the previous project namely VPHC (Village Primary Health Care).

#### **5.5.4 Human resources for Child Survival**

During the period 1993 up to mid September 1994, there were some changes in project staffing and organization such as the Project Manager (PM) joined another CARE project; the Assistant Project Coordinator (APC) took a leave of absence for studying out of the country and one Field Officer (FO) resigned from CARE. Since there is no qualified PM candidate from outside CARE, an internal promotion was scheduled by HRD division. As a result of this, the Project Officer (PO) was accepted in CARE's Internal Management Trainee Program and being prepared to hold the position of the Project Manager (PM).

Due to restructuring in CARE International Indonesia organization effective December 1993, a Health sector Coordinator was appointed and took responsibility for managing the VMCH project. She formerly was an APC for CSFW project. The VMCH Project Coordinator (PC) resigned in January 1994 (Mr. Greg Fernandez) and the FO in February 1994 after delivering a baby. One of the FOs was promoted to become the PO and then the project hired 3 additional FOs who were mainly internal transfer from two other projects in Lombok.

The whole project was under the responsibility of the CARE Representative (CR) stationed in Mataram, the capital of Nusa Tenggara Barat province. Supposedly there was a Project Manager who reported to the CARE Representative, however, since several months ago this position was not occupied. Presently there is a person who is an "Internal Management Trainee", who is planned to be the Project Manager in a couple of months.

The person who is in day-to-day charge of the project is a Project Officer, who oversees the implementation of the whole project. He has the responsibility to negotiate with the counterparts at the district down to sub district level. Internally, he oversees the field officers.

The spearhead personnel of this project are field officers. There are nine FOs who are working with the counterparts at the sub-district, village and sub village levels. None of them have a medical nor health background, but all of them are field experienced persons. They mostly have been working in CARE's previous agriculture, safe water supply or VPHC (Village Primary Health Care) projects which are already finished and then the personnel were transferred to this particular project.

In the project there is also an MCH advisor, an expatriate midwife who has been working in India. She is from VSO (Voluntary Service Organization), and has been assigned to this project for almost a year and a half.

Currently the total VMCH project field staff consists of 13 persons (one CR, one each of the following: IMT, PO, and MCH advisor and nine (9) FOs. Considering the scope of the project and the task assigned to all personnel involved, it seemed that the load of each person is reasonable, given the limitation of the resources available for the project. Detail original project structure can be seen in Appendix 9.

#### 5.5.5 Supplies and materials for local staff

As has been stated, the focus of the project was encouraging community development and involving in provision of education and information to the community with no involvement on direct service delivery. In turn, the community was encouraged to organize sessions which the government health service staff would utilize to improve the community's understanding and encourage better practice on maternal and child health related problems.

The materials used by government health staff were those provided by Ministry of Health. From observation in the field and interviews with cadres and "Bidan di desa", it was clear that their understanding on related matters varied greatly from place to place.

The project provided some supplies to Polindes, such as examination bed, furniture and cupboard to store supplies. Understandably, these were essential equipment needed by Polindes for the midwives to work effectively.

The TBAs received some delivery equipment from the government and the project provided also some supplies. Again, the utilization of this equipment also varied. A TBA in Suntalangu village in Lombok Timur happily used them, but an old TBA in Bale Buwuh sub-village in Lombok Tengah kept them nicely for months. From the interview she said that she used it, but observing the labeling of the kit the evaluation team convinced that it has never been used. The evaluation team probed as to why she never used the kit and the TBA kept on smiling. A demonstration of using the forceps was requested to the TBA and she did not know even how to hold the instrument correctly.

#### 5.5.6. Quality

All the field officers were enthusiastic and experienced workers working with the community. However, all of them did not have any health background. To orient them to the public health program a cross visit to two districts in East Java was conducted in January 1993. The purpose of the visit was to learn and observe about the Community Medicine Post (CMP) and Polindes. Six (6) field staff and the APC joined this visit. After the cross visit, a three day in-service training on CMP and Polindes was conducted in Mataram on March 17-20, 1993. Through this training ten (10) VMCH staff members learned more about the MOH policy, MCH program, "Bidan di desa" placement plan, and Polindes guidelines and operation. During this training, the MOH at the province level (Kanwilkes) served as facilitator.

In addition, the project has utilized the expertise of the VSO (Ms. Bhoomkar) to assist with specific health orientation training for the FOs. Several topics were selected such as developmental assessment of a baby 0 - 3 years, stimulating and learning through play, process of normal delivery including possible emergencies, immediate after care and postnatal care. The teaching and learning process used the appropriate technology (birthing box), slides, flip charts, etc. One of the FOs acted as interpreter for all the sessions in English, so if there was no language barrier the results would be much improved.

As part of the staff development, selected IMT and FOs have joined several training courses such as Participatory Rural Appraisal (PRA), developing a Winning Team (Team Building), HIV/AIDS Prevention and Rapid Ethnographic Assessment courses. After completing the training, the selected participants shared their knowledge and experience with the rest of the field staff. To share the information and knowledge on the technical problems of the Child Survival Project among middle management of International Private Voluntary Organizations (IPVO), a network was established on April 3, 1990. Regular meetings were conducted and up to now ten different meetings have been held. Several field staff have benefited from these particular meetings.

The quality of service provision was also not the focus of the current evaluation. However, from the interviews with a limited number of pregnant and lactating mothers and mothers of children under two years old, it was not yet clear whether the important messages have been received appropriately by the population beneficiaries.

#### **5.5.7. Supervision and monitoring**

The CARE Headquarters in Jakarta had fully delegated the implementation of the project to the CARE Representative in Mataram. Limited meetings were held for supervision and monitoring purposes. However, since the detailed implementation plan was sufficiently clear for guidance purposes by the field office, the current mechanism of supervision and monitoring from the central office in Jakarta seemed adequate.

Supervision and monitoring were carried out by the project through a regular meeting in the CARE office in Mataram every week. At these occasions accomplishments in the field were reported and problems were discussed to get input from other colleagues to solve these problems. There was an impression that the meeting was not yet utilized effectively by the group.

#### **5.5.8. Use of central funding**

A letter of request was made to the USAID Jakarta to observe the on-going project implementation and provide feedback and input for improving project implementation. At the last quarter of 1993, the Director of OCCP - USAID (Jakarta) visited the project site and provided valuable input to the project. In addition, in February 1994 the Director of PHC CARE USA and Senior Program Officer PHC Unit visited the project site and provided valuable

feedback to the project implementation. In so far there are no expressed constraints faced in regard to monitoring and technical support from PVO regional as well as central office.

From the 1994 Country Project Pipeline Analysis CARE Indonesia VMCH (Form A), there were no specific items for administrative monitoring and technical support for the project. However, there was an item on service/consultants (local and expatriate) which show the agreed budget of US \$4875 (9% of the total USAID contribution). It is also assumed that administrative monitoring and technical support were allocated under Travel and Perdiem (both in and out of country) with a total budget of US \$92,712 (18% of the total USAID contribution).

Up to now the absorption capacity for these two (2) items namely services/consultants was 83% and Travel/Perdiem was 26%. It is likely that this funding does not serve a critical function, although the budget absorption of the international travel/perdiem was relatively low. Up to now there is no particular aspect of USAID central funding which may have a positive or negative effect on meeting the objectives of the program.

So far, there was an impression that no problems have been encountered in the field with regard to funding from the CARE central office. However, there was a concern of arbitrary number of year of a project life. Why a particular project is limited to 3 years or 5 years or even 6 years, what is the ground justification of the time limit? If a project is addressing a purely medical issue then a 3 year period will be sufficient but in the case that a project is actually conducting a problem solving approach to an underlying cause of socioanthropological issues then the 3 year limited time is insufficient.

#### **5.5.9. PVOs use of technical support**

Looking at the nature of the project which was focusing on community development, it seemed that expatriate technical assistance was not yet needed at present. There was also no expressed demand for a consultant from the project staff.

To improve knowledge of the project staff, especially the field officers, assistance was needed to provide training and materials for the maternal and child health program and medical related matters. This can be worked out with the local program and medical officers of the provincial health office. So far, the expatriate technical advisor (Ms. Elizabeth Bhoomkar from VSO who joined in March 1993) had tried to carry out some sort of informal training on technical aspects of maternal health to one of the Field Officers, with the expectation that it would be disseminated to other field officers. Her assistance was considered very helpful in providing appropriate technical training for the TBAs and orienting the FOs to the health field. Language is still a potential barrier for effective communication between both parties.

For provision of consultancy on social and anthropological analysis of women in Lombok, CARE has selected Center of Women Resources Development (PPSW) to conduct the analysis of women in Lombok (August, 1993). The results of the analysis was used for selecting the strategies in mother's group establishment.

#### **5.5.10. Assessment of counterpart relationships**

The chief counterparts of this project came from various administrative levels, which included Provincial and District Development Planning Boards (Bappeda I and II), provincial and district health offices (Dikes I and II), Public Health Centers (Puskesmas), sub-district

government offices (kecamatan), and village government offices (desa). Open dialogues have taken place between two parties, which resulted in a common understanding on the respective role for community health improvement. In the central office, a productive working relationship between CARE and Ministry of Health is yet to be expected.

At the provincial level some collaborative activities have taken place, including the provision of matching funds, provision of equipment and supplies for Polindes, and placement of technical advisor from VSO (Voluntary Service Organization of Britain).

Counterpart contributions were increasing from 1993/94 to 1994/95. In 1993/94, from a total of Rp 79.734.000 VMCH project budget, CARE, GOI, and community contributions in cash and in kinds was 47%, 14% and 39% respectively. In 1994/95 the proportion became 36%, 50% and 14% each, which shows that CARE's contribution is decreasing while the GOI's increased. For PVO funding, in each district namely Lobar, Loteng and Lotim the community contribution varied from 24.5% (Loteng) up to 36% (Lotim). Meanwhile analysis contributions for Polindes in each district was totally funded by both community and GOI. There was no budget contribution at all from CARE. Detail of budget contributions can be seen in Appendix 10.

At the district level, some matching funds for supervision and monitoring have also been agreed upon in Lobar and Lotim, while in Loteng a process of negotiation has taken place.

It seemed that the relationship between CARE and counterparts could be a productive one. CARE had the ability to offer knowledge, skill and experience on community development, while the health system could complement the project with their knowledge and skill on health and medical related matters.

#### **5.5.11. Referral relationship**

The villagers or community members who need simple care could see the trained cadre at the POD to receive simple, low cost medicine. If she/he needs further care, the cadre usually referred him/her to the Puskesmas. A simple form or note was used to refer the case to the Puskesmas.

The pregnant, lactating mothers and eligible women for family planning can go to visit the Posyandu to receive care. The women can come on their own or be referred by cadres or a member of KP KIA group. For antenatal care, family planning services and simple treatment the women can either go to visit the "Bidan di desa" at the Posyandu or Polindes. If the "Bidan di desa" cannot provide appropriate treatment, she will refer the case to the Puskesmas in the sub-district level where a medical doctor will take care of the patient.

From the community it is also possible that in the case of pregnancy/complicated cases of delivery a mother was referred and accompanied by the TBA to go for further treatment at the Polindes, Puskesmas or directly to the district level hospital. In this case, usually there is no special form or record, instead the TBA physically accompanied the mothers directly to the point of services. This is mostly due to her high emotional attachment and responsibility of the TBA toward her clients.

In other words, at the primary level one could seek care and treatment directly from the Puskesmas in which there is a doctor or midwife or via cadre, "Bidan di desa" or TBA who will refer the case to the Puskesmas.

If for some reason the personnel at the Puskesmas cannot handle the cases which need further treatment, the cases will be referred to the district hospital using the Puskesmas mobile

services (Puskesmas keliling - Puskel) which is usually available in each Puskesmas 24 hours. The Puskesmas doctor will provide a letter of referral to send the case to the hospital.

The project has provided training on CMP to cadres including the importance of referral system. However, there was a continuous problem of high drop out rate of the trained cadres due to marriage. In addition, from the observation there were some faulty practices of the cadres in handling the medicine. However, the trained cadres were mostly perceived useful by community members who need simple treatment which is close by. In some villages, some of the villagers perceived that the service of the cadres was considered low due to low quality of packaging of the drugs and medicine served at the POD. These villagers reported that they were often visited by uncertified sales persons of a drug company. In terms of making the services close to the clients, the project was successful although the quality of its services was insufficient.

#### **5.5.12 PVO / NGO Networking**

On the national level, CARE is a member of the International Private Voluntary Organizations Child Survival Programs Forum, a media for improving skills and exchanging information related to child survival. In NTB, CARE is also an active member of the NGO Coordinating Group, along with PATH, UNICEF, World Bank, and Safe the Children. It is also recommended that CARE become a member of the KHPA (Kelangsungan Hidup dan Perkembangan Anak - Child Survival and Development Forum) forum which was organized by Bappeda, Unicef and Dikes Dati I. This group gathered together monthly to share ideas and to develop working coordination whenever possible. In the field, due to arrangements made by the local government, duplicating work by NGOs in one area is avoided.

#### **5.5.13. Budget management**

The rate of expenditures compared with the project budget up to June 30, 1994 was in average 60%. The rate of each element varied from 15% (Evaluation) and 66% (Program cost). Up to September 30, 1994 in relation to the use of funds, the field activities had absorbed 80% of the allocated funds, a quite satisfactory performance. Detail can be seen in Table 4 and Appendix 11.

The budget is being managed in a responsible but flexible manner. If it is very significant and there is a sound justification, then it is possible to have budget shifts. However, it is very important to keep in mind that the total budget cannot be exceeded. The project will likely achieve its objectives with the remaining funding (with some modification for the project indicator concerning the income generating targetted to POD). Looking at the rest of the activities up to next September 30, 1995 it is unlikely there will be an underspent budget by the end of the project.

Table 4: Pipeline Analysis of VMCH Project  
(Rates of Expenditures up to June 30, 1994)

Element	AID	PVO	Total
I. Procurement	58 %	37 %	50 %
II. Evaluation	17 %	12 %	15 %
III. Indirect Costs	60 %	0 %	45 %
IV. Other Program Costs	64 %	75 %	66 %
Total	60 %	60 %	60 %

### 5.6. Sustainability

To promote sustainability in the first place the VMCH project was designed in such a way that the sustainability will be maintained. One of the main strategies of the project was the development of village supervision teams (VSTs) which was created through the establishment of Supervisory District Teams (SDTs). Additionally, community resource mobilization among others was achieved through the establishment of self-financing Community Medicine Posts (CMPs).

Secondly, at the same time the project actively solicited support from the local government at various levels starting right from the beginning of the planning stage of activities. As a result of this, local government both at the province and district levels allocated funds. At the province level namely Bappeda Tk I the funds are primarily intended to provide materials and equipment. Meanwhile from the district level (Bappeda Tk II) the funds were allocated for monitoring and supervising activities. Third, through endless motivational efforts, the Field Officers (FOs) activated the function of local community institutions especially at the sub-district, village and sub-village (hamlet) levels.

Community volunteers and counterparts received no incentives. This was a government policy especially for the community volunteers (cadres) as it was clearly stated by the counterpart (Dikes). However, a self-managed incentive system was developed and implemented in one of the project areas which was actually a substitute for transport cost for cadres in attending the meeting. This mechanism was initiated partly responding to the high drop-out of the cadres. So once the VMCH project ends there is nothing to worry about incentives from the project point of view.

During the project preparation as well as implementation the community was actively involved in the activities. This involvement was primarily achieved through FOs and project staff who provided ideas and stimulation so that the proposed activities could take place. Almost all sources of information at the subdistrict and village levels of all the project sites visited during the evaluation expressed demands for CARE's continuous involvement in the on-going development project activities such as Posyandu, POD and KP-KIA.

Up to the mid-term evaluation, there was no involvement from local organizations at the district as well as province levels. Assessment on their perception on project effectiveness was unfeasible. However, in implementing the project at the sub-district level down to the hamlet levels, local NGOs such as Family Welfare Movement (PKK) and religious groups took an active role. In so far there are no concrete plans for project activities to be institutionalized by local NGOs.

The main counterpart of the CARE project is the Ministry of Interior especially Directorate General Bangda (Regional Development). By this type of working relationship, unfortunately in so far the Ministry of Health (MOH) at the Central level was hardly involved in the VMCH project which was primarily aimed at promoting maternal and child health. At this time, it was difficult to assess the perception of effectiveness of the project by MOH and their concrete plans of continuing project activities at the central level are nonexistent. During this midterm evaluation a representative of the Central MOH was fully involved in the process (as an observer) and also participated in the field data collection. It is an indication of the effort of the project to share the information with the MOH.

#### **5.7 Recurrent cost and cost recovery mechanism**

The VMCH project is intended to facilitate in such a way that the government health services can be improved without provision of direct services from the project. The project encouraged the establishment and functionalized the SDT, VST, Polindes, KPKIA and Posyandu and does not provide direct services to the community. Since the beginning of the project the supplies for the Puskesmas, Polindes, TBA, and Bidan Desa such as medicine, furniture, equipment, TBA kit were mainly provided by the GOI (Bappeda I, Dikes I and Dikes II). Therefore, the issue of recurrent cost and cost recovery is not relevant in this particular project.

### **VI. KEY RECOMMENDATIONS:**

For the purpose of future direction, the recommendations were divided in two parts namely short-term and long-term. The short-term recommendations focus on the planning and implementation of the VMCH project within the time frame of the life of the project up to September 1995. It also highlights recommendations which are operationally feasible and put in the order of priority. Hopefully, it will provide guidelines for the project staff and management to replan and modify the coming project activities accordingly.

The long-term recommendations describes innovations beyond the life of the project. However, the time frame is flexible so the project should make use of the opportunity for looking into developing the proposed innovations.

#### **6.1. Short-term recommendations should be implemented before Sept.1995**

##### **6.1.1. Improving communication and coordination with counterparts.**

The improvement of communication and coordination with counterparts can be done simultaneously at different levels. Although the main counterparts of CARE are the Ministry of Interior (Dirjen Bangda) at the central and (Bappeda) at the province levels, health was the major

component of the VMCH project, therefore, communication linkage with MOH at the central level should be made possible in future implementation. The primary objective of the linkage is information/experience sharing and possibly joint field supervision. Through joint field supervision by project staff and a representative of the MOH, learning experience gathered from the field and shared. This information might become in-put for public policy by program holders in the MOH.

Based on the Buku Petunjuk Pelaksanaan Kerjasama Pemda dan CARE (Guideline on Implementation of Cooperation between Local Government and CARE) it was mandated that all government levels from central down to the village levels (ideally and supposedly) should perform coordination functions in order to ensure the achievement of GOI-CARE cooperation. Additionally, the nature of cooperation and communication between CARE and GOI, CARE and local institutions must relate to project activities. These two documents are excellent official guidelines for the implementation. Certainly, there are potholes in the implementation of both communication and coordination which are "beyond" the official documents. Unfortunately, the VMCH project's major component activity is "health" but the main counterpart of CARE is Bappeda and not "Government health institutions" such as Kanwilkes or Dikes (PATH has more productive communication and coordination with MOH at the province level due to its official counterpart being Kanwilkes).

The two official documents cannot ensure productive communication and coordination because "coordination" becomes a kind of jargon in the bureaucracy which means easy to talk about but it is always a problem when it comes to implementation (especially in the government system). From the observation and experience usually the key success is communication which most of the time is the "informal one". The project should focus in this area to ensure its coordination with the counterpart especially in the province level (as it was observed in the meeting that coordination between Bappeda and Dikes I is missing a part).

At the province level, effective information sharing can be made through project involvement and optimizing of the existing forum of KHPA in which representatives of prominent indigenous NGOs in health are members of the forum. The Bappeda Tk I and the Dinas Kesehatan Tk I are among the key counterparts which organize the forum. This forum can also serve as a coordination meeting so that duplication of activities between the government and NGOs will be avoided.

At the district level, both sharing of information and coordination with chief counterparts namely Bappeda Tk II and Dikes Tk II should be improved. Monitoring tool of the VMCH project should be discussed with Dikes Dati II to avoid duplication but specific needs of information for project purposes can still be integrated into the monitoring forms. Results of monitoring data should be communicated regularly, discussed and feedback should be solicited from the Dikes Dati II. If at all possible, sharing information by sending reports only should be avoided since this mechanism has proven to be ineffective. The coordination with Bappeda Tk II especially at the District Lombok Tengah must be improved to avoid any delay in securing counterpart funding in the future. In this case a special negotiation should be made that counterpart funding as promised via ABT (special additional budget) will be confirmed by this October 1994.

In the project proposal, there is a written document that the project will involve a special NGO namely PKK (Family Welfare Movement) and Bangdes (Village Development Directorate of the Ministry of Interior). At the operational level from sub-district, village and sub-village levels the FOs have made considerable efforts in involving these two institutions. However, there

is virtually no evidence of involvement of PKK and Bangdes at both province and district levels. Therefore, the project should strengthen the involvement of these two institutions at both levels. Given the paternalistic feature of the Indonesian bureaucracy a stronger involvement of these institutions will result in greater and continuous commitment at the village and sub-district levels.

#### **6.1.2. Improving internal communication and coordination (in the project and in the CARE organization)**

##### **6.1.2.1. Improve quality of regular meetings for staff**

The on-going regular meetings of project staff should focus on supervisory purposes. It was indicated that there are many expressed unmet needs of problem solving from the FOs which were quite often unresolved during the meetings. On the other hand, it is of absolute importance to raise the awareness of the PO to the needs of FOs in problem solving capacity.

The quality of communication developed between the PO (supervisor) and the supervisees (FOs) should be improved. This can be achieved through improving management capabilities of the PO and at the same time conducting an opened two-way dialogue between PO and FOs in such a way that they mutually agree as to future supervisory mechanism meetings.

##### **6.1.2.2. Improve sharing of information and coordination among different activities in CARE.**

Currently there are two projects running in NTB namely VMCH and Environmental Education Teaching Materials program (EETM). The VMCH focuses on the facilitating role so that women can become planners and users of governmental services. Among the indirect target of the project are pregnant women and mothers of the under two years. The EETM works through the school system in which important messages including health message are directed to the target audience (school children) through a special media namely ASYIK magazine which is published every two months.

Due to different counterparts of the two projects, the targeted area of the two projects are unsimilar. It is important to change the behavior of the mothers which must always take into consideration the environment at home. The environment at home should be conducive for program implementation, achievement and behavior change both at individual and family levels. So a sharing of information of the two projects must be done in the near future. At least a joint meeting of the field staff (FOs, management) will be useful for sharing information and ideas. This sharing of materials and expertise should be made to the greatest extent during the life of the project in order that the beneficiaries can gain maximum results.

When the VMCH is promoting training for detection of high risk pregnancy to TBAs and "Bidan di desa", arrangements must be made that the primary issue of the publication is also concerning detection on high risk of pregnancy at the same time. The school children can strengthen the similar message at home since discussion on the same topic can be initiated during home visits of the FOs of the EETM.

There is an expressed interest and need for communication and sharing of information between projects. At the HIIQ, an informal mode of sharing of information is preferred. Considering the high working load of both project staff and the different direct and indirect mechanisms of communication already used, there is a felt need by the staff for the CR to discuss with both project staff as to what mode of communication should be used for sharing the information at the field level. The evaluation team recommends using both formal and informal communication in sharing this information. During the formal meeting the CR should act as catalyst who constantly remind them of the information sharing.

### **6.1.3. Negotiating with GOI for completing the original design of intervention.**

The focus of the VMCH project is on community organization and facilitating health system at the primary level mostly from Puskesmas down to the subvillages. In the original proposal it was specifically documented that this intervention required the availability of "Bidan di desa" in each of the 17 villages under the intervention. This condition cannot be fully met and is primarily due to the fact that the government recently issued a special IDT (Special President Instruction for Least Developed Village Program). Therefore, the local government put priority on the deployment of the "Bidan di desa" in the so called least developed villages. As a result of this the VMCH intervention by facilitating the establishment of the Polindes cannot fully function operationally due to still a lack of "Bidan di desa". The Dikes Dati I of NTB recently received newly graduates of the "Bidan di desa" which will be employed using a contract-based system (PTT). There are 159 new "Bidan di desa" who are ready to be deployed in overall NTB province. The project should make early negotiation with the local government so that the needed "Bidan di desa" will be placed in the required project area. The project in cooperation with the Bappeda should convince the local health officers (Dikes I/Kanwilkes) of the needs of placement of the "Bidan di desa" in the project area.

### **6.1.4. Optimizing use of data**

#### **6.1.4.1. Internal use of monitoring & problem solving**

The project should maximize the use of routine data collection and monitoring for internal use. During the regular meeting the data which usually includes identifying existing operational problems should be discussed between FOs and project management. A solution must be achieved during this meeting and feedback to the on-going implementation must be obtained through this routine internal monitoring system.

#### **6.1.4.2. Sharing information with counterparts**

It is also strongly recommended to have regular sharing of information and discussion of the monitoring data with different levels of counterparts. In each level namely desa, kecamatan, Puskesmas, Dikes tingkat II and I, appropriate relevant data should be shared and discussed through a special meeting conducted at each level. This strategy should be discussed internally by the project staff as to how and who will communicate the data at each level in order to gain better results.

## **6.1.5. Strengthening capacity of human resources**

### **6.1.5.1. Technical aspects of health for the FOs**

Although implementation of the VMCH project requires a lot of skills in community organization, this project will still have health as major components. Unfortunately, all of the FOs' background are not health-related since recruiting such personnel was apparently unsuccessful due to the availability of manpower in the market. To make up the deficiencies, a special health orientation training program by the VSO was instituted but it was felt that basic knowledge concerning mother and child health was still insufficient.

A further short training on additional knowledge concerning basic mother and child health which can be organized in-house or attached to health related institutions such as local midwifery or nursing schools is strongly recommended prior to the end of the project. The purpose of this training is to equip the FOs with basic knowledge and public health aspect of MCH and sensitize it to the health issues. Early prelacteal feeding is very common practice among newborn babies and the role of the elderly is considered importance among the Sasak ethnic (see report Nanik Kasniah et al). It was also reported that there is a high incidence of LBW which are improperly handled at the primary level. Specific health issues need to be added to the coming training of FOs such as ensuring successful breastfeeding for mothers (simple physiology of lactation, identification and prevention of common breastfeeding problems, breastfeeding of low birth weight babies, technique of expressing breastmilk, simple technique of preserving breastmilk, good position and different positions of breastfeeding, developing and establishing breastfeeding mother support groups/KP2ASI), identification, prevention of low birth weight and first aid care or home care for the LBW babies.

The methodology should be geared in such a way that the adult education approach is used. To complement the learning experience an observational tour to a hospital and field program can be arranged. For an observational tour a Puskesmas located in Pamanukan, Kab Subang, West Java can be optionally suggested. The KP KIA in the Puskesmas area has been developed in the field especially with prominent activities in breastfeeding promotion through training of KP ASI (Kelompok Pendukung ASI).

In cooperation with the "Bidan di desa" and the cadres, the FOs need to facilitate the needs of surveillance of the hard to reach high risk groups of pregnant mothers and children. This effort should be made by making use of dynamic cohort registration forms which were recently implemented by Dikes I/II. If the total coverage of pregnant mothers and high risk under two children can be achieved in the whole area, then the targeted audience is fully under control. In such a case the number and availability of the "Bidan di desa" in each village is likely required. In addition, after careful consideration the number of FOs can be increased especially in a large and dispersed geographic location such as in Lombok Tengah.

### **6.1.5.2. Increase sensitivity of PO towards the needs of FOs**

As discussed above there is a need to improve the quality of regular meetings for supervisory and problem solving purposes. This can only be effectively achieved if there is an increase in sensitivity of the PO to the needs of the FOs. It is recommended that the PO should acquire additional sensitivity to the subordinate needs in a supervisory capacity. By combining such meetings with the regular meetings between FOs and PO of the ASYIK project, it is

expected that through this opportunity for observation and interaction with other FOs/management (ASYIK Program) can improve the sensitivity of the PO towards the needs of the FOs of the VMCH project.

If the ratio between PO and FOs is fixed at present and the needs of the FOs could not be backed up sufficiently, then a delegation of authority and decision making process should be defined and exercised. In this case the limited number of PO (one PO) would not affect the fulfillment of needs of productive supervision of the FOs.

#### **6.1.5.3. Needs availability of the VMCH project manager**

To be able to function effectively, the management staff as it is required in the project document should be implemented. The unavailability of a project manager is partly responsible for ineffective supervision function of the project. An incoming Project Manager has been appointed and is still undergoing internal management training. Hopefully, the new appointed Project Manager will take over some of the managerial responsibilities for further effective functioning of the project activities.

#### **6.1.6. Facilitating the improvement of quality of intervention**

##### **6.1.6.1. SDT (Supervisory District Teams) and VST (Village Supervision Teams)**

The main strategy of the VMCH implementation is the activating of the establishment and functioning of VSTs. The team members are assigned with the primary responsibility of effective supervision of grassroots health activities such as Polindes, Posyandu, KPKIA and POD.

It was generally found that the supervision cost from the subdistrict down to the village, and the village level to the community was very limited. In fact, the most important supervision for active functioning of all grass root activities depends on the involvement and commitment of these two teams. Therefore, it is strongly recommended that the project should negotiate with the Bappeda II in such a way that there will be sufficient cost of supervision from these two teams to the grassroots activities (Pokjanal Kecamatan and Pembina Lapangan Desa). In addition, it is also recommended that the frequency of supervision (administrative and technical aspects) for VST by SDT should be increased.

The commitment of the VST also largely depends on their understanding and sensitivity to maternal and child health issues. The results of the interview suggested that some members of the Tim Pembina Desa (VST) were unclear about their role and responsibilities. It is recommended that the project facilitate more effective training methods for this group (if there are still any) so they really have a clear understanding of their role and responsibility. Additionally, it was also suggested to have more health orientation for SDT to increase their sensitivity to health issues which eventually is expected to increase their commitment for health promotion activities.

##### **6.1.6.2. KP KIA**

The KP KIA (Mother Awareness Group) has a very strategic position in changing behavior of the members since the ultimate objective is to influence the health behavior of the

mothers through health education. The establishment of KP KIA could become the main thrust of the intervention. However, the number of the KP KIA is still limited due to the requirement of certain criteria to develop KP KIA.

The typical KP KIA members are the pregnant and lactating mothers. In NTB, it was found that the elderly have a very strong influence in child care. Quite often there is still unproper infant care and practice i.e. prelacteal feeding which was induced by the grandmother or elder member of the family.

By extending the KP KIA membership not only to lactating and pregnant women but also include the elderly and the young people is very important from the point of view of intervention. In Lombok island, it is very common that young girls get married early, by education interventions through the KP KIA this kind of issue can be dealt with and reduced gradually.

Targetting those groups to health education messages is very relevant. It was observed that in some of the KP KIA groups the cadres are also men. The KP KIA should also consist exclusively of women targeted for women groups. In this case there is a feeling of privacy, meaning that quite often the women can talk easily with other women without the presence of male members in the group.

In putting variability of health education topics which are relevant to the existing problems, it is recommended to make use of the community records from POD. These records indicate the most prevalent complaints or diseases and the materials should be used by the "Bidan di desa" for discussion topics (preventive health promotion activities) in the KP KIA groups. The topic of the discussion should also include some new materials such as taking care of low birth weight babies which is apparently very common and also preparing home made fluid substitute for oralit. The meetings of the KP KIA should become health education opportunities and, therefore, need more locally adapted IEC materials. The skills of the cadres in providing health education needs to be strengthened.

It was noticed that the problem of high drop out of cadres is still prominent. In order to keep the cadres, a creative reward system should be developed for them which is mainly non-financial rewards such as conducting cadre competition, providing uniforms, free treatment, observation and study tour between activities. With continued input from CARE field staff and committed GOI staff the growth of the women groups should continue to improve the health and lifestyle of the villagers as a whole.

#### 6.1.6.3. Polindes

It has been found that there has been good community support and reaction to the Polindes. Although the target of placing a "Bidan di desa" in every village has not yet been achieved, the GOI policy of doing so is seen as a positive step forward. There is a need for the newly qualified "Bidan di desa" to work more closely with the TBA and to build a positive relationship between each other. The combination of the professional skills of the bidan together with the tremendous background knowledge of the TBA about the village and its people should lead to positive results in reducing the infant and maternal mortality.

From the observation and discussion it is obvious that the lack of mobility of the "Bidan di desa" due to unreliable public transport adds to their difficulties and does nothing towards dealing with the situation especially in obstetric and child emergencies. It is clear that there is a need for some form of transport for the "Bidan di desa" if she is to practice efficiently. In Lombok Barat (Desa Rempek) the "Bidan di desa" was provided an unsuitable bicycle, which

of course is not appropriate for the rough, dusty and unpaved roads. The bicycle was easily damaged and cannot operate anymore. It was reported that in Lombok Timur the Dikes II has provided motorbikes for selected "Bidan di desa" which of course provided better mobilization.

#### **6.1.6.4. POD**

It was reported that training for POD cadres was three days. Training was provided by the GOI staff with some administration training by CARE. There were some concerns on the results of the visit and interview:

Incorrect techniques for labeling and storing (unmarked bottles of medicine, no expiration date on bottles, medicine not stored properly i.e. open bottles kept in direct sun light), 2unproper management of the drugs (medication given incorrectly/ inappropriate medication, unnecessary use of antibiotics, less than minimum dosage of medicine given, and incorrect records, and untrained family members of cadres giving out medicine).

The pattern of "ill-health" information gathered within POD records is a good opportunity for health education. The curative aspect of POD can be replaced with an excellent source of preventive health care messages. However, the cadres at present do not have enough knowledge to carry out this job. The "Bidan di desa" working together with the cadres as part of the village health care team is the ideal person for health education . Therefore, there is also a need for the availability of locally adapted IEC materials for use in POD. In addition, there is a need to improve the health education skills of the cadres. In future sessions all these concerns should be taken into consideration.

#### **6.1.6.5. Posyandu**

It was generally found that Posyandu is welcomed by the village women and the discussion is considered being beneficial to them and their families. From the discussion results, it was identified there is much room for improvement in the training of the staff and the education of the village women in health and safe health care for themselves and their families.

It was also noticed that there is a constant problem of high drop out of cadres mostly due to the fact that the female cadres get married and no longer have free time available to give advice. Even though male cadres gave longer service after training their input to some areas is limited. For example in the breastfeeding issue, many young mothers are reluctant and discouraged to discuss their problems with a member of the opposite sex. The cadres also admitted themselves that there were some difficulties.

Based on the interview with selected cadres in the field the following are among the concerns regarding the skills of the cadres: incorrect filling in of weight, there was no follow-up of babies with obvious weight loss. Therefore, it is recommended that the project should increase the facilitating role by improvement of the cadre training and skills by government health services.

#### **6.1.7. Marketing use of appropriate, low cost technology for TBA training.**

Training of the TBA is one of the important areas in the VMCH project. The majority of the TBAs are illiterate, old and some find difficulty in concentrating for long periods of time in an unusual setting. Therefore, it is very important that the training session be kept short,

interesting, and participative in order to prevent their lack of attention and keep them from falling asleep.

With the technical advise from Ms. Elizabeth Bhoomkar (VSO) the project has produced low cost audio visual aids especially for teaching TBAs in the training program. Although the effectiveness has not been assessed, the teaching model for TBAs seems very appropriate to use for the illiterate persons. This experience and approach is worthwhile to disseminate to local program officers and health trainers (MCH section and KLKM/BLKM - Provincial Health Training Institution) in which sharing can take place. It is also indispensable to transfer this technology to the local midwifery schools in which the graduates are expected to be able to teach the illiterate TBAs. This inexpensive technology could be one of the skills which should be mastered by the new "Bidan di desa".

The experience in preparing low cost technology should be documented (through video program) so that the techniques can be transmitted to other needed persons/institutions such as midwifery schools, midwife organizations, training institutions, etc. A small budget should be secured from the project or funding opportunities should be explored to make this idea take place.

It is also very important to further disseminate this experience to a wider audience especially those institutions who are teaching midwifery training and also training/service institutions at the MOH in which innovative approaches are needed in dealing with the TBAs. Linking with relevant NGOs such as Perinasia (Indonesian Society for Perinatology) which is very interested and involved in the appropriate technology for TBA training and also to the Forum Pengembangan Bidan Indonesia (FPBI- the Forum for the Development of Indonesian Midwives), IBI (the Indonesian Midwives Association) is very important. These organizations have a strong interest in working with TBAs. Additionally, they should also share their experience with Pusdiknakes (Center for Health Manpower Education) which is responsible for the national curriculum of the "Bidan di desa", Pusdiklat (Center of Health Manpower Training) and the Binkesga (Family Health Division, MOH) which are concerned with in-service training of the "Bidan di desa" in the field.

#### **6.1.8. Documentation and dissemination of practical knowledge & skills in CO/CD in Sasak community**

Through the VMCH project and the untiring efforts of the FOs in the field, the project has gained abundant practical experience in CO/CD which has a unique setting. The predominantly Sasak ethnic community provided a specific setting to work which makes the experience very unique and valuable. However, it is very important to document the experience as without any written documentation the steps and practical experience of the project will be gone when the project ends. This documentation can become a guideline for those many interested donors/NGOs in working at the grassroots level for promoting community health, especially in Lombok Island. The experience should be marketed not only to donor community/NGOs community but also useful for local program officers.

This documentation can be prepared by conducting a special workshop in which the project is recommended to put aside a special budget allotment. The documentation should be made in two languages which is Indonesian and English for wider distribution and use. The VSO (Mrs. Elizabeth Bhoomkar) can assist in the preparation of the English version. If considered necessary, a short term technical advisor can be assigned to guide the writing of the fruitful

experience. This experience is a real asset for CARE and the best should be made of the unusual opportunity to keep and further market this valuable asset.

### **6.1.9. Review of project indicators**

The VMCH project has set measurable objectives and indicators to track progress towards sustainability. From the project achievement so far there is variation of 30% up to 300%. Especially for goal number three - 30 Community Medicine Post (CMP) are functioning viably making available first line treatment for 120,000 villagers and generating support for 30 Posyandu. It is written in the already revised indicator as follows: Eighty percent CMP restock the supplies as required and generate at least 80,000 rupiahs of profit for Posyandu activities.

Results of the midterm evaluation indicated that achieving the all stated goals would be likely no problem for the rest of the life of the project. However, attendance of CMP in average was about 10 - 20 villagers per month and the income generation was approximately 10,000 - 20,000 rupiahs per year per POD. Given the available 12 months to complete the VMCH project, it is unlikely that this indicator can be achieved. Therefore, it is recommended that the project make special note on this issue or otherwise it is recommended to revise this indicator for targeting 20 - 30 persons (30% of the revised indicator) attending POD per month and 10,000 - 20,000 rupiahs per year per POD for income generating profit. In addition, the assessment of sustainability of the project should focus on the establishing and functioning of the SDT/VST rather than on the average number of attendance and amount of income generating profit for POD.

## **6.2. Long-term recommendations (beyond Sept. 95)**

One of the strengths of CARE is in the field of CO/CD. Based on this strength, opportunity for searching new innovation should be looked into. The following are among main areas in which CARE can play an important role using the strengths which are owned by this organization.

### **6.2.1. Trying new focus of interventions at the district level**

The official government policy in the future is decentralization. The kabupaten (district level) will become the center of autonomy of administration. This is also true in the health development. Therefore, its worth trying new interventions for the coming project of CARE which is based in the district level. There will be some advantages for this design such as more effective negotiation and close supervision. In addition, the project will have more control and influence in the planning purposes. One of the disadvantages will be less resources from counterparts especially in the district known as "miskin" (poor or less resources district).

### **6.2.2. Developing community based emergency transport for maternal and child care.**

In order to reduce maternal mortality and child mortality in any area, especially the more difficult areas, transportation is very indispensable for saving the life of a person. Due to the problems of transport a women or child's life sometimes cannot be saved. At this time there is

a strong need of developing a model of community based transport for emergency maternal and infant care. These issues are always referred to by the Dikes Dati I NTB.

Having a lot of experience in organizing communities in the area, CARE is in the best position to take the opportunity to develop the proposal and respond appropriately to this issue. This opportunity is also a chance for CARE to work cooperatively with other NGOs which have strong clinical skills and advocacy such as POGI, Perinasia, IBI, etc. This innovation will become critical areas in the new Safe Motherhood intervention program.

### **6.2.3. Enhancing the role of prominent religious leaders**

Taking successful intervention lessons from family planning especially in ensuring support for the family planning program and provide a conducive environment for adoption of selected effective contraceptive methods (IUD, Implant and sterilization), religious leaders were oriented and exposed to the current development of contraceptive technology through study tours and traveling seminars.

From NTB and other provinces, selected Moslem religious leaders (Tuan Guru) joined the traveling seminar in which they saw the involvement of other religious institutions in actively promoting family planning in the more developed/progressive areas. Upon returning to their respective provinces, the religious leaders organized a seminar and shared their experience (what they saw and what they now believe) and observation. A few of the selected religious leaders were then asked to join a special study tour to visit Islamic countries with progressive programs to promote the use of selected effective contraceptive methods. Seeing is believing. As a result, almost all Moslem religious leaders were very supportive towards family planning especially the more effective selected contraceptives (MKET).

CARE could use the same approach for promoting the support and involvement of religious leaders on the issue of reducing maternal and infant mortality. With the cooperation of the Kanwil/Kandep Depag (Regional/District Office of Religious Affairs), arrangements should be made for selected Tuan Guru to join the observation and traveling seminar tour to broaden their knowledge and views regarding maternal and child health. In NTB, role of Tuan Guru is very dominant and it is very indispensable to involve them in the promotion of health of mothers and children.

### **6.2.4. Taking opportunity of the current GOI policy on IDT (Inpres Daerah Tertinggal)**

The government is now expanding its program on development of the less developed villages through IDT program. Through this program the government will eliminate poverty by providing a special fund of 20 M rupiahs (about US \$10,000) in each village. The GOI has committed to provide funding for the development of the less developed villages all over Indonesia.

In the village development, the CO/CD aspect is very important. CARE with all its experience is actually in the best position to offer the expertise and must take an active part in that effort. This involvement can be taken as resource person or technical expert for the above mentioned project.

#### **6.2.5. Expanding new areas of activities on STD (Sexually Transmitted Disease), AIDS, and reproductive health**

Using the strength of CO/CD, a proposal can be developed in which donor priority is on the current list. The issue of AIDS/HIV, reproductive health, STD is among the current important areas in which CARE using the strength of CO/CD can play an important role. So it is only logical that CARE should be involved in this area in the future.

#### **6.2.6. Tapping of local resources from NTB**

NTB province is one of the provinces in which the health development is supported by the World Bank (HP IV Project). This project is intended to assist the province in implementing decentralization of health policy. The main issue of the project is Quality of Care.

The design and model which was field tested by CARE is a primary health care concept referring to quality of care with component of KPKIA, Posyandu and Polindes and POD. In this case CARE should take the opportunity to sell the ideas and experience both to the local and national government so that in the near future it can develop an appropriate project proposal which is able to tap local resources.

#### **6.2.7. Initiating working together with locally based IPVOs and NGOs**

Each NGO has a unique strength. One of the results of NGO programs is usually aimed at providing input to policy makers. To be able to provide a such an input on a service model which is very comprehensive and useful to the government, it is recommended that CARE in cooperation with other agencies can develop a comprehensive model for field test.

By using this model, CARE will have the opportunity to implement the innovation with support from different sources. The combination program with the other NGOs will make the advocacy stronger and at the same time will provide input of a comprehensive service model from the government for future program replication.

#### **6.2.8. Advocating replication of CARE's Primary Health Care (PHC) model into another area**

The success of the program can be an asset to CARE. Therefore, CARE should negotiate and lobby with the GOI so that the experience gained from the project can be taken into consideration in future program implementation. Expansion of similar projects into other areas will become a proof of the acceptability of the innovation as well as sustainability initiated by CARE. In NTB, there are 6 districts (kabupaten) and there is still much room to play in NTB for CARE II. Efforts should be made by CARE II to go on working in NTB with diversified projects.

### **VII. LESSONS LEARNED FOR OTHER CHILD SURVIVAL PROJECTS:**

This section will highlight important lessons derived from this particular VMCH project in NTB. Some of the lessons were unique to the NTB situation while the rest were intended for general interest. The facts expressed in this section were equally important and there was no

order of priority in the documentation.

### **7.1. Field-testing of a model and design of PHC (primary health care) institution linkages for Child Survival in Indonesia.**

The on-going VMCH project has provided operational linkages of PHC institutions based on the current government health policy. In reducing maternal and infant mortality the government focussed priority on the deployment of the "Bidan di desa" and the establishment of Polindes. The Polindes was intended to be established with community participation. The VMCH project made the utilization of the "Bidan di desa" and at the same time establish the Polindes with mobilization of community resources. The project has gained a handful of practical experience in field testing at the grass root level the linkages of KP KIA, Posyandu, Polindes and POD. Simple indicators and stage assessment of each of these institutions has been developed. It is likely that this approach is unique to the Indonesian setting in which this particular PHC policy was implemented.

### **7.2. Positioning unique approach of CARE's VMCH project.**

It is very common that other PVOs provided direct intervention to the target beneficiaries. In targeting the beneficiaries, however, CARE's VMCH project did not implement direct intervention at all. The project focussed on a facilitating role in strengthening capabilities of counterparts, stimulating intersectoral involvement at different levels and generating more indigenous resources at the community level. These three combinations are able to give image of the unique approach of the VMCH project.

### **7.3. Sustainability versus inherent inability**

The VMCH project focuses its role as change agent, catalyst of a village health development process. The project did not come and interact directly with beneficiaries and provided direct services to the community. Its primary involvement is facilitating the role and function of existing or supposedly available structure and services. By this nature indeed it has high probability of sustained activities once the project ends.

By putting emphasis on the facilitating role, it is very clear that the CARE/VMCH project did not have full control on the success of the project. There are many other intervening variables which determined the success of the project and were beyond the control of the project. The new PTT policy is not wanted by the majority of the doctors and midwives as the expectation to be government employees in both groups was very high. Such factors as work motivation of the health personnel (Puskesmas doctor, nurse, midwife etc), the new government system of PTT (doctor and "Bidan di desa" with contract basis of employment), of course, has a significant impact on the success of the project.

### **7.4. Proof of the old myth of disadvantage community.**

Working in the community setting of NTB province is of special interest because the province has known to be the province with the least income and low level of general education. It is a popular believe that working with such an "inert community" will face a lot of frustration

and low expectation. The VMCH project has proven and provided evidence that even though there is such a low community image and status there are indications of the existence of high spirits of altruism in which community members devoted endless time and efforts voluntarily for other disadvantaged members of the community. It was also clearly observed that substantial voluntary community contributions in kinds and cash took place especially in the development of the Polindes.

#### **7.5. Gaining of practical steps of CO/CD.**

The VMCH project has a particular strong component in community development and organization. In fact, this particular role was explicitly perceived unique by the main counterparts which expressed the needs of continuous support in this field. The practical experience which was gained by the project took place in a very specific setting in NTB in which the community is predominantly of the Sasak ethnic group. This distinctive community actually made the gained experience very resourceful. There are many agencies, NGO's interested in working for social development in NTB, therefore, the VMCH project has the opportunity to market the skills and experience in CO/CD to the potential clients. Room for becoming prominent technical assistants and resource materials is there. However, the CO/CD experience should be documented and widely published to eventually be known by different authorities, agencies and donor community.

#### **7.6. Gaining experience in implementing participatory evaluation process**

Through a first experience in conducting the participatory evaluation process there are certain benefits to the project. It provided an intensive two way communication between staff and project management, and between project staff with their counterparts. Additionally, it also gave an unusual opportunity for self-critical review to the on-going project.

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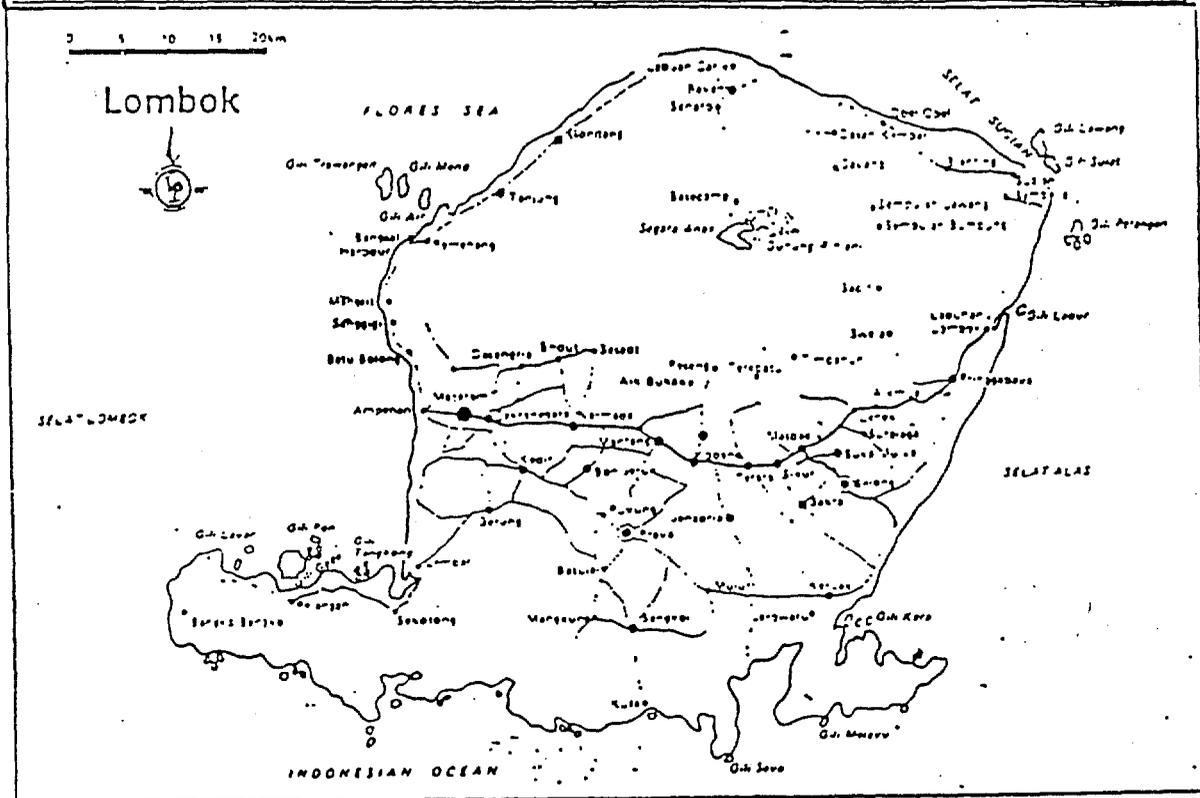
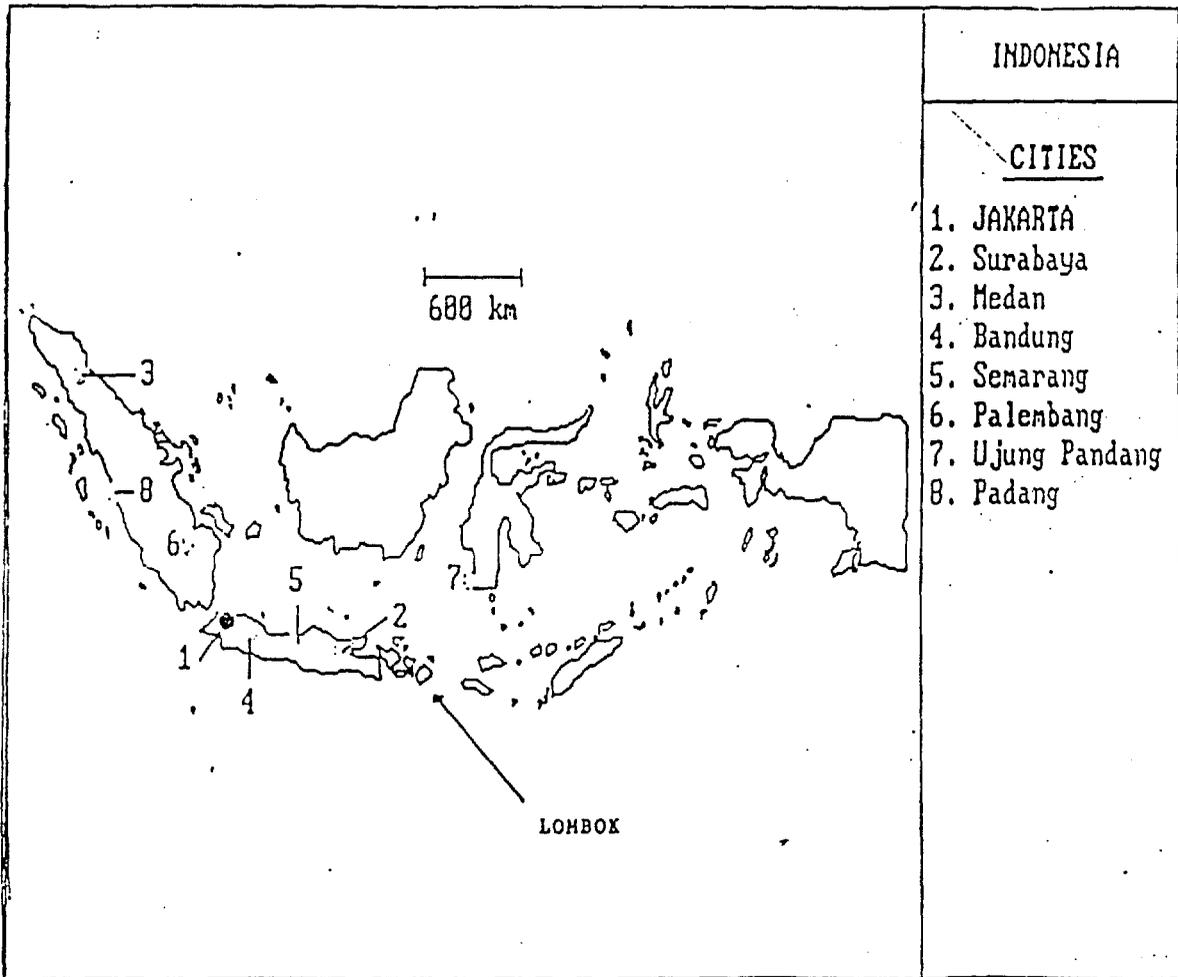
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# APPENDICES



Appendix 2

LIST OF PARTICIPATING EVALUATION TEAM  
 VCH PROJECT CARE, NTB  
 Sept. 12 - 25, 1994

Name	Institution
Counterparts	
1. Mr. Syafrudin Aly	Bappeda Tingkat I (Regional Development Planning Board), Mataram
2. Mrs. Dr. Margaretha Cephas	Subdin KIA, Dikes I (Chief, MCH Section, Provincial Health Office), Mataram
3. Mrs. Wachidah (midwife)	Staff Subdin KIA, Dikes I, Mataram
4. Mr. Dr. I. Nengah Sudana	Seksi KIA, Dikes II, Lombok Tengah, Praya (Chief, MCH Section, District Health Office)
5. Mrs. Ertiah (midwife)	Staff Seksi KIA, Dikes II, Lombok Tengah, Praya
6. Mr. Lalu Buchari	Sekwilcam (Secretary of Sub district), Kec. Praya Barat, Praya, Lombok Tengah
7. Mr. Akmaludin, SH	Kepala Desa (Village Chief), Desa Suntalongu, Kec. Pringgabaya, Lombok Timur
8. Mr. Dr. Arif Priatna	Kepala Puskesmas (Chief Public Health Center), Kec. Gangga, Lombok Barat
CARE	
9. Mrs. Catharina Haryono	Coordinator, Health Sector CII HQ
10. Mr. Adji Setioprojo	CR, NTB
11. Mr. Slamet Riyadi	IMT, NTB
12. Mr. Widodo Goentarto	PO, NTB

Name	Institution
CARE	
13. Mrs. Elizabeth Bhoomkar	VSO
14. Mrs. Vidiya Nefowaty	FO, Lombok Barat
15. Mrs. Hidayatul Fatikiyah	FO, Lombok Barat
16. Mr. Drs. Shyami Tarik	FO, Lombok Barat
17. Ms. ETTY Nuzuliyanti	FO, Lombok Tengah
18. Mrs. Nurikawati	FO, Lombok Tengah
19. Mr. Ngadiran Zalib	FO, Lombok Tengah
20. Ms. Asdiah Triana	FO, Lombok Timur
21. Mrs. Hartati	FO, Lombok Timur
22. Mr. Saharudin	FO, Lombok Timur
External Evaluators & Observer	
23. Mr. Dr. Hadi Pratomo (Team leader)	FKM-UI (Faculty of Public Health, Univ. of Indonesia)
24. Mr. Dr. Anhari Achadi (Co-Team Leader)	FKM-UI (Faculty of Public Health, Univ. of Indonesia)
25. Ms. Dr. Maya Hosein (Observer)	Dit. Binkesga, DepKes RI (Family Health Division, MOH)

MIDTERM EVALUATION SCHEDULE  
SEPTEMBER 12 - OCTOBER 3, 1994  
VMCH PROJECT - CARE NTB

NO.	TIME	TOPICS	FACILITATOR	SUPPORT DOCUMENT	PARTICIPANTS	REMARKS
1.	12 Sept. 1994 (Monday)					
	16.30 - 17.30	Discuss draft of midterm evaluation schedule.	- Widodo	The draft of schedule.	Evaluator/(team leader)	Place : CARE NTB office
	19.00 - 22.00	Informal gathering for getting to know each other	- Adji S./ Hadi P.	-	BAPPEDA Tk. I NTB DIKES Tk. II Loteng Camat Praya Barat Kades Sentalangu - Project Staff - Evaluator (Team leader) - CARE HQ	Restaurant "45"
2.	13 Sept. 1994 (Tuesday)					
	09.00 - 09.30	Opening ceremony	- Adji S.		- BAPPEDA Tk. I NTB - DIKES Tk. I NTB	Place : Graha Ayu Mataram
	09.30 - 10.15	Introduction of participants Pre-evaluation workshop (Ice-breaker)	- Hadi P.		- DIKES Tk. II Loteng - Camat Praya Barat - Puskesmas Gangga - Desa Sentalangu - Project Staff	- Mod. : Syani - Rec. : Yidiya
	10.15 - 10.30	Coffee break				
	10.30 - 12.30	Overview of CARE NTB and VMCH project	- Widodo G./ Adji S.	Project Document	- Project Staff - Evaluation Team	
	12.30 - 13.30	Lunch				

NO.	TIME	TOPICS	FACILITATOR	SUPPORT DOCUMENT	PARTICIPANTS	REMARKS
	13.30 - 15.15	General explanation of field activities of the counterparts (Kades, Doctor, Puskesmas)	- Slamet R.			
	15.15 - 15.30	Coffee break				
	15.30 - 17.00	- Expectation and fear of evaluation	- Hadi P.	Questionnaire		
	15.30 - 17.00	- Group discussion and plenary session : *> Objectives of the Evaluation *> Perception of participatory evaluation *> Identification of counterparts *> Role responsibilities in the evaluation	- Hadi P.	Group discussion guide		
3.	14 Sept. 1994 (Wednesday)	Panel discussion	- Anhari			
	08.00 - 09.45	- Overview of project implementation (West Lombok, Central Lombok, East Lombok)	- Vidiya, Ety, Asdiah)	Summary Project	All participants : - BAPPEDA Tk. I NTB - DIKES Tk. I NTB - DIKES Tk. II Loteng - Camat Praya Barat - Puskesmas Gangga - Desa Suntalangu - Project Staff	Place : Graha Ayu Mataram  - Mod. : Ety N. - Rec. : Ngadiran Z.
	09.45 - 10.00	Coffee break				
	10.00 - 11.00	- Discussion of indicators of project achievement	- Anhari			
	11.00 - 12.30	- Discuss of frame-work of evaluation - Definition of issues, key questions, source of information, methods of data collection	- Hadi P.	Discussion guideline		
	12.30 - 13.30	Lunch				

NO.	TIME	TOPICS	FACILITATOR	SUPPORT DOCUMENT	PARTICIPANTS	REMARKS
4.	13.30 - 15.15	Development of instruments	- Hadi P.			
	15.15 - 15.30	Coffee break				
	15.30 - 17.00	Group presentation	- Hadi P.			
	15 Sept. 1994 (Thursday)					
	08.00 - 09.45	Review of project design	- Anhari		All participants : - BAPPEDA Tk. I NTB - DIKES Tk. I NTB - DIKES Tk. II Loteng - Camat Praya Barat - Puskesmas Gangga - Desa Suntalangu - Project Staff	
	09.45 - 12.00	- Evaluation plan	- Anhari			
	12.00 - 13.00	Lunch				
	13.00 - 14.30	Group A and B Visit BAPPEDA Tk. I/DIKES Tk. I	- Hadi P. - Adji S. - Widodo G. - Elizabeth	Questionnaire guideline	Kabid Sosbud Ka. Dikes Tk. I Kasubdin KIA	
14.30 - 14.45	Travel to Lombok Barat					
14.45 - 16.00	Visit BAPPEDA Tk. II Lobar and Dikes Tk. II Lobar	- Widodo G. - Elizabeth		Ka. Dikes Tk. II Lobar Kasubdin KIA		

NO.	TIME	TOPICS	FACILITATOR	SUPPORT DOCUMENT	PARTICIPANTS	REMARKS
	13.00 - 14.45	Group C Development of Instruments	- Anhari			
	14.45 - 15.00	Coffee Break				
	15.00 - 16.00	Discussion continued				
	16.00 17.00	Plenary session : Presentation of instruments and guideline and schedule of field activities				

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Group A :

1. Responsible officer : Hadi Pratomo
2. Chairperson : Catharina Haryono
3. Member team : Elizabeth & Lalu Buchori
4. Transcriber : Widodo Goentarto
5. Data compiler : Arif Priatna

Group B :

1. Responsible officer : Maya
2. Chairperson : Adji Setijoprodjo
3. Member team : Syafrudin & Akmaludin
4. Transcriber : Slamet R. & Asdiah
5. Data compiler : Ertiah

Group C :

Those who were not participating in the field interview

Note :

- Posyandu - Integrated village/ family planning post
- KP-KIA - Mother Awareness Group
- Tim Desa - Village Supervision Team
- POD - Community Medicine Post
- Puskesmas - Public Health Center

No.	DATE/TIME	TEAM A			TEAM B		
		Activity	Place	FO	Activity	Place	FO
8.	19 Sept. 1994 (Monday)	West Lombok					
	08.00 - 09.00	Travel to Gondang			Travel to Gondang		
	09.00 - 10.00	Visit to : - Puskesmas Gangga	Puskesmas Gangga	Syami Tarik	Camat Gangga (Sub-district chief)	Kantor Camat Gangga	Vidiya Nefowaty
	10.00 - 12.00	- Tim desa Rempek (10.00 - 11.00)	Balai desa Rempek (village hall)	Syami Tarik	- KP-KIA Jugil (10.00 - 11.00)	Dusun Jugil (Sub-village)	Vidiya N./Hidayatul F
		- Polindes Rempek (11.00 - 12.00)	Polindes	Syami Tarik	- Posyandu Jugil (11.00 - 11.30)		
	12.00 - 13.00	Lunch			Lunch		
	13.00 - 16.00	Visit to : - KP-KIA Sesait (13.00 - 14.00)	Dusun Sesait (Sub-village)	Syami T. / Hidayatul F.	Visit to :	Kantor desa Sesait	Vidiya Nevowaty
- Posyandu Sesait (14.30 - 16.00)		- Tim desa Sesait (13.00 - 14.00)					
				- Polindes Sesait (14.00 - 15.00)			
				- POD Santong Asli (15.00 - 16.00)	Dusun Santong Asli (Sub-village)	Vidiya Nevowaty	
16.00 - 17.00	Return to Mataram			Return to Mataram			
9.	20 Sept. 1994 (Tuesday)	East Lombok					
	07.00 - 09.00	Visit to Pringgabaya			Visit to Selong		

No.	DATE/TIME	TEAM A			TEAM B		
		Activity	Place	FO	Activity	Place	FO
	09.00 - 11.00	Visit to : - Camat Pringgabaya (09.00 - 10.00) - Puskesmas Swela (10.00 - 11.00)	Kantor camat  Puskesmas Swela	Saharudin	Bappeda Tk. II Lotim and Dikes Tk. II Lotim	Bappeda Tk. II Lotim	Widodo G.
	11.00 - 12.30	- Tim desa (VST) Selaparang (11.00 - 11.45) - Posyandu Selaparang Timur (11.45 - 12.30)	Kantor desa  Dusun Selaparang Timur	Asdiah T. / Saharudin	- POD Selaparang Barat	Dusun Selaparang Barat	Hartati / Widodo G.
	12.30 - 13.30	Break			Break		
	13.30 - 16.00	Visit to : - POD Aik Embuk (13.30 - 14.00) - Posyandu Aik Embuk (14.00 - 15.00) - KP-KIA Aik Embuk (15.00 - 16.00)	Dusun Aik Embuk	Asdiah T. / Saharudin	Visit to : - Tim desa Sentalangu (13.30 - 14.30) - Polindes Sentalangu (14.30 - 16.00)	Kantor desa Sentalangu  Polindes Sentalangu	Hartati / Widodo G.
	16.00 - 18.00	Return to Mataram			Return to Mataram		

FIELD VISIT AND OBSERVATION SCHEDULE  
MIDTERM EVALUATION TEAM

No.	DATE/TIME	TEAM A			TEAM B		
		Activity	Place	FO	Activity	Place	FO
5.	16 Sept. 1994 (Friday)	Central Lombok					
	08.00 - 09.00	Travel to Praya Sub-district			Travel to Darek Sub-district		
	09.00 - 10.00	Visit to : - Bappeda Tk. II and Dinkes Tk. II Loteng	Kantor Bappeda Tk. II Loteng	Widodo G.	Visit to : - Puskesmas Darek	Puskesmas Darek	Ngadiran Z.
	10.00 - 12.00	- POD dusun Wentokan (Sub-village)	Dusun Wentokan (Sub-village)	Ika / Widodo G.	- Tim desa Darek (10.00 - 11.00) - KP-KIA Bale Buwuh I (11.00 -12.00)	Kantor desa Darek Dusun Bale Buwuh I	Etty N. / Ngadi n Z
	12.00 - 13.00	Break/Friday Prayer			Break/Friday prayer		
	13.00 - 15.00	Visit to : - Tim desa Kabul	Dusun Kabul (Sub-village)	Ika/Widodo G.	Visit to : - POD Orok Solong	Dusun Orok Solong (Sub-village)	Etty N. / Ngadi n Z
	15.00 - 16.00	- Posyandu Kabul			- KP-KIA Orok Solong		
16.00 - 17.00	Return to Mataram			Return to Mataram			
6.	17 Sept. 1994 (Saturday)						
	10.00 - 16.00	Field preparation (by Evaluation team only)	Hotel Pasific Beach				
7.	18 Sept. 1994 (Sunday)						
	10.00 - 14.00	Focus Group Discussion among field officers	Pasific Beach Hotel (Senggigi)	Hadi P./Maya	Indeph-interview - Incoming Project Manager - Project Officer	Pasific Beach Hotel	Anhari

NO.	TIME	TOPICS	FACILITATOR	SUPPORT DOCUMENT	PARTICIPANTS	REMARKS
10.	21 Sept. 1994 (Wednesday)	Data Synthesis	- Hadi P./ Anhari	Transscript	- FO's - PO - PM (incoming)	Place : CARE Office
11.	22 Sept. 1994 (Thursday)	Data Analysis Workshop	- Hadi P./ Anhari	Draft of report	Participants : - BAPPEDA Tk. I NTB - DIKES Tk. I NTB - DIKES Tk. II - PO - CM - CR - Project Staff - CIIHQ - Evaluation Team	Place : Graha Ayu
12.	23 Sept. 1994 (Friday)	Data Analysis	Evaluation Team			Place : Hotel Granada
13.	24 Sept. 1994 (Saturday)	Writing Draft report	Evaluation Team			Hotel Granada
14.	26 Sept. 1994 (Monday)	Writing Draft report	Evaluation Team			Hotel Granada
15.	27 Sept. 1994 (Tuesday)	Presentation of Result  Evaluation team return to Jakarta	Evaluation Team	Executive summary	Quarterly Staff Meeting participants (CARE)	Place : Santai Hotel

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## Appendix No. 4

**THE EVALUATION INSTRUMENTS**  
(English version)

The instruments which were developed and modified from the 1994 CS VIII standard guideline were used to gather data and information in the mid-term evaluation of Village Maternal and Child Health Project in West Nusa Tenggara. This is the English version which was translated from the Indonesian version. It consists of the following 18 instruments.

No.	Instrument	Source of Information	Method
1.	Instr. No. 4.1	Prov. Planning Board & District Planning Board (Bappeda I & II)	Interview
2.	Instr. No. 4.2	Local government, Sub-district and village (Pemda Kec & Desa)	Interview
3.	Instr. No. 4.3	Health Office, Provincial and District level (Dikes I & II)	Interview
4.	Instr. No. 4.4	Religious leaders Informal comm. leaders (TOGA & TOMA)	Interview
5.	Instr. No. 4.5	Government Public Health Center (Puskesmas) personnel (doctor, midwife, vaccinator)	Interview
6.	Instr. No. 4.6	Community Village midwife (Bidan di desa)	Interview
7.	Instr. No. 4.7	Traditional Birth Attendant (Dukun)	Interview
8.	Instr. No. 4.8	CARE personnel (Headquarters)	Interview

- |     |                 |  |           |
|-----|-----------------|--|-----------|
| 9.  | Instr. No. 4.9  | CARE personnel<br>(Country Representative)   | Interview |
| 10. | Instr. No. 4.10 | CARE personnel<br>(Project Management)   | Interview |
| 11. | Instr. No. 4.11 | CARE personnel<br>(Field Officers)   | FGD       |
| 12. | Instr. No. 4.12 | Community/Beneficiaries<br>(Pregnant mothers and<br>mothers of two year old<br>children) | Interview |
| 13. | Instr. No. 4.13 | Community Medicine Post  | Interview |
| 14. | Instr. No. 4.14 | VST members & cadres   | Interview |
| 15. | Instr. No. 4.15 | Women group members<br>(Mothers Awareness<br>Group - KP-KIA)                             | Interview |
| 16. | Instr. No. 4.16 | Polindes   | Interview |
| 17. | Instr. No. 4.17 | Posyandu   | Interview |
| 18. | Instr. No. 4.18 | VST<br>(Tim Pokjanal Posyandu<br>Kecamatan)  | Interview |

## Appendix 4.1

### Instrument for Prov. Planning Board District Planning Board (Bappeda I & II)

1. Accomplishments
  - What supports have been provided to the project ?
  - What outputs of the project have been shown ?
2. What is the policy of the local government on child survival?
3. Is there any constraint to meet the health needs of the children ? What are those ?
4. Supervision and Monitoring
  - What is the nature of supervision and monitoring carried out in this project?
  - How far is the information gathered discussed with other government officials and community?
5. Assessment of Counterpart Relationships
  - What are the chief counterpart organizations to this project?
  - What collaborative activities have taken place to date?
  - Are there any exchanges of money, materials, or human resources between the project and its counterparts?
  - Do the counterpart staff have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?
  - Is there an open dialogue between the PVO project and counterparts?
  - What is the government's view on this project?
6. Sustainability
  - How is the sustainability of this project?
  - What steps have been taken to promote sustainability of effective child survival activities once project funding ends?
7. What are the suggestions to improve the implementation of the project or the same project in the coming years?

## Appendix 4.2

### Instrument for Local government, Sub-district and village (Pemda Kec & Desa)

#### 1. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?
- What are the child survival interventions and health promotion activities initiated by the project?
- Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community?
- Is the focus or prioritization of interventions appropriate?

#### 2. Relevance to Development

- What are the main community barriers to meeting the basic needs of children?
- What has the PVO project done to date to increase the ability of families to participate in and benefit from child survival activities and services?
- Is the PVO fostering an environment which increases community self reliance, and enables women to better address the health and nutrition needs of their families?

#### 3. Human resources for Child Survival

- How many persons are working in this child survival project?
- Does the project have adequate numbers and mix of staff to meet the technical, managerial and operational needs of the project?
- Do these staff have local counterparts?
- Are community volunteers taking part in this project? How many are in place?
- Are they multi-purpose workers or do they concentrate on a single intervention?
- Is their workload reasonable?
- How many days of initial training and how many days of refresher training have they received since the start of the project?
- Is there evidence that the PVO carried out a needs assessment before embarking on initial and refresher training?
- Was the training methodology appropriate for the nature of the health workers jobs?
- Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

4. Supplies and Materials for Local Staff.
  - What educational or other materials have been distributed to the workers?
  - Do these materials or supplies give any evidence of being used?
  - Are they valued by the health worker?
  - Are they appropriate to the health worker's job?
  - Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?
5. Quality
  - Do the local project staff currently have the technical knowledge and skill to carry out their current child survival responsibilities?
  - Do the local staff counsel and support mothers in an appropriate manner?

### Appendix 4.3

Instrument for Health Service, Provincial and District level  
(Dikes I & II)

1. Accomplishments
  - What are the supports that have been provided to the project ?
  - What are the outputs of the project that have been shown ?
2. What is the policy of the local health services on child survival?  
What are the steps taken to avoid overlapping activities?
3. Is there any constraint to meet the health need of the children? What are those?
4. Supervision and Monitoring
  - What is the nature of supervision and monitoring carried out in this project?
  - How far is the information gathered discussed with the other government officials and community?
5. What are the social marketing activities that have been carried out so far?  
How far are the local health services involved in developing media for health education?

6. Assessment of Counterpart Relationships

- What are the chief counterpart organizations to this project?
- What collaborative activities have taken place to date?
- Are there any exchanges of money, materials, or human resources between the project and its counterparts?
- Do the counterpart staff have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?
- Is there an open dialogue between the PVO project and counterparts?
- What is the government's view on this project?

7. For Dikes II only:

Is the referral system successful? How far?

8. What steps have been taken to anticipate the situation after the project ends?

9. How does the local health service manage the available resources (man, money, materials)?

What is the community's potential in health?

What is the local health service's view on the existing budget mechanism?

10. What are the suggestions to improve the implementation of the project or the same project in the coming years?

#### Appendix 4.4

#### Instrument for Religious leaders and Informal community leaders (TOGA & TOMA)

1. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?
- What are the child survival interventions and health promotion activities initiated by the project?
- Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community?
- Is the focus or prioritization of interventions appropriate?

## 2. Community education and Social Promotion

- What is the balance between health promotion/social mobilization and service provision in this project?  
Is the balance appropriate?
- Is education linked to available services?
- Has the project carried out any community information, education, or communication activities?
- Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages?
- Have the messages been tested and refined?
- How does the PVO ensure that messages to mothers are consistent?
- Does the project distribute any printed materials?
- Did the PVO pre-test printed materials?
- Do members of the community regard these materials as simple, useful, and of value?
- Has the project been creative in its approach to community education, such as incorporating any non traditional or participatory education activities?
- Has the project assessed the level of learning that has occurred with these methods, or is the evidence for effectiveness anecdotal?

## 3. Recurrent costs and cost recovery mechanisms

- Do the project managers have a good understanding of the human, material, and financial inputs required to sustain effective child survival activities?
- What is the amount of money the project calculates will be needed to cover recurrent costs?
- Does the community agree to pay for any part of the costs of preventive and promotive health activities?
- Is the Government prepared to assume any part of the recurrent costs?
- What strategies is the PVO implementing to reduce costs and make the project more efficient?
- What specific cost recovery mechanisms are being implemented to offset project expenditures?
- Are the costs reasonable given the environment in which the project operates?
- Is the cost per potential beneficiary appropriate?
- Identify costs which are not likely to be sustainable.

### Appendix 4.5

Instrument for Government Public Health Center (Puskesmas) personnel (doctor, midwife, vaccinator)

1. Accomplishments

- What sort of training has been attended by health center staff? From which institutions were the trainers?
- How many and what kind of training has been carried out last year?

2. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?

3. Effectiveness

- Are the targetted high risk groups being reached effectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

4. Community education and Social Promotion

- How is education on maternal and child health delivered to the community?
- Is there any attempt to utilize the women group for communicating maternal and child health messages to community?

5. Supplies and Materials for Local Staff.

- What educational or other materials have been distributed to workers?
- Do these materials or supplies give any evidence of being used?
- Are they valued by the health worker?
- Are they appropriate to the health worker's job?
- Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?

6. Quality

- Does the local project staff currently have the technical knowledge and skill to carry out their current child survival responsibilities?
- Does the local staff counsel and support mothers in an appropriate manner?

7. Referral relationships

- Can you identify the supposedly referred cases? Was it done?
- What is the continuity of relationships between the referral site and the community project? Is the dialogue between project and referral site adequate?
- Is the project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

## 8. Sustainability

- What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?
- Are the incentives received by community volunteers, project staff, and counterparts meaningful for project commitment? Would those incentives continue once the project funding ends?
- How is the community involved in planning and implementing of project activities? Do community members see this project as effective? Is there a demand in the community for the project activities to be sustained?
- Do local organizations see the project as effective? Are there any concrete plans for project activities to be institutionalized by local NGOs?
- Is the MOH involved in the project?  
Does the MOH see this project effective?  
Are there any concrete plans for the MOH to continue particular project activities after funding ends?

## Appendix 4.6

### Instrument for Community Village midwife (Bidan di Desa)

#### 1. Accomplishments

- How many months has the project been operating?
- What are the measurable inputs ( e.g. training sessions held), outputs (e.g. persons trained, mothers educated), and outcomes (e.g. immunization coverage, change in mothers' use of ORT)?
- To date, how many infants, children under five, and mothers have been reached by CS interventions under this project?
- What proportion is this of the total potential beneficiary population of infants, children under five, and women of child bearing age?

#### 2. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?
- What are the child survival interventions and health promotion activities initiated by the project?
- Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community?
- Is the focus or prioritization of interventions appropriate?

### 3. Effectiveness

- What is the relationship between accomplishments for this period and objectives for this period?
- Has there been sufficient progress in meeting stated objectives and yearly targets?
- Are the targetted high risk groups being reached efectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

### 4. Community education and Social Promotion

- What is the balance between health promotion/social mobilization and service provision in this project?  
Is the balance appropriate?
- Is education linked to available services?
- Has the project carried out any community information, education, or communication activities?
- Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages?
  
- Have the messages been tested and refined?
- How does the PVO ensure that messages to mothers are consistent?
- Does the project distribute any printed materials?
- Did the PVO pre-test printed materials?
- Do members of the community regard these materials as simple, useful, and of value?
- Has the project been creative in its approach to community education, such as incorporating any non traditional or participatory education activities?
- Has the project assessed the level of learning that has occurred with these methods, or is the evidence for effectiveness anecdotal?

### 5. Supplies and Materials for Local Staff.

- What educational or other materials have been distributed to workers?
- Do these materials or supplies give any evidence of being used?
- Are they valued by the health worker?
- Are they appropriate to the health worker's job?
- Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?

### 6. Referral relationships

- Identify the potential referral care sites and comment on access and service quality.
- Has the project made appropriate use of these referral sites?

- What is the continuity of relationships between the referral site and the community project? Is the dialogue between project and referral site adequate?
- Is the project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

#### Appendix 4.7

##### Instrument for Traditional Birth Attendant (Dukun)

#### 1. Supplies and Materials.

- What educational or other materials have been received?
- Have these materials or supplies been used?
- Are they useful?
- Are they appropriate to your job?
  
- Do you have the necessary materials, supplies, and equipment to carry out your current responsibilities?

#### 2. Referral relationships

- Identify the potential referral care sites and comment on access and service quality.
- Has the project made appropriate use of these referral sites?
- What is the continuity of relationships between the referral site and the community project? Is the dialogue between project and referral site adequate?
- Is the project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

#### Appendix 4.8

##### Instrument for CARE Int. Indonesia Headquarters personnel

#### 1. Accomplishments

- How many months has the project been operating?
- What are the measurable inputs ( e.g. training sessions held), outputs (e.g. persons trained, mothers educated), and outcomes (e.g. immunization coverage, change in mothers' use of ORT)?
- To date, how many infants, children under five, and mothers have been reached by CS interventions under this project?

- What proportion is this of the total potential beneficiary population of infants, children under five, and women of child bearing age?
2. Design
    - Has the project limited its project area or size of impact population?
    - Has there been a careful expansion of project service activities?
    - Has the PVO set measurable objectives of outputs and outcomes?
  3. Budget Management
    - How does the rate of expenditures to date compare with the project budget?
    - Is the budget being managed in a reasonable manner?
    - Can the project achieve its objectives with the remaining funding?
    - Is there a possibility that the budget will be underspent at the end of the project?
  4. Sustainability
    - What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?
  5. Recommendations
    - What steps should be taken by PVO field staff and headquarters for the project to achieve its output and outcome objectives by the end of the project?
    - Are there any steps the project and PVO headquarters can take to make the project activities more sustainable?
    - Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the services of higher quality?
    - Are there any steps the project and PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by USAID, or by the PVO?
    - Finally, are there any issues or actions that USAID should consider as a result of this evaluation?

#### Appendix 4.9

##### Instrument for CARE Representative of Nusa Tenggara Barat

1. Accomplishments
  - How many months has the project been operating?

- What are the measurable inputs ( e.g. training sessions held), outputs (e.g. persons trained, mothers educated), and outcomes (e.g. immunization coverage, change in mothers' use of ORT)?
- To date, how many infants, children under five, and mothers have been reached by CS interventions under this project?
- What proportion is this of the total potential beneficiary population of infants, children under five, and women of child bearing age?

## 2. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?
- What are the child survival interventions and health promotion activities initiated by the project?
- Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community?
- Is the focus or prioritization of interventions appropriate?

## 3. Relevance to Development

- What are the main community barriers to meeting the basic needs of children?
- What has the PVO project done to date to increase the ability of families to participate in and benefit from child survival activities and services?
- Is the PVO fostering an environment which increases community self reliance, and enables women to better address the health and nutrition needs of their families?

## 4. Design

- Has the project limited its project area or size of impact population?
- Has there been a careful expansion of project service activities?
- Has the PVO set measurable objectives of outputs and outcomes?
- Has the project management been willing to make changes when appropriate, and can the PVO justify or give a reasonable explanation of the directions and strategies the project has undertaken?

## 5. Management and Use of Data.

- Is the project collecting simple and useful data?
- Do the indicators need refinement?
- What is the balance between qualitative and quantitative methods of data collection?
- Is the project using surveys for monitoring and evaluation?
- How were baseline data used for project development?
- Are data being used for decision making? (Please give examples).
- Is the project's routine health information system fully functional?

- Do the local staff have the management and technical capacity required to maintain the health information system?
- Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members?
- Is the PVO, headquarters and/ or field staff institutionalizing lessons learned by documenting, incorporating and sharing?

## 6. Human resources for Child Survival

- How many persons are working in this child survival project?
- Does the project have adequate numbers and mix of staff to meet the technical, managerial and operational needs of the project?
- Do these staff have local counterparts?
- Are community volunteers taking part in this project? How many are in place?
- Are they multi-purpose workers or do they concentrate on a single intervention?
- Is their workload reasonable?
- How many days of initial training and how many days of refresher training have they received since the start of the project?
- Is there evidence that the PVO carried out a needs assessment before embarking on initial and refresher training?
- Was the training methodology appropriate for the nature of the health workers jobs?
- Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

## 7. Quality

- Do the local project staff currently have the technical knowledge and skill to carry out their current child survival responsibilities?
- Do the local staff counsel and support mothers in an appropriate manner?

## 8. Use of Central Funding

- Have administrative monitoring and technical support from the PVO regional or central offices been appropriate in terms of timing, frequency and needs of the field staff? If not, what constraints does the project face in obtaining adequate monitoring and technical support from PVO regional or central offices?
- How much central funding has USAID given the child survival cooperative agreement for administrative monitoring and technical support of the project?
- Do these funds serve a critical function? Does this function appear to be underfunded or overfunded?
- Are there any particular aspects of USAID funding to the central office of the PVO that may have a positive or negative effect on meeting child survival objectives?

## 9. PVO's Use of Technical Support

- What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained?
- Was the level of technical support obtained by the project adequate, straight forward and worthwhile?
- Are there any particular aspects of the technical support (from all sources) which may have had the positive or negative effect on meeting project objectives? (For example, consultant visits, evaluations, workshops, conferences, exchange field visits).
- Is there a need for technical support in the next six months? If so, what are the constraints to obtaining the necessary support?

## 10. Assessment of Counterpart Relationships

- What are the chief counterpart organizations to this project?
- What collaborative activities have taken place to date?
- Are there any exchanges of money, materials, or human resources between the project and its counterparts?
- Do the counterpart staff have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?
- Is there an open dialogue between the PVO project and counterparts?

## 11. PVO/NGO Networking

- What evidence is there of effective networking with other PVOs and NGOs working in health and child survival?
- Are there any particular aspects of the situation which may have had a positive or negative effect on networking?
- Can the project cite at least one lesson learned from other PVOs or from other child survival projects?

## 12. Budget Management

- How does the rate of expenditures to date compare with the project budget?
  - Is the budget being managed in a reasonable manner?
  - Can the project achieve its objectives with the remaining funding?
  - Is there a possibility that the budget will be underspent at the end of the project?
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### 13. Sustainability

- What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?
- Are the incentives received by community volunteers, project staff, and counterparts meaningful for project commitment? Would those incentives continue once project funding ends?
- How is the community involved in planning and implementation of project activities? Do community members see this project as effective? Is there a demand in the community for the project activities to be sustained?
- Do local organizations see the project as effective? Are there any concrete plans for project activities to be institutionalized by local NGOs?
- Is the MOH involved in the project?  
Does the MOH see this project effective?  
Are there any concrete plans for the MOH to continue particular project activities after funding ends?

### 14. Recurrent costs and cost recovery mechanisms

- Do the project managers have a good understanding of the human, material, and financial inputs required to sustain effective child survival activities?
- What is the amount of money the project calculates will be needed to cover recurrent costs?
- Does the community agree to pay for any part of the costs of preventive and promotive health activities?
- Is the Government prepared to assume any part of the recurrent costs?
- What strategies is the PVO implementing to reduce costs and make the project more efficient?
- What specific cost recovery mechanisms are being implemented to offset project expenditures?
- Are the costs reasonable given the environment in which the project operates?
- Is the cost per potential beneficiary appropriate?
- Identify costs which are not likely to be sustainable.

### 14. Recommendations

- What steps should be taken by PVO field staff and headquarters for the project to achieve its output and outcome objectives by the end of the project?
- Are there any steps the project and PVO headquarters can take to make the project activities more sustainable?

- Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the services of higher quality?
- Are there any steps the project and PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by USAID, or by the PVO?
- Finally, are there any issues or actions that USAID should consider as a result of this evaluation?

## Appendix 4.10

### Instrument for VMCH Project Officer/Project Manager

#### 1. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?
- What are the child survival interventions and health promotion activities initiated by the project?
- Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community?
- Is the focus or prioritization of interventions appropriate?

#### 2. Effectiveness

- What is the relationship between accomplishments for this period and objectives for this period?
- Has there been sufficient progress in meeting stated objectives and yearly targets?
- Are the targetted high risk groups being reached effectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

#### 3. Relevance to Development

- What are the main community barriers to meeting the basic needs of children?
- What has the PVO project done to date to increase the ability of families to participate in and benefit from child survival activities and services?
- Is the PVO fostering an environment which increases community self reliance, and enables women to better address the health and nutrition needs of their families?

#### 4. Design

- Has the project limited its project area or size of impact population?
- Has there been a careful expansion of project service activities?

- Has the PVO set measurable objectives of outputs and outcomes?
- Has the project management been willing to make changes when appropriate, and can the PVO justify or give a reasonable explanation of the directions and strategies the project has undertaken?

5. Management and Use of Data.

- Is the project collecting simple and useful data?
- Do the indicators need refinement?
- What is the balance between qualitative and quantitative methods of data collection?
- Is the project using surveys for monitoring and evaluation?
- How were baseline data used for project development?
- Are data being used for decision making? (Please give examples).
- Is the project's routine health information system fully functional?
- Do the local staff have the management and technical capacity required to maintain the health information system?
- Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members?
- Is the PVO, headquarters and/or field staff, institutionalizing lessons learned by documenting, incorporating and sharing?

6. Human resources for Child Survival

- How many persons are working in this child survival project?
- Does the project have adequate numbers and mix of staff to meet the technical, managerial and operational needs of the project?
- Do these staff have local counterparts?
- Are community volunteers taking part in this project? How many are in place?
- Are they multi-purpose workers or do they concentrate on a single intervention?
- Is their workload reasonable?
- How many days of initial training and how many days of refresher training have they received since the start of the project?
- Is there evidence that the PVO carried out a needs assessment before embarking on initial and refresher training?
- Was the training methodology appropriate for the nature of the health workers jobs?
- Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

7. Quality

- Do the local project staff currently have the technical knowledge and skill to carry out their current child survival responsibilities?
- Do the local staff counsel and support mothers in an appropriate manner?

## 8. Supervision and Monitoring

- What is the nature of supervision and monitoring carried out in this project? Is it field based supervision?
- Has supervision of each level of health worker been adequate for assuring quality of services?
- From the view point of the health worker, how much of the supervision is counseling/support, performance evaluation, on the job education, or administration?
- What are the monitoring and supervision requirements for the remainder of the project?

## 9. PVO's Use of Technical Support

- What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained?
- Was the level of technical support obtained by the project adequate, straight forward and worthwhile?
- Are there any particular aspects of the technical support (from all sources) which may have had the positive or negative effect on meeting project objectives? (For example, consultant visits, evaluations, workshops, conferences, exchange field visits).
- Is there a need for technical support in the next six months? If so, what are the constraints to obtaining the necessary support?

## 10. Assessment of Counterpart Relationships

- What collaborative activities have taken place to date?
- Are there any exchanges of money, materials, or human resources between the project and its counterparts?
- Do the counterpart staff have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?
- Is there an open dialogue between the PVO project and counterparts?

## 11. PVO/NGO Networking

- What evidence is there of effective networking with other PVOs and NGOs working in health and child survival?
- Are there any particular aspects of the situation which may have had a positive or negative effect on networking?
- Can the project cite at least one lesson learned from other PVOs or from other child survival projects?

## 12. Budget Management

- How does the rate of expenditures to date compare with the project budget?
- Is the budget being managed in a reasonable manner?

- Can the project achieve its objectives with the remaining funding?
- Is there a possibility that the budget will be underspent at the end of the project?

### 13. Sustainability

- What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?
- Are the incentives received by community volunteers, project staff, and counterparts meaningful for project commitment? Would those incentives continue once project funding ends?
- How is the community involved in planning and implementation of project activities? Do community members see this project as effective? Is there a demand in the community for the project activities to be sustained?
- Do local organizations see the project as effective? Are there any concrete plans for project activities to be institutionalized by local NGOs?
- Is the MOH involved in the project?  
Does the MOH see this project effective?  
Are there any concrete plans for the MOH to continue particular project activities after funding ends?

### 14. Recommendations

- What steps should be taken by PVO field staff and headquarters for the project to achieve its output and outcome objectives by the end of the project?
- Are there any steps the project and PVO headquarters can take to make the project activities more sustainable?
- Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the services of higher quality?
- Are there any steps the project and PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by USAID, or by the PVO?
- Finally, are there any issues or actions that USAID should consider as a result of this evaluation?

## Appendix 4.11

### Instrument for CARE Field Officer

#### 1. Accomplishments

- How many months has the project been operating?
- To date, how many SDT, VST, KP-KIA, and POD have been established?
- How many cadres have been trained?

## 2. Relevance to Child Survival Problems.

- What are the major causes of child mortality and morbidity in the project service area?
- What are the child survival interventions and health promotion activities initiated by the project?
- Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community?
- Is the focus or prioritization of interventions appropriate?

## 3. Effectiveness

- What is the relationship between accomplishments for this period and objectives for this period?
- Has there been sufficient progress in meeting stated objectives and yearly targets?
- Are the targetted high risk groups being reached effectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

## 4. Relevance to Development

- What are the main community barriers to meeting the basic needs of children?
- What has the PVO project done to date to increase the ability of families to participate in and benefit from child survival activities and services?
- Is the PVO fostering an environment which increases community self reliance, and enables women to better address the health and nutrition needs of their families?

## 5. Management and Use of Data.

- Is the project collecting simple and useful data?
- Do the indicators need refinement?
- What is the balance between qualitative and quantitative methods of data collection?
- Is the project using surveys for monitoring and evaluation?
- How were baseline data used for project development?
- Are data being used for decision making? (Please give examples).
- Is the project's routine health information system fully functional?
- Do the local staff have the management and technical capacity required to maintain the health information system?
- Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members?
- Is the PVO, headquarters and/or field staff, institutionalizing lessons learned by documenting, incorporating and sharing?

## 6. Community education and Social Promotion

- What is the balance between health promotion/social mobilization and service provision in this project?  
Is the balance appropriate?
- Is education linked to available services?
- Has the project carried out any community information, education, or communication activities?
- Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages?
- Have the messages been tested and refined?
- How does the PVO ensure that messages to mothers are consistent?
- Does the project distribute any printed materials?
- Did the PVO pre-test printed materials?
- Do members of the community regard these materials as simple, useful, and of value?
- Has the project been creative in its approach to community education, such as incorporating any non traditional or participatory education activities?
- Has the project assessed the level of learning that has occurred with these methods, or is the evidence for effectiveness anecdotal?

## 7. Human resources for Child Survival

- Are community volunteers taking part in this project? How many are in place?
- Are they multi-purpose workers or do they concentrate on a single intervention?
- Is their workload reasonable?
- How many days of initial training and how many days of refresher training have they received since the start of the project?
- Did the PVO carry out a needs assessment before embarking on initial training?
- Was the training methodology appropriate for the nature of the health workers jobs?
- Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

## 8. Supplies and Materials for Local Staff.

- What educational or other materials have been distributed to workers?
- Do these materials or supplies give any evidence of being used?
- Are they valued by the health worker?
- Are they appropriate to the health worker's job?
- Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?

## 9. Supervision and Monitoring

- What is the nature of supervision and monitoring carried out in this project? Is it field based supervision?
- How much of the supervision is counseling/support, performance evaluation, on the job education, or administration?
- What are the monitoring and supervision requirements for the remainder of the project?

## 10. PVO's Use of Technical Support

- What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained?
- Was the level of technical support obtained by the project adequate, straight forward and worthwhile?
- Are there any particular aspects of the technical support (from all sources) which may have had the positive or negative effect on meeting project objectives? (For example, consultant visits, evaluations, workshops, conferences, exchange field visits).
- Is there a need for technical support in the next six months? If so, what are the constraints to obtaining the necessary support?

## 11. Assessment of Counterpart Relationships

- What collaborative activities have taken place to date?
- Are there any exchanges of money, materials, or human resources between the project and its counterparts?
- Do the counterpart staff have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?
- Is there an open dialogue between the PVO project and counterparts?

## 12. PVO/NGO Networking

- What evidence is there of effective networking with other PVOs and NGOs working in health and child survival?
- Are there any particular aspects of the situation which may have had a positive or negative effect on networking?
- Can the project cite at least one lesson learned from other PVOs or from other child survival projects?

## 13. Budget Management

- How does the rate of expenditures to date compare with the project budget?
- Is the budget being managed in a reasonable manner?
- Can the project achieve its objectives with the remaining funding?
- Is there a possibility that the budget will be underspent at the end of the project?

#### 14. Sustainability

- What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?
- Are the incentives received by community volunteers, project staff, and counterparts meaningful for project commitment? Would those incentives continue once project funding ends?
- How is the community involved in planning and implementation of project activities? Do community members see this project as effective? Is there a demand in the community for the project activities to be sustained?
- Do local organizations see the project as effective? Are there any concrete plans for project activities to be institutionalized by local NGOs?
- Is the MOH involved in the project?  
Does the MOH see this project effective?  
Are there any concrete plans for the MOH to continue particular project activities after funding ends?

#### 15. Recommendations

- What steps should be taken by PVO field staff and headquarters for the project to achieve its output and outcome objectives by the end of the project?
- Are there any steps the project and PVO headquarters can take to make the project activities more sustainable?
- Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the services of higher quality?
- Are there any steps the project and PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by USAID, or by the PVO?
- Finally, are there any issues or actions that USAID should consider as a result of this evaluation?

### Appendix 4.12

#### Instrument for pregnant mothers and mothers of two years old children (Bumil and Baduta)

1. Do you think Posyandu is useful? In what sense?
2. Do you go to have your pregnancy checked? Why? Where? By whom?
3. Have you had toxoid tetanus shot? How many? What's that for?
4. Do you know what oralit is? What's that for? How and how many oralit should be given a child when she/he got diarrhoea?
5. What do you do if your child has a runny nose and is coughing?
6. Have you ever seen a child with fever and fast breathing? What do you do?
7. What food is good for pregnant mothers? For lactating mothers? For children?

8. What's family planning for? Why? Can you mention some contraceptives? Where can you get those?
9. Where do you bring your child when he/she are ill? Why?

#### Appendix 4.13

Instrument for POD (Pos Obat Desa) organizer.

1. Could you please tell the names of people who are actively managing this POD? Please show us the drugs and how are those stored.
2. How many cadres have been trained to manage this POD? When?
3. How many patients were served this month? Monthly average?
4. When should the patient be referred? Where to? How is it done?
5. Has this POD be restocked? How? Where does the stock come from?
6. Is there any guidance and direction from Health Center or Health Sub-Center? From Village Supervisory Team?
7. Please tell us what are all those drugs for. What's the dosage? How and when should the patient take it?
8. Do you know what the side effect is? What's the side effect of those drugs?
9. How were those drug stored?
10. How much was sold this month? The month before? The whole year? Is there any benefit? How much? Did POD ever support Posyandu? How much?
11. What's the support from other institutions beside Health Center and Health Sub-Center?

#### Appendix 4.14

Instrument for Posyandu cadre and Village Supervisory Team members

1. Who are the personnel of Village Supervisory Team of Posyandu? What is the role of each individual?
2. How is Posyandu managed?
3. Is there any work plan? What is it?
4. Is there any routine meeting among the members of the team?
5. How is the direction and guidance to Polindes, Posyandu, POD, and KP-KIA provided?
6. Is there any direction and guidance from the Sub-district Supervisory Team?

#### Appendix 4.15

Instrument for KP-KIA members (Women Awareness Group for Maternal and Child Health)

1. How many people are KP-KIA cadres in this hamlet?

2. How many are members of KP-KIA? What are their characteristics (sex, age, occupation, etc).
3. Who are the organizers of the group?
4. What are the group's activities?
5. Is there any education media for the group? What are those?
6. Is there any routine meeting of the group? When? Who leads the meeting? What is the agenda of the meeting?
7. Does the group receive any direction and guidance? From whom?

#### Appendix 4.16

##### Instrument for Polindes (Village Maternity Post) Committee

1. Please tell us about the building used for Polindes. Who built this building? Where did the money come from? Is there any contribution from the community?
2. What is the equipment available? Where does the equipment come from?
3. How long has the midwife been stationed here?
4. Did the midwife attend any training? What kind of training? When?
5. What are the daily activities of the midwife? Activities in Polindes? In the community?
6. How many deliveries have been attended? Where? In this Polindes? In the patient's house?
7. Is there any arrangement between the midwife and TBA, Health Center, Health Sub-center, and village community organization (LKMD)? How?
8. How is the Polindes being managed?
9. How much is the monthly average income of Polindes? Where from?
10. How is the referral system implemented?
11. Is there any infant death due to tetanus neonatorum?  
How many? When? Who attended the delivery?
12. How many patients come for curative services? What are their problems?

#### Appendix 4.17

##### Instrument for Posyandu (Integrated health services)

1. How many Posyandu cadres are available in this hamlet?
2. How many are actively working? What are their activities?
3. How many cadres have ever attended training? What kind of training? When? How long?
4. How is the Posyandu managed? Is there any report of activities? Who made those reports?
5. How is the Posyandu schedule made? By whom? How is the schedule communicated to the community?

6. Is there any direction and guidance received? From whom? When?  
Questions to the individual cadre:
7. Do you know what oralit is? What's that for? How and how many oralit should be given a child when she/he got diarrhoea?
8. What do you do if your child has a runny nose and is coughing?
9. Have you ever seen a child with fever and fast breathing? What do you do?
10. What food is good for pregnant mothers? For lactating mothers? For children?
11. What's family planning for? Why? Can you mention some contraceptives? Where can you get those?

#### Appendix 4.18

##### Instrument for Posyandu Sub-District Team (Tim Pokjnal Posyandu Kecamatan)

1. Who are the members of Posyandu Sub-District Team? What is the role of each member?
2. Is there any work plan? What is that? Is there any evaluation?
3. Is there any routine meeting among the members of the team?
4. How is the direction and guidance to Village Supervisory Team provided?
5. Is there any direction and guidance from the Posyandu District Team?
6. Has the team ever carried out training? When? Who are the participants? Where did the funds come from?

## List of Contacted Persons

No.	Date	Name	Position/Institution
I.	15-9-94 (Bappeda TK I-MTR)	1. Mr. W. Langkir	Wakil Ketua (Vice Chairman) Bappeda TK I NTB
		2. Mr. Sanusi	Sie Kependudukan (Population Sect.) Bappeda
		3. Mr. drs. Gusti Rai Sukertha	Sie Kesra (Welfare Sect.) Bappeda
		4. Mrs. dr. Margaretha Chepas	Kasubdin KIA Dinkes Dati I NTB (Subdiv. of MCH, Prov. Health Office)
2.	15-9-94 (Bappeda TK II - MTR)	5. Mr. I.Made Lile, SH	Sekr. Bappeda TK II, Lobar
		6. Mr. Nurjati	Staf Sosbud (Social Cultural Div.) Bappeda TK II, Lobar
		7. Mr. dr. Sagaf Umar	Kepala Dinkes (Chief, Dist. Health Office), TK II Lobar
3.	16-9-94 (Bappeda TK II Lombok Tengah)	8. Mr. Drs. H.L. Soekarna Parlan	Ketua (Chairman) Bappeda TK II Loteng
		9. Mr. drs. Kama	Kabid Sosbud (Chief, Social Cultural Div.) Bappeda TK II Loteng
		10. Mr. Supardi	Kasie Kesra (Chief Welfare Section) Bappeda TK II Loteng
		11. Mr. dr. I. Nengah Sudana	Kasie KIA Dinkes (Chief MCH, Distr. Health Office) TK II, Loteng
		12. Mr. Ir. Nasrun	Kasie Pembangunan Masy. Desa (Chief Section of Village Development), Loteng

No.	Date	Name	Position/Institution
4.	16-9-94 Darek Village, Subdist. Praya Barat Lombok Tengah	13. Mr. dr. Sigit Djatkika	Kepala Puskesmas (Chief Public Health Center) Darek, Loteng
		14. Mr. Nurisyo	Kepala Desa (Village Chief), Kabol
		15. Mr. Deni	Sekretaris Desa (Village Secretary), Kabol
		16. Mr. Amsun	Kepala Dusun (Sub-village Chief), Kabol
		17. Mr. Yusuf	Ketua Karang Taruna (Chairman of the Youth Organization), Desa Kabol
		18. Mr. Rajab	Sekretaris Tim Pembina Posyandu (Secretary to the Village Supervisory Team) Kabol
		19. Mr. Kaspan	Kader (Cadre for CMP) POD Orok Solong, Kabol
		20. Mr. Nurasim	Kader KP-KIA (Cadre for Mother Awareness Group) Orok Solong, Kabol
		21. Mr. Salimin	Kader (cadre) Posyandu Kabul
		22. Mrs. Inaq Base	Trained TBA (2 yrs)
		23. Mr. Mamiq Samidah	Sekretaris Desa Darek (Secretary Darek Village)
		24. Mr. Rasidi	Sekretaris Tim Pembina Posyandu (Secretary to the Village Supervisory Team) Desa Darek
		25. Mr. Supardan	Kaur Kesra (Welfare Sect. Chief), Desa Darek
26. Mrs. L. Wirame Adnan	Ketua TP. PKK (Chairman Family Welfare Movement) Desa Darek		

No.	Date	Name	Position/Institution
		27. Ms. Arummi Herawati	Kader KP-KIA (Cadre for Mother Awareness Group) Bale Buwuh I, Darek
		28. Ms. Baiq Sukarni	Kader KP-KIA (Cadre for Mother Awareness Group) Bale Buwuh I, Darek
		29. Ms. Sainip	Kader (Cadre) Posyandu Bale Buwuh, Darek
		30. Mr. Saridun	Kader (Cadre) Posyandu Bale Buwuh, Darek
		31. Mr. Tahir	Toma & Ketua Dana Sehat (Religious leader & Chairman of the Health Insurance Program) "Barakah", Darek
		32. Ms. Inaq	Dukun Bayi (TBA) Darek
		Direct Beneficiaries:	
		33. Mrs. A	Pregnant mother, Orok Solong, Kabol
		34. Mrs. B	Lactating mother, Orok Solong, Kabol
		35. Mrs. C	Lactating mother, Orok Solong, Kabol
		36. Mrs. D	Lactating mother, Orok Solong, Kabol
		37. Mrs. E	Lactating mother, Orok Solong, Kabol
5.	19-9-94 (Gangga Subdist. Lombok Barat)	38. dr. Sri Widarti	Dokter Puskesmas Gangga Lobar
		39. Mrs. Made Sriwardani	Bidan (Midwife) Puskesmas Gangga
		40. Mr. Putu	Jurim (immunization technician) Puskesmas Gangga

No.	Date	Name	Position/Institution
41.		Mr. drs. Rachmadi	Camat Wilayah (Subdist. Chief) Gangga
42.		Mr. Ishak	Kaurbang (Development Sect. Chief), Kec. Gangga
43.		Mr. Resadep	Kepala Desa (Village Chief) Rempek
44.		Mrs. Tasnip	Ketua TP-PKK (Chairman of the Family Welfare Movement) Desa Rempek
45.		Mr. Ketut Kulan	Kasie PMD (Chief, Village Development), Kec. Cangga
46.		Mr. Ragiyo	Staf Pemerintahan (Village Staff), Desa Rempek
47.		Mr. Sumiarto	Kepala Dusun (sub-village chief) Busur, Rempek
48.		Mrs. Sriwati	Kader (cadre) Posyandu Busur
49.		Mr. Sriyadi	Kader (cadre) Posyandu Busur
50.		Mr. Nasri	Kader (cadre) Posyandu Dusun Kuripan
51.		Mrs. Inaq Srianip	Dukun Bayi (TBA) Rempek
52.		Ms. Adminyanti	Bidan Desa (Community Village Midwife), Rempek
Direct Beneficiaries:			
53.		Mrs. F	Lactating Mother, Desa Rempek
54.		Mrs. G	Lactating Mother, Desa Rempek
55.		Mrs. H	Lactating Mother, Desa Rempek
56.		Mrs. I	Lactating Mother, Desa Rempek

No.	Date	Name	Position/Institution
57.		Mr. Artim	Kepala Dusun (subvillage chief) Santong Asli, Sesait
58.		Mr. Salikin	Sekretaris POD (Secretary for CMP) Santong Asli
59.		Mrs. Haini	Bendahara POD (Treasurer for CMP) Santong Asli
60.		Mr. Kadir	Sie Pengadaan Obat (Drug Procurement Sect.) Santong Asli
61.		Mr. Suparman	Sie Penjualan Obat (Drug Sales Sect.), Santong Asli
62.		Mrs. Sri Indaryati	Staf PMD (Staff Village Development), Kec. Gangga
63.		Mr. H. Syaifudin	Kepala Dusun (Subvillage Chief) Jugil
64.		Mr. Pardi	Kader (Cadre) Posyandu KP-KIA, POD (MCH, CMP) Jugil
65.		Mr. Sahdip	Kader (Cadre) Posyandu KP-KIA, POD (MCH, CMP) Jugil
66.		Mr. Muslimin	Kader (Cadre) Posyandu KP-KIA, POD (MCH, CMP) Jugil
67.		Mr. Kreatip	Kader (Cadre) Dasa Wisma Jugil
68.		Mrs. Inaq Kreatip	Dukun Bayi (TBA) Jugil
69.		Ms. Nyoman S.	Bidan (Midwife) Desa Sesait
70.		Mr. Ahmad	Kader KP-KIA (Cadre for Mother Awareness Group) Posyandu, Dusun Sesait
71.		Mr. Salihin	Kader KP-KIA (Cadre for Mother Awareness Group) Posyandu, Dusun Sesait

No.	Date	Name	Position/Institution
		72. Mr. Saleh	Kader KP-KIA (Cadre for Mother Awareness Group) Posyandu, Dusun Sesait
		73. Mr. Masdin	Kader KP-KIA (Cadre for Mother Awareness Group) Posyandu, Dusun Sesait
		74. Mr. Mulsif	PLKB (Family Planning Field Writer), Sesait
5.	20-9-94	75. Mr. Lalu Masyhur (Pringgabaya & Selong)	Sekretaris (Secretary Bappeda TK II, Lotim
		76. Mr. Ir. Lukmanul Hakim	Staf Sosbud (Social Cultural Div) Bappeda II Lotim
		77. Mr. Muryadi	Staf Sie KIA Dinkes (MCH Div. Dist. Health Office) TK II, Lotim
		78. Mr. H. Muh. Kasim	Ketua POD. Selaparang Barat & Ketua I LKMD Desa Selaparang (Chairperson)
		79. Mr. Zainul Muttaqien	Kader POD (CMP Cadre) Selaparang Barat
		80. Mrs. Sami'atul W.	Kader Pelaksana POD (Supervisor CMP Cadre) Selaparang Barat
		81. Mr. Lalu Wirakarnom	Kepala Desa (Village Chief) Selaparang
		82. Mr. Lalu Salman	Kepala Dusun (Sub village Chief) Selaparang Barat
		83. Mr. Hasyim	Kepala Dusun (Sub-village Chief) Selaparang Timur
		84. Mr. Nasri	Kepala Dusun (Subvillage Chief), Batman
		85. Mr. Samsudin, BSc	Kaur Kesra (Community Welfare Sect.), Kec. Pringgabaya

No.	Date	Name	Position/Institution
86.		Mr. Abdul Haris	Wkl Kantor Urusan Agama (Vice, Religious Affairs), Kec. Pringgabaya
87.		Mr. Tayib Kamran, BO	Kaurbang (Development Sect.), Kec. Pringgabaya
88.		Mr. Drs. Alfiah	Ajun PLKB (Family Planning Field Worker), Kec. Pringgabaya
89.		Mr. Sim	Jupen (Information Field Officer)), Kec. Pringgabaya
90.		Ms. Lis Andayani	Staf Gizi (Nutrition Div.) Puskesmas Suela
91.		Ms. Nurhayati	Staf Gizi (Nutrition Div.) Puskesmas Suela
92.		Ms. Rohani	Bidan (Midwife) Puskesmas Suela
93.		Mr. Lufti	Perawat (Nurse) Puskesmas Suela
94.		Mr. Muhammad	Juru Imunisasi (Immunization Technician) Puskesmas Suela
95.		Mr. Tayub	PLKB (Family Planning Field Worker)
96.		Mr. Akmaludin, SH	Kepala Desa (Village Chief) Suntalangu
97.		Mr. Mahrudin	Sekretaris (Secretary) Desa Suntalangu
98.		Mr. Amirun	Kaur Pemerintahan (Village Staff), Desa Suntalangu
99.		Mr. Kamaludin	Staf Keuangan (Finance Sect.), Desa Suntalangu
100.		Mr. Junep	Kaur Kesra (Welfare Sect.) Desa Suntalangu

No.	Date	Name	Position/Institution
		101. Mr. Jayadi	Staf Desa, Kader Posyandu & POD (Cadre CMP)
		102. Mr. Supriadi	Kepala Dusun (Subvillage Chief) Batu Basong I, Desa Suntalangu
		103. Mrs. Papuis Hur	Dukun Bayi (TBA) Suntalangu
		104. Mrs. Papuk Mustianah	Dukun Bayi (TBA) Suntalangu
		105. Ms. Ernawati	Bidan (Midwife) Desa Suntalangu
		106. Mrs. Zubaedah	Kader POD, KP-KIA (Cadre CMP, MCH) Posyandu, Aik Embuk, Suntalangu
		107. Mrs. I. Warni	Kader POD, KP-KIA (Cadre CMP, MCH) Posyandu, Aik Embuk, Suntalangu
		108. Mr. A. Warni	Kader POD, KP-KIA (Cadre CMP, MCH) Posyandu, Aik Embuk, Suntalangu
		109. Ms. I. Mustiarap	Kader POD, KP-KIA (Cadre CMP, MCH) Posyandu, Aik Embuk, Suntalangu
		110. Mr. H. Mahsun Saleh	Tokoh Agama (Religious Leader) Desa Suntalangu
	18-9-94	111. Mr. Adji Setijoprojo (Pacific Hotel, Senggigi)	Chief Representative CARE, NTB
		112. Mr. Slamet Riyadi	Internal Management Trainee CARE
		113. Mr. Widodo Goentarto	Project Officer, CARE NTB
		114. Mrs. Vidiya Nefowaty	Field Officer Lobar CARE NTB
		115. Mrs. Hidayatul Fatikiyah	Field Officer Lobar
		116. Mr. Ngadiran Zalib	Field Officer Loteng
		117. Mrs. Nurikawati	Field Officer Loteng

No.	Date	Name	Position/Institution
		118. Ms. ETTY Nuzuliyanti	Field Officer Loteng
		119. Ms. Asdiah Triana	Field Officer Lotim
		120. Ms. Hartati	Field Officer Lotim
		121. Mr. Saharudin	Field Officer Lotim
23-9-94		122. Mr. Sinung Darukristanto, SKM	Kepala Perwakilan (Chief Representative) UNICEF, NTB
		123. dr. I.G.G. Djelantik DSA	Dokter Spesialis Anak (Pediatrician), RSU Mataram
		124. Mrs. Chatarina Haryono	Health Sector CII HQ
		125. Mr. Drs. Syami Tarik	FO, Lombok Barat
24-9-94		126. dr. Aswandono	Kadinkes TK I, NTB (Chief Provincial Health Office)
25-9-94		127. Mrs. Elizabeth Bhoomkar	Technical Advisor VMCH Project (VSO)
		128. dr. Soesbandoro, DSOG	Obgyn, RSU Mataram
		128. dr. Reny Bunyamin, MPH	Eks PKBI Officer
		129. Dra. Latifah Bay	Assistant Program Officer, (APO) PATH, NTB
28-9-94	130.	Ms. Yanti Kusumanto	Project Manager, Save the Children, NTB
		131. Mr. Muh. Aminullah	Program Officer EETM, CARE, NTB
17-10-94	132.	Mr. Paul McCarthy	CD, CIIHQ
	133.	Mr. Dave Adriance	ACD Program, CIIHQ
	134.	Ms. Geerda Wulandari	EETM Program Coordinator CIIHQ

FORM I: SUBDISTRICT BASIC DATA

I. SITE IDENTIFICATION

District : \_\_\_\_\_

Subdistrict : \_\_\_\_\_

Total villages : \_\_\_\_\_

Number of VMCH villages: \_\_\_\_\_

Field Officers in charge:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

II. PROJECT BASELINE DATA

1. Total number of SDT members

- Number of PLD (SDT officer for village supervision)

2. Total of Community Health Center (PUSKESMAS)

- Number of medical doctor

- Number of midwife

- Number of staff for immunization

3. Total of Community Health Subcenter (PUSKESMAS Pembantu)

- Number of staff

Date of data collection: \_\_\_\_\_

Data collected by : \_\_\_\_\_

I. SITE IDENTIFICATION

District : \_\_\_\_\_  
 Subdistrict : \_\_\_\_\_  
 Village : \_\_\_\_\_  
 Field Officer: \_\_\_\_\_

II. PROJECT BASELINE DATA

- |   |                      |
|---|----------------------|
| 1. Total village population   | <input type="text"/> |
| - Number of pregnant women  | <input type="text"/> |
| - Number of under one babies  | <input type="text"/> |
| - Number of mothers with children of<br>1 - 3 years old                         | <input type="text"/> |
| - Number of 1 - 3 years old children  | <input type="text"/> |
| 2. Number of Village Supervision Team (VST)<br>members                          | <input type="text"/> |
| 3. Total of Community Medicine Post (CMP)                                       | <input type="text"/> |
| - Kinds of medicines supplied (#)   | <input type="text"/> |
| - Number of <u>kader</u> (health volunteer)                                     | <input type="text"/> |
| - Average monthly sales revenue   | <input type="text"/> |
| - Kinds of medicines resupplied within the<br>past three months (#)             | <input type="text"/> |
| - Number of supervisory visit made by<br>PUSKESMAS during the past three months | <input type="text"/> |
| 4. Total number of Village Maternity Health<br>Post ( <u>Polindes</u> )         | <input type="text"/> |
| - Number of Village Midwife   | <input type="text"/> |
| - Number of TBAs  | <input type="text"/> |
| . Trained TBAs  | <input type="text"/> |
| . Non-trained TBA   | <input type="text"/> |
| - Number of <u>Polindes</u> referring its client<br>within the last month       | <input type="text"/> |
| 5. Total Posyandu   | <input type="text"/> |
| - Number of Posyandu <u>kader</u>   | <input type="text"/> |

- . Trained kader
- . Non-trained kader
- Available facilities:
  - . Weighing scale for under fives (BALITA)
  - . KMS (growth monitoring chart) for BALITA
  - . KMS for pregnant women
  - . Forms: -- R/O Nutrition
  - R/I Nutrition
  - F/1 Nutrition
  - . Ferro capsules
- Average monthly attendance:
  - . 1 - 3 years children (D/S)
  - . Pregnant women (K1)
  - . Pregnant women (K4)
  - . Average % of TT coverage
- Number of Posyandu with routine funding system
- 6. Total of Community Health Subcenter (PUSKESMAS Pembantu)
- Number of staff

Date of data collection: \_\_\_\_\_  
 Data collected by : \_\_\_\_\_

FORM III: WOMEN GROUP BASIC DATA  
(Data renewal per 6 months)

Name of group: \_\_\_\_\_  
 Hamlet: \_\_\_\_\_  
 Village: \_\_\_\_\_  
 Subdistrict: \_\_\_\_\_  
 Period: \_\_\_\_\_

01. Total members

02. Number of women group kader

03. The average age of group members  
 - oldest member: \_\_\_\_\_ years old  
 - youngest member: \_\_\_\_\_ years old

04. Average number of member's children  
 - highest number: \_\_\_\_\_ children  
 - lowest number : \_\_\_\_\_ children

05. Number of members without BATITA

06. Number of members with BATITA

- BATITA 1 child

- BATITA 2 children

- BATITA 3 children

- BATITA > 3 children

07. Number of member who consulted her pregnancy to

- medical doctor/hospital

- medical doctor/PUSKESMAS

- midwife/PUSKESMAS

- POSYANDU

- Village Midwife

- Trained TBA

- Non-trained TBA

- Other (specify): \_\_\_\_\_

08. Members who had delivered babies

- attended by hospital medical doctor
- attended by PUSKESMAS medical doctor
- attended by PUSKESMAS midwife
- attended by private midwife
- attended by Village Midwife
- attended by trained TBA
- attended by non-trained TBA
- Other (specify): \_\_\_\_\_


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FORM V: TRAINING PROVIDED BY CARE

1. Training provided for (check the appropriate box)

Village Midwives	<input type="checkbox"/>	TBAs	<input type="checkbox"/>	CMP kader	<input type="checkbox"/>
Posyandu kader	<input type="checkbox"/>	Women Group kader	<input type="checkbox"/>	VST	<input type="checkbox"/>
Informal leaders	<input type="checkbox"/>	Other, specify _____			

2. Name of training: \_\_\_\_\_

3. Starting and ending dates: \_\_\_\_\_

4. Total participants: \_\_\_ persons

5. Facilitator and Institutional base:

	Name	Institution
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____
e.	_____	_____

6. Training duration: \_\_\_ days or \_\_\_ hours

7. Training venue: \_\_\_\_\_

8. Training subjects:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

**FORM VI: QUARTERLY DATA SUMMARY**  
 (For all VMCH sites)  
 Period: \_\_\_\_\_

Data Source	Data	Goal Indicator
FORM IV		
1.12	Number of pregnant women <input style="width: 50px;" type="text"/>	1.1
1.15	# of pregnant women receiving complete TT <input style="width: 50px;" type="text"/>	
1.16	% of pregnant women receiving complete TT <input style="width: 50px;" type="text"/>	
4.1	Total KP.KIA (women group) <input style="width: 50px;" type="text"/>	2.1
4.4	Total # of KP.KIA members <input style="width: 50px;" type="text"/>	
	Average # of members per KP.KIA <input style="width: 50px;" type="text"/>	
4.2	Number of KP.KIA conducting monthly meeting <input style="width: 50px;" type="text"/>	2.2
4.3	% of KP.KIA conducting monthly meeting <input style="width: 50px;" type="text"/>	
2.1	Total CMP <input style="width: 50px;" type="text"/>	3.1
2.3	Total individuals served <input style="width: 50px;" type="text"/>	
	Average # of individuals served per CMP <input style="width: 50px;" type="text"/>	
2.7	CMP referring clients to PUSKESMAS <input style="width: 50px;" type="text"/>	3.2
2.8	% CMP referring clients to PUSKESMAS <input style="width: 50px;" type="text"/>	
2.1	Total CMP <input style="width: 50px;" type="text"/>	3.3
2.4	Number of CMP making medicines restocking <input style="width: 50px;" type="text"/>	
	% of CMP making medicines restocking <input style="width: 50px;" type="text"/>	
2.11	Number of CMP providing financial contribution for Posyandu <input style="width: 50px;" type="text"/>	
2.12	% of CMP providing financial contribution for Posyandu <input style="width: 50px;" type="text"/>	

**FORM VI: QUARTERLY DATA SUMMARY**  
 (For all VMCH sites)  
 Period: \_\_\_\_\_

Data Source	Data	Goal Indicator
2.13	Total financial contribution made by CMPs for Posyandu <input style="width: 50px; height: 15px;" type="text"/>	
	Total CMPs providing financial contribution for Posyandu <input style="width: 50px; height: 15px;" type="text"/>	
	Average contribution per CMP <input style="width: 50px; height: 15px;" type="text"/>	
	Largest contribution <input style="width: 50px; height: 15px;" type="text"/>	
	Smallest contribution <input style="width: 50px; height: 15px;" type="text"/>	
5.6	Total supervisory visits made by SDT <input style="width: 50px; height: 15px;" type="text"/>	4.1
	Total VSTs receiving supervisory visit <input style="width: 50px; height: 15px;" type="text"/>	
FORM V		
1.	Total number of training conducted for VST <input style="width: 50px; height: 15px;" type="text"/>	4.2
4.	Total number of participants <input style="width: 50px; height: 15px;" type="text"/>	
5.	Number of facilitators from SDT <input style="width: 50px; height: 15px;" type="text"/>	
8.	Training subject	
	1. _____ <input style="width: 50px; height: 15px;" type="text"/>	
	2. _____ <input style="width: 50px; height: 15px;" type="text"/>	
	3. _____ <input style="width: 50px; height: 15px;" type="text"/>	
	4. _____ <input style="width: 50px; height: 15px;" type="text"/>	
	5. _____ <input style="width: 50px; height: 15px;" type="text"/>	

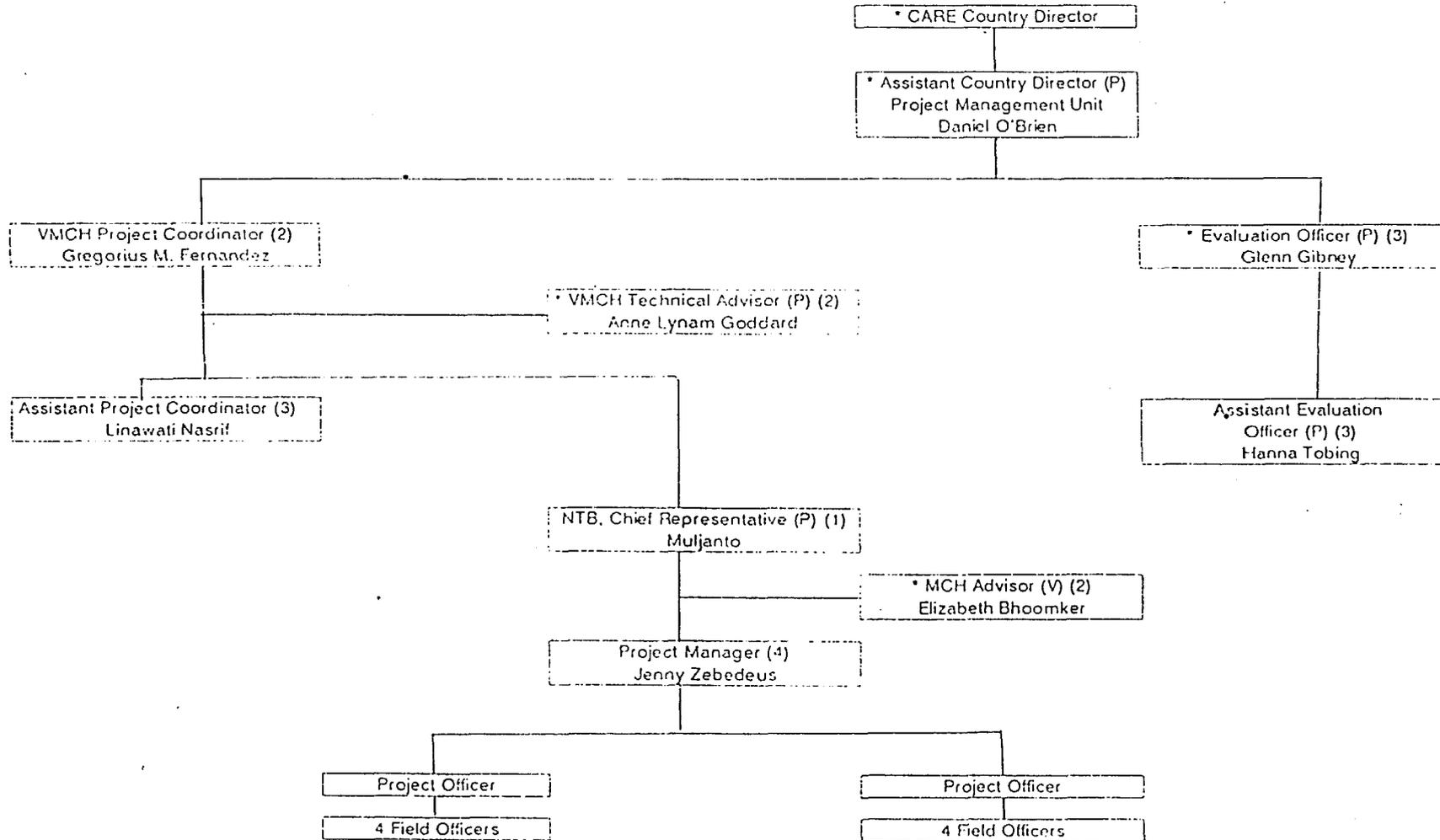
## COMPONENT STATUS IN VMCH PROJECT LOCATION

CURRENT STATUS (# village)	CLASSIFICATION	CRITERIA
	<u>KP-KIA</u>	
19	INITIAL STAGE	1. Have cadre 2. Have member
3	DEVELOPMENT STAGE	1. Have cadre 2. Have member 3. have regular KP-KIA meeting (on schedule)
1	ADVANCE STAGE	1. Have cadre 2. Have member 3. Have regular KP-KIA meeting (on schedule) 4. Have a schedule on extension activities 5. Have a good administration 6. TBA attends in KP-KIA meeting
	<u>POLINDES (Village Maternity Hut)</u>	
5	INITIAL STAGE	Have midwife
2	DEVELOPMENT STAGE	1. Have midwife 2. Have committee to manage Polindes 3. Have recording & reporting system 4. Midwife trains TBA
2	ADVANCE STAGE	1. Have midwife 2. Have committee to manage Polindes 3. Have recording & reporting system 4. Midwife trains TBA 5. Develop Rules and Regulations 6. Have regular schedule to supervise TBAs 7. Have regular supervision and guidance to posyandu 8. Provide supervision and guidance to KP-KIA 9. Referral mechanism from TBA to Polindes exist

CURRENT STATUS (# village)	CLASSIFICATION	CRITERIA
	<b>COMMUNITY MEDICINE POST (CMP)</b>	
10	INITIAL STAGE	<ol style="list-style-type: none"> <li>1. Have committee</li> <li>2. cadre able to simple diagnosis the sympton</li> <li>3. Cadre provide service with no counselling</li> <li>4. Have recording on medicine use and supply</li> </ol>
24	DEVELOPMENT STAGE	<ol style="list-style-type: none"> <li>1. Have committee</li> <li>2. cadre able to simple diagnosis the sympton</li> <li>3. Have recording on medicine use and supply</li> <li>4. Able to restock the medicine supply</li> <li>5. Cadre able to refer the patient to Puskesmas/Pustu</li> <li>6. Cadre provide service and counselling</li> <li>7. Have cash book/administration</li> </ol>
2	ADVANCE STAGE	<ol style="list-style-type: none"> <li>1. Have committee</li> <li>2. cadre able to simple diagnosis the sympton</li> <li>3. Have recording on medicine use and supply</li> <li>4. Able to restock the medicine supply</li> <li>5. Cadre able to refer the patient to Puskesmas/Pustu</li> <li>6. Cadre provide service and counselling</li> <li>7. Have cash book/administration</li> <li>8. CMP able to expand the type of medicine supply</li> <li>9. CMP support funds to Posyandu</li> <li>10. Have regular report activity</li> </ol>
	<b>POSYANDU (Integrated Health Center)</b>	
39	INITIAL STAGE	<ol style="list-style-type: none"> <li>1. Only 1 or 2 cadre active in each Posyandu session</li> <li>2. Supporting facilities not complete (either for babies or pregnant women)</li> <li>3. Less than 3 services are provided</li> <li>4. Cadre is not able to do on recording and administration</li> </ol>
77	DEVELOPMENT STAGE	<ol style="list-style-type: none"> <li>1. At least 3 or 4 cadres present during Posyandu session</li> <li>2. supporting facilities for children under five complete</li> <li>3. Posyandu able to provide 3 - 4 services</li> <li>4. Cadre able to fill in simple administration</li> </ol>
10	ADVANCE STAGE	<ol style="list-style-type: none"> <li>1. More than 4 cadres present during each Posyandu session</li> <li>2. Have complete supporting facilities for children under five and pregnant women</li> <li>3. Posyandu able to provide more than 3 services</li> <li>4. Cadre able to fill in all posyandu form</li> <li>5. Religious Leader actively motivate women to come to posyandu</li> <li>6. TBA attend posyandu session</li> <li>7. Posyandu have financial support system</li> </ol>

CURRENT STATUS (# village)	CLASSIFICATION	CRITERIA
	<b>VILLAGE SUPERVISORY TEAM (VST)</b>	
4	INITIAL STAGE	<ol style="list-style-type: none"> <li>1. Have committee</li> <li>2. VST member attend posyandu session</li> </ol>
11	DEVELOPMENT STAGE	<ol style="list-style-type: none"> <li>1. Have committee</li> <li>2. VST member provide guidance to health cadres</li> <li>3. Have routine members meeting</li> </ol>
2	ADVANCE STAGE	<ol style="list-style-type: none"> <li>1. Have committee</li> <li>2. VST member provide guidance to health cadres</li> <li>3. Have routine members meeting</li> <li>4. Have written workplan</li> <li>5. Have reporting and recording system</li> <li>6. Provide training to cadres</li> </ol>
	<b><u>SUBDISTRICT TEAM (SDT)</u></b>	
1	INITIAL STAGE	<ol style="list-style-type: none"> <li>1. Team is established</li> <li>2. Conduct training to VST</li> </ol>
2	DEVELOPMENT STAGE	<ol style="list-style-type: none"> <li>1. Team is established</li> <li>2. Conduct training to VST</li> <li>3. supervise to VST regularly</li> <li>4. Conduct meeting regularly</li> </ol>
0	ADVANCE STAGE	<ol style="list-style-type: none"> <li>1. Team is established</li> <li>2. Conduct training to VST</li> <li>3. supervise to VST regularly</li> <li>4. Conduct meeting regularly</li> <li>5. Have written workplan</li> <li>6. Have reporting and recording system</li> <li>7. Conduct technical meeting every three months</li> </ol>

VMCH PROJECT ORGANIZATIONAL CHART



KEY:

- (1) Responsible for project administrative management
- (2) Responsible for oversight of technical health activities
- (3) Responsible for the health information system
- (4) Responsible for the training of health workers
- \* Expatriate positions, all other national positions
- (P) Part-time position, all other full time positions
- (V) Volunteer, all other salaried positions

NOTE:

Project implementation includes the Project Manager and all positions below. Project evaluations include the Evaluation and Assistant Evaluation Officers.

## BUDGET CONTRIBUTION FOR VMCH PROJECT

FY	Institutions	Contribution (Rp.)	Remarks
93/94	CARE	37,234,000	Training, Cross Visit, Equipment.
	GOI	11,500,000	Service Equipment, Polindes, Building.
	COMMUNITY	31,000,000	Medicine, Equipment, Polindes, Building.
	TOTAL	79,734,000	
94/95	CARE	34,382,000	Training, Cross Visit, Equipment.
	GOI	47,754,000	Service Equipment, Polindes, Building, Income Generating Support.
	COMMUNITY	12,882,000	Medicine, Equipment, Polindes, Building.
	TOTAL	95,018,000	

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BUDGET CONTRIBUTION FOR POLINDES

Polindes	Material and equipment			Remarks
	CARE	COMMUNITY	GOI	
Lombok Barat				Total GOI contribution Rp. 26.200.000 (Bappeda Tk. I contribute Rp. 3.500.000 for made midwives and TBA's)
1. Sesait	-	-	4.000.000	
2. Rempek	-	16.000.000	4.000.000	
Lombok Tengah				CARE support training fund and a part of TBA kits
1. Darek	-	15.000.000	3.500.000	
2. Ungga	-	6.000.000	3.700.000	
3. M.Sapah	-	3.000.000	3.700.000	
Lombok Timur				
1: Suntelangu	-	3.000.000	3.800.000	
Total	-	43.000.000	22.700.000	

P O D F U N D I N G

Month/Year : September, 1994

No.	Village	Medicine and Equipment (Rp.)			Remarks
		CARE	Community	GOI	
	Subdistrict Gangga				
1	Sesait	33.000	75.000	10.000	Puskesmas con- tributed Rp.48.000 for training
2	Kayangan	-	50.000	10.000	
3	Rempek	33.000	60.000	10.000	
4	Gondang	33.000	150.000	10.000	
5	Bentek	33.000	85.000	10.000	
	Total	132.000	420.000	50.000	
	Subdistrict Praya Barat				
6	Darek	136.364	-	-	Old
7	Plambik	204.546	60.000	-	
8	Montong Sapah	627.606	115.000	-	
9	Ungga	-	-	-	
10	Kabol	272.728	75.000	-	
11	Ranggagata	136.364	88.182	-	
	Total	1.377.608	338.182	-	
	Subdistrict Pringgabaya				
12	Sapit	-	40.000	-	Dikes Tk.II contibute Rp.60.000 for training
13	Suwela	40.000	125.000	-	
14	Suntelangu	40.000	135.000	-	
15	Ketangga	20.000	80.000	-	
16	Selaparang	20.000	50.000	-	
17	Perigi	-	-	-	
	Total	120.000	440.000	-	

Note : Bappeda Tk I will provide equipment

1994 COUNTRY PROJECT PIPELINE ANALYSIS REPORT FORM A  
 CARE INDONESIA VILLAGE MATERNAL AND CHILD HEALTH

FIELD	Actual Expenditures to Date (10/1/92 to 6/30/94)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Column 1 & 2) (10/1/92 to 9/30/95)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
<b>I. PROCUREMENT</b>									
A. Supplies	13,341	5,643	18,984	22,893	6,433	29,326	36,234	12,076	48,310
B. Equipment	6,373	2,130	8,503	(6,373)	8,700	2,327	0	10,830	10,830
C. Services/Consultants									
1. Local	4,038	1,348	5,386	(1,038)	(1,348)	(2,386)	3,000	0	3,000
2. Expatriate	0	0	0	1,875	1,950	3,825	1,875	1,950	3,825
SUB-TOTAL I	23,752	9,121	32,873	17,357	15,735	33,092	41,109	24,856	65,965
<b>II. EVALUATION/SUB-TOTAL II</b>	4,415	1,540	5,955	21,324	11,631	32,955	25,739	13,171	38,910
<b>III. INDIRECT COSTS</b>									
Overhead on HQ/HO (%) 7.6% for FY93 & FY94	22,447	0	22,447	14,606	13,388	27,994	37,053	13,388	50,441
SUB-TOTAL III	22,447	0	22,447	14,606	13,388	27,994	37,053	13,388	50,441
<b>IV. OTHER PROGRAM COSTS</b>									
A. Personnel (list each position & total person months separately)									
1) Technical	106,956	43,685	150,641	83,006	19,636	102,642	189,962	63,321	253,283
2) Administrative	63,425	22,184	85,609	(5,322)	(2,817)	(8,139)	58,103	19,367	77,470
3) Support	22,645	8,959	31,604	2,196	(679)	1,517	24,841	8,280	33,121
B. Travel/Per Diem									
1) In country	24,117	9,132	33,249	17,359	4,692	22,051	41,476	13,824	55,300
2) International	326	120	446	50,910	18,158	69,068	51,236	18,278	69,514
C. Other Direct Costs (utilities, printing, rent, maintenance, etc.)	49,713	19,256	68,969	5,360	(4,189)	1,171	55,073	15,067	70,140
SUB-TOTAL IV	267,182	103,336	370,518	153,509	34,801	188,310	420,691	138,137	558,828