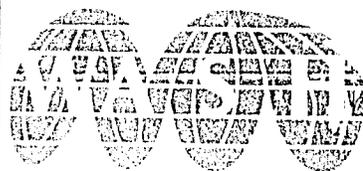


PW-AAA-745

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FOR HEALTH PROJECT



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# INTEGRATION OF HEALTH EDUCATION IN THE 'CARE' WATER AND SANITATION PROJECT IN INDONESIA

## WASH FIELD REPORT NO. 39

APRIL 1982

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International Science and  
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search Triangle Institute,  
University of North Carolina,  
at Chapel Hill.

Prepared For:  
USAID Mission to the Republic of Indonesia  
Order of Technical Direction No. 73

WATER AND SANITATION  
FOR HEALTH PROJECT



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April 15, 1982

T-73

Mr. William Fuller  
Mission Director  
USAID  
Jakarta, Indonesia

Attn: Mr. Nicholas Studzinski

Dear Mr. Fuller:

On behalf of the WASH Project I am pleased to provide you with fifteen (15) copies of a report on "Integration of Health Education in the 'CARE' Water and Sanitation Project in Indonesia". This is the final report by David Drucker and is based on his trip to Indonesia from December 28, 1981 to January 9, 1982.

This assistance is the result of a request by the Mission in October, 1981. The work was undertaken by the WASH Project on December 7, 1981 by means of Order of Technical Direction No. 73, authorized by the USAID Office of Health in Washington.

If you have any questions or comments regarding the findings or recommendations contained in this report we will be happy to discuss them.

Sincerely,

Dennis B. Warner, Ph.D., P.E.  
Director  
WASH Project

DBW:cdej

cc: Mr. Victor W.R. Wehman, Jr.  
S&T/HEA

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Technology Institute, Re-  
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University of North Carolina  
at Chapel Hill

WASH FIELD REPORT NO. 39

INDONESIA

INTEGRATION OF HEALTH EDUCATION IN THE  
'CARE' WATER AND SANITATION PROJECT IN INDONESIA

Prepared for USAID Mission to the Republic of Indonesia  
under Order of Technical Direction No. 73

Prepared by:

David Drucker

April 1982

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## SUMMARY AND CONCLUSIONS

If the public health objectives of the CARE Water and Sanitation Project in Indonesia are to be fully realized, it is essential that a "social aspects" dimension be built into the very much "hardware" oriented work of the project and include health education and community participation.

The present staff feels much under pressure to fulfill the physical objectives of the project and should be assisted in incorporating social objectives and targets into the project as a legitimate and recognized part of their work.

The social aspects need to be placed within a conceptual framework in the project and in this sense must become an integral part of project design. To assist this design process the following principles are suggested:

1. To provide a very rough guide to the scope of this work in relation to the total program, two or perhaps three percent of the total budget and the total number of man hours might be considered as the requirement for the development of the social aspects of the project. The funds and manpower allocation should appear firmly and formally in the project's annual budget and detailed work plans.
2. Consider the project from the perspective of the community.
3. See the impact on the community in terms of "the circus is coming" and consider the practical implications.
4. Consider the formation and support of community cadres with specific tasks agreed upon in detail as an essential feature of the project.
5. Consider training for specific tasks which are to be clearly defined and described in detail in work plans and timetables at the operational level.
6. Consider training programs as a cumulative process based on an as-you-go, what-have-we-got "cafeteria" style rather than a set "banquet" of courses.

In order to fulfill the above concepts in project implementation, the following steps are recommended:

1. A detailed "scenario" based on local conditions will need to be spelled out, looking at the project from the community's point of view. This scenario should include how the community will first come to hear about and consider the need for a water and sanitation system, the possibilities of securing a system, the implementation and maintenance of the system and the consideration of further development projects.
2. In full discussion with the community, decisions must be realistically made regarding what the particular community can organize and do for itself and what it cannot do that must therefore come from outside, and how community responsibilities and activities and external responsibilities and activities will be detailed.

3. As each of the tasks for field worker and community is identified, training for both can then be devised item-by-item, step-by-step in relation to motivating and teaching skills and facilitating collaboration with, and support to the community.
4. Training of field workers should initially be focused upon skills in promoting community activity through the formation of community cadres and assisting these cadres in planning and carrying through project tasks. These detailed tasks should be incorporated into a specific community work plan and realistic timetable. The community, through its cadre should be prepared to undertake formally and on a contractual basis a whole range of agreed upon tasks in exchange for the outside inputs including on-going health education campaigns.
5. Based on the identification and priority of each task requiring training, training modules (methods, materials, "how to" guides, etc.) will need to be devised and gradually developed and improved upon.
6. Training inputs will have to be organized according to the status of the above processes and the "production" demands made upon, and the potential capabilities of, each of the field workers.
7. Gradually CARE field workers and program officers will need to be replaced so as to strengthen the community development skills of such personnel and thereby improve the balance of such skills in relation to the present hardware skills.

#### Needed and Available Resources:

1. Dr. Zeke Rabkin is currently in Indonesia and is well able and well placed to make some exploratory beginnings along the lines suggested above, but between now and his departure in August, cannot be expected to fully meet the terms of reference which have been agreed upon between him and CARE. His contributions should follow the concepts discussed above and should be considered a first phase in the development of an integrated program.
2. The full initiation of the follow-up to Dr. Rabkin's initial contribution would certainly require a person with community development/health education skills in order to establish and maintain the momentum of the social components of CARE's project. In addition, such a person would need the time of a "lead officer" designated from the field staff of each of the four project areas to carry local responsibility for the development of the social aspects. It has been suggested that skilled leadership might be sought from the three different sources as follows:
  - A specially appointed CARE officer (possibly sharing his work with CARE projects in countries beyond Indonesia?).
  - A USAID officer responsible for the social components of the whole range of AID projects in Indonesia who could provide some assistance to the CARE project.

- Qualified Indonesian personnel who are, however, scattered among and committed to individual agencies and who at present are not a viable working consortium in Indonesia.

There is already a considerable amount of health education material and a number of people and agencies in Indonesia working in fields very much related to CARE's present activities. However, these resources are scattered and diffuse and therefore not easily drawn upon. CARE's program and others could be more enhanced if there were efforts to:

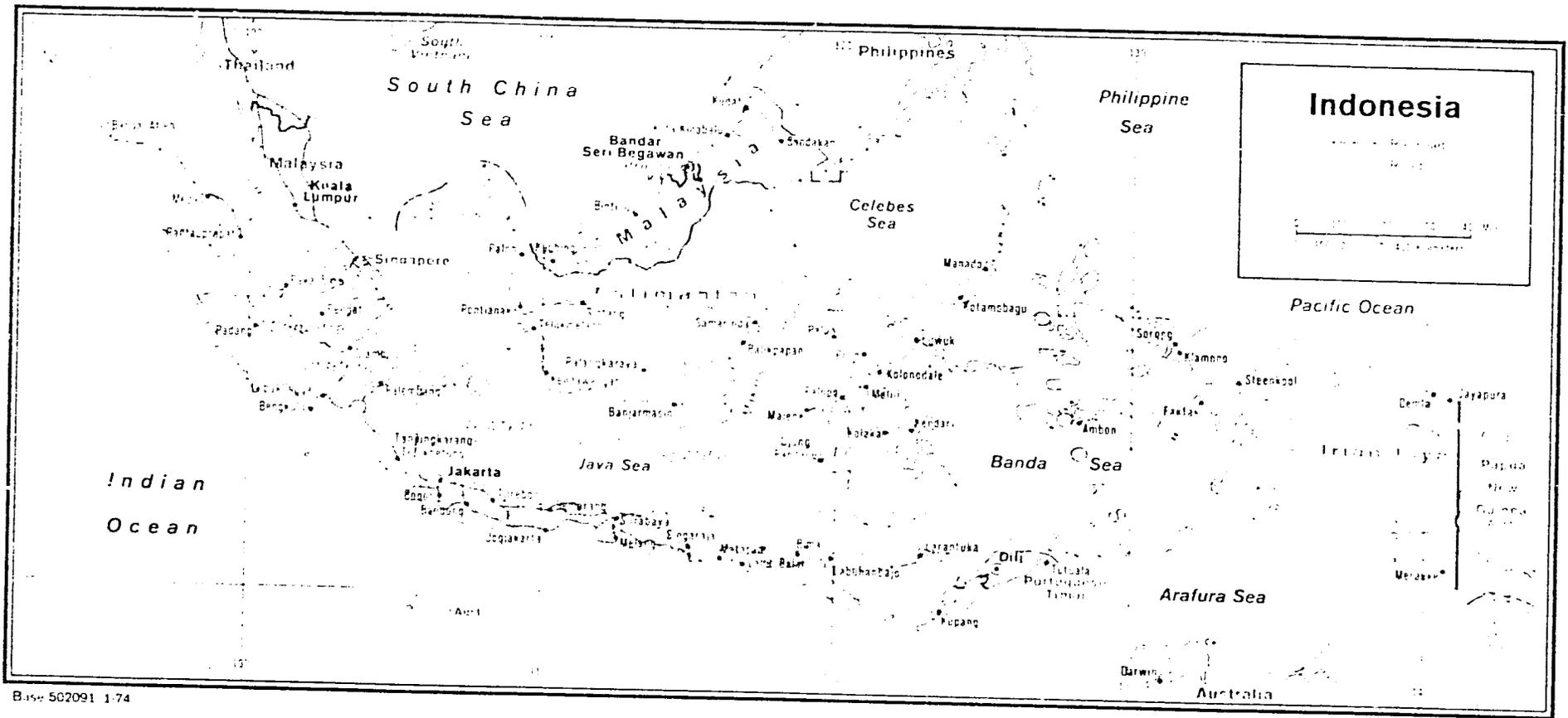
- Establish a clearinghouse of materials;
- Establish an ongoing task group (or local groups) to design and produce materials and training modules in a systematic and collaborative way; and
- Establish links at each of the CARE field areas with those working in the social aspects of community projects and set up arrangements for working together.

CARE/USAID have expressed the view that further consultant services would be of great value in assessing the progress made by Dr. Rabkin and in assisting in the integration of health education in the CARE program

## ACKNOWLEDGEMENTS

Thanks are due to the USAID staff in Jakarta. Nick Studzinski and Walter North smoothed the way around a number of stumbling blocks. They and many others in the USAID Mission showed a very keen interest in the project and contributed much to the consultant's understanding of the current conditions and possibilities in Indonesia.

Mr. Iskandar of the CARE Jakarta office also provided much needed support, background information and insight. Outstanding has been the full-time and indefatigable attention given by the Program Officers, Dana Khrisna, Maurice Alarie and Scott Faiia. The quality of Zeke Rabkin's challenging and creative non-stop exchanges were much appreciated. Mr. Harik deserves special mention for deciphering difficult handwriting and producing a beautiful draft of this report in a very limited space of time. Mr. Ellis Franklin, Director of CARE, also deserves special thanks for the encouragement he provided from first meeting to last.



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## Chapter 1

### INTRODUCTION

The objective of the CARE water systems and sanitation facilities project is to improve the public health conditions of rural villages. In common with many such programs, CARE has begun by concentrating on the "hardware" (pipes, pumps, distribution points, etc.), and the field and program staff have been assembled primarily for their skills in such activities.

Now, both at the policy level ("There should be no water/sanitation project without health education/community participation.") and pragmatically at the field level ("Are we in fact improving the public health situation if the community is not utilizing the facilities to the full and in ways which promote health?"), CARE is expressing the need for adding/integrating health education and community participation components to the project. In response to this expressed need, USAID/Jakarta through the AID Office of Health, requested the services of a consultant to assist CARE in the development of a scope of work for such activities. The request resulted in the issuing of Technical Direction No. 73 by the AID Office of Health which provided the services under the Water and Sanitation for Health (WASH) Project.

## Chapter 2

### BASIC ISSUES AND PROBLEMS IN INTRODUCING A HEALTH EDUCATION COMPONENT INTO A RURAL WATER SUPPLY AND SANITATION PROJECT

"Social aspects," "health education" and "community participation" are used somewhat interchangeably in this report because it is necessary to consider all the social dimensions of any development program and therefore the reason for the earlier suggestion to spell out the scenario. Health education is rarely successful when carried out on an occasional basis by health professionals as they have time, perhaps using visual aids. Visual aids used alone have limited effectiveness. Not much will be achieved without the community's specific and active involvement in as many stages of the development process as possible.

#### 2.1 Current Burdens on CARE Staff

One feature of the CARE project, which emerges very strongly from discussion with field staff and program officers, is the sense of very limited time and great pressure on the staff to "produce" or obtain and install the physical components of the project if the commitments made formally by CARE to the government of Indonesia are to be fulfilled.

This pressure has resulted in a tendency to see the social aspects of the program as an additional responsibility which will impede production or, alternatively, requires much increased and specialized manpower.

However interested the present staff is (and it is interested) in the social aspects of the program there is great caution in adopting anything which diverts efforts from the primary task of production. Although the quality of the hardware seems not to be neglected, quantitative matters are very important. The staff seem to be both looking over their shoulders at headquarters demands in this respect and carry within themselves a hounded sense of urgency. Agreement and targets appear to be in terms of cash and cash flow. This phenomenon tends to diminish concentration on public health impact considerations. The social and public health benefits of a water/sanitation program are fully acknowledged but "if we only had time." Health education and community participation are accepted ambivalently everywhere, and there is always anxiety about the demands that they will make in terms of unfamiliar skills and especially in terms of resources (budget and manpower). It is very rare indeed to find programs where such activities have been properly integrated into the project design and work plan from the very beginning.

#### 2.2 The Overall Conceptual Problem

A basic problem of the CARE project arises from the common concepts related to planning and training for the health education component. These concepts can be characterized as "banquet" concepts. The banquet is a course of prepared set dishes which begins, so to speak, with the aperitif and hors d'oeuvres and

continues through to completion with dessert and coffee. Banquets of this kind are highly organized and rigid, allow no choice, and require extensive prior inputs. Their natural habitat is in educational establishments. The demand for total plan packages is reinforced by the current funding and budgeting practices which do not accommodate process plans that in turn seem open-ended and not easily controlled. What is being suggested is a beginning phase for setting up CARE's health education inputs.

One must differentiate education from training. Education is imparting knowledge about things and is for some future and unspecified use and for adapting to need. Training should be training to do something specific and is for now or at least in the very immediate future. Each component of training must be seen as resulting in trainees able to perform tasks they were not able to previously or at least will demonstrate that they are able to do them much more effectively. These tasks must also be firmly embedded in their job descriptions and specifically located in their operational work plan. Too much training is unrelated to what is needed by the employing agencies.

### 2.3 Community Participation Theory and Practice: A Field Observation

One Program Officer emphasized very clearly and correctly that the projects must belong to the community--it must be their project and not CARE's or the Governments'.

During one inspection of a pump and its apron many women, children and some men stood respectfully some way off looking at the groups of inspectors. Three or four little girls were squatting down under the mouth of the pump washing clothes. Anyone coming for water would have had to push them aside. They were asked whether it was good practice to separate where one does the laundry and where one woman washed her baby's bottom, and the answer was, "yes, of course." Then how would one design a place for doing their washing? Would they prefer to squat, sit, stand, or meet at a central trough and talk to each other? "We don't really know, I'll ask the lurah (head man)." It was suggested that women be asked who were standing there. When the program officer asked, they began to laugh. It was said they are laughing because they thought it very funny. No one had ever asked them such things before. No one had ever asked them how best, from their point of view, their project ought to be! How then can it be their project?

Examples of this gap between theory and practice are very very common everywhere in the world. The women and the lurah agreed to meet and think about a possible design for washing purposes and the program officer said he would return in two weeks and see what they had come up with. A sum of perhaps \$250 was mentioned as the cost of such a facility (much less if installed). The lurah felt that such a sum might well be found within the community. (Incidentally there was a lot of rubbish around the pump. A house had been beside it and laundry hung very inconveniently all around--signs that community involvement and foresight left much to be desired.)



...a place for doing their washing. Would they prefer to squat, sit, stand...?



...they think it very funny, no one has ever  
asked them such things before.

...washing her baby's  
bottom directly  
under the faucet...



In Indonesia there is a whole range of designs for water distribution points (simple platforms, bathing "booths" sometimes combined with latrines, separate drinking water faucets, etc.). There does not seem to be a "catalogue" of designs and there is no evidence that communities are invited to comment upon the different designs, consider their merits, demerits, and appropriateness from their point of view. Nowhere do they seem to be partners contributing technical advice in the actual selection or modification of the design. (Actually the community often modifies the facility afterwards--bamboo extensions on faucets, metal tanks added, partitions, etc.)

The distribution points are at locations convenient to many villagers, and as they are being built there is much curiosity and watching the work in progress. Field staff for the most part know how to do the mechanical work. (Although the pipes were set in the wrong place in one facility where work was in progress.) However, the community or public relations and health-education work is not so familiar.

#### 2.4 Village Selection

According to some, selection of villages has been a problem for CARE.\* Selection is firmly in the hands of the provincial government and although it is impolite to say so, it is commonly the case that the provincial planning body is not very well aware of the village conditions. Frequently CARE officers find that the village does not at all meet the agreed upon criteria; or after feasibility studies are done and procurement begun it is learned that another scheme exists or is to be carried out by other bodies. Such situations take up much valuable time, energy, and scarce skills and resources.

#### 2.5 Fears Around Loss of Manpower

CARE sent some of its field officers to a 'course' in Surabaya. It is said that the value of the course was primarily in terms of the officers meeting with each other and sharing experience, but the loss of production during their absence in Surabaya has made the program officers cautious about recommending training for field officers.

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\* Although in Lombok perhaps because the operation is smaller, it is said that this is not such a problem, and Scott Faiia says he likes his field officers to visit the villages which prove to be unfeasible, because they get a feel for things and might identify other possible project inputs.

".....the community often modifies  
the facility afterwards."



Note the plastic covered tube  
which is the cup of rice col-  
lecting box for payment for water.



## Chapter 3

### POSSIBLE APPROACHES TO COMMUNITY PARTICIPATION AND HEALTH EDUCATION FOR RURAL WATER SUPPLY

#### 3.1 Two Percent Solution

One approach to integrating health education and so-called software into project design and implementation is the "two percent solution." The two percent solution (one should bargain for three percent) is a rough guide to what one should seek for the social aspects of programs which have a large hardware component. Two percent of the total budget of the program should be secured as the development costs of the social components. Two percent likewise should be seen as that share of the total manpower given exclusively for these purposes. Also, the two percent should be acknowledged as a firm budget line so that it cannot be switched. Start-up funding might be necessary but in the first fiscal year after such funding two percent should appear in the regular budget to acknowledge such activities and to assure their continuity. Two percent does not include health education materials. It is for program development only. If and when such materials are to be produced and distributed, provision for them should be made from the regular hardware procurement funds. Two percent is small enough to disarm those who are skeptical of the value of the social aspects in a program, but it should be enough to be able to demonstrate their potential. Two percent is little enough to assure that production will not be eroded unduly because of the diversion of funds.

#### 3.2 A "Cafeteria" System

What is required for CARE is not the familiar banquet or total plan and complete set of courses but what may be characterized as a "cafeteria" system. The cafeteria system is flexible and relies upon starting with whatever is available. It is also cumulative and allows for adding dishes as they become necessary and available. The wider and more varied the training components put into the cafeteria system, the more related, timely, and custom made for different situations and staff they will be. Exhaustive preparation is not required nor is a set beginning and end. So to speak one can, if it is sensible to do so, start with the dessert and go back to the soup and leave out some items altogether. Within each component of training, of course, sequence is of some importance for learning, but there is no one correct sequence for the range of components, especially in the human relations field where the talents and skills of trainees are highly individualistic.

The cafeteria approach can also be applied in managing the CARE program in relation to deployment of manpower (discussed earlier). Those field officers with skill in the social aspects of the program can be assigned to villages where the community problems are most acute and complicated and sent to reinforce the work of colleagues who are less capable in such matters. The cafeteria style allows for orchestration of both training and manpower as needed. Trainers and management, of course, must develop "diagnostic" skills in identifying need and in responding with the appropriate module for a gradually expanding range of items prepared for the cafeteria.

### 3.3 "The Circus is Coming" Approach

It might be useful to think of water and sanitation projects which have the objective of improving public health conditions and requiring much community involvement and health education inputs in the context of "The Circus is Coming!"

The circus is the excitement, activity, and sense of event and entertainment generated by the arrival of technicians and their equipment in the villages. Circuses are planned well in advance. Staff move ahead to negotiate sites and service, place notices about the circus, fix dates, open ticket booths, arrange the circus parade, clean up and repair sites, and make sure expenses (and fines) are paid and that the community will be ready for the circus to come again next time, etc.

The coming of project staff should be thought about in the same way. The actual physical work will be only one dramatic point in a continuum of work to be undertaken in villages.

Usually (and in the case of CARE) there is a kind of circus publicity but the arrival and departure is often very weak. As a matter of practicality one must start with the circus as it is now and move gradually back into the preparatory stages and little by little into the follow-through stages.

### 3.4 Health Education, Communities, and Cadres

To date CARE has conducted "one day courses" in some villages focusing on the importance of clean water supply, the importance of latrines, and the formation of cadres. The role of the cadres is "to tell others" about clean water and latrines and so spread the health messages. Cadre formation is very important, indeed, and very little improvement in health can be expected without an on-going and active presence of village based workers organized to that end. It is clear that the cadre idea needs to be much strengthened and more highly organized and supported if it is to become the foundation for development.

An example of minor improvements would be to place cadre formation at the center of village training/health education courses. Cadres should be either an existing active group within the village, or if strongly approved and supported by the village leaders, perhaps a new group especially appointed because of work capacity and interest rather than status. Women and children should be prominent in such cadres.

Initial work with the cadre should focus on village level planning. Even in the current efforts to "talk to others" (echo sessions) the emphasis should be on when exactly, how, and who will do what. The content of the "telling" is less important to begin with than organization around a specific activity. When that foundation is laid, new and more sophisticated messages can be added from the cafeteria to match the success and pace of the cadre's activity.

In the villages there were large pyramid-like concrete tanks and other flat surfaces around water facilities with nothing on them at all except date of construction by CARE and/or the Government. The big surfaces at meeting places around the water taps are ideal for health message posters, stickers, and so forth. To the extent that such posters have real impact at all, they need to be regularly replaced otherwise the viewer tends to stop seeing them. Therefore, a specific planning task for the cadre is when, how often, and who will replace the posters and where will the supply of posters come from (CARE?) and how will they be distributed. In what order (by season, by topic, etc.) should different messages be posted? Can some other activities be planned so that each poster is not isolated but is part of some village based mini-campaign etc. The activities should be planned perhaps six months to one year ahead of time. Cadres can become the powerhouse of village development in the context of the overall "scenario" and can (and should) be instrumental in the beginning phase of planning water and sanitation projects, even as early as the selection process and right through to maintenance and the initiation of new projects.

### 3.5 Village Contract

When introducing new projects (all of which in principle have community participation components) into villages, there should be attempts to negotiate a package. A package would embrace all the present contributions from the village (gravel, stones, labour, etc.) and include specific requirements for health education inputs over a considerable but detailed period of time and of course the usual maintenance (and probably reporting).

It has proved useful elsewhere (and should be also in Indonesia where ceremony is so important) for a formal contract to be signed between a village and CARE and/or the Government which commits the village to certain, mainly social, contributions in exchange for the hardware and other inputs from outside. Such an agreement is not enforceable, but it makes a symbolic and significant point and is more likely to be heeded than not.

### 3.6 Deployment of Staff and Training

It is suggested that there should be no extensive across-the-board training. Instead, in the initial stage, CARE should be selective in its deployment of staff. For the immediate future the present field staff will have to be the initiators of community development and deliverers of health education services at the village level.

Some field officers will have skills which are essentially technical with little talent for work in human relations. Others may have natural potential for work of this kind. It would be wise to assess field officers in this respect and to arrange for likely candidates to give a fair portion of their time to the development of the social aspects of projects while for the time being the least likely should continue to work much as they do now. Each project area, however, should have one field officer who is designated the lead officer for the social components, while others are



.....the big surfaces at meeting places around the water are ideal for health message posters.....



assigned fewer such activities. Work schedules inevitably will need to be appropriately adjusted to give varied proportions of each field officer's work to the new responsibilities.

It is recommended that one should think in terms of an in-service on-the-job, build-up of an exploratory but energetic kind, at least until the potential of the field officers is known.

Dr. Zeke Rabkin, who is with the University of Hawaii School of Public Health, has been working on a "questionnaire" for field officers to use as a guide for field visits. It would be a very useful item to add to the cafeteria. It needs quite a bit more work and should be simplified. The questions should be framed as conversation pieces, and each of the questions should have clear implications for problem identification and problem solving as well as for monitoring purposes.\* In time the community cadres should be able to ask the questions for themselves and share their findings and resultant monitoring with CARE.

### 3.6.1 A Specific Example

Scott Fatta, who works in Lombok, has scheduled a two-day training period for his field staff. One day is being devoted to the structure of CARE as an organization and the design of water systems, and one day is to be given to community participation and health education.

Dr. Rabkin has been asked to provide the content for and to conduct the sessions on community participation and health education. The session on the structure of CARE and the design of water systems, though necessary, cannot be considered "training" as such. It could become so if, for example, participants were to practice completing specific forms required by CARE or if some kind of "In tray-Out tray" activity was introduced during the design period.

Dr. Rabkin is very keen on learning activities rather than didactic teaching, and that is exactly what is required for training. But for the moment the question remains "training to do what?"

---

\* See for some general ideas D. Drucker "Where There is not...in Water Supply and Sanitation Projects" UNICEF/EAPRO, Bangkok 1981.

\*\* A training method in which information is placed in the participant's "in-tray" and he is requested to design an appropriate system. As one item of the information is incorporated he puts it into his "out-tray." New information and corrections to earlier information are placed in the in-tray, and the participant has to revise his work accordingly. This is practice in performing actual tasks and is, therefore, training rather than education.

It has been suggested to Dr. Rabkin and agreed upon with Scott Faiia that the Lombok training might be a hurried "sampler" for the beginning of the "cafeteria" approach. Initially, Dr. Rabkin should, with help from the designers, spell out the health implications, i.e. the need to separate drinking faucets from bathing faucets, etc. in the particular distribution designs in the Lombok area and suggest (and possibly prepare) material from which the field officers can choose during a training period. The training should include a practice session on how they will publicly explain the facility and its finer points to communities and the way in which proper use of the facilities will improve the health status of the people. In three weeks time Dr. Rabkin will not be able to produce all the possible aids (materials) needed by field officers, even for this very limited exercise, but he could outline the range of possibilities (models, posters, charts, perhaps songs, etc.), sketchily design some of these, offer some more completed items, and invite the field officers to make suggestions and develop materials on their own.\*

Scott Faiia has made the point that he will require his field officers to arrange specifically for such presentations in the field following the training, and Dr. Rabkin should then modify his input according to the results and, if appropriate, offer similar beginning sessions for the Bali, Sulawesi, and West Java personnel. Dr. Rabkin and CARE should thus have an opportunity to focus on one limited exercise and begin to demonstrate the process of identifying appropriate content, how to integrate mini-training and practice elements into the broader context of community participation/health education aspects of CARE's long range plans. It will not be asking too much of field officers and should reveal which of them has a "feel" for this kind of community focused work. As the cafeteria idea implies, little by little is the best way to proceed.

### 3.7 Preparation of Health Education Materials

It is possible, but for now very unlikely, for health education "brochures" to be produced drawing attention to the importance of village water and sanitation.\*\* The brochures could be designed around "How to access the water and sanitation system of your village" with self-survey material which might become part of a formal application for selection purposes. Looked at this way the self survey and application would be an indicator that an active group (a cadre) exists within the village which is capable of carrying out its part of a health program. Indeed some kind of track record of successful community work might be one of the important criteria for selection. Without a working group within the village, little public health impact can be expected from external inputs.

- 
- \* A mobile notice board perhaps? Two poles with a canvas stretched between, with pictures showing the completed design and its parts so the onlookers can watch what's being done and follow the steps on the notice board set up near the building site. With such illustrative materials one bright child could have drawn the attention of the workers to the fact that the pipes were set in the wrong place!!!
  - \*\* Regarding future planning with community participation, see D. Drucker "Ask a Silly Question - Get a Silly Answer, Community Participation, Entry Points, and the Demystification of Planning." Bangkok, March 1981.

## Chapter 4

### RESOURCES

On the briefest of reviews it is clear that there is within Indonesia a considerable range of skills and materials related to health education and the promotion of community development. Within the water and sanitation field alone there has been much productive effort. To widen sights just a little to include nutrition and other health related areas, reveals much more. If we include agriculture and rural development generally, the magnitude of resources becomes impressive.

#### 4.1 Indonesia Resources

Inpres (Instruksi President), Yayasan Indonesia Sejahtera, U.S.P.I. in Bandung, Yayasan Social Tani Membangun and the Government Directorate of Health Education and Directorate of Hygiene and Sanitation, just to name a few, are important agencies.

In West Java Mr. Dana Khrisna (CARE) was introduced to the Ministry of Labour and Social Welfare, School of Social Work (STKS). STKS has an extensive training program and conducts internships and field placements in rural community development projects and has over the years been involved among other things in health, water and sanitation projects. With Mr. Dradjat (adviser to the Minister) and later on during a private visit to Mr. Holil the possibility was explored (on a strictly informal basis) of placing students with CARE. The students might prove to be very helpful in developing the community participation and health education aspects of CARE's program, and CARE would be contributing much excellent experience in return.

It was left with CARE's approval that Mr. Dana would explore this possibility further to see whether in fact there would be a mutual advantage in such an arrangement and some modest beginnings developed. It certainly is a potentially strong and interesting resource.

A former colleague, now retired, lives in Bali. His name and address are:

Mr. I.S.P. Kamayana  
Jalan Laksmana 1/4  
Tanjung Bungkak  
Jalan Sanur, Denpasar, Tel 4657

For many years he was Social Development Officer at the United Nations Economic and Social Commission for the Asia and Pacific region. He might be a useful person for the development of CARE's Bali project. He is Balinese and a former Chief of the Social Welfare Department. His contacts and background might be of some value. Mr. Maurice Alarie might contact him informally and introduce CARE and its project and explore with Mr. Kamayana the possibility of his helping Dr. Rabkin and CARE.

## 4.2 External Resources

USAID supports a number of projects. UNICEF is very active as is WHO and Save the Children Foundation.

### 4.2.1 UNICEF

It was discovered only after the consultant's return from Lombok that there had been a UNICEF sponsored Water and Sanitation Project Support Communications Workshop in Lombok in October 1980 in which, among other things, "visual materials mainly pertaining to the problems of rural water supply in Lombok were developed and tested" and "these visual materials, consisting of a flip-chart, charts and posters were further revised and pre-tested and are now being printed for distribution in early 1982."

Handbooks on maintenance of handpumps are being printed also, and a "Training of Trainers" workshop has been held. A workshop on overall communications strategy for water and sanitation was being planned by UNICEF and the Directorate of Hygiene and Sanitation to be held March 8 to 13, 1982.

"The intention of such a workshop is to ensure that Program Support Communication activities are systematically integrated into the overall programme and implemented as a well thought out and well planned package rather than as an afterthought or on an ad hoc basis. In this way it is hoped that the intended beneficiaries are better prepared and consulted and become participants in the program and so become more responsive to changes and the introduction of any new technology."\*

### 4.2.2 Japanese Organization for International Cooperation in Family Planning

The Japanese Organization for International Co-operation in Family Planning Inc. (JOICFP) (Hoken Kaikan Bekkan 1-1, Sadohara-Cho, Ichigava Shinjuku-ku Tokyo) has done interesting community work in such areas here in Indonesia. CARE might wish to contact JOICFP which has developed health education materials for the South Asia region and West Sumatra and has produced a series of films one of which was made in Indonesia.

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\* Alas, also after his return the consultant discovered that Mr. Gufran Mahamad (Coordinator of Hygiene and Sanitation) from Mataram had attended a country workshop on planning water supply in Bangkok which the consultant conducted early in 1981. Mr. Gufran and those who attended the Lombok workshop might prove a useful resource for CARE's Lombok area project.

## Chapter 5

### PHASE I AND LONG RANGE PLANNING

#### 5.1 Phase I

CARE will of course, need someone to promote this new aspect of its program. The person and the back-up resources will take sometime to find and mobilize. In the meantime CARE has obtained the services of Dr. Zeke Rabkin. Dr. Rabkin is highly committed and eager to contribute to the CARE program. Formal terms of reference have been drawn up in which Dr. Rabkin is expected to: a) develop an overall plan, b) produce appropriate health education materials, and c) implement the plan and test the materials in training sessions.

Dr. Rabkin has some facility with the Indonesian language, understands public health matters, and is enthusiastic, innovative, and quick to learn. He is also on the spot. Any new staff is likely to take eight months or a year to place in position. Dr. Rabkin should be seen as a resource for exploring and initiating a first-phase of CARE's social aspects effort. CARE's formal job-description is perhaps too ambitious given the time at Dr. Rabkin's disposal and the complexity of the task. For instance, it requires at least a year for the development of a poster, its testing, modification, production and distribution. Dr. Rabkin can make a valuable start but CARE must begin now to think about a second phase which will pick up and build upon his work.

Dr. Rabkin who will be available until August 1982, is currently debating whether or not to work out a broad overview (including a complete framework for a CARE health education project), and to respond thereby to the demand for some immediate training of field officers. He feels that if he gets involved too soon in producing materials and training, he and CARE will lose sight of the proper direction and objectives. There were long discussions regarding this dilemma which included Scott Faia, and specific agreed-upon recommendations have been made and generally agreed upon.

#### 5.2 The Scenario and Long-Range Planning

The "scenario" should evolve from the village's perspective--from the first hearing about the possibility and establishing the need for new water and sanitation facilities right through to the on-going maintenance of the systems and even into the utilization of the new skills and organizational ability acquired by the community for further development projects.\* What realistically only technical expertise can provide should be separated from what it is possible (with some help) for the community to do for itself.

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\* See "Social Aspects of Water Supply - A Guide to Planning Community Participation" D. Drucker UNICEF NY, October 1980

Such an exercise should provide the framework, timing, and different inputs, within which the project should ideally operate. However, nowhere has this been done correctly until now and a great deal of work needs to be done before it is.\*

There will certainly be a need for professional leadership to follow up the first-phase work of Dr. Rabkin's and to permanently establish the new program, expand it, and integrate new skills into it. Three kinds of options are suggested:

#### 5.2.1 An Exclusively CARE Located Service

It has been said that CARE has done a very good job in the water supply and sanitation field and has acted as a model and inspiration for other projects and organizations. It is argued that CARE might lead the way also in the social aspects of such programs and play a valuable role in community participation/health education developments elsewhere.

To do this CARE would need to plan for a specialized staff member to spearhead the new emphasis. This person would need back-up resources (consultation, special skills, etc.) and he/she would need to promote a considerable shift in the composition of CARE field staff and their ability to utilize community development and health education skills.

There is some fear regarding bringing in an outsider for a year or two who would perhaps have no real understanding of or sympathy with Indonesian conditions. However, a suitable candidate probably could be found given adequate support and briefing. He/she would then gradually develop and eventually take charge of CARE's program.

This option assumes CARE's continuing and expanding presence in Indonesia, and even with such a presence an alternative would be to consider a CARE regional staff person serving a number of countries. In that case, the specialist would set up the activity, monitor it, and continually return to appraise, stimulate, and set new targets and to support local staff.

#### 5.2.2 A USAID Located Service

As has been repeatedly stated, the need for social/community participation/health education aspects are common to a whole range of projects and programs extending well beyond CARE projects and indeed beyond water and sanitation. In Indonesia this is certainly the case and the state of the art is still very embryonic. This perspective also suggests an alternative to a CARE do-it-themselves and contribute-to-others option.

USAID which has been an initiating and active partner in the present consultation, supports financially and technically a very large range of projects. USAID personnel have opened discussion with this consultant over a wide range of

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\* See "Towards a Programmers Guide" UNICEF-EAPRO Thailand Regional Water and Sanitation Workshop 12-20 Jan 1981.

health projects, but there are strong indications that the social aspects need to be promoted well beyond health to other development programs (e.g., agriculture, rural electrification, etc.). The magnitude of the projects would provide for a substantial professional input based on the "two percent" principle discussed earlier. One option, therefore, might be for USAID to consider developing its own capability and resources to support a number of projects including specifically the CARE project.

### 5.2.3 A Consortium of Existing Expertise

In Indonesia as already indicated, there are a number of skilled personnel currently active in the community participation aspects of development. Their efforts, however, are scattered, fragmented, and uncoordinated, and they are clearly unable to bring their potential capabilities to bear in a systematic way.

Some pooling and coordinating of tasks and effort is obviously required and would yield much of value. It would make sense, but is also fraught with many obvious problems, to form some kind of consortium of the many personnel involved in kindred work and projects. However, given the poor track record of effective and detailed collaboration it seems doubtful that this latent but potentially strong pool of resources could contribute anything of value to the CARE project without much difficulty. Certainly efforts should be made along the above lines and the feasibility of consortium formation explored. CARE could certainly derive much from and contribute to the overall development efforts if such a consortium could become truly functional. However, it does not seem to be a full fledged option at the present time, and the best that can be expected is to draw occasional back-up resources from the existing pool to supplement one of the other activities as the opportunity arises.

The options discussed above are in very general terms and require decisions based on planning, administrative, and budgeting considerations well beyond the terms of reference of the present consultation. Decisions will need to be made. Much detailed professional work remains.

### 5.3 Need for a Clearinghouse

Impressive as the full list of resources undoubtedly is, it is also impressive that much effort goes on unknown to those working in the same and allied fields and sometimes unknown to those working in different sections of the same agency! UNICEF did have monthly meetings (to which CARE was invited) on water and sanitation but they were discontinued a year ago and "were mainly on technology." Mr. Mesbahuddin Akhter, Programme Co-ordinator for UNICEF, says he intends to reinstate the meetings and focus much more on the social aspects.

Clearly there needs to be some clearinghouse arrangement for all health education materials. The representative of the World Food Programme had not seen the nutrition materials produced by the Directorate of Health Education and asked how one got to know what was available. Under what auspices such a collection would be solicited and housed needs to be decided and supported and a

circular needs to be distributed with information about new acquisitions. Mr. Victor Soler-Sola, UNICEF representative, said that his agency could possibly provide such a resource. Someone needs to take the lead and someone needs to be given the specific responsibility. Ms. Jae Hee Kim of UNICEF says she will see that this issue is placed on the agenda for the March workshop (referred to above) and she will also see if CARE can be invited.

#### 5.4 Task Groups

Beyond the value of having a centrally located range of materials, it might be possible to set up a series of "task groups" in different parts of the country. Those community workers, health educators, graphic artists, etc. who are recognized by their peers as being the best in their respective fields should come together perhaps two or three days a month as a working professional group of perhaps 12 to 15 members to produce and develop specific materials which are placed high on a list of priorities. These workshops (with the accent on the "work" in the original sense of manufacturing things) perhaps should be held under some neutral auspices, and the members should be seconded as professionals in their own right for the two/three days rather than as representatives of their particular agencies. There have been positive responses to this kind of organizational structure but also, of course, there have been the familiar reasons offered for why it would be difficult to get an on-going self-sustaining commitment to such an arrangement. Once again who might spearhead such an effort?

#### 5.5 Conclusion

The CARE Water and Sanitation Project in Indonesia has the potential to be very effective if it includes community participation and health education activities as well as user perceptions of need and convenience in the planning and the implementation of such programs. If communities, planners and technicians work together in the installation, operation and maintenance of such facilities, it is far more likely that they will be properly used and maintained than if the recipients are left out of the process.

In order to achieve these ends, the current approach will have to be modified to include a small budget for the community oriented activities, and selected members of the field staff will have to be trained in the development of local cadres to promote water and sanitation projects and to generate support for their installation, proper use and maintenance. A rational approach would be the training of selected staff as trainers of others, so as to institute a self-perpetuating training mechanism. Similar strategies for materials production and for the design and sustenance of the system for delivering health education supports to community participation need to be instituted.

APPENDIX A

WATER AND SANITATION FOR HEALTH (WASH) PROJECT  
ORDER OF TECHNICAL DIRECTION (OTD) NUMBER 73

December 7, 1981

TO: Dr. Dennis Warner, Ph.D., P.E.  
WASH Contract Project Director

FROM: Victor W.R. Wehman, Jr., P.E., R.S. *JWW*  
S&T/HEA/CWSS  
AID WASH Project Manager

SUBJECT: Provision of Technical Assistance Under WASH Project Scope of Work  
for USAID/Indonesia (Jakarta) and C.A.R.E.

REFS: A) Memo Keller/Wehman, 2 Dec 81  
B) JAKARTA 18010, 1 Dec 81  
C) Memo Isely/Wehman on C-180, 30 Nov 81  
D) WASH Telex 137, 25 Nov 81  
E) Chaing Mai Thailand Meeting (Keller, McJunkin, Isely,  
Studzinski, Calder), 10 Nov 81  
F) STATE 291566, 31 Oct 81  
G) Memo Keller/Wehman, 22 Oct 81  
H) JAKARTA 16020, 21 Oct 81

1. WASH contractor requested to provide technical assistance to USAID/Indonesia and C.A.R.E. as per Ref. B and para. 2 of REF. C. This consultancy is assessment and scope of work development in nature and should not be construed as detailed materials development, health education plan design, testing of materials or preparation of an evaluation or final report as described in initial C.A.R.E./USAID scope of work in Ref. H., para. A. (1-4).
2. WASH contractor/Subcontractor/consultants authorized to expend up to 15 person days of effort over a 2 month period to accomplish this technical assistance effort.
3. Contractor to coordinate with ASIA/TR/HNP (H. Keller), AID/ASIA desk officer for Indonesia, and mission. Contractor should provide copies of this OTD to Mr. Keller, desk officer, USAID/HPN officer (Calder) by telex and consultant by telex.
4. Contractor should ensure that consultant is provided for 10 day TDY beginning in late Dec. 81. Contractor will ensure that consultant is well qualified to accomplish this task.
5. Contractor authorized to provide one (1) international round trip from consultant's home base to Jakarta, Indonesia and return to home base.
6. Contractor to detailedly brief and debrief consultant by some means before and after mission.

7. Consultant to leave a final report with mission before leaving USAID/Jakarta. Contractor to request USAID/health officer to send final report by Air Pouch or with personnel going back on TDY to Washington, D.C. to WASH Project Coordination and Information Center, 1611 N. Kent Street, Arlington Virginia or to ST/HEA (Wehman).
8. Contractor authorized to obtain secretarial or reproduction services in Indonesia if necessary. Request USAID/Jakarta provide secretarial and reproduction services if at all possible. These services are in addition to level of effort identified in para. 2 and are NTE \$800 if necessary to obtain on commercial market.
9. Contractor authorized to provide for car rental, train tickets, taxis or miscellaneous transportation within Indonesia. Mission or C.A.R.E. is encouraged to provide local support transportation.
10. Up to 2 round trips within Indonesia (air trips) from Jakarta to point of destination and return are authorized if necessary.
11. Consultant should call WASH CIC to provide detailed progress report at end of 6th day of consultancy in Indonesia and after final report is finished (typed).
12. WASH contractor definitely should be prepared to administratively and/or technically backstop field consultant as necessary.
13. Mission, C.A.R.E, and consultant should be contacted immediately and technical assistance initiated before the end of Dec 81.
14. Appreciate your prompt attention to this matter. Good luck.

VWW:ja

*Memorandum*

TO : Mr. Victor Wehman, S&amp;T/NEA

DATE: December 2, 1981

FROM : Howard B. Keller, Asia/TR/HPN  
*Heller*

SUBJECT: Request for Wash Services, Jakarta 18010

Attached is a copy of Jakarta telegram # 18010 in which the Mission requests the services of a consultant under the WASH project for 5 to 10 days to assist CARE- Indonesia in refining the scope of work for a Water Supply project.

This request is well within the scope of technical assistance to be furnished by WASH. The Mission suggests that Mr. David Drucker who is presently in Thailand for WASH is suitable for the job. Using the services of Mr. Drucker will greatly reduce the cost of this T/A since transportation costs will be limited to Thailand-Indonesia- Thailand.



5010-109

*Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan*

UNCLASSIFIED

ACTION AID-35

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ACTION OFFICE ( TR-01  
INFO ASEM-01 ( .SOP-02 FVA-02 ASPD-03 PVA RELO-01 MAST-01  
ASSP-02 /015 A3 81  
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INFO OCT-00 AMAD-01 /038 W

-----242613 011248Z /38

R 010751Z DEC 81  
FM AMEMBASSY JAKARTA  
TO SECSTATE WASHDC 8506

UNCLAS JAKARTA 18010

AIDAC

FOR HOWARD KELLER, ASIA/TR

EO 12065: N/A

SUBJECT: CARE REQUEST FOR WASH SERVICES

REF: (A) JAKARTA 18020; (B) STATE 291568

MISSION HEALTH NUTRITION OFFICE ADVISES THAT PER REFTTEL B WASH INDICATED IN CHIANG MAI THEY ARE ABLE TO PROVIDE A SHORT TERM CONSULTANT FOR 13-18 DAYS TO REFINE CARE SCOPE OF WORK. CARE AND MISSION WELCOME THIS ASSISTANCE. THIS CONSULTANT SHOULD BE PREPARED TO ASSESS LOCAL RESOURCES AVAILABLE FOR TRAINING OF CARE STAFF AND MATERIALS DEVELOPMENT. MISSION BELIEVES CARE HAS RECENTLY PROCURED SERVICES OF A RESOURCE PERSON WITH AN MPH WHO MAY ASSIST WASH CONSULTANT. EARLY SCHEDULING OF THIS VISIT WOULD BE DESIRABLE. WE UNDERSTAND DAVID DRUCKER FROM BANGKOK IS AVAILABLE. MISSION WELCOMES HIS PARTICIPATION. HE WILL WORK FROM SCOPE OF WORK ALREADY SUBMITTED BY CARE PER REFTTEL A IN SO FAR AS IS POSSIBLE DURING VERY BRIEF VISIT.  
MONJO

UNCLASSIFIED



November 30, 1981

C-180

MEMORANDUM

TO: Victor W. Wehman, Jr  
FROM: R. B. Selye *W. Wehman* *12/1/81*  
RE.: Results of discussions of recent request from USAID Djakarta (see attached Ref. Tel.)

On November 10, 1981, Gene McJunkin, Howard Keller, and myself held conversations with Dave Calder and Nick Studzinski of the Indonesia Mission concerning the recent request from that Mission for WASH assistance in promoting the integration of health education into a USAID funded CARE water and sanitation project. It was agreed that the scope of work in the cab'ed request surpasses generally accepted WASH guidelines and fails to take into account possible local resources for implementing the desired integration of health education into the CARE program.

As an alternative I suggested that David Drucker, an experienced sociologist/health educator, now based in Bangkok, might be available for a 7-10 day trip to Djakarta to sit down with Mission and CARE people in order to assess the needs of the above mentioned integration, possible local resources to be applied in implementing, and any missing resources to be later obtained from WASH. I asked Nick Studzinski to prepare a detailed scope of work for the 10 days after talking with CARE representatives, and to specify what materials and other preparation if any the consultant should bring with him.

I have subsequently determined that Mr. Drucker is available from late December through mid-January and have communicated his availability to Nick Studzinski in order to stimulate him to send a detailed scope of work. Dave Calder had specified that the visit must be before January 31, in order to avoid conflict with upcoming national elections.

*What is the scope of work?*  
*WWS 12/1/81*



November 30, 1981  
page 2  
V. Wehman

Although the details from the Mission might help to clarify a few points, it is my impression that we have enough information to move ahead with an OTD. For any further help from me just let me know.

.RBI:cdej

V. Wehman

WUI GA  
1112\*  
WASHINGTON 64552

TELETYPE 015 1436 11/25

FR

USAID MISSION  
DJAKARTA, INDONESIA

ATTN: NICHOLAS STUZEWSKI

FROM: R. ISELY, WASH PROJECT

OUR CABLE 137

RE PROPOSED 10 DAY VISIT TO ASSESS CARE NEEDS AND RESOURCES WITH RESPECT TO INTEGRATION OF HEALTH EDUCATION IN WATER SUPPLY AND SANITATION.

DAVID DRUCKER, BANGKOK-BASED, SPECIALIST IN HEALTH EDUCATION AND COMMUNITY ORGANIZATION IS AVAILABLE FROM LATE DECEMBER THROUGH EARLY JANUARY. PLEASE CONTACT ME THROUGH H. KELLER WITH DEFINITIVE SCOPE OF WORK ASAP.

THANK YOU.

NNNN\*  
ACCEPTED TNC967 BEING PROCESSED

WESTERN INTERNATIONAL  
A  
Western Union International, Inc.  
E

Department of State

TELEGRAM

PAGE 01  
ORIGIN AID-35

291566

9757 018189 AID7394

ORIGIN OFFICE ASTR-01  
INFO ASEM-01 ASPD-03 AAST-01 STHE-01 RELO-01 ASSP-02 3V-00  
/010 AD

INFO OCT-00 /035 R

DRAFTED BY AID/ASIA/TR/HPN: H KELLER: PAC  
APPROVED BY AID/ASIA/TR/HPN: G CURLIN  
AID/ST/HEA: J AUSTIN (INFO)  
AID/ASIA/ISPA: (INFO)  
WASH: (INFO)

*Austin JAC*  
*Jury*  
*McJunkin*

R 311330Z OCT 81  
FM SECSTATE WASHDC  
TO AMEMBASSY JAKARTA

-----75606 312348Z /38

UNCLAS STATE 291566

AIDAC

E. O. 12065: N/A  
TAGS:

SUBJECT: CARE REQUEST FOR WASH SERVICES

REF: JAKARTA 16020

1. HAVE DISCUSSED MISSION REQUEST CONTAINED REFTEL WITH AUSTIN AND WEHMAN. ST HEA. SUGGEST THAT KELLER, MCJUNKIN AND ISELY (WASH) MEET WITH AID/JAKARTA DURING CHIANG MAI WORKSHOP TO DISCUSS WASH POTENTIAL INVOLVEMENT.
2. PLEASE BRING ADDITIONAL INFORMATION OF LOCAL CAPABILITIES (GOI) TO ASSIST WITH PROJECT.
3. TOTAL TIME REQUESTED OF WASH IS IN EXCESS OF WHAT CAN BE CONSIDERED AS SHORT TERM CONSULTING SUPPORT. WASH RESOURCES ARE LIMITED. WE CAN CONTEMPLATE WASH CONSULTANT ASSISTING RETURNED UNIVERSITY OF HAWAII PARTICIPANTS WITH DESIGN AND SETTING UP EFFORT, NOT IN PREPARATION OF MATERIALS, FIELD TESTING OR OTHER EXTENSIVE OPERATIONS. HAIG

*TS vww*

*Vic -*

*Rayley and I discussed this in Cheng Mai with David Calder, A w/Johnston,*

UNCLASSIFIED

UNITED STATES GOVERNMENT

# Memorandum

TO : S&T/HEA, Mr. Victor Wehman

FROM : ASIA/TR/HPN, Howard B. Keller

DATE: OCTOBER 22, 1981

SUBJECT: Jakarta Request for WASH Assistance to CARE  
for Integration of Health Education into  
Ongoing Water Projects

A copy of Jakarta 16020 Telegram is attached. In this telegram the Mission asks for WASH assistance to CARE in helping them to design and integrate a health education component into ongoing water projects currently funded by Mission Special Support grants.

ASIA/TR is pleased to receive and pass on this request for WASH assistance. We are all aware of the fact that Health Education is an essential component of successful water supply and sanitation projects. We would like to meet with you and representatives of WASH as soon as possible to discuss the best way to assist the Mission, and to discuss "the best way to structure assistance; bearing in mind that WASH assistance should be limited to short term consulting assistance rather than long term assignments.

This seems to be an excellent opportunity to build Health Education into projects which may lack it and also to work with VOLAG like care.

Attachment: a/s

PAGE 01  
ACTION AID-35

JAKART 16020

5172 009771 A102465

JAKART 16020 2106372

5172 009771

ACTION OFFICE ASTP-01  
INFO ASEII-01 ASDP-02 FVA-02 ASPD-03 AAST-01 STNF-01 PVC-02  
RELO-01 HAST-01 ASCP-02 /017 A4 821

INFO OCT-02 EA-12 /B49 W

-----113153 2105432 /22

R 210627Z OCT 81  
FM AMEMBASSY JAKARTA  
TO SECSTATE WASHDC 7692

UNCLAS JAKARTA 16020

AIDAC

FOR HOWARD KELIER, ASIA/TR

EO 12055: 11/A

SUBJECT: CARE REQUEST FOR WASH SERVICES

MISSION HAS RECEIVED AND ENDORSES CARE REQUEST TO USE WASH SERVICES TO DESIGN AND INTEGRATE A HEALTH EDUCATION PROGRAM INTO ONGOING WATER PROJECTS CURRENTLY FUNDED BY MISSION SPECIAL SUPPORT GRANTS. CARE HAS PROVIDED A DRAFT SCOPE OF WORK. MISSION REALIZES THAT TIME FRAME AND EXPECTED OUTPUTS MAY BE AMBITIOUS. MISSION WOULD APPRECIATE AID/W ADVICE ON BEST WAY TO STRUCTURE ASSISTANCE. CARE DRAFT SCOPE OF WORK FOLLOWS:

A. SCOPE OF WORK:

1. ASSIST IN DESIGNING A DETAILED HEALTH EDUCATION PROGRAM INTEGRATED WITH OUR ONGOING AND PLANNED WATER PROJECTS.
2. PREPARE THE MATERIALS SUCH AS PAMPHLETS, BOOKLETS, POSTERS, TRAINING MANUALS ETC. FOR THE PROPOSED PROGRAM.
3. TEST THE MATERIALS AND PROPOSED PROGRAM IN EACH PROVINCE WITH A TRAINING SESSION FOR THE CARE FIELD OFFICERS.
4. PREPARE AN EVALUATION AND FINAL REPORT WITH RECOMMENDATIONS FOR FOLLOW UP.

B. TIME FRAME:

1. THE DESIGN OF THE PROGRAM WOULD REQUIRE A PERIOD OF FAMILIARIZATION IN JAKARTA AND FIELD TRIPS TO THE FOUR CARE FIELD OFFICES FOR SITE VISITS, DISCUSSIONS WITH PROVINCIAL OFFICIALS AND CARE PERSONNEL; A TOTAL OF 3 TO 10 WEEKS WOULD BE NECESSARY.
2. THE PREPARATION OF THE MATERIALS FOLLOWING PROGRAM DESIGN WOULD TAKE 6 TO 8 WEEKS.
3. TESTING OF MATERIALS IN THE VILLAGE AND TRAINING OF CARE FIELD OFFICERS WOULD REQUIRE AT LEAST ONE WEEK IN EACH FIELD OFFICE OR A TOTAL OF 4 TO 6 WEEKS.
4. THE FINAL REPORT AND EVALUATION SHOULD BE COMPLETED AND DISCUSSED BEFORE THE PERSON LEAVES INDONESIA AND WOULD REQUIRE ABOUT 2 WEEKS.
5. AT LEAST TWO WEEKS SHOULD BE ALLOWED FOR MAKING UP ANY POSSIBLE DELAYS.

C. JOB QUALIFICATIONS:

1. KNOWLEDGE OF PUBLIC HEALTH PRACTICES AND EPIDEMIOLOGY TO ENSURE THAT ALL RELEVANT FACTORS ARE TAKEN INTO CONSIDERATION.
2. PREVIOUS EXPERIENCE IN HEALTH EDUCATION.
3. PREVIOUS WORK EXPERIENCE IN A DEVELOPING COUNTRY, PREFERABLY WITHIN SOUTHEAST ASIA.
4. FAMILIARITY WITH ISLAMIC CULTURES AND CUSTOMS.
5. WILLING TO TRAVEL EXTENSIVELY.
6. ABILITY TO PREPARE TRAINING MATERIALS IN BAHASA INDONESIA.

PLEASE PASS TO WASH. MASTERS

WOW!!!

Received ST/HA (Wehman) 10/22/81

Passed to WASH ✓ WEHMAN 10/22/81

Passed to Dr. Austin for his direction 10/22/81

V/W/W

WORLDWIDE COMMUNICATIONS, Inc.  
WORLDWIDE COMMUNICATIONS

OCT 22 1981

UNCLASSIFIED

APPENDIX B

Itinerary

29 December 1981	Bangkok - Singapore
31 December 1981	Singapore - Jakarta
1 January 1982	Singapore - Bandung
2 January 1982	Field Visits in West Java
4 January 1982	Bandung - Jakarta
5 January 1982	Jakarta - Bali
8 January 1982	Bali - Lombok
10 January 1982	Lombok - Bali
11 January 1982	Bali - Jakarta
22 January 1982	Jakarta - Bangkok

APPENDIX C

Officials Visited

Dr. Yetti Herawati  
Museum Negeri Jawa Barat  
Jl. Otto Iskandardinata 638  
Bandung

Achmad Kartiwa  
Jawatan Topografi

Ibu Molly  
BAPPEDA  
Nagrak desa

Peter Hornby  
Health, Training, Research  
and Development  
KOBA/MSH

Mr. Agung Wuydood  
and Assistants  
Department of Social Affairs

Mr. Dradjat Dradjat  
Advisor to Minister of  
Labor and Social Welfare

Dr. Ida Bagus Mantra  
Health Education Directorate

Scott Faiia  
Lombok

Jl. Guning Sahari 90  
Jakarta Pusat

Dr. Wachjoe Soerawidjaja  
M.P.H.  
Province Public Health Officer

USAID - Jakarta

Dr. David Calder

Mr. Michael Philly

Ms. Rebecca Cohn

Dr. Sobekti

Mr. Connor

Mr. Studzinski

Mr. R.C. Coggins

Ms. Molly Gingerich

Dr. E. Voulgoropoulos

Michael Morfitt

Mr. Walter North

Jakarta

Dr. Soedarso, Chief  
Jakarta Health Service

UNICEF

Mr. Misbahuddin Akhter  
Dr. Sukker Aslam  
Alan Court  
Cynthia DeWint  
Jae Hee Kim  
Mallica Ratne  
Victor Soler-Sola (Rep.)  
Nancy Terreri  
University of Hawaii  
Dr. Peter  
WHO Representative  
Dr. El Zawary  
Museum Nasional  
Jl. Merdeka Barat 12  
Jakarta Pusat  
Ii Suchriah Satadinata  
Dra. Suwati Kartiwa

CARE

Maurice Alarie Bali	Mr. Dana Khrisna Bandung
Bob Chaples Sulawesi	Dr. Harlina Mortono Office Jakarta
Mr. Ellis Franklin Jakarta	Mr. Nengah Jakarta
Nurul Fazrie Bandung	Dr. Z. Rabkin University of Hawaii
Dr. Soeharto Heerdjan Jakarta	Mr. Rachmad Jakarta
Mr. Iskandar Jakarta	Save the Children Foundation Martin Poland
	Dr. R. Poland