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**MID-TERM EVALUATION
OF
THE HEALTHY START FOR CHILD SURVIVAL PROJECT
IN NUSA TENGGARA BARAT PROVINCE, INDONESIA**

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EXECUTIVE SUMMARY

MID-TERM EVALUATION OF THE HEALTHY START FOR CHILD SURVIVAL PROJECT IN NUSA TENGGARA BARAT PROVINCE, INDONESIA

The USAID-funded Healthy Start for Child Survival (HSCS) project is located in the urban Mataram area of Lombok island and three districts in Sumbawa island (Sumbawa, Dompu, and Bima) covering a total of 48 villages in Nusa Tenggara Barat Province (NTB). The project started in October 1994 with preparatory meetings with local officials, KAP studies at project sites, and training for related working teams; however, due to a 14 month delay in project approval, field activities were not begun until April 1996.

The mid-term evaluation was carried out to observe the activities conducted by the project, to assess its achievements, to identify problems and constraints faced at the halfway point in the project, and to suggest alternatives for improvement of the project. The results of the evaluation will be used as input for further planning to increase the activities and quality of the second half of the project. The data was collected using various techniques including reviewing and analyzing reports; in-depth interviews with the project teams at all administrative levels; interviews with implementers (midwives, pustu staff, TBAs, cadres, hamlet heads); visits to the health centers, villages, pustu, hamlets; and observations of the birth-centered interventions.

The health interventions conducted by the project are not new; the uniqueness of HSCS is in integrating existing health services for mothers and the newborns through a neonatal home visit. To conduct this, a hamlet level system for reporting and recording of all births and deaths was developed, involving the hamlet chiefs, health staff, and community health volunteers.

The evaluation found that the project in general was carried out according to plan. Though running for less than one year, the project has shown benefits in many aspects. It has affected the performance of community midwives. They stated that they are now more confident in performing their job and are closer to the community. The project has encouraged them to become proactive; they are more involved in the activities at the health post, and visit mothers at home instead of waiting for them to come to health posts. By having an organized and workable reporting system at the hamlet level, health services at the village level are now more predictable. This results in better planning of supplies needed (vaccine, micronutrients, syringes and needles, forms). The project has brought integration among MCH, Immunization, and Nutrition vertical programs. The project also carried out several innovative activities such as the identification and follow

up of low birthweight babies and a system to track causes of death through the use of a verbal autopsy system.

The project is scheduled to finish in September 1997. The issue of sustainability of the project has been discussed at all administrative levels. Indicators of success have to be developed to assess the project's achievements at both urban Mataram and Sumbawa island. The district health office should develop budget plans for sustainability which should be included in the provincial health budget (APBN) or the district budget (APBD). Therefore, the district health office should always maintain and improve good relationships with the district head (Bupati). The timing for budget plan submission to APBN or APBD is crucial. Besides working with government, the project should be encouraged to work more closely with NGOs.

Hamlet and Subdistrict Level

The evaluation team found that there is a need for a monthly meeting at the hamlets to encourage and motivate hamlet heads to be more involved in the reporting system, and also to motivate the TBAs, cadres, and community midwives in better team work. Since the project activities are specific, a monthly meeting at the health center to discuss the activities of the HSCS project is also considered an important need by many health center heads.

The pustu staff and/or the midwives mentioned occasional shortages of vaccines or micronutrients during their work, which could delay the opportunity to visit mothers and the newborns within 0-7 days postpartum. The evaluation team found that there should be better communication, regular checking, and better planning of supplies at all levels. Technical problems in filling out the forms still exist; therefore, routine supervision from health center to the hamlets is still needed.

District Level

Supervision is another important issue. The supervision from the provincial level and from the district level is still weak. One reason is lack of personnel and busy schedules of the district health staff. However, supervisory visits from the district health office to the subdistrict level is important, especially to fill in the gaps of the provincial visits.

The evaluation team also recommends the development of a standardized HSCS data analysis at the district level. This is in response to the various data analysis methods found at the district and provincial level, which resulted in inconsistencies in results. Each district health office has a computer and should be able to conduct a standardized analysis on the surveillance data.

Some of the villages are far away and need cold chains (refrigerators)

Provincial Level

A letter has been issued by the Directorate of Nutrition, MOH, to stop intake of high dose vitamin A to infants due to the possibility of development of bulging fontanel. The evaluation team suggests a study on the effect of vitamin A in project areas.

One of the project interventions is to give mothers health messages all of which are given during the birth centered home visit, covering exclusive breast-feeding, umbilical cord care, family planning, the benefits of iron tablets and tetanus immunizations, and the care of low birthweight babies. We found that mothers are overloaded with too many messages than can be absorbed, especially considering their postpartum condition. Two recommendations are 1) to evaluate the behavioral changes due to the health messages via the final KAP study, and 2) to work with the health education section to find the most appropriate health messages to be given to mothers. There is also a need expressed by the health center heads to expand the project to all villages in their work areas.

Urban Mataram is unique in that it provides alternatives for mothers to give birth. The project so far has faced difficulties in conducting the interventions at the hospital setting. Mataram hospital should improve the coordination between the obstetric and pediatric wards to avoid missed-opportunities in giving immunizations to mothers and babies. In Bima hospital, coordination of the supply of syringes should be given more attention. Through interviews at the hospital, we found that mothers are willing to purchase syringes and/or vaccine. This is a supportive attitude for the development of privatization at the urban sites.

The provincial health office has recorded 2% hemorrhagic postpartum cases in 1995. This percentage should be compared with the national data and discussed further to decide whether oxytocin injections should now be given to all postpartum mothers to prevent bleeding.

National Level

The performance of the national team needs to be improved. The evaluation team recommends the national team conduct more frequent regular meetings at the national level and more supervision to the project sites. The national level meetings can be used for marketing the project for replication and expansion, and for encouraging better program integration. Supervision trips to the province will be useful to discuss alternatives for sustainability of the project and for trouble shooting the project 's technical problems.

This project is not provided with UniJect™ prefilled injection devices. To avoid problems of supply shortage, lack of refrigerators or sterilizations, and transmission of infection through injection needles, the team encourages the use of UniJect and discussion of the use of UniJects at higher decision making levels.

The national team should also discuss two things: 1) evaluate the possibilities for a “project extension at no cost ” past September 1997. Justifications for the extension should be made as clear and logical as possible; and 2) reallocation of funding to support recommendations made by the evaluation such as: a) monthly HSCS meetings at the hamlets and health centers, b) expansion of project to potential villages under similar health centers, and c) standardized HSCS data analysis at the district health office level.

CHAPTER 1

CONCLUSION AND RECOMMENDATIONS

I. CONCLUSION

1. The Healthy Start for Child Survival (HSCS) project **is the latest of a number of projects in NTB aiming to improve MCH status through immunization at the earliest possible contact with newborns.** The first project started in November 1987 by giving Hepatitis B immunization to newborns in their homes within the first week of life. Next, the USAID-funded Child Survival - Plus Two (CS-P2) project (October 1990 - September 1993), also focused on health interventions for newborns, but added interventions on Acute Respiratory Infections, early identification of pregnant mothers, and follow up of postpartum mothers and infants. The HSCS project added interventions directed toward pregnant women through antenatal care on top of the previous ones. The first HSCS project, funded by the Australian Agency for International Development (AusAID), started in July 1993. It finished in September 1996. Since October 1994, the HSCS project has also been funded by USAID, including all interventions from the previous project and looking at infant and mother as one unit. This HSCS-USAID project is scheduled to end in September 1997.

At the end of each of previous projects, all activities, including the instruments, were analysed and evaluated. Revised activities and instruments were reused for the following project. In this HSCS project, for example, the operational system and forms are similar to the previous one. The opportunity to reuse the various forms and procedures brings chances to increase validity and reliability of the instruments. As with the other previous projects, the HSCS project provides:

- Birth centered intervention, focusing on infants and mothers.
- Birth notification at the grassroot level.
- Strong working together involving the whole system: provincial down to the hamlet level, inter-sector and inter-program.
- Service to target groups (newborn infants, pregnant women, postpartum mothers) carried out using an integrated approach combining multiple health programs (MCH, nutrition, immunization, health education).

2. The success of the project achievements cannot be separated from the **long evolutionary exposure** of the health system in NTB in accepting the project. One thing can be learned is that these interventions required 10 years for NTB to adopt.

3. HSCS needs **high level commitment.** Though not always smooth, the project has shown intersectoral commitment, which is one of the keys to success of this project. In places visited, almost everyone showed good collaboration among the health cadres, TBAs, community midwives, and pustu 's staff. However, only around one half of the

hamlets show good working relationship with the hamlet and village leaders. High commitment and seriousness is shown by the provincial health office. Supervision is done almost on a regular basis (mentioning also the strong encouragement from the PATH Lombok team), and meetings to come up with provincial decisions are followed up by operational plans.

4. Besides the high-level commitment, the project also shows the importance of **people executing the project**. Teams are built in each administrative level, usually through a letter of decree or a letter of duty assignment (Surat Tugas). Teams established in this project are the national team at the MOH, the provincial team, subdistrict team, down to the puskesmas team assigned by the puskesmas head. The category of team members is determined by the kinds of programs being involved in the project. Therefore, a representative from the nutrition program, MCH, and immunization are the main categories involved. However, through the short evaluative visit, differences were seen in progress and activities performed by each team. Some hypothetical reasons effecting the phenomena are personal ability, individual communication skills, interpersonal relationships, team working, the ability to make decisions, and leadership.

The PVO established a local team located in Lombok consisting of head officer, assistant to the head officer, one secretary, one treasurer, and one administrator. The local PVO plays an important role in maintaining the execution of the project. Its tasks of liason between the PVO headquarters and the executing agency, motivating supervision, encouraging regular meetings, and assistance in trouble shooting technical problems are well performed. The local PATH also plays a role as a data and information source of the project. The ability and fluency in speaking Bahasa Indonesia of the expatriate project manager, Mr. Carib Nelson, and the vast knowledge and familiarity on the existing government health system of the Field Manager Mr. IGP. Suradana, are absolutely two dominant factors affecting the success. Such experience should be encouraged to other PVO projects.

5. The heart of the project is **the team and its dynamic at the executing level**, primarily from the district level down to the hamlets. The district health office team should be the strongest component of the whole project, followed by the puskesmas head, especially in their role as supervisors. Collaboration between the community (TBAs, health cadres), the formal leaders (hamlet as well as village leaders), and health staff (community midwives, pustu staff) is the core of the grass root reporting system. The combination of active and committed people at the district health team, puskesmas doctor. and the grass roots core is assumed as a criterion for success. In this project, the Pustu is the actual base home health service institution.

6. It can be concluded that HSCS is quite successful in operation and is able to merge existing health programs. The question is whether such interventions **can be replicated to other provinces?** The provincial health office of NTB and the PVO presented the project at a formal national meeting in June 1996. Sharing experiences and showing the

success of the project is not enough to ensure replication. Formal commitment of higher level of decision makers seems to be the more important variable, besides the funding availability.

II. BENEFITS

1. The project demands responsibility and performance of the community midwives. With the birth event as the focal point of intervention, stress on identifying infant and mother between 0-7 days postpartum requires the community midwives to do active outreach through increased community interaction during the project. The **community midwives now are more confident in rendering their tasks and functions**. They also feel closer to the community and TBAs. They are now proactive and are not passively awaiting clients at the polindes.
2. The HSCS project has made a **strong contribution in providing vital statistic data at the very grassroots level** which was not touched before.
3. The **target groups of health services at the village level are now more predictable**. Prior to the project, posyandu activities are conducted based on estimates of number and condition of clients. With the B4.1 and B4.2 reporting form, the pustu and puskesmas are prepared with exact numbers of clients, so exact interventions can be made. Forms B4.1 and B4.2 have made a major impact in succeeding to find and gather the target groups.
4. The evolutionary process of the project brings **the opportunity for integration among various vertical health programs inside MOH**. Starting with the notion of making the first contact event more effective, it was then decided to try for not only giving health service intervention to infants but also to mothers. The realization of an integration theory is a long anticipated event. Theories on mother-infant relationship state the importance of analysing and looking at the mother-infant as an in toto, since undoubtedly the infant's life is dependent to its mother, starting since the intrauterine life.
5. The project, to some extent, though still needing improvement, does **prove that integration can be operationalized**. Antenatal visits have increased at the project sites. At the time interventions to newborns are given, pregnant women and mothers at birth are obtaining benefits. Exposure to various self-care and infant care messages, immunization, and micronutrients are provided on a door to door basis by health staff. It can be done by a midwife, by a vaccinator, or by a nurse.
6. The incidence of low birthweight babies in Indonesia is still relatively high. The national data from National House Hold Survey 1993 indicated 8.9%. This project **has focused attention on Low Birthweight (LBW)**. The TBAs are equipped with simple weighing scales to detect the LBW babies upon birth. Though the reliability of the

instrument can be questioned, the timing of collecting the data is valid, because the newborns are expected to be weighed between 0-7 days postpartum. The result shows 2-3% LBW babies in Sumbawa. The project also follows up these cases using three additional home visits. The outcome of the follow up is still unclear, and no data can be utilized to support the effectiveness of such efforts.

III. SUSTAINABILITY

1. The word sustainability becomes very important in such a project. This issue has been discussed at all administrative levels. One aspect that can already guarantee the sustainability of this project is that all interventions are **carried out within the existing system.**
2. The sustainability of this project should also be seen from its relation to the previous projects. The previous project, which had similar activities but in different sites, has just finished in September 1996. Discussions have been made to guarantee the survival of the project, one of which is the taking over of full responsibility by the provincial health office in continuing the activities. This project can **learn from the previous one.**
3. The HSCS project will end in September 1997. In general, the MOH should be encouraged **to market the project** to other international funders. Another option is to start **to lobby with local decision makers** to collaborate and support the continuation of the project. The evaluation team felt satisfied with the encounters with bupati of district of Sumbawa, Dompu and the Sekwilda at Bima. All Bupatis and Sekwilda were very positive toward the health development in their areas, and willing to support it. It is now the task of the district health office to be **alert to** the Bupati's positive sign, and respond immediately through developing future plans and needs, and discussing with the Badan Perencanaan Pembangunan Daerah (Bappeda =Regional Planning Development Board) as soon as possible.
4. There are at present about 21 kinds of reporting and recording paper work that must be completed every month at the puskesmas. The data collected by the HSCS project, which is at the very grassroots level, has proven usable and beneficial as input for other recording forms from various program input. To be more efficient, the provincial health team has thought of simplifying and decreasing the number of reporting forms by **merging** some of the HSCS forms into the existing reporting recording system, including:
 - a. Hamlet book with "Kohort Ibu and Kohort Bayi"
 - b. Verbal Autopsy form with the Audit Maternal Perinatal (AMP) form
 - c. Form for Home visit 1 and 2 (KN1 and KN2) for follow up of normal and LBW babies

Merging forms for simplification without sacrificing their value and substance is one good example toward sustainability. This effort should be encouraged and supported. As a

consequence of merging, training to introduce the new forms and to provide skills to be able to fill in the new forms are indeed necessary.

5. Some of the project site districts in Sumbawa have been mentioned as having good performance (enough community midwives, availability of pustu 's, committed puskesmas coordinator) in health and manpower and, therefore, are potential sites for **project expansion**. To be sustainable in the long run, the health staff and health workers should first be empowered through training. Training is an investment, and requires funding; therefore, budget should be planned and sought.

6. The HSCS project chose urban Mataram and Sumbawa with purpose. The **urban Mataram is seen as a challenging site** due to its specific population characteristics, and this project had never been tried in an urban setting. Sumbawa was chosen because Sumbawa represents other rural and remote areas in east Indonesia. If success is met in Sumbawa, it can be assumed that such a project can be replicated to other areas in east Indonesia. The KAP survey (MOH, 1996) at urban Mataram found that the socioeconomy of the population is far better off than the rural Lombok. As an illustration, 80% of urban Mataram women are literate where 40% respondents finished junior high school; monthly family expenditure ranged from 30 to 900 thousand rupiah, twice as high as spent by the rural Lombok residents. The majority of them, almost 80%, live very close to a health centre or pustu. They also are exposed to choices of health services, from government to private health care. Discussion with the HSCS project coordinator at the government hospital of Bima indicates that clients are willing to provide their own syringes. For further development, urban Mataram can be thought **as a trial case for privatization**, in collaboration with professional organizations such as IBI, IDI, IDAI, POGI and private practices.

7. This project proved **a high value of integration** between health programs directed toward infants and programs directed toward mothers. Infants and mothers are looked at as one entity. Another integration is among the related vertical health programs which are immunization, MCH, nutrition, health education and HIS. How the integration is beneficial was addressed by a member of HSCS team at the district health office: " With the project, the various program people sit together more often, at least for planning the supplies needed for the project (supplies are still provided through programs). I am more aware of the practice of coordination, because I experience it myself now. The psychological integration is there." But a negative response was mentioned by another person in another district health office: "I am overburdened. There is not enough staff here but the load of work is very high. Actually we should meet or do supervision on regular basis but we simply cannot do it. I need help."

IV. RECOMMENDATIONS

A. General

1. The birth centered intervention at the project sites in Sumbawa and urban Mataram is an innovation to the regular primary health care programs carried out by the puskesmas. The intervention activities, though not yet perfectly conducted, are progressing and show promising results. From 6 months data at puskesmas Alas and data calculated by PATH Lombok or by the provincial health office of NTB, the coverages of immunization, nutrition, and MCH programs are increasing. The evaluation team recommends that **project activities should be continued** not only for the rest of the project time, but also after the completion of the project, and taken over by the MOH as a system for improving the quality of its primary health care programs.

B. To the Health Centre at Subdistrict Level

There are still a few hamlets with inactive leaders. Involvement of hamlet leaders and village leaders in reporting vital data is still low (range 25 % to 50%). Information on new births, deaths, and new pregnancies is often received directly from the TBAs or posyandu cadres. Considering that the hamlet leader is also responsible for vital statistics in his area, the project is obligated to encourage the hamlet leaders to be involved actively. Effective supervisory visits and informal meetings at the hamlet and village level (called: “silaturachmi”) by the puskesmas staff on a regular basis are a means which could improve motivation.

C. To the District Health Office

1. Many reports on achievements of coverage show slight differences in rates of coverage of TTM, HB1, OPV1, Vitamin A and iron tablets for mothers, which actually should be similar. Reasons for the differences have been addressed in the previous chapter. This indicates that **reading of the coverage should be done carefully**, since some of the differences will always occur though maximum efforts of the project have been made. More implicit is that any report on coverage should be followed by a short narrative and explanation on differences, especially if differences occurred between the coverage of HB1, TTM, OPV1, Vitamin A, or postpartum iron tablet sachet (these are all interventions given to a new born and mother together during the home visit).

2. **Supervision** should be strengthened, especially from Kabupaten to Subdistrict and from Subdistrict to Pustus and Villages. The strengthening effort should be made in encouraging the kabupaten team to conduct regular supervision and make use of the supervisory checklist. Supervision funding is available. Supervisory techniques has been given to the team. However shortage of people at the district health office, and capable people to do supervision will always be a potential problem in the frequency and quality of supervision. The existing mechanism is considered effective, where district health staff

are asked to join the provincial and PATH Lombok supervisory visits, but this happens as scheduled: once in two months. The above strengthening effort is focusing on filling the supervisory visit gap between those 2 months visits.

3. To provide the health workers at the spearhead with readily available micronutrients and vaccines, the mechanism of **supply** request and distribution at the grassroots level (the puskesmas to pustu) should be given attention and priority. The puskesmas staff should conduct **regular checking** on the need and stock at the puskesmas and pustus. Provision of supplies from the provincial level down to district level and to puskesmas should be monitored on a regular basis to avoid shortages.

4. There is a need for **a monthly meeting at the puskesmas** for monitoring purposes of the HSCS project, to discuss more detailed problems faced and to plan better interventions. We realize there is no budget provided for such a specific meeting at the puskesmas. Looking at the positive effect of the objective, we suggest assisting the puskesmas with funding. Monthly meetings at the hamlet level could increase work performance and interpersonal communication since one time training is not enough. However, concerning the sustainability of the project, it should be considered whether such exclusive meetings for discussing HSCS project matters is wise, since it is outside of the existing system.

5. Top down approaches in some places show effectiveness. The project should make use of the motivated District Heads (Bupatis) in Sumbawa, Bima and Dompu through giving routine reports on the progress of the project, asking advice for troubleshooting field problems, etc. **Relationship with local government** must be maintained for sustainability. The local government, if not mistaken, provides funding where some of the project 's activities can be integrated. The Bappeda should be always given the latest information on the project to create the sense of belonging toward the project.

6. One of the potential problems with this system is the **high drop out rate of cadres**, who are mostly young unmarried girls. The drive to work abroad as women labours (Tenaga Kerja Wanita), especially in Sumbawa, is very high. Therefore training of new cadres must always be made available in order to maintain the reporting system at the grassroots level.

7. A specific request for **widening the sites covered by the project** is expressed by the puskesmas head of Dompu Barat. The HSCS project has been running in 8 of its 12 villages. As time passed, the 4 villages have grown and become as potential as the previous 8. The replication of the project in these additional villages will also benefit the puskesmas in simplifying and making the reporting recording more efficient.

D. To the Provincial Health Office

1. A letter from the Directorate of Nutrition, MOH, dated September 4, 1995, was sent to the head of Directorate of P2M to stop the distribution of high dose of vitamin A to infants because of outside reports of bulging fontanelles. There will be another instruction when results of a study in West Java is announced. The evaluation suggests a study to see the effect of high dose vitamin A intake.

2. Variations in analysis of data are found between all kabupaten. Kabupaten Sumbawa for example, compares 6 month achievements of years 1995 and 1996, using the 6 month targets as standards. PATH Lombok, through its supervisory visits, took the FB5 from the Puskesmas and analysed the data itself. There seems to be no standardized data analysis of the HSCS. We suggests that the project could **develop a standardized data analysis at the kabupaten level**, which will make the information flow much more efficient.

As consequence of this suggestion, the project should think about developing the software and hardware system, along with training for the data analysis at the kabupaten level. As mentioned by Dr. Agus Sutanto, the NTB province has successfully tested a system of analysis for surveillance data, which is based at the kabupaten level. Its system has brought the NTB province to number 1 among the 27 provinces in Indonesia in quality of reporting and recording of the surveillance data.

3. Not all project intervention activities can be measured quantitatively. One is the health education intervention, which theoretically, aims to change one 's behaviour. The project time itself is felt insufficient to change health behaviour of mothers and pregnant women; however, indications toward the outcome effect can still be obtained through surveys or in-depth interviews and/or Focus Group Discussions of specific groups. We recommend that **the final KAP survey include specific questions addressed to measure the outcome of health messages given through this project**, focusing on: the purpose-benefit-utilization of antenatal care, meaning-methods-practice of exclusive breastfeeding, purpose-benefit-compliance of taking iron tablets, purpose-benefit of vitamin A for infants, meaning-purpose-benefit-risks of TT immunization for mothers and infants, purpose-practice of various personal hygiene. and care of the umbilical cord.

4. One remark in the sustainability chapter is the possibility of **expanding the project to other potential districts**. In this subchapter we encourage funding of the expansion, which is needed for the preparatory and preconditioning meetings, process in selecting the location, training related groups, provision of supplies, and the intervention activities. If the budget is restricted, funding for training should be the priority.

5. The project should continue improving the relationship with hospitals and private practices in urban Mataram. Coordination should be encouraged between the pediatric ward and the obgyn ward in the hospital to avoid missed opportunity for immunization,

especially to mothers. A specific problem that occurs at the hospital at Bima is the coordination with the District Health Office on the provision of supplies. Dr. Agus Sutanto has requested the urban Mataram team to develop a proposal for **specific intervention in an urban setting**.

6. Verbal autopsy is very important to predict causes of maternal or infant deaths. Through discussion with the community midwives, puskesmas doctors and ob-gyns at the hospital, the verbal autopsy information becomes a topic of discussion at the regular midwives's monthly meeting or at the audit maternal perinatal meeting. This indicates that information from verbal autopsy is used.

As mentioned earlier, each completed verbal autopsy form is sent to the provincial health office, and each case will be reimbursed for case search transportation fee (Rp 1000,-). **A practical mechanism should be encouraged to disburse this small amount of reward** so it can be directly received by the health staff who conducted the verbal autopsy.

E. To the MOH at the National Level

1. Cold chain and sterilizers are needed for remote areas to reduce the cost of immunization. The provincial health office has suggested to the district health office to prioritize the provision of both instruments at the project sites. However, the decision for the distribution of the cold chain (refrigerators) and sterilizers lies at the District Health Office. The puskesmas head should approach the district health office and convince the high need for it.

By using syringes and multi-dose vials, there is a problem with vaccine wastage as mentioned by some midwives and vaccinators interviewed during the field visit. Some of them have thought of delaying the home visit until they reach a certain number of mothers or infants to be immunized in one day, but this creates other problems. The mothers do not live in one area so it is difficult to reach all of them at the same day. The delay could result in the midwives losing the "golden moment" of the home visit, which is 0-7 days. With such constraints, the evaluation team **encourages the use of UniJect**, which has proven potential to solve such field constraints. UniJect could also prevent the spread of infections through blood transmission, which is impossible to control by the use of disposable syringes. Without evaluating the cost efficiency of the use of UniJect, we encourage and support negotiations on the use of UniJect at higher decision levels.

2. The HSCS project is a unique project. We believe that there are many experiences that can be disseminated and learned by other parties. Some articles on the project have been published in English journals with limited distribution. With permission of the MOH, **more publications on this project** should be encouraged, especially in Bahasa Indonesia. We also urge the active participation of the project team in related national

or international health seminars or workshops for dissemination of information on this project.

With almost ten years of experience, the health province of NTB is believed confident in **marketing this project** to be replicated in other provinces. Higher political commitment is needed to support provincial replication

3. As mentioned before, the project was delayed for 14 months. With the termination of the project by September 30, 1997, the actual project total time is now compressed into a total of 22 months, to be carried out with 36 months funding. There is not much time between now and September 1997; in addition there may be a slow down of activities during the election in May 1997. We ask whether **“at no-cost extension of project time”** is possible. If possible, the project will benefit from more time to show better performance.

4. Finally, some of the recommendations forwarded above demand funding, which is not allocated in the work plan. The recommendations are:

- a. Expansion of the project to other villages within project subdistrict sites.
- b. Expansion of the project to other potential districts.
- c. Development of standardized HSCS data analysis at the district level.
- d. Monthly HSCS project meetings at puskesmas.
- e. “Silaturachmi” and refresher training at the pustu level.

If **reallocation** is possible, funding can be drawn from either the national or provincial budget.

CHAPTER 2 METHODOLOGY

I. METHODOLOGY

The mid-term evaluation took place in urban Mataram and within subdistricts (kabupatens) Sumbawa, Dompu and Bima on Sumbawa island.

Methods used to collect and gather information were: analysis of reports and secondary data, in-depth interviews, observations, and discussions in plenary sessions.

Group and/or individual interviews were conducted with the HSCS project team and/or team members at the national, provincial and district level; PATH Jakarta, PATH Lombok, puskesmas head and puskesmas HSCS team, pustu staff, village leader, TBAs, mothers, HSCS team at the type C hospital, and cadres. Courtesy calls were made to the Bupati Sumbawa, Bupati Dompu, and Sekwilda Bima.

Dr. Siti Hariani, MSc, and Dr. Nita Kurniawati, MSc, from the Directorate of Family Health, MOH, went with the evaluation team to the project sites. During field visits, the team was accompanied by PATH Lombok: Mr. Carib Nelson, and Mr. IGP Suradana, Dr. Husin Fahmi, MPH, and Dr. IK. Artastra MPH from the provincial health office who are in charge for the execution of the project at Lombok and Sumbawa.

The evaluators visited puskesmas, pustu, and 2 mothers at home in urban Mataram; district health office and puskesmas in Alas; a village delivery post (polindes) a pustu at Bungin island; 3 mothers at home in district Sumbawa; district health office and puskesmas in Dompu Barat; polindes at district Dompu, district health office, and type C government hospital and pustu at district Bima.

II. LIMITATIONS

During the evaluation, not all staff at the NTB provincial health office (Kanwil Dep.Kes. Prop. NTB) nor at the district health office who are related to the project were available. Dr.Margaritha Cepas, Kepala Subdinas KIA Dinkes Dati I, Dr. Mar'ie Sanad, Ka Dinkes Dati II Sumbawa were in Australia for a comparative study on Women's Health.

Due to limitation of time, not all villages at the HSCS project were visited. However, the visits were made to villages which had similarities to the others.

Mrs. Aurorita Mendoza, head of PATH Thailand, one of the team 's evaluators, was not be able to join the team completely. She went back to Bangkok in the fifth day (November 29th, 1996).

CHAPTER 3 THE FINDINGS

I. ACCOMPLISHMENTS

The Work Plan showed that this HSCS project is a 3 year project, started in October 1, 1994 to September 30, 1997. However, the approval from the Cabinet, Secretariat with the MOH, was delayed by the signing of the MOU until November 28, 1995. If the project was not delayed, then several sequential activities as planned could have been done according to the schedule. (KAP surveys in November-December 1994, continued by Training in January-March 1995 and the Interventions, which could have been started in May 1995 at the latest). Due to the late signing, the core activity of field Interventions were only started in April 1996.

However, prior to the signing of the Memorandum of Understanding (MOU) several preparatory activities were conducted, starting with the KAP surveys in both Lombok and Sumbawa. In urban Mataram it was held in January 1995 and at Sumbawa in June 1995. The training program for all 4 district sites was carried out in January through March 1996.

The project will end in September 1997. To date it is in its second year (regarded 1995 as the first year activity). Compared to the DIP where HSCS project was planned for October 1, 1994 through September 30, 1997, the time elapsed of the project is 10/22 = 45 %. (December 1, 95 - September 30, 96/December 1, 95 -September 30, 97).

Project Life Time and Main Activities

1	1	1	1	1	1	1
Oct. 1 94	Jan, Jul 95	Nov 28 95	Jan 96	April 96	Nov 96	Sep 97
	3-9 mos	5-11 mos	3 mos	4 mos	6 mos	12 mos
<i>Proj. Agreed</i>	<i>KAPS</i>	<i>MOU Signing</i>	<i>Trgs</i>	<i>I'vention</i>	<i>Midterm</i>	<i>End.</i>

The project objectives are: 1) to strengthen the maternal and child survival services through promotive, preventive and treatment activities outside static facilities through home health care, aiming to reach the unreached community; and 2) to demonstrate an integrating health service model which is replicable, cost effective and sustainable.

As the name Healthy Start implies, the primary aim of the project is directed toward pregnant women, newborns, and postpartum mothers in maintaining and improving their health through immunization, maternal care, family planning, nutrition, perinatal care, care of low birth weight infants, and health education. Interventions are directed to new born infants and pregnant mothers through activities as follows:

1. Delivery of Hepatitis B injection and oral polio vaccine to new born infants aged 0-7 days.
2. Support at birth mother's nutritional status through delivery of high dose I capsule vitamin A and 30 iron tablets.
3. Distribute iron tablets and deliver 2 TT immunizations to pregnant women.
4. Weighing of newborn babies to detect low birthweight.
5. In order to optimally conduct the interventions as close as possible to the birth, the project also strengthens the reporting/recording system of vital statistics at the hamlet level.
6. Promotion of antenatal care, exclusive breastfeeding, child care, and family planning.

By the termination of the project, the outcome objectives will be as follows:

Project Interventions	Outcome Objectives
Immunization	<ul style="list-style-type: none"> • 80% pregnant women obtained TT1 and TT 2 prenatally • 80% postpartum women obtain TTM 0-7 days after birth of youngest child • 80% newborns obtain HBI 0-7 days of life • 90% 12-23 months infants obtain full immunization before age of 12 months • 80% infants in cold chain accessible areas obtain OPVO 0-7 days of life
Maternal-FP care	<ul style="list-style-type: none"> • 90% pregnant women obtain at least 4 times ANC + high risk group screening • 50% of reported PPH are stabilized with oxytocin • 90% women obtain education on exclusive breastfeeding • 90% postpartum women referred to FP service

Project Interventions	Outcome Objectives
Nutrition	<ul style="list-style-type: none"> • 40% pregnant and early postpartum women correctly comply to 90 iron tablets during pregnancy and 30 tablets supplementation at early postpartum period • 95% of mothers started breastfeeding within 8 hours of birth • 60% infants are exclusively breast fed • 90% postpartum mothers obtain 200,000 IU vitamin A capsule
Perinatal care	<ul style="list-style-type: none"> • 95% TBAs and midwives screened newborn for low birthweight • 100% LBWs obtain follow up visits and care
Diarrheal Disease	<ul style="list-style-type: none"> • 60% postpartum women demonstrate correct hand washing practices • 60% postpartum women breastfeed babies with diarrheal disease and give additional fluids to infants aged 4 months and over • 90% women educated on breastfeeding practice exclusive breastfeeding until 4 months and continue to breastfeed until 2 years

Supplemental Activities to Project Interventions	Inputs	outputs	Outcome Objectives
Training outreach vaccinators	Training Courses	<ul style="list-style-type: none"> . Number of training . Skills demonstration . Pre- and post-testing 	<ul style="list-style-type: none"> . 90% outreach vaccinators obtain refresher training in sterilization techniques and universal precautions
KAP Surveys	<ul style="list-style-type: none"> . Proposal of study . Instruments for data collection 	<ul style="list-style-type: none"> . Baseline KAP . Final KAP 	<ul style="list-style-type: none"> . Baseline data as input for intervention . Change in health behaviour of mothers, and health workers in provision of MCH care
Training programs	<ul style="list-style-type: none"> . 22 modules . Various training courses 	<ul style="list-style-type: none"> . Number of training . Skills demonstration . Pre- and post-testing 	<ul style="list-style-type: none"> . 100% Village and hamlet leaders are knowledgeable on the reporting system of the project . 100% of health workers (TBAs, Cadres) conduct reporting of births, pregnancies and deaths of infants, mothers etc.

II. EFFECTIVENESS

One measurement of the HSCS project effectiveness is the target coverage achieved after a period of time.

The project has demonstrated sufficient progress towards achieving its stated objectives and yearly targets in spite of the compressed operating time frame due to a late starting date. Achievements in some components have been impressive, as shown in Table 1. Achievement rates for maternal health, newborn care: and nutrition will be presented in the final KAP survey.

Table 1: Achievement Rates by Component, April 1- September 30, 1996, in Urban Mataram and average rates for districts of Sumbawa, Dompu and Bima, NTB Province

Component	Target	Actual to Date Sumbawa'	Actual to Date Urban Mataram'
Immunization	TT2 for 80% pregnant women	78%	60%
	TTM <7 days after birth for 80% of infants	87%	48%
	HBI <7 days after birth for 80% of infants	97%	53%
Nutrition	Iron for 80% of ppartum women	97%	45%
	Vit A for 90% of ppartum women	98%	39%

'Average of 3 districts: Sumbawa, Bima and Dompu
'Covers Ott '95-June '96

Due to the integrated approach in the recording and reporting system established by the project, high-risk groups, such as low birthweight infants, high-risk pregnant mothers, delivery complications, can be covered, and appropriate care extended, whether by follow-up or referral to the district hospital.

Follow-up of low birthweight babies is provided through subsequent home visits by the community midwife, pustu (puskesmas pembantu= subhealth centre) staff or puskesmas (subdistrict health centre) staff. However, this system does not aim to track outcomes of the referred high-risk pregnancies. since the district hospital is not within the scope of the project.

There is no direct link with the district hospital, and the only contact again would be in the event of mortality through the verbal autopsy.

In puskesmas (subdistrict health centre) Alas in Sumbawa, over the six month period of April to September 1996, increases happened with the coverage of TT2, OPV4, DPT1, K4 if compared with similar months coverage in 1995. Significant increases of coverage occurred with HB1, where 414 out of 477 targeted infants were immunized. The increase is contributed by the HSCS intervention at 10 villages in Alas subdistrict.

The once a month posyandu activity at the village level is also strengthened by the existence of the HSCS project. Prior to the project, data on how many infants and women to be served at posyandu relied on the “kohort ibu” and “kohort bayi” books (Mother kohort registration, infants kohort registration) which is maintained by the community midwife. Since she covers a village (consists of average of 20-24 hamlets) and works alone, the completion of data and data update were questionable.

The project has developed and implemented a grassroots level reporting system, where community and health workers at the hamlet level are encouraged to actively report births, new pregnancies and deaths. The new system obviously increases the completion and validity of vital statistics data. The B4.1 and B4.2 forms, which are compilations of reports from hamlet level are now used to determine number of target groups to be called upon to posyandu or visited at home and the kinds of health services that should be given. Since profile of target groups are more predictable, many hamlet leaders are happy to assist health workers to invite women to come to posyandu.

Prior to the project, home visits to give various health care intervention to the infant and mother at 0-7 days after birth was theoretical, but difficult in practice. In “birth centred” intervention, the health service and contact is made at the earliest moment of life, which obviously can prevent the infants and mothers from health hazards.

Another measurement of effectiveness is the active performance of the community midwives. At sites where no HSCS project occurred, many complaints are addressed to the passive role of the majority of the community midwives, They stay at the “polindes” to await for clients to come. The HSCS intervention demands an active role of the pustu providers and community midwives. They are responsible to visit new births at home and render services. The home visit provides change to the community midwives to build relationships with clients.

As will be explained in more detail in the Supervision section, the project has built means to motivate supervision.

III. RELEVANCE TO DEVELOPMENT

The province of Nusa Tenggara Barat (Lombok and Sumbawa islands) is among the provinces in Indonesia with high infant and maternal death rates. The existence of puskesmas, pustu and posyandu were concluded insufficient to reduce the risk factors. The Government of Indonesia (GOI) deploys midwives in the villages and expects that this new setting will result in accessible service to the needy women. The project relevancy with the health service system of the country is indeed very close. The project makes maximum use of the community midwife and the pustu.

Many other agencies working in the area of health are found in NTB province; among others are CARE, Save the Children, UNICEF, PLAN, and the World Bank. The operations have been mostly in Lombok island. Sumbawa has been relatively neglected, yet conditions in Sumbawa are similar to the other eastern Indonesia areas. If the intervention works well in Sumbawa, it may provide a model for adaptation in other eastern areas.

A huge women's organization with a solid structure at each administrative level is the Pembinaan Kesejahteraan Keluarga (PKK= Family Welfare Movement). The PKK members at the hamlet level are usually asked to become health cadres. Through PKK cadres, the existing community reports on births, deaths and pregnancies in this project.

IV. DESIGN AND IMPLEMENTATION

A. THE PROJECT DESIGN

The HSCS project was implemented after some changes were made in the project design. The DIP proposed giving newborn infants high dose vitamin A, as used to be implemented in the former HSCS project. At the end of the former project the Directorate of Nutrition, MOH provincial health office decided to discontinue this intervention. An outside study reported that high dose vitamin A given to infants will effect bulging fontanelle.

Iodine supplementation (200 mg iodine per capsule) to pregnant women also was one of the HSCS project objectives. The GOI policy is to give iodine capsule as supplementation only in endemic areas. The project's sites are not endemic, therefore iodine supplementation was dropped from the project.

Dr. Valerie Stott, the project officer for the AID-funded HSCS component resigned in early January of 1995. Mr. Carib Nelson, of PATH Seattle, who was involved in the use of UniJect at the Lombok project. was assigned to Lombok as project officer. The Field Manager is Mr. IGP. Suradana. who has worked with the project since 1987. Mr. IGP. Suradana was formerly head of the immunization section at the provincial health office at Nusa Tenggara Barat. He now works full time for PATH Lombok.

The previous plan was to divide the activities of the project into 2 phases: phase 1 which is the execution of the project at urban Mataram and Sumbawa: and phase 2, the expansion to Bima and Dompu, carried out after phase 1. The delay of the project compressed the activities into one phase where all four sites were implemented at once.

B. MANAGEMENT AND USE OF DATA

The project's effectiveness is fundamentally rooted in an integrated recording and reporting system that will generate data on pregnant women, delivering/ breastfeeding women, and newborns. This information is received by the community midwife or pustu staff from various sources, including the hamlet leader, or directly from the health cadres or TBAs or family members themselves. The data is recorded in the Hamlet Book. Based on this book, the health providers are able to organize the service needs of the target group and the delivery schedule and record when they have actually taken place (FB3).

The FB3 form is submitted to the puskesmas. Under the supervision of the puskesmas head/doctor, the data are consolidated, and used in local area monitoring. The puskesmas then is able to plan the suitable strategy, e.g., "sweeping" for unmet immunization targets, and instruct the community midwife to implement the strategy.

Each health centre's form is consolidated further on the district and provincial levels, whose data will be expectedly more reliable due to the community-based data-gathering. On the larger planning level, these data will indicate which program (whether immunization or nutrition or MCH) will need to be further supported or strengthened.

This system has been effective in terms of identifying service delivery or intervention needs, which is a priority consideration in health care. The district and sub-district teams confirm this benefit, which has created a sense of great satisfaction and motivation to the service providers.

The system has been integrated into routine activities of the sub-district health centre. Discussions with the district head (Bupati) and the District Health Office clearly indicated desire to institutionalize this information system. The district health office plans to continue this system even after the end of the project and to expand it to other sites using its own budget. The project must be commended for a successful effort towards facilitating ownership of the system.

From interviews with the community midwives and pustu staff, the level of difficulties in filling various forms has been minimized. Minor technical mistakes such as mistakes in adding numbers, putting data in the wrong column, or conflicting data occurred during the first months of the project implementation. Delays in tilling out the B3 form after posyandu still occur among one or two staff. These technical problems were usually corrected during the supervisory visits.

Frequently, family members or cadres or TBAs report new pregnancies, births and deaths directly to community midwives or to pustu staff; bypassing the hamlet leaders. The bypass does not seem to bother the hamlet leaders, and most of them are observed to have very little motivation to be involved in the HSCS project: giving reasons of not having enough time, busy, no rewards etcetera. In Dompu Barat for example, after 7 months of project time, only 50% of the hamlet leaders are active.

The coverage of HB1, TTM, OPV1 and Vitamin A interventions given through the birth-centred visit at home ideally must be similar in numbers. In practice, there are always slight differences in the reports. Several logical reasons are:

- . lack of supply, so service cannot be given at the same time
- . missed opportunity of postpartum mothers in the hospitals because of little coordination between the pediatric ward who handles the HB immunization for the babies and the obgyn unit who handles the TTM for mothers
- . TTM not given to mother because she obtained TT2 less than a month ago
- . registration of data where HB is the total of HB 0-7 days plus >7 days from former months
- . late reporting from family members, hamlet leader, or TBAs or posyandu cadre on births, new pregnancies and deaths
- . mother gave birth at another town and did not come back before 42 days
- . mother gave birth at hospital and did not report the event to a cadre
- . low birthweight babies or infants born in critical condition are not given immunization

MOH only covers 55% of iron tablet supply for pregnancy cases. To date, iron tablets are always available. One reason is due to still limited utilization of iron tablets in other places, which benefits the HSCS project.

About 21 records originating from 15 health programs must be completed every month by the puskesmas. For puskesmas where some of the villages are used as project site, the vital statistics report at the hamlet level is a tremendous input to be used to fill in the other records.

The provincial health office does realize the load of paperwork on reporting and recording, besides the amount of expenditure spent for multiplication and distribution of forms. Some forms of HSCS are at present successfully merged with the existing reporting recording system, and a new simplified form is ready at the provincial level. The funding for duplication of new forms is available and soon training at the kabupaten level will be conducted. The following forms have been combined:

1. Hamlet book and Maternal and Baby Cohort Registration.
2. Verbal Autopsy form and the AMP (Audit Maternal Perinatal) form .
3. Form for Home visit 1 and 2 will be conducted to follow up normal babies and Low Birth Weight babies.

The district health office should be the strongest in the HSCS system since this level is a strategic point to unify top down decisions with the local bottom up planning. The reality is that district health office capabilities in Sumbawa Besar, Dompu and Bima need to be improved and supported. One reason is the limitation of capable persons. Another burden is the heavy load of work on the district health office. To focus on the HSCS project, a strong coordinator is needed.

The HSCS project in urban Mataram faces more difficulties due to the availability of choices in birthing places. Besides home delivery assisted by midwife or TBA, a mother can go to the hospital, or to a MCH clinic. This also happens with antenatal care, which is available at posyandu, with the TBA, health centre, hospital obgyn outpatient care, or at doctor's/midwife's private practice. The larger the variety of the birthing or antenatal care sites, the more complex the reporting and supply system are.

To obtain better understanding of the complexity, the team visited the district Bima government class C hospital. The Birth Centred intervention at the hospital setting is involving the OBGYN and the PEDIATRIC functional units, which seems to work well in this hospital. The director assigned the pediatrician to coordinate the HSCS intervention. While in the hospital, all newborn infants and mothers are given immunizations as recommended by the project. Data on each birth is filled into the blue or yellow "Birth Card of Mother" (Kartu Persalinan Ibu). The card is designed to be cut off in the middle. Half of the card is handed to the mother to be brought and showed to the health provider if she goes to another health service afterwards. The other half is kept at the hospital. The coordination among both units goes smoothly in Bima, but less so in Mataram hospital. Frequently, immunization has been given to the newborn infant, but not to the mother. or vice versa.

There has been no formal strategy so far to utilize the data. However direct use of the raw data is obviously evident:

- The B4.1 and B4.2 data is used as base line data for planning the targeted clients to be served at posyandu or home visit.
- The B4.1 and B4.2 data is used by the hamlet leaders to develop list of invitees for posyandu.
- The data becomes a means to integrating health programs.

Motivated health centre heads (the doctors) use the data to see the progress of achievements of program coverage. However, there is no standardized analysis of the raw data. Denominators used to calculate achievements of coverage are different: statistical software to analyse is also different. These differences occurred between analysis by the puskesmas heads, by the provincial level, district level, and PATH Lombok. As a consequence results are incomparable.

Another specific data system established by this project is the verbal autopsy. The form consists of data on retrospective inquiry of possible causes of deaths of infants or women.

The verbal autopsy is conducted by community midwives, midwives from puskesmas or nurses from the pustus; and the cause of death then determined by the puskesmas doctors.

Table 2: Causes of Deaths as reported in Verbal Autopsy, April 1-September 30,1996, from HSCS project areas in Sumbawa, NTB Province

Causes of Deaths	Sum bawa	Dompu	Bima	Total
ARI	3	5	2	10
Low Birth Weight	1	1	6	8
Still Birth	2	0	6	8
Complications at Birth	0	3	1	4
Infection of Spinal Cord System	1	2	0	3
Premature	0	2	1	3
Diarrhea	1	1	0	2
Congenital Diseases	0	0	2	2
Asphyxia	1	0	1	2
UFD	0	0	1	1
Prolonged Labor	0	0	1	1
Neonatorum Sepsis	0	0	1	1
Undernourished	0	0	1	10
Others	6	3	0	0
Total	15	17	23	55

Source: Bidang Bimda, P.K.P.P, 1996

If dubious data is found, the surveyor is called to give an explanation, or go back to the community to find more data. The doctor writes the diagnosis and signs. One complete form is sent to the provincial health office. another copy is left at the puskesmas. The provincial health office provides a Rp 1000,- transport fee for each completed verbal autopsy form. Table 2 shows the causes of death based on verbal autopsies in Sumbawa from April to September 1996

The verbal autopsy form consists of 11 topics and each is followed by several questions. One death can have multiple causes. LBW in this case is an underlying cause. Identification of low birth weight babies is carried out by TBAs, community midwives or other health staff who assisted the deliveries. A simple weighing scale is provided for each provider. A low birth weight baby will be visited at minimum three times after the O-7 days home visit and the health progress will be observed. To date, no available data is found on survivors of those babies. No data is available to trace the correlation between the low birth weight babies and causes of deaths in the verbal **autopsy**.

Women who are reported pregnant will be given antenatal care examination (body weighing, measurement of blood pressure and fundal height, TT immunization, a sachet of 30 iron tablets) and health education at the monthly posyandu health post. Detection of risk factors is also conducted. High risk pregnant women are told to obtain further intensive treatment at the puskesmas and encouraged to give birth with the health provider's assistance.

Identification of low birth weight babies are carried out by TBAs, community midwives or other health staff who assisted the deliveries. A simple weighing scale is provided for each provider. A low birth weight baby will be visited at minimum three times after the O-7 days home visit and the health progress will be observed. To date, no available data is found on survivors of those babies. No data is available to trace the correlation between the low birth weight babies and causes of deaths in the verbal autopsy.

C. COMMUNITY EDUCATION AND SOCIAL PROMOTION

Among the total of 22 modules, five modules are on antenatal care, personal hygiene, care of low birth weight baby, umbilical cord care and breast feeding. These modules consist of information to be transferred to mothers, to improve their awareness and knowledge on taking care of their own health during pregnancy and their infants.

To improve health providers skills in providing health education, a module on interpersonal communication skills was developed and given during training. A video cassette was also developed on this subject where PATH Lombok collaborated with an NGO: Yayasan Keluarga Sehat Sejahtera Indonesia (YKSSI).

The former project, CS-P2, assisted the health education section at the provincial level in producing leaflets, posters for purposes of health education to women as well as for health providers. They consist of illustrated leaflets on breastfeeding (Air Susu Ibu), and care of low birth babies with very short explanations in Bahasa Indonesia and Bahasa **Sasak**. The brochure on reporting recording system for health providers was well done.

Messages on MCH to women are given by the health providers (most of the time by the midwives) during home visits on individual basis or at the health post.

The evaluation team observed two deliveries of health education during home visits. The team could not generalize the quality of education given by the midwives because of the small number of home visits observed; however none of them used leaflets or pamphlets during education. Most of them said they didn't have the materials. In some cases the midwife still uses too many medical terms with the women. Delivery is too fast, and too many messages are given at one time.

It is also observed that health education is mostly given to the women and not to the other family members. The family involvement while transferring health messages is felt needed

especially to raise family awareness in the importance of the health of pregnant mothers and newborn infants, so they can also motivate and encourage mothers to obtain antenatal care as early as possible and improve care to their babies.

Though the team did not visit posyandu, based on former experiences it can be said that group health education at the posyandu is less effective as compared to individual education during a home visit. On a posyandu day, usually it is very crowded and the focus is more likely given to the under-fives' activities. Health staff and the cadres are usually very busy with weighing, taking notes and providing food supplements. There are also periods where midwives are not available during posyandu days.

According to data, most of the first antenatal visit happens at 4-5 months pregnancy. A small percentage falls to 2-3 months pregnancy. These women usually come to the community midwife or to the pustu due to no menstruation for 2-3 weeks.

D. HUMAN RESOURCES FOR CHILD SURVIVAL

The HSCS project focuses on the development of early reporting recording of births, pregnancies and infants/maternal deaths at hamlet level. The reporting design relies on first hand oral information on such evidence reported by family member, or health cadre or TBA who assisted the birth. The hamlet head will write the information in form B3, which will be picked up by the- pustu staff or the community midwife.

Health cadres, assigned by the hamlet leader, assist health providers in conducting health services in the community through the posyandu activities. The posyandu is held once a month and emphasizes reaching better health status of infants and the under fives, and pregnant women. Cadres work as volunteers. Their tasks include preparation for the posyandu (reminding the community of the posyandu, weighing babies, preparing food supplement, and taking notes). The ones who are active help also in distributing invitations to mothers to come to the posyandu. As a reward, in many places, they can obtain health service at no charge. The hamlet leaders usually assign active women to become cadres.

From interviews, we realized that drop out rate is quite high in Dompu Barat area. Usually cadres are young and become bored after 2-3 months as cadres. It is the community midwife's tasks to always encourage and motivate the cadres,

The TBA is usually a respected woman in the community, mostly illiterate. From the KAP survey around 60% of women in Sumbawa gave birth using TBAs. The MOH has trained those TBAs; only a small percentage of untrained TBAs are left nowadays.

A hamlet leader is usually chosen by the community, and the name of the candidate is forwarded to the Camat (subdistrict leader). The letter of decree for the approved hamlet leader will be issued by the provincial Home Affair Office. His main task is to handle

administrative matters at the hamlet level. There is no fixed monthly salary given to the hamlet leaders. Still in many places, this position is highly desirable because of the status in the hamlet community. A national Regulation (Undang-Undang) in 1974 stated that hamlet leader is responsible for the vital statistics in his area of work.

The project does not provide honorarium to be given to the community members. However, small transportation fee for cadres or TBAs who report births, new pregnancies or deaths to the community midwives or to the pustus staff is usually given. The funding is allocated from the project's funding provided for operational purposes at the village level. Since hamlet leaders are often bypassed by the TBAs, family members or health cadres, the B3 form kept by the hamlet leader is also often outdated. The community midwife or the pustus staff, who theoretically should come to the hamlet leader to collect the data, do not come. The health providers then collect the report in the Buku Dusun (Hamlet Book), one for each hamlet in her working area. Two kinds of Buku Dusun are available: Buku Dusun Ibu (Hamlet Book for Mothers) with a pink cover and Buku Dusun Bayi (Hamlet Book for Infants) with yellow. Besides the Buku Dusun, the community midwives and pustus staff are also responsible for filling the Buku Kohort Ibu and Buku Kohort Bayi (Mother and Baby Kohort Registration). These two Kohorts are an example of the Recording Reporting (RR) system used by a program, in this case: the MCH program.

Based on data at the Buku Dusun, the community midwife or the pustus staff fill in the B4.1 and B4.2 forms. The forms are used for planning the service given and also as guidelines for "pengerahan massa" (community mobilization) to come for the posyandu activity. Reported births will be immediately visited at home and be given a package of services to the mother and newborn baby. If the delivery is assisted by a TBA or health provider, the baby will also be weighed using a simple low-birth-weight detection scale. Data of mothers giving birth to low birth weight babies will be filled in on the yellow card. Data of mothers giving birth to normal babies will be filled in on the blue card. Three white cards will be attached to each yellow card, to be used for entering data on the progress of the low birth weight babies through three follow up visits.

The community midwife or the pustus staff then record their achievements of activities in Form B3 (FB3). One copy goes to the health center at least before day 10 of each month, one copy will be kept by her. The Puskesmas compiled data received from all pustus and community midwife serving in its area in form FB4. The FB4 is forwarded to the district health office.

All health providers and community personnel involved in the execution of the project have been trained prior to the beginning of the interventions. The training uses a competency based model. messages are kept short and clear using simplified medical terminology. The training scheme can be seen at the Attachment. No pre- or post-testing was conducted as part of the training.

Only master trainers at all levels owned complete sets of the 22 modules. The HSCS team members from Puskesmas Dompu, for example, who are the nurse and midwife, trained the pustu nurse, community midwives, posyandu cadres and the TBAs. They did the training by using transparencies provided in the modules.

Each module is estimated to be delivered in a certain number of hours. All modules, numbered 1-22 were given to the district level master trainers, through training. Table 3 describes the various modules given to various training teams. From interviews it was found that in general, the training time was too short, especially for mastering skills in filling various new reporting forms. This is a reason why supervision are important. All training was funded by the project.

Training

To obtain a better understanding of the level of health knowledge and perceptions of the community, PATH's first step was to obtain assistance from a local NGO to conduct KAP survey in Mataram and Lombok. The results were used as baseline data, but also served as input for making the intervention plan more specific to local conditions.

The second step was to conduct training using the 22 modules will train the district level HSCS master trainers and team. Due to geographical reasons, training of all master's trainers for Sumbawa was conducted in the city: Sumbawa Besar. Information on this project was also given to all hamlet leaders, village heads and camat (subdistrict head).

Training as a preparatory phase of the project intervention for three kabupatens on Sumbawa island was conducted in January 1996. The training started with training of District Master Trainers, taught by the Provincial Master Trainers (consisting of PKPP staff, Wydia Iswara Bapelkes and staff PATH Mataram) down to training at the hamlet and village levels, conducted by the puskesmas trainers. Besides producing district level master trainers. the training also attempted to improve the quality of district supervisors, since they are also the master trainers.

The topics of the 22 modules are:

- . Principles of Training of Trainers
- . General Orientation on the HSCS project
- . Interpersonal Communication
- . Antenatal Care
- . Birth Weighing
- . Care of Low Birthweight Babies
- . Umbilical Cord Care
- . Breastfeeding
- . Personal hygiene
- . Immunization of infants

- . TT immunization for mothers
- . Verbal Autopsy
- . Cold Chain
- . Sterilization
- . Vitamin A Supplementation for postpartum
- . Iodine Supplementation
- . Iron Supplementation
- . UniJect
- . Cadre Health Education Card
- . Reporting/ Recording for the Health Personnel
- . Reporting/Recording for Hamlet Head and Village Staff
- . Supervision

Table 3: Various Modules used for Various Related Project Team at District, Subdistrict , Pustu and Village Level.

Type of Training	Modules Used
1. District Master Trainers	1-22
2. Health Center Team	all except 12,14, 18, 19, 21
3. Training of Pustu Staff & Vaccinators	all except 1, 4, 7, 12, 18, 21. 22
4. Training of Midwives	all except 2, 18,19, 21, 22
5. Training of Village Level Team	2. 21
6. Training of TBA & Cadres	2, 19, 21

In Sumbawa, training of the district master trainers was conducted on 8-10 January 1996. They, in turn, trained the health center coordinators and staff (midwives, pustu staff, vaccinators) on 10- 12 January 1996 in Sumbawa, 4-6 March, 1996 in Dompu, and 6-8 March, 1996 in Bima. The training at the village level for village office staff, hamlet leaders, cadres, TBAs were carried out on 2/26-3/13, 3/4-30, and 3/8-14, 1996 at each of the three districts.

To introduce the project and familiarize other sectors with the health intervention, intersectoral and public administrator training was conducted during the preconditioning period.

The methods used in all trainings varied from lectures and discussions, demonstrations using video cassette and in class simulations. Table 4 shows a list of types and numbers of related groups trained in Sumbawa island. This table is based on tables developed by PATH Lombok and the provincial Health Office.

Table 4: Types and Numbers of Project Teams Trained in Sumbawa island, 1996

Types of Training Groups	Sumbawa	Dompu	Bima	Total
1. District Level Trainers	6	4	4	14
2. Subdistrict health center trainers	4	2	4	10
3. Pustu Staff	6	7	5	18
4. Vaccinators	5	2	5	12
5. Community Midwives	9	4	13	26
6. Village Office Staff	10	7	8	25
7. Hamlet Head	32	38	38	108
8. Staff of Village Office	21	8	9	38
9. Cadres	58	64	66	188
10. TBAs	46	48	45	139
11. Village level Trainers/coordinator	2	1	2	5
12. Village Level Coordinators	2	1	2	5

Source: Bimdal PKPP-1996, PATH, Lombok-1996 for Sumbawa.

The HSCS teams at various administrative levels

A formal team to handle the HSCS project was established in each level of the health office. At the national level, a new decree was recently launched by the Sekretaris Jenderal Depkes RI (Secretary General of the MOH), announcing the replacement of Dr. Nardho Gunawan with Dr. Rachmi Untoro MPH as the new chairman of the National HSCS team. At the provincial level, Dr. Agus Sutanto is assigned by the Head of Kantor Wilayah DepKes Propinsi NTB as the HSCS project leader, with team members consisting of chiefs of three sections under the Kanwil: the Epidemiology, CDC and Family Health, plus two subdinass under the Dinas Kesehatan Dati I propinsi NTB who are chief of the MCH and chief of the CDC.

At the kabupaten (district) level the HSCS team is chaired by the Head of the Dinas Kesehatan Dati II (chief of the District Health Office) and the team includes chiefs of the MCH, CDC, and Nutrition sections. At the kecamatan (subdistrict) the team consists of the head of the health center, the nurse and the midwife.

E. SUPPLIES and MATERIALS

The HSCS project is a project designed to give newborn babies and mothers immunizations and micronutrients. Immunization given to newborn infants are Hepatitis B vaccine and Oral Polio Vaccine. Mothers giving birth were given Tetanus Toxoid (TT) immunization, known as TT Maternal (TTM), 1 sachet of 30 sugar coated iron tablets and one 200.000 IU vitamin A capsule. Immunization of sick newborn infants will be postponed until their health is improved.

The HSCS project also focuses on pregnant women. On the first antenatal visit, women are given TTI immunization and a sachet of 30 sugar coated iron tablets. A second TT immunization is given at the second antenatal visit, together with another sachet of iron tablets. The third sachet of iron tablets is given at the third visit.

Distribution of iron tablets for pregnant women is a national government program. The provision of iron tablets and vitamin A are through the Directorate of Nutrition, MOH. It is sent to the Provincial Health Office and distributed to the health centres based on the plan submitted by the District Health Office. The government, through the national budget (APBN), could only provide 55% of the iron tablet demand which is primarily for pregnant women. There is no provision for iron tablets at birth. The APBD II (Local district government budget) is not providing iron tablets. In theory, the supply of iron tablets would not be sufficient, but this does not occur in the project sites

For micronutrients, if shortages occur from the provision by APBN and INPRES, local funding through APBD can be another channel. The decision lies in the Bupati's hands (District Head).

In contrast, vaccine is always available. Vaccine is produced by Perusahaan Umum Bio Farma, and provided through Direktorat P2M, MOH. Vaccine is directly dropped to the district health office and kept in the refrigerator which is at the office. The health center plans the need for vaccine, and takes the supply from the district health office and stores it in the health center refrigerator.

The supply and distribution of micronutrients or vaccines seemed to be no problem from the provincial level down to the district puskesmas level. The problem lies at the spearhead level with the pustu staff, midwives, and vaccinators. They claimed that sometimes they do not have stock on hand at when they need it. This creates a delay in the intervention.

The HSCS project provides disposable syringes and needles. which are used for HBI and TT immunization. So far there is no shortage of syringes and needles at the project sites.

The use of UniJect for TT and Hepatitis B immunization as a trial ended with the termination of the HSCS project in Lombok in September 1996. With the use of

disposable syringes, a cold chain is needed to keep the vaccine. Refrigerators are badly needed in remote areas such as Labangka in Sumbawa and Kolo in district Bima.

The need for various reporting forms at various levels is obvious in this HSCS project. The provincial health office is responsible for multiplication of all HSCS forms. A formula has been established to calculate the number of various forms needed at various levels. In practice, the formula is not applicable and is not used any longer for estimating the distribution of forms. This situation causes the lack of stock of forms at the health center or pustu. A health centre doctor mentioned the shortage of verbal autopsy forms. To overcome this, the 5 page form was photocopied.

F. QUALITY

The quality of the HSCS project can be measured through several indicators. First, is the punctuality of the birth entered intervention; which must be done within O-7 days of birth. Data on the increased proportion of births covered during O-7 days is not available at the moment, but will be collected in the future. Second, is the support of a ready stock of vaccines and micronutrients at the hands of the pustu staff, vaccinators, or community midwives, those who are directly facing the target groups. From interviews, vaccines and micronutrients are sometimes not available. Third, is the validity of data collected and reported at the hamlet level, which is sent to the higher level to be compiled. From the field visits we realized that data collection and data reporting is improved, which is to some extent the result of the fourth measurement: the intensity of supervision (detailed information on supervision is explained in the following subheading).

G. SUPERVISION AND MONITORING

Supervision is an important means to accelerate the success of a reporting/recording activity. Fully aware of that concept, the project added to the training modules a module on supervision. The module was developed by staff of the provincial health office and PATH Lombok. In addition to the module, a supervisory checklist was also developed, which can be used for any level of supervision, and should be filled out during supervision. The training on supervision was conducted for the District level Master Trainers. Senior Nurse Midwives at the health centres, and the HSCS team at all levels.

Supervisory checklist forms are provided by Kanwil Kesehatan/Provincial HSCS team and made available at the province, the district health office, and puskesmas. The supervisory targets are the process at the dusun level (the reporting mechanism of kader, TBA. kadus); at the village level (the reporting mechanism among kadus and community midwife or health staff at pustu); and the birth centered intervention (conducted by the pustu health staff or the community midwife).

The ideal supervisory visit is once a month by the puskesmas team to the pustu. once every two months by the district level team to puskesmas and sometimes to the pustu.

Any supervision made by either Kanwil or district or puskesmas staff should fill out two copies of the supervisory checklist. One copy should be left at the pustu, one copy should be given to the district team. Trouble shooting should be done directly at the pustu or, if unresolvable there, at the district level.

Besides the project's provision of funds for supervision, each health program also provides a certain routine allowance for supervision, taken from the "Biaya Luar Gedung" (Allowance for Outside puskesmas activities).

Facts showed that supervision still must be encouraged and improved. The four page supervisory checklist is available at each level. Some district health offices multiply the forms to reduce the photocopy budget.

Once every two months, the Kanwil staff, together with staff of PATH Lombok, conduct supervision to urban Mataram and all three kabupatens in Sumbawa island. One trip usually takes 5-6 days by car. The provincial team goes to the district health office, and together they go to puskesmas, selected pustus, and to the field. The pustus supervised are usually the ones who show low coverage of the "birth entered activities," and/or show technical mistakes in the report.

Any problems faced during supervision were brought to the district health office and discussed with the team. PATH Lombok was also active in the discussion. If the problem needs a higher decision level, it was brought to the provincial health office to be discussed with the HSCS provincial team.

So far, the provincial team, together with PATH Lombok, has conducted supervision almost always on a regular basis. What they did is go to the district level and then together with the district team, go to the pustu. The supervisory checklists are filled out and left as planned.

District supervision still needs to be improved in frequency and in quality of supervision (the use of supervisory checklist and its analysis).

One pustu visited in Bima showed very neat supervisory visit notes. The notes could tell how the next supervisory visit monitored the progress of the last visit's suggestions. None of the 5 supervisory visits were conducted by the puskesmas team.

H. REGIONAL AND HEADQUARTERS SUPPORT

This section was discussed between the evaluator and the country representative in PATH Jakarta with input from Nancy Muller and David Allj from PATH Seattle.

The Healthy Start project in Lombok and Sumbawa received administrative monitoring and technical support from PATH Jakarta and Seattle offices. Technical support was provided

on a quarterly basis by PATH Jakarta country director, Mr. Don Douglas and project medical advisor, Dr. Anton Widjaya, with administrative backstopping from Mrs. Yanti Triswan.

The visits have been timed to coincide with major review meetings wherever possible. Technical assistance visits were made by PATH Seattle staff: Dr. Vivien Tsu in October 1995 and Ms. Donna Robinett in December 1995 and September/October 1995. Dr. Tsu facilitated a staff planning retreat with Lombok and Jakarta project staff; Ms. Robinett provided assistance with personnel matters, participated in a Healthy Start project review meeting, and assisted Lombok and Jakarta staff in planning for the midterm evaluation and documenting project accomplishments. These visits from Seattle staff were supported through AusAID cofunding of the Healthy Start project in Lombok and Bali. Dr. James Maynard of PATH Seattle has also provided technical assistance through AusAID and USAID HealthTech co-funding in the area of overall project design and implementation, with particular focus in the area of Hepatitis B. A cost effectiveness analysis on the birth-centered model of service delivery was carried out in 1996 by two local economists: Laura Bailey and Anna Wetterberg. This was covered through AusAID co-funding and with pro bono services.

Routine technical assistance in issues of program design, problem solving, reporting, evaluation and management has been provided by Ms. Nancy Muller, headquarters project manager. In particular, Ms. Muller was instrumental in identifying a replacement program manager when Dr. Stott left the project. Mr. David Alli from PATH Seattle has provided ongoing administrative assistance in overseeing budgets, subagreements, and reports, including monitoring of monthly expenses against project budgets. Approximately 10 project staff, located in Lombok and Jakarta, are backstopped by the headquarters.

I. BUDGET MANAGEMENT

As reported in the PATH second annual report (covering the period October 1, 1995 through September 30, 1996), the overall rate of the project expenditures is lower than anticipated for a number of reasons, primarily the 14-month delay in the approval of the Cooperative Agreement with the Ministry of Health and cost sharing arrangements with the AusAID-funded component of the project. For example, the cost for the midterm evaluation are just now being incurred, several months later than originally anticipated, because of the delay in the launch of the project. It is fully expected that the project will be able to achieve its objectives with the funds available to it, and that the funds will be fully expended at project completion; however, because of the delay in implementation, it is likely that a request for a "no-cost" extension will be necessary.

J. PVO's USE OF TECHNICAL SUPPORT

Based on the recommendation addressed by the midterm evaluation, there is a need to request an expert in developing program for standardized analysis of the HSCS data.

Previous experience showed no constraints or problems are faced in obtaining technical support.

K. ASSESSMENT OF COUNTERPART RELATIONSHIPS

The Indonesian Ministry of Health is the chief counterpart to the HSCS project. Effective links between the PVO and the Ministry of Health have been created on every level. At the national level PATH Jakarta works closely with the Ministry of Health national HSCS team in setting policy and evaluating the appropriateness of the project in the broader Indonesian health context. At the provincial level, PATH Lombok and the provincial health office, led by the project's principal investigator, work closely in the design, implementation, supervision, and trouble shooting of the operational aspects of the project. PATH Lombok staff discuss the project frequently with district, subdistrict, and village-level health staff. In this way the project has been effective in collecting feedback from all levels of Ministry of Health counterparts and incorporating it into project refinements. The Ministry of Health counterparts fully manage the project and provide appropriate technical assistance. Ten years of HSCS-type activities have created a very strong capability to conduct and replicate the project among the MOH counterparts.

L. REFERRAL RELATIONSHIPS

The HSCS-USAID project can be regarded as a community based project, focusing on intervention at the family level. As a public health action, the strategy chosen is promotive and preventive. The project is not designed for handling the curative system, though relationships with hospitals (in Lombok and Bima) are built, mainly to capture the hospital based deliveries to be given the birth-centered interventions.

M. PVO/NGO NETWORKING

So far, the HSCS-USAID project has worked with a local NGO: the Yayasan Keluarga Sehat Sejahtera Indonesia (YKSSI) to conduct the KAP surveys in both Lombok and Mataram. YKSSI analyzed and reported the survey results. YKSSI was also requested to develop the video cassette for Interpersonal Communication. Initiated by WHO, there is a once in a two week meeting in Jakarta where all donor agencies are invited: among others is PATH Jakarta. This forum is also used to share experiences and activities among donors.

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LIST OF FIELD VISITS AND INTERVIEWS

Monday, November 25, 1996

- 08.00-09.00: Discussion with Dr. Wiadnyana MPH, Kepala Direktorat Bina Upaya Kesehatan Puskesmas, Depkes RI
- 09.00- 10.00: Plenary Meeting: Drs. Rachmi Oentoro MPH, Kepala Direktorat Bina Kesehatan Keluarga, Ina Herawati MPH, Kepala Seksi Kesehatan Balita, Ardhi Kaptiningsih MPH, Kepala Seksi Kesehatan Maternal; Depkes RI
- 19.00-10.30 Discussion with Dr.Nardho Gunawan MPH, former Ketua Tim Teknis HSCS Tingkat Pusat, Depkes RI
- 13.00-15.30: Discussion with Dr.Anton Wijaya MPH, Consultant HSCS at PATH Jakarta

Tuesday, November 26, 1996

- 09.40: Departure to Lombok: Dr.Siti Hariani from MOH, Mrs. Aurorita Mendoza, Director of PATH Thailand, Dr.Adik Wibowo MPH
- 15.00-17.00: Plenary Session with Mr. Carib Nelson, Project Officer, Mr. IGP. Suradana, Field Manager, PATH Lombok

Wednesday, November 27, 1996

- 08.00-12.30: Plenary Session: Presentation on HSCS Urban Mataram by ibu Nurmawati and HSCS Sumbawa by Dr.IK. Artastra MPH, chaired by Dr.Agus Sutanto, Kepala Bidang Bimdal PKPP Kanwil Depkes Prop. NTB
- 13.00-4.00: Visit Puskesmas Ampenan at Kodya Mataram
Plenary Session with Dr.Didi Chandradikusuma . Head of Puskesmas and staff
- 14.00: Departure to Sumbawa: Evaluation Team and Path Lombok

Thursday, November 28, 1996

- 08.00-09.30: Individual interview with team HSCS at Dinas Kesehatan Dati II Sumbawa: Mr. Agus Witjaksono, Koordinator Catpor, Mr. Syahbuddin, Bendahara HSCS, Mr. Umar
- 10.00-10.30: Meet Bupati Sumbawa: Yakob Koswara. Present in the meeting: Evaluation Team, PATH Lombok. Mr. Umar, Dr.Husin Fahmi MPH, Kasie P2M Kanwil Depkes Prop. NTB. Ketua Bappeda Kab. Dati. II Sumbawa
- 11.00-17.00: Field Visits:
1. Puskesmas Alas
Individual interview with Dr.Sugeng, Head of Puskesmas and Staff.

2. Puskesmas Pembantu (Pustu)
Discussion with Bidan
3. Visit mother at birth at village Luar
Saw the conduct of Birth Centered service by Bidan
4. Visit mother at birth at village Baru
Saw the conduct of Birth Centered service by Bidan
5. Pustu Pulau Bungin, a Bajo island, 10 minutes by ferry from Alas
Discussion with Pustu Staff
Visit and saw Birth Centered service to 3 mothers
Interview 2 TBAs

Friday, November 29, 1996

- 09.30-12.00: Discussion and individual interview with HSCS staff at Dinas Kes. Dati II Sumbawa
- 15.00: Ms. Aurorita Mendoza and Dr.Siti Hariani departed to Jakarta

Saturday, November 30, 1996

Free

Sunday, December 1, 1996

- 13.00: Move to Kabupaten Dompu

Monday, December 2, 1996

- 08.00-08.30: To District Health Office
Meet bapak Nurdin, Ka TU who arranged schedule in Dompu
- 09.00- 11 .00: Pukesmas Dompu Barat
Discussion with HSCS Team at Puskesmas: Dr.Mudita, Puskesmas Head, midwife Masrani and nurse, HSCS team, community midwife Nurfatimah from village
- 11.00-1 1.45: To Bupati Dompu
- 12.00-13.00: Visited Polindes
Discussion with community midwife Nurfatimah
- 13.30: Back to District Health Office
- 13.30: Depart to Bima

Tuesday, December 3, 1996

- 08.00-09.00: To Hospital Bima at Raba
Discussion with Hospital Director: Dr.H. Ibrahim,
Discussion with HSCS team at the hospital: Dr.Tatang, paediatrician. coordinator of HSCS hospital. Dr.Tono. Obgyn, midwife Nur

09.00- 10.00: Visited pustu
Discussion with midwife Any Nuraeny, Pustu Head. Misfah,
community midwife, pustu nurse
10.15-10.45: Meet Sekretaris Wilayah Daerah (Sekwilda) Bima: Drs.
Miraffuddin
11.45: Depart to Mataram
13.00: Meet Drg. Nita Kumiawati, MOH staff who arrived yesterday

Wednesday, December 4, 1996

08.30-10.00: Meeting at Provincial Health Office
Discuss findings with Dr. Agus Sutanto and PATH Lombok team
Wrap up session
16.00: Depart to Jakarta

Tuesday, December 12, 1996

13.00-15.00: Meeting and discussion with Dr. Sri Duryati and Mrs. Yanti
Triswan from PATH at the USAID Office Jakarta

Tuesday, December 17, 1996

07.30-10.30: Meeting and discussion with PATH Jakarta Office Manager: Mrs.
Yanti Triswan at PATH

Thursday, December 19, 1996

09.00-11.00: Presentation of Draft Report at PATH Jakarta Office

Friday, December 20, 1996

09.00- 11.30: Presentation at MOH Jakarta