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IMPACT ANALYSIS

COMPREHENSIVE HEALTH IMPROVEMENT PROJECT PROVINCE SPECIFIC

(CHIPPS)

FINAL EVALUATION OF CHIPPS

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EXECUTIVE SUMMARY

1. The USAID/Indonesia Comprehensive Health Improvement Program - Province Specific (CHIPPS) was a broad-ranging primary health program designed to promote decentralized health planning and programming in three provinces - Aceh, West Sumatra and Nusa Tenggara Timur (NTT). Using a "problem solving approach", the project provided funding and technical assistance to assist provincial and district health officers develop their own capacity for identifying problems, implementing solutions and monitoring and evaluating these activities. Through this process provincial and district officials developed dozens of CHIPPS supported activities that included community - based training for medical students and nurses, data management and epidemiological training and studies, other management training, and innovative approaches to disease control such as neo-natal tetanus, malaria and tuberculosis.

2. One of the central problems earlier evaluations of CHIPPS identified was that the activities that were being developed in the provinces were generally unknown or poorly understood at the national level and in other provinces.

   The final evaluation was designed to overcome this central constraint by involving health officials from the national level in all stages of the evaluation over a six month period.

   Specifically, the objectives of the final evaluation were to: 1.) determine the effectiveness of selected CHIPPS program innovations and consider whether they should be sustained and replicated in other provinces, 2) calculate the true costs of sustaining and replicating these innovations, 3) increase awareness at the national level of what had been learned from the CHIPPS program about project implementation and about program innovations that could be applied elsewhere, 4) gain participation of key health officials in the review of evaluation results and the formulation of recommendations so as to enhance potential implementation of evaluation recommendations.

   Three process workshops over a six month period were used to involve many key health officials from the national level, along with external and domestic consultants, in the selection of priority areas for evaluation, design of evaluation methodologies, review of findings and data analysis, and development of appropriate recommendations to present to top level policy makers in the Ministry of Health.

   The activities that were chosen for evaluation were:

   1) data management and epidemiological training,

   2) health information system for health post level (MONEV Posyandu),

   3) nursing school field training,

   4) use of recent nursing graduates in remote areas (Relawan Posyandu),

existing integrated health information system be extended to the posyandu level with the MONEV approach -- after gaining the coordinated support of other community level agencies (PKK and BKKBN). Data Management Training was recommended for a national program to develop decentralized planning and management especially at the district level -- in line with the policy directives of the current Five Year Plan. Other management training activities for organizational effectiveness and development were recommended to be integrated into current in-service training programs.

Drug management activities of CHIPPS were seen as addressing only part of the problem. The seminar recommended that they be incorporated into a more systematic effort that would include I.E.C., revised reporting forms, and assistant pharmacists.

The Nursing Field Practice was already a national policy, however it had been shortened and its emphasis shifted from a community approach to a family orientation. The seminar recommended that the policy be more in line with the CHIPPS experience. The relawan program was to be adopted nationally, and the communities expected to provide funding through social insurance schemes.

Finally, the seminar recommended that alternative project implementing units be designed and that block grant financing mechanisms be designed to replicate the benefits of the CHIPPS experience for decentralization.

5. Lessons Learned:

The unusual CHIPPS approach to developing provincial capabilities through a problem solving approach resulted in a wide variety of useful activities that were effective at the province, district, and lower levels. The approach's major weakness was the lack of involvement of national level officials who would be able to replicate the successful efforts of the project in other provinces.

The unusual evaluation process was useful for gaining a greater awareness at the national level of a relatively successful province-based project and to encourage policy makers and high officials of the health ministry to become interested in using the evaluation results to recommend policy, strategy and program changes necessary to implement useful lessons from CHIPPS on a wider scale.

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GLOSSARY

BKKBN	Indonesian Family Planning Agency
CHIPPS	Comprehensive Health Improvement Program--Province Specific
DEPKES	Ministry of Health
Dinas	Provincial or District Government Health Office
DIS	Charts for Village Health Coverage
Formaci	Official Postings
Kabupaten	District Administrative Unit
Kader	Village Volunteer Health Workers
Kandep	District Level Office of Ministry of Health
Kanwil	Provincial Level Office of Ministry of Health
LB5	Health Center Reporting Form for Ministry Health Information System
MONEV Posyandu	Health Post Monitoring and Evaluation Information System
OD/OE	Organizational Development/Organizational Effectiveness Training
PKK	Indonesian Women's Organization
Posyandu	Village level Health Post
Pusdiklat	Training Unit of Ministry of Health
Puskesmas	Health Center
Pusat	National level of Ministry of Health
Relawan	"Volunteer" Nurses Assigned to Communities
Repelita V	Fifth Five Year Health Plan (1989-93)
SPK	Provincial Nursing School
Sumbar	West Sumatra
NTT	Nusa Tenggara Timur
US$ =	Rp. 1,765

III. EVALUATION PROCESS AND METHODOLOGIES

A. Background

The USAID/Indonesia Comprehensive Health Improvement Program - Province Specific (CHIPPS), which began in 1981 and ended in 1989, was a broad-ranging primary health program designed to promote decentralized health planning in three provinces - Aceh, West Sumatra and Nusa Tenggara Timur (NTT). During its eight year history CHIPPS supported dozens of activities that included community - based training for medical students and nurses, epidemiological training and studies, and innovative approaches to disease control such as neo-natal tetanus, malaria and tuberculosis. CHIPPS funding also provided substantial support for academic training for nurses, nursing school instructors, para-medics and other health personnel.

From the beginning, the CHIPPS program was unusual for large-scale foreign-assisted health programs. Rather than beginning with clearly defined aims to deal with a specific health problem, CHIPPS was designed to promote innovative solutions to locally defined problems in three under-served provinces, each with very different histories, cultural back-grounds, health problems, and health management capabilities.

In all three provinces the program began with epidemiological studies to determine the major health problems of the province. Based upon the findings of these studies interventions were designed to deal with priority problems. This approach was unique for Indonesia where most health programs had been planned by the central ministry of health and carried out by provincial health officials. These centrally planned programs often failed to meet local needs or wasted resources on non-existent problems and inappropriate implementation approaches.

The CHIPPS program included two main elements, 1) manpower development through local training and study fellowships, and 2) service delivery improvement in a wide variety of health programs. These programs varied from province to province based upon the needs of the provinces but often programs -- such as drug management training to encourage more rational prescribing practices and improve supplies & inventories -- were carried out in all three provinces with minor variations. Through the years the specific approaches and priorities of the CHIPPS program have changed due to changing priorities of the Ministry of Health, changing program personnel and changing perception of the health problems in the three provinces.

Prior to this final evaluation three previous program evaluations had documented the impacts of the CHIPPS program and recommended solutions to implementation problems. The last evaluation assessed the extent to which CHIPPS had contributed to decentralized planning and decision-making in the three provinces. This evaluation found that indeed these provinces were more active in initiating ideas for new programs and were more successful in convincing Pusat (Central MOH) to support and fund those initiatives. During his work with Pusat and the provinces the evaluator also discovered that many program innovations developed in the CHIPPS program were largely unknown in Pusat and non-CHIPPS provinces. He also found that project

activities had not addressed the costs of continuing these program innovations or replicating them in new areas of the country.

After discussion of these issues with officials in the MOH and USAID it was decided to carry out a final evaluation, not with the aim of looking back at the overall impact of CHIPPS or determining its strengths and weaknesses, but with the objective of looking forward to how the lessons learned during the CHIPPS experience could be applied to improving policies at the MOH and USAID.

Specifically, the objectives of the final evaluation were to:

- Determine the effectiveness of selected CHIPPS program innovations and consider whether they should be sustained and replicated in other provinces.
- Calculate the true costs of sustaining and replicating these innovations.
- Increase awareness at Pusat of what had been learned from the CHIPPS program about project implementation and about program innovations that could be applied elsewhere.
- Gain participation of key health officials in the review of evaluation results and the formulation of recommendations so as to enhance potential implementation of evaluation recommendations.

B. Evaluation Approach

In designing the final evaluation it was apparent that traditional approaches to evaluation were not appropriate. First, CHIPPS was not a single definable program with a clearly measurable objective but was a broad mix of sub-projects which differed from place-to-place and also changed over time. It was not a single dish which evaluators could measure but a moveable feast. Secondly, very little base data were available to compare conditions before CHIPPS with conditions after the CHIPPS interventions. Thirdly, it was not possible to identify control groups in the three provinces that were not 'contaminated' with contact from CHIPPS or that were comparable with those who were involved with CHIPPS programs. Therefore, the most basic conditions needed to meet the assumptions of 'quasi-experimental' field evaluation were not available for this post-hoc final evaluation. It might be noted, however, that this situation is not unusual for A.I.D. projects and that the methodology utilized here may have broad applicability.

Since the purpose of this evaluation was to increase awareness at all levels of the MOH about the CHIPPS experience, the fact that traditional evaluation approaches were not feasible for this evaluation were not viewed as a major difficulty by the evaluators. As stated by Donald Michaels:

> There is a question of whether the purpose of Social Experimentation-including evaluation should be to gather data and test hypotheses, or whether it should be to provide a means by which "evaluators" and

"subjects" alike learn new ways to improve their work effectiveness. To my mind, our work should lean toward the latter". (On Learning to Plan - and Planning to Learn, Jossey-Bass, 1978).

A more appropriate methodology for this final evaluation was the "utilization-focused evaluation" approach described by Michael Quinn Patton (Utilization-Focused Evaluation, Sage Publication, 1978). In this approach the evaluators collaborate closely with the eventual users of the evaluation findings in defining the evaluation questions, collecting data and most importantly, drawing conclusions from the data and formulating the recommendations that come out of the evaluation.

The utilization-focused approach gathers data from a wide variety of sources, including data on program impact as well as the observations of program participants and program managers to help decision makers find answer to their questions about the program. In contrasting the traditional "hypothetico-deductive" approach to the utilization based approach, Patton states, "what fundamentally distinguishes the utilization-focused approach to evaluation from other approaches is that the evaluator does not alone carry the burden for making choices about the nature, purpose, content and methods of evaluation. These decisions are shared by an identifiable and organized group of decision makers and information users" (pg. 72).

Table I summarizes some of the differences between the hypothesize - deductive and utilization - focused paradigms of evaluation.

Table I

Comparison of Hypothesize-deductive and Utilization-focused Paradigms of Evaluation

	Hypothesize deductive	Utilization focused
Focus of Evaluator	Methodology	Needs of decision-makers
Data	Quantitative	Quantitative & Qualitative
Statistics	Comparative	Descriptive
Evaluator Stance	Outsider	Involved
Dissemination	Written Report	Discussion w/Decision-makers
Evaluation Question	Narrow	Broad
Time focus	Past	Future
Purpose	Summative	Formative

Although it was not intentionally based upon the Patton model,, the CHIPPS final evaluation design was very similar to the five steps outlined by Michael Quinn Patton as typical of the utilization-focused evaluation. These steps are:

1. Identify relevant decision-makers.

2. Identify and focus evaluation questions in collaboration between the evaluators and decision-makers.

3. Select evaluation methods that generate useful information for identified decision-makers.

4. Decision-makers and evaluators participate in data analysis and data interpretation.

5. Evaluators and decision makers cooperate in making recommendations and in dissemination efforts.

C. Evaluation Design

1. Identification and Organization of Relevant Decision-makers.

To guide the design and planning of the evaluation a high level steering committee was formed, consisting of six director level (Echelon 2) officials from the MOH and USAID. The purpose of this committee was to decide on the basic frame-work of the evaluation and to approve the overall design.

A mid-level group of 12 Pusat and provincial officials were chosen to form three working groups to participate actively in the design of the evaluation. The three working groups were to guide the evaluation in three areas: cost analysis (Working Group I), training (Working Group II), and service delivery (Working Group III). As the work began it become apparent that the areas covered by working groups II and III were very similar so they were combined into one working group. In addition to these MOH officials, each working group included the long term consultant (LTC) from each CHIPPS province.

The day-to-day technical work of the evaluation was carried out by four domestic (Indonesian) consultants who worked full time on the project for six months. Their activities included writing evaluation instruments, collecting and analyzing data and presenting the results of the evaluation to decision-makers. Three part-time external consultants also provided technical assistance to the evaluation. These outside advisors included a health policy analyst, a financial analyst and a training specialist.

2. Identification of the Relevant Evaluation Questions

The overall evaluation design and relevant evaluation questions were identified during a three day workshop held in Ciloto on January 12 - 14, 1989. During this workshop,

attended by the working groups and the domestic and external consultants, it was determined that the evaluation would focus on seven CHIPPS components:

1) Drug Management,

2) MONEV Posyandu -- an innovative management information at the posyandu level

3) Data management and Epidemiological Training

4) Relawan Posyandu -- the placement of recent nurse graduates directly in under-served communities

5) Nursing School (SPK) Field Training,

6) Management Training -- both Organizational Development and Organizational Effectiveness (OD/OE),

7) Training in Report Writing,

Of the many projects implemented in the CHIPPS program, these seven components were selected for study because they were viewed as offering the most potential for adoption elsewhere, they had been implemented in more than one CHIPPS province, and they had not been satisfactorily evaluated previously.

For each of the seven components chosen for study the working groups discussed and agreed upon the essential evaluation questions that should be answered, the sources of data (e.q. relevant documents, interviews) and the data collection methodologies to be used (e.g. questionnaires, interviews, focus groups). The working group also approved the data collection schedule that should be followed. One important suggestion made by the working groups was that the evaluators should locate and train interviewers in each province to help the researchers understand local conditions.

3. Evaluation Methods

Three different methodologies were used for evaluation of the CHIPPS project:

1) survey of participants in CHIPPS activities;

2) financial analysis

3) inter-province comparisons

a. Survey of Participants

Following the design workshop one team of evaluators (external and domestic consultants and working group members) met for several days in Jakarta to develop specific interview guides and questionnaires for use in survey data collection. These instruments were based upon the evaluation questions identified by the working groups

during the Ciloto workshop. In all, twenty-one instruments were developed for gathering data on the seven program components.

This large number of instruments were needed because interviews were conducted at the provincial level, the Kabupaten (district) and Puskesmas (sub-district) levels. Interviews regarding the programs were also done with community leaders, volunteers (Kader) in community clinics (Posyandu) and with officials of nursing schools (S.P.K.).

Drafts of these instruments were taken by the evaluators to the province of Aceh for field testing. Based upon these field tests the instruments were modified and several minor changes were made in the evaluation plan.

After returning from the field testing the evaluators wrote a final draft of the evaluation instruments and designed a plan for selecting and training data collection assistants in each of the three provinces. It was decided to select four interviewers in each province and to conduct the interviews in two teams, each team consisting of one evaluator (domestic consultant) and two local interviewers.

The actual data collection was carried out in the three CHIPPS provinces during the months of March and April 1989. A total of 486 individuals were interviewed during this data collection effort.

b. Financial Analysis

A team of economists, financial analysts and public health officials (external and domestic consultants and working group members) designed and pretested a methodology for providing historical cost data for each of the seven intervention areas and also to estimate prospective costs of sustaining current program activities in the CHIPPS provinces or replicating those activities in other provinces or on a national scale.

This team visited each of the provinces and reviewed available project budgets and expenditure data during the period of February through April, 1989.

The team established activity definitions for each of the seven intervention areas, collected cost data, developed analysis of unit costs for each intervention and explored assumptions necessary for sustaining or replicating the project activities.

One central assumption for historical cost analysis was that it was only necessary to determine the additional (marginal) cost of project activities and not include the routine salary costs of officials who would have been paid, or services that would have been expensed, regardless of CHIPPS activities.

c. Inter-province Comparisons

In order to provide some indication of over-all impact of CHIPPS on the provinces, three analyses were designed to compare CHIPPS provinces to similar control provinces. These comparisons reviewed specific indicators of health planning, service

delivery performance and drug ordering for the three CHIPPS provinces and selected control provinces.

4. Data Analysis

The evaluators conducted a preliminary analysis of the evaluation data during the months of April and May and wrote first drafts describing the results of the evaluation, including a description of each component, its objectives, variations in implementation in each province, data on the effectiveness of the program component, difficulties in implementing the component and data on the historical and prospective costs of each component. These preliminary drafts were distributed to working group members in early May.

On May 16-18 a "pre-seminar" was held with working group members and selected policy makers such as key Pusat directors. The purpose of this pre-seminar was to obtain guidance and feedback on the reports. The working groups had several suggestions for improving the quality of the reports.

Unlike traditional evaluation reports, these reports specifically avoided making recommendations or drawing conclusions. This was to be the central activity of the final "Process Documentation Seminar" in which health officials themselves would be expected to review the evaluation findings and make their own recommendations.

5. Final "Process Documentation" Seminar

A final evaluation seminar was held on June 12-14 in Wisma Kenasih, in Caringin outside of Jakarta for the purpose of reviewing the evaluation results and developing recommendations to the Ministry of Health. A total of 74 people were invited to the seminar including representative of key MOH directorates and departments (Community Health, Food and Drug, Communicable Disease Control, Planning Bureau, and the Pre-service and In-service Training Units), officials from the Provinces of Aceh, West Sumatra and NTT who had participated in the implementation of the CHIPPS program, representatives from other provinces of Indonesia and representatives of international funding agencies.

Plans for the seminar were developed jointly by the evaluators and members of the working groups and steering committee. The seminar was a "Process Documentation Seminar" designed to involve high level policy makers in review of the findings of the various evaluation studies to allow them to explore the implications of these findings for future policy and to make recommendations to the Eschelon 1 officials (Directors General, Inspector General, and Minister).

The first day of the seminar involved a brief presentation of the unusual design of the seminar and the expectations of full participation of the health officials of all levels in the review of findings and development of recommendations. A brief overview of the findings was presented and the full reports of the findings of the evaluation studies were distributed. The health officials were then divided into five discussion groups to focus on specific interventions.

The five discussion groups included :

1. Information System (studying the components of MONEV and Data Management and Epidemiology Training).

2. Management Improvement (OD/OE training and Report Writing).

3. Drug Management.

4. SPK Training and Relawan Posyandu.

5. Overall Project Design and Implementation.

Special care had gone into selecting appropriate officials with experience and decision-making roles in the issues of their respective discussion groups. In addition, an effort was made to have officials from each of the CHIPPS provinces who had worked directly in the respective CHIPPS activity in each discussion group. To broaden the perspective, several provincial and kabupaten officials from non-CHIPPS provinces also participated in discussion groups.

Discussion guidelines led the groups to analyze: 1) the problems that were being addressed by the CHIPPS intervention, 2) the nature of the CHIPPS intervention to solve those problems, 3) the effectiveness of that intervention based on the findings of the evaluation studies, 4) the costs of the intervention, 5) obstacles and constraints to implementation, 6) recommendation to sustain or replicate, 7) suggestions to improve the intervention beyond what CHIPPS had done, 8) conditions necessary for replication, 9) consideration of alternative solutions (interventions) that might solve the problems more effectively.

The discussion groups spent the afternoon and evening of the first day reviewing the findings of the evaluation studies and developing preliminary recommendations which were presented to a plenary session on the afternoon of the second day. In most cases the recommendations suggested that the activities that had been developed under CHIPPS be sustained and replicated as national programs. The plenary made suggestions for revisions and changes, usually calling for more specific recommendations which were then developed by the leaders of the discussion groups that evening.

The morning of the third day the recommendations that had been developed by the discussion group leaders were submitted to a session of "reality testing" using "force field analysis" -- a methodology developed by sociologist Kuth Lewin -- to determine the positive and negative factors involved in implementing proposed recommendations. This discussion was designed to sensitize the participants to the obstacles that would have to be overcome and helping forces that could be enlisted to achieve the implementation of their recommendations. It was hoped that this discussion would help refine the recommendations and would assist officials to define an action plan for getting their recommendations adopted.

In general the recommendations sought to implement CHIPPS activities on a national scale. The MONEV program was used as a basis for recommending that the existing integrated health information system be extended to the posyandu level with the MONEV approach after gaining the coordinated support of other community level agencies (PKK and BKKBN). Data Management Training was recommended for a national program to develop decentralized planning and management especially at the Kabupaten level in line with Repelita V policy. Other management training for organizational effectiveness and development was recommended to be integrated into current in-service training programs.

Drug management activities of CHIPPS were seen as addressing only part of the problem. The seminar recommended that they be incorporated into a more systematic effort that would include I.E.C., revised reporting forms, and assistant pharmacists.

The Nursing Field Practice was already a national policy, however it had been shortened and its emphasis shifted from community to family orientation. The seminar recommended that the policy be more in line with the CHIPPS experience. The relawan program was to be adopted nationally, and the communities expected to provide funding through social insurance schemes.

Finally, the seminar recommended that alternative project implementing units be designed and that block grant financing mechanisms be designed to replicate the benefits of the CHIPPS experience for decentralization.

For each recommendation the conditions necessary for implementation were discussed as the initial basis for a future effort to develop a plan of action for implementation, should the policy makers move to adopt them.

The afternoon of the final day was devoted to the brief presentation of the recommendations and the conditions necessary for implementation. This presentation was received by the Inspector General who invited the organizers of the seminar to prepare a presentation to a future routine policy meeting of Eschelon 1 officials.

6. Conclusion

This unusual evaluation process was designed to gain a greater awareness at the national level of a relatively successful province-based project and to encourage policy makers and high officials of the health ministry to use the evaluation results to recommend policy, strategy and program changes necessary to implement useful lessons from CHIPPS on a wider scale.

It was hoped that with greater involvement of many health officials in the evaluation itself, knowledge of the CHIPPS activities would be widely spread and the many positive aspects of a province program would not be lost once the project funding stopped.

It was also hoped that a more involved process would result in greater commitment by health officials to implementing recommendations. This participation involved not only

the usual process of having officials review the actual findings of the evaluation, but also expecting them, rather than the evaluators, to formulate the implied recommendations. In this process, these officials were able to go beyond the actual findings and consider their own and other experiences that were relevant for each type of intervention. In addition, since they were involved in the formulation of the recommendations, they may also be more committed to seeking ways to implement these recommendations then they would have been had they only received the report and recommendations of consultant expert evaluators. It will be interesting to evaluate this impact in the next few years to see if, indeed, the recommendations are adopted.

Not surprisingly, the recommendations followed the thrust of the findings of the evaluation studies which tended to find each intervention worthy of continuation and replication. As such the evaluation was a testament to the effectiveness and utility of the CHIPPS approach. The recommendations, however, also went beyond the CHIPPS experiences and made appropriate suggestions for additional activities to solve the problems that CHIPPS had addressed.

APPENDIX A

The schedule of the final "Process Documentation Seminar" was as follows:

Day 1:

- Introduction-purpose of the seminar, objectives and agenda.
- History and overview of the CHIPPS program.
- Evaluation Approaches and Design of Evaluation.
- Major Findings of the Evaluation.
- Discussion groups discuss findings and prepare draft recommendations. The five discussion groups included :

  1. Information System (studying the components of MONEV and Data Management and Epidemiology Training).
  2. Management Improvement (OD/OE training and Report Writing).
  3. Drug Management.
  4. SPK Training and Relawan Posyandu.
  5. Overall Project Design and Implementation.

Day 2:

Each discussion group prepared and presented the findings and recommendations developed by their group.

Preparation of findings and recommendations by a sub-committee comprised of members of each discussion group.

Day 3:

Report to Plenary of Draft Recommendations.

Reality Testing of Draft Recommendations in 2 groups Using Method of Force Field Analysis.

Report of Final Recommendations and Adoption by Plenary.

IV. SUMMARY FINDINGS OF EVALUATION STUDIES

A. Survey of Participants and Financial Analysis

1. Overview

The survey of participants and the financial analysis show that the activities supported by CHIPPS in each of the three provinces have been generally important and effective contributions to improving health services in these provinces. Each of the seven major activities that we evaluated merits consideration for both continuation in these provinces and replication in other provinces or on a national scale.

We found that the costs some programs that were perceived to be expensive, such as MONEV, were at a level that could reasonably absorbed by national or provincial budgets. The costs of sustaining the existing MONEV programs or replicating them in other provinces were estimated to be only Rp. 3,900 per posyandu per month. In service training programs (data management, drug management, organizational effectiveness) were generally around Rp. 50,000 per person per day. Nursing field training was around Rp. 67,000 per student per month and relawan programs were around Rp. 40,000 per person per month.

The following discussion reviews the methodology and major findings and discusses some of the implications and programmatic options that emerged from these two evaluation studies.

2. Methodology

The survey of participants in CHIPPS programs involved 21 separate questionnaire instruments for officials at all levels and for each of the seven areas of investigation. Interview teams made up of consultants and hired interviewers from the provinces interviewed:

1) the Provincial Doctor and Kanwil/Dinas staffs in each province

2) 3 District (Kabupaten) Doctors and their Kandep/Dinas staffs in each province

3) 3 Health Center (Puskesmas) Doctors and their staffs for each District (total of 9 Puskesmas per province)

4) group interviews with Kader for one Posyandu in each Puskesmas

5) Directors, staff and Graduates of two of the Nursing Schools (SPK) in each province

These interviews totaled 486.

Since the evaluation was designed to provide the most information possible within a restricted budget and time frame, the sample was not randomly selected and makes no

claims to scientific rigor. The sample was selected for research convenience to evaluate the maximum impact of CHIPPS. Facilities were selected on basis of interview team schedules and the location of officials who had had CHIPPS training programs.

Interviews were designed mainly to tap respondents' judgements about the effectiveness of training programs. However, these judgements were often checked by reviewing documents and by some hard data evidence, as available.

The financial analysis was based on the financial team's field visit to each province to gain historical cost data by reviewing both the original budgeted funding and the expenditures for receipts. This study found that usually official expenditures were the same as original budgets regardless of the actual implementation of project activities. The historic costs were determined for the marginal increase in routine costs implied by the project and assumed the recurring availability of funds for current salaries and other routine expenses that would have been incurred regardless of CHIPPS activities.

The historic cost estimates were then used as a basis for projecting future costs for sustaining the activities in the CHIPPS provinces after the end of the project, and for replicating these activities in other provinces or on a national scale. These projections were based on a variety of assumptions that are specified in the financial study reports.

The following sections give details of the findings from the survey and financial evaluation for each of the seven activities reviewed.

3. Information Systems, Data Management and Epidemiological Training

Central to the CHIPPS program was the development of provincial and local level capabilities to identify problems, initiate specific activities to resolve those problems and monitor and evaluate the implementation of those activities. This process was initially called the "epidemiological approach", or more recently the "problem solving approach". This approach assisted in the development of provincial, kabupaten and puskesmas skills for identifying problems, selecting priority areas for interventions, developing activities to resolve those problems, and monitoring and evaluating the interventions. Using these skills provincial and local officials implemented many of the other interventions that are evaluated in this report, as well as numerous other activities that we were not able to evaluate here.

Two of the major activities evaluated in this final evaluation were directly related to this central CHIPPS approach: the MONEV Posyandu system and the training programs in data management and epidemiology. These activities helped develop skills in problem identification and in monitoring and evaluation. Both activities emerged themselves from the problem solving approach. MONEV was initiated in part as a response to the inconsistent reporting from the posyandu levels. The data management and epidemiological training programs were means to enhance problem solving skills as various levels after the initial epidemiological studies implemented in the early years of the project.

a. Data Management and Epidemiological Training

Central to the CHIPPS approach was the emphasis on the use of data for problem identification, problem solving and program monitoring and evaluation. In all three provinces, CHIPPS sponsored special training programs to strengthen the capacity of health officials to utilize data in their daily work. In all provinces skills in routine data management were emphasized. In Aceh and NTT this training also involved skills in survey methods.

The core of the training emphasized the "epidemiological" approach which focused on techniques necessary for:

- the collection, recording, reporting of data;
- means of analyzing data to identify problems and develop solutions; and
- using data to monitor and evaluate program implementation.

Training was normally two weeks in duration and began as early as 1983 (in Aceh). Most of the training involved the use of the participants' own data.

In all provinces over 80 % felt that the training was useful for the utilization of data in their health units and that the epidemiological approach was being used in decision-making. It was specifically used for problem identification, and problem solving in routine meetings (with the exception of Aceh where only 48% were using data for problem solving).

Overall the participants were satisfied with the content, material and methodology of the training itself. Those who had had other epidemiological training tended to find that CHIPPS training to have better material and methodology and that the techniques for data collection, problem identification and data analysis were more appropriate than the other courses.

In open-ended questions in which respondents were asked to give specific examples of the uses they had made of the training all were able to give appropriate responses showing that they were using methods from the training for planning, target setting, supervision and monitoring, as well as for task analysis and description. These responses were generally well supported by a review of available documents.

Suggestions for improvement included providing simple statistical analysis in the course, training for other levels of health officials, and refresher training.

Overall, this training was seen as having been extremely effective.

Costs: Our prospective cost analysis estimated that sustaining or replicating data management training programs would cost approximately Rp. 45 - 50,000 per person per day.

b. MONEV Posyandu

MONEV is a health information system designed to improve reporting at the Posyandu level so as to give kader and community more accurate and useful ways of identifying community health status, motivating outreach activities to assure coverage of specific target groups (children under 5, pregnant women, eligible couples). It also provides monitoring information for health officials at the puskesmas, kabupaten and provincial levels so that planning and supervision can be more effectively implemented. It is based on the PKK kader reporting forms and also assists in reporting through the DEPKES Integrated Health Information System -- the LB5 form that is filled in at the Puskesmas level. It uses two basic forms: the three colorful coverage posters (DIS) which list each child, pregnant woman and eligible couple and notes appropriate data (immunizations, weighing, prenatal visits, contraceptive use) and prominently displays them on posyandu walls; and the reporting form to the Puskesmas which provides a means of calculating monthly coverage.

Unusual features that make this system potentially more effective than most other information systems in the country include: 1) coverage based (or status based) data; 2) rapid means of analyzing problems; 3) rapid feedback mechanisms to all levels. The system provides an easy means for kader to identify actual coverage levels in the community, rather than the traditional output measures of the health services. The use of coverage data shows clearly how many children must be immunized, etc. in any given month. It is based on a relatively accurate house to house census (which the kader in theory are responsible for in their PKK activities) rather than the DEPKES population estimates based on national inter-census reporting.

Because the data is based on actual month-to-month coverage, the system allows supervisors to determine the effectiveness of monthly activities in reaching target groups. The existing system reports cumulative process toward target estimates over the year, but does not measure monthly achievement of actual target groups.

The system allows provincial and kabupaten officials to compare coverage from each puskesmas to assist in identifying problem areas and to develop responsive plans of action. Through supervision, routine meetings and reports each level receives monthly feedback on how well they are doing in respect to targets and in comparison to other units.

The MONEV activities involved 1) design and provision of the two forms (DIS and Reporting Forms); 2) training of kabupaten and puskesmas doctors and some staff who in turn were responsible for training kader; 3) in Sumbar, the provision of computers at kabupaten level.

MONEV was initiated in two of the three provinces: Sumbar and Aceh. In Aceh the program was only recently initiated and therefore many of our findings reflect the start-up situation. In Sumbar, where the program was implemented for over a year and a half, we have clearer evidence of the impact and effectiveness of the program.

Comparing the situation in both provinces we see that 90%? of the posyandu in Sumbar were using MONEV while only 30% ? in Aceh had initiated the system. While the system in Aceh did not have time to demonstrate impact on several key dimensions, we did see in Sumbar that the system was almost universally perceived as effective. One measure of success was that it appears to have assisted in improving the general LB5 reporting. With kader providing MONEV information more consistently than they had been providing the data necessary for LB5, it appears that the Puskesmas were now more reliably sending in the LB5 reports. The MONEV was also seen as producing useful feedback to the puskesmas and posyandu levels. Even though MONEV implied some extra work for kaders and for puskesmas staff, it was perceived by respondents as being worth the extra effort; in other words, in terms of their time it was seen as cost-effective. In addition, respondents in Sumbar felt that the kader had sufficient skills to fill in the coverage list (DIS), while in Aceh, where the kader were just learning how to use the forms, the respondents were more skeptical.

In both provinces, respondents were satisfied with the MONEV training and thought that MONEV was useful for achieving Posyandu goals. Respondents felt that MONEV was particularly effective for identifying outreach targets to increase coverage.

One difference was observed in the implementation of the program in the two provinces. In Aceh the tendency was for the kader to fill out the coverage posters (DIS) alone, while in Sumbar the puskesmas staff more often worked with the kader in filling out the forms. We have been informed that Aceh now is changing its procedures to encourage more combined efforts. This interaction will assist kader in properly filling in the forms and will likely encourage greater motivation in achieving targets. We find in other systems what frequent interactions between village volunteers and health staff encourages volunteer motivation as well as improving skills and accuracy of reporting.

We found also that the information used for filling out the forms tended to be the PKK activities involving the household census for the 10 household groups -- suggesting that MONEV is complementary to the other village activities of the kader.

General observations at all levels in Sumbar found high levels of motivation and very positive evaluation of the MONEV program. It seemed clear that those who used the system saw its utility for their own work as well as their supervisors -- an unusual situation for MIS systems in Indonesia in general. Kader found the system immediately useful for their own community work. It appears to have put the information that they were supposed to be gathering for PKK into a form that was immediately useful for their activities -- encouraging them to perform activities that previously had been left undone. The health officials also found that MONEV as a monitoring tool was useful for routine meetings and for identifying problems in a timely fashion. The feedback mechanism appears to also have been appreciated.

In Aceh there was more skepticism about the program. We think most of this skepticism is due to the normal process of initiating new activities and is likely to disappear as the program becomes fully implemented. However, observers suggested caution in two areas. The education levels of kader may be lower in Aceh than in Sumbar (although we have obtained no comparative evidence on this point) which

might make it more difficult for kader to fill out the DIS without assistance. Secondly, the Aceh MONEV forms may be slightly more complicated to fill out (since they list children's ages by month) suggesting a review of the forms might be useful after six months of implementation to see if the greater complexity is still a problem.

Costs: MONEV had a reputation as an extremely expensive program that would be difficult to sustain in Sumbar and Aceh, and impossible to replicate in provinces that did not have the benefit of CHIPPS funding. However, our cost analysis showed that MONEV was a reasonably priced program that could be sustained or replicated for approximately Rp. 3,900 per posyandu per year.

4. Nursing Field Training and Relawan

The second major CHIPPS focus was on nurses -- both field training activities and the use of graduates in an innovative program to promote posyandu activities, called Relawan.

a. Field Training

Field practice was introduced to Nursing School curriculum in the three CHIPPS provinces in order to provide a means of improving nurses' capabilities in community service. Prior to the field practice most of the curriculum had emphasized traditional curative practice. The program was initiated after several evaluations of the nursing curriculum had been implemented by Pusdiklat. In one province NTT, the field practice was actually started before CHIPPS but was maintained and strengthened by CHIPPS from 1983 to 1987, after which the program was supported by internal funding.

The center of the program was the establishment in 1982/3 of field practice component in the third year of the curriculum in SPK of all three provinces. This component was generally for two months, although it varied from 45 days to three months during some years. Throughout this period in the field nursing students would live in the communities. Usually their instructors would also live in the communities on a two week rotation, although shortage of staff in NTT meant that instructors rotated on a daily basis.

The students would begin the field practice with a house to house census to identify problems and select priorities to discuss with the community. They then would plan activities with the community and assist in implementation.

In all three provinces the field training was judged by SPK directors, teachers, students and Depkes staff to be an important experience which provided relevant skills for the nurses' future work in the community. Only in NTT where the field practice had been in operation before CHIPPS provided support did the respondents see no significant improvement from before the CHIPPS field training. Almost all the respondents thought that the experience was worth the extra expense and effort.

The respondents found the program particularly useful in developing skills for working in the community or puskesmas levels and for supplementing the curriculum with

practical real-life cases. They identified several constraints involving the interaction between the training program and the health officials at the Puskesmas level and with community leaders. Others noted transportation and funding problems.

Suggestions for improvements included: an exchange of information and students among different SPK schools in each province, better preparation before field practice, longer period in the field, and more involvement with local health staff.

Since field practice has been adopted as a national policy, observations on the sustainability of the program in the CHIPPS provinces is particularly pertinent.

In general the respondents thought that the program would have to be modified in three ways that might affect the impact and effectiveness of the program. Many thought that the period for field practice would have to be shortened from 60 days. Others were planning to select locations closer to the schools and to decrease supervisory visits by the field instructors. Most thought that such modifications would weaken the program. Shorter field practice would not allow sufficient time for the full process from data collection to implementation – especially in NTT where some respondents felt that there was insufficient time even in the current program. Choosing locations close to the school would make it easier for students to leave the communities during the training and would not give sufficient experience in remote areas where problems may be more acute. Supervision by field instructors was seen as crucial to the effectiveness of the program and better results were felt to come from continuous presence of instructors.

The financial plans for sustaining the program included charging additional fees from parents (either through direct fee or through transferring responsibility for food and transportation costs to the parents). Another option was gaining support from local governments. Indeed, during the evaluation two governors pledged to provide support in the next year's budget if no other sources could be found. Finally, support from other donors, in particular the Australian government, would be sought. While none expected to gain additional funding from the routine Depkes budgets, several respondents thought that funds for other SPK activities might be diverted to maintain this priority program.

Costs: We estimated that the costs to sustain or replicate the two month field training program would cost approximately Rp. 67,000 per student per month. If the program was shortened to 45 days, as some officials suggested was planned, our cost analysis suggested that little would be saved. The cost of a 45 day program would save less than Rp. 5,000 per student per month.

b. Relawan

The Relawan program grew out of two problems faced by the health officials in Sumbar and Aceh. First they were faced with a large number of nursing school graduates who were unable to find official government positions the first year after graduation. Secondly,there was a new national policy emphasis that had selected Sumbar as one of several provinces to accelerate the creation of Posyandu and called on all other provinces to improve posyandu performance. The relawan program was seen as a

means to address both problems. NTT did not develop a relawan program in part because they did not have a nursing student surplus.

In both provinces, the relawan program involved a short (five day) training period for graduate nurses to prepare them to work specifically at the posyandu level. It also provided Rp.45,000 per month to defray transportation costs. This incentive was, however, greater than the usual salary for nurses in the field. The relawan were promised priority selection for the following year staff openings in health facilities.

The particular innovation of this program is that it placed nurses primarily at the community level with responsibility for creating and/or supporting posyandu. Other nurses work primarily in the health facilities (puskesmas and puskesmas pembantu, or hospitals) and only secondarily participate in posyandu. Many relawan were assigned to work in the more remote areas where it was difficult for puskesmas staff to provide support for the communities.

There were two differences in the ways the two provinces implemented the program. Since Sumbar was an "accelerated" province, a major task for relawan was the creation of new posyandu, while Aceh emphasized the improvement of existing posyandu. Secondly, while Sumbar placed its relawan primarily directly in the villages (often remote villages far from puskesmas), Aceh tended to place them in puskesmas or puskesmas pembantu to serve the nearby communities.

Our sample of respondents found that, compared to other health staff with more experience in the field, relawan were more effective in performing their major tasks of community organizing and posyandu improvement, however, the relawan were not any better at diagnosis or treatment of illness.

We did find evidence that the posyandu that were created or supported by relawan in Sumbar were more effective than those without relawan in maintaining weight and immunization coverages.

On the negative side, some respondents expressed concern that jealousy over the higher income from the transportation stipend was creating a problem among other nurses. Others were concerned that relawan not be placed in hospitals after their service (as they were in the first year) since they were better trained for preventive and community activities.

In Pesisir Selatan, an innovative kabupaten in Sumbar, we found an unusual experiment in the use of relawan that allowed them to charge an additional Rp.700 to 1200 for providing treatment and drugs directly to the community (in addition to the usual Rp.300 charged at puskesmas for similar services).

These charges provided a relatively high income for each nurse and brought an additional 15% income to the puskesmas. Relawan were seeing approximately 2-3 patients a day, in addition to their primary activities at posyandu. Since there was no discernable change in attendance at the puskesmas, most of these patients probably would have been lost to the health system.

epidemiological approach displayed the most rational drug need based on reported disease patterns and the standard therapies for those diseases. The consumption approach showed how to better estimate actual utilization and to account for stock-outs and lead time in planning. Comparison of both methods would show how "irrational" the current utilization pattern was and provide a basis for incrementally shifting drug orders toward the more rational standards.

The training program also provided techniques to improve drug distribution, inventories and storage practices.

In general the participants in the drug management training programs felt that there was improvement in drug provisions in their units after the training program, although about one quarter of those at puskesmas level still thought that there had been no improvement. Those participants who had used their own data during training (87%) were particularly satisfied with the training. Some improvement in drug supplies was reported to have occurred after the training. In particular, we found that after the training provincial and kabupaten levels were less likely to provide unrequested drugs and more likely to provide the full drug order of the lower units than they were before the training. Almost all facilities had stock recording forms at the time of the interviews. Respondents had several suggestions for improving the training process by providing refresher training, greater use of own data, longer training sessions, and more follow-up by superiors.

In all provinces the respondents thought that planning methods had shifted from the traditional methods -- e.g. previous year's order plus 10% -- to the more complex methods that were taught in the training program: the epidemiological and consumption approach. We found that almost all our respondents were still involved in health planning and that the trained drug staff was not excluded from the process...

However, when we asked respondents to demonstrate how the use the two new methods (epidemiological and consumption approaches) to plan a drug order for chloroquine, we found some weakness in knowledge and skill. Many of the thirty one respondents did not attempt to answer the question, even though they had said that they used the methods in their own drug ordering processes. Of those officials who did attempt an answer, only three were able to give the correct answer.

We also found that the availability and utilization of standard therapy manuals and of guidelines for drug planning was limited. In general only half of the respondents had standard therapy manuals available in the health facility. The manuals and guidelines were least available at the puskesmas level where they are most needed to induce changes in prescribing practices.

In an attempt to determine whether there was significant improvement of prescribing practices, we examined records of the last 20 cases of diarrhea and common cold that were recorded at each puskesmas in the sample. We found little evidence that prescribing practices were following the standard therapies. In general antibiotics were still over-prescribed in both cases and oralite appears to have been under-prescribed for diarrhea.

Our evaluation shows that the participants felt that the training process had been effective and that there had been a perception of change toward better planning and management of drug supply. However, it is not clear that this training had a significant impact on actual planning techniques or prescribing practices. It is likely that drug management is such a complex process, dependent on changes that must occur at various levels and with various techniques that drug management training alone should not have been expected to demonstrate a significant impact in a short time period. Our study suggests that, as an initial step, additional efforts to provide manuals and guidance, especially at the puskesmas level, should be made and future training should involve a system of follow-up by superiors.

Costs: The drug management training program was implemented with considerable variability in each province. The amount of domestic and external consultant support, the numbers of officials trained, the amount of transportation necessary all varied considerably. Therefore, cost estimates ranged from Rp. 23,900 per person per day in NTT to 54,900 in Sumbar.

6. Organizational Effectiveness and Report Writing

Two separate training programs, one in organizational effectiveness and the other in report writing were initiated to strengthen administration of health programs in the CHIPPS provinces. Organizational effectiveness was implemented in Aceh and NTT, while report writing training occurred in all three provinces.

a. Organizational Effectiveness

The objective of this program was to improve management ability by developing skills of health officials in identifying problems of organizational effectiveness and developing strategies for resolving these problems. This program was designed especially to improve the management of programs that involved the Kanwil and Dinas or the Kandep and Dinas where both the Ministry of Health and the provincial or district governments shared responsibilities for implementing health programs. Central to the training was analysis of roles and tasks, improving superior-subordinate relations, enhancing inter-departmental cooperation.

In Aceh, the program trained 155 people from province and kabupaten levels in five separate five-day training sessions from 1987 to 1989. In NTT one session in 1986 trained 15 people from the province level only.

In general the respondents to our survey found the training to be useful. 80% in Aceh and 67% in NTT felt that they had been able to implement follow-up activities resulting from the training. Over 70% in both provinces felt that inter-program cooperation had been improved by the training. Almost all felt that the training would be useful for officials at lower levels.

In open-ended responses the respondents felt that the training had been particularly useful in developing clear task assignments for subordinates, strengthening work discipline, and developing better working relationships among implementing units --

especially between Dinas and Kanwil and between Dinas and Kandep. The respondents felt that major constraints that inhibited implementation of the skills they had learned were 1) misunderstanding and jealousy from officials and units that had not participated in the training, 2) lack of support from superiors, 3) lack of human resources, materials and funds to implement activities that were part of the training, and 4) low motivation of many staff members.

Suggestions for improving the course included: the use of more practical materials in problem-solving exercises, more capable facilitators, more suitable indicators for evaluation of the training, and greater follow-up and feed-back by superiors.

Costs. This program was estimated to cost between Rp. 40,900 and 55,600 per person per day to replicate or sustain

b. Report Writing

It was felt that improved skills in report writing would assist in the management of program activities and strengthen analytical skills in the use and presentation of data.

The program involved a five day workshop in each province in 1987. Participants learned general approaches to report writing (outlines, systematic presentation, brevity, timeliness) and practiced on examples of their own previous reports. In Aceh and Sumbar the training involved department heads at the province level, while in NTT only the staff was trained. A total of 30 people were trained.

Most of the respondents found that the training was useful in helping them write good reports -- systematic, clear, brief and logical -- they also felt that the quality of the reports of others had improved. In Aceh and NTT respondents tended to feel that the training had improved the frequency and timeliness of reports. (In Sumbar, frequency and timeliness was not emphasized in the training.)

When asked to describe the key elements of good report writing, almost 70% could still identify this content of the course. Almost all reported constraints on effective report writing -- including lack of data, lack of motivation, delays from subordinates, and lack of understanding of superiors.

Suggestions for improvements emphasized the need to focus on practical cases and more follow-up and refresher courses. A key recommendation was that other levels be given similar training and that superiors be taught "How to Read a Report" and give feedback.

Costs: To sustain or replicate this program our estimates varied from Rp. 89,000 per person per day in Aceh to Rp. 106,000 in NTT.

B. Inter-Province Comparisons

To follow up on the survey and financial analysis we prepared three indicative evaluations of potential impact of CHIPPS on health planning, service delivery, and

showed a 100% improvement in attendance at deliveries over the five years, while the control provinces showed only a 31% to 48% improvement. For indicators of family planning and prenatal care, however, there was no clear trend.

We also evaluated the proportional use of oralite for diarrhea cases in 1987 (there were no figures for before CHIPPS) and found the CHIPPS provinces again to have higher rates of utilization than the control provinces.

3. Drug Ordering

We attempted to evaluate the rate of improvement of CHIPPS provinces in drug ordering, expecting that drug management training would result in a decline in the provincial drug orders for anti-biotics. Our data was incomplete, because only two of the three drug ordering lists are routinely collected at the national level. Our findings, with only 80% of the total estimated drug orders, did not find significant trends that would support or reject our hypothesis.

4. Conclusions of Inter-Province Comparisons

For the comparisons where we had sufficient data to compare CHIPPS provinces to control provinces, the general trends were suggestive of a greater improvement of health planning and service delivery performance in CHIPPS provinces. While there may be a variety of explanations for these findings, they suggest that CHIPPS was a major influence on these improvements.

V. RECOMMENDATIONS OF FINAL PROCESS DOCUMENTATION SEMINAR

This section is a translation of the final recommendations adopted by the Process Documentation Seminar -- June 1989.

A. Overview

Based on the review of the evaluation results of CHIPPS the seminar approved a set of recommendations for each of the areas of investigation. These recommendations

- the on-going problem,
- the recommended activities to resolve the problem,
- the current policies and needs for policy modification when necessary, and
- the conditions necessary for implementing the recommendations.

The following is a summary of these recommendations.

B. Recommendations for Improving Information Systems

Ongoing problems of the current information system (SP2TP) include:

- the lack of knowledge and skills in collecting, processing and utilization of data by health officials;
- lack of information on the real targets of Posyandu program, especially the information necessary for monitoring monthly status as a management tool at all levels.

1. The seminar recommends:

   National program of epidemiological and data management training involving a program of regional training of provincial training teams, training of kabupaten training teams, and a curriculum for pre-service training.

   Current policy favors this recommendation and does not need modification.

   Conditions necessary for implementation:

   a) commitment of Echelon I

   b) development of training materials

   c) budget for training

d) cooperation between DEPKES and Ministry of Education for Medical School curriculum

2. The Seminar Recommends:

National development of a new monitoring tool to be added to the current system (SP2TP) and integrated with PKK to monitor status and condition of the targets of Posyandu program.

Current policy would have to be modified to focus on monitoring real status of target groups.

Conditions necessary for implementation:

a) Director General of Community Medicine should issue new policy statement

b) Development of agreement among DEPKES, PKK, BKKBN on forms

c) Budgetary support for printing forms and for initial orientation in each province to be sought from local government.

C. Recommendations for Organizational Effectiveness and Organizational Development

Continuing need for management training integrated into current training system.

1. This Seminar Recommends:

Continue and expand the CHIPPS-developed Organizational Effectiveness/ Organizational Development training activities and integrate them into the current in-service training programs of Pustiklat.

Make better use of existing Health Management Trainers already in provinces.

This recommendation requires no modification of current policy.

Conditions necessary for implementation:

a) Commitment to improve kabupaten management

b) Use of existing training modules

c) use of existing Health Management Trainers

D. Recommendations for Drug Management

The CHIPPS drug management program had some effect on improving ability and motivation of drug managers but because it was narrowly focused it was insufficient for addressing the prescribing and supply problems.

1. This Seminar Recommends:

   Sustain and replicate the drug management training, especially for Kabupaten level

   Current policy need not be modified.

   Conditions necessary for implementation:

   a) Publish Implementing Guidelines

   b) Develop drug management trainers at Pusat level

   c) Budgetary support for training

2. This Seminar Recommends:

   Improved utilization of Standard Therapies

   Standard Therapy is already national policy.

   Conditions necessary for implementation:

   a) Implementing Guidelines

   b) Budget

   c) Compliance of Drug Prescribers

3. This Seminar Recommends:

   I.E.C. for Rational Drug Use for Providers and Patients

   Conditions necessary for implementation:

   a) Implementing Guidelines

   b) Facilitators

   c) Media

4. This Seminar Recommends:

Improvement of SP2TP forms for reporting drug use

Need policy to revise SP2TP forms

Conditions necessary for implementation:

a) support of related programs

b) trained human resources

c) draft revisions

5. This Seminar Recommends:

Placement of Pharmacy Assistants at Puskesmas level

This is current policy.

Conditions necessary for implementation:

a) need official positions (formaci)

E. Recommendations for SPK Field Practice and Use of Nurses in Remote Areas

Current problems:

Health system needs to emphasize the community diagnosis approach.

Health services in remote areas is insufficient

Recent nursing graduates remain unemployed for at least a year due to delay in hiring process and continued surplus production of nurses.

1. This Seminar Recommends:

National implementation of two month field practice that emphasizes community diagnosis approach:

- integrated with puskesmas and local government
- with active role of teachers in the field
- coordinated and evaluated by Kanwil

Current field practice policy is directed toward individual and family practice rather than community diagnosis and is only for one month.

Conditions necessary for implementation:

a) Change national policy to emphasize community diagnosis and two months

b) sufficient teachers with skills in community diagnosis

c) Puskesmas doctors and staff need training in community diagnosis approach

d) local government and parents assume part responsibility for funding program (@ Rp. 38,000 per student per two month period)

e) Kanwil assume responsibility for coordination and evaluation

2. This Seminar Recommends:

National program to place recent nursing graduates in remote communities.

- the communities should support the nurses through a social financing mechanism, not fee for service.
- nurses should be permitted to provide simple treatment.

There is currently no national policy on unemployed recent nursing graduates. Current policy for community level positions is only for midwives.

Conditions necessary for implementation:

a) Change in national policy through Implementing Guidelines to allow placement of graduates and practice of simple treatment

b) community interest and active involvement

c) sufficient resources and ability for social insurance

F. **Recommendations for Management of Foreign Assistance Projects**

CHIPPS experience suggests need to improve:

a) program management at Pusat level

b) decentralization of project to kabupaten level

c) financing mechanisms

d) flexibility in funding

e) more responsiveness to province needs

Condition necessary for implementation:

a) need Implementing Guidelines